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IN THE CORONERS COURT IN NORTHERN IRELAND

CORONER MARIA DOUGAN

IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF RORY HUGHES

Mr Nick Scott appeared on my behalf (instructed by Mr Eamon O'Connor, Coroners Service for Northern Ireland (CSNI))
Mr Michael McGarvey appeared on behalf of the Next of Kin (NOK) (instructed by Ms Emma Williamson, Brendan Kearney & Company Solicitors)
Mr Michael Lavery appeared on behalf of the Western Health and Social Care Trust (WHSCT) (instructed by Ms Sarah Loughran, Directorate of Legal Services (DLS))
Mr Christopher Summers appeared on behalf of the Police Service of Northern Ireland (PSNI) (instructed by Ms Sue-Helen McConnell, Crown Solicitor's Office (CSO))
Ms Leona Gillen appeared on behalf of the Department for Infrastructure (DfI) (instructed by Ms Maeve Toal, Departmental Solicitor's Office (DSO))
Mr Robert Millar appeared on behalf of Dr Michael Warren (instructed by Mr Kevin Hegarty, Tughans Solicitors)

Introduction

[1] The inquest was held in Laganside Courthouse from 13 to 22 January 2025. During the 8-day inquest, I received oral evidence from 20 witnesses, and I carefully considered a further nine statements, together with voluminous medical notes, records, reports, photographs and CCTV footage, which were admitted pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ('the 1963 Rules'). While it is not feasible to set out all the evidence in these findings, I wish to make clear that I have duly considered all evidence presented before reaching my conclusions.

[2] The deceased, Rory Hughes, born on 11 November 1965, of Tyrone and Fermanagh Hospital, 1 Donaghanie Road, Omagh, died on 15 December 2019 in the River Foyle, Derry.

Summary of events

[3] The deceased had been diagnosed with schizoaffective disorder. His mental health remained stable from 2005 until he began to experience a relapse in 2018. In early 2018, his medication required modification due to the development of serious complications arising from his long-term Lithium therapy. During 2018 and early 2019, he required periods of hospitalisation. In June 2019, he was readmitted to Lime Ward, Tyrone and Fermanagh Hospital, Omagh, where he remained, as a detained patient under the Mental Health (Northern Ireland) Order 1986 ('the 1986 Order') until the date of his death. Factors which were causing the deceased significant distress included ongoing and intrusive concerns relating to his finances and his future placement. On 10 December 2019, the deceased requested unaccompanied leave. He was assessed by the multi-disciplinary team (MDT), who jointly agreed to grant such leave. At approximately 15:00 hours on 14 December 2019, the deceased availed of unaccompanied leave and departed from Lime Ward. He did not return to the ward. At 19:00 hours, the Absent Without Leave (AWOL) policy was initiated and at 19:55 hours, the PSNI were notified. At 23:13 hours, the deceased was observed on the Foyle Bridge. PSNI officers arrived at the scene at 23:20 hours, as the deceased climbed the railings and threw himself into the river below. The deceased was recovered from the water by Foyle Search and Rescue. Life was pronounced extinct at 00:29 hours on 15 December 2019.

Scope of the inquest

[4] It was agreed by the Properly Interested Persons (PIPs) prior to the inquest commencing that:

(1) The scope of this inquest is to consider the four statutory questions.

(2) When considering the four statutory questions the Coroner will consider in particular:

    (a) Insofar as they informed or should have informed the Trust's assessment of the risk Mr Hughes posed to himself on 14 December 2019:

        (i) Mr Hughes' psychiatric condition and his treatment for that condition.

        (ii) Mr Hughes history of suicidal ideation and the Trust's knowledge of that ideation.

        (iii) Mr Hughes status as a detained patient of Lime Ward.

        (iv) Mr Hughes' history of going AWOL from Lime Ward and the Trust's response.

(v) Mr Hughes' history of visiting Foyle Bridge and/or rivers.

(b) The decision to grant Mr Hughes unaccompanied leave on 14 December 2019.

(c) The decision to initiate the AWOL policy on 14 December 2019.

(d) The steps taken by the Trust once the AWOL policy was initiated.

(e) The PSNI's response to the report from the Trust that Mr Hughes was AWOL.

(f) Mr Hughes' movements on 14 December 2019.

(g) Suicide prevention at the Foyle Bridge prior to 14 December 2019, including the steps taken by the Department for Infrastructure and the Derry City and Strabane District Council prior to 14 December 2019 to minimise the risk of people committing suicide at the Foyle Bridge.

[5] An inquest is a fact-finding exercise; it is not a criminal or civil trial. The correct standard of proof to be applied when considering any issue at inquest, is the civil standard, the balance of probabilities, and I must be satisfied that any act or omission caused or contributed in more than a minimal or negligible way to the death.

[6] I am satisfied that this inquest has addressed all the relevant issues and that, where possible, I have reached a finding in respect of the matters which come within the scope of this inquest

Evidence

[7] These findings are divided into five parts:

- **Part 1**: The deceased's diagnosis, care and treatment from 2018 including his admission to Lime Ward in June 2019;
- **Part 2**: The decision on 10 December 2019 to grant unaccompanied leave from Lime Ward;
- **Part 3**: Events on 14 December 2019: unaccompanied leave;
- **Part 4**: The search for the deceased on 14 December 2019;
- **Part 5**: Suicide prevention on the Foyle Bridge.

Summary of evidence

Background

Evidence of Martin Hughes

[8] Mr Martin Hughes, the deceased's brother, gave evidence to the inquest on behalf of the deceased's family. He told the inquest that the deceased's life was unusually turbulent and challenging, he stated "everyone around him, particularly our parents did the very best they could for him, but his childhood, teen years and early adult years were very troubled for him and for those around him."

[9] Mr Hughes described his brother as "very intelligent", and funny. The deceased loved music and singing. Prior to his admission to Lime Ward, he was an active member of multiple choirs and a community group. He was "functioning at quite a high level and being as content as he probably could be." Mr Hughes described how things started to go significantly wrong for the deceased when Disability Living Allowance (DLA) was changed to Personal Independence Payment (PIP) in June 2016. The deceased became very concerned about his financial status and concerned that he was going to be homeless.

[10] The deceased was readmitted to Lime Ward in Tyrone and Fermanagh Hospital, in June 2019, and as time progressed, the deceased's family were increasingly concerned about the communication with Lime Ward and the deceased's trajectory.

[11] In November 2019, Mr Hughes and his sister Barbara, who both live outside Northern Ireland, visited home. Prior to this visit, Mr Hughes tried to resolve some of the issues around the deceased's rumination and obsessive behaviours, primarily triggered by the state of his finances, by repeatedly emailing and telephoning Lime Ward. Mr Hughes explained that all efforts with the deceased's consultant, Dr Patrick Manley and his social worker, Ms Geraldine Kerr, failed to come to any meaningful conclusion. Mr Hughes sent numerous detailed emails to Lime Ward throughout the deceased's admission which went unanswered.

[12] Mr Hughes and Ms Barbara Hughes had two meetings with the Lime Ward team, on 7 November 2019 and 11 November 2019. During both meetings the deceased's family raised concerns over the deterioration in the deceased's physical and mental condition. The deceased had become a heavy smoker, having been smoke-free for about 8 years; he had put on a significant amount of weight; become addicted to sugary drinks and his demeanour was slow and ponderous.

[13] Mr Hughes detailed how the Lime Ward team repeated the mantra that the patient was the prime decision maker, with regards to their own care. However, Mr Hughes was of the view that the deceased's mental illness directly impaired his decision-making capacity.

[14] The deceased's finances were an ongoing issue. One issue remained, namely the activation of a bank card with a PIN number. The deceased's family had resolved a name issue on the deceased's bank cards, and the PIN was the only remaining issue. Ms Kerr verbally agreed to action this, by taking the deceased to the bank to change a PIN on one of his bank cards, which Mr Hughes stated did not occur.

[15] Mr Hughes told the inquest that in the month prior to taking his life, the deceased had made attempts to travel to the Foyle Bridge while in his family's care. On 8 November 2019, the family took the deceased to a concert, and he tried to steal their father's car and go the Foyle Bridge. On the same day, they were shopping for new clothes and the deceased disappeared. When he was found leaving the shopping centre, he told his siblings that he wanted to go to the bridge. The deceased's family briefed staff when they returned him to Lime Ward. Their concern from this point onwards was that deceased would escape from Lime Ward and go AWOL. Mr Hughes commented that they never believed that the deceased would be granted unaccompanied leave. They also expected they would be informed of such a significant change in his care plan should it occur.

[16] When Mr Hughes returned to New Zealand, the deceased continued to telephone him about the lack of resolution in relation to his bank card. The family made multiple follow-up phone calls to Ms Kerr. The deceased's family believed this further amplified the deceased's paranoia, ruminations and anxiety, and in turn heightened his families concerns about him escaping Lime Ward and travelling to the Foyle Bridge.

[17] On 13 November 2019, Mr Hughes emailed Lime Ward and expressed safety concerns for both the deceased, their father and sister Aideen, should the deceased go AWOL. Mr Hughes stated, "our concern around Dad's safety relates to Rory's historical capacity to lie about not being suicidal (when he is) coupled with his ability to carefully plan events that might allow him to travel when he is not allowed to. As discussed, a hypothetical future possibility could be that when Rory is deemed safe enough to, for example, walk to the shop, he could easily get a taxi and bus and be on dad's doorstep (or the Foyle Bridge) before his absence at Lime (or a residential home) might be noticed and acted upon." Mr Hughes gave specific phone numbers for staff to ring should this occur. Mr Hughes was not contacted until 19.00 hours, four hours after the deceased had left Lime Ward on 14 December 2019. Mr Hughes stated that had the deceased's family been contacted at the earliest opportunity, they would have taken direct action in terms of looking for him. In total, 8 hours passed between the deceased leaving Lime Ward and him jumping from the Foyle Bridge.

[18] Mr Hughes told the inquest that it was the family's prediction that the deceased would escape from Lime Ward and travel to the Foyle Bridge. He explained, "a very strong characteristic of Rory, was that he was very, very stubborn and that could sometimes be a strength, and it could sometimes be a weakness, but if he decided he was going to do something or not do something, he would really lock

on to that. And it was that understanding of his history that had us concerned, that one way or another he was going to get to the bridge."

[19] Mr Hughes told the inquest that the deceased's death has left an indescribable void within their family, a void filled with grief and an enduring sense of needless loss that transcends words. Before his admission to Lime Ward, the deceased was an active, vibrant man, who enthusiastically engaged in choirs, music groups and relationships. Mr Hughes stated that the deceased died a heavy smoker who had become overweight. In his view, the steady deterioration in the deceased's physical health in Lime Ward was directly linked to his worsening mental health issues.

[20] Mr Hughes stated that the deceased was "a very talented guy, he was very bright, but for whatever reasons, he probably didn't get to express those talents and capabilities due to a lot of the turbulence and difficulties that he experienced in his life." The deceased's family held the view that the deceased's death was as preventable as it was predictable..

Evidence of Sarah Hughes

[21] Ms Sarah Hughes, sister of the deceased, gave evidence to the inquest, which was admitted by way of Rule 17. She stated that despite the deep trauma and numerous challenges that the deceased put her and the rest of the family through over the years, even at his most seriously ill, she was able to see the 'real Rory' was still there and that he was worth fighting for. She and her family have been dealing with the shockwaves caused by the deceased's mental health issues since she was 10 years old, over 36 years. She stated that the last chapter of the deceased's life – from December 2017 onwards, was the most difficult to manage.

[22] Between January 2018 and September 2019, she was the primary family carer/representative in the deceased's care. She visited him often bringing supplies, playing Scrabble and taking him out to lunch with their father. She dealt with the medical staff and the Community Mental Health team, spent time trying to contact his social worker to clarify his benefits and finances, and attended several meetings to discuss his condition and future care. By September 2019, the stress of managing this situation had become too much and from October 2019 onwards she had to step back from the deceased's care.

[23] Ms Hughes took the view that if Lime Ward staff had listened sufficiently to the family and acted on the information, they provided or the requests they made, his suicide could have been prevented, or at the very least postponed. She disagreed with using self-guarantee of safety – a verbal acknowledgement from the deceased that he was not suicidal, despite recent and repeated clear examples that he was and a clear, long and widely known history of not being fully honest with staff about his mood, as documented in his extensive notes. She was also critical of Lime Ward staff not informing the family that the deceased would be allowed out for unaccompanied walks and not sharing vital communications with all staff such as contact details of

those that should be contacted if he left the ward, and significantly, taking notice of the family's view that he would head to the Foyle Bridge.

[24] Ms Hughes outlined her concerns in the deceased's care, such as how there should have been senior level cover for Dr Manley, the deceased's consultant, when he was off on leave; how an important decision of unaccompanied leave was left in the hands of a junior member of staff; the lack of a sign-in, sign-out policy for Lime Ward residents, and the failure to give the deceased a time limit for unaccompanied leave so the staff could monitor his return.

[25] Ms Hughes made several suggestions to the inquest on how care and treatment for patients, like her brother, could be improved. These included the development of a robust, internal and external communications policy across the Trust; listening to families and taking their ideas on board as they know their loved ones best; security improvements in Lime Ward with sign-in, sign-out sheets, cameras, allocated times for unaccompanied walks, AWOL protocols tested, and the introduction of flexibility in patient treatment plans as mental health is not 'one size fits all' and treatments should not be either.

Evidence of Dr Anne Louise Hicks

[26] Dr Anne Louise Hicks, the deceased's GP, gave evidence to the inquest, which was admitted by way of Rule 17. She described how the deceased joined the practice in 2005, when he was living in Woodbank House. He was diagnosed with Bipolar disorder which stabilised well with medication. He had regular reviews by the mental health team but no hospital admissions.

[27] The deceased was on Lithium medication and on 2 July 2015 he was diagnosed with Diabetes Insipidus Nephrogenic secondary to Lithium therapy, and his medication was subsequently changed.

[28] On 14 January 2018, the deceased had his first acute admission in 10 years. He was voluntarily admitted to Silverwood Ward in Craigavon Area Hospital. The deceased felt this mental deterioration was due to the death of his mother in 2017.

[29] The deceased was admitted to Lime Ward in April 2018. He was monitored and discharged and reviewed regularly by the Community Mental Health Team. The deceased then was readmitted to Lime Ward in June 2019 where he remained until his untimely death.

Evidence of Caroline Swift

[30] Ms Caroline Swift, Manager of Woodbank House Residential Care Home, Omagh, gave evidence to the inquest, which was admitted by way of Rule 17. She described how the deceased was a patient in Beech Villa Omagh and then admitted to Woodbank House on 25 April 2005, which is accommodation for adults with enduring mental health difficulties. Ms Swift explained that during his residency, the deceased passed his driving test, travelled to various concerts, was actively

involved in social events and was a member of the choir. She described him as a quiet gentleman who preferred his "own space" in Woodbank.

[31] In January 2018, the deceased expressed concern about "losing his money." He had completed a PIP form and following this, he became "fixated" and anxious about how he had completed the form.

[32] On 14 January 2018, PSNI contacted staff as the deceased had been observed near the Foyle Bridge in Derry. The deceased was admitted to Bluestone Unit in Craigavon Area Hospital and then moved to Lime Ward. He was discharged from Lime ward in April 2018. The deceased continued to present with agitation and paranoia towards staff, mainly Ms Swift. He agreed to voluntary admission to Lime Ward in May 2018. The deceased was discharged from Woodbank House on 31 March 2019 (having retained a place there while in Lime Ward), and the deceased remained in Lime Ward from that point on.

Part 1: The deceased's diagnosis, care and treatment from 2018, including his admission in Lime Ward in June 2019

Evidence of Dr Farooq Ahmed

[33] Dr Farooq Ahmed, Specialty Doctor, Mental Health Service, Omagh Hospital and Primary Care Complex, gave evidence to the inquest. Dr Ahmed knew the deceased since 2011. He recounted how the deceased was diagnosed with schizoaffective disorder and maintained on a combination of antipsychotic medication Olanzapine and mood stabiliser Lithium Carbonate on a long-term basis.

[34] Dr Ahmed reviewed the deceased several times in 2016 and 2017, during which time, he was diagnosed with Diabetes Insipidus. Lithium was reduced and Olanzapine was increased. The deceased continued to enjoy a relatively stable mental state.

[35] In August 2017, Dr Ahmed reviewed the deceased as he had become very concerned after receiving a letter regarding his eligibility to continue to receive employment support allowance.

[36] The deceased was assessed by the Crisis Response/Home Treatment Team on 15 January 2018 following a referral of low mood and active suicidal intent. He was admitted to Bluestone and was subsequently transferred to Lime Ward.

[37] During this admission he required a transfer to the South West Acute Hospital after having marked deterioration of his physical health. He was diagnosed with complications due to increased sodium levels. His Lithium was completely stopped, and a new mood stabiliser Sodium Valproate was commenced. He returned to Lime Ward and after a short discharge, he was readmitted and required a further lengthy admission due to acute deterioration of his mental state between 26 April 2018 and 2 May 2019.

[38] On 30 May 2019, Dr Ahmed was informed by staff from Rathview Mews, that the deceased had developed a further deterioration of mental state and there was evidence of early psychotic features in relation to his fixation on his finances.

[39] Dr Ahmed reviewed the deceased again on 6 June 2019 and he continued to demonstrate moderate low mood and mild psychotic features, and he was commenced on an antidepressant medication Sertraline.

[40] Dr Ahmed's last interaction with the deceased was a crisis assessment on 18 June 2019, following a deterioration of mental state. Following this, the deceased was admitted to Lime Ward.

Evidence of Dr Sarah Heal

[41] Dr Sarah Heal, Specialty Doctor in Forensic Psychiatry in the Community Forensic Mental Health Team, gave evidence to the inquest. She described how the focus of their work is the care and management of patients with a history of a mental disorder and who are involved or at risk of becoming involved with the criminal justice system. She explained that between 2000 and 2003, three separate referrals were made to Forensic Mental Health Services. Dr Heal's initial assessment of the deceased was on 10 February 2005, and she subsequently reviewed the deceased during his engagement with the Forensic Mental Health Team both in the inpatient clinical setting in Beech Villa, Tyrone and Fermanagh Hospital and on an outpatient basis when he resided in Woodbank House, Omagh.

[42] Over the following years, the deceased engaged intermittently with the Community Forensic Mental Health Team. He was initially diagnosed with bipolar affective disorder and was later diagnosed with schizoaffective disorder in early 2019. She stated that in practice, both diagnoses are a combination of symptoms which involve both mood symptoms and psychotic symptoms and the treatment of both is broadly similar.

[43] Dr Heal commented on a potential brain injury, for which the deceased underwent CT scans in February 2018, whilst in the South West Acute Hospital. She stated that, to her knowledge, the clinical team in the medical ward did not relay any requirements for follow up or investigations. She stated that around that time she had reviewed the deceased quite regularly and at no point had she seen any evidence of cognitive impairment or disorientation, or any concerns regarding his cognitive function. During assessments, beginning in March 2019, concerns about the deceased's cognitive function were picked up by Dr Heal, as well as being mentioned by ward staff, and the deceased's family. Further investigations by way of cognitive assessments and blood investigations followed, which did not show any ongoing issues that needed to be addressed by psychiatric staff.

[44] On 9 May 2018, the deceased was re-referred to the Community Forensic Mental Health Team by Dr Manley, Consultant Psychiatrist, Lime Ward. The deceased had been admitted to Lime Ward on 26 April 2018. Dr Heal assessed the deceased on 13 June 2018. The deceased stated that his admission followed an

increase in psychosocial stressors including his PIP application, financial concerns and discontinuation of Lithium treatment. He described how, prior to this admission, he had been experiencing suicidal ideation and in January 2018, he had been found on the Foyle Bridge by the police.

[45] Between July and August 2018, Dr Heal conducted a series of inpatient reviews which documented variable progress, periods of irritability, residual persecutory beliefs, and ongoing concerns regarding accommodation and physical health. Dr Heal documented that the deceased presented with evidence of deterioration in his mental state and evidence of increased prominence of symptoms of psychosis.

[46] In December 2018, Dr Heal recorded the deceased's continued concerns regarding an alleged incident with a member of staff and his PIP application process. He had evidence of rumination and difficulty in distracting from these themes, and his level of insight was limited.

[47] By January 2019, the deceased described a 4-to-6-week history of deterioration in his mood, characterised by difficulties in identifying hope in relation to his future. He discussed fleeting thoughts of life not worth living but specifically denied any suicidal thoughts or plans. He discussed worries in relation to his future accommodation on discharge from Lime Ward.

[48] On 11 February 2019, Dr Heal reviewed the deceased and he did not spontaneously discuss an incident which occurred on 20 January 2019. The deceased had entered the river in Omagh. He stated that he was experiencing lowered mood and worries in relation to recent events. He was unsure in his expectation if the consequence of this would be to end his life by drowning. He stated he entered the water to his waist, and it was cold, so he left and returned to Lime Ward. He specifically denied any ongoing thoughts of life not worth living or suicidal ideation. Dr Heal recorded that the deceased remained at risk of potential harm to himself. She explained that "one of the best predictors of future suicidal ideation attempts is past history of suicidal attempts, and that is why it is very difficult to say that a risk has gone away completely. That risk will persist because it is in someone's history. It does not mean that necessarily that risk is acute and present at all times, but it isn't ever going to go away…and, therefore, the focus is on about trying to improve his overall mental health and his mental state."

[49] Dr Heal's impression at this time was that the clinical presentation could be more in keeping with a diagnosis of schizoaffective disorder as opposed to his previously diagnosed bipolar affective disorder.

[50] A planned review 20 March 2019 did not proceed as the deceased left the ward on 16 March 2019 and had been located on the Foyle Bridge by the police.

[51] During the following review, on 27 March 2019, the deceased stated that he had visited the Foyle Bridge with a view to ending his life but that he had changed his mind and had been located by police. He indicated that he was ambivalent that

he had not ended his life. A note recorded, "He stated 'I went to the bridge again…the Foyle Bridge…I didn't see another way out…I went to the bridge but it was too high to climb…I contemplated doing it…I stood for a while and then I changed my mind…I didn't really change my mind…I'd decided to do it…but then the police came and they brought me back to Lime Ward." During this and a subsequent review, Dr Heal documented fluctuating mood and intermittent thoughts of life not worth living and suicidal ideation.

[52] By April, an improvement in presentation was recorded. On 2 May 2019, the deceased was discharged from Lime Ward and returned to Rathview Mews. He returned to Lime Ward on 18 June 2019.

[53] Following a review in July 2019, Dr Heal noted a deterioration in his mental state with evidence of elation of mood, persisting psychotic symptoms, and possible cognitive decline. In August 2019, further deterioration was identified. A cognitive assessment and referral to the Psychiatry of Older Persons Team were recommended.

[54] A multidisciplinary review took place on 9 October 2019 attended by Dr Heal. At this meeting, the deceased's mood was described as mildly low but stable and he denied suicidal ideation. Plans were made for transfer to supported accommodation, in Woodbank House. Following this meeting, Dr Heal had no further direct clinical contact with the deceased.

[55] Dr Heal stated that over the course of 2018 and 2019, there was quite a significant fluctuation in the deceased's mood state from assessment to assessment. At times he presented with quite marked lowered mood and associated symptoms, and other times he presented with elation of mood and hyper manic and manic symptoms. In addition to that, he also presented with evidence of psychotic symptoms, in that he had quite firmly held beliefs in relation to his personal circumstances, and particularly his financial situation. She commented that "his worries impacted on his mental wellbeing, but also his mental health difficulties impacted and were part of the reason that he had the constellation of worries and concerns."

Evidence of Anthony McGale

[56] Mr Anthony McGale, Community Mental Health Nurse, Omagh Recovery Community Mental Health Team (CMHT), gave evidence to the inquest, which was admitted by way of Rule 17. Mr McGale was the deceased's community mental health nurse when he was discharged from Lime Ward to Rathview Mews on 2 May 2019. He stated that the deceased presented as well until 16 May 2019 when he began to express concern regarding his benefits.

[57] The deceased continued to have twice weekly contact with members of Omagh Recovery CMHT until 29 May 2019 when Mr McGale reviewed him following a deterioration in his mental health. During assessment, the deceased presented with depressed mood and preoccupation with his benefits. The following

day he was reviewed by the Crisis Response and Home Treatment, and he was readmitted to Rathview House, a step-up step-down facility from Lime Ward. On 3 June 2019, he was transferred back from Rathview House to Rathview Mews.

[58] Mr McGale described how, during several reviews in June, the deceased presented as perplexed and worried about his benefits. On 18 June 2019, the deceased was referred for readmission to Lime Ward. During his admission, Mr McGale continued to have regular contact with the deceased who presented with prolonged periods of mental ill health evidenced by lack of insight and ongoing paranoid beliefs and preoccupations/worries regarding his benefits and finances. The deceased presented with fluctuations in his mood, including being elated, agitated and hostile with episodes of verbal and physical aggression. There were periods when he presented with depressed mood with poor levels of motivation and self-care. The deceased also presented with thoughts of life not worth living and episodes of active suicidal intent. At other times he presented with an improvement in his mental health and expressed hope and talked about making plans regarding the future. Mr McGale's last contact with the deceased was on 8 October 2019.

Evidence of Trudy Strahan

[59] Ms Trudy Strahan, Band 7 Supported Living Manager for Rathview Mews, Rehabilitation and Recovery Support Living Facility, gave evidence to the inquest, which was admitted into evidence pursuant to Rule 17. Ms Strahan first met the deceased on 11 April 2019, as he was moving items into his allocated flat. She attended a discharge planning meeting in Lime Ward on 24 April 2019 and there was an agreed date of 2 May 2019 set for his move to Rathview Mews.

[60] On 13 May 2019, the deceased presented as perplexed and preoccupied as he was worried that he had not declared his recent hospital admission and was worried he would have to repay benefits.

[61] Over the next week, the deceased remained concerned about finances. During the period from 27 May 2019 to 30 May 2019, the deceased was reporting low mood with an overall deterioration in his mental health. Staff from Rathview Mews met with the Mental Health Recovery Service and it was agreed he would be referred for a Crisis assessment. Following this, the deceased was transferred to Rathview House (Crisis Assessment Unit). On 3 June 2019 he returned to Rathview Mews.

[62] On 11 June 2019, Rathview Mews staff informed the Recovery Team that the deceased's mental health continued to decline. He was assessed by the Crisis Team on 18 June 2019, and he was admitted to Lime Ward.

Evidence of Una Hackett

[63] Ms Una Hackett, Occupational Therapist in the Crisis Inpatient Unit, gave evidence to the inquest, which was admitted by way of Rule 17. She stated that throughout his admission to Lime Ward from June to December 2019, the deceased

attended and engaged well in Occupational Therapy interventions to promote his recovery. He availed of Rowan Villa (social and rehabilitation centre) and as his motivation improved, he then sourced community services, and it was agreed that discharge from Occupational Therapy was appropriate.

Evidence of Geraldine Kerr

[64] Ms Geraldine Kerr, Social Worker, gave evidence to the inquest. She was a hospital social worker covering the admission wards and crisis service and she was also employed as an Approved Social Worker for the WHSCT. She explained that she had contact with the deceased as the Social Worker during his admissions to Lime Ward in 2018 and 2019. She retired three years ago, and she told the inquest that her memories of work were poor and that she has "left all of that work behind me."

[65] Ms Kerr believed that she was the only ward social worker at that time. Her role was to cover the three wards in the Tyrone and Fermanagh Hospital as well as the crisis service and accordingly she had a "very heavy case load, that was tough at times."

[66] Following the death of the deceased, the WHSCT undertook a Serious Adverse Incident ("SAI") investigation. An extract from the SAI Report was put to Ms Kerr. The report commented that she was the only social worker for Lime Ward, and several other wards at the same time. The SAI observed that it is difficult to see how one individual with responsibilities across a number of areas would have sufficient band width to give the issue of the deceased's financial issue the attention it needed. It added that Ms Kerr was not covered by a colleague during times of leave or illness, which made the service vulnerable and inefficient. Ms Kerr agreed with this and added "I felt under stress, and on my own to cover a lot of areas within the wards, as well as my own professional role as an approved social worker." Ms Kerr recalled that she did ask for support by way of additional social workers to assist her for "probably years."

[67] In relation to the deceased, Ms Kerr's involvement included supporting the deceased to apply for supported accommodation, contacting staff, relatives and other agencies, and initiating adult safeguarding processes. She stated that she did not recall any specifics of her client work since retiring. In relation to the deceased's financial position, the SAI Report commented that a number of attempts were made to stabilise the situation by Ms Kerr and his family were reassured the matter would be addressed by Ms Kerr in November 2019 and this was not done and, on a number of occasions, the notes reflect the situation as having been finally addressed when it, in fact, had not been. Ms Kerr replied that she had no recollection of this. Another comment from the SAI report was put to Ms Kerr, that it appeared she reassured the deceased's family that progress was being made in relation to his financial affairs, when it was not and that practitioners should be mindful of their duty to be candid, especially when things are not going to plan. Again, Ms Kerr had no recollection of this.

[68] Emails from the deceased's family to Lime Ward for the attention of Ms Kerr and entries from the PARIS (Patient Administration and Information System) Electronic Patient Record, were put to Ms Kerr. They indicated that from 13 November 2019 until 14 December 2019, there was an issue in relation to the PIN number on the deceased's bank card, which she was informed of and for which she provided reassurance that she would assist the deceased with. The SAI Report highlighted that the family engaged extensively with Ms Kerr to address an important source of rumination, namely that of financial security and she in turn gave assurances that she would address this. This was not happening, and he continued to ruminate excessively, and the family were not made aware that the situation was ongoing. Ms Kerr told the inquest she could not comment on this.

[69] It is disappointing that this witness chose not to engage with questioning, citing an inability to recall events due to her retirement. She appeared to be a reluctant witness before this Court.

Evidence of Dr Patrick Manley

[70] Dr Patrick Manley, Consultant Psychiatrist, gave evidence to the inquest. At the time of the deceased's death, he was a consultant in Lime Ward for 23 years. He gave the inquest an overview of the deceased's mental health history. The deceased had presented to psychiatric services firstly in 1986 whilst studying in Liverpool and had been diagnosed then with a bipolar condition. His mental state appeared to have been settled for a number of years until his presentation again to psychiatric services in and around 1993 triggered by an act of attempted suicide involving a fire escape. He was soon discharged after stabilization in mood to the care of his parents. He had ongoing contact with local mental health teams in Derry over the next few years but required a number of detained admissions.

[71] In 2000 the deceased required a prolonged detained admission to Gransha Hospital before a gradual stabilization in his mental health led to his step down to Beech Villa rehabilitation ward in 2003. He progressed well and was stepped into a residential unit Woodbank House in 2005. His placement there was successful, and his mental state remained stable from 2005 until 2018.

[72] The deceased's mental health deteriorated from 2018 onwards and he required psychiatric hospitalisations. Dr Manley described an evolution of increasingly paranoid beliefs and mood fluctuations. Dr Manley stated that when well, the deceased was a pleasant man who was a good conversationalist and had an active interest in many areas. This was reflected in his enjoyment of quizzes and musical events. He was socially appropriate in his interactions with others and had a good sense of humour.

[73] This contrasted with his presentation during periods of illness with irritability, paranoia and threats towards others evolving with associated verbal and, at times, physical aggression. He also suffered periods of more severe depression. A constant theme when his mood was lower was his preoccupation with and concern

that his monies were not safe in the bank and that others were attempting to interfere in his finances and belongings.

[74] Dr Manley explained how the deceased had pre-existing complications of Long-term lithium therapy including Nephrogenic Diabetes Insipidus and Lithium was replaced by an alternative mood stabiliser.

[75] Entries of Dr Manley's reviews of the deceased in 2019 in both multidisciplinary team (MDT) meetings and ward rounds recorded in PARIS notes, were put to him, in particular the information under the heading 'plan.' Dr Manley agreed that the notes did not contain sufficient information for staff to be able to understand and follow the treatment plan for the deceased. He recounted how he did not always read the previous MDT entries before the next MDT meeting, and he accepted "in retrospect I should have been more diligent in reviewing other people's documentation of medical consultations with patients in general."

[76] Dr Manley was a 'Responsible Medical Officer' (RMO), Part II doctor, in charge of the assessment or treatment of individuals detained patient for the purposes of the 1986 Order. Dr Manley was asked who, in December 2019, in Lime Ward, did he think was allowed to grant leave to a detained patient under the 1986 Order. He replied that "it wasn't something that I had thought about" and "it never came up" and he was unaware of the legal position.

[77] When unaccompanied leave was granted to a detained patient, Dr Manley stated that a risk assessment should be documented at the time of the approval. There should also be documentation detailing whether the leave was successful. The decision to grant leave should also include duration, location and purpose. In relation to safety plans, he agreed that they were beneficial for patients going out on leave, as they may assist with dealing with potential suicidal behaviour. He expressed how he would have expected a risk assessment and safety plan to have been completed for the deceased on 10 December 2019, when unaccompanied leave was granted.

[78] Dr Manley's last contact with the deceased was on 7 November 2019 when he also met members of the deceased's family on Lime Ward. Dr Manley went on leave from 25 November 2019 until 19 December 2019.

[79] In relation to medical staffing cover arrangements for periods of leave, Dr Manley explained that he had an ongoing arrangement with Dr Stephen Moore, then the Fermanagh in-patient consultant, that they covered each other for periods of annual leave.

[80] Dr Manley explained that, at the time, the in-patient units (Lime, Elm and PIC Wards along with crisis and home treatment teams) had been holding daily MDT meetings starting at 09:30 hours (Mondays to Fridays) and were attended by all disciplines working in the units (senior and junior medical staff, nursing staff, social workers, occupational therapists, crisis and home treatment personnel).

[81] Dr Manley told the inquest that specialty doctors, including Dr Michael Warren, provided care and assessment of patients in the in-patient setting and had broad experience of in-patient psychiatry.

[82] He explained that the units in the Tyrone and Fermanagh Hospital operated an open-door policy (08.00 hours to 20.00 hours) at the time of the deceased's death, but this has changed in the last 2 years and there now operates an electronic locking system to the external door of the wards.

[83] Dr Manley told the inquest that he was not in receipt of emails from the Hughes family in November 2019. He was aware emails had been sent to ward staff through the ward email address.

Part 2: The decision on 10 December 2019 to grant unaccompanied leave from Lime Ward

Evidence of Dr Michael Warren

[84] Dr Michael Warren, Specialty Doctor in Psychiatry, Crisis Service, Tyrone and Fermanagh Hospital, gave evidence to the inquest.

[85] Dr Warren first met the deceased when he was admitted to Lime Ward in June 2018. Dr Warren commenced work in Lime Ward in May 2018. He provided care during several inpatient admissions between mid-2018 and December 2019, attending weekly MDT ward rounds. Dr Warren explained that there were MDT meetings every morning and ward rounds thereafter. MDT meetings and ward rounds were routinely led by a consultant psychiatrist. However, on occasion, Dr Warren stated that he chaired MDT meetings when deputising for the consultant psychiatrist, consistent with custom and practice and as per his job description and as a senior permanent member of staff.

[86] Dr Warren explained that there were certain aspects of the 1986 Order, such as completing Form 10s (medical report for detention for treatment), which required a consultant and therefore he would not complete those tasks. He stated that he also would have contacted a consultant if he was unsure about a decision or if he felt they needed to inform him of additional information. He stated that, at that time, it was very rare that he would need to contact a consultant, as he was confident in the decisions he was making.

[87] In relation to notetaking in MDT meetings, Dr Warren stated that, in 2019, a secretary took notes, which would have been typed into PARIS. PARIS contained clinical and nursing notes as well patient safety plans and risk assessments. Dr Warren stated that risk assessments and safety plans were usually updated whenever there was a change in risk and could be amended by any treating staff member.

[88] Dr Warren recounted a history of the deceased's admissions in Lime Ward. In January 2019, the deceased attempted suicide by entering a local river. On

19 March 2019, the deceased reported that on 16 March 2019 he had gone absent without leave, consumed alcohol, and attempted suicide at the Foyle Bridge. No further leave was to be permitted at that time. When asked whether he was surprised at the deceased's actions on 16 March 2019, Dr Warren stated that it was "somewhat of a surprise." He explained that suicidality is something which can vary over time. There can be several factors to it and "whenever we do an assessment, we utilise the patient's current mental state. We look at their trajectory and their treatment plans and recent changes to their treatment. The other factor that seemed to be a big thing with Rory would have been stressors. I can see that he was anxious about the move to the new accommodation, and I think he referenced staff to the fact that that was a factor in why he had gone to the bridge and become suicidal. At the time with the information available, I would have assessed his risk as low and after that, then, it became apparent that he had gone to the bridge and done something."

[89] Dr Warren told the inquest that he was aware of the WHSCT 'Absent Without Leave (AWOL) Policy (March 2009)', which applied at the time. He explained that on return from a period when a patient was AWOL, the patient would be reviewed, risk assessed, and a plan would be documented. It was put to Dr Warren that the WHSCT's SAI Report, identified that after the 16 March 2019 AWOL incident, which was significant and had elements in common with the January 2018 incident in that it involved travelling to the Foyle Bridge, was not incorporated into any systems, nor were the warnings from the family that this type of incident would occur. Dr Warren replied that "if incorporated means how we're managing the patient, then it's everybody's, it's the MDT's responsibility and I'm part of that."

[90] Dr Warren told the inquest that a safety plan serves two purposes – it is a practical document that includes information on who to contact for help should a patient feel suicidal, and it also includes things that a patient can do to help themselves get over any suicidal thoughts that they are experiencing. It appeared that a safety plan had been agreed with the deceased in March 2019 and it was updated on 17 March 2019 and 19 March 2019. When asked whether that same safety plan carried through to the deceased's readmission to Lime Ward in June, Dr Warren replied that safety plans were not routinely done at that time. It was put to Dr Warren that there was a similar incident on 1 April 2019 and in November 2019, and he was asked whether the safety plan from March was updated given the deceased's history of going AWOL. Dr warren replied, "I don't think so" and he agreed that it should have been done.

[91] On 26 March 2019, Dr Warren assessed the deceased, and his mood was 3/10, and he expressed regret for his attempt. On 1 April 2019, deterioration was noted, with suicidal thoughts and hopelessness. He described a pre-occupation with finances. The deceased described booking a taxi that morning with thoughts of ending his life and expressed the idea of travelling to Derry to jump off a bridge to attempt to end his life.

[92] By late April 2019, mood improved to 8/10, and sertraline was discontinued, and unaccompanied leave granted. He was discharged on 2 May 2019 from Lime Ward to Rathview Mews but was readmitted on 18 June 2019.

[93] Through July and August 2019, the deceased's mood fluctuated. He felt safe on the ward but remained preoccupied with money. On 27 July 2019, he was detained under the 1986 Order, due to a risk to others and treatment refusal.

[94] By August 2019, the deceased denied suicidality and wished to return to Woodbank upon discharge. On 2 October 2019, Dr Warren discussed step-down to Rathview House, which the deceased welcomed.

[95] In October and November 2019, MDT reviews focused on placement and finances. On 7 November 2019, a meeting with siblings Martin and Barbara, Dr Manley, and Ms Kerr reviewed his ongoing care. That morning, his family accompanied him to the bank to resolve financial matters. He was allowed accompanied leave the following day.

[96] On 11 November 2019, the MDT meeting with Dr Warren, discussed how the deceased had gone to the Millennium Forum in Derry, and that it did not go well. On 8 November 2019, the deceased stated that he had intended to take his father's car to go to the bridge in Derry with the intention of suicide and he was once again preoccupied with financial matters. His brother stopped him. The notes recorded a preoccupation with different names on two bank accounts. Later that day, Dr Warren met the deceased's brother and sister and the plan was that the deceased had been accepted for residence in Granard, and that the deceased should remain an inpatient at present, with no further leave until his current mental state had improved. Dr Warren explained that the fact that there was one attempt so recently was enough to suspend all leave.

[97] On 13 November 2019, the MDT meeting, at which Dr Warren was present, noted that the deceased stated that the suicidal thoughts were intermittent and stated his preoccupation with finances were the cause of his suicidal thoughts/low mood. The plan was to continue with leave being restricted for the time being due to safety concerns.

[98] On 22 November 2019, the deceased described no current suicidal thoughts, ideas or plans. He reported feeling '*a bit low*' and he lacked motivation most of the time. That day, eleven days after the decision of Dr Warren to stop all leave, Deputy Sister Harpur recorded in the PARIS notes "Only accompanied leave, if family or friends are aware of recent risks, where Rory took hold of the driving wheel of brother's car." Dr Warren stated that this must have been Dr Manley's decision.

[99] On 28 November 2019, the deceased reported to Dr Warren a similar mood with no thoughts his life was not worth living or suicidal ideation — and reported the last time he had experienced these was in Derry.

[100] On 2 December 2019, Nursing staff had observed a verbal altercation between the deceased, and a fellow inpatient in relation to cigarettes. The deceased described his mood as 5/10 — saying it again improved. Dr Warren noted an absence of suicidal thoughts since 13 November 2019.

[101] Dr Warren last reviewed the deceased on 10 December 2019, as Dr Manley was on leave and Dr Moore was attending a meeting in Derry, although he was contactable. Dr Warren was the most senior doctor on site. He explained that for him to deputise for a consultant at meetings or ward rounds was not unusual. At this MDT review were Dr Caolan Kerr, Foundation Year 2, and Staff Nurse Rory Doherty.

[102] The deceased reported his mood as 4/10 and felt it was much the same as at his previous review when he felt he was improving. He reported improvement in appetite and sleep. He described having no thoughts of his life not being worth living and specifically denied any suicidal thoughts. He complained he was getting no exercise as he remained "confined to ward."

[103] The deceased stated that he would "like to get out for a walk" as he thought "it would help lift his mood." He also spoke of the fact he was in a choir previously before hospital and "had a good social life pre-hospital," and talked about re-establishing this through "re-integrating into choir." Dr Warren took this as a positive sign and this conversation took place between Dr Warren, the deceased, Staff Nurse Donaghy and Dr Kerr. The conversation and assessment lasted approximately 20 minutes. Dr Warren confirmed that, had the deceased not asked for leave, there would have been no change in his care plan. He explained that the decision could have been put off to the following day, but he did not postpone the decision to another time, as "normally decisions are made on the ward round" and he wanted the deceased "to get the exercise that he wanted. I assessed the risk as low. I didn't think I needed to wait." He did not feel the need to contact Dr Moore as he was confident in his decision.

[104] Dr Warren explained that he wanted to capitalise on this increased motivation in a positive way and work with the deceased to promote recovery. The plan was to "continue current meds" and "focus on psychosocial approach at present."

[105] Dr Warren told the inquest that he accepted the notes in PARIS from the MDT ward round do not record the discussion and decision to grant leave and he did not know why this was the case. The note of the MDT, as recorded by Staff Nurse Donaghy, stated: "Rory reviewed by Lime MDT today. Please refer to today's SHO, Dr N Mohan for particulars and plan of same. Lime MDT, joint decision in partnership with Rory for agreed unaccompanied leave to walk to local shop for exercise." PARIS contained an entry attributed to Dr Mohan 10.47 hours and this was believed to have been recorded by Dr Kerr. It recorded, "feels 'much the same', appetite ok, mood 4/10 as per patient, no suicidal thoughts, no TLNWL, no daytime sleeping. No exercise as 'confined to ward'; would like to get out for a walk, thinks it would lift his mood; was in a choir previously before hospital. Had a good social life

pre-hospital; chat about re-integrating into choir; goes to rowan now and again. Encouraged to attend more for structure and routine by Dr Warren; continue current meds, focus on psychosocial approach at present." Dr Warren stated that the MDT decision was documented in the non-contemporaneous nursing notes later in the day that the "Lime MDT [made the] joint decision in partnership with the deceased, for agreed unaccompanied leave to walk to [the] local shop for exercise."

[106] Dr Warren explained that the deceased's recent depressive episode was subjectively and objectively resolving, and he considered that the deceased had not described suicidal thoughts or thoughts that his life was not worth living in any ward round in the previous month, and Dr Warren assessed his risk to self as low.

[107] The deceased's notes stated the last incident of suicidal thoughts was 13 November 2019, and he denied having suicidal thoughts in all subsequent interviews in the following month with Dr Warren.

[108] Dr Warren explained that he was acutely aware that in some instances suicidal patients may mask or lie about their suicidality or intentions in order to conceal them from their treating clinicians, and whilst he takes into account subjective assessments, he relies on his objective assessment of the patient in the current interview, as well as feedback from the MDT, plus any recently observed behaviours or symptoms by MDT members, friends or family.

[109] Dr Warren stated that he had found the deceased to be a consistently reliable source in describing his own mental state openly and honestly when it came to symptoms, although he did not always retain insight/knowledge of the fact he was unwell.

[110] Dr Warren detailed how he believed refusing leave at that stage would damage their therapeutic relationship and potentially increase his risk of relapse. He considered granting supervised leave instead, as opposed to unsupervised leave, however he explained that supervised leave can be a challenge to achieve consistently due to competing priorities for staff time.

[111] Dr Warren accepted that there was a history of the deceased going to the Foyle Bridge as far back as 2001 and that it was a pattern. He stated, "that any previous attempt is a risk factor and things can be repeated, but based on the assessment that I did, I didn't think it was likely based on his current mental state."

[112] When asked to what extent his decision could be challenged by Staff Nurse Donaghy during the MDT, Dr Warren replied that if he advised that leave was not a good idea because for example, he noticed a dip in the deceased's mood, it would have a joint decision to refuse the request.

[113] In relation to specifics of the leave that was granted, Dr Warren explained that leave can be time based, or activity based. In this case, it was granted to walk to the local shop, which was approximately 15 to 20 minutes' walk away. Dr Warren stated that leave to that shops would customarily be for an hour, and two hours was

probably the upper limit of what he would have granted. As a time was not specified in the notes, Dr Warren could not be sure he had stipulated a time.

[114] Dr Warren agreed that timings for leave should be documented, especially when an AWOL policy may have to be implemented. He accepted that the deceased had not had unaccompanied leave in a month (since 11 November) and that it was a significant decision. He stated that apart from entries in the notes, there was nothing disseminated to other staff about leave decisions. Dr Warren told the inquest that a pro forma is now used to record the decision to grant leave and the specifics of same.

[115] Dr Warren commented, "based on all the information that I had, I was confident at that time that the risk was low. Obviously, with hindsight and the outcome, that's difficult to stand by, but I still stand by it."

[116] There was a discussion with Dr Warren in relation to who exactly has the authority to grant leave to a detained patient, such as the deceased. Dr Warren explained that, in 2019, it was his understanding that he could do it as he was deputising for the consultant on the ward round. He acknowledged that the SAI Report highlighted that this was a decision which could not be delegated and since the Report, in Lime Ward, this decision lies with the consultant. Dr Warren still works in Lime Ward and still deputises but in relation to leave for a detained patient, he would assess the patient and then discuss with one of the Part II qualified consultants.

[117] Dr Warren was referred to the Trust's AWOL Policy. Under '1.0 Introduction' it stated, "A patient/client detained under the Adult Mental Health Order (N.I) 1986 can only lawfully be outside a hospital, residential, nursing or day care facility with the authorisation of the Responsible Medical Officer (RMO), or his/her delegate." Dr Warren told the inquest that, he believed that he was authorised to make those decisions.

[118] Dr Warren was then referred to 'Regional Guidelines for the Management of Patient's Absent Without Leave (AWOL) from Adult Mental Health/Learning Disability Inpatient Settings August 2015' ('Regional Guidelines'), which applied to all Trusts throughout Northern Ireland, and stated "All Trusts will review existing Policies in light of these guidelines and update them as appropriate." Paragraph 1.3 'Legal Context' outlined, "A patient detained under the Mental Health (NI) Order (1986) can only be given leave outside a hospital premises with the authorisation of a Consultant Psychiatrist." Dr Warren told the inquest, that, at the time, he was working on the basis of being a 'delegate' under the WHSCT policy, in order to grant leave to detained patients. He was not aware of the Regional Guidelines. He stated that if he thought the Regional Guidelines applied, he would have contacted Dr Moore by telephone, as he was off site, and explained the circumstances and asked him, "can I give him some unsupervised leave to go for a walk to the local shop?" Dr Warren stated that he had since spoken to Dr Moore and he stated he would have made the same decision.

[119] Dr Warren accepted during evidence that he had no legislative authority under the 1986 Order to make the decision to grant the deceased unaccompanied leave for a detained patient as he was not a 'Responsible Medical Officer' under Article 15 of the Order or a 'consultant psychiatrist' as stipulated by the Regional Guidance.

Evidence of Rory Doherty

[120] Mr Rory Doherty, Registered Mental Health Nurse in Lime Ward, gave evidence to the inquest. He described how he had nursed the deceased throughout 2018 and 2019. On 10 December 2019, he was the deceased's named nurse. In the morning, the deceased had been reviewed by the MDT, which Staff Nurse Doherty accepted consisted of him and Dr Warren.

[121] In relation to notetaking at MDT meetings, Staff Nurse Doherty explained that sometimes medical staff would take the notes and other times, the nursing staff, and that it was "ad hoc" on each day. He described how the notes should inform nursing staff of any identifiable risks, changes in medications, changes in leave status, as well as discharge planning. When asked whether he thought, at the time, in Lime Ward that sufficient information was captured in notes, Staff Nurse Doherty replied, "I'm reflecting now, it's got much better. There have been positive changes and back then at that particular time, I felt we had robust systems in place but through learning identified, no, you can see where improvements were needed."

[122] Staff Nurse Doherty told the inquest that in 2018/2019 there was a white board in the office which recorded the names of the 13 patients and a box for detained status and leave status. Staff Nurse Doherty stated that he also used the PARIS notes for checking this information, by scrolling through the pages to the last MDT meeting notes.

[123] Staff Nurse Doherty described how, during his assessments of the deceased in late November, early December, the deceased's mental state fluctuated, but he did see evidence of future planning. On 29 November 2019, the deceased attended a comedy show with his friend and on 1 December 2019 he walked around the hospital grounds with his sister and father. Consequently, Staff Nurse Doherty stated that this accompanied leave, with no issues, was relevant to the decision on 10 December 2019.

[124] At the MDT meeting on 10 December 2019, Staff Nurse Doherty stated that he and Dr Warren had a conversation and Dr Warren asked for his view, whilst the deceased was still in the room. Staff Nurse Doherty stated that he had no concerns.

[125] Staff Nurse Doherty told the inquest that, "based on evidence and how I knew Rory, even today with the improvements, robust systems, given the evidence presented I would confidently have made the same decision. But the only thing that, in hindsight, I should have done, I should have stipulated the time frame because, I know that was a contributing factor for my colleagues Maria (Harpur) and Oonagh

(Russell)…For me that day, I would still make the same decision based on the evidence that was given, but in hindsight I should have stipulated the time."

[126] In relation to parameters for leave, Staff Nurse Doherty explained that a walk to the shop and maybe into town would be roughly two hours and after that he stated he "would be starting to get worried." He stated that on 10 December 2019, he would have been comfortable for the deceased to go into town as he "felt the risk was low." Staff Nurse Doherty described how after the MDT, he recorded his note at 13.48 hours, and he had looked at the note attributed to Dr Mohan recorded at 10.47 hours. He stated that it was unusual that note did not record the decision in relation to leave. Staff Nurse Doherty accepted that his note of the MDT decision was not accurate and did not provide his nursing colleagues with sufficient information. He stated that he could not give an answer as to why this was. He could not recall whether the board in the office was updated to reflect the change in leave, and he accepted that he should have updated it.

[127] In relation to a note made on 8 December 2019, that the deceased went out for a walk unaccompanied whilst not being authorised to do so, Staff Nurse Doherty agreed that the deceased should not have been allowed to do this and this is information which should have been brought to the MDT on 10 December 2019 and that is the type of issue which would be taken into account when deciding whether or not to grant unaccompanied leave.

[128] When asked why the decision could not have waited until the MDT meeting the next morning when there may have been more members of the MDT present, including a consultant, Staff Nurse Doherty replied that "I think we were confident, the decision was made there and then."

Part 3: Events on 14 December 2019: Unaccompanied leave

Evidence of Anne Hewitt

[129] Mrs Anne Hewitt, friend of the deceased, gave evidence to the inquest. She knew the deceased for 8 years and she called him her best friend. She knew he suffered with his mental health and said he was very independent. She stated, "Rory got involved in lots of things; he was a great friend; always happy. He did have a mental health problem. He told me it was caused by his family. He didn't get on with his dad. He certainly didn't get on with Barbara or Martin. He didn't want them to have anything to do with his life."

[130] Mrs Hewitt explained that in January 2018, the deceased attempted suicide by going to the Foyle Bridge. Ms Hewitt explained, "after that I was concerned that he would do it again. Rory's problem was when the DLA, changed to PIPs and Rory worried that he wouldn't get this PIPS, so he got a form filled out and he thought he told lies on the form, that he couldn't cook, and he thought that they would come after him because he had told lies... he started to worry about money and that was his problem, the money worries is what started Rory's back again to the way he felt."

[131] When the deceased was admitted back to Lime Ward in June 2019, Mrs Hewitt continued to visit him. She stated that there was no formal procedure for taking the deceased out or conditions imposed that she knew of.

[132] At approximately 14.45 hours on 14 December 2019, Mrs Hewitt was driving home along the Hospital Road, Omagh, when she met the deceased on the pavement near the bridge. She pulled her car up onto the footpath and asked him where he was going; and he replied that he was going into town. Mrs Hewitt told him that she thought he was not allowed out, and he replied that he was allowed out for an hour and a half and he was going for a walk. He then said he was going to the shop, meaning 'McClean's' Spar shop on Hospital Road, which was less than a mile away from Lime Ward. She stated that it would have taken the deceased approximately 10 to 15 minutes to walk there. Mrs Hewitt asked if he had money and he said no. Mrs Hewitt then told the deceased to get into the car, and she would take him back to Lime Ward to get his bank card.

[133] The deceased went in to Lime Ward and came out with two bank cards. Mrs Hewitt then drove him to the Spar shop. They both went to the bank machine and Ms Hewitt stated that he inserted both bank cards using PIN numbers which worked, and he checked his balances, and he had a considerable amount of money in both accounts. He took out £50. The deceased then went into the shop while Mrs Hewitt sat in the car. He came back with cigarettes and a few other things in his hand. They then drove back to Lime Ward where she dropped him off at the gate and headed home. She thought she left the deceased off between 15.00 hours and 15.15 hours.

[134] During the car journey, Mrs Hewitt described the deceased as very cool and calm and worried about money, "Rory's life was just money, money, money." He told her that he was going to the bank on Monday with Ms Kerr, his social worker. Ms Hewitt described the deceased as in good form. Mrs Hewitt stated that she did not think that there were any problems with the deceased that day. The only thing that was strange was that he was out walking alone. At around 20.00 hours that evening she received a telephone call from his sister Barbara informing her that he was missing. She then telephoned Lime Ward, and they confirmed this, and she went to look for him.

Evidence of Maria Harpur

[135] Ms Maria Harpur, Registered Mental Health Nurse and Deputy Sister in Lime Ward, gave evidence to the inquest. She was the most senior nurse on the ward on 14 December 2019. Also on shift was Staff Nurse Russell and two bank nurses.

[136] Deputy Sister Harpur described how patient's notes need to be very clear and specific, particularly in relation to leave. The notes should specify the amount of time allowed, whether it was accompanied or unaccompanied and whether there is anything else relevant to their day-to-day nursing. She stated that, at the time, Ward

Sister Mary Maguire conducted an informal audit of the notes of patients because, as Deputy Sister Harpur stated, note keeping at that time in Lime Ward was "poor."

[137] In relation to a patient who has requested to exercise leave that was granted, Deputy Sister Harpur stated that the nurses would have a discussion with the patient and review the PARIS notes, the whiteboard in the main office and the handwritten notes which would have contained information about risks. She stated that if there is a change to leave status, then the risk assessment (MH33) and safety plan, both on PARIS, should be updated. When a patient leaves the ward, the PARIS notes should be updated with the time of departure. She accepted that if staff had to go to another ward such as Elm, and if the time the patient was due back was not recorded in PARIS, the information would not have been known by other staff, and she agreed that that system did not assist nursing staff in ensuring the safety of patients. Deputy Sister Harpur agreed with the suggestion that with the system in place at the time, it was "difficult to keep track" of the 13 patients in Lime Ward, some of whom were detained.

[138] On the afternoon of 14 December 2019, the deceased approached Deputy Sister Harpur and Staff Nurse Russell while they were in the nursing office. The deceased asked if he could avail of a few hours leave from the ward and he explained that he was allowed unaccompanied leave "for a couple of hours" for exercise to the town. They initially believed that he was only allowed accompanied leave as Staff Nurse Russell had recorded this in the notes at 11.54 hours that day. Deputy Ward Sister Harpur agreed that this erroneous information highlighted that the system did not give nursing staff with day-to-day management of the ward an accurate understanding of the status of their patients. She agreed that the named nurse on 11 December 2019 should have read the PARIS notes and noted the MDT decision and recorded that on the deceased's updated care plan.

[139] Staff Nurse Russell consulted the deceased's notes and saw that on 10 December 2019 the MDT allowed unaccompanied leave for exercise. Deputy Sister Harpur did not read the note and relied on Staff Nurse Russell telling her what it contained. She stated that they both asked if the deceased had any thoughts of life not worth living or thoughts of self-harm and he denied same. She stated that after her "mental state assessment on that interaction, I felt Rory was safe for leave." She stated that the shop would take around one hour there and back and the town two hours there and back. No timeframe was specified in the notes, and she stated that she would have expected that to have been recorded. Whilst the MDT noted explicitly stated 'shop', Deputy Sister Harpur stated that the deceased told them, 'the town' and so they allowed him to go to the town. He left the ward at 15.00 hours. No exact time was given to him to return. She told the inquest that she wished they had sought further information and clarity around leave and how long it should have been for. She added, "on that particular day, I had no concerns about Rory, and I think maybe that misled our judgment."

[140] The deceased requested to take his bank card out of the ward safe, and Staff Nurse Russell and Deputy Sister Harpur signed two cards out. He left the ward at

approximately 15.00 hours. Contrary to Mrs Hewitt's evidence, Deputy Sister Harpur had no recollection of the deceased coming back to the ward. She described how it was her expectation that the deceased would return to the ward in two hours.

[141] The deceased did not return and around 17.00 hours, the office received a phone call from Ward Manager Jackie McCutcheon about another issue, and while she was on the phone they informed her the deceased was out on leave but had not yet returned. She informed them she had saw the deceased in the company Ann Hewitt. Both she and Staff Nurse Russell were therefore not duly concerned, "we felt that he was safe with Ms Hewitt" and "in my head I thought they've gone somewhere." She told the inquest that "I do believe the AWOL policy would have been implemented at that time had we not got that information."

[142] Staff Nurse Russell telephoned Ms Hewitt and left messages. Deputy Sister Harpur accepted that the wrong telephone number had been recorded in the deceased's notes. At 18:00 hours, Deputy Sister Harpur decided that staff should conduct searches of the grounds of hospital and local roads surrounding the hospital site and bus depot however there were no sightings of the deceased. When asked why the AWOL policy was not initiated at this time, Deputy Sister Harpur stated that they still believed he was with Mrs Hewitt. She agreed that she should have initiated it around 17:00 hours and, at the latest, 18:00 hours.

[143] Sometime later, the office received a telephone call from an unknown gentleman about a message left on his voicemail. That indicated to staff that the phone number they held for Mrs Hewitt was incorrect. At this stage staff managed to get the correct number for Mrs Hewitt and left a message for her to contact the ward.

[144] Deputy Sister Harpur made the decision that the deceased's next of kin, his brother Martin, be informed. Mrs Hewitt returned their call at 19:30 hours.

[145] At this stage the night duty staff were coming on duty, and Staff Nurse Russell and Deputy Sister Harpur took the decision to commence the AWOL policy and Deputy Sister Harpur nominated Staff Nurse Russell to be AWOL co-ordinator as she was the nurse in charge of his care that day.

[146] Night staff continued the AWOL procedure when Deputy Nurse Harpur went off duty at 20:15 hours. Deputy Sister Harpur explained that Staff Nurse Russell started to complete the 'Patient/Client Absent Without Leave Information Report' and Staff Nurse Helen Rafferty continued the report. Staff Nurse Rafferty became AWOL co-coordinator when Staff Nurse Russell ended her shift and Staff Nurse Rafferty made the call to the PSNI. When asked why the PSNI were not contacted before 20.00 hours, Deputy Sister Harpur explained that they were handing information over to the night staff and "it was a busy time." She did not make the call as, "I was in and out of the ward, so I wasn't there when that information was given." She stated that it was her understanding that PSNI would

have been informed that there was a likelihood that the deceased was going to the Foyle Bridge rather than a 'bridge' in Derry.

Evidence of Oonagh Russell

[147] Ms Oonagh Russell, Registered Mental Health Nurse in Lime Ward, gave evidence to the inquest. On 14 December 2019, Staff Nurse Russell was the deceased's named nurse. When the deceased approached Staff Nurse Russell and Deputy Sister Harpur asking for leave, Staff Nurse Russell told him that she would have to check and he replied, "No I'm definitely allowed out on leave." She consulted the deceased's notes on PARIS. They confirmed that the outcome of the review on 10 December 2019 was that he could have unaccompanied leave to walk to the shop. There was no timeframe, which she thought was unusual, as it was going to be his first unaccompanied leave.

[148] Staff Nurse Russell agreed that the system of recording leave in Lime Ward in December 2019 was not as robust as it should have been to minimise risks to patients. She still works in Lime Ward and stated that systems are now more structured with a full MDT meeting each morning with a checklist to ensure all decisions are documented and that risk assessments and safety plans are updated accordingly. She added that handover sheets are used and there is a poster which records leave status as well as detained or voluntary status. Staff Nurse Russell told the inquest that at the time, there was a general observation sheet, filled in by the nursing staff which recorded the times patients left the ward and the time they were expected to return. She stated that this should have been filled in for the deceased on 14 December 2019. The observation sheet could not be found and was therefore not made available to the inquest.

[149] Staff Nurse Russell explained that the deceased's risk assessment should have been updated to reflect the grant of unaccompanied leave. In relation to personal safety plans, she agreed that following the deceased's attempt to go to the Foyle Bridge in November 2019, the deceased should have been given a personal safety plan. He had one in March 2019. She advised that on each admission a patient would have been given one which would be updated accordingly.

[150] Staff Nurse Russell told the inquest that as there was no timeframe specified, "I presumed wrongly and assumed that two hours would be alright for him to go out on." She agreed that she could have contacted the SHO or consultant on call to discuss the matter. When asked if she should have told the deceased that due to the lack of clarity in the notes, he would have to wait until Monday when the MDT would meet, Staff Nurse Russell replied, "I definitely could have now in hindsight" but she felt that refusing the deceased "could have destroyed the trust." Staff Nurse Russell accepted that the MDT stated, 'local shop' rather than 'town' and that she should have corrected the deceased and told him it could only be to the shop, "I didn't but I should have. That was a failure on my part."

[151] At 17.17 hours, Staff Nurse Russell recorded in PARIS that the deceased "requested to go to the town on a few hours leave" and left the ward at 15.00 hours. He was not noted on the close observation sheet at 15.00 hours which was completed every 30 minutes.

[152] Staff Nurse Russell stated that no exact time was given to the deceased to return to the ward. When they were told he was last seen in the company of Mrs Hewitt, Staff Nurse Russell then made attempts to make telephone contact with Mrs Hewitt.

[153] When asked why the AWOL policy was not commenced at this time, Staff Nurse Russell replied that the therapeutic relationship with the deceased may have been damaged if the police found him near the hospital and she acknowledged that "his safety was paramount, and we should've done it" and therefore should have commenced the AWOL policy around 17.30 hours.

[154] Staff Nurse Russell told the inquest that she did not believe they had the deceased's mobile number recorded in his notes and they should have.

[155] Staff Nurse Russell told the inquest that whilst she commenced the AWOL process, the AWOL Co-ordinator was Martin Cartin who was the Crisis Service Manager on call, and he had overall responsibility.

[156] Staff Nurse Russell claimed that all relevant details were handed over to the night staff who continued the AWOL procedure, and she left the ward at 21:00 hours. She explained that she has started completing the AWOL information report and this was then taken over by Staff Nurse Rafferty. The AWOL report could not be found and was not provided to the inquest. When asked why Staff Nurse Rafferty phoned the police rather than someone, like her, who had first-hand knowledge of events that day, she replied that it was handover time, and she was trying to write up her notes and "I was busy, and I probably delegated that to Helen." She agreed that she should have made this call, and she agreed that the PSNI should have been given more information than what was actually provided by Staff Nurse Rafferty.

Evidence of Jackie McCutcheon

[157] Ms Jackie McCutcheon, Crisis Service Manager, gave evidence to the inquest. She was responsible for Lime and Elm Wards as well as the Community Home Treatment team and Rathview House. She commenced this role in September 2019. Prior to this, she was the Ward Sister of Elm and Lime. She explained the staffing structure in Lime Ward. There were around three nurses who were managed by a Deputy Ward Sister, who in turn was managed by the Ward Sister. In relation to guidance given to nursing staff about the quality of note taking, Ms McCutcheon explained that the staff were members of the Nursing and Midwifery Council (NMC) and so obliged to follow NMC rules and regulations requiring notes to be written accurately, clear and contemporaneously. She could not recall whether she audited the notes at that time.

[158] Ms McCutcheon told the inquest that the PARIS notes should contain an accurate detailed record of what was agreed by the MDT. She explained that, at the time, risk assessments and safety plans were used for all patients. There was a general safety plan called MH33, and certain patients had personal safety plans. The deceased had a personal safety plan in March 2019 when he went to the Foyle Bridge. He was not provided with an updated safety plan following his attempts in November. She explained that after the decision on 10 December 2019, the deceased's risk assessment should have been updated in the PARIS notes. He should also have been given a personal safety plan.

[159] At approximately 15:20 hours on 10 December 2019, Ms McCutcheon stopped at McClean's shop. She noticed the deceased outside the shop with Ms Hewitt. The deceased was using the bank link and Ms Hewitt was standing behind him. She could see that Ms Hewitt was motioning at the deceased. Ms McCutcheon then left.

[160] At around 17:00 hours Ms McCutcheon contacted the ward and was told by Staff Nurse Russell that the deceased had not returned to the ward. Ms McCutcheon informed her that she had observed the deceased at the shop and reassured Ms Russell that he was in the care of Mrs Hewitt.

[161] Ms McCutcheon agreed that when staff checked the grounds, that's when the AWOL policy should have commenced. The PSNI should also have been informed at that time rather than PSNI being informed at 20:00 hours and the AWOL co-ordinator, Mr Cartin, being contacted at 20:15 hours.

[16] Ms McCutcheon was asked about the differences between the Trust's AWOL policy and the Regional Guidance (2015). She explained that the WHSCT policy was only updated to take account of the Regional Guidance in 2021 as she was involved in the process. She stated that in 2019, had there been a conflict, Lime ward would have followed the WHSCT guidance. In the WHSCT guidance, if a patient satisfied the definition of "Absent without leave" in section 4.0, then certain actions must be taken as set out in section 5.0 "Roles and Responsibilities and Action Required." It required an AWOL Co-ordinator to be appointed who would be the Service Manager or if out of hours, the Manager on Call, in this case Martin Cartin.

[163] As Crisis Manager, Ms McCutcheon was referred to entries in PARIS. An entry made by Staff Nurse Russell at 11.54 on 14 December 2019 read "Rory can have accompanied leave with family." Ms McCutcheon agreed that this reflected the decision in November rather than the MDT decision on 10 December 2019 and agreed that there was a lack of clarity amongst nursing staff about the deceased's leave status. Another entry recorded by Staff Nurse Russell read "Requested to go to the town on a few hours leave as leave was granted during the week. Denied any TNLWL or TSH prior to going out on leave at 3.00 p.m." Ms McCutcheon agreed that there was no entry stating that the deceased left the ward at 15.00 hours on unaccompanied leave. There should have been a note detailing the parameters of that leave and what time he was expected back, as the NMC guidance clearly states that all records should be clear and timely. As the record of the MDT meeting did

not include a timeframe for leave, Ms McCutcheon agreed that it would have been prudent for Staff Nurse Russell and Deputy Sister Harpur to have sought clarification by contacting the on-call doctor.

[164] In relation to the information the police were provided, Ms McCutcheon agreed that PSNI should have specifically been told of the deceased's history of attending the Foyle Bridge.

Evidence of Eugenia Mackey

[165] Ms Eugenia Mackey, Registered Mental Health Nurse in Lime Ward, gave evidence to the inquest, which was admitted by way of Rule 17. On 14 December 2019, she stated that there was not anything untoward in the deceased's demeanour. When he did not return from leave, Staff Nurse Mackey was asked to do a search of the local area and the shop area when he was last seen. She then drove into Omagh town centre, and she did not see the deceased during her search.

Evidence of Helen Rafferty

[166] Ms Helen Rafferty, Staff Nurse in Lime Ward, gave evidence to the inquest, which was admitted by way of Rule 17. She reported for duty at 19.30 hours on 14 December 2019 and was informed the deceased was AWOL. She initiated the AWOL protocol and telephoned police to report him missing.

[167] At approximately 03.30 hours on 15 December 2019, she received a telephone call from Constable Andrina McDonagh that a body had been recovered from the Foyle River and had been identified as the deceased.

Evidence of Martin Cartin

[168] Mr Martin Cartin, Head of Crisis and Lead Nurse, gave evidence to the inquest. As part of his role, he was Head of Service and Strategic Manager for the Trust. The operational manager was Jackie McCutcheon.

[169] In relation to the note of the MDT written by Staff Nurse Doherty, Mr Cartin stated that it was a limited note, and he did not believe it provided sufficient information and should have included a timeframe for leave. With reference to the nursing notes made between 10 December and 14 December, he agreed that the deceased's care plan should have been updated to reflect the new leave status. He stated that "clear, concise and accurate communication makes life easier for nurses on very challenging environments." From the documentation, he was of the view that there was not a sufficiently clear level of communication about leave decisions for nurses in Lime Ward in December 2019.

[170] In relation to the reporting and coding of incidents on DATIX, the Trust risk management system, Mr Cartin was asked whether previous incidents of the deceased leaving the ward, for example in January 2019, and October 2019 should have resulted in a Datix for review and learning; he replied that it would be decided by the clinical team whether or not in their view they met the criteria for a DATIX or

for a clinical incident. He added that whilst he did not know the specifics of those incidents, if there is a patient who is deemed to be of risk, then that should be recorded appropriately and contained within the MDT plan and if that requires DATIX, or AWOL policy deployment, then, that should occur.

[171] On 14 December 2019, he was the manager on call and was telephoned at 20.15 hours and informed that the deceased had not returned to the ward. He became the AWOL co-coordinator.

Part 4: The search for the deceased on 14 December 2019

Evidence of Constable Ian Honeyford

[172] Constable Ian Honeyford gave evidence to the inquest. At the time he was attached to Strand Road Police Station. On 14 December 2019, he was performing mobile patrol duties. He commenced his shift at 21:00 hours. An entry timed at 21:01 on 14 December 2019 in a PSNI control works log recorded that the details of the deceased were circulated to H District 1. Constable Honeyford did not recall hearing this information.

[173] At 23:17 hours, Constable Honeyford was tasked to a report of a male, the deceased, on the Foyle Bridge who looked disorientated and matched the description of a missing person from the Omagh area.

[174] On arrival, at 23:20 hours, Constable Honeyford observed the deceased on the Waterside bound lane of the Foyle Bridge, at approximately the highest point of the bridge. The deceased had one leg over the railings. Constable Honeyford opened the car door and jumped out. He was approximately two metres away from the deceased when the deceased rolled over the railings and entered the water. This all occurred within a matter of seconds. This was captured on CCTV, which was provided to the inquest. The next time he saw the deceased was when he was being removed from the water at Gillilands by a Foyle Search and Rescue crew. He observed NIAS crews administer CPR for a period before pronouncing life extinct at 00:29 hours on 15 December 2019.

Evidence of Inspector Joni Beatty

[175] Inspector Joni Beatty gave evidence to the inquest. She was attached to G District (Fermanagh and Tyrone) and stationed at Omagh Police Station. On 18 December 2019, she was asked to review a missing person incident involving the deceased.

[176] On review, Inspector Beatty was satisfied that the PSNI response to this incident was prompt and proportionate to the level of risk identified from the information received at the time.

[177] During the initial missing person report call at 20:00 hours from Staff Nurse Helen Rafferty, the information provided included the deceased's date of birth, telephone number, description, last clothes worn, diagnosis, his last sighting and she

advised that he had a history of going AWOL and "on the last occasion he might have been found on Derry Bridge." The information was recorded by a call handler on the PSNI 'control works print' which is a control work log that records any information passed to the contact management centre.

[178] During a second call the control works log recorded that Staff Nurse Rafferty told the police that "his friend said he may go to Derry to jump the bridge." There was then a discussion between the call handler and Staff Nurse Rafferty about this being the Foyle Bridge. The 'Foyle Bridge' was not recorded in the control works log by the call handler and Inspector Beatty stated that it should have been, as H District 1 could have directed a crew to that bridge. The 999 calls were played during the inquest.

[179] Inspector Beatty explained the process for such calls. When a call about a missing person is received, details are recorded by a call handler. Then a contact management Sergeant would review those details for missing persons, and makes a grading of the missing person, low, medium or high. That then is reviewed by the duty inspectors. She told the inquest that upon her review, the risk agreed as Medium, recorded at 21:10 hours, by Sergeant McClelland, was the correct level given the information gleaned from the hospital, family and friends. She explained the definition of medium risk as the risk posed is likely to place the subject in material danger to their life or safety or they are a significant threat to themselves or others. She stated that it was agreed that the deceased posed a significant threat to himself due to his mental health, however, from speaking with his friend Mrs Hewitt and staff at Lime Ward there were no significant, immediate concerns that he was actively suicidal. She explained that to be high risk, they would need evidence he was actively suicidal and demonstrate present active intention.

[180] Inspector Beatty explained that the investigation of a medium risk missing person sits with a Constable at District level. At 20:30 hours Constable Dean Curry was appointed investigating officer. At 22:11 hours he recorded his actions as checks of Omagh including Riverview parks and waterways, and the bus depot. He spoke with Mrs Hewitt, Lime Ward and Aideen Hughes. Ms Hughes stated that she was looking for the deceased around bridges as he was found there previously. Inspector Beatty accepted that Constable Curry could have asked her more specific information in relation to this. He handed over to Constable Bogue before finishing his shift. At 23:43 hours Constable Bogue recorded his actions as called Omagh hospital, Altnagelvin, called and visited a taxi company and visited two pubs in Omagh with the deceased's photograph.

[181] In relation to the actions of the assigned constable in Omagh, Inspector Beatty explained that either could have looked at NICHE in relation to any previous interactions the deceased had with the police, and this would have shown the incident on 16 March 2019 when the police brought the deceased back from the Foyle Bridge. She stated that this may have affected the risk assessment and investigation.

[182] At 20:47 Staff Nurse Rafferty telephoned PSNI and reported that Martin Hughes advised that he believed the deceased would go to one of the bridges in Derry as he had done so in the past and he requested police in Strand Road to be made aware and CCTV. Following this CCTV were notified at 20:59 hours and details circulated to H District 1 at 21:01 hours.

[183] Inspector Beatty described how this category of risk requires an active and measured response by police and other agencies to trace the missing person and support the reporting person. She was of the view the police did respond in a timely fashion and any information passed by the reporting person was actioned immediately. She stated that crews in H District were made aware within 12-14 minutes of information being received to say that the deceased may have gone to one of the bridges.

[184] Inspector Beatty explained to the inquest that dispatchers liaised with Foyle Search and Rescue and City centre CCTV to make them aware. There was a sighting by a member of the public and reported to police at 23:13 hours, that a male was walking along the footpath on the Foyle Bridge who appeared intoxicated and looked disorientated. Police responded immediately, recognising that it may be the missing person, the deceased. Unfortunately, he had just jumped into the water as Police were exiting the Police vehicle to try to assist him. This occurred at 23:20 hours, 7 minutes after initial report came in.

[185] Inspector Beatty explained that there was a 3 hour 15-minute window from the time of report coming in from Lime Ward to the time the deceased was reported to having jumped in the river. She stated that the initial checks and answering of missing persons questions account for the first 30 minutes, which is a normal amount of time as call handlers are gaining as much information about the missing person within this time as possible. A risk assessment must then be completed. Omagh officers carried out physical checks of his home address less than one hour of the time of the report. At the same time, information had been passed to H District to inform officers that he may be on one of the three bridges. Omagh officers continued with local enquiries to locate the deceased within G District. Inspector Beatty noted there was a 34 mile/52-minute distance between Lime Ward and the Foyle Bridge.

Evidence of Maeve Conway

[186] Ms Maeve Conway, paramedic with the Northern Ireland Ambulance Service, gave evidence to the inquest. At approximately 23:33 hours on 14 December 2019, she was tasked to Gilliland's Londonderry to reports of a male who had been recovered from the Foyle River having jumped from the Foyle Bridge. As she arrived on scene, she observed CPR was in progress by Foyle Search and Rescue. NIAS colleagues arrived on scene, and they removed the male to the ambulance where they continued advanced life support. At 00:29 hours on 15 December 2019, they pronounced life extinct.

Part 5: Suicide Prevention on the Foyle Bridge

Evidence of Stephen Twells

[187] Mr Stephen Twells, Chairman of Foyle Search and Rescue, gave evidence to the inquest. Foyle Search and Rescue is a registered, voluntary based charity, operating in Derry/Londonderry. Mr Twells described it as a suicide prevention, water rescue charity which has been in operation since 1993. They are made up of approximately 90 volunteers from the local community. They patrol the Foyle River on Thursday, Friday and Saturday nights, from 21:00 hours until 03:00 hours. There is an Emergency Response Pager Team, made up of around 14 volunteers who are on call 24 hours a day, 365 days a year, for incidents and emergencies outside of patrol times. This team also acts as a body recovery team who search for any person missing in the river.

[188] Mr Twells explained that members of the public can contact Foyle Search and Rescue by way of telephone Monday to Friday 09:00 hours to 17:30 hours.

[189] Mr Twells described how they have a radio link between the Service, CCTV operators in the City and the PSNI. He told the inquest that a missing persons report was completed for the deceased. It recorded that the PSNI made contact at 21:45 hours on 14 December 2019 providing a description. This information was then distributed to all team members. He stated that if information is received in relation to an individual going to a bridge, that information would have been recorded in the report, and in the deceased's case it was not. Mr Twells stated that if they do receive that sort of information, they can deploy resources to that area, for example a vehicle could have been sent to the Foyle Bridge.

[190] At 23:15 hours, Foyle Search and Rescue received a further report from PSNI that a male was reported on the Foyle Bridge. There was also information received from the CCTV operator. The Foyle Search and Rescue log recorded that the male was climbing on the railings. At that time, Mr Twells explained how the team would have activated their blue lights on the mobile vehicle and would have made their way to the Foyle Bridge while at the same time the boat would have gone directly to the Foyle Bridge at full speed. Neither got to the deceased before he went over the railings.

[191] Mr Twells told the inquest that the Foyle Search and Rescue Log recorded the male impacting the water and moving towards the boom hall marker. At 23:27 hours, the boat located the deceased just after the marker. Once in the boat, CPR was administered and on arrival at Gilliland's paramedics took over.

[192] Mr Twells gave evidence about the effectiveness of suicide prevention at the Foyle Bridge. He explained that fatalities from Foyle Bridge have been greater than any other location within the district area. Fatalities from the three bridges, currently in existence, Foyle, Craigavon and Peace Bridges are greater than all other locations combined. Since 2016, 14 deaths have occurred by falling from Foyle

Bridge, while 16 people have survived the fall, albeit many with major trauma injuries.

[193] Regarding suicide prevention measures on Foyle Bridge, Mr Twells explained that there are 6 movable CCTV cameras: 3 on each side of the carriageways. Two of these cameras are due to be upgraded with thermal imaging capability. These cameras are part of the city-wide camera network, and the CCTV operators are in place, monitoring 24/7, however he commented that it is extremely difficult for one operator to know which camera to physically watch at any one time. He stated that the CCTV operators do not hesitate in contacting Foyle Search and Rescue to report individuals by noticing certain behaviours and have helped save many lives indirectly through their quick actions.

[194] Mr Twells stated that throughout their duty nights the volunteers physically carry out a patrol of the Foyle Bridge every hour or so, as well as responding to calls from CCTV operators. They also patrol the area from Craigavon Bridge to Foyle Bridge during this time. During a duty night, the response time can be as little as a few minutes, through to 15 minutes.

[195] Between 2016 and 2024, Foyle Search and Rescue volunteers have responded to 403 incidents of attempted suicide or cause for concern at the Foyle Bridge.

[196] In relation to engagement in a cross-departmental co-ordinated action group established by the Mental Health Champion for Northern Ireland and involving the Derry City and Strabane District Council and the Department for Infrastructure on suicide prevention, Mr Twells explained there has been no engagement with Foyle Search and Rescue, and he was of the view that the Service is pivotal to keeping the people of the city and surrounding area safe and they are the only active suicide prevention charity in the city. He did add that that there is good interaction with their statutory emergency services partners and City Centre Initiative who operate the CCTV.

[197] Mr Twells told the inquest of the Foyle Search and Rescue's view as to whether further steps should be taken to help prevent suicides at the Foyle Bridge. He explained that they believe that realistic steps within peoples' control have been taken so far. For example, CCTV capability has been improving, response times to incidents are as fast as they can be, and preventing suicide remains a focus for Foyle Search and Rescue during patrols.

[198] In relation to the height of the railings on the Foyle Bridge, Mr Twells commented that has been a topic for discussion with various departments for some time and whilst the cost may be substantial, he stated that significant money has already been spent on public consultations.

[199] Mr Twells stated that it was the view of Foyle Search and Rescue that the "Our Future Foyle" project which proposed installing steel "reeds" across the Foyle Bridge, attached to the current railings, at a much greater height than the current 1.3m, should be funded. This infrastructure comprised an art instillation known as

the Reeds that would act as a suicide prevention barrier. In his view, the project has not been promoted as it was intended: a suicide barrier and preventative measure rather than an art project.

[200] Mr Twells went on to state that there should be visible and easily accessible signposting to suitable services and resources at the Foyle Bridge and other locations for those in crisis. He added that bus shelters, taxi ranks, pub toilets, lampposts should be used as well. Foyle Search and Resuce has developed its own signposting website. He stated, "more should be done to make people aware of what help is available out there and it should be easier for them to find."

[201] A Public Health Agency (PHA) report titled, 'Safety Review of the Foyle Bridge, Options study for suicide deterrent system' (2010), examined an option that could have been taken forward, including signs and emergency/crisis counselling telephone help points (section 7.2). It described how a study by the Golden Gate Bridge Suicide Deterrent System Project (San Francisco, California USA) revealed that approximately 70% of potential suicides on the Golden Gate Bridge were prevented using a combination of non-physical measures which include: Emergency/crisis counselling telephones/signs located along the bridge; patrols by trained personnel to detect people exhibiting suicidal behaviour; travelling public assisting by notifying authorities of suicide attempts via their cell phones. The report set out how the Foyle Bridge could also benefit by placing strategically located signs/telephone help points along the bridge. Mr Twells agreed with this suggestion and added that the only signs on the bridge are the ones placed by Foyle Search and Rescue and more could be done.

[202] He stated that the availability of life-rings, alongside CCTV monitoring, railings, and a proactive suicide prevention service all help to minimise suicides and access to services and resources need to improve.

Evidence of Seamus Donaghy

[203] Mr Seamus Donaghy, Head of Health and Community Wellbeing at Derry City and Strabane District Council, gave evidence to the inquest. Mr Donaghy explained that Derry City and Strabane District Council ('the Council') is the local authority in whose administrative area the Foyle Bridge is situated. The bridge is owned and maintained by the Department for Infrastructure. In relation to suicide prevention, Mr Donaghy explained that the Council has no legal obligation to provide services, however, they do have a civic and community leadership role in relation to health promotion, and they work with a range of statutory and non-statutory partners to try and deliver that.

[204] For many years the Council has been involved in discussions with statutory health partners around suicide prevention particularly around the Foyle, Craigavon and Peace Bridges. In 2019, the CCTV was installed on the Foyle bridge, which was partially funded by the City Centre Initiative and partially funded by the Council. In

2024 the City Centre Initiative could no longer provide a funding contribution for CCTV and the Council made up the shortfall to ensure it remained in place.

[205] Protect Life 2 (2019 – 2024), a long-term strategy for reducing suicides and the incidence of self-harm with action delivered across a range of Government departments, agencies, and sectors was established by the Department of Health. It is the main strategy in terms of preventing suicide across the entirety of Northern Ireland. In 2024, Northern Ireland recorded a higher suicide rate than the rate in other UK regions.

[206] Mr Donaghy stated that because of the high rate of suicide, particularly in Derry City, the Council has been proactively working with the statutory partners, and it has established a civic forum which relates not just to mental health and emotional wellbeing, but alcohol, drugs, and homelessness.

[207] Through his role, Mr Donaghy sits on the 'Cross departmental coordinated action group to consider crisis services and suicide prevention in Derry/Londonderry' which was established by the Mental Health Champion for Northern Ireland, Professor Siobhan O'Neill in 2023. The main aim of that group is to improve regional crisis intervention or implement a regional crisis intervention service; implement the Protect Life 2 suicide prevention strategy and action plan; and consider funding aspects of this strategy.

[208] The Council also sits on the Western Protect Life Implementation Group (WPLIG); a multi-agency group, the primary purpose of which is to ensure implementation of Protect Life 2 at a local level. Mr Donaghy explained that the objectives in the Protect Life 2 Strategy which WPLIG focus on are: to ensure a collaborative, co-ordinated cross departmental approach to suicide prevention; improve awareness of suicide prevention and associated services; restrict access to the means of suicide; enhance community capacity to prevent and respond to suicidal behaviour within local communities; ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour.

[209] Mr Donaghy stated that the action plan 2023-2025 includes the following tasks: establish task and finish group to update existing community response plans and to address issues related to the Foyle Bridges and waterways - continue to lobby relevant agencies to progress the erection of suicide prevention barriers on the Foyle Bridge.

[210] In relation to suicide prevention on the Foyle Bridge, it was noted that in 2017 there was an online petition to raise the railings on the Foyle Bridge signed by 8,745 people. Mr Donaghy stated that this was discussed by the Council through the 'Our Future Foyle' project and it was referred to the Department for Infrastructure. The view at the time was that there was no resource within budgetary constraints to move this issue forward. He advised that the discussions are continuing. When asked if there has been any actual substantive progress in those 7 years to provide additional suicide prevention measures on the Foyle Bridge in that time,

Mr Donaghy replied, "through the cross-departmental action group, discussions are ongoing in relation to having consultants engaged with viability of that work" and it really is a matter for the Department for Infrastructure.

[211] When asked whether there are any steps the Council intends to take or is discussing taking at any point over the next couple of years to try and improve suicide prevention on the Foyle Bridge, Mr Donaghy replied that Council will continue to liaise with the various partners and lobby the Departments in relation to the way forward and that will be based on recommendations made by the various groups.

Evidence of Daniel Healy

[212] Mr Daniel Healy, Divisional Roads Manager for Western Division in the Department for Infrastructure, gave evidence to the inquest. He explained that the Minister for Infrastructure has overall responsibility for the public road network. Mr Healy told the inquest that the Department is responsible for the management and maintenance of approximately 5800 bridges on the road network. The Department operates a road asset maintenance regime designed to maintain road safety within the limited resources available through a system of bridge inspections, identification of defects and prioritisation of repairs or replacement.

[213] The Foyle Bridge was originally opened in October 1984 and was designed in compliance with the national design codes of that time. Mr Healy talked about Bridge Parapet (safety barrier/railing) Policy and Guidance. The Foyle Bridge is approximately 36 metres in height. The approach spans are 144.3 metres in length, and the main span is 233 metres.

[214] The pedestrian parapets were designed in line with the Department of Transport Technical memorandum H9/73, and the height of the parapets comply with British Standard Specification BS 3049 (1976). The minimum height for pedestrian parapets designed in this period was 1000mm. The parapet height on the Foyle Bridge is 1340mm.

[215] When the bridge was being built, there was no mention of suicide prevention measures in national codes. These have since been superseded and the current design standard, which applies to new bridges - CD 377 – Requirements for Road Restraint Systems does mention suicide risk, and where suicide or self-harm is perceived to be a potential problem, there is a recommendation that organisations engage with relevant local bodies to determine appropriate solutions. In the current design standard, the minimum height of a pedestrian parapet in a locus such as the Foyle Bridge is 1150mm, which the current parapet exceeds.

[216] Mr Healy told the inquest that the Department is under no legal requirement within roads legislation to provide an increased height barrier on the Foyle Bridge. He went on to explain to the inquest about the Department's input into suicide prevention at the Foyle Bridge.

[217] Firstly, in 2010 the PHA funded an Options Study for Suicide Deterrent on Foyle Bridge by Hyder Consulting titled 'Public Health Agency Safety Review of Foyle Bridge' (2010). This was presented to the then DRD Roads Service. The report indicated that any proposed new barrier should be sufficiently porous to minimize the wind load on the bridge, and that aerodynamic stability could be a potential issue and it would need to be lightweight. Essentially further work on options needed to be carried out. Mr Healy did not believe there was any active pursuit of the recommendations of the report.

[218] Secondly, between 2016 and 2020, the Public Health Agency funded the development of 'Our Future Foyle' project which aimed to improve the health and social well-being of everyone using the riverfront of the Foyle, through the rejuvenation of the banks and bridges as a shared positive space. One of the key components of the initiative was the 'Foyle Reeds' project which proposed an innovative suicide prevention barrier for the bridge. The Department for Infrastructure was involved given its responsibility for the Bridge. The Foyle Reeds would replace the existing pedestrian parapet with a metal barrier manufactured to mimic river reeds in excess of 3.0 metres in height. The barrier aimed to promote a new perception of the bridge as a positive landmark whilst also acting as an effective prevention barrier. The Department was involved in the initial discussions regarding the capacity of the bridge to sustain any increased loading from the installation of the Foyle Reeds.

[219] In late 2018, a Project Board was set up, facilitated by the Department of Health (DoH) and chaired by the Chief Executive of the Derry City Centre Initiative. The Department were represented on this Board. The idea was that business cases for each intervention to assess value for money would be developed and the Department transferred £35k to DoH to cover half of the anticipated costs of developing the Foyle Reeds Outline Business Case (OBC).

[220] To inform development of Foyle Reeds Outline Business Case an engineering and design company, COWI, were commissioned in 2019 to undertake a review of the feasibility of installing a public safety barrier on the Foyle Bridge. The COWI review fed into a draft Outline Business Case submitted to the Department in December 2020. The Department concluded that further work was required to fully explore the nonmonetary costs and benefits of the proposals on Foyle Bridge such as increased safety. The PHA undertook to progress this through a revised Outline Business Case.

[221] However, Mr Healy stated that a final business case was never received by the Department. The draft that was made available did not identify Foyle Reeds as the preferred option. Instead, an option for to replace the existing parapets with higher barriers and provide standard lighting was identified. Mr Healy agreed with Mr Twell's comment that the Foyle Reeds project was not advanced primarily as a suicide prevention.

[222] Thirdly, the Protect 2 Life Strategy, requires the Department engage with stakeholders to 'Reduce risk of suicide at high-risk locations and develop plans for enhancing safety at those locations.' As a result, Mr Healy stated that the Department completed a Strategic Outline Case (SOC) for the provision of active travel on the Foyle Bridge in 2022. This included consideration of suicide prevention measures and recommended the completion of a structural assessment to determine the maximum height of barrier that could be sustained by the bridge.

[223] In July 2022, the Department commissioned an external consultant to determine if the original structural model used to design the 2005 strengthening works on Foyle Bridge could be used to complete the barrier assessment. The original model was not available meaning a new model would have to be built. The estimated cost of a new structural assessment of the Foyle Bridge, including model, to help inform any future business case development was £417k. Mr Healy confirmed that it was estimated by the Department that it would take around £10 million to install a standard height containment barrier on the Foyle Bridge.

[224] Mr Healy explained the Department is a member of the 'Cross Departmental Coordinated Action Group' established in 2023, which aims to develop actions to address suicide prevention, along with any other relevant issues, at the river and bridges in Derry/Londonderry. In a note of a meeting on 18 October 2023, the Chair, Professor O'Neill advised the group that barriers on the bridge had been a Ministerial priority of the previous two Ministers. Mr Healy was asked, if barriers on the bridge were the ministerial priority of those two ministers what practical difference did that make to the way the Department responded to business cases, discussions and meetings about whether to impose barriers or to take further steps to see whether they were feasible and Mr Healy replied, "The Department would act at the discretion of the minister. If the minister instructed progress to be made in a certain way, then it's inherent on the Department to do as they instruct." Asked whether, at present, there was any instruction given by a minister to progress the structural assessment, Mr Healy replied, "To my knowledge, there was no instruction to progress it." He also confirmed that no submission seeking further funding has been submitted as "the Department of Engineering has made the point at repeated meetings that unfortunately we're just not funded to carry out this work." He added that if the cross-departmental group raised the issue with the Minister it would be considered.

[225] In summary, Mr Healy stated that suicide prevention is complex and no single Department, or any other publicly funded body, is wholly responsible for addressing this complex issue, therefore a collaborative approach is required.

[226] While the Department has no legal requirement within roads legislation to provide increased height barrier on the Foyle Bridge, the Department recognises how such measures could contribute to the wider health objectives of improving the safety and wellbeing of vulnerable individuals within local communities. The Department will continue to work with all stakeholders to identify funding to complete the structural assessment for increased barrier heights at Foyle Bridge.

When asked if the public in Derry/Londonderry are any closer to having suicide prevention barriers on the Foyle Bridge in 2025 than they were in 2019 when the first feasibility study was carried out, Mr Healy replied, "there has been progression with regards to refining the estimate since that date, however, that's wholly dependent on funding being made available to progress."

Expert evidence

Evidence of Professor Jogin Thakore

[227] Professor Jogin Thakore, Consultant Psychiatrist, and Associate Professor of Psychiatry, provided an expert report on behalf of Dr Warren, and gave evidence to the inquest.

[228] Professor Thakore discussed the MDT's decision on 10 December 2019 to grant unaccompanied leave. He noted that Dr Warren told the inquest the deceased described having no thoughts of life not worth living and specifically denied any suicidal thoughts. Further, nursing feedback in the notes stated that he denied thoughts of life not worth living or suicidality or impulsivity to self-harm and so all members of the MDT agreed to his request for unaccompanied leave. In Professor Thakore's opinion, this was a clinically reasonable decision to make based on the deceased's presentation at that time.

[229] It was put to Professor Thakore that Dr Warren last reviewed the deceased on the 2 December 2019 and then on 10 December he took the decision to grant unaccompanied leave. He was asked what level of assessment he thought Dr Warren should have conducted given that he had not seen the deceased for eight days. Professor Thakore replied that Dr Warren was familiar with the deceased, and he expected that he conducted a mental state examination, reviewed MDT notes of ward rounds and asked the other team members if they had any concerns. It was put to Professor Thakore that at the MDT, there was realistically only two members involved in the decision making – Dr Warren and Staff Nurse Doherty. He stated that this did not change his view, "as both Dr Warren and Nurse Doherty knew Mr Hughes very well and they were best placed from a familiarity perspective to see whether he was well or not well and could have leave or couldn't have leave." He accepted that the decision should have been signed off by a consultant. He added that "I think in hindsight because of the outcome it would have been better if Dr Warren had consulted with the consultant that was cross-covering but I'm not sure who that would have been. But Dr Warren seems to have made such decisions in the past. That's my understanding with respect to such patients and he felt comfortable doing so."

[230] In relation to whether the issue of leave should have been discussed in the presence of the deceased, Professor Thakore stated that "that's really dependent upon the clinical presentation of the patient at the time, but my practice would be to discuss leave in front of the patient to see what they thought of and how they'd actually react to any strictures that we might put on to them."

[231] Professor Thakore explained that the decision to offer leave is a judgment call. Such decisions are difficult to make and are based on the clinician's experience and familiarity with the patient, the patient's history, recent wellbeing and clinical presentation and the views of other MDT members. The risks of granting leave are that the patient might self-harm, commit suicide or harm others. He explained the benefits of leave include allowing the patient to leave the confined quarters of an inpatient unit, allowing the patient to get a sense of normality pre-discharge, indicates that the MDT trusts the patient, and it allows a patient to determine what they feel like while on leave and whether they are capable of leave.

[232] Professor Thakore told the inquest that in the two weeks prior to his suicide, the deceased was assessed on a regular basis, and he denied any thoughts of life not worth living or suicidal ideation during this period. On the 14 December 2019, a clinical entry indicated that he denied any such thoughts.

[233] In terms of leave arrangements, Professor Thakore explained that typically the type of leave is specified (accompanied or unaccompanied) as is location. He stated that if it were a first unaccompanied leave, he would like to keep it local, for example to the shop and that should be recorded along with the time, for example one or two hours. He stated he would have expected the MDT to have recorded this detail.

[234] He stated that in the Republic of Ireland, where he practises, under legislation, only consultants can grant leave to detained patients and that the decision must be written down in a pro forma as well containing information including the time, duration, whether it is accompanied, or unaccompanied, and location.

[235] In relation to safety plans, Professor Thakore explained that they provide clarity for the patient on the expectations of the leave that has been granted and advise what to do in the event they feel unwell as well as providing contact information and they are useful for patients.

[236] In relation to whether the deceased's risk assessment should have been updated following the decision on 10 December 2019, Professor Thakore stated that "I'm not a huge fan of risk assessments because I don't think they actually predict behaviour. I think the initial risk assessment is very important if they're a brand-new patient or if they're relatively new to the service it's really valuable to see what they have done in the past to themselves or to others…But after the events have occurred it's very difficult to see how valuable it would be. A better indication is to write down what you felt the patient's clinical state was like, what was actually agreed to and who you had consulted in making that decision."

[237] In Professor Thakore's opinion, based on the documentation available to him, the deceased's death was tragic but in no way predictable. He further clarified his "in no way predictable" comment, by stating, "there is a notion, perhaps less so than before, that having a full risk assessment is an adequate tool to try and see whether

someone will or will not do something to themselves. I don't think that's a credible anymore. Even the NICE [guidance] has come out saying risk assessments by themselves are not that good. What's better is suicide prevention training for staff, knowing that staff know how to, for example, develop rapport with a patient, know what the patient's triggers might be, understand, what a patient might do if they find themselves in a stressful situation on leave or even on the ward. I think that's a better way of assessing someone's risk in terms of self-harm. That's all I mean by predictable."

Evidence of Oscar Donnelly

[238] Mr Oscar Donnelly, former Director of Mental Health and Disability Services in the Northern Health and Social Care Trust, and former Co-Chair of the Department of Health's Mental Health Strategic Advisory Panel and former Chair and Regional Lead for the Northern Ireland Towards Zero Suicide, Mental Health Patient Safety Collaborative, provided a report on my behalf and gave evidence to the inquest. His report specifically addressed the approach to suicide prevention and risk management within acute mental health inpatient services, with reference to the care provided to the deceased whilst an inpatient at Lime Ward. His report examined current clinical practice, evidence-based approaches to suicidality, and specific issues relevant to this case, including the significance of the Foyle Bridge as a high-risk location.

[239] Mr Donnelly outlined the current approach to suicidality in inpatient care. In acute mental health inpatient care, treatment focuses primarily upon assessment and treatment of mental illness and risk assessment for patient safety. Suicidal behaviours are generally understood as secondary to, and arising from, an underlying mental illness. The clinical assumption is that improvement to mental state will be accompanied by reduction in suicidal thoughts and behaviours.

[240] Mr Donnelly explained that risk assessment serves to determine the level of suicide risk and inform decisions regarding observations and restrictions. The primary approach is therefore treatment of the underlying mental disorder, accompanied by safety measures pending treatment efficacy. He stated that the deceased's management whilst at Lime Ward broadly reflected this approach.

[241] Mr Donnelly discussed evidence-based approaches to suicide prevention. One such approach is suicidality as a distinct behaviour. Research indicates suicidality should be viewed as behaviour strongly associated with, but distinct from, mental illness and amenable to direct intervention. This approach requires that suicidal behaviour be addressed directly alongside treatment of mental illness, through sensitive exploration to provide insights for care planning and patient understanding.

[242] Mr Donnelly stated that this necessitates staff training in brief interventions addressing suicidal behaviours through suicide risk formulation, safety planning, and counselling on access to lethal means. He explained that within the past 18

months, these approaches have been introduced in Northern Ireland mental health crisis and liaison services through a developing suicide prevention care pathway.

[243] In relation to suicide risk formulation, Mr Donnelly told the inquest that the National Confidential Inquiry into Suicide and Homicide has consistently reported that for the majority of mental health service patients who die by suicide, immediate risk was judged low or absent at last contact. He explained that therefore, risk assessment tools cannot reliably predict future suicidal behaviour and should not be used for that purpose.

[244] He explained that suicide risk formulation is a collaborative process between patient, family where appropriate, and practitioner, aiming to summarise current risks and difficulties and understand their causation to inform treatment planning. It considers historical factors, recent problems, and existing strengths and resources, creating insights into risk emergence and informing collaborative safety and care planning.

[245] Risk formulation requires attention to factors beyond psychiatric diagnosis, including demographic, social and psychological factors, thoughts of belonging or burdensomeness, potential triggers, protective factors, and previous suicidality history. This approach is central to the Zero Suicide model and was included in NICE Self-harm guidelines published September 2022.

[246] In relation to understanding past suicidal behaviour, Mr Donnelly commented that a principal variable distinguishing those who die by suicide from those who do not is past history of significant self-harm or suicidal behaviours. He stated that this pattern was evident in the deceased's case, wherein he visited the Foyle Bridge twice prior to the fatal third visit and on another occasion walked into a local river before returning to the ward.

[247] Mr Donnelly stated that research demonstrates past and future suicidal behaviours are directly related, independent of association with chronic conditions such as mood or personality disorders. Past suicidal behaviour confers risk for later suicidality, including death by suicide.

[248] Mr Donnelly discussed collaborative safety planning. He noted that the Trust's SAI Report stated that a safety plan could have been put in place for the deceased which could have helped him develop new patterns and Mr Donnelly agreed with this. He stated that safety plans are recognised as one of the most effective evidence based brief interventions in suicide prevention. In Northern Ireland the term 'collaborative' safety plan has been used to emphasise the importance of this exercise being completed collaboratively with the patient and as appropriate a relative or carer.

[249] Mr Donnelly discussed how expressions of hopelessness and statements of life not being worth living are red flags, and he agreed with the comment in the SAI Report that denial of same does not constitute reassurance of itself and "an ability to self-guarantee safety should not be assumed simply on the verbal confirmation of a

patient." Mr Donnelly stated that either a confirmation or a denial of thoughts of life not worth living should engender further sensitive exploration with the patient, particularly where they have had a recent history of suicidality. He emphasised that previous suicidal behaviour and particularly recent suicidal behaviour is a strong predicator of the risk of future suicidal behaviour. He stated that the completion of a collaborative safety plan would have supported therapeutic conversations with the deceased with regards to his suicidal thoughts and behaviours, informed by consideration of previous suicidal behaviours and the presence of any triggers and how these might best be avoided, responded to and/or mitigated against.

[250] Mr Donnelly explained that limiting access to the means of suicide is recognised as an evidence-based suicide prevention measure. It is a component of collaborative safety planning. In the deceased's case his choice of means was jumping from the Foyle Bridge. Mr Donnelly stated that the SAI Report rightly identified that decisions around giving time off the ward for patients are finely balanced and difficult to get right. In relation to the decision on 10 December 2019 to allow unaccompanied leave, Mr Donnelly stated clinicians should have given full consideration to the risks identified, any protective factors and should have been informed by previous experiences. If taken, such an approach would have been evidenced by a clear decision-making process setting out how a decision was made including how the decision would be effected to help mitigate and manage any identified risks, underpinned and informed by an updated safety plan. This approach was not evident for the deceased. He added that his understanding of leave for detained patients under the 1986 Order and the AWOL Regional Guidelines, is that leave can only be granted by a Responsible Medical Officer, which would be the consultant. He added that he would have expected the medical staff in Lime Ward to have been familiar with legislation.

[251] In relation to the inclusion of relatives, Mr Donnelly noted, that in the deceased's case, important input was offered by the deceased's family, but evidently not acted upon. There was no evidence that the 16 March 2019 incident or the warnings from the family had been incorporated into any systems. He commented that the family's emails to the ward ought to have been acknowledged. Mr Donnelly stated that the experience of the deceased's family raised a concern that this may have been indicative of a culture on the ward, where the value of family involvement and the important contribution they can make to the safe and effective care of patients, was not fully recognised or understood by staff. Mr Donnelly recommended the Trust reflect on this further including the need to support the Lime Ward staff team through training and reflection on ward practice regarding the appropriate involvement of family in the triangle of care across staff, service users and carers/family.

[252] Mr Donnelly discussed the Foyle Bridge as a high-risk location. The deceased's history demonstrated that he was drawn to the Foyle Bridge as a means of suicide, attending on three recorded occasions. Mr Donnelly told the inquest that PSNI research from September 2019 to August 2020 identified 414 CCTV bridge

incidents in Derry/Londonderry, including actual suicides, persons in water, distressed persons, and interventions by others. Five deaths occurred from the Foyle Bridge during this period, predominantly involving males, with elevated occurrence rates on late evenings and early weekend nights. As the inquest heard, authorities have responded with CCTV monitoring enabling trained police intervention, public vigilance campaigns including taxi driver awareness, and the valuable work of Foyle Search and Rescue Service.

[253] Mr Donnelly opined that restriction of access to suicidal means is crucial in prevention. He explained that evidence from comparable initiatives demonstrated that barriers and nets constitute effective public health measures, with studies showing barriers save lives without simple displacement to alternative locations.

[254] The absence of fully effective barriers at the Foyle Bridge is noted in the SAI Report. Whilst acknowledging the importance of proper testing for technical demands, Mr Donnelly opined that relevant agencies must prioritise completion of planning, testing, funding and installation of new barriers, such as the 'Foyle Reeds' Project, to prevent further loss of life.

[255] Mr Donnelly concluded by stating that when the deceased left Lime Ward on 14 December 2019, staff recorded no concerns for his safety. This assessment appeared based upon presentation over a relatively short recent timeframe rather than informed by complex understanding of his suicidal behaviour and associated risks. Even absent clear intent at his 15.00 hours departure, his recent history of suicidal behaviours indicated vulnerability for the urge to arise or be triggered again. Eight hours after ward departure, he took his life at a location and in manner consistent with previous suicidal behaviour.

[256] Mr Donnelly stated that his evidence to the inquest should highlight the need for new practice development and associated staff training ensuring better informed, safer and effective approaches to suicidality in inpatient care.

[257] He added that whilst particular aspects are specific to this case, Lime Ward is not unique in requiring different approaches and specialist training for staff in acute mental health inpatient care responding to patients presenting with suicidal risk and behaviours. Specialist practitioner training is being provided in mental health services through the Towards Zero Suicide initiative on a prioritised basis. He stated that this training is most effective as an element of an overall suicide prevention approach which must include designing and embedding new practices into care models.

Pathology evidence

Evidence of Dr Peter Ingram

[258] Dr Peter Ingram, the Assistant State Pathologist for Northern Ireland, conducted an autopsy on the deceased on 15 December 2019 and thereafter

produced a post mortem report, which was admitted into evidence pursuant to Rule 17.

[259] Dr Ingram described how the deceased was seen to fall from a bridge some thirty metres into a river. His body was recovered about ten minutes later and he was taken to shore. Attempts at resuscitation were made but to no avail.

[260] As a result of falling into the water, Dr Ingram described how the deceased sustained multiple injuries. These included a fracture of the base of the skull associated with bleeding over the surface of the brain, fractures of seven of the right ribs, some in two places, fractures of five of the left ribs, lacerations of the fatty attachments of the bowel and six lacerations of the liver. Dr Ingram explained that whilst these injuries would undoubtedly have posed a very great risk to life, it seemed likely that drowning also played a role in the fatal outcome and as such, it too warranted inclusion in the cause of death, albeit that the pathological features seen in drowning had probably been altered by the attempts at resuscitation. Dr Ingram stated that it is quite possible that the deceased's head injury caused an immediate loss of consciousness.

[261] Dr Ingram added that no significant natural disease which may have caused or accelerated the deceased's death was detected.

[262] A report of Forensic Science Northern Ireland showed that, at the time of his death, there was some alcohol in the deceased's body. Dr Ingram stated that its concentration in the blood, 18mg per 100ml, was of no great significance.

Conclusions on the evidence

[263] I find, on the balance of probabilities, that the death of the deceased at the Foyle Bridge on 15 December 2019 was preventable. I find that, had the decision to grant unaccompanied leave on 10 December 2019 been clearly and contemporaneously recorded with sufficient particularity as to its duration, purpose and permitted location; had that decision been subject to review by a Consultant on 14 December 2019; had the implementation of the decision been accompanied by an adequate and contemporaneous risk assessment; had the Absent Without Leave Policy been activated at the earliest practicable opportunity; or had comprehensive, accurate and timely information been provided to and recorded by the PSNI, the death of the deceased on 15 December 2019 would, on the balance of probabilities, have been avoided.

[264] On the evidence before the Court, I am satisfied that there were a number of missed opportunities in the care and treatment of the deceased; in the implementation of relevant policies and procedures on 14 December 2019, and in the search undertaken on that date. Each of the findings set out below is made on the balance of probabilities.

[265] Before proceeding to my specific findings, I consider it appropriate to commend some of the Trust witnesses for their candid evidence before this court. It

was evident from the oral testimony received at inquest that lessons have been learned within the Trust following the deceased's death.

Part 1: Diagnosis, Care and Treatment from 2018, Including Admission to Lime Ward in June 2019

[266] I find that the deceased's diagnosis and treatment was, in general terms, appropriate and in accordance with accepted clinical standards.

[267] I acknowledge that there was considerable multi-disciplinary input into the deceased's treatment, including valuable contributions from forensic mental health services and other specialist clinical teams, which demonstrates the complexity of his presentation and the commitment of staff to his care.

[268] I find that the allocation of one social worker to cover three wards plus a crisis centre was manifestly inadequate and resulted in insufficient support being available to Ms Kerr in the proper discharge of her professional duties.

[269] I find that Ms Kerr was in a position to have addressed certain aspects of the deceased's financial concerns at the material time, although I accept that further financial worries may subsequently have developed notwithstanding any such intervention.

[270] I find that when the deceased was discharged from Lime Ward in May 2019 and subsequently readmitted in June 2019, a comprehensive and collaborative safety plan ought to have been established and implemented from the point of readmission to ensure continuity of protective measures for the deceased.

[271] I find that a comprehensive safety plan ought to have been implemented and agreed following the absconding attempts in November 2019, with meaningful input from and collaboration with the deceased's family members who had demonstrated their commitment to his wellbeing. The failure to provide such a plan represented a missed opportunity to enhance protective measures and improve collaborative safety planning.

[272] I find that had the deceased been provided with a written personal safety plan, as ought to have been the case following the November 2019 incidents, and had he been carrying this plan together with his mobile telephone on 14 December 2019, this may have provided additional protective factors and means of contact during the critical period.

[273] I find that the formulation and completion of a collaborative safety plan would have facilitated structured and therapeutic discussion with the deceased concerning his suicidal thoughts and behaviours. Such a plan should have been informed by consideration of his previous suicidal conduct, any identifiable triggers, and the measures by which such triggers might reasonably be avoided, addressed, or mitigated.

[274] I find, and it is accepted by the Trust, that an adequate, current, and comprehensive risk assessment ought to have been maintained and regularly reviewed throughout the entirety of the deceased's admission to Lime Ward.

[275] I find that the deceased's Integrated Care Pathway documentation and PARIS electronic notes were lacking in requisite clinical detail and contemporaneity and were inadequate for the purpose of ensuring safe and effective clinical care. They were characterised by a lack of sufficient clinical detail, an absence of clear management plans, and insufficient clarity as to whether the deceased was detained under the Mental Health (Northern Ireland) Order 1986 at any given time, whether leave had been granted, and the specific conditions and restrictions attached to any such leave. This significant deficiency in record-keeping may have materially affected subsequent management planning for the deceased and, in turn, may have influenced Dr Warren's clinical decision-making on 10 December 2019, which I address in the section below.

[276] I find, and it is candidly acknowledged by Dr Manley, the consultant in charge of the deceased's care, that the clinical notes pertaining to the deceased's care plan were inadequate and insufficiently detailed within the PARIS electronic system.

[277] I find that there existed on Lime Ward a systemic culture of poor specificity and inadequate detail in the maintenance of PARIS electronic records, handwritten records and record keeping generally, which represented a broader Service failing in clinical documentation standards.

[278] I find that there existed on Lime Ward an inappropriate culture whereby junior or resident medical doctors made significant clinical decisions concerning patient leave and management notwithstanding that they possessed no statutory authority under the Mental Health (Northern Ireland) Order 1986 to make such decisions in respect of patients detained under the Order. This practice created a risk of decisions being made by clinicians without the requisite experience, authority, or accountability.

[279] I find that any expression by the deceased of thoughts of life being not worth living — whether by way of confirmation or denial — ought to have prompted further sensitive and probing exploration, particularly given his recent history of suicidality. His responses were, on a number of occasions, accepted at face value without adequate enquiry. It is well-established that previous suicidal behaviour, and recent suicidal behaviour in particular, constitutes a significant predictor of future suicidal risk.

[280] I find that the deceased's family provided important and relevant information, yet there is no evidence that this input was acted upon. In particular, there was no indication that the incident of 16 March 2019, or the subsequent warnings communicated by the family, had been incorporated into any operational or clinical systems. The family's emails to the ward — notably those sent in November 2019 — ought to have been formally acknowledged. They were detailed,

insightful, and offered valuable observations capable of informing and improving the care provided.

[281] I find that the failure to respond to communications from the deceased's family evidences a culture within Lime Ward in which the value of family involvement, and the important contribution that family members can make to the safe and effective care of patients, was not adequately recognised or understood by staff.

[282] I find, having considered the evidence, that whilst specialist practitioner training is being delivered within mental health services on a prioritised basis under the Towards Zero Suicide initiative, as articulated by Mr Donnelly, such training is most effective when implemented as part of a broader, system-wide approach to suicide prevention. In considering the future direction and prioritisation of the Towards Zero Suicide initiative, I find that regard should be given to its further development and regional roll-out across acute mental health inpatient settings, together with consideration of the need to increase overall capacity for specialist practitioner training to meet the needs of staff working within those environments.

[283] I find, on the basis of the evidence before me, that there is a requirement for further suicide prevention training for all staff in Lime Ward. Such training should equip staff with the necessary skills to better understand patients, to develop and maintain an effective therapeutic rapport, to identify potential triggers for distress and to recognise how a patient may respond when exposed to stressful situations, whether whilst on leave or within the ward environment.

Part 2: The decision to grant unaccompanied leave on 10 December 2019

[284] I find that Dr Warren, a Specialty Doctor, did not have the requisite statutory authority to grant leave to a patient detained pursuant to the Mental Health (Northern Ireland) Order 1986. Such authority rests with the Responsible Medical Officer, or with a consultant psychiatrist acting under appropriately delegated authority. I further find that Dr Warren ought to have been aware of this limitation, as a clinician practising within the Crisis Service, and that Dr Manley similarly ought to have been aware of the statutory framework governing leave for detained patients. The apparent lack of awareness among staff on Lime Ward of the statutory requirements imposed by the 1986 Order, at the relevant time, is a matter of concern.

[285] I find that, when approached by the deceased seeking unaccompanied leave, Dr Warren ought to have deferred any decision until the following day, when a full multidisciplinary team meeting, including the consultant psychiatrist, Dr Moore, was available to consider the request.

[286] I find that on 10 December 2019, the decision to grant unaccompanied leave made by Dr Warren was not adequately informed by a comprehensive risk assessment and was not supported by appropriate safeguards including time limits and specified parameters.

[287] I find that Dr Warren's assessment appeared to be based upon presentation over a relatively short recent timeframe, rather than informed by a complex understanding of the deceased's suicidal behaviour and associated risks and his recent history of suicidal behaviours indicated vulnerability for the urge to arise or be triggered again.

[288] I find that the deceased's recent history of absconding attempts, including the incidents in November 2019, ought to have been given greater weight in the assessment conducted prior to the decision to grant unaccompanied leave from the ward and ought to have been supported by a clear and documented decision-making process, specifying the basis upon which the decision was reached and the manner in which any identified risks were to be managed and mitigated. This process should have been underpinned by an updated safety plan. Such an approach was not evident in the care of the deceased.

[289] I find that the decision to grant unaccompanied leave on 10 December 2019 was not adequately documented in the clinical records, with insufficient detail recorded concerning the clinical rationale for the decision, the risk assessment undertaken, or the conditions and restrictions to be applied to such leave.

[290] I find that had appropriate time limits been specified for the leave granted on 10 December 2019 and had the absent without leave policy been activated promptly when the deceased failed to return within those time limits, earlier intervention would have been possible, which may have altered the subsequent course of events.

[291] I find that a balance must be struck in clinical practice between maintaining a therapeutic relationship with a patient and ensuring that patient's safety. Staff members involved in clinical decision-making on 10 December 2019 failed to strike that balance appropriately and failed to appreciate the paramountcy of safety considerations, affording undue weight to other therapeutic factors.

Part 3: Events of 14 December 2019

[292] I find that on the morning of 14 December 2019, when the deceased disclosed to Staff Nurse Russell that he was preoccupied with financial issues and was difficult to reassure about same; this disclosure constituted a significant clinical indicator of immediate risk which ought to have prompted urgent clinical review before any decision was made to permit him to leave the ward that afternoon.

[293] I find that, in the circumstances, nursing staff ought to have sought senior medical review and advice from a Consultant prior to permitting the deceased to leave the ward on 14 December 2019. This was particularly so given the absence of clarity in the contemporaneous clinical records concerning the decision made four days earlier and bearing in mind that this was the deceased's first period of unaccompanied leave from the ward.

[294] I find that the deceased ought not to have been provided with his bank cards on 14 December 2019, given his disclosure that he was preoccupied with financial

issues during review that morning. Providing access to his bank cards and permitting him to attend a bank machine unaccompanied demonstrated insufficient appreciation of the clinical risk presented.

[295] I find that when the deceased failed to return to the ward at the expected time on 14 December 2019, the absent without leave policy ought to have been activated more promptly than in fact occurred.

[296] I find that had accurate and current contact telephone numbers for Mrs Hewitt and the deceased's family been recorded and readily available to staff, this may have facilitated earlier contact and intervention when the deceased failed to return to the ward as expected.

[297] I find that the staff members involved in clinical decision-making on 14 December 2019, as was the case on 10 December 2019, failed to strike an appropriate balance between therapeutic considerations and patient safety. In particular, they failed to afford due primacy to safety considerations, instead attaching disproportionate weight to other therapeutic factors.

Part 4: The Search for the Deceased on 14 December 2019

[298] I find that Staff Nurse Russell, as the deceased's designated named nurse with detailed knowledge of his clinical history and risk factors, was best placed to provide a comprehensive handover of relevant information to the PSNI and ought to have made the initial call to report the deceased as a missing person.

[299] I find that Lime Ward staff did not communicate all relevant clinical and risk information to the PSNI in a sufficiently clear and specific manner. I find that although Staff Nurse Helen Rafferty did inform the PSNI call handler that the deceased might attend a bridge in Derry, and a discussion followed concerning which bridge, Staff Nurse Rafferty could and should have been explicit and definitive in explaining the deceased's documented recent history of attending the Foyle Bridge as his preferred location for potential self-harm.

[300] I find that the PSNI call handler should have recorded 'Foyle Bridge' specifically in the incident log. This critical and specific information was not recorded in the PSNI Control Works Log, and ought to have been so recorded. Proper recording of this specific information could have materially assisted the PSNI in determining the appropriate search area and optimal deployment of resources, such as a police crew from H District 1 being directed immediately to attend the Foyle Bridge.

[301] I find that Constable Curry at 20:30 hours, and subsequently Constable Bogue, ought to have conducted checks on the NICHE database, which would have contained the record of the deceased's attendance at the Foyle Bridge on 16 March 2019. The conducting of such database checks was not recorded in the Operational Event Log. Such checks ought to have been conducted as a matter of routine practice in addition to physical searches of licensed premises, taxi ranks, and other locations.

Information regarding the deceased's history was readily available within PSNI systems and could have materially informed the direction and focus of the search operation. Had such database checks been conducted, the officers could have contacted H District 1 and informed them that the deceased might be at the Foyle Bridge.

[302] I note that it was Staff Nurse Rafferty's communication with the deceased's family, regarding the potential relevance of CCTV coverage, which led to CCTV footage being reviewed at 20:47 hours. This important initiative came from the family rather than from the PSNI's operational procedures.

[303] I commend the valuable work undertaken by Foyle Search and Rescue, a charitable organisation which provides an invaluable and life-saving service to the community through the dedication and commitment of its volunteers.

Part 5: Suicide Prevention Measures at the Foyle Bridge

[304] I accept that the Department for Infrastructure has no current legal requirement under existing legislation or regulations to raise the height of barriers on the Foyle Bridge, and that any such requirements presently apply only to new bridges where suicide or self-harm is perceived to be a potential problem.

[305] I find that the railings and barriers on the Foyle Bridge ought to be increased in height in order to provide enhanced physical protection and to act as an effective deterrent to persons in crisis who may be contemplating self-harm.

[306] I accept the evidence provided by Mr Healy that there exists a lack of available dedicated funding within current budgetary allocations to implement physical modifications to the Foyle Bridge infrastructure. However, I find that substantially greater efforts must be made by the relevant Departments and public agencies, specifically the Department for Infrastructure, the Department of Health, and Derry City and Strabane District Council, working collaboratively, to secure such funding and to prioritise this life-saving measure within their respective budgets.

[307] I find that the Department for Infrastructure, in collaboration with the City Centre Initiative partnership and Derry City and Strabane District Council, ought to erect appropriate preventive signposting on the Foyle Bridge indicating available support services, as well as crisis intervention telephones without delay. These essential life-saving provisions ought not to be dependent upon or left to charitable organisations operating with limited resources.

[308] I find that Foyle Search and Rescue ought to be included as a matter of course in all working groups and strategic discussions pertaining to suicide prevention in the Derry/Londonderry area, given the valuable and informed contribution which this organisation can make based on its extensive practical experience and understanding of the challenges presented by the local geography.

[309] The evidence received by this Court demonstrates that there ought to be an unequivocal commitment by all relevant public authorities to achieving the objective of zero suicides from bridges in this jurisdiction. The Department of Health and the Department for Infrastructure ought to undertake substantially greater and more urgent action, particularly given that Derry/Londonderry has one of the highest rates of death by suicide in Northern Ireland and the Foyle Bridge accounts for the greatest number of bridge-related fatalities in this jurisdiction.

[310] I find that years of discussion and deliberation must now conclude in decisive and effective action. The time for implementation of preventive measures is now. Too many lives have been lost during the intervening period since these matters were first raised and discussed. Since formal discussions concerning suicide prevention measures at the Foyle Bridge commenced some seven years ago, no substantive physical modifications have been made to the bridge infrastructure.

Cause of death

[311] I have considered whether the deceased took his own life, the essential components of which are the act being voluntary, the deceased's intention was to take his own life and the deceased died as a result of his own act. On the balance of probabilities, and at a time when the balance of his mind was disturbed as a consequence of schizoaffective disorder, I find that at approximately 23.20 hours on 14 December 2019, the deceased voluntarily climbed over the railings of the Foyle Bridge and jumped into the water below, with the intention of ending his life. The injuries sustained as a result of that fall, together with drowning, caused his rapid death.

[312] A post mortem was performed and it records, and I find that death was due to:

1(a) Multiple Injuries and Drowning

[313] It is apparent from the evidence that the deceased was a much-loved son and brother, and that his untimely death has caused profound and enduring grief to his family. As set out in these findings, this death serves to underscore the critical importance of adherence to relevant legislation, policies and professional guidance; the maintenance of clear and contemporaneous clinical documentation; and effective multidisciplinary communication in the management of complex patients such as the deceased. It further highlights the need for enhanced training in suicide prevention to support staff in the discharge of their duties; proper recognition of the value of family involvement and the significant contribution that family members can make to the safe and effective care of patients; and the necessity for effective communication and coordination between public authorities, together with the prompt implementation of suicide prevention measures in respect of the Foyle Bridge.

[314] The foregoing findings must be considered within their proper context. Following the death of the deceased, the WHSCT Serious Adverse Incident ("SAI")

investigation, resulted in a number of recommendations. At the inquest, I heard evidence from Dr Elizabeth Brady, Consultant Psychiatrist and Divisional Clinical Director, Adult Mental Health and Disability Directorate, regarding the measures implemented by the Trust in response to the deceased's death. Dr Brady confirmed that all recommendations arising from the SAI investigation and subsequent Report have been actioned by the Trust. I further note that a number of systemic and procedural changes have been introduced, some of which are directly relevant to, and address, the matters identified in my findings above.

[315] Dr Brady told the inquest that the SAI Report acknowledged that, at the time, Lime Ward did not function well for the deceased and that there were systemic failings and individual failings.

[316] The SAI Report recommended that both physical and psychiatric factors be afforded appropriate clinical weight, with new pathology identified being referred to appropriate specialties. The Trust undertook to encourage clinicians to commission second opinions for patients whose clinical condition fails to improve as expected. Dr Brady explained that Clinical teams have been advised to avail more readily of neuroimaging and to seek neurological input where physical intracranial pathology may exist. Multi-disciplinary second opinions are now sought where a patient's progress remains suboptimal for several months.

[317] For patients prescribed medications associated with weight gain, regular dietetic input and weight measurements have been established as standard practice. The pathway for referral to community dietetics services was clarified. Eligible patients include those with a body mass index exceeding 30, those with recent diabetes diagnosis, or those commencing insulin therapy.

[318] Within community teams, a baseline audit was completed in December 2022 against National Institute for Health and Care Excellence guidance CG178 concerning psychosis and schizophrenia in adults. The antipsychotic monitoring pathway has been reviewed and extended to Learning Disability services.

[319] Dr Brady stated that smoking cessation continues to be offered to all service users. Adult Mental Health assistant directors met with the Mental Health Smoking Cessation Lead in May 2022, resulting in identification of Smoking Cessation Champions within all Adult Mental Health teams. Quality improvement initiatives to enhance physical health monitoring in community teams are being undertaken by Consultant Nurses and Advanced Nurse Practitioners.

[320] The SAI Report recommended that when consultants are absent for extended periods, their clinical work must be undertaken by similarly qualified senior doctors. Multi-disciplinary team decision-making must be led at all times by a consultant psychiatrist. Dr Brady described how ongoing challenges persist within the medical workforce across mental health services within the Trust. This has been the subject of an Early Alert issued to the Department of Health on 16 May 2022, subsequently updated and resubmitted on several occasions, most recently on 16 May 2024. She

stated that the directorate has continued substantive recruitment efforts without success to date. Recruitment and Retention Premia have recently been approved by the Department of Health to improve uptake of difficult-to-fill posts. The critical nature of medical staffing is captured on the Directorate Risk Register. Dr Brady advised that whilst suitably qualified locum staff have at times been difficult to attract and retain, this situation has improved in recent weeks.

[321] The SAI Report recommended that improvement work be undertaken to clarify when detained patients can benefit from unaccompanied visits. It stated that a system should be developed to enable this valuable function as safely as possible, incorporating fixed interval risk assessments, time limits, waypoints, and two-way communications. The Report stated that first unaccompanied leave must be underpinned by senior medical decision-making, consultation with family and multi-disciplinary team, and development of a robust safety plan. Dr Brady stated that following the incidents in November 2019, a safety plan should have been developed, which would have allowed staff to spend time with the deceased to consider additional supports. This would in turn have been shared with the deceased's family so they would be aware of their expected role.

[322] In relation to leave for detained patients under the 1986 Order, Dr Brady stated that it was the Trust's understanding that in 2019, a senior doctor could grant leave, and this included a consultant and specialty doctor. She stated that this remains the position. In relation to the wording of the 1986 Order, she stated that the Trust has not confirmed the position to its staff, namely that it must be a consultant psychiatrist. She accepted that there remains a lack of knowledge in the Western Trust in relation to this issue.

[323] Dr Brady told the inquest that the Trust has developed best practice guidance to support multi-disciplinary decision-making when leave for detained patients is planned. As part of the regional Towards Zero Suicide Collaborative, a Building Safer Wards covering has developed regionally endorsed standards for Adult Mental Health inpatient units covering: access and admission; care and treatment; discharge planning and transfer of care; patient and carer involvement; risk and safeguarding; ward environment; leadership and culture; and safe staffing. A Multi-Disciplinary Meeting Checklist has been developed and implemented across inpatient wards, and this should reflect information recorded in the body of the multi-disciplinary notes.

[324] In relation to Absent Without Leave, Dr Brady explained that the Trust has reviewed and updated the Absent Without Leave policy, most recently in May 2024, to ensure it clearly meets the needs of patients when they go missing and incorporates the recommendations of the SAI Report. Dr Brady told the inquest that, in relation to the AWOL incident in March 2019, this would now be captured on the DATIX system and discussed at the next multi-disciplinary meeting. In relation to the new AWOL policy, the wording around who can grant leave to detained patients is identical to that in the 2009 Policy and does not reflect the 2015 Regional Guidance. Dr Brady could not explain why this was the case and agreed that there

remains a lack of clarity for staff and this remains an issue which needs to be addressed. This ambiguity, which continues to exist, may have affected important clinical decisions made by Dr Warren and Dr Manley for detained patients under the 1986 Order.

[325] Dr Brady told the inquest that the SAI Report emphasised the importance of family involvement. She stated that the Trust developed a practice note for all staff in January 2023. Regional training modules for the SHARE Guidelines concerning gaining consent and sharing information to promote safety in mental healthcare were launched in December 2023, with a local promotion event held on 26 June 2024. This one-hour online training module is promoted to support staff development and induction.

[326] Patient information leaflets, available at admission to each inpatient ward, outline how families can maintain contact with the acute multi-disciplinary team. Each ward email account now has an established response explaining appropriate usage. Urgent queries are redirected to the relevant ward facility and requests to meet with the multi-disciplinary team are redirected to local ward administration.

[327] The SAI Report recommended daily social work support for patients with complex needs to mitigate real-world threats contributing to instability. Dr Brady explained that additional Social Workers have been allocated to Tyrone and Fermanagh Crisis Services since June 2021. An additional business case has been submitted for expansion of multi-disciplinary teams in Crisis Services, including social work staff.

[328] Dr Brady told the inquest that as the SAI Report recommended upgrading CCTV infrastructure across mental health sites; CCTV is now operational at the entrance to Lime Ward. Wider CCTV across the Tyrone and Fermanagh site has been discussed at the Mental Health Environmental Safety Group, and a review of CCTV across mental health inpatient units has established the need for internal and external works on both the Grangewood and Tyrone and Fermanagh sites. The required business case is in development.

[329] Concerning the Foyle Bridge infrastructure, a representative from the Trust attended and presented at the Public Health Agency, Police Service of Northern Ireland, and Community Collaborative Board Meeting. The Department for Infrastructure has expressed commitment to bringing improvement work forward in coming years.

[330] Dr Brady concluded by stating that learning from the deceased's death and subsequent implementation of the action plan has contributed to enhancement of safety systems within inpatient environments. She stated that the Trust recognises this area is a constantly evolving learning environment, requiring continued vigilance in developing staff and services to improve how individual complexities and presenting needs are met.