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CORONER FOR NORTHERN IRELAND

MRS ANNE-LOUISE TOAL

INQUEST INTO THE DEATH OF

ANDREW QUIGLEY

FACTUAL FINDINGS

1ST April 2021

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[1] The deceased, Andrew Quigley, was born on 2 November 1994, and resided at 4 Knockalla Park, Derry. I will return to the issue of the date of his death later in these findings.

[2] Ms Colette Quigley, Andrew's mother gave evidence to the inquest. She described how her son was referred to as a 'gentle giant', with a keen interest in football and a deep love for his family. Although unemployed, he had been training to be a joiner.

[3] She described how Andrew suffered greatly with anxiety and depression, especially in the last year of his life and that a number of significant issues occurred in his personal life from the age of 15, including family illness and bereavement of immediate family members, which led to an increased use of drugs and alcohol. She described how, in the final year of his life, Andrew often expressed thoughts of life not worth living and made numerous suicide attempts, the first being in February 2013, another in May 2013, another in late August 2013 and one in December 2013 and how, as his mother, she felt totally helpless, out of her depth and unable to give him any assistance due to her lack of knowledge regarding depressive illness.

[4] She explained how, when they attempted to seek help, usually after the suicide attempts, including Andrew asking to be hospitalised, the view they were often met with was that it was drugs and alcohol that were to blame. She felt the help they received was a "simple plaster" and not enough or appropriate to address the range of issues Andrew had.

[5] She described how he attended Grangewood Day Care as an outpatient in September 2013 as a result of a referral by the Crisis Team after he had attempted suicide on 31 August 2013 at Foyle Bridge, passers-by on that occasion brought him to safety. However, on questioning, it was her view that Andrew was getting progressively worse, not better at this time. She also stated that he attended counselling, weekly or fortnightly at this time, and as a result of an assessment in October 2013, was offered a place for 4 November 2013 at the Alcohol Treatment Unit Omagh. She acknowledged that Andrew had declined this date for placement to organise his benefits.

[6] She then described an incident on 6th November 2013 when Andrew self-presented at Grangewood. She explained how it had been his birthday week and he had "gone out of control on drink and drugs". She described how, en route to a hospital appointment, she had encountered her son walking along the Madamsbank Road, in the direction of the Foyle Bridge, drenched by rain, hood up and wearing her brother's old trainers and she described this as a pitiful sight. When she approached in the taxi and Andrew realised it was her, he said "Why now Ma", which gave her the firm impression that she had stopped his plan to jump off the bridge. She brought him to Grangewood en route to the hospital and dropped him off so he could speak to someone. While at the hospital she received a call from

someone at Grangewood, in her words, scolding her, for leaving Andrew to Grangewood and was told that, as he had consumed alcohol and drugs in the days before, he would have to be assessed at Altnagelvin first. She stated she was not told anything other than that and was not told that A&E were expecting him. She described how she was very upset during this phone call and "just wanted the phone call to end" and had asked for a taxi to be called to bring him to A&E. She then went on to explain how, although Andrew duly arrived at A&E by taxi, she had already formed the view that it was too crowded and that Andrew would be in no fit state to wait for hours so she walked to the taxi he was in and took him home. She recounted how, by this stage, she had lost all hope in medical intervention and was emotionally and physically exhausted with the situation.

[7] She confirmed that she was aware that Andrew met his counsellor the week after this incident, on the 14th November 2013 and understood that Andrew could not avail of his place in Omagh Alcohol and Treatment Unit (ATU) a few days later on the 18th November, as had been previously arranged, because, in her view, he had taken drink and drugs on the weekend of 2nd November 2013 and he would have to be "clean" again of alcohol and drugs 6 weeks before he could attend the placement.

[8] She described how, on 17th January 2014, Andrew had been at a party with friends who all said he had been in good form and had shown no signs of distress. Upon police calling at the house she realised he had sent her three texts which she had not heard during the night. The first asked her to lend him £10, the second said that she better hurry up and reply or that would be the last time she heard from him and the third said love you forever mum.

[9] She describes her view that, had he received the proper care and medical interventions, then he would have recovered but that the mental health professionals always seemed of the view that the issue was the drink and drugs whereas she was of the view that he was using the drink and drugs because he didn't feel right.

[10] Giving evidence to the inquest Dr Lyness, State Pathologist, described how Andrew was identified by means of dental records. The post mortem examination he conducted on 18 February 2014 did not reveal any natural disease to account for his collapse or death and there were no serious signs of violence. As it appeared he had been in the water since his disappearance, a month previous, the typical changes seen in the respiratory system in drowning had been obscured by the process of decomposition. He concludes, taking everything into consideration, that it would seem reasonable to say that this death was most likely due to drowning.

[11] Analysis of blood and urine taken at post mortem revealed an alcohol level of 146 milligrams per 100mls in the blood and 194 milligrams per 100ml in urine, just under twice the legal limit for driving and indicated that Andrew was no more than moderately intoxicated when he died. Dr Lyness confirmed that the presence of a comparable level of alcohol in the urine sample would strongly suggest that the

alcohol detected was the result of his alcohol consumption prior to death rather than as the result of decomposition. Further analysis of a sample of blood revealed the following drugs; a low concentration of diazepam and its two main breakdown products Nordiazepam and Temazepam, but he is of the opinion that this was of no significance and likely to have represented only a low level of sedation. 0.16 milligrams per litre of Methylethcathinone (MEC) was also detected. MEC is a class B drug, also known as "Plant Food", with no therapeutic use which is abused for its stimulant and euphoric effects. While Dr Lyness indicated that some deaths had more recently been attributed to the consumption of this drug, the level detected at post mortem was below the range where death has been associated with this drug.

[12] Dr Lyness gave evidence regarding the possible potential effects of drug interaction given the combination of drugs and alcohol in Andrew's system. While the low levels of diazepam and temazepam would have augmented the alcohol intoxication to a degree, he would not have expected this to be significant, given that Andrew was an individual prescribed those drugs and likely tolerant to their effects. He said that it is more difficult to be certain of the effects of MEC at a particular concentration but he would not have expected it to enhance the depressive effects associated with the alcohol and diazepam/temazepam combination however, he noted that drug interactions are complex.

[13] In her evidence, admitted under Rule 17, Marie Claire McGlone, who was at the time a Community Addictions Nurse and had previously worked as a mental health nurse, describes how she assessed Andrew on Tuesday 13th August 2013 on foot of a referral to the Alcohol and Drug Service (ADS). The assessment lasted approximately two hours, Andrew informed her that he drank alcohol and used a variety of substances from Friday until Sunday evening and this had been an established pattern of use for the previous two years. His perception of his primary problems were his use of cannabis, ecstasy and alcohol at the weekends.

[14] When assessing his mental health issues, he described himself as paranoid but could not identify the symptoms of his paranoia. He identified that he experienced lower mood when stopping alcohol use. His current mental state, appearance, behaviour, speech and mood were all identified as appropriate although he described his concentration as poor. He rated his mood as 8/10 (where 0 is worst and 10 at best).

[15] He stated that he had attempted to take his own life on 2 occasions in 2013, the last time being in May. He discussed the circumstances which had triggered his suicide attempts. He stated that prior to this he had no previous thoughts of wanting to end his life and denied any current thoughts or plans of suicide or self-harm.

[16] He identified his mother as a good support alongside his uncle and discussed various other physical health issues and social circumstances.

[17] He rated his psychological health, physical health and quality of life as 6/10, 0/10 and 7/10 respectively. A Promoting Quality Care online Risk Screening Tool was then completed and, based on the information provided by Andrew, a Comprehensive Risk Assessment was not indicated and no further action was required at the time.

[18] After assessment a future management plan was agreed, including 1-1 counselling in Shantallow. A letter was sent to the referral agent, outlining the details of the assessment and the future management plan, and a copy was also sent to his GP.

[19] I find that Ms McGlone acted appropriately.

[20] Constable Patrick Bradley gave evidence to the inquest and described how on 18th January 2014 he was tasked to Foyle Bridge in response to a mobile phone, a coat, a passport and a debit card being located on the top of the bridge by two joggers. The passport and debit card belonged to Andrew Quigley. After making investigations into the possible addresses for Andrew, he proceeded to speak to Ms Quigley, Andrew's mother, at her home. Ms Quigley checked her phone and discovered text messages from her son. The first was received at 0334 on 18 January and stated, "Do you have a tenner u can lend me", the second, at 0549 hours, "Ring me if you want to hear ur sons voice again", the third at 0553, "u have about 10 secs an if u don't ring I understand but just no I always loved an appreciated u … love always, ur son Andrew … I'm sorry". The final text message was received at 0557 hours, "I'm sorry love always xx." From his conversation with Ms Quigley, it was apparent that Andrew had a history of self-harm and had ongoing issues of drug and alcohol abuse. An extensive search for Andrew was commenced, involving the Tactical Support Team along the banks of the River Foyle and Foyle Search and Rescue. On Monday 17th February 2014 a body was recovered in the Foyle River at the rear of Sainsbury's on the Strand Road and this body was believed, by police, to be Andrew. Constable Bradley confirmed that Andrew's mobile phone was triaged to ascertain his last contacts.

[21] Cormac Jackson, a Band 6 Mental Health Nurse, had his evidence admitted under Rule 17. He described how on 31 August 2013 he received a referral from the on-call GP at Western Urgent Care requesting an urgent mental health assessment of Andrew, who earlier in the day had been under the influence of alcohol and drugs and had been removed by PSNI from Foyle Bridge. He found Andrew's mood both objectively and subjectively lowered, thoughts of life not (worth) living were present, but Andrew denied any suicidal intent. Following assessment, he agreed a referral to the Home Treatment Team and arranged for them to visit him the following day to provide further short term support and to monitor his mental state. Mr Jackson also agreed to contact ADS to clarify commencement of one to one treatment and support.

[22] I find that Mr Jackson acted appropriately.

[23] Mr Jude O'Neill, a Registered Mental Health Nurse within the Mental Health Crisis Response Home Treatment Team (HTT), gave evidence to the inquest and described how lead responsibility for Andrew's immediate care at the time of his involvement lay with the Crisis Service. The role of the Crisis service was to see people in the community experiencing mental health difficulties and try to get a plan together to treat them at home, refer them to other services or, if required, admit them to hospital. The purpose of a Home visit would be first to ensure the person is safe to be at home and then to provide reassurance to family members, assess the person's mental state, agree a safety plan and see if anything was required to be put in place, such as Banagher, which was utilised in Andrew's case. He visited Andrew and his mother on 1st September 2013 on foot of the meeting with Cormac Jackson the day before. He described how Andrew was in bed when he arrived and initially refused to get up for the visit. When he got up he remained dressed in night attire. He was initially pleasant in manner but as the visit progressed, he became dismissive in manner.

[24] Andrew stated that he had thoughts of suicide every day but denied any plans or intent to harm himself, so Mr O'Neill's assessment was that they could work out a plan to keep him safe at home and, if there was a deterioration, he could contact HTT again. He said Andrew was reluctant to acknowledge that his use of illicit drugs and alcohol were having a negative impact on his mental health. He asked to be admitted to hospital to stop taking drugs but Mr O'Neill advised that this alone was not a reason for admission to hospital. He also asked to be sent to the addiction treatment unit in Omagh (ATU) and, was advised that he needed to attend ATU for assessment of his suitability. Andrew then became reluctant to engage further in the visit. Mr O'Neill could not recollect whether he had any specific conversation with Ms Quigley about the plan, but believed he had given her reassurance and contact numbers to contact the crisis team. Regarding assessment of suitability for addiction services, he said this would not be done by the Crisis Unit, who would simply refer a patient for assessment. He agreed with Ms Quigley's view that a patient would normally be required to be free of alcohol or drugs for six weeks before admission to ATU. Mr O'Neill confirmed that Andrew had a visit the following day from Andrea Magee, whose evidence was admitted by way of Rule 17, and that Andrew was referred by the Crisis Team to Banagher Day Care Centre, where he was seen between the 3rd and 16th September 2013, to deal with the issues of suicidal ideation that Andrew was experiencing. Following on from that, a referral was also made to the Addictions Unit to deal with the Andrew's addiction issues.

[25] I find that Mr O'Neill acted appropriately.

[26] In her evidence admitted under Rule 17, Louise Kitson, a mental health nurse, described a rocky start at Banagher on 3rd September 2013, where Andrew initially was very reluctant to join in activities or have a conversation, but later joined the

group, fully participated and interacted well with staff and clients. He later stormed out of a medical review, which had been arranged at his request, stating he was unsure if he was going to return. But he ended up settling in very well and, on following occasions, interacted well and participated fully in group discussions. While she noted lowered mood at the group discussion on the 3rd September, she assessed him as having no evidence of lowered mood or thoughts of life not worth living (TLNWL) in all later interactions, with the exception of 16th September, which I will come to presently, Andrew indicated to her that he found Banagher helpful. Indeed her entry on 13th September noted that Andrew "attended day care well-presented and on time, pleasant and friendly during interaction, fully participated during group taking leadership role within his team, laughing and joking throughout reports mood stable at present denies any drug or alcohol use, denies any thoughts of life not worth living, agreeable for discharge on Monday to attend ATU (alcohol and addiction service) next week, has all relevant crisis telephone numbers should need arise."

[27] In her final entry on 16 September 2013 she stated, "Andrew attended day care on time and well presented, no agitation or distress, speech normal in rate rhythm volume and tone, no thought disorder evident, no TLNWL, rates mood 7/8-10 (1 being worst 10 best) oriented to time, person and place, cognition good, has good insight into his addiction of drugs. Andrew states mood lowered at weekend "due to coming down off drugs, states 1st week wet week as drugs still in your system however 2nd week worst." Contacted his uncle for advice who encouraged him to attend Narcotics Anonymous which he found very helpful. agreed to attend ATU appointment on 19/9/13 at 2pm. No evidence of lowered mood, bright and reactive, good eye contact throughout interview."

[28] Edel Murphy, Band 6 Mental Health Nurse in Banagher, gave a similar positive account of Andrew's interactions with Banagher in her evidence admitted under Rule 17.

[29] Julie Anne Kerlin, a Nurse in the Home Treatment Team based at Grangewood Hospital, described how on 6 November at 1.15pm she was made aware that Andrew, with whom she had had no previous interaction, had self-presented to reception at Grangewood, looking for help. She said this was an unusual occurrence. He was alone and when she spoke with him, he stated he wanted help. She was unsure in her evidence whether she had accessed the EPEX system before or during her interaction with Andrew, to check his previous history and I find, on the balance of probabilities, given her failure to state same in her statement and her admission during her evidence that, when a person self-presented, you would not necessarily have checked the system but go speak to them, that she did not. He reported he was hearing a voice telling him to do things and having difficulty managing this voice. She could not remember whether she asked him what those voices were saying or if she had, what they were telling him to do. He also reported experiencing thoughts of

self-harm but she confirmed in her evidence that he denied any plan or intent to harm himself or act on these thoughts. He admitted that he had been using alcohol and mephadrone until Sunday 3rd November 2013 and appeared tremulous and shaking with a fixed stare.

[30] Given his current physical condition, her clinical judgement was that he was either still under the influence of alcohol and drugs or was suffering from withdrawal of alcohol and drugs, and that he was unfit for assessment, so she referred him on to Altnagelvin Hospital for a medical assessment. She advised that she was concerned about possible withdrawal or being under the influence, as this could be a high risk due to the depressant effects of drugs and alcohol. When asked whether she considered a different diagnosis, such as psychosis, given the report by Andrew that he was hearing voices and that he was finding it difficult managing those voices, she said that hearing voices would often be a symptom of alcohol and drug withdrawal and that same could be assessed at hospital and then referred back if needed. She said Andrew agreed to attend A&E and she then contacted Ms Quigley and formulated a plan. She said Ms Quigley agreed to meet her son at A&E. She then contacted A&E and informed them that he would be attending the Department to be met by his mother. She could not remember who she spoke to at A&E, though she usually would phone the nurses' station and she was not aware if they took note of her call, but confirmed that she did not think it would have led to Andrew being afforded priority at triage. She advised that Andrew could, if required, be referred back to CRHT for assessment when he was deemed medically fit. She telephoned a taxi, at the request of Andrew's mother, to transport him to A&E, contacted his key worker and informed her that he had presented and the action taken. Although her statement reads as though she contacted Andrew's key worker in and around the same time he was sent to A&E for medical assessment, having heard the evidence of Ms Donnelly, who I will come to shortly, I find that this was not in fact done until at least a day later or a few days later. I find that this reflected the disjointed communication between the various agencies dealing with Andrew at this time.

[31] In her evidence Ms Kerlin confirmed that there was no further follow up and that she had no way of knowing if Andrew, who had been hearing voices which he described as difficult to manage and had indicated thoughts of self-harm, was seen by A&E when she sent him alone in the taxi to meet his mother. It was her view that she had developed a safety plan with Ms Quigley, as his mother, to meet him at A&E and, as it was an individual choice to stay and be seen, it was out of her control. He had indicated he wanted help and she had no reason to believe he wouldn't stay to be seen. She could not remember if she had told Ms Quigley whether A&E were expecting Andrew and did not tell her that Andrew would be assessed and then would come back, as that would not be the process. It was not her view that she had scolded Ms Quigley nor had that been her intention and she apologised if this was how Ms Quigley had taken their conversation as she accepted this would have been

a distressing conversation for Andrew's mother. In her evidence Ms Kerlin explained that the practice has now changed within the Trust and under current procedures she would now check ECR to see if the person had been seen at A&E and, if not, a letter would be sent to the person's GP. She would also now get a contact number to contact the person if they had not been seen and would contact the triage nurse at A&E to let them know someone was to arrive and their name.

[32] Given the circumstances in which he self-presented to Grangewood, and the symptoms that he described experiencing, I find that the onward referral of Andrew to Altnagelvin hospital, to travel alone to the hospital and to meet his mother at A&E, without any follow up to check whether he had arrived or been assessed, was inappropriate. While I accept Ms Kerlin's evidence that she was concerned that he was either still under the influence of alcohol or drugs or was in withdrawal from same, either one of which would have made him unsuitable for immediate mental health assessment, nevertheless the failure of a medical professional to follow up a vulnerable person sent to A&E for medical assessment, who was deemed a possible high risk, with thoughts of self-harm and who had reported hearing voices, that he found difficult to manage was inappropriate, despite the agreement of the next of kin to meet him at the hospital. Although I make this finding, I do not find that this failing had any bearing on the death of Andrew, given his attendance back at Addiction Services a week later. I commend the change of practice now within the Trust, to check whether such a person has arrived and been seen by A&E.

[33] In her evidence to the inquest, Carmel Donnelly confirmed she was the assigned key worker for Andrew between from 4 September 2013 until 5 December 2013 as a result of the assessment by Marie McGlone in May 2013. She confirmed that Shantallow was within walking distance of Andrew's home and was assigned as his clinic in order to maximise the motivation and ability of the client to attend. She said Andrew was motivated to abstain and indeed had been abstaining for a period before meeting her, however, whilst motivation was an important part of treatment it was acknowledged that the majority of people would be anxious to let go of their coping mechanisms at the start so it was recognised that a build-up of a therapeutic relationship with the individual would be required.

[34] Her first contact with Andrew was on 19th September 2013, which would be the usual interval between referral and first contact, due to the demands on the service. At the first appointment they agreed a contract for treatment and treatment goals. Andrew's goal was to abstain from alcohol and drugs. They agreed he would attend a number of educational and motivational counselling sessions to support his efforts to remain abstinent. It was contained within the contract, amongst other things, that he agreed to attend and engage in his treatment options, agreed to regular reviews and blood and urine testing and that two non-attendances, without adequate notice, would lead to early discharge from treatment.

[35] He attended appointments on 26th September 2013, 3rd October 2013, and 17th October 2013, and she said he engaged well and remained motivated and abstinent, recognising the impact of drugs and alcohol on his mental health. She described how they explored and indeed worked towards the option of him attending Omagh Inpatient 6 week programme (ATU). She described how Andrew would have been a lot younger than the usual age profile they would deem suitable for such an inpatient programme, but that Andrew conveyed such an articulate, mature character and was so committed to completing what would be a difficult period of inpatient treatment, that she arranged a medical review appointment with Dr Slane to review his mental state and assess his suitability for the inpatient programme.

[36] Following Andrew's medical review with Dr Slane, whose evidence was admitted by way of Rule 17, he was assessed as suitable and it was agreed that he would be offered a place on the inpatient programme. He was given a date of 18th November 2013. An earlier date of 4th November then became available. She contacted Andrew regarding the new start date and he agreed to discuss this with his family. He attended his review appointment on 13th October 2013 and stated that he remained abstinent from substances and had used alcohol occasionally at a controlled level. They discussed his recent use of alcohol and Ms Donnelly highlighted that alcohol use increased the risk of drug relapse and potentially his ability to engage in and complete the inpatient programme, which required a period of abstinence and stability (duration based on individual circumstances but usually 4-6 weeks) to complete the emotionally challenging group work, and reminded him of the importance of working to remain abstinent in order to avail of this opportunity.

[37] Following this discussion Andrew chose his original admission date of 18th November 2013, the reason being that he needed time to sort out his benefits and finances to attend the ATU.

[38] Her final face to face contact with Andrew occurred on 14th November 2013 and she described how Andrew told her he had relapsed on his birthday on 2nd November, binge drinking and using mephedrone over a three day period. This resulted in suicidal feelings and he described experiencing a voice in his head. He stated he presented to Crisis Service and was advised to attend Altnagelvin Hospital. She explained in her evidence that she had already been told of his self-presentation to Grangewood on the 6th November, however this occurred a few days later and I find her evidence credible on this issue. She acknowledged in her evidence that this was a breakdown in communication. During this discussion, in which she described Andrew as being open and honest about his relapse, Andrew said he did not feel ready to enter the inpatient programme as his family relationships were strained as a result of him damaging property at his mother's home whilst intoxicated. He stated he needed to pay for the damage he had caused to the family home and Ms Donnelly in her evidence described her view that at this

point Andrew's commitment and enthusiasm for completing an inpatient programme had reduced and he no longer viewed it as important or his priority but instead his priority was taking responsibility for the damage he had caused to his mother's home. Ms Donnelly clarified in her evidence the need for a period of abstinence and stability prior to commencing the programme, which would result in a delay in his being able to avail of the inpatient programme by at least a few weeks after his relapse and she explained he may have required a further medical review before being able to avail of a place. With Andrew's consent she contacted his mother to clarify collateral history and to inform her that Andrew had decided to defer entering the inpatient programme. She described how Ms Quigley was upset and distressed at her son's alcohol related behaviour. She advised Ms Quigley of the Out of Hours Crisis and LIFELINE contact numbers and advised she would continue to offer Andrew one to one appointments.

[39] An appointment was arranged for Andrew to attend on 21st November 2013 which he did not attend. Following this non-attendance in her evidence she described how a written appointment was sent for 5th December 2013. Although a copy of this letter was not available for the inquest, I find on the balance of probabilities that it was sent based on the fact that it is referred to in the later letters to both Andrew and his GP. Ms Donnelly confirmed that this was a standard issue letter after a non -attendance and that the letter would have indicated that a failure to attend would lead to his discharge from the service.

[40] During this period Andrew did not contact her or the Addictions Team and I find, on the balance of probabilities, on the basis of the evidence given at the inquest by Ms Donnelly and the fact there was no documentary evidence of such a call, that no telephone contact was made by the Addictions Team to Andrew or his mother. Ms Donnelly described in her evidence how she discussed his case with the Team Manager and Team Consultant before making a decision to discharge and although there are no records of this discussion, which is very unfortunate and highlights the need for good record keeping, especially as she accepted minutes would usually be taken, I find her evidence credible in this regard. She also discussed how they would try to research the reasons for non-attendance before making a decision to discharge, either by contacting the individual to try and establish a reason for non-attendance or checking the electronic system and whilst I find this may be the case on occasion or even usually, I find, on the basis that there is no documentary evidence of any attempt to contact Andrew or his mother, the fact that it was not indicated in her detailed statement and nor could Ms Donnelly recall what factors she considered in the decision to discharge with any clarity, that this did not happen on this occasion. Ms Donnelly accepted that, with hindsight, she could have contacted Andrew's mother. I find that the decision was taken, as was reflected in her statement, to discharge Andrew back into the care of his GP shortly after two non-attendances in consultation with other Team members, based on the initial treatment contract

agreed with Andrew and in light of his failure to make any direct subsequent contact with the service to provide any reasons for his non-attendance on two occasions.

[41] A discharge letter was sent to his GP and Andrew informing them of the discharge decision. He was also advised how to get re-referred via his GP to the Alcohol and Drug Service and his GP was advised regarding alternative non-statutory support options including Opportunity Youth DAISY and the self-referral service HURT and Andrew advised of the self-referral service HURT.

[42] It was clear from all the evidence I heard at this inquest that Andrew found his interactions with Ms Donnelly very beneficial, indeed this was acknowledged by Andrew's mother and his GP and it was clear that Ms Donnelly was greatly saddened by the death of Andrew with whom she described having a good therapeutic alliance. I find that Ms Donnelly acted appropriately throughout her encounters with Andrew. While it is extremely unfortunate that Andrew was discharged from the service which had proved so beneficial, I find the decision to discharge him was not inappropriate in circumstances where he failed to engage with the service across two appointments, with no reason given, at the time or after, in breach of his treatment contract and in light of a written warning that failure to attend the further appointment provided for him on 5 December 2013 would lead to discharge. He was referred back to the care of his GP and given advice on other non-statutory agencies that required no referral as an alternative to the service and information on how he could be re-referred to the service via his GP.

[43] In her evidence to the inquest Jean Browne, Mental Health Nurse, described her interaction with Andrew on 7th December 2013 following his presentation to Altnagelvin Hospital after what she described as an impulsive overdose following the consumption of alcohol and drugs. He was referred by staff in the acute medical unit as he was fit for discharge.

[44] He reported to Ms Browne that he took the overdose on the Friday after a drinking binge at his friend's house. He then went home to his own house and took some of his own tablets impulsively and his mother came into his room and found that he was drowsy so he came to A and E by taxi.

[45] A history was taken and he stated that he had a long history of mainly drug abuse as he had been taking drugs since age 12. He stated that he started with cannabis but now he was taking everything except heroin. He stated that his mum, with whom he had a very close and supportive relationship, was his protective factor and that he would not commit suicide because his father's brother committed suicide when he was 6 and he denied any debts or worries. He stated that he had no plans or intent to kill himself and that he was not actively suicidal.

[46] During this mental state assessment he was described as being dressed appropriately. His behaviour was described as normal and it was noted he was very pleasant throughout the entire assessment. His speech was clear and coherent and

followed a logical train of thought. He denied any abnormal thought processes and stated that he would normally be a happy go lucky type of person. He stated that his mood was fine and rated it as 7 out of 10, his energy levels and interest he rated as 7 out of 10. (1 meaning mood very low and 10 being good). She found no evidence of depressed mood as he was reactive on assessment. His perception was intact and his long and short term memory was good. She described him as having good insight as he knew that drugs were his main issue and he knew how to access help for this.

[47] She advised him to continue to work with Carmel Donnelly from the ATU in respect of his drug issues, as he had told Ms Browne she was his key worker and he agreed to make contact with her for an appointment. He was offered a referral to the SHINE project however he declined this.

[48] Ms Browne, a mental health nurse with over 30 years' experience, was very clear in her evidence that at this time she did not assess Andrew as being a risk or danger to himself which would merit hospitalisation, either voluntarily or under the Mental Health Order. She confirmed that she could have made a direct referral to Addiction Services, however as Andrew had reported to her that he was already engaged with Carmel Donnelly in Addiction Services (he was at this time unaware he had been discharged), this was not considered. She confirmed that her information came solely from Andrew in this regard and she had no access to electronic records during the assessment at that time in the place where she conducted the assessment. She confirmed that the fact he had been discharged from Addiction Services would not have changed her view regarding risk requiring hospitalisation and if she had been aware she would have acted differently only by referring Andrew back to Addiction Services. She confirmed a letter was sent subsequently to Andrew's GP on 19 December 2013 outlining her engagement with Andrew and believed, although no documentary evidence was available to confirm same, that a letter had been sent to Addiction Services also.

[49] I find that Ms Browne acted appropriately.

[50] In her evidence to the inquest, Dr Devlin, Andrew's GP, outlined Andrew's previous history of self-harm and referrals. She described how, in the period of his counselling with Carmel Donnelly, Andrew seemed to settle, denied suicidal thoughts and was prescribed a mild antidepressant.

[51] She described how she saw him on 23rd December 2013. She was aware that he had been discharged from Addiction Services. Andrew had gotten into difficulty with an incident at the weekend and as a result was referred back to Addiction Services and was commenced on twice weekly diazepam and temazepam. At this consultation he reported that he felt relieved that he had not come to harm after his previous suicide attempt on 7th December 2013 that he was feeling positive and that he was looking forward to attending the ATU, as he had found this helpful. He agreed to see Dr Devlin again in two weeks. When referring Andrew to Alcohol and

Drugs Services Dr Devlin marked the referral as routine. She explained that she did this for two reasons, firstly she believed that all referrals to Alcohol and Drug Services could only be marked as routine, and secondly, in any event, she believed that a routine referral was appropriate for Andrew, whose primary requirement was for long term help. She spoke to him again on 3rd January 2014 and described things as appearing relatively stable.

[52] She said that on 16th January 2014 he rang upset about there being recent newspaper coverage about him and that she tried to reassure him to which he seemed to respond. He requested a sick line and an increase in his temazepam which she did and he agreed to come in and see her on 21st January 2014. She was emphatic in her evidence that at this time she did not perceive nor assess Andrew as being in any way suicidal however she described the newspaper coverage as putting him back. She expressed her view that Andrew needed a long term plan and help. She expressed her shock at what then happened to Andrew.

[53] She strongly indicated her view that more support is needed at weekends for people who may have difficulties with their mental health such as happened with Andrew, however acknowledged she was not familiar with what services were open at the weekend, other than GP services or community mental health services which would be closed, but has found in her experience that suicides seem to increase at the weekends, however she did not express any view on whether there was a causal link.

[54] Pausing here, it was clear from the subsequent evidence given by Mr McKenny that mental health services are fully staffed and open at the weekends. However, he acknowledged that there may be an issue around the messaging that such services are accessible over the weekend and there would be obvious public benefit in having this message be made clearer to the wider public.

[55] I find that Dr Devlin acted appropriately and she made a timely and appropriate re-referral to Addiction Services.

[56] In her evidence to the inquest admitted by Rule 17, Claire Crossan confirmed that the referral from Andrew's GP was received by the Alcohol and Drug Service on 8th January 2014 and a letter was sent to Andrew on 10th January 2014 inviting him to make contact with Addiction Services within two weeks for an appointment. As there was no response, a second letter was sent on 24th January 2014 and the referral subsequently closed.

[57] I find that this offer of services was timely being two days after receipt of the re-referral.

[58] In his evidence admitted by way of Rule 17, Constable Houston describes how on the morning of Monday 17th February 2014 he attended an area to the rear of Sainsbury's Supermarket, Strand Road, Derry following a report of a body floating

in the river. On arrival he identified a body lying down and motionless in the water. Foyle Search and Rescue arrived and retrieved the body from the water removing it to Gilliland's Boathouse.

[59] Dr Munroe, whose evidence was also admitted by way of Rule 17, described how he attended the Foyle Search & Rescue facility at Gilliland's Quay on 17th February 2014 and was informed by Constable Houston that the remains of a young man, believed to be Andrew Quigley, had been brought ashore. He pronounced life extinct at 11:15.

[60] Based on all the evidence, I find that Andrew's interactions with both mental health services and Addiction Services were appropriate. Although I have identified failings in regards to communication between various agencies and a failure to follow up whether Andrew did in fact attend A&E on the 6th November 2013, I do not find these failings had a bearing on or contributed to Andrew's death.

[61] I find that on 17th January 2014 Andrew attended a party and consumed both alcohol and drugs, and these were indicated in the post mortem findings in addition to the temazepam and diazepam that he was prescribed. I find that he was in good form at the party, based on the indications from those who were present with him on that evening, although I accept the evidence of Ms Quigley that this presentation may not have reflected his long term emotional state. I find, on the balance of probabilities, that he was not actively suicidal in the days leading up to his death and that his death was not preventable. I find that Andrew had a history of impulsive suicide attempts, usually in conjunction with the depressant effects of both alcohol and drugs.

[62] I find on the balance of probabilities that Andrew, in the early hours of the morning of 18th January 2014 after 5.57am, after leaving the party and under the influence of both alcohol and drugs, jumped off the Foyle Bridge in Derry. I find that he died by his own act whilst the balance of his mind was disturbed and that this was an impulsive act.

[63] The Post Mortem report recites a date of death as between 18th January 2014, which is the last date on which there is communication from Andrew and 17th February 2014, which is the date that a body is recovered and life is pronounced extinct. Andrew's belongings were found on the Foyle Bridge in the early hours of the mornings of the 18th of January, and the last message from Andrew was at 5.57am on the 18th of January, the cause of death is drowning, an extensive search was mounted after Andrew's disappearance. On the basis of those facts and on the balance of probabilities, I find that Andrew died on 18th January 2014.

[64] I extend my upmost sympathy to Andrew's mother who conducted herself with dignity during the course of the inquest. It is clear she and her son had a very close bond and he regarded her as an invaluable support. I commend her efforts to try to combat the dual tragedies of suicide and addiction and to try and highlight the need

for increased services to tackle these issues both in her hometown of Derry and beyond.

[65] An SAI was undertaken as a result of Andrew's tragic death and a Root Cause Analysis Report was completed as a result of this. Although the inquest did not deal in detail with the report itself, Mr Ciaran McKenny, Chair of the SAI Review and Report author, spoke to both the recommendations made by the Report and the how the changes have been implemented practically on the ground.

[66] I want to emphasise that I have not found that any of the procedures that have been altered as a result of the SAI report or the level of provision of services that has been increased after this death, were causative of this death, which I have found was not preventable.

[67] It is now normal practice that when patients are seen by self-harm or out of hours mental health services, and those patients have ongoing contact with, or state that they will contact, a key worker or team as part of their commitment to a follow up plan, then the assessing mental health practitioner will contact the key worker or team by telephone to inform them of the follow up arrangements and forward the assessment documentation and follow-up plan to the key worker or team. I commend this recommendation. Ms Donnelly also spoke to the practical application of this recommendation in her evidence and that how there is now much more access to information through the new electronic record system.

[68] The Trust are now in the final stages of a process which will allow more Tier 2 agencies to refer directly to ADS.

[69] Most importantly when a patient presents to Crisis Response and are assessed by a mental health practitioner as requiring review by acute medical services and are asked to proceed to A&E to be assessed medically, as Andrew was, now the mental health practitioner must contact the A&E department, within a 12 hour timeframe, to establish the outcome of the medical assessment. As standard practice the Crisis team will now contact the Emergency Department, provide a handover and, if the patient is deemed medically fit, they will be referred back to the Crisis Team if appropriate. The crisis team now have access to the electronic ECR records and, before the end of their shift, will check to see that the patient has attended. Now the patient will never be asked to attend A&E alone; either staff will escort them or family will be contacted to do so.

[70] While not part of the SAI process, I also note that the ATU in-patient facility in Omagh now has a detox facility in addition to the intensive group work and therapy that was available at the time of Andrew's death.

[71] I commend all of the change and recommendations and it was clear from the evidence given to the inquest by Julie Ann Kerlin and Carmel Donnelly that the communication between the various services involved in Andrew's care has

improved dramatically and the issues highlighted by Andrew's care, will be unlikely to occur in the future.

[72] I find in light of the findings of the post mortem report that the cause of death was:

1(a) Consistent with drowning.