SHERIFFDOM OF TAYSIDE, CENTRAL & FIFE AT DUNDEE

[2021] FAI 49

DUN-B78-20

DETERMINATION

BY

SHERIFF JILLIAN MARTIN-BROWN

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

into the death of

MARK JOHNSTON

Dundee, 10 August 2021

The sheriff, having considered the information presented at an inquiry on 19, 20 and 21 May 2021 and the written submissions received on 18 June 2021, under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, finds and determines that:

Findings

Section 26(2)(a)

Mark Johnston died on 20 October 2017 at Flat 2, 1 Nursery Road, Broughty Ferry, Dundee.

Section 26(2)(b)

His death was not the result of an accident.

Section 26(2)(c)

The cause of Mark Johnston's death was multiple stab wounds.

Section 26(2)(d)

His death was not the result of an accident.

Section 26(1)(e)

There were no precautions which could reasonably have been taken whereby his death might have been avoided.

Section 26(2)(f)

There were no defects in any system of working which contributed to his death.

Section 26(2)(g)

There are no other facts which are relevant to the circumstances of Mark Johnston's death.

Recommendations

Section 26(4)(a)

There are no recommendations as to the taking of reasonable precautions which might realistically prevent other deaths in similar circumstances.

Section 26(4)(b)

There are no recommendations as to the making of improvements to any system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(c)

There are no recommendations as to the introduction of a system of working which might realistically prevent other deaths in similar circumstances.

Section 26(4)(d)

There are no recommendations as to the taking of any other steps which might realistically prevent other deaths in similar circumstances.

NOTE

Introduction

[1] This was a discretionary inquiry held under section 4(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the 2016 Act").

[2] Preliminary hearings were held on 23 July 2020, 15 December 2020 and 12 January 2021. The inquiry was held on 19, 20 and 21 May 2021. Written submissions were received on 18 June 2021. Oral evidence of the witnesses was given by way of WebEx and the preliminary hearings took place by teleconference due to Covid-19 restrictions.

[3] Mr Sadiq, Procurator Fiscal Depute, represented the Crown. Mr Stuart, Advocate, represented Tayside Health Board. Miss Watts, Advocate, represented Grampian Health Board. Mr Renucci, QC, Vice Dean of Faculty, represented Mr David Reid.

[4] The following witnesses gave evidence to the inquiry:

1. Andrew Warren, Mental Health Nurse;
2. Ronald Menzies, Mental Health Nurse;
3. Jonathan Fish, Psychiatrist (Trainee in October 2017);
4. Malcolm Kinnear, Consultant Psychiatrist;
5. Andrew Robinson, Consultant Psychiatrist;
6. Ashleigh Phillips, General Practitioner (Trainee in October 2017);
7. Dr Stuart Doig, Clinical Lead, Forensic Psychiatry;
8. Dr Alastair Palin, Associate Medical Director;
9. Dr Allan Scott, Retired Consultant Psychiatrist (Crown expert); and
10. Dr Lawrence Tuddenham, Consultant Forensic Psychiatrist (Grampian Health Board expert).

[5] A joint minute of agreement was entered into by the parties. Affidavits and police statements were used for evidence-in-chief.

Background Facts and Circumstances

[6] The facts outlined within this section of the determination were agreed between the parties and were contained in the joint minute.

[7] Mark Johnston ("the deceased") lived in Montrose. David Reid lived in Broughty Ferry, Dundee. Both men lived with paranoid schizophrenia and became acquainted when they were treated at the same time in Murray Royal Hospital in Perth.

[8] David Reid was successfully managed in the community under the care of Dr Simonsen, Consultant Psychiatrist, Community Mental Health Team, Wedderburn House, Dundee. His medical condition was regularly monitored and managed by the prescription of clozapine and other medication. David Reid attended twice monthly at Wedderburn House in respect of his prescription. His last prescription appointment was on 29 September 2017, at which he had a one to one meeting with Eileen Macey, Health Care Assistant. David Reid was well known to Ms Macey who described him to be a very pleasant individual. On 29 September 2017 David Reid was seen to be his usual self and exhibited no problems.

[9] On Monday 16 October 2017 Gail Davey, Reception Administrator at Wedderburn House, was at work when she took a call from housing services at Dundee House regarding David Reid. Ms Davey was informed that David Reid had reported

that he could no longer stay in his accommodation. This information was noted and passed to Sheena Sutherland, Community Mental Health Nurse.

[10] Around 30 minutes later David Reid attended at Wedderburn House in Edward Street, Dundee without a prior appointment. He asked to see the duty nurse. David Reid was reminded that he was supposed to telephone and arrange an appointment at which point he stated that he would go to the bridge and jump off. On hearing David Reid make this threat, arrangements were made for him to see the duty nurse Freda Oswald.

[11] Nurse Oswald attended immediately at reception and spoke with David Reid. She assessed his presentation as she spoke with him. David Reid told her that he was receiving messages from God, that a demon was trying to harm him and that he couldn't go home. On being questioned he said that he had not taken alcohol or drugs and had been taking his anti-psychotic medicine. On being told that Nurse Oswald required to get a crisis worker to attend, David Reid said that he wouldn't leave the building or if he did, he would jump off the bridge and it would be Nurse Oswald's fault. Due to her concern at David Reid's presentation, Nurse Oswald spoke with Ronald Menzies, Community Mental Health Nurse, who had known David Reid as a patient for around 15 years.

[12] On Monday 16 October 2017 David Reid was transferred from Wedderburn House in Dundee to Royal Cornhill Hospital, Aberdeen as an informal patient. The circumstances of his admission and transfer from Dundee were part of the focus of the inquiry and are discussed in full elsewhere in the determination at paragraphs [29] to

[35] David Reid's clozapine records, including details of his blood results and medication, were also transferred to Royal Cornhill Hospital in Aberdeen.

[13] On Wednesday 18 October 2017 David Reid discharged himself from hospital against medical advice. The circumstances of his stay in hospital from 16–18 October 2017 and his discharge on 18 October 2017 were part of the focus of the inquiry and are discussed in full elsewhere in the determination at paragraphs [36] to [57].

[14] On the morning of Thursday 19 October 2017 David Reid phoned the pharmacy where he usually picked up his prescribed medication in Broughty Ferry. The pharmacist manager who spoke to him on the phone, Kimberley Lockhart, was familiar with David Reid through his previous attendances at the pharmacy. Her impression at the time of the phone conversation was that he sounded like his normal self.

[15] Later on 19 October 2017 David Reid attended at the pharmacy. He sat in the pharmacy waiting for the medication and when it was ready he collected it and left. The pharmacy supervisor, Heather Hebenton, was familiar with David Reid through his previous attendances at the pharmacy. Her impression at the time of his attendance that day was that his behaviour was the same as every other time he had been in.

[16] On the afternoon of 20 October 2017 Eileen Macey, a Health Care Assistant based at Wedderburn House, phoned David Reid at around 15:00. Her job included speaking to patients and authorising the dispensing of medication, including clozapine, to them after their blood test results had been checked. She had known David Reid for about seven years through her work. She spoke to David Reid and said who she was. He recognised who she was. She asked him if he had his clozapine and he said that he did.

Ms Macey's impression at the time of that conversation was that he sounded a bit flatter than normal, but she thought nothing of it, as her impression was that he was not a bubbly person in any event.

[17] Later on 20 October 2017 at about 20:50, Debbie Reid, sister of David Reid, received a phone call from her brother. He stated, "I've killed Mark." He was sobbing as he made the statement. He said that "I thought he was the devil." Debbie Reid panicked and phoned the Relief Support Worker at Anchor House, Perth for assistance who reported the matter to the police.

[18] Police attended at David Reid's flat in Broughty Ferry and pressed the buzzer which was answered by David Reid. He allowed the officers entry to the block. As the officers approached the front door, he said, "It's okay officers, I'm coming." The flat door was unlocked and opened. David Reid was covered from head to toe in what appeared to be blood. Police officers asked him if anyone had been stabbed and he stated "Yes, he's in the living room."

[19] On entering the living room, witness Constable Kerr observed the lifeless body of the deceased lying on the living room floor.

[20] Whilst David Reid was escorted from the locus, he stated, "I don't know what I've done," and "I'm mentally ill."

[21] At about 21:50 on 20 October 2017 David Reid was cautioned and detained in terms of section 14 of the Criminal Procedure (Scotland) Act 1995 on suspicion of murder. He indicated that he understood the caution and his detention and replied, "I'm just unwell."

[22] Whilst within the charge bar waiting area, David Reid made several comments regarding the incident and these comments were to the effect that he could not believe what he had done and that the deceased had been his only friend. He stated that he had thought that the deceased was the devil and that the television had told him to kill the deceased. He further stated that he had taken a knife, put it in his pocket and thereafter tried for two hours to stop himself killing the deceased. He also stated that the deceased was pleading for his life.

[23] Mark Johnston's life was pronounced extinct at 21:31 hours on 20 October 2017 and a subsequent post mortem examination identified the cause of death as being: I(a) Multiple Stab Wounds.

[24] Toxicology analyses were performed on the body fluids of the deceased which disclosed no alcohol in the blood and gave negative results for a variety of drugs of abuse.

[25] Photographs of the deceased at the police mortuary taken by the scenes of crime officers showed multiple sharp force injuries numbering in excess of one hundred and twenty on the body of the deceased.

[26] The Crown accepted that David Reid was not criminally responsible for his actions at the time of the killing due to his mental disorder in terms of section 51A of the Criminal Procedure (Scotland) Act 1995. The court was invited to make a disposal in terms of section 57 of the Act whereby David Reid was found not to be criminally responsible.

[27] On 22 February 2019 David Reid having previously been found not guilty by reason of insanity, the Crown asked the court to put in place a compulsion order and a restriction order without a limit of time in respect of David Reid. This was not opposed by the defence. A compulsion order and a restriction order without a limit of time were imposed. David Reid was returned to the state hospital at Carstairs.

Scope of Inquiry

[28] In light of the detailed joint minute, the scope of the inquiry was restricted to: (i) the decision to discharge David Reid from in-patient care on 18 October 2017 (which, in light of the evidence led, should be more accurately described as the decision not to detain David Reid on 18 October 2017 rather than to discharge; and (ii) information sharing between Carseview and Royal Cornhill Hospital (which in light of the evidence led, should be more accurately described as information sharing between Tayside Health Board and Grampian Health Board).

(i) Decision Not To Detain David Reid on 18 October 2017

Presentation at Wedderburn House – Monday 16 October 2017

[29] Community Mental Health Nurse Ronald Menzies gave evidence on 19 May 2021. He was based at Wedderburn House in Dundee on Monday 16 October 2017. He was familiar with David Reid and knew he had been diagnosed as a paranoid schizophrenic. At around 10:00 Nurse Oswald told him David Reid had turned up and was to be assessed to see what his needs were.

[30] Nurse Menzies explained that he assessed David Reid, who told him that he had met a new neighbour in his block of flats and he recognised him as a demon. David Reid was god-fearing and mentioned jumping off a bridge to escape the demon. This rang alarm bells, though David Reid did not present as particularly distressed and was fairly matter of fact. Nurse Menzies made notes of his assessment.

[31] After assessing David Reid, Nurse Menzies explained that his firm belief was that he required to be admitted. David Reid was more than happy to go in. He wanted away from the person he saw as a demon. Nurse Menzies spoke with Dr Kinnear about how David Reid had presented and gave him the medical notes. Dr Kinnear agreed that David Reid required admission.

[32] Dr Malcolm Kinnear, Consultant Psychiatrist in Dundee, gave evidence on 19 May 2021. Dr Kinnear never met David Reid but read the medical notes. Dr Kinnear agreed with Nurse Menzies' assessment that David Reid should be admitted. David Reid was happy to be admitted at that time. Nurse Oswald established that there was not a suitable bed in Tayside for his admission so he required an out of area transfer. A bed was located at Royal Cornhill Hospital in Aberdeen.

Transfer from Dundee to Aberdeen – Monday 16 October 2017

[33] Dr Kinnear explained that he spoke to Dr Andrew Robinson, Consultant Psychiatrist in Aberdeen, by telephone on Monday 16 October 2017 in order to make him aware of all the circumstances that brought Mr Reid to his attention as well as his history from his medical notes for the safety of staff. Having relayed the details to him,

Dr Robinson agreed and allowed for David Reid to be transferred to Royal Cornhill Hospital in Aberdeen.

[34] Dr Jonathan Fish gave evidence on 19 May 2021. Back in 2017, he was in the first part of his psychiatry training. He saw David Reid on Monday 16 October 2017 at Wedderburn House in Dundee. He spoke to consultant Dr Kinnear, who indicated that he was doing a consultant to consultant referral in order to get David Reid a bed in Royal Cornhill Hospital, Aberdeen. He completed the paperwork to arrange David Reid's transfer from Tayside to Aberdeen.

[35] Nurse Andrew Warren gave evidence on 19 May 2021. Together with Nurse Menzies, he accompanied David Reid in a taxi to Aberdeen on Monday 16 October 2017. Nurse Menzies indicated that the closer David Reid got to Aberdeen, the more relaxed he became. Nurse Menzies indicated that David Reid had insight into the fact that he was not well and was quite happy to go to hospital in Aberdeen. Nurse Menzies handed over the paper records to staff at Aberdeen.

Admission to Royal Cornhill Hospital – Monday 16 October 2017

[36] Dr Robinson, Consultant Psychiatrist at Royal Cornhill Hospital in Aberdeen, gave evidence on 19 May 2021. He had almost 40 years of experience as a psychiatrist. He first heard of David Reid's planned admission on Monday 16 October 2017. He spoke with Dr Kinnear, Consultant Psychiatrist in Tayside, by telephone. Dr Kinnear informed him, *inter alia*, that David Reid was an informal patient and they could not find

a bed for him in Tayside. Dr Robinson agreed to the transfer of David Reid and left it to his secretary to arrange the transfer from NHS Tayside to NHS Grampian.

[37] Dr Robinson indicated that David Reid was admitted to Royal Cornhill Hospital around 15:30 – 16:00 on Monday 16 October 2017. He was admitted to the Drum Ward by Dr Ashleigh Phillips.

[38] Dr Phillips gave evidence on 19 May 2021. She was now qualified as a GP but had previously been acting as a junior doctor at the time that she saw David Reid on Monday 16 October 2017. David Reid told her that he had had schizophrenia for a long time, and he normally coped well with it. He said that he regularly heard auditory hallucinations, but that they were positive things, like for him to continue taking his medication in order for him to stay well. He confirmed that he took his clozapine medication regularly, and he felt that this helped. She carried out a physical examination of David Reid and noted that his renal/kidney function was abnormal, but everything else was fine.

In-Patient Review - Tuesday 17 October 2017

[39] Dr Robinson saw David Reid within 24 hours of his admission, in line with normal practice, at around 09:15 – 10:00 on Tuesday 17 October 2017. At the review, he noted David Reid's risk to be moderate in terms of harm to himself and to others. A moderate risk patient is allowed to leave the ward for short periods of time unescorted.

[40] Dr Robinson indicated that there were no issues with David Reid overnight. The nursing notes were reassuring.

Decision Not to Detain – Wednesday 18 October 2017

[41] Dr Phillips indicated that she saw David Reid on the morning of Wednesday 18 October 2017 to get blood tests. He said he didn't want to give more blood right then and there but did not give any reason for this. She said she would give him some time to re-think things and went into the nurses' office.

[42] Dr Phillips indicated that about five minutes later David Reid came to the door of the nurses' office and said he was leaving and he was signing himself out of the hospital. She spoke to him in the corridor outside the nurses' office and had a good rapport with him. She could tell he had made his mind up to leave.

[43] Dr Phillips asked David Reid how he was feeling and he said he felt himself and was having no audible hallucinations. She asked him if he was sure and tried to talk him into staying by saying it was a long way to go on his own. David Reid said it was okay, he was fine and had medication at home. He said he was going to get a taxi home. Dr Phillips said that would be very expensive, trying to talk him round into staying at the hospital, but David Reid said he had money for the taxi. David Reid was an informal patient at the hospital so she could not physically stop him from leaving.

[44] Whilst she was speaking to him, Dr Robinson was just behind her listening to what was going on. She asked Dr Robinson if David Reid was detainable and he said he wasn't and to get the form signed for discharge against medical advice. Dr Phillips went into the nurses' office to get the form but when she came back out, David Reid had already left the ward.

[45] Dr Phillips spoke to Dr Robinson for direction and advice on what to do next. Upon his instruction, she contacted Wedderburn House in Dundee and spoke to Community Psychiatric Nurse Stewart Robertson who knew David Reid. Dr Phillips passed on what had happened and that David Reid had left without his morning dosage of clozapine. The abnormal blood details were sent to David Reid's GP for further investigation if they felt necessary.

Criteria For Detention

[46] Dr Robinson indicated that ultimately, he did not think that David Reid fulfilled the five criteria for short-term detention of a patient in terms of section 44 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act").

[47] The first criterion was whether the patient was suffering from a mental disorder. David Reid was suffering from schizophrenia and therefore this criterion was met.

[48] The second criterion was whether the patient had significantly impaired decision making ability because of the mental disorder. That meant something was interfering with his ability to recognise that he was ill, needed treatment and had to make judgements around that treatment. David Reid had originally presented because he was aware that he had problems with his schizophrenia. He had gone to see staff in Dundee and was happy to go to Aberdeen. He had already told Dr Simonsen at Wedderburn House, Dundee that he had hallucinations and was distressed because of the intensity of them. He also had insight into his beliefs. He had some abnormal beliefs that he recognised, such that he was God. He therefore had insight when Dr Robinson spoke to

him on Tuesday because he knew at that point that he was not God. On Wednesday 18 October 2017 when asked why he wanted to leave he simply said that he wanted to go home. He was not wanting to leave to commit suicide. That had been the greatest risk that had been brought to their attention in Aberdeen. He also denied hearing commands or hallucinations. On that basis, Dr Robinson felt that David Reid had sufficient insight to be able to manage his illness. He said he would continue taking his medication, had clozapine at home and could continue taking it. Therefore, Dr Robinson concluded that he did not have a significantly impaired decision-making ability and the second criterion was not met.

[49] The third criterion was whether detention was necessary for the purpose of determining what medical treatment should be given or giving medical treatment to the patient. David Reid was happy to receive pharmacological treatment. There was no intention to change his medication and so the third criterion was not met.

[50] The fourth criterion was whether, if the patient were not detained, there would be a significant risk to the health, safety or welfare of themselves or others. David Reid denied that he wanted to commit suicide. There was no evidence that he wanted to harm anyone else. He was asked specifically about that and simply said that he wanted to go home to Dundee. There was no evidence that he wanted to go anywhere to harm anybody else and so the fourth criterion was not met.

[51] The fifth criterion was whether it was necessary for the patient to be kept in hospital for some aspect of his treatment to be dealt with. In Dr Robinson's view that

was not necessary. David Reid had clozapine at home and the services in Tayside were able to take up further management and so the fifth criterion was not met.

[52] Therefore, Dr Robinson was of the view that four of the five criteria for short-term detention were not met.

[53] Dr Robinson had wanted to speak to David Reid in more detail, particularly to explain why he was concerned about the deterioration of his kidney function and why he wanted to check his clozapine levels. Dr Robinson wanted to check that the dosage was not too high. In the past, David Reid had asked about reduction of his clozapine due to side effects. It was possible that David Reid was worried about the dose being increased rather than reduced.

[54] Dr Robinson explained that he was disappointed that David Reid left. He felt that there were some things that they had not been able to accomplish for him, in particular sorting out what was happening with his kidney function. He would have preferred that David Reid stayed in order to be able to complete the treatment. He thought he had enough information in order to make the assessment which he did.

[55] Dr Robinson indicated that David Reid was prepared to go and had got himself ready. He had packed his bags and was not showing distress. He was not shouting or swearing and was not acting in an unreasonable way. Even if David Reid had been detained, his detention would have been reviewed again within 24 hours.

[56] It was Dr Robinson's judgement that it was not appropriate to detain David Reid. Had he thought that the criteria for detention were fulfilled then he would have discussed matters with Tayside Health Board and asked the police to become involved.

This was the only occasion in his entire career when a patient had committed such an offence after being discharged from his care.

[57] Dr Robinson accepted that a comprehensive record of David Reid's mental state was not documented on the day of his departure on Wednesday 18 October 2017. However, Dr Robinson considered that his decision not to detain Mr Reid was justified because he did not fulfil each of the necessary criteria. In his view, those aspects were documented in his record.

Expert Opinion

[58] Dr Allan Scott, Consultant Psychiatrist, prepared independent expert reports on behalf of the Crown and gave evidence on 20 May 2021. Based on what was in the medical records, he was concerned both about the adequacy of the risk assessment and about the decision to allow David Reid to take his own discharge from in-patient care. In Dr Scott's opinion, the clinical decision to allow Mr Reid to take his own discharge from in-patient care was a significant one and should have been explained and understandable in the medical records. A comprehensive mental state examination was not documented.

[59] There would have been a means to prevent him from leaving the ward without an adequate risk assessment. A voluntary patient with a mental disorder in hospital and in receipt of medical treatment could be detained by a nurse of the prescribed classes for two hours to allow an examination by a medical practitioner to consider detention, if it was necessary for the protection of the patient's health, safety or welfare.

[60] However, Dr Scott felt it was not possible to say that detention on Wednesday 18 October 2017 might have avoided the deceased's death. Even if David Reid had been detained on Wednesday 18 October 2017, it could not be assumed that the criteria for detention would still have been met 24 or 36 hours later. If the criteria for detention were no longer met, then an approved medical practitioner would have been obliged to revoke the emergency detention certificate and he would have been able to leave hospital.

[61] Dr Laurence Tuddenham, Consultant Forensic Psychiatrist, prepared independent expert reports on behalf of Grampian Health Board and gave evidence on 20 May 2021. He explained that there were three routes whereby a patient might be detained. The first route was detention by a nurse, which was of very brief duration to allow examination by a doctor to take place. The second route was emergency detention under section 36 of the 2003 Act by a medical practitioner for up to 72 hours, with an expectation that the patient would be reviewed within 24 hours by an *approved* medical practitioner. An approved medical practitioner was a medical practitioner who was approved as having special experience in the diagnosis and treatment of mental disorder and was usually a senior trainee or a consultant psychiatrist. The third route was short-term detention under section 44 of the 2003 Act for up to 28 days, which could only be granted by an approved medical practitioner and required the consent of a mental health officer. As David Reid had already been in hospital for two days and had been assessed by his consultant psychiatrist during that period, the most appropriate type of detention in this circumstance would be short-term detention.

[62] With reference to the five criteria for detention under section 44 of the 2003 Act, Dr Tuddenham was of the opinion that the first criterion was met because David Reid had a well-established diagnosis of schizophrenia and presented with symptoms of that mental disorder.

[63] As far as the second criterion was concerned, there were several factors in David Reid's history which weighed against this condition being met. In Dr Tuddenham's opinion, on balance, the evidence was more strongly in support of David Reid's ability to make decisions about the provision of medical treatment as not being significantly impaired, although some psychiatrists might take a different view.

[64] The third criterion of necessity to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient was on balance met, although some psychiatrists might take the view that this treatment could be carried out adequately in the community, depending on the community services available.

[65] As far as the fourth criterion was concerned, on balance, the evidence did not suggest that David Reid would present a significant risk to his health, safety or welfare or to the safety of any other person if he were not detained in hospital. A minority of psychiatrists might take the view that he presented a significant risk at the point of discharge.

[66] Finally, the fifth criterion was not met because David Reid strongly indicated that he would continue to co-operate with medical treatment in the community on an informal or voluntary basis.

[67] Therefore, Dr Tuddenham was of the opinion that the decision not to detain Mr Reid was a reasonable one because he did not meet at least three, possibly four, of the five criteria necessary to detain him in hospital for further treatment. Clearly there was concern over his sudden decision to return home and the doctors preferred that he should remain in hospital for further assessment. That was reflected in the attempts of the clinicians to hold a further discussion with him and to persuade him to stay in the hospital on Wednesday 18 October 2017. There would likely be a range of medical opinions on David Reid's detainability. If a psychiatrist did not consider that a patient met the statutory criteria for detention then it would be completely improper for the patient to be detained.

Submissions

[68] No findings in terms of section 26(2)(e) or (f) were sought by any party in relation to the decision not to detain David Reid. Counsel for David Reid submitted that detention was a precaution that could reasonably have been taken, but accepted that even if David Reid had been detained it could not be said that such detention might realistically have resulted in the death being avoided, particularly given his presentation following his discharge on 18 October 2017.

Legislation

[69] Section 1 of the 2003 Act sets out principles for discharging certain functions under the 2003 Act as follows:

1 Principles for discharging certain functions

(1) Subsections (2) to (4) below apply whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act in relation to a patient who has attained the age of 18 years.

(2) In discharging the function the person shall, subject to subsection (9) below, have regard to the matters mentioned in subsection (3) below in so far as they are relevant to the function being discharged.

(3) The matters referred to in subsection (2) above are–

(a) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;

(b) the views of–

(i) the patient's named person;

(ii) any carer of the patient;

(iii) any guardian of the patient; and

(iv) any welfare attorney of the patient,

which are relevant to the discharge of the function;

(c) the importance of the patient participating as fully as possible in the discharge of the function;

(d) the importance of providing such information and support to the patient as is necessary to enable the patient to participate in accordance with paragraph (c) above;

(e) the range of options available in the patient's case;

(f) the importance of providing the maximum benefit to the patient;

(g) the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;

(h) the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.

(4) After having regard to–

(a) the matters mentioned in subsection (3) above;

(b) if subsections (5) and (6) below apply, the matters mentioned there; and

(c) such other matters as are relevant in the circumstances,

the person shall discharge the function in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.

(5) Whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act (other than the making of a decision about medical treatment) in relation to a patient, the person shall have regard, in so far as it is reasonable and practicable to do so, to–

(a) the needs and circumstances of any carer of the patient which are relevant to the discharge of the function and of which the person is aware; and

(b) the importance of providing such information to any carer of the patient as might assist the carer to care for the patient.

(6) Whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act in relation to a person who is, or has been, subject to–

(a) detention in hospital authorised by a certificate granted under section 36(1) of this Act (any such certificate being referred to in this Act as an "emergency detention certificate");

(b) detention in hospital authorised by a certificate granted under section 44(1) of this Act (any such certificate being referred to in this Act as a "short-term detention certificate");

(c) an order made under section 64(4)(a) of this Act (any such order being referred to in this Act as a "compulsory treatment order"); or

(d) an order made under section 57(2)(a) or 57A(2)1 of the 1995 Act (any such order being referred to in this Act as a "compulsion order"),

the person who is discharging the function shall have regard to the importance of the provision of appropriate services to the

person who is, or has been, subject to the certificate or order concerned (including, without prejudice to that generality, the provision of continuing care when the person is no longer subject to the certificate or order).

(7) A person falls within this subsection if the person is discharging the function by virtue of being–

(a) the patient;

(b) the patient's named person;

(c) the patient's primary carer;

(d) a person providing independent advocacy services to the patient under section 259 of this Act;

(e) the patient's legal representative;

(f) a curator ad litem appointed by the Tribunal in respect of the patient;

(g) a guardian of the patient; or

(h) a welfare attorney of the patient.

(8) In subsection (3)(a) above, the reference to wishes and feelings of the patient is a reference to those wishes and feelings in so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise), appropriate to the patient.

(9) The person need not have regard to the views of a person mentioned in subsection (3)(b) above in so far as it is unreasonable or impracticable to do so.

(10) In subsection (3)(d) above, the reference to information is to information in the form that is mostly likely to be understood by the patient.

(11) In this section, a reference to "discharging" , in relation to a power, includes a reference to exercising the power by taking no action; and "discharge" shall be construed accordingly.

[70] Section 44 sets out the circumstances in which short-term detention can be made as follows:

44 Short-term detention in hospital

(1) Where–

(a) an approved medical practitioner carries out a medical examination of a patient;

(b) the patient does not fall within subsection (2) below; and

(c) subsection (3) below applies,

the approved medical practitioner may, before the expiry of the period of 3 days beginning with the completion of the medical examination, grant a short-term detention certificate authorising, if the condition mentioned in subsection (6) below is satisfied, the measures mentioned in subsection (5) below.

(2) The patient falls within this subsection if, immediately before the medical examination mentioned in subsection (1)(a) above is carried out, the patient is subject to –

(a) a short-term detention certificate;

(b) an extension certificate;

(c) section 68 of this Act;

(ca) section 113(5) of this Act; or

(d) a certificate granted under section 114(2) or 115(2) of this Act.

(3) This subsection applies where–

(b) the approved medical practitioner considers that it is likely that the conditions mentioned in subsection (4) below are met in respect of the patient;

(c) the approved medical practitioner consults a mental health officer; and

(d) the mental health officer consents to the grant of a short-term detention certificate.

(4) The conditions referred to subsection (3)(b) above are–

(a) that the patient has a mental disorder;

(b) that, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired;

(c) that it is necessary to detain the patient in hospital for the purpose of–

(i) determining what medical treatment should be given to the patient; or

(ii) giving medical treatment to the patient;

(d) that if the patient were not detained in hospital there would be a significant risk–

(i) to the health, safety or welfare of the patient; or

(ii) to the safety of any other person; and

(e) hat the granting of a short-term detention certificate is necessary.

(5) The measures referred to in subsection (1) above are–

(a) the removal, before the expiry of the period of 3 days beginning with the granting of the short-term detention certificate, of the patient to a hospital or to a different hospital;

(b) the detention of the patient in hospital for the period of 28 days beginning with–

(i) if, immediately before the certificate is granted, the patient is not in hospital, the beginning of the day on which admission under authority of the certificate of the patient to hospital first takes place;

(ii) if, immediately before the certificate is granted, the patient is in hospital, the beginning of the day on which the certificate is granted;

(c) the giving to the patient, in accordance with Part 16 of this Act, of medical treatment.

(6) The condition referred to in subsection (1) above is that the measure mentioned in subsection (5)(b)(i) above is authorised by the certificate only if, before the patient is admitted to hospital under authority of the certificate, the certificate is given to the managers of that hospital.

(7) If an approved medical practitioner grants a short-term detention certificate in respect of a patient who, immediately before the certificate is granted, is in hospital, the approved medical practitioner shall, as soon as practicable after granting the certificate, give the certificate to the managers of that hospital.

(9) The short-term detention certificate–

(a) shall state the approved medical practitioner's reasons for believing the conditions mentioned in subsection (4) above to be met in respect of the patient; and

(b) shall be signed by the approved medical practitioner.

(10) Before granting the short-term detention certificate, the approved medical practitioner shall, subject to subsection (11) below, consult the patient's named person about the proposed grant of the certificate; and the approved medical practitioner shall have regard to any views expressed by the named person.

(11) The approved medical practitioner need not consult a named person as mentioned in subsection (10) above in any case where it is impracticable to do so.

(12) In this section and sections 46 to 49 of this Act, a reference to a hospital may be read as a reference to a hospital unit.

(13) For the purposes of subsection (12) above, *"hospital unit"* means any part of a hospital which is treated as a separate unit.

Findings and Recommendations

[71] Applying the principles of the 2003 Act, in deciding whether to detain David Reid, it was necessary to have regard to the range of options available and to act in a manner which involved the minimum restriction on the freedom of David Reid that was necessary in the circumstances. It would not have been appropriate for David Reid, or for any other patient suffering from paranoid schizophrenia, to simply be detained out of an abundance of caution.

[72] In light of Dr Tuddenham's explanation of the three different routes to detention, I am of the view that short-term detention under section 44 of the 2003 Act was the most appropriate type of detention. David Reid had been in hospital for two days and had already been assessed by his consultant psychiatrist. There was no need for detention by a nurse or for emergency detention pending him being seen by an approved medical practitioner.

[73] In light of Dr Robinson's evidence that the five criteria for short-term detention under section 44 of the 2003 Act were not met, which was supported by the independent expert Dr Tuddenham, I do not consider that detaining David Reid was a precaution which could reasonably have been taken. Though Dr Scott was of the view that nurse

detention would have been appropriate in order to allow for examination by a medical practitioner, that did not take into account the detailed explanation which Dr Robinson gave in his evidence of his consideration of the five criteria for short-term detention and why he exercised his clinical judgement in the way that he did.

[74] Dr Tuddenham indicated that there would likely be a range of medical opinions on David Reid's detainability. That is reflected in the difference of opinion between, on the one hand, Dr Robinson and Dr Tuddenham who considered that the criteria for detention had not been met and, on the other hand, Dr Scott who considered that nurse detention should have been utilised. As highlighted by Sheriff Braid in the Fatal Accident Inquiry into the death of Marion Bellfield:

> "A Fatal Accident Inquiry cannot prescribe how doctors or nurses should exercise their judgement. Put another way, the true precaution which ought to be taken in any given case may simply be a requirement that a patient is seen by a suitably skilled doctor, rather than how the doctor exercises his skill and judgement thereafter."[1]

[75] I therefore accepted the evidence of Dr Robinson and Dr Tuddenham in relation to the reasonableness of the decision not to detain.

[76] Furthermore, in light of Dr Robinson's evidence of the short timescale for review of detention, which was supported by Dr Scott, I do not consider that even if David Reid had been detained to allow for fuller assessment, that would have resulted in David Reid being detained for long enough such that the death of the deceased might

[1] [2011] FAI 21.

realistically have been avoided. The evidence of how David Reid presented after his discharge did not suggest that he ought to have been detained.

[77] In terms of section 26(2)(g), both the Crown and David Reid's counsel sought a finding in relation to the importance of good clinical record-keeping. Whilst it is axiomatic that good clinical record keeping is important, that does not appear to me to be a fact which is relevant to the death of the deceased, in light of the evidence led.

[78] I therefore have not made any findings or recommendations in relation to the decision not to detain David Reid.

(ii) Information Sharing

[79] Dr Doig gave evidence on 20 May 2021. He carried out a local adverse event review for NHS Tayside. The report concluded, *inter alia*, that there was no delay in communication between Dundee and Aberdeen. It was not possible to conclude that having been admitted out of board was a root cause for the deceased's death. There did not appear to have been a loss of significant information in the process of transfer. The clinical information available to staff in Aberdeen about a recent relapse in psychosis and historical information about risk of harm to others was the same as would have been passed from the community mental health team to Dundee if David Reid had been admitted locally.

[80] Dr Doig also explained that since the deceased's death, a new electronic patient record had been implemented which made it easier to record information and print it out in a usable format when a patient was transferred.

[81] The information passed to the community mental health team at the point of discharge on 18 October 2017 did not highlight David Reid being at imminent risk of harm to himself or others. Telephone contact was made within 24 hours by a member of staff who knew David Reid well and arrangements were made to review David Reid in person within seven days of his discharge from hospital. David Reid had experienced transient breakthrough of symptoms previously which had resolved quickly. At the last point of contact by mental health services in Tayside on 18 October 2017 there was no concern about a willingness to attend for the next appointment or concern about non-adherence to medication or substance use. David Reid did not present as having active psychotic symptoms. Taken as a whole, the clinical picture did not clearly suggest it was necessary to review David Reid in person on 19 or 20 October 2017.

[82] Dr Palin gave evidence on 20 May 2021. He carried out a level two incident review summary report at NHS Grampian. There was evidence of good multi-disciplinary working and communication between medical, nursing and pharmacy staff as well as the GP with regards to David Reid's physical care. In addition to a transfer clinical letter, the transfer team from NHS Tayside included a nurse who David Reid was familiar with and this was recognised as good practice. The nursing risk assessment and medical clerking were completed within the recommended timeframe. He also noted the good practice of contacting a member of the Tayside community mental health team to inform them of David Reid's unexpected discharge by telephone.

Submissions

[83] No findings in terms of section 26(2)(e), (f) or (g) were sought by any party in relation to information sharing.

Findings and Recommendations

[84] In the absence of any evidence of a material shortfall or other deficiency in the information provided by Tayside Health Board to Grampian Health Board or by Grampian Health Board to the community mental health team, I have made no findings or recommendations in relation to information sharing.

Conclusions

[85] Fatal Accident Inquiries enable us to scrutinise the decisions of medical professionals and others with the benefit of hindsight to see if any lessons can be learned to avoid such tragic events in the future. It is tempting to assume that because David Reid killed Mark Johnston within three days of discharging himself against medical advice from Royal Cornhill Hospital, something must have gone wrong in terms of the exercise of clinical judgement. However, that was not borne out by the factual or opinion evidence in this inquiry. It is not clear why David Reid's mental state deteriorated after his departure from Royal Cornhill Hospital but that was not due to any failings on the part of the medical professionals who worked with him, nor the system within which they worked.

[86] I would like to thank the witnesses for their time and co-operation with this inquiry. I am also very grateful to all the solicitors and counsel involved for their assistance in focusing the scope of the inquiry, conducting the inquiry via WebEx and for their detailed written submissions.

[87] Finally, I wish to express my sincere condolences to Mark Johnston's family and friends, which were echoed in the submissions made by all parties.