

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

DETERMINATION

by

Sheriff Principal Edward Bowen QC

In an Inquiry into the deaths of

**Marion Helen Adam Ramsay, John Rodgers Cowe
and Isabella McGregor**

APPEARANCE:

Mr B M Logan, Senior, Procurator Fiscal for the Crown

Mr R Hayhow. Advocate, instructed by Messrs Tods Murray, Edinburgh acting for the Randolph Hill Group Limited

Mr J William son, acting for Michael Brammer and Graham Birnie

Mrs J Martin-Brown, acting for Jennifer Pugh

Mr D Mawby, acting or Dr James Fair

Mrs D King, acting for the Scottish Commission for the Regulation of Care

Mrs J Collinson, acting for Lothian Health Board

**DETERMINATION IN AN INQUIRY INTO THE DEATHS OF
MARION HELEN ADAM RAMSAY, JOHN RODGERS COWE
AND ISABELLA MCGREGOR**

EDINBURGH, 31 DECEMBER 2007

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

- (a) That Marion Helen Ramsay who was born on 30 January 1916 and who was latterly a resident at Ashley Court Nursing Home, 33 Craighouse Terrace, Edinburgh died at 18.45 hours on 1 May 2004 at Liberton Hospital, Edinburgh.
- (b) That the cause of death was (I)(a) bronchopneumonia and (b) carcinoma of the pancreas with spread and (II) generalised atheroma and senile dementia.

Further in terms of said section 6(1):

- (a) That John Rodgers Cowe who was born on 23 June 1912 and who was latterly a resident at Ashley Court Nursing Home, 33 Craighouse Terrace, Edinburgh died at 17.30 hours on 9 September 2004 at said Ashley Court Nursing Home.
- (b) That the cause of death was (I)(a) cardiac failure (b) renal failure, (c) metastatic disease and (II) Parkinson's disease.

Further in terms of said section 6(1):

- (a) That Isabella Russell McGregor who was born on 24 June 1912 and who was latterly a resident at Ashley Court Nursing Home, 33 Craighouse Terrace, Edinburgh died at 23.30 hours on 17 September 2004 at Liberton Hospital, Edinburgh.

- (b) That the cause of death of said Isabella Russell McGregor was (I)(a) superative bronchopneumonia and (II) cerebral atrophy, generalised atheroma and extensive pressure sores.
- (c) That there are no reasonable precautions whereby the deaths of Marion Ramsay, John Cowe or Isabella McGregor might have been avoided.
- (d) That no defects of any system of working contributed to the causes of death.
- (e) That the following facts are relevant to the circumstances of Miss McGregor's death.

FINDINGS IN FACT

ASHLEY COURT

1. Miss McGregor was admitted to Ashley Court Nursing Home in September 1997. She had previously been in two Nursing Homes. She suffered from dementia. In 2004 she occupied a bed in a bedroom on the ground floor.
2. Ashley Court Nursing Home is owned by the Randolph Hill Group Limited of which the sole shareholder is Mr Elliot Scott Nicoll and the Managing Director is Peter McCormack. Neither Mr Nicoll nor Mr McCormack have any direct involvement in the running of the home which is run by a Manager who reports to Mrs Ingrid Neville. She acts as Senior Manager for the Randolph Hill Group.
3. From 8 March 2004 until May 2005 the Manager of the home was Mrs Benita Brammer. Mrs Brammer qualified as a Registered General Nurse in 1991 having previously been an enrolled nurse for seven years. She had management experience in care homes in Manchester and Devon. She had been Head of Nursing Care for a home in Falkirk from 1998 to 2001 and manager of a Nursing Home in Tullibody thereafter.

4. In addition to the Nurse Manager there were two Charge Nurses at Ashley Court and a Nurse on each of the three floors for each shift. They supervised Senior Care Assistants and Care Assistants. The staff complement was always sufficient to meet Care Commission requirements.
5. Mrs Jennifer Pugh was employed at Ashley Court from 2000 until 2005. Mrs Pugh qualified RGN in 1969. She was initially employed at Ashley Court as a Senior Staff Nurse. She acted as Manager prior to Mrs Brammer's arrival in March 2004. At that time she reverted to being a Charge Nurse. She was appointed Deputy Manager after Miss McGregor's death.
6. Mr Graham Birnie was employed as a Registered Nurse at Ashley Court from April 2001 until May 2005. He qualified in nursing and registered as a General Nurse in November 2000. He had five months experience as an Agency Nurse prior to joining the staff at Ashley Court. He had no experience in a hospital, nor had he had an opportunity to gain experience under close supervision.
7. In 2004 Mr Birnie worked on the ground floor at Ashley Court. He was the qualified nurse responsible for the care of Miss McGregor. Mr Birnie was off work for a period of five weeks from 7 September 2004 due to ill health.
8. Miss McGregor was registered as a patient of Doctor James Fair of the Hermitage Medical Practice. She had been so registered for a period of seven years. Doctor Fair visited Ashley Court every Wednesday as a matter of routine.

PRESSURE SORES

9. Persons who are bed ridden are at risk of developing pressure sores. These are caused extrinsically by pressure friction and shear forces. The vulnerability of a patient varies depending on a number of intrinsic factors namely, age, mobility, underlying medical conditions, nutrition, dehydration, and the use of medication with anti-coagulant effect. Pressure sores can occur within about 12 hours if a patient sits or lies in the same position without moving.

10. The majority of pressure sores are located on the heels and sacral areas. Pressure sores are graded on a scale normally from one to four. In general terms a grade one sore is present when erythema (non-specific redness of the skin) is observed when light pressure is applied and removed, indicating some micro-circulatory disruption. A grade two sore involves visible damage to the epidermis and dermis. A grade three sore is a lesion extending into subcutaneous fat. A grade four sore involves necrosis penetrating down to the deep fascia often causing rapid destruction of muscles and other tissue.
11. The risk of developing pressure sores is assessed by reference to one of a variety of scoring systems, of which the Braden scale is the most common. Scoring is carried out on six sub-scales namely, mobility, activity, and sensory perceptions (reflecting the intensity and duration of pressure) and skin moisture, nutritional status, and friction (reflecting tissue tolerance). Each of the sub-scales have three or four levels which are defined and rated from one (least favourable) to three or four. A total score is produced in the range from six to 23. Patients are deemed to be at risk with a score of 16 or less.
12. The prevention of pressure sores is an issue for nurses, physiotherapists and occupational therapists. When the skin breaks down and ulcers form the de-sloughing, cleaning and re-dressing is a matter for nurses. Advice may be sought from a general practitioner regarding antibiotic prescriptions and dressing changes, including the administration of pain killers when dressing changes take place.
13. The onset and development of bed sores in an elderly, frail, and demented patient should be addressed by proper nutrition, regular mobilisation, turning, and provision of a special mattress or bed.
14. Where pressure sores show signs of developing immediate steps should be taken to relieve pressure on the area affected. When a patient is turned, a regular record should be kept on a turning chart. Special mattresses, which

may be foam or air-filled or attached to a pump to provide alternating pressure, may be required.

15. Once sores develop to grade 2 level or beyond the wound requires to be cleaned and kept moist. If it becomes necrotic it is necessary to use hydro-gel to remove dead tissue slowly. A hydro collide which gels on contact with exudates may also be required in certain cases. Dressing changes will be required normally on a daily basis when a wound develops and wound chart should be kept and a record of dressing changes maintained.
16. All qualified nurses of any grade should be able to carry out scoring for risk of pressure sores; identify and grade such sores; and be aware in general terms of the products available to treat wounds. They should also be aware of the need to keep full and proper records including wound and turning charts.

CARE OF MISS MCGREGOR

17. In the period leading up to her death Miss McGregor had severe dementia. During the last three months of her life she spent most of her time in bed or in a chair in her room. She was extremely agitated at times. Latterly she lay in a contracted position which would have caused pressure between limbs. She was doubly incontinent and had difficulty in communicating.
18. Miss McGregor's weight was charted monthly from November 2002 until January 2004 during which period it fell from 32.2kgs to 30.8kgs. It had fallen further to 26.7kgs by 4 April 2004. Such degree of weight loss is not unusual in patients with severe dementia.
19. Staff at Ashley Court were aware that Miss McGregor had extremely fragile and delicate skin. An entry in the Care Plan of 27 June 2003 indicated that staff should be careful in handling her as she tended to bruise easily. Skin integrity nevertheless remained good until April 2004. It was recorded on 23 April 2004 that her skin condition was quite poorly due to her general physical deterioration.

20. A red area on the sacrum was first noted on 7 June 2004. On 18 June it was noted that the pressure sore was necrotic, which would place it at grade 4 of the grading scale, and a wound chart was commenced. On 28 June the nursing note reads: “dressing renewed to sacrum. Foul smelling” and on 30 June Mr Birnie noted: “pressure sore on right buttock getting bigger”
21. On 21 July a sore was noted on the left buttock. On the following day swabs were taken from the left buttock and right hip. These were recorded on 26 July as having produced “positive” results requiring prescriptions of antibiotics.
22. On 27 July Mr Birnie fitted a “suzric” mattress to Miss McGregor’s bed. A suzric mattress is a ripple pump mattress which requires a compressor to operate the ripple function. Mr Birnie found a spare mattress which was not working. As he had electrical, mechanical skills from his previous employment he reassembled the compressor and satisfied himself that the mattress was working before fitting it. He did so in the belief that it would have taken 24 to 36 hours to get a new mattress supplied to the home.
23. On 31 July and 1 August Miss McGregor was noted as having good days and was still sitting in her chair for periods of time.
24. Miss McGregor was seen by Doctor Fair on 11 August at the request of Mr Birnie because of bruising over the sternum. This had occurred because of attempts to relieve Miss McGregor from choking. At the time of her examination by Doctor Fair Miss McGregor was sitting in a chair wearing a long nightdress. Doctor Fair did not observe any bandages, dressings or pressure sores and was given no indication that she had such sores.
25. Between that date and 8 September the nursing notes indicate that Miss McGregor continued to take a good diet and fluid intake was good. There are repeated recordings of changing dressings. The entry of 7 September (made by Mr Birnie) indicates that dressings were changed “as they were soiled from the outside”.

26. On 10 September it was noted that her condition “remains low”. The entry also read “dressings – very extensive and skin peeling off and bleeding – slough observed on hip wounds – smelling and all renewed”.
27. Helen Mullen, an experienced Enrolled Nurse who qualified in 1988, worked at Ashley Court for about three months commencing on or about 28 August 2004. On her first day Mrs Mullen changed a dressing on Miss McGregor along with Jennifer Pugh. Mrs Mullen subsequently became concerned about the condition of Miss McGregor’s bed sores.
28. On 14 September Mrs Mullen changed Miss McGregor’s dressings except those on her arms. She was concerned about the condition of her legs. She spoke to Michelle Brammer and told her that there was a resource available to deal with this type of problem. Mrs Mullen had in mind a Tissue Viability Nurse. Mrs Brammer agreed that Mrs Mullen could contact the District Nurses and she did so.
29. In response to Mrs Mullen’s telephone call District Nurse Stewart and Staff Nurse Hoy attended Ashley Court on 15 September. They were aware of a pungent smell before reaching Miss McGregor’s room. They found her in a very contracted position. They had difficulty in obtaining a history from the Nurses present and no records appeared to be available. Mrs Brammer said that she had not seen Miss McGregor for several weeks.
30. Sister Stewart and Nurse Hoy noted that Miss McGregor was on a very hard mattress which she considered to be unsuitable. They asked for provision of a nimbus mattress which Mrs Brammer agreed to provide. They proceeded to remove some of the dressings on Miss McGregor and replace them with fresh dressings which they had brought, and arranged for the attendance of Doctor Fair.
31. Doctor Fair attended Ashley Court on 15 September in response to the District Nurses request. He was shocked by the condition of the pressure sores on

Miss McGregor and concerned that they had not been brought to his attention earlier. He was of the view that Miss McGregor would not survive for more than a week. He considered that the best course was to attempt to keep her comfortable and provide painkilling medication. He did not consider it appropriate to move her in the frail condition in which she was found. He would not authorise her transfer to hospital.

32. Sister Stewart did not agree. Her note in Miss McGregor's records states "I stated that in my professional opinion this patient requires to be admitted to hospital for pain and wound management. I had no doubt that the staff did not have the skill and knowledge to deliver the care that this patient needed. Review by medical staff in hospital was required. Doctor Fair did not agree, wants to keep patient in Ashley Court feels she is too frail and would block an acute bed. Care Manager wants to keep her in an attempt to improve her management". Following her return to the Health Centre Sister Stewart against attempted, unsuccessfully, to persuade Doctor Fair to admit Miss McGregor to hospital.
33. On 15 September a chiropodist attended and cut Miss McGregor's toenails. It was documented that she was turned every two hours through the night. On the following day she appeared comfortable. 10 milligrams of oral morphine were given before her dressings were changed.
34. Doctor Fair went on leave on the evening of 16 September. He did not provide a note for his locum regarding Miss McGregor.
35. Doctor Sharon Stewart is a General Medical Practitioner who qualified MBCHB in 1996 and after a number of hospital posts completed GP training in 2003. On Friday 17 September 2004 she worked as a locum covering Doctor Fair's absence. She arrived at Hermitage Health Centre at 0800 and was told by one of the Practice Nurses that there was a problem with a patient at Ashley Court who had Grade 4 pressure sores.

36. Doctor Stewart attended at Ashley Court at 0900. She saw Miss McGregor and was gravely concerned by the circumstances in which she found her. Doctor Stewart considered the pressure sores to be “life threatening”. She noticed a bruise on Miss McGregor’s neck and that her nails appeared to be embedded in her palms. She formed the view that Miss McGregor required care, including palliative care, which the Home could not provide and arranged for her immediate admission to Liberton Hospital.
37. On admission to Liberton Hospital Miss McGregor was seen by Doctor Andrew McIntosh, Associate Specialist in geriatric medicine and by an experienced Registered Nurse, Maureen Lucas. They noted that Miss McGregor was very frail, semi-conscious and unable to communicate. Her skin was dry and easily torn. They found extensive pressure sores, four of them being in category 5. Nurse Lucas had never seen pressure sores of such severity. Doctor McIntosh was shocked by the severity of them. They both considered that the pressure sores had been there for some time, which they estimated at weeks and probably months.
38. At 1500 hours on 17 September Miss McGregor was examined by Doctor Rachel Miller, a Forensic Medical Examiner, who had been called to the hospital by a police officer. Miss McGregor was lying on a bed in a curled up foetal position. She was extremely thin and had been weighed at 27.4 kilograms (4 stone 4 lbs). There appeared to be minimal subcutaneous fat on her body. She was unable to speak but could respond to requests. Her limbs were fixed in front of her chest, hands were clenched in fists, and knees were flexed, the left limb to the extent that her heel made contact with the left buttock. She was incontinent of urine and faeces.
39. Doctor Miller noted a total of 22 areas of damage to the skin. Several areas of damage were consistent with rubbing and shearing of vulnerable skin. Doctor Miller’s overall impression was of “lack of appreciation of generalised care of a frail and elderly bed bound lady resulting in serious neglect and proper treatment of her bed sores”.

40. Miss McGregor was prescribed 2.5 millilitres of diamorphine to ease pain. It was thought unlikely that she would survive the night. She stopped breathing and was pronounced dead shortly before midnight.

CONCLUDING INVESTIGATIONS

41. A post-mortem examination of the body of Miss McGregor was carried out by Professor Anthony Busuttil on 22 September 2004. He noted bruising to the head and neck which he considered to be insignificant because of Miss McGregor's general condition. He noted a number of bed sores as follows:

- (i) on the right hip a circular deep bed sore measuring 6 x 7cm extending to bone beneath, with necrotic tissue at its edges and necrotic tissue at its base extending as far as bone. The exposed bone was necrotic and gangrenous;
- (ii) marked ulceration of the skin across the lower part of the right shin;
- (iii) marked deformity of the right foot with overriding of the second toe by the big toe;
- (iv) a pressure sore below the big toe over the first metatarsal phalangeal joint measuring 4 x 3 cm and gangrenous at its base;
- (v) a pressure sore over the front of the left shin extending over a distance of 7.5 x 2 cm and exposing bone beneath. It was infected with necrotic tissue at the base;
- (vi) blistering of the skin and slippage over the medial and posterior aspect of the left calf;
- (vii) a superficial pressure sore on the back of the left hip;
- (viii) a pressure sore measuring 4 x 1 cm situated over the sacroiliac joint on the right hand side extending to the bone and extensively infected and necrotic;
- (ix) a bed sore involving the left sacroiliac joint measuring approximately 12 x 4 cm and extending to the lower end of the sacrum and coccyx with necrotic gangrenous tissue at its base and extensive inflection.

Professor Busuttil was of the view that the extensive bed sores, with gangrene at their bases would have given rise to systemic infection and general toxemia.

42. On 16 September 2004 the Care Commission received a complaint from Jill Harker, a colleague of Sister Stewart regarding the care of Miss McGregor.

The Care Commission conducted an investigation into the complaint and upheld it. A letter intimating that decision was sent to Mr Elliot Nicoll on 11 January 2005.

43. On 13 January 2005 the Care Commission intimated to Mr Nicoll that certain additional conditions would be imposed on the continued registration of Ashley Court under the Regulation of Care (Scotland) Act 2001. These conditions were as follows:

- “(1) The providers of the Home are required to commission an independent investigation of the conduct of two staff named in the complaint investigation of letter of 11 January 2005, in order to establish their fitness. During this time external management of the service must overview the day to day delivery of care to residents. The provider of the Home, within two weeks, of receipt of the independent investigation report must, report to the Care Commission the detailed findings of this report and actions to be taken by the provider.
- (2) For the period of identifying the lead nurse in tissue viability as described in the complaint investigation of letter of 11 January 2005, the Primary Health Team must be contacted at the point where someone is diagnosed as having a wound. Their guidance on treatment must be implemented.
- (3) All nursing staff must be trained in wound management.
- (4) All staff must be made aware of the best practice documentation, Pressure Ulcer Best Practice Statement, NHS May 2002 relating to pressure sore prevention and wound management. The Home’s policy and procedure regarding tissue viability must be amended to take account of this document.
- (5) All staff must be trained in the pressure sore risk assessment score identified by the Home for use”.

44. The additional conditions imposed by the Care Commission were implemented or attended to as appropriate. By letter dated 24 February 2005 addressed to Mr McCormack the Care Commission, in relation to each of the conditions imposed in terms of the letter of 13 January 2005 stated as follows:

- “(1) The Care Commission are satisfied that you have investigated the conduct of the two named members of staff, and that appropriate disciplinary action has been taken which does not prejudice the outcomes of any further actions the procurator fiscal may take in relation to the police investigation into the circumstances of the death of Miss Isabella McGregor. The Care Commission does not believe that there is anything further to be gained by insisting on a further investigation by an outside body. As providers you are satisfied that the named staff are “fit” to carry out the responsibilities of their roles within the Care Home.
- (2) You have confirmed that the Primary Health Care Team have been involved in the ongoing assessment and monitoring of wound management in the Home. You have also satisfied the Care Commission that you have now put in place two link nurses who will provide an overview of tissue viability.
- (3) You have confirmed that all nursing staff are now trained in wound management and that the previously described link nurses for tissue viability will oversee all wound dressings and skin disorders. Staff are also evidenced to be now able to identify ongoing training needs.
- (4) You have confirmed in writing and the inspection of the service carried out on 3 and 4 February 2005 further confirms that guidance is now in place in the Home with regard to pressure area care. The Home’s policy and procedure has been updated.
- (5) You have confirmed in writing that the inspection of the service carried out on 3 and 4 February 2005 further confirms that training has

taken place and that staff are able to demonstrate their knowledge and understanding of the training”.

45. On 25 September 2004, at the request of the Care Commission and the City of Edinburgh Social Work Department, Dr Michael Winter, Medical Director, NHS Lothian Primary and Community Division led a group of experienced doctors who, together with an experienced District Nurse carried out a review of 30 residents of Ashley Court all of whom were registered with Doctor Fair. The group reviewed the records of these patients and undertook medical examinations, including specific review of pressure care areas and any lesions being treated by external dressings.
46. Of the 30 residents identified one was currently an in-patient in the Royal Edinburgh Hospital. Of the other 29 there were, in 19 cases, no issues for comment. In 8 cases specific follow-up action was suggested and in a further 2 cases there were minor questions relating to current prescription. No specific concerns were identified and the group expressed a view that any detailed “snapshot” of this nature would be expected to identify a similar number of issues for future improvement. The group considered that the medical review undertaken suggested that a satisfactory level of basic care was being delivered and clearly had been so from some time.
47. On 28 October 2004 the suzric mattress which had been fitted to Miss McGregor’s bed was examined in the Department of Medical Physics and Medical Engineering of the Royal Infirmary of Edinburgh. It was noted that the ripple effect was working intermittently due to a loose external fuse holder causing loss of main supply. The mattress was otherwise functional. The fault in the fuse holder may have occurred in the course of transit. The mattress itself was not inappropriate for Miss McGregor’s use during those last few weeks of her life.

(signed) *E.F. Bowen*

NOTE:

This is an Inquiry into the circumstances of death of two elderly ladies and one elderly gentleman who had all been residents at Ashley Court Nursing Home prior to their deaths either there or in Liberton Hospital between May and September 2004. In the case of two of the deaths I was not invited to make anything other than formal findings and on the evidence led there is no cause to do otherwise; indeed I feel obliged to go further in this note and question why, once the available information had been properly considered, it was ever thought necessary to include the circumstances of their deaths in this Inquiry at all.

The first death was that of Mrs Marion Ramsay who died on 1 May 2004. A close and long-standing friend who visited her regularly said that she noticed bruising on the upper part of Mrs Ramsay's torso about a week before her death. Apart from that she had no concerns about her care and welfare. Extensive bruising was noted prior to post-mortem dissection and examination of Mrs Ramsay's body. That revealed the presence of cancer of the pancreas, a condition which in itself would have caused widespread bleeding and diminished blood clotting – in other words, the appearance of bruising. It is not clear if anyone thought that Mrs Ramsay had been manhandled, but the fact is that the apparent presence of widespread "bruising" on Mrs Ramsay was entirely consistent with her underlying condition and there was no hint of a reason to suspect any other cause.

Mr John Cowe died on 9 September 2004. One morning, about a week before his death, he complained of severe pain in his arm. He had been undressed by staff the following day, one of whom had helped to remove his shirt. As a result of his complaint of pain another member of staff took Mr Cowe to the Accident and Emergency Department of Edinburgh Royal Infirmary. He told a doctor there that the staff at the Home had used force when removing his shirt. His arm was x-rayed, revealing a fracture, and Mr Cowe was sent back to the Home, where he died a few days later. Post-mortem examination in his case revealed that, amongst other conditions which led directly to his death, Mr Cowe had metastatic disease, a cancer which spreads from an unknown site. This can lead to spontaneous fractures, and it

would have taken very little by way of sudden movement for a fracture of Mr Cowe's arm to have occurred. There is in consequence no cause to suspect that Mr Cowe was mistreated, and it is extremely unfortunate that the member of staff who removed his shirt, and who was identified, came under any form of suspicion.

The third death – that of Miss Isabella McGregor – was primarily due to suppurative broncopneumonia and cerebral atrophy, both common causes of death in the elderly. She was, however, also suffering from extensive pressure sores which precipitated her admission to hospital on the day before her death, and the presence of these sores, and the nature and extent of them, was rightly a matter for concern. Whether it was a matter of such concern as to justify a Fatal Accident Inquiry is, however, debatable for a number of reasons. Firstly, and most significantly, the matter was the subject of a full investigation by the Care Commission for Scotland. In consequence the Commission placed a number of requirements on the Home as set out in finding 43 above. All recommendations made were acted on by the Home with much greater expedition than the findings of an FAI could ever have been. It is questionable whether anything is served in the wider interest by the public scrutiny of the standard of care given by any residential home some three years after the events in question, by which stage key staff have changed and procedures have been improved radically. Secondly, the scope of an Inquiry under the 1976 Act is limited by the terms of the statute to consideration of any reasonable precautions which might have avoided the death, or defects in a system of working which contributed to it. In the case of the death of an elderly person through natural causes there are no findings which can be made under either of those heads. Whilst the court is entitled to make findings as to “any other facts”, that power is confined to facts “which are relevant to the circumstances of the death.” It follows that this Inquiry was not in the nature of a wide-ranging examination of the standard of care provided at Ashley Court in 2004; even less is it an inquiry into relationships between care homes and other healthcare professionals and services. To enter into that area would run into the danger of failing to give proper regard to the allocation of both private and public resource issues - the latter being clearly beyond the scope of consideration of any court: see the observations of the Court of Appeal in *R v Central Birmingham Health Authority ex parte Collier* (6 January 1988, unreported). I mention this partly because I did form the impression in the course of the evidence that care homes have a difficulty in

recruiting and retaining the best quality nursing staff, simply because salary levels are lower and prospects of advancement restricted in that sector. That is not without relevance to the case because it did appear that Mr Birnie, who was Miss McGregor's principal carer and whose position I shall deal with in greater detail, was a nurse of somewhat limited experience. It is not within the scope of this Inquiry for any suggestion to be made as to how recruitment of nurses to work in care homes could be improved.

Against this background, and the factual matrix in the above findings, I propose to deal with three main issues. These are (1) whether the quality of care given to Miss McGregor in the last few weeks of her life was adequate (2) if not, who was responsible; and (3) whether the decisions taken on 15 and 17 September in relation to whether to leave her in Ashley Court are susceptible to criticism. I shall also touch briefly on such recommendations as I feel able to make.

1. The quality of care

There is no basis for criticising the general quality of care provided to Miss McGregor at Ashley Court. Her half-sister, who was in reasonably regular contact, expressed no concerns, nor did Dr Fair. More than one professional witness indicated that Miss McGregor would simply not have lived as long as she did if she had not been well looked after. The only areas of concern in consequence arise in relation to the development of pressure sores, and possibly to the manner in which she was fed. My conclusion in respect of bedsores can be summarised by saying that there was undoubtedly a lack of proper attention to Miss McGregor's condition from somewhere between 7 and 18 June, and thereafter. It is not possible to say that with proper care and attention the development of any bedsores would have been avoided; Miss McGregor was in a condition, both physical and mental, which made her extremely vulnerable to the development of such sores and indeed there was evidence from a tissue viability specialist nurse that sores of the type seen on Miss McGregor can occur even when all care is in place. That evidence might tend to suggest that there was not necessarily an absence of proper care, but the overwhelming weight of medical evidence from those witnesses who saw Miss McGregor shortly before her death or examined her body *post mortem* was that that the sores were such as to give

real cause for concern. What is beyond doubt is that there was no appreciation of the magnitude of the problem until Mrs Mullen insisted on the attendance of the District Nurses on 15 September, and that the medical records gave no real indication of the serious condition of Miss McGregor at that stage. Mr John McGregor FRCS, a retired plastic surgeon who was the most eminent and in many respects most impressive medical witness to give evidence, arrived at the overall conclusion that, whilst there was no clinical evidence that Miss McGregor was either deliberately neglected or mistreated, there was “a complete lack of understanding and insight relating to the care of such an elderly patient with regard to recognition and management of pressure sores”. That conclusion, which I accept, was based on the view that advice ought to have been sought on the first sign of incipient wound breakdown, and that there was no recognition of the fact that Miss McGregor’s food intake was generally poor and her fluid output unknown. In conclusion, I am satisfied that whilst Miss McGregor was likely to have developed bedsores of a significant nature, the likelihood is that they would not have developed to the extent they did had there been proper care. That conclusion is reflected in the report of Dr Brian Chapman, a Consultant Physician in Geriatric Medicine who said : “The development of deep pressure sores with associated infection may have been inevitable but I believe more could have been done to prevent deterioration of the pressure sores and to control her symptoms”. I would add that it is not possible to say that the bedsores caused Miss McGregor significant pain. The level of pain suffered by someone with severe dementia is unknown for obvious reasons, and tissue deterioration resulting in damage to nerves adds to the complexity of the problem. But this is not a question of importance. The fact is that Miss McGregor might have been suffering when she should not have been.

I have mentioned, for the sake of completeness, a possible concern as to the manner in which Miss McGregor was fed. I do so for the purpose of indicating that I consider this to be of no relevance or significance. The matter was raised by one witness, Doctor Harrington, whose report and evidence I shall not dwell on save to say that it was given in terms which were at times somewhat extreme and in certain respects wholly unjustified. Doctor Harrington’s report sought to link Miss McGregor’s bronchopneumonia with the aspiration of food into the airways caused by inappropriate feeding with a syringe. There was no evidence that Miss McGregor was fed by having food squirted into the back of her throat with a syringe as Doctor

Harrington suggested. Moreover the link between feeding and the cause of death was excluded by the evidence of the pathologist, Professor Busuttil who said there was no evidence of the inhalation of food in the blocks of lung which he examined. The procurator fiscal depute did not, correctly, in my view, attempt to attribute the cause of Miss McGregor's death in any way to the aspiration of food stuffs during attempts to feed her. I reject any criticism of staff at Ashley Court in this respect.

2. Responsibility

I embark on this area with considerable hesitation. As I have indicated, the death of Miss McGregor in the autumn of 2004 was inevitable and it would be wrong in the context of this Inquiry to give any impression that anyone was "responsible" for it. My observations are confined to commenting on who might be said to have principal responsibility for the system of caring for her at the time of her death, and of implementing that system. I also stress that it is not the function of Fatal Accident Inquiry to determine fault and it is wholly inappropriate to give any indication that the actings of any individual fell short of a particular professional standard. It is, however, an area which does call for some comment, partly because there was an attempt by at least one witness to avoid any responsibility at all for Miss McGregor's care, and also because the Procurator Fiscal Depute, in his concluding submissions appeared to indicate that there was responsibility on the part of the owners of the Home which had not been fulfilled, and which was in some way part of a culture in the care home sector.

I find it very difficult to see how one can direct any criticism at the owners of Ashley Court. They had put in position a staff structure, involving an experienced care home manager with overall responsibility. Staffing levels met the standards expected by the Care Commission and nurses were all, on the face of it, suitably qualified. There was no evidence which might lead to a conclusion that there was any inadequacy of equipment. The contention of the PF Depute was that the owners "cannot simply appoint someone with a nursing qualification on paper without scrutiny of their ability and then sack and replace with another nurse if events turn out for the worse". That is all very well, but it does not lead to a conclusion as to what nursing home owners should do. Unless they themselves have nursing experience it is inevitable that they

will entrust the running of a home to professionals, and the competence of those professionals must be relied on. Had it been the case that there was something in the employment history or record of Mrs Brammer to indicate that she was inexperienced, or otherwise unsuitable, to take charge of a care home of the size of Ashley Court, the owners might well be susceptible to criticism. Nothing of that nature emerges. Mrs Brammer was experienced and well qualified for the task.

It is accordingly quite clear that overall responsibility for what happened, or did not happen, in Ashley Court, rested with Mrs Brammer. In relation to her position, the first matter to be taken into account is that she was only appointed Manager in March 2004. There had been no manager in post for five or six months prior to that, and there is no reason for doubting Mrs Brammer's evidence that (a) policies and procedures within the Home were "not as clear as they should have been" and (b) there was high percentage of agency staff and staff turnover. As an example of the first of these she said that there was no clear wound management policy. She also said that she became aware that the trained nursing staff were "not taking responsibility for the role that they had" and that she wanted them "to take a step back and concentrate on their clinical role". It is, in the light of this, fair to assume that in the first six months of her time at Ashley Court, Mrs Brammer was pre-occupied with matters such staff recruitment and the improvement of policies and procedures. She was not, as she herself accepted, much involved in the supervision of staff or what might be described as "hands on" involvement in the care of residents. Whatever the justification for that, certain matters in her dealings with Miss McGregor are a little surprising. First, whilst she herself initiated a wound assessment chart for Miss McGregor on 31 July, she does not appear to have made any attempt to see that it was maintained thereafter. More remarkably, she does not appear to have looked at Miss McGregor in the light of the conversation with Nurse Mullen on 14 September (see finding 27). In consequence, she had not seen Miss McGregor from the end of July until the District Nurses attended on 15 September. Her reaction, on seeing Miss McGregor, was one of shock and lack of understanding as to why staff had not consulted her earlier. Mrs Brammer accepted that she was perhaps not a "robust" manager; it is difficult to avoid the conclusion that she was too detached from the day to day activities of the wards.

The charge nurse, Jennifer Pugh, commenced her evidence by accepting the terms of Mr McGregor's report to the effect that there had been a "complete lack of understanding and insight relating to the care of Miss McGregor". She said that there was not much discussion about the condition of patients in the Home. She said that she got very little support from Mrs Brammer who "didn't share anything". She agreed that record keeping was not good. When asked why Miss McGregor deteriorated to the state she was in on 15 September, Mrs Pugh said: "I wasn't taking care of Miss McGregor before the District Nurses came". She declined to accept any responsibility for what had occurred and, initially, denied any responsibility for supervising Mr Birnie. However, in the course of two sets of cross-examination she admitted that such responsibility was part of her job, and that in particular she had a responsibility to check record keeping. In this situation it seems to me to be tolerably clear that Nurse Birnie was not supervised by either of his superiors, and it appears likely from what was said by Mrs Pugh that neither of them was likely to have been forthcoming with advice. Given the level of Mr Birnie's experience this was far from satisfactory. This was his first nursing position and he had no hospital experience at all. I am sure that he should have sought advice in how to deal with Miss McGregor in the interval between 7 and 18 June, but he was working in an environment in which the sources of advice to which he might have been expected to turn were not providing the support which he needed. I formed the impression, both from what I saw of him and what was said about him, that Mr Birnie was a gentle and caring individual who was deeply upset by the circumstances of Miss McGregor's end. He himself recognised that record keeping was not his strong point and that, I consider, gave rise to one of the justified criticisms that on 15 June the records of Miss McGregor gave no real indication of her dire condition. Whatever professional strictures others may place on it, bad record keeping was not the cause of Miss McGregor's condition (although it is certainly true that, in a situation where staff regularly come and go, on shift or otherwise, the absence of proper records can lead to a breakdown in proper care), and at the end of the day all that can really be said of Mr Birnie is that he should have sought help and advice sooner. It is not that he was inactive; in particular, the provision of a ripple effect mattress on Miss McGregor's bed on 27 July was a sensible step to take. It is also fair to observe that Mr Birnie was off work from 7 September. It is well within the realm of possibility that there was a significant deterioration in the condition of Miss McGregor's bedsores between then

and 15 September and that in consequence Mr Birnie cannot bear direct responsibility for what was found on that date.

In conclusion, therefore, this appears to have been a situation in which an inexperienced nurse was working without adequate support or supervision. Had he been more experienced, or had there been better support or supervision, it is likely that advice would have been sought about the condition of Miss McGregor in the critical interval in June when things started to go wrong. It is not possible to say in precise terms what would have happened had such advice been obtained; all that one can say is that the likelihood is that Miss McGregor's sores would not have developed to the stage they did.

3. Decisions on 15 and 17 September.

No attempt was made by any party to the Inquiry to suggest that Dr Fair, Miss McGregor's General Practitioner, ought to have been aware of the state of her bedsores before 15 September. Where Dr Fair did come in for some criticism, in terms which I considered to be somewhat extreme and emotive and which in the end proved to be unjustified, was in his decision to leave Miss McGregor in Ashley Court after he had seen her on that date. This decision was one with which the District Nurses strongly disagreed. The strength of their feeling led to the attendance on 17 September of Dr Stewart, who determined that Miss McGregor should be admitted to hospital.

One cannot say that either doctor was wrong or misguided in these decisions. Dr Fair considered that Miss McGregor would not live for more than a week; that the best plan was to keep her comfortable, and that transport arrangements and assessments would be intrusive and unnecessary. That view found support from others, Mr McGregor in particular, who said that the decision to move Miss McGregor at a very late stage "may not have been helpful"; but he accepted that this was a judgement made with the benefit of hindsight. Dr Fair himself accepted that some GPs would have decided to admit a patient in similar circumstances, and no one sought to criticise Dr Stewart for her actions. In my judgment the situation which presented itself to both Drs Fair and Stewart on 15 and 17 September was one for

which there was no perfect answer. Either course had both its benefits and drawbacks. The only criticism that could be directed against Dr Fair is that he did not leave any note for Dr Stewart about the problem relating to Miss McGregor. He accepted that as an oversight. Beyond that the actions of the doctors were entirely professional.

4. Recommendations

I do not feel that it is either appropriate or necessary to make recommendations at the conclusion of this Inquiry, apart from one of a general nature. In his final submission the procurator fiscal depute put forward three suggest recommendations namely:

- “1. That there should be greater working together of multi-disciplinary health care professionals. Care Home Managers should meet regularly with Specialist Nurses, such a Tissue Viability Nurses, and Community Nurses of related general medical practices and with Medical Practitioners to discuss the needs and treatment of residents of care homes.
2. General Medial Practitioners should be more proactive in the care of patients in residential care homes to the extent of making regular visits even if not called upon for particular concerns and should be aware of and examine the nursing records and discuss the condition of the patient with the nursing staff and with those responsible for the management of the care home.
3. Consideration should be given to the introduction of Consultant Geriatricians as raised in the testimony of Doctor Harrington in accordance with the models used elsewhere in the United Kingdom. This would enable a specialist resource to be called in for advice and guidance both in individual cases and on the general approach taken by care workers and management in care homes”.

I do not feel disposed to make any recommendation in terms of the first two of these. They both have clear resource implications which are outwith the ambit of this Inquiry. In the circumstances disclosed by this case there ought to have been greater “working together” between the Care Home Manager and other qualified staff in the Home. Had that occurred it may well have been the case that other professionals, whether Tissue Viability Nurses or Community Nurses would have been called in. It is unnecessary however to go the length of suggesting that this should occur as a matter of routine. So far as the position of General Medical Practitioners is concerned, as I have indicated in Finding 12 prevention of pressure sores is an issue for nurses, physiotherapists and occupational therapists. It is not clear to me what the examination of the nursing records by a General Practitioner would have achieved in this case. The evidence tended to suggest that visiting GPs do discuss the general care of patients when visiting care homes.

The third suggested recommendation is, however worthy of serious consideration. Doctor Harrington made the valid point that the number of elderly, frail and demented patients in care homes is constantly increasing and the need has been felt in areas in England to appoint Consultant Geriatricians to work in the community. Such consultants, as I understand it, have a number of care or nursing homes within their ambit of responsibility. One cannot say that the existence of such a consultant would have necessarily made a difference in this case but it is not difficult to see the benefit both from the point of view of staff in care homes having such a source of advice, and from the point of view of public confidence in knowing that residents in such homes were under the watchful eye of someone with appropriate specialist knowledge and professional standing. Having regard to the resource implications I can only support the suggestion that Community Health Authorities with substantial numbers of care homes in their area give consideration to this possibility.

(signed) *E.F. Bowen*