

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT DINGWALL
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976

DETERMINATION
By
SHERIFF ALASDAIR LORNE
MACFADYEN
IN
FATAL ACCIDENT INQUIRY
INTO THE DEATH OF
JAMESINA MACKENZIE

DINGWALL, JULY 2012

The sheriff, having resumed consideration of this inquiry, Determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, section 6 as follows:

1. In terms of section 6(1)(a), Miss Jamesina MacKenzie, born 2 October 1922, formerly resident at Wyvis House Care Home, Station Road, Dingwall, Ross-shire died on 31 May 2009 at Invergordon County Community Hospital, Invergordon, Ross-shire.
2. In terms of section 6(1)(b), the cause of death was sepsis, pseudomonas enterococcus and proteus infection, due to multiple pressure ulcers and terminally complicated by bronchopneumonia. While resident at said Wyvis House, Jamesina MacKenzie developed the said pressure ulcers.
3. In terms of section 6(1)(c), the following are reasonable precautions which, if taken, might have avoided the death:
 - (a) The complete and accurate recording, from the moment the wounds were first observed, of a wound assessment chart, a wound care plan, a

daily record of the application of dressings and treatments and the monitoring and recording of routine physiological observations such as blood pressure, temperature etc. and the turning of Miss MacKenzie by the care staff employed at Wyvis House.

(b) The exercise of proper leadership and supervision by the management at Wyvis House to ensure that care was not only being given but was properly documented and to ensure that Miss MacKenzie's condition was being adequately monitored and that significant deteriorations were promptly noted and reported.

(c) It would have been a reasonable precaution for the General Practitioner to have asked to see and for the Care Home staff to have volunteered the information documented in the daily support plan notes kept by Wyvis House staff in respect of Miss MacKenzie, as this would clearly have drawn the attention of the Medical Practice to the history, duration and progression of the pressure ulcers, the detailed report thereon prepared by the Vascular Nurse Specialist and the regime which the Care Home staff were instructed to follow and the fact that no specialist advice from the Vascular Nurse Specialist was available to the Care Home staff between 8 and 22 May 2009 which was the crucial period for what became the terminal progression of these wounds.

(d) It would have been a reasonable precaution for the General Practitioner to examine Miss MacKenzie's pressure ulcers on a regular, i.e. at least weekly, basis between 8 and 22 May 2009, since such examination would have made the deterioration in their condition obvious and would in all likelihood have led to a decision being made to admit her to hospital for treatment which might have prevented the death.

4. In terms of section 6(1)(e), the following are facts which are relevant to the circumstances of the death:

(a) The circumstances of inadequate care and recording of the level of care given to Miss MacKenzie, under particular reference to the management of the pressure ulcers from which she was suffering, occurred in the context of a change of ownership of Wyvis House Care home where the obligation on the new owners and management was to maintain or improve the quality of care to individuals, including Miss MacKenzie, who were already resident there. During the period of the new management familiarising itself with the operation of Wyvis House Care Home there was a failure to minimise disruption to the daily routine of the residents and to bring in any changes, in particular to levels of staff on duty at any one time, considered necessary or desirable, gradually so that to the residents, any alteration to their daily lives would be imperceptible and managed in such a way as to maintain or improve the quality and care and attention to them.

(b) Against the background of Miss MacKenzie suffering a the progression of a significant illness in the form of pressure ulcers, while living in a care home setting, it is appropriate in the future for the Social Care and Social Work Inspectorate Scotland in the course of their fulfilment of their statutory duties of inspection and regulation of care homes to have regard to the level of medical and nursing expertise (whether internal to the care home or available externally) available to the care home and to include in their inspection regime an audit of the necessary record keeping.

Findings in fact established by the evidence:

1. Jamesina MacKenzie, born 2 October 1922 was a retired veterinary surgeon. Most of her professional career had been spent overseas.
2. When she retired, she lived initially in London. Then she moved to Scotland in order to live nearer to her relatives.
3. Miss MacKenzie suffered from diabetes.

4. In Scotland, she lived at first in Perth. Thereafter she purchased a flat in Dingwall, Ross-shire.
5. However, she became incapable of living independently and in the autumn of 2008 she moved into a privately arranged respite home.
6. On 11 December 2008 Miss MacKenzie moved into a care home, namely Wyvis House Care Home, Station Road, Dingwall, Ross-shire ('Wyvis House').
7. Wyvis House was owned and operated latterly by RDS Healthcare Limited, a limited company first incorporated in 2006 ('RDS').
8. RDS operate four care homes for the elderly, three in Highland and one in Angus.
9. RDS purchased Wyvis House in March 2009 and took over the running thereof from 23 March 2009.
10. On taking over the running of Wyvis House, RDS quickly instituted changes to the shift patterns of nursing and care staff there.
11. Those changes were unpopular with staff.
12. RDS employed Mrs. Joyce Reiman as manager. Although a qualified nurse, Mrs. Reiman spent the overwhelming majority of her working hours engaged on management issues and spent virtually no time dealing with or supervising care of the residents.
13. Her attention was focused on the issue of reduction of the working hours of staff, i.e. effectively cutting the number of staff on duty at any particular time.
14. Mrs. Reiman found the work as manager very stressful, in particular as she had to deal with staff who were unhappy at having their working hours reduced, while at the same time being answerable to the directors of RDS who wanted to effect a reduction in staff hours.
15. The detailed staff rotas were prepared and managed by the deputy manager, Mrs. Alison Britton, also a qualified nurse.
16. The changes in the staff rotas and shift patterns had the following effects. They reduced the number of staff, including nursing staff on duty at any particular time.
17. That reduction had an effect on the level of care devoted to the residents of Wyvis House. The time taken to respond to calls for assistance extended. There was a

- delay in the service of breakfast to residents. The timing of dispensation of medicine was changed. Bed-time was brought forward for many residents.
18. These changes were a matter of concerns to the family members of some of the residents and to a general practitioner, Dr. Denys Greenhow, who had dealings with Wyvis House.
 19. Complaints were made in early April 2009 to various bodies, including the local Member of Parliament, the social work department of the Highland Council and the Care Commission.
 20. The Care Commission acted on those complaints and carried out three unannounced inspection visit of Wyvis House in early April 2009.
 21. The Care Commission upheld the complaint made to it by way of a letter dated 22 April 2009. Its findings were that there was a negative effect on the amount of time available for staff, including nursing staff, to devote to the care and support of the residents of Wyvis House, in particular those residents on the first floor (where Miss MacKenzie then resided).
 22. The Care Commission recommended to the Social Work Department of the Highland Council that a temporary embargo on the admission of new residents to Wyvis House be put in place.
 23. That recommendation was made as a protective measure for current and any new residents and was intended to be in place until management at Wyvis House took steps to address the concerns raised by the care Commission.
 24. Such a temporary embargo was put in place by the Social Work Department of the Highland Council in mid-April 2009 pending implementation of improved staffing arrangements which would ensure appropriate care for all residents at all times. The embargo was lifted after about two days.
 25. From 11 December 2008 until her final admission to hospital on 2 May 2009, and subsequent death in hospital, Wyvis Care Home was Miss MacKenzie's place of residence.
 26. Wyvis House contains accommodation for residents on two floors. The first floor is intended for occupation by residents suffering from dementia. However, if a resident does not suffer from dementia but no bed is available on the ground floor

- but one is available on the first, then a resident would in the first instance be offered a place on the first floor.
27. On her arrival at Wyvis House, Miss MacKenzie did not suffer from dementia to any significant degree. However in the foregoing circumstances, she was allocated a room on the first floor. That was intended as a temporary arrangement.
 28. Once in Wyvis House, Miss MacKenzie's condition deteriorated. She became less mobile and spent most of her time lying on the bed in her room.
 29. Initially she was seen to be dressed when lying on the bed. As time progressed, she was seen not to have dressed herself or to have been dressed and was seen in her night attire.
 30. She was capable of walking with support. On occasion she was taken out for visits to the doctor and dentist.
 31. Miss MacKenzie was incontinent.
 32. She was fitted with a catheter in order to address her incontinence.
 33. In Wyvis House, Miss MacKenzie's general condition deteriorated.
 34. Pressure ulcers, also referred to as pressure sores or bed sores, are caused by pressure on prominent areas of the body such as hips, heels and the sacrum, when the person is lying supine on a surface, such as a bed. The pressure interferes with the blood supply and thereafter the tissue breaks adown and decays. If even minor and apparently insignificant reddening of the skin at a bony prominence is left unattended to, it can go on to ulcerate and develop into an obvious pressure sore. Even simple reddening of the skin at a bony prominence is a pressure sore.
 35. Pressure ulcers are graded according to seriousness and severity. Grading is not an exact science. Gradation ranges from Grade I, being the least severe, consisting of simple discoloration of the skin to Grade IV, being the most severe, consisting of deep ulceration on occasion to the bone.
 36. A person suffering from diabetes can be more prone to suffer from pressure ulcers.
 37. On 17 March 2009 nurse Leilani Velasco employed by Wyvis House noted that there was redness on Miss MacKenzie's left hip. That was not obviously a

- pressure sore or ulcer at that time, but treatment was administered in the form of application of a protective gel.
38. However on 3 April 2009, Nurse Jacqueline Fraser, another member of the nursing staff at Wyvis House, recognised that Miss MacKenzie had a pressure sore on her left hip and recorded it as such in her notes.
 39. The staff at Wyvis House included nurses, were qualified and able to deal with the care of residents' skin and wounds.
 40. Following the ascertainment that Miss MacKenzie was suffering from pressure sores, the nursing staff set about managing the situation. They changed her mattress to an Airflow pressure mattress, a mattress designed to minimise the risk of development or deterioration of pressure sores. They commenced a turning chart, that is a recorded regime of turning Miss MacKenzie in her bed at regular intervals. Turning of a person suffering from pressure sores reduces the possibility of development or deterioration of pressure sores. On one occasion, the nursing staff debrided (removed dead or damaged tissue from) the wound.
 41. The management of Miss MacKenzie's pressure sores in April 2009 was inadequately recorded.
 42. No regime of turning Miss MacKenzie in her bed was instituted for three weeks after the first realisation that she had a pressure sore. A regime of turning should have been instituted immediately.
 43. A wound care plan should have been instituted immediately on the realisation that Miss MacKenzie had a pressure sore. That was not done until 8 May 2009.
 44. During the period between April and 8 May 2009 the pressure sores were not improving. They continued to slough (i.e. cast off dead tissue from living flesh).
 45. On 29 April 2009 Miss MacKenzie was examined by Alison Britton, at the time the deputy manager of Wyvis House.
 46. Mrs. Britton became concerned. She considered that the wounds were infected. She decided to seek advice from a vascular nurse specialist.
 47. To that end, she contacted Miss Delia Law, a vascular nurse specialist employed by Highland Health Board, based at Raigmore Hospital, Inverness. Miss Law was an expert in the treatment of pressure sores. One of her duties was to provide

- effectively a consultancy service to staff at care homes, such as Wyvis House, on the treatment and management of pressure sores suffered by any resident.
48. In addition on 30 April 2009 Dr. Miles Mack, a general practitioner of Dingwall Medical Group attended and examined Miss MacKenzie. He saw the pressure ulcers.
51. His note of the examination of the pressure ulcers was in the following terms:
‘Very nasty. This was a significant case to be called out to. It was more serious than I am likely to see.’
52. Dr. Mack took no steps to follow up after this visit and does not seem to have specifically drawn his colleagues’ attention to Miss MacKenzie’s condition. He expected only to be called back if the pressure ulcers did not improve.
53. Dr. Mack had no doubt about the competency of the carers or the regime of care available to Miss MacKenzie from the nursing staff and their ability to request assistance and guidance from the vascular nurse specialist employed by Highland Health Board.
54. On 8 May 2009 Delia Law visited Miss MacKenzie at Wyvis House in response to the request of the nursing staff. She made that visit in her capacity as a vascular nurse specialist. She examined Miss MacKenzie and recommended a course of treatment and management for her to the nursing staff at Wyvis House in regard to the pressure ulceration to her left heel and a hip wound, which was also a pressure sore.
55. Examination demonstrated that the pressure ulcer to the left heel was consistent with a blood blister forming and being rehydrated. There was a hard scabbed area which was not quite ready to be removed but which Miss Law hoped had healed beneath. Miss Law also observed a small pressure ulcer to the right buttock which appeared superficial with a thin layer of slough and that that time appeared to her to be a Grade III pressure ulcer. Miss Law suggested that Prontosan wound gel with Allevyn be applied to this area on a daily or alternate day basis depending on the level of exudate (fluid that filters from the circulatory system into lesions or areas of inflammation).

56. Miss Law examined the left hip and considered that it had what appeared to be a Grade IV pressure ulcer which was undermined by at least 4.5 inches in a half-moon shape, which was marked with a pen to demonstrate the size to the nursing staff. She demonstrated and recommended that the nursing staff gently pack this area with Aquacel AG and Prontosan wound gel which would have to be renewed on a daily basis. She also suggested that she would expect this wound to become a larger area as the sloughy tissue was removed and she hoped that with the use of anti-microbials wound care products that bacterial loading within the wound would be controlled.
57. Miss Law discussed with the nursing staff pressure-relieving measures for Miss MacKenzie, whom she knew to be diabetic, as well as encouraging nutritional supplements suitable for her diabetes.
58. Miss Law wrote a detailed note containing all of her advice into the Daily Care Plan Notes, kept by Wyvis House nursing staff in respect of Miss MacKenzie on 8 May 2009.
59. The nursing staff at Wyvis House suggested that Miss MacKenzie may require a blood transfusion at some point and they expected her to be admitted to hospital for that.
60. Miss Law went on annual leave and had other duties to attend to. She left the staff at Wyvis House in no doubt that if Miss MacKenzie's condition did not improve, they should contact the General Practitioners or medical staff at Raigmore Hospital, Inverness.
61. Thereafter the records of Wyvis House in respect of the treatment and management of the pressure ulcers were incomplete.
62. It is not possible to say with any certainty that Miss Law's treatment and management plan was followed.
63. While some wound dressing took place between 8 and 22 May 2009, the frequency of such wound dressing cannot be stated with any certainty.
64. During that period, Miss MacKenzie's position deteriorated further. In particular the pressure ulcers became more serious and at some point, date unknown, they became infected.

65. During that period, there did not seem to be any adequate regime of monitoring of the nursing staff by management of Wyvis House.
66. During that period nursing staff attempted to alert the general medical practice to their concerns regarding Miss MacKenzie.
67. In particular Nurse Velasco contacted the Dingwall Medical group on more than one occasion in mid-May 2009 requesting assistance and a GP visit.
68. Nurse Velasco spoke directly to Dr. Lindsey Ross on 18 May 2009. Dr. Ross did not accede to Mrs. Velasco's request that she come to Wyvis House and examine Miss MacKenzie's pressure ulcers.
69. Neither Dr. Ross nor any other general practitioner examined Miss MacKenzie in response to that request.
70. The general medical practice assumed, wrongly, that monitoring of Miss MacKenzie was in the hands of the vascular nurse specialist.
71. Had the general practitioners examined the Daily Care Plan Notes, it would have been apparent that the vascular nurse specialist was not to re-examine Miss MacKenzie until 22 May 2009.
72. Had the general practitioner examined Miss MacKenzie on or about 18 May 2009, the progression of the wounds would have been apparent and she would have been hospitalised for more intense treatment.
73. When Miss Law returned from leave on 20 May 2009, she thought that it was likely that Miss MacKenzie would be in hospital for the blood transfusion. However she discovered from checking the hospital records that Miss MacKenzie had not been admitted for the transfusion.
74. She therefore telephoned Wyvis House to enquire of Miss MacKenzie's progress in regard to her pressure ulceration. In the course of that call, the nursing staff suggested that she was quite poorly and that the left hip ulcer had increased in size with a cavity. After discussion it was agreed that Miss Law would visit again as planned on 22 May 2009 to review Miss MacKenzie.
75. On 22 May 2009 Miss Law attended at Wyvis House and examined Miss MacKenzie again. She found her in very poor general condition which she considered to have deteriorated considerably since 8 May 2009. Her mouth was

- very dry and her teeth coated with what appeared to be debris and she was obviously dehydrated. She was quite muddled and confused and in considerable pain even at the slightest touch.
76. Miss Law examined the pressure sores. The necrotic area on the left heel was much harder and had increased in size to approximately 2 to 2.5 cm in a circular wound.
77. The left hip cavity was now much larger than Miss Law had expected or anticipated. On examination the Aquacel AG was applied to the cavity hole but was not actually packed into the cavity. On examination Miss Law could feel what appeared to be the pelvis, i.e. the bone, and could only visibly identify granulation tissue and possible tendons or muscle sheath. Granulation tissue is the perfused, fibrous connective tissue that replaces a fibrin clot in healing wounds. Granulation tissue typically grows from the base of a wound and is able to fill wounds of almost any size it heals.
78. Miss Law's examination disclosed that the largest area of deterioration was Miss MacKenzie's sacral area which visibly had a huge black area to both buttocks, proceeding through to the cleft and seemed to extend through to the genital area. Around the anal area and what seemed to be the genital area was boggy to the touch and extremely foul smelling. This area was too painful for Miss MacKenzie to allow thorough inspection by Miss Law.
79. Miss Law discussed the sacral area and deterioration with the attending nurse who did not seem to be aware of the extent of the pressure ulcer to the sacrum and was unaware if any of the attending GPs were aware of the pressure ulceration and the extent of the ulceration to the sacral area.
80. Miss Law's initial impression was that Miss MacKenzie was septic and possibly acidotic.
81. The nursing staff informed Miss Law that Miss MacKenzie was to be admitted to Invergordon Hospital after attendance by a general practitioner before Miss Law's arrival.
82. Nevertheless Miss Law considered it appropriate to contact the hospital and to inform staff there of Miss MacKenzie's poor condition.

83. Further enquiry by Miss Law of the nursing staff at Wyvis House disclosed that Miss MacKenzie was said to tend to roll on her back when turned on to her side and on examination had obviously been very restless. However, Miss Law did not find that that explained the extent of the deterioration of the sacral area.
84. The nursing manager of Wyvis House was unavailable to be spoken to by Miss Law during her visit on 22 May 2009.
85. The daily support plan notes are made by nursing staff and should include all events and developments of significance in respect of the resident in question. They should also record the administration of any medicine and treatment to the resident.
86. Separately in the case of a resident suffering from pressure ulcers, there should be kept a turning chart, showing the time and frequency of the turning of the resident in her bed. Turning a resident can help to alleviate the development or deterioration of pressure sores by reducing the exposure of any particular part of the body, in particular bony prominences such as the hip to pressure.
87. A document entitled 'Daily Support Plan Notes' was filled in by nursing staff in respect of Miss MacKenzie during her time of residence in Wyvis House.
88. The Daily Support Plan Notes, contrary to any implication which might be drawn from their title, were not completed on a daily basis in respect of Miss MacKenzie. They do not record a consistent pattern of compliance with the treatment regime recommended by Miss Law on 8 May 2009.
89. It is impossible to tell from perusal of the notes whether there was any such compliance with that treatment regime.
90. The turning charts were not recovered by the Crown or the police for reference at this inquiry.
91. That was due to no fault on the part of the Crown or the police. Their absence from the inquiry was because Wyvis House intimated that they had existed but had been lost.
92. The absence of the turning charts means that it cannot be said with any certainty what regime of turning of Miss MacKenzie was instituted and whether that turning regime was followed.

93. During the period between 8 and 22 May 2009 Miss MacKenzie's condition deteriorated dramatically. The pressure sores became much more severe. She developed sepsis.
94. On 8 May 2009 it was possible for Miss MacKenzie to recover from the ill-effects of the pressure sores as they then existed and to survive.
95. By 22 May 2009, the situation had deteriorated to the extent that the pressure sores were no longer survivable.
96. During the time that Miss MacKenzie was a resident in Wyvis House she was powerless to do anything herself about the pressure sores.
97. She was reliant for her care and the treatment of the pressure sores on the management and staff of Wyvis House during that period.
98. Had the treatment regime recommended by the vascular nurse specialist, Delia Law, been complied with after 8 May 2009, there was every chance that Miss MacKenzie would have survived said pressure sores, that they would have recovered and that they would not have led to her death.
99. However, it cannot be said with any certainty, even on the balance of probabilities, that that regime was complied with by the nursing staff.
100. Miss MacKenzie was admitted to County Community Hospital Invergordon on 22 May 2009.
101. She was taken there from Wyvis House by ambulance.
102. Her admission to hospital followed the expression of concern by her nephew and niece to the general practitioners regarding the level of care which she was receiving in Wyvis House.
103. Once admitted to County Hospital, Invergordon, Miss MacKenzie received satisfactory care and was dealt with entirely appropriately by medical practitioners and nursing staff there.
104. In particular, nursing staff continued to dress the pressure sores.
105. However, it was quickly realised that she was not going to survive.
106. The focus of treatment then was on the making of Miss MacKenzie comfortable and to minimise pain and discomfort.
107. That regime was followed until 31 May 2009 when she died.

108. The cause of death was later certified by a pathologist as sepsis caused by Pseudomonas, Enterococcus and Proteus infection, due to multiple pressure ulcers and terminally complicated by bronchopneumonia.
109. At autopsy, Proteus mirabilis, enterococcus and mixed anaerobes were cultured from the subcutaneous tissue at the left hip and also from a swab taken from the wound on the left hip.
110. Accordingly, the sepsis was found to have been caused by the infection and the infection caused by the occurrence of the pressure ulcers.

NOTE

Introduction

[1] This inquiry was held in terms of section 1 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ('the Act') in respect that the Lord Advocate considered it in the public interest that an inquiry be held into the death of Jamesina MacKenzie on 31 May 2009 at Invergordon, following her residence at Wyvis House Care Home, Dingwall. Although the application for the holding of the inquiry does not specify it, it seems that the inquiry was sought under section 1(1)(b) because the Lord Advocate considered that the death had occurred in circumstances such as to give rise to serious public concern.

[2] Section 6(1) of the Act requires 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; and
- e) any other facts which are relevant to the circumstances of the death.

[3] The only method of establishing those circumstances is by the assessment of the evidence led by the Procurator Fiscal and any other interested party represented at and participating in the inquiry. In addition it has often been said, correctly, that a fatal accident inquiry is concerned with fact-finding, not fault-finding. That is a statement which should be borne in mind at all times. The purpose of the inquiry is not to attach fault, far less criminal responsibility, to any person. Rather it is to inquire into all the circumstances of the accident and the death in order to discover the truth, identify any reasonable precautions which might have been taken and ascertain if any lessons can be learnt which might serve to prevent the re-occurrence of any similar accident or death.

[4] At this inquiry, parties were ably represented as follows:

- The Lord Advocate: Alasdair MacDonald, Procurator Fiscal;
- RDS Healthcare Limited: Niall Ramsay, solicitor, Anderson, Shaw & Gilbert, Inverness;
- Highland Health Board: Richard Pugh, advocate, Central Legal Office, Edinburgh.

[5] Miss MacKenzie's family was not represented at the inquiry, although her nephew and niece attended after they gave evidence and listened to the majority of the remaining evidence. Dingwall Medical Group, a general medical practice whose patient list included Miss MacKenzie, was not represented.

[6] I heard evidence from the following witnesses, all led by the Procurator Fiscal:

1. Murdoch MacDonald, nephew of the deceased;
2. Mrs. Jane Barker, niece of the deceased;
3. P.C. Scott MacDonald, Northern Constabulary;
4. Detective Constable Eoin Coull, Northern Constabulary;

5. Dr. Rosslyn Rankin, consultant pathologist, Raigmore Hospital, Inverness;
6. Mrs. Joyce Reiman, manager in 2009 of Wyvis House Care Home, Dingwall;
7. Mrs. Alison Britton, deputy manager in 2009 of Wyvis House;
8. Miss Delia Law, vascular nurse specialist, Raigmore Hospital, Inverness;
9. Mrs. Jacqueline Fraser, state registered nurse, Wyvis House;
10. Dr. Miles Mack, general practitioner, Dingwall;
11. Mrs. Leilani Velasco, nurse, Wyvis House;
12. Dr. Lindsey Ross, general practitioner, Dingwall;
13. Dr. Kim Miller, general practitioner, Alness;
14. Mrs. Catriona Sutherland or Gillan, staff nurse, County Community Hospital, Invergordon;
15. Dr. Alastair Gordon, consultant physician, Melrose;
16. Paul Hersey, in 2009 inspection manager, the Scottish Commission for the Regulation of Care ('Care Commission');
17. Dr. Denys Greenhow, out-of-hours general practitioner, Easter Ross;
18. Jonathan King, in 2009, head of operations, Community Care, Social Work Department, the Highland Council;
19. Ashley Sham, director, RDS Healthcare Limited;
20. Dr. Martin Wilson, consultant physician, Raigmore Hospital., Inverness;
21. Mrs. Rosemary Stallard, in 2009, Care Commission officer, Care Commission;
22. Keith Phillips, in 2009, team manager, Care Commission.

[7] Substantial documentary productions were lodged. The most significant of those were the resident's record folder kept by Wyvis House in respect of Miss MacKenzie, including daily notes on her progress and management described as 'Daily Support Plan Notes', the General Practitioner records, the records of County Hospital, Invergordon, the post-mortem report and inspection reports on Wyvis House prepared by the Care Commission.

[8] Parties helpfully prepared and read out written submissions at the conclusion of the inquiry. There is no need to repeat them herein, but I hope that this determination and note reflect and address the issues raised in the respective submissions.

[9] The application for the holding of this inquiry identified three areas of concerns, expressed as objectives which it was hoped would be met. Those were described as follows:

1. In the public interest, to explore the care given to Jamesina MacKenzie at Wyvis House Care Home.
2. To highlight the need for vigilance by health care professionals to the risk of development of pressure ulcers and to highlight the need for accurate and complete record keeping in relation to the treatment of same.
3. To bring to public attention the availability of tissue viability advice within the NHS Highland area.

[10] All of those were addressed in the evidence led at the inquiry.

[11] The history of Miss MacKenzie's time at Wyvis House and the circumstances leading to her death are recorded in the above findings in fact. There is no need to repeat them in this note.

[12] There is no doubt that Miss MacKenzie's health deteriorated during April and May 2009. The only significant health issue to which she was then subject was that of the pressure sores, otherwise referred to herein as pressure ulcers or bedsores. Her general health otherwise seems from the evidence to have attracted no concerns on the part of those caring for her. Her diabetes was under control. There was mixed evidence as to whether she was suffering from dementia. On the balance of the evidence, it did not seem to me that dementia, if present to any significant degree at all (which was doubtful), played any part in the circumstances leading to the death.

[13] At some point in May after the first visit by Delia Law, the vascular nurse specialist, on 8 May 2009, the pressure sores became septic. That was a very serious development and one which ultimately led to her death. It occurred when Miss MacKenzie was resident at Wyvis House. The primary question therefore was how did such a situation come about when Miss MacKenzie was resident in a care setting?

[14] Much time at the inquiry was devoted to consideration of the Daily Support Plan Notes kept by the nursing staff at Wyvis House for Miss MacKenzie. Those formed part of production 5 for the Crown. In any inquiry into a factual history, such documents form the basis of examination of witnesses. That of course is because they are believed to be accurate, contemporaneous documentation of what happened during the period of interest. Such documents frequently serve to refresh the memory of witnesses or form the basis of challenge to faulty or inaccurate recollection. They can also fill in gaps left by non-existent recollection, whether innocent or otherwise.

[15] That is a purpose to which such notes can be put in the event of an examination, such as this inquiry, being necessary. However, these notes were not designed with litigation or a fatal accident inquiry in mind. They had a specific purpose connected with the care of the resident. That was described in evidence by an important witness, namely the independent physician led by the Crown, Dr. Alastair Gordon, as the recording of monitoring and treatment of the resident. In the context of Miss MacKenzie's case, it would also serve to demonstrate the administration of the detailed care package carefully prescribed by Miss Law on 8 May 2009, recorded in findings in fact number 55, 56 and 57. It was clear from the evidence that such detailed recording could only assist nursing staff in keeping up-to-date with the resident's progress, or deterioration, during the periods when other staff members were on duty. The importance of such record-keeping seems self-evident for those reasons.

[16] A useful comparison to the notes kept at Wyvis House could be found in the nursing notes made in respect of Miss MacKenzie at County Community Hospital Invergordon after her admission thereto on 22 May 2009, continuing up to the date of her death, 31

May 2009. The record-keeping at the hospital was exemplary. It was detailed and meticulous. It was accepted by Dr. Gordon that time spent making notes was time spent away from caring for residents or patients. That is obvious. However, I cannot see how that pressure of time is any different in a care home setting from a hospital: nevertheless, the difference between the two sets of notes in respect of the same lady is very wide.

[17] Catriona Gillan was an impressive witness. She was a charge nurse at Invergordon Community Hospital. She also had experience in the care home sector. She expressed the situation regarding note-making in stark, but entirely understandable, terms:

‘If you don’t document something, you can’t prove that it happened- it didn’t happen.’

[18] In my view, that amounts to an excellent and easily understandable summary of the importance of making notes.

[19] However, the making of notes does not serve only to protect the nursing staff from professional criticism. Its principal purpose is that it serves to monitor the effectiveness of the care package being provided to the resident or patient. The notes can be examined by nursing colleagues. They can be considered by the general practitioner. If the resident is admitted to hospital, they can be considered by medical and nursing staff there. In Miss MacKenzie’s case, properly kept, they could have provided invaluable information regarding the progress or deterioration of the state of the wounds, namely the pressure sores.

[20] The evidence pointed towards what should have been done in the context of note-taking, in particular in the Daily Care Plan Notes.

[21] The inquiry heard evidence from Dr. Alastair Gordon, a consultant physician base in Melrose in the Scottish Borders. Dr. Gordon was led as an independent skilled witness. He had had nothing whatsoever to do with Miss MacKenzie’s care and had no professional or personal connection with any of the personnel involved in this inquiry.

[22] In his evidence, Dr. Gordon gave his impression that the record of care, which he said did not document a high standard of care during the worsening of Miss MacKenzie's illness, may be unreliable. He acknowledged that it may be that much of the care which was given was not recorded, recognising that time to document must come from time to care. However, his view was that the record-keeping suggested a care provision which did not meet Miss MacKenzie's needs.

[23] Dr. Gordon's views regarding the record-keeping are important and deserving of considerable weight. They have to be considered in light of his opinion that while in the care of Wyvis House in April and May 2009, Miss MacKenzie's health, in the form of the pressure sores, significantly deteriorated. His view however was that that deterioration was not inevitable. Options other than care in the Care Home were available and he was firmly of the view that it was not inevitable or acceptable to allow progression of pressure sores. He had seen patients with pressure sores worse than those suffered by Miss MacKenzie survive, when dealt with by high grade nursing.

[24] His view was that Miss MacKenzie's needs were not adequately met in Wyvis House in that the pressure sores were allowed to progress to the point where they caused the death, which he characterised as untimely.

[25] Dr. Gordon accepted under cross-examination on behalf of the owners of Wyvis House that he did not hold a nursing qualification and that he did not have knowledge or experience of the operation of care homes. However, in my view that did not materially affect the weight that I felt able to attach to his evidence. He was clearly a very experienced consultant physician. He spoke with authority on the issue of the management of pressure sores. In my view, it made no difference whether that management was in the context of a hospital or a care home or even the patient's own home. What he described was what his reasonable expectation of nursing care was. As an experienced consultant physician, he was well-placed to express an opinion about that

issue. In all the circumstances, I felt able to attach a great deal of weight to Dr. Gordon's evidence in the witness box and his report (production 15 for the Crown).

[26] A crucial aspect of Dr. Gordon's evidence was that he was of the view that the staff in Wyvis House failed to recognise and respond appropriately to the fact that Miss MacKenzie's condition was deteriorating, especially during the period following the specialist vascular nurse's visit on 8 May 2009. In his opinion, during that period the situation was not irrecoverable and he was therefore critical of the failure by Wyvis House to react appropriately and to seek further advice.

[27] In reaching that conclusion, I do not doubt the good intentions of the nursing staff responsible at Wyvis House for the care of Miss MacKenzie. I heard evidence from two of them, namely Mrs. Jacqueline Fraser, aged 53 years, a state registered nurse qualified in mental health nursing, with 30 years experience in nursing, and Mrs. Leilani Velasco, aged 43 years, a nurse who originally qualified in the Philippines and who had considerable experience of nursing in both hospitals and the care home sector in the United Kingdom.

[28] Mrs. Fraser gave evidence to the effect that, when on shift, she did what she could to deal with Miss MacKenzie's pressure ulcers. However, she also gave evidence of there being a lack of time available due to the changes and reduction in staff following the change of ownership of Wyvis House.

[29] The difficulty with Mrs. Fraser's evidence is that, accepted at face value, it painted a picture of Miss MacKenzie receiving appropriate treatment from the nursing staff, yet that evidence could not account for the significant deterioration in the condition of the wounds in particular between the two visits by Delia Law on 8 and 22 May 2009. Mrs. Fraser could only of course speak to the care given by her to Miss MacKenzie. She knew nothing of what happened when she was off shift. That situation was not helped by the poor quality of note-keeping in the daily care Plan Notes.

[30] Mrs. Velsaco's evidence was similar to that of Mrs. Fraser. She described the regime of management of pressure ulcers consisting of dressing the wounds and turning the patient. She could not account for the absence of a turning chart. She was however insistent that Miss MacKenzie was regularly turned. She was clear in her evidence that the making of notes was part of the normal working routine of a nurse. She said'

'You write down changes or if you've done something to a patient.'

[31] If Mrs. Velasco and Mrs. Fraser are correct in what they said in evidence regarding the changing of dressings and turning of Miss MacKenzie, then the question arises as to why the taking of those actions was not recorded in the Daily care Plan Notes.

[32] Mrs. Velasco conceded that given the absence of recording of these steps in the note, she would have been unable to confirm to Miss Law that her detailed management plan of 8 May 2009 was being implemented.

[33] I do not consider that these nurses were deliberately neglecting the care of Miss MacKenzie. They both impressed me as caring individuals who were doing the best that they could. However, the fact of the serious deterioration of the pressure ulcers cannot be ignored.

[34] Another matter of concern was that the nursing staff does not seem to have taken the issue of dehydration of Miss MacKenzie seriously enough. On her admission to County Community Hospital Invergordon, she was found to be dehydrated, yet that does not seem to have registered as a serious cause for concern at Wyvis House up to the date of her departure from there.

[35] In that connection I found it instructive to compare the differing descriptions of Miss MacKenzie in the nursing notes written on her admission to Wyvis House on 11 December 2008 and the note made on her admission to County Community Hospital, Invergordon, on 22 May 2009. The former identified incontinence as a problem, but

otherwise recorded no serious concerns about her, recording her likes and dislikes and the fact that her diabetes was under control.

[36] The latter in a box headed 'Presenting Diagnosis and Current Problems' contains the following:

'Deterioration of general condition 4/52 [i.e. four weeks].

? Neglect.

Brief History: NH [presumably "nursing home"] resident.'

[37] The fact that the admission note to hospital in respect of a patient coming in directly from a care home includes the word 'neglect' can only be characterised as astonishing.

[38] The impression which I formed was that the nurses at Wyvis House were doing what they considered to be the best for Miss MacKenzie. However, it also seemed to me that they were being left somewhat unsupervised and, in Mrs. Fraser's case, did not seem to appreciate the severity of the deterioration of the wounds. In Mrs. Velasco's case, she did take steps to alert the general practitioner in mid- May 2009, but did not challenge the reaction of the general practitioner. An effective system of supervision of the nursing staff would have addressed those issues. Had there been proper note-taking, then, on the assumption that they were being truthful about following Miss Law's treatment plan, the failure to respond to that treatment would have been highlighted much earlier than it actually was. Had that problem been identified, then action could have been taken much earlier.

[39] In all the circumstances, I have concluded that a reasonable precaution which might have avoided the death was the complete and accurate record keeping by Wyvis House nursing staff. Had that been done, then the deterioration of Miss MacKenzie's position would have been clearly noted and appropriate action taken more timeously than it was.

[40] That conclusion is made against the following factual background or inferences drawn from the facts:

- that as a matter of fact, for whatever reason, Miss MacKenzie's situation in respect of the pressure ulcers deteriorated during April and May 2009;
- the actual treatment administered during that period failed to reverse or slow down that deterioration;
- properly managed, the deterioration would not have been inevitable to the extent discovered by Miss Law on her return visit on 22 May 2009.

Those facts and inferences are based on the evidence of Dr. Gordon and Miss Law.

[41] The taking of the step of seeking more specialist advice, however, would have depended on somebody of sufficient authority in the management structure of Wyvis House accepting responsibility to do so. That responsibility could only have been exercised on the basis of full, accurate and up-to-date information being available to management in the care home. The evidence pointed to the absence of any system of supervising of the note-making by the nursing staff. That was apparent from the poor and inadequate note-making which was allowed to prevail. Had there been a system of the manager or deputy manager checking the notes and taking remedial action in the event of notes being found to be inadequate, then that would have led to a more structured approach being taken by nursing staff and managers towards the issue of care, the condition of Miss MacKenzie and the reporting of deteriorations in her condition being noted and acted upon appropriately and at the appropriate time.

[42] In my view, the fact that somebody of the status of a nurse, such as Mrs. Velasco should not have had the sole responsibility of deciding whether to call in the general practitioner. That decision should have been made by the manager or deputy manager and if somebody of that status within the organisation were dissatisfied with the response from the general practitioner, then they would have had more authority in raising concerns with the medical practice.

[43] Accordingly, I have decided that another reasonable precaution whereby the death might have been avoided would have been the institution in the care home of an adequate

system of supervision of the note-making and documentation in respect of the condition of and care given to a resident such as Miss MacKenzie.

[44] A care home such as Wyvis House is not a hospital, notwithstanding the employment of qualified nurses, among others, to provide care for the elderly residents. From the date of her arrival there in late 2008, Miss MacKenzie's home was Wyvis House. Nurses have expertise and experience in the practice of the management of pressure sores. Pressure sores come across from time to time in the residents of care homes. It is against that background that the actions of the medical practitioners of Dingwall Medical Group have to be judged. However, it is also correct to say that there was a direct conflict of evidence between Mrs. Velasco from Wyvis House and Dr. Lyndsay Ross, one of the general practitioners in that medical practice. Dr. Ross's evidence was criticised by the solicitor for Wyvis House. With the benefit of hindsight, it may be that the partners of the Dingwall Medical Group would have considered it appropriate for them to be represented at this inquiry. However, they were not.

[45] The impression which I formed from the evidence was that the management of a condition such as pressure sores by medical and nursing personnel was, if anything, a team effort, rather than being based on a pyramid shaped structure with the general practitioner at the top. Certainly the day to day management of pressure sores is an activity exclusively carried out by the nursing staff, in this case, in the care home. Specialist advice was available from the specialist vascular nurse. Interestingly her qualification and background was, as is clear from her job title, in nursing. Dr. Gordon had the greatest of respect for the skill, knowledge and experience of specialist vascular nurses. It seemed to me that that respect was well-founded in the case of Miss Law, who was the only vascular nurse specialist who gave evidence at the inquiry.

[46] Against the background of nursing staff at the care home being experienced and used to seeing residents developing pressure ulcers and the availability of specialist nursing advice, it seemed appropriate for Miss MacKenzie's general practitioner to become involved only if the management of the wounds required intervention from a professional

with skills, qualifications and prescribing authority, beyond that of the nursing staff at the care home. That was the burden of the evidence and I do not criticise that method of working in any way. Its effectiveness as a method of management and treatment however relies heavily on the imparting of timely and accurate information by the care home to the general practitioner. Neither does it absolve the general practitioner of the responsibility of making appropriate decisions as time goes on, depending on the seriousness of the condition of his patient. The existence of that responsibility was something stressed by Doctor Gordon.

[47] This situation was highlighted in the evidence of Dr. Mack and Dr. Ross, both partners in Dingwall Medical Group evidence, and in the observations of Dr. Gordon on the role of the general practitioner in his report and in his evidence.

[48] Dr. Miles Mack, a partner in the Dingwall Medical Group, gave evidence that Wyvis House had called him out to see Miss MacKenzie on 30 April 2009 and he had seen the pressure sores, which he described as ‘Very nasty. This was a significant case to be called out to. It was more serious than I am likely to see.’ However, he took no steps to follow up after this visit and does not seem to have specifically drawn his colleagues’ attention to Miss MacKenzie’s condition. He said:

‘I expect they [Wyvis House] would call us in if it didn’t improve. I would only follow it up if I had any doubts about the competency of the carers.’

[49] However, the independent physician, Dr. Gordon, was critical of that approach. He said:

‘I would expect the practice to tell the staff that the wounds were serious and significant and for the doctor to review in about a weeks time. I would expect there to be active monitoring by the doctor who had seen the wound or his team. Even though the GP expected that a specialist nurse would get involved that was no reason for the GP Practice not to also get involved.’

[50] As noted, information about the pressure sores does not seem to have been shared in the general practice. The next visit appears to have been that made by Dr Ross on the 6th of May. The evidence about that visit was unsatisfactory. She said:

‘On the 6th of May I visited to follow-up blood tests. I can’t remember any information about sores. I did not look at them. On the 6th of May I did examine the deceased but I did not undo any dressing. I can’t recall any sore. No sore was drawn to my attention. I don’t remember being aware of the hip sore and I may not have been. Dr Mack’s visit of 30th April would be on the computer but may not have been on the paper in my hand during the visit on 6th May. When I visited on 6th May the entry for 30th April would have been available to me but we were working between paper records and the computer system.’

[51] I have to agree with the Procurator Fiscal when he says in his written submission:

‘It is indeed remarkable that if Dr Ross conducted a physical examination on the 6th of May in the presence of one of the care staff from the nursing home that either Dr Ross did not see for herself that the deceased had dressings applied to obvious wounds or the existence of these dressings, the need for them and the documented history of pressure sores was not drawn to her attention at that time by the member of the care staff present.’

[52] The identity of that member of staff is unknown as no record of Dr Ross’ visit on 6th May was ever entered in the Care Home notes. Dr Gordon comments:

‘In relation to the examination of the patient on 6th May the only way to assess the patient adequately in my opinion would have involved removing the dressings applied. This could either be done at the time of the examination or coinciding the examination with the next dressing change as long as this was not too long away.’

[53] Dr Ross certainly seems to have been made aware of the existence of pressure sores and the involvement of Delia Law, the vascular nurse specialist, by 11th May 2009 when she was asked to sign a prescription for the medication and said:

‘On the 11th of May when I signed the script that’s when I knew of Delia’s involvement. I would not need to examine the sore. I would rely on the specialist nurse’s advice. If the Home did not call us in we would not feel it necessary to proactively follow this up. The current guidance as I understand it would be for the staff from the home to seek advice from the tissue viability nurse or a hospital specialist. We are approachable but only if the home had concerns. I thought that she (Delia Law) was retaining responsibility for the care of the deceased. I can’t say how I got that impression. It was nothing that anybody said to me. I was pleased they had taken the initiative. That was the first time I knew of the pressure sores. If I had known Delia Law was away I would have been more concerned myself to review the patient. I would have checked the wound and the dressings. I could have discussed the deceased with a hospital specialist.’

[54] The involvement of the Dingwall Medical Group over the period between 15th and 18th May 2009 was the subject of some conflict and confusion on the evidence. Dr Ross’s recollection was

‘There was a phone call on 15th May. I am not aware of any explicit request for a visit. If I had known of the deceased’s condition, I would have gone and looked at her.’

[55] When asked to comment on her own practice’s records which appeared to conflict with this and to record that a request for a visit was indeed made (Production 6) Dr Ross’s explanation was:

‘It is recorded under a visit section but that doesn’t mean it’s a request for a visit. It’s simply a request for input of some kind. I can’t say what that was, maybe even a BU. The 15th of May entries may not have been allocated to me. I may not have been free.’

[56] The entries in the Care Home’s Daily Care Plan Notes for 15 May 2009 included the following:

‘Generally quite poor today. Very confused and agitated @ times. Remains pale. D & V this morning [+++ x 1]. Please obtain specimen if further episode occurs...Wounds re dressed as per instructions from Delia Law (Tissue Viability Nurse). (L) heel appears to show slight improvement. Buttocks less inflamed but sloughy area remains. (L) hip-lge area slough removed. Some slight granulation in 2 areas of wound (edges). Purulent and extremely foul smelling exudate. GP asked to review Janet’s overall condition.’

[57] When that entry was put to Dr Ross, she said:

‘I agree that that records a significant deterioration from when I saw her on the 6th of May. The deceased’s condition at that time would still have been manageable but I would agree that admission to hospital should have been considered.’

[58] Dr Ross conceded

‘I chose not to visit on 15th May. If I had gone out I agree that I would have found the deceased in a condition that could have put her in hospital.’

[59] The evidence of the witness Velasco was that on 18 May 2009 she personally contacted the Medical Practice. She said,

‘I wanted a visit but this time Dr Ross did not examine her. Dr Ross said “Lannie if you keep taking blood from her she will be pale.” She didn’t examine the patient. I thought the doctor wasn’t interested.’

[60] Dr. Ross in evidence denied any recollection of a request to visit the deceased. There was no record in the GP records of any visit or indeed any discussion with any member of staff although there were numerous requests on that date from the Care Home requesting a GP visit. The most that Dr Ross would concede was to say,

‘I may have been in to visit another patient when the conversation (with the witness Velasco) took place. I think it was a phone call.’

[61] I appreciate that Dr. Ross was not represented at the inquiry and did not have the opportunity of exploring this conflict of evidence with other witnesses, in particular Mrs. Velasco. However, the balance of the evidence, namely Mrs. Velasco's clear recollection that she called the medical practice and the recording of what in my view can only have been that call on the Dingwall Medical Group's computerised system as a request for a visit persuades me to prefer Mrs Velasco's evidence to that of Dr. Ross on this issue. In coming to that conclusion, I am not being unduly critical of Dr. Ross's evidence. I daresay that there are many demands on her time as a general practitioner and it would be impossible to recall accurately every request relayed to her from or on behalf of a patient of the practice. However, the situation recalled by Mrs. Velasco in light of its unique characteristics in her experience, supported by the care home notes and the obvious interpretation of the medical practice records clearly point to Mrs. Velasco's version of events being more likely to be correct.

[62] The doctor justifies her actions with the benefit of hindsight saying

‘If I had known that Delia Law was away I would have been more concerned myself to review the patient. I would have checked the wound and the dressings. I could have discussed the deceased's condition with the hospital specialist. If I had received Delia Law's letter of 22 May documenting her visit on 8 May (Production number 6 – dated 22 May 2009 and stamped as received on 1 June 2009). I would have gone out as the staff were unsupported. If I had this letter on the 9th of May we would have been more proactive. We would have gone in to visit ourselves.’

[63] As the Procurator Fiscal observed, the difficulty with this explanation is that all of the information in the letter of 22 May 2009 was recorded in manuscript by Delia Law and placed on the daily support plan notes Production number 5 which would have been available to the GP had she asked to see them but do not appear to have been drawn to the GP's attention by any of the Wyvis House care staff. Dr Gordon comments

‘On the 15th of May it was unwise for the doctor not to go out. There was clearly a concerned nurse asking for a doctor's opinion. The 18th of May would have

been a good time to visit and check the wound. That would have been the right thing to do. The GP wasn't taking the lead or following up or carefully monitoring the wounds. It would have been sensible for the GP to examine the deceased on 18th May as clearly four days later she was beyond help.'

[64] It has already been noted that the management of pressure ulcers is primarily an activity undertaken by nurses as opposed to doctors. It is self-evident that time pressures exist on all professionals in this area of activity and that priorities have to be determined. However, there is no doubt that Miss MacKenzie's pressure sores can only have been advanced by mid-May 2009, yet they were not seen by any doctor from Dingwall Medical Group after 30 April 2009 against a background of a request for a visit specifically to examine the sores being made by the care home.

[65] Dr. Gordon, in his report, writes:

'Antibiotic therapy was prescribed appropriately and continued. Had the practice been more proactive in reviewing the progress of the wounds, the lack of response to treatment may have been recognised and acted on earlier- preventing the terminal decline which followed. Had the practice taken the lead in monitoring the response to the treatment and assumed a position of leadership in this lady's management the outcome may have been different.'

[66] Again, I recognise that Dingwall Medical Group did not take the opportunity to cross-examine Dr. Gordon on that assertion and beyond the evidence of two partners being led by the Crown, did not lead any evidence themselves to comment on or contradict that assertion. Nevertheless, on the basis of the evidence I am satisfied that that comment by Dr. Gordon was well-founded. This lady was a patient of the Group; she was suffering from significant pressure sores; the care home was requesting a visit; the wounds were not even looked at by any member of the practice following Dr. Mack's visit on 30 April 2009. By the time of Miss MacKenzie's admission to hospital on 22 May 2009, a tipping point had been passed and she was beyond saving. I am persuaded

in all those circumstances that had the medical practice dealt with this lady otherwise, then the death might have been avoided.

[67] It seems that the medical practice may have made an assumption that the management and treatment of Miss MacKenzie's pressure ulcers were being supervised by management in the care home and by the vascular nurse specialist. The first of those assumptions was reasonable, although on the evidence not mirrored in reality.

[68] The second of those assumptions should not have been made. Miss Law attended on 8 May 2009, examined Miss MacKenzie and prescribed a course of wound management. As it happened, due to other commitments and her intention to take time off work on annual leave, she indicated that she would only return to review Miss MacKenzie on 22 May 2009. That, in the circumstances, was reasonable and, in my view, beyond criticism. She advised the care home staff to contact the GP Practice or the consultants at Raigmore Hospital should the need for further expert advice arise before 22 May 2009.

[69] Again, what the care home did about following, or not following, that advice was not directly under the control of Dingwall Medical Group. However, standing the seriousness of the wounds, as identified by Dr. Mack on 30 April 2009, it would have been reasonable for the medical practice to take steps to monitor Miss MacKenzie's progress during May more thoroughly than it seems they actually did.

[70] In all those circumstances, I was satisfied that a reasonable precaution which might have avoided the death would have been for the Medical Practice to take a more interventionist approach than in fact they did between 8 and 22 May. It seems that they were unaware of what turned out to be the extreme deterioration in the condition of the pressure ulcers during that period. A simple system of asking to see the Daily Support Plan Notes followed by examination of the wounds, perhaps on a weekly basis, as suggested by Dr. Gordon, would have alerted the General Practitioner to the situation and in all likelihood would have led to the General Practitioner making a decision to admit Miss MacKenzie to hospital before she was beyond saving.

[71] A body of evidence was led regarding staffing levels at Wyvis House, the effect of the change of ownership and management of the care home in March 2009 and general concerns or unease regarding the level of care being provided to residents during the period of 2008/9. There were significant staff concerns regarding the change of shift patterns. There was evidence of the new owner negotiating with the local authority regarding funding for the residents. Dr. Denys Greenhow, a general medical practitioner, attached to the Dingwall Medical Group, felt sufficiently concerned by complaints to him from staff members at Wyvis House to write to the local Member of Parliament about the situation. The situation in Wyvis House found its way into the general discussion among the partners at Dingwall Medical Group. The Care Commission were alerted to the concerns and made three unannounced non-routine visits in April 2009.

[72] The Procurator Fiscal observes in his submission that it was a background of ‘administrative turmoil and financial pressure’ against which ‘action was taken to cut staffing costs which undoubtedly impacted on the ability of the care staff at Wyvis House to meet the increasing demanding nursing and care needs of the deceased.’

[73] There is no doubt that all of those factors were present. Equally, there is no doubt that Miss MacKenzie’s condition worsened during May 2009. However, can it be said that there was a causal connection between those difficulties and the poor standard of care of Miss MacKenzie and mismanagement of her pressure sores?

[74] The managing director of RDS, Mr. Ashley Sham, gave evidence. He accepted that the company set about making some radical changes to shift patterns, involving the use of fewer hours of qualified nursing staff per week and the employment of fewer bank nurses, i.e. nurses engaged on an *ad hoc* basis through an agency, for example. However, Mr. Sham would not accept that the disruption caused by these changes, which he agreed caused some disquiet among the permanent and bank staff, had any bearing on the level of care given to Miss MacKenzie. He was of the view that the nursing staff had the responsibility to attend to the needs of the residents.

[75] That evidence has to be judged against the evidence of the witnesses employed in 2009 by the Care Commission. I accepted their evidence that there was genuine cause for concern in March and April 2009, based on the reduction in overall hours worked by staff and the consequent negative effect on the care and service provided to the residents. It was clear that the imposition of an embargo on the admission of new residents was viewed as an extreme measure. Nevertheless I accepted that there was justification for the Care Commission recommending to the Highland Council that one be put in place, notwithstanding that RDS had a good record of dealing with the regulatory bodies.

[76] I did not doubt the good intentions of the nursing staff at Wyvis House, charged with Miss MacKenzie's care. The Care Commission and its successor body, the Social Care and Social Work Inspectorate Scotland ('the Care Inspectorate'), were and are well-placed to monitor such matters in the operation of the care home sector. Necessarily the evidence led was focused on the care provided to Miss MacKenzie and I heard no detailed evidence regarding the standard of care provided to the other residents in Wyvis House. Accordingly it is inappropriate to conclude that a causal link exists between the problems being experienced at Wyvis House and the deterioration in Miss MacKenzie's condition during May 2009.

[77] On the evidence led, I cannot conclude that different management of staff ratios and numbers would have prevented the progression of the pressure ulcers during April and May 2009. However, there is no doubt that the decline in Miss MacKenzie's health occurred at exactly the same time as these staffing problems were taking place.

[78] What is self-evident is that owners and managers of care homes must at all times give priority to the quality of care being provided to their residents. The practicability of any proposed changes, for example in shift patterns, must be measured against the maintenance of that quality of care. It is management's responsibility to remind staff of their primary duty to the residents and to monitor staff's fulfilment of that duty.

[79] This situation arose in the context of a change of ownership of a care home where the obligation on the new owners and management was to maintain or improve the quality of care to individuals, including Miss MacKenzie, who were already resident there. In such a situation, one would have thought that a short-term goal would be to minimise disruption to the daily routine of the residents and to bring in any changes considered necessary or desirable gradually so that to the residents at least, any alteration to their daily lives would be imperceptible. That would not appear to have been the case at Wyvis House.

[80] Accordingly, while I am not persuaded to go to the extent of finding that different management decisions might have amounted to reasonable precautions whereby the death might have been avoided, nevertheless I consider it appropriate to refer to them in the finding in terms of section 6(1)(e) which I have made.

[81] The public interest in the monitoring of care homes is, in my view, already served very well by the inspection regime operated by the Care Commission in 2009 and now by the Care Inspectorate. This inquiry was reassured by the quality of the inspectors and managers who gave evidence about the conscientious way in which they went about their duty, always putting the interests of the ‘service user’, i.e. resident, first.

[82] What can be said however, and on this I do agree with the Procurator Fiscal, is that there is a role in the Care Inspectorate in considering the level of medical and nursing expertise available to the care provider and further for that body to audit the quality of the necessary record-keeping. I have made a finding in terms of section 6(1) (e) to that effect.

[83] Otherwise, my view is this: Care Inspectorate is well-placed to audit the level of care provided in care homes to residents such as the deceased. It has serious sanctions available to it to enforce compliance with its licensing standards. I heard nothing in this inquiry to raise any concern whatsoever about the way in which that public body goes about the performance of its statutory responsibilities.

[84] The application for the holding of this inquiry made mention of the vascular nurse specialist employed by Highland Health Board. I heard evidence from the holder of that post, Miss Delia Law. She was an impressive witness. She gave evidence that she works alone, providing advice to other nurses, such as those working in care homes such as Wyvis House. Her expertise included the management of pressure sores. She was referred to by some witnesses, such as Mrs. Britton, as a tissue viability nurse. She was the only vascular nurse specialist employed in the Highlands by Highland Health Board. She mentioned that from time to time she felt pressured and had requested assistance for busy periods or when she was on leave. Dr. Gordon gave evidence that advice on tissue viability is not always delivered through the agency of a vascular nurse specialist. It was a question of how to apply resources for any particular health board. He was not critical of the fact that she was the only holder of this post in Highland Health Board's area.

[85] Miss Law gave evidence that when she went on leave in May 2009, she had made it clear that assistance could be sought by the staff at Wyvis House from the consultant medical staff at Raymore Hospital or from Miss MacKenzie's general practitioners. In my view, that was entirely reasonable and there is no question of the staff of Wyvis House being left with no avenue to take to seek appropriate advice during the period between 8 and 22 May 2009. In all the circumstances there is no need to make any finding in respect of tissue viability advice under section 6(1)(c) or (e).

[86] There is no doubt that Miss MacKenzie's relatives will feel that she was badly let down in the last few weeks of her life. She entrusted her care to a care home and the professional services of her general practitioners and Highland Health Board. Highland Health Board, in the person of Miss Law, the vascular nurse specialist, fulfilled its responsibility and, in my view, is beyond criticism. Otherwise, in the midst of apparent misunderstandings and inadequate management and supervision of her care, her deterioration was not properly recognised or addressed by the care home or the general practice until it was too late to prevent her death as a result of the progression of the pressure ulcers.

[87] The knowledge that this combination of circumstances was allowed to occur will, I hope, enable care homes and general medical practices, to identify similar factors at an earlier stage and allow measures to be taken to prevent the recurrence of such a situation being allowed to develop.

[88] I close by expressing my personal condolences to Miss MacKenzie's family.