

SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN
DETERMINATION
of
SHERIFF GRAEME NAPIER
in
Inquiry
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND)
ACT 1976
into the death of
NICHOLAS PAUL WOOD

ABERDEEN, 31 March 2014.

The Sheriff, having resumed consideration of the cause, Determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:

Section 6(1) (a)

1. Nicholas Paul Wood, whose date of birth was 26 July 1976, who resided at Margaret House, 72 Crown Street, Aberdeen and who was then in police custody, died at Grampian Police Headquarters, Queen Street, Aberdeen in an ambulance en route to Aberdeen Royal Infirmary or in Aberdeen Royal Infirmary between about 2344 hours on 2 May 2011 and 01.21 hours on 3 May 2011. Any 'accident' resulting in the death, namely the ingestion by the deceased of cocaine and other controlled drugs and prescribed drugs and the abuse of alcohol occurred at an indeterminate time before his detention and amounted to chronic drug and alcohol abuse over a number of years.

Section 6(1) (b)

2. The cause of death was drug intoxication complicated by chronic alcoholism.

Section 6(1) (c)

3. There were no reasonable precautions whereby the death might have been avoided.

Section 6(1) (d)

4. No defect in any system of working contributed to the death.

Section 6(1) (e)

5. The facts relevant to the circumstances of the death are as follows:

- 5.1 At the time of his death Nicholas Paul Wood resided at Margaret House, 72 Crown Street, Aberdeen. This is a facility run by the Cyrenians for those without a permanent home.

- 5.2 He suffered from chronic alcohol and polydrug abuse problems which had persisted for many years. He was Hepatitis C positive (related to his drug abuse) and his liver was damaged through alcohol abuse.

- 5.3 At the time of his death he was in receipt of a regular prescription from his GP for methadone, diazepam and fortisip (a nutrient supplement for malnutrition). His prescription was for four (4) 2 milligramme tablets of diazepam and 100 millilitres of oral methadone solution (at a strength of one milligramme per millilitre) daily.

- 5.4 The deceased was in police custody at the time of his death having been detained in terms of Section 14 of the Criminal Procedure (Scotland) Act 1995 about 13.17 hours from the locus of an alleged serious assault by stabbing at 221 Formartine Road Aberdeen, he having admitted assault, albeit allegedly in defence of his girlfriend. He had been transported to the then Grampian Police Headquarters, Queen Street, Aberdeen where he arrived at about 1340 hours, although he had to remain in the police vehicle until members of staff were able to complete the booking in process.

- 5.5 Standard booking in procedures were followed and his detention was accepted at 14.42 hours. During this process the deceased indicated that he was suffering from what he described as a dislocated shoulder. He said that he had had his last alcohol drink shortly before being detained and that he had consumed his daily dose of methadone. He disclosed that he was Hepatitis C positive, said he took medication for his stomach and suffered from alcoholic seizures. He also stated that he took 40 milligrammes of diazepam each day.
- 5.6 Once at the police station, the deceased was allocated to a detention room. There were no drugs in this room which the deceased could have consumed. The deceased was also searched and no drugs were found on him.
- 5.7 The deceased was visited routinely in the detention room until at about 1940 hours he was allocated to a cell (11). Although he was kept in a detention room longer than normal, pending a decision being made as to a possible forensic examination, nothing turns on that extended period which is directly relevant to his death. However had he been moved from the detention room to a cell earlier he might have been more comfortable.
- 5.8 At 2049 hours, a custody officer completed an illness/injury report in relation to the deceased's complaint about his shoulder although he had complained of it when initially detained at his home and when processed at the police station.
- 5.9 At 2120 hours he was examined by a doctor (Hinkley) who confirmed that the deceased was fit to be detained. Although the deceased continued to complain of pain in his shoulder the doctor did not consider that he required urgent treatment in hospital. The doctor recognised that the deceased showed mild signs of alcohol withdrawal. He prescribed diazepam for the alcohol withdrawal and co-dydramol for the painful shoulder. The doctor also advised that the deceased should be taken to hospital to have his shoulder x-

rayed but did not consider this to be an urgent requirement. . Had the doctor considered that the deceased was seriously ill he would have arranged for his immediate transfer to a hospital. The deceased subsequently declined to go to hospital. He was concerned that attendance at hospital would impact on when he would appear in court. On the evidence led this was not a factor in his death.

5.10 At 2156 hours, the deceased was taken from his cell to an interview room where he was interviewed in relation to the incident in respect of which he had been detained. He was fit to be interviewed and was returned to the cell at 2304 hours. Shortly after he was given his previously prescribed medication.

5.11 At 2320 hours, the deceased in cell 11 the deceased was cautioned and told that he was now under arrest. He walked to the charge counter where custody staff processed his arrest before returning him to the cell pending a court appearance on Tuesday, 3 May 2011.

5.12 At 23.30 hours the deceased was lying on his back within that cell. A DNA sample was taken from him at 23.37 hours.

5.13 At about 2344 hours, what was described as a 'long drawn out cough' was heard from the deceased. His attention having been attracted to by another member of staff, the duty Sergeant (Gillies) entered the cell. The deceased appeared to be fitting. This was not an epileptic form type seizure but rather an agonal event.

5.14 Sergeant Gillies who had received first aid training and had prior experience of putting that training into practice to revive a prisoner made strenuous efforts to revive the deceased. These were unsuccessful.

5.15 An ambulance had been called at 23.50 hours and paramedic staff attended at about 23.56 hours and took over resuscitation efforts. They noted that the

deceased's jaw was tightly clenched and he appeared to be in ventricular fibrillation that is a he had an abnormal and potentially fatal rhythm (arrhythmia) of the heart. A defibrillator was employed in an attempt to restore a normal rhythm to the heart without success the equipment registering only pulseless electrical activity that is some residual electrical activity but no cardiac function.

- 5.16 The deceased was transferred to Aberdeen Royal Infirmary by ambulance where further resuscitative efforts were made and although a pulse was regained at 00.47 on 3 May 2011 that was then lost and at 0121 hours life was pronounced extinct.
- 5.17 On 3 May 2011, a post-mortem examination and dissection of the body of the deceased was carried out by Doctor James Kerr Henderson Grieve, an experienced forensic pathologist and his colleague, Doctor Paul Anthony James Brown. The brain was separately examined by Doctor MacKenzie, consultant neuropathologist. Samples taken at autopsy were retained for histological examination and samples of bodily fluids were submitted to the Department of Clinical Biochemistry at Aberdeen Royal Infirmary for toxicological examination by Doctor Stephen a senior clinical biochemist and forensic toxicologist and Doctor Simpson a consultant chemical pathologist.
- 5.18 A number of features of remote trauma, previous surgical interventions and chronic disease were noted following external examination of the deceased. A bruise had been noted on the deceased's left shoulder on external examination which was consistent with an area of trivial bleeding found on dissection. However the shoulder joint appeared normal and was not dislocated.
- 5.19 The examination of the brain disclosed no abnormalities which were clearly significant to the cause of this man's death, although a small haemorrhage may have been associated with drug misuse (and in particular cocaine).

- 5.20 Histological examination disclosed very severe fatty changes and mild increase in fibrous tissue in the liver. The pancreas and kidneys showed autolytic change but no significant histopathological abnormalities were detected.
- 5.21 The toxicological analysis of the samples showed that cocaine and methadone were active in his system at the time of his death. There was no evidence of recent heroin use and there was no alcohol in his blood. There were therapeutic levels of paracetamol, diazepam (or its metabolites) and dihydrocodeine in the deceased's blood samples, consistent with his having taken the medication prescribed to him in custody.
- 5.22 The deceased had consumed cocaine within the 24 to 36 hours prior to his death. Cocaine ingestion may cause acute damage to the heart with microfibrosis (scarring) which can produce sudden death at any time, irrespective of the presence of the drug in the body.
- 5.23 Methadone at the level found in the deceased's system can lead to sudden death.
- 5.24 Chronic alcoholism can lead to sudden death.
- 5.25 All police officers and custody staff responsible for Mr Wood's care dealt with him with appropriate care.

Sheriff

NOTE:

The Fatal Accident Inquiry

[1] This was a mandatory inquiry in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 section 1 of which provides that such an inquiry should take place where “the person who has died was, at the time of his death, in legal custody”.

[2] The purpose of such an inquiry is to determine where and when the death and any accident resulting in the death occurred; the cause of such death or accident; the reasonable precautions if any which might have avoided the accident or death; the defects in any system of work which led to the accident or death; and any fact relevant to the death. The Procurator Fiscal is charged with the responsibility of leading all the relevant evidence and interested parties are also entitled to lead evidence. It is on the basis of the evidence led before me that I require to make my determination. I cannot speculate. My findings have to be based on the evidence and the facts I find established to my satisfaction. The standard of evidence is on the balance of probabilities not the higher standard that applies in the criminal courts of satisfaction beyond reasonable doubt.

[3] The holding of a public inquiry into deaths which occur while a person is held in custody by the state is intended to ensure that although the death may have occurred behind closed doors those doors are opened up after the event for public examination. In most cases the focus of such an inquiry is on the way in which the state authorities (in this case Grampian Police) have dealt with the deceased whilst in custody. Whilst evidence was led before me of the police dealings with the deceased up to and at the time of his death, the focus of the inquiry was the cause of death and the evidence of a toxicologist and a pathologist about the consequences of the use and abuse of various drugs in particular alcohol, methadone and cocaine. Whilst the circumstances surrounding the death of Mr Wood are of particular interest to his family in this case the evidence led of the dangers associated with the abuse of alcohol and controlled drugs, in particular cocaine, is of wider interest.

[4] The inquiry ran over four consecutive days with three full days of evidence from nineteen witnesses (one witness giving evidence by way of affidavit). The case was presented by Miss Shaw, procurator fiscal depute. The family was represented by Mr Murray, solicitor, Aberdeen and the Police Service of Scotland (as successors to Grampian

Police in whose custody, the deceased was when he died) was represented by Mss Nunn, solicitor.

[5] The pathologist Doctor Grieve and the toxicologist Doctor Stephen gave complex evidence about the pathology and toxicology relevant to Mr Wood's death whilst he was in police custody. These witnesses found this a perplexing case and had clearly thought long and hard about the evidence which they gave. I was grateful to them for the care which they took in presenting complex concepts to the inquiry.

[6] The deceased's father, Richard Wood, gave evidence on the first day and remained in court while the rest of the evidence was led. I recognise that it must have been uncomfortable listening to some of the evidence and seeing video images of his son in the hours preceding his death. Nonetheless, Mr Wood conducted himself throughout with a quiet dignity which I found humbling.

The Witnesses

[7] All of the witnesses gave their evidence in a straightforward manner. There was nothing to indicate that anyone was doing anything other than telling the truth to the best of their ability.

[8] *Richard Wood*, the deceased's father, gave general evidence as to the deceased's background.

[9] *Doctor Katherine Findlay*, who had worked at the Whinhill Medical Practice, the deceased's G.P. Practice, at the time of his death, spoke to his medical records and his then current prescriptions (for methadone, diazepam and 'forsips'). The last prescription for methadone and diazepam issued to the deceased was dated 19 April 2011 was intended to cover the period 22 April to 12 May 2011. The witness gave evidence that the prescribed daily amount of methadone was 200 millilitres. Although I was not addressed on the point in submissions, I am satisfied that is an error. All the other evidence and the copy prescriptions produced at the inquiry make it clear that the prescriptions (which each lasted for 1 month) were for methadone in oral solution at a strength of 1 milligramme per millilitre (1mg/ml) at the prescribed daily dose of 100 millilitres to be consumed on the premises of the pharmacy (unless the pharmacy was to be closed, when it was to be dispensed the preceding day for consumption off the premises). The diazepam prescription

was for four 2 mg tablets per day. Again if the pharmacy was to be closed more than 1 day's supply would be dispensed. Monday, 2 May 2011 was a public holiday but I heard no direct evidence as to whether the deceased's pharmacy was closed that day or on the immediately preceding Sunday. I heard no evidence as to when, in fact, the deceased was last dispensed methadone or diazepam. There was evidence that after his death 3 empty containers for methadone, one with his name on it, were found in the address from which he was detained. No evidence was led as to when and how much methadone he had consumed in the day or so prior to his death. He claimed to custody staff at the police office that he had taken his methadone for the day. The diazepam prescription covered the same period as the methadone prescription and was for 2 milligramme tablets with four to be taken daily and these to be dispensed on the same basis as the methadone.

[10] *Doctor Kevin Hinkley*, a police casualty surgeon, examined the deceased at Grampian Police Headquarters on 2 May 2011 when the deceased complained of pain in his shoulder. The doctor did not detect any obvious explanation for that pain but noted that the deceased seemed to be suffering from mild alcohol withdrawal symptoms. Doctor Hinkley prescribed him diazepam to deal with the alcohol withdrawal and co-dydramol for his pain. He did not consider that the deceased required immediate admission to hospital but did indicate that he should be taken to hospital to allow his shoulder to be x-rayed. Had he considered it necessary he would have arranged for him to be admitted by ambulance. He considered that the deceased was fit to be detained. There was no evidence led to contradict Dr Hinkley's evidence which was given in an appropriate professional manner and which I accept.

[11] *PC Eoin Maxwell* and *PC Jayne Forman*, gave evidence about attending at the Formartine Road address and detaining the deceased in relation to an allegation of assault (by stabbing) and transporting him to the then Grampian Police Headquarters in Queen Street, Aberdeen. Most of the officers' dealings with the deceased were captured on a body worn camera. It was clear from the footage I saw that these officers dealt with the deceased courteously and with consideration allowing him to be handcuffed to the front rather than the rear when he complained of a sore shoulder.

[12] *Leonard James Shaw*, one of the civilian custody and security officers employed by Grampian Police to deal with prisoners held in police custody gave evidence about the process for recording the deceased's details when he arrived at Queen Street police office

including the information the deceased provided to them about his drug and alcohol consumption and relevant medical conditions for a form referred to as a vulnerability form. This information provided was recorded in an IT system (Cell File). The whole process was recorded on CCTV. It was during this process that the deceased said he had taken his methadone that day and also stated that he had a diazepam habit of 40 milligrammes per day. The witness also spoke to various checks on the deceased's condition whilst detained in the police office. He spoke to the deceased expressing concern that if he was detained in custody he may not have access to methadone (unlike the position if detained in Dundee). The witness went off duty at 23.00 hours on 2 May 2011 and last saw the deceased at 20.14hrs.

[13] *Norman Blaickie*, another of the custody and security officers who had dealt with the deceased. At about 14.45 on 2 May 2011 he assisted Constable Maxwell remove the clothing the deceased had been wearing on being detained. This was in the detention room which did not contain any substances the deceased could have consumed and the deceased appeared not to be secreting any on his body. He was also involved in carrying out visits to the prisoners. At 20.49 hours when the deceased was seen by the witness he was still complaining of a sore shoulder and the witness created an illness/injury form recording "sore shoulder and bruising over body" as a result of which Dr Hinkley was contacted.

[14] *PC Richard Greaves*, who along with a colleague, interviewed the deceased at Grampian Police Headquarters in relation to the allegation of assault at 221 Formartine Road, Aberdeen. This witness first became involved with the deceased at 22.00 hours on 2 May 2011. There was video footage of this interview available to the inquiry. The deceased was able to answer all the questions put to him. As far as the witness was concerned the deceased was showing no obvious signs of being under the influence of anything or suffering alcohol withdrawal. He did complain of a sore shoulder. The interview was suspended at 23.04 hours. The witness was aware that the deceased was to be arrested, a DNA sample was to be obtained and that there were arrangements for him to go to hospital. The deceased had been returned to cell 11 and the witness attended there and told the deceased that he was now under arrest. A DNA sample was taken from the deceased who was sitting up on his bed and was coherent. It was now about 23.20 hours. The deceased had already been told that he was to attend hospital but said he was not going. He was concerned that this might lead to a delay in his release from police custody (with a

consequent delay in access to methadone). Moreover he did not wish to attend in the alternative clothes (blue suit) he had been provided with.

[15] *Police Sergeant Stephen Gillies* was the custody sergeant responsible for the cell block area where the deceased was detained at the time of his death. He had been due to commence duty at 22.00 hours on 2 May 2011 to take over from Sergeant Harrower although he appears to have arrived early. He was aware that Doctor Hinkley had indicated that the deceased should attend hospital and had received a letter to go with Mr Wood from the doctor. The witness was aware that the deceased was being interviewed in relation to the serious assault and then sometime between 22.00 and 23.00 he learned that the deceased was not keen to attend hospital. He intended to discuss this with the deceased recognising that it would be difficult to get him to hospital without his cooperation.

[16] At about 23.44 Sergeant Gilles was told by the custody assistant, witness Mitchell, that the deceased appeared to be fitting. He attended at the deceased's cell and found the deceased lying on his mattress on the cell bunk fitting or struggling to breathe, his eyes were rolling back in his head and he was a purple colour. The witness tried to find a pulse but could not and started cardiopulmonary resuscitation. He gave evidence about his strenuous efforts to revive the deceased using his first aid training pending the arrival of paramedics. He was clearly upset that he had been unable to save the deceased.

[17] *Police Inspector Christine Gordon* was duty inspector at Grampian Police Headquarters from about 10 pm on 2 May 2011. She was aware that the doctor had indicated that the deceased should be taken to hospital for an x-ray of his shoulder. She was involved in making arrangements for him to go to hospital with an appropriate escort but was then told that the deceased did not wish to go (something she described as not being up for debate). Sergeant Gillies was to deal with that situation.

[18] *Alexander William Craigmyle*, a paramedic who was one of the team which responded to an emergency call after the deceased had been found in cell 11 apparently fitting. He spoke to the condition of the deceased when he and his colleague were called to attend at Grampian Police Headquarters at 23.50 hours, arriving 6 minutes later. At the time they arrived, Sergeant Gillies was carrying out chest compressions but the deceased was clearly unconscious, cyanosed, had no pulse, his pupils were fixed and dilated. He was not breathing and he was described as being in cardiac arrest. It was difficult to gain an airway

to give oxygen as his jaw was locked (trismus) but they did manage to administer oxygen via a laryngeal masked airway. The witness was unable to gain IV access to administer cardiac drugs as Mr Wood appeared to be in total shutdown. Defibrillator pads were fitted, the patient was found to be in ventricular fibrillation. An unsuccessful attempt was made to restore a regular rhythm by shocking the heart without success (one shock of 150 joules). Only pulseless electrical activity (PEA) was detected. PEA was described as a sign of some remnants of electrical activity but no cardiac function and was the stage immediately before death supervenes (flatline).

[19] *David Mitchell*, another of the police custody and security officers, spoke to giving the deceased two co-dydramol and two diazepam tablets as had previously been prescribed by Doctor Hinkley. This appears to have been at around 23.00 hours. This was the witness who was first alerted to the problems with the deceased at about 23.44 hours or thereabout when he heard a strange noise from the cell area and went to carry out a check. He described this as a “long drawn out cough”. He determined that this was coming from cell 11 where he saw the deceased whom he now described as “shaking, taking a fit”. Sergeant Gillies was contacted and became involved in cardio pulmonary resuscitation (CPR) having instructed that an ambulance be called.

[20] *Mark Andrew Scott* is another police custody and security officer who was involved in dealing with Mr Wood and assisted David Mitchell when the deceased was given his medication of two co-dydramol and two diazepam tablets after he was free from being interviewed (at 23.07 hrs). When the witness saw the deceased in the cell he was shaking (which the witness attributed to signs of withdrawal) and asked for his medication when the witness enquired how he was. After he took the medication the deceased sat down and said that he would be fine. The witness saw him again at about 23.20 hours and his condition had improved, his shaking had reduced and he was able to talk normally and joke with the officers who were taking him through the rights of arrested persons form.

[21] *Police Sergeant Nina Harrower*, who was the sergeant on duty in the custody area of Queen Street Police Headquarters on 2 May when the deceased was originally admitted passing over to Sergeant Gillies from 22.00 hrs.

[22] *Doctor Thomas Owen Hopkins (MB ChB)*, who is a trainee in emergency medicine was on duty at Aberdeen Royal Infirmary when the deceased was admitted from Grampian Police Headquarters at about 00.30 hrs on 3 May 2011. Further attempts were made to revive the deceased. Tests indicated ventricular defibrillation so the heart was shocked again. The deceased was also given adrenalin and medication to reverse the effects of any drugs he may have consumed. At about 00.47 hours a pulse was regained but then lost. Further shocks were applied, an anaesthetics team was involved and an endotracheal tube was inserted but by 01.21 hrs there had been no improvement. CPR was discontinued and Doctor Hopkins pronounced life extinct. The doctor gave some evidence about the use of defibrillators and confirmed that the types available to properly trained personnel such as paramedics and doctors are more sophisticated than the type made available for use by members of the public (which he has had occasion to use). Training in the use of the more sophisticated equipment was said to be essential although those more publically available indicate to the user what to do. However the witness was clear that the restarting of the heart was attributable in Mr Wood's case to a combination of the CPR, the administration of adrenalin and medication and oxygen and the ability to shock the heart by the trained professionals.

[23] *Police Constable Gillian Esson*, who is trained in search procedures specifically in counter terrorism measures. She spoke to being part of a search team which carried out a detailed search of the police vehicle in which the deceased had been transported to police headquarters; the address from which he had been detained; and male cell 11 at Police Headquarters. Nothing untoward was found although three empty methadone bottles were recovered from 221 Formartine Road. One had been prescribed for the deceased in April 2011 and two were prescribed for another female whose details were not given.

[24] *Doctor Duncan Stephen*, a toxicologist who spoke to the analysis of samples which were taken post-mortem from the deceased and the toxicological interpretation of those results.

[25] *Doctor James Kerr Henderson Grieve* who carried out the post-mortem examination and dissection of the deceased.

[26] An affidavit was produced for the evidence of a *Morag Steele*, a forensic scientist then based in Aberdeen who examined three tablets recovered from a desk in the cell block at Police Headquarters, Aberdeen and a wrapper found on the floor of cell 11. She confirmed that the tablets were co-dydramol 10/500 (1) and diazepam, 5 milligrammes (2) (the drugs prescribed for the deceased by the police surgeon Doctor Hinkley).

Deceased's personal background and relevant history of drug and alcohol abuse

[27] The deceased was aged 34 at the time of his death (born 26/7/76). He was single and had accommodation with the Cyrenians at Margaret House, 72 Crown Street, Aberdeen. He had a girlfriend who resided [in] Aberdeen who was not a witness [.....]

[28] The deceased was an only child and his mother died when he was about 6 years of age. His father has since remarried.

[29] The deceased had a long history of drug and alcohol abuse. These are well documented in the medical records which also record his father's concerns about this aspect of his life. Mr Wood senior spoke about these at the Inquiry.

[30] At the time of his death he was prescribed 100 millilitres of oral methadone solution (1mg/ml) per day together with four 2 milligramme tablets of diazepam. The methadone solution contained 1 milligramme of methadone per 100 millilitre solution. The prescriptions required to be dispensed daily and his methadone was to be both dispensed and consumed in the pharmacy. If the pharmacy was to be closed the following day, the diazepam and methadone for that day were to be dispensed as normal and that for the following day were to be supplied for consumption off the premises. No direct evidence was led as to whether the pharmacy was closed on the Monday the deceased was taken into detention or on the preceding day (Sunday 1 May 2011). There was evidence from the custody officers that the Monday was a public holiday (the cells were busy because detained persons who might normally have appeared in court on the Monday were being kept until the Tuesday). It is therefore possible that the deceased had been dispensed more than his normal daily prescribed amount of these drugs on the last occasion he attended at the pharmacy before his death. No direct evidence was led about this. The deceased was also prescribed 'fortisip' which is a nutritional drink often prescribed for people who become malnourished through abuse of drugs and alcohol.

[31] The deceased's medical records document a troubled youth and a history of early alcohol and drug abuse and offending. The deceased reported that his only periods of absence from alcohol abuse coincided with time spent in prison or young offender's institutions. He is recorded as blaming all of his offending on drug or alcohol abuse.

[32] Although it appears the deceased had been heroin dependent (from aged 16), in February 2011 at a meeting with a consultant psychiatrist with NHS Grampian Integrated Alcohol Services the deceased described his illicit drug use as "recreational only". At that time it was noted that he was on a regular prescription of methadone and diazepam at the rate I have indicated. The deceased admitted additional illicit drug use including of 'crack' cocaine and 100 to 150 milligrammes of illicit diazepam every day, on top of his prescribed methadone and diazepam. He also described having been a 'very heavy drinker for the last 8 years' consuming 8 to 10 cans of super – lager each day with symptoms of tolerance and withdrawal (including 'the shakes', sickness and diarrhoea and delirium tremens). He reported being Hepatitis C positive. He was, at that time, (February 2011) referred for in-patient 'detox' but failed to attend. He was given until 29 April 2011 to make contact to progress this but appears not to have done so prior to his death.

[33] There is no direct evidence as to what, if any, drugs and alcohol the deceased had consumed in the days prior to his detention on 2 May 2011. When seen by custody officers at Queen Street Police Headquarters he indicated that he had already consumed his daily prescription of methadone. The results of the toxicology of the post-mortem samples, however, raise questions as to whether this was all that he had consumed, as far as methadone was concerned. The toxicology also suggests that within the 24 hours prior to his death he had also consumed cocaine. He had also said to the custody officers that he had consumed alcohol shortly before his detention and when seen by the police surgeon there were signs that he was experiencing mild alcohol withdrawal.

The circumstances leading to the deceased being in detention cell 11 at Queen Street Police Station

[34] Police Officers attended at the address in Formartine Road [from which the deceased was detained on]. On 2 May 2011 after a report was received of assault. Constables Forman and Maxwell dealt with the deceased. Much of their involvement with the deceased was recorded on a body mounted CCTV camera. Some of the footage was shown at the inquiry and a transcript of the interaction was a production in the case. The deceased was detained

at 13.17 hours. When being detained, he complained of having dislocated his left shoulder and the officers were shown to have dealt with him very considerably and cuffing him to the front to cause less discomfort.

[35] The deceased accepted that he had assaulted a person by the name of ["G"] but explained that was to defend his girlfriend from an assault, ["G"] having allegedly previously raped her on a number of occasions.

[36] When the deceased arrived in the police vehicle at the then Grampian Police Headquarters, Queen Street Aberdeen there was a significant delay in dealing with him and he had to remain with the two police officers in the police vehicle for some time. When being booked in, he again complained of having a dislocated shoulder but nothing else. He accepted that he was an alcoholic and said that he had had his last alcoholic drink about 5 minutes before the detaining officers attended (around 13.00 hours). He indicated that he was on methadone, "100 millilitres per day". He said that he had already taken that day's methadone. He agreed that he had a "diazepam habit" which he described as being 40 milligrammes a day. That is less than stated in February but more than his prescribed level. If that is correct, he must have been 'topping up' his prescribed diazepam. He also stated that he suffered withdrawal symptoms if he did not get his alcohol and methadone. These were said to take the form of fits and alcohol seizures. He admitted to being Hepatitis C positive.

[37] The deceased was initially placed in a detention room pending a decision being made about a forensic medical examination. I am satisfied that there were no drugs in this detention room or in the cell to which he was subsequently transferred that could have been abused by him. The deceased had his clothing removed for possible forensic examination. I am satisfied that he was not concealing any drugs.

[38] At 21.20 hrs the deceased was examined by Dr Hinkley who was employed by Grampian Police as a police surgeon. The doctor had been asked to examine the deceased because of the complaint of a sore ('dislocated') shoulder. The deceased reported having taken his day's methadone prescription (100ml). He said he was prescribed 34 mg of Diazepam daily (in fact 8 mg) but said he had not taken that day's prescription. He reported drinking about 1 litre of vodka per day but said he had not taken any street drugs. He also reported having suffered an alcohol withdrawal seizure about 1 month previously. The

doctor diagnosed mild alcohol withdrawal (there was an evident tremor) for which he prescribed diazepam. He also recorded pain and limited movement in the left shoulder for which he prescribed co-dydramol. He requested that Mr Wood be taken to hospital for an x-ray. He did not consider the attendance for x-ray to be urgent and considered the deceased fit for detention and interview.

[39] After some delay because a decision about a forensic examination of Mr Wood was awaited, the deceased was eventually interviewed under caution in connection with the alleged assault between 2212 hours and 2304 hours on 2 May 2011 by Detective Constable McRobb and Constable Greaves. This interview was video recorded and part of that was played to the inquiry. The deceased was told that the interview was in relation to an allegation of assault with intent to rob. The deceased claimed that the alleged victim ["G"] had attacked him and [his girlfriend]; but said that he had no recollection of assaulting ["G"] and denied having used a knife. He also said his memory was blank; that he had been drunk; and that he had taken methadone and diazepam.

[40] He was returned to male cell 11 and was given the medication prescribed by Dr Hinkley. At 2320 hours, the deceased's section 14 detention was ended and he was advised that he was under arrest. The intention was to detain him in custody pending an appearance in court the following day. He was made aware of the intention to take him to hospital for an X-ray but said that he did not wish to go apparently because of concerns that his possible release from police custody would be delayed and he might not have access to methadone in the meantime.

[41] When originally detained he had been taken to detention room 4 but had then been transferred to male cell 11 at about 1940 hours and it was to this cell that he was returned after being arrested. He was subsequently seen lying awake in the cell and was asked about going to hospital but declined. It was from this cell that at about 23.44 hrs witness Mitchell heard sounds and realised that the deceased was 'fitting'. Sergeant Gillies was alerted and entered the cell where he attempted to resuscitate Mr Wood. An ambulance had also been called arriving at about 2355 hours. I am satisfied that from the time the deceased was found, apparently fitting, all reasonable steps were taken to save his life. This applies to the actions of Sergeant Gillies, the paramedics and the doctors who dealt with him from then until CPR was stopped at 0121 hours on 3 May 2011 by which time he had been taken to Aberdeen Royal Infirmary. 01.21 hrs is recorded as the time of death in the medical records.

The investigations into the cause of death and any accident resulting in a death

[42] I heard detailed evidence from Doctor James Henderson Kerr Grieve who carried out the post-mortem examination and dissection of the body of the deceased; and from Doctor Duncan William Samuel Stephen, a senior clinical biochemist and forensic toxicologist with NHS Grampian who carried out an analysis of samples taken from the deceased's body.

[43] The evidence of these two witnesses is essential to provide some insight into the cause of death in this case. This is not a straightforward matter. As Doctor Grieve put it: *"It really is a truly perplexing case"*. Despite their evidence (which extended for most of 1 day of the inquiry) I am only able to make my determination as to the cause of death on a balance of probabilities and in more general terms than I perhaps would have wished.

[44] Doctors Grieve and Stephen had each produced a report and expanded upon these in oral evidence. It is perhaps helpful to consider first the toxicology and then to place Dr Stephen's findings in the context of the other post-mortem findings.

The toxicology

[45] Doctor Stephen has held his post as Senior Clinical Biochemist and Forensic Toxicologist since 1999. He holds Bachelor of Science degrees in Biochemistry and Pharmacology and a Master of Science degree in Clinical Biochemistry. His PhD is in Molecular Biology and Toxicology. He is a Fellow of the Royal College of Pathologists and a Diplomat of the American Board of Forensic Toxicologists. He is a Fellow of both the Canadian and Australasian Associations of Clinical Biochemistry. He also has qualifications from the American Board of Clinical Chemistry and Toxicological Chemistry.

[46] Doctor Stephen was involved in the analysis of the various post-mortem samples of bile, blood, liver, stomach contents, urine and vitreous humour taken by Dr Grieve during his post-mortem examination of the deceased. Dr Stephen's detailed findings are set out in his report (production 2). In summary these are that:

- a. There was no alcohol detected in the fluoride oxalate-preserved blood sample but 57 milligrammes of alcohol per 100 millilitres of urine was detected in the fluoride oxalate-preserved urine sample; there was no acetone detected in the

fluoride oxalate-preserved blood sample but 11 milligrammes of acetone per 100 millilitres of urine were detected in the fluoride oxalate-preserved urine sample; and there was no isopropanol detected in either the fluoride oxalate-preserved blood sample or the fluoride oxalate-preserved urine sample.

- b. In the non-preserved blood sample the free dihydrocodeine level was 0.143 milligrammes per litre; the methadone level was 0.896 milligrammes per litre; the 2-ethylidene-1, 5-dimethyl-3, 3-diphenylpyrrolidine (hereafter referred to as EDDP) level was 0.198 milligrammes per litre; the diazepam level was 0.069 milligrammes per litre; the N-desmethyldiazepam level was 0.075 milligrammes per litre; the temazepam level was 0.003 milligrammes per litre; and the paracetamol level was 15.62 milligrammes per litre.
- c. Quinine (probably from a soft drink such as tonic water) was found in the non-preserved blood sample (at a level of 0.047 milligrammes per litre).
- d. Morphine, 6- monoacetylmorphine, codeine and oxazepam were not detected in the non-preserved blood sample.
- e. In the fluoride oxalate-preserved blood sample the benzoylecgonine level was 0.096 milligrammes per litre; and the cocaethylene level was 0.020 milligrammes per litre.
- f. Cocaine and ecgonine methyl ester were not detected in the fluoride oxalate-preserved blood specimen.
- g. Dihydrocodeine, methadone, EDDT, paracetamol, quinine and benzodiazepines were detected in the non-preserved urine specimen but screening of this specimen for the presence of other drugs proved negative.
- h. Cocaine, benzoylecgonine and cocaethylene were detected in the fluoride oxalate- preserved urine specimen but ecgonine methyl ester was not detected.
- i. Benzoylecgonine, cocaethylene, methadone EDDP, diazepam, dihydrocodeine, paracetamol and quinine were detected in the non-preserved stomach contents specimen, but screening of this specimen for the presence of other drugs proved negative.
- j. Dihydrocodeine was detected in the non-preserved vitreous humour specimen, but morphine, 6-monoacetylmorphine and codeine were not detected. The sodium level in this specimen was 156 mmol per litre; the urea

level was 1.8 mmol per litre; the creatinine level was 31 μ mol per litre and the glucose level was less than 1mol per litre.

[47] Benzoylecgonine and cocaethylene are metabolites (derivatives) of cocaine. Coacaethylene is produced when cocaine is ingested and alcohol is also present in the system.

[48] The deceased was known to abuse alcohol and evidence was led before me indicating that he had consumed alcohol shortly before being detained but this was no longer present in the blood at the time of death. Acetone and alcohol were found in the urine but none in the blood and no isopropanol were found in either. There can be a number of explanations for these findings but ante-mortem consumption or pathological metabolism as witnessed in diabetes mellitus, dehydration, starvation and chronic alcoholism are recognised explanations. The lack of evidence of isopropanol taken together with the other bile chemical parameters and also with the finding of acetone suggest that the deceased had a poor diet and was malnourished as is experienced in chronic alcoholics and drug addicts. The finding of alcohol in the urine but not in the blood shows that it was some time before death when alcohol was last consumed but the level of that consumption cannot be determined. At the inquiry there was discussion of a theoretical maximum for the consumed level of alcohol of about 220 milligrammes per 100 millilitres of blood but a number of assumptions were necessary for that and I am not satisfied that it would be safe to make any conclusion as to how much alcohol the deceased had consumed prior to his detention. In any event, the precise alcohol level does not seem to be particular relevant to the cause of death.

[49] The presence of dihydrocodeine, methadone EDDP, diazepam, N-desmethyldiazepam, temazepam, paracetamol, benzoylecgonine, cocaethylene, benzodiazepines in the samples were all considered as being of significance in explaining this death: as were the sodium, urea, creatinine and glucose levels found in the vitreous humour.

[50] The dihydrocodeine and paracetamol levels are consistent with the deceased having consumed a therapeutic level of the co-dydramol tablets prescribed to the deceased for his shoulder pain relief whilst in custody.

[51] The finding of methadone is consistent with the deceased having consumed methadone before his death although perhaps not simply the daily prescribed amount as indicated to Doctor Hinkley and the custody officers. Methadone is an opiate type compound (as are morphine and codeine). Methadone can be used for pain relief in, for example, treating cancer but, as is well known, also as a (substitute) treatment for individuals addicted to heroin. It is known that the deceased was prescribed methadone for this purpose. I also heard evidence that methadone can be obtained illicitly (street methadone). It is normally prescribed in oral solution as with the deceased.

[52] Although methadone has a therapeutic purpose it also has the potential to compromise heart function. As with any drug ingested by the body, the body will try to eliminate it to detoxify itself through the enzyme processes in the liver. Here the drug is metabolised into a form which is suitable for elimination from the body via urine and faeces. A compromised liver function can affect the body's efficiency in eliminating such drugs. I heard evidence from the pathologist that the deceased had such a compromised liver function. Different drugs take different times on average to be eliminated from the body. An indication of this is given by the half-life of the drug (the time for a quantity of methadone in the blood to reduce by half). Methadone has a lengthy plasma half-life. I heard that it would normally be expected to be cleared by the body in approximately 24 hours (with a range of 5 to 55 hours). This appears to be one of the attractions of methadone for substitute prescribing so that a daily dose can be prescribed.

[53] Doctor Stephen expressed the view that the methadone level found in Mr Wood's samples was high. He accepted that over time a level of tolerance to a drug is built up by an individual. Although levels of 0.1 milligrammes per litre might normally be expected to avert withdrawal symptoms from the abstinence of methadone, habitual users may tolerate up to 1 milligramme per litre or possibly more. However, such high levels also have the potential to kill someone not previously exposed to the drug. The level discovered here (0.896 milligrammes per litre in the non-preserved blood sample) is consistent with the levels quoted in the literature as being found in people who have died either through direct methadone toxicity or through poly-drug misuse with methadone being included. Doctor Stephen gave evidence that from his local experience of deaths where methadone is indicated as the primary the cause of death the levels found average 0.5 milligrammes per

litre. He also spoke of a study in California which suggested that the average there was 0.95 milligrammes per litre. The suggestion therefore is that the level of methadone found in this case might be sufficient on its own to cause death although according to Doctor Grieve the circumstances of Mr Wood's death would not be typical of such a death.

[54] Doctor Stephen also explained the significance of the finding of EDDP. This is one of the substances methadone is converted into by the body (metabolites) for elimination from the body. The level discovered here (0.198 milligrammes per litre) is at a level consistent with other deaths attributed to methadone toxicity. Dr Stephen accepted that EDDP, like methadone, has a long half-life and therefore the level found may possibly be explained by an accumulation over time and not simply be the result of ingestion on one occasion. Doctor Stephen drew attention to the interesting feature of the methadone level being approximately five times the level of the EDDP and indicated that whilst it is not possible to be absolutely certain, it is at least possible to infer that at the time the deceased last consumed methadone the previous quantity of methadone consumed by him had not been excluded from his system. There was nothing inconsistent in these findings with Mr Wood not having had access to methadone throughout the time he was in detention. It was suggested by Dr Grieve that it might be consistent with the deceased having topped up his prescribed methadone with other methadone not prescribed to him.

[55] Apart from its direct toxic potential, methadone has been suggested to cause problems with the heart and lead to arrhythmia.

[56] As to the finding of benzodiazepines (diazepam, N-desmethyldiazepam and temazepam, the latter two being metabolites of the first) these were individually at what Doctor Stephen described as sub-therapeutic levels. Taken cumulatively these levels would be consistent with the therapeutic level of the diazepam prescribed by the police casualty surgeon. Doctor Stephen's evidence was that although it is not usual to find fatalities associated with abuse of benzodiazepines, the toxic levels reported normally start at about 1 milligramme per litre or seven times the level found in Mr Wood's samples. These drugs are, however, central nervous system depressants as are dihydrocodeine, methadone and even alcohol. As all of these were found they could all have combined to depress the central nervous system and, in turn, lead to a depression of respiration.

[57] Doctor Stephen confirmed that the samples were all analysed for evidence that the deceased had recently ingested heroin but there was none. There was, however, some evidence that cocaine had been ingested. Metabolites of cocaine were found. Benzoylecgonine and cocaethylene were found in one of the urine samples and in the fluoride oxalate-preserved blood sample. The benzoylecgonine level in the latter was 0.096 milligrammes per litre of blood. Benzoylecgonine is one of the principal metabolites of cocaine. Cocaethylene is a transesterification product of cocaine. It is found when alcohol (or ethanol) and cocaine are taken together. The significance of this finding, according to Doctor Stephen, is that whilst the cocaine metabolite benzoylecgonine is inactive, cocaethylene is active and can exert a stimulant effect similar to cocaine itself. This evidence suggests that not only had cocaine been ingested by the deceased in the past, it had been ingested relatively recently. Cocaine is known to have a half-life of about four hours and would normally be expected to be cleared from the system, if used therapeutically, in about 20 hours. Had a large quantity been consumed, Doctor Stephen would have expected to have found a high level of benzoylecgonine. A normal usage level of 0.521 milligrammes per litre is suggested by experience but here it is 'only' 0.096 milligrammes per litre. This would suggest that the deceased died at the 'tail end' of metabolism of the cocaine and that not a lot had been taken. That is not to say, however, that the cocaine was not still exerting an effect on the body as evidenced by the cocaethylene. Cocaine was described by Doctor Stephen as having the potential to affect a variety of the body's organs, being particularly problematic for the heart as it can sensitise the heart and potentially cause arrhythmia (just as methadone apparently can). This is particularly so with abuse over time although, as Doctor Grieve pointed out, abuse of cocaine is particularly problematic with even a limited amount of abuse potentially causing virtually undetectable changes to the heart. Doctor Stephen's conclusion is that the deceased had been exposed to cocaine in the 24 hours or 36 hours prior to his death.

The pathology

[58] Doctor Grieve is a senior lecturer in forensic medicine at the University of Aberdeen. He holds the medical qualifications MB ChB. He became a Member of the Royal College of Pathologists in 1984. He was elected to a Fellowship with the Royal College of Pathologists in 1996. He is also a Fellow of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London. He has been a forensic pathologist for 25 years. He and

a colleague carried out the post-mortem examination and dissection of the body of Nicholas Paul Wood.

[59] They had access to his medical records and noted that he was said to consume alcohol to excess and to abuse controlled drugs. It was also noted in his records that his liver function was abnormal, something often associated with alcohol and drug abuse. He was also recorded as having hepatitis C (most normally associated with intravenous drug abuse. Three weeks prior to his death he had presented at his GP complaining of a sore shoulder having fallen downstairs. He had a regular prescription of diazepam as a sedative; methadone as an opiate substitute; and fortisip, a fortified drink to help nourish him. Doctor Grieve and his colleague were made aware of the circumstances leading up to the deceased being in custody. They were aware that whilst in custody he had been prescribed diazepam and co-dydramol.

[60] Their external examination disclosed obvious signs of medical intervention on the deceased's body. There were also a number of injuries not related to his death. These included much trivial bruising which they considered not inconsistent with a history of alcohol abuse particularly in someone with a compromised liver.

[61] The dissection of the deceased's body included an examination of the major organs. There was evidence of extensive and strenuous attempts to revive the deceased.

[62] The brain was examined by a neuropathologist and disclosed nothing of obvious significance to explain this death. Doctor Grieve was particularly interested in the result of the examination given the history he had been given of the deceased fitting in his cell. An isolated 5mm lesion in the left superolateral splenium of the corpus callosum, if significant at all, is not likely to have been responsible for anything more than a mild headache. In this case there was no evidence to suggest that the deceased suffered from primary epilepsy.

[63] The lungs were found to be very heavy (very oedematous) which tends to point away from the deceased having suffered a primary epileptic fit as in deaths associated with such circumstances the lungs would tend to be quite light or more like a normal weight.

[64] Doctor Grieve concluded that the 'fitting' described by witnesses was an agonal event caused by a lack of oxygen getting to the brain when the heart had stopped pumping

for whatever reason. Uncontrolled brain activity would have been transmitted through the nerves causing muscle spasm.

[65] No obvious damage was noted to the heart or major blood vessels. The bladder had some urine (so had not been voided as often happens in primary epileptic fits); the large bowel was full of solid faecal material (as is often typical of people with significant doses of sedative drugs including methadone). The liver was enlarged (at 3,280 grammes) and fatty as would be expected with a chronic alcohol problem although this damage could also be associated with the deceased's hepatitis C.

[66] Given the history of the deceased complaining of a sore (dislocated) shoulder, the pathologists examined his shoulders by x-ray and on dissection. Nothing of significance was noted: the left shoulder was found to operate properly and would not dislocate readily; and although there was some 'trivial' bleeding associated with an external bruise in the left shoulder area, here was no bone damage or damage to deeper tissue. This does not exclude the possibility that the deceased had a painful shoulder as he could have been suffering from a trapped nerve or a frozen shoulder which would not show up on dissection.

[67] Samples were taken for histological examination, but again nothing of direct significance was discovered. The only matters of any significance related to historical events or resuscitation efforts.

[68] The results of the toxicological examination of the various samples taken post-mortem did, in the view of Doctor Grieve, offer some findings that might account for the death. The low alcohol reading (56 milligrammes per 100 millilitres) in the urine was not as significant as the lack of any alcohol in the blood. The absence of 'active' alcohol was described as being particularly dangerous for an alcohol dependent individual such as the deceased. It can lead to delirium tremens and epileptic type seizures in the form of alcohol withdrawal fits.

[69] The deceased's alcohol dependence might also have another role to play in his death. It can also lead to alcoholic ketoacidosis where the body cannot metabolise adequately; and to liver disease (and the deceased had a fatty liver) with people dying of that for a variety of reasons whether they have alcohol in their systems or not.

[70] As Doctor Grieve put it *“Alcohol dependence just on its own... is a very dangerous situation... [which] is potentially fatal”*.

[71] The therapeutic levels of sedatives in the deceased's system would have militated against a fit whether an alcohol withdrawal fit or not. Doctor Grieve pointed out that diazepam is often used in the treatment of epilepsy and also for alcohol withdrawal (although for treating an epileptic fit a higher dose of sedative would be administered). The purpose is to sedate the brain. Opiates, including heroin and methadone, are also sedatives. Accordingly, what Doctor Grieve describes as the significant amount of methadone in the deceased's body along with the diazepam and dihydrocodeine (also a sedative) found in the deceased's system would have suppressed the likelihood of a fit.

[72] This leads to the conclusion that an alcohol withdrawal fit is not the explanation for the 'fitting' witnessed in the deceased's cell.

[73] As to the methadone, although Doctor Grieve agreed that the level found falls within the documented lethal range, he pointed out that an individual may be more or less habituated. The body, in other words, for somebody who is a regular user, begins to accommodate the drug's effects over time. The drug is eliminated more quickly as the metabolic activity becomes attuned to dealing with the drug. This is seen in the range of the half-life of the drug described by Doctor Stephen. Doctor Grieve suggested this could be up to 50 hours for someone who has never used the drug before down to 15 hours for someone who takes it regularly.

[74] Doctor Grieve echoed the evidence of Doctor Stephen about the possibility of methadone misuse having caused this death. He described his experience as a pathologist of finding many deceased who had died suddenly where there is nothing else other than methadone implicated, and with blood methadone levels similar to those found in Mr Wood's case. He described having dealt with cases where much lower levels of detected methadone on their own having led to the cause of death being attributed to methadone ingestion. There is, however, no absolute level above which death is inevitable. It is, he suggested, necessary to accommodate the toxicological findings along with the other medical and pathological evidence.

[75] Had there been nothing other than the methadone level, the diazepam and the dihydrocodeine, then Doctor Grieve's view would have been that that combination could be lethal even though methadone, dihydrocodeine and diazepam had all been prescribed for the deceased in therapeutic doses. In combination they can have what Doctor Grieve described as a synergistic effect in that one potentiates the effects of the other so that in combination the whole is greater than the sum of the parts.

[76] The pathologist considered, however, that the dosage of co-dydramol and diazepam prescribed by the police casualty doctor were well within the therapeutic range (and as far as the dihydrocodeine component of the co-dydramol was concerned, perhaps even in the low therapeutic range). On their own they would not have led to death but their effect could be significant when combined with the methadone level.

[77] The deceased was prescribed a dose of 100 millilitres of methadone (1mg per ml). This was not considered by the pathologist to be a particularly unusual level for its purpose. Although the deceased's liver disease might also compromise his ability to metabolise the methadone his being habituated to this drug should have allow his body to cope with it, at least at prescribed levels. He was, however, surprised that a large amount was found in the blood. The peak absorption of methadone would normally be expected to be in the order of four hours after its consumption so finding such a high level 12 hours after the deceased was taken into police custody was, Doctor Grieve thought, perplexing unless the deceased had consumed more than his prescribed daily amount of methadone. Although there is no direct evidence for this he did not exclude the possibility that the deceased had "topped up" his methadone, something which he suggested was relatively well known in Aberdeen where methadone had been relatively easy to source during a time when heroin was in short supply. That could explain the relatively high level of methadone found in the blood. The only evidence about recent consumption comes from the deceased's self-report to the custody officer that he had taken his daily amount before being taken into custody; and the finding of three empty containers for methadone in the house from which the deceased had been detained.

[78] In his post-mortem report Doctor Grieve suggested that this indicated a relatively 'recent' consumption his evidence. His evidence was that 'recent' was a flexible term and was not intended to indicate that the methadone had been taken in the hours immediately

prior to his death. His position was that for this purpose recent would encompass during the day or so preceding Mr Wood's death.

[79] The other perplexing aspect of the methadone was that identified by Doctor Stephen, namely the disproportion of the methadone level to that of EDDP. Again this could be suggestive of the metabolic process not working as well as it could have. However the evidence of the police staff who dealt with the deceased and the doctor who examined him only a few hours before his death showed that he was able to function. The treatment prescribed by the doctor was entirely appropriate. There seemed to be a stabilisation of the deceased's condition within 20 minutes of receiving the prescribed drugs but within another 20 minutes police staff witnessed 'fitting' in what proved to be a terminal event.

[80] This sequence of events would not be consistent with the classic progression of a death associated with abuse of sedatives. In the classic case an individual tends to progress through stages of drowsiness, sleep, unconsciousness, coma and then death.

[81] What Doctor Grieve considered was of particular significance was the finding of cocaine and its metabolites benzoylecgonine and cocaethylene in the urine and blood benzoylecgonine and cocaethylene levels of 0.096 mg per litre and 0.020 mg per litre respectively. As previously noted the presence of the cocaethylene indicates that the deceased had consumed cocaine whilst there was alcohol in his system (and there was none in his blood at the time of death). Doctor Stephen had suggested that this consumption had been within 24 hours or at most 30 hours prior to death.

[82] Doctor Grieve explained that unlike the position with sedative drugs, where it is possible to see a dose related response (that is the more you take the greater the effect) that is not true of cocaine, although as with sedative drugs an individual can become habituated to it (tolerate more). Accordingly some individuals can take quite high levels of cocaine without dying yet others, particularly those not accustomed to it, may die in an almost idiosyncratic manner with very small doses of cocaine. Importantly, however, even those habituated to cocaine can die of an idiosyncratic response.

[83] Cocaine is, as Doctor Grieve put it, "a drug that is absolutely unpredictable" making it very dangerous. The effect of cocaine may be to cause spasms in small blood vessels. Should that be in a critical part of the heart or brain it can cause sudden death. Cocaine

causes tiny areas of damage to organs, in particular the heart, where, if the blood vessel has gone into spasm depriving it of a blood supply, an area of the heart in effect dies. Although there can be healing after the spasm, the resultant scarring can compromise the function of the heart. Then if, for example, there is a demand for extra cardiac output as in stressful situations there can be cardiac failure: this can happen even years after the person has stopped abusing cocaine. Whilst the histology of the small samples taken from the deceased's heart did not show any such damage, Doctor Grieve could not exclude its existence. He pointed out that only very small areas were sampled and any defect could have been in another area.

[84] In the case of the deceased in addition to any chronic effects of cocaine abuse, cocaine and the cocaethylene metabolite were both still active in his system. It is known that active cocaine can cause problems when people are under stress such as in the situation of being detained or arrested. As in the case of residual damage from prior abuse strain is placed on the heart is unable to cope with that strain because of the active effects of the cocaine.

[85] Doctor Grieve pointed out that there is a significant problem of cocaine related deaths associated with arrests in the United States of America where there is a more significant cocaine problem.

[86] During the course of his evidence it was suggested to Doctor Grieve by the agent for the family that the deceased had been used to taking 40 milligrammes of diazepam per day as he claimed on admission to the police station (rather than the 8 milligrammes prescribed) then he is likely to have been withdrawing from that. Doctor Grieve suggested that the amount of N-desmethyldiazepam found by the toxicologist was not suggestive that such a large quantity had been taken by him recently.

[87] Doctor Grieve was also examined about the delay in the deceased's body being released to the family for burial. It was suggested that this had taken up to four weeks. He explained that the body had been retained pending the conclusion of the toxicological examination and examination of the brain with a view to producing a death certificate that contained more of an explanation than a bland "unascertained". There was no further issue made of this at the inquiry.

[88] He was also invited to comment on the possibility that had a defibrillator been available in the police custody suite it may have had an impact on the outcome in this case. Whilst Doctor Grieve accepted that the earlier someone in ventricular fibrillation (VF) is defibrillated the better the chances of survival, the window of opportunity is relatively small (he suggested from a few seconds to perhaps up to two minutes) to allow the effects of VF to be reversed. A defibrillator is effective, he said, only in a proportion of cases. He talked about the need for specialist training. He did not put himself as having any expertise in this area of emergency medicine and said simply that he was aware that defibrillators were being made more readily available in public places. He did also point out that use of a defibrillator in the wrong circumstances can have potentially fatal results. He did not comment on the evidence (of Dr Hopkins) that some defibrillators are now designed to be used by laypersons and may not need the level of expertise that he described. What he was able to say, however, was that the availability of such a device might not have had any impact whatsoever in this case.

Submissions

[89] Miss Shaw for the Crown invited me to make a formal determination. She invited me to conclude that the custody staff and police officers responsible for the deceased's care after his detention on 2 May 2011 took appropriate measures to secure his health and wellbeing and that nothing could have been done by police officers or the police surgeon (Doctor Hinkley) to prevent the tragic death of Mr Wood. Miss Shaw highlighted the fact that on arrival at the police station the deceased did not appear to be a man in need of urgent medical attention. It was submitted that I should conclude that although it was not possible to exclude the possibility that the deceased had drugs concealed internally, there was no evidence from which I could conclude that he had access to anything other than the prescribed diazepam and co-dydramol which Doctor Hinkley had prescribed; and in any event it was unlikely that he had access to methadone. There was, Miss Shaw submitted, no suggestion that had the deceased received the diazepam and co-dydramol sooner than he did that that would have had any impact on his death. Moreover, once the deceased was found 'fitting' it was her position that everything that could be done to resuscitate him was done and accordingly there were no precautions that could have been taken by Grampian Police to avoid the death of Mr Wood; and there were no defects in police practice and procedure that contributed to the death. Whilst the pathologist's evidence was complex, I was invited, on balance, to find that Mr Wood died as a result of drug intoxication on 2 May

2011 at Grampian Police Headquarters, Queen Street, Aberdeen. She did not invite me to speculate about the possibility of a defibrillator, had it been available, having been likely to have avoided the death.

[90] Mr Murray, for the family, expressed concern that the deceased's complaints about shoulder pain had not been taken sufficiently seriously. He accepted that the officers involved in his initial detention had dealt with him in a considerate manner. His concerns focussed on a comment made in evidence by one of the custody officers that if his own wife had come into the police station complaining of a sore and dislocated shoulder, he would have taken her to Accident & Emergency. The officers interviewing the deceased were also criticised by Mr Murray for not interrupting their interview with Mr Wood who, it was submitted, was showing signs of discomfort, to allow his prescribed medication to be administered. It was not clear to me how Mr Murray thought that this might have had any impact upon the ultimate outcome. Mr Murray was not able to point me to any evidence that their having done so or the deceased having been moved more promptly from the detention room to a cell would have had any bearing on his death. I was persuaded that the evidence supported Miss Shaw's contention that any delay had no impact on the death.

[91] At one point Mr Murray suggested that there needs to be review of medical attention provided to persons on admission to Queen Street Police Station but could not, it seemed to me, link this to the question of this deceased's death.

[92] Further, Mr Murray invited me not to find the cause of death in this case was drug intoxication but rather cardiac arrest. Even though cardiac arrest was involved in the mechanism of death, it seems to me that the clear evidence was that this was as a consequence of abuse of drugs or alcohol, a combination of them or even just of the abuse of cocaine.

[93] Finally Mr Murray's suggested that I determine that it was unreasonable for there to be no requirement for police cell blocks, such as at Queen Street Aberdeen, to be provided with resuscitation equipment and someone trained in its use.

[94] Miss Nunn described Mr Wood's death as a personal tragedy arising out of a chaotic lifestyle. She suggested that the deceased was treated with appropriate respect and dignity by the police staff involved with a full appreciation of their responsibilities for his care throughout the time following his detention in relation to the serious allegation of assault

with a knife. In particular, she sought to refute the suggestion on the part of the family that the police officers demonstrated a lack of concern for the deceased's wellbeing. She suggested that the evidence did not support that contention and drew attention to the involvement of the police surgeon (between 2120 hours and 2130 hours) in relation to the deceased's complaint that he had a sore shoulder and for what the doctor described as mild alcohol withdrawal. She reminded me that the doctor did not consider that any urgent medical attention was required and said that had he thought that the deceased was seriously ill he would have arranged for his immediate admission to hospital, by ambulance.

[95] She invited me to determine, on the basis of the evidence led, that the death took place in police custody (probably cell 11) at Grampian Police Headquarters, Queen Street, Aberdeen, failing which, in an ambulance en-route to Aberdeen Royal Infirmary between 2344 hours on 2 May 2011 and 0121 hours on 3 May 2011.

[96] Miss Nunn was the only agent to address specifically the issue of the requirement in terms of Section 6(1) (a) of the 1976 Act for me to determine when any accident resulting in the death occurred. That, she suggested, could be in the days, weeks, months or possibly years before the deceased was detained, referring to his chronic alcoholism, his use of methadone and his ingestion of cocaine including in the 24 hours before he was taken into custody. There was, she pointed out, no reliable information about when and how much methadone the deceased may have consumed. Although he said to custody staff he had consumed his prescribed 100 millilitres on the day of his detention he could, of course, have consumed more. There was evidence from the toxicology which would support such an inference as might the three empty methadone bottles found at the address from which he had been detained. His reliability as a witness to his own drug consumption might be suspect as he told custody staff that he was prescribed 40 milligrammes of diazepam per day when it was 8 milligrammes, the inference being that he may have been abusing additional diazepam. She also pointed out that if methadone was implicated in his death (as was possible given the evidence of the pathologist and toxicologist) then given the toxicology findings it was at least possible to infer that the deceased had 'topped up' his prescribed methadone.

[97] As to the cause of death, Miss Nunn took me carefully through the rather complex evidence and suggested that I should find that the cause of death was drug intoxication

complicated by chronic alcoholism, the latter having compromised the deceased's liver function.

[98] She invited me to determine that there were no defects in any system of work and no reasonable precautions which might have avoided the death or any accident resulting in the death. In particular, she invited me to conclude that there was no evidence that any earlier or more extensive medical treatment of Mr Wood would have avoided the death.

[99] As to whether I should make any determination under Section 6(1) (e) of the 1976 Act as urged by Mr Murray in relation to the availability of resuscitation equipment at the police station, Miss Nunn submitted that there were too many imponderables to know whether or not the availability of such equipment would be relevant. That, she said, was particularly so given the evidence of Doctor Grieve that it is not just the availability of equipment but the availability of properly trained people to take advantage of the small window of opportunity for its use balanced against the possibility that more harm than good can be caused that I have to take into account.

Determination

[100] In this Inquiry I have to rely upon the evidence led. I cannot speculate as to what might have happened had there been evidence led on a particular point. In terms of section 6 of the 1976 Act 6(1) at the conclusion of the evidence and any submissions thereon the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction –

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death.

The cause of death

[101] Doctor Grieve had originally granted a death certificate giving the cause of death as:-

- I (a) Drug intoxication;
- II Hepatic stenosis.

[102] In his subsequent report he suggested that the cause of death was drug intoxication. At the inquiry, having had the opportunity to re-consider matters and hear that the paramedics had found the deceased in ventricular fibrillation, he said that he could expand upon the conclusions of his report. As he put it, the conclusions had almost been rewritten during the course of his evidence.

[103] He remained of the view that the death was attributable to the deceased's abuse of controlled drugs and possibly his abuse of alcohol, the role of which he could not exclude either on its own or taken together with the drug abuse. He expressed concerns about the role of methadone given the higher level of it compared to the lower level of EDDP. As already noted it could be that the deceased's liver malfunction had a role to play. The role of alcohol could not be ignored, as I understood it, if only because of its chronic impact.

[104] There is no direct evidence of the deceased's consumption of drugs prior to his death other than the diazepam and co-dydramol prescribed and administered in the police station. I am satisfied on the evidence led that these are not implicated in the death. The deceased is not a reliable historian, as far as his drug abuse habits are concerned. Not only did he make an incorrect claim about the amount of diazepam prescribed to him but also he denied to Doctor Hinkley having taken any street drugs. The toxicology clearly demonstrates that cocaine had been consumed. Inferences require to be drawn from the toxicology, the pathology and the deceased's presentation to those who saw him in the hours before his death. There is no reason to suppose that the deceased should be assumed only to have consumed the methadone prescribed to him. That is not entirely consistent with the levels of methadone and EDDP found.

[105] Considering all the available evidence Doctor Grieve initially suggested that the most appropriate formulation for the cause of death, avoiding the phrase unascertained, was that it was due to "drug intoxication and chronic alcoholism" or "chronic alcoholism and

drug intoxication” without giving either precedence. Taken with the evidence of Doctor Hinkley, who examined the deceased at 2120 hours on 2 May and the relatively sudden death after he was medicated, a cardiac mechanism could be considered. There was methadone in the deceased’s system. There was historical evidence that the deceased had abused cocaine and evidence that not only had he ingested cocaine in the day or so prior to his death but that it was also still active in his system. Methadone can produce cardiac arrhythmia. Cocaine can compromise the heart function. The finding of ventricular fibrillation by the paramedics and the pulseless electrical activity following the attempts to shock the heart by the paramedics points to a cardiac mechanism of death. Ventricular fibrillation is a fatal arrhythmia of the heart. It is itself an end phase. Even if a defibrillator is used, it is not always effective. In this case for example, the paramedics were able to use a defibrillator but were unable to induce a ‘normal’ rhythm.

[106] Taking into account the whole circumstances Doctor Grieve’s view was that whatever the mechanism of death it was reasonable to say that in this case the cause was attributable to drug and alcohol abuse. It seems to me given the evidence I heard about how dangerous cocaine abuse is that it is at least possible that the precipitating factor in Mr Woods’s death was his recent or more historic abuse of cocaine. Clearly there are aspects of his death that point to the type of heart problems seen in such deaths. It seems to me difficult, even on the balance of probabilities, to select that one factor from the spectrum of the deceased’s drug and alcohol abuse as the primary cause of death. That is particularly so when the chronic impact of that drug and alcohol abuse on the heart and liver is considered. On balance therefore I consider that the death of Nicholas Paul Wood is due to his recent and historic drug and alcohol abuse. It is unnecessary to separately refer to the liver dysfunction as that is itself a symptom of his chronic alcohol abuse.

Where and when any death or accident resulting in the death occurred

[107] In this case not only is the cause of death complex but also the place and time of death is not straightforward. On the basis of the evidence of the pathologist that the sounds heard from the deceased’s cell and the fitting observed were agonal events it might have been thought that the time and cause of death should be stated as at around 23.44hrs in male cell 11 at the then Grampian Police Headquarters, Queen Street, Aberdeen.

[108] However it is also clear that CPR was carried out immediately thereafter at Police headquarters, in an ambulance and at Aberdeen Royal Infirmary, continuing until 01.21 hours on 3 May 2011. The deceased was found to be in VF when the paramedics arrived although there was then evidence of PEA. However there was also evidence that as a result of the efforts of the medical staff at Aberdeen Royal Infirmary a pulse was regained at 00.47 hours. The significance of this was not commented on by the pathologist. Given the whole evidence therefore it may be appropriate to conclude that the deceased died between 23.44 hrs on 2 May and 01.21 hrs on 3 May 2011 at Police Headquarters Queen Street Aberdeen, in an ambulance en-route from there to Aberdeen Royal Infirmary or at Aberdeen Royal Infirmary as was suggested by Miss Nunn.

The cause of any accident resulting in the death

[109] I also agree with Miss Nunn that no 'accident' in the normal sense of that word understood by the lay person led to this death. Rather an 'accident' consisting of a series of events with no doubt unintended consequences, that is the deceased's abuse of controlled drugs and alcohol in the days, months and years preceding his death, resulted in this death..

The reasonable precautions if any whereby the death or any accident resulting in the death might have been avoided; the defects in any system of work which contributed to the death or any accident resulting in the death; and any other facts that are relevant to the circumstances of the death.

[110] I am not satisfied that there was any evidence which would justify me in holding that there were any reasonable precautions which were not taken which had they been taken might have avoided the death or the events leading to the death (other than the obvious and unhelpful one of the deceased not abusing alcohol and drugs in the way he did). Nor did I hear any evidence of any defect in any system of work which contributed to the death.

[111] I was invited to make a determination about the non-availability of a defibrillator as a standard piece of equipment in a custody suite. There was evidence that there was no defibrillator in the custody suite where the deceased was detained. The matter had been raised by Mr Murray in cross-examination of witnesses but I was not satisfied that there was evidence from which I could conclude that the availability of such equipment was appropriate or would have influenced the outcome here. In her submissions the procurator

fiscal depute said “It was unfortunate that I wasn’t able to have any witness speaking to that because clearly that would have assisted”. Although the 1976 Act places the responsibility for leading relevant evidence on the Procurator Fiscal, evidence could have been led by other parties. What I cannot do is speculate about what that evidence would have been

[112] I heard evidence from the paramedic (Alexander William Craigmyle) that a defibrillator had been used by him when he dealt with the deceased in the police station in an attempt to restore a proper cardiac rhythm. He also gave evidence that the output indicated that the deceased was, at that time, in ventricular fibrillation, that is that there was an opportunity to apply a shock to restore a regular rhythm. There was evidence that the sooner a defibrillator is used, so long as its use is appropriate, the better the prospects for restoring a normal rhythm in the heart although the window of opportunity is small (from a few seconds to a couple of minutes). From the evidence there was a period of 8 minutes between the deceased’s problems being identified and the ambulance attending although during that time CPR was being administered. Doctor Grieve gave some limited evidence about this issue but urged caution about the chances that had a defibrillator been used at an earlier stage the result would have been any different. As he put it, the opportunity for a positive outcome from the use of a defibrillator is small. The police surgeon gave some evidence that new equipment had, following Mr Wood’s death, being received at the police office but his understanding was that it was intended for use by medically qualified staff and he was unsure what was included.

[113] I cannot speculate. I have to make my determination on the basis of the evidence led before me. There is clearly none which would justify my making any determination that the presence of a defibrillator unit within the police station would have made any difference to the outcome in this case. I am certainly not in a position to make a determination that such equipment should be provided in custody suites with appropriately trained staff.

[114] I have set out in my determination such other facts as I consider are relevant to Mr Wood’s death.