SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

DETERMINATION

by

SHERIFF GORDON LIDDLE, Advocate, Sheriff of Lothian and Borders at Edinburgh

in Inquiry into the circumstances of the death of

KIERAN NICHOL

under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

_____

APPEARANCES

For the Crown:	Mr Reith, Principal Depute Procurator Fiscal
For Castle Craig Hospital:	Mr Wood, Solicitor, Messrs. Simpson & Marwick
For Doctor McCartney:	Mr McBride QC, instructed by Messrs. Brechin Tindal Oatts
For Doctor Young:	Mr Pollock, Solicitor, Messrs. Peacock Johnston
For Doctor Sharma:	Mr Jessiman, Solicitor, Messrs. Brechin Tindal Oatts
For Nurse Ainslie:	Mr Brodie, QC, instructed by Messrs. HBM Sayers
For Nurse Wood:	Mr Williams, Solicitor, Messrs. R S Vaughan & Co

CONTENTS **Page**

Edinburgh 3rd June 2010

The sheriff, having resumed consideration of the evidence adduced, **FINDS and DETERMINES** in terms of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:

SUMMARY OF FINDINGS

(a) Kieran David Nichol (date of birth 5 March 1985) was admitted to Castle Craig Hospital, Blyth Bridge, on Friday 9 December 2005 and was found dead at or around 08:25 on Sunday 11 December in the Romano Room of the said hospital. He died at some time between 11.33pm on Saturday 10 December 2005 and about 6am on Sunday 11 December 2005.

(b) The cause of death was the ingestion and subsequent combined effects of the prescribed drugs methadone and benzodiazepine and unprescribed temazepam.

(c) The following were reasonable precautions whereby the death might have been avoided:

i. It would have been a reasonable precaution that Kieran undergo urine screening on admission.

ii. It would have been a reasonable precaution that a further comprehensive history be noted from Kieran as to his drugs abuse from the time he had been discharged from Castle Craig Hospital on 7 October 2005 and his re-admission on 9 December 2005.

iii. It would have been a reasonable precaution for the prescriptions of methadone to have been within the Castle Craig protocols and the Orange Book Guidelines.

iv. It would have been a reasonable precaution to have refrained from prescription of controlled drugs, in particular methadone, until Kieran exhibited physical signs of withdrawal.

v. It would have been a reasonable precaution to have limited prescription of controlled drugs to those to be dispensed on the day of admission after the exhibition of physical signs of withdrawal with further prescription, when and if then medically considered appropriate, the following day.

vi. It would have been a reasonable precaution at the time for dispensing the second dose that day of 30mls of methadone on Saturday 10 December 2005 either for Nurse Ainslie to have withheld it, or for Dr Lal Sharma, the locum doctor, to reassess Kieran in sufficient depth and detail to enable him to adequately review the prescription before dispensing.

vii. It would have been a reasonable precaution that Nurse Julie Ainslie undertake a vital signs assessment and observation of Kieran at the time of the share meeting

and/or immediately on its conclusion and communicate those findings to Dr Sharma together with both the concerns reported to her and her own concerns.

viii. It would have been a reasonable precaution at the time of his telephone conversation with Nurse Ainslie at 20:50 for Dr Sharma to have obtained from Nurse Ainslie, sufficient information on Kieran's condition, including his vital signs, and observations in order to enable him to make a properly informed decision on what steps to take.

ix. It would have been a reasonable precaution for Dr Sharma, following the telephone conversation with Nurse Ainslie at 20:50, to have come immediately to the hospital or to instruct Nurse Ainslie to call for an emergency ambulance.

x. It would have been a reasonable precaution for Staff Nurse William Wood, the registered nurse on duty, immediately following handover on Saturday 10 December 2005, to have requested the Dr Sharma's attendance or to have called for an emergency ambulance.

xi. It would have been a reasonable precaution that, after handover, Nurse Wood respond to the disclosed concerns expressed by other patients following conclusion of the film earlier by personally going to and assessing Kieran including taking his vital signs and assessing his manifest state of overmedication.

xii. It would have been a reasonable precaution, in the knowledge that Kieran had to be assisted upstairs by fellow patients, for the Nurse Wood to have assessed Kieran,

taken vital signs and requested the immediate attendance of the locum doctor or called for an emergency ambulance.

xiii. It would have been a reasonable precaution, having directly observed Kieran's intoxicated state, for Nurse Wood to have refrained from allowing Kieran to retire to bed in the absence of continuous observation.

xiv. It would have been a reasonable precaution for Castle Craig Hospital to have required visual observations and the taking of vital signs at regular set intervals at night of patients undergoing the first 72 hours of detoxification.

(d) That the following defects in systems of working contributed to the death:

i. A failure to carry out sufficient or proper training of staff engaged in a specialist unit

ii. A failure to audit or check if staff were receiving the requisite level of training.

iii. A failure to audit whether Castle Craig protocols and guidance, to which staff were referred, were being adhered to.

iv. A failure to insist in and enforce adherence to Castle Craig protocols and guidance.

(e) There were no additional facts relevant to the circumstances of the death.

NOTE:

Introduction

[1] This is an inquiry instituted by the Lord Advocate under the discretionary provisions of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976. It was considered expedient in the public interest that such an inquiry should be held into the circumstances of the death of Kieran David Nichol (date of birth 5 March 1985) who was found dead at or around 08:25 on Sunday 11 December in the Romano Room of the hospital.

[2] Having regard to the complexity of some of the medical evidence and the length of the Inquiry I considered it was appropriate to request transcription of the tape recording of the evidence, copies of which were made available to each of the parties. It is evident from reading these transcripts that numerous errors of transcription exist. That has made the task of reviewing the evidence very difficult. No issue was made of that by any party to the Inquiry. Another very substantial difficulty arose. Those immediately responsible for care at the time of death, namely Dr Lal Sharma and Nurse Wood, were not led in evidence by the Crown. That is a very unusual and unsatisfactory state of affairs. Some witnesses gave evidence that related to the actions or otherwise of these two people but I do not know what the respective positions would have been of Dr Sharma and Nurse Wood.

[3] The family of the deceased did not become a party to the Inquiry and was not represented. That was clearly not through lack of interest. The deceased's mother, herself a qualified nurse, was present throughout most of the lengthy proceedings. She was furnished with copies of the transcript and, without objection, was invited by me to make any submissions she thought appropriate at the conclusion of the Inquiry. She availed herself of that opportunity and I have taken into account her submissions along with the other written submissions that each party submitted.

[4] Evidence was led by the Procurator Fiscal Depute from the following witnesses (whose designations are stated as they were at the time of the deceased's death) in order of their testimony:

Jacqueline Nichol, mother of the deceased

David Nichol, father of the deceased

Ann Wylie, former patient at Castle Craig Hospital

Mark Rafferty, former patient at Castle Craig Hospital

Ross Dixon, former patient at Castle Craig Hospital

Crawford Fee, former patient at Castle Craig Hospital

Corinne Al Zuherri, former patient at Castle Craig Hospital

Michael Carruthers, friend of deceased

Mark Madden, former patient at Castle Craig Hospital

James Terence Docherty, former patient at Castle Craig Hospital

John Lewis McCann, financial director, Castle Craig Hospital

Christopher Thomson, former patient at Castle Craig Hospital

William Francis Stevenson, auxiliary nurse, Castle Craig Hospital

Heather Jean McKenzie, former patient at Castle Craig Hospital

Peter John McCann, chairman, Castle Craig Hospital

Barry Pinchbeck, former patient at Castle Craig Hospital

James Russell, former patient at Castle Craig Hospital

Susanne Hope, senior nursing assistant, Castle Craig Hospital

Sharon Anne Laing, auxiliary nurse, Castle Craig Hospital

Donna Campbell, auxiliary nurse, Castle Craig Hospital

Elizabeth Smillie, auxiliary nurse, Castle Craig Hospital

Asif Asgarali, former patient at Castle Craig Hospital

Douglas McFarlane, former patient at Castle Craig Hospital

Margaret Mills Crush, auxiliary nurse, Castle Craig Hospital

Lavina Taylor, therapist, Castle Craig Hospital

Robert Murray Allan, therapist, Castle Craig Hospital

Helen Katherine Robertson, auxiliary nurse, Castle Craig Hospital

Nancy Campbell Yuill, bank registered general nurse, Castle Craig Hospital

Mary Christine Hayes, nurse in charge, Castle Craig Hospital

Thomas Walter Bruce, deputy head therapist, Castle Craig Hospital

Clare Donaldson, registered general nurse, Castle Craig Hospital

Rachael Elizabeth Marples, registered general nurse, Castle Craig Hospital

Bruce Ramsay, forensic computer analyst, Lothian and Borders Police

Eileen Mary Dickson, registered mental nurse, Castle Craig Hospital

Dr Margaret Anne McCann, director, Castle Craig Hospital

Dr David James McCartney, Castle Craig Hospital

Dr Robert Alasdair Brims Young, Castle Craig Hospital

Julie Elizabeth Ainslie, bank registered general nurse, Castle Craig Hospital

Richard Latto, police inspector (then sergeant) Lothian and Borders Police

Alistair Bruce, police sergeant, Lothian and Borders Police

Professor Kevin Gournay, Emeritus Professor of psychiatric nursing, University of London

Dr Nat Wright, Clinical Director, Leeds cluster of prisons

Julie Marie Evans, Toxic Resident Director for Toxicology and Forensic Services, Eurofins Forensic Science Services

Dr Martin Oakley, Forensic Scientist, Scottish Police Services Agency

Professor Gerhard Kernbach-Wighton, senior pathologist, Department of Pathology, University of Edinburgh

Dr Eilish Gilvarry, Consultant Psychiatrist, Clinical Director of Northern Drug and Alcohol Addiction Service, Newcastle

Sergeant Alexander McColl, Lothian and Borders Police

Dr Robert Anderson, Senior Lecturer in Forensic Medicine and Science Department, University of Edinburgh

Roy Young, Care Commission Officer

DC Stephen Halls, Lothian and Borders Police

Helen Ireland, Housekeeper, Castle Craig Hospital (McBride QC witness)

Purpose and scope of the Inquiry

[5] Section 6(1) of the Fatal Accidents and Sudden deaths (Scotland) Act 1976 provides that at the conclusion of the evidence and any submissions thereon the sheriff shall make a determination setting out the following circumstances of a 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 death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in death might have been avoided;

(d) the defect, 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 relate to the circumstances of the death."

[6] Some of the solicitors and counsel acting for the parties represented at the Inquiry made certain submissions as to how the terms of the subsections of section 6(1) of the Act should be interpreted and applied in my determination. It was submitted that particular rules apply in the case of fatal accident inquiries that involve medical professionals. It was said that in order for me to hold that there were reasonable precautions that might have been taken by members of the medical profession whereby the death might have been avoided the standard required to be applied was, by analogy, the one to be found in *Hunter v Hanley* 1955 SC 200. In other words, I was not entitled to consider evidence of what others say they might have done or do in deciding whether there existed a reasonable precaution. Only expert evidence on what would have been a reasonable precaution for the particular medical practitioner to have taken considered similarly to the *Hunter v Hanley* professional negligence standard was sufficient. In the absence of the Crown leading such expert evidence, it was argued, I did not have sufficient evidence before me to entitle me to be satisfied that such reasonable precautions existed. I reject that argument. It is based on a misunderstanding of the law in relation to fatal accident inquiries. Entitlement to

decide whether I am satisfied that it has been established that there exists a reasonable precaution whereby the death and any accident resulting in the death may have been avoided, in my opinion, only requires it to be demonstrated, with the benefit of hindsight, that the precaution might have prevented the death or accident and, that it was a reasonable precaution in the ordinary sense of that word. In that regard I agree with the comments made by Sheriff Reith QC (et. al.) that the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned.

[7] Similar submissions were made to Sheriff McColl in the inquiry into the death of Marlene Patricia Wightman, issued on 6 November 2009. I notice that one of the solicitors representing a party in the Inquiry before me was also involved in the inquiry before Sheriff McColl. Sheriff McColl reviewed a number of decisions and I agree entirely with the conclusions she reached. A fatal accident inquiry is not the proper forum for determination of criminal or civil liability. In *Black v Scott Lithgow Ltd 1990 SLT 612 at 615***,** Lord President Hope said, in relation to section 6(1) of the 1970 Act:-

> "There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. This is in contrast to section 4(1) of the 1895 Act, which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident was attributable. It is plain that the function of the sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination

> the circumstances to which the subsection refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required."

[8] Like Sheriff McColl, I agree with the observations made by Sheriff Kearney in his determination in relation to the death of James McAlpine, issued on 17 in January 1986, and referred to at paragraph 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Ian Carmichael. Sheriff Kearney observed:-

> "In deciding whether to make any determination (under section 6(1)(d)) as to the defects if any in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect a question did in fact cause or contribute to the death. The standard of proof and rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard of proof is that of the balance of probabilities."
>
> "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one."

Sheriff Kearney went on to say:-

> "The phrase 'might have been avoided' is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

As was said by Sheriff McColl, Sheriff Kearney's observations and interpretation of the phrase "might have been avoided" has been referred to and adopted with approval in many determinations since then.

[9] Finally, it was suggested that I ought not to rely upon hindsight when identifying reasonable precautions. In my opinion it is precisely with the benefit of hindsight that some, though perhaps not all, such precautions can be identified. I agree with the view expressed by Sheriff Reith QC in her determination in relation to the death of Sharman Weir issued on 23 January 2003, where she said:-

> "in my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided. A Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the death. The statutory provisions are concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of death which would be a concept relevant to the context of our fault-finding exercise, which this is not. The statutory provisions are widely drawn and are intended to permit retrospective consideration of the matters with the benefit of hindsight and on the basis of the information and evidence

available at the time of the Inquiry. There is no question of the reasonableness of any precaution depending upon the foreseeability of risk. In my opinion, the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned… In my opinion, the purpose of a Fatal Accident Inquiry is to look back, as at the date of the Inquiry, to determine what can now be seen as no reasonable precautions, if any, whereby the death might have been avoided, and any other facts which are relevant to the circumstances of the death… The purpose of any conclusions drawn is to assist those legitimately interested in their circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the Inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future."

Summary of events

[10] Kieran David Nichol was born on 5 March 1985. He was first admitted to Castle Craig Hospital, Blyth Bridge, on 25 August 2005 for drugs detoxification treatment in relation to a diazepam addiction. He was successfully detoxified on a reducing diazepam prescription. He was discharged from the hospital on 7 October 2005. By that time he was drug free and had lost his tolerance to all drugs.

[11] Kieran was re-admitted to the hospital on Friday 9 December 2005. He was medically examined by Nurse Mary Hayes. She thought he looked sedated. He told her he used £60 worth of heroin per day and 500mg diazepam per day. Those are very high amounts, even for an entrenched user, which he was not. That contrasted

with a declared use of 300mg diazepam per day on his first admission and use of heroin on only about seven occasions up until then. In December he misleadingly said he had been "clean" for about two weeks following his earlier discharge in October 2005 when, in fact, the period had been longer. He was not asked for information on how his use had built to the levels he subsequently declared. He was not asked whether he took those amounts of drugs every day.

[12] Kieran was then clinically examined by Dr McCartney. He observed Kieran to be drowsy and intoxicated. He took a similar history from Kieran except that by that time Kieran claimed he used £80 heroin per day. Dr McCartney did not ask for information on how his use had built to the levels he declared. He did not ask him whether he took those amounts of drugs every day. He did not query the discrepancy.

[13] A urine analysis test would have confirmed the presence of whatever drugs had been used within the preceding 24 hours or longer. No urine analysis test was carried out. No supporting history was taken from any other family member. Had it been, it might have become obvious that Kieran had been free from drugs for longer than the two week period he claimed. No history was obtained from Kieran's GP. The only support for what Kieran was saying was his sedated appearance suggestive of recent use of some substance. That indicated nothing of length or frequency of use. Dr McCartney made certain assumptions which would prove to be wrong. Those assumptions were discussed with and approved by his supervising superior, Dr Young. Dr McCartney proceeded on the assumption that Kieran was telling the truth about his levels of use and, critically, assumed that the frequency and extent of use

was such as to have developed into addictions at those levels. Those assumptions were erroneous.

[14] Treatment of heroin abuse, in particular, with reducing amounts of the opiate substitute, methadone, has distinct steps. There is first of all induction, the first dose. Then stabilisation, during which the appropriate level of methadone required is established through titration. That equates to the minimum quantity needed to avoid withdrawal symptoms. There follows the detoxification exercise beginning with the level of methadone established in the stabilisation process and gradually reducing. That is not what happened. On the very limited, unreliable and uncorroborated information available to him, Dr McCartney made a diagnosis of polysubstance abuse and went immediately on to devise a medical care plan for detoxification with specific amounts of methadone and diazepam. He wrote what were effectively four prescriptions. For methadone he wrote a 30ml prescription bearing the commencement date of 9 December 2005. He wrote a further 60ml prescription "in divided doses + reducing by 5ml per day", bearing the commencement date of 10 December 2005. For diazepam he wrote a prescription for 40mg in "divided doses", bearing the commencement date of 10 December 2005 and a prescription for 80 mg in divided doses reducing by 10mg per day to 30mg, bearing the commencement date of 10 December 2005. It is possible, on the evidence, that the prescriptions dated for 9 December 2005 were intended to be induction. There did not appear to be any provision for stabilisation to occur.

[15] Under the heading "Detox Prescribed", Dr McCartney told Nurse Hayes to enter that Kieran had been seen by him and that he "prescribed a methadone and diazepam

detox to commence when starting withdrawal". That course of action may be considered against the Castle Craig Protocol for methadone detoxification which stipulated for titration against clinically evident symptoms of withdrawal. The plan and instruction to Nurse Hayes was ambiguous. Methadone is a poison. It is a respiratory depressant. Diazepam is also a respiratory depressant. Writing a speculative prescription for a poison, methadone, was an unnecessary risk. A simultaneous speculative prescription for diazepam increased the risk. Dr Nat Wright referred in evidence to a "stat prescription". It is a one-time starting prescription, perhaps part of the way through a day, as opposed to a prescription to cover the whole day. It was not clear whether Dr McCartney's prescriptions dated 9 December were meant to be that. Observation of withdrawal starting was delegated to nursing staff. Interpretation of the instructions was left to nursing staff. It could not have been known to Dr McCartney when withdrawal symptoms would commence if at all and to which substances. Symptoms to more than one substance might have commenced at different times. There was no need for any prescription when the prescriptions were written. A Castle Craig protocol warned against over sedation and provided that there was often no need to prescribe within the first 24 hours of admission which would allow baseline observations to be made.

[16] More than one medical expert said in evidence that if a prescription is written by a doctor then nurses will dispense the drugs. That proved to be correct. Although he had been observed as intoxicated shortly beforehand, Kieran was given 30ml methadone and 20mg diazepam at 5.30pm on Friday 9 December by Staff Nurse Wood. It is not known why, in the absence of clearly identified withdrawal symptoms, these drugs were dispensed. What is clear is that they were dispensed at a

traditional time within the hospital for drugs to be dispensed to patients. Kieran was given a further 20mg diazepam at 10pm. From the note made by the nurse it is clear he was given the diazepam because that is what was on the drug kardex. It was again a traditional time for dispensing drugs.

[17] On Friday 9 December Dr McCartney had written a note in the clinical file he said was intended for the locum doctor the next day. It stated:- "Says on 500mg Diazepam per day and £80 of heroin. Initial detox at 80mg diazepam and 60 ml methadone in divided doses to prevent toxicity. Review mane." (i.e. the next morning). That obscured the picture even more. Questions include - was the 30ml methadone and 40mg diazepam a stat dose? Had the detox started by Saturday 10 December, by which time drugs had certainly been dispensed? Was the detox only to start the next day? When was the review to take place? Was it intended to happen before any drugs were given the next morning? Where did stabilisation feature in all of this, if at all? How was it intended that a review could take place, insofar as it required observation of withdrawal in order to titrate, if there had already been methadone and diazepam dispensed? These questions I address later on.

[18] A further 30ml methadone and 20mg diazepam were given to Kieran at 6.40am by Nurse Dickson. Kieran was showing no signs of withdrawal at the time. Nurse Dickson took the view that by this time Kieran was in a definite reduction programme and gave him what had been prescribed in doses divided as she understood doses to be traditionally divided in the hospital. Kieran reacted to these drugs. He became gradually and obviously sedated. That should not have happened were he on appropriate doses of drugs in relation to which he had a dependency and tolerance.

He had been given too much. The locum doctor, Dr Lal Sharma, did not arrive in the morning and so could not review in the morning. He did not turn up until 2.20pm. In line with the hospital's normal dispensing times, Kieran was due to get another 20mg of diazepam at about noon. Because he was obviously sedated when he should not have been, Nurse Hayes, who had come on duty, withheld that prescription. She was right to do so. She had earlier phoned Dr Sharma in the mid-morning to get him to attend to Kieran but she accepted the doctor's proposition to come later in the afternoon.

[19] Dr Sharma saw Kieran in the afternoon. He told Nurse Hayes that Kieran was difficult to assess because he was agitated. On his instruction, in order to calm him down, Nurse Hayes gave Kieran the 20mg diazepam she had earlier withheld. Kieran should not have been given detoxification medication for that purpose. Dr Sharma told Nurse Hayes that Kieran was to have the 30ml methadone and 20mg diazepam scheduled to be dispensed at about 5.30pm. Before he left the hospital, at about 5.25pm, Dr Sharma instructed Nurse Julie Ainslie, who had come on back-shift duty, to give Kieran those drugs. She gave Kieran those drugs at 5.30pm. There is nothing to suggest that Kieran was withdrawing from any substance at that time. Blood pressure and pulse readings were taken at that time and were within the normal parameters. Those were the last such readings to be taken.

[20] Kieran's condition deteriorated. It was noticed by staff and patients alike. He presented as severely over sedated. That was dealt with inappropriately. Nurse Ainslie was the only registered nurse on duty between the hospital's primary care centre and extended care centre. She was hopelessly out of her depth. She did not

know how to identify withdrawal symptoms or over-sedation. She received reports of Kieran's condition. She ought to have gone and examined him in order to decide what to do but she did not. She ought to have measured his vital signs but she did not. She sent an auxiliary nurse to sit with Kieran "to keep an eye on him". She was engaged in dealing with another elderly patient who required assistance. That patient was not in the critical condition Kieran was in. She was counting down the time when her colleague, Nurse Wood, would come on duty to relieve her. She considered him to be very experienced and she thought he would be able to take matters in hand. She wanted to get assistance from Dr Sharma but she did not telephone him. She knew he had said he would phone in later and she waited for his call. That call came about 8.30pm. There is uncertainty about what information was exchanged. Kieran had already been discussed earlier in the day. It is clear is that Nurse Ainslie was concerned about Kieran's condition. She told Dr Sharma she was concerned. Having been asked by him what she was doing about Kieran, she told him she had an auxiliary nurse sitting with him. She had not taken vital signs readings and passed no vital sign information on. Dr Sharma did not ask her to provide that information. Neither of them took the initiative to deal with an over sedated patient in circumstances where over sedation is a clear warning sign of danger and possible danger to life.

[21] Nurse William Wood came on duty from about 9.30pm. By this time Kieran's condition had got even worse. Expert medical opinion was that he had become a medical emergency. Either the locum doctor ought to have been summoned or an ambulance should have been called. Kieran had to be assisted upstairs by other patients. Patients informed Nurse Wood of Kieran's condition. It would, in any

event, have been obvious to anyone including the nurse. He withheld the diazepam Kieran was due to receive at about 10pm. At around 11.30pm he dealt with Kieran by first of all taking him to the bathroom to be searched for illicit drugs and then by assisting him to his bedroom. He did not measure vital signs. He made no observation of him at all during the rest of the night. Kieran died at some point between being put to bed by Nurse Wood at about 11.33pm and 6am the following morning, some two hours before he was discovered dead at around 8am.

The hospital

[22] Castle Craig Hospital first came into existence as a nursing home dealing with clients with alcohol or drugs addictions in 1988. It was set up as a limited company by Mr Peter John McCann and Dr Margaret McCann, his wife. [vol 2 p 46] It later became a hospital in around 2002. There are now two companies. One company operates the primary care unit and the other, which is owned by the first company, operates the extended care unit. Both units are within the same grounds. Peter John McCann, Dr Margaret McCann, John McCann and Dr Mike McCann are directors of the companies.

Expert evidence

[23] I had the benefit of hearing from a number of leading expert witnesses.

[24] Consultant Psychiatrist, Eilish Gilvarry, both provided a report and gave evidence to the Inquiry. Eminent in her field, she has been a specialist in drug addiction since 1988. She was a leading member of the working group involved in the preparation for the 1999 publication of the 'Orange Book' (infra). Her work on

that publication required consideration of the roles of both doctors and nurses in the treatment of addiction. She was able to assist me greatly in relation to the actions of both doctors and nurses. I had no difficulty in finding her a credible and reliable witness.

[25] Dr Nat Wright, was a member of the group that was involved in the preparation of the later edition of the Orange Book, published in 2006. He covered a similar area of evidence to that covered by Dr Gilvarry. They provided very similar opinions on the material points.

[26] Consultant psychologist, Professor Gournay, gave expert evidence in relation to nursing, an area also commented on by Eilish Gilvarry. Again, there was vast agreement between them on material issues. Included in Professor Gournay's experience was his work at the Priory clinic in London, an establishment with similarities to Castle Craig. Professor Gournay still worked at the Priory for 20 hours per week.

Guidance and Protocols

[27] Drug addiction is a specialised area of medicine. There is a joint publication by The Department of Health, The Scottish Office department of Health, The Welsh Office and Department of Health and Social Services Northern Ireland providing guidelines in clinical management in drug misuse and dependence (widely known and referred to as the "Orange Book"). It contains evidence based guidelines formulated by a working group whose eminent members include psychiatrists, general practitioners and nurses. Dr Eilish Gilvarry, psychiatrist, who gave evidence to the

inquiry, was a leading member of the working group involved in the 1999 publication. That edition was the one current at the time of Keiran's death. It was updated in September 2007. The updated report is referred to later in this Determination.

[28] Castle Craig Hospital has, and had at the time, its own guidelines and protocols. In her evidence, Clinical director of Castle Craig, Dr Margaret McCann, explained that the Castle Craig guidance and protocols were to a significant extent based on the Orange Book. Consideration of the terms of each demonstrates that to be true. In order to set the scene for discussion, relevant parts of the Orange Book and Castle Craig guidance and protocols are set out below.

[29] The 1999 **Orange Book** provides inter alia:-

"FOREWORD

Who are the Guidelines for?

These guidelines are written for all doctors. They are intended for those doctors who are 'generalists' in the sense that they do not have any particular expertise in drug misuse (e.g. general practitioners, physicians, surgeons and obstetricians); and for those practitioners who have varying degrees of training and expertise treating drug misusers, including specialists in drug misuse and some general practitioners.

CHAPTER 3 ASSESSMENT….

2. c) Special investigations

ii) Urine assessment

Urine analysis should be regarded as an adjunct to the history and examination in confirming drug use, and should be obtained at the outset of prescribing and randomly

throughout treatment. Results should always be interpreted in the light of clinical findings, as false negatives and positives can occur.

A urine test shows the range of drugs that are being used and, unless specially requested, results from laboratories are qualitative rather than quantitative. If a drugs misuser is dependent, opiates persist in the urine for up to 24 hours (methadone up to 48 hours)….

iii) Hair analysis

A single strand can yield information covering a period of several weeks or months. Hair analysis is increasingly employed commercially in pre-employment screening for drug misuse. Hair analysis potentially has a place in the treatment of drug misuse, particularly in methadone treatment….

CHAPTER 4…

Prescribing

1. The responsibility of prescribing

Prescribing is the particular responsibility of the doctor signing the prescription. The responsibility cannot be delegated....

2. Deciding whether to prescribe….

A prescription for substitute drugs should only be considered if:

i) the drug/s is/are being taken on a regular basis – particularly for daily misuse;

ii) there is convincing evidence of current dependence (including objective signs of withdrawal symptoms wherever possible);

iii) the patient is motivated to change at least some aspects of their drug use:

iv) the assessment (history, urine toxicology, drug diary) clearly substantiates the need for treatment…

CHAPTER 5

THE MANAGEMENT OF DEPENDENCE AND WITHDRAWAL

Key chapter recommendations

For all reduction regimes, prior dose assessment, a period of stabilisation with a substitute drug (which be over several days or weeks) supervised ingestion (at least in the initial period) and a regular review of treatment aims should be undertaken.

Doctors need to understand that the first two weeks of treatment with methadone is associated with a substantially increased risk of overdose mortality. Starting a prescription requires careful assessment for evidence of opiate dependence, withdrawal and tolerance, and the use of confirmatory tests such as urine screening. Furthermore, good knowledge of the pharmacology and toxicology of the drugs prescribed and a careful induction regimen is critical. This should ensure that, in the early phase, dosages of the drug are not prescribed that could result in fatal overdose, either alone or in combination with other prescribed or non-prescribed drugs….

1. Withdrawal/detoxification….

The severity of withdrawal symptoms is not clearly or directly related to the quantity of drugs previously consumed. When assessing withdrawal, for the purpose of dose titration, it is better to place greater weight on observable signs rather than objective symptoms…

2. Opiates

Withdrawal from opiates is associated with a specific withdrawal syndrome. Untreated heroin withdrawal typically reaches its peak 36-72 hours after the last dose and symptoms will subside substantially after 5 days…

a) Symptoms and signs of opiate withdrawal

1) Sweating
2) Lachrymation and rhinorrhea
3) Yawning
4) Feeling hot and cold
5) Anorexia and abdominal cramps
6) Nausea, vomiting and diarrhoea
7) Tremor
8) Insomnia and restlessness
9) Generalised aches and pains

10) tachycardia, hypertension

11) Goosflesh

12) Dilated pupils

13) Increased bowel sounds…

b) Treatment of the withdrawal syndrome with substitute opiates

i) Methadone

Detoxification with methadone can be undertaken under a number of different regimens in the short and long term…

It is straightforward to titrate in order to achieve the correct dose…

c) Treatment of the withdrawal symptoms with non-opiate drugs…

i) Lofexidine

Licensed for the management of symptoms of opiate withdrawal.

Lofexidine is now licensed in the UK for the management of the symptoms of opiate withdrawal. It is a useful non-opiate treatment for opiate addiction. Lofexidine hydrochloride is similar in action to clonidine, but cause much less hypertension. It can be used with supervision in inpatient, residential and community settings. There is evidence to suggest that it is equally as efficacious as methadone in withdrawal. Lofexidine has a role in the treatment of opiate-dependent individuals seeking abstinence and whose drug use is already well controlled. Some experienced doctors use lofexidine prior to and during initial assessment, to control symptoms of opiate withdrawal and enable a full assessment to take place. It is also sometimes useful to control symptoms when a patient claims to have lost a prescription for methadone, instead of reissuing the methadone prescription or refusing to prescribe…

3. Benzodiazepines

a) Withdrawal syndrome associated with benzodiazepine use

Anxiety symptoms:

anxiety

sweating

insomnia

headache

tremor

nausea…

b) Prescribing

Withdrawal prescribing should only be initiated where there is clear evidence of benzodiazepine dependency from the patient's history and examination…

CHAPTER 6 DOSE REDUCTION REGIMENS….

a) Commencement of dose

Initial doses of methadone should take into account the potential for opiate toxicity. This should include consideration of the assessment of the patient's opiate tolerance based on a history of the quantity, frequency and route of administration of opioids, use of other drugs such as benzodiazepines and alcohol, and also the half-life of methadone.

The commencement dose should aim to achieve an effective level of discomfort, both physical and psychological, while minimising the likelihood of overdose. Inappropriate dosing can result in overdosing in the first few days: as cumulative toxicity develops to methadone, this can lead to death. Deaths have occurred following the commencement of a daily dose of 40mg methadone.

In general the initial daily dose will be in the range of 10-40mg. If neuroadaptation (i.e. tolerance to opiates) is present then the usual daily dose is 25-40mg. If tolerance is low, or uncertain, then 10-20mg is more appropriate. Care is needed in starting a dose greater that 30mg because of the risk of overdose. If a low starting dose of 10mg is used, supervision after a few hours and further small doses can be given depending on the severity of the withdrawal symptoms

In cases where dose assessment is undertaken, the patient should be re-assessed about 4 hours after the administration of an initial dose.

With heavily dependent users, i.e. those who are neuroadapted or tolerant, a first dose can be up to 40mg but it is unwise to exceed this dose. A second dose may follow after at least 4 hours and may be up to 30mg depending on the persisting severity of

withdrawal. It is important that consideration is given to the cumulative effects of administering such a long-acting drug as methadone.

Severity of withdrawal: mild – no methadone

Severity of withdrawal: moderate (muscle aches and pains, pupil dilation, nausea, yawning) – 5-10mg

Severity of withdrawal severe: (vomiting, piloerection, tachycardia, elevated BP) 20-30mg.

A supplementary dose should only be considered where there is evidence of persisting opioid withdrawal. These cases need to be assessed by an experienced medical practitioner.

b) Stabilisation dose

i) First seven days

If managing the opiate addict as an out-patient, it is recommended that patients attend daily during the first few days in order that their dose can be titrated against withdrawal symptoms for assessment by the prescribing medical practitioner. Where doses need to be increased during the first seven days, the increment should be no more than 5mg on one day. in any event, a total weekly increase should not usually exceed 30mg above the starting day's dose. Steady state plasma levels should be reached five days after the last dose increase...

2. Other pharmacotherapies

a) Lofexidine community detoxification…

The treatment course is between 7-10 days. It is probably most likely to be successful for patients with an average daily heroin use (up to 1gm per day or 50mg methadone equivalent), non polydrug users and those with shorter drug and treatment histories…

3. Benzodiazepine

a) Benzodiazepine Reduction…

ii) How much to prescribe

- As in any substitute prescribing, the doctor should aim for the lowest dose that will prevent withdrawal symptoms…"

[30] **Castle Craig Hospital** had **internal guidelines** and **Protocols** in place in December 2005. Staff, including doctors, were expected to be familiar with them. They included *inter alia* as follows:-

"MANAGEMENT OF WITHDRAWAL: GENERAL PRINCIPLES

1. All patients admitted to the clinic, no matter how long the duration of abstinence, are placed under intensive nursing monitoring for at least three days and for a further three days after medication has been discontinued.

2. Check vital signs every 4-6 hours and more frequently e.g. ½ hourly if the patient's condition indicates a need.

3. The doctor performs a physical examination giving special attention to neurological signs.

4. Take a history from the patient. If possible verify the key information with a relative.

5. The patient's level of consciousness is monitored following admission. If the patient becomes increasingly unconscious and unresponsive then an alcohol and drug overdose should be suspected. Other causes of clouding of consciousness must be considered, such as an intracranial bleed or Wernicke's encephalopathy or hypoglycaemia. and prompt admission to hospital must be organised and treatment instituted.

6. Check the dose: Addicts tend to exaggerate their needs. Confirm with their G.P. the precise doses they are prescribed and if necessary check with the pharmacist if the stated maintenance dose was taken that day.

7. Drug seeking behaviour should be seen as a symptom of addiction. It may also be due to fear or poor motivation.

Medication should only be given if the clinical indicators of withdrawal justify it or in a definite reduction programme.

PRN detox medication should not be given in response to the subjective needs of the patient but according to what the nurse judges the clinical requirement to be."

"PROCEDURE & PROTOCOL

<u>OPIATE OVERDOSE</u>

- Opiate overdose – all opiates including co-proxamol
- Signs and Symptoms
- Pin point pupils
- Depressed respiration – shallow breathing
- Bradycardia
- Drop in BP – acute cardiovascular collapse
- Coma
  Later Pulmonary oedema

History

- Opioid use (ask about drug, amount, time of last use)
- Polydrug use

Management of Opiate Overdose

1. 100% oxygen (Assess airway; ensure a clear airway, basic life support)

2. If necessary, assisted ventilation, CPR, intubation

3. I/V Fluids if hypotensive

4. Consider whether alcohol or benzodiazepines or other drugs have also been taken

5. Rule out hypoglycaemia, metabolic or electrolyte abnormalities

6. Toxicology screen for drugs

Specific Therapy for Opiate Overdose

Naloxone Hydrochloride (Onset of action 2 minutes)

- 0.4 – 0.8 mgs initially intravenously or intramuscularly if venous access not possible Should be given immediately
- Repeat at intervals of 2-3 minutes; if these is no response give in doses of 0.4 mgs, if no response to a maximum of 10 mgs
- Administer I/M pr S/C if unable to establish IV access

- Can be given with safety

- Re-administer if signs of overdose reappear

- Respiration observed every 15 minutes for 24 hours. The antidote effect is only for 2 – 3 hours whereas the depressant effect of methadone may last 48 – 72 hours.

- Call an ambulance at the outset.

PROTOCOL
METHADONE DETOXIFICATION

There is only one method of detoxification at Castle Craig….

- Methadone mixture DTF 1 mg/ml is prescribed for detoxification and full and accurate records of all prescriptions are kept in the DDA book.

- The dose of methadone should not be revealed to the patient. Management is easier and the dose lower when the patient does not know the dose. Research therefore, reassurance and information are important.

- All doses of methadone must be approved by doctor. PRN is not to be used. In the case of inpatient detoxification where constant staff support is available and rapid detoxification is normally possible a dose of 40 mgs of methadone can normally be reduced to zero over a period of 10 days.

- It is the consultant and doctor on duty at the time of stabilisation who must be responsible for supervising the stabilising dose and informing the nurses on the dose to administer. The doctor on duty for the evening should be made aware by the day doctor, handing over, that a patient is being stabilised on

methadone and they should be asked to confer with the nurses to check stabilisation is proceeding satisfactorily.

- If it is thought that the patient is grossly exaggerating his daily drug requirement the base line should be established at no more than 60% of the alleged dose and usually not more than 50 mgs of methadone.

- NB:- Cumulative toxicity develops to methadone (Methadone has a slow onset of action 2-4 hours and protracted duration of action, therefore, effects are greater after 2 days).

- Establishing Base Line Daily Dose. In the case of a patient who has been abusing heroin it will be essential to establish the base line daily dose of the drug, which is the minimum daily dose, that ensures stabilisation of the patients and the absence of withdrawal symptoms.

- A drug history of the preceding week's drug use and the use of a methadone equivalent (see Table to opiod equivalents for prescribing) will give a reasonably accurate daily dose requirement for oral methadone.

- Most patients will fall between 20-50 mgs of methadone on the whole. It must be noted that patients tend to exaggerate their high use of illicit heroin. Most patients are usually comfortably stabilised on a daily dose not exceeding 40 mgs.

- Because the addicts history cannot be relied upon and because symptoms are sometimes feigned, N.B.: methadone should be initiated after the appearance of physical signs of withdrawal. The presence of fresh needle tracks and a positive urine screen (heroin is rapidly re-ecetylated to morphine which may be present in the urine for 12-24 hours after last use) at the outset are sufficient evidence to commence with 10 mgs when withdrawal signs appear.

- The patient's opioid needs should be titrated against clinically evident symptoms of withdrawal i.e. tachycardia, mydriasis, perspiration, high blood pressure, restlessness, sweating, piloerection rather than any psychological discomfort. After 24 hours one should have calculated the base line twice-daily dose.

There are 2 categories of opiate addicts:- those on methadone maintenance and street addicts addicted to heroin. All are likely to be abusing other drugs.

- Addicts on methadone maintenance If the patient is on a prescribed methadone prescription from the GP. For example, taking 0 mgs of methadone per day then the dose can usually be reduced by 1/3 without any significant distress to the patient; i.e. in this case the dose would be reduced to 40 mgs.

- It is important to explain the above factor to the patient and reassure him or her that most distress is experienced when detoxifying from the last 15 mgs. Reduce by 5 mgs daily. Maintain on 5 mgs for last 3 days.

- Prescribing Methadone: For those not on methadone maintenance, "street addicts". Consider the patient's opiate tolerance. Consider the history of the quantity, frequency and route of intake of opiate drugs. A history of concurrent use of benzodiazepines and alcohol should be taken into consideration. The commencing 24 hour dose should provide relief, allowing the patient to be comfortable, alert and stabilised but avoid the danger of overdose.

- The initial 24-hour dose is usually in the range of **10-40 mgs**.

- If tolerance is low or uncertain **10-20 mgs** may be sufficient for the 24 hour period.

- Use a low starting dose of **10 mgs**.

- Re-assess after 4- hours.

- If mild withdrawal, no further methadone.

- With moderate withdrawal (muscle aches, yawning, pupil dilation).

- Give **5-10 mgs**

- In severe withdrawal with vomiting tachycardia 20 mgs could be given as a supplementary dose.

- Care is needed starting a dose greater than 30 mgs because of the risk of overdose.

Prescribing for Higher levels of tolerance or severe withdrawal

- Commence with **20 mgs** of methadone. (Guidelines on Management Department of Health 1999 state that with heavily dependent users a first dose of 40 mgs can be given though it is unwise to exceed this dose). At Castle Craig the lower starting dose is used. Re-assess 4-6 hours later, and provide additional doses as above in the first 24-hour period to a total of usually no more than 40 mgs in that 24 hour period. (10-30 mgs per day in 2 divided doses is usually sufficient).

- Reassess the dose requirement after 24 hours and then prescribe methadone 12-hourly.

Reduction

Once stabilised the initial reduction is by 5 mgs per day to 5 mgs. The patient should be maintained on 5 mgs for 3 days. (A reduction of 20% can be tolerated without discomfort).

THE USE OF ADJUNCTIVE MEDICATION

Benzodiazepines – These drugs have an addictive potential in dependent patients and should, therefore, not usually be prescribed….

AVOIDANCE OF OVER SEDATION

NB: Under no circumstances administer opiates, or any sedation, if there are signs of drowsiness.

- Signs of intoxication such as drowsiness, slurred speech, contracted pupils indicate a need to discontinue drug.

- Be prepared to give naloxone for signs of over-sedation, observe special precautions prescribing to those with respiratory disease and liver disease.

- In estimating the starting dose of methadone err on the side of caution or the patient may suffer a respiratory arrest which may be deceptively slow on onset.

- Oral administration takes 2-4 hours to have any significant effects.

- The dose of methadone should not be revealed to the patient. Management is easier and the dose lower when the patient does not know the dose. Research shows severity of withdrawal is related to the degree of expected distress, therefore, reassurance and information are important.

- Be careful of prescribing equivalent doses of methadone to the amount of heroin a patient claims to be taking.

- Be extremely careful when giving other sedatives.

- There is often no need to prescribe within the first 24 hours of admission and this will allow baseline observations to be made."

Castle Craig Staff

[31] In December 2005 alongside Dr Margaret McCann, there were two full time doctors employed by the hospital, Dr Alasdair Young, clinical director, and Dr David McCartney, junior doctor. Dr Young was qualified as a psychiatrist. He had been employed by the hospital since April 2000. He began as a locum doctor and then became employed full time. In 2005 he was in overall charge of treating patients with drug addictions.

[32] Dr David McCartney is a general practitioner. He commenced employment with the hospital on 16 August 2005. He was given no formal induction on commencing his employment with the hospital. On the first day, Dr Young, the consultant and his superior, took him through the admissions procedures. Thereafter he learned from Dr Young on a patient by patient basis. He quickly became involved in medically assessing patients and commencing them on detoxification prescriptions. Both doctors were aware of and familiar with both the Orange Book guidelines and the local, Castle Craig, guidelines and protocols. Dr McCartney was aware that the instruction he got from Dr Young constituted a departure from both sets of guidelines.

[33] Dr Young had two supervisory responsibilities over Dr McCartney. The first was a General Medical Council supervisory role. The second was a responsibility over Dr McCartney's prescribing. It was part of Dr Young's duty to approve Dr McCartney's prescription of controlled drugs as was provided for in the Castle Craig Guidance and Protocol. The way that duty was discharged was, not to approve every

prescription before it was dispensed but rather a more general approval based on the earlier instruction by Dr Young in relation to the prescribing regime.

The first admission

[34] On Kieran's first admission on 25 August 2005, Nurse Mary Hayes assessed Kieran. She took a history from him. He told her that he had an alcohol and drug addiction with a drugs habit of 300 mg of valium daily, none having been taken that day, and cannabis of approximately ¼ ounce per day, valued at £25. She noted Kieran as having said that his past drug use included ecstasy, cocaine, crack cocaine, acid and heroin (smoked) roughly seven times. Dr Wright said he thought it was unlikely that Kieran had a heroin addiction at this time and did not declare it. Without treatment, a heroin addict can expect very severe withdrawal symptoms and that is what they fear the most.

[35] Dr David McCartney was the doctor who medically examined Kieran on his first admission on 25 August 2005. The information already obtained by Nurse Hayes was before Dr McCartney when he examined Kieran. During the examination, Dr McCartney noted Kieran as appearing under the influence of drugs. He had slurred speech, heavy eye lids and ataxic. Dr McCartney prescribed a detoxification regime of a daily reducing dose of diazepam. That prescription was directed at Kieran's valium habit. Dr Wright said that, on the history given by Kieran, he was vulnerable to developing a heroin problem. In the circumstances he, like Dr McCartney, would have commenced Kieran on a benzodiazepine prescription. There was no prescription made that related to any opiate drug abuse. Nurse Hayes subsequently noted that Dr McCartney was to discuss the detoxification with Dr Margaret McCann. Nurse Hayes

noted, on 25 August 2005, that the discussion had taken place. I think that discussion did take place. Dr McCartney said in evidence that he discussed Kieran by name. Dr McCann said there was a general discussion without the patient being named. Dr McCann also said that she would not speak about a patient in the abstract although she claimed to have done precisely that in relation to Kieran. I preferred the evidence of Dr McCartney to Dr McCann on this point. I got the impression that Dr McCann was trying to distance herself from having discussed a detoxification without seeing the patient notes. That was inconsistent with her general position on having to see the notes in order to be able to prescribe.

[36] A diazepam detoxification was completed by 8 September 2005. No further diazepam was dispensed to Kieran. On that date Kieran was drug free. Kieran was transferred from the hospital primary care unit to the extended care unit on 5 October 2005. He remained drug free and within the hospital confines until he discharged himself against medical advice on 7 October 2005. There was some initial suggestion by Dr Young that Kieran had not had a particularly comfortable detoxification. On scrutiny that evidence amounted to nothing unusual. His detoxification was normal. Kieran was not treated for a heroin habit. There are no medical notes of him showing any signs of heroin withdrawal. There was no evidence of him showing any signs of withdrawal from heroin. Dr Young suggested that Kieran might have withdrawn from an undeclared opioid habit during this diazepam detoxification. I was not impressed by that suggestion. In an establishment such as Castle Craig, if proper observation were being made, the withdrawal that would arise from a significant opioid habit, left untreated, should have been obvious and noted. No such withdrawal was noted. Dr Gilvarry thought it was unlikely that Kieran would have settled during

his first admission had he been concealing a large dependent history. Dr Wright said he did not think it feasible that Kieran had a heroin addiction on his first admission and concealed it. For him, the proposition was one step away from impossible. If Kieran had a heroin habit on his first admission it would have come to light through signs and symptoms. A benzodiazepine detoxification would not replace opiate loss. There were very specific opiate withdrawal symptoms which would have been picked up had he an addiction. He thought that on the first admission Kieran had been essentially truthful and he had received detoxification consistent with the account he gave. I am satisfied that Kieran did not have heroin habit prior to or during his first detoxification.

Period between discharge and readmissions

[37] Kieran returned home to live with his parents on 7 October 2005. I accepted the evidence of his mother, Mrs Jacqueline Nichol, who said that he remained under their close scrutiny for approximately four to six weeks. He was in the company of his mother or father for about 90% of the time during that period and showed no signs of drug abuse, which his mother at least would have been alive to. Michael Carruthers, was Kieran's friend. He spent some time with Kieran immediately before Kieran's return to Castle Craig. He was involved with drugs and involved with Kieran's drug abuse during that time. He broadly agreed with Mrs Nichol as to the initial period following discharge when Kieran was under the scrutiny of his parents and not at liberty to abuse drugs. He was confident that if Kieran had abused drugs during this period his mother would have noticed. Although there were some attempts to discredit Mr Carruthers with questions about who his supplier was, which he was, not surprisingly, reluctant to answer, I accepted his evidence on the issue of the timing of

Kieran's return to drug abuse. It had the ring of truth and he had no reason to lie. It also corresponded with other evidence.

[38] Independently, close cropped hair samples taken from Kieran after his death showed no evidence of drug abuse during the period prior to about one month before his death. I am satisfied that Kieran ingested no significant quantity of opiates or benzodiazepines during this earlier period.

[39] From about two to four weeks before 9 December 2005 Kieran returned to drug abuse. I am satisfied that that abuse included benzodiazepines. It might have included an opioid drug such as heroin. If it did, there is no evidence apart from Kieran's account as to quantity and period of abuse. On his first admission Kieran claimed to have abused heroin on about seven occasions. Dr Gilvarry described such use as recreational and said it was very unlikely to have resulted in an addiction. Dr Wright thought there might have been the potential for a problem developing. On his second admission to the hospital, Kieran claimed to have a heroin habit of £60 or £80 per day. According to Dr Young, a habit costing £60 per day could not be acquired in one or two months. He thought that such a large habit would require to be built up over six to nine months. On the hypothesis that Kieran did have a heroin habit on first admission which he disguised, a proposition not accepted by him, Dr Wright pointed out that when Kieran was discharged in October 2005 he was tested and found to be negative for all substances. According to Dr Wright, following a 16 day detoxification, Kieran would have lost any tolerance he might have had to heroin. He would be opiate naïve at that point. It would be reasonable for clinicians to proceed on the basis of opiate naivety after 16 days. Dr Wright accepted that had there been a

level of tolerance, it could be rapidly regained in two to four weeks. Approaching from a different angle, Dr Gilvarry said that mild dependence can develop within weeks if there is excessive use. What was not clear, was Kieran's level and frequency of use, both of which, according to Dr Gilvarry, were important factors relating dependence and tolerance.

[40] According to all the medical evidence there is a close relationship between addiction and tolerance. Both are the result of changes to receptors in the brain (neuroadaptation). After detoxification, tolerance is gradually lost. It takes time to develop tolerance to opioid drugs. There are differing levels of tolerance. It is not an exact science and dependence on one type of drug can predispose an individual to dependence on another. On the evidence Kieran did not, during the two to four weeks period before his death, have enough time to develop even the £60 per day heroin habit he claimed to have had, let alone the £80 habit. Even with a predisposition to dependence likely to exist with polydrug abuse, he would not, against his initial history, have had time to develop a high level of heroin dependence. He would not have had sufficient time and exposure to heroin to develop a high level of tolerance. With the benefit of hindsight it became clear that indeed Kieran did not have a sufficient level of tolerance, if any, to withstand the regime of drugs he was to be placed on at the hospital.

Readmission

[41] Persuaded by his parents, Kieran was re-admitted to Castle Craig Hospital on Friday 9 December 2005 at about 1pm. It was not normal for the hospital to admit patients on Fridays. Newly admitted patients placed on a detoxification regime

require close and intensive nursing monitoring for at least the first three days. That is set out in the Castle Craig guidance. The hospital was not set up for admission of patients at weekends. From Monday to Friday the hospital had a staff doctor on site during the day and on call out of hours. By contrast, at weekends there was no staff doctor. There was a locum doctor exclusively available but not on site and there was restricted nursing staff on duty. In particular, only one registered nurse was at the time available between the primary care unit and the extended care unit.

Medical Examination

[42] At about 1pm on Friday 9 December 2005 Kieran was interviewed by senior nurse, Mary Hayes. She filled in a medical admission form. Kieran presented to her as sedated. She noted him as looking sedated. She took a history from him. She noted him as telling her that he smoked 1/8 ounce of heroin, costing about £60, per day, having taken it since aged 15, the last use being £20 worth in the morning of the previous day. That declared abuse of heroin was inconsistent with the account given by Kieran on his first admission. Nurse Hayes noted Kieran as telling her that he took approximately 500 mg of non-prescribed diazepam daily, having taken it since aged 13, last having taken 20 mg the previous day. He was noted as saying that he smoked ¼ ounce of cannabis daily, the last use being two joints the day before. He also said that he took non-prescribed methadone if there was no heroin available, last taken over a month before and that he had snorted 1 gram of cocaine on 3 December 2005 and had last take that drug about one year before that. She noted Kieran as claiming that he had been clean for about two weeks after his discharge from the hospital on 5 October 2005. In error, she entered in the admission notes, that he had had a drugs dependency for 13 years rather than since aged 13.

[43] Kieran was not required to submit to a urine analysis test.

[44] As part of the admissions procedure Kieran was searched by senior nursing assistant, Susanne Hope, before being taken to his bedroom, the Romano Room. His luggage was searched. No drugs were found. I am satisfied that he brought no drugs with him into the hospital at that time.

[45] After Nurse Hayes had interviewed Kieran and completed his medical admission form, he was medically examined by Dr McCartney. Dr McCartney was familiar with Castle Craig management of withdrawal guidance and other documentation including those relating to procedure and protocol. He was familiar with the guidance provided in the Orange Book. He was aware that addicts about to undergo detoxification had a tendency to exaggerate their needs. Dr McCartney said that he remembered Kieran from his previous admission. However, I doubt that. Nurse Hayes said that Dr McCartney could not recollect anything about Kieran until he saw the photograph of him on the previous file that was brought to him. At the time he examined Kieran, he had the new notes taken by Nurse Hayes and Kieran's previous hospital notes available to him. There is no evidence that he paid any particular attention to the earlier notes. He noted Kieran as being difficult to assess due to intoxication. He considered Kieran to be under the influence of some substance and to have mildly impaired consciousness. It follows Kieran was not showing signs of withdrawal. Dr McCartney independently took a history from Kieran. He noted Kieran as declaring that he had a habit of 500 mg diazepam daily and £80 heroin daily. The declared daily heroin use did not correspond with that declared to Nurse

Hayes of £60 per day. There is no note in Kieran's medical records of that discrepancy being noticed. I do not believe it was noticed at the time. Dr Wright said that with such a high declared level of heroin abuse on the second admission his starting point would be to presume Kieran was exaggerating. Set against the clinical picture only two months earlier of a valium habit, there was a marked entrenched use being declared. If Kieran had been telling the truth about levels of abuse and last taking drugs the previous day then some state of withdrawal would be expected and not intoxication on admission. It was very likely Kieran was not being completely truthful. Dr Gilvarry said that the history given was inconsistent with the presentation. She pointed out that there were self-reported significant amounts of heroin and benzodiazepines taken daily for some years but only small amounts taken before admission. She thought that it would be unusual, had a true account been given, for there to be no withdrawal symptoms. Dr Gilvarry thought Kieran must have taken some drugs within a shorter time frame than he admitted and probably that morning.

[46] Following an eye examination using an opthalmoscope, Dr McCartney wrote in the notes that he was unable to see the fundi due to restriction of the pupils. Dr McCartney relied heavily on the pupil restriction. It was his evidence that this indicator confirmed the history given of opiate abuse. According to the expert evidence, it was no more than a possible indicator of very recent opioid abuse. It said nothing about the level of abuse or the extent of the habit. The expert clinicians were cautious about over-reliance on restricted pupils. Both Dr Gilvarry and Dr Wright said that restriction of pupils, while being a strong indicator of recent opiate use, was not conclusive. There were other causes of restricted pupils, including extreme

agitation. Dr Wright said he would not use restricted pupils to confirm declared opioid abuse. He would trust a urine sample above observation of restricted pupils. Safety was paramount. Induction was a high risk time for overdose and death. One could not just trust what a patient said about levels of drug abuse. Patients were known to exaggerate. Corroboration was important and the taking of a urine sample for that purpose was common practice. Dr Gilvarry was of the view that a urine analysis should have been done. It was a simple test. She would have required one, placed in a similar situation. Had such a test been carried out it could have revealed whether opiates or benzodiazepines were present though not the quantity present. That, according to Dr Gilvarry, would at least provide some confirmation of use of particular drugs if not the extent or duration of such use. Although test kits were not particularly expensive, it was not Castle Craig hospital policy routinely to conduct a urine analysis test on admissions. In her evidence, Dr Margaret McCann said that the routine testing was already in the process of being introduced at the time. Although responsible for such matters, she said she was not aware it had not happened. That did not sit comfortably with Dr McCann's later evidence of internal meetings that took place around the time from which it was clear that Dr Young was opposed to the introduction of the tests and the matter was unresolved. Following Kieran's death, routine urine analysis tests on admission were introduced by the hospital. Furthermore, inclusion of a respiratory test, done when vital signs were measured, was introduced.

[47] Dr McCartney accepted the history given to him by Kieran. He did not reconcile the seeming discrepancy between the histories given by Kieran on his earlier admission and his subsequent re-admission. Neither he nor Nurse Hayes made any

entry in the notes about the discrepancy. Professor Gournay said the discrepancy ought to have been picked up. He said that sort of discrepancy crops up all the time. It was why it was important to get hold of the previous notes. He expected to find notes of such a discrepancy littered throughout Kieran's nursing and clinical notes because it was so important. Stressing the importance of examining the previous notes, Professor Gournay said he would want to see the previous care plan before devising a new care plan. It might reveal something that needed to be followed up. In his evidence, Dr McCartney claimed that he was aware of the discrepancy. He said that he presumed Kieran must have concealed the true extent of his heroin habit on his first admission. According to him, Kieran was telling the truth on his second admission. Dr Young did not complete his evidence to the Inquiry. He elected to stop answering questions part of the way through his examination in chief. In his restricted evidence, Dr Young said he agreed with the presumption that Kieran had concealed a heroin dependency on his first admission and told the truth on his second admission. No other medical professional who gave evidence supported such a presumption of earlier dependence. I had doubts about whether Dr McCartney and Dr Young were being truthful about having made any such presumption at the time as opposed to simply proceeding in temporary ignorance of Kieran's previous history.

[48] Following his medical examination of Kieran Dr McCartney devised a medical care plan. He, on 9 December 2005, wrote four prescriptions. His plan was for Kieran to have a dose of 60mg of methadone per day in divided doses reducing by 5mg per day and 80mg of diazepam per day in divided doses reducing by 10mg per day to 30mg. He wrote what might have been initiating prescriptions for 30mg of methadone and 40mg diazepam for dispensation on 9 December 2005 and

prescriptions for dispensation from 10 December 2005, for 60 ml methadone and 80 mg of diazepam daily to be taken by Kieran in divided doses. He did not specify precisely how the divided doses were to be divided. Professor Gournay said that lacked precision. It was often seen in specialised clinics where the nurses were aware of how doses were divided but it was then necessary to ensure all the nurses were so aware. At the time of prescribing Kieran was intoxicated. He was not showing physical signs of withdrawal. It was not clinically necessary for any prescription to be written at that time.

[49] The prescribed doses of methadone were in excess of the guidelines in the Orange Book and in excess of the levels specified in the Castle Craig guidance and protocol. Dr McCartney was aware of all the guidelines and protocols, as was Dr Young. Most of the clinicians agreed that in appropriate circumstances, experienced clinicians will depart from guidelines. They said that if they so do, they must be able to justify the departure and that justification ought to be noted. No explanation for going beyond the Orange Book guidelines and Castle Craig guidance and protocols was written in Kieran's medical notes. There was clear evidence, which I accepted, that recommended levels were routinely exceeded in line with an approach favoured by Dr Young, followed by Dr McCartney and known to Dr McCann. She described Dr Young's approach as "robust".

[50] In contrast to heroin, methadone is a slow release opioid drug with a long half life. It is longer acting, with residual remaining in a patient's system for 24 to 48 hours. There are known risks of cumulative toxicity within the first few days of dosing. Although they did not entirely agree in what they thought the half life was,

Dr Young, Dr Margaret McCann and Dr McCartney were aware of the slow release nature of methadone and the risks of cumulative toxicity. It is well documented.

[51] Dr McCartney was due to, and did, go off duty later in the afternoon of Friday 9 December 2009. He was not scheduled to be on duty over the weekend. Dr Young, his superior, had gone into to Edinburgh on the personal business of being fitted for a kilt on 9 December 2005. He had left his dog at the hospital and required to return and collect the dog. He made a quick visit to the hospital around 5pm in the afternoon of 9 December 2005, during which he and Dr McCartney clearly had no more than a brief discussion about Kieran. Dr Young neither saw nor considered Kieran's medical notes. Dr Young approved Kieran's care plan including the prescriptions written by Dr McCartney.

[52] The presumptive prescription written by Dr McCartney for a commencing dose of 30ml of methadone to be administered on Friday 9 December 2009 was in excess of Orange Book guidelines which, where tolerance is low or uncertain, recommend an initial daily dose of 10 – 20mg. It was in excess of Castle Craig's guidelines and protocols which recommend an initiating dose of 10mg after the appearance of physical signs of withdrawal, with further guidance echoing the Orange Book that if tolerance is low or uncertain 10 – 20mg may be sufficient for the 24 hour period.

[53] As a result of the two prescriptions for methadone being written as they were, along with a large quantity of diazepam, a total of 90 ml of methadone was administered in a period of just over 24 hours, namely a period of 24 hours and 15 minutes. That amount of methadone in just over 24 hours well exceeded all

guidelines despite clear and explicit warnings in the Orange Book and Castle Craig documentation relating to over-sedation and mortal danger from the cumulative effects of methadone.

[54] Dr Wright said that a day has to be seen as a 24 hour period. When a prescription is written up for drugs to be dispensed during a day it means within a 24 hour period from when you start. That is how he would expect an instruction for an amount of drugs on the first day to be understood by others. He expected the prescription for 30ml in the first day to be understood as 30ml in the first 24 hour period. He went on to say that there could be a 'stat' dose on the first day and then divided doses. In such a hospital setting, Dr Wright would have restricted his prescription to 30ml methadone in the first 24 hours. He could not think of ever having given 60ml methadone in the first 24 hours of a detoxification. He said that prescribed diazepam would have an additive effect. Both had a sedative action and would increase the risk of suppression of the respiratory system and death. The prescribing doctor, by writing up the prescriptions for such high amounts, had put himself in a state of heightened clinical risk. Where there was lack of corroboration there was a need to stick more strongly to guidelines. On the history taken it might have been the case that there had been intermittent use of opioids. With a reasonable doubt as to history, minimal intervention could alleviate symptoms while minimising risk. The greater the doubt the lower the dose should be. It was a simple matter to withhold medication until there were clear signs of withdrawal and then prescribe as necessary. Dr Gilvarry said that the correct and cautious approach of starting low and building slow would have led to an accurate and safe understanding of the level of Kieran's dependencies and tolerance levels.

[55] On an instruction from Dr McCartney, Nurse Hayes wrote in the nursing note section entitled "Detox Prescribed":- "S/B [seen by] Dr McCartney and prescribed a methadone and diazepam detox to commence when starting withdrawal". Dr Gilvarry criticised that vague instruction. She was apprehensive about responsibility being placed onto nurses to decide when appropriate withdrawal signs were seen and to start the drugs regime. She would have preferred to see no prescription written at all until a clinician was satisfied there were physical signs of withdrawal associated with the particular habit. This was more difficult when there was more than one habit and symptoms may be confused. In any event, were there to be an initial presumptive prescription, according to Dr Gilvarry, the subsequent prescription for the next day and beyond ought not to have been written. It was Dr Gilvarry's view that if a prescription is written by a doctor it will be dispensed by nurses, the more so if the nurse lacks experience. Dr Wright said he was apprehensive about what he referred to as an over-delegation of risk. He would not have left it to the nurse to decide. Clinicians have more training. Many treatment centres would not delegate risk in this way. It was passing control into someone else's hands at the risk of death. A nurse could observe signs of withdrawal and then, if out of hours, contact the doctor and describe the signs. A clinician then might be able to prescribe over the phone. He said that if a decision is made to delegate then the risk has to be managed in another way, the easiest of which was to start with a low dose. If there is a decision to delegate then there is a need for withdrawal validating tools.

[56] There was no recorded note of withdrawals in the nursing record relating to the commencing dose on Friday 9 December 2005.

[57] Dr McCartney inserted into the clinical notes that the detoxification prescription of 60ml methadone and 80mg diazepam in divided doses to prevent toxicity for 'commencement' on 10 December 2005 was to be "reviewed mane" - the following morning. Neither the quantity nor timing of divided doses was specified by Dr McCartney. Dr Gilvarry said that lacked precision. It was not clear when the next morning review was to be. A nurse might interpret that to mean a review at 10 or 11am and not at 7am when drugs were due to be dispensed. It was normal, and well known, practice within the hospital for divided doses of methadone to be two doses given at about 7am and 5.30pm each day. It was normal practice for divided doses of diazepam to be four doses given alongside methadone, if prescribed, at the times already mentioned as well as around lunchtime and around 10pm before retiring. Dr McCartney said he expected the locum doctor to review the prescription. He would have known that the first of the two divided doses would fall to be administered at about 7am, before any locum doctor would be in attendance to carry out a review. He must have known that methadone takes a few hours to reach maximum effect and then slowly wears off. Accordingly, the administration of methadone having commenced as anticipated by Dr McCartney and Dr Young, and as it did, the locum doctor was bound to be presented with a patient who had received two doses of methadone in slightly over 12 hours against the background of the half-life cumulative effects known for the drug. In such circumstances it would be unlikely for a doctor, reviewing in the morning after a dose had been given at 7am, to be in a position to observe any withdrawal symptoms and to carry out a review.

Locum doctor

[58] No staff doctor was on duty on Saturday 10 December 2005 nor scheduled to be on duty throughout the weekend. A locum doctor, Dr Lal Sharma, was on duty over the weekend. The hospital expectation of a locum doctor was for the doctor to be exclusively available at the end of a telephone over the weekend and to visit daily. It was not the invariable practise of locum doctors to visit the hospital on Saturday mornings. Some of them did and some left it until later in the day. It was the known usual practise of the particular locum doctor on duty to postpone visiting until the afternoon. Dr Sharma, in fact, did not attend until 2:20pm that Saturday.

Nursing notes

[59] At 17.15 hours on 9 December 2009 the nursing notes in relation Kieran commence.

They are as follows:-

"17.15 pm – Bp 128/71 P64 Commenced on detox methadone 30ml + diazepam 20mg given. (Signed Nurse William Wood)

Found by ECU *(Extended Care Unit)* staff wandering about down there. Asked to return and spoken to about same. Advised about leaving the building, stated he went down to see Martin. (Signed Nurse William Wood)

10pm Bp 136/102 P94 Given diazepam 20mg as per cardex. (Signed Nurse Eileen Dickson)

ND *(Night Duty)* Up and down on several occasions during the night. Requesting methadone and diazepam at 2am. Bp 133/75 P82. – same refused. Advised to try and sleep. Restless remainder of night but no obvious signs of opiate or benzodiazepine withdrawals.

Bp 138/75 P75. Given methadone 30ml & diazepam 20 mg as per Kardex. (Signed Nurse Eileen Dickson) *(N.b. No time was noted against this entry but the corresponding entry in the Kardex is timed at 7am.)*

10/12, 14.00 Kieran remains restless and appears over-medicated drowsy at times disorientated. Reports from aux nurse and therapist Kieran was gouching in the lounge. Bp at lunchtime 144/82 P84. No detox given, awaiting review by Dr Sharma who will be coming in at 13.30 hours. (Signed Nurse Rachael Marples)

14.30 seen by Dr Sharma, Kieran difficult to assess due to intoxicated appearance. Becoming agitated & verbally aggressive re being questioned about his medication. Discussed with Dr Sharma & 20mg diazepam given. Bp147/86 P 76. Kieran to be assessed again by Dr Sharma later today.

No prior assessment or history in Kieran's notes making it difficult for Dr Sharma to assess the pt. Also no notes from Kieran's previous admission available to read. (Signed Nurse Rachael Marples)

PM. Methadone 30ml & diazepam 20mg given as per Kardex at 17.30. Bp 141/86 P 81.

Kieran noticed at 7pm to be very drowsy 7 disorientated in group. Also noted by several of his peers to be 'overmedicated'.

21.00 Dr Sharma phoned re Kieran's condition. He is not unduly worried & will see him tomorrow. (Signed Nurse Julie Ainslie)

ND. Fellow peers have approached M/C *(medical centre)* and raised their concerns over Kieran's obvious over-sedated appearance. Falling asleep during tonight's film and snoring loudly. Did not wake at the end and was difficult to waken. Eventually assisted upstairs by three peers. Tried to use toilet but couldn't pass urine at this time. In the corridor asked if he had used anything over and above his detox which he

denied. Very unsteady on his feet and when this was pointed out tried unsuccessfully to walk normally. Eyes 'pin prick' in size, flushed looking in appearance. Stagger back to his bed and told to sleep. Detox withheld at this time due to his obvious oversedated appearance. (Signed Nurse William Wood)

Patient's previous notes located in the file drawer behind his current notes in a blue folder (cardboard). (Signed Nurse William Wood)"

[60] The clinical notes were as follows:-

"9/12/05 says on 500mg diazepam per day + £80 of heroin. Initial detox at 80mg diazepam and 60 ml methadone in divided doses to prevent toxicity. Review mane. (Signed Dr McCartney)

10/12/05

14.30 N/staff found patient appear somewhat 'odd' somewhat agitated "I am not agitated" ? confuse.

Demanding detox drugs.

Unfortunately previous Admission assessment notes not available.

PT not keen on interview.

D/w therapist – Lee. Difficult to assess. (Signed Dr Lal Sharma)

10/12/05

16.30 Oriented to time person place

Sitting in Conference room

Doing his writing work. (Signed Dr Lal Sharma)

11/12/05

0800 urgent call pt not breathing.

0822 *Having made a number of observations, Dr Sharma pronounced Kieran dead."*

Witness observations of Kieran

[61] Many witnesses, both staff and patients, saw Kieran in the short period from his admission until his premature death. As time progressed the evidence became overwhelmingly of Kieran in a progressive state of over medication. A number of the peer witnesses came across as relatively weak historians and even quite hostile while giving their evidence. They had all been patients for substance abuse and I do not doubt that many of them had experience of authority being exercised over them both by the police and the courts. I got the impression that, with the significant passage of time, some of the evidence was a bit confused. Some had a natural tendency to be suspicious of questions relating to their own habits, which questions, apart from tending to strike at credibility if prevarication followed, were of doubtful relevance. The majority of these witnesses were content to rely on what they told the police contemporaneously as being accurate. These witnesses painted a tragic, detailed picture of Kieran being in a progressive state of intoxication or over-medication. That evidence was increasingly supported by the testimony of nursing staff. As I will come to pass comment on, I did not hear evidence from the staff nurse who was last responsible for Kieran nor the doctor who was last responsible for Kieran.

Friday 9 December 2005 1pm to 5.15pm

[62] Kieran was under the influence of some substance when he was admitted to Castle Craig on Friday 9 December 2005. During the period of time from his admission until 5.15pm that day, when he was given his first dose of 30ml methadone and 20mg diazepam, Kieran was observed by a number of staff members and peers. Most saw signs of sedation or intoxication with pin-prick eyes. He appeared to some

medical staff to be less sedated as the afternoon and evening progressed. One witness, Douglas McFarlane, a former patient, said that he was the first to see Kieran when he came in with his father. He gave a police statement shortly after the death when he said that he immediately noticed Kieran was on something. Kieran's speech was slow and slurred. At the inquiry, Mr McFarlane's position had changed. He said that Kieran appeared to be withdrawing when he first saw him. He then said that he had been telling the truth when he gave his police statement. Standing that Kieran soon afterwards was seen by both Nurses Hayes and Dr McCartney, who both recorded sedation, I attach no weight to Mr McFarlane's suggestion that Kieran was withdrawing when he saw him. I think that the passage of time left him confused.

[63] Dr McCartney told Nurse Hayes that the first of the prescriptions was to be commenced when Kieran showed signs of withdrawal. She entered that into the nursing notes. Professor Gournay was critical of that instruction. He said it was not a satisfactory plan. It was not specific enough. The instruction was more directed to nursing staff than anyone else. At 5.15pm Kieran was given commencing doses 30ml of methadone and 20mg diazepam by staff Nurse William Wood. Nurse Wood had taken vital signs recordings of blood pressure 128/71 and pulse of 64. He placed a note in the nursing record that Kieran had been commenced on detox with methadone 30ml and diazepam 20mg given. Nurse Hayes identified his signature on the kardex verifying he had dispensed those drugs. Although there ought to have been, there is no witnessing signature to these drugs being dispensed. There is no evidence that Kieran was showing any clear signs of withdrawal before or around 5.15pm when he was given his initiating doses of 30ml methadone and 20mg diazepam. It is not known to the Inquiry, short of it being prescribed, what prompted Nurse Wood to give

the medication. Although represented by a solicitor throughout, Nurse Wood was not called by the Crown to give evidence. No offer was made for him to give evidence on his own behalf. My understanding is that the Crown had yet to decide on other matters possibly relating to Nurse Wood and outwith the scope of this Inquiry. That state of affairs is both very unusual and very unhelpful. It is all the more so, considering that subsequently Nurse Wood was the last qualified nursing member of staff to have dealings with and responsibility for Kieran.

Friday 9 December 2005 5.15pm onwards

[64] Two fellow patients, Mark Rafferty and James Docherty, were clear about observing Kieran on the Friday evening. Both referred to him as "being full of it". Mr Docherty said his eyes were pinned and he was gouching. That evidence stands in stark contrast to the evidence from Auxiliary Nurse Elizabeth Smillie. Still employed by Castle Craig, she was on back shift (until 9.30pm) with her brother, Nurse William Wood, who was on duty on Friday 9 December 2005. She said that she saw Kieran on the CCTV monitor and then spoke to him in his room, when he was in the company of other patients. She accepted the proposition put to her by Mr McBride QC that when she saw him his condition was fine by answering: "I think yes from my memory". She further accepted the leading propositions that Kieran was coherent, did not appear to be under the influence of anything and was acting normally. From the CCTV evidence led, that would have been approximately between 6.36pm and 6.45pm. Auxiliary Nurse Smillie initially said she had no recollection of any involvement in Kieran's medication at 5.15 that day or what medication he received. She had not signed the drugs record, Crown Production 32, as a witness. On seeing the CCTV recording played back in court, which appeared to place her in the medical

room at the time, she accepted that she may have witnessed the administration of the prescription but must have neglected to sign the record. She was unable to assist in relation to an alteration that appeared to have been made in the record. I had considerable doubts about the reliability of Auxiliary Nurse Smillie. She saw Kieran later after he returned from an unauthorised visit to the extended care unit. She challenged him about the visit and he told her he had been there to see a patient named Martin that he knew from his previous admission. He said he wanted Martin to purchase some toiletries for him that he had omitted to bring with him to the hospital. An entry recording Kieran's unauthorised visit was placed by Auxiliary Nurse Smillie into the nursing record. She reported nothing untoward about Kieran's presentation. It did not appear that she paid any particular attention to his demeanour. Her evidence was that she had no concerns for his appearance at the time. Her concern was that he had been to the extended care unit. On the uncontroverted medical evidence of slow onset, it was unlikely that Kieran so soon after receiving his first dose of methadone would be displaying any effects from it.

Friday night/Saturday morning

[65] Registered Mental Nurse Eileen Dickson came on duty at 9pm on Friday night. Following handover from Nurse Wood she set about the task of evening medications. She did not read through Kieran's clinical notes. She said that she had a quick flick through his nursing notes. At 10pm Kieran's vital signs were measured and blood pressure136/102, pulse 92 recorded. No record was otherwise made of his medical condition or demeanour. She gave him 20mg diazepam at that time which she noted in the nursing notes to be "as per Kardex". It was clear from her evidence that she

considered the detoxification drug regime to have started. She said she was generally looking for signs of withdrawal in patients, that in relation to comfortable detoxification. She made no observation of signs of withdrawal from Kieran. It is reasonably clear that none were evident.

[66] Kieran was subsequently noted by Nurse Dickson to have been up and down on several occasions during the night. He was noted to have requested methadone and diazepam at 2am. His vital signs were recorded as blood pressure 133/75 and pulse 82. A request from him for medication was refused. He was said to be restless the remainder of the night but showing no obvious signs of opiate or benzodiazepine withdrawals. He was seen wandering about. On viewing the CCTV record in court Nurse Dickson saw one occasion in the middle of the night when Kieran appeared to stumble. She saw him drop and retrieve something, thought to be soap. She said she had not noticed these events on the CCTV monitor that night, explaining that she might not have been looking at the monitor at that moment. Her opinion remained that there was nothing untoward in what she saw of Kieran. According to Dr Wright, methadone can cause insomnia. Wandering about can be a sign of disorientation. He said that the increasing reports of disorientation gave rise to an increasing index of suspicion of opiate naivety.

[67] At 6.40am Nurse Dickson gave Kieran 30ml methadone and 20mg diazepam which she again noted in the nursing record as "per kardex". The note was not entered in the record until 7am and the medication purports to have been given then. Nurse Dickson explained that it was sometimes the case that medication was given but not written up until a little later if it is a busy time. That is less than ideal

although nothing turns on that omission. As was clear from the CCTV evidence, which she accepted, she only saw Kieran for a matter of three and a half minutes. She was aware of the Castle Craig guidelines, Management of Withdrawal: General Principles, at paragraph 7 which provided:- "Medication should only be given if the clinical indicators of withdrawal justify it or in a definite reduction programme". She said, unhesitatingly, in her evidence that her justification for giving Kieran the early morning dose of 30ml methadone and 20mg diazepam was that "Kieran was on a, what we would have classed as a definite reduction programme". That evidence, given in examination in chief, was not challenged by anyone. It highlighted weakness in the care plan. Professor Gournay described the care plan as minimal. He said there was plenty of information available for a comprehensive care plan. It was nowhere written clearly whether the initial doses on the Friday constituted the commencement of the detoxification. There was no specification of precisely when drugs were to be dispensed. There was no specification of how divided doses were to be divided. Dr Gilvarry said that if drugs were prescribed nurses will dispense them and that is what indeed happened. Nurse Dickson said in evidence that Kieran was not showing signs of over-sedation. She related that partly to having seen him at intervals throughout the night. She was not specifically looking for signs of withdrawal.

Saturday Morning and afternoon, 10 December 2005

[68] Staff Nurse Rachael Marples gave evidence about her knowledge, experience and practise as a nurse. She expected medical examinations to take place in the medical room. She had no knowledge as at that time of examinations occurring anywhere other than in the medical room. There was no Castle Craig practise at the time of routinely checking detox patients during the night. That contrasted with the protocol

in relation to observations. She mentioned a specific previous experience of a patient presenting as over-medicated. She was familiar with the signs. On that occasion she, along with the doctor on duty, had arranged for an ambulance to be called. Referred to the drugs record, Crown Production 32, she saw an erasure beside the entry for Methadone at 5.15pm the previous day where there ought to have been a witness signature. She could not explain why that was there. She had not seen it before. She said it was unusual for there to be a correction with no explanation. It was unusual for no auxiliary to witness the administration of controlled drugs and sign as having witnessed. Once the drug is administered she, Nurse Marples, would sign for it there and then and so would the auxiliary before any other drugs are administered. That was her invariable practise. Professor Gournay said that an illegible signature and no witness was a serious matter because of the nature of the drug involved. If it came to the attention of the Nursing and Midwifery Council it would certainly lead to a censure. Nurse Marples accepted the proposition put to her, that Kieran's history on the second occasion appeared to be of a serious addiction. She said that on admission one would want to be looking back at the previous notes. All medical experts who gave evidence thought that the previous notes were important and should be looked at.

[69] Nurse Marples came on duty about 8am on Saturday 10 December 2005, later to be joined by Auxiliary Nurse Donna Campbell at 10am. She said morning medication was given around 7am by the night staff. She was not involved with Kieran's morning medication. She accepted handover from Nurse Dickson. They discussed Kieran. Nurse Dickson told her that Kieran had been up and down all night and had asked for medication. Nurse Dickson said she "got round that" by telling him that it was written up by the doctor for the morning and so he would have to wait until then.

Following changeover, Nurse Marples went to observe Kieran. She found him to be under the influence of something. She was sure he was intoxicated and she was surprised because he had come in the night before and she expected him to have been medicated to the extent only to alleviate the effects of withdrawal. He appeared sedated and he ought not to have so appeared. She was concerned enough to want clinical assistance. Between around 10am to 10.30am she telephoned the locum doctor, Dr Sharma. She did not want to wait for him to arrive at an unspecified time. She said that she told him she required him to come in and assess Kieran and he said he would be there at about 1.30pm. She accepted that. Doubtful about Kieran's presentation and the history he had given on admission, Nurse Marples decided to go through the admissions questions with him again as a check. Kieran gave a similar, though not completely identical, history to the one given to Nurse Hayes the previous day. Still not satisfied, Nurse Marples decided to investigate further. She wanted to see his previous notes which she expected to have been archived onto disc. She could not find the disc. It transpired that they had not yet been processed onto disc as she expected. They had been present all along within a blue folder beside the current notes. She rang the nurse, Clare Donaldson, on duty at the Extended Care Unit to see whether she had any recollection of Kieran from his previous admission. Nurse Donaldson had seen Kieran at one point and confirmed similar views to Nurse Marples in relation his demeanour.

[70] A larger number of peers and staff members observed that Kieran was over-sedated on Saturday morning. Peer evidence came from Crawford Fee, Mark Madden, James Docherty and Barry Pinchback. Auxiliary Nurse Donna Campbell came on duty at 10am. As was contained in her police interview, she said Kieran

looked sleepy and his speech was slurred. His eyes were pin-holed. She was so concerned that she reported to Nurse Marples that she thought Kieran "was out of his face on something". Auxiliary Nurse William Stephenson, saw Kieran around 10.30am and observed that his speech was slurred and he was struggling to keep in one position. He was nodding a bit. He reported his observations to Auxiliary Nurse Campbell who in turn reported to Nurse Marples. Therapist, Lavinia (Lee) Taylor, could remember little when called to give evidence. When her police statement was put to her, she recalled that she saw Kieran on the Saturday morning and that his speech was slurred, he seemed sleepy and his eyes were half shut. He seemed confused and asked the time thrice. She met Nurse Marples and mentioned Kieran's confused state to her. Nurse Marples told her that Dr Sharma was coming in and would see Kieran.

Saturday afternoon and early evening

[71] The few who saw Kieran during Saturday afternoon said that he was more "with it" or more lucid than he had been earlier. Kieran was due to be given 20mg of diazepam around mid-day. Nurse Marples said that when Kieran came for medication at 12 noon he was showing no signs of withdrawal and did not warrant medication. She refused him medication. She decided to withhold that medication until Kieran had been seen by Dr Sharma. Kieran was unhappy and agitated about the refusal. In a verbal exchange with Auxiliary Nurse Donna Campbell he said he "wasn't using" and had done nothing wrong.

[72] Dr Sharma was another witness who, for identical reasons to Nurse Wood, was legally represented throughout the Inquiry and was not called to give evidence by the

Crown. No offer was made for him to give evidence on his own behalf. He arrived at the hospital at about 2.10pm. After he arrived, Nurse Marples discussed the case with him while Kieran waited outside the medical room. Nurse Marples suggested to Dr Sharma that, just as she had sought a second opinion earlier, he might contact Dr Young for a second opinion. According to her, Dr Sharma declined the suggestion and said it was not necessary. Dr Sharma went off to assess Kieran. He returned to say Kieran was too agitated for him to assess and instructed her to give Kieran the outstanding 20mg of diazepam to calm him so that he could be further assessed later. On that instruction, Nurse Marples gave Kieran 20mg of diazepam at 2.30pm. Dr Gilvarry was critical of that procedure. Nurse Marples had earlier made a nursing note of reports of Kieran gouching. Dr Gilvarry said that reports of 'gouching' meant that Kieran was well sedated**.** According to her Dr Sharma ought to have carried out a review of Kieran before any further drugs were administered. Dr Wright said it was inappropriate to give Kieran diazepam at the time. The nurse had properly withheld the drug earlier because Kieran was sedated. Dr Sharma should not have instructed her to give Kieran the diazepam. The instruction should have been to watch and wait. Nurse Marples saw Kieran later around 3.30pm when she thought he was more lucid. Nurse Donna Campbell saw him at 3pm when she thought he was not as drowsy as when she had seen him earlier. No witness described Kieran as showing any physical signs of withdrawal.

[73] Nurse Marples was aware that Kieran had further drugs set down to be dispensed later that day. Knowing that a relatively inexperienced registered nurse, Julie Ainslie, was coming on duty, according to her, she asked Dr Sharma whether Kieran was to have the further medication. She said that Dr Sharma commented that Kieran knew

what had been prescribed and that they were pretty much obliged to let him have that. Dr Sharma was still in attendance when Nurse Marples handed over to Nurse Julie Ainslie at the end of her shift at about 3.30pm. In a detailed handover, she told Nurse Ainslie about Kieran. Nurse Ainslie asked about the drugs still prescribed for Kieran for later that day. Nurse Marples told Nurse Ainslie that Dr Sharma was to further assess Kieran and she would take it from there. Nurse Marples went off duty about 4pm. With the qualification that I did not hear directly from Dr Sharma, I accepted the uncontroverted evidence from Nurse Marples whom I considered to be a particularly credible and reliable witness.

Nurse Ainslie

[74] Julie Ainslie had been a registered nurse since 1983. She was experienced as a nurse but not in the specialised are of drug detoxification. She gave evidence to the Inquiry over the course of three days. At times she was obviously distressed and uncomfortable doing so. Some of her evidence was confused and inconsistent. She often appeared suggestible. However, on some matters she was adamant and would not be deflected. It should be noted that there was delay at the beginning of Nurse Ainslie's evidence because, like Dr Sharma and Nurse Wood, she had not been given immunity from prosecution by the Crown. Most unsatisfactorily, the Crown took time to consider its position, even at that late stage, before granting immunity and allowing Nurse Ainslie to complete her evidence without her requiring to be given a warning from me in terms of section 5(2) of the 1976 Act.

[75] Nurse Ainslie applied to Castle Craig for employment in order to broaden her experience. She disclosed in her application that she did not have previous experience

in the specialised field of drug detoxification. She was hoping to gain experience and expected to be trained. She commenced her employment with the hospital on 5 October 2005 as a bank nurse. She was not employed on a full-time basis but was available for shifts from time to time. The training she got fell into two categories. Firstly, she shadowed other experienced nurses on various shifts. There were 10 such shadowing experiences over the course of about one month. Eight of those were at the primary care unit and three of the eight were back shift, the shift she was doing on 10 December 2005. She had not shadowed on a weekend shift and had not previously done a weekend shift. In none of those shadowing shifts did she encounter anyone who was over-sedated. Secondly, there was formal training with compulsory attendance at courses. She attended a Moving and Handling course on 16 November 2005. That was a health and safety course provided at Castle Craig by an outside agency. She attended a Basic Life Support and Defibrillation course on 30 November 2005. That also was provided at Castle Craig by an outside agency and lasted about one to two hours. Critically, she did not attend any course relating to detoxification prior to being allowed to take charge on her own. She was not alone in lacking relevant training. The evidence relating to other nurse training and training records records revealed a disturbing pattern of gaps. Nurse Ainslie attended an in-service training day course on 11 January 2006 entitled: Intoxication and reflex Scheme, emergency Assistance for Detoxification, Nursing Observation and Nursing Care.

[76] Up until December 2005 Nurse Ainslie worked about two shifts per week. Some were mid-week backshifts. She said that she was confident doing these shifts because a regular doctor was available during the day and sometimes he stayed late, up until about 7pm. She contrasted that with the situation she found herself in on 10

December 2005 with only an off-site locum doctor available. She had not felt confident. She had seen methadone dispensed when she was shadowing. Apart from the fact it was a controlled drug, she knew little about it. She had no experience of seeing anyone over-sedated and would not know the signs of over-sedation. She had not seen anyone with withdrawal symptoms. She had little experience of the appearance of a drug addict.

[77] Professor Gournay described (the recruit) Nurse Ainslie as completely naïve in the area of detoxification. According to him, she was commencing employment at Castle Craig with a blank sheet. A huge amount of additional knowledge and skill was required to work in an addiction programme. The onus was on the employers. They knew what was needed and whether an employee was up to the job. There should have been a learning needs analysis. That depended on the person's experience. There should have been a defined period within which monitoring took place and an assessment should have been carried out at the end of it. A record of that should be kept in the employment record. Professor Gournay said employing someone with Nurse Ainslie's C.V. the onus was on the employer. He could not think of anything more important than the ability to recognise withdrawal symptoms and overmedication. Even learning protocols off by heart was just the beginning. There was a responsibility on the employer to ensure proper and sufficient training. Nurse Ainslie should have attended a course on the opiate antidote naloxone. Key skills were identified by him. These were, ability to identify withdrawal symptoms, ability to identify overmedication, knowledge of an opiate antidote and when and how to operate it, and knowledge of when it is appropriate to call for clinical help. Experience of opiates in a general hospital setting did not equip a nurse with sufficient

understanding of the use of methadone in a specialist setting such as Castle Craig. There, much higher doses of opioids were given to addicts than would be used in a therapeutic setting. Professor Gournay said an employer needed to ensure that a naïve nurse had proficiency in these key skills before allowing the nurse to operate autonomously. The nurse in charge should have the confidence to insist on the doctor attending. On the basis of her C.V. and training record, Nurse Ainslie was certainly not qualified to be put in charge of the unit by her employers. Recognising that there will be training cycles in respect of certain courses, Professor Gournay said that if the training cycle for particular skills had not come round it would be reasonable for a nurse to remain under supervision until the training was completed. Then there should be a learning needs analysis done before the nurse was allowed to take charge of a backshift as Nurse Ainslie did. Nurse Wood was a different proposition. With his knowledge and experience it was reasonable for the hospital to have him in charge.

[78] Nurse Ainslie arrived late for work on 10 December 2005. She had been held up in traffic due to roadworks. Arriving at 3.34pm, she went straight into a changeover with Nurse Marples in the medical centre. Dr Sharma came into the medical centre two minutes later. As could be seen from the CCTV images shown, Dr Sharma was present for only 90 seconds. The first topic of discussion that day was Kieran. Nurse Marples passed on information about the difficulties she had encountered with Kieran and his sedated presentation. She told Nurse Ainslie about earlier having withheld medication until instructed by Dr Sharma to give it. Nurse Ainslie became aware early in the handover that Kieran was due to receive further medication around 6pm.

She was concerned that the medication Nurse Marples had withheld and then given had been only at 2.30pm. She was apprehensive about whether the next medication, due about 6pm, should be delayed or even withheld. According to her, in the medical room while in the presence of Nurse Marples, she asked Dr Sharma directly whether Kieran was to have his prescribed medication and Dr Sharma said yes, he was to get it at the proper time. That evidence differs somewhat from Nurse Marples, who did not think she was present during such conversation. When it was put to Nurse Ainslie that she might be wrong about the timing of the conversation with Dr Sharma she reluctantly accepted that might be so. Importantly, she would not move, despite repeated questioning, from the proposition that the conversation with Dr Sharma took place and the terms of that conversation. Professor Gournay said that if Nurse Ainslie, with her experience, was told by a doctor to give the medication he would not be critical of her for complying with the instruction. According to Dr Wright, there should not have been an instruction to Nurse Ainslie to give the prescribed methadone and diazepam. The drugs should have been withheld to wait and see whether there were any withdrawal symptoms. Dr Gilvarry said that the 5.30pm medication should not have been given without clear authorisation from the doctor. Nurse Ainslie's position was that she had that authorisation.

[79] Dr Sharma was still present in the hospital at the beginning of evening medication time. He was observed on CCTV to leave the medical room at 5.24pm. Kieran came into the medical room at 5.26pm. As was noted in the nursing notes by her, Nurse Ainslie took vital signs readings. The point of taking such readings was to see if there was anything untoward. In the context of overmedication or withdrawal, Nurse Ainslie was not sure of the interpretation that should be put on a higher or

lower measurement. As was the case with all Kieran's vital signs measurements that had been taken, the readings were within normal parameters. Dr Gilvarry described such various vital signs readings that had been recorded as relatively stable. Professor Gournay explained that blood pressure readings often do not change until late on in a process when there might be a sudden collapse. At some point in the evening there would have been blood pressure changes. It was important to do regular checks. Despite what was to follow, those were the last vital signs readings taken by any of the medical personnel.

[80] According to Nurse Ainslie, Kieran did not appear drowsy when he attended for medication at 5.26. She said he just walked in and sat down. It was Nurse Campbell's evidence that Kieran looked more with it at that time. She said that he did not look drowsy or disorientated. Nurse Ainslie said she was aware that she had the power to withhold medication if she considered that appropriate. Witnessed by Auxiliary Nurse Donna Campbell, she gave Kieran 30ml methadone and 20mg diazepam 'as per kardex'. That was the first time that she could recollect administering methadone and the first time she had administered any medication to Kieran. She was critical of the instruction for medication to be given in "divided doses", a criticism shared with Dr Gilvarry. In Nurse Ainslie's prior experience in the NHS prescriptions were detailed on the amount to be dispensed, if divided, and when the drugs were to be dispensed. In Castle Craig she, on advice previously given by another nurse, followed what had been done before.

Share meeting

[81] A ‘share’ discussion group meeting, where views and experiences were discussed, commenced about 7pm on Saturday 10 December 2005, in the main building. Kieran along with the other patients attended that meeting. From the significant volume of evidence led it appears to have been obvious to all who saw him that by that time something was seriously wrong with Kieran. Auxiliary Nurse Campbell said she saw Kieran just before the meeting and saw he was back to being drowsy and sleepy looking. She heard other patients discussing concerns about Kieran’s condition. She was concerned and reported her concerns to Nurse Ainslie. Nurse Ainslie told her to keep an eye on Kieran. She went back downstairs and stood outside the French doors looking in at Kieran. Dr Gilvarry was of the opinion that if a nurse had cause to write in her note that a patient was very drowsy she should have gone and seen the patient. Vital signs should have been measured at that stage and noted. Professor Gournay agreed that Nurse Ainslie should have gone and seen Kieran. Kieran should have been observed for a number of things including pallor and his vital signs should have been taken. Looking at him through a window was not enough. Sending an auxiliary nurse to sit with Kieran demonstrated that Nurse Ainslie did not know what she was doing.

[82] Auxiliary Nurse, Sharon Laing had come on duty at 5pm. She was in attendance at the share meeting. She could hear other patients speaking about Kieran and saying he was over-medicated. Nurses and patients were concerned. She went to the medical centre to tell Nurse Ainslie what the patients were saying about over-medication. According to her, Nurse Ainslie told her to keep an eye on Kieran.

Auxiliary Nurse Laing then sat with him for some time. There is a question mark over whether Nurse Ainslie personally went to observe Kieran at any point. She certainly did not carry out any examination and did not measure vital signs.

[83] An extended care unit therapist and sometime auxiliary nurse, Margaret Crush, had been in attendance at the share meeting. She described Kieran as asleep, kind of tired and zonked. Around 8pm, after the share meeting had ended, Auxiliary Nurse Crush communicated from the extended care unit. She reported that she had passed Kieran on his way to the smoke hut outside with a cup of tea. He looked different to her and she was concerned he might burn himself.

[84] The evidence from fellow patients was overwhelming. Ann Wylie said some of Kieran's speech was not coherent. Mark Rafferty said that Kieran's eyes were puffy. He mumbled something at the meeting. After the meeting he spoke with Kieran and noticed his face was swollen and his eyes were glazed. Ross Dixon said Kieran's speech was very very slurred during the meeting. Al Zuherri said Kieran could not speak properly. He told him he had been given green stuff. Mark Madden described Kieran as babbling and no-one could understand him. Kieran told him that he had been given extra methadone. That on the evidence would appear not to have been the case. Barry Pinchbeck said Kieran did not make any sense whatsoever. Asif Asgrali said Kieran was completely incoherent. Douglas McFarlane, who was sitting next to Kieran, said that he was not himself. James Russel said Kieran was coughing for air and shouting out incoherently. He said that he raised concerns with auxiliary nurse Crush and was asked whether he knew better than the doctors and to mind his own business. That was not admitted by Auxiliary Nurse Crush. She said that she could

not remember saying it to anyone but accepted it was possible that she did. I had no reason to think Mr Russell had made this up. He had no reason to do so and was visibly moved during this part of his evidence.

[85] As mentioned above, Nurse Ainslie sent auxiliaries to keep an eye on Kieran. She said that she was concerned. Through one of the auxiliary nurses she had heard a fellow patient had described Kieran as overmedicated. It did not occur to her to take vital signs or take any other action. She wanted the assistance of Dr Sharma but did not telephone him for assistance. She said that she did not do so because she knew he was going to phone, as he had said he would. According to Nurse Ainslie, Dr Sharma did phone about 8.30pm. The evidence about this phone call was confused. At one point in her evidence Nurse Ainslie said she told Dr Sharma that she was concerned about Kieran. He looked drowsy and she relayed what Kieran's peers had been saying about overmedication. Nurse Ainslie was subjected to a lot of questioning about this telephone conversation. She became uncertain and ultimately departed from her original position. She maintained that she told Dr Sharma she was concerned but said she probably did not mention anything about peer opinion on overmedication. Dr Sharma asked her what she was doing and she told him she had an auxiliary sitting with him while had had a cup of tea and a cigarette. Dr Sharma asked who was coming on duty next and she told him it was Nurse Wood. According to her evidence, Dr Sharma said he was not unduly worried and would see him the next day. He told her that Nurse Wood had his mobile phone number should he need him. She clearly, on her own evidence, did not press the point and insist on Dr Sharma attending. She felt he ought to have taken the initiative. Nurse Ainslie had not taken vital sign readings. She said that she did not think to do so. According to

her, Dr Sharma did not ask for information on vital signs. Nurse Ainslie said that she was not satisfied. She did not feel that Dr Sharma's response was enough for the concerns there had been throughout the day. She had confidence in Nurse Wood who was very experienced and was relieved that he was coming on duty. She felt confident that he would be proactive in doing something. She did not know what to do but thought he would have answers for the next step. She thought that maybe he would speak to Dr Sharma and something different might happen. According to Dr Gilvarry the described terms of the exchange between Nurse Ainslie and Dr Sharma did not amount to a sufficient transfer of information. Nurse Ainslie ought to have had taken vital signs and be relaying that information. Saying that someone was sitting with Kieran was not enough. Dr Sharma should have been asking for more information. Professor Gournay said that if a nurse did not volunteer vital signs information he would have expected the doctor to ask for the information. Dr Gilvary said that if a doctor had been informed that peers had reported Kieran was gouching and had suggested he was overmedicated she would expect that doctor to get into a car and head straight for the hospital. Dr Wright said that if a nurse is saying she is worried and using words like drowsy it is highlighting risk. In that situation he would want to go back and assess Kieran or contact the emergency services.

[86] During her evidence the terms of the Nursing Medical Council Code of Professional Conduct were put to Nurse Ainslie. She accepted that it was her responsibility to maintain professional knowledge and competence. She accepted that it was for her to only undertake practice and accept responsibilities for those activities in which she was competent. She accepted that, in Castle Craig, she had been working beyond her level of competence. She had been out of her depth in assessing

whether a patient was overmedicated or withdrawing. She did not have sufficient backup. She was "ok" if everything was going well, which it had been during all of her shadowing sessions. She was not sure about the situation where methadone was involved. She did not think beforehand that if something went wrong she would not know what to do. With the benefit of hindsight she could have carried out regular checks on Kieran in his room and insisted on Dr Sharma attending. She never thought that Kieran was in immediate danger to life.

[87] Nurse Wood came on duty at 9.04pm. Nurse Ainslie greeted him in the medical centre with "thank god you are here". She said she told him of her concerns about Kieran. She read out her nursing notes, including the peer reference to overmedication. She told Nurse Wood that Dr Sharma had phoned. She said that Nurse Wood responded by rolling his eyes and asking "where is he?". Handover completed, Nurse Ainslie left the medical centre at 9.32 to carry out some remaining duties in the Extended Care Centre before going off duty.

Saturday from 9pm

[88] There was no evidence from Nurse Wood. There is only surrounding evidence from which to draw such inferences as that may yield. As was normally the case on Saturdays, there was a video film shown in the hospital later in the evening. This was attended by many of the patients. Nursing staff were present for at least some of the time. Kieran's condition had worsened. Kieran was asleep or unconscious during the film. Many patients said they spoke to Nurse Wood about Kieran's condition and were given reassurances that he was aware and would keep an eye on him. Mark Madden said Kieran was choking and grunting. His face was black. It was blatantly

obvious to him that Kieran was overdosing. He commented to Nurse Wood that an ambulance was needed. James Docherty said Kieran's skin was turning blue and his lips were blue. His breathing was not normal. He was coughing with no force in it. His eyes were pin prick. Rather than getting better he was getting worse. William Murray said Kieran was lying, gouching. He told Nurse Wood that something was wrong and suggested that the nurse had better check on Kieran. Barry Pinchbeck described Kieran as having a can of cola he was holding spilled over him as he sat. His pupils were microscopic. His face was puffed and purply-reddy. He explained that his mother had died aged 36 and he recollected what he described as a "death rattle". He said Kieran sounded like that. Al Zuherri twice told Nurse Wood that Kieran was sleeping. Ross Dixon saw Kieran after the film and described him as unconscious. He suggested to Nurse Wood that Kieran had had too much methadone. According to him Nurse Wood agreed Kieran probably had had too much methadone. With the sheer volume of evidence I am satisfied that it may be inferred that Nurse Wood was aware of the Kieran's ill condition. After the film, three of the patients had to assist Kieran upstairs. Nurse Wood took Kieran to the toilet where he was searched and then escorted Kieran to his bedroom. It was clear from the CCTV evidence shown at the Inquiry that Kieran was unsteady on his feet as he was escorted to his room by Nurse Wood. Kieran was never seen alive after that. No medical staff member entered the Romano Room from Kieran being escorted there, at about 11.33pm until his body was discovered the following morning, at about 8am, after he failed to come to the medical centre for medication.

[89] The peer evidence relating to Kieran's condition in late evening is consistent. The volume of that evidence leaves me with no difficulty in accepting it as a true

representation of the facts, even in the absence of evidence from Nurse Wood. What is missing is an account from Nurse Wood in relation to what he did or did not do. On the evidence available of Kieran's condition, Dr Gilvarry's opinion was that Kieran was already in overdose by the time he was led upstairs. According to her, the time had been reached for the doctor to be summoned, an emergency 999 call to be made for an ambulance and/or naloxone to be administered. It was not appropriate for Kieran to be allowed to go to bed. Professor Gournay said that on the information, anybody with experience in the management of detoxification should have been worried. It was becoming a medical emergency. Reports of blue lips was an indication of an unfolding emergency. Anyone would know it was a sign of something seriously wrong. A registered nurse would know absolutely that it was a life threatening situation. Kieran was about to go into a coma. The doctor should have been contacted or alternatively there should have been a 999 call for an ambulance. Meantime, Kieran should have been placed in recovery position to prevent choking and he should have been constantly monitored. Oxygen should have been given to him. The presumption should have been that things would get worse, not better.

[90] While I have been able to identify, on the evidence led, things that could have been done that might have avoided the death, in the absence of evidence from Nurse Wood and Dr Sharma I cannot go on to consider why they did or did not do certain things. To do so would be to enter into the realm of speculation.

Sunday morning, 11 December 2005

[91] Registered Nurse Nancy Yuille came on duty about 8am on Sunday morning 11 December 2005. She was met by a distraught Nurse Wood who told her Kieran had died. She went into the Romano Room and looked at Kieran. She found his body cold to the touch. She noticed post-mortem lividity. She formed the unqualified view that Kieran had been dead for some time. A call was made to Dr Sharma at 8am. Dr Sharma attended and having made a number of observations pronounced Kieran life extinct at 8.25am. I did not hear directly from Dr Sharma in this regard. Police Sergeant Alistair Bruce (at that time Constable Bruce), along with a colleague, received a call to attend at the hospital, which he did. He interviewed Dr Sharma who told him that he had examined Kieran and had pronounced life extinct at 8.25am. Police Inspector (then Sergeant) Richard Latto attended and took photographs of Kieran's body in the Romano Room. These photographs were subsequently examined by Professor Kernbach-Wighton. He commented on the very intense post mortem lividity seen, which he said was indicative of acute poisoning. He went on to say that it was difficult to establish time of death because there were a number of variable factors affecting body temperature. His evidence was that it takes a couple of hours for the lividity seen to develop but that once it develops it will remain present.

[92] Kieran was not seen by anyone from being put to bed at 11.33pm until his body was discovered at 8am. On the evidence, the limited conclusion that can be drawn is that he died between the hours of 11.33pm on Saturday 10 December 2005 and 6am on Sunday 11 December 2005.

Care Commission inspection 16 and 25 January 2006

[93] Care Commission Officer, Roy Young, gave evidence. He was formerly a registered nurse and joined the Care Commission (Scottish commission for the regulation of care) in 2003. His nursing experience included drug and alcohol addiction. Mister Young firstly referred to an announced Care Commission inspection of Castle Craig in May 2005. He was not involved in that inspection. He then referred to an unannounced inspection which took place on 16 and 25 January 2006. He was part of that inspection. At that time he was aware that there had been a death in the hospital. The police had asked them not to interfere in any way with the incident. He said he was aware of the Orange book and when asked to go and regulate a service that was dealing with drug or alcohol problems he would refer to it for best practice guidelines. The resultant report made a number of requirements and recommendations as follows:-

[94] " **Requirements**

1. All sections of the admission and assessment documentation should be completed. This includes entering "Not applicable" where information is not pertinent to the individual. Nursing care plans should reflect all the assessed needs of the individual, for example nutritional need. This is in order to comply with SSI 2002/114 Regulation 4.(1)(a) - a requirement to make proper provision for the health and welfare of service users.

Timescale for implementation from date of the next new admission.

2. Policy and procedure documents, particularly relating to Detoxification, need to be further reviewed in line with best practice guidance. In addition all policies and procedures should indicate date of issue and date of review. All policies and

procedures should be checked in order to minimise the risks of discrepancies, for example medication dosage. This is in order to comply with SSI 2002/114 Regulation 4. (1)(a) - a requirement to make proper provision for the health and welfare of service users.
Timescale for implementation 4 weeks from publication of report.

3. The training needs of nursing staff in relation to detoxification and substance abuse must be undertaken as a matter of priority. This is in order to comply with SSI 2002/114 Regulation 4.(1)(a) - a requirement to make proper provision for the health and welfare of service users.
Timescale for implementation 8 weeks.

4. All staff files should be reviewed to ensure that references, Disclosure Scotland checks, record of induction and on-going training are included. This is in order to comply with SSI 2002/114 Regulation 9.(1) and (2).(a)(c)(c) - a requirement to ensure the fitness of employees and take into account National Clear Standards for Independent Hospitals 10 – Staff.
Timescale for implementation within 24 hours of publication of this report.

5. Managers should ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health and welfare of service users. This is in order to comply with SSI 2002/114 Regulation 13(a) - a requirement to ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health and welfare of service users.

Timescale for implementation within 24 hours of publication of this report.

6. Policies and procedures for the checking of clinical equipment should be developed. This is in order to comply with SSI 2002/114 Regulation 15 - a requirement for the provider of an independent health care service to make such arrangements as are necessary for securing any treatment or services provided by the service are of a quality which is appropriate to meet the needs of service users.
Timescale for implementation within 24 hours of publication of this report.

7. This service should clarify to all staff which guidance on baseline methadone prescribing should be in operation. This is in order to comply with SI 2002/114 Regulation 4(a) - a requirement to make up provision for the health and welfare of service users and takes into account National Care Standards for Independent Hospitals - 20.1 and 20.6 - Medication.

8. The temperature of any fridge with medication requiring cold storage should be recorded on each working day using a maximum and minimum thermometer and the audit trail of medication should clarify the form of medication ordered, received, and administered and returned. This is in order to comply with SSI 114 Regulation 4.(1)(a) - a requirement to make proper provision for the health and welfare of service users and takes account of National Care Standards for Independent Hospitals 20:1 and 20:2 – Medication.
Timescale for implementation within 24 hours of publication of this report.

[95] **Recommendations**

1. All information pertaining to individual assessments leased to be centralised, for example drug screening tests and results. This takes into account the National Care Standards for Independent Hospitals 5 Planning your care.

2. There were no records of supervision available for medical or nursing staff, police should be in place. This takes into account the National Care Standards for Independent Hospitals, Standard 10:9 - Staff.

3. The audit trail of medication should clarify the form of medication ordered, received, and administered and returned. This takes into account the National Care Standards for Independent Hospitals 20:1 and 20:2 - Medication.

4. The service should operate a system that ensures that all medication is administered at times that will maximise benefits and minimise harm. This takes into account the National Care Standards for Independent Hospitals 20:1 & 20:3 - Medication.

5. The service should operate a symptomatic relief policy for the administration of pharmacy and general sales list medication in line with best practice guidance. This takes into account of the National Care Standards for Independent Hospitals 20:1 - Medication.

6. The service should ensure the amount of medications stored is appropriate to the needs of the service users and that medication is stored in an organised manner. This

takes into account the National Care Standards for Independent Hospitals 20:1 and 20:2 - Medication.

7. The present system of labelling of medication for service users on discharge, should be to the same standard as expected of a pharmacist. This takes into account the National Care Standards for Independent Hospitals 20:4 - Medication."

Care Commissions inspection 19 June 2006

[96] A further Care Commission inspection took place on 19 June 2006. It was unannounced. Mr Young was a party to the inspection. It was noted that the service, Castle Craig Hospital, was currently subject to enforcement action. It was noted in the Report that Recommendations1, 3, 4 and 7 from the January 2006 inspection had been met. Recommendations 2, 5 and 6 had been partially met. Requirements 1, 2, 5 and 7 from the previous report had been implemented and the Report was silent on them. It was noted that the remaining requirements from the previous Report still required follow up or implementation on an ongoing basis.

Care Commission inspection 24 and 25 August 2006

[97] An announced Care Commission inspection took place on 24 and 25 August 2006. Mr Young was not involved in that inspection. A long list of examples of satisfactory practice were found and noted. These included:-

Staff files revealed that a systematic process for the recruitment of staff was in place. There were employment checklists in place in most files examined.

There was evidence in the files that recently appointed staff had undergone and were undergoing induction.

A system of supervision and appraisal had been developed for nursing staff.

A training needs analysis for 2005/06 had been carried out and identified general and specific training needs for the organisation and its staff.

The procedure for admissions was clearly defined and documented.

The staff appeared aware of the admissions procedure and there was no evidence of digression from the procedure.

The admissions procedure clearly highlighted responsibilities of various professionals.

There were comprehensive protocols and procedures.

It was noted there were good algorithms in relation to prescribing and noted that nursing staff highlighted within the care plans any changes in relation to dosage or new medication.

There was an effective risk management protocol.

There was clear procedure in relation to critical incidents.

The detoxification regime, including supervision and monitoring, as well as recording were clear, evidence-based and the nursing staff were well aware of detoxification protocols.

The new policies and procedures had been peer reviewed prior to implementation.

There had been no enforcement action taken against the service since the previous report. No pertinent requirements or recommendations were made.

Castle Craig Practice

[98] Dr Margaret McCann said she was the Castle Craig Hospital manager and medical director. She was responsible for the management of the resources and responsibility for the policy, procedures and systems within the hospital. She had

responsibility for the governance of the hospital, staff governance, and ethical and clinical governance. She was responsible for setting up systems to direct the training of staff. Her evidence spanned her medical, corporate and managerial responsibilities. She said Castle Craig opened in 1988. In its first year it dealt only with alcohol dependency then branched into drugs dependency following the Minesota model of rapid detoxification. It fell within the remit of the Care Commission from 2002 as a nursing home. It was approved as an independent hospital by the Care Commission in 2004.

[99] Dr McCann was questioned about Kieran's first admission and accepted that she did discuss a benzodiazepam detoxification with Dr McCartney. It was her evidence that the name of the patient was not disclosed to her and she said she thought the matter had already been discussed with Dr Young before discussion with her.

[100] It was evident from Dr McCann's evidence that despite her multiple and wide ranging responsibilities she knew relatively little about what had gone on in the hospital from day to day and little about staff training and ability. She knew little about the unnecessary risks that were being taken.

[101] An experienced clinician in a specialised field, Dr McCann agreed with much of the expert evidence. She agreed that both methadone and diazepam were central nervous system depressants. She agreed that methadone can cause respiratory depression if the doses are larger than the patient tolerance. She agreed that addicts tended to top up on drugs before entering into detoxification. She agreed that addicts tended to exaggerate their needs on admission. She agreed that care was required in

accepting what an addict said he or she was taking. She agreed that corroboration of the amount said to be used was important. She would personally want more information before prescribing. She accepted that a urine sample could provide corroboration of the drugs recently taken.

[102] Dr McCann said she had learned that urine screening had not been practised for drug addicts on admission. She claimed that she had not been aware that urine screening was not done routinely for patients who had been inducted onto methadone. That did not entirely correspond with Nurse Hayes' evidence to the effect that urine screening was routinely not done and that she had been indirectly informed that Dr McCann did not want them routinely done in order to save costs. Dr McCann made reference to an admission protocol said to be circulated in September 2005 to Nurse Hayes, Dr Young and to the members of the Castle Craig quality standards committee. She said it had an explicit direction in it that all drug addicts on admission would have an observed urine specimen taken to check for drugs. She said there was some delay in the procedure being finalised but that it was eventually given to the quality standards manager at the beginning of November and was completed by the end of November. Ultimately, she said that it was only after Kieran's death she discovered it was still on a desk and had not been circulated. According to her it was then immediately circulated. It later emerged in her evidence about the meetings at which it was discussed, that Dr Young had not favoured routine urine analysis being introduced.

[103] Along with others professionally qualified to comment, Dr McCann described withdrawal as crucial. She said dependency was clear from withdrawal. She would

expect detoxification to commence when withdrawal symptoms were established. She said it was not known if a person was truthful or how much they used or had taken before they came in. It was necessary to wait and see. That was a continuous process. She agreed that if there were signs of intoxication when a person was assessed by a nurse or a doctor, no methadone should be given. Dr McCann said there was a distinction between induction and stabilisation. The aim of induction was to reach a baseline or minimum daily dose that ensures stabilisation. That is what was meant by induction. She said that she would deal with the patient on the basis of giving an initial dose with a further dose possibly being required to relieve withdrawal symptoms. She said that to discover tolerance a dose should be administered and the patient should be observed. Criteria affecting tolerance included the amount, frequency, duration, previous exposure, time span and genetic variation. 20ml of methadone in a non-tolerant patient would be dangerous. It would show intoxication manifested in slurred speech, staggering and disorientation within the space of an hour. Blood pressure would drop and be measurable. There would be a blueness discolouration of the lips. The patient would be difficult to rouse. She accepted that Kieran had not been treated in the manner she described and spoke approvingly of.

[104] In Dr McCann's opinion, the doses prescribed by Dr McCartney for 60ml methadone and 80mg diazepam in divided doses to prevent toxicity were high doses. She was more cautious in her own approach to prescribing. She said she told Dr McCartney, when he began his employment, to start low and stay low and handed him copies of the Castle Craig protocols, which she had written and introduced in 2002. Both Dr Young and Dr McCartney were very familiar with the protocols. The methadone detoxification protocol was updated in 2004. She said the protocols were important and that she would follow them.

[105] Dr McCann said she was aware that occasionally doses of 20, 25 and occasionally 30ml of methadone were used as a commencing dose. At the time she considered Dr Young to be very experienced and higher doses could be prescribed for someone who was severely dependent. If commencing at a higher dose, the assessment of the patient must justify that. According to her, Dr Young himself said that at a peer group meeting. She said she had understood that the prescribing in Castle Craig was mostly compatible with the Orange Book guidelines. I do not accept she was in a position to make such a statement. At best she knew far too little and at worst she ignored what was going on under her nose.

[106] Dr McCann said that she personally would not have written the prescriptions presumptively. According to her, that should not have happened. However, she accepted that presumptive prescribing was at that point done in Castle Craig and she had carried out no audit of prescribing at the time. She accepted that once a prescription was written it could be left to a nurse to decide on administration of the drugs prescribed. She said it was not acceptable to her as a doctor or as director of Castle Craig for a prescription to be written up before withdrawal and left to another, who might be a nurse, to judge whether to administer. Acknowledging that it was left to interpretation, Dr McCann said that "divided doses" seemed to have been interpreted by the nurse and the doctor on duty as 7am and 5.30pm. Although she must have known by the time she gave her evidence that there was no evidence of Kieran showing signs of withdrawal, she said that it was possible the patient presented with very severe withdrawal and on assessment was administered at these hours. She

must also have known that 7am and 5.30pm were regular times for medication in the hospital. Patients and staff were universally aware of that.

[107] Dr McCann was referred to Castle Craig Protocol on Methadone detoxification, bullet point 4, which provided:- "It is the consultant and doctor on duty at the time of stabilisation who must be responsible for supervising the stabilising dose and informing the nurses on the dose to administer." Dr McCann said she considered that was what should happen. The nurse administering the dose would trust to the doctor who decided on the dose. She said that she did not allow the protocol to be ignored (from what I understood her to mean, she did not actively allow it). She claimed she did not know it was being ignored. She said she had not checked out what was happening and had made assumptions. In fact the protocol was being routinely ignored and Dr McCartney was following practise shown to him by Dr Young. With regard to weekend cover, she said she was not otherwise aware of any patient being admitted on a Friday to be commenced on a methadone detoxification. She would not admit a patient on a Friday. That decision was taken by a consultant, by which she meant Dr Young. It has to be noted that does not accord with Dr Young's evidence. He said that he did not want Kieran admitted on a Friday. He said that John McCann, acting for Castle Craig, decided that Kieran was to be admitted.

[108] In December 2005 Mary Hayes was the head nurse. She worked a five-day week. Dr McCann said she would expect registered nurses working in Castle Craig Hospital to be aware of the signs of withdrawal. They should have had their attention drawn to this during their induction period. She said that was the responsibility of the head nurse. She would expect and require that Nurse Ainslie had her attention drawn to the detoxification protocols during her induction. However, she accepted that there

was a responsibility upon her to ensure nurses did actually familiarise themselves with the procedures and protocols. She said she had given a lecture to nurses in December 2004 on the topic of detoxification and identification of withdrawal symptoms. Later in her evidence, under closer scrutiny, she accepted that the lecture had been largely on the topic of alcohol addiction. There had been a section of about 45 to 60 minutes duration relating to detoxification. I observe that from other evidence in the Inquiry that whatever length of time was dedicated to methadone it had little impact. Nurses who had attended the lecture could remember little in relation to methadone and its effects. They could remember nothing about naloxone.

[109] Dr McCann accepted that there was no detoxification training lecture given throughout 2005. It was only on 11 January 2006, following the death, that a further lecture was given. That lecture did focus on management of intoxication and detoxification. At the time of the death, there was always one registered nurse on duty on a 24-hour basis. Dr McCann accepted, and it necessarily followed, that Nurse Ainslie had not attended any such lecture before being allowed take charge on duty as the only registered nurse covering both the primary care unit and the extended care unit on Saturday 10 December 2005. Dr McCann also had to accept, as was evident, that there were numerous gaps in nursing staff training.

[110] Asked about locum doctors, Dr McCann said that Dr Young must have had confidence in Dr Sharma's ability to review Kieran's prescription. She said she had no misgivings about Dr Sharma and considered him to be conscientious.

[111] Dr McCann said she believed that the death could have been avoided if the special observations procedures had been followed and a proper risk assessment had been done on Kieran. By that, she said she meant, that when Kieran presented on the Saturday evening between the hours of 7pm and 11pm his condition was clearly a cause for concern by several members of staff and several patients. No medical training was required to notice that. If a person was turning blue it would be obvious something was wrong with them. If the person was sleeping and snoring that should cause alarm. It raised a strong suggestion of over-sedation. If the situation had been risk assessed and a risk view taken of the situation, perhaps the outcome would have been different. There was a close monitoring form kept in the front of the patient kardex. It was another way of alerting the nurses to the needs for the close monitoring of patients who were on that particular form. The closer monitoring was those observations to be undertaken already set out in the management of withdrawal general principles and protocols.

[112] Dr McCann said that the Castle Craig protocol has a recommendation for patients to be monitored during the period of stabilisation. There should have been patient special observation every 4 to 6 hours and more frequently if needed. Dr McCann said it was her expectation that that would happen. She said that she drew attention to it in her lecture in December 2004. Although she conceded that she had not audited whether the nurses were carrying out observations during the night she said she would be astounded to learn that they were not visiting and observing patients at night. However, she accepted that it would be a simple matter for her to have checked the nursing records and learn this was not happening.

Comfortable chairs

[113] No doubt in response to a suggestion that was aired in the course of the Inquiry inferring that nurses slept in the medical centre at night, Dr McCann, at one point, volunteered that she expected nurses to be wakeful during the night. Her remark has to be considered in the light of the evidence there was in relation to the activities, or lack thereof, of some nurses. A number of witnesses spoke about nurses taking large comfortable chairs from patient bedrooms into the medical centre at night. There was also evidence of blankets or duvets being taken in.

[114] Nurse Marples said she was aware of the practice among some nurses. She thought the chairs were taken out of the patients' bedrooms. She had experience of being on duty when it happened. She said such chairs were a more comfortable place in which to sit and catch up on notes or read through materials. She said she was not aware of staff using them to sleep on but she could only speak for herself. She said she had never heard of a nurse taking a duvet into the medical centre but possibly a blanket, adding that there was a period of time when the medical centre was very cold.

[115] Nurse Dickson said that she was aware of the practice on night shift of comfortable chairs being taken into the medical centre. She said some staff did do that and some staff did not. She said the chairs in the medical centre were uncomfortable to sit on for any time at all. It was the auxiliaries who fetched the chairs. Sometimes quilts would be taken in because it got "perishing cold" overnight.

[116] Former patient, William Murray, said that prior to Kieran's death the only time he was aware of nurses coming into the bedroom at night was to remove the two chairs that were there. He said the nurses were really not meant to do that. He described the chairs as big and old fashioned comfy chairs. He spoke of one occasion, before Kieran's death, when he went to the medical centre at night some time between midnight and 4am. He was feeling ill and wanted pain-killers. He found Nurse Wood sitting on one of the comfortable chairs with a quilt around him and his feet up on another comfortable chair. He thought that an auxiliary nurse was also present and sitting on the second chair. Unprompted, he stated that nurses should not be lying going to sleep but should be going round doing their checks.

[117] Auxiliary Nurse Robertson was on duty the night Kieran died. She remembered going into the Romano Room in the morning to put the soft chair back into the room. She said that sometimes nurses take the soft chairs into the medical centre to sit on through the night because they were comfortable. The chair was for the nurse and not for the auxiliary. She said that happened most nights. She said she was unaware of a night nurse on duty taking a duvet into the medical centre. She then said it might have happened but she could not remember it.

Castle Craig post 11 December 2005

[118] Dr McCann said admissions procedure was under review at the time of the death but not "rolled out". A new admissions procedure was written in March 2006. There was now a minimum requirement of history of opiate use, evidence of withdrawal symptoms and urine toxicology. She said that urine screening became immediately mandatory following the death. She thought the practice now was for no

prescription until there were signs of withdrawal. Now a doctor will supervise, check for withdrawal and write up the induction dose. Lofexidine was a non-opiate substitute drug for treatment of opiate addicts. After Kieran's death there was a switch from methadone to lofexidine except in cases where a patient was already on a methadone prescription.

[119] There had been shortfalls, particularly in regard to observation. Respiratory readings have been introduced. If a person is over-sedated the reading would be down. Now, during stabilisation, vital signs are monitored every 4 hours with a chart to be filled in that includes respiration. That must be done and recorded.

[120] The hospital now had a resident medical officer. At the time of the incident there was only one registered nurse on duty throughout a 24 hour period at the weekends. That nurse had to cover both the primary care unit and the extended care unit. Following the incident, and in implementation of a Care Commission requirement, there were now two registered nurses on duty at night as well as two assistant nurses.

[121] Dr McCann accepted there had been an audit shortcoming. At the time of the death, there was no audit in relation to which nurses had attended which training sessions or lectures. That had changed. There was now a much more structured and formalised induction procedure that was subject to audit. There had been implementation of a systematic approach to audit. Now every single procedure was subject to audit so that the practice was monitored and was audited. There was close tracking of implementation.

[122] Following the death there were a number of Care Commission requirements made. These had all been implemented.

[123] Dr McCann said that under no circumstances would an opiate dependent patient now be admitted on a Friday. However, she then qualified that by saying that if a consultant was willing to come in and assess over the weekend and there was resident clinical care and sufficient nursing staff it might be considered.

Toxicology

[124] The toxicology evidence establishes that the death occurred as a consequence of the respiratory inhibitant combined effect of methadone, diazepam and possibly temazepam in its own right. No other substance was found in any material concentration. Professor Kernbach-Wighton explained that each of methadone and benzodiazepam affect the respiratory centre and stop the main trigger for breathing regulation. The drugs have unpredictable cross effects. Martin Oakley, Forensic Scientist, also gave evidence as to the combined effect of depressants and the potential added effect of temazepam if included in the equation.

[125] A question arose as to whether, in addition to the methadone and diazepam he was dispensed in the hospital, Kieran had also taken an unknown quantity of unprescribed temazepam. Temazepam is a metabolite of diazepam. It is also a drug that can be taken in its own right. Accordingly, temazepam found on toxicology could have occurred through Kieran taking it in the form of temazepam or taking diazepam and that drug having, to some extent, metabolised into temazepam.

[126] Robert Anderson, toxicologist, said that the drug concentration found in the autopsy blood could be explained on the basis of the drugs dispensed in the hospital with the possible exception of the temazepam. He said that the level of temazepam found was a bit higher than it should be. While it was possible that the levels of temazepam found were the result of metabolism of the diazepam dispensed, in his experience of it there would normally be a lower concentration if it had come from diazepam. He said that the results tended to suggest the possibility of some drugs having been taken outside the prescribed medicine that was given. He later went on to explain that there were three possibilities. Kieran could have taken temazepam while in the hospital and receiving the other drugs, he could have taken temazepam before he came into the hospital or it could be down to the way he metabolised the diazepam, which was different in each person. It could have been a combination of two or more of these possibilities. He said it was very complicated.

[127] Martin Oakley gave similar evidence. He initially said that the taking of temazepam independently could not be ruled out. He then said that he thought that the level of temazepam was sufficiently high, on balance, to make it more likely than not that temazepam was taken independently. He too was unable to say whether any such temazepam was taken before or after Kieran's admissions to the hospital. He was reluctant to use half-life as a measure because that measure arose out of and was used in clinical situations. The research was not based on post mortem situations.

[128] While there was clear evidence that Kieran was under the influence of some substance when he was admitted to Castle Craig there is no evidence that he took

anything other than prescribed medication after admission. Looking to all the toxicological evidence I think that it can be inferred that Kieran took an unknown quantity of temazepam some time before being admitted to the hospital.

[129] In their written submission, it was properly accepted by Castle Craig that it was immaterial whether any temazepam was taken before or after Kieran's admission because in either situation what mattered was not the precise combination of drug taken but rather the effect of the combination upon Kieran and the reaction of the hospital to that presentation. Castle Craig accepted that they had an obligation to look after Kieran whether he had taken only the medication prescribed for him or something in addition to it. They accepted that it was known to them that, though uncommon, patients did sometimes have a 'stash'.

Recommendations

[130] In the light of my findings and determination in terms of section 6(1)(c), (d) and 9e) of the 1976 Act I make the following recommendations:-

1. The Orange Book guidelines are, as is stated in the foreword to the 2007 edition, intended for all clinicians, especially those providing pharmacological interventions for drug misusers as a component of drug misuse treatment. The drug misuse treatment provided to those misusers in the community is significantly different to the treatment provided in specialist residential establishments such as Castle Craig Hospital. In the community it is often the case that a long time is spent in titration, up or down, to find equilibrium. It is also the case that a long period of months or years may follow during which methadone is dispensed.

What happens in the community can be contrasted with what occurs in specialist residential establishments, or at least some such establishments. There, it might be the case that the whole process of chemical detoxification is completed in a matter of weeks or months, a far shorter time than might be committed to titration in the community.

As part of a range of NHS reforms, non-medical prescribing has been introduced. That provides, for example, for nurses in certain circumstances, to be able to prescribe drugs such as methadone. The topic is discussed at paragraph 2.4 of the 2007 Orange Book.

A problem that was apparent in the Inquiry was the ease with which some clinicians may justify departure from the Orange Book guideline and the danger arising out of doing so. I think that the public might benefit and confidence might be restored if it were less easy for there to be such departure. I also think it would be of benefit to the public if the level of departure from the guidelines was linked to the extent of the departure.

I recommend that consideration be given to devising specific guidance directed towards those providing drug misuse treatment within a residential setting such as Castle Craig where it is likely that the process of titration and stabilisation will be rapid.

2. I recommend that all nursing staff recruited in Castle Craig Hospital to care for drug detoxification patients should undergo a learning needs analysis and either:-

(i) have sufficient, current experience in caring for drug detoxification patients as to be fully familiar with the nature and extent of the industry standard guidance found in the Orange Book and be aware of the nature and side effects of methadone; the half-life cumulative effect of treatment with methadone in the first few days of treatment with the drug; the withdrawal symptoms associated with opiate withdrawal; the intoxication symptoms associated with opiates; the nature, use and administration of opiate antidotes such as naloxone; the cumulative respiratory depressing effects of drugs such as methadone and benzodiazepines when taken in conjunction with one another; and the withdrawal symptoms associated with benzodiazepines;

or

(ii) have sufficient training provided by the hospital to bring any such nurse up to the level of awareness set out above before that nurse is allowed to operate autonomously within the hospital.

3. I recommend that only those with appropriate medical qualification or other relevant and current accreditation should be allowed to prescribe methadone or upwardly alter any existing prescription.

4. There is a clear and unnecessary risk of mortal danger associated with presumptive prescription of methadone. I recommend that no prescription for methadone be written by anyone in Castle Craig Hospital prior to there having been definite signs of opiate withdrawal observed and recorded by the prescription writer.

5. There is a clear and unnecessary risk of mortal danger associated with the prescription of a quantity of methadone that exceeds a patient's tolerance. I

recommend that only after stabilisation has been achieved and recorded should there be any prescription for methadone written in association with any detoxification care plan.

6. There is a clear and unnecessary risk of danger associated with a person not qualified to prescribe methadone increasing a dose of methadone. I recommend that, without prejudice to the right and duty of a nurse to withhold medication if considered appropriate to do so and to apply reduced doses within a specific dose reduction regime, the responsibility, within Castle Craig Hospital, for altering any prescribed dose of methadone should remain, at all times, with those qualified to prescribe that drug.

7. There is a clear and unnecessary risk associated with allowing any doctor to be in sole charge of medical duties at any time if such a doctor is not sufficiently and currently qualified to deal with all aspects of drug detoxification and medication associated with detoxification. I recommend that no locum GP should be employed by Castle Craig Hospital to perform duties unless that GP has current and relevant qualification or accreditation and experience in the field of drug addiction and detoxification and full familiarity with any and all drugs that may be used in the hospital in connection with such purpose including opiate antidotes.

Conclusions

[131] I am satisfied that the evidence which has been led in this inquiry amply demonstrates that Kieran Nichol's death was entirely preventable. There were numerous occasions over the period of about 36 hours following admission to Castle

Craig Hospital on 9 December 2005 when a different decision or choice by a number of individuals could have made the difference. There were instances when better training of Castle Craig staff by Castle Craig or better control of affairs by Castle Craig could have made the difference. It has been, in fact, difficult to identify anything that went significantly well.

[132] There were many opportunities for the untimely death of Kieran Nichol to have been avoided. The number of reasonable precautions I have set out might be regarded as a measure of the malaise that was present in the hospital at that time.

[133] Following the death, the hospital, partly at the insistence of the Care Commission, made a number of changes. These have been discussed above. The nature and extent of the changes said to have been made address the major shortcomings and issues that arose in the course of the inquiry.

[134] Kieran Nichol's death is a tragedy. It is especially so for his family. I have sympathy for family and particular sympathy for his mother, who sat through the many days of evidence and, an experienced nurse herself, must have been very alert to all of the issues that arose. She could scarcely have imagined that what she at the time saw as a rescue exercise for her son, namely getting him rapidly back into Castle Craig Hospital, might turn out as it did.

[135] The point of such a discretionary inquiry as this, at the instance of the Crown, is to discover what has happened and why it happened. That is in order to prevent a recurrence of such a tragedy. I regret to say that I regard the Crown position, in

relation to those central witnesses not led, to have been unhelpful. There remain questions unanswered. It is all the more surprising considering that it took from December 2005 to April 2009 for the Inquiry to commence with the Crown position in relation to witnesses still unresolved. I hope that this inquiry has been able to provide enough insight as to how the death occurred and that it might assist, in whatever can be learned from it, in death in similar circumstances in the future being avoided.

Sheriff of Lothian and Borders at Edinburgh