INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRIES (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF JACQUELINE HUGHES

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2013 FAI 1

INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 SECTION 1(1)(a) SECTION 1(1)(b)	DETERMINATION by NORMAN COCHRANE RITCHIE, Q.C., Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on various days between 13 August and 21 November Two Thousand and Twelve into the death of **JACQUELINE HUGHES,** aged 35 years, who resided at 19 Rosewood Street, Temple, Glasgow.

GLASGOW,

31 December 2012.

The Sheriff, having considered all the evidence adduced, the submissions and the relevant statutory provisions, DETERMINES:

(1) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Jacqueline Hughes, who was born on 17 February 1972, and who resided at 19 Rosewood Street, Temple, Glasgow, died at 1520 hours on 19 August 2007 at 19 Rosewood Street, Temple, Glasgow;

(2) in terms of section 6(1)(b) of the 1976 Act that on 19 August 2007 Jacqueline Hughes was attacked by her long term partner, James Bryceland, who resided with her at 19 Rosewood Street. James Bryceland repeatedly struck Jacqueline Hughes on the head and body with a spanner, knives and a crowbar and killed her. After an autopsy the cause of death was certified as "stab wounds of the head and neck and blunt force trauma of the head". On 27 February 2008 James Bryceland appeared on indictment in the High Court in Glasgow charged with the murder of Jacqueline Hughes. After psychiatric evidence, the jury found, by direction of the court, that James Bryceland was not guilty of the crime of murder by reason of his insanity at the time of the offence. Compulsion and restriction orders were made and James Bryceland was detained in the State Hospital at Carstairs;

(3) in terms of section 6(1)(c) of the 1976 Act that there were no reasonable precautions whereby the death of Jacqueline Hughes might have been avoided; and

(4) in terms of section 6(1)(d) of the 1976 Act that there was no defect in any system of working which contributed to the death of Jacqueline Hughes.

NOTE:

[1] I wish to extend my condolences to the family of Jacqueline Hughes. Their concern and sense of loss, even many years later, were made eloquent by their attendance at every diet. The terms of the joint minute narrating the circumstances of Jacqueline Hughes' death make for horrifying reading. On 19 August 2007 Jamie, David, Jack and Adam lost their mother in the most tragic way. In a different way they also lost their father.

[2] This inquiry was not mandatory in terms of section 1(1)(a) of the 1976 Act. Accordingly, it was held in terms of section 1(1)(b) that:

"it appears to the Lord Advocate to be expedient in the public interest in the case of a death to which this paragraph applies that an inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern..."

[3] The application by the procurator fiscal for the inquiry was in order

"to publicly examine the standard of treatment and care provided to James Bryceland while an in-patient at Glasgow Royal Infirmary (sic) and to do so in the public interest where the circumstances may have caused serious public concern and to allay those concerns".

[4] The application was to allow the parties:

"To adduce evidence leading to the sheriff making a recommendation so as to allay any public concerns which may have been caused, particularly with regard to

(1) Ensuring full and comprehensive psychiatric histories and assessments are carried out by both medical and nursing staff

(2) Ensuring therapeutic relationships between patients and treating teams are enforced

(3) Ensuring that proper information sharing arrangements are established between medical and nursing staff

(4) Ensuring patients are made aware of their diagnosis and that their treatment plan are clear to them."

[5] Miss Margaret Dunipace, procurator fiscal depute, conducted the inquiry on behalf of the procurator fiscal. Mr Michael Thompson, solicitor, appeared on behalf of the family of Jacqueline Hughes. Miss Cara Docherty, solicitor, appeared on behalf of Dr Philip Ewart and Mr Douglas Ross, advocate, appeared for the Greater Glasgow and Clyde Health Board.

[6] At a preliminary hearing on 24 July 2012 I was addressed by the parties on the state of their preparation for the forthcoming inquiry. It was apparent from the terms of the procurator fiscal's original application and the submissions of the parties that their focus would be upon the evidence from various medical practitioners about the

treatment received by James Bryceland when he was admitted to Gartnavel General Hospital (not Glasgow Royal Infirmary as the application says) in March 2006 and later when he was an outpatient. I issued a warning to the parties that I would not conduct an inquiry solely on the question of the medical treatment of James Bryceland. Any inquiry had to be conducted in terms of the 1976 Act and any medical issue had to be relevant within the context of a statutory inquiry into the circumstances of the death. In due course that admonition was not heeded.

[7] The Fatal Accident Inquiry into the death of Jacqueline Hughes, who was aged 35 years at the time of her death and who resided at 19 Rosewood Street, Temple, Glasgow, was heard over the course of several days between 13 August and 21 November 2012. The procurator fiscal depute led evidence from fourteen witnesses, namely, Mr Archlaus Hughes, Mrs Audrey McClay, Miss Jacqueline McClay, Dr Philip Ewart, Dr Louise Wilson, Dr Alastair Wilson, Mr Charles Stewart, Dr Paul Malis, Miss Karen Mooney, Dr David Scott, Dr Andrew Gray, Dr Lucy Colvin, Dr James Finlayson and Dr Moira Connolly. No evidence was led by the other parties. However, the parties entered into three joint minutes of agreement to which I shall made reference later.

[8] On 13 August I heard from Mr Archlaus Hughes, the brother of Jacqueline Hughes and from Mrs Audrey McClay, her sister. I also heard from her niece, Miss Jacqueline McClay. Little, if anything, was said by them about the circumstances of the death of Jacqueline Hughes although their continuing grief about her death was plain. It was revealed that James Bryceland had been a heavy and enthusiastic consumer of cannabis resin on a daily basis for a period of years, perhaps for twenty five years. Mr Hughes described James Bryceland as smoking "at least ten joints a day". He was a happy and easy-going man who had no violent tendencies.

[9] After his discharge from Gartnavel General Hospital in March 2006, according to their accounts, James Bryceland was withdrawn and was occasionally still hearing voices. He was unable to return to work. In the weeks before Jacqueline Hughes' death James Bryceland was becoming more agitated. Mrs Audrey McClay was aware that he had placed tools or weapons at various locations throughout the house. No member of the family feared for Jacqueline Hughes' safety or foresaw what was to happen.

[10] The other witnesses were medical practitioners of various sorts. They testified to the diagnosis and treatment of James Bryceland. There was no dispute that the diagnosis of a cannabis induced psychosis was correct and that the treatment was appropriate. One doctor was criticized for recording symptoms as a diagnosis but his description did not mislead anyone and, in fact, was more informative of James Bryceland's condition than the diagnosis itself.

[11] There was no certain opinion if James Bryceland's recovery was due to his prescribed medication, his abstinence from cannabis or a combination of those factors. As a corollary to that, no one seemed certain if any later deterioration was attributable to his failure to take his medication or to his resumption of cannabis consumption or both. In any event there was unanimity that James Bryceland was not detainable in terms of the Mental Health Act in the period leading up to Jacqueline Hughes' death. As a voluntary patient it was his decision whether or not

to take his medication or to have the assistance of a community psychiatric nurse. The evidence was clear that a community psychiatric nurse was not always involved with outpatients like James Bryceland. The evidence, which I accepted without hesitation, was that James Bryceland had refused to accept the offer to involve a community psychiatric nurse. It is hard to see his refusal as being correct but it was his right to refuse.

[12] The few issues which did arise in the course of the inquiry were limited and frequently vague. For example, some criticism was offered from Jacqueline Hughes' family that she had, perhaps on more than one occasion, telephoned "the doctor" for help only to be told that any information about James Bryceland's medical condition and medical records was confidential. It was not clear when she had made any phone call, to whom she had actually spoken, what she had said and what the precise response was. There was no evidence and no submission from any party to contradict the principle that a patient's medical information is confidential and is not to be revealed to his partner whether married or not. However, if there had been any concern for the safety of Jacqueline Hughes a warning would have been communicated to her. No medical practitioner anticipated that James Bryceland would become violent. No one thought that there was any concern for the safety of Jacqueline Hughes.

[13] I had a growing concern that there would be no evidence about the circumstances of Jacqueline Hughes' death. On 4 October, which was the fourth day of the inquiry, the procurator fiscal depute tendered two joint minutes of agreement which, in brief terms, agreed the provenance of James Bryceland's GP and psychiatric records, the Mental Welfare Commission Investigation Report and the post mortem report. The second minute confirmed the cause of Jacqueline Hughes' death as certified by the pathologist. Dr Moira Connolly then gave evidence. Thereafter the procurator fiscal depute closed her case. The parties indicated they did not intend to lead any evidence. I heard oral submissions from the parties which supplemented their written submissions.

[14] In reading and considering my notes of the evidence for the preparation of my determination it became apparent that, apart from the brief mention of Jacqueline Hughes' death by the three members of her family, the only circumstances of her death about which I had heard were contained in the second joint minute and related to the cause of her death. All the evidence from the various medical practitioners stood apparently unconnected to the circumstances of Jacqueline Hughes' death. There had been no evidence about the state of mind of James Bryceland at the time of her death. I considered that should have been an essential component of the inquiry. I was, therefore, unable to issue anything other than the most formal determination. I considered that, in all the circumstances and given the serious nature of the matter and the obvious concern and anxiety of the family, a formal determination would be insufficient. I took the view that the family were entitled to more than that. Accordingly, by interlocutor of 23 October 2012, I fixed a diet for 7 November "as a hearing to hear the parties on the competency and desirability of further evidence being led".

[15] On 7 November 2012 I explained my difficulty to the parties. The motion by the procurator fiscal depute, which was not opposed, was for an adjournment for that

matter to be considered. I continued the hearing to 19 November. On that date the procurator fiscal depute submitted that it was competent for an inquiry to be re-opened and she sought an adjournment for a further joint minute to be prepared. That was not opposed.

[16] On 21 November, the procurator fiscal depute lodged the third joint minute of agreement which in paragraphs 1, 2 and 3 explained the procedural history in relation to the indictment against James Bryceland in the High Court. Paragraphs 4-18 reproduced the joint minute which was placed before the High Court. Paragraphs 19-24 agreed the provenance of various documentary productions. There was, therefore, no controversy over the circumstances of Jacqueline Hughes' death. No further evidence was to be led about her death.

[17] I questioned the parties, in view of the agreed provenance of the productions, about what use I was to make of the documentary productions and in particular the reports on the psychiatric assessment of James Bryceland immediately after the death of Jacqueline Hughes. The parties maintained a neutral stance on this issue except for Mr Ross who, thinking aloud on his feet, suggested that it was "not appropriate to trawl through the reports" at my leisure. He expressed, with considerable care, his concern at the approach of the procurator fiscal depute in agreeing the reports in this way. He had expressed his concerns privately to the depute. With hesitation, he made the observation that this mode of agreement did not admit the contents of the reports in evidence. The appropriate way to proceed would have been for the psychiatrists who examined James Bryceland to give evidence on oath and to be subject to cross-examination. He further observed, it seemed to me pertinently, that if the contents of the reports were to be admitted in evidence and to be used to criticize any of the medical practitioners then they had not been afforded any opportunity to respond to that criticism. He concluded by pointing out that it might be necessary, in the interests of fairness, to recall each and every medical witness.

[18] I decided that it would not be right for me to trawl through the psychiatric records, in private and at my leisure, picking and choosing from their contents. I decided that the contents of the reports had not been admitted in evidence. The contents should have been spoken to by the psychiatrists. It was not proposed that any additional evidence be led and accordingly I indicated that I would issue my determination within a few weeks.

Norman Cochrane Ritchie Q.C.

Sheriff of Glasgow and Strathkelvin at Glasgow

31 December 2012.

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https://www.scotcourts.gov.uk/search-judgments/judgment?id=e8a18aa6-8980-69d2-b500-ff0000d74aa7