SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT ALLOA

[2025] FAI 30

ALO-B53-23

DETERMINATION

BY

SHERIFF JOHN A MACRITCHIE SSC

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

WALLACE HUNTER

ALLOA, 15 July 2025

DETERMINATION

1 The Sheriff having considered the evidence presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") that:

Time and place of death

a. In terms of section 26(2)(a) of the Act, Wallace Hunter, born 5 May 1944, lately residing in Eaglesham, East Renfrewshire, ("Mr Hunter"), died on 1 December 2019 at or about 0831 hours, in Room 211, Pitlochry Hydro Hotel, Knockard Road, Pitlochry ("the hotel").

Time and place of accident

b. In terms of section 26(2)(b) of the Act, between at or about 0730 hours and 0800 hours on 1 December 2019, in the bathroom of Room 211 of the hotel, Mr Hunter while having a bath was accidentally and fatally scalded by further bathwater discharged from the bath tap.

Cause of death

c. In terms of section 26(2)(c) of the Act, the cause of death was:

(i) A. Scalding to the torso and limbs;

B. Immersion in a bath; and

(ii) Atherosclerotic and valvular heart disease.

Cause of the accident

d. In terms of section 26(2)(d) of the Act, the cause of the accident resulting in the death of Mr Hunter was the collective failure of safety components in the unmaintained bath tap, thereby causing Mr Hunter to accidentally discharge scalding water into the bath in which he was lying, *viz*:

i. an excessively stiff and overly sensitive temperature control dial ("temperature dial"), making it difficult for Mr Hunter to accurately regulate the water being discharged into the bath at a safe bathing temperature of at or about 38°C;

ii. a temperature safety override button ("safety button") which was stuck in the depressed override position, making it ineffective in preventing Mr Hunter from unwittingly discharging scalding water into the bath above at or about said safe bathing temperature; and

iii. a defective thermostatic mixing valve ("TMV"), preventing it from mixing the hot and cold water inputs to maintain the water at a safe bathing temperature, particularly in the event of changes to water temperature and pressure, as it was designed to do.

Reasonable precautions

e. In terms of section 26(2)(e) of the Act, the precautions which could reasonably have been taken, and had they been taken:

i. might realistically have resulted in the death, and the accident resulting in the death, being avoided were:

1. at least annual maintenance of the bath tap and its components;

2. a more formal analysis of guest complaints about the discharge of excessively hot water in the hotel bathrooms, with immediate and full consideration of the safety issues arising therefrom, and the identification and, reduction or elimination, of the relative risks by a qualified plumber, without any preconceived misapprehension as to the potential for fatal consequences arising therefrom; and

ii. might realistically have resulted in the death being avoided, was the fitting of a bathroom door lock release, operable from the bedroom, to allow for emergency access to the bathroom to remove Mr Hunter from the scalding or to become scalding bathwater.

Defects in system of working

f. In terms of 26(2)(f) of the Act, defects in the hotel's system of working, which contributed to the death and the accident resulting in the death of Mr Hunter, were the absence of:

i. At least annual maintenance of the bath tap and its components; and

ii. more formal analysis of guest complaints about the discharge of excessively hot water in bathrooms, as detailed above.

Other factors

g. In terms of section the 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death of Mr Hunter.

RECOMMENDATIONS

2 In terms of section 26(1)(b) and (4) of the Act, no further recommendations require to be made to the hotel or otherwise as:

a. All older taps in the hotel rooms such as that in Room 211 have been replaced and are now at least annually maintained as part of the hotel's legionnaire health and safety procedures;

b. hotel management are now aware of the benefits of a more formal analysis of guest complaints about the discharge of excessively hot water in bathrooms, and the need to fully consider such without any preconceived misapprehension as to the potential for fatal consequences arising therefrom, as detailed above;

c. the bathroom door locks have been removed, pending the fitting of emergency bathroom door lock releases when finances permit; and

d. The publication of this determination should reinforce to any other hotels (particularly those with older sanitary ware), the potential for fatal consequences arising from bath water being discharged into a bath at unsafe temperatures. This is especially so where a significant number of the hotel's guests are expected to be elderly and therefore potentially less physically or mentally able.

NOTE

Introduction

[1] The inquiry was held under the Act into the death of Mr Hunter.

[2] On 1 December 2019, the death was reported to the Crown Office and Procurator Fiscal Service.

[3] The dates of the Preliminary Hearings were 1 September and 27 October 2023, 12 January, 8 March, 5 April, 12 July and 2 August 2024.

[4] These hearings allowed for identification of and intimation of the inquiry to all potential participants and an opportunity for a participant to obtain legal aid.

[5] The dates of the Evidential and Submissions Hearings were 6, 7, 8, 12, 13, 15 and 19 August 2024, 22 January and 30 April 2025.

[6] Due to the lengthy and technical nature of the inquiry evidence, participants unanimously required the evidence to be transcribed before making submissions.

[7] The representatives of the participants in the inquiry were:

a. Gail Adair, procurator fiscal depute, for the Crown;

b. Lesley Allan, solicitor (Kennedys Law LLP, Solicitors), for Protector Forsikring ASA t/a Protector Insurance; and

c. Drew Mckenzie, advocate (instructed by Virgil Crawford, Solicitors) for Mark McLean.

[8] There were two Joint Minutes of Agreement lodged, the terms of which are incorporated into the undernoted summary of the facts.

[9] Evidence was also led or agreed from:

Victor Aitken ("Mr Aitken"), hotel guest;

Elena Cespedes ("Ms Cespedes"), Night Porter;

Christopher Stanton ("Mr Stanton"), Hotel General Manager;

Mark Mclean ("Mr McLean"), Hotel Maintenance Operative;

Kimberley Clark ("Mrs Clark"), Mr Hunter's daughter;

Peter Dodd ("Mr Dodd"), Mechanical Engineer, Health and Safety Executive ("HSE");

Izaak Mansell ("Mr Mansell"), Mechanical Engineer, HSE;

Lee McDowell, Hygiene 2 Health Ltd ("H2H"), Health and Safety Consultant;

Martin McLelland, Building Standards Team Leader (Crown Production 50); and

Mrs Janice Hunter ("Mrs Hunter"), Mr Hunter's widow (Part of Crown Productions 48 and 49).

[10] There were no issues with the credibility of witnesses who all appeared to be doing their honest best to recall the facts spoken to, and, in the opinions they expressed.

[11] There were relatively minor issues of factual conflict in the evidence. In that respect, the shorter timeline of Mr Aitken was preferred to that of Ms Cespedes, as the former appeared to be following his standard routine and its relative timings.

[12] Accordingly, Mr Aitken appeared more certain and reliable in his timings of the comparatively short period over which he described these tragic events taking place.

[13] Likewise, where there were limited differences of opinion between experts and where such are significant these were considered and conclusions reached as detailed below.

The legal framework

[14] The inquiry was held under section 1 of the Act. It was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[15] The purpose of the inquiry under section 1(3) of the Act was to (a) establish the circumstances of the death, and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[16] The matters which require to be covered in this determination under section 26 of the Act in relation to the death to which the inquiry relates, are findings as to:

a. when and where the death occurred;

b. when and where any accident resulting in the death occurred;

c. the cause or causes of the death;

d. the cause or causes of any accident resulting in the death;

e. any precautions which:

(i) could reasonably have been taken; and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

f. any defects in any system of working which contributed to the death or any accident resulting in the death;

g. any other facts which are relevant to the circumstances of the death; and

h. such recommendations (if any) as to:

(i) the taking of reasonable precautions;

(ii) the making of improvements to any system of working;

(iii) the introduction of a system of working; or

(iv) the taking of any other steps;

which might realistically prevent other deaths in similar circumstances.

[17] This determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

[18] The procurator fiscal represents the public interest, an inquiry is an inquisitional process, and it is not the purpose of an inquiry to establish civil or criminal liability.

Summary

Background

[19] On 5 May 1944, Mr Hunter was born.

[20] At or about the end of 2018, Mr Hunter fell and struck his head. He attended hospital at the time and was shortly thereafter discharged. He was not perceived by his wife, Mrs Hunter, to be "entirely the same" after this fall. Mr Hunter gave up driving. He could be forgetful and occasionally confused about where he was. Mr Hunter was referred by his General Practitioner to an older adult mental health clinic. They advised that Mr Hunter was experiencing mild cognitive impairment. They did not propose any treatment.

[21] This mild cognitive impairment was mainly presenting as a loss of confidence in the details of arrangements or with the use of technology. However, Mr Hunter remained very independent. He had no difficulty with, for example, collecting his young grandchild from school and then walking back to the home of Mrs Clark, his daughter. Mr Hunter was not diagnosed with any specific medical condition, such as dementia.

Pitlochry Hydro Hotel

[22] The hotel was operated by Coast and Country Hotels Limited ("Coast and Country"), a wholly owned subsidiary of Specialist Leisure Group Limited ("Specialist Leisure").

[23] A significant number of the hotel's guests were elderly and therefore had the potential to have physical limitations or the mild cognitive impairment that Mr Hunter had.

[24] On 21 May 2022, Coast and Country were dissolved.

[25] On 25 August 2023, Specialist Leisure were dissolved.

[26] The hotel now operates under new ownership. Accordingly, Protector Insurance participated in the inquiry as the hotel's public liability insurers at the time of Mr Hunter's death.

Previous issues with the water temperature in Room 211

[27] Any specific maintenance complaint made by a member of staff or guest should have been recorded in the hotel maintenance logbook ("the logbook"). This had columns to be completed with the date, the person's name, the place of the fault, what the fault was, whether the job was completed, and comments. The logbook was kept at the reception desk.

[28] Mr McLean, maintenance operative, and an Artur Banat, leisure assistant, ("Mr Banat") who covered for Mr McLean for instance at weekends, were responsible for general hotel maintenance. Neither Mr McLean nor Mr Banat were qualified

tradespersons. If they were not personally able to complete a required job, they reported this to Mr Stanton, the hotel's General Manager. A local qualified tradesman would then be instructed, for example, for a specialised plumbing issue the hotel instructed a local plumber in Pitlochry.

[29] Mr McLean or Mr Banat checked the logbook several times each day depending on their work commitments. They would action any job as and when they could. Mr McLean and Mr Banat's usual practice was to sign the "job done" column in the logbook once completed.

[30] If no fault was readily identified, they may not have signed the job as having been completed and have left the job "open" in case a further similar issue was thereafter reported. Most entries in the logbook have been signed off as having been completed.

[31] On 12 March 2019, there is a complaint logged, "showers are boiling hot, temperature handle not working well" relative to Rooms 229 and 231. This has not been signed off as having been completed. These were among ten rooms in the hotel where the bathrooms were awaiting being upgraded.

[32] On 22 March 2019, there is a complaint logged, "Shower not working well" relative to Room 227. This has a "?" and a comment "TAP – CONTROL OF TEMP NOT WORKING WELL (NEEDS NEW TAP)".

[33] On 23 March 2019, there is a complaint logged, "Shower mixer needs attention" and another separate comment "shower mixer broken", both relative to Room 113. This has not been signed off as having been completed.

[34] On 25 April 2019, there is a complaint logged, "Temperature control not working in shower, (low pressure)" relative to Room 212. This has not been signed off as having been completed. This was also one of the ten bathrooms in the hotel still to be upgraded.

[35] On 29 April 2019, there is a complaint logged, "NO COLD WATER IN BATH" relative to Room 231. This was also one of the ten bathrooms in the hotel still to be upgraded. This has been signed off as having been completed.

[36] On 11 July 2019, there is a complaint logged, "shower only hot – temp not working" relative to Room 212. This has not been signed off as having been completed. This was also one of the ten bathrooms in the hotel still to be upgraded.

[37] On 15 July 2019, there is a complaint logged, "Hot tap not working properly guest complained". This has been signed off as having been completed.

[38] On 30 July 2019, there is a complaint logged, "hot water tap in bath not working" relative to Room 103. This has been signed off as having been completed.

[39] On 12 August 2019, there is a complaint logged, "cold water not in bath" relative to Room 205. This has been signed off as having been completed.

[40] On 17 August 2019, there is a complaint logged, "shower hot hot water" relative to Room 232. This has been signed off as having been completed.

[41] On 23 August 2019, there is a complaint logged, "bath tap has problem opening" relative to Room 112. This has been signed off as having been completed. This may have been one of the ten bathrooms in the hotel still to be upgraded.

[42] On 24 August 2019 there are complaints logged as, "no cold water" relative to both Rooms 102 and 212. Only the former has been signed off as having been completed.

[43] On 3 August 2019, there is a complaint logged, "shower too hot" relative to Room 112. This has been signed off as having been completed. This may have been one of ten bathrooms in the hotel still to be upgraded, as detailed above.

[44] On 24 September 2019, there is a complaint logged, "shower temp" relative to Room 231. This has been signed off as having been completed. This was one of the ten bathrooms in the hotel still to be upgraded.

[45] On 1 October 2019, there is a complaint logged, "shower difficult to regulate" relative to Room 231. This was one of ten bathrooms in the hotel still to be upgraded. This has not been signed off as having been done.

[46] Of even date, there is a complaint logged "shower problem, water is too hot, no cold water, TEMP CONTROLLER VERY HARD WORKING NEEDS NEW TAP" relative to Room 112. This has been signed off as having been completed.

[47] There were in addition regular unrecorded instances of guests having difficulty in operating the older bath taps in the ten bathrooms awaiting upgrading. Mr McLean then required to assist guests and considered that the issues were essentially ones of user error.

[48] On Thursday, 10 October 2019, there is a complaint logged, "Temp Control in shower is iffy" relative to Room 211. This is not attributed to a named person. The "Job Done" column has not been signed off and there are no further comments. Room 211

was also one of the ten bathrooms awaiting upgrading, all having a similar older style mixer tap.

[49] For Saturday, 26 October 2019, the first four entries in the logbook are signed by Mr Banat and then an entry is signed by Mr McLean. As Mr McLean did not work at weekends he must have completed the latter job on his return to work thereafter. These four entries were unconnected to Room 211.

[50] However, of even date, only 16 days after the previous complaint, there is a complaint logged, "SHOWER TOO HOT", relative to Room 211. This is again not attributed to a named person. Unlike all other entries from that date, again, the "Job Done" column has not been signed as having been completed, and there are no further comments.

[51] Mr McLean has no recollection of these .complaints relative to Room 211. He was not therefore able to advise the inquiry what action, if any, was taken in relation to these entries. Mr McLean volunteered that the entries had not been signed off because the jobs had deliberately been left open to monitor the situation or the maintenance operative had simply forgotten to complete the entry.

[52] The hotel maintenance system was such that Mr McLean readily accepted that on 26 October 2019 he may not have looked as far back as the 10 October 2019 to the similar issue which had also not been signed off relative to Room 211. This was even though he may have left the job "open" in case a further similar issue was thereafter reported.

[53] Mr Stanton checked the logbook "periodically". However, there was no formal analysis of these numerous guest complaints about the discharge of excessively hot

water in what was predominantly the ten older bathrooms awaiting upgrade, including repeatedly in Room 211. There was no immediate and full consideration of the safety issues arising therefrom, and the identification and, reduction or elimination, of the relative risks from scalding.

[54] Mr Stanton candidly conceded that he had not considered that there was a risk that a death could occur from scalding as there had only been "two or three" minor scalding incidents in the previous 20 years he had been working at the hotel.

[55] Mr Stanton attributed the repeated failures to sign these complaints as having been completed, to Mr McLean being busy. Mr Stanton considered Mr McLean's general performance to be satisfactory and saw no need to micromanage him. In Mr McLean's personnel file from 2016, it was however noted in his performance appraisal that he sometimes needed to be reminded to complete the maintenance log.

[56] Neither Mr McLean nor Mr Stanton had identified any need for an immediate and full consideration of the safety issues arising from these repeated, recent and continuing complaints about excessive water temperatures in these older bathrooms including Room 211, or the said ongoing unrecorded difficulties being experienced by other guests in simply operating the taps. The hotel had taken no consequential steps to reduce or eliminate the risk to guests from being scalded by such water. Despite these repeated issues with guest's operation of the older sanitary ware and regulation of the temperature of the water in these older bathrooms, including Room 211, the hotel did not at any time instruct a qualified plumber to investigate and report on whether there was a defect or defects with the taps which could explain these repeated issues.

[57] The hotel proceeded on the assumption that such repeated issues were simply the result of user error, without properly considering if the taps and their components were operating correctly and fit for purpose.

[58] A maintenance system which was so informal that from the logbook and with the lack of recollection of Mr McLean it is now unknown what consideration was given to these repeated operative and excessive water temperature issues, and if so, what had been completed, without any apparent analysis of the risks associated with these repeated complaints, namely the scalding of guests, was patently defective.

[59] In his current maintenance role Mr McLean uses an electronic maintenance log system which continuously highlights open jobs until they are signed off as having been completed.

[60] On 10 October 2019, a Claire Robertson occupied Room 211. She had not experienced any problems with the temperature control for the shower.

[61] On 26 October 2019, a Mr and Mrs Whelan occupied Room 211. They did not have any issues with the shower or bath taps being too hot.

[62] From 16 to 19 November 2019, a Neil Jack, occupied Room 211. He had used the shower every morning and could not recall having had any issues with it or the water temperature.

[63] On 19 November 2019, a William Collins, occupied Room 211. He had not used the bath or shower during his stay and had no issues with the water temperature.

[64] On 20 November 2019, a Donald Nicolson and his wife, occupied Room 211. He could not recall having any issues with the water temperature or water temperature control for the shower or bath taps within the bathroom.

[65] However, on 21 November 2019, a Victoria Nicholson ("Mrs Nicholson") and her husband, occupied Room 211. She saw the laminated signs in the bathroom, one advising how to work the shower and one at the hand basin, warning of hot water. She washed her hands at the sink (*cf* bath).

[66] Mrs Nicholson required to alternate between the hot and cold taps because the water was so hot and "scalding". When she used the shower, she struggled to get the temperature right and had a cooler shower than usual because the hot setting was too hot.

[67] Mrs Nicolson left the shower running for her husband to use because she did not want him to have the same problems she had. Unless she was careful with the shower, the water could have "scalded" her. The water temperature was so hot that she described it as "boiling".

[68] From 22 to 24 November 2019, a Mr and Mrs C & I Morris occupied Room 211 as guests. Police Scotland have been unable to trace them.

[69] From 24 to 25 November 2019, Room 211 was not occupied.

[70] From 25 to 29 November 2019, a Peter Barron and his partner occupied Room 211 as guests. He also had noticed that the hot water tap at the bathtub was "quite hot". He observed a sign at the hand basin, reading "beware of the hot water" or something

similar. He had one or two baths. He nor his partner otherwise experienced any issues with the shower.

[71] On Friday, 29 November 2019, a Mr Aitken and his spouse also arrived at the hotel. They were allocated Room 111 which was immediately below Room 211. This was also one of the ten bathrooms in the hotel still to be upgraded.

[72] Of even date, Mr and Mrs Hunter arrived at the hotel. Mr Hunter was by then retired. Mr Hunter ordinarily resided with Mrs Hunter in Eaglesham, as detailed above.

[73] Mr and Mrs Hunter were allocated Room 211. This remained one of the ten bathrooms with older sanitary ware in the hotel which were still to be upgraded, as detailed above.

Events of 1 December 2019

[74] In the morning of 1 December 2019, Mr Hunter indicated to Mrs Hunter that he was going to have a shower. Mrs Hunter was packing their luggage as they were due to leave the hotel that day.

[75] At or about 0730 hours, Mr Hunter entered the en suite bathroom of Room 211. He locked the door. Despite having indicated that he was to have a shower, for some unknown reason Mr Hunter then ran a bath.

[76] It is reasonable to infer that Mr Hunter then got into the bath when the water was at a safe temperature, as it is inherently unlikely that Mr Hunter would have stepped into and remained submerged in scalding water, there having been no sounds emanating from the bathroom to indicate that he had done so.

[77] It is, therefore, also reasonable to infer that Mr Hunter allowed the water to continue to run once he had got into the bath to bring the water up to a desired level and/or temperature as (i) he had not been in the bathroom for any particularly significant period that would make it likely that he would require to top up the bathwater temperature; and (ii) had the bath reached the desired level, there would have been no requirement for further water to have been dispersed from the tap.

[78] Having done so Mr Hunter was then unable to turn off the bath tap.

[79] It is again reasonable to infer that Mr Hunter, particularly with the mild cognitive impairment which affected his use of technology, had likewise found the bath tap difficult to operate at a safe temperature, as had been the experience of the said other guests as detailed above.

[80] It is reasonable to infer that the water flowing from the tap increased the temperature of the bathwater to a scalding temperature while Mr Hunter was in the bath. Why Mr Hunter was not able to get out of the bath is unknown.

[81] The water continued to be dispersed from the tap with the result that the water overflowed from the bath and ran down to the walls in the bathroom of Room 111 below.

[82] Meanwhile, in the bathroom of Room 111 below, Mr Aitken had noticed hot water running down the bathroom mirror from the ceiling above. He telephoned the Night Porter, Ms Cespedes, and reported this. Ms Cespedes attended at Room 111 and provided Mr Aitken with the use of another bathroom. She then returned to the hotel

reception and consulted the hotel layout plans and identified Room 211 as being the room above Room 111.

[83] Ms Cespedes then telephoned Mrs Hunter to advise that there was water coming through the ceiling of the room below. Mrs Hunter indicated to Ms Cespedes that all was well, without realising that it was not. Ms Cespedes looked around the hotel endeavouring to ascertain where the water coming into Room 111 was coming from, but without success.

[84] Mr Hunter then told Mrs Hunter through the bathroom door that he was not able to get out of the bath or turn the tap off. Mrs Hunter telephoned Ms Cespedes and indicated to her that Mr Hunter was stuck in the bathroom.

[85] Together with other hotel guests, Ms Cespedes attended at Room 211 and tried to break into the locked bathroom.

[86] Mr Aitken on hearing banging also went upstairs to Room 211 to assist. He unsuccessfully attempted to break through the bathroom door using a fire extinguisher and small crowbar.

[87] All attempts to break into the bathroom were unsuccessful as the door jambs prevented the door from being easily broken inwards.

[88] Initially Mr Hunter was heard by Ms Cespedes although she could not hear what he was saying. Mr Hunter was therefore still conscious at this time. Mr Hunter however then became silent.

[89] Mrs Hunter indicated to Ms Cespedes that Mr Hunter was suffering from dementia. This was an inadvertent misdescription by Mrs Hunter of Mr Hunter's mild

cognitive impairment, it being factually inaccurate that Mr Hunter had dementia, as detailed above.

[90] Ms Cespedes urged Mrs Hunter to call the emergency services, although Mrs Hunter was not eager to do so, probably not fully appreciating the seriousness of the situation and naturally not wishing to be an unnecessary burden on the emergency services.

[91] At or about 0748 hours, the Scottish Fire and Rescue Service (SFRS) received a call from the night porter seeking their assistance in accessing the bathroom.

[92] At 0750 hours Police Scotland received a call from an Alice Bates, who was also a guest at the hotel. She reported that a male was locked in the bathroom of Room 211, and that no one could get into it.

[93] At or about 0800 hours SFRS firefighters and then officers of Police Scotland arrived at the hotel. After a short time, the SFRS firefighters succeeded in breaking into the bathroom. The police officers entered the bathroom and found Mr Hunter in the bath, with his feet towards the tap. He was unresponsive.

[94] The bath was still running and therefore overflowing with scalding water. The firefighters and police officers were required to wear gloves to tolerate the water temperature.

[95] Police Constable David Petrie attempted to pull the bathplug out of the plughole. The plug chain came away from the plug. Constable Petrie had to remove his hand from the water, before then succeeding in removing the plug, draining the water.

[96] Mr Hunter was removed from the bath by SFRS officers and taken into the bedroom. The SFRS firefighters and Police Scotland officers unsuccessfully attempted cardiopulmonary resuscitation ("CPR") of Mr Hunter.

[97] At or about 0808 hours the Scottish Ambulance Service personnel arrived at the hotel and took over these attempts at CPR and endeavoured to provide medical assistance to Mr Hunter.

[98] At 0831 hours Mr Hunter's life was pronounced extinct by the Scottish Ambulance Service personnel.

Cause of death

[99] On 5 December 2019, following a post-mortem examination by pathologist Dr Helen Brownlee, the cause of Mr Hunter's death was found to be:

1a Scalding to torso and limbs

1b Immersion in bath

2 Atherosclerotic and valvular heart disease

[100] Mr Hunter had suffered extensive, full-thickness scalding type burns covering approximately 83% of the skin surface only sparing his head, left upper chest wall, shoulders, outer aspect of his upper arm, buttocks where they were in contact with the base of the bath, and his left shin.

[101] From this widespread scalding, Mr Hunter had experienced cardiovascular shock and circulatory collapse. This caused acute cardiac failure, loss of functional blood pressure (hypotension) and cardiac arrest.

[102] Burns involving more than sixty per cent of the body's surface area are usually fatal in the elderly. This prognosis is further impacted by co-morbidity factors such as cardiovascular diseases, for instance the atherosclerotic and valvular heart disease which Mr Hunter had.

[103] As the temperature of water increases above 50°C, the duration of exposure needed to suffer third-degree burns decreases rapidly.

[104] Healthy adult skin requires 30 seconds of exposure to water at 54°C – 55°C before third-degree burning occurs; only 5 seconds at 60°C and less than 1 second at 70°C.

[105] The skin of children and the elderly is more sensitive to extreme temperatures than that of healthy adults (The Building Research Establishment 2003 report entitled "*Preventing Hot Water Scalding in Bathrooms: Using TMVs*") ("the BRE Report").

[106] There is, however, no specific information as to the temperature of the bath water other than that it was "scalding".

Plumbing system at the hotel

[107] There are two hot water boilers on the ground floor of the hotel. The cold water storage tanks are in the loft space. Both Rooms 211 and 111 are fed by a single hot water supply pipe from these boilers, which pipe feeds no other rooms.

Legionnaires' disease v safe water temperatures

[108] The Building (Scotland) Regulations 2004 ("the Building Regulations") and relative *Building Standards Technical Handbook – Non-Domestic 2020* ("the Building Guidance") were not applicable to the sanitary facilities in the bathroom of Room 211 as these were installed prior to these regulations coming into force. Such does not, however, prevent an inquiry considering modern best practice as detailed therein for the purposes of making findings and recommendations in these proceedings.

[109] Regulation 4.9 of the Building Regulations 2004 provides that:

> "Every building must be designed and constructed in such a way for the protection of the people in, and around, the building from the danger of severe burns or scalds from the discharge of steam or hot water".

[110] Paragraph 4.9.5 of the Building Guidance (which contains non-mandatory guidance on how to comply with the Building Regulations) provides that:

> "to prevent the development of Legionella or similar pathogens, hot water within a storage vessel should be stored at a temperature of not less than 60ºC and distributed at a temperature of not less than 55ºC [in healthcare premises] …
>
> If water is supplied at high temperature from any source, there is a danger of scalding to building users. Risk of severe injury increases proportionally with increase in temperature and with extent of contact.
>
> Facilities used for personal hygiene - to prevent scalding, the temperature of hot water, at point of delivery to a bath, shower or bidet, should be limited.
>
> A device or system limiting water temperature should not compromise the principal means of providing protection from the risk of legionella. It should allow flexibility in setting of a delivery temperature, up to a maximum of 48ºC, in a form that is not easily altered by building users … [that is users should have to make a conscious effort to raise the temperature to 48°C].

> Where both hot and cold water are supplied to a facility, the above may be achieved, for single or limited outlet applications, by use of a thermostatic mixing valve or fitting (TMV) complying with BS EN 1111: 1999 or BS EN 1287: 1999, fitted as close to the point of delivery as practicable."

[111] The NHS Estates "'*Safe hot water and surface temperatures – Health Guidance Note*" recommends a maximum set hot water temperature of 44°C for bath fills (as does the Thermostatic Mixing Valve Manufacturers Association's "*Recommended Code of Practice for Safe Water Temperatures*" paragraph 3.1.1 for unassisted bath fills), and 41°C for showers. Temperatures above 44°C should only be considered in exceptional circumstances where there are difficulties in achieving an adequate bathing temperature such as with cast iron bath from which heat is lost quickly.

[112] Legionnaires' disease is however a potentially very serious lung infection caused by inhaling tiny droplets of water containing the bacteria legionella.

[113] To prevent the development of the bacteria or similar pathogens, it is recommended, that hot water temperatures should be:

a. not less than 60°C in all storage vessels, such as the said boilers; and

b. not less than 50°C when distributed to the furthest outlet, such as the taps towards the end of the said supply pipe to Rooms 111 and 211.

(*HSG274 Legionnaires' disease – Technical guidance - Part 2: The Control of legionella in hot and cold-water systems* ("HSG274") – paragraph 2.82)

[114] However, to prevent severe burns or scalds to users, it is recommended that hot water temperatures from taps within bathrooms should be limited to what is considered a safe temperature of at or about 38°C, with a user having the ability to choose to

discharge water at higher temperatures of up to at or about 48°C by depressing a safety button.

[115] Accordingly, the hottest safe temperature of bath water should ordinarily be at or about 38° to 44°C, or on a user choosing to depress the safety button, at or about 48°C. This latter figure of 48°C is however not considered to be a safe bathing temperature, as detailed above.

[116] Discharging bath water at 48°C could be appropriate, for example, when filling a metal bath or in a cold bathroom, where the water would more rapidly lose its temperature as compared to standard porcelain sanitary ware, all as detailed above.

[117] For most people, the risk of scalding by bath water is low, although the consequences can be, as in this instance, fatal. However, any risk assessment should take account of susceptible "at risk" people including young children, people who are disabled or elderly and those with sensory loss, for whom the risk is greater (*HSG274* – paragraph 2.6).

[118] An effective way of meeting these competing objectives is, therefore, to store and distribute water at high temperatures yet preserve user safety from scalding by having safety components in the tap. These components include a temperature dial, safety button and/or a TMV as part of the tap which, if operating correctly, can discharge and maintain the outlet water at a safe temperature for bathing.

[119] The temperature of the water discharged from a tap would therefore be determined firstly, by the user turning the temperature dial to the desired temperature. The temperature dial should move the whole shuttle assembly inside the tap closer to or

further from the hot water inlet, to further open or close that inlet, thereby increasing or reducing the flow of hot water into the mix with the cold water and so increasing or reducing the overall temperature of the water flowing from the tap to achieve the set temperature.

[120] The additional protection of a safety button has already been described earlier.

[121] Although not mandatory, as detailed above, suggested best practice for a hotel is to have the further protection of a TMV2. This operates to maintain outlet temperatures at a chosen safe temperature, such as 38°C, again as detailed above.

[122] However, a TMV2 will also permit higher water temperatures to be discharged if selected, as contrasted with the more restricted TMV3 used in schools and healthcare settings, such as hospitals or care homes (*Guidance to the Water Regulations (*G18.5*); Thermostatic mixer valve application table* – in "the BRE Report"*;* and *HSG274* - Info box 2.3: Thermostatic mixing valves).

[123] A TMV2 operates by a thermally sensitive mechanism within the TMV2 that proportions the amount of hot and cold water entering the tap to produce the required blend of hot and cold water. The mechanism should then automatically compensate for any variations in supply pressures or temperatures and safely maintain the water at the pre-selected temperature. The temperature sensitive wax element or thermostat in the TMV2 should expand or contract depending on the temperature of the water surrounding it. When the thermostat senses a temperature change, it moves a shuttle assembly which changes the proportion of hot and cold water being mixed in the valve.

[124] This movement enables the valve to remain stable and to shut down in case of cold or hot water failure and to prevent the discharge of dangerously hot water.

[125] It is recommended that a TMV2 is tested once a year to check its performance has not changed from the time of installation using the following performance checks:

a. measuring the mixed water temperature;

b. carrying out the cold failsafe shut-off test by isolating the cold-water supply to the TMV2 and waiting for 5 seconds; if water is still flowing, checking that the temperature is below 46°C (*cf* 48°C mentioned earlier) [That being the recommended absolute maximum as opposed to a safe recommended bathing temperature].

c. If there is no significant change to the set outlet temperature (2°C or less change from the original settings) and the failsafe shut off is functioning, the valve is working correctly, and no further service work is required.

d. If the outlet water temperature has drifted from its set point by more than 2°C or if the failsafe function does not work, a full service and recommissioning of the valve is required (*Maintaining the TMV - the BRE Report*).

[126] If an issue is identified with a TMV's operation, then a qualified plumber would ordinarily be required to rectify this.

Risk assessments

[127] H2H prepared and audited compliance with Specialist Leisure's "*Water Systems Policy*". They also provided health and safety services including policy development, risk assessment, training and audit services to Specialist Leisure across the UK and therefore to the hotel.

[128] The hotel carried out risk assessments on 14 February 2018 and 6 March 2019. Scalding was rated as "frequent, often or likely to occur" with the severity of the consequences being assessed as an "over three-day injury, moderate damage or loss to property, equipment, profit or the environment".

[129] Accordingly, control measures were put in place to mitigate the risk of scalding. These were:

a. signs above the wash hand basins warning of hot water;

b. user instructions in guest bathrooms for showers; and

c. thermostats in showers which prevented water temperatures of higher than 60°C.

[130] However, the hotel's priority was to control legionnaires. Accordingly, the target temperature for hot water outlets was between at or about 50°C and 55°C, and the hotel's boilers were set up accordingly.

[131] Occasionally the hotel would identify a hot water outlet temperature of less than 49°C or at other times temperatures of 57°C or 59°C, the latter temperatures being capable of causing severe burns to a bather in a short space of time, as detailed above.

The hotel would then try and remedy this to their target temperature range by adjustment of the boilers' temperature.

[132] On hot water temperature checks in October 2018 and October 2019 in Room 211, the temperature was recorded as being 59°C and 50°C respectively.

[133] When the temperature was at 59°C the hotel would retest on another day to ensure it had fallen "in line" with the targeted 50°C to 55°C temperature.

[134] As stated in the Specialist Leisure "*Water Systems Policy*":

> "Although the number of confirmed cases of legionnaires disease and other similar illnesses remain relatively low, the high mortality rate amongst susceptible individuals is such that the control of legionnaires is a real consideration in hotels, especially those that accommodate more elderly persons than normal".

[135] H2H carried out the risk assessments for legionella and fire. For other general risk assessments, the hotel would carry these out with direction from H2H in the form of templates, examples and general guidance, as required. In addition, where specific issues were drawn to the attention of H2H they would assist by drawing up a risk assessment, if necessary. In the few years prior to 2019 the hotel generally scored very well across the board in health and safety audits carried out by H2H.

[136] However, in safety audits between 2018 and 2019, one recurring theme was that outlet water temperatures were considered by the hotel and H2H to be too low on occasions for the purposes of reducing the risks from legionella, as detailed above.

[137] Accordingly, the hotel and H2H considered that the risk of legionella developing within the water system and then being spread throughout water outlets within the hotel, particularly shower outlets where the spray created would increase the risk of

inhalation with potentially fatal consequences, to be a greater priority than the risk of a tap user encountering excessively hot water and sustaining a burn or scald injury.

[138] To monitor the risk of legionella, the temperatures at the first and last tap drawing water from the boilers were also measured monthly by Mr McLean. The hotel's aim was for the hot water to be at a temperature of 50°C or above after 1 minute, as detailed above, and for the cold water to run at a temperature of 20°C or less after 2 minutes.

Bath tap in Room 211

[139] The bath tap in Room 211 was manufactured in or around 1987. Despite this, the tap had all of the said safety features *viz* a temperature dial, safety button and TMV2. As such it was designed to safely discharge water at a pre-determined safe temperature.

[140] These older style taps were used by guests to either fill the bath or supply the showerhead; for the latter the tap was connected by a flexible hose to the showerhead which was fitted above the end of the bath.

[141] The tap had three controls. The left-hand control when facing the tap, directed water to the shower, the right-hand control discharged water into the bath, and the temperature dial in the middle determined the water temperature, as detailed above.

[142] The temperature dial had a marked scale of between 30°C and 50°C. In fact, the tap had a potential operating range of between 20°C to 60°C as there were unmarked areas below and above that scale.

[143] The water temperature from the bath tap in Room 211 should, therefore, have been capable of being determined and maintained by the guest simply rotating the temperature dial to the desired temperature, if it were operating correctly.

[144] The safety button should then have restricted the temperature of the bath water to at or about 38°C, unless the guest chose to depress it, to obtain a higher temperature, as detailed above.

[145] The internal TMV2 should then have controlled the mix of the hot and cold-water supply at the point of use, thereby producing and maintaining the water temperature which had been selected by the guest on the temperature dial, even if there was a change in the temperature or pressure of the water, for example by another bathroom using the same supply or for some other reason a hot or cold water failure as guests had previously complained of.

[146] If operating correctly, the TMV2 should have maintained the selected water temperature or simply shut off the discharge of dangerously hot water.

[147] Whilst there were marks of unknown origin on the end covers of the check valves on the tap, these end covers would not need to have been removed to service the tap as access would have been gained from the front of the tap unit. There was no persuasive evidence to indicate that the bath tap in Room 211 or its said safety components had ever been serviced in the at or about three decades since their manufacture, despite annual servicing of a TMV being recommended as detailed above.

Temperature dial

[148] On 10 December 2019, the temperature dial of the Room 211 tap was inspected by Mr Dodd, HSE Specialist Inspector of Mechanical Engineering.

[149] The temperature dial was set at 50°C. However, in police photographs taken at some stage on 1 December 2019, the temperature dial is shown as set at 41°C. It is unclear if the temperature dial had altered between Mr Hunter using the tap and the police photographing it, and unexplained as to how the temperature dial came to be thereafter altered to 50°C.

[150] Mr Dodd could only rotate the temperature dial upwards from the 50°C scale to the unmarked maximum. He could not rotate the temperature dial lower than the 50°C scale marking as the dial was too stiff to do so.

[151] On testing, with the water flowing from the tap at just less than full flow, the water temperature was 49.6°C with the temperature selector aligned just below the 50°C mark on the scale. After turning the temperature selector to the unmarked upper end of its scale a marginally lower water temperature of 49.2°C was then measured.

[152] Shortly thereafter, the tap was inspected by Mr Mansell, Mechanical Engineer in the Major Hazards Capability Group, which is part of the HSE Science Division. Mr Mansell also found the temperature dial to be excessively stiff.

[153] It is reasonable to infer, based on the proximity in time of such inspections and the events of 1 December 2019 and the prior difficulties which other guests had in operating the tap to attain a desired temperature referred to above, that this excessively

stiff temperature dial had also likewise made it difficult for Mr Hunter to select and maintain the water being discharged into the bath at a safe bathing temperature.

[154] There was no misalignment of the spindle for the temperature dial to explain this stiffness. In the absence of other identifiable reasons, the most probable cause of the stiffness was corrosion of its relative parts, which was unsurprising standing the absence of any evidence that the tap had ever been serviced in decades.

[155] Even then, on further testing, the temperature dial was also found to be too sensitive to movement for a user to easily choose a specific temperature. Mr Mansell was accordingly unable to accurately plot formal graphs for the sensitivity and fidelity tests he performed.

[156] The tap failed a sensitivity test, as small adjustments of the temperature dial resulted in disproportionately large temperature adjustments, consistent with the issues guests were previously having as detailed above. Accordingly, fine motor control was required to achieve a desired temperature which Mr McLean and Mr Stanton may have mastered over time and thus their attributing the issues to user error.

[157] However, the tap also failed a fidelity test, as there was insufficient consistency in temperature when turning the dial past 38°C in either direction.

[158] At a selected temperature of 40°C the hot water valve closed and water output was at 16°C (composed of only cold water) while at a selected temperature of 50°C the cold water valve was closed, and the water output was at 50°C (composed of only hot water). It was extremely difficult to achieve a "happy medium" water temperature,

again entirely consistent with the complaints and experiences of some of the said guests as detailed above.

[159] The tap also failed the cold-water supply failure test at all selected temperatures other than 17.5°C. This meant that in the event of a cold-water supply failure, the hot water was not isolated and excessive hot water was able to enter the outlet. At 17.5°C the valve was able to shut off the hot water supply because it was almost closed already.

[160] The tap also failed the pressure variation test which meant that the valve was unable to effectively respond to changes in pressure.

[161] It is reasonable to infer, based on the proximity in time of such inspections and the events of 1 December 2019 and the prior difficulties which other guests had in operating the tap to attain a desired temperature as detailed above, that the tap would have similarly repeatedly failed all such tests as of 1 December 2019 and was unfit for purpose at that time.

Safety override button

[162] There was a notice on the bathroom wall of Room 211 explaining how to operate the mixer tap and explaining that to select a higher temperature than 38°C the small red safety button should be pressed in and held whilst rotating the water temperature control to that higher temperature.

[163] However, on inspection by Mr Dodd and Mr Mansell the safety button was stuck in the depressed override position.

[164] It is again reasonable to infer, based on the proximity in time of such inspections and the events of 1 December 2019 and the prior difficulties which other guests had in operating the tap to attain a desired temperature referred to above, that the safety button had become stuck in the depressed override position a significant time before 1 December 2019. This is consistent with the build-up of residue found around the side of the safety button at the level where it had become stuck in this position.

[165] This also deprived Mr Hunter of this safety mechanism by making the safety button ineffective in preventing Mr Hunter from unwittingly discharging scalding water into the bath above a safe bathing temperature of 38°C.

TMV2

[166] As detailed above, the TMV2 should then have maintained the pre-set temperatures, even if the water pressure or temperature had varied when other appliances on the water network may have used the supply or if there was otherwise a failure of the hot or cold water supply.

[167] The TMV2 in Room 211 was so dated that it was manufactured prior to the creation of TMV standards (eg *BS EN 1111: 1999 Sanitary tapware – thermostatic mixing valves PN10 – General technical specification: BS EN 1287: 1999 Sanitary tapware- Low pressure thermostatic mixing valves – General technical specifications*).

[168] It was accordingly never likely that this TMV was ever certified on the NSF International Register (a globally recognised organisation for public health standards).

[169] Mr Mansell used tomography; a technique used to create detailed, cross-sectional images of the internal structures of the object using penetrating waves to create a 3D image of the internal components of the TMV. The wax element of the TMV was not as Mr Mansell would have expected it to appear.

[170] The wax element of the TMV2 was tested alongside two new TMV2 wax elements of different sizes (not identical as the wax element in the Room 211 bath tap is no longer manufactured). While these new wax elements varied in size compared to each other and compared to the wax element in the Room 211 bath tap, all three should have operated in similar way as detailed above.

[171] Each wax element was tested in the same way, being measured, then submerged into boiling water for 5 minutes, then removed and re-measured, then submerged into cold water, and then removed and measured for a third time.

[172] The wax element in the Room 211 TMV2 measured 58.02mm at outset, increased by 0.1mm (0.17%) when submerged in boiling water and then after being returned to cold water, retracted to 50.06mm.

[173] The shorter of the two new wax elements measured 42.92mm at the outset, increased by 1.27mm (2.96%) when submerged in boiling water and then after being returned to cold water, retracted to 43.24mm.

[174] The other new wax element measured 60.76mm at outset, increased by 2.47mm (4.07%) when submerged in boiling water and then after being returned to cold water retracted to 60.26mm.

[175] Comparatively, the wax element in the Room 211 TMV2 had only a very slight reaction to the water temperature changes. When the wax element in the Room 211 TMV2 was compressed from end to end, there was very little "give", when compared to the two new elements purchased for comparison purposes. The wax element in the Room 211 TMV2 had collapsed and become essentially inactive. It is reasonable to infer that this was due to a negative pressure arising inside the casing over time, the same not having never been replaced during recommended annual servicing.

[176] This wax element had the appearance of having solidified and having been "crimped" as if someone had physically squeezed it with a tool at some time. However, it was more probable than not that the wax substance within the element had evaporated or deteriorated with age, as detailed above.

[177] If the wax element had been damaged by a tool one might have expected some evidence of repairs or an immediately obvious cessation of the operation of the same, of which there was no persuasive evidence.

[178] In the absence of any evidence of the wax element ever being serviced, it is reasonable to infer that the failure to service it annually as recommended, or at all, over more than three decades, had caused it to become ineffective. From the said complaints from guests prior to 1 December 2019, it is reasonable to infer that the wax element in the Room 211 TMV2 had already failed for some time previously. It is also of note that the measured temperature of the tap water in the October 2018 audit was as high as 59°C, which should not have occurred if the TMV2 was limiting the temperature to a safe limit of at or about 50°C.

[179] It is reasonable to infer, based on the proximity in time of such inspections and the events of 1 December 2019 and the prior difficulties which other guests had in operating the tap to attain a desired safe temperature referred to above, that the wax element in the Room 211 TMV2 was not elongating and contracting in a manner which would allow it to perform its function of safely maintaining the water temperature within the taps as it was designed to do, when Mr Hunter was using the tap.

[180] As of 1 December 2019, although some bathrooms had been upgraded with newer sanitary ware, the older taps as in Room 211 had not been replaced because of the size of the hotel, the number of other matters that required to be dealt with, and the relative cost. However, all these older taps have now been replaced.

[181] Additionally, the hotel legionella risk assessment forms used for the legionella audit, have since 2019 been updated to include specific reference to maintenance of the TMVs.

Bathroom door lock

[182] The bathroom door in Room 211 was hung to open outwards, from the bathroom into the bedroom. There was a slip bolt on the inside of the door.

[183] In or about 2018 a person had fallen in a bathroom in the hotel. They had been trapped behind the door, causing difficulties in assisting them. If the door in Room 211 had opened inwards to the bathroom this could have presented a similar issue if someone became stuck immediately behind the door.

[184] Accordingly, there is no issue with the door opening outwards into the bedroom *per se*.

[185] Standard 3.12 in schedule 5 of the Building Regulations provides that:

> "Every building must be designed and constructed in such a way that sanitary facilities are provided for all occupants of, and visitors to, the building in a form that allows convenience of use and that there is no threat to the health and safety of occupants or visitors".

[186] Paragraph 3.12.6 of the relative Building Guidance states that: "General provisions in all sanitary accommodation **…** a door fitted with a privacy lock should have an emergency release, operable from the outside …"

[187] The slip bolt on the bathroom door did not *de facto* comply with paragraph 3.12.6 of this guidance, as it did not have an emergency release, operable from the bedroom to allow for emergency access.

[188] As stated above the Building Regulations and relative guidance are not applicable to the sanitary facilities in the bathroom of Room 211 as these were installed prior to these coming into force.

[189] However, again, such does not prevent an inquiry considering modern best practice as detailed therein for the purposes of making findings and recommendations in these proceedings.

Submissions

Crown

Time and place of death and accident, and cause of death

[190] There was no substantive dispute as to the findings to be made in terms of section 26(2)(a), (b) and (c) of the Act.

Cause of accident

[191] In terms of section 26(2)(d) of the Act, the immediate cause of the accident resulting in the death was the failure of the TMV2.

Reasonable precautions

[192] The Crown referred to Ian HB Carmichael, *Sudden Death and Fatal Accidents Inquiries* (2nd Ed, W Green, 1993), paragraph 5.53 mentioned below; Sheriff AC Normand's determination relative the *Inquiry into the death of Ian Loudon*, dated 14 December 2015, paragraph 7.22 mentioned below; and the decision in *Fraser Sutherland,* mentioned below.

[193] In terms of section 26(2)(e) of the Act, if, following the two complaints in October 2019 concerning the shower temperature in Room 211, a plumber had been called in to examine the bath tap in Room 211, its condition would have been discovered, and it would have been repaired or replaced.

[194] The lack of sensitivity of the TMV and the stiffness of the temperature dial and consequent difficulties in achieving a safe blend of hot and cold water was the real cause

of the guests experiencing hot water issues and not user error. It can be reasonably inferred that Mr McLean's familiarity with the bath tap enabled him to operate the defective temperature dial and TMV with significantly more acuity than a hotel guest would have been able to.

[195] Mr McLean's limited understanding of plumbing matters prevented him from appreciating that the tap was defective. It was reasonable to have expected the precaution that the multiple guest complaints about the excessively hot water in guest bathrooms – almost all of which had old TMV units - would have been formally reported to and/or there to have been other oversight by Mr Stanton of such (for example formal daily checks of the maintenance log), with immediate and full consideration of all safety issues arising therefrom.

[196] There should have been the identification and reduction or elimination of the relative risks, without any preconceived misapprehension as to the potential for fatal consequences arising therefrom.

[197] Where there was a TMV fitted, this should have been in working order and allowed Mr Hunter not only to select the temperature of his choice but also protect him from being exposed to excessively hot water resulting from fluctuations in water supply or pressure.

[198] It would have been a reasonable precaution, whereby Mr Hunter's death might realistically have been prevented, for the hotel to have contracted a plumber following the two complaints in October 2019 to examine the bath tap and carry out repairs or replacement as required.

[199] In addition, had the TMV in Room 211 been regularly serviced by a suitably qualified person, its condition would have been discovered, and it would have been repaired or replaced.

[200] The control of legionella in hotel premises requires that TMVs should be regularly serviced. Accordingly, this requirement should have been a feature of the risk assessment drawn up by H2H for the hotel [as it is now].

[201] Whilst this precaution would not itself have been aimed at the prevention of scalding, it would have had that effect by virtue of ensuring that TMVs were regularly maintained.

[202] It would have been a reasonable precaution, whereby the death of Mr Hunter might have been prevented, for the hotel to include reference to maintenance of TMVs in its legionella risk assessment and to have audited the hotel against that entry.

[203] Had the bathroom door lock in Room 211 been accessible from the outside of the door, efforts to rescue Mr Hunter after it became evident that he was in difficulty would have stood a much greater chance of success. There were equal arguments for and against the direction of the door opening inwards or outwards. The real issue was in relation to the expediency of rescuing Mr Hunter after he had become incapacitated in the bathroom by there being accessibility to any lock from the outside of the door.

[204] While it would have been a reasonable precaution to have fitted the bathroom door with such a lock, there was insufficient evidence about the effect that such a precaution might have had on Mr Hunter's survival, to make a submission under section 26(2)(e) of the Act. In terms of the realistic possibility test, and in view of the

speed with which any scalding injury would have become fatal, it is simply not possible to state whether earlier rescue would have had any effect.

Defects in system of working

[205] The Crown referred to Sheriff Kearney's determination of 17 January 1986, in the *Inquiry into the death of James McAlpine*, mentioned below.

[206] It was submitted that a defect may, on the balance of probabilities, cause the death; or it may, on balance of probabilities, contribute to the death. To contribute to something simply means "to help to cause or bring about". This might, in real terms, involve reducing the chances of survival of a person who was already on the balance of probabilities not likely to survive.

[207] While the Crown accepted that a *de minimis* contribution would not meet that required, it was submitted that a finding in terms of section 26(2)(f) of the Act does not require a defect in a system of working to be the main cause of death or even the major contributor to death.

[208] It was suggested that it was reasonable that a finding in terms of section 26(2)(f) of the Act could be made in respect of a person who had a less than 50% chance of survival at the outset. To suggest otherwise would not, it was submitted, be in keeping with the spirit of the legislation. The Crown submitted that in terms of section 26(2)(f) of the Act, the hotel maintenance system was vulnerable to failure because there was no effective oversight or quality assurance by management and because it relied to some

extent on Mr McLean remembering what had and had not been completed, with the potential for jobs to be overlooked, or for open entries not to be revisited.

[209] The system was defective in that it did not provide for formal and focused checking or auditing of entries made in the logbook by management, to:

a. reduce or eliminate the risk of open entries being unnoticed or forgotten about;

b. ensure that all entries have been actioned and followed up if necessary; and

c. provide information to management about emerging patterns or themes.

[210] If this had been the case, management might have noticed a pattern of the TMVs in the "old" bathrooms being the subject of regular complaint.

[211] The utilisation of a modern electronic system that would constantly remind of jobs which had not been signed off is of no relevance as there is no evidence that the jobs were in fact overlooked. Rather, a culture prevailed of not taking these hot water complaints seriously.

[212] However, if there had been a formal system of review, the prevailing views of Mr Stanton and Mr McLean that hot water issues were attributable to user error meant that it cannot be stated with any confidence that a more formal or mindful review would have led to action being taken.

[213] It was submitted that it was therefore not possible to link these defects directly to Mr Hunter's death and to state on balance of probabilities that the lack of effective oversight contributed to Mr Hunter's death.

Other factors

[214] While it cannot be said that the lack of effective oversight contributed to Mr Hunter's death, the said defects in the system of working anent the hotel maintenance log if not rectified could lead to future deaths and accordingly it was submitted that a finding should be made in this respect in terms of section 26(2)(g) of the Act.

Protector Insurance

[215] Protector Insurance referred to the passages from the decision in *Fraser Sutherland FRCS* (2017) CSOH 32 and *Karen Duncan* [2024] CSOH 114, mentioned below.

Time and place of death and accident, and cause of death

[216] There was no substantive dispute as to the findings to be made in terms of section 26(2)(a), (b) and (c) of the Act.

Cause of accident

[217] It was ultimately accepted in verbal submissions that, in terms of section 26(2)(d) of the Act, the cause of the accident was the failure of the TMV.

Reasonable precautions

[218] It was submitted that there should be no findings in terms of section 26(2)(e) of the Act.

[219] There was no evidence supporting maintenance which was more frequent than an annual test to check whether the temperature of water flowing through the tap appeared to be in line with the temperature displayed on the temperature dial.

[220] There was no evidence from previous occupants of Room 211 or specific timings from Mr Dodd or Mr Mansell to allow for a conclusion that the temperature dial or override button would have been found to be unduly stiff or stuck in the depressed override position, respectively, on any test or inspection at any time prior to the material date.

[221] The most likely explanation for the two recent complaints in the maintenance log relating to difficulties with the temperature control and for these not being signed to show that they had been dealt with, consistent with other occupants having not complained, is that Mr Banat or Mr McLean attended at Room 211 but were unable to replicate any issue which the complainers had experienced with the water.

[222] While the wax element within the TMV was not fully active and operational at the material date, the experts did not agree on the most likely cause for this.

[223] Mr Dodd indicated that the rubber casing on the wax element had probably been damaged by direct interaction with it, possibly at some point when the valve was being adjusted and that it was doubtful that the inactivity of the wax element was because of ageing, there being limited evidence on how wax reacts to ageing.

[224] Mr Mansell was of the view that ageing was the more likely cause, where the wax element would have gone from being fully effective to being less effective, to being largely ineffective, to being wholly ineffective.

[225] There was no evidence as to when any test or inspection could have identified that the wax element was becoming less effective or had become ineffective.

[226] It is not possible, on the evidence available, to draw a conclusion on how the wax element would have appeared at any date prior to the material date, or what Mr McLean or Mr Banat ought to have expected it to look like, as even Mr Dodd and Mr Mansell were unsure of how the wax element should have looked.

[227] The was no evidence as to whether it was common practice to test or check the temperature of flowing water against the temperature on the dial on an annual basis in a hotel setting, or that Mr Dodd and Mr Mansell's fields of knowledge, experience and expertise would allow them to give an expert view on standard practice within a hotel setting.

[228] Even if such testing would have been a precaution which could reasonably have been taken, it cannot be concluded that there was a lively possibility that this might realistically have prevented the accident or the death of Mr Hunter, as it is not possible to state that an annual inspection carried out at any time prior to the material time would have identified any of these issues with the TMV, as it is not possible on the available evidence to form a conclusion on when these issues came into existence, or were there to be found.

[229] There was no evidence which allows a conclusion that there is a lively possibility that any particular response to the complaints about the water temperature, including taking action to seek the assistance of a plumber, might realistically have prevented the accident or the death of Mr Hunter.

[230] Given the advanced stage which events had reached before any efforts to open the bathroom door began, no conclusion can be drawn that there is a lively possibility that removing or replacing the lock, or altering the hanging of this door, might realistically have prevented the accident or the death of Mr Hunter.

Defects in system of working

[231] There should be no findings in terms of section 26(2)(f) of the Act. For all the reasons with reference to the submissions anent section 26(2)(e) of the Act, there is no evidence to allow a conclusion that there were any defects in any system of working which, as a matter of fact, contributed to the death or any accident resulting in the death of Mr Hunter.

Other factors

[232] With reference to section 26(2)(g) of the Act, there are no other facts relevant to the circumstances of Mr Hunter's death.

Mr McLean

[233] Counsel for Mr McLean made no submissions. For whatever reason Mr McLean's legal aid certificate had been suspended for unknown reasons.

Discussion and conclusions

Time and place of death and accident, and cause of death

[234] As detailed above, other than there being an issue with the timeline (ie if events had started nearer 0645 hours as opposed to 0730 hours) there was no substantive dispute as to the foregoing findings made in terms of section 26(2)(a), (b) and (c) of the Act.

Cause of accident

[235] In terms of section 26(2)(d) of the Act, the cause of the accident resulting in the death of Mr Hunter was a bath tap which was defective. It was defective in having:

(i) an excessively stiff and overly sensitive temperature dial, making it difficult for Mr Hunter to accurately regulate the water being discharged into the bath at a safe temperature;

(ii) a safety button which was stuck in the depressed override position making it ineffective in preventing Mr Hunter from unwittingly discharging scalding water into the bath above a safe bathing temperature of at or about 38°C; and

(iii) a defective TMV, preventing it from mixing the hot and cold water inputs to maintain the water at a safe bathing temperature, particularly in the event of changes to water temperature and pressure, as it was designed to do.

Reasonable precautions

[236] For a finding under section 26(2)(e) of the Act in an inquiry, there need only be a real and lively possibility that a precaution might realistically have avoided the accident or death.

[237] In *Fraser Sutherland*, referred to above, Lord Sutherland stated in paragraph 29 that:

> "It was not in dispute before me that the conduct of an FAI is not a fault finding exercise. It is a process which is entirely separate and is distinct from the determination of any question of civil liability. Thus, reasonable foreseeability is not a relevant consideration. Rather, the aims of the process are to identify the circumstances of the death and, to the extent that it is possible, to inform any subsequent actings with a view to avoiding of such a death in future. Such a process necessarily involves use of the benefit of hindsight, without reference to the state of knowledge at the time of death. Were it otherwise, the utility of the inquiry into the facts, necessarily after the events, would inevitably be undermined"

[238] Lord Sutherland continued at paragraph 31:

> "In determining whether the death might have been avoided by a reasonable precaution, the appropriate test has been described as that of a 'lively possibility' … in considering whether a precaution is reasonable, foreseeability has no part to play. That question falls to be determined with the benefit of hindsight, and a finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the precaution was negligent or unreasonable. Whether or not a precaution was reasonable does not depend on

> foreseeability of risk, or whether at the time the precaution could or should have been recognised".

[239] In *Karen Duncan* [2024] CSOH 114 paras [49] - [50], Lady Haldane considered the following passage from the determination of the now Lord Braid in the *Inquiry into the death of Marian Bellfield*, unreported, 28 April 2011, as instructive:

> "… negligence is not in issue and it is not the function of this inquiry to attribute blame. It is therefore nothing to the point to inquire as to whether what was done was reasonable, and it seems to me to involve a non sequitur to hold that a precaution which was not taken can be held to have been reasonable only if what was done was not reasonable. To take that approach respectfully seems to me to apply the principles and language of negligence, which are irrelevant for the purposes of this Inquiry. I do not see why it is not open to me to hold that, even though what was done was reasonable, other reasonable precautions might also have been taken which might have prevented the death."

[240] Lady Haldane continued:

> "Although that analysis is not binding on me, it encapsulates entirely correctly the proper approach and I respectfully adopt and endorse it having regard to the more expansive language of section 26(2)(e) [of the Act] it is entirely consistent with the language of the statute as now framed."

[241] In Carmichael, paragraph 5.53:

> "Certainty that the accident or the death would have been avoided by the reasonable precautions is not what is required. What is envisaged is not a 'probability', but a real possibility that the death might have been avoided by the reasonable precautions."

[242] In the *Inquiry into the death of Ian Loudon*, at Glasgow Sheriff Court, Sheriff AC Normand, in his determination dated 14 December 2015, considered the matter of reasonable precautions at paragraph 7.22, stating:

> "The test to be applied in considering, for purposes of section 6(1)(c) [now 26(2)(e) of the Act] whether the death 'might have been avoided' is well known and relates to whether there is a 'real and lively possibility' that death might have been avoided by a reasonable precaution or precautions."

[243] In terms of section 26(2)(e) of the Act, the precautions which could reasonably have been taken, and had they been taken:

(i) might realistically have resulted in the death, and the accident resulting in the death, being avoided were:

1. at least annual maintenance of the bath tap and its components;
2. the more formal analysis of guest complaints about the discharge of excessively hot water in the bathrooms, with immediate and full consideration of the safety issues arising therefrom, and the identification and, reduction or elimination, of the relative risks by a qualified plumber, without any preconceived misapprehension as to the potential for fatal consequences arising therefrom; and

(ii) might realistically have resulted in the death being avoided, was the fitting of a bathroom door lock release, operable from the bedroom, to allow for emergency access to the bathroom to remove Mr Hunter from the scalding or to become scalding bathwater.

[244] The first of these precautions is at least annual maintenance of the bath tap and its components as is latterly recommended in the BRE Report. It is reasonable to infer that there was a lively possibility that this maintenance might realistically have prevented the accident and therefore the death of Mr Hunter by averting the bath tap

from becoming defective in the foregoing respects. In that event, there is a lively possibility that the tap with its operative safety components would have prevented the excessively hot water being issued from the bath tap and thereby protected Mr Hunter from being fatally scalded.

[245] Protector Insurance submitted that no findings should be made as it was unknown precisely when the stiffening of the temperature dial, the sticking of the safety button and the failure of the TMV had happened and accordingly whether the recommended annual service would have prevented the accident.

[246] Where it had never been serviced for *prima facie* decades, the tap and particularly its components would as a matter of common sense have been likely to fail in the way it did at any time on or before 1 December 2019, as compared to if the reasonable precaution of it the being serviced annually as recommended had taken place.

[247] If, as here, the tap and its components had never been annually serviced over such an extensive period, it is reasonable to infer that it was *de facto* just a matter of time before the same was likely to fail. Whether these defects arose on the day of the accident or years before is accordingly of limited relevance to the findings in the inquiry.

[248] There was plainly a real and lively possibility that such a precaution might realistically have avoided the safety components of the tap failing in the foregoing three respects and thereby allowed Mr Hunter to accurately control the temperature, prevent it from exceeding the safety override temperature and avoid any fluctuations in the water temperature or pressure from, for example, another bathroom such as Room 111 using the same feed, or otherwise.

[249] The second of these precautions is the more formal analysis of guest complaints about the discharge of excessively hot water in the bathrooms, with immediate and full consideration of the safety issues arising therefrom.

[250] This would reasonably lead to the identification and, reduction or elimination, of the relative risks, without any preconceived misapprehension as to the potential for fatal consequences arising therefrom. Due to the plethora of complaints about these issues of excessively hot water being discharged from the water outlets, particularly in the older bathrooms awaiting upgrading, it is difficult to contemplate a situation where any reasonable system of work would not have recognised a requirement for such analysis to be performed by a qualified plumber and thereafter any necessary maintenance carried out. Even where the risk of these fatal consequences was not recognised, the risk of significant harm from scalding had been recognised by the hotel in its said risk assessments.

[251] There were repeated complaints from guests as to the operation of these older taps and two recent complaints relating specifically to the excessive water temperature in the bathroom of Room 211. Whether the hotel, if it had such a more formal analysis would have been so blinkered in its risk assessment as to remain of the opinion that the issue was one of operator error is essentially irrelevant to the conclusions of this inquiry anent reasonable precautions which could have been taken.

[252] As stated in *Fraser Sutherland FRCS* paragraph 31 mentioned above, whether a precaution was reasonable does not depend on whether the precaution could or should have been recognised by the hotel at the time.

[253] There was therefore a real and lively possibility that this reasonable precaution if properly applied could realistically have identified that the real issue with the tap discharging water at an excessive temperature, resulting in these repeated guest complaints, was the defects with the tap components, and that it was reasonable to have a more formal analysis of these complaints such that they should have been considered by a qualified plumber.

[254] There was equally a lively possibility that a qualified plumber on viewing and testing the tap components (as detailed above) would readily have identified the defects in all the various safety components and advised the hotel to repair or replace the same, allowing these safety features to operate effectively and thereby preventing the accident and death of Mr Hunter. Alternatively, the hotel would have had the option to cease the use of the relative rooms, such was the risk to guests, until finances were available to allow remedial or replacement works to be performed.

[255] Whether a TMV was legally or factually necessary in this hotel setting is of limited relevance in this context. The undisputed fact is that there was a TMV2 in the bath tap. Mr Hunter could therefore have been expected to rely on the same functioning properly.

[256] The third of these precautions is the bathroom door having no lock, or an emergency bathroom door lock release operable from the bedroom, to allow for emergency access.

[257] It was submitted by the Crown that while this would have been a reasonable precaution, there was insufficient evidence about the effect that such a precaution might

have had on Mr Hunter's survival, to make a submission under section 26(2)(e) of the Act.

[258] However, it is this unknown that creates a foundation for the conclusion that there was a real and lively possibility that this precaution might realistically have avoided Mr Hunter's death.

[259] At the time when it was first realised that Mr Hunter was having difficulty in operating the tap, he was conscious and able to describe to Mrs Hunter that he was having these difficulties. He was still conscious and making sounds after Ms Cespedes had come from reception and gone up to the second floor and into Room 211.

[260] In those circumstances, there remains a real and lively possibility that Mr Hunter had not, by the time his difficulties in shutting off the tap had become known to Mrs Hunter, reached the stage yet of his having been subjected to the excessive water temperatures that resulted in his being fatally scalded. It is correct to state that it is not possible to definitively state whether earlier rescue would have resulted in Mr Hunter's survival. However, because it is known that Mr Hunter remained conscious for a significant period of time without any indication that he was being scalded, after he stated that he was having difficulty turning off the tap, there remains the real and lively possibility that had Mrs Hunter or others been able to enter the bathroom and assist Mr Hunter from the bath and/or turn off the tap at an earlier time Mr Hunter may have survived.

Defects in system of working

[261] For a finding under section 26(2)(f) of the Act to be appropriate, it is necessary to establish a causal connection between a defect and the accident or death as a matter of fact.

[262] In the determination of 17 January 1986, in the *Inquiry into the death of James McAlpine*, Sheriff Kearney stated:

> "In deciding whether to make any determination (under section 6(1)(d)[now 26(2)(f) of the Act]) as to the defects if any in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof … is that of the balance of probabilities".

[263] In terms of section 26(2)(f) of the Act the said reasonable precautions of (i) at least annual maintenance of the bath tap and its components; and (ii) more formal analysis of said guest complaints about the discharge of excessively hot water in the hotel bathrooms, resulting in the said instruction of a qualified plumber, were also defects in the hotel's system of working.

[264] These defects on the balance of probabilities contributed to the death and the accident resulting in the death of Mr Hunter. As detailed above, it is reasonable to infer that the lack of, not just annual, but any maintenance of the tap and its components did in fact contribute to the death.

[265] Again, this is because it is reasonable to infer that the tap and its safety components could be expected to have failed in the foregoing three respects at any time prior to 1 December 2019, having never been serviced for *prima facie* decades.

[266] Again, it is reasonable to infer that the recommended annual maintenance of the tap and its components would have avoided the accident and consequential death of Mr Hunter as, had the three safety features been regularly serviced, it is more probable than not that they would have allowed Mr Hunter to accurately control the temperature, preventing it from exceeding the safety override temperature, and preventing any fluctuations in the water temperature or pressure to an unsafe level, as detailed above.

[267] Accordingly, the failure to have such annual maintenance with ongoing repair or replacement of the bath tap and its components for decades, on the balance of probabilities, contributed to the death of Mr Hunter.

[268] It is also more probable than not that the lack of a more formal analysis of guest complaints about the discharge of excessively hot water in the bathrooms, with immediate and full consideration of the safety issues arising therefrom, and the identification and, reduction or elimination, of the relative risks by a qualified plumber, without any preconceived misapprehension as to the potential for fatal consequences arising therefrom, caused the said defective tap and its components not to be maintained, repaired or replaced as required.

[269] Were such a system to have properly functioned it would have ensured that the complained of temperature issues were fully addressed by a qualified plumber and that the said defects would have been identified and prevented by maintenance, repair or replacement. The failure to have a system of working, such that the tap and its component were not recognised as requiring to be immediately maintained, repaired or replaced, on the balance of probabilities also contributed to the death of Mr Hunter.

[270] In deciding whether the inquiry is satisfied that the defect in question did in fact contribute to the death of Mr Hunter, whether the hotel personnel would have been so blinkered in their assessment of the cause of the excessively hot water being discharged from the bath taps as to blame only operator error, as suggested by the Crown, and therefore not to instruct a qualified plumber, is again irrelevant to this determination, as any such failure was part of what was defective about the system which was operating.

[271] A reasonable system of maintenance should proceed on the basis that the hotel would have properly operated a system of work which recognised that these repeated issues of guests complaining about excessive water temperature presented at least a serious risk of scalding to them and would have require the seeking of expert advice on the issue from a qualified plumber, as detailed above.

[272] The understandable concentration of the hotel on preventing legionella, or similar pathogens in the water system, did not create a situation where the hotel could not still have serviced the tap and its safety components as recommended, so that it was more probable they would have functioned effectively as they were designed to do, to protect the end user, such as Mr Hunter from being scalded.

Other factors

[273] In terms of section 26(2)(g) of the Act there are no other facts which are relevant to the circumstances of the death of Mr Hunter.

Any other information, observation or comment

[274] All participants in this inquiry offered sincere condolences to the family of Mr Hunter, recognising their consistent attendance throughout the hearing of evidence, the details of which will have been undoubtedly harrowing. The lessons learned from the death of Mr Hunter should now be utilised to prevent such events from happening again elsewhere, and the findings of this inquiry should alert all hotels or other establishments to recognise the real potential for such a fatal scalding to take place, and to analyse relative risk accordingly.