

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2017] FAI 8

B1727/15

DETERMINATION

BY

SHERIFF LINDSAY WOOD

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

into the death of

**DORIS MARGARET GILCHRIST
(better known as Margaret Gilchrist)**

Glasgow, 7 April 2017

PART 1

Productions and legal framework

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Margaret Gilchrist who died at 903 Carntyne Road, Carntyne, Glasgow on 26 September 2013. Mr Brian Duffy, procurator fiscal depute, represented the public interest, Ms Kate Dowdalls QC, represented Enable Scotland, Mr Matt Jackson, Advocate, represented City Building (Glasgow) LLP (City Building), Mr Peter Gray QC, represented Glasgow Housing Association (GHA), Mr Steven Love QC, represented Glasgow City Council (GCC), Mr Kenny Gibson and Mr Owen Mullen, both Advocates, represented Mary Cameron at

different times and Mr Peter Graham and Helen MacNeill represented the family of the late Margaret Gilchrist at different times.

[2] The Inquiry heard evidence over the course of 16 days between 16 November 2015 and 19 September 2016. There was a hearing on submissions on 21 October 2016.

The Crown led evidence from the following 25 witnesses:

- 1 Eileen Graham
- 2 Helen MacNeill
- 3 Dr Paula Rogers
- 4 Barbara Anderson
- 5 PC James MacDonald
- 6 Stephen Mason
- 7 Gina McDougall
- 8 Jackie Hickey
- 9 Katerina Maguire
- 10 Marlene Martin
- 11 Michelle Mathieson
- 12 Beverley MacNair
- 13 Dr Julie McAdam
- 14 Sheena Milton
- 15 Jennie Stafford
- 16 Mary Cameron
- 17 DC John Laurie
- 18 Jan Lindsay
- 19 Alan Burns
- 20 Alexander Allison
- 21 Lorraine Starrs
- 22 David Gostick
- 23 Colin Goldie
- 24 Anthony Clarke
- 25 Kuldip Dhesi

A joint minute of agreement on certain uncontroversial evidence was entered into by parties and received by the Inquiry. No other evidence was led.

Legal framework

[3] Section 6 of the said 1976 Act requires the presiding sheriff to make determinations in the following matters: (a) where and when the death and any accident resulting in the death took place; (b) the cause of such death and any accident resulting in the death; (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and (e) any other facts which are relevant to the circumstances of the death.

[4] The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised. The sheriff has no power under the said 1976 Act to make a finding as to fault or to apportion blame between any persons who may have contributed to the accident even although his findings on the matters upon which he must make his determinations may implicitly disclose fault.

PART II

Determination as to the circumstances of the death

[5] The sheriff having considered all the evidence, finds and determines:

- (i) That in terms of section 6(1)(a), Margaret Gilchrist, born 8 December 1962 of 903 Carntyne Road, Glasgow died at about 2008 hours on 26 September 2013 within a bath in the upstairs bathroom at the said 903 Carntyne Road, Glasgow.

- (ii) That in terms of section 6(1)(b), the cause of death was unascertained but hot water scalding was a significant contributory factor in Margaret Gilchrist's death.
- (iii) That in terms of section 6(1)(c), the reasonable precautions whereby the death and any accident resulting in the death might have been avoided:
 - (a) The scalding accident which contributed to Margaret Gilchrist's death might have been avoided if the hot water tap was not left running and if visual checks had been made whilst she was in the bath every 3 minutes or less.
- (iv) That in terms of section 6(1)(d), the defects, if any, in any system of working which contributed to the death or any accident resulting in the death:
 - (a) There was not in place a sufficiently detailed risk assessment in respect of the bathing of Margaret in conjunction with a related bathing plan emphasising that staff had to ensure that the hot water tap was switched off after running a bath and to carry out visual checks on Margaret Gilchrist whilst she was in the bath every 3 minutes or less.
- (v) That in terms of section 6(1)(e), it should have been recorded in 2010 when a new Triton Thermostatic Mixing Valve (TMV) was to be installed in the upstairs bathroom that it was not in fact installed and that the original Caleffi TMV remained in place and which was of a type which required to be regularly checked and maintained as opposed to Triton TMVs which were installed in other GHA properties and which were of a type which did not require regular

maintenance. Further, the specific location of the Caleffi TMV should have been recorded.

PART III

[6] After hearing and considering all of the evidence and submissions I made the following findings:

(1) Margaret Gilchrist was born on 8 December 1962 with a severe learning disability and was registered blind. She required 24 hour care 7 days a week and was aged 50 when she died. She was the youngest of five children having two brothers and two sisters. Her sisters Eileen Graham and Helen MacNeill survived her. Her brothers, Graeme and Douglas, passed away after her death. At 6 months old, Margaret's family realised she had a considerable learning disability as her development was not progressing as expected. She could not walk until she was aged 6. She was cared for within the family home until the age of 21. Margaret's mother wished Margaret to remain one of the family and to stay within that setting. Unfortunately, Mrs Gilchrist who was by then widowed, passed away in 1984 and thereafter, Margaret stayed in places of care within the community. On 27 February 1993, Margaret moved to 903 Carntyne Road, Glasgow where she resided until the date of her death. She was cared for there on a 24/7 basis and latterly, she shared the accommodation with one other lady who also had significant disabilities. Margaret had severe learning disabilities throughout her life. She had an IQ of between 20 and 34 with the average IQ being 100. She could not follow instructions. She had very limited cognitive ability and

lacked the ability to problem solve. In particular, she did not have the cognitive ability to understand the function of a tap and had never been seen to operate a tap. Margaret's ability to communicate verbally was very limited. She had severe difficulties with speech. She was known to repeat phrases and words of songs from her childhood but she could not converse. She was known to sing in the bath and to be quite vocal which appeared to indicate she was happy. Margaret's ability to summon assistance whilst in the bath was compromised due to her learning disability and she would very rarely be able to vocalise when she was in pain. She would not cry if she was in pain and would also "go into herself" if unwell. She could be vocal and made loud noises but she could not shout for help. During a previous scalding incident in a bath on 9 November 1998, Margaret squealed which was described as an unusual sound but not a loud one.

Margaret was registered blind and had been diagnosed as suffering from bilateral optic atrophy. Although registered blind, she was thought to have had some peripheral vision in both eyes but had very poor vision. Margaret could walk unaided but walked slowly due to her vision impairment and although she could walk without support, she preferred to be supported. She had the physical ability to climb and descend stairs but invariably received assistance to do that. Margaret always required assistance to get in and out of a bath. Margaret had a strong grip but it was clear that she did not have the cognitive ability to operate a tap and was never seen to attempt to do that. Margaret was 5 or 6 years old when she suffered her first epileptic seizure. She had a complex history of epilepsy and suffered infrequent seizures with the last one recorded in March 1997. She was last prescribed anticonvulsant medication in 2007.

(2) At the time of Margaret's death, she was receiving support 24 hours a day, 7 days a week. This included an element of individual one-to-one care and an element of shared care throughout the day. Margaret also attended the Royal National Institute for the Blind (RNIB) for a few hours three days a week. In addition, a shared sleepover service was also provided. Margaret required full support with all aspects of her life which included washing, bathing, dressing and toileting. The support service, with the exception of Margaret's attendance at the RNIB in Bishopbriggs, was delivered to Margaret at 903 Carntyne Road which is a GHA owned property and leased to Enable Scotland. Enable Scotland provided the support service out of an allocated budget provided by GCC.

(3) On 11 January 2013, the Social Care (Self-Directed Support) (Scotland) Act 2013 came into force in Scotland with further provisions coming into force in February and April 2014. The Act made provision to enable local authorities to provide support to certain carers. Self-directed support was a mechanism by which personalised services were provided to users of social care services. The changes to service delivery were known as "Personalisation". Prior to the commencement of the said Act, Glasgow City Council set up a personalisation pilot scheme. The pilot scheme commenced around 2009 and on 21 September 2010, Margaret and the other service user residing at 903 Carntyne Road were included in the scheme. The pre-personalisation budget allocated to Enable Scotland by Glasgow City Council for the delivery of the support service to Margaret was £1,332.78 per week. This budget was provided to Enable Scotland for the delivery by them of 92.5 hours of support per week to Margaret and of the 92.5 hours of

support, Enable delivered 70 hours of one-to-one support. Following the introduction of personalisation, the budget allocated to Enable Scotland by Glasgow City Council for the delivery of the support service to Margaret was reduced to £1,093.88 per week. This included a total sum of £477.72 from the Independent Living Fund and a personal Benefits contribution from Margaret. This budget was provided to Enable Scotland for the delivery by them of 70.5 hours of support per week to Margaret and of the 70.5 hours of support, Enable delivered 42.5 hours of one-to-one support. As a result, personalisation resulted in less one-to-one care and more shared care. Budgetary constraints were a significant factor in the change.

(4) Margaret resided at 903 Carntyne Road, Glasgow from 27 February 1993 until the date of her death. Initially, she resided there with four other service users but this changed around 2007 and from thereon, only Margaret and one other service user resided there. The house was leased by Enable Scotland from Glasgow Housing Association and the lease specified that the house would be used as supported accommodation. From 7 March 2003 until the date of Margaret's death, GHA was responsible for the maintenance and repair of fixtures and fittings within the house. The house is a four in a block type building with two flats on one side and the other side converted from two flats into an up and downstairs single property in which Margaret and the other service user resided. The property was arranged over two floors with a living room, kitchen, shower room and bedroom on the ground floor for the other service user. Margaret's bedroom was located on the upper floor along with a bathroom, office, sensory room and support worker sleepover room.

(5) On the day of the death of Margaret on 26 September 2013, Mary Cameron, a support worker, commenced her shift at 3 pm until 11 pm and she was also due to provide the sleepover service from 11 pm until 7 am the following morning. Another support worker, Katerina McGuire worked the shift from 7 am until 6 pm. Accordingly, there was one-to-one support delivered to Margaret and the other service user by Katerina McGuire and Mary Cameron from 3 pm until 6 pm. Katerina McGuire signed out at 6.20 pm that day. By then, Margaret and the other service user had had their dinner. Mary Cameron did not eat at that time. At around 6.30 pm, Mary Cameron put on a DVD for the other service user and she then went upstairs to check on Margaret. At that time, Margaret was in her bedroom sitting on her couch. Mary Cameron took Margaret into the bathroom to check that she was toileted and clean. She then went downstairs as the other service user wanted to go to bed and she read her two or three stories and said prayers before putting her to bed. After about 15 minutes, Mary Cameron went back upstairs and ran a bath for Margaret, put her in the bath, washed her hair within the bath and left her to soak and relax. It is not possible to be absolutely conclusive as to what happened when Mary Cameron ran the bath for Margaret and indeed, she gave varying accounts to the police and others afterwards and in her evidence at the Inquiry. What is certain is that the water in the bath came from both taps into a single spout and the norm was to run the hot water first and then add bubble bath and cold water. The temperature was checked by hand. The thermometer was not used. Margaret was then helped into the bath and she sat down. The electric shower above was used to wash Margaret's hair and Mary Cameron then believes that she turned both

taps to put the water off. Given what happened thereafter, it seems apparent that the hot water tap was not turned off fully. Mary Cameron then put the radio on as Margaret enjoyed listening to music and she was left alone in the bath while Mary Cameron went downstairs and put Margaret's clothes into the washing machine and did other things such as tidying up, washing dishes and making herself a cup of coffee. She then sat down and had a coffee and a biscuit as she had not eaten earlier. Sometime later, she went upstairs and the radio was still playing. She went into the bathroom and saw water on the floor and the bath was full of water right up to the top. She thought the tap was still running and she saw Margaret lying on her back in the water and unresponsive. She tried to get Margaret out of the bath after pulling the bath plug but she was not able to and she ran downstairs and telephoned 999. The closing music of the BBC programme EastEnders was heard by Mary Cameron when she went upstairs and that was confirmed as played at 1957 hours. Mary Cameron made a call to the emergency services at 1958 hours. It is a matter of agreement that Mary Cameron telephoned Marlene Martin at 1928 hours and at that time Margaret was in the bath. Taking all evidence into account, I am satisfied that Margaret was alone in the bath for over 30 minutes but unlikely to have been much more than that.

(6) A thermostatic mixing valve (TMV) is a mechanical valve which mixes supplies of hot and cold water to produce a mixed water outlet of a required temperature. TMVs are used to control the supply of water at the taps within a limited range of temperatures accommodating changes in input water pressure and temperature. These can either be user adjustable or pre-set requiring adjustment by a competently trained

person. A wax thermostatic element in the outlet of the valves senses the temperature of the mixed water and controls the flow using a single piston which varies the flow of the hot and cold water. The Health & Safety Executive carried out an investigation into the death of Margaret and visited 903 Carntyne Road on 1 October 2013. The purpose of that visit was for HSE inspectors to familiarise themselves with the house and to take water temperatures. The temperatures of the hot water taps in the upstairs bathroom were measured using a calibrated digital thermometer and the temperature of the hot water tap of the bath was measured as 54.9 degrees centigrade. If hot water used for showering or bathing is above 44 degrees centigrade, there is an increased risk of serious injury or fatality. On 3 October 2013, HSE inspectors and a plumber from City Building attended again at the house. During that visit, the plumber located a Jewsons manufactured type 3 TMV in the kitchen under the sink and the body of the valve had the letters "CR" embossed on it and the numbers "50/04" marked on it. However, no TMV was found in the downstairs shower room or in the upstairs bathroom. On 5 November 2013, an Operational Manager for City Building attended at the house. He noted there was a loose panel behind the wash hand basin in the upstairs bathroom and when he prised the panel open, he noted the presence of a TMV. He did not touch it. On 8 November 2013, another plumber for City Building attended at the house and went again to the upstairs bathroom. He found a TMV fitted to the water supply which supplied hot water to the wash hand basin and bath. A Caleffi manufactured type TMV was removed from the upstairs bathroom. Prior to the removal of the TMV, the mixed hot water temperature was measured in the bath and sink. Using a plumber's digital

thermometer, the temperature of the hot tap at the sink was measured at 60.1 degrees centigrade and the temperature at the hot tap of the bath was measured at a maximum of 55.5 degrees centigrade. Using a HSE calibrated digital thermometer, the temperature at the sink was measured at an average of 56 degrees centigrade with a maximum of 57.9 degrees centigrade. The temperature of the hot water at the bath was an average of 54 degrees centigrade with a maximum of 54.9 degrees centigrade. The Caleffi TMV was found with the cover fitted upside down and the temperature adjustment locking ring missing. It was also found to have been adjusted to its maximum temperature setting. The TMV also had the numbers "2104" engraved on its temperature spindle which referred to the date of its manufacture, ie 21 of 2004. Further examination of the TMV was carried out and it was established that the TMV in its installed condition failed to shut off the mixed water supply in the thermal shut-off tests resulting in a wide range of mixed water temperature variation. It was also found to fail the temperature stability with changing water pressure tests. When the TMV was adjusted to the correct temperature setting and supplied with a water pressure of 1.0 bar or higher, the TMV passed the thermal shut-off test but it was not able to provide mixed water temperature stability to the standard of NHS engineering specification MES D08. The TMV was disassembled and was found to have a lack of grease on the spool of the valve. This lack of grease was most likely the cause of the TMV's poor mixed water temperature stability performance. It was unlikely that the TMV had been tampered with and the setting that the valve was adjusted to was most likely that which it was set to either during installation or during maintenance. Therefore, it seems more than likely that the TMV

could not prevent water at a temperature sufficient to cause scalding to flow from the hot water bath tap in the upstairs bathroom when Margaret was in the bath. This was due to the fact that the TMV was set to its maximum temperature setting and also the lack of grease on its spindle.

(7) In 2009, GHA entered into a repairs and maintenance contract with City Building for GHA's housing stock in Glasgow. In terms of that contract, City Building were contracted to carry out repairs and maintenance to the house at 903 Carntyne Road, Glasgow on a planned, cyclical and reactive basis. In 2010, GHA embarked upon a programme of refurbishment of its housing stock. That programme of refurbishment involved the re-fitting of kitchens and bathrooms and also the rewiring of properties. The house at 903 Carntyne Road was included in that programme and City Building were contracted by GHA to carry out that programme of work. This programme of work included the installation of type 3 TMVs. City Building subcontracted JMS Construction (Scotland) Ltd (JMS) to carry out the refurbishment work on a number of properties including 903 Carntyne Road. This was a labour only contract and City Building supplied the materials. City Building supplied Triton manufactured TMVs and did not supply Caleffi TMVs. Alexander Allison, who worked as a plumber for JMS at the time of the refurbishment programme, stated in evidence that when he was contracted to work for City Building he fitted Triton TMVs which were supplied by City Building. He stated he never installed any other make of TMV and he would not have installed a Caleffi TMV as they only installed Triton TMVs. Mr Allison could not recall fitting a TMV within the upstairs bathroom at 903 Carntyne Road as he was fitting

around five bathrooms a week at that time. However, he did remember being in the house due to the fact it was two flats converted into a single house. He stated that the Caleffi TMV could have been an existing valve and after speaking to the City Building agent or his manager at JMS, it could have been decided to leave it in place. If that was the case, he said he would have tested it by checking the temperature of the water. In his evidence, Mr Allison was shown a TMV installation record sheet dated 22/10/10 for 903 Carntyne Road in which a temperature of 45 degrees centigrade is recorded. His norm was to fix it at 47 degrees. The document was not signed by Mr Allison. It is more than likely that the Caleffi TMV was not installed at the time of the refurbishment work to 903 Carntyne Road, Glasgow in 2010. It seems more probable that Mr Allison observed the Caleffi TMV in situ and after consultation, left the Caleffi TMV in position. A repairs history was kept and maintained by City Building which was shared with GHA in relation to work carried out at 903 Carntyne Road, Glasgow. It recorded the works carried out and completed at the house from January 2000 until October 2013. There is an entry on 20 May 2004 which describes work as "install thermostatic mixing valves in the bathroom" with a completion date of 26 May 2004. There is another entry dated 10 January 2005 which describes the work as "supply and fit thermostatic control valve taps throughout" with a completion date of 30 March 2005. The Caleffi TMV found within the upstairs bathroom had a date of manufacture of 2004. It is therefore very likely that the Caleffi TMV was installed between 20 May 2004 and 30 March 2005 by Building Services of Glasgow City Council for their client GHA. It is a matter of agreement that between 7 March 2003 and 27 September 2013, GHA was responsible for

the maintenance and repair of fixtures and fittings which it owned in the house at 903 Carntyne Road, Glasgow. Such work was carried out by City Building. There was never any planned or cyclical duty on City Building to maintain TMVs. There was no contract in place for the maintenance or servicing of TMVs at 903 Carntyne Road and the preference was for the installation of TMVs which did not require maintenance and the Triton TMV was selected for that reason. There is no evidence that GHA or City Building maintained the Caleffi TMV found in the upstairs bathroom of 903 Carntyne Road, Glasgow. Accordingly, it is more likely that the Caleffi TMV was not maintained after it was installed within the upstairs bathroom at 903 Carntyne Road, Glasgow in 2004/2005. That said, no compelling evidence was led from any of the support workers that there were any issues with the temperature of the bath water.

(8) The only risk assessment produced in evidence during the Inquiry relating to the bathing of Margaret was a Hot Water Management Risk Assessment. There is no evidence that any other risk assessment documents were produced by or on behalf of Enable Scotland in relation to the identification and control of any risk when bathing Margaret. The evidence from those involved in the creation of Margaret's Bathing Plan was that the period of 20 minutes for leaving Margaret in the bath was decided upon as it seemed to be a reasonable time to expect the bath to remain warm. There was no form of risk assessment carried out in relation to the bathing of Margaret other than the Hot Water Management Risk Assessment and it was submitted that if anything happened to the other service user who was prone to having seizures, there could be challenges for a single support worker in caring for both service users at the same time.

(9) The most recent Support Plan for Margaret, updated in April 2013, stated that Margaret required full support with washing and bathing. It also stated that staff needed to ensure that they filled the bath to the appropriate level and also monitored the temperature. Various support workers gave evidence at the Inquiry and gave differing views as to what the bathing routine should have been and was in practice. It seemed clear that the Support Plan and Bathing Plan did not contain sufficient detail to ensure that the staff adopted a safe system of work in relation to the bathing of Margaret and the documents failed to prescribe a consistent approach and application.

(10) The precise time of Margaret's death is unknown. Mary Cameron made a call to emergency services at 1958 hours after she found Margaret unresponsive in the bath. She stated in the call that Margaret was unconscious and white as a ghost and also that she had drowned in the bath. The paramedic, Stephen Mason, arrived at the house at 2003 hours. He spoke firstly to Mary Cameron and then made his way to the upstairs bathroom where he saw Margaret in the bath. Her fists were clenched, her arms were tight against her chest and he could not move her arms from her chest. It appeared rigor mortis had already set in. He established there were no signs of life and pronounced life extinct at 2008 hours. The pathologist Dr Julie McAdam said that it was unusual for rigor mortis to set in within 30 minutes of death but it was certainly possible. It can set in more quickly in a hotter environment.

(11) On 2 October 2013, a post-mortem examination was carried out on the body of Margaret Gilchrist by Dr Julie McAdam and Dr John Williams, both pathologists. The cause of death could not be definitively ascertained. Drowning as the cause of death

was considered but on the balance of probabilities, there was insufficient evidence to determine that the cause of death was drowning due to the absence of any definitive pathology in that regard. Epilepsy was also considered but again, there was no definitive pathology to establish an epileptic seizure as the cause of death. In addition, Margaret had not had recent seizure history and she had been seizure free since 1999. Evidence was heard from PC James MacDonald who stated that when he attended the emergency call and entered the bathroom at 903 Carntyne Road that Margaret appeared to have scald injuries to her shoulders, toes and knees and that the scald injuries were bright red and beginning to blister. He did not recall Margaret's face being scalded. Dr McAdam stated that Margaret had sustained scalding to 80-90% of her body. It was noted in the post-mortem report that she had generalised reddening of the skin of her entire neck, the majority of her trunk, the upper two-thirds of her right arm, the back of her left upper arm, the back and front of her legs with sparing to her face, the upper part of her right breast, the entire left breast, the centre of her abdomen, the front of her left shoulder, the upper part of her left arm, the bend of each elbow, both hands, the lower part of both thighs extending across both knees and the top of each shin. It was stated that this pattern of scalding and sparing would be entirely in keeping with Margaret having been partly immersed in hot water, the spared areas being above water level. Dr McAdam stated that she favoured ante-mortem scalding although there remained a possibility that some scalds had been caused after death. The extent of the scalding of the body could potentially account for death due to shock. It therefore seems likely that Margaret was unconscious when the bath water reached a temperature sufficiently hot

enough to cause scalding to her body. Dr McAdam also observed that due to the well demarcated ages of the reddening of the skin that Margaret moved very little as the water became hotter. Margaret was known to react to heat and hot surfaces and it would seem improbable that she would not react to water hot enough to cause scalding which would in turn result in irregular scald splash marks. There was substantial water on the floor of the bathroom. Dr McAdam said she would be surprised if the scald injuries did not have a role to play in Margaret's death and would be very surprised if Margaret had not sustained some scald injuries prior to her death. Whilst Dr McAdam would not go as far as to state that the hot water scalding was the cause of death, it seems likely that Margaret had sustained a number of significant scalding injuries whilst alive and this was a significant contributory factor in her death. There was no evidence to suggest that Margaret could operate a bath tap and indeed, there is a persuasive body of evidence that she would not have had the cognitive ability to do so. There was no evidence that she tried to do so or indeed would understand what a tap would do. Accordingly, it cannot be accepted that Margaret accidentally operated the hot water tap of the bath. It further seems likely that the hot water tap of the bath had not been turned off fully by Mary Cameron after she had washed Margaret's hair and left her alone in the bath. When Mary Cameron made the emergency call after finding Margaret, she said *inter alia* "The water's come oot the bath and I forgot tae switch aff the water". She further said "I must have forgot to put the water aff". Further, in her statement to the police on the night of the accident, Mary Cameron said "As I went into the bathroom I could see water on the floor, the bath was full of water and it was right up to the top. I

think the tap was running.” Further, the Caleffi TMV feeding mixed water to the hot water tap of the bath allowed water at a temperature sufficient to cause scalding to flow from the hot water tap of the bath. Accordingly, the combination of the hot tap not having been turned off properly and the TMV allowing water at a temperature sufficient to cause scalding to flow from the hot water tap of the bath is the cause of the scalding accident.

(12) On the date of her death, Margaret was left in the bath for at least 30 minutes during which time no visual checks were made. Instead, the support worker Mary Cameron relied on listening for Margaret although she had switched on the radio and the television was on downstairs. The various support workers who gave evidence said that they would have carried out a visual check every couple of minutes, every few minutes or every 3 or 4 minutes. Had those visual checks been made, there is a strong possibility that Mary Cameron would have noticed that the hot water tap was still running and the level of the bath water had increased or she would have noticed visible signs of distress from Margaret. There was no detailed system in place requiring staff to carry out very regular visual checks on Margaret while she relaxed in the bath. Had such a system been in place and adhered to then it is probable that the support staff would have been alerted to any developing situation. Accordingly, this lack of detail contributed to Margaret’s death. In addition, the bathing system in place at the time of Margaret’s death was defective in that the Bathing Plan and Support Plan were lacking in detail in that it did not stress the need to turn off the hot water tap and failed to specify the frequency and nature of checks to be made during the period Margaret was

left to relax in the bath. From the evidence of various support worker witnesses, there was not a consistent approach to the bathing of Margaret.

(13) The lease for the property was between GHA and Enable Scotland. Enable Scotland is a commercial enterprise providing care to Margaret Gilchrist and the other service user within an adapted property for the purpose of providing support to them which included washing and bathing. It is a matter of agreement that the lease agreement specified that the house would be used as supported accommodation.

Submissions

[7] The legal representatives of the various interested parties and the family themselves all made extensive submissions which I have taken time to consider fully before making statutory determinations, findings and conclusions. There is a degree of common ground on certain aspects and in the following chapter headed “Conclusions”, I detail why I made the particular determinations and I also cover other relevant aspects which emerged at the Inquiry and how I treated them. I do confirm that in respect of matters which might have contributed to the death of Margaret Gilchrist, I offer no criticism of Glasgow Housing Association or Glasgow City Council. Further, I do not uphold the submissions of the family in respect of their criticism of *inter alia* the Care Commission, the COPFS and the HSE. Neither do I support the vast majority of the family’s criticism of Enable Scotland and Glasgow City Council in respect of its Social Work Department.

Conclusions

[8] To begin with, the court formally recognises how difficult it must have been for Margaret's family to not only deal with her loss and the way it occurred but also having to participate in the Inquiry both in giving evidence and listening to it. It is clear that they have been significantly affected and as a consequence, they have asked for certain matters to be addressed. In a similar way but from a quite different perspective, this tragedy has also had a significant impact on Mary Cameron who cared for Margaret on the night in question and for many years before.

[9] Margaret Gilchrist should not have died in the manner she did on the evening of 26 September 2013. She died in an accident which was preventable. There were reasons for this and I will come back to that. She did not die in a conventional care home as such but in her own home where she had stayed for many years with care being provided to her and the other occupant by Enable Scotland. Margaret was 50 when she died and due to her various disabilities she did not lead a normal life. She needed 24/7 care. She received that from Enable Scotland through their employees and having listened to all of the evidence as I have, I did not get the impression that Margaret was not properly cared for and looked after by the various support workers who treated her with respect, dignity and much consideration. There were strong bonds of affection towards Margaret from a number of the support workers including Mary Cameron. There were regular routines every day and every week and there was no independent suggestion that Margaret did not benefit from the standard of care she was afforded. In fact, it was apparent that despite her difficult circumstances, Margaret was generally a happy lady

and I would go as far as to say she was much loved by those looking after her including Mary Cameron.

[10] Margaret enjoyed relaxing in a bath every night. It was a treat. She enjoyed the relaxation aspect and the sensation of warm water. She listened to music in the bath, she sang and was left to savour the experience until the water began to cool and it was time to get out. She would then be dried, put in her pyjamas and taken to her bed for the night.

[11] On 26 September, after being put in an appropriately warm bath and having her hair washed, she was left there by Mary Cameron with the radio playing. Tragically, Mary Cameron did not ensure the hot water tap was turned off before she went downstairs to attend to various matters. As a result, the hot water continued to flow from the tap and the temperature became increasingly excessive as the TMV did not function properly. Consequently, Margaret was scalded by the hot water and thereafter died. Between 80% and 90% of her body had been scalded as unfortunately, Mary Cameron had left her in the bath for longer than usual, certainly in excess of 30 minutes. If she had been checked regularly during that time, Mary Cameron may well have seen the distress being caused and might have been able to do something about it.

[12] When Mary Cameron did discover Margaret unresponsive in the bath with the water overflowing, she more or less immediately telephoned emergency services and a paramedic was on the scene very quickly and pronounced life extinct only 10 minutes after the emergency phone call was made.

[13] Clearly, this has been a traumatic and hugely difficult time for Mary Cameron who committed an enormous human error that evening and such is the magnitude of the error that she will require to live with it for the rest of her life. She was called as a witness at this Inquiry and due to the fact that she had not been granted immunity from prosecution by the Crown, she was properly and professionally advised not to say anything which might incriminate her. Accordingly, she did not have an appropriate opportunity of telling the Inquiry what she remembered from the events that night and nor was she able to express her deep regret and offer her heartfelt apologies to the family as I expect she would have wanted to have done. As a consequence, Margaret's family were denied the benefit of such honesty and disclosure which may have been a helpful cathartic experience for everyone. It is noted by this Inquiry that Mary Cameron's employment was terminated by Enable Scotland and she no longer works in the care sector.

[14] There are other suggestions as to how Margaret died. I discount these as flawed:

- (a) Margaret did not switch on the tap accidentally or otherwise. She was not capable of doing that. The hot water tap was left on by Mary Cameron.
- (b) Margaret did not drown. There was no definitive pathology to that effect.
- (c) Margaret did not have a fit. There was no definitive pathology to that effect and in addition, her last epileptic fit was over 14 years ago.

[15] The pathologist chose not to state conclusively that scalding was the cause of death but given the extent of the scalding and the effect it would have, it seemed inevitable that hot water scalding was a significant contributory factor in Margaret's

death. Dr Julie McAdam more or less said so in terms. Significantly, she did not come up with any other viable alternative as to cause of death. The same pathologist said that the scalding could well have caused shock and it would be difficult to argue against that. Accordingly, my determination under section 6(1)(b) reflects the foregoing.

[16] There was almost consensus that Margaret died in the bath at 903 Carntyne Road, Glasgow on 26 September 2013. It is formally recorded as at 2008 hours as that was when life was pronounced extinct but it seems clear that she died a short time before then and the paramedic saw signs of rigor mortis when he first found Margaret in the bath. My determination under section 6(1)(a) reflects the foregoing.

[17] I have determined in terms of section 6(1)(c) that the scalding accident might have been avoided if the hot water tap was not left running and if visual checks had been made every 3 minutes or less. I would go further than that and say that the accident would have been avoided if the hot water tap was not left running. My determination under section 6(1)(c) reflects the foregoing.

[18] In terms of section 6(1)(d), I have identified defects which contributed to the death by stating that there was not a sufficiently detailed risk assessment in respect of the bathing of Margaret in conjunction with a related bathing plan which emphasised that staff had to ensure that the hot water tap was completely switched off after running a bath and to carry out visual checks on Margaret when she was in the bath every 3 minutes or less. My determination under section 6(1)(d) reflects the foregoing.

[19] In terms of section 6(1)(e), I detail the other facts which were relevant to the circumstances of the death. I do not include in that the introduction of personalisation

as that was not relevant to the death. It was clear that as a result of the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013, there were changes made to the way in which local authorities allocated budgets to carers for the benefit of users of social care services. In effect, due to budgetary constraints, less funding was available and as a result, carers such as Enable Scotland had to adjust the service they provided. In Margaret's case, this led to less one-to-one care and supervision. That of itself did not lead to or cause the accident leading to Margaret's death as it was still possible for one carer to look after two service users at the same time by the careful application of common sense and timing. When Mary Cameron was downstairs when Margaret was in the bath that evening, it was not because she was attending to the other service user as she was already asleep in her bed. Mary Cameron was dealing with other matters but left Margaret in the bath for too long. That, of itself, would not have been an issue if she had not left the hot tap running.

[20] What was relevant to the death in terms of section 6(1)(e) was the whole scenario of the new TMV not being installed in 2010 in the upstairs bathroom at 903 Carntyne Road when it should have been. When the HSE became involved immediately after Margaret's death, a search was conducted for a TMV and it was eventually found and identified as the one which was originally installed in 2004/2005. If the Caleffi TMV had been replaced by a Triton TMV, it is possible the latter may not have malfunctioned and there would not have been hot water scalding. It seems that for whatever reason, the Caleffi was not replaced by the Triton and not only that, there was no record of why it was not replaced and where it was situated. On the Caleffi being tested on 8 November

2013, the maximum temperature of the hot tap of the bath was recorded as 54.9 degrees centigrade and it had been set at the maximum setting. Anything in excess of 44 degrees centigrade could cause serious injury or fatality. The testing also confirmed that the TMV was not mixing the water properly and the lack of grease on the spool of the valve was causing that. It is unlikely that the TMV had been tampered with by Enable Scotland staff and the setting which the valve was adjusted to was most likely the setting fixed either during installation or during any maintenance. Accordingly, the TMV could not prevent water at a temperature sufficient to cause scalding to flow from the hot water bath tap in the upstairs bathroom when Margaret was in the bath. Given that this state of affairs was not recorded anywhere, no-one could possibly be alerted to it and realise that there could be an inherent risk of scalding if the TMV was not regularly checked, repaired and maintained when necessary. My determination under section 6(1)(e) reflects the foregoing.

[21] It is of significance to record that the absence of a suitable and sufficient assessment of the risk to the health and safety of service users at 903 Carntyne Road, Glasgow, during bathing was identified by the HSE and was the subject of an Improvement Notice dated 14 October 2013 and that said Notice had been complied with by the required date of 2 December 2013. Enable Scotland's practice and procedures in relation to the assessment of risk to service users during bathing had therefore been addressed and changes made as required post Margaret's death. This clearly had followed an investigation post death by the HSE and the serving of an Improvement Notice on Enable Scotland requiring them to "carry out a suitable and

sufficient assessment of the risks from bathing service users to ensure that they are not at risk of being scalded in water that is too hot.” Compliance with the said Improvement Notice is welcomed by this Inquiry in the public interest.

[22] Finally, I wish to thank all of the witnesses for their assistance with this Inquiry and all counsel and solicitors for their valuable and professional contributions. I conclude by recording my condolences to Margaret’s family and in particular to her two sisters and nephew who sat in court throughout the Inquiry as observers, witnesses and lay representatives. I commend them for the way they conducted themselves with dignity and humility throughout and for their unfailing dedication in serving Margaret’s interests.