SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2019] FAI 1

Case Ref: B166-17

DETERMINATION

BY

SHERIFF DAVID OMAN SUTHERLAND

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

CHRISTINA ANNE WILSON

Inverness, 4 January 2019

[1] The Sheriff, having resumed consideration of the cause, determines that in terms of section 6(1) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976:

(a) Christina Anne Wilson (date of birth 16 June 1940) then a resident at Highview House Care Home, Scorguie Avenue, Inverness, died at 12.15 hours on 8 June 2013 within room 62 of Highview House.

(b) Her cause of death was certified as:

(1) chronic kidney disease with urinary tract sepsis and bacteraemia

due to (or as a consequence of)

(2) nephrostomies for obstructive uropathy

due to (or as a consequence of)

(3) sequela of treatment for cervical carcinoma

(c) There existed no reasonable precaution whereby her cause of death might have been avoided.

(d) There existed no defects in any system of working which contributed to her death.

(e) There are no other facts which are relevant to the circumstances of her death.

[2] Mr Main, Procurator Fiscal Depute, represented the Crown. Mrs Nicholson, Advocate, represented NHS Highland. Mr S Crabb, Advocate, represented Barchester Health Care. Mrs N McCartney, Solicitor, represented Karen Rose and Mr D Jessiman, Solicitor, represented Dr Mary Cauldbeck.

[3] A Fatal Accident Inquiry of this nature does not determine any question of civil or criminal fault or liability. Lord President Hope in *Black* v *Scot Lithgow Limited* 1990 SLT612 explains the purpose of such an Inquiry stating:

> "The function of a 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 pleadings, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required"

[4] Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 sets out the strictly limited statutory scope of the Inquiry and provides that a sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:

(a) Where and when the death and any accident resulting in the death took place.

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

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

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

(e) Any other factors which are relevant to the circumstances of the death.

[5] I heard evidence from the following witnesses:

1. Morag Fraser, daughter of the deceased Christina Anne Wilson.

2. Katherine Buchegger, Referral Assessment Officer with Social Work Department.

3. Fiona Pitt, South Highland Area Manager, NHS Highland.

4. Katherine Fraser, Lead Colorectal and Stoma Clinical Nurse Specialist.

5. Karen Rose, General Manager, Highview House Care Home, January 2012 to September 2013.

6. Mary MacLennan, Head of First Floor Unit, Highview House Care Home.

7. Fiona Munro, Staff Nurse, Highview House Care Home.

8. Ruth MacDonald, Lead Social Work Officer with NHS Highland.

9. Dr Mary Cauldbeck, GP.

10. Jane Blair, Care Inspectorate Officer.

[6] I also had access to various productions which included inter alia a post-mortem report, Care Home file notes, copy medical records and care service inspection report. I also had before me two joint minutes of agreement signed on behalf of the parties represented.

[7] I heard first in evidence Mrs Morag Fraser, daughter of the deceased, Mrs Christina Ann Wilson. She described how her mother had two daughters and one son. She described how she raised concerns with NHS about her mother not being able to manage at home with a care package on her eventual release from hospital. It was therefore agreed with NHS that her mother would go to Highview House Care Home. Mrs Fraser visited her mother at least twice per week, with other family members visiting at other times. She did not think that her mother was eating or drinking very much although she did not know how this compared with when she had been in hospital. She mentioned to one of the nurses in the care home her concerns about her mother's eating and drinking.

[8] She had not seen staff feeding her mother and had not viewed any records of food and fluid intake. She was unaware of what was therefore being monitored. She had never seen any of her mother's records. Sometimes her mother would simply refuse food and she would try and ensure her mother ate a few mouthfuls. She would sometimes take in food for her mother which she knew she liked and would take. Her mother would always say to her that she wanted to go back into hospital and go on a drip.

[9] Mrs Fraser described how her mother had a colostomy and ileostomy. She did not discuss this with any of the staff although she did go and get a member of staff if her mother wanted a bag changed. She described how, in her previous role as a care assistant, she had changed patients' colostomy bags although she had never done any ileostomies. She described how her mother liked to change her own colostomy bag describing it as part of her routine.

[10] She did not report any of her concerns to the manager, Karen Rose. She felt that her mother was just getting used to the home and a different environment.

[11] She had last seen her mother on Thursday 4 June 2013 and was hoping to visit on Saturday 8 June at lunchtime, her sister having visited on Thursday. There had been no warning of her mother's death although she was aware that she was quite unwell. She described how, on 23 July 2013, she had made a complaint to the Care Inspectorate in relation to her mother's care and in particular of her concern over failings regarding colostomy and ileostomy. She also made a complaint regarding the care home's monitoring of nutrition and hydration.

[12] The court then heard from Katherine Buchegger who in 2013 was employed as Referral Assessment Officer for Adult Services, NHS Highland. She was part of the discharge team from hospital and described how the initial intention was that Mrs Wilson (the deceased) would be discharged home with a care package put in place. That had been the position in March but it became apparent that her condition had changed and both she and the family felt that a care home would be the best place for her care needs to be met.

[13] A Single Shared Assessment Form was begun in March and updated during Mrs Wilson's stay in Raigmore Hospital. This was done in conjunction with Mrs Wilson's family and a multidisciplinary team. The patient's specific care needs were written down. In particular it stated that:

> "The client needs assistance and supervision of one carer to ensure she eats and drinks adequately".
>
> and
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> "She needs a trained nurse to attend to the care of her colostomies, change the water in her balloons, check it for leaking, changing her bags, checking her stoma bags and monitoring her stoma bag".

[14] It mentioned her going in and out of acute kidney injury and having recurrent infections and requiring a trained nurse to monitor this and symptoms of dehydration. Mrs Buchegger went on to explain that a residential care home did not require a trained nurse to be on shift and any nursing needs could be dealt with by a visiting district nurse. In Mrs Wilson's case it was deemed necessary for the residential care home to be a nursing care home with trained nurses on site who could monitor her condition from day to day. After discussing with district nurses and a consultant it was not deemed necessary that a specialist nurse be required.

[15] This Single Shared Assessment Form was sent to the manager of Highview House Care Home. Highview House indicated on 3 May that they would be able to take Mrs Wilson with a provisional booking for 16 May. There was a phone call with the manager of Highview House on 14 May confirming that they had visited Mrs Wilson in Raigmore on 13 May and confirmed the 16 May admission.

[16] She explained how NHS Highland had a requirement to follow-up the patient within four to six weeks. She had phoned Highview House on 22 May and was told Mrs Wilson was not drinking much and was becoming dehydrated. She had been told that they had called NHS 24 and that Mrs Wilson was on 30mls every 15 minutes orally, having been put on subcutaneous fluids a few days before. She felt the care home had acted appropriately, calling a doctor to have her medical condition checked. Mrs Buchegger's telephone call was simply a check on how Mrs Wilson was settling in, review being programmed for July. When she spoke to the member of staff on 22 May there was no mention of any difficulties with ileostomy or colostomies. She spoke to Mrs Fraser (daughter) on the phone on 6 June and there were no issues raised which would have caused her to make further enquiries with Highview House.

[17] The court then heard from Mrs Fiona Pitt, Area Manager with NHS Highland who explained that once the single shared assessment was sent to the care home, the care home could carry out its own assessment as to whether it was appropriate for that person to be admitted to their establishment. They would be expected to visit the patient in hospital.

[18] NHS Highland would only discharge a patient to a care home that was on an approved list. There were instances where NHS Highland would not admit people to certain care homes where they had concerns about the quality of care.

[19] The next witness to give evidence was Mrs Katherine Fraser, Lead Colorectal and Stoma Clinical Nurse Specialist with NHS Highland. She explained how she had

involvement in the care of Mrs Christina Wilson for a number of years prior to her being discharged to Highview House in May 2013.

[20] She explained how Mrs Wilson had an ileostomy and nephrostomies, an ileostomy being an opening of the small bowel onto the surface of the tummy and into a small bag, and nephrostomies involving tubes going into the kidneys to drain urine. Nephrostomies were classed as a foreign body and therefore there was always a greater risk of infection but there was a lower risk of infection with ileostomies.

[21] Mrs Fraser spoke of the discharge notification given to the patient's GP with a copy being given to the care home by the ward discharging the patient. These notes included a note on her ileostomy and nephrostomies and were to be found on Mrs Wilson's care home notes. The discharge notes requested encouragement of good fluid intake and recommended what foods were suitable and which were to be avoided. While a copy of this was on the patient's care home notes, a copy was forwarded to the care home kitchen. She stressed the importance of getting enough fluids, dehydration having a bearing on the risk of infection and damage to the kidneys.

[22] Mrs Fraser went on to describe how she attended at Highview House on 17 May 2013 where she reviewed Mrs Wilson's ileostomy and advised members of staff on ileostomy and nephrostomy care. She commented to staff that both nephrostomy sites were healthy and suggested changing the flanges and pouch every three days, three to five days being normal.

[23] She explained how she went to the care home having been contacted by a member of staff. She thought there had been three members of staff present when she was showing them what to do and she also left with them an information sheet.

[24] She also spoke to her colleague, Susan Donaldson, attending the care home on 27 May for further training of staff. She said that there would, as a matter of course, have been a discussion on infection control, e.g. wearing gloves, having a protective field and wearing an apron. All staff whether trained or untrained would have known that already. As long as staff were wearing gloves and apron and are cleaning and drying the skin there would be no greater risk of infection in changing the pouches. A general lack of confidence would not increase the risk of infection.

[25] She went on to explain how patients in the community were often sent home with nephrostomies and therefor a guide for such patient care was prepared.

[26] When she visited the care home on 17 May to provide training to staff members, it was her expectation that they would cascade this down to their colleagues. Changing a nephrostomy bag was not a complicated procedure and she would not expect it to cause a trained nurse any particular difficulty.

[27] The next witness to give evidence was Karen Rose, who was employed as the General Manager of Highview House Care Home between January 2012 and September 2013. She confirmed that either herself or the deputy manager or head of unit would go to a hospital and see the patient for a pre-admission assessment before admitting someone to the care home.

[28] She visited Raigmore Hospital, Inverness, and met with Mrs Wilson on 13 May 2013. She would also have met with the staff nurse responsible for Mrs Wilson's care and possibly one of the doctors if they were available. She would then have returned to Highview House and discussed the case with the unit manager or senior staff nurse. She could not recall whom she had spoken to but she would always discuss a prospective admission with staff although ultimately it was her decision whether or not to admit a resident.

[29] She thought that she had spoken to Mary MacLennan, Lead Nurse in the unit which was to admit Mrs Wilson and suggested that she should contact the ward in Raigmore direct because she felt additional training might be required. That could happen before the patient was admitted or shortly after admission. Admission could even be delayed for a few days if it was deemed necessary.

[30] She confirmed that there had been numerous occasions when having considered all the information from the single shared assessment and the pre-admission assessment Highview House had not felt that they should take a particular patient.

[31] She had not been involved in any of the additional training from the stoma specialists and confirmed that that was the responsibility of the deputy manager. The deputy manager was responsible for day-to-day overall management of care and delivery.

[32] She was not aware of any issues that Mrs Wilson was having as a resident at Highview House. She was not aware of any complaint made to the Care Commission.

[33] She confirmed that the staff nurses and sister on the unit would have been responsible for an individual patient's care plan and Barchester had a policy on procedure for care plans.

[34] She said that infection control was covered in basic nursing training and confirmed that qualified staff should have been aware of symptoms of infection. There was guidance in Highview House for recording fluid intake with a fluid balance chart which would be completed whenever drink was taken and bags emptied. Monitoring of this was part of a patient's care plan.

[35] Although she could not recall, with the passage of time, any particular issues relating to Mrs Wilson she confirmed that Highview House held daily morning meetings when any particular problems were discussed, including particular concerns regarding a patient. She was not responsible for the day-to-day care of the residents which was the responsibility of the deputy manager. Her role as the general manager of a nursing home with 77 residents related to the business – ensuring appropriate staffing, maximising revenue, discipline, audits, speaking to social workers and families and making monthly reports to Barchester.

[36] She explained that the nurses in Mrs Wilson's unit were experienced nurses. She spoke of Mrs Wilson being quite a frail lady but someone who was very aware of what she wanted. If she wanted to eat or drink she would do so but equally could refuse. She was fully aware of her condition.

[37] With her nephrostomies and colostomy the priority was to ensure that Mrs Wilson was taking in enough fluid to keep the nephrostomies functioning. Mrs Rose felt

that Highview House was able to meet Mrs Wilson's care needs because she considered them to be basic nursing care needs. She felt that there should be refresher training regarding stomas and nephrostomies but confirmed that such care was straightforward nursing care. She did not consider that admission to the home be delayed to allow for such training. In her previous role in district nursing, it was common to show family members how to take care of stomas and nephrostomies and therefore did not feel that it was actually complex care.

[38] Mrs Rose confirmed having completed the pre-admission assessment but explained that in the production handed to her (2) page 55, there were two or three sheets missing including the page which bore her signature. These sheets would include details of the patient's care and also details of whom she had spoken to.

[39] The next witness to give evidence was Mary MacLennan, who was Head of Unit at Highview House in which Mrs Wilson was a resident. As head of unit her duties involved the running of the unit including ensuring care plans were prepared, medications ordered and dispensed and generally ensuring the welfare of the residents. She described how Highview House had a care home manager (Karen Rose) a deputy manager and three heads of the three units, namely first floor, ground floor and dementia unit.

[40] She could not recall being involved in the discussion to admit Mrs Wilson which, she said, would have probably been between the manager and deputy manager. She was not on duty when Mrs Wilson was admitted nor on the next day when the stoma

nurse had come to give training, although one of the unit staff passed on the training to her. She was not aware of a further session of stoma training on 27 May.

[41] She stated that staff found changing Mrs Wilson's nephrostomies quite challenging as Mrs Wilson did not like having it done. She was constantly taking her stoma bags off and staff were constantly having to put them back on.

[42] She explained that Mrs Wilson was quite unwell and quite agitated. It was difficult to get her to drink anything. She was on fluid charts with her fluid intake being recorded. She felt with hindsight that they should not have taken Mrs Wilson as a resident. She did not want to be there and the staff had no prior additional training. Mrs Wilson did not want the bags, was constantly trying to take them off with a resultant increased risk of infection. Infection controls were in place with handwashing, gloves and aprons but it was still challenging.

[43] The court then heard from Fiona Munro who worked as a nurse in Highview House from 2003 to 2014. She worked on the unit in which Mrs Wilson had been a resident, although she had only had contact with her on one occasion when she had administered medication. She had not been involved in changing of the stoma or nephrostomies but not having carried out such procedures before she contacted the stoma nurse in Raigmore who attended and gave specific training. She had not been present when Susan Donaldson showed four members of staff what steps to carry out. She advised her head of unit, Mary MacLennan, of their training.

[44] She confirmed that the most important factor in the procedures for nephrostomies was strict hygiene and all nurses were trained in that from the onset of

their training. She also confirmed that all nurses were trained to recognise the symptoms of urinary tract infection in elderly people.

[45] The court then heard from Ruth MacDonald, Lead Social Work Officer with NHS Highland. She explained how, in 2013, patients being discharged from hospital into a care home would have a Single Shared Assessment Form which would be given to the care home to consider whether they were able to meet that person's care needs. Since then the Single Shared Assessment Form had been replaced by a Personal Outcome Plan but the standard procedure was still the same. The change had come about to reflect changes in legislation for self-directed support. However, a move into a care home was still under what was classed as traditional service and there would not have been any changes to the information on the document.

[46] She went on to explain that the health board had a list of approved care homes and would only refer a patient to a home on the approved list. If a home received a bad care inspectorate report the board would start a process to consider whether the home was still suitable. They would not admit to a certain home while enquiries were being carried out.

[47] In addition to the single shared assessment provided by the health board, the care home would then assess the patient to see whether they should be admitted. The patient and their family would also be involved in deciding which care home was appropriate. She felt that it was good practice for there to be a dialogue between the lead professional in the hospital and the manager of the care home.

[48] The next witness to give evidence was Doctor Mary Cauldbeck, GP who was employed as a trainee GP with Crown Medical Practice in 2013.

[49] She explained how her first involvement with the deceased had been on 24 May 2013 following Mrs Wilson having fallen from her bed. She explained how the patient appeared as though she did not require any treatment as a result of the fall but that she instructed a specimen of urine to be taken due to slightly raised pulse and low blood pressure checking for a possible infection.

[50] Doctor Cauldbeck explained how Mrs Wilson was seen on 30 May 2013 at the request of her family for an assessment of her capacity but that was carried out by another doctor.

[51] Again she explained from reading the medical records that the patient had been seen by NHS 24, Doctor Andrew Dexter and prescribed cephalexin antibiotics. This had been replaced by another antibiotic macrodantin due to Mrs Wilson being allergic to cephalexin.

[52] Doctor Cauldbeck went on to say that she had been contacted by 'phone regarding Mrs Wilson on 6 June with the request for pain relief. She decided to increase the patient's paracetamol to 500 grams four times per day and offer tramadol as required.

[53] She had visited the care home later that day regarding another patient and was advised by a member of staff that Mrs Wilson had "settled since change in meds". That was in relation to the pain relief authorised and she did not see her that day. Her notes

indicated that the patient was to continue with the current plan and be reviewed in the next week.

[54] She explained how patients varied but she would usually expect an indication within 48 hours that an antibiotic was working. An elderly person with a urinary infection could display a variety of symptoms including reduced activity, increased activity, high temperatures, high pulse rates, low blood pressures. Equally, the possible signs of UTI could possibly be signs of something else altogether.

[55] She had not been given any indication that her UTI was an ongoing issue and understood it to have been resolving. She explained that it was possible to have more than one bug or pathogen causing the UTI. She confirmed that macrodantin was a relatively broad spectrum antibiotic and could be used for different bugs.

[56] Doctor Cauldbeck explained that when she saw Mrs Wilson after her fall on 24 May, her examination showed 15 out of 15 on the Glasgow Coma Scale. Her pupils were equal and reactive to light and accommodation with no display of temperature.

[57] She noted the ileostomies and colostomy and checked the patient's abdomen and limbs. From the patient's sheets she spoke of the administration of the antibiotic commencing on 1 June, carrying on to include 6, 7 and 8 June.

[58] The court then heard from Mrs Jane Blair, Complaint Inspector with the Care Inspectorate. She confirmed that the Care Inspectorate received a complaint from Mrs Fraser, daughter of the deceased Mrs Wilson, about the care of her mother in Highview House Care Home.

[59] The first complaint was that the home failed to ensure adequate care with particular reference to colostomy and nephrostomy. Mrs Blair explained that in her previous role as a nurse she had experience with ileostomies but not nephrostomy. She confirmed, however, that they were similar and needed the same sort of infection control measures.

[60] She thought she had spoken to five or six members of staff although her report of 10 December 2013 states that she spoke to the Deputy Manager and two nurses. Some of the staff, she said, did not feel confident regarding colostomies and nephrostomies not having had direct guidance from the stoma nurse. She was aware of two visits from stoma nurses to Highview House, the first on 17 May and the second on 27 May. She did not know how many of the staff had attended to be trained by the stoma nurses but accepted that the plan of having some nurses instructed by the stoma nurse and for that training to be cascaded to the other staff was acceptable. She felt that such training should have been given to all staff who were going to be involved in Mrs Wilson's care before her admission. In particular, she felt that specific guidance regarding infection control should be included in the patient's care plan given the high risk of infection.

[61] The second issue raised by Mrs Wilson's daughter was in relation to care and support of her mother's nutrition and hydration. She noted that Highview House had carried out a MUST Assessment – a Malnutrition Universal Screening Tool. She noted that on 21 May it was recorded that Mrs Wilson was receiving subcutaneous fluids because she had not been drinking. This was not something she had come across very often and she felt that a dietician should have been involved although she did state that

the Must Tool gave advice on fortifying the diet with, for example, double cream and full fat yoghurts.

[62] She explained that when she visited the care home in October and spoke to members of staff she did not see any of the care plans and didn't view these until December when they were received from the procurator fiscal's office. Neither did she see any of the fluid charts.

[63] A copy of her report dated 10 December 2013 was sent to Barchester Healthcare Limited, owner of Highview House which required that the care home:

1. Ensure that a detailed pre-admission assessment be completed with the full involvement of the service user and or their representative.
2. Ensure that a care plan is prepared which includes all service users' needs and how these needs should be met.
3. Ensure that adequate infection control measures are recorded in the care plan.
4. Ensure that the risk of cross infections are fully assessed.
5. Ensure staff receive appropriate training in relation to the work they are to perform.
6. Ensure that where a risk is identified adequate monitoring of food and fluid intake is recorded and the service user's weight is monitored.
7. Ensure that service users receive appropriate medication when required.

[64] She went on to explain how these requirements would be followed up by the Care Inspectorate Inspection Team at the next inspection.

[65] She confirmed that the subsequent inspection report confirmed that Highview House had responded appropriately to the requirements made within the improvement notice and that that was reflected in the improved grading awarded within the report.

Submissions

[66] All parties to the inquiry were agreed as to the findings which I should make in terms of section 6(1)(a), 6(1)(b), 6(1)(c) and 6(1)(d). Mr Main for the Crown invited me to make the following findings in terms of section 6(1)(e):

1. When arranging the discharge of a patient from a hospital to a care home, both the NHS Health Board and the care home should take sufficient measures to satisfy themselves that staff at the care home are sufficiently trained and equipped to deal with the patient's particular care needs prior to the date of discharge; and
2. Care homes responsible for residents requiring to maintain a good food and fluid intake should ensure they have sufficient measures in place to ensure that intake is not only recorded but also adequately monitored and reviewed and that sufficient measures are in place to ensure staff know how to address matters where intake requires to be improved.

[67] In respect of discharge of a patient from a hospital to a care home, Mr Main said that Mrs Wilson had been considered to require trained nursing needs and suggested that the evidence indicated that Highview House should not have taken her on the agreed date when it transpired that some staff were unfamiliar and uncomfortable with the procedure of changing ileostomy and nephrostomy bags. This training was given the day after Mrs Wilson's admission. Such training should have been given before Mrs Wilson's admission. While he accepted that the court did not have before it clear documentation regarding the discussions that took place before admission, both amongst staff in Highview House and with NHS Highland, he felt that a "two-way dialogue" between the Health Board and the care home would be an appropriate approach and suggested that that had not taken place fully in Mrs Wilson's case.

[68] With regard to his second suggested finding, he said that NHS Highland had highlighted to Highview House the need to ensure Mrs Wilson maintained a good fluid intake to minimise the risk of infection. He agreed that the care home had recorded this in her food and fluid intake but the Care Inspectorate felt a detailed care plan should have been in place showing monitoring and action taken. He felt that care homes should, in such circumstances, ensure that processes were in place to ensure that intake is being recorded and monitored so that any issues can be quickly identified and dealt with.

[69] Mrs McCartney, for Mrs Rose, stated that her client had attended at Raigmore Hospital for a pre-admission assessment in Mrs Wilson's case. Although some of the pages of her assessment form were missing, including the page with her signature,

nonetheless her client's evidence was clear regarding her normal practice of speaking to the staff nurse in the ward responsible for the patient's care and the consultant and family, if available.

[70] She would not accept anyone without being fully satisfied that the care home could meet their needs. Highview House employed trained nurses. Mrs Bucheggar of NHS Highland had discussed the matter with her district nurses and the consultant responsible for Mrs Wilson and specialist nurses were not deemed necessary.

[71] Mrs Katherine Fraser, Stoma Nurse, had given evidence that providing care in relation to ileostomy and nephrostomies was within basic nursing competence. Although Mrs Fraser stated that caring for nephrostomies and ileostomy was straightforward, additional training was given to staff on the day after Mrs Wilson's admission and further training given ten days later.

[72] With regard to the monitoring of food and fluid intake and the Care Inspectorate findings, she noted that the care inspector had not looked at the food and fluid charts as part of her investigation. However, the nurses caring for Mrs Wilson were trained experienced nurses and the care home did have measures in place for monitoring and action to be taken in the form of a Malnutrition Universal Screening Tool, audits, care plans, care notes, food and fluid charts and procedures to be followed where issues arose.

[73] In all the circumstances she submitted that there was nothing to indicate that any finding was appropriate in terms of section 6(1)(e).

[74] Mr Crabb, Advocate, representing Barchester Health Care Homes Limited, owners of Highview House Care Home, maintained that there was no evidence before the inquiry regarding the relationship between either the discharge and the training of staff at the care home or the patient's intake of fluids and the circumstances relating to her death. There had been a "two-way dialogue" between the health board and Highview House's manager. There had been no evidence that the discharge process or training of staff had any relevance to the circumstances relating to Mrs Wilson's death.

[75] With regard to Mrs Wilson's fluid intake, no evidence was heard that this matter had any link at all to the circumstances surrounding her death. Her fluid intake was being monitored and there was guidance on fluid intake within Highview House. Procedures were in place to ensure good fluid intake.

[76] Mr Jessiman, solicitor for Dr Cauldbeck, maintained that there was no evidence to support findings in terms of section 6(1)(e) in relation to Dr Mary Cauldbeck. Dr Cauldbeck had attended at Highview House on 24 May after Mrs Wilson had suffered a fall. She had carried out a detailed assessment and examination regarding the care home to obtain a urine sample for infection testing. This was done and a UTI identified and an antibiotic prescribed by an out of hours GP.

[77] She was telephoned by care home staff on 6 June regarding pain medication for Mrs Wilson. She visited another patient at the home on 6 June and was told by staff that Mrs Wilson had "settled since the change in medication" (a second antibiotic had been prescribed on 1 June, Mrs Wilson being allergic to the original antibiotic). She had not been asked to see the patient nor was any concern raised in relation to the UTI. Dr

Cauldbeck therefore had no reason to believe the UTI was ongoing and had not been resolved.

[78] Mrs Nicholson, Advocate, Counsel for Highland Health Board maintained that an objective analysis of the evidence at the inquiry made it clear that no facts relevant to the circumstances of the death had been established under section 6(1)(e). Mrs Wilson had passed away on 8 June 2013 while sitting in her chair having been resident in Highview House for three weeks and two days. Her death resulted from chronic kidney disease and urinary tract infection. As a direct result of her treatment for cervical carcinoma, she had bilateral nephrostomies and was predisposed to developing a urinary tract infection. She was a very frail, elderly lady whose general health was failing. There was no evidence that any failures in care of the nephrostomies or ileostomy played any part in her death. Indeed there was no evidence that there were in fact any failures in care of her nephrostomies or ileostomy by the nursing staff.

[79] She indicated that the stoma nurse, Mrs Katherine Fraser, had explained in evidence that caring for nephrostomies and ileostomies was straightforward. Mrs Fraser indicated that providing care in relation to ileostomy and nephrostomies was within basic nursing competence and the agreed evidence in the joint minute of Susan Donaldson was that the changing of nephrostomies was not a complicated process.

[80] All this was in contrast to the Crown's submission that Highview House was not fully in a position to take Mrs Wilson on 16 May and should not have done so. Mrs Rose had said that there were numerous occasions when patients were not accepted to the

home. A discharge letter was sent with Mrs Wilson to Highview House with advice and a training session took place only the day after.

[81] NHS Highland had provided sufficient information to Highview House to enable it to determine whether it could accommodate Mrs Wilson. There had been no concerns raised about Highview House by the Care Inspectorate reports prior to admission. She said that the "two-way dialogue" between the health board and the care home had taken place and that that was best practice.

[82] The health board should be reasonably entitled to have regard to Care Inspectorate reports and to be able to rely on responsible care home managers' assurances that appropriate care could be delivered in nursing homes.

[83] Mrs Wilson died at 12.15 hours on 8 June 2013 within Room 62 of Highview House Care Home, Scorguie Avenue, Inverness.

Conclusion

[84] On 11 June 2013 Dr Mark Ashton, Consultant Pathologist, carried out a post-mortem examination. His conclusion was that Mrs Wilson had a history of carcinoma of the cervix which had been treated by radical radiotherapy. She subsequently developed bladder and bowel fistula with marked intra-abdominal adhesions requiring the formation of an ileostomy and ureteric obstruction requiring bilateral nephrostomies. Renal function was known to be poor. She had recently been a hospital inpatient but had been discharged to a nursing home. She was found dead sitting in a chair in her room.

[85] Post-mortem examination by Dr Ashton confirmed the complications of the radiotherapy treatment for her cervical carcinoma. This had necessitated the formation of an ileostomy and bilateral nephrostomies. A gram negative organism had been isolated from her urine and a similar organism was found within her blood. Her death had resulted from her chronic kidney disease and urinary tract infection. The nephrostomies, which were a direct result of the treatment for her cervical carcinoma, would have predisposed her to develop a urinary tract infection.

[86] He certified her cause of death to have been:

> 1(a) Chronic kidney disease with urinary tract sepsis and bacteraemia
>
> due to (or as a consequence of)
>
> (b) Nephrostomies for obstructive uropathy
>
> due to (or as a consequence of)
>
> (c) Sequela of treatment for cervical carcinoma.

[87] Mrs Wilson was a lady with an extensive medical history. She had developed cervical cancer in 1985 and subsequently developed bladder and bowel fistula with marked intra-abdominal adhesions requiring the formation of an ileostomy and ureteric obstruction requiring bilateral nephrostomies. In 2002 she had vagina vesical fistula and then kidney problems in 2006 when she developed obstructive uropathy.

[88] She attended the renal clinic regularly from 2008 until her death in 2013. Her condition began to worsen in 2011 and, in accordance with Mrs Wilson's wishes, a decision not to attempt cardio pulmonary resuscitation was taken. A DNACPR notice

was placed in her hospital records. Between January 2011 and her death in 2013 she had ten hospital admissions.

[89] Since 2011 she was having recurrent urinary infections with different organisms. There were approximately 15 to 20 urine cultures that were positive from June 2011. The reason for the multiple urine infection would be the nephrostomies. The infections were treated but unfortunately would have resulted in increasing resistance of the bacteria to antibiotics.

[90] Mrs Wilson was last admitted to hospital on 26 March 2013 when she was found to have chronic kidney disease, low sodium and with decreased blood volume. Her stool culture was positive for clostridium difficile and this infection was treated successfully by an antibiotic.

[91] She also had E. coli in her urine which was highly resistant and only sensitive to three antibiotics, gentamicin and meropenan (which required to be given intravenously) and oral nitrofurantoin. Gentamicin is known to worsen kidney disease and oral nitrofurantoin is not effective where kidney function is less than 30%.

[92] The joint minute of agreement informed the court that a decision was made – including on the advice of microbiology – that NHS Highland would only treat Mrs Wilson's urine if she became acutely unwell. The reason for this was to ensure that she did not become resistant to meropenan leaving that treatment option for when it was really needed. The joint minute goes on to say that E. coli is a common urinary tract infection in elderly people and does not require treatment unless there are symptoms. During her final hospital stay, Mrs Wilson struggled to eat and drink and often had to

go back on intravenous fluids because of her kidney problems. A review by the dietician showed a significant weight loss in the previous ten months. It had become clear that Mrs Wilson's general health was failing and that she was not going to be able to go back to her own home. In April 2013 all members of the multi-disciplinary team agreed, as did Mrs Wilson herself and her family, that a nursing home placement would be the best option for her care and safety needs.

[93] She was deemed fit to be transferred to Highview House Care Home on 16 May 2013 after being reviewed by a consultant. She was no longer requiring intravenous fluids. The C difficile infection had been successfully treated and she was not on antibiotics. She did not require hospital treatment. She was frail and prone to infection and being in hospital might increase the risk of infection.

[94] Dr Nicola Joss, Consultant in renal medicine, in summary indicated that Mrs Wilson's general health was failing and the reasons for that included her various comorbidities, the multiple admissions to hospital, her resistant bacteria, her significant weight loss and her chronic kidney disease. The fact that she had nephrostomies meant that she was always going to be an ongoing risk of infection.

[95] I do not consider that the evidence before the court justifies a finding in terms of section 6(1)(e). While section 6(1)(e) permits a wider scope than 6(1)(c) and 6(1)(d) nonetheless the facts established under this must be relevant to the circumstances of the death.

[96] While the documentation relating to Mrs Wilson's admission was limited and Mrs Rose advised the court that two or three pages of her pre-admission assessment

were not before her, including the page which would bear her signature, nonetheless the evidence of Mrs Bucheggar of NHS Highland and Mrs Rose was clear that a two-way process had taken place between NHS Highland and Highview House with Mrs Wilson's care needs appreciated and understood.

[97] As far as training was concerned the specialist stoma nurse, Mrs Kathy Fraser, explained that caring for ileostomies and nephrostomies were straightforward and caring for such patients was within basic nursing competence. She had given additional training to staff the day after Mrs Wilson's admission, which training had been repeated by a colleague some ten days later. There was no evidence before the court to suggest any difficulty in the management and care of Mrs Wilson's ileostomy and nephrostomies. Equally, I consider that the evidence before the court showed that Highview House did have measures in place for monitoring and action to be taken in the form of a malnutrition universal screening tool, audits, care plans, care notes, food and fluid charts and procedures to be followed where issues arose.

[98] While Mrs Blair of the Care Inspectorate spoke of visiting Highview House following on receipt of a complaint from Mrs Fraser, daughter of the late Mrs Wilson, she explained that she did not see any of the care plans, nursing records or fluid charts which were all held by the police in the course of their investigation. This is not a criticism of Mrs Blair, who very properly came and made an unannounced visit in October 2013, but was clearly hampered in her enquiries by not having access to the full records. She did have sight of some of the records in December but not when interviewing any of the members of staff at Highview House. The requirements

narrated in her Care Inspectorate Report are a proper professional statement of what should be expected in a nursing care home, but given the whole evidence before the court I do not consider that it is appropriate to make a finding that there were any other factors which are relevant to the circumstances of Mrs Wilson's death.

[99] In all the circumstances I do not consider that any finding was appropriate in terms of section 6(1)(e).

[100] That being said, I think it is important that there should be full dialogue between the lead professional in the patient's care in the hospital and the care home manager before any patient is transferred from hospital to a care home. This dialogue should include the patient and, if possible, a family member and should be fully documented.

[101] Clearly Mrs Wilson had suffered serious health issues since 1985 when she developed cervical cancer. She had suffered kidney problems since 2008 and had ten hospital admissions since 2011. The evidence before the court speaks of her being a strong character who battled against her infirmities and failing health.

[102] She was deeply loved by her family and the court extends its sympathy to her daughters and son and all who loved her.