

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

DETERMINATION

by

JOHN MILLAR STEWART HORSBURGH

Queens Counsel, Sheriff

in Inquiry into the circumstances of the death of

DANIELLE LORRAINE SCOTT

in terms of section 6 of the Fatal Accidents and Sudden
Deaths Inquiry (Scotland) Act 1976

For the Crown: Elizabeth A Paton, Principal Procurator Fiscal Depute

For the mother of the deceased: Marian Gilmore QC, Ross Harper & Murphy

For Greater Glasgow Health Board: G F Coll, Advocate

For Dr Anne Greer: Hugh R Donald, Shepherd + Wedderburn LLP

For City of Edinburgh Council: John P Campbell, Advocate

For East Dunbartonshire Council: Diane M McGowan, Simpson & Marwick, Glasgow

For Lothian & Borders Police: Roderick A S Jackson, McClure Naismith, Edinburgh

EDINBURGH, 30 July 2009

The Sheriff, having resumed consideration of the Inquiry, DETERMINES as follows:

1. In terms of section 6(1)(a) of the Act that Danielle Lorraine Scott, born on 29 July 1987, and late of 6 Melville Gardens, Bishopbriggs, Glasgow, G43 3DF, died within 6/4 Medwin House South, 22 Calder Park, Edinburgh sometime between 22.00 hrs on 7 February and 10.30 hrs on 8 February 2005.
2. In terms of section 6(1)(b) of the Act, that the cause of her death was acute methadone and alcohol poisoning.

NOTE:

Introduction

This inquiry occupied 42 days of evidence heard between 9 June 2008 and 12 May 2009. Written closing submissions, extending to 190 pages, were exchanged. These were discussed on 15 July 2009, and have been placed with the papers.

The facts upon which the foregoing determinations were made are not in dispute. Danielle died in a stranger's flat in Edinburgh because she took methadone he had given her. He was convicted of her culpable homicide. He committed a crime by supplying that drug to her, and she committed a crime by taking possession of it. It is in that context that her death occurred, and it is against that background that the other provisions of section 6 must be considered.

The vast quantity of documents produced and referred to at the inquiry comprise the contemporaneous records and reports of Gartnavel Hospital, the Department of Child and Family Psychiatry at Possilpark Health Centre, and Stobhill Hospital, all in Glasgow, East Dunbartonshire Council Social Work Department, and Howdenhall Young Persons' Centre in Edinburgh, through whose hands Danielle passed at one time or another. These were very clear and detailed, and were submitted to meticulous examination on behalf of the parties represented. That has enabled me to state my conclusions about the evidence reasonably succinctly.

Danielle's history

But first it is necessary to make brief reference to significant events in Danielle's life, and to her contact with medical and social work services.

She lived with her parents and older brother. Her earliest primary school years seemed happy, and she made satisfactory progress. But she was aware that her parents' marriage was stormy, and marred by her domineering father's repeated alcohol-fuelled violence towards her mother. In an acrimonious separation in 1997 her mother left home with the children, spending some time in a women's refuge before she gained occupancy rights to the matrimonial home. Danielle's parents divorced in 2005.

Danielle developed disturbing behavioural patterns from an earlier age than her parents were prepared to acknowledge. At primary school she had drunk alcohol to excess, had self-harmed, and had attempted suicide. At secondary school from the age of 12 she was

subjected to non-physical bullying. In the spring of 2000 she began to exhibit signs of bulimia, eating abnormal quantities of food, and engaging in a constant cycle of bingeing and purging. Her academic performance deteriorated. She became sexually active, sullen and withdrawn, and had mood swings.

On 3 November 2000 the family GP referred Danielle to Possilpark Health Centre. She attended Gartnavel as an out-patient. On 21 February 2001 she took an overdose, and required treatment in Stobhill A & E Department. Between then and May 2001 she received input from the Deliberate Self-Harm Team at the Health Centre. She ceased to attend school, and transferred to another, where she did not flourish. Despite intensive input, her symptoms worsened. Her bingeing and vomiting behaviours escalated. She was self-harming and engaging in promiscuous under-age sex. In July 2001 her GP referred her to East Dunbartonshire Council Social Work Department. A social worker with particular skills and experience was assigned to her case. Danielle remained under the care of the Council until the time of her death.

Danielle was admitted as a voluntary in-patient to Gartnavel Adolescent Unit on 6 September 2001. For a period, treatment helped her to manage her bulimia, and relieved her depressive symptoms. But she still continued to indulge in sexual promiscuity, observing no boundaries, behaving oppositionally, absconding, showing no fear of anything, self-harming, and abusing alcohol and illegal substances.

She was discharged from Gartnavel on 11 December 2002 to the care of the Health Centre. For a period she made some progress, but in the longer term the same behavioural problems continued, despite intensive home support from the Social Work Department.

She was referred by the Reporter to the Children's Hearing, as being outwith parental control, and a supervision order was made on 27 June 2003. That step was taken to bring her within the Children's Hearing system before her 16th birthday, after which the Council would have been unable to intervene. But she still overdosed, self-harmed, and observed no boundaries.

Danielle became a voluntary patient in the Priory Clinic, Glasgow on 2 February, 2004. There she was ambivalent about treatment, and attended therapy sessions only spasmodically. She was discharged on 29 March 2004, after breaching her third warning about the continuing misuse of aerosols.

When she returned home her acting-out behaviour and her risk-taking escalated. On 26 April 2004 Dr Anne Greer, consultant psychiatrist at the Health Centre, requested the Children's Hearing to consider placing Danielle in secure accommodation because she was putting herself at significant risk.

On 28 April 2004 the Hearing placed Danielle on a 21-day assessment order with a requirement of residence in the Braid secure unit at Howdenhall. On 23 June 2004 she was moved to the Calton close support unit at Howdenhall, and her supervision requirement was altered accordingly.

On 1 July 2004 Danielle was seen by Dr Louise Quinn, consultant psychiatrist at St Andrew's Hospital, Northampton, for a second opinion. Dr Quinn advised a continuation of the current treatment plan at Calton, which was appropriate, and acceptable to all, including Danielle's parents. She suggested that if Danielle withdrew her co-operation and relapsed, consideration should be given to her being admitted to St Andrews Hospital. Danielle was not keen to go there.

On 2 September 2004 Danielle started a course at Stevenson College, but was expelled on 5 November 2004. She skipped classes, returned late from college, took alcohol, and behaved promiscuously. She got a job at Burger King, and was employed there between 5 and 15 November 2004. On 9 December 2004 she took an overdose of drugs when on home leave. She was admitted to the Western General Hospital, Glasgow, where she was seen by Dr Greer, and was, on 10 December 2004, admitted to Struan Ward, Stobhill Hospital, Glasgow, for assessment. A Children's Hearing on 16 December 2004 was continued, to await the outcome of that assessment.

Danielle was discharged from Stobhill on 13 January 2005, and attended the Children's Hearing where all the options for her future were considered. Initially she did not want to return to Calton, but she came to accept that was her only option.

On 17 January 2005 Danielle did not come back from time-out, although she had returned from an earlier outing that day. She was found by the police in Burntisland two days later. On 27 January 2005 she absconded from time-out and was arrested by the police for shoplifting. She was later seen by two general practitioners, and by an on-call psychiatrist at the Royal Edinburgh Hospital. She was not detained, and was returned to the Calton unit.

On 2 February 2005 she returned under the influence of alcohol at 4.45 am, after a cinema visit. On 5 February she failed to return from time out, but came back at 12.55 am. On 7 February, at a care plan meeting at Howdenhall Danielle was vehemently opposed to being placed in a medical resource for treatment. That had been followed by a happy family outing.

At 5.50 pm on 7 February 2005 Danielle left Howdenhall on a one-hour pass. Thereafter she picked up a man named Peter Meaney by making sexual advances towards him. They went to Princes Street by bus, and then by taxi to near Medwyn House, and entered it at 8.47 pm. At Meaney's flat there he offered her and she consumed both alcohol and methadone, of which he had a two-week supply. She collapsed and was placed on a bed. Some time between 10 pm on 7 February and 10 am on 8 February 2005 she died, and an ambulance was called.

The parties' positions in final submissions

None of the parties sought any determination in terms of section 6(1)(d). The Crown did not seek any determination under section 6(1)(c). It tentatively suggested that consideration might be given to making a recommendation about the lack of secure or semi-secure psychiatric beds for children and young persons in Scotland. For Greater Glasgow Health Board, for Dr Anne Greer, for the City of Edinburgh Council, for East Dunbartonshire Council, and for Lothian and Borders Police it was submitted that no determinations should be made under section 6(1)(c) or (e). For Danielle's mother a determination was sought under section 6(1)(c) that the death might have been avoided by the diagnosis and treatment of bipolar disorder, and a return to secure accommodation from the close support unit at Howdenhall. Under section 6(1)(e) the only recommendations sought were that (1) the practice of assessing adolescents in adult

psychiatric wards is sub-optimal, (2) there were *lacunae* in the system of reporting missing persons from Howdenhall, (3) there was, and remains, an inadequate provision of secure child and adolescent psychiatric beds in Scotland, (4) the prescription of methadone without accompanying supervised consumption is unsafe, and (5) the illegal use of cannabis on psychiatric wards is unsafe, and may compromise assessment, treatment and good order. I will deal with each of these in due course.

In the course of the evidence counsel for Mrs Scott raised a number of issues which were not mentioned in her closing submissions. In her closing submissions a number of criticisms were offered of acts and omissions by those through whose hands Danielle had passed, but these were neither linked to the section 6(1)(c) determinations nor focussed in the section 6(1)(e) recommendations which she sought. On behalf of the other parties much time was devoted to exploring the evidence about these matters, and much of their submissions was taken up by countering them. I presume that, on reflection, all such matters were not considered by counsel for Mrs Scott to be of such significance as to support the determinations or to justify the recommendations. I do not propose to make any mention of them in this note. It is sufficient to say that, had they remained live issues, I would not have been prepared to find in support of them, for the reasons set out in the submissions for the other parties.

Guidance on the approach to the evidence

In closing submissions reference was made to section 6, Carmichael: *Sudden Deaths and Fatal Accident Inquiries* (3rd edn) para 5.75, to *Black v Scott Lithgow Ltd* 1990 SC 322, *Steven Dekker FAI*, 2000 SCLR 1087, *James McAlpine FAI* (Glasgow June/October 1985), *Sharman Weir FAI* (Glasgow 28 January 2003) and *Bolitho v City & Hackney Health Authority* [1998] AC 232. From these I deduced that section 6(1)(c) is directed towards considering the reasonable precautions, if any, whereby, on a balance of probability, Danielle's death might have been avoided. It focuses on what practicable precautions could give rise to a real or lively possibility of that. Subsection 6(1)(e) is a catch-all provision, and enables the court to make a determination in relation to "any other facts which are relevant to the circumstances of the death". Hindsight may inform such determinations. The inquiry is not the forum to determine questions of civil or criminal liability, and it is to be noted that the consultants who disagreed with the

diagnosis of the clinicians who treated Danielle did not regard them as having been at fault.

Family attitudes

The records and the evidence of other witnesses show that at almost every stage Danielle's treatment was subject to criticism by members of her family. They became over-involved, to the extent of hindering plans for her care. They were often oppositional. They encouraged her to think she was mentally ill, and was therefore absolved of responsibility. This inhibited the progress she had to make towards independence. They were much too ready to focus on the need for medical treatment, to the exclusion of dealing with her numerous behavioural problems. They made a complaint about Dr Greer within weeks of Danielle's death, questioning her fitness to practise. That was dismissed after inquiry. I was therefore cautious about accepting their views about Danielle's condition. They have to be balanced against the views and observations of trained and highly experienced social workers, residential care officers, nurses and doctors who had worked with Danielle in settings as varied as home, residential care units and hospitals.

The Family as witnesses

I concluded that the Scott family were not to be regarded as accurate historians for a number of reasons.

Danielle's carers called her a liar at times. She could be extremely manipulative, and was capable of saying things which she saw as suiting her own ends. Much of what she is recorded as having said has to be viewed with a good deal of scepticism.

Mr Scott, her father was eager to blame almost everyone. The records showed him quick to express anger and dissatisfaction when things did not go as he wished. He belittled any small advance that had been made. At meetings he was very aggressive. He regularly badgered Howdenhall staff with questions which would have been answered had he bothered to attend more than 5 of the 23 care plan meetings to which he had been invited. He made threats about going to lawyers and Members of Parliament. He would not accept a view other than his own, and, typically and significantly, he described the rejection, after enquiry, of the complaint referred to above as "a whitewash". His

evidence demonstrated bias against those who had the medical care of Danielle, and he was ever ready to make some barbed comment or another to cast them in a bad light. He was devious as a witness, and when he suspected questioning might be critical of him or contrary to his thesis, he would claim that his memory had failed him. I was not prepared to accept his account of events unless that was undisputed or was supported by independent reliable evidence. I was thus unable to accept the information he gave to a psychiatrist in January 2005 that on both sides of the family in the previous generation there had been mental illness. Likewise, I was not prepared to accept that he did not know that the decision of the Children's Hearing of 13 January 2005 could be appealed. He had said at the hearing that he would appeal.

Mrs Scott I also regarded as an unreliable witness at times. She claimed that she had been excluded from care plan meetings. The records prove the contrary, for she attended 23 out of 26 such meetings. They also showed that staff from the Calton unit went to Glasgow to collect Danielle in times of crisis much more often than she claimed. She could be oppositional. Prior to the Children's Hearing on 13 January 2005 she had accepted that the Social Work Department had no recommendation to make, but at the hearing she became angry and said it was ridiculous that the social worker was being paid and had no recommendation to make. Without any justification she dismissed that hearing as "a total farce". She wrongly implied that the police were not advised that Danielle went missing on 19 January 2005.

I did not accept David Scott's evidence that Dr Greer had ignored or had not understood the implications of the information he said he gave her on 28 October 2003 about Danielle having highs and lows of mood. All the other evidence demonstrated that Dr Greer was always caring, careful and thoughtful in her dealings with Danielle's case, and always receptive to information about her.

The Diagnosis

Much of the evidence centred on whether or not Danielle may have been suffering from bipolar disorder. None of the consultants who had charge her case from time to time, or had the opportunity to examine her, thought she did so, although that was considered. Dr Gardiner and Dr Greer found no signs of it, and even with hindsight, held to that position. So too did Dr Quinn, who had been consulted for a second opinion. Psychiatrists at

Stobhill were looking for signs of this particularly, but found no evidence of it. That was also the view of two of the consultants who reviewed the records subsequently, Dr Jane Morris, on behalf of the Crown, and Dr Anthony James on behalf of Greater Glasgow Health Board. They concluded that there was insufficient evidence that Danielle was suffering from bipolar disorder, and supported that with very clear, well balanced and convincing reasons. The consensus was that she was suffering from multi-impulse bulimia and a uni-polar depressive disorder, or an emerging personality disorder.

Two retired consultants were of the contrary opinion. Dr Robert Wrate thought that Danielle was suffering from bipolar disorder from as early as her time in Gartnavel, and that this had been missed by the clinicians. Dr Ian Berg thought that she may have been suffering from bipolar disorder.

I accepted that, by cherry-picking in the case notes, it is possible to locate some indicators of bipolar disorder. But these were far out-weighted by many more contra-indicators of that, and pointers in favour of uni-polar depression. In addition, there were also signs that Danielle suffered from a borderline personality disorder. That also points away from bipolar disorder as a diagnosis.

But apart from that, there are a number of reasons why I was unable to accept the opinions of Drs Wrate and Berg. Firstly, their opinions were expressed from standpoints of some disadvantage. As reviewers of the records *post mortem* they had the benefit of hindsight. But the clinicians involved in Danielle's actual treatment had a particular advantage. They had direct knowledge of the patient. They could see things in the round, and take a broader view than those who simply had the notes to study. Secondly, I thought that these doctors were inclined to place too much significance on Danielle's reported statements and on the family history without critical examination. In view of the reservations I have already expressed about the reliability of such sources of information their opinions are to that extent weakened. Thirdly, the diagnosis of bipolar disorder which they had reached was undermined by the fact that they had arrived at the same conclusion for different reasons. Dr Wrate found signs of ultra rapid cycling, but not of rapid cycling. Dr Berg thought there was rapid cycling, which had been missed.

Moreover, I did not accept Dr Wrate's views. His report had been carelessly produced. He was inclined to speculation. His evidence did not stand up well to cross-examination. It became clear that central to his thesis was the proposition that Danielle suffered from ultra-rapid or ultradian cycling. These did not feature in his written report. I found that to be quite astonishing, and his lame explanations for this omission to be entirely unacceptable. I concluded that he was deliberately shifting ground when he realised the force of cross-examination. I thought that reduced the objective quality of his evidence, and rendered it of little assistance to the court. I thought it was oddly illogical that he criticised the diagnosis of multi-impulse bulimia because it did not appear in the standard clinical guidelines used in the UK and the US, yet ultra-rapid or ultradian cycling, on which his favoured diagnosis depended, did not feature in these publications either. I rejected his view that even during the 15 months Danielle was in Gartnavel there was evidence of bipolar disorder. Had that been so, that condition would have been much more manifest by the time she was in Stobhill and at the time of her death.

As his evidence progressed he became readily defensive and more partisan in support of his thesis. I thought he over-stated the case for bipolar disorder, under-emphasising the importance of some of facts and over-emphasising the importance of others. His conclusions involved a particular selection and juxtaposition of facts, and ignored the broader picture. He made pejorative comments and offered dismissive criticisms of the other clinicians. I flatly reject his arrogant and ill-considered assertion that all those who treated Danielle in life, in different circumstances, had insufficient familiarity with bipolar disorder in adolescence to be able to recognise it, and that this resulted in incorrect interpretations of their carefully described signs and symptoms.

In reaching a diagnosis of bipolar disorder he followed the thinking of some US psychiatrists who regard affective mood instability in the form of ultra-rapid or ultradian cycling as symptomatic. That is not the mainstream view in the UK or the US, and during Danielle's lifetime this phenomenon was not generally regarded by clinicians as indicative of bipolar disorder. In fact in many cases, children with affective mood instability have an increased risk of depression, but do not go on to suffer bipolar disorder. Dr Wrate appeared not much troubled by modesty, and adopted the stance that his knowledge and experience was superior to that of others. I was not impressed, and not prepared to accept his diagnosis.

Dr Berg's opinions appeared to me to be expressed with a certain lack of certainty, as in his treating transient episodes of mild distress and elevation of mood as a sufficient indication of rapid cycling. He said bipolar disorder was not the most common explanation for a teenage girl going off the rails, but as Danielle had been treated for bulimia and depression for four years, without any noticeable long-term improvement, consideration might have been given to treating her for bipolar disorder, as being at least worth a shot. That default-approach did not strike me as having much in the way of logic to commend it, and it was strongly criticised by Dr James, whose views impressed me. At times Dr Berg's evidence appeared to be imprecise, and the impact of much of his evidence in chief was lost by the number of leading questions put to him.

My conclusion is that the psychiatric assessment made was sound, and the care Danielle received from the various doctors was entirely appropriate. There was insufficient acceptable evidence to support the conclusion that she was suffering from an undiagnosed bipolar disorder. The evidence by contrast demonstrated comprehensively and logically that the diagnosis made by the clinicians was correct.

But the matter does not end there. It is quite clear that Danielle was *never* detainable under section 17(1)(b) of the Mental Health (Scotland) Act 1984. Even if she had bipolar disorder, her condition could probably have been treated in the community, and it is unlikely that she would have needed to be in hospital for this. There was therefore never a stage when she required to be in hospital for treatment to be given, and thus she was never detainable. There was insufficient evidence to support an emergency admission to a mental hospital in Scotland under sections 24 or 26, or to St Andrew's Hospital in Northampton. Just to lock Danielle up in a mental hospital would not have been justifiable legally or therapeutically. In these circumstances the opportunities for the fatal misfortune that occurred would not have been avoided by reason of her freedom within the community.

Nothing arises in this aspect of the case that would have caused me to conclude that there were any reasonable steps in the medical area which could have been taken whereby Daniele's death might have been avoided. It is to be noted that in the closing submissions

for the Crown no criticism was offered “of Danielle’s medical treatment and the approaches taken by the clinicians involved” .

Freedom at Calton

The second main issue at the enquiry was whether or not the Calton close support unit at Howdenhall had given Danielle too much freedom.

While she was in the secure unit no practical steps could be taken to address her behaviours or to prepare her for the future. It was always anticipated that she would in due course be moved from there to the close support unit, and there would be given increasing periods of structured freedom. A careful plan was drawn up as a stepping stone to her rehabilitation in society, which is in accordance with the Social Work Department’s statutory obligations. Its aim was to provide highly intensive support to improve her life-skills, to build up her self-esteem and self-confidence, to engage in normal day-to-day activities, to take more responsibility for her actions, to offer further education and employment opportunities, to have more home contact, and to integrate her back into the community. This plan would involve only slow progress over several months, and was up-dated and reviewed at regular care plan meetings. The inherent risks in increasing periods of freedom were well recognised. But time-out, developed in a structured way, is an important part of the regime, a normal part of young people’s lives, a test of their capacity to self-regulate, and an opportunity to learn, with support, from their mistakes. In my view that was an entirely appropriate plan. On behalf of Mrs Scott it was contended that it ceased to be so in the last weeks of Danielle’s life, and the primary focus ought to have been on her safety and protection. That raises sharply the appropriateness of continuing to give Danielle the benefits of the close support unit.

A proper consideration of this aspect of the case requires account to be taken of all the evidence relating to Danielle’s stay there, and not just of what happened in her final days.

On a statistical approach, up to the time of her admission to Stobhill, the records show that Danielle was allowed time-out on many occasions, sometimes more than once a day, sometimes with her mother, with staff, or on her own. She had several overnight stays at home. Mostly she was back on time, or reasonably soon thereafter. On less than 10% of her times-out was she back very late, when she was brought back, or self-returned. When

she attended Stevenson College and worked at Burger King, only 1 of her 20 times-out from Howdenhall caused concern. During her time at college, to and from which she normally travelled on her own, were only 4 occasions when she returned significantly late or under the influence of alcohol.

But other factors are of relevance. Firstly, while one view was that her college placement and job were ill-advised, as offering temptations, they both represented real progress towards normality, and the job, which she obtained on her own initiative, was an important step in fostering her independence. Secondly, when her time-out was restricted in November 2004 at her parents' insistence, Danielle was affected adversely, and this probably led to her hospitalisation in December 2004.

It is clear that before she was returned to Calton from Stobhill the appropriateness of her placement was considered very carefully by the Children's Hearing on 13 January 2005. All options for the future were reviewed. It appreciated that there would be risks involved in returning her to Calton, but recognised it was very important that Danielle should be given the skills that could regulate her life, and that had to come before tackling her mental health problems. In my view that was a sensible approach, and well-justified on the foregoing considerations.

By the time of the Looked After Child Review on 19 January there were other factors to be added to the equation. On the one hand, Danielle was missing, and nobody knew what had happened to her. On the other hand, when she returned to Calton from Stobhill Danielle had engaged with the care plan better than expected. There were small signs of progress, and she had had a number of times-out that had been quite uneventful. In my view this was not an overwhelmingly bad picture, and it certainly was not one which supports the proposition that she was desperately and increasingly out of control. Her behaviour in her last weeks was simply a recurring manifestation of on-going problems.

The Review was a multi-disciplinary meeting which involved a very high level of input from participants. It discussed the possibility of returning Danielle to the secure unit. It was unanimously agreed that would not be in her interests, and that efforts should continue to assist her to take responsibility for her own actions by continuing her placement in the close support unit. There was a universal awareness of the risks

involved in that. Simple containment would not advance her development, and valuable preparation time for equipping her for life as an adult after her she became 18 would be lost. I consider that too was a sensible approach, for which there was sound justification. In fact, in the last 25 days of her life Danielle had 21 unsupervised times-out, and only twice were there significantly late returns, and only twice was she returned by the police. While her absenteeism rate had increased a little, there had been similar occurrences in the past, eg she had disappeared when on home leave in July 2004. I reject Dr Berg's view that the Review had reached an irrational decision.

Moving Danielle back to the locked environment of the secure unit from close support there would have been justified only by a very significant escalation of risk in her behaviours. But that was absent. There were simply peaks and troughs in a long and entrenched history of acting-out, risk-taking and sexually promiscuous behaviour. On 7 February there was nothing to suggest that she ought to have been returned to the secure unit. My conclusion is that a continuation of her placement in the close-support regime at Calton was appropriate.

But, in any event, the notion that it would have been acceptable simply to lock Danielle up for her protection is a very doubtful one. It would have offended her basic human rights, and depended on the existence of an absolute duty on the part of her carers to keep her safe at all costs. In my view the thesis that she ought to have been returned to the secure unit pitches the duty on them too highly, for two reasons. Firstly, the duty on her carers is that of taking reasonable care for her safety. Secondly, it is by no means certain that Danielle was being allowed out in the full and certain knowledge that she would get into trouble, as Dr Berg implied. Her behaviour at this time was frequently unremarkable.

I therefore reached the conclusion that it cannot be said that Danielle's death might have been avoided by returning her to the secure unit at Howdenhall. Such a course would not have been justified on a consideration of all the relevant circumstances.

On behalf of Mrs Scott it was also contended that it would have been possible, on 19 January 2005, when Danielle was missing, for steps to have been taken to place her in secure accommodation by resort to the emergency procedures in the Secure

Accommodation (Scotland) Regulations 1996, (SI 1996/3255). Such a course would have had to be initiated by her designated social worker. An application would have had to be made by the Director of Social Work at East Dunbartonshire Council and the Unit Manager at Howdenhall, on their both being satisfied that it would be in Danielle's best interests to do so. In addition, the Director would have to be satisfied that such a placement in secure accommodation would have been appropriate to Danielle's needs, having regard to the functions and objectives of the unit. While Danielle had absconded before, was likely to do so again, and was a young person whose physical, mental and moral welfare could be at risk, there was, in my view, an insufficient basis for the conclusion that a return to secure accommodation would be in her best interests and appropriate for her needs. Her best interests comprised not only her safety, but advancing preparations for independent living. Simple containment in the Braid unit would not advance these, and thus was inappropriate for her needs. I therefore thought it unlikely that such an application would have been made. In addition, the Children's Hearing, which is an independent body, having considered and rejected the option of a return to the secure unit only five days previously, in favour of placement in the close support unit, would, in my view, also have been unlikely to consider that there had been a change of circumstances by way of lapses of such significance as to justify returning her to the secure unit. Thus there were no grounds for the operation of the emergency procedures.

I now turn to the section 6(1)(e) issues

Cannabis

Much was made of Danielle's claims of having almost constant access to cannabis during hospital stays. I was not satisfied that these claims could be taken at face value. Only once, during the summer of 2002, did she test positive for cannabinoids. These can be found in urine samples weeks after consumption of the drug. At that time, in Gartnavel, she was on constant supervision because of the risk of self-harm. When she was admitted to Stobhill, Danielle was pre-screened for cannabinoids, with negative result. On the ward she was under close observation, not least because she was a young person in an adult ward. She showed no signs of inappropriate cultural behaviour, or increase in appetite, consistent with regular cannabis consumption. I therefore think it is unlikely that she was taking cannabis on a regular basis during either of these hospital stays. But even if she was taking it as she said, that would not necessarily have compromised the

value of the assessment made by masking the symptoms, rather it might cause psychotic episodes like delusions or hallucinations or uncover mental disorder. Medical opinion on this issue was divided. For these reasons I came to the conclusion that the issue of cannabis consumption was not relevant to the treatment Danielle received. It is a red-herring.

Adolescents on adult wards

It was contended that admitting Danielle to an adult ward at Stobhill was sub-optimal. The evidence was that in most health board areas this practice is not uncommon. It is only in the large conurbations that there is separate provision for children and adults. I was not persuaded that it would be appropriate to endorse such a criticism. The consultants who had cared for Danielle and those who had examined the records were all alive to the fact that brains still in development can complicate the diagnosis and treatment of young people with mental illnesses. There is no reason to suppose that was not understood at Stobhill. In Danielle's case she was close to being an adult. She was closely observed because she was a young person. In a few months she would have been in the care of Stobhill anyway. They frequently had adolescent patients on that ward.

The provision of secure adolescent beds

There is evidence that there is an inadequate provision of secure beds for young people detained under the Mental Health Act. Because Danielle never qualified to be detained, and even if she had been diagnosed as suffering from bipolar disorder, was unlikely to have been detained, it does not seem to me to be appropriate to make any recommendation about this.

Availability of methadone

The evidence disclosed that Peter Meaney, who supplied Danielle with a 20 ml measure of methadone which she consumed, had obtained 1580 mls, a two-week supply, because he was starting a labouring job away from Edinburgh. It was argued that had heroin addicts been obliged to consume their prescribed methadone under supervision daily, it is less likely that Meaney would have been in a position to supply her. However, that argument assumes that addicts will obtain their daily prescription from the same chemist, and allows them no mobility for reasons of work or holiday. That does not seem reasonable. No practicable solution for that was suggested. Besides, daily experience of

the courts shows that addicts are adept at manipulating any system, and avoiding checks where they see it to their advantage to do so. I was not persuaded that it could be concluded on a balance of probabilities that an effective and fail-safe system of supervision of daily methadone consumption would have made it less likely that Danielle would have obtained any. I therefore thought it inappropriate to make any determination about this matter.

Lacunae in system for reporting persons missing

On behalf of Mrs Scott a finding that there were defects in the reporting system was sought. However the facts do not appear to support this. On 7 February 2005 Danielle should have returned from time-out by 6.50 pm. That she did not do so was not of great significance, since she had often self-returned late in the past. A check for her presence in the unit was made at 7.15 pm, and thereafter the Unit Manager made a check for her in the locality, which lasted about one hour. He reported her missing to the police at about 8.40 pm. CCTV footage showed that at 8.47 pm Danielle entered the building where she later died. That was in an area of the city with which she was not known to have any connection. In these circumstances it is highly unlikely that she would have been traced by the police. It was not suggested that she should have been reported missing any earlier, and in all the circumstances I reached the view that the steps taken to find her were reasonable. There was some question about the grading given to Danielle's status as a missing person, in that it did not call into action immediate steps being taken by the police to search for her. But that grading was understandable, because she had self-returned, though late, in the past, and, given the narrow time-frame, the issue of how she was graded is of no practical relevance.

For these reasons I do not consider that it would be appropriate in the public interest to make any findings or recommendations under section 6(1)(e).

Conclusions

It is important to bear in mind that there are some cases involving mental illness and behavioural problems for which there is a cure, there are some where the best that can be achieved is control of the symptoms, and there are some where nothing can be done, and neither cure nor alleviation is possible. This case fell into the last category. The actions which Danielle herself took on 7 February 2005 were the direct and immediate cause of

her death. They could have happened at any time during the preceding five years, whenever she had some freedom, wherever she was living. Her death was not the direct result of any the decisions taken about her, but simply the consequence of her own choices.

It is also important to recognise that the levels of care Danielle received from the doctors who treated her, from the Social Work Department staff of East Dunbartonshire District Council, and from the staff at Howdenhall were of the very highest order. The consultants in the psychiatric services who dealt with her were caring and compassionate, and brought a wealth of professional experience in treating adolescents with mental health problems to bear on her case. Dr Greer in particular showed great perseverance in seeking the best outcome for Danielle. She participated to the full in the work of the multi-disciplinary team which had been assembled to work on the case. She secured funding to pursue treatment outwith the NHS for Danielle's bulimia, she obtained a second opinion from Dr Quinn, and always, quite rightly, kept an open mind about diagnosis and treatment. The input from the social workers from Danielle's home area was thoughtful and supportive, and the staff who dealt with her had been specially selected as having the insight, ability and experience to deal with complex cases such as hers. The quality of support Danielle received at Howdenhall was of the very highest professional standard, and the care plan produced for her stay there was entirely appropriate.