SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2B2485/09

INQUIRY HELD UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976, SECTION 1(1)(a)

DETERMINATION

by

IAN HARPER LAWSON MILLER, Esquire, Advocate, Sheriff of the Sheriffdom of Glasgow and Strathkelvin

following an Inquiry

held at Glasgow on 5th and 6th November and 4th December 2009, all days of 2009

into the death of

JOHN BRENDAN HUGHES

GLASGOW, 10th DECEMBER 2009. The sheriff, having resumed consideration of the evidence, joint minute of admissions, productions and submissions,

FINDS AND DETERMINES:

(1) In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, that John Brendan, whose date of birth was 9 May 1972, and who resided latterly at Flat 2/1, 74 Kenmore Street, Shettleston, Glasgow , died on 5 November 2007 at 0850 hours within Stobhill Hospital, Glasgow;

(2) In terms of section 6(1)(b) of the said Act, that the cause of his death was hanging;

(3) In terms of section 6(1)(c) of the said Act, that there were no reasonable precautions whereby his death might have been avoided;

(4) In terms of section 6(1)(d) of the said Act, that there were no defects in any system of working which contributed to his death; and

(5) In terms of section 6(1)(e) of the said Act, that there were and are no other facts which are relevant to the circumstances of his death.

HAVING MADE THE FOLLOWING
FINDINGS IN FACT

Mr Hughes

1. John Brendan Hughes ("Mr Hughes") was born on 9 May 1972. He resided latterly at Flat 2/1, 74 Kenmore Street, Shettleston, Glasgow.
2. On 25 May 2007 he was admitted to Stobhill Hospital ("Stobhill") where he remained until 12 June 2007, when he was transferred to Parkhead Hospital. He returned to

Stobhill on 8 July 2007, where he remained within Portree Ward ("Portree"), MacKinnon House, subject to home passes approved by the hospital, until the date of his death. Stobhill is a hospital that falls under the control of the Greater Glasgow Health Board.

Mackinnon House

3. Mackinnon House consists of four wards. All four accommodate patients suffering from psychiatric illness. Three of the wards are open, general adult wards. The fourth, Portree, is a closed ward. It is an intensive psychiatric care unit. It was so at all times material to the circumstances of the death of Mr Hughes. Portree has twelve single rooms. As at 4 November 2007 Mr Hughes had been allocated room number seven.
4. One item of furniture in that room was a wardrobe. Its door was opened by means of a handle in the form of a circular knob made of wood. It was situated at about one metre above floor level.
5. All patients within Mackinnon House are made subject to one of three observation levels: general, constant or speciality. The observation level of a patient is reviewed continuously throughout the patient's residence in the House.
6. A patient on general observation has to be checked hourly while on the ward. The practice in Portree is, and was at all material times, to increase that requirement to half hourly checks.
7. Mr Hughes was on general observation throughout his time in Portree.
8. Whatever the observation level no patient in Portree was allowed anything sharp in his room but generally patients were allowed items such as shoe laces, belts and scarves unless a member of staff had any concerns about a particular patient being at risk of self harm in which case those items would be removed and the observation level for that patient increased.
9. In the event of a medical emergency occurring on any of the wards, there is and was at all material times a system for calling for medical and nursing assistance. That involved calling the main Stobhill switchboard. One feature of the response team was the crash team. It was based in a building separate from Mackinnon House. It was the responsibility of the operator on duty at the switchboard to summon that team by telephoning them.

The system of passes out from the ward

10. A patient in Portree could be released from the ward on a pass. They could be day passes, overnight passes or weekend passes.
11. When a patient returned to the ward having been out on a pass the practice was for a member of staff to discuss with the patient how the time on pass went.
12. It was very common for a patient to return early to the ward while on a pass.

The psychiatric history of Mr Hughes from 1993 to about early August 2007

13. Mr Hughes suffered from a particularly severe form of bi-polar disorder, which is a serious mental disorder. His first admission to hospital in respect of psychiatric illness was in 1993. From the time of first diagnosis in 1993 he had no sustained periods of well-being and no lengthy periods of time out of hospital. Over the years subsequent to 1998 he conformed to a pattern of admissions to hospital both voluntarily and as a result of detention.
14. He had a history of a number of episodes of self-harm. He had attempted to hang himself in August 1998 while in Barlinnie Prison, Glasgow and he had taken a number of overdoses in 1998, 2001 and 2002. He had a long history of aggressive behaviour.
15. On 23 May 2007 within the High Court of Justiciary sitting at Glasgow, Mr Hughes was sentenced in respect of a charge of assault with intent to rob involving the use of an imitation firearm committed on 21 November 2006. He was found to be sane when he committed it but insane and unfit to plead when the case came before the Court. As a result the Court ordered that he be detained at the State Hospital, Carstairs, in terms of sections 57A of the Criminal Procedure (Scotland) Act 1995. From there he was transferred to Stobhill two days later.

The care of Mr Hughes from about early August to the beginning of November 2007

16. By August 2007 Mr Hughes was considered well enough to be discharged from hospital and the medical staff in charge of him were preparing him for discharge from the ward.
17. His first discharge date was 15 August 2007 but his flat was then in an unsuitable condition and this forced a postponement of that date.

18. He began to have regular day passes from the ward to work on his flat and to prepare him for discharge.
19. At the end of August he reported that he was starting to feel down in mood. He was reviewed and assessed. The decision was taken to continue overnight passes home to prepare for discharge. Throughout September he was granted day passes out and he continued to take these passes.
20. On 12 September he was given a pass that lasted for one week. On his return he was reviewed on 19 September by a doctor who recorded that he denied any thoughts of self-harm.
21. He continued to be quiet and withdrawn which resulted in another review on 24 September. This described clear depressive symptoms and documented that he denied any thoughts of suicide or self-harm.
22. On 26 September an improvement in mood meant that he was allowed a week long pass. During it the community psychiatric nurse visited him at home and found him to be lethargic and flat in mood.
23. On his return to hospital on 3 October he was commenced on Lamotrigine, an anti epileptic drug increasingly used to treat depression during the depressive phase of bi-polar disorder.
24. On 10 October he was reviewed, and the entry stated that his mood remained flat but he was not expressing thoughts of self harm.
25. Further assessments of suicide risk were documented on 17 and 24 October.
26. In the month prior to his death his mood had been noted as being flat but here was some improvement in that mood and his dosage of Lamotrigine was increased to try to alleviate this.
27. For the week prior to his death he had requested day or weekend passes. These had been granted despite continuing problems with his flat.
28. In the weeks preceding his death there was no suggestion that Mr Hughes was suicidal.

The events of 4 November 2007 until about 8.25 am on 5 November 2007

29. On Sunday 4 November 2007 Mr Hughes was out of Portree on a weekend pass that expired on 5 November 2007.

30. On that Sunday Ms Caroline McLaughlin and her son by Mr Hughes and her other, younger, son were living in Mr Hughes' leased property at flat 2/1. Their stay there was of indeterminate duration.
31. In the course of that Sunday he confided to her that he was going back to hospital to get something to sleep. He gave her no indication that he was feeling suicidal. He returned to hospital by himself and by bus.
32. On that day Staff Nurse Linda McGlynn was on night shift, which started at 8.00 pm and ended the following morning at 7.40 am.
33. Mr Hughes returned to the ward at about 11.00 pm. He explained his early return by saying that there was no room for him to sleep at his flat because it had only one bedroom and a female friend and her two children were staying there.
34. *Inter alia* she asked him if he was all right and he replied that he was fine. She discussed with him his priorities on discharge and in particular whether he would be able to tell his female friend that he needed his own space. He replied along the lines that that sounded right.
35. To her he appeared agitated. She asked him if he wanted any medicine to relax him. He said that he did. Having checked his regime of medicine she secured a prescription for him of two milligrams of Lorazepam which she administered to him. He thanked her and said that he could get a sleep now.
36. In her considerable experience of him his anxiety could be allayed by being reassured. She and he then sat together in the sitting room of Portree where he had a cup of coffee and a cigarette and they indulged in some light hearted banter.
37. At sometime between 11.45 pm and midnight he said that he was ready for sleep, returned to his room and went to bed.
38. She mentioned to other staff that he had returned and why. She had no concerns about him.
39. Overnight she was involved in checking him at half hourly intervals. She encountered no bother from him throughout the rest of her shift. She had no further direct contact with Mr Hughes that night.
40. At the half-hourly check on Mr Hughes carried out at 8.00 am he was seen to be in bed and apparently asleep.

From 8.25 until 8.50 am on 5 November 2007

41. The next half hourly check was done at 8.25 am by a member of staff. Mr Hughes was seen to be suspended from the door knob of the wardrobe with a ligature around his neck.
42. The member of staff who found him called for help. A second member of staff arrived and both held him aloft to relieve any pressure in his airways while they called for more help. Another member of staff arrived with special cutters to relieve the ligature. That done, he was placed on the floor.
43. At this point in events Dr Tonya Sheridan arrived. She was the specialist registrar in psychiatry who was the doctor on call overnight on 4 and 5 November 2007 for all four psychiatric wards that formed McKinnon House. Her involvement with Mr Hughes, her first ever, began when her pager went off indicating that there was an emergency in Portree. She ran immediately to the ward and then to Mr Hughes' room.
44. On entering, she found him lying on his back on the floor. He was cold at the peripheries, cyanosed with a swollen protruding tongue and had no pulse or respiratory effort. She began her attempts at resuscitation immediately even although she had assessed the chance of a successful resuscitation as very unlikely.
45. Following her arrival cardiopulmonary resuscitation (CPR) was initiated immediately while she tried to open his airway. She was unsuccessful due to oedema. Mr Hughes was given pure oxygen through a bag and mask but this did not result in effective ventilations.
46. Resort was then made immediately to the portable defibrillator. It indicated that he was in asystole (an absence of heart beat) and therefore no shock was advised.
47. While awaiting the arrival of the crash team she managed to gain intravenous access whilst members of the nursing staff continued with CPR and she was able to administer adrenaline 1 milligram on two occasions.
48. It took about ten to fifteen minutes for the crash team to arrive. They then gradually took over the task of resuscitation.
49. The crash team arrived after a second alert for them was put out, and they managed to achieve airway access by performing a cricothyroidectomy.

50. After twenty five minutes of CPR Mr Hughes remained in asystole. At that point the medical and nursing staff agreed that it would be futile to make further attempts at resuscitation. Accordingly Mr Hughes was declared dead. This was at 8.50 am.
51. His life was declared extinct on 5 November 2007 at 08:50 within McKinnon House, Stobhill Hospital, Glasgow.

The immediate aftermath of the death of Mr Hughes

52. Police Constable MacIver of Strathclyde Police was on duty on the morning of 5 November 2007. He answered a call to attend at Portree where he was advised that Mr Hughes had hanged himself and the body of Mr Hughes was identified to him. He requested the attendance of officers from the Criminal Investigation Department of Strathclyde Police, the Identification Bureau and the Police Casualty Surgeon. PC MacIver was present when the Police Casualty Surgeon, Dr McNaught confirmed that there were no suspicious circumstances. PC MacIver arranged for the remains of Mr Hughes to be taken to the Glasgow City mortuary. He then took statements from staff at McKinnon House and from Caroline McLaughlin.
53. An immediate consequence of the death of Mr Hughes was the removal of all the wardrobe door knobs.

The post mortem examination and subsequent reports

54. On 7 November 2007, a post mortem examination on the body of Mr Hughes took place at the City Mortuary, Glasgow. The examination was conducted by Dr Linda Iles, a Forensic Pathologist at the University of Glasgow.
55. After conducting that examination Dr Iles prepared a Post Mortem report. It is dated 3 December 2007. She submitted it to the Procurator Fiscal, Glasgow. A copy of her report is Crown production number 2. In her report Dr Iles recorded the cause of death as hanging.
56. Her report details her external and internal findings and her conclusions. Those conclusions were that Mr Hughes died as a result of neck compression from hanging. That compression was of the large arteries and veins supplying and draining the head and neck, airway compression, pressure on the carotid sinuses, or maybe a combination of

these. She found evidence of an attempted tracheotomy. The tracheotomy tube was correctly placed *in situ*. She found a small amount of Lamotrigine in post mortem toxicological studies. She found no post mortem evidence of natural disease contributing to the death. She concluded that her findings at post mortem were consistent with the circumstances surrounding the death of Mr Hughes as they were reported to her.

57. The relative Toxicology report concluded that the only drug found in Mr Hughes's blood was Lamotrigine. Lamotrigine was prescribed to him for the treatment of bipolar disorder and is a drug approved to assist the patient as a mood stabilizer. The amount of Lamotrigine found in the deceased's blood was consistent with the therapeutic range prescribed to him. No other medications or drugs of abuse were detected. A copy of that report dated 30 November 2007 is Crown Production number 3.
58. The death was registered in the register for the district of Glasgow on 9 November 2007. The Registrar's intimation of the death to the Procurator Fiscal at Glasgow stated the cause of death as hanging. No other cause was stated. A copy of that intimation is Crown Production number 4.

The standard of care that Mr Hughes received at Stobhill

59. It was normal to allow a patient with a low mood to leave the hospital on day passes and indeed it could help to prevent the mood becoming deeper.
60. It was appropriate for his level of observation to be general because there was no indication that he was suicidal. That assessed level was not affected by his psychiatric history but by his immediate situation on the ward. As with any patient it was reviewed daily on the ward.
61. On his return early from weekend leave, the staff on duty took appropriate measures to speak to Mr Hughes in order to ascertain the reason for his early return. His responses did not indicate any reason for concern over his mental state.
62. The care of Mr Hughes was of high quality over a period of some years. The severe course of his illness was related to the nature of the illness itself rather than to any deficit in treatment.
63. The death of Mr Hughes by hanging was not caused by any deficit in his care regime.

His retention of the dressing gown cord

64. It was appropriate for him to have a dressing gown cord. As at early November 2007 he was in the advanced stage of planning for discharge from hospital. In furtherance of that aim, he was permitted to spend nights at his own home on a regular basis. It made no sense to take away his dressing gown cord while he was in hospital when he was spending much of his time out of the hospital. There was nothing in his actions or mood to suggest a need to remove the cord while he was on the ward. Moreover, it was entirely in line with usual policy that a patient on general observation would have access to items which could be used as a ligature, such as a dressing gown cord.

Should the door knob of the wardrobe have been removed prior to the death of Mr Hughes?

65. The wardrobes in Portree had been supplied by specialist hospital suppliers. They had carried out a risk assessment on them to the extent of modifying the door hinges in order to reduce the risk of injury to a patient by the use of a ligature. In construction the door knob on the wardrobe in Mr Hughes' room was relatively flimsy.
66. The door handle was not the cause of Mr Hughes' suicide but its means. Mr Hughes had to form the necessary intent.
67. Mr Hughes had not been monitored for access to wardrobe door handles when out of the ward. He had ready access to ligature points when out of the hospital on a pass.
68. It is only with the benefit of hindsight that the door knob could be seen as a potential ligature point.

The chances of successful resuscitation

69. By the time that he was discovered, Mr Hughes' chances of successful resuscitation were unlikely at best. That however, made no difference to the several, sustained attempts made to achieve that.
70. His stature, which was short, stocky and obese with a short thick neck, taken together with his history of suffering from asthma, meant that his airway would have been compromised very quickly.

71. The late arrival of the crash team did not affect the outcome. Their lateness was caused by the forgetfulness of the switchboard operator on duty who did not call them when first contacted and did so only when prompted again.
72. Even if the crash team had arrived earlier, Mr Hughes would not have been amenable to resuscitation because from an early point in the attempts at resuscitation the portable defibrillator consistently showed asystole which was not a shockable rhythm.

Should the suicide of Mr Hughes have been anticipated?

73. Bi-polar disorder has a lifetime risk of completed suicide of between 10 and 15 per cent. Mr Hughes had a history of repeated attempts at self-harm. This predicted an increased risk of suicide although it did not help in predicting when suicide might occur. Moreover he had a long history of violent and aggressive behaviour which was a further risk factor for completed suicide.
74. Aware of this background, the hospital had assessed his level of suicide risk consistently and in particular had done so from late August 2007 onwards. During that period of time he persistently denied there was such a risk. Such a risk was always present. The staff had noted that his mood had been low for a period of weeks before his death. The case notes recorded that the risk of suicide had been assessed at regular intervals by suitably trained staff and that Mr Hughes had consistently denied being suicidal.
75. At the time of his death he was not considered to be a suicide risk. That was an appropriate conclusion to draw from the various individual assessments and reviews made of him over the last few months of his life.

Conclusion

76. The death of Mr Hughes could have been neither predicted nor prevented.

NOTE:

Introduction

[1] This Fatal Accident Inquiry has been convened to inquire into the circumstances of the death of John Brendan Hughes ("Mr Hughes") which occurred on 5 November 2007 within Stobhill Hospital, Glasgow at the age of 35 years.

[2] It has been convened under section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act") because at the time of his death Mr Hughes was subject to detention by an order of the High Court of Justiciary dated 23 May 2007. Under that order he remained *inter alia* in Stobhill Hospital from 8 July 2007 until the date of his death, subject to home passes approved by the Hospital. Within Stobhill he was a patient in Portree Ward, an intensive psychiatric care unit that formed part of Mackinnon House.

[3] The application of the Procurator Fiscal for the holding of an Inquiry narrated that Mr Hughes was born on 9 May 1972, resided latterly at Flat 2/1, 74 Kenmore Street, Shettleston, Glasgow, and died at 0850 hours on 5 November 2007 at Stobhill Hospital, Glasgow, with the cause of death being hanging.

[4] The circumstances of and preceding his death are, in outline, that he returned to Portree Ward at about 11.00 pm on Sunday 4 November 2009 having been out on a pass that entitled him to stay out over that weekend but, for his own reasons, he had returned early to the ward. He retired to his room on the ward at about midnight and at about 8.00 am on 5 November 2007 he was seen to be in bed, apparently asleep. At the half hourly inspection carried out at about 8.25 am he was seen to be sitting on the floor with a ligature around his neck the other end of which was tied to the handle of the wardrobe in his room. He was cut down and despite prolonged attempts at resuscitation by both medical and nursing staff he was declared dead at the scene at 8.50 am.

The duty of the Sheriff in a fatal accident inquiry

[5] The duty on me as the sheriff presiding over the inquiry is set out in section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"). It is to hear all the

evidence tendered and any subsequent submissions made on that evidence, and then make a determination setting out the circumstances of the death of Mr Hughes under reference to the five considerations set out in subsection (1) of that section, in so far as they have been established to my satisfaction.

The function and purpose of a fatal accident inquiry

[6] All fatal accident inquiries are brought under, and are governed by the provisions of, the Act. It imposes duties on the Lord Advocate, the procurator fiscal for the district with which the circumstances of the death in question appear to be most closely connected and the sheriff to whom application is made for holding an inquiry. It also makes provision for making rules that govern procedure and the payment of fees, and the procedural rules currently in force are the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 ("the Rules").

[7] The primary duty on the sheriff is that enjoined by section 6(1) of the Act: to issue a determination at or as soon as possible after the conclusion of the evidence and any submissions thereon setting out the circumstances of the death in question by reference to the five criteria listed in that subsection so far as they have been established to his satisfaction. Those five are: -

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

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

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

(e) any other facts which are relevant to the circumstances of the death.

The scope of all fatal accident inquiries is determined, delineated and circumscribed by this subsection.

[8] The function of the sheriff at a fatal accident inquiry in making his determination does not include making any finding of fault or apportioning blame between any persons who might have contributed to the accident. The Act does not empower the sheriff to do that. This was

authoritatively stated in the case of **Black** v **Scott Lithgow Limited** 1990 SC 322; 1990 SLT 612 in which Lord President Hope, in his opinion, took the opportunity to state the function in the following terms: -

> "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. … 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 or damages by anyone and there are no grounds of fault upon which his decision is required. The inquiry is normally held within a relatively short time after the accident …It provides the first opportunity to canvass matters relating to precautions which might have avoided the death or any defects in any system of working which contributed to it, at a stage when these issues have not been clearly focused by the parties to any future litigation which may arise. And it is not uncommon … to find questions being asked about possible precautions or defects which are not the subject of averment in the subsequent action of damages." (p 327 and 615G to H)

[9] As Lord President Hamilton observed in the recent case of **Global Santa Fe Drilling** v **Lord Advocate** 2009 SLT 597 under reference to **Black** "[a] fatal accident inquiry is a statutory procedure" .. and "[a]lthough the sheriff presiding at it has judicial duties …he does not sit to determine the rights or obligations of parties" (paragraph [28] at p 604). It is a fact finding inquiry not a fault finding inquiry. It is inquisitorial in form rather than adversarial. The standard of proof of the circumstances of the death is on the balance of probabilities. The onus of proof rests on the Crown because, by virtue of section 1 of the Act, the duty of investigating those circumstances lies on the Crown.

[10] The word "accident" is not defined in the Act. Various views have been expressed as to its meaning and scope. In his Determination following an Inquiry into the death of

Alexander Cusker, dated 16 December 2008, Sheriff J K Mitchell sitting at Glasgow Sheriff Court expressed the following views:

> "[4] In Mr. I H B Carmichael's *Sudden Deaths & Fatal Accident Inquiries*, third edition, at paragraph 5.69, the learned author states:- 'Accidents can occur anywhere and in almost any context...If a patient died...as the result of an error which occurred in a...therapeutic procedure, that death results from an 'accident'. I respectfully accept the learned author's approach to and interpretation of the term 'accident' as it is used in the 1976 Act. In its common usage, an 'accident' is 'an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury': see the New Oxford Dictionary of English."

I respectfully adopt and follow that approach.

The inquiry

[11] The inquiry was held over three days: 5th and 6th November and 4th December, all days of 2009. The Crown were represented by Miss Nicol, procurator fiscal depute, and the Greater Glasgow Health Board, under whose responsibility Stobhill fell, by Mr Wightman, solicitor.

[12] In the inquiry, the Crown relied upon the evidence of five witnesses: Ms Caroline McLaughlin, the former partner of Mr Hughes; Ms Linda McGlynn, a staff nurse in Stobhill; Doctor Tonya Sheridan, a specialist registrar in psychiatry in Stobhill; Doctor Moira Connolly, a consultant psychiatrist and clinical director for the West Glasgow quarter of the Mental Health Partnership for Greater Glasgow Health Board based at Gartnavel Hospital; and Doctor Timothy Dalkin, a consultant psychiatrist at the Royal Edinburgh Hospital. Three gave their evidence orally and two (Ms McGlynn and Doctor Sheridan) by way of affidavit. In addition the parties had entered into a Joint Minute of Admissions which they tendered before any evidence was led.

[13] At the conclusion of the evidence I adjourned the Inquiry at the request of both Crown and the Board to allow them time to prepare and lodge written submissions, which they did. At the hearing on the evidence the Crown, having had the opportunity to consider the submissions lodged on behalf of the Board, withdrew its stated attitude to a determination under section 6(1)(c). I will deal with this change of position later in this Note.

The evidence

Ms McLaughlin

[14] Ms McLaughlin said that she had been in a relationship with Mr Hughes for about seven years but that it had ended in about early 1998 when their son was about seven years of age. That notwithstanding, she and their son and her other, younger, son were living in Mr Hughes' leased property, flat 2/1, 74 Kenmore Street, Shettleston, Glasgow as at early November 2007 and for an indeterminate period of time. Her evidence dealt in general with what sort of a person Mr Hughes was and in particular his behaviour over his last weekend. She said that he had spent most of his time in hospital but was granted days out with a view to being discharged. On Sunday 4 November he confided to her that morning that he had not slept the previous night and was very tired. He went back to bed but not for long. He then said that he was going back to hospital to get something to sleep. She thought that he appeared tired and quiet but fine. He gave her no indication that he was feeling suicidal. He returned to hospital by bus.

Ms McGlynn

[15] Ms McGlynn was a staff nurse on Portree Ward. She had considerable experience of working with psychiatric patients, having done so since 1985, and having been a staff nurse for twenty years. She explained the construction of McKinnon House into three wards of which Portree was one with twelve single rooms. Patients on the ward were observed on one of three levels: general, constant and speciality. A patient on general observation had to be checked hourly but on Portree Ward the practice was to increase that to half hourly. She explained how and by whom the appropriate level was assessed for each patient and that at the end of each shift the staff on the ward discussed each patient with the incoming staff. Regardless of the observation level no patient was allowed anything sharp in their room but generally patients were allowed items such as shoe laces, belts and scarves unless a member of staff had any concerns about a particular patient being at risk of self harm in which case those items would be removed and the observation level for that patient increased. When a patient returned to the ward having been out on a pass the practice was for a member of staff to discuss with the patient how the time on pass went. It was very common for a patient to return early to the ward while on a pass. She explained the procedure to follow in the event of an emergency on the ward which included the

use where necessary of the crash team who were situated in a different building from McKinnon House.

[16] She then narrated her involvement with Mr Hughes. She had nursed him off and on for about thirteen years. She did not recall him having been on any observation level higher than general. By early November 2007 he was on the approach to being discharged. As part of that he was granted overnight passes out from the ward. He was on one such that expired on 5 November 2007. On the evening of 4 November 2007 she was on night shift, which started at 8.00 pm and ended the following morning at 7.40 am. Mr Hughes returned early to the ward at about 11.00 pm. *Inter alia* she asked him if he was all right and he replied that he was fine. He explained his early return by saying that there was no room for him to sleep at his flat because it had only one bedroom and a female friend and her two children were staying there. She discussed with him his priorities on discharge and in particular whether he would be able to tell his female friend that he needed his own space. He replied along the lines that that sounded right. He appeared agitated to her. She asked him if he wanted any medicine to relax him. He said that he did. Having checked his regime of medicine she secured a prescription for him of two milligrams of Lorazepam which she administered to him. He thanked her and said that he could get a sleep now. In her experience of him his anxiety could be allayed by being reassured. She and he then sat together in the sitting room where he had a cup of coffee and a cigarette and they indulged in some light hearted banter. At sometime between 11.45 pm and midnight he said that he was ready for sleep, returned to his room and went to bed. She mentioned to other staff that he had returned and why. She had no concerns about him. Overnight she was involved in checking him at half hourly intervals. She encountered no bother from him throughout the rest of her shift. After she went off shift she was informed that Mr Hughes had hanged himself.

[17] She never thought of the door knob on the wardrobe as a risk factor. All the furniture had been assessed for risk when the ward opened. All the door knobs were removed after Mr Hughes' death.

Dr Tonya Sheridan

[18] Dr Sheridan was the speciality registrar in psychiatry who was the doctor on call overnight on 4 and 5 November 2007 for all four psychiatric wards that formed McKinnon House, of which Portree Ward was the one that was an intensive psychiatric care unit. Her involvement with Mr Hughes, her first ever, came at about 8.20 to 8.30 am towards the end of her shift when her pager went off indicating that there was an emergency in Portree Ward. She ran immediately to the ward and then to Mr Hughes' room.

[19] On entering, she found him lying on his back on the floor. He was cold at the peripheries, cyanosed with a swollen protruding tongue and had no pulse or respiratory effort. Following her arrival CPR was initiated immediately while she tried to open his airway. She was unsuccessful due to oedema. Mr Hughes was given pure oxygen through a bag and mask but this did not result in effective ventilations. Resort was then made immediately to the portable defibrillator. It indicated that he was in asystole (the absence of heart beat) and therefore no shock was advised. While awaiting the arrival of the crash team she managed to gain intravenous access whilst members of the nursing staff continued with CPR and was able to administer adrenaline 1 milligram on two occasions. The crash team arrived after a second alert for them was put out, and they managed to achieve airway access by performing a cricothyroidectomy.

[20] After twenty five minutes of CPR Mr Hughes remained in asystole. At that point the medical and nursing staff agreed that it would be futile to make further attempts at resuscitation. Accordingly Mr Hughes was declared dead. She recalled this as being at approximately 8.50 am. Dr Sheridan gave it as her opinion that when she assessed Mr Hughes she thought it unlikely that it would be possible to resuscitate him.

Dr Moira Connolly

[21] Dr Connolly said that she had been a consultant psychiatrist since about 1996. As at November 2007 she was a consultant psychiatrist at the Riverside Community Health team in Partick and in addition was the consultant clinical director for the West Glasgow sector of the Mental Health Partnership for the Greater Glasgow Health Board. In that latter capacity she was

asked to take charge of an investigation into the circumstances of the death of Mr Hughes and prepare a Critical Clinical Incident Review. She and the two others who conducted the review were fully trained in how to carry that out and had previous experience of them. It required them to have regard to the care provided to Mr Hughes for about one year prior to his death and to pay particular attention to his clinical care in the period of time that led up to his death to see if there were any gaps in that care and also whether there were any features that could lead to an improvement in the standard of care provided within the Hospital. Stobhill Hospital is situated within the North Glasgow sector and it was felt that she would be able to bring to the task a fresh and critical eye. Her Review was dated 12 May 2008 and a copy was Crown Production number 5. She adopted it in whole as her evidence and then commented on parts of it as and when requested to do so.

[22] Section 1 of the Review included information about his psychiatric history from the date of his first admission in 1993. Over the years subsequent to 1998 he conformed to a pattern of admissions to hospital both voluntarily and as a result of detention. His last admission was the consequence of a criminal offence that he committed on 21 November 2006 for which he was found to be sane when he committed it but insane and unfit to plead when the prosecution came before the High Court of Justiciary resulting in an order that he be detained as the State Hospital, Carstairs. From there he was transferred on 25 May 2007 to Portree Ward, an intensive psychiatric care unit. Apart from a brief period spent in Parkhead Acute Psychiatric Unit he remained a patient in Portree Ward until his death. The Unit were preparing him for discharge from the Ward. His first discharge date was 15 August 2007 but the unsuitable condition of his flat then forced a postponement. Throughout September he was granted day passes out followed by a week of passes at the end of that month. For the week prior to his death he had requested day or weekend passes. These had been granted despite continuing problems with his flat. In the month prior to his death his mood had been noted as being flat and his medication had been amended to try to alleviate this.

[23] Section 2 of the Review contained the analysis and findings of the review group. The group listed four problems or issues that were considered to be of greatest significance. The first was the recent incidence of low mood which was described as being an affective disorder that

was difficult to treat, the second his subjective stress at his impending discharge whose root cause was his established dependency on the psychiatric in-patient services. The third was his access to a ligature point in the wardrobe door knob which was described as inappropriate. The fourth was the delayed response of the crash team. Its late arrival was due to the switchboard operator forgetting to call them when first contacted and doing so only when prompted again. Dr Connolly said that an immediate consequence of the death of Mr Hughes was the removal of all the wardrobe door handles.

[24] She said, from information given to her, that when Mr Hughes was found suspended from the door knob the member of staff called for help. A second member of staff arrived and both held him aloft to relieve any pressure in his airways while they called for more help. Another member of staff arrived with special cutters to relieve the ligature. That done he was placed on the floor at which point a doctor arrived and began her attempts at resuscitation. It took about ten to fifteen minutes for the crash team to arrive. They then gradually took over the task of resuscitation.

[25] Section 3 dealt with the response to the incident, over various periods of time. The immediate action taken included the removal of all similar wardrobe door handles. Under action required by the end of June 2008 she noted that the late arrival of the crash team probably did not affect the outcome but it did have a negative impact on the staff who continued with their basic resuscitation and were aware that no additional medical assistance was forthcoming. She also noted that the switchboard operator was to have a formal update of training in dealing with any request for emergency assistance. This took place.

[26] She then referred to the timeline that was part of the Review she said that there was no suggestion that Mr Hughes was suicidal. She supported this by referring to the entry for 10 October 2007 which stated: "Mood remains flat but not expressing thoughts of self harm." She said that staff would have routinely asked him about this. He had had one incidence of self-harm a long time ago and thoughts of self-harm were very infrequent. At the time of his death he was not considered to be a suicide risk. It was appropriate for him to have a dressing gown cord because by then he spent days out of the hospital unseen by staff and there was nothing to

suggest a need to remove that cord when he was on the ward. From the information she had been given she opined that resuscitation would have been difficult at best but that had made no difference to the attempts made to achieve that, nor should it. She inferred from his stature which was short, stocky and obese with a short thick neck taken together with his history of suffering from asthma that his airway would have been compromised very quickly.

[27] In cross-examination she conceded that without the benefit of hindsight she would not have considered the wardrobe door knob to be a ligature risk. Its height was one factor for holding that opinion and another was her impression that it was innocuous and flimsy in construction. The wardrobes had been supplied by specialist suppliers who had taken the trouble to modify the door hinges to reduce the risk of injury which betokened that someone had carried out a risk assessment on the construction of the wardrobes. Mr Hughes had not been monitored for access to wardrobe door handles when out of the ward. The level of observation to which he was subject on the ward, general observation, was appropriate. The observation level of any patient was reviewed daily on the ward. She opined that the door knob on the wardrobe in Mr Hughes' room was about one metre above the floor level.

Dr Timothy Dalkin

[28] Dr Dalkin was led by the Crown as a skilled witness. He was appointed a consultant psychiatrist in 1995 and practiced at the Royal Edinburgh Hospital and at Inchkeith House, Edinburgh. He examined a variety of documents that he had been given by the Crown and thereafter prepared a report into the death of Mr Hughes. It was lodged as Crown Production number 6. Dr Dalkin adopted the whole terms of his Report as his evidence and commented on it as and when requested.

[29] In the course of giving the past psychiatric history of Mr Hughes he observed that there was evidence of a number of episodes of self-harm, that he had attempted to hang himself in August 1998 while in Barlinnie Prison, Glasgow and that he had taken a number of overdoses in 1998, 2001 and 2002. He had a long history of aggressive behaviour. In discussing the final hospital admission of Mr Hughes, which had begun on 2 December 2006 to the State Hospital as a consequence of a serious crime involving an attempt to rob a supermarket in Glasgow while

using an imitation firearm, he said that by mid-August 2007 Mr Hughes was considered well enough to be discharged from hospital but he could not be because his flat was not then in a fit state. He began to have regular day passes from the ward to work on his flat and to prepare him for discharge. At the end of August he reported that he was starting to feel down in mood. He was reviewed and assessed. The decision was taken to continue overnight passes home to prepare for discharge and he continued to take these passes. On 12 September he was given a pass that lasted for one week. On his return he was reviewed on 19 September. The doctor recorded that he denied any thoughts of self-harm. He continued to be quiet and withdrawn which resulted in another review on 24 September. This described clear depressive symptoms and documented that he denied any thoughts of suicide or self-harm. On 26 September an improvement in mood meant that he was allowed a week long pass. During it the community psychiatric nurse visited him at home and found him to be lethargic and flat in mood. On his return to hospital on 3 October he was commenced on lamotrigine, an anti epileptic drug increasingly used to treat depression during the depressive phase of bi-polar disorder. Subsequent assessments indicated that there was some improvement in his mood although he continued to be flat and therefore the dosage of lamotrigine was increased. On 10 October he denied any thoughts of self-harm and further assessments of suicide risk were documented on 17 and 24 October.

[30] He commented that it was normal to allow a patient with a low mood to leave the hospital on day passes and indeed it could help to prevent the mood becoming deeper. It was appropriate to have his level of observation as general. It was not affected by his history but by his immediate situation. The hospital had assessed his level of suicide risk. He denied there was such a risk. Such a risk was always present. It made no sense to take away his dressing gown cord or his shoelaces or belt when in hospital when he was spending much time out of the hospital. On the matter of the foreseeability of finding a ligature point, he commented that any patient was likely to look for one and having a door knob was something that should be avoided. In that regard he conceded in cross-examination that the door knob in question looked to be a comparatively frail structure situated fairly low down. It was not the cause of suicide but the means. Mr Hughes had to form the necessary intent. In his life at the time he had access to any number of ligature points.

[31] In the opinion section of his report, Dr Dalkin, said that Mr Hughes suffered from a particularly severe form of bi-polar disorder, a serious mental disorder. From the time of first diagnosis in 1993 he had no sustained periods of well-being and no lengthy periods of time out of hospital. Bi-polar disorder has a lifetime risk of completed suicide of between 10 and 15 per cent. Mr Hughes had a history of repeated attempts at self-harm. This predicted an increased risk of suicide although it did not help in predicting when suicide might occur. Moreover he had a long history of violent and aggressive behaviour which was a further risk factor for completed suicide. Turning to the care of Mr Hughes, Dr Dalkin described it as being of high quality over a period of some years. The severe course of his illness was related to the nature of the illness itself rather than to any deficit in treatment.

[32] Dr Dalkin went on to say that he did not consider that there was any way that the suicide of Mr Hughes could have been predicted. The staff had noted that his mood had been low for a period of weeks before his death. The case notes recorded that the risk of suicide had been assessed at regular intervals by suitably trained staff and that Mr Hughes had consistently denied being suicidal.

[33] With regard to Mr Hughes' early return from weekend leave, Dr Dalkin opined that this was not unusual. On his return the staff on duty took appropriate measures to speak to Mr Hughes in order to ascertain the reason for his early return and the case notes and witness statements that he had seen did not indicate any reason for concern over his mental state. He remained on general observation. This level was entirely appropriate because there was no indication that he was suicidal. He was in the stage of planning for discharge from hospital and was spending nights at his home on a regular basis. It was entirely in line with usual policy that a patient on general observation would have access to items which could be used a ligature, such as a dressing gown cord or a belt.

[34] With regard to the wardrobe door knob, he said that it was clear with the benefit of hindsight that it was a potential ligature point. He noted that the wardrobes had been purchased from a recognised hospital supplier and had anti-ligature modifications, that the handles had not

previously been considered a potential ligature point and that they were removed from other wardrobes following the death.

[35] With regard to the late arrival of the crash team, he opined that the outcome would not have been any different if the team had arrived earlier, because the defibrillator showed asystole which was not a shockable rhythm and Mr Hughes would not have been amenable to resuscitation.

[36] He concluded and summarised his opinion by saying that he did not consider that the death of Mr Hughes could have been either predicted or prevented, or that it arose out of any deficit in his care.

The submissions for the Crown

[37] The procurator fiscal depute intimated that the final position of the Crown was to invite a determination in light of the evidence given at the Inquiry that was in formal terms for all five elements of section 6(1): for section 6(1)(a) that Mr Hughes, born on 09 May 1972, formerly residing at Flat 2/1, 74 Kenmore Street, Glasgow and the Portree Ward, Stobhill Hospital, Glasgow died on 05 November 2007 within the Portree Ward, Stobhill Hospital, Glasgow; for section 6(1)(b) that the cause of his death was hanging; for section 6(1)(c) that there were no reasonable precautions whereby his death might have been avoided; for section 6(1)(d) that there were no defects in any system of working which contributed to his death; and for section 6(1)(e) that there were no other facts which were relevant to the circumstances of his death.

The submissions for the Board

[38] Mr Wightman invited a determination in the following terms: for Section 6(1)(a) that the death of Mr Hughes took place at Room 7, Portree Ward, McKinnon House, Stobhill Hospital, Glasgow between 0800 and 0825 on 5 November 2007 and that after resuscitation attempts life was formally declared extinct at 0850; for Section 6(1)(b) that the cause of death was neck compression from hanging; and for each of sections 6(1)(c), (d) and (e) that no findings should be made.

[39] Turning to the law, he said that it is well established that it was not the purpose of a Fatal Accident Inquiry to determine any question of civil or criminal fault or liability and referred to the words of Lord President Hope in the case of **Black v Scott Lithgow Limited 1990 SLT 612** at page 615 G-H**.** The entire scope of the determination was set out within section 6 of the Act.

My determination

(i) My assessment of the evidence

[40] As with any Inquiry I have to decide whose evidence I accept. In this case that is an easy task. The submissions made no criticism of the reliability of the evidence of any of the witnesses and the cross-examinations of the three who gave their evidence orally did not raise any questions that impacted on the reliability of any of them. I have no hesitation in accepting their evidence as entirely reliable and the same applies to the other two whose evidence was admitted under Rule 10 of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977. One feature of the evidence of all the witnesses to fact is that at no point material for my determination did their evidence overlap in respect of time, place or circumstance, for each spoke to different aspects of the death of Mr Hughes. As for Dr Dalkin I am satisfied that he was well able to assist the Inquiry in the capacity of a skilled witness and that I could and should rely upon his opinion. I have formulated my findings in fact using all the evidence that I consider relevant for that purpose and have done so on the balance of probabilities.

(ii) My determinations under section 6(1)

[41] Following on from my findings in fact I have drawn what I consider to be the correct conclusions for making my determination under the five mandatory elements of section 6(1).

Section 6(1)(a)

[42] Under section 6(1)(a) I am satisfied that John Brendan Hughes, whose date of birth was 9 May 1972, and who resided latterly at Flat 2/1, 74 Kenmore Street, Shettleston, Glasgow, died on 5 November 2007 at 0850 hours within Stobhill Hospital, Glasgow. This finding follows the narrative in the application which both sides accepted. The evidence for the time of his death comes from Dr Sheridan who was present at the time and from the Joint Minute of Admissions.

It is the time recorded in the form of intimation of death dated 9 November 2007 from the Registrar for the district of Glasgow to the Procurator Fiscal in respect of Mr Hughes. A copy of that form is Crown Production number 4.

Section 6(1)(b)

[43] Under section 6(1)(b) I am satisfied that the cause of his death was hanging. The evidence of Dr Sheridan supported this, as did the evidence of the post mortem examination conducted by Dr Iles which is included in the Joint Minute.

Section 6(1)(c)

[44] Under section 6(1)(c) I am satisfied that there were no reasonable precautions whereby his death might have been avoided. In the course of the Inquiry the questioning of Dr Connolly and Dr Dalkin by both the depute and Mr Wightman raised the prospect of the parties being at odds over whether in advance of the death of Mr Hughes the Board ought to have carried out a risk assessment on the handle on the wardrobe and concluded that it posed a risk of acting as a ligature point in the case of Mr Hughes. The prospect became an actuality in the competing positions taken in the written submissions. However at the hearing on expenses the depute intimated that she had considered the written submissions for the Board and was persuaded in light of them that the Crown should invite only a formal determination under this subsection. Whether or not there were reasonable precautions that might have been taken whereby the death of Mr Hughes might have been avoided is understandably an issue of some importance not only for the Crown and the Board but also for his family. With that in mind I think it only right to record my response to the change of position at the hearing. I say this because the final decision on what the determination says is mine: there is a statutory duty on me to set out any reasonable precautions whereby the death of Mr Hughes might have been avoided so far as that has been established to my satisfaction. In furtherance of that, if I concluded that there were such a precaution, it would be open to me to reject a submission that sought to persuade me that no such precaution existed.

[45] In her written submissions on behalf of the Crown the depute had requested that the determination include the statement that a reasonable precaution which might have avoided the

death of Mr Hughes, would have been for the inappropriate door handles referred to in the evidence to have been removed and anti-ligature handles applied prior to the wardrobes being placed in the ward.

[46] In the written submissions on behalf of the Board Mr Wightman said that for a finding under section 6(1)(c) any "precaution" which was identified had to be "reasonable", and it had to be shown that if that precaution had been taken the death "might have been avoided". He submitted that the evidence supported neither. For guidance on what is meant by "reasonable precaution" in this context and for a warning against relying on hindsight he referred to passages in the Determination of Sheriff Mhairi Steven dated 27 February 2004 in the FAI held within Edinburgh Sheriff Court into the death of Lynsy Myles found at pages 23,25,29 and 30 of the decision. With regard to the door handles, he submitted that quite properly they had been removed from all wardrobes of the type looked at in the Inquiry. He added that this had extended to all psychiatric units throughout the Health Board area, and within 24 hours of the death of Mr Hughes. This action, taken with hindsight, should not be seen as indicating that this was some "reasonable precaution" not taken in advance. When the Critical Incident Review described the door handle as inappropriate, and Dr Connolly repeated that in the course of her evidence, it was important to recall the scope and purpose of the Review. They differed from the purpose of the Inquiry. The Review was looking for any learning points, arising out of the investigation of the incident, even if they had no bearing whatsoever on the outcome of the incident. It used hindsight to a greater degree than was open to the Court.

[47] In light of the evidence presented at the Inquiry I have concluded that the final position of the Crown was the correct one to advance. The evidence does not disclose any reasonable precaution that ought to have been taken whereby the death of Mr Hughes might have been avoided. I agree with the approach taken by Sheriff Stephen on what is meant by the phrase "reasonable precautions" in subsection (c) and also her warning against the use of hindsight. I respectfully adopt what she said and have applied that to my examination of the evidence and the submissions. As she said, for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and the treatment of that patient. To that I would add that the whole circumstances should be those that were known or ought to have been known

at the material time or times with which an inquiry is concerned. As for hindsight, it should not be employed in deciding whether a precaution was reasonable, or whether, if implemented, it might have avoided the death in question.

[48] Applying that approach to the present circumstances I have concluded that there was nothing in the actions or conduct of Mr Hughes throughout the last three months or so of his life that could give rise to a genuine and well founded concern in the minds of the hospital staff who were involved in his care that he posed an imminent risk of committing suicide at all let alone doing so by the means that he employed. The nature of his chronic illness increased the risk of suicide as did his propensity for violent and aggressive behaviour, but the qualified staff in Stobhill were aware of this background and as part of his overall care regime assessed his level of suicide risk consistently and repeatedly from late August 2007. They could be expected to detect any such tendency and discerned none. That is a perfectly understandable and appropriate response when viewed and assessed in light of his then condition and circumstances. His flat mood was addressed by medication and this alleviated his condition to some extent. There was no suggestion that that condition increased his accepted level of suicide risk. He was being prepared for discharge from hospital and as part of that was granted a succession of passes out, giving him the opportunity to work on his flat and also to experience life outwith the security and attendant constraints of the hospital environment. The trust reposed in him by the staff in pursuing this path to release was rewarded in a way that did not raise any suggestion of a risk of suicide committed within Portree. Staff nurse McGlynn, the last member of staff to spend any significant time with Mr Hughes, carried out appropriate, sensible and sympathetic questioning of him when he returned early to Portree and had no concerns about him as a result. I consider her conclusion to be entirely justified.

[49] As for allowing Mr Hughes to retain the cord for his dressing gown, there were no valid grounds on which the staff could have justified removing it from him at any point in the last three months of his life. The same applies to the suggestion that the door knob on his wardrobe should have been recognised before his death as a potential ligature point and therefore removed. This could only be said applying the benefits of hindsight. Looked at in context and prospectively, there was no valid or sound reason for removal. The fact that the knob was

removed immediately after his death, as were door knobs from an unspecified number and type of other wardrobes within the Board's estate, is understandable but that act should not be interpreted as a tacit admission that this was a precaution that it would have been reasonable to have taken earlier. That simply does not follow of necessity and there was no evidence to suggest that the Board, through its staff, ought to have realised that the removal of the knob was a reasonable precaution against this particular suicide conducted in the particular way that it was, and effected that removal in advance of the death of Mr Hughes.

Section 6(1)(d)

[50] Under section 6(1)(d) that there were no defects in any system of working which contributed to his death. There was no evidence that justified a determination in terms other than in the formal.

Section 6(1)(e)

[51] Under section 6(1)(e) that there were and are no other facts which are relevant to the circumstances of his death. Under this subsection the Crown submitted that there were two relevant factors which were worthy of comment but not of incorporation in the determination because neither was a factor that caused or contributed to the death of Mr Hughes. The first was that there was no evidence before the Inquiry to suggest that a patient on general observation, who had not been considered a suicide risk and who was regularly using day passes should not have access to items which could be used as ligatures, such as a dressing gown cord. There was no indication that the deceased was suicidal and therefore he was on general observation and regularly spent nights at home on a day, weekend or week pass. The evidence suggested that appropriate measures were taken to ascertain the reason for the deceased's early return to the Portree Ward on 4 November 2007 and the evidence did not indicate that the deceased was suicidal. In his report Dr Dalkin acknowledged that the deceased was subject to general observation which he considered to be entirely appropriate as there was no indication that the deceased was suicidal. Dr Dalkin confirmed that it was entirely in line with usual policy for a patient on general observation to have access to items which could be used as ligatures such as a dressing gown cord.

[52] The second was in relation to the delay in the arrival of the "crash team". There was no evidence led to suggest that the delay in arrival at the scene contributed to the death of Mr Hughes. Dr Dalkin stated in his report that he did not believe the outcome would have been any different if the 'crash team' had arrived earlier. He explained to the court that the defibrillator showed asystole which is not a shockable rhythm and Mr Hughes would not have been amenable to resuscitation. This conclusion was supported by the evidence of Dr Connolly. It was acknowledged by her that switchboard operators do receive appropriate training on how to respond to a 2222 call. However, in respect of this incident the failure to call the 'crash team' was due to human error and not to any systematic failure. She advised in her Critical Incident Review that that the switchboard operator have a formal update of training in respect of dealing with any request for emergency assistance.

[53] The response of the Board to these matters was to say with regard to the arrival of the crash team being later than it should have been, Dr Dalkin's evidence was that Mr Hughes would not have been amenable to resuscitation in any event. Mr Hughes might have been hanging for up to 25 minutes. The evidence of Dr Sheridan was that at the commencement of CPR Mr Hughes was cold at the peripheries, cyanosed with a swollen protruding tongue and had no pulse or respiratory effort. She went on to say that the defibrillator was attached immediately but indicated that Mr Hughes was in asystole and hence no shock was advised. Asystole means that there is no electrical activity in the heart whatsoever, and Dr Dalkin explained that the defibrillator could only be effective in improving the activity which was there. It could not start a heart which was devoid of activity. The impact of the late arrival of the crash team was felt on the local team on whom it did have a negative impact because they had to continue CPR until the crash team arrived. The failure to call the crash team was a human error on the part of the switchboard operator, and steps had been taken to avoid its recurrence. Whilst the human error is clearly regrettable, it had been dealt with, and was not a matter which should form the basis of a finding within the determination.

[54] I agree that neither requires inclusion in my determination. Neither contributed or was relevant to the circumstances of the death of Mr Hughes. I have dealt with the cord on his dressing gown under (c) above. As for the lateness of the crash team, I am satisfied that even if

they had been summoned as a response to the first call made to the switchboard, it would have made no difference to the eventual outcome. By then Mr Hughes, on balance, had gone beyond the point where he could be resuscitated successfully. There is nothing else that I consider I should include under this subsection.