

FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

DETERMINATION

by

CRAIG CALDWELL, Esquire,
Sheriff of Tayside Central and Fife at Falkirk

following an Inquiry held at Falkirk

into the death of

ANNEMARIE DOOHER

FALKIRK, 11 February 2009

The Sheriff having considered all the evidence adduced determines:

1. In terms of S6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Annemarie Dooher died on 25 June 2007 between the hours of 2.45pm and 4.45pm in her home at 22 Glynwed Court, Falkirk.
2. In terms S6(1)(b) of the said Act the cause of Miss Dooher's death was Diphenhydramine Toxicity as a consequence of the voluntary ingestion of a lethal dose of proprietary sedative drugs.
3. In terms of S6(1)(c) of the said Act that the death might have been avoided had the following reasonable precautions been taken:
 - a) Had management devised, instituted, maintained and audited a system of assessment of patients deemed to be at high risk to themselves or others in order to determine whether such patients would be entitled to spend time off ward (TOW) and if so entitled, the times and frequencies of such periods off ward.
 - b) Had the management devised, instituted, maintained and audited a system of monitoring patients' time off ward including the times of leaving and returning, the place or places visited, and the person or persons with whom the patient had spent time.
 - c) Had Dr. King, Consultant Psychiatrist activated the Missing Persons Action Plan, determined by her on 14 June, between the hours of 11.00am and 1.30pm on 25 June and notified the Police that Miss Dooher was missing from the ward all in terms of the Trust's Missing Persons Policy and Miss Dooher's Missing Person Action Plan.

- d) Had nursing staff in ward 19 notified the Police after 11.00am on 25 June that Miss Dooher was missing from the ward in terms of the said Policy and Action Plan.
 - e) Had accurate records been maintained by hospital management of contact details including names, addresses, telephone numbers of next of kin and other persons who were allowed to accompany the patient on accompanied time off ward.
4. In terms of S6(1)(d) of the said Act that the following defects in the system of working contributed to the death:
- a) There was no defined and ascertainable structure of hierarchy and responsibility of personnel in the ward for operating the procedures relative to patients using time off ward.
 - b) There was no monitoring of the adherence of patients to imposed time off ward periods nor of the frequency at which these periods were to be utilised.
 - c) Any recording of the use of time off ward by patients depended on those patients advising staff when they intended to leave the ward and when they returned.
 - d) High risk patients ostensibly detained in terms of S44 of the Mental Health Care and Protection (Scotland) Act 2003 were free to come and go from the ward as they pleased as were all other patients.
 - e) There was no auditing of adherence by staff or clinicians to the Time off Ward procedures and records, the Missing Person Procedures and the Missing Person Action Plan.
 - f) The Trust's policies, procedures and guidelines in relation to time off ward, missing persons and Missing Persons Action Plans were in and amongst themselves contradictory, inconsistent and ambiguous.
 - g) There was a failure, at least in the case of Miss Dooher, to maintain accurate records of addresses and telephone numbers of her next of kin and of the identities, backgrounds, addresses and telephone numbers of those friends and associates with whom she was allowed to leave the ward to enjoy accompanied time off ward.

In this Inquiry evidence was presented on behalf of the Procurator Fiscal by his Principal Depute, Mr Bowie. Mr Stewart, Solicitor, appeared for the Forth Valley NHS Trust and Mr Mawby appeared on behalf of Dr. Keren King, Consultant Psychiatrist, who was Miss Dooher's appointed Psychiatrist during the currency of her detention in ward 18 of the Falkirk and District Royal Infirmary between 29 May 2007 and the time of her death on 25 June 2007.

The Inquiry was sought by the Procurator Fiscal. The proposed scope of the Inquiry being set out in the following excerpt from the application:

From information received by the Applicant it appears that ANNE MARIE DOOHER, born 7 July 1954, suffered from a Psychiatric condition and was at various times treated both as an inpatient and an outpatient at the Falkirk and District Royal Infirmary ; that on 29 May 2007, the symptoms of her psychiatric condition recurred and she was taken to the said Falkirk and District Royal Infirmary, Ward 18 where she was admitted for treatment; on 25 June 2007, she left said hospital ward without authorisation; and was reported as a missing person; officers of Central Scotland Police searched for said ANNE MARIE DOOHER who was found dead on the 26 June 2007; life was pronounced extinct at 0245 hours said date; the cause of death has been certified as 1 (a) Diphenhydramine Toxicity;

and it appears to the Lord Advocate to be expedient in the public interest that an Inquiry under the said Act should be held into the circumstances of said death to examine in the public interest, whether the deceased who was patient under psychiatric care both in and out of hospital was provided with appropriate treatment and care, to ensure that public concerns regarding treatment of patients in care are met and to examine whether the search by Central Scotland Police of a missing person in the circumstances was appropriate to ensure that public concerns regarding police responses to missing persons are met.

I heard evidence in relation to this Inquiry over 3 days on 9, 12, and 13 May 2008 after which the Inquiry was continued to enable parties to make submissions.

Parties very helpfully submitted written submissions. The Inquiry had been continued to 28 July but on my unavoidable absence from Judicial duties on that date and for some months thereafter due to ill health parties intimated that they had no further submission to make having regard to the terms of the respective other party's written submissions. I have therefore concluded my Determination on the basis of the evidence which I heard over the 3 days mentioned and on taking account of the terms of the various submissions each of which I found extremely helpful and in respect of each of which I am indebted to their respective authors. It will be noted however, that in this Determination, I have in general, preferred the submissions of Mr Bowie Procurator Fiscal Depute, to those of Mr Stewart and Mr Mawby.

PSYCHIATRIC CARE AND TREATMENT – THE BACKGROUND

The Forth Valley National Health Service Trust operates a number of hospitals including Falkirk and District Royal Infirmary. That Institution incorporates a division offering psychiatric care and treatment for patients with mental health illnesses. As I understand it psychiatric services are delivered principally through the maintenance of 2 wards, wards 18 and 19 respectively, ward 19 being a locked or secured ward for the accommodation of patients who are deemed to be at such risk either to themselves or to members of the public that they are not allowed to leave the ward.

Ward 18, which was the ward to which Miss Dooher was admitted, is a ward which accommodates both patients detained in terms of the Mental Health Care and Treatment (Scotland) Act 2003 S44 and other voluntary treatments. It is a matter of fine clinical judgement whether a particular patient who is detained will be accommodated in the secure ward or in the open ward. In the case of Miss Dooher when she was admitted at the end of May 2007 she was assessed as being of high risk of injury to herself, such risk although being high, being such that it was assessed as manageable within the perceived regime of ward 18.

Although patients detained in terms of S44 may be subject to a prohibition against leaving the ward at all, as was Miss Dooher for the first week of her admission, the Trust operates a policy of granting leave to patients to leave the ward in certain circumstances. This policy is known as the “Time Off Ward” policy (TOW).

Time Off Ward is an acknowledged tool in the treatment of mentally ill patients and is allowed in relation to detained patients according to their assessed level of risk. The Trust’s guidelines in relation to the consideration of the granting and operation of TOW are set out in Crown Production 5. This document sets out the frame work in terms of which TOW is granted. It is detailed and in many elements prescriptive.

TOW can be “accompanied” or “unaccompanied”. Unaccompanied TOW means that the patient is free to leave the ward alone for a specified period; accompanied means what it says, that the patient will be in the company of another individual or individuals whether member of staff, family or friend.

In order that a patient’s TOW is monitored a form is provided (Crown Productions 204-228) headed TOW Record in which the name of each patient utilising TOW is to be recorded along with the time period allowed, the destination, the time of departure from the ward together

with the time of return. Times of departure and return are to be certified by the signature of a member of the nursing staff.

As TOW is regarded as an important part of the therapy for patients it is deemed important for nursing and clinical staff to have knowledge of the time and frequency of the exercise of TOW rights and any benefits or disadvantages derived from that exercise.

For reasons not explained by management at the Inquiry the operation of these guidelines and records were not audited or monitored with the inevitable result that they became observed, if at all, only in a superficial manner. This in turn resulted in a situation in which patients detained in terms of the Mental Health Act were free to come and go from the ward as they pleased. Any practise of monitoring their whereabouts depended entirely on the patient volunteering to a member of staff that he or she intended to leave the ward.

The guidelines were universally ignored and no proper records of patient movements were maintained. Those patients who were signed out were very frequently not signed as having returned. The TOW records for the period 27 May 2007 to 25 June 2007 were produced at the Inquiry (Crown Production 204-228). Fewer than 20% of the entries made in those records were completed.

On the day of Miss Dooher's death there was no entry relating to her absence from the ward in the TOW Records.

WARD HOURLY OBSERVATION

Miss Dooher's absence from the ward on 25 June 2007 was noted only by the operation of another process, the Hourly Ward Observation (Crown Production 229) in which it is recorded at hourly intervals the presence or absence of each patient in the ward.

Miss Dooher was recorded as having been present in the ward at 10.00am. Every hour thereafter until 6.00pm she was recorded as "out". That entry according to a legend on the sheet denoting that she was accounted for when patently she was not as staff were well aware. The legend appended to the record sheet contains the following:

"If it is noted that a patient is AWOL the nurse in charge must be advised immediately."

The expression AWOL is defined thus:

“Patient out of ward not accounted for.”

The observation sheet contains a sidebar of guidance specifically on these issues including the direction “if it is noted at any time that a patient is AWOL the nurse in charge should be advised immediately”.

MISSING PERSON’S POLICY

The Trust has a set of guidelines to assist staff in dealing with the situation where a patient is missing from the hospital or wards of (Crown Productions 197-203). It is not confined to psychiatric patients in wards 18 and 19 but apparently to all patients. It contains however specific reference to “informal or detained patients”.

The scheme envisaged by this document appears from the outset to be somewhat optimistic in that for example at paragraph 1.1 it exhorts the nurse in charge to co-ordinate staff to search local hospital grounds, the staff in question to be two members of nursing staff from the ward or department from which the patient is missing. This provision would appear to be somewhat onerous and probably futile.

In any event the guidelines provide for the maintenance apparently for each patient of the “missing persons action plan” of which Crown Production 266 is an example. That plan purports to prescribe the actions to be taken in circumstances where the patient absconds (while either accompanied or unaccompanied) or fails to return at the agreed time. It does not cross reference to the definitions or instructions given on the hourly observation sheet (Crown Production 229). It simply notes that resort is to be made to the “missing person procedure” in the event of any of the three events occurring. The plan is to be retained in the patient’s medical records. It is noteworthy that the action prescribed in the notes in Miss Dooher’s clinical records of 14 June have not been reiterated in the document prescribed in the Missing Persons Policy guidelines which is also to be found in her records. In the records of 14 June clear instruction is given to anyone perusing these records that Miss Dooher is assessed as “being at high risk of self harm, impulsive” and that if she is missing, “(1) put out a missing persons call, (2) contact next of kin, (3) telephone Police”.

HISTORY OF MISS DOOHER'S ADMISSION TO WARD 18

Miss Dooher had a long history of significant mental health problems including delusional disorder and depression. She had been a patient in ward 18 on many occasions, some for extended periods. Between 2002 and January 2007 she overdosed on drugs on at least two occasions. She had been admitted to ward 18 on 26 April 2007 and discharged on 18 May that year, she having expressed thoughts of suicidal actions. These were apparently caused by her concerns for her mother to whom she was extremely close and who was then terminally ill as well as concerns about the future relationship with her partner. It is noteworthy that during this period she was granted time off ward on one occasion allowing her to stay overnight at her home. She did not return the next day. The response of the hospital was simply to extend her "pass" from one night to two.

Her Consultant Psychiatrist at the end of this period in the ward was Dr. Keren King who remained her Consultant until her death.

On 24 May 2007 Dr. King was advised that Miss Dooher had been admitted to Stirling Royal Infirmary on the 22nd of that month having taken an overdose. She had been seen by Dr. King as an outpatient on 23 May but had not mentioned this incident. Dr. King contacted her on 24 May to discuss this.

On 29 May nursing staff were unable to contact Miss Dooher to administer her medication. On 30 May the hospital was advised that Miss Dooher's mother had died. Later that day Miss Dooher contacted Dr. King from Stirling Royal Infirmary having taken another overdose attributing this to the death of her mother.

Miss Dooher was admitted to ward 18 on 30 May 2007 at 9.00pm. At that time she was the subject of a Community Treatment Order in terms of the Mental Health Care and Treatment Act 2003 part 7.

On admission Dr. King determined that a short term Order in terms of the Mental Health Care and Treatment (Scotland) Act 2003 was appropriate and an Order was subsequently made in terms of S44 authorising her detention in hospital. Dr. King saw her on a frequent and regular basis during the period from her admission to her death.

She was initially confined to the ward but after the first week and after persistent lobbying on her own behalf she was allowed time off ward although it is noted that her mental condition continued to deteriorate. Initially TOW was allowed in the company of her family and a friend, Mr Robertson. By 15 June she was allowed 15 minutes time off ward unaccompanied notwithstanding that Dr. King continued to assess her as being at high risk of self harm. This assessment continued to apply until her death. Notwithstanding the continued deterioration in her health Dr. King increased the time of unaccompanied time off ward to 30 minutes. In her evidence to the Inquiry Dr. King explained that she did so in order to show Miss Dooher that she, Dr. King, was listening to her claims that she had no thoughts of self harm although as noted Dr. King continued to assess her throughout that admission as being at high risk. That assessment is graphically illustrated by the entry on 14 June referred to above.

In other words, whereas clinical observations and assessments showed her condition to be deteriorating and the risk of self harm to be high she was allowed increasing time off ward simply because she asked for it. It is difficult to understand the rationale of this decision.

On 19 June it was reported by a fellow patient that Miss Dooher had asked that patient to bring prescription drugs to the ward for her. The type or types of drugs was not specified. Miss Dooher denied this when it was put to her. She was apparently making no progress although continuing to deny suicidal thoughts and Dr. King decided to apply for a further Order to extend the period of her detention for treatment. However no change was made to her time off ward status.

It is significant that Miss Dooher was examined by another psychiatrist, Dr. Lynch, on 22 June in connection with her application to a Mental Health Tribunal. Dr. Lynch concluded after that examination that she suffered from “suicidality in the context of an adjustment reaction following the death of her mother and also in the context of delusional disorder”.

That opinion was communicated to Dr. King and noted by her in the medical records sometime prior to her final departure from the ward on 25 June at approximately 1.45pm. That information apparently did not alert Dr. King to treat Miss Dooher’s continued absence from the ward with any greater degree of urgency.

THE EVENTS OF 25 JUNE

Miss Dooher was seen in the ward between 8.00 and 9.00am on 25 June. Nothing untoward was noted about her demeanour. She was last seen on the ward at 10.00am by Claire Watson, a staff nurse who was the shift co-ordinator that day. According to Miss Watson, Miss Dooher was dressed in outdoor clothes. Miss Dooher spoke to Miss Watson's colleague in the ward office and Miss Watson assumed that she was then leaving the ward.

At the hourly observation check carried out at 11.00am by nursing assistant Denise Sneddon, Miss Dooher was noted to be absent. Miss Sneddon's evidence was that she advised Miss Watson as co-ordinator of Miss Dooher's absence around 11.15am. This is denied by Miss Watson but there is agreement that Miss Dooher's absence was discussed between Miss Sneddon and Miss Watson at some stage. Miss Sneddon said she checked the TOW sheet and discovered that there was no entry or relating to Miss Dooher therein. Miss Watson said she told Miss Sneddon that Miss Dooher had spoken to Staff Nurse McLean and that he would have made an appropriate entry in the TOW record. I am unable on the evidence to resolve this conflict between the two witnesses but it is clear that a proper examination of the relevant records, inadequate as they were, would have shown that Miss Dooher's absence was unaccounted for. While I would tend to prefer the evidence of Miss Sneddon on this point to that of Miss Watson who presented as an extremely defensive and at times truculent witness it was not explained why, if Ms Sneddon had seen the TOW records showing no entry for Miss Dooher, that Miss she nonetheless recorded her as being "out", that is "accounted for" rather than "AWOL" which denotes that the patient is absent from the ward and unaccounted for.

As noted above the relevant observation sheet contains a sidebar of guidance specifically on these issues including the direction "if it is noted at any time that a patient is AWOL the nurse in charge should be advised immediately".

Miss Dooher was noted as "out" at each of the subsequent hourly observation checks until 6.00pm when she was noted as being AWOL notwithstanding that the Police had been advised prior to that time that she was missing from the ward.

Dr. King arrived in the ward after, coincidentally, a meeting with Miss Dooher's sister (Rosemary Deans) sometime after 11.00am. She intended to see Miss Dooher and was advised that she was out of ward. She was advised that it was unknown whether she was accompanied or unaccompanied.

It is clear that at this stage when Miss Dooher had not been seen in the ward since 10.00am that no one in the hospital had any idea where this patient was and why she was absent from the ward. However notwithstanding that she had been assessed only a few days earlier as being at a high risk of self harm and that Dr. King had made or caused to be made an entry in her medical records to the effect that if she was missing the Missing Persons Procedures were to be activated, the next of kin and the Police to be contacted, no steps were taken by Dr. King to do any of these things.

Instead Dr. King left the ward to attend to other business and returned between 1.00 and 2.00pm. She again sought Miss Dooher and was told again that she remained absent. No steps had been taken in the interim to determine whether she was accompanied or unaccompanied as Dr. King said she had requested. Only at that time were instructions given to attempt to make contact with Miss Dooher via her mobile telephone. Dr. King left the ward again just before 2.00pm, almost 4 hours since her patient had been last seen in the ward. She took no steps to implement the Missing Persons Procedures. Dr. King did not return to the ward that day.

In her evidence to the Inquiry when being asked about the entry noting the assessment of high risk on 14 June Dr. King said the following:

“The statement high risk of self harm impulsive reflects that if she wasn’t in the ward then the risk that she would act impulsively had to be regarded as high given her presentation so that in the event she was missing we would take these steps of calling the next of kin and the Police in an attempt to find her because of worries that she would injure herself”.

No improvement in Miss Dooher’s clinical state which might justify a revisal of that view was noted in any subsequent clinical assessments between then and the time of her death. On the contrary it was clear that her condition continued to deteriorate.

Carol Ann Wallace who was the Deputy Nurse in charge was asked around this time (she says around 1.30pm) to contact Miss Dooher. She asked a student to do so via her mobile telephone. There was no response and a message was left asking Miss Dooher to contact the hospital.

Claire Watson, the co-ordinator on that shift, had the duty to carry out a hand-over to the on-coming shift which took place between 2.00 and 2.30pm. The on-coming shift co-ordinator was to be Staff Nurse Margaret Thomson. Claire Watson told the Inquiry that although she

had not heard from Carol Ann Wallace as to whether she had been successful in contacting Miss Dooher she advised Miss Thomson that Miss Dooher had been missing since 10.00am. Claire Watson left the ward at 2.40pm believing that the matter was being dealt with by Carol Ann Wallace who had left the ward at 2.30pm.

Miss Dooher continued to be recorded as “out” in the hourly observation sheet throughout the afternoon. No steps were taken to initiate the Missing Persons Policy until after 4.00pm.

Staff Nurse Thomson had been aware that Miss Dooher had been unaccounted for for several hours but said that Miss Dooher “had done this before”. (Other witnesses gave evidence to the effect that Miss Dooher had a tendency to extend her TOW by 15 or 30 minutes; several witnesses said that patients were often allowed “leeway” in the times they were due to return). Staff Nurse Thomson hoped that Miss Dooher would return. She became concerned when she was advised after the 4.00pm hourly observation that Miss Dooher was still absent. She discussed the matter with Charge Nurse Wilson and with a House Officer, Dr. McCool. It was agreed that the Missing Persons Policy would be initiated.

In her evidence Staff Nurse Thomson said that she telephoned the Police at approximately 4.30pm. Police records indicate that the report was made at 5.30pm.

I make no criticism of Miss Thomson in this regard but I prefer the Police evidence. It is supported by the fact that the hourly observation sheet records Miss Dooher as “out” at 5.00pm whereas at 6.00pm she is noted to be “AWOL”.

Staff Nurse Thomson did not advise the Police that Miss Dooher was assessed as being a high risk of injury to herself. She was unable to give the Police the home telephone number of Miss Deans, Miss Dooher’s sister and the named person/next of kin. The hospital had no records of the full names and addresses of Miss Dooher’s two friends “Leo” and “Mr Robertson” both of whom had been allowed to accompany Miss Dooher on her accompanied TOW.

THE POLICE RESPONSE

In stark contrast to the response by the hospital, including Dr. King, to Miss Dooher's absence, the response of the Police was a model of professionalism, organisation, commitment and diligence.

It was led by Inspector Gerrard Crawford who, while on duty at Falkirk Police Office, had overheard a call coming from ward 18 to the effect that a patient was missing. He immediately instructed one of his Officers to obtain a risk assessment from the hospital to search the ward and he directed the dog section to search the grounds and review close circuit television. He recalled being advised that there were no immediate concerns for the missing person's safety and that she was likely to be in the company of two males or in a public house. On being advised that the missing person was a detained patient he instructed his officers to query the risk assessment that the missing person posed no threat to her own or anyone else's safety. He was advised in due course that the patient had been seen by a Doctor that day and had been assessed as being at no risk to herself or others and was also advised that nothing drastic would occur if she failed to take her medication. His Officers searched local public houses which Miss Dooher was known to frequent and visited her home but obtained no reply. He was assisted and directed in the Inquiry by Sergeant Leishman who tasked Officers from Stenhousemuir to try to trace Miss Dooher's sister. They however became involved in another inquiry. They were of course hampered in this inquiry by the fact that the hospital had been unable to provide them with a full address or a landline telephone number. In view of the information from the hospital that they had no concern for her safety Inspector Crawford felt precluded from enforcing entry to Miss Dooher's home and decided to conclude other inquiries before taking further steps. The hospital had been unable to provide them with the full names, address or other information relating to the two males with whom Miss Dooher was known to associate and who had accompanied her on accompanied time off ward. These were known only as Leo and Mr Robertson. Through the diligence of his tasked Officers, P.C. Alison Robson and P.C. Carolyn Isong, the identities of these two men were ascertained as were their addresses and they were eventually interviewed by the two Police Officers. Neither man had seen Miss Dooher or had contact with her that day. Officers Robson and Isong continued their inquiries and were ultimately able to trace Miss Dooher's sister, Rosemary Deans, who advised that she held no spare set of keys to Miss Dooher's flat. After further activity and a case conference it was determined that entry would be forced to Miss Dooher's home under the common law provision that Police Officers are entitled to force entry in order to preserve life. Inspector Crawford felt that he had no recourse in terms of S292 of the 2003 Mental Health Care and Protection (Scotland) Act. The basis for this judgement was that the

hospital had advised his Officers that the missing person was not at risk to herself. Had he been advised that she had been assessed as being at a high risk of suicide then he would have forced entry to her home within an hour of first receiving the report that she was missing.

As well as himself and Sergeant Leishman a total of six Officers had been involved from 5.30pm on 25 June until the early hours of the morning after Miss Dooher had been found.

The inquiries being made by each of these Officers were significantly hampered by the lack of full and accurate information from the hospital as to (a) the assessment of risk, (b) contact details of her next of kin, (c) contact details of those individuals with whom she exercised accompanied time off ward.

Both Constables Robson and Isong made lengthy, involved and diligent inquiries throughout the course of the evening of the 25th. These inquiries included visiting the hospital on a number of occasions, visiting a number of local public houses which Miss Dooher, according to the hospital, was in the habit of visiting, researching various Police databases to establish the identities of the two men with whom she went off ward from time to time and in attempting to trace Miss Dooher's sister for whom they had only a street address with no number.

These two Officers in particular are to be commended for the diligence and determination with which they carried out their duties in an attempt to trace Miss Dooher that evening.

Following the decision to force entry to her home two Officers attended with a joiner at 1.20am and found Miss Dooher in one of the bedrooms in her home. She was lying face down on the bed. A Doctor was called and Miss Dooher was pronounced dead at 2.45am by Dr. Craig Sayers, a Police Casualty Surgeon, who had been contacted just after 2.00am. When Dr. Sayers attended he observed that rigor mortis had set in and that there was substantial lividity.

A post mortem examination was carried out by Dr. David Saddler, a Senior Lecturer in Forensic Pathology at Dundee University. The post mortem was carried out at the Police mortuary in Bell Street in Dundee. He confirmed that the cause of death was toxicity. There were no suspicious marks, no trauma, no disease and no cause for concern that her death had been caused by any other means. A blood sample was taken and passed to Dr. Wylie for toxicological analysis. That analysis revealed a very high, potentially lethal level of the anti-histamine Diphenhydramine of which 11.6mg/l was found in the femoral blood. The usual therapeutic level is approximately 0.1mg/l and fatalities have been reported at levels ranging

from 3.00mg/l to 31.0mg/l. Therapeutic levels of other drugs which she had been prescribed were also detected.

Having regard to the degree of rigor mortis and the degree of lividity observed in Miss Dooher's body Dr. Saddler's opinion was that she had died at least ten and possibly up to twelve hours before Dr. Sayers had pronounced her dead. By analysis of the tablet debris found in her stomach Dr. Saddler expressed the opinion that her death had been quite rapid from the time of ingestion of these drugs. In his opinion, the period between the ingestion of the Diphenhydramine and unconsciousness would have been a period measured in minutes rather than hours and that death would have resulted fairly rapidly thereafter. Had Miss Dooher been discovered after taking the drugs but before her death the only practicable means of preventing her death would have been immediate medical attention in the form of evacuating the contents of her stomach.

Dr. Saddler's evidence was substantially confirmed by that of Dr. Fiona Wylie BSC BHD Forensic Toxicology, a Forensic Toxicologist in the University of Glasgow. She confirmed Dr. Saddler's view that the presence of two packets of drugs each containing the lethal drug, together with the tablet debris found in her stomach contents indicated that the overdose of Diphenhydramine was not accidental. It is extremely rare to see death caused by an overdose of this particular drug which has hitherto been regarded as being relatively safe as evidenced by its availability in supermarkets and chemist shops.

It is on the basis of the evidence of Inspector Crawford that had he known the true level of risk to herself that Miss Dooher presented he would have instructed the forced entry to her home within an hour of her being reported missing; that she was known to be missing by 11.15am on 25 June; that Dr. King was aware that she was missing around that time; that Dr. Saddler estimates that the time of death was between ten and twelve hours prior to Dr. Sayers certifying her as dead at 2.45am I have concluded that if either Dr. King or any of the nursing staff on ward 18 on the morning of 25 June had notified the Police that she was absent it is possible that her life could have been saved.

THE CRITICAL INCIDENT REVIEW

Following Miss Dooher's death a review of the circumstances surrounding it was set up and executed by four Senior Managers of the Trust. The report of the review was presented to the Inquiry and became Crown Production No. 236-250.

The remit for the review was as follows:

"To investigate the circumstances leading up to Miss Dooher's death, to review her care and treatment and to make any recommendations for improvements to clinical practice, protocols or systems".

This document was spoken to in evidence by Dr. Rhona Morrison who is a Consultant Psychiatrist and Associate Medical Director of the Forth Valley NHS Trust having responsibility as Manager for all Psychiatric Services. It was relied upon in his submissions by Mr Stewart, representing the Trust

I do not propose to forensically dissect that report but a comparison of it with the terms of this determination will see that I disagree with its' principle conclusions. For example, at paragraph 8.1 it is concluded that:

"Time out of the ward status was properly applied being progressive and appeared to try and balance Miss Dooher's strong wish for more freedom outwith the ward and the risks associated with her current presentation."

In relation to this I would observe that whereas in the clinical notes there are references to Miss Dooher using her time off ward "appropriately" there is no source of information from which that conclusion can be derived. It is patent from an examination of the various records or lack of them that staff did not know when she was off ward, for how long she was off ward and on how many occasions she was off ward. It is further a reasonable inference that on frequent occasions they did not know where she was and who, if anyone, she was with. The evidence of Staff Nurse Thomson and of the Police to the effect that she frequently did not return at the anticipated time and that she was permitted to frequent public houses while on medication is evidence which is directly contradictory of this conclusion.

“There was a delay in responding to Miss Dooher’s failure to return to the ward on 25 June 2007. This resulted in an unnecessary and unacceptable delay in contacting Police.”

The failure lies not in the delay in responding to her return but in the fact that there was no response to the fact of her absence without leave when this was determined just after 11.00am on 25 June. It is a failure which is compounded by the fact that Miss Dooher’s Consultant Psychiatrist, the Clinician who had her care, was aware of the circumstances but took no steps despite her recent assessment of Miss Dooher as being of high risk of self harm to protect her.

“There was no failure in the availability of appropriate systems and processes, for example, Time Off The Ward and Missing Persons Policy. The separate investigation under the Employee Conduct Policy has identified local issues in the application of these Policies.”

This conclusion underlines the superficiality of this review and the complacency of its conclusions. As was amply demonstrated in this Inquiry, there were no effective systems of management control of the time Off Ward Policies and the Missing Persons Policy. The review team appears to conflate the existence of policies and protocols with a system of managing their application. A system which depends on the coherent integration and application of these distinct elements simply did not exist. As I have observed, where there should have been a coherent interface between these three elements (time off ward, Missing Persons Policy and hourly observation checks), there was only at best ambiguity and confusion and at worst culpable failures in the mechanics of their applicability.

It is clear that the review report attributes most of the responsibility for this tragic outcome to failings of the staff. This is to miss the point. There was clearly a culture amongst nursing staff and clinicians alike of paying no more than lip-service to the requirements of the Trust’s policies in the management of detained patients. That is a culture which clearly had existed for at least a number of years and of which management should have been aware and which management should have addressed. This was not principally a failure of individual members of staff but a systemic failure which was acquiescent by clinicians and by managers.

If Miss Dooher’s Consultant Psychiatrist, who was best placed to understand and assess the risk she presented to herself, failed to impart any degree of urgency into the circumstances of her absence from the ward between 11.00am and 2.00pm then there is no reason why any

individual members of nursing staff of whatever apparent status should have felt that degree of urgency before they ultimately did sometime after 4.00pm that day.

Furthermore, any confusion amongst individual members of nursing staff as to their respective responsibilities is at least partially attributable to the lack of a defined and ascertained hierarchy of responsibility within the ward at any given time. In this context I would observe that the ward is staffed from time to time by a Charge Nurse who has in each shift a Deputy Charge Nurse and in each shift there is also a Co-ordinator. None of the witnesses to the Inquiry whom I heard were able to give a precise definition of the respective roles and responsibilities of these three levels of staff.

I would also observe that whereas the review report notes at 8.2 that:

“A more robust system of monitoring patients leaving and entering the ward was put in place very quickly after this event. While more staff intensive and more restrictive for patients, it ensures that patients are unable to leave the ward without staffs’ knowledge.”

I was advised that this more robust system of monitoring patients leaving takes the form of a member of staff being placed at a desk in the foyer with the intention of recording patients leaving and returning. Dr. Morrison, when giving evidence about this matter, was unable to give any details such as what provision is made for changing the duties from time to time; what happens when an emergency occurs which requires the attention of additional staff; what happens when that member of staff has to take breaks.

It was a surprise to me, although perhaps it should not have been, that despite the elapse of 11 months between Miss Dooher’s death and the time of her giving evidence to the Tribunal Dr Morrison advised the Court that no auditing or monitoring of the application and efficacy of this “more robust system” had been conducted.

In making these observations and findings I readily acknowledge the serious and significant challenges which confront staff and management in the psychiatric care environment. The ward had at any one time approximately twenty five patients, no doubt exhibiting various forms and degrees of mental illness. There were only five full time members of nursing staff (including two nursing assistants) present at any one time. Of these, at least two of the senior nurses were engaged from time to time in specific duties which took them out of the main ward for lengthy periods. Miss Dooher was not their only patient. They had many other calls

on their time and expertise. I also acknowledge and accept the evidence of Dr Gray, Consultant Psychiatrist, who offered and independent oversight, to the effect that the standard of psychiatric care offered to Miss Dooher during her admission to the Ward in May and June 2007 was generally of a very high standard..

These factors however emphasise the clear and obvious requirement for management to put in place and robustly maintain appropriate systems for managing the high level of risk inherent in caring for the mentally ill.

The following persons gave evidence to the Inquiry:

- Ms Rosemary Deans, Rosmar, 39 Kennedy Way, Airth
- Dr. Keren King, Psychiatrist, F & DRI, Major's Loan, Falkirk
- Dr. Rhona Morrison, Psychiatrist, F & DRI, Major's Loan, Falkirk
- George Asher, Scene Examiner, Central Scotland Police, Police HQ, Stirling
- Fiona Mary Wylie, Forensic Toxicologist Forensic Medicine and Science, University of Glasgow, Glasgow, G12 8QQ
- John Wilson, Charge Nurse, 104 Main Street, Townhill, Dunfermline
- Carol Ann Wallace, Deputy Charge Nurse, Ward 18, F & DRI, Major's Loan, Falkirk
- James Walker, Staff Nurse, Ward 18, F & DRI, Major's Loan, Falkirk
- Claire Watson, Staff Nurse, Ward 18, F & DRI, Major's Loan, Falkirk
- Carol Carr, Nursing Assistant, Ward 18, F & DRI, Major's Loan, Falkirk
- Denise Sneddon, Nursing Assistant, Ward 18, F & DRI, Major's Loan, Falkirk
- Margaret Thomson, Staff Nurse, Ward 18, F & DRI, Major's Loan, Falkirk
- Isabel Gardiner, Nursing Assistant, Ward 18, F & DRI, Major's Loan, Falkirk
- Craig Sayers, Police Surgeon, Central Scotland Police, Police HQ, Stirling
- Gerrard Crawford, Police Inspector, Central Scotland Police, Police Office, Falkirk
- Yvonne Leishman, Police Sergeant, Central Scotland Police, Police Office, Falkirk
- Alison Robson, PC 854, Central Scotland Police, Police Office, Falkirk
- Carolyn Isong, PC 851, Central Scotland Police, Police Office, Falkirk
- Mark Richardson, PC 4, Central Scotland Police, Police Office, Falkirk
- Dr. David Saddler, Pathologist, Centre for Forensic & Legal Medicine, University of Dundee, Dundee
- Dr. Douglas Gray, Consultant Psychiatrist, The State Hospital, Carstairs, Lanark