SHERIFFDOM OF TAYSIDE CENTRAL & FIFE
AT KIRKCALDY

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

DETERMINATION
BY
SHERIFF AG MCCULLOCH

IN RESPECT OF

FATAL ACCIDENT INQUIRY

INTO THE DEATH OF

THOMAS KILPATRICK

Kirkcaldy 23 April 2009

The Sheriff, having considered the evidence adduced, Determines in terms of Section 6(1) of the Act

I. That in respect of subsection (a), Thomas Kilpatrick, born 27 June 1954, died at 6 Otterston Place, Kirkcaldy, between the hours of 0317 and 0517 on 30 January 2007, life being formally pronounced extinct at 1250 on 31 January 2007.

II. That in respect of subsection (b) the cause of death was gastrointestinal haemorrhage, from a duodenal peptic ulcer; and with chronic alcoholism as a significant condition contributing to death.

III. That in respect of subsection (c) death might have been avoided if Annette Culross had entered the deceased's flat immediately on her arrival, and summoned an ambulance.

IV. That in respect of subsection (d) there were no defects in any system of working which contributed to the death.

V. That in respect of subsection (e), (1) there was a lack of proper management in place within the Sheltered Housing section of the Housing Department of Fife Council, in that decisions regarding the deceased were not properly

disseminated to all relevant parties, were not in writing and thus were open to differing interpretation, and were not followed up or reviewed; (2) wardens were allowed to exercise discretion and policies towards the deceased without approval by line managers; (3) tenants such as the deceased were housed in a complex which was unsuitable, there having been no proper and continuing assessment of needs, nor training to meet those needs; (4) no attempt was made to determine why there were a significant number of "phantom" calls from the deceased's flat; (5) there was no automatic procedure to follow up a visit by out of hours officers to tenants such as the deceased; and (6) the guidance subsequently issued puts in place a protocol to deal with emergency calls, but does not deal with daily, morning calls to residents which go unanswered.

REPRESENTATION

[1] The inquiry was led by Ms Pasportnikov, Procurator Fiscal Depute. Mr Munro, Solicitor appeared for Fife Council.

[2] The Procurator fiscal led evidence from the following witnesses:

1. Mr John Kilpatrick, the brother of the deceased.
2. Annette Culross, Response Team Officer, Fife Council
3. Eunice Houston, Sheltered Housing Officer, Fife Council
4. Alan Glennie, Former Housing Manager, Fife Council
5. Professor Derrick Pounder, Director, Centre for Forensic & Legal Medicine, Dundee
6. Elizabeth Rae, Sheltered Housing officer, Fife Council
7. June McKinnon, Housing Officer, Fife Council

Mr Munro,Solicitor, Fife Council led evidence from:

1. Barbara Wilson, Housing Officer, Fife Council
2. Fiona McGregor, Housing Manager, Fife Council

LEGAL FRAMEWORK OF THE INQUIRY

[3] The purpose of an inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 is for the Sheriff to 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 causing the death took place
b) the cause or causes of death and any accident resulting in the death
c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided
d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death
e) any other facts which are relevant to the circumstances of the death

[4] The court proceeds upon the evidence and information placed before it, and the Sheriff's powers generally do not go beyond the making of a determination in relation to the circumstances established to his satisfaction from the evidence following investigation by the procurator fiscal, and other relevant parties. It is not truly an inquiry, and it is not the appropriate forum for determining negligence, or civil liability and thus such inquiries should not enter into a discussion of negligence. This is in contrast to the position which existed under the previous legislation. Accordingly, in the context of this inquiry, it is not the function of the court to look for evidence of fault in the care, management or supervision of the late Mr Kilpatrick.

EVIDENCE TO THE INQUIRY

[5] A joint minute of agreement was lodged which agreed on a number of matters including the evidence of Dr David William Saddler, a forensic pathologist, who

performed the autopsy on the deceased, and his report is Crown production 4 which was held to be incorporated within the evidence. Additionally Crown production 6 is a book of photographs taken on 31 January 2007 by scenes of crime officer Malcolm Foy and depicted 43 photographs of the deceased, together with interior and exterior shots of his home.

[6] Thereafter the first witness was John Kilpatrick, the brother of the deceased. He spoke of seeing him twice a week and that they were close. Prior to his death the last occasion that he had seen him was on Sunday 28 January at which time, although not keeping good health, he was cheerful and seemed to be reasonably well. He spoke of his late brother having poor physical and mental health, and had a fractured skull some years before which had led to him having poor balance, being quite withdrawn, and spent a lot of time on his own. He accepted that he had alcohol issues. He was due to see his brother again on 31 January 2007, as they met every Wednesday to go for the groceries. When he arrived he was surprised to see that his brother was not sitting at the window waiting for him. He received no reply from a knock at the door and was concerned, and went to the warden. He explained that his brother was living in a form of sheltered and supported accommodation. Although he had been provided with a key to the flat, he did not have it with him on this occasion. The warden was summoned and attended with a key, opened the door and they found the deceased lying between the kitchen and the living room. The warden telephoned the police because the deceased was clearly dead, and there was a lot of blood on the carpet and walls. In cross-examination he was asked if he was aware that there had been some problems with the tenancy, and he confirmed that there had been an incident with a family nearby, and that there had been some false alarm call outs during the night but beyond that was unable to assist further.

[7] The next witness was Annette Culross, a response team officer working with Fife Council. She worked between 3pm and 9am, answering emergency calls. She was 17 years with Fife Council, and had been working with the response team since it was set up in 2004. Previously she had been a relief warden in sheltered housing accommodation. She described what happened if a tenant pulled the alarm cord. It would ring at the response team office in Glenrothes, where they would use the intercom to ask if there were any problems. If there was a response they would deal with it appropriately, but if there was no response they would contact the on duty response team officer who would drive there. She referred to production 11 which

was an alarm report which indicated that on the 30 January at 03.17 hours the alarm had been activated. She had been called at 03.25 hours, and production 9 was her report sheet. She was based in Methil, and drove to Kirkcaldy, having been told that there had been no response to the intercom following the pulling of the cord. She arrived at 03.47 hours and knocked on the door and tried to open it. It was locked and there was no reply. She looked in the window and the curtains were open with the house in darkness. She said that there was no sign of Mr Kilpatrick, nor was there any sign of a disturbance of any sort. She indicated that she could see three quarters of the way across the living room and all appeared to be in order. Accordingly she left but when she did so, and in accordance with practice, she put a card through the door of the warden's office, which was in the following terms – "checked, nothing untoward".

[8] She confirmed that she had quite frequently checked on Mr Kilpatrick before and had met him on a number of occasions; however she had been instructed on an earlier occasion not to attend on Mr Kilpatrick without a police escort, because of a knife incident involving a neighbour. She spoke of the seven occasions previous to the one in question that she had attended between November 2005 and December 2006. She confirmed that she had not had any problem with Mr Kilpatrick and that he had never acted inappropriately towards her. The instruction to call the police had been given to her by June McKinnon, her supervisor. No such instructions had been given with any other tenant, and it had not been given in writing, nor were there any guidelines. She confirmed that it was not particularly common for community alarms to receive no response. Sometimes the cord had been pulled accidentally and that would easily be resolved. Sometimes it had been pulled intentionally, and the tenant would know that they would shortly receive an intercom communication. Occasionally there were what she described as a phantom call, where the tenant claimed not to have pulled the cord at all. The incident of 18 October 2006 was probably one such phantom, or false, call. She was shown production 14 which had been issued in July 2008, some 18 months after the death. These were guidance notes for answering calls which confirmed that the property must now be entered if there was no response. She confirmed that although the document was headed "updated version" she had not seen one previously and was unaware of any written guidance before July 2008. She confirmed that given her previously dealings with Mr Kilpatrick, when she arrived on the 30 January and could

not find him she assumed that he had gone out, this having happened before. Alternatively, he could have been lying in the flat intoxicated, again as had happened before although on that previous occasion she had been able to see him through the window.

[9] The next witness was Eunice Houston, a sheltered housing officer with Fife Council for the past six years. She had been a warden at the complex in Otterston Place, Kirkcaldy. It was a sheltered housing complex, where residents could seek assistance from a warden on duty, or out of hours via a centre in Glenrothes. Each flat had an emergency pull cord in each room, and there was an intercom with which the warden, or Glenrothes, could speak with a tenant. The normal criteria for being housed in such accommodation was being 60 years or older, but occasionally this sort of accommodation was allocated to others, such as the deceased. He had a number of disablements, of slight deafness, mental handicap, physical handicap, moderate nervous debility and severe alcoholism. This was noted on his assessment form as a new tenant, production 7. She said that her relationship with him was quite different from her relationship with all of the other tenants in the complex, who were mostly old ladies. It was quite evident to her that he drank a lot, and told many lies. She resented the fact that he was in sheltered accommodation, as it upset the other tenants. His history of using the pull cord was much higher than others who seldom used the cord, unless ill or by accident. It was her habit to check with all of the tenants via the intercom in the morning to make sure that all was well. She stopped doing that with Mr Kilpatrick because of his aggressive attitude. However she would quite frequently see him going about his daily business and would note that in her diary. She claimed to have been instructed not to enter his house at all if she was threatened or felt threatened, and accepted that there was a risk of Mr Kilpatrick not being helped should he be in need. However she did not feel that he was at risk, given his age, and he had other support. She had left the sheltered housing complex in July 2006 but confirmed that at the time she had left there had been no instructions, or written guidance, regarding response to emergency alarm calls. She confirmed that if there had been a call out at night, the response team officer would put a blue card through the door, which should be followed up in the morning. She complained she had been given no training in how to deal with alcoholics.

[10] The next witness was Alan Glennie, who has now retired from his position as team leader for housing allocation and sheltered housing within Fife Council. He had held that position from 1996 to November 2006. He gave advice and assistance to 24 local offices and had line management responsibility for over 80 staff, including the Otterston Place complex. Mr Kilpatrick had been brought to his attention in August 2006, when he had received a call from June McKinnon, saying that Mr Kilpatrick, who had serious alcohol problems, had stabbed a neighbour. He had given the immediate instruction that Mr Kilpatrick should not be seen on his own. He had made no enquiries of the police or the procurator fiscal, assuming the allegation had been confirmed. He understood that there would be a meeting in the future about this instruction, but perhaps due to his retirement, it had not taken place. He was shown production 10, which was an incident report regarding Mr Kilpatrick. There was an entry for 14 August 2006, some eleven days after Mr Kilpatrick had been arrested and charged with the stabbing of another resident, when the entry related to Glennie wishing a case conference to discuss Mr Kilpatrick, and it was further noted – "instructions from Alan Glennie that no contact (apart from intercom in morning) be made to Tam. This is not easy to enforce if he comes to you". When this was put to Mr Glennie, he denied saying this, his position being that he only said that staff were not to enter his house unaccompanied. He said that he was not considering the daily dealings with this tenant, merely in reference to emergency calls and thinking of situations where the house needed to be entered. This had been a one off situation which ought to have been reviewed at a case conference. Unfortunately this had never taken place. His primary concern had been staff safety.

[11] The next witness was Elizabeth Rae, the sheltered housing officer who had started in July 2006. Consequently she was the warden at the time of Mr Kilpatrick's death. Her job entailed promoting independent living, and assisting in requests for help. Accordingly she did a morning call to all tenants to see if anyone was in need of assistance. When she had started she had been told about Mr Kilpatrick, and the entry for him read "no contact". She decided that she wanted to check on him herself and first met him on 12 July. She had given him the regular morning calls but had indicated to him that he was not welcome to come to the lunch club that she ran three days per week. After the stabbing incident, she had informed June McKinnon, her manager, who had come to see her about it. She was told to have no contact with Mr Kilpatrick, other than the morning call and there would be no visits. She had not

been told what to do if he required a visit or if there was a genuine emergency. After that incident, she had not really had any difficulties in communicating with Mr Kilpatrick. Most mornings she got a response but if she did not, she would not visit. She usually saw him around the complex. When asked about the blue card system she confirmed the direct response team left it for the wardens to follow up and she said that she specifically made a point of going to see the other tenants when the response team had been out during the night. However, she confirmed that she had not been to check on Mr Kilpatrick after she came on duty on 30 January. She confirmed from her notes that she had tried the intercom on 29, 30 and 31 January, all of which had received no response and had not followed up any of these calls. She confirmed that Mr Kilpatrick's brother had come to see her late morning on 31 January as he had been unable to get in. Production 13 was her note made at the time regarding the finding of Mr Kilpatrick, and production 12 was the report that she had prepared for Barbara Wilson, the operational manager for sheltered housing in Fife. She confirmed that Mr Kilpatrick had never been abusive or threatening to her, but she just did not wish to put herself in a situation where something might have happened. He had not been aware until October 2006 of the instruction from management not to enter the house. She confirmed from production 4 that she had made contact with Mr Kilpatrick on most days in each month. In the first month, July 2006, she had contact or sight of him every day. In August, it was all but three days, and September all bar one day. Moving up to January, the month that he died, it was all bar 10 days. She saw no particular significance or reason for this. She did not think that there was any significance in a string of three no responses in a row, and while it was unusual for there to be no response to the direct line response team, Mr Kilpatrick had had a fair number of no responses, so she took the view that there was no real emergency. She said that had it been any other tenant, she would have checked on them. She said that because the card indicated "nothing untoward", she assumed that a check had been made and that she did not need to follow it up. She was unable to say when she would have started getting concerned, perhaps after three or four days but she did confirm that she treated Mr Kilpatrick quite differently from all other residents.

[12] June McKinnon, housing officer for 17 years with Fife Council gave evidence. She was a supervisor for the sheltered housing officers and the first point of contact for them. She dealt with the Otterston Place complex and dealt with incidents as they

arose. She visited the complex at regular intervals, meeting with the housing officers Eunice Houston and Elizabeth Rae. She confirmed that following the stabbing incident she had spoken to Alan Glennie who had told her to tell the staff not to go into Kilpatrick's house unless accompanied by the police. She had also told the direct response team management that this instruction had been given. She was quite satisfied that the instruction was given for the protection of staff. She indicated that she had not been aware that Eunice Houston had made up her own mind not to visit Mr Kilpatrick, indicating that in most circumstances she thought he should have been visited. Eunice had her own discretion but she had not mentioned her own safety as an issue. She thought that perhaps Elizabeth Rae had misunderstood the instructions, because her belief was that whilst she was still not to enter the premises, unless with the police, she was still to be in contact with Mr Kilpatrick and was told to maintain her daily check. She accepted that no consideration had been given to what would happen if there had been no response to the intercom or if he had not been seen for a day or two. She accepted that the instruction had never been reviewed, that the case conference that was anticipated had never taken place. She also confirmed that it would have been more appropriate for the instruction to have been given in writing and that perhaps something had been lost in translation as the instruction filtered down from Mr Glennie.

[13] The final witness for the Crown was Professor Derrick Pounder, the Director of the Centre for Forensic and Legal Medicine in Dundee. He had been a specialist in forensic pathology since 1980 and had produced the report as production 5. He confirmed that chronic alcoholism was a recognised risk factor for a duodenal peptic ulcer, and that such an ulcer was likely to cause gastrointestinal haemorrhage, which had in fact occurred here leading to the death. The only treatment for a gastro-intestinal haemorrhage from a duodenal peptic ulcer was immediate admission to hospital and then surgery to try to stop the bleeding. In less serious cases, if the bleeding had stopped on its own accord, a transfusion and keeping an eye on the patient may be sufficient. He indicated that survival rate of about 90% was to be expected, leaving aside those admitted in extremis. Clearly the quicker the patient was brought in, the better were the chances of survival. He was unable to say at what stage the deceased had been, but given the amount of blood that was found in the deceased's bowel, it is probable that the duodenum was full, and the blood then backed up into the stomach, causing vomiting. Vomiting was a late part of the

process, and it was likely that loss of conciseness occurred shortly after vomiting. The bleeding would cause dizziness, confusion and collapse, as internal pressure dropped. He took the clear influence from what he had seen, both from the post mortem report, and the photographs from the locus, that it was quite likely Mr Kilpatrick had died shortly after the alarm had been pulled, but it was impossible to say when death had actually occurred, probably within two hours. The window of saving his life was unknowable, and he accepted that even if access had been made at 03.47 hours, when the response team officer had arrived, the point of no return may already have been passed. Adding in ambulance response time, and police response time if they had been summoned as well, due to the instruction given, it was more likely than not that Mr Kilpatrick would not have survived even if an ambulance had been called at 03.47 hours on 30 January. He was critical of the apparent lack of thought of what was supposed to happen if a member of staff had to attend in an emergency, such as happened, standing the instruction not to enter the premisies.

[14] Fife Council called two witnesses. The first was Barbara Wilson, the operational manager for sheltered housing, June McKinnon's manager. She had become aware of issues regarding Mr Kilpatrick from Eunice Houston, who had been concerned about his tenancy. When he moved in, he was supposed to get support from other agencies but this was not in place. Subsequently there would be apparent false alarms from cord pulling incidents, but she had been unaware of Eunice's practice of not visiting if there had been no response to an alarm, or to the morning intercom call. After the stabbing incident, which had occurred when she was on holiday, there had been a team meeting and she understood that Mr Glennie had indicated that staff should not go in on there own and that all contact was to be by the intercom. She accepted that the case conference regarding Mr Kilpatrick had never been held, and after she was advised of the death of Mr Kilpatrick, and the fact that the response team had gone during the night, but there had been no follow up for a couple of days, she indicated that the structure and guidance was not clear enough. She had produced a report for Fiona McGregor, who was Alan Glennie's replacement. This formed defence production 5. She had compiled her report from review of the diary kept by the wardens. It listed the various call outs occasioned by Mr Kilpatrick. Between August 2005 and January 2007 there had been 13 calls to the direct response team. Of these, 10 resulted in either the warden or the response officer actually seeing Mr Kilpatrick. There were only 3 occasions when he was not seen during the

night time call, or shortly after the warden had come on duty. Of these three, one was because he was in hospital, one was during a weekend afternoon, shortly after there had been "a false call" earlier in the day, and the third one was when the officer had attended on 30 January. She accepted that the instruction that had emanated from Alan Glennie, was not that clear an instruction, and was open to different interpretation, and to confusion. However, matters have been pulled together as a result of this incident and policies and procedures were now in place for attending calls. These had been finalised in July 2008 as production 14. She confirmed this applied to morning calls as well as out of hours calls, although the witness seemed to be confused as to whether the sheltered housing officers at the complexes had been advised that it had been applied to the morning call system as well as to the emergency pull cord. This witness seemed very defensive, both whilst giving evidence, and in the preparation of her report which seemed to have been based on the premise that in some way Mr Kilpatrick was at fault.

[15] The final witness was Fiona McGregor, the housing manager responsible for sheltered housing services and others. She had taken over after Alan Glennie had retired, although she understood that there was a gap between him leaving and her starting. It was her position that Mr Kilpatrick would not be allocated a place in a sheltered housing complex under the current regime, without more input and support. However, she had no knowledge of Mr Kilpatrick at all until his death was discovered and it was clear to her that as staff had no written instructions, something had to be done. It took some months to produce the report, as it went through a number of focus groups and eventually in July 2008, the protocol was put in place. Put simply, in an emergency, the tenant must be seen, and night calls must be followed up the next morning. In the unlikely situation of risk to staff from a tenant, paragraph 3.5 of the protocol dealt with the situation. She took the view that the protocol just dealt with the activation of the alarm, and as far as the morning calls were concerned, it was not written in procedure, but would be just good practice to check why there had been no response. She accepted that because of Mr Kilpatrick's actions previously, with his alleged misuse of the call system, that a view had been taken of him which meant that he had no service at all from the sheltered housing team. She accepted that because the instructions from Alan Glennie had not been written down or reviewed, it had led to ambiguity and confusion. There was now a supervision structure in place, so that issues such as Eunice Houston exercising what she thought was the discretion

not to visit Mr Kilpatrick would not now take place, at least without discussion without line managers. She confirmed that she had been unaware of Glennie's instruction at the time she took over his responsibilities, but had she known, she would have ensured that the case conference would have taken place and the situation reviewed with the tenant advised.

SECTION 6(1)(a) – WHERE AND WHEN THE DEATH TOOK PLACE

[16] Parties were agreed that there was no doubt that the death took place within 6 Otterston Place, Kirkcaldy. The issue of when is more problematic and cannot be answered with any measure of certainty. The evidence of Professor Pounder was that he could not say when the death had occurred, and it was necessary to speculate. It is clear that Mr Kilpatrick sounded the alarm at 03.17 hours on 30 January 2007. When Annette Culross arrived at 03.47 hours, the property was in darkness and she received no answer. It was Professor Pounder's view that Mr Kilpatrick is likely to have died around or shortly after the time the alarm was activated, certainly within a couple of hours. It was impossible to say whether or not he was still alive at the time that Annette Culross arrived at the property. He was formally pronounced dead at 1250 on 31 January 2007, but had clearly been dead for some considerable time before then.

SECTION 6(1)(b) – THE CAUSE OF DEATH

[17] The death intimation indicated that the cause of Mr Kilpatrick's death was "gastrointestinal haemorrhage and duodenal peptic ulcer", with chronic alcoholism being a significant contributing condition. From the evidence I would accept that this is accurate.

SECTION 6(1)(c) – REASONABLE PRECAUTIONS, IF ANY, WHEREBY THE DEATH MIGHT HAVE BEEN AVOIDED

[18] It was generally accepted that the death might have been avoided had Mr Kilpatrick received appropriate medical attention at the appropriate time, and for this to have happened, he would have required to have arrived at hospital in a condition other than near death. Mr Kilpatrick may have been suffering from the gastrointestinal haemorrhage, but would have been unaware of the seriousness of it until he started vomiting blood. By that stage, the window of opportunity for his life to be saved might have been very small. Mr Kilpatrick did not summon medical

assistance, instead he activated the alarm. By the time Annette Culross arrived, it might already have been too late from Mr Kilpatrick to receive the appropriate medical intervention, indeed he might already have been dead. However, on the basis that the enquiry deals with possibilities rather than probabilities in consideration of this section, I find that had Annette Culross entered the property, and summoned an ambulance, his death might have been avoided.

SECTION 6(1)(d) – THE DEFECTS IF ANY IN ANY SYSTEM OF WORKING WHICH CONTRIBUTED TO THE DEATH

[19] The Crown did not seek any finding under this section, and it is clear to me that Fife Council have a system of working, in respect of the answering of community alarm calls, and now have in place a protocol setting out the proper way in which emergency calls should be dealt with. No defect in any system contributed to the death of Mr Kilpatrick.

SECTION 6(1)(e) – ANY OTHER FACTS RELEVANT TO THE CIRCUMSTANCES OF THE DEATH

[20] Under this heading, the procurator fiscal argued that there were five points of criticism. The first was the decision taken by the wardens of their own accord, to stop visiting Mr Kilpatrick. This decision was neither monitored, challenged or authorised. To consider this objection, it is necessary to consider Mr Kilpatrick as a tenant. He was not an ordinary sheltered housing tenant. On one view he ought not to have been placed within the complex, at least without proper supports and assessments in place. But the fact remains that he was in the complex, and as such he expected, and was entitled to receive, the same level of care and support as the other tenants. The second point raised by the procurator fiscal was that Alan Glennie's instructions should have been communicated to appropriate staff, and to Mr Kilpatrick, and that it should have been issued in a clear and concise manner. Witnesses conceded that their understanding of the precise terms of the instruction varied and how it was to be implemented was unclear. All agreed it would have been better if the instruction had been in writing. It is clear that Mr Kilpatrick was alone among all the sheltered housing tenants of Fife Council in being the subject of an instruction to staff concerning staff involvement with him. How staff interpreted the instruction seemed to be a matter for their discretion, and varied from person to

person. Matters have moved on as a guidance note has now been drawn up. In passing I comment that it is stated to be an "updated version" which I find to be disingenuous, as it was accepted by all witnesses that this was the first and only version. The third issue raised by the Crown was that the frequency of alarm calls from Mr Kilpatrick's house ought to have been investigated. It does seem accepted, and I find it so, that there were false or phantom calls emanating from his property, but no serious check on the system was carried out. Had it been done, some of the calls may not have happened, and thus staff attitudes towards Mr Kilpatrick may not have been quite so hardened. The fourth point from the Crown was that there should be clear guidelines in relation to responding to an emergency call, and to a call from Mr Kilpatrick in particular. The fifth point was that there should have been clear guidelines to all sheltered housing staff regarding daily contact with tenants, and Mr Kilpatrick specifically, and in particular to the circumstances when it may be appropriate not to make contact with such a tenant. It is of course the case that guidance is now available for response to the emergency alarm call system, but there remains no formal guidance to cover the daily intercom contact, and particularly senior management, agreed that "no response – no contact" would not be an acceptable practice now, but it was conceded that this had not been set out in the form of a written policy.

DISCUSSION

[21] It is clear to me from the evidence that sheltered housing staff at the Otterston Place complex, would rather that Mr Kilpatrick had not been a tenant there, and thus fall within their area of responsibility. The fact remains however that he was such a tenant, and as such was entitled to certain levels of support. For various reasons, the staff failed adequately to give him that support. However, that failure could not be said to have contributed to his death. It certainly contributed to the unfortunate circumstance of his body lying undetected for over 30 hours, a situation which can best be described as regrettable. It is also the case that the instruction issued by Alan Glennie, appeared to have been spontaneous, and brought about with the intention of protecting staff, rather than giving any consideration to how best to serve Mr Kilpatrick's needs and to deal with requests for emergency assistance, or visits following a failed morning call. I do not consider that it was acceptable for wardens to make their own decisions on whether or not a tenant should be contacted,

but the creation of the guidance for dealing with emergency alarm calls is welcomed. There ought also to be proper considered and written guidance for dealing with the morning intercom calls when no response is received. Evidence was taken over two years after Mr Kilpatrick's death, sad to say there still seems to be some confusion amongst staff as to what was expected of them should such a situation arise again. There were also, in my opinion, failures at management level. Mr Glennie as I understood him thought that there would be a case conference regarding Mr Kilpatrick. That did not happen, and sight appears to have been lost of the importance of such a conference after his retrial. Nor were wardens properly supervised, and thus were able to act as they saw fit, based on prejudice rather than reason.

[22] My findings under section 6(1)(a-e) are set out at the beginning of this determination. I comment only that the systems in place at the time of Mr Kilpatrick's death in dealing with emergency call outs, and dealing with the follow up to such call outs, and dealing with a lack of response to a daily call, all indicated to me a lack of thought for, and care of, Mr Kilpatrick about whom it can be said that he was a difficult man, but he was not a well man, and deserved better. Whether he should have been allocated a place within this complex is another issue and it would be appropriate for very careful consideration, and assessment, to be carried out before such a person is allocated such a tenancy in the future.

[23]. Finally, I wish to express my condolences to the family of the deceased, and my thanks to agents for their preparation, and assistance in the presentation of this Inquiry.