INQUIRY UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY ACT 1976 INTO THE SUDDEN DEATH OF MRS. JANET ALLEN

SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

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

FATAL ACCIDENT INQUIRY INTO THE DEATH OF

MRS JANET ALLEN

SHERIFF'S DETERMINATION

GREENOCK 2nd March 2006

The Sheriff, having on 25 and 26 January 2006 held an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Mrs Janet Allen, and having considered all of the evidence adduced, and submissions thereon at the Inquiry, DETERMINED as follows:-

1 In terms of Section 6(1) (a) of the Act, that the death of Mrs Janet Allen, who resided latterly at 6 Westfield Drive, Greenock, and whose date of birth was 15 December 1907, took place in the Larkfield Unit at Inverclyde Royal Hospital at 17.40 hours on 9 June 2004.

2 In terms of Section 6(1) (b) of the Act, that the cause of death was -

(a) Choking on food

3 In terms of Section 6(1) (c) of the Act, the death might have been avoided by -

(i) having in place a system of ensuring patients were provided with the consistency of food for their individual dietary needs

(ii) the Catering Management and the Speech and Therapy Department had liaised over the type of food which was suitable for particular patients' dietary needs.

4 In terms of Section 6(1) (d) of the Act, the death was contributed to by the following defects in the system of working -

1 The failure to have available at each mealtime a soft consistency food for patients with eating and swallowing difficulties.

I declined to make any findings in terms of Section 6(1) (e) of the Act.

NOTE:

The Fatal Accident Inquiry was held under Section 1(1) (a) of the Fatal Accident and Sudden Deaths Inquiries (Scotland) Act 1976.

The Crown evidence was led by Mr Brady, the Procurator Fiscal Depute. Mrs Sergeant represented Inverclyde Royal Hospital NHS Trust. Evidence was led by Mr Brady from Mr David Allen, the deceased's son, Dr Paul Lawson, Consultant Geriatrician at Inverclyde Royal Hospital, Bernadette McLachlan, Staff Nurse at the Larkfield Unit, Inverclyde Royal Hospital, Helen Coyle, Auxiliary Nurse at the Larkfield Unit, Inverclyde Royal Hospital, James McColm, Charge Nurse at the Larkfield Unit, Inverclyde Royal Hospital, Dr Marjorie Black MB ChB FRCPath Dip FM, Forensic Pathologist of University of Glasgow, David Clugston, Catering Services Manager at Inverclyde Royal Hospital, Mrs Katherine Gaffney, Speech Therapist from the Speech and Language Pathology Department, Inverclyde Royal Hospital and Dr Martin Goh, who had been working at Inverclyde Royal Hospital at the time of Mrs Allen's death and attended to her at the time of her death.

I also heard from Mrs Krawczyk, Lead Clinician for the Speech and Therapy Department at Inverclyde Royal Hospital.

A number of productions were also produced and referred to by both the Procurator Fiscal and Mrs Sergeant.

In his submissions, Mr Brady asked me to make findings in terms of Section 6(1) (a) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976 and to find that Mrs Janet Allen died on 9 June 2004 at 17.40 in Ward 1 of the Larkfield Unit of Inverclyde Royal Hospital, Greenock. In terms of Section 6(1) (b) he asked me to determine that the cause of death was choking on food. The forensic report and medical evidence suggested that mashed potato and the sausage were both factors in Mrs Allen's death. He asked me to find, in terms Section 6(1) (d), that there were defects in the system of work, and highlighted the evidence in support of his submission. The system of work, at the time of Mrs Allen's death, did not adequately ensure that patients received the appropriate food. Although Mrs Allen had been assessed by the Speech and Language Therapy Department, that department did not have an input in the type of food that was given to patients and whether or not it complied with their dietary needs. Furthermore, Mr McColm accepted in his evidence that at the time of her death, there was a gap in the system in relation to the types of food available to patients. Mr Brady made no specific submissions in relation to Section 6(1)(c), (d) or (e).

I heard brief submissions from Mrs Sergeant, who adopted Mr Brady's submissions, but asked me not to make any findings in terms of Section 6(1)(d) of the Act as it was not clear, whether any changes to the system of working might have avoided her death. She could have choked on soft, moist food and this was referred to by Dr Black when she referred to the soft white substance found in her lungs. She also asked me to consider that in the light of the evidence that was put to the Inquiry, it was clear that Inverclyde Royal Hospital NHS Trust had made positive changes since Mrs Allen's death. They included protected mealtimes, a full complement of staff at mealtimes, clarity as to which meal a patient was to have, menu choices to include another category called "soft moist", and staff training in swallowing mechanisms.

On the evidence presented to the Inquiry, the circumstances of the death which I have set out in detail in support of my Determination, were as follows: -

The deceased, Janet Allen, was a ninety-six-year-old widowed woman who is survived by her son, David, and her daughter, Janet. In the late 1970s, Mrs Allen developed cancer of the tongue, for which she underwent surgery to remove the tumour. The cancer returned in the mid to late 1980s, when further surgery was carried out. Mrs Allen had eating difficulties and was unable to wear dentures as a result of the surgery. To assist with her eating, she had muscle removed from her shoulder to build up her tongue. It meant that for a good number of years, Mrs Allen had to get used to eating food with a soft texture, as she was unable to chew food effectively. Her speech was also affected, but she was able to communicate with her family and to those who knew her. Her son, David, looked after her and ensured that she was fed food that was appropriate for her needs. He said his mother sometimes became frustrated that she could not eat foods that required chewing and gave the example of turkey at Christmas, but that she was accepting of the limitations placed on her as a result of the cancer which she had suffered. She would eat small amounts of soft food and was well aware of the limitations that her disability placed upon her.

In the final year of her life, Mrs Allen had a few falls and had to attend Inverclyde Royal Hospital. Prior to her death she was admitted to hospital on 5th May 2004. Mr Allen visited his mother regularly and was concerned that, on occasions, it appeared to him from the conversations with his mother, that the food she was given was not appropriate for her diet. He felt that she was sometimes hungry. However, as Mrs Allen considered that the staff were being caring and were good to her, she did not wish to cause any difficulty and asked her son not to speak to the nursing staff about that. Her hope was that she would not remain in that hospital for very long and therefore preferred not to make any comment about the consistency of the food that she sometimes given. Mrs Allen also told her son that she had been given stewed sausages on an occasion before 9 June 2004, but that she had not complained. It was not clear from the evidence whether or not she had attempted to eat the sausage on that occasion. On the evening of her death, she was given stewed sausages gravy and mashed potatoes. It was Mr Allen's belief that although his mother was well aware that sausages were not suitable, she may have attempted to eat them, if she were hungry.

Mrs Allen had been a patient in the Larkfield Unit on previous occasions and was known to some of the nursing staff. However, on admission, she was assessed on each occasion and her medical and dietary requirements were noted in the nursing notes. In her admission notes on 5 May 2004 her dietary needs were noted as "a soft diet". On the day of her death, it was Staff Nurse Bernadette McLachlan who made the decision to give Mrs Allen the sausage, gravy and mash for her evening meal. Staff Nurse McLachlan recollected from previous visits that Mrs Allen had had cancer and therefore had particular dietary needs in relation to the consistency of food that was provided to her. On the evening concerned, there were three options available. One was pureed food, which was not for patients such as Mrs Allen, a gammon steak and the third option, which she considered to be the soft option, was the stewed sausages, gravy and mash. Although there was a dining room for patients, Mrs Allen was at her bed, where she wished to eat. The Auxiliary Nurse

Coyle physically gave the plate of food to Mrs Allen and assisted her with cutting the food, although she accepted that Mrs Allen was capable of cutting her food and eating by herself. She did, however, recollect cutting up the sausage for her. Nurse Coyle then left the ward to attend to other patients. A short time later, Staff Nurse McLachlan realised that there was a problem when a buzzer alert came from Room 6. On arrival, she discovered that Dr Goh was already there, having been alerted by another patient in the Ward. Dr Goh attempted to dislodge the sausage from Mrs Allen with the Heimlich manoeuvre, but was unsuccessful. Dr Lawson was also present when Dr Goh then attempted to use a suction instrument to remove the sausage. This was again unsuccessful. Thereafter, Dr Goh asked the nursing staff for McGill Forceps to try and retrieve the sausage but he was told these were not available. They were not standard on the "crash" trolley at that time, although are now. Dr Goh pronounced her dead at 17.40, having been unsuccessful in his attempts to revive her.

In the post-mortem report, it is without doubt that Mrs Allen died as a result of choking on food. Apart from the sausage in her pharynx, there was also an obstruction in her right main bronchus, which was probably mashed potato. There was also a piece of carrot found in her oesophagus. The post-mortem examination also revealed that Mrs Allen had a moderate amount of food in her stomach, but that it consisted of the white substance which was probably the potato. There was no sign of any carrot or sausage in her stomach.

From the evidence before the inquiry, it is clear that Mrs Allen's death arose as a result of the food that she ate on the evening of 9th June. The purpose of the Fatal Accident Inquiry is to establish the cause of death and this has been done. It is also the purpose of a Fatal Accident Inquiry to inquire consider whether or not there was anything that could have been done which might have prevented the death or if a system of working should have operated, which may have prevented the death. The standard or proof applicable for my Determination is the balance of probabilities. It is not for me to be satisfied that the proposed precaution, if any, would, in fact, have avoided death, only that it might have done. I must also be satisfied that the precaution taken was a reasonable one. The phrase, "might have been avoided", is a wide one, meaning less than, "would in the probabilities have been avoided". Families and relatives of the deceased undoubtedly want answers as to why their loved one has died. In Carmichael's book on Fatal Accident Inquiries and Sudden Deaths, he states, "If the cause of an accident is known, then it may well be possible, even with what is now said to be the "wisdom of hindsight", point to something which, if done, might have avoided or even prevented the death or the accident resulting in death". The findings I have made in terms of Section 6(1)(c) and (d) have been made after consideration of all the evidence and submissions I have heard. Clearly, Mrs Allen was an elderly lady. She was 96 years old, had had recent difficulties with falling at home and had ended up in hospital on a number of occasions. She was also, however, what could be commonly described as a survivor of cancer. She had had cancer of the tongue in the 1970s and and 1980s but until her death had managed to overcome the disability by being careful in what and how she ate. For over thirty years, she had managed to cope with the disability. The hospital authorities were aware of her eating difficulties and had made what they considered to be sufficient provision for her eating needs. In my view, in hindsight, that was not the case. While the post-mortem report does suggest that she choked

on her food, and that there was potato found in her right bronchus, it also states that there was only potato in her stomach. That suggests to me that the sausage certainly played a proportionate part in her choking to death.

Mrs Gaffney said in her evidence that Mrs Allen was unable to use a sweeping motion to take food to the back of her throat to swallow and therefore, for her, the kind of food that she ought to have been given was soft food. However, Mrs Gaffney did not accept that sausage could be termed a "soft food". She specifically said that sausage had skin and that skin with meat inside would be described as "normal" food and not "soft food". Mrs Gaffney clearly stated that she would never advise that it be given to a patient with needs such as Mrs Allen's. In my view, that is the basis on which I must make my findings in terms of Section 6(1)(c) and (d). Although an assessment was made by the Speech and Language Therapy Department about the category of food required there was no liaison between them and the Catering Department as to what foods would be categorised and described as "soft" and "normal". Furthermore, when devising the menu, sufficient care was not taken to ensure that there would be appropriate options available at each mealtime for the patients' specific needs. Staff Nurse McLachlan indicated to the Inquiry that had she been dissatisfied with the options available for the patients, she could actually have telephoned to ask for something soft, like scrambled eggs, if she felt the options were unsuitable. On that evening, she did not consider that sausages, gravy and mash were inappropriate but perhaps with better training and categorisation of options she may have. Furthermore she could have simply given Mrs Allen gravy and mash.

I have heard evidence that Mrs Allen was well aware of the kind of food that she could and could not eat and had lived with her disability for over 30 years. On this occasion however, having eaten the gravy and mash, which was found in her stomach, she then attempted to eat the sausage. As David Allen said, he felt that sometimes his mother was hungry and that may have been why she began to try and eat the sausage. That temptation should not have been put in her way. She was an elderly lady who ought to have had the appropriate considerations given to her dietary needs. Inverclyde Royal Hospital NHS Trust failed in their obligations to her. It is my view that there was a defect in the system of work where there was no liaison between the Speech and Language Therapy Department and the Catering Department, about soft option categories. In my view, had there been appropriate systems in place, such as there are now, the death might have been avoided.

From the evidence presented to the Inquiry I am satisfied that Inverclyde Royal Hospital NHS Trust having investigated the matter have recognised that their systems were inadequate and needed to change. I heard evidence about what steps have been put in place since Mrs Allen's to her death to ensure that there is no a repeat of the incident which contributed to the death of Mrs Janet Allen. Inverclyde Royal Hospital NHS Trust has taken very clear and definitive steps to ensuring that such an incident does not re-occur. Subsequent to her death a liaison group met to oversee a number of very positive steps in relation to changing their systems for patients' dietary needs. These were highlighted by Mrs Sergeant in her submissions and it is my view that given the changes that have now taken place, it is unlikely that such an incident would re-occur. These include ensuring that there are full complements of staff at the time of eating, no visiting at mealtimes, the introduction

of another option called "soft moist" and training of staff in the dietary requirements of elderly patients and their particular needs. They also have an integrated approach in the assessments made in deciding a patient's dietary needs. I was urged by Mrs Sergeant not to make any Findings in terms of Section 6(1)(d), but I am satisfied that it was appropriate to do so, because at the time of her death, an appropriate system of work was not in place.

Mrs Allen was a woman who had lived with her disability and had adapted well. She was also the sort of person who considered that the nurses were doing their job, were caring and had enough to do without her causing any fuss in respect of the food that they had served her. Although Mrs Allen was an elderly lady, she had successfully lived with her disability for almost one-third of her life and it is unfortunate that her death occurred in the hospital, which was meant to take care of her. Individuals such as Mrs Allen's family put their faith in our healthcare professionals and are entitled to assume that their loved ones are being looked after properly in relation to their needs. Mr Allen cared for his mother at home and specifically catered for her dietary needs and he and Mrs Allen's family was entitled to expect the same standard of care. On this occasion there was a departure from the standard expected in the system of work.

Sheriff Rajni Swanney