OUTER HOUSE, COURT OF SESSION

[2023] CSOH 1

A291/19

OPINION OF LORD ARTHURSON

In the cause

(FIRST) VIOLET PATERSON; (SECOND) ROSS PATERSON; (THIRD) JANET FINDLAY; (FOURTH) ALISSA GIBLEN; and (FIFTH) KRISTOFER WILLIAM GIBLEN

Pursuers

against

LANARKSHIRE HEALTH BOARD

Defenders

Pursuers: Smart KC, Waugh; Levy & McRae
Defenders: Stephenson KC, Gardiner; NHS Scotland Central Legal Office

6 January 2023

Introduction and chronology

[1] Mrs Lynette Giblen ("the deceased") was born on 20 June 1981 and died at her own hand on 10 October 2016. She was a beautiful singer, a gifted photographer, a loving mother and a most affectionate and dutiful daughter to her beloved mother, the first pursuer, Mrs Violet Paterson, who was herself born on 6 November 1944. The deceased was the sibling of the second and third pursuers, from whom she was in large part sadly estranged due to a family rift. The fourth and fifth pursuers were her equally beloved children, now aged 20 and 22 respectively. There are other family members, including the deceased's husband, but none is a party to the present action.

[2] Following a discharge from Ward 19 at Hairmyres Hospital on 16 September 2016, the deceased moved within days from the family home that she shared with her husband and children to live with her mother in Glasgow. On 9 October 2016, the deceased was at the first pursuer's home and speaking in a disturbed manner. The first pursuer left her to calm down and briefly visited local shops. On returning from the shops, she thought that the deceased was in the bathroom. She called up but got no response. Having banged on the door of the bathroom she managed to get the door open and found the deceased hanging behind the bathroom door by her dressing gown. She carried out mouth to mouth resuscitation. Ambulance staff attended and transported the deceased to the Southern General Hospital, Glasgow where she died the next day, with the first pursuer at her bedside. I consider it necessary, to record that following departure of the deceased with paramedics in the ambulance, the first pursuer was sufficiently traumatised that she had a seizure.

[3] The deceased had a long history of suicide attempts. She had taken eight overdoses by the age of 14 and took ten further overdoses in the next 7 years. She took her first overdose at the age of 11. Subsequent additional overdoses were recorded in 2007, 2008, 2009, 2013, 2015 and March 2016. That month she had given evidence at the trial in England of a relative who was in due course acquitted of sexually abusive conduct towards her. At the age of 16 the deceased had been diagnosed as suffering from an emotionally unstable personality disorder ("EUPD").

[4] The principal events detailed in the deceased's extensive medical records were not at issue between the parties, who helpfully produced an agreed chronology. Supplementing that material with the evidence led by the parties at proof, I will now attempt to set out the uncontroversial factual and clinical background to this truly tragic case as follows.

[5] On 17 June 2016 the deceased attended at Wishaw General Hospital Accident and Emergency Department and was subsequently admitted to Hairmyres Hospital. On 20 June 2016 she was discharged from Hairmyres Hospital. On 14 July 2016 she was admitted to Leverndale Hospital and detained on an emergency detention certificate, being transferred to a psychiatric intensive care unit. On 1 August 2016 the deceased was discharged from Leverndale Hospital. On 8 August 2016 she was admitted to Hairmyres Hospital and detained under a short-term detention certificate. On 9 August 2016 the deceased was reviewed by Dr Vusikala and a mental health officer and her detention was continued. On 26 August 2016 the short-term detention certificate was revoked and she agreed to remain on the ward at Hairmyres Hospital. On 27 August 2016 she was granted a two day pass. On 29 August 2016 she was escorted back to Hairmyres Hospital by police and ambulance services. On 30 August 2016 the deceased went missing from the ward. Ward staff were contacted by staff at Lindsay House, who advised that she had presented there. She returned to the ward in a taxi. On 31 August 2016 she left the ward but later returned that day under a police escort. On 1 September 2016 the deceased was detained under a short-term detention certificate. She required constant observation. An admission to a psychiatric intensive care unit was considered. On 12 September 2016 she was reviewed by a nurse and noted to appear calmer for longer periods. On 13 September 2016 she was reviewed by Dr Waddell, Consultant Psychiatrist, and Martin McGavin, a mental health officer. She was allowed home on an overnight pass, which was extended to 16 September 2016. On 15 September 2016 the Lanark Community Mental Health Team had a Multi-Disciplinary Team ("MDT") meeting at which Dr Vusikala and Mr McGavin were present and it was noted that the deceased's mental health was much improved. On 16 September 2016 the deceased returned from her pass. An MDT meeting took place on the ward at Hairmyres

Hospital. The deceased and her husband Christopher Giblen were present. The deceased was reviewed and discharged by Dr Vusikala.

[6] On 19 September 2016 the deceased's case was allocated to Community Psychiatric Nurse ("CPN") Mark Hume. Following her discharge the deceased had various interactions in person and by telephone with a variety of professionals, including general practitioners and latterly the police. She also interacted with family and friends, in particular the first pursuer and a Ms McDevitt, and I will return to those interactions in due course. On 20 September 2016 she attended the East Kilbride office of Women's Aid and met Lynsey Queen. The deceased appeared to be very emotional and advised that she and her husband were being evicted. She made allegations in respect of her husband and said that she wanted to stay in Glasgow close to her mother. Miss Queen, who had previously been a support worker with the Richmond Fellowship, stated that the deceased had displayed a "kind of paranoia". On 21 September 2016, the deceased telephoned the CMHT and spoke to staff nurse Donna Cairney about her medication. Donna Cairney recorded that she was calm and thankful but advised that the call was a brief one. On the same day the deceased attended a face to face appointment with Dr Hadrian Ofoegbu of the Glebe Medical Practice, Lesmahagow who recorded that she was "upset ++" and "agitated ++". He advised her to stay on her medication. She indicated to him that she did not agree with her diagnosis. Dr Ofoegbu confirmed that he had received no training in mental health assessment. On 22 September 2016, the deceased spoke by telephone with another general practitioner, Dr Susan Dixon, and asked to change her psychiatrist. On 23 September 2016, she had a telephone conversation with Thomas Durkin, of the Clydesdale Resource Network, a social worker member of Lanark CMHT. The deceased asked where and when her appointment was with her doctor and the CPN. On 27 September 2016 she had a telephone conversation

with Steven McKendrick, a senior social worker who was a member of the Lanark CMHT. He arranged to meet her on 28 September 2016, but she did not attend.

[7] On 28 September 2016 the deceased had a face to face appointment with another general practitioner at the practice, Dr Alistair Kerr. He advised that he had been trained in mental health assessment as part of his GP training but had received no training in the risk of assessment of self-harm. He advised that the focus of the consultation was the deceased's wish to change her consultant. She made an allegation against her husband. The rest of the consultation note refers to her computer being hacked, to live feeds coming up on that computer and to a person who told her that she would be imprisoned and abused by "the Elite". On 28 September 2016 Dr Kerr advised CPN Hume that the deceased had mentioned certain odd ideas, including masonic conspiracy, at the consultation. Dr Kerr sent a referral letter to the Clydesdale Resource Network at Lanark Health Centre on 29 September 2016, which letter was received on 3 October 2016. In a box marked "additional administrative information", Dr Kerr recorded in respect of "Suicide/self-harm Risk" the response "Yes". Addressing this in evidence, Dr Kerr advised that if the deceased had been, in his view, suicidal at the time of the consultation, there would in fact have been no letter of referral; instead, he would have sent her directly to hospital. He explained that the response "Yes" related to her history and in particular to her history of self-harm.

[8] On 29 September 2016 an MDT meeting took place at Lanarkshire CMHT during which the deceased's case was discussed. On 29 September 2016 a telephone message was left for CPN Hume from the National Stalking Helpline. On that date CPN Rebecca Tait spoke to the deceased by telephone. The deceased asked about her diagnosis and said that she was not sure that it was correct. The witness recorded that the deceased was very upset at the beginning of the conversation, but managed to calm down following reassurance. On

3 October 2016, the deceased attended a face to face appointment with another general practitioner at the practice, Dr Zia Islam. He confirmed that he had no specialist training in mental health and advised that the deceased had wanted a referral to a psychiatrist for another opinion. She had stated that she was not psychotic and did not have a personality disorder. Dr Islam advised that there were no signs at that consultation which would have caused him to send her to a specialist, for example suicidal ideations or intentions. He accepted, however, that he had not asked her about suicidal intention. On 4 October 2016 the deceased telephoned the police and made allegations about her treatment at Leverndale Hospital. The police later submitted an adult concern report to Lanarkshire Social Work Department. On 5 October 2016, the deceased telephoned the CMHT and left a message with the psychological therapies team. On 9 October 2016 the deceased attempted to take her own life by hanging at her mother's home in Glasgow. She was admitted to Queen Elizabeth Hospital, Glasgow, on that date and died on 10 October 2016 in the Intensive Care Unit there.

The evidence of Dr Vusikala

[9] In written pleadings duties of care were advanced on behalf of the pursuers in respect of Dr Vusikala, the deceased's Consultant Psychiatrist at Hairmyres Hospital and her Responsible Medical Officer ("RMO") and additionally in respect of CPN Hume. In the course of the pursuers' proof, senior counsel indicated that she was no longer insisting upon her case against CPN Hume. Accordingly, the sole case against the defenders was in respect of their vicarious liability for the conduct of Dr Vusikala. All of the averred duties focused upon that conduct as at 16 September 2016, being the date of the deceased's discharge from

Hairmyres, but none involved criticism of the decision to revoke the short-term detention certificate or indeed the decision to discharge the deceased into the community.

[10] Dr Vusikala in 2016 was a locum Consultant Psychiatrist based at Lanark Health Centre. He had certain duties in respect of inpatients at Hairmyres Hospital, Ward 19. In respect of the deceased's presentation in the course of her admission to Hairmyres Hospital in June 2016, Dr Vusikala's view was that while paranoid ideation was demonstrated, there was no suicidal ideation. She was in extreme distress and the features of her illness appeared to be changing considerably. Dr Vusikala himself met with the deceased for the first time on 6 July 2016 at an outpatient appointment at Hairmyres Hospital. She had presented with distress and, in Dr Vusikala's view, was not able to focus on the actual consultation. Dr Vusikala candidly confirmed in his evidence that he had at no time been aware of the deceased's suicide attempt by overdose in March 2016. Curiously, Dr Vusikala's letter to the deceased's general practitioner in respect of that outpatient appointment consultation was not sent until as late as 30 September 2016. Following the deceased's admission to Hairmyres Hospital on 8 August 2016, she was assessed by Dr Vusikala on 9 August 2016. She presented with acute distress due to her ongoing beliefs, all in the context of an existing disorder and with a background of trauma. Dr Vusikala's view was that the beliefs were fleeting and fragmentary, rather than fixed in nature. He advised that she had disagreed with her diagnosis of EUPD from the outset; indeed, her disagreement with the clinical team was always a feature of her time at Hairmyres Hospital. In Dr Vusikala's view her condition fluctuated. A variety of atypical antipsychotic medications were prescribed, with Dr Vusikala agreeing in his evidence that a change of medication on 20 August 2016 could be read as a marker on an index of the severity of her condition at this point. By 23 August 2016, Dr Vusikala's impression at a ward round was

that the deceased's condition was improving. The chronology in late August 2016 of the granting of a pass and her various returns to the ward, notably on 31 August 2016 under police escort, are set out above. On 1 September 2016 facedown restraint techniques were utilised by staff as the deceased attempted to abscond on several occasions, with high expressed emotion and the voicing of paranoid ideation. Dr Vusikala advised that the proportion of inpatients at Hairmyres Hospital requiring such restraint techniques was between 10 and 20% only. On 2 September 2016 at a ward review, Dr Vusikala discussed the possibility that a reference to the IPCU may be required. On 9 September 2016 at a ward review with Dr Vusikala, the deceased continued to display delusionary beliefs. Treatment began that day with a new antipsychotic medication, namely Aripiprazole. The minutes of a MTD review meeting held on 15 September 2016, with Dr Vusikala present, record an increase in Aripiprazole medication and that her mental health was much improved. An overnight pass granted on 13 September 2016 is recorded as having been successful and it was noted that it was highly likely that the short-term detention certificate would be revoked. Dr Vusikala accepted that the minute recorded no discussion of any putative discharge. The likely revocation of the short-term detention certificate was due, Dr Vusikala advised in his evidence, to the progress that the deceased had made that week.

[11] At Dr Vusikala's ward review on 16 September 2016 it was recorded that the deceased's mental state was much improved and that the passes had gone well. Her husband was present with her on the ward. The detention certificate was duly revoked and the decision made to discharge her to her home address where she lived with her husband and children. The discharge is recorded as having occurred at 1300 hours on 16 September 2016. The note of the discharge entry was taken by a junior doctor who was at year two in her training and not a qualified psychiatrist. Dr Vusikala fully accepted that he alone was

responsible for the decisions made at the time of the deceased's discharge. In a subsequent letter dated 10 October 2016 to the medical officer at the Mental Welfare Commission for Scotland, Dr Vusikala confirmed a diagnosis of, *inter alia*, EUPD and "psychosis - not specified". In terms of follow-up, the patient was to continue with Aripiprazole as prescribed and there was to be an outpatient appointment and CPN follow-up and clinical psychology referral in due course. The ward review note of 16 September 2016 noted an outpatient follow-up with Dr Vusikala "in 2 weeks at Lanark HC" and confirmed that "CPN referral will be done by Dr Vusikala". Dr Vusikala accepted that there was no mention in the MDT minutes of 15 September in respect of any discussion about discharge or indeed any plan for discharge. He agreed that these would be important matters to record in the minutes of such a MDT meeting. He further accepted that the plan for discharge made on 16 September 2016 was a plan that he was responsible for devising on that date, and that he had anticipated that the CPN follow-up in the community would take place within a week or two as he put it in his evidence, that period reflecting his understanding of the deceased's presentation on the ward at that point.

[12] Dr Vusikala advised that at the ward round on 16 September 2016 during which the decision was made to discharge the deceased, she and her husband each declined the support offered by the way of the Extended Hours Service ("EHS"). Dr Vusikala accepted that her decision to decline that support was not recorded. He also accepted that no formal letter was sent to any community psychiatric nurse or to the team. CPN Hume's evidence on this matter was that he had returned from leave on 19 September 2016 and that, on finding that the deceased's CPN care had been transferred to his caseload, he had arranged to meet her when she attended in due course for an outpatient appointment on 11 October 2016 at 11am with Dr Vusikala. Mr Hume confirmed that he had attended Dr Vusikala's

office and that it was then agreed that a joint assessment between himself as the CPN and Dr Vusikala as the consultant psychiatrist could and would take place on 11 October 2016. CPN Hume had made that decision on the basis of information gleaned from his discussion with Dr Vusikala that it was appropriate to see the deceased on that date.

[13] Dr Vusikala accepted that it would be important to record arrangements for the follow-up of the deceased in the community and that this had not been done. He accepted that the decision of the CPN to arrange to meet the deceased on 11 October was an appointment fixed with him, being the outpatient appointment date which he had made due to, as I understood it in terms, caseload pressure. Senior counsel for the pursuers asked Dr Vusikala why he would have told CPN Hume that there was no need for him to see the deceased until 11 October 2016. Dr Vusikala indicated that he had "no clear answer for this". He accepted that he knew that she was unsupported by the EHS, being the post-discharge follow-up service staffed by the CPN team. Once more, having been asked why, with his knowledge of her illness history on the ward and his knowledge that the deceased was at home, unsupported, he would indicate to CPN Hume that it was appropriate to postpone the first CPN appointment in the community until 11 October 2016, Dr Vusikala's response was that he did not "have an answer to that". The plan made at discharge, which was for CPN cover on discharge and an outpatient appointment with Dr Vusikala within two weeks, that is to say by 30 September, simply did not happen, Dr Vusikala accepted.

[14] By way of further relevant background, the discharge letter to the deceased's general practitioners was dictated on 27 September 2016 but not typed until 4 October 2016 and therefore was presumably received by the practice after that date. In any event, Dr Vusikala accepted that the discussion in respect of the refusal by the deceased and her husband to accept EHS support had not been recorded in the electronic notes used by the junior doctor

who had prepared the discharge letter, and that accordingly and of considerable significance, the general practitioners supervising her care in the community, and who met with her from 21 September 2016 onwards, did not know that the deceased had been at home from 16 September 2016 without the support of the EHS; nor did they know that she had not yet met with any CPN after discharge and while in the community. In respect therefore of the matter of the monitoring of the deceased's compliance with medication between the date of discharge and the scheduled outpatient appointment on 11 October 2016, Dr Vusikala's position was that responsibility was on the patient, here the deceased, and that she had been given certain phone numbers to contact the team. Dr Vusikala further confirmed that he did not himself take any steps to ensure that the deceased was receiving follow-up in the community during the post-discharge period.

[15] With regard to the change in the discharge plan from an outpatient appointment within two weeks, to making one for 11 October 2016, that is to say 24 days after discharge, Dr Vusikala was unsure when this change had taken place but advised that this was an appointment which had been found to be available in his outpatient clinics. Senior counsel asked Dr Vusikala whether such a 24 day period would be normal or usual practice for follow-up by the treating psychiatrist of a patient discharged from a short-term detention certificate while on antipsychotic medication. Dr Vusikala's candid evidence was that this was not usual practice. Dr Vusikala further accepted that the discharge planning had taken place on 16 September 2016 on the ward with the deceased's husband, and that her mother, the first pursuer, with whom she had moved to live after only a few days following discharge, would not have received the advice that the husband did in respect of what to do if faced with signs of deterioration.

[16] Senior counsel for the pursuers put a guidance document published on 30 August 2016 by the National Institute for Health and Care Excellence (NICE) to Dr Vusikala, who indicated in his evidence he was simply not aware of this guidance. He accepted the proposition arising from the guidance, however, that there was an increased incidence of suicide in mental health inpatients within the first three months after their discharge, and he himself volunteered that there was, in general, a high risk of this within such a cohort.

The expert evidence led by the parties

[17] Dr Charles Musters, led by senior counsel for the pursuers, was a Consultant Psychiatrist based at Newham University Hospital, East London. He had been a consultant since 2009 and from 2015 to 2021 had been the Associate Clinical Director at the East London NHS Foundation Trust, which Trust covered a total population in excess of one million people. He had been responsible for designing and implementing a new service known as the Crisis Care Pathways at the Trust. His clinical speciality was as a perinatal psychiatrist. Dr Musters had listened, by Webex link, to the bulk of the evidence of Dr Vusikala and to the evidence of the first pursuer and CPN Hume.

[18] In general terms Dr Musters took no issue with the diagnosis of EUPD, noting that suicidality was a core diagnostic feature of that condition, and that the deceased's illness was at the upper end of severity of such a condition. He noted that, with regard to gaps between suicide attempts, there were quite lengthy periods of remission, whereby levels of distress and of high risk behaviour had been considerably reduced. With regard to the delusions which emerged in 2016 following the criminal trial in March, it was unusual for a patient with this personality disorder to have such delusions appearing repeatedly and with consistent themes over such a length of time; indeed, this was, looking at the overall history

of her illness, unusual for the deceased herself. The experience of hallucination, rather than delusion, was more common in patients with such a personality disorder. During her Hairmyres admission, the deceased had demonstrated a very poor level of insight. She had disputed her diagnosis and the appropriateness of her medications. Further, she had acted on her delusions, that is to say that her deluded beliefs drove what Dr Musters termed as real world behaviour, for example her behaviour at the end of August 2016, where she had required to be returned under police escort.

[19] In terms of treatment, those with this personality disorder are properly subject to short-term safety planning and long-term psychological therapy. The prescription of antipsychotic medication has as its principal purpose the effect of tranquillising the patient. The *quasi* psychotic symptoms emerging during the Hairmyres admission were, in Dr Musters' opinion, new, evolving and carried a high degree of unpredictability, which unpredictability elevated risk. The deceased had endured a profoundly turbulent time while in hospital and had received the highest levels of psychiatric intervention, having been sectioned. She had been as sick as anyone could be in a psychiatric ward. While at the point of discharge she was willing to engage, in the context of all that had recently gone before, it was not reasonable to suppose that this stability would be maintained. Dr Musters on several occasions during his evidence referred to the term "cliff edge", which as I understood it was, in the context of such a discharged inpatient, a shorthand reference to the requirement upon clinical staff to ensure a close and timely follow-up with considerable support at home while a discharged inpatient such as the deceased was in the community. The package of care selected at discharge on 16 September 2016 would not, in Dr Musters' view, have provided the intensive care required by the deceased. The 24 day period that she was expected to wait, and of course remain stable, before any single aspect of her care plan

would be implemented, was wildly out of keeping with the timescales over which her own mental health had fluctuated within the preceding period. Dr Musters illustrated this by reverting back 24 days from the date of discharge, which took the patient back to the period before her discharge in late August 2016.

[20] Turning to the NICE August 2016 guidelines, Dr Musters considered these to be illustrative of what safe care would look like in the context of a long recognised risk. The guidelines were themselves syntheses of already known evidence, and constituted recommendations in respect of the care to be provided in the context of that previously undertaken research. The two concrete recommendations applicable in the circumstances of this case were that a discharged inpatient should be followed up within seven days, and, if a risk of suicide has been identified, that discharged inpatient should be followed up within 48 hours. In the local context in which the deceased found herself, the EHS available was provided by community psychiatric nurses into the early evening on a seven day a week basis. This indeed had been set up to provide such care in the context of a seven day follow-up. Dr Musters inferred that the care plan here was accordingly out of keeping even with local practice. She did not receive an adequately planned discharge from hospital and the follow-up in the community was not in keeping with the care that she actually required. The treating clinical team had been faced with a pattern of repeated crises admissions followed by abrupt deterioration; it was accordingly their responsibility to develop a plan to attempt to halt this pattern. The discharge on 16 September 2016 had been the deceased's fourth discharge from hospital since June 2016. The deceased had left hospital not actually knowing when she would be seen by any member of the team. The date of her future appointment with Dr Vusikala, her appointment with the CPN, and even the name of that CPN, were all unknown to her. She had been left without a sense of when she would be

seen again, and this was important for someone with EUPD, which was essentially a disorder of attachment. In addition, the deceased had been discharged to the marital home, which was known to be an unstable environment for her, and of course which the patient required to leave within a few days to move to Glasgow to stay with the first pursuer.

[21] There was here an overall risk of a whole range of unwanted outcomes including suicide, which risk should have been incorporated into a management plan, in particular by Dr Vusikala agreeing with the deceased what a safe follow-up in her case would and should comprise. In the context, in this case, of the deceased and her husband declining the EHS, Dr Musters stated that it would be mandatory to have had had a very careful and on the record discussion of why that was their position, and thereafter to agree on a negotiated "Plan B" care plan, ranging for example from daily home visits to home visits every other day or twice a week and from office appointments to telephone contact. There was no indication in the medical records or from the evidence of Dr Vusikala that such a discussion took place at all. Dr Musters' position on timing of any follow-up was that the outer limit would be a seven day period, and indeed such a Plan B care plan would require to be accompanied by a warning that this was not the recommended plan nor a plan guaranteed to keep her well.

[22] Suicide prevention was a vast topic, Dr Musters advised, and while there was no silver bullet, as it were, to effect substantial change in this area, there were many interventions which could be introduced at various levels. In that context, a seven day follow-up would indeed have comprised the outer limit of safe follow-up care for this patient, the deceased. Within this period it would have been obvious that her mental health had deteriorated and in such circumstances her care plan could then be stepped up and made more intensive. In routine clinical practice such a negotiated care plan discussion

need only take four or five minutes, with the team effectively undertaking to support the patient by way of various components of safe scaffolding, as Dr Musters put it, around such support. The fact that the patient was detained at the time of this discussion would have given considerable scope for a negotiated plan, with the section only being revoked in the event of a safe negotiated and agreed care plan being put in place for going home.

Dr Musters concluded his evidence on the standard of care by asserting that it was very firmly his belief that no competent psychiatrist would have devised such a plan that would have allowed this particular patient to remain in the community in the circumstances that she did for a period of 24 days. Looking at the period after discharge, by 28 September 2016 and her attendance with Dr Kerr at the GP practice, it was very clear that her mental health had deteriorated. It was likely that she had stopped her antipsychotic medication and relapsed into an agitated and delusional state. It was of note that in the post mortem report, the medication that the deceased had left hospital with a prescription for, namely Aripiprazole, was not present on toxicology findings.

[23] On causation, Dr Musters was clear that in his view the deceased's suicide was associated with and indeed a function of her mental health relapse. Suicidality was a diagnostic feature of her personality disorder condition, and the risk of suicide would increase when a person with this disorder was unwell. It was clear that she had become unwell again after her discharge, and that was the context in which she died. The provision of adequate care would have prevented, or at least noted and thereby prevented, the deterioration in her mental health and, more likely than not, her death would have been prevented. Her history had been one of extended periods of stability, interspersed with periods of instability. The condition was itself a relapsing and remitting one. In Dr Musters' view the deceased would have achieved a period of lasting remission with competent

treatment and considerable input; indeed, that would have been the purpose of therapeutic follow-up and community psychiatric nurse allocation. It was an achievable target, even in her circumstances, to return her to a period of relative remission. Even in the brief window prior to her discharge on 16 September 2016, it had been demonstrated what could be achieved in terms of stability with comprehensive care, including antipsychotic medication and nursing care. With all of the scaffolding of her inpatient stay having been removed very abruptly and not replaced with anything which would have been tangible to her, she had very quickly slipped back into a condition of unwellness.

[24] Since the late 1990s the longer term prognosis for those with EUPD had been considered to be better than previously thought, with the delivery of appropriate therapies and a shift towards the view that effective treatment could bring about real change. Therapies were available in most NHS settings, comprising group therapy over 18 months, and Dr Musters was confident that this would have been the correct stepping stone to guide further treatment pathways in the deceased's case. With EUPD, the exact timing and nature of any impulsive behaviour was not predictable to the outsider; nevertheless impulsivity as a trait was one which could be observed, recognised more broadly and taken into account. Dr Musters concluded his evidence by asserting that not everything that a patient suffering from EUPD does is impulsive in nature. With regard to a final act of suicide, this, Dr Musters reflected, was often the end of a long road of despair and hopelessness.

[25] Dr Nabila Muzaffar, Consultant Psychiatrist, was led as an expert by senior counsel for the defenders. Dr Muzaffar became a consultant in 2004 working as in inpatient and outpatient consultant from 2004 to 2006 and then as an inpatient and intensive home treatment consultant from 2006 to 2019. Since 2019 she had worked in an eating disorder service. She is the clinical director for specialist services at NHS Forth Valley. In summary,

her position was that she did not find evidence of negligence in the care and treatment of the deceased in this case; indeed, the deceased's diagnosis and treatment plan were in accordance with what other psychiatric services would have provided in 2016. Prior to being instructed in the present case for the defenders, Dr Muzaffar had only prepared one previous court report, and her appearance in the witness box in this proof was her first appearance in court as an expert witness. Dr Muzaffar had viewed, by Webex link, part of the evidence of the first pursuer, and the bulk of the evidence of Dr Vusikala.

[26] Dr Muzaffar observed that Aripiprazole had first been prescribed on 9 September 2016. It would have taken some four to six weeks to begin to alleviate any psychotic symptoms. This drug was not a calming medication. Olanzapine was the antipsychotic medication preferred for its sedating effects. With regard to the condition EUPD, Dr Muzaffar described this as a disorder of emotional dysregulation and advised that when in a state of heightened emotional distress, patients can experience auditory hallucinations and paranoid ideas. She advised that some 30 to 40% of patients in this cohort present with psychotic symptoms. NICE guidance suggest that the prescription of psycho-pharmacology ought to be time-limited, but in practice clinicians tended to continue with it. The EUPD cohort had an elevated risk of suicide over their lifetimes. Dr Muzaffar considered the deceased to be a low risk of death by suicide, standing the nature of her presentations during her admission. She had not expressed any wish to die and her actions appeared to be future-focussed in particular after discharge, requesting help from bodies such as social work and accommodation assistance, and indeed she had agreed to attend in due course for outpatient appointment. Dr Muzaffar concluded that the deceased was on her discharge considering a future for herself. A patient, such as the deceased, was legitimately entitled to make a choice to decline the EHS service, albeit an appropriate care plan on discharge

would require to comprise a multidisciplinary approach. Such an approach had been duly adopted in her case by the proposed psychological therapies in due course and the appointment of a community psychiatric nurse.

[27] The deceased herself had, in Dr Muzaffar's view, a tendency to be impulsive, and it was likely that her final action of suicide was of the nature of a reaction to a crisis. A feature of EUPD was that of an excessive reaction to something others would regard as a minor matter. Such patients are entirely dysregulated and can carry out an emotional reaction which can endanger their lives.

[28] The NICE guidance published in August 2016 had been preceded by guidance dated December 2011, which did not set out a follow-up timeframe. Dr Muzaffar explained that it could take several years for guidance like this to filter into practice. In her own health board area the August 2016 guidance had taken some two years to do so, and in any event, the witness advised, not all recommendations are followed to the letter. The referral to psychology and the scheduling of an appointment with a CPN at the consultant outpatient appointment some 24 days after discharge was within the range of acceptable practice in 2016, the witness asserted. In any event, EUPD was not a diagnosis that would necessarily be prioritised as urgent by all psychiatrists. Dr Muzaffar drew a distinction between a gold standard practice and a reasonable practice. The treatment itself would take a long time to deliver. In the whole circumstances, Dr Muzaffar's view was at odds with Dr Musters, and she advised that she did not agree that the care plan adopted by Dr Vusikala was an unsafe one.

[29] In cross-examination Dr Muzaffar accepted that in her report summary of the deceased's clinical history, she had omitted to mention an overdose of Sertraline which featured in the records in August 2015, and another overdose, this time of Amitriptyline, in

March 2016. She had further omitted to mention the patient's presentation immediately prior to her August 2016 Hairmyres admission whereby the records indicated that she had tried to push a knife through her neck in the presence of her children. The witness took the view that she would not regard this an episode of self-harm, but changed that opinion when advised that the court had heard evidence from a witness who had seen a mark on the deceased's neck after she had tried to cut herself, which cut was not a deep one. The witness also changed her position on her assessment of the patient as presenting at discharge with a low risk of dying by suicide, when advised that Dr Vusikala's evidence was that there was a medium risk of that at discharge. The witness indicated that she would then revise her own position to accord with medium risk.

[30] Dr Muzaffar agreed with senior counsel for the pursuers that suicidality was a diagnostic feature of EUPD; that there was an elevated risk of suicide on discharge; and, that since June 2016, the deceased had presented with agitation and persecutory ideas which resulted in suicidality. Dr Muzaffar explained that patients with this personality disorder tended to carry a high risk of suicide but contended that it cannot be predicted when that might manifest itself. The vast majority of patients do not go on to kill themselves. In short, it was very difficult to predict who would do so and when. That said, the witness accepted that a deterioration in the patient's mental health could have been predicted after she left hospital. When, however, senior counsel put to the witness that it was predictable that suicide could occur if she developed delusional persecutory ideas following discharge, Dr Muzaffar stated that it was not predictable when the deceased would have developed these ideas and when she would carry out such a final act. In the case of this patient there had been periods when distress and persecutory ideas were not prominent, she asserted, but agreed that from June 2016 onwards the longest period she had managed to go without

outpatient or inpatient contact was one week, and that the discharge on 16 September 2016 had been her fourth. Dr Muzaffar further agreed that in terms of illness the deceased was at the more severe end of the EUPD inpatient cohort at the time of her discharge.

[31] Dr Muzaffar asserted that the deceased was entitled to make a choice to decline the EHS service offer, if she had the capacity to do so, but accepted that she had not declined the offer of EHS contact at the time of her earlier discharge on 20 June 2016, and that she had met with Dr Vusikala at an outpatient appointment on 6 July 2016, that is to say within a 16 day follow-up period. It was put to Dr Muzaffar that it had not been safe to leave the deceased in the community without support from a CPN or EHS services during the 24 day period between discharge and the scheduled first appointment with the CPN and Dr Vusikala. Dr Muzaffar indicated that she would be safe as she would have come to the attention of "services", should her condition deteriorate. The witness nevertheless accepted that such putative contact with social workers and general practitioners after discharge was no substitute for a structured assessment and proper care plan on discharge. Dr Muzaffar emphasised in general that in such circumstances the patient has a responsibility for her own wellbeing and safety. The referrals here to a CPN and to psychology constituted evidence of a multidisciplinary approach to care, in the witness's view. Dr Muzaffar indicated that she was unaware of the reasons for the first CPN appointment being left to coincide with the first outpatient appointment. The witness did not criticise Dr Vusikala for this, but confirmed that she had indicated in her joint statement, following her meeting with Dr Musters in September 2020, that it would be unusual to leave the first CPN appointment to the first outpatient appointment. Curiously, while accepting that she was not aware of the reasons for this decision, Dr Muzaffar continued to defend the decision, stating, as if the argument was closed, and without developing the point, that "the decision itself can stand".

Submissions for the parties

[32] Senior counsel for the pursuers submitted that the primary duty of care in respect of Dr Vusikala should properly be characterised as a failure in treatment rather than a duty to reduce, avoid or prevent the risk of suicide. Under that analysis, the issue became one, in relation to treatment and follow-up after the deceased's discharge on 16 September 2016, of whether there was a foreseeable risk of deterioration. The breach of duty arose during the intervening period between discharge and death, and it was during that period that the evidence supported, senior counsel submitted, the proposition that there was a foreseeable risk of the occurrence of a devastating episode of self-harm, an attempted suicide, or suicide itself. There was accordingly a foreseeable risk of potentially adverse outcomes for the deceased, one of which, suicide, sadly came to pass.

[33] Senior counsel submitted that the deceased had an unusually severe episode of illness while in Hairmyres Hospital, having required compulsory detention in hospital on three occasions along with physical restraint, one to one constant observation and intramuscular sedation. From around 10 September 2016 a period of more settled mood had followed the commencement of the atypical antipsychotic aripiprazole on 9 September 2016. This period of stability was short, and it was plain, senior counsel submitted, that that relatively stable state would require continuing treatment and significant support to maintain. Any deterioration would be marked by the return of delusional beliefs, into which the deceased would not have insight, resulting in agitation and distress. Founding on the factual evidence led and the opinion of Dr Musters, senior counsel submitted that such a deterioration was entirely foreseeable. Senior counsel observed that Dr Muzaffar had also accepted in evidence that a deterioration would be predictable. In the absence of any safe

care plan for the period of 24 days following discharge and the scheduled outpatient and the CPN appointment on 11 October 2016, such a deterioration was indeed likely to occur. It was not controversial that there was an elevated risk of suicide for EUPD inpatients in the first three months following their discharge, and that suicidal behaviour was part of the diagnostic description of EUPD, and a picture of post-discharge deterioration had duly emerged from the evidence of those who had interacted with the deceased between her discharge and death.

[34] Senior counsel submitted that, there being no record anywhere in the medical notes, including in the letter written by Dr Vusikala to the Mental Welfare Commission on 10 October 2016, no offer in respect of the EHS had been made to the deceased at discharge. Dr Vusikala's position was that he would have made such an offer, on the basis that such an offer was made as a matter of practice to all patients. *Esto* the court accepted that such an offer had been made to the deceased by Dr Vusikala at discharge, no attempt had been made in respect of any explanation of the range of services which could have been provided by way of support or even to negotiate a level of involvement which may have been acceptable to the deceased. The evidence of CPN Hume was that he had not been made aware by Dr Vusikala of the deceased's refusal of the EHS.

[35] Dr Vusikala could not offer any clinical rationale for delaying the first CPN appointment until 11 October 2016. He had accepted that a period of 24 days until the CPN and psychiatry outpatient appointment was not normal practice. The initial discharge plan for a psychiatric appointment within two weeks and a follow-up by the community psychiatric nurse within one week had plainly been varied by Dr Vusikala following his discussion with CPN Hume on 19 September 2016, whereby it was agreed that the first CPN appointment could coincide with the outpatient appointment already scheduled for

11 October 2016. The revised discharge plan, allowing for a CPN and psychiatric review at the 24 day mark was not in accordance with normal practice for planning and managing the care of an inpatient such as the deceased following discharge. The pursuers' case, put short, was that in such circumstances it was negligent to discharge the deceased without a care plan which provided her with support, supervision, monitoring and intervention for the period prior to the joint appointment on 11 October 2016. Dr Vusikala's actions in relation to devising and managing the post-discharge care plan for the deceased accordingly fell below the standard expected of an ordinarily competent consultant psychiatrist. Following an analysis of the evidence of the competing experts, senior counsel submitted that Dr Vusikala had failed to arrange a follow-up for the deceased in the community for assessment after one week, which would have been the least period to constitute acceptable practice in the light of the deceased's recent history and relatively brief period of stability prior to discharge on her particular medication.

[36] Turning to causation, senior counsel contended that the absence of any psychiatric follow-up care for the deceased for the period of 24 days gave rise to a reasonably foreseeable deterioration in her psychiatric condition. Accepting that what must be foreseen in this case was psychiatric harm in the form of significant deterioration in the deceased's mental health occurring in consequence of there being no arrangement for her support, that being the damage founded on by the pursuers, senior counsel emphasised that the act of suicide was not the damage, but a consequence of the damage: the damage was the significant deterioration in her mental health, and the negligence identified in the present case had increased her psychotic illness. Put short, the suicide of the deceased should properly be seen as a consequence of unmonitored psychiatric deterioration, but in the context of the deceased's relapse from a period of relative stability, the occurrence of suicidal

behaviour was itself a foreseeable type of harm which could have resulted. But for the negligence, it was submitted that the deceased would have received follow-up from a CPN within a week at the latest, and with intervention, support and the monitoring of her medication, the deceased's condition would not have deteriorated in the severe manner in which it did. The pursuers' approach on the issue of causation was accordingly to submit that "but for" causation had been established in the circumstances of this case. This was an appropriate approach, given the impossibility of tracing the actual course of the deceased's decline, as of course there were no records available to facilitate such a trace, this problem having arisen precisely because of the negligent failure to provide appropriate and timeous community follow-up.

[37] Turning briefly and finally to quantum, senior counsel set out a series of ranges of damages for each of the pursuers in respect of section 4(3)(b) of the Damages (Scotland) Act 2011, rather than advancing a particular figure for each party. Lump sum awards should additionally be made, it was submitted, in respect of loss of services to the fourth and fifth pursuers. It was conceded by senior counsel very properly that insufficient evidence had been led to allow any claim in respect of loss of support to be advanced.

[38] Senior counsel for the defenders submitted that there was a paucity of pleadings in respect of causation in the pursuers' principal condescendence of fault. It was of note that the pleadings had failed to pin any colours to the mast, as it were, in respect of the date by which the deceased should have been seen by Dr Vusikala, or indeed whether she should have been seen more than once after that. The longstop position for review spoken to by Dr Musters was a period of seven days. The pursuers accordingly, senior counsel submitted, should be seen as having perilled their case on the deceased being in a particular condition at that seven day period, that is to say by 23 September 2016, in respect of which

condition further care would indeed have been offered to and accepted by her. The court accordingly required to determine the condition of the deceased as at 23 September 2016, as a matter of logic, it was submitted, and further required to determine what intervention would have been offered to and agreed by her as at that date. Accordingly, on causation, which had been pled only on a "but for" basis by the pursuers, the court would have to be convinced that there was a duty by 23 September 2016 to institute a system of care that would have avoided the deceased's death. Senior counsel emphasised that it should be remembered that this was a fatal case, and, as a helpful check on that proposition, observed that there was no entitlement on the part of any of the pursuers to any damages apart from by way of the death of the deceased. The court had heard no real evidence in respect of how the deceased was on 23 September 2016, nor had it heard any proper evidence on what a putative care plan would have been at that time, had the deceased been seen and assessed, senior counsel submitted.

[39] Senior counsel observed that a patient such as the deceased had what he characterised as a "right to refuse" on the basis of her autonomy, it having been determined that she had capacity. While clinicians could and would provide advice and offer a care plan, a patient is entitled to refuse all of that while they remain competent and non-detainable, senior counsel submitted.

[40] The pursuers' case in this action was entirely, senior counsel submitted, one based on failure; it was, in short, a case which should properly be characterised as one of negligent omission. Both experts in the present case had been able to express views on causation on a "but for" basis, and accordingly the principle of material contribution was not a relevant one. Indeed, senior counsel submitted that the present case had nothing to do with material

contribution, and no evidence had been led in respect of that alternative approach to causation.

[41] The events that Dr Vusikala required to speak of in his evidence had occurred six years ago. No direct contradictor to his evidence had been led. The junior doctor who had been present at the discharge had presented a soul and conscience certificate, and the deceased's husband had not given evidence. There was no real reason not to accept Dr Vusikala's evidence, accordingly, on the principal facts in issue in the case.

[42] The composite effect of the deceased's post-discharge contacts with a variety of professionals was compelling, senior counsel submitted. None of these contacts had appeared to escalate her care because, for example, they thought that she was at imminent risk or even that she should not be in the community. The referral made by Dr Kerr was routine, and the focus of that referral was on the deceased's wish to change psychiatrist.

[43] Commending the evidence of Dr Muzaffar as a qualified expert with directly relevant clinical experience, including of EUPD, senior counsel observed that it had not been put to her what the reasonably competent psychiatrist or indeed CPN would have advised on 23 September 2016. In any event, the issue was not what would have been done, but was whether what was done was within the scope of the exercise of clinical care of a reasonably competent consultant psychiatrist. Dr Musters, in contrast, lacked relevant experience and in this case appeared to have stepped over the line between expert and advocate for the pursuers' case. In particular, senior counsel submitted that Dr Musters' evidence about the deceased's post-discharge pathway amounted to speculation.

[44] Senior counsel submitted that the eventual suicide by hanging had happened in the context of a significant stressor in respect of the deceased's husband's refusal to bring the children to Glasgow to see her. In so far as the first pursuer had left the deceased in the

house on 9 October 2016, it was clear that she had had no concerns of prospective self-harm, and this put the deceased's condition at that time into a proper perspective.

[45] In concluding his submissions on causation, senior counsel for the defenders contended that there had been no evidence that after discharge the deceased had suffered a significant relapse. The pursuers' causation argument relied on an inference of mental collapse, but Dr Musters' position on that was a speculative one, particularly so on the key date of 23 September 2016. No evidence had been led from the clinical team caring for the deceased in respect of what care would have been offered to the deceased had she been seen by that date. In respect of the final act of suicide by hanging, the court may consider, senior counsel observed, that it is simply unable to express a view, standing the lack of evidence on this matter.

[46] Finally, on matters of quantum, senior counsel referred to a short written submission thereon prepared by his junior, in which certain figures were referred to, relative to each pursuer, in terms of section 4(3)(b) of the 2011 Act. It was accepted in that document that a small lump sum would be appropriate as a services award for the fourth pursuer, but the document was, on my reading, inexplicably silent in respect of any potential services award for the fifth pursuer.

Discussion and decision

[47] The facts of the case were in very large part not in dispute between the parties, save the single issue of whether Dr Vusikala had indeed offered the facility of the EHS to the deceased and her husband during his pre-discharge meeting with them on 16 September 2016. At the outset therefore it may be helpful for me to indicate that I accepted Dr Vusikala's evidence on this point. He was the only witness to this pre-discharge

discussion who gave evidence at the proof. Put short, Dr Vusikala had no contradictor on the point. In any event, however, I found Dr Vusikala to be a credible witness who gave evidence, it has to be said, in a subdued manner, but with considerable candour throughout, which was to his credit. He himself accepted that he did not thereafter, however, engage in any negotiated, as it were, follow-up arrangements with the deceased at the meeting.

[48] A key moment in the evidence led at the proof arose in Dr Vusikala's examination by the pursuers' senior counsel when he accepted, again quite frankly, (i) that he did not take any steps, having fixed an appointment with himself for 11 October 2016, to see to it that the deceased was receiving any follow-up in the community; and (ii) that the fixing of that consequent 24 day period prior to 11 October 2016, in respect of an inpatient such as the deceased who had been discharged from a short-term detention order while on anti-psychotic medication, was not usual practice. Other examples of Dr Vusikala's candour included his equally frank admission that he had not seen the August 2016 NICE guidance before it was presented to him in the witness box during examination in chief. In this context Dr Vusikala further, again with candour, agreed that there was an increased incidence of suicide in respect of discharged inpatients within the first three months following their discharge, and that this could be categorised as a high risk.

[49] Having had his EHS offer rejected and not attempted to reach a compromise with the deceased on follow-up arrangements, it is trite to observe that Dr Vusikala plainly knew that the deceased was being discharged into the community with no EHS support. On that hypothesis of fact, which I have found to be established, Dr Vusikala was asked why, with his own knowledge of how the deceased had been in hospital as an inpatient, and with the knowledge that she was at home unsupported during the post-discharge period, he had indicated, as he accepted he had done, to CPN Hume that it was acceptable to postpone her

appointment with CPN Hume to 11 October 2016. With equal candour Dr Vusikala's response was that he did not have an answer to that. When pressed on the point, his position was that he "thought it might be okay to have a joint appointment that day". I have reached the view, in the whole circumstances of this truly tragic case, that this answer and approach are simply not good enough.

[50] The original plan on discharge on 16 September 2016 was for CPN involvement on discharge and an outpatient appointment with Dr Vusikala within two weeks, that is to say by 30 September 2016. Dr Vusikala accepted that this plan simply did not play out in reality, even although the deceased was plainly, given her history, at the higher end of nursing care need. He further accepted that he had made no record of the deceased's refusal of the EHS on 16 September 2016 nor any of his discussion with CPN Hume on 19 September 2016 in respect of the scheduling of the CPN appointment, and that accordingly these significant discussions had simply not been documented. Against that background, in which at no point was any clinical rationale for the revisal of the discharge plan recorded, let alone articulated, I found it difficult to accept the *ipse dixit* evidence of the defenders' expert that the decision to have a joint follow-up in 24 days in respect of this particular patient, the deceased, could, as that witness put it, "stand".

[51] The *de quo* of the pursuers' case, as developed in the evidence and based on the pleadings in the case in respect of duty of care, was that it was negligent of Dr Vusikala to discharge the deceased without an appropriate care plan which would have provided her with support, supervision and potential intervention during the period between discharge on 16 September 2016 and the rescheduled joint appointment with himself and CPN Hume on 11 October 2016.

[52] On the evidence led I am content that the pursuers have established such negligence. In my view the deceased was foreseeably at risk of deterioration in respect of her psychiatric health following discharge. The approach adopted by the responsible clinician, and apparently endorsed by the defenders at proof, of leaving her to fend for herself with phone numbers only could not on any view be said to take into account the significant risk of deterioration applicable in her particular case. Over a period of months following the criminal trial in March 2016 at which the deceased had given evidence, the deceased had been subject to multiple admissions and discharges. It was uncontroversial that there was an elevated risk of suicide for those with her condition following their discharge and indeed that suicidal behaviour was part of the diagnostic description of that condition. Contrary to the defenders' expert's view that the prior history of suicide attempts comprised only the taking of overdoses, there was evidence for the deceased attempting to set her hair on fire while in hospital on 28 July 2016 and further evidence that she had threatened to kill herself while holding a knife at her throat prior to her admission on 7 August 2016, in respect of which incident her friend Ms McDevitt confirmed that she saw a mark on the deceased's neck inflicted by her while she was trying to cut herself. It is worth noting that despite the successful three day home pass in the week prior to her final discharge, the deceased was only released from the September 2016 short-term detention order on the date of her discharge. The overall picture presented of the deceased's residence at Hairmyres Hospital as an inpatient was one of severe illness. The records themselves refer to the application of physical restraint and one to one constant observations.

[53] The decision of Dr Vusikala to discharge the deceased was never the subject of criticism in this case. The criticism encapsulated in the pursuers' case focused instead upon the intervening period following discharge during which there had been a failure to provide

appropriate care and treatment to the deceased and further that that failure carried with it the foreseeable risk of a devastating episode of self-harm, attempted suicide or indeed suicide. For the foregoing reasons I accept these advanced propositions in this case, supported as they were by the compelling evidence of Dr Musters against the whole background of the factual and clinical evidence led. For the avoidance of doubt I am content to hold that Dr Musters' outlier period of seven days, echoed in the applicable professional guidance of the time, can be endorsed by the Court in this case.

[54] For the pursuers it was further contented that, had the discharge been planned and managed in such a way that it took account of the significant risk of psychiatric deterioration, on the balance of probabilities that deterioration would have been avoided, as would the deceased's completed act of suicide. I do not find it difficult to hold that such a deterioration occurred. In particular on 20 September 2016, several days of course prior to senior counsel for the defenders' putative 23 September 2016 key date, the deceased visited Women's Aid at East Kilbride. The team manager, Ms Queen, formerly and significantly a mental health support worker, described the deceased's presentation as paranoid, very emotional and confused. Ms McDevitt, the deceased's friend, described meeting her at the end of September when the deceased had told her that the hospital had been injecting her; indeed, her impression of the deceased was that she was actually worse than ever. Dr Kerr spoke to his consultation of 28 September 2016 during which the deceased described her computer being hacked and had made reference to being told that she would be imprisoned and abused by "the Elite". Prompted by reference to the evidence of CPN Hume, Dr Kerr additionally accepted that he must have conveyed to CPN Hume in his follow-up telephone conversation that the deceased had also spoken at the consultation of a Masonic conspiracy. Additionally, on the basis of uncontested evidence from Ms Queen, I am content to hold that

the deceased moved to Glasgow to stay with the first pursuer on 20 September 2016. In a statement adopted by her as part of her evidence, the first pursuer described the deceased coming to live with her (para 12 of her statement of 31 October 2022). She advised that it was clear that the deceased was not getting any better. She was pacing the hall, biting her nails and telling her that people were coming to get her. The deceased told her that she felt that the doctors at the hospital were after her.

[55] On the basis of that substantial body of evidence I am content to hold that there was a significant deterioration in the deceased's condition with obvious signs of delusional beliefs. That psychiatric deterioration being unmonitored by the professionals charged with her care, without any supplementary ongoing community-based care and intervention, appears to me to fortify the proposition advanced on behalf of the pursuers, which I accept, that, suicidality being a predictable outcome of such a deterioration, had her improvement been maintained by appropriate post-discharge follow-up and care, the deceased's deterioration and consequent completed suicide could and would on balance have been avoided. The fact that the deceased was seen by several general practitioners does not assist the defenders here. The practice had simply not been notified by the hospital, for example, of the non-involvement of EHS, the deceased having declined that service and no alternative support having been agreed with her by Dr Vusikala. In any event, the evidence of Dr Musters was that with a safe care plan in place, involving support and monitoring, the pre-discharge period of stability could and again would have been maintained, in particular by way of CPN support, all under reference to the deceased's prior periods of stability.

[56] Senior counsel for the defenders further submitted that the final act of suicide occurred following the deceased's husband's refusal to bring their children to Glasgow to see her. Standing the terms of Dr Kerr's note of 28 September, Ms Queen's observations of

20 September and the cumulative effect of the evidence on these matters from the first pursuer herself and Ms McDevitt, I regard this contention as neither here nor there given the broader picture of the development of the deceased's illness over the weeks during which she was left alone in the community without assistance from the responsible psychiatric professionals charged with her care. In her statement adopted in evidence, the first pursuer at paragraph 16 described the deceased as being "a bit ratty" on the day of her suicide. The first pursuer's statement goes on to state that:

> "It didn't seem like any one thing in particular that upset the deceased that day. The deceased was just doing her usual ranting and saying that there were people coming to get her and that people were trying to do things to her. I told her she needed to calm down and that I was going to the shops."

On the basis of that adopted evidence I further wholly reject the defenders' contention, on the evidence, of any part whatsoever in what occurred being due to any issue about the children being brought to Glasgow or not.

[57] Pausing at this point, I consider it apposite in the whole circumstances of the causation chapter of this case to refer to a *dictum* of Lord Pentland in *Andrews* v *Greater Glasgow Health Board* 2019 SLT 727 at paragraph 162 where his Lordship stated:

> "… It is highly likely, as the evidence amply shows, that in those circumstances her AMI would have been identified and successfully treated by expert medical staff. That is a matter of common sense, as it seems to me. I remind myself of the famous observations of Lord Reid in *McGhee* v *National Coal Board* 1973 SC (HL) 53, that the legal concept of causation is not based on logic or philosophy; it is based on the practical way in which the ordinary man's mind works in the everyday affairs of life."

In my view, and adopting if I may with respect that sound approach, this is such a case.

[58] In all of these circumstances I hold that the completed suicide of the deceased in this case on 9 October 2016 was a direct consequence of the deterioration of her psychiatric

condition following her discharge, being one of a range of damaging outcomes foreseeable in the whole circumstances, all as outlined at length in this opinion.

[59] Finally, in respect of parties' submissions, senior counsel for each party advanced some criticism of the other side's expert. For the record I found none of these criticisms to be well-founded and was content that each expert was duly qualified and of sufficient experience to advance the opinion evidence that they did. The court indeed wishes to express its gratitude to both Dr Musters and Dr Muzaffar for their most helpful and illuminating opinion evidence in this case.

[60] Turning far more briefly and finally to matters of *quantum*, I propose to take a broad approach and to make the following awards. The first pursuer on any view experienced considerable distress and anxiety in contemplation of the deceased's suffering before her death, during the period of discharge and as she encountered her on 9 October 2016 hanging behind the bathroom door in her home, administered mouth to mouth resuscitation and then collapsed when the deceased was taken to hospital by ambulance. The first pursuer's grief, distress and sorrow manifested itself in an extreme physical way, and I observe in passing that during her evidence the distress exhibited by her, even from a remote location through Webex link, was quite tangible. In these circumstances I make an award under section 4(3)(b) of the Damages (Scotland) Act 2011 in respect of the first pursuer in the sum of £100,000, inclusive of interest to date.

[61] The deceased's siblings, the second and third pursuers, had a very distant relationship with the deceased. The medical notes record that the deceased had been ostracised by members of her family, and I considered that this entry included those pursuers. The second pursuer did not return to complete his evidence in court and struggled even to remember the time of year that his sister had died. I note also that the

third pursuer, actually the deceased's half-sister, only lived for a very short period with the deceased and that there was a 16 year age gap between them. In the whole circumstances, in respect of these pursuers, I award each under section 4(3)(b) of the 2011 Act the sum, again inclusive of interest, of £5,000. Finally, the fourth and fifth pursuers, now aged 20 and 22 respectively, being the children of the deceased who were respectively as at her date of death aged 13 and 15, awards under this head will be made in the sum of £70,000 each, again inclusive of interest.

[62] In the course of submissions the claim advanced on record for loss of support for the fourth and fifth pursuers was abandoned, but a claim in respect of each for services was maintained, albeit on a nominal lump sum basis. I take the view that there was no adequate evidential basis led in respect of this head and make no such award for either pursuer.

Disposal and expenses

[63] For all of the reasons set out above, I now sustain the pursuers' first and second pleas-in-law, repel the defenders' pleas-in-law and pronounce decree in favour of the respective pursuers all as set out in the immediately preceding paragraphs. Senior counsel for the defenders invited the court to reserve matters of expenses in the event that the defenders were unsuccessful on the merits and causation, and as a courtesy to him, I now do so. These determinations will all be reflected in the accompanying interlocutor.