

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNFERMLINE

DETERMINATION

of

Sheriff Ian D Dunbar, Sheriff at Dunfermline

in Inquiry into the death of

WILLIAM AITKEN LILLY

Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

DUNFERMLINE 8 April 2009.

The Sheriff, having resumed consideration of the cause, in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 determines as follows:-

- (a) William Aitken Lilly, date of birth 27 August 1944, died between 13.30 and 16.30 hours on Saturday 25 June 2005 at the River Forth in an area adjacent to the Forth Road Bridge.
- (b) The cause of death was multiple injuries as a consequence of a fall from height.

NOTE

In this matter the Crown was represented by Ms Yousaf, procurator fiscal depute. Mr Stewart, Solicitor appeared for NHS Lothian and Mr Jessiman, Solicitor appeared for Dr Lefevre. It will become obvious in the course of this Note that it was only thanks to the co-operation of these parties that a full picture was presented to the Inquiry and I am grateful to them for the parts they played.

I would also extend my sympathy to Mrs Dean. The evidence painted a sad and often distressing picture of a very difficult period in her life. That she has apparently managed to get on with life says much for her strength of character. It is little short of a disgrace that she has had to wait so long for this matter to come to court.

Before I deal with the evidence and the conclusions which can be drawn, I wish to say something about the preparation of this Inquiry by the Crown and the time it took to get the matter before the Court. The purpose of doing that is to make sure that this case (and one other with which I am currently dealing) is brought to the attention of the Law Officers so they might enquire as to the reasons for the considerable delay and the apparent lack of preparation of the case. In saying that, I exempt completely from any criticism the procurator fiscal depute who ran the case in court, Ms Yousaf and the current District Procurator Fiscal Ms Dalrymple. Once in post the Procurator Fiscal ensured that this and other Inquiries were given priority and allowed the depute involved time and resource to prepare. In this case, Ms Yousaf apparently had a woefully inadequate file of papers when the case first came to court in October 2008 but in the end of the day was able to present a full and well conducted case to the court.

Mr Lilly died on 25 June 2005. The Crown expert witness was Dr John Callender and his report is dated 5 November 2007. That gap of nearly two and a half years remains unexplained and it was still mid-July 2008 before any application was made to the court to hold an Inquiry. Even then, only one day was requested. At a pre-Inquiry hearing Ms Yousaf was completely frank about the absence of preparation. Even the medical notes were not with the Crown until Mr Stewart handed them over. They had or at least some of them had, however, apparently been sent to Dr Callender which begs the question of what happened to them thereafter. There was also, apparently, a distinct lack of statements from witnesses or potential witnesses. It appeared to me that but for a good deal of co-operation from Mr Jessiman and Mr Stewart, the Crown may not have been able to prepare the case to any satisfactory standard.

We convened on 17 October 2008 when we heard the evidence of Mr Lilly's widow, Adrienne Wendy Lilly who has now re-married and her married name is Dean. We thereafter adjourned having identified that approximately one further week would be

required. This allowed time for the matter to be more fully prepared and diaries of the various doctors to be consulted. We sat again from 9 to 13 March inclusive and, thanks again to co-operation amongst the parties, we were able to conclude the evidence and hear submissions. I am grateful for the detailed written submissions prepared.

The upshot of this whole delay is that Mrs Dean has had to wait for nearly four years for the matter to come to court and, regardless of how well she presented when giving evidence, it cannot have been easy for her to speak about the very sad, indeed, tragic events and circumstances leading up to and culminating in the death of her husband. Equally, the whole medical team at the Royal Edinburgh Hospital have had the prospect of this Inquiry and possible criticism of their professional judgement hanging over their heads for nearly four years and that is neither right nor fair.

These comments will not come as a surprise to the parties involved in the Inquiry and they are made in this Determination in the hope that the Crown gives serious consideration to the shortcomings in this case and the apparent lack of urgency or prioritisation of this, and possibly other, Fatal Accident Inquiries. I repeat that those currently involved have done their level best to progress this and at least one other long outstanding Inquiry which I am presently hearing.

The evidence.

- (1) We heard firstly, on 17 October 2008, from the widow of the deceased, Mrs Adrienne Wendy Lilly (now Dean). Thereafter we adjourned until 9 March 2009 and from then until 12 March we heard from Mrs Victoria Wiewiorka, an occupational therapist with the Northwest community mental health team who was based at the Inverleith Day Unit (IDU); Diane Bostock, a staff nurse at the Royal Edinburgh Hospital; Stewart Marshall, a nursing assistant there; Katriona Paterson, a senior staff nurse, Dr Jane Walker who was then a Senior House Officer but is now a research fellow at the University of Edinburgh based at the Western General Hospital with the grade of honorary consultant; Dr Peter Lefevre, then and now a consultant psychiatrist and now also clinical director and Dr Nathan Langsley who was then Specialist Registrar and who is now a

consultant psychiatrist in Midlothian. The Crown led as an expert witness Dr John Callender, consultant psychiatrist at Royal Cornhill Hospital, Aberdeen and Associate Medical Director, NHS Grampian Mental Health Services. Mr Jessiman led Professor Anthony Pelosi, consultant psychiatrist and honorary professor in the department of psychiatry at the University of Glasgow. It is appropriate to record that I considered that all witnesses to fact gave their evidence well and to the best of their recollection although in the cases of Mrs Bostock and Mr Marshall their memory of events was dimmed slightly by the passage of time. The two expert witnesses were also very clear in their evidence but each held a particular view about aspects of the case. I will comment on this shortly.

- (2) The facts and circumstances in the time before Mr Lilly's death are fairly clear and not really in dispute. Mr Lilly was an electronic engineer latterly working for British Aerospace and was dedicated and committed to his work. While the exact dates are not clear it seems that from some time before early 2005 he was aware that the company were conducting an early retirement/redundancy programme. He was selected for early retirement a step which his widow described as devastating for him and once he knew it was coming he did not know how to face the world or how he would cope financially despite all efforts by Mrs Lilly to reassure him they would not have any financial problems. Mrs Lilly had seen signs that her husband was becoming unwell three to five years before this. He was introverted, sullen, not coping, not sleeping well and a bit anti-social. He saw his GP and was occasionally prescribed sleeping tablets or sedatives. In addition, his mother who had suffered from dementia, died in April 2004 and this had an effect on him. Mrs Lilly remembered clearly returning from the funeral when her husband stopped the car on the Forth Bridge and made a comment about never letting himself become like her (his mother).
- (3) In April 2004 Mr Lilly was referred by his own general practitioner to the community mental health team and was seen by a senior occupational therapist. A plan was discussed but Mr Lilly decided to deal with any problems through his GP. His mental health continued to be a cause of concern and deteriorated to the extent that in March 2005 the GP sent him as an urgent referral to the Mental

Health Team. He was seen by Dr Walker on 16 March 2005 and she sent a report to the GP dated 24 March 2005. Reference had been made to increased depression and thoughts of suicide. Dr Walker carried out a detailed psychiatric examination wherein she elicited some suicidal thoughts but Mr Lilly said he did not intend to carry them through. The plan was to see if an increased dose of antidepressant medication would lead to improvement. When she reviewed Mr Lilly about three weeks later (9 April 2005) there was no improvement.

- (4) Mrs Lilly was extremely concerned about her husband and was unhappy that he was not being kept in hospital as she thought he was “on a path to self destruction”. She wrote to Dr Walker (Crown Production 15) outlining her concerns. The letter is not dated but it is clearly written before there was any admission to hospital. The letter states in some detail her concerns and worries. It states that his mother died on 14 April 2004 and that he was emotional and concerned as to how to commemorate the anniversary. It is also relevant that Mrs Lilly’s mother, aged 85, was ill, suffering from dementia and in hospital. There was ongoing discussion about a care package to allow some independent living. That too was causing stress to Mrs Lilly. In the end of her letter she said she was at her wits end and, having heard the evidence, it is easy to understand why that should be.
- (5) On 14 April 2005 Mr Lilly presented as an emergency at the Royal Edinburgh Hospital and was seen again by Dr Walker. She carried out a detailed psychiatric assessment and her notes form production 1.52 for the Crown (also marked note 4). Suicidal thoughts were again noted but Mr Lilly said he would not go through with it because of his love for his wife. Dr Walker decided that there should be an admission to the inpatient unit. The next day Dr Lefevre reviewed Mr Lilly and diagnosed mild to moderate depression. Changes were made to his antidepressant medication and he was to be referred to the IDU for ongoing work. There was a review by the whole multi disciplinary team led by Dr Lefevre on 19 April and he was discharged thereafter with the plan being that he should attend the IDU and the outpatient clinic. The IDU contacted him the next day and he was seen by Margaret Anderson on 22 April. That meeting is noted at Crown production 9.

She noted that he was “*concrete in his thinking*”, blaming the system for his problems. He banged his fist on the table two or three times, spoke about losing everything including financial security and could not be persuaded otherwise. A plan of action was put in place for activities on four days a week starting on Monday 25 April 2005. He attended and the note is Crown production 1.112 (also highlighted at 9). That describes him as being at times angry, tearful, acting in a hysterical manner, not coping, concerned about his relationship with his wife and financial worries. It stated that he described himself as a “useless bastard”.

- (6) The following day, another occupational therapist, Victoria Wiewiorka, called Mr Lilly at home and was told by him he was coming into the Unit. Shortly afterwards Mrs Lilly contacted the Unit to see if her husband was there as he seemed to have disappeared and left what appeared to be a suicide note. What seems to have happened is that Mr Lilly had gone into the centre of Edinburgh and had sat on the parapet of the North Bridge before jumping down to the pavement and then running down to Holyrood Park. He was found by the police in the vicinity of Arthur’s Seat and taken to hospital for assessment. He was seen by Dr Walker with Mrs Lilly present for the latter half of the interview. In her report to the GP (Crown production 11), Dr Walker describes “*ambivalence (ambivalence?) regarding suicide, at times feeling that this was the only option and at other times felt this was not a good idea*”. Mrs Lilly tried to reassure him on their financial situation but he could not accept it and at times he became agitated bordering on aggression. There was a discussion about the options, attending the IDU or another admission to Ward 6 at the Royal Edinburgh Hospital. Mr Lilly was not keen on admission and although it was noted that he remained at risk of self harm many of the risk factors were not amenable to change through hospital admission. He was accordingly released to attend the IDU and the Clermiston Health Clinic for review. Mrs Lilly said that she was “very, very unhappy” at that decision and she relayed that to Dr Walker. She felt her husband was a risk to himself. She felt strongly that her husband was putting on a façade to medical staff and that the real position only manifested itself with her. She tried to convey that to Doctors but did not feel she was being listened to.

The occupational therapists were sufficiently concerned about this release that they drafted a letter to Dr Lefevre (Crown production 13). The letter was not sent by the team leader but the contents were given to Dr Lefevre by her and he acknowledged he was aware of them. The two therapists expressed serious concern at the suicide risk posed by Mr Lilly and felt they would be unable to contain that in the community. They were also concerned for Mrs Lilly. Ms Wiewiorka confirmed her view in evidence when she said that she *“had rarely met anyone so focussed on self-destruction”*. She did also say that in retrospect she did not think it would have made any difference if he had been an in-patient as he was very focussed on his own death.

- (7) Mr Lilly attended the IDU most weekdays for psychological and social/occupational therapy intervention. He was variously recorded as being angry or anxious. There were some confrontations with his wife. Arrangements were made for him to see a psychologist. On 11 May he was noted as saying that the IDU was “paradise” as he could forget his troubles there. That remark may be of some significance when read along with some of the later evidence about the stresses arising when he was with those he loved most.
- (8) On 13 May Mr Lilly was admitted as an emergency to the Royal Infirmary of Edinburgh having taken an overdose of various prescribed medicines. The accounts of the circumstances leading up to this differ slightly. Mrs Lilly said that on that morning she had arranged to take her mother to go to look at a care home and she asked her husband to accompany her. He did not want to go and did not want her to go. She said she had to do it and would only be an hour or so. In the hospital records Mr Lilly is said to have described a row with his wife over financial worries and the health of her mother. Significantly he also said he did not find the IDU as being any benefit and he described it as “tea and biscuits”. On her return Mrs Lilly went into the house and heard strong snoring from the upstairs bedroom. When she got no reply to shouts she went up and found her husband on the bed surrounded by empty packets of pills. He was in a very deep sleep. She could not rouse him. An ambulance was called and he was taken to hospital where he remained for some days. He required to be intubated and

artificially ventilated. He was assessed by Dr Prakash, a psychiatrist based there, who consulted Dr Walker who agreed Mr Lilly should be admitted to the Royal Edinburgh Hospital, Ward 6. He was admitted there on 17 May 2005 and remained a patient in that ward until his death. During the whole period he was a voluntary patient.

- (9) The medical notes regarding this period are full and show a varying picture. At the time of admission he was noted by Dr Walker to have a potential for suicide and to be “*currently detainable*”. He was subdued but built up relationships with doctors and staff. His mood gradually improved. Mrs Lilly raised concerns that her husband was very different when with her. He was putting on a façade for the benefit of the medical team but the true position was only evident when he was with his wife. Dr Walker said that she was aware of that but did not think he was trying to pull the wool over their eyes. There were people about him all the time and to keep up a pretence for such a long time would have been difficult. He did say that he found being at home difficult. Mrs Lilly felt so strongly about the apparent façade that she wrote to Dr Lefevre on 22 May 2005 (Crown production 1-138). The terms of that letter are quite stark and she concluded it by saying “*I think he is on the road to self-destruction and I need you to be fully aware that what you see in hospital is not the true picture once he leaves the secure confines of the hospital or the clinic*”. The notes make it very clear that his mood varied sometimes even in the course of the same day. There are regular references to the fact that there are no current suicidal thoughts but at the same time he was said to be a significant suicide risk. His status regarding passes also varied from time to time. Mrs Lilly was concerned that he was receiving unescorted or “negotiated” passes in case he would harm himself when away from the hospital. An entry of 26 May shows a discussion involving Dr Walker and Mr and Mrs Lilly when diagnosis appears to have been discussed. His depressive symptoms were described as a reaction to his current social situation, he had no current biological symptoms of depressive illness and no current suicidal thoughts. At that stage it was decided he should have negotiated passes.

(10) The next day Mr Lilly had argued with his wife in the car, had locked her in it and she had become very distressed. She advised staff at the hospital she needed some space and was going to visit her son in England. Mr Lilly did not want her to go. She said he telephoned her when she was on the road. For some reason various members of staff seemed to think that the marriage was in trouble and that the Lillys were talking of a trial separation. There is no doubt that Mrs Lilly found it all a considerable strain but I can find no reference at that time to her suggesting that she was going to separate from her husband. Nevertheless the idea that there was matrimonial difficulty and a possible separation in the offing was something that was spoken to in evidence by medical witnesses. (The first note of it is in fact on 22 June). At this time Dr Walker noted that there were no current suicidal thoughts but there was a significant suicide risk. Passes were changed to staff escort. Two days later he was noted as pacing the corridors and self-isolating. On 30 May he said he would be safe in the grounds and a two hour escorted pass was agreed. If that went well he would have unescorted passes home. He planned to do things in the house and garden in readiness for Mrs Lilly returning from England. On 1 June he went home although escorted and was anxious and complained of palpitations and shakiness. He was tearful and upset at an email received from Mrs Lilly's son. She described this as an attempt to persuade and reassure her husband that there were no financial difficulties but he perceived it as raising an issue of trust. Dr Walker saw him and described him as more positive which seems surprising given his reaction to the visit home.

(11) On 2 June he described his situation as unreal. On 3 June he was said to have been more positive about the future and denied any suicidal thoughts. Nurses reported him as brighter and displaying a sense of humour for the first time. On 4 June he was downcast and preoccupied but on 5 June relaxed and calm in the morning but very negative in the afternoon. On 6 June he saw Dr Walker and said he was in a low mood. On 7 June there was a meeting with Mr and Mrs Lilly when he seemed to be more positive and could talk about the future. There was a plan for passes from the ward with Mrs Lilly and to recommence attendance at the IDU. However on 9 June he was found sobbing on his bed and described things as

hopeless and negative. On 10 June Mrs Lilly had told staff she could not cope when he was in the state he was in the previous day. Later she telephoned Dr Walker saying that he had expressed thoughts of jumping from North Bridge and he was not coping at home. Mr Lilly confirmed to Dr Walker that he was feeling hopeless but denied he intended to carry out any of the thoughts. The next day he was out with staff for a haircut and was said to have joked with them yet on return was anxious about the future.

(12) On 13 June he was noted to have fluctuations in mood. Mrs Lilly had visited on 12 June but left as she was frustrated or upset by the continual negative comments. The ward round records continuing thoughts of suicide and that he had been on escorted passes the previous weekend. Both Mr and Mrs Lilly had expressed concern that medication was not working and a change was made. On 16 June he was still negative and unable to guarantee safety in the long term but still denied any suicidal ideation. On 18 June he was said to be struggling at home and complaining of anxious, nervous feelings. On 20 June he was preoccupied by finance. On 22 June he was taken to the IDU by Mrs Lilly who reported that he had remarked along the lines of *“why don’t we cut each other’s throats?”* This comment had been heard at the IDU and recorded by staff who told staff at ward 6. He returned from the IDU unescorted and on a bus. The note by Staff Nurse Paterson says *“Time spent with Bill and Wendy on return. Bill continues to block any positive suggestion and won’t take responsibility for behaviour. Wendy is now requesting a trial separation and ‘space’. She has requested Bill does not contact her.”* That is the first mention I can find of any reference to a trial separation. Later it is noted that he looked pale and “defeated” although it maybe should be “deflated” and he spoke of being very stupid. The next day Dr Langsley decided he should continue to go to the IDU. On 24 June Dr Walker recorded that there was still a low mood and he was concerned at his relationship with his wife. There were no ongoing suicidal thoughts and she recommended that negotiated passes should continue.

(13) On 25 June nursing staff noted he was feeling very low and had no motivation to do anything. He did eventually get organised and got a pass to go

into town. In the event he went to the Forth Road Bridge where he fell to his death. At around 16.30 that day Dominic Walczak was cycling across the Forth Road Bridge on the westbound footpath when he looked over and saw a body floating in the water. The body was extracted from the water and was later identified as being that of William Aitken Lilly.

Submissions

- (14) I am obliged to the parties for their written submissions. Mr Jessiman and Mr Stewart produced detailed submissions which I do not propose to set out at length. All parties were in agreement as to the findings which should be made under section 6(1)(a) and 6(1)(b) of the 1976 Act and I agree with their submissions. Ms Yousaf suggested that there could be a finding under section 6(1)(c) relating to passes and reassessment of Mr Lilly's mental state following the comments he made to his wife on 22 June. She also suggested that under section 6(1)(e) that there could be finding that more cognisance could have been taken of the verbal and written communications of Mrs Lilly that he was on a road to self-destruction and at high risk of suicide. In supporting this she simply said that the issue was whether his death could have been avoided.
- (15) Mr Jessiman's submission opens with a statement of what he sees as the law relating to the function of the Sheriff in a Fatal Accident Inquiry. In doing so he made reference to:- *Carmichael on Sudden Deaths and Fatal Accident Inquiries 3rd edition*, *Black v Scott Lithgow Ltd 1990 SLT 612* and the *Determination of Sheriff Stephen at Edinburgh Sheriff Court on 27 February 2004 in the death of Lynsy Myles*. I do not take issue with any of the proposition he puts and in particular I agree with Sheriff Stephen's statement "*I specifically reject the submission that the nature of a Fatal Accident Inquiry and of the associated statutory requirements is such that I can make findings under section 6 based upon hindsight. Inquiry into a death whilst undergoing medical treatment is a significantly different concept to an Inquiry into say a catastrophe at work where the facts surrounding the incident are susceptible to inquiry with the use of*

common sense and logic. Medical issues depend on the presentation of the patient, and the clinical judgement of those treating the patient, having regard to all the circumstances which prevailed at the time both with regard to the patient and the standing experience and field of expertise of the clinicians.” Thus hindsight should not be used and the Sheriff would should be satisfied from the evidence that a party did not act reasonably and that there was a real possibility that the death may have been avoided by a reasonable precaution. Mr Jessiman was critical of Dr Callender and suggested that his view was dictated by hindsight. His suggestion that the medical team either misled themselves or became fixated on their diagnosis of mild to moderate depression was not borne out by the evidence.

(16) Mr Stewart went even further in his criticism of Dr Callender stating he regarded his report and evidence as “worrying”. He was dogmatic and inflexible. Like Mr Jessiman he asked that I consider Professor Pelosi’s report and evidence to be a much better and fairer assessment. I was clearly faced with a conflict between two expert witnesses and he suggested that the approach of the civil courts in such cases was a relevant consideration. He referred to the judgement of Lord Hodge in *Honisz v Lothian Health Board and Others* [2006] CSOH 24. Following the tests set out there I would have to determine that the evidence of the four main factual witnesses and Professor Pelosi was illogical before preferring the interpretation of Dr Callender. Mr Stewart went on to suggest that the treating doctors have had the Inquiry hanging over their heads for several years and they have also had Dr Callender’s criticisms for some time. If I accepted the evidence of Drs Lefevre, Langsley and Walker along with Professor Pelosi and Katrina Paterson I should make a finding that the care was of an impressively high standard. He pointed to communication described as “faultless”, intensive treatment at the IDU as “of a very high quality” as was the treatment during the second admission.

(17) I did have the benefit of two expert reports and the evidence of their authors, Dr Callender and Professor Pelosi. There were significant differences between them with regard to interpretation of events and notes and how they

would have respectively dealt with such a case. It was clear that different consultants will operate with their teams in different ways. Also, different terms are used in different hospitals to describe such matters as passes. Dr Callender said both in his report and in evidence that he was conscious of the danger of looking at matters with hindsight and in the knowledge that there has been a tragic outcome. I find it puzzling that Dr Callender can, on the one hand, find so many faults with the diagnosis and treatment of Mr Lilly yet Professor Pelosi had no criticisms in these areas and indeed spoke with high praise of certain aspects of the treatment. I share the concerns of Mr Jessiman and Mr Stewart about Dr Callender's somewhat dogmatic and inflexible approach. He could not, for example, be shifted from the view that Mr Lilly had a severe depression and that the three doctors were simply wrong in their diagnosis. He conceded that certain matters were for clinical judgement at the time by the treating doctor but still maintained they were wrong. In assessing suicide risk he said that he did not think enough emphasis was placed on certain factors and he would have said that there was a high risk. Is the assessment of suicide risk that not simply an exercise of clinical judgement? In dealing with the level of passes he agreed it was reasonable when suicidal ideation had been expressed on 10 June that passes were changed to escorted and then back to negotiated or standard four days later. His criticism of the decision on passes on 24 June was that there had been the incident referring to cutting throats and this was indicative of a more disturbed state of mind. Once again, from the evidence, there had been careful consideration by the treating doctors of his state of mind and pass level throughout. It was not clear in what way he thought that there was a difference between that mention of suicide and previous mentions of it.

- (18) Dr Callender was critical of the level of involvement of the senior doctor, Dr Lefevre. Once again the evidence does not bear that out and I accept the evidence about his day to day involvement. It has to be said, however, that if one was depending on reading the notes to check when or how often Dr Lefevre was involved outwith ward rounds, it would be difficult to find many references. However, in the context of a small team dealing with a small number of patients I

can see nothing to be gained by having to create an entry in the notes simply to record that the consultant had been in the ward. At times it was difficult to reconcile Dr Callender's report and evidence with what I heard in evidence especially from the clinicians. I also found the evidence of Katrina Paterson very helpful. She was clear, articulate and knowledgeable.

(19) I found Professor Pelosi's approach easier to follow in particular the idea that diagnosis of a level of depression was not as important as what was done about it. He was particularly complimentary about certain aspects of the treatment and sounded quite jealous at the speed at which some services were available to Mr Lilly when compared with the area of his authority. Once he had the opportunity of seeing Dr Callender's report his views did not change. He emphasised that diagnosis was a matter of clinical judgement although there were certain criteria such as ICD or DSM4 to give broad pointers. One of his final comments was that he was not sure there was more in the field of psychiatry which could have been done.

(20) In fact the analysis provided by both experts is much the same. Their differences arise in their opinions on diagnosis, where they agree or disagree with the courses of action adopted by the treating clinicians or with the apparent level of supervision at a high level. What I can say is that there is nothing illogical in the evidence of the four main witnesses, Drs Lefevre, Langsley and Walker and Ms Paterson. It is clear that careful consideration was given to Mr Lilly's case and that certain clinical decisions were made. Professor Pelosi supported these decisions. Dr Callender disagreed with some of them and, indeed, offered other suggestions. He raised the possibility of electro convulsive therapy (ECT). This is regarded as a fairly extreme measure and was never considered by those treating him. Professor Pelosi firmly disagreed with the use of ECT which he described as an extreme measure.

(21) A number of issues arise as a result of the evidence in this Inquiry. The first is the assessment of the level of Mr Lilly's depression and the treatment of it. This also involves the question of the level of involvement of senior medical staff and supervision. The second relates to the issue of passes, in particular the

question of the granting of negotiated passes on 24 June. The third is the question of communication with Mrs Lilly and, in particular whether or not sufficient attention was paid to her views on her husband's depression, his ability to deceive doctors, treatment, risk assessment and the granting of unescorted passes. Finally, whether or not there was a heightened risk of suicide immediately prior to 25 June 2005 and whether the assessment of that risk and the granting of passes were reasonable.

- (22) By their very nature, Fatal Accident Inquiries deal with sudden and unexpected deaths. In the vast majority of them, death is the furthest thing from the mind of the unfortunate deceased at the time it occurs. It is often the result of some catastrophic incident. What was in the mind of the deceased is rarely a feature of the Inquiry. In the present case, however, what was in Mr Lilly's mind in the weeks, days and hours before his sad death and the interpretation of that is at the heart of the Inquiry. It is that which makes it difficult to reach any hard and fast view about certain aspects. I have to rely on notes made at the time about what Mr Lilly was saying, feeling or doing, the evidence of his widow and the clinical judgements made at the time in light of the relevant information. The fact that two undoubted experts in Mr Callender and Professor Pelosi reached different conclusions from their interpretation of the notes illustrates the difficulty in such a situation.

Assessment of the level of depression

- (23) In looking at this aspect I heard evidence from all the doctors who were involved with Mr Lilly's care. It is worth noting the level of involvement of all medical staff in ward 6. As I understand it there are three "teams" in the ward each caring for a geographic area of Edinburgh. The ward has about 24 or 25 patients so each team has about 8. To treat these 8 or so patients there was a consultant, Dr Lefevre, a specialist registrar, Dr Langsley and a senior house officer, Dr Walker. Each team also had a dedicated team of nurses. By any stretch of the imagination the ratio of doctors and nurses to patients was high. While each of the doctors also had other responsibilities such as clinics or out-

patients, all were responsible only for the patients in their care in Ward 6. Dr Walker was in the ward every weekday. Dr Langsley was there three days a week and Dr Lefevre was either in the ward or available for discussion every day even if there was no formal ward round. It should also be noted that both Drs Langsley and Walker were close to the end of their periods in their respective posts. Dr Langley is now a Consultant Psychiatrist with Midlothian Healthcare and Dr Walker is a research fellow and Honorary Consultant at Edinburgh University. The medical team was experienced and it was clear from the evidence that the head of that team, Dr Lefevre, had confidence in the rest of them. There were regular meetings between Dr Lefevre and the other two doctors both from the point of view of patient care and their continuing professional development. In turn the two more junior members of the team spoke highly of their consultant. I accept all that from the evidence of the doctors. If there can be any criticism, and for the avoidance of doubt I do not think there should be criticism, it is that the level of involvement of Dr Lefevre is not always obvious from the notes.

- (24) Dr Walker first saw Mr Lilly on 16 March 2005 and she described him as *“currently suffering from a depressive episode that has been partially treated by antidepressant therapy but unfortunately has worsened again.”* She next saw him on 9 April and there is no record of her changing her views on the nature or extent of his illness. He was admitted as an emergency on 14 April and there is a full note (Crown production 1.52 and highlighted at 4) which does not contain any reference to an assessment of the level of his depression. He remained in hospital until 19 April. He was reviewed by Dr Lefevre on 15 April and a diagnosis was made of mild to moderate depression. Dr Lefevre was also present (along with Drs Langsley and Walker) at the ward round on 19 April when the decision was made to send him home and refer him to the IDU. The records from the IDU do not appear to suggest that there was any further or different diagnosis made. He was readmitted to ward 6 on 17 May following his release from the Royal Infirmary of Edinburgh after the apparent suicide attempt by taking an overdose of prescribed medication. The admission note (1.70) describes *“moderate depression for past 18 months”*. It is apparent looking at the notes that Mr Lilly

was constantly subject to assessment during his stay in ward 6. The notes, both nursing and medical are full and there appears to be a good system of communication between nurses and doctors on the one hand and amongst doctors on the other hand. There was also excellent communication between the IDU and the ward

(25) In his report and evidence, Dr Callender felt that there was sufficient information available for a diagnosis of a severe depressive illness to have been made. He suggests that the severity of the illness was underestimated by some of the staff who were responsible for him. He also said that Dr Walker “*did all that could be expected of someone at Senior House Officer level.*” In evidence he criticised what he saw as the lack of face to face contact by Drs Lefevre and Langsley with Mr and Mrs Lilly. He also said that the fact that the illness was more severe “*leaps off the page*”. In cross-examination he conceded that many decisions are matters of clinical judgement and his concern seemed to be a lack of evidence from the notes of more senior doctors coming in. It is clear that he thought Dr Lefevre’s only involvement was the initial ward round which was not attended by the patient. That is clearly wrong and it begs the question of how much of the medical file did Dr Callender have or has he misinterpreted ward round notes which clearly show the presence of a consultant? It has to be said that some of the ward round/multi disciplinary team notes do not have a completed attendance list which may well have led him to that conclusion. He also did not have the benefit of hearing evidence which disclosed considerable involvement at all levels, appropriate delegation and a suitable level of supervision.

(26) Professor Pelosi, on the other hand, took an entirely different slant on the notes as presented to him. He felt Dr Walker’s initial assessment was detailed and comprehensive. That was followed by the review by Dr Lefevre who diagnosed mild to moderate depression. He agreed that diagnosis is a matter of clinical judgement which can be guided to some extent by certain tools or tests available to the profession. These give broad pointers. Dr Callender’s view was that there was no sustained improvement but Professor Pelosi thought that there was fluctuation but overall the trend was improving but with setbacks. That was the

view of the treating clinicians. The stay in hospital was long (6 weeks) but the length of the stay was not determined by the diagnosis but by the risk. Any view about the level of depression did not affect the level of care. He also commented about the role of the doctors within the team. The SHO would take the notes (as seems to have happened more often than not here) but that does not imply no one more senior was not present.

(27) Dr Callender criticised the withdrawal of olanzopine and the lack of consideration of ECT. The doctors involved said that olanzopine was being used for its calming effects. It is an anti-psychotic drug but it was not being used for anti-psychotic treatment. There was no evidence of psychosis. Dr Callender did not appear to accept that it could be used as anything other than an anti-psychotic drug and suggested it should have been continued. Professor Pelosi said that olanzopine could be used for calming effects and that the dose here of 5mgs was a dose for such a purpose. For anti-psychotic treatment it would have to be 15 to 20 mgs. Dr Callender also suggested that ECT should have been tried and I have commented already on the view of Professor Pelosi. The fact was that it was never, according to the evidence or the notes, considered. If it is an extreme treatment as stated by Professor Pelosi, it may not have been appropriate for a mild to moderate depression.

(28) The differences between the two experts come down to a matter of interpretation. Both agree that clinical judgement is a vital factor. Neither criticises the clinical judgement of Dr Walker, indeed it could be said that she performed her role as SHO to a high standard. Dr Callender criticises the level of involvement of the more senior doctors while Professor Pelosi considers it adequate. I accept from the evidence that all the doctors were involved in decisions about Mr Lilly's care. The level of involvement seems to have been high. It is clear from the notes that he was constantly assessed even if there is no reference to any change in the level of his depression. While Dr Callender was critical of certain of the decisions taken regarding drugs, it is clear that regime was also under constant review. Dr Callender makes the remark at paragraph 71 that *"It is always difficult to assess in retrospect issues such as psychiatric*

diagnosis and suicide risk and to avoid this assessment being biased by knowledge of a tragic outcome.” He, on the basis of the information available to him, then concluded that there were pointers to the fact that Mr Lilly was severely depressed. He felt that this may have been given if there had been more direct involvement of senior staff. As I have said, I have concluded that there was much more involvement by senior staff than is recorded. It may be that some more could have been recorded but simply to note that there had been a discussion which led to no action seems to me to be pointless except to record that such a conversation had taken place. Given that there seemed to be agreement with the proposition that diagnosis is a judgement call for the treating doctor, it is not appropriate, with the benefit of hindsight and in view of the tragic outcome to say at this stage that a particular diagnosis was wrong. The reasons for the diagnosis and all the factors taken into account in ongoing assessment are well documented as is the level of contribution from the senior medical staff. I make no criticism of the assessment of the level of depression.

(29) Mr Lilly was being treated for some of the time with an anti-psychotic drug, Olanzapine. It was discontinued on 14 June. It had been used for its calming effect not for anti-psychotic qualities. There was no evidence that Mr Lilly’s illness was psychotic. Dr Callender seems to suggest he was but that may be because he was being prescribed an anti-psychotic drug.

(30) Equally it is clear from the notes and evidence that there was a good level of supervision. I must bear in mind that both Dr Langsley and Dr Walker were nearing the end of the periods they were to spend in their particular posts before moving on to more senior posts. Neither of them was inexperienced. They had the full confidence of their consultant, Dr Lefevre who spent time with them both formally and informally on both patient matters and professional development. I accept the evidence in that regard. I accept also that for the most part it is not noted but there is no reason it should be. I am fairly certain that if either Dr Langsley or Dr Walker felt for a minute that his or her professional development was not progressing due to any perceived lack or failing on the part of a superior something would have been done.

Issue of passes

(31) It was clear from the evidence of Dr Callender that passes from the ward go by different names in different hospitals. If I understand the position in ward 6, there were various levels of pass. Initially patients would be restricted to the ward until their condition was assessed. The next level was called an escorted pass. This could be escorted by staff or by family. It could be for a specific purpose or could be for a set time to allow, for example, time out with family. The next level was called negotiated passes. This allowed a patient to go out unescorted for a specific time or perhaps for a specific purpose. There could also be a time fixed by which the patient had to return to the ward. Where any patient was placed within the pass regime was a matter of judgement by doctors which was reviewed regularly. If a patient breached the trust of a negotiated pass that could affect his status until the next review. In the case of Mr Lilly it is clear from the notes that his pass status was reviewed regularly and changed from time to time. He did not abuse it. In other words, he had been subjected to changes in pass level when his risk had been re-assessed after, for example suicidal ideation. On restoration to negotiated passes he had conformed to the rules. Was there any reason to think that 25 June would be any different?

(32) Looking at the records from 1.81 onwards passes are mentioned many times. On 20 May the plan was half hour escorted passes. This seems to have been both with staff and Mrs Lilly as there is an entry on 25 May of a call from Mrs Lilly to make sure he had returned after she dropped him off. At a review on 26 May he moved to negotiated passes. The same day he went home for the day. However the next day, following an argument with Mrs Lilly he was placed on staff escorted passes. This was the time when Mrs Lilly went to England to visit her son. On 30 May it was arranged he would have an escorted pass to the house (Mrs Lilly was still away) and if all went well unescorted passes home. He was allowed half an hour unescorted in the grounds. On 1 June he went home and was

tearful and upset. Nevertheless he was given a one hour unescorted pass. On 3 June Dr Walker recorded 5 hours unescorted to go home. On 6 June passes were to remain as before, 5 hours maximum. He was then attending the IDU and it seems that sometimes at least he went and returned on his own. On 10 June, following a reported conversation with Mrs Lilly expressing suicidal intention, passes were changed to staff or family escorted over the weekend. On 13 June he was to remain on escorted passes. On 16 June he was placed on negotiated passes but only after consideration with the IDU and with a condition that he discuss with a trained member of staff before leaving. That remained his status until his death. It can be seen, therefore, that the question of passes was kept under constant review. The notes were nearly all written by Dr Walker but there were often others recorded as being there. The ward round notes also mention passes and these were attended by more senior doctors even where there is no attendance list completed. It cannot be said therefore that the issuing of passes was not fully and properly considered and at an appropriate level. Action was taken if there was reason to believe that the level of risk had changed. Mrs Lilly several times expressed concern at the level of passes and on occasions claimed to be ignorant of the change to negotiated status. I do not doubt her concerns and they mirror her concerns in the letters she wrote to Drs Walker and Lefevre about her worries for her husband. It is clear from the hospital records however that she was often present at meetings when passes were discussed. The doctors all said that her concerns were taken into account when decisions were taken. I must accept that.

- (33) The other issue is whether or not it was appropriate that Mr Lilly should have had negotiated passes in the few days before his death. It is clear from the notes that his mood fluctuated between 16 and 25 June. The remark made to Mrs Lilly at the Day Centre three days before he died about cutting each others throats is of some significance. Mrs Lilly was very concerned about it. It may be that it was the last straw at that time but she told staff that she did not want him to contact her in the meantime. It was then that the notes suggested a trial separation was to take place. The IDU staff was aware of the remark and, quite properly, informed ward 6. It is noted at 1-92 on 22/23 June that *“Bill looked pale and*

defeated last night.” He described himself as having been “*very stupid*” and did not sleep. He was, apparently, able to go to the IDU on 23 June but on return to the ward went straight to bed and had no contact with nursing staff. On 24 June in the course of discussion with occupational therapists about ongoing work at the IDU, it is noted that he had appeared low and that he had some concerns about weekends when both the OT department and the IDU were closed. Nurses noted he was less evident about the ward using his time off the ward appropriately and having little contact with fellow patients. Dr Walker saw him that day and noted negative thoughts again, low mood and concern regarding his relationship with his wife. The plan was that negotiated passes were to continue and to review mood on Monday. Nurses noted he was using passes off the ward appropriately.

(34) On the day of his death the nursing notes state that “*William continues to express he feels very low and has no motivation to do anything however he did eventually managed to organise himself and go off into town.*” He had apparently told staff at 13.00 that he was going to the shops and would be back at 18.30.

(35) The multi-disciplinary team meeting record of 21 June records that all three doctors were in attendance. It noted that there was concern that on Thursday (16 June?) at the IDU he had reported as feeling low and suicidal. On return to the ward he had been interviewed by Staff Nurse Paterson and Dr Walker who noted there were no active suicidal ideation, he was low and anxious and he was placed on negotiated passes. The rest of the note is, in my view, significant. “*Did not tolerate long periods of time at home over w/e. No overnight passes over w/e.*” He reported feelings of anxiousness/nervousness whilst at home. He was seeking lots of reassurance from staff. In dealing with Mrs Lilly the meeting identified a lot of stress for her. She was finding recent events very stressful and had multiple other stresses. A few days later at the IDU he made the remark about cutting each others throats which provoked Mrs Lilly to seek some space for herself.

(36) Mrs Lilly had on many occasions made it clear that she had concerns about the level of passes granted to her husband. Her concerns had been noted and, in evidence, they were considered when decisions were taken. It is also clear from notes that Mrs Lilly was present at some of the meetings when passes were

discussed and decisions taken. The doctors faced a considerable dilemma. On the one hand the plan was to improve Mr Lilly's health and find a balance of medication which would permit his discharge from hospital on a regime of medication and appropriate attendance at out patient clinics or the IDU. On the other hand, it became clear that going home, being with his wife, contemplating their future was all causing so much stress that it seemed to set him back when he returned to the ward.

(37) Putting it at its simplest, the picture painted is of a man who was depressed due to a number of social and domestic circumstances. He had made one possible attempt at suicide when he left a note and went to North Bridge and was found by Arthur's Seat. He had made a more serious suicide attempt when he took an overdose of prescribed medication which necessitated hospitalisation before he was admitted, as a voluntary patient, to the Royal Edinburgh Hospital. Over the period of approximately six weeks when he remained there, his condition fluctuated. He was seen regularly by doctors, in particular, Dr Walker. Full notes were kept by nursing staff and the IDU. There was good communication amongst all involved in his care and treatment. He had, at times, made remarks about suicide. These were noted and investigated by doctors. He had commented, possibly on 16 June, at the IDU that he was feeling low and suicidal. He made a remark on 22 June at the IDU about he and his wife cutting each others throats. He then apparently took his own life on 25 June. Given that picture, should he have been allowed negotiated passes in the three days before his death?

(38) Taking care not to use hindsight and the knowledge of the consequences in assessing clinical decisions made at the time, it is clear that all information was available to Dr Walker on 24 June when the decision to continue negotiated passes was taken. Mr Lilly was a voluntary patient. The evidence suggested that he would not have met the criteria required for compulsory detention at that time. In theory, therefore, he could have walked out at any time. He had been on negotiated passes in the days before 25 June. It is specifically noted that he had used them appropriately. There was evidence that he had been out earlier on 25

June, possibly to buy a newspaper. He had done nothing in the exercising of his passes to warrant staff declining to allow him permission to go out. There was an element of trust about negotiated passes and he had not given any cause for anyone to think he was abusing or would abuse that trust. He had discussed his plans with the nurse on the ward and he had been given consent to go out. That was all recorded in the ward records. I do not think Dr Walker can be criticised for taking the decision she did about negotiated passes.

- (39) Mrs Lilly commented that she was unhappy about the level of her husband's passes and there is no doubt she expressed that on several occasions. She was present on a number of occasions when the level of passes was discussed. For example, she was at the ward round on 13 June where it is noted that Mr Lilly was voicing thoughts of suicide and therefore staff/family escorted passes over the weekend. By the following week the stresses of the visits home were showing. Then, after the incident at the IDU and the remark about throat cutting, Mrs Lilly did not want her husband to contact her and she wanted some space. I accept her evidence that if anyone had asked her the last thing her husband would have wanted to do would be to go into Edinburgh city centre on a Saturday afternoon. However, the notes were by this time referring to a trial separation. I do not think that any member of staff can be criticised for not contacting Mrs Lilly before allowing her husband out.

Communication with Mrs Lilly

- (40) Mrs Lilly gave very good and forthright evidence at the outset of the Inquiry. Unfortunately we did not have all the productions available when she gave evidence. There is no doubt whatsoever that from a very early stage she was active in telling those who were involved in her husband's care how things were from her perspective. Her life must have been very difficult at this time. She had seen her husband's mental health deteriorate over a period. She had lived with the stresses when his future employment was being considered. Her elderly mother was in hospital and steps had to be taken for her care. One of her main concerns

was that her husband was able to put on some sort of façade to medical staff and that the true picture was only apparent when he was at home. She was concerned that staff to whom she spoke did not pay heed or did not give sufficient importance to this information. Crown production 1-13 is a letter Mrs Lilly sent to Dr Walker. It is undated but it is clearly written before there was any admission to hospital. It is a very clear enunciation of her thinking at this time. She describes what she sees in her husband's presentation and her own feelings. Once Mr Lilly was in hospital she continued to tell nurses and doctors that his behaviour and presentation in hospital was markedly different to his behaviour and presentation with her. There were various incidents between her husband and herself about which Mrs Lilly felt nurses and/or doctors did little.

- (41) The stress of the relationship almost inevitably led to difficulties. There was the period when Mrs Lilly went to England to see her son following an incident and a discussion with Dr Walker on 27 May. While Mr Lilly was at first low he improved and by 31 May he was said to be a little more upbeat. Then on 1 June he had an escorted visit home which caused anxiety.
- (42) On 22 May Mrs Lilly wrote to Dr Lefevre. The letter is Crown production 1-138. She described a significant change in mood while on a car journey during which Mrs Lilly broke down. She expresses her thoughts and concerns and ends the letter as follows: - *"I think he is on a road to self-destruction and I need you to be fully aware that what you see in hospital is not the true picture once he leaves the secure confines of the hospital or the clinic."* In his evidence, Dr Lefevre said he was not sure what he did after he got the letter. He could not recall if he spoke to Mrs Lilly afterwards. He said that after the letter was sent Mrs Lilly went to stay with her son. He then said in answer to Mr Jessiman that he discussed the letter with staff. He did not accept that Mrs Lilly was saying she was not being listened to. It was a broader reflection of their relationship and the team were meeting both Mr and Mrs Lilly regularly to address their issues. In further cross-examination by Mr Stewart he confirmed he was not sure if he discussed the letter with Mrs Lilly. There were notes that he discussed her husband's care with her and addressed her concerns. He thought the relationship

between them may have contributed to her view. Dr Walker recalled that either the letter was read out at a ward round or that she had seen it before. It was discussed at the time. Mrs Lilly was already in regular contact with key workers and the plan was to see her when she came in (to the ward). She did not agree that Mr Lilly was on the road to destruction but did agree that he was different outside the hospital. She thought that it was difficult to re-assure Mrs Lilly partly at least because Mr Lilly was so anxious and he conveyed that to her and she had other issues. There was nothing unusual about the fact that she was expressing concerns. Dr Walker got the impression that Mrs Lilly was just very worried, not that she was questioning treatment. Most of the discussions with both Mr and Mrs Lilly centred round Mr Lilly feeling more secure in hospital and very stressed at home which tied in with the other factors like financial security etc.

- (43) It cannot be said that there was any failure to communicate with Mrs Lilly at any level. Indeed, communication seems to have been good. Should doctors have paid more attention to what she was saying? That is difficult. She was the person who knew her husband best. She saw how he presented and how that was different from how he apparently presented to doctors and nurses. She expressed her concerns about that. She expressed concerns that medication may not be working and that was noted and acted upon. On the other hand, if her husband was putting on a façade for the benefit of doctors and nurses, he had been able to keep that up for nearly six weeks and had pulled the wool over the eyes of all. As was stated in evidence, keeping up a pretence for so long would be very difficult. Further, Mr Lilly was constantly being seen by the same, relatively small, team of nurses. He saw doctors regularly with Dr Walker seeing him most often. They had knowledge of Mrs Lilly's fears about the façade. Clinical judgements were made on a fully informed basis. I can understand why Mrs Lilly felt then and feels now a sense of frustration that what she was saying was being ignored or insufficient emphasis was being placed on it. The evidence and the notes do not suggest that was the case.

Increased risk of suicide

- (44) Was there an increased risk of suicide between 22 and 25 June 2005? Mr Lilly was a voluntary patient following on a serious attempt to end his life by taking an overdose of prescribed medication. He had spoken to staff at IDU about suicidal feelings and they in turn had told ward 6. The incident on 22 June when he had mentioned cutting each others throats was overheard by staff at the IDU and details were passed to ward 6 Dr Walker was fully aware of the remark. On 22 June on his return to the ward, staff nurse Paterson noted that she spent time with Mr and Mrs Lilly and that “*Bill continues to block any positive suggestion and wont take responsibility for behaviour.*” She then goes on to note that Mrs Lilly was requesting a trial separation and “*space*”. She requested her husband not contact her.
- (45) Staff Nurse Nurse Paterson said that she often struggled to get Mr Lilly to see another perspective in his relationship with his wife. In her discussions with him he would deny suicidal ideation and she considered that a main factor in all their discussions. She was aware of Mrs Lilly’s concerns and of her letter to Dr Lefevre the contents of which were not a surprise to her nor, in her view, would they have been to Dr Lefevre. Nurse Paterson had tried to reassure Mrs Lilly that they did not always get a stable picture of her husband and there were times he was distressed, agitated, tearful or emotional. It was her impression that Mr Lilly’s mental state was worse in his wife’s company and there were often heated rows or discussions. With regard to the incident on 22 June it was not the first time he had said something like this; it usually happened when they were having a row. Nurse Paterson was not concerned. When the trial separation was being discussed, Mrs Lilly asked Nurse Paterson to stay while she talked to her husband. She said that did not seem to be something he did not expect. It must, however, have been something of a blow to him in the overall context of his illness.
- (46) Nurse Paterson last saw him on 23 June and felt that while he still had some way to go there was some progress and he was beginning to address other

activities and could see there was a future. She discussed matters with Dr Langsley. On 24 June he was seen by Dr Walker, again in the full knowledge of what had gone on over the previous two days. She noted no ongoing suicidal thoughts.

(47) Mr Lilly's suicide was a surprise to all the witnesses except Ms Viewieorka who thought he was a man determined to take his own life. What is clear throughout the notes is that the whole issue of suicide was something very much in the forefront of everyone's thinking. Following the incident on 22 June the case was discussed with Dr Langsley. He was seen by Dr Walker who was the doctor who had most direct contact with him. From the evidence, Dr Lefevre was in the ward most days. He could not say if he became aware of the comment before or after Mr Lilly's death but he did say that if Dr Walker was aware of it and took it into account in agreeing negotiated passes then he supported the decision. He was aware that the comment had been discussed with Dr Langsley. Mr Lilly was either an extremely good actor who could fool doctors and nurses regularly over a six week period or, by a process of constant assessment taking into account all factors, the doctors were correct in their diagnosis, treatment and decisions on matters such as passes.. It is too simplistic to say that because he committed suicide on 25 June the doctor's assessment on 24 June must have been wrong. He had previously tried to commit suicide. There was some family history of depression and/or suicide although there is very little of that in the notes. He had talked of self harm but mainly to his wife who in turn told the staff. If said to anyone else it was usually at the IDU and it was also conveyed to ward staff and was noted. There were frequent rows between Mr and Mrs Lilly and emotions were running high. He would have been aware that a trial separation (at worst) or a bit of space for Mrs Lilly (at best) was about to happen. All that had happened was known to Nurse Paterson, Dr Langsley and Dr Walker and possibly Dr Lefevre.. In Dr Walker's her clinical judgement there was no increased risk. If there had been then the history of his treatment suggests that steps would have been taken. I have concluded therefore that despite the views of Dr Callender, there is nothing to suggest that any mistake was made in assessing suicide risk, or

re-assessing suicide risk following the incident of 22 June. Appropriate investigation was made and a clinical view was taken. It is not appropriate to say with the benefit of hindsight and knowledge of the consequences that what was done was wrong.

(48) It follows from what I have said that I do not think that it is appropriate that I make any finding under section 6(1)(c) that there were any reasonable precautions whereby the death might have been avoided. As I said at the outset we cannot know what was going through Mr Lilly's mind. He remained unwell; his condition fluctuated; there was an overall general improvement with fluctuations; he was aware that there were difficulties with his relationship with his wife but that was against a background that there had been strains between them over the previous few weeks and a short spell of separation when Mrs Lilly went to see her son; his pass entitlement had been varied over the weeks depending on his condition and how he presented; he had not abused negotiated passes. He had been seen since 22 June by Nurse Paterson who had talked to Dr Langsley. He had been seen on 24 June by Dr Walker. The process of assessment was constant and ongoing. The decision made by Dr Walker cannot be criticised.

(49) I have been asked to make two findings under section 6(1)(e). As will be clear from what I have written I am satisfied that the views expressed by Mrs Lilly both verbally and in writing have been taken on board by the medical staff. The letter to Dr Lefevre was dated 22 May and it is in that letter she spoke of her husband being on the road to self-destruction. Witnesses spoke to that letter being discussed. Her view was certainly known. She was present in the ward many times thereafter and at ward rounds. There is nothing to suggest her views were not considered. Should they have been given more cognisance? Short of keeping Mr Lilly locked up in hospital and/or under constant supervision it is difficult to see what more could have been done. The suicide risk features frequently in the notes. The views of the nearest relative in such a case are important but they form only one part of the whole complicated picture. It is again too simplistic to say, with hindsight and because there has been a tragic outcome, that more attention should have been paid to Mrs Lilly's views. The relationship was under a degree

of strain. The medical team had identified that Mr Lilly suffered increased stress and anxiety when he was going home. Yet they were working with both Mr and Mrs Lilly towards a discharge into home. They faced a difficult and delicate situation and in my view handled it appropriately and well. .

(50) With three doctors, a consultant, specialist registrar and a senior house officer along with a dedicated nursing team for about eight patients, the staff/patient ratio is high. I do not know precisely how many patients Dr Lefevre's team had at the time of Mr Lilly's admission nor do I know the level of demand placed on doctors and nurses by any patient other than Mr Lilly. However, it is quite clear both from the medical notes and the evidence that the care provided to Mr Lilly in the weeks before his death was of a high standard. There was involvement both from ward 6 and the IDU and the level of communication and co-operation between them was very good. I do not think that it is appropriate that I make a specific finding under section 6 (1)(e) simply because a medical team has done what it is supposed to do and done it well. It is however appropriate that I note that is what happened.

(51) This Inquiry was necessary and it raised a number of important issues. It does not necessarily follow that where someone dies suddenly or in unexpected circumstances that there must have been a failing or shortcoming in a system or some fault on the part of one or more individuals. This was a tragic event and we will never know what triggered it. The concern of all involved in Mr Lilly's care was obvious to see. The fact that the Inquiry has been hanging over them for nearly four years is little short of disgraceful. Equally the fact that Mrs Lilly has had to wait so long is unacceptable and, as I stated earlier, I hope some enquiry is made into the inordinate delay and apparent dearth of preparation in the time before Ms Yousaf took control of matters.