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

DETERMINATION

by

Sheriff Principal Edward Bowen QC

In an Inquiry into the deaths of

Jane Mein Constance and Elizabeth Swinscoe

APPEARANCE:

Miss F MacDonald, Procurator Fiscal Depute, for the Crown

Mr R Hayhow, Advocate, instructed by Messrs Tods Murray, Edinburgh acting for the Galashiels Nursing Home

Mr F McShane, Advocate, acting for The Care Commission

Mr I Sharpe, Advocate, acting for Scottish Borders Council

DETERMINATION IN AN INQUIRY INTO THE DEATHS OF JANE MEIN CONSTANCE AND ELIZABETH SWINSCOE

SELKIRK, 15 FEBRUARY 2006

The Sheriff Principal having considered all the evidence adduced determines in terms of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 section 6(1):

(a) That Jane Mein Constance who was born on 19 December 1906 and who was latterly a resident in Galashiels Nursing Home, Kirkbrae, Galashiels died at 12.30 hours on 7 November 2001 at Borders General Hospital, Melrose.

(b) That the cause of death was (1a) calcific mitral and aortic valve stenosis; and (1b) generalised atheroma.

Further in terms of said section 6(1):

(a) That Elizabath Swinscoe who was born on 19 April 1921 and who was latterly a resident in Galashiels Nursing Home, Kirkbrae, Galashiels died at 03.00 hours on 25 June 2004 at Borders General Hospital, Melrose.

(b) That the cause of death was (1a) combined effects of early bronchopneumonia and congestive cardiac failure; (1b) mitral valve disease and ischaemic heart disease (ii) senile dementia and pressure sores.

(c) That there are no reasonable precautions whereby the death of Mrs Swinscoe might have been avoided.

(d) That no defects in any system of working contributed to the cause of death.

(e) That the following facts are relevant to the circumstances of Mrs Swinscoe's death.

1. Galashiels Nursing Home ("GNH"), Kirkbrae, Galashiels is a registered Care Home. It is owned by Pryde and Co which has its registered office care of Alex Morison & Co at 68 Queen Street, Edinburgh. The directors of the company are Charles, Evelyn, Nicholas and Gillian Ingram. Charles and Nicholas Ingram who are father and son are directly involved in the management and administration of GNH.

2. GNH has capacity for 40 residents. It was not full at any of the times material to this inquiry. A Matron/Manager is in overall charge and is responsible for the nursing care of residents. The Matron at the end of 2003 was Sandra Howe. She went on sick leave in about April 2004 and resigned in July 2004. From April 2004 onwards Michelle Cass acted as Matron and was confirmed in that position in December 2004.

3. On of the functions of the Matron is to see and assess potential residents prior to admission. All residents have reached a stage of life where they are unable to care for themselves and may have mild to moderate dementia. The home does not provide full time nursing care nor does it provide for those with severe dementia.

4. A total of approximately 35 staff are normally employed at GNH. Of these six including the Matron holding nursing qualifications. In addition since March 2003 June Harper, a former nurse tutor, has acted as Director of Nursing. One of her specific duties is the auditing of care plans.

5. At all material times staff at GNH worked on a three shift pattern, vis: Dayshift from 0800 to 1400 hours (with some staff working a 12 hour shift until 2000); Backshift 1400 to 2000 and Nightshift 2000 to 0800. Duty rotas are prepared by the Matron.

6. Each resident in the home retains his or her own general medical practitioner. The doctor will make visits to his or her patient either as required or as a matter of routine when in the home on other business. Mrs Swinscoe's general practitioner was Dr John Glenfield of Galashiels. The prescribing of medicines and issuing of prescriptions for residents is the responsibility of the individual GP. GNH had an arrangement for the provision of medicines in bulk in sealed containers from a Pharmacy within Tesco Galashiels.

7. Prior to 31 March 2002 GNH in common with other care homes was regulated by the provisions of the Nursing Homes Registration (Scotland) Act 1938 as amended by the National Health Service (Scotland) Act 1972 and the Health Services Act 1980. Responsibility for regulation of the home was vested in Borders Health Board.

8. An unannounced inspection visit was paid to GNH by one of the Board's Inspecting Officers (who was a qualified nurse with experience in tissue viability and incontinence management at clinical tutor level) on 30 May 2001. The focus of the inspection included records and record keeping. It was noted that there was "a very effective yet simple assessment care plan system for residents"; and evaluation of care was completed three monthly by registered nurses with full involvement of the care staff and that "a great deal of effort had gone into record keeping in this establishment".

9. An annual unannounced visit was carried out on 24 September 2001. That inspection covered a number of matters including staffing levels, equipment and quality of care. It was noted that "this home fully complied with the clinical audit completed by the Health Board and the outcome was very satisfactory". Pressure sore prevalence was recorded as less than 3% against a United Kingdom average in similar homes of 30%. The report stated that the low level of pressure sore prevalence "was to be commended, particularly with the current high dependency resident group".

10. At all material times Borders Health Board Inspectors considered staffing levels at GNH to be adequate for the number and level of dependency of the

residents. In particular, although the Matron/Manager was regarded as supernumerary to the staff to enable her to concentrate on management duties the presence of that individual was regarded as sufficient to satisfy the requirements that there should be at least one registered nurse on duty at all times.

11. The relationship between the home and the officials of Borders Health Board was at all material times positive and constructive. The Health Board Inspectors felt able to give advice to the Managers of GNH and on occasions when they did so the home responded and acted upon that advice.

12. On 1 April 2002 the Scottish Commission for the Regulation of Care ("The Commission)" assumed the functions of regulation of the care home sector in Scotland in terms of Part 1 of the Regulation of Care (Scotland) Act 2001.

13. Section 4(1) of the 2001 Act imposes on the Commission a duty to provide information to the public about the availability and quality of care services. Section 4(3) provides that the Commission shall, when asked to do so, provide advice to persons who provide, or seek to provide, care services. The Commission are empowered to charge a fee for doing so in terms of section 4(4).

14. Section 5 of the Act imposes a duty on the Commission to prepare and publish, following consultation, "National Care Standards" applicable to care services. The Commission duly produced a document headed "National Care Standards. Care Homes for Older People". That document from its terms is directed to providing information to persons who are or who may wish to become resident in a care home, or their relatives. For example, under the heading "Using the National Care Standards" it is stated: "If you are thinking about moving into a home you will want to refer to the standards to help you decide which home to choose".

15. Sections 25, 26 and 27 of the Act made detailed provision for the inspection of care services by persons authorised by the Commission. Section 29 provides

regulations relating to care services. In exercise of the powers contained in this section Scottish Ministers, following appropriate consultation, issued the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 2002 No 114) which came into effect on 1 April 2002. The regulations contain a scheme regulating the provision of care services, covering such matters as fitness of providers and managers, staffing, fitness of homes, keeping of records, and the preparation and maintenance of personal plans for care and welfare of service users.

16. Whilst the Commission acknowledges its obligation to provide advice when required in terms of section 4(1) of the Act, it did not regard that as a priority. It considered its priority to be regulation and the function of its authorised officers to be that "Regulators".

17. An inspection of GNH was carried out by two Commission Officers, on 11 October 2002. They provided a report dated 4 November 2002. The observations in that report, some of which appeared to be critical of the Home, were made by reference both to the National Care Standards and the Regulation of Care Regulations. The report concluded with a summary paragraph in the following terms: "During the period of this inspection the Care Commission Officers noted a relaxed and homely atmosphere throughout the home. Interactions between the staff and residents were seen to be respectful and appropriate, and staff were noted to engage well with residents. Residents spoken with all expressed satisfaction with the level of care received, the quality of the food, and their accommodation. The standard of décor in most of the home is bright clean and pleasant and the Management have stated their intention to continue the process of refurbishment where necessary".

18. A further inspection took place on 30 and 31 July 2003 resulting in a report dated 26 September 2003. A number of recommendations and requirements were made, including a requirement to renew policy on the use of restraint. GNH produced an action plan thereafter which was considered by the Commission Officers to be satisfactory.

19. The home was again inspected on 11 November 2003 the Inspecting Officer's report being dated 12 February 2004. It included the observation that "the staffing notice is not being met on 7 days out of 7". That observation related to the fact that a second level (formerly enrolled) nurse was "in charge" at times when the Matron was also present on a supernumerary basis. By letter dated 23 January 2004 the Commission agreed that such an arrangement met the staffing notice, a position which had been accepted by Borders Health Board prior to 1 April 2002.

20. Mrs Swinscoe was a retired registered nurse. She lived with her sister at 1 Wheatlands Road Galashiels. She had been housebound for about five years prior to October 2003.

21. Mrs Swinscoe had been a patient of Dr John Glenfield for about 10 years. She suffered from osteo-arthritis in both hips and high blood pressure. Latterly her mobility was increasingly poor and she was showing signs of dementia.

22. On 27 October 2003 Mrs Swinscoe fell at her home address and suffered injury to both hips but no fractures. She was admitted to Borders General Hospital (BGH) for treatment. She was transferred from Ward 10 to Ward 12 on 19 December 2003.

23. During Mrs Swinscoe's stay in BGH it was noted that she had significant dementia, persistent urinary incontinence, and progressive poor mobility. Her condition deteriorated at BGH. She had progressive cachexia (a feeble condition brought about by dementia). By 23 December 2003 her serum albumin, a marker of malnutrition in the elderly, was low.

24. By January it was clear that Mrs Swinscoe did not meet the criteria to remain under NHS care but would require full-time nursing care. Contact was made with the Social Work Department with a view to arranging her placement in a Nursing Home.

25. Following assessment Mrs Swinscoe was accepted to GNH on 20 January 2004. Her admission there was agreed with her son and next of kin who was told that there "had been a problem" with the home but it was being satisfactorily monitored. It was understood to be Mrs Swinscoe's own wish that she remain in Galashiels.

26. The care plan for Mrs Swinscoe prepared on 20 January 2004 noted that she was incontinent of urine and faeces, had low blood pressure, poor mobility, no awareness of environmental dangers and was unable to wash or dress. She was assessed as "heavily dependent". Despite her poor condition she settled down well. On 21 January she was noted as having eaten a good breakfast but had a poor lunch. Some of the staff knew her from her nursing days. She had a poor short-term memory but some intermittent recollection of names and events from the past.

27. Different systems exist for assessing the vulnerability of a patient to pressure sores. These include the Braden system and the Waterlow system, both of which involve a series of scores, producing a total which places the patient in a category of risk. The system in use in GNH in 2004 was the Braden system. Ms Swinscoe was assessed as being at the upper end of the "moderate risk" category. Her bed had a pressure relieving mattress.

28 On 24 January it was noted that Mrs Swinscoe's ankles were both "very oedematous and she was encouraged to elevate her legs on a foot stool. On 15 February both heels were "extremely red and spongy" with a risk of skin breaking. The nursing record contains the note "please elevate heels of (sic) mattress as per care plan". The heels remained red and ankles swollen on 4 March.

29. By the end of March Mrs Swinscoe's general condition had deteriorated and caused greater concern. She was noted as "off her diet" on 27 March and having no interest in anything on the following day. Her temperature was up and a urinary tract infection was suspected. She was seen by Dr Glenfield. She was encouraged to drink "adequate amounts of fluid".

30. Mrs Swinscoe was seen again by Dr Glenfield on 16 April in connection with her legs. It was noted that these were to be "elevated while sitting and in bed". On 23 April her sacral area was noted as very red and in danger of breaking down. She was to be "nursed on alternate sides overnight".

31. On 2 May a small break was noted on the right buttock. This was treated by means of a dry dressing. A dressing was applied to a superficial break on the sacral area on 4 May. By that date her poor diet was repeatedly recorded. She was spending most of her time in bed, being nursed "side to side".

32. Continuing concern about her poor diet and the vulnerability of the heels and sacral area was expressed by care and nursing staff throughout May. Mrs Swinscoe was seen and fully examined by Dr Glenfield on 10 May. That examination did not reveal any specific problem relating to pressure sores. A large discoloured area was observed on her left hip on 19 May and she was kept on her back and right hip overnight. Granuflex, a special dressing obtained by prescription for use on broken skin, was applied. This was removed on 22 May and tegaderm, a type of transparent dressing, was applied to protect the wound.

33. On 27 May an area of left hip was noted to be broken. This was recorded on a wound assessment chart which indicated two red areas surrounded by a "sloughy area not deep". There was a large amount of exudate. Dressing was to be changed daily. She was seen by Dr Glenfield on that date. He did not consider that she had a major abscess. The wound was redressed on the following day. On or about that date her mattress was changed to an air wave mattress.

34. Nursing records from 28 May to 11 June confirm that the wound on the left hip was under regular observation and was regularly re-dressed. A swab was taken on 1 June. On 3 June it was noted that pressure points were "marking badly despite regular turns". She was being turned on 2-3 hour intervals. On

7 June the swab result revealed that the wound was infected and Dr Glenfield who saw her on that date prescribed an antibiotic.

35. On Friday 11 June exudate was noted to be "heavy" when the wound was re-dressed. Contact was made with the District Nurse who in turn asked the Community Staff Nurse, Christine Davidson to attend at GNH. Ms Davidson examined the wound which was oozing pus and bloodstained fluid. She cut away necrotic tissue and drained the wound using a syringe and saline. She put intrasite gel – used to lift slough and necrotic tissue – on top of the wound and covered it with a pad and dressing. Ms Davidson was concerned about Mrs Swincoe's condition but considered that she could remain in GNH unless she became pyrexial. She advised staff at GNH to contact a doctor if Mrs Swinscoe's temperature rose and that in any event her GP should be contacted to consider a change of antibiotic.

36. The wound was cleaned by GNH staff on 12 June, and twice on 13 June.

37. On Monday 14 June Dr Glenfield visited Mrs Swinscoe. On removing the dressing from the left hip a "plug" of necrotic tissue fell away from the wound and a large quantity of pus poured out. Dr Glenfield was concerned that Mrs Swinscoe might become septicaemic and arranged for her admission to Borders General Hospital. Mrs Swinscoe's son was informed.

38. On admission to Borders General Hospital Mrs Swinscoe was given a full nursing assessment. She was not dehydrated and had clearly received adequate hydration for some weeks before admission. Her serum albumin had however fallen below that recorded in December. On the waterlow pressure sore assessment system she was given a score of 19, being a rating of "high risk". She was seen by Dr Carol Norris, Consultant Physician and Head of Department for the Care of the Elderly on 15 June. Dr Norris observed that she had necrotic pressure sores, the worst on the left hip "with pus" and others on the right hip and buttock cleft.

39. From 14 June to 23 June, under Dr Norris' direction, Mrs Swinscoe was nursed conservatively. She was placed on a pressure reducing mattress, her wounds were regularly cleansed and redressed, and she received intravenous antibiotics. She was seen by a dietician. On 22 June the dietician recorded that her nutritional intake was not adequate to promote healing of pressure sores. Records indicate that Mrs Swinscoe was taking only a few mouthfuls of food and was reluctant to take fluids.

40. On 23 June there was a marked change in the appearance of the wound on the left hip which appeared deeper and bigger. At 1700 hours she was seen by Mr Michels, a Consultant Orthopaedic Surgeon who described the left hip wound as 10cm by 5cm in size and approximately 20cm by 20 cm "underlying". Mr Michels considered that the wound was unlikely to heal without removal of dead tissue and suggested surgical debribement. There was a significant risk of her developing sepsis.

41. On the evening of 24 June 2004 Mr Michaels carried out a debribement operation. Mrs Swinscoe left theatre and returned to Ward 10. In the course of the surgical procedure her blood pressure and heartbeat were satisfactory. However at 23.45 hours on said date she was documented as "drowsy but opening eyes". Thereafter her condition deteriorated and despite attempts to stabilise her she died at 0.30 hours on 25 June 2004.

42. A condition of severe dementia with progressive cachexia together with complete immobility is a situation in which severe bedsores can occur in an elderly person even with optimum nursing care being given. Where there is very low serum albumin tissues can disintegrate rapidly and pressure sores can deteriorate significantly over the space of a few days. The presence of severe pressure sores on a person with severe dementia and low serum albumin is not necessarily indicative of neglect.

NOTE:

This is an Inquiry into the circumstances of death of two elderly ladies aged 94 and 83 years respectively who died in Borders General Hospital in November 2001 and June 2004, in each case following a period as a resident at Galashiels Nursing Home. It should be noted at the outset that as the residents of that Home are all in the declining stage of life such deaths are by no means uncommon, the evidence being that about a dozen or so residents of the Home die of natural causes each year.

At the conclusion of the Inquiry I was not invited by any party represented at it to make anything other than formal findings in relation to the death of Mrs Constance, and on the evidence led that is the only course open to me. In short Mrs Constance died of natural causes at the age of 94. From the terms of the petition seeking the Inquiry, and from the inevitable sight of certain productions not dealt with in evidence, it appears that a question arose as to whether Mrs Constance died because of an overdose of insulin. It now appears that any such suspicion was not justified. I mention this although strictly speaking not required to do so, partly to "clear the air" in respect of Mrs Constance's death, but also to comment that from late 2001 onwards Galashiels Nursing Home was caught up in a wave of suspicion that at the end of the day appears to have been based, at best, on misunderstandings.

In respect of the death of Mrs Swinscoe it is the case that she died following surgical intervention designed to avert the onset of sepsis at the site of a large pressure sore. It is beyond dispute that the surgical intervention was appropriate if there was to be any prospect of saving her life, and it is also clear that the very frail condition of physical health in which she was meant that there was a risk that she would not survive surgery.

In that situation the principal issues relating to the death of Mrs Swinscoe concern her period of care at Galashiels Nursing Home, and in particular whether any steps ought to have been taken by the staff of that home to prevent the occurrence of the pressure sore which subsequently required surgery, or whether there was any failure of their part to obtain medical advice and treatment at an appropriate time. At the conclusion of the Inquiry I was not invited by the Procurator Fiscal Depute, or by any other party,

to make findings in terms of sub-section 1 (c) or 1(d) of the 1976 Act, namely that there were any reasonable precautions whereby the death might have been avoided, or that any defects in a system of working contributed to the death. The absence of any submissions seeking such findings was, on the evidence, entirely appropriate. The first point to note is that staff at Galashiels Nursing Home were aware from the time of Mrs Swinscoe's admission that she was vulnerable to pressure sores. Within a matter of days there was a problem relating to her ankles and heels. This was dealt with appropriately. Further problems which arose in April and May concerning the sacral area and right buttock were also dealt with as well as could be. A problem with the left hip was first noted on 19 May. Again steps were taken to deal with it. Mrs Swinscoe was seen by Dr Glenfield on 27 May and 7 June and a Community Staff Nurse dressed the wound on 11 June.

Once admitted to hospital Mrs Swinscoe was not seen by a surgeon for a period of nine days. The reason for this delay, as explained by Dr Norris, an experienced physician whose evidence I have no difficulty in accepting, was that it was "absolutely proper" that there should be a conservative plan for treatment in place since, as proved to be true, surgery might prove fatal. The alarming appearance of the wound when Mrs Swinscoe underwent surgery appears to have arisen because the superficial appearance concealed the true extent of the underlying severity until a very late stage. A staff nurse from Ward 10 of the Hospital said that she was shocked by the appearance of the wound on 23 June, and that it had noticably deteriorated in the space of 24 hours. In that situation any suggestion by anyone that staff at Galashiels Nursing Home failed to observe the development of the pressure sore, or failed to arrange for it to be treated until it had reached a serious stage, was wholly misconceived. A view to that effect appears to have been communicated to Mrs Swinscoe's son, Alan, by someone at Borders General Hospital. The identity of that individual and the precise terms of what was said were not established in evidence. Whilst I have no doubt that staff found themselves dealing with a pressure sore which was outwith the normal ambit of their experience the communication of the view to Mr Swinscoe that this had come about because of some form of neglect was unfair and ill-considered, as was the communication of that view to any investigating authority.

Part of Mr Swincoe's concern about his mother's care was that on the last occasion when he saw her she appeared to have shrunk in appearance somewhat dramatically. One area which the evidence did not touch on was the extent to which Mr Swinscoe was informed of the true state of his mother's health or the likelihood that she would fail quickly following her move from hospital to the nursing home in January 2004. As recorded in Finding 23 above the fact of the matter is that by the end of 2003 Mrs Swinscoe had reached a stage where, because of progressive dementia, her loss of mental faculties themselves prevented her from eating properly. Aside from her vulnerability to pressure sores caused by the absence of nutrition vital for proper tissue viability, I am satisfied that her deterioration from the point of admission to Galashiels Nursing Home was inevitable and was not caused by any want of care.

There is a mild degree of controversy over the appropriate terms in which Mrs Swinscoe's death should be certified. Dr Norris expressed the view that the primary cause was dementia. She took issue with the terms of the certificate of the causes of death issued by the pathologist Professor Busuttil which, she said, set out the modes of death rather than the causes of it. I have sympathy with the view expressed by Dr Norris, but her evidence was given subsequent to the lodging of a joint minute in which parties agreed that the cause of death, for the purposes of section 6(1)(b) of the 1976 Act can be take as those set out in Professor Busuttil's report. That is the course which I have taken. The fact remains that it was senile dementia which brought her to a stage whereby death from other causes was likely to ensue.

In her concluding submissions the Procurator Fiscal Depute observed that it might be appropriate to make findings in relation inadequate care planning and record keeping in the home; failure to comply with Care Commission requirements; and to find that there were inadequacies in respect of staff training. That submission was based on the evidence of witnesses from the Care Commission, but for reasons which I shall come on to it is not evidence upon which I would feel able to place any great reliance. Before turning to certain specific aspects of the Care Commission evidence it is worth commenting on the regulatory framework. Prior to 1 April 2002 regulation of Care Homes in the Borders was a matter for Borders Health Board. Evidence from that source indicated that officials were entirely satisfied with the running of Galashiels

Nursing Home and it is clear that a positive relationship existed between those officials and staff at the home. There would appear to have been a dramatic change in climate when the regulation of the care sector was taken over by the Care Commission for Scotland on1 April 2002. To a certain extent that was inevitable because of the form of the legislation. At the forefront of the provisions of the Regulation of Care (Scotland) Act 2001 is the laudable provision that the Commission shall have "the general duty of furthering improvement in the quality of care services provided in Scotland" (section 1(1)(b)). That is followed in section 4(1), by a requirement that the Commission shall provide information to the public about the availability and quality of care services, and in section 5 by a provision for the preparation of what are described as "National Care Standards applicable to care services". The National Care Standards published by virtue of that provision are plainly intended to provide potential users of Care Homes with information as to what they are entitled to expect. Those who actually provide care services are however placed in a somewhat disadvantaged position compared to the general public. By virtue of section 4(3) the Commission is only required to provide advice to such persons when asked to do so, and it is empowered to charge a reasonable fee for providing such advice by virtue of sub-section 4. I think it is understandable, if unfortunate, that the Commission did not see its function as being an "advice giving" body in relation to Care Homes, but focussed in that respect on its regulatory function as provided by section 25 and subsequent sections of the Act.

Unfortunately the emphasis on regulation appears to have been accompanied by a somewhat bureaucratic and unhelpful attitude on the part of at least one officer of the Commission. It is not the function of this Inquiry to examine the actings of the Care Commission in detail, and in the absence of proper notice of any potential criticism or evidence about training or instructions given, it would not be fair to direct criticism at any identified individual. It did appear to me, however, that certain criticisms directed at the home – which significantly appear to have found their way into reports to other investigating authorities and in consequence prompted the need for this Inquiry – were misleading if not wholly unfounded. There are three specific examples all of which are mentioned in the application made by the Procurator Fiscal for the Inquiry. These relate to non-compliance with staffing quotas, failure to review a policy on restraint, and failure to intimate the appointment of a new Matron. The

last of these was, I consider, trivial and purely technical. There was no intention of concealing the appointment of a new Matron and the Commission was always involved ultimately in approving such appointment. I am surprised that it was mentioned.

The issue of staffing appears to have been a source of unnecessary contention until it was eventually resolved in January 2004. The Home was required to have two qualified staff on duty on any given shift. These normally came from a pool of six nurses who were qualified at SRN or EN (Enrolled Nurse) level. It had always been the position, agreed with Borders Health Board, that if the Matron of the home held a nursing qualification her presence, along with that of one other qualified nurse, was sufficient to provide adequate supervision to unqualified staff even although the Matron was generally regarded as supernumerary in order that she could devote her time to administrative duties. That did not meet with the approval, or understanding, of Care Commission officials. When it appeared that at times only the Matron and one qualified nurse were on duty it resulted in the somewhat alarming observation that "the staffing notice is not being met seven days out of seven", as recorded, for example, in the Inspecting Officer's Report of an inspection in November 2003. In fact there never was a problem about staffing levels; the practice as approved by Borders Health Board was finally accepted by the Commission in January 2004; all the evidence suggested that although there is a national problem in obtaining staff for Care Homes due to low wage levels Galashiels Nursing home was always adequately staffed.

The evidence about a policy on restraint struck me as particularly disingenuous. A Commission Report dated 26 September 2003 required the home to review its policy "on the use of restraint". Those responsible for running the home found this difficult to comprehend. It was accepted that there was no policy on restraint, but the physical condition of the residents meant that the use of restraint was simply not a relevant issue. The explanation given by the Care Commission official was that "restraint" referred to more than physical handling and could cover for example, the placing of bed rails on a bed. Some support for this view might be thought to be found in the comment in the report of 26 September 2003 that: "the restraint policy in use in the home did not encompass the broader definition of restraint as contained in the

National Care Standards". If that was what was intended it was certainly not made clear to anyone in the Home. That is not wholly surprising when National Care Standard 9 refers to confidence "that staff will use restraint only when it is necessary and after other forms of intervention have been thoroughly tried and found to be unsuccessful". Any normal understanding of the word "restraint" in the context of a Care Home for the Elderly means physical restraint and to suggest that the home was in some way deficient for not having a policy on this matter was in my view unfair.

Inspections of the home by the Care Commission took place in June and July 2004. I have made no specific findings in relation to the terms of the Inspection Reports because I am in considerable doubt as to the value to be placed on them. An announced inspection was carried out on 17 June 2004. The report of that inspection was not produced until after a further unannounced inspection had taken place on 6 July. The witness who carried out this latter inspection refuted any suggestion that the purpose of the second inspection was to examine specifically the care that had been given to Mrs Swinscoe, but it is clear from the terms of the report of this latter visit that wounds and pressure area management were the direct focus of attention. Thus the report contains a general finding that "pressure area risk assessments were not reviewed in response to changes in the residents condition or circumstances" and indeed the report of the earlier visit, which as I have indicated was not completed until some time after the second visit, refers to the need to have systems in place to carry out risk assessments and that this "relates particularly to pressure ulcer prevention and wound care". Viewing the evidence as a whole it cannot be seriously maintained that there was an inadequate response to changes in Mrs Swinscoe's condition. It may well be that record keeping was less than perfect, but this is an entirely different matter from suggesting that care was inadequate. I have the distinct impression that the terms of the reports following the visits in June and July 2004 were intended to be protective of the Care Commission's position by demonstrating that their officers were alive to the fact that not everything which might have been recorded had been recorded. I am not persuaded that anything contained in these reports can be reasonably relied on as evidence of any failings on the part of staff at the home.

A further difficulty which I have with the Care Commission witnesses is that very often any criticisms which they had of Galashiels Nursing Home were based on a

failure to meet non-specific expectations or a failure to aspire to their view of "best practice". I do not intend any criticism of the witnesses who are using terminology which may be appropriate to their professional roles, but it is difficult, if not impossible, to comment adversely on any particular practice which does not meet with the subjective expectations of one individual. To give an example, one witness was prepared to say that every time an elderly patient is turned over in bed that should be recorded along with a note of the condition of their skin. Failure to do so, it was contended, would be a deviation from "best practice". Even accepting that somewhat extreme view as correct, I would find it very hard to criticise a system which failed to aspire to that level of meticulous record keeping, or to recommend any improvement, without some evidence of the pressures under which staff were working or the implications which an improvement in practice to the proposed level would produce. In my view much of the adverse comment on the operation of Galashiels Nursing Home often flowed from attempts to treat as "standards" what were often aspirations or expectations of a continuously evolving nature.

Recognising the imperfections of human character and the limitations often imposed by time and resources, those who sit in courts of justice are normally content to judge the actions of others in a professional setting by reference to objective standards of reasonable competence. It is clear from the findings of Borders Health Board as recorded in Finding in Fact 9 that the ability of staff at Galashiels Nursing Home to deal with the problem of pressure sores was, viewed objectively, of a standard much higher than merely "competent". There is no reason for concluding, or even suspecting, that in the care of Mrs Swinscoe that standard was departed from. There is equally no evidence that any changes in staffing or deterioration in the availability of resources should have led to a decline in the standard of care available to Mrs Swinscoe at the time of her admission in early 2004. There is, in short no reason to doubt the testimony of one wholly independent witness with extensive experience of the Care Home sector who described Galashiels Nursing Home as "at least" a "good" care home and one in which she would happily place her own parents.

(signed) *EJB*