

Sheriffdom of South Strathclyde, Dumfries and Galloway at Hamilton

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976
(Hereinafter referred to as “the Act”)

Determination

by

Joyce Powrie, Advocate
Sheriff of South Strathclyde,
Dumfries and Galloway at
Hamilton

in the

Fatal Accident Inquiry

regarding

Mary Smith Devine

Hamilton: 24th July 2008

The Sheriff determines:-

- (1) In terms of Section 6(1)(a) of the Act that Mary Smith Devine residing formally at Greenbank Nursing Home, 24 Wellhall Road, Hamilton died at Wishaw General Hospital at 05:45 on 27th May 2005.

- (2) In terms of Section 6(1)(b) of the Act that the cause of death was (a) bronchopneumonia due to (b) fracture of cervical spine due to (c) fall at said Greenbank Nursing Home on 18th May 2005.
- (3) In terms of Section 6(1)(c) of the Act that reasonable precautions whereby the death and the accident resulting in the death might have been avoided were:-
- (i) Primarily, the use of appropriately fitted foot rests to the wheelchair in which Mrs Devine was being carried; and
 - (ii) Secondarily, the fitting and use of a seat belt or lap belt restraint in the wheelchair but only when used in conjunction with the above reasonable precaution.
- (4) In terms of Section 6(1)(d) of the Act defects in the system of working which contributed to the accident resulting in the death were:-
- (i) The lack of any clear formalised training of staff in Greenbank Nursing Home as to the safe transporting of residents within the care home in wheelchairs.
 - (ii) The lack of clear training for staff within Greenbank Nursing Home as to the need to use foot rests on wheelchairs at all times when transporting residents.
 - (iii) The lack of clear direction to staff within Greenbank Nursing Home as to the additional benefits of using seat belts or lap restraints in wheelchairs within the residential home when transporting residents and using footrests on wheelchairs.
 - (iv) The lack of any clear personalised risk assessment in respect of each resident when being transported in a wheelchair including the recording of the views of the resident, and/or relatives, and the addition risks involved in the use of pressure cushions in wheelchairs.

All the above defects have now been addressed by Greenbank Nursing Home.

- (5) That the facts relevant to the circumstances of death in terms of Section 6(1)(e) are set out fully in the note appended to this determination.

Sheriff

NOTE

A preliminary hearing into the circumstances of the death of Mary Smith Devine (hereinafter referred to as “Mrs Devine”) was held before me on 28th May 2008. At that time, Mrs Carnan, Procurator Fiscal Depute, appeared on behalf of the Applicant. I was advised that all relevant Productions had been lodged and that all interested parties had been intimated of the hearing assigned for 18th June 2008. I was further advised that although the family of the deceased had taken legal advice, they were not to be legally represented at the hearing. Apparently they were content for the Procurator Fiscal Depute to represent their interest. I was also advised that Greenbank Nursing Home (hereinafter referred to as “the Nursing Home”) was not to be legally represented.

Evidence was led before me on 18th, 19th and 20th June 2008. The late Mrs Devine’s two sons and two daughters were in court for the vast majority of the proceedings. In the course of proceedings, it became clear that one son, namely Mr Thomas Devine, normally resident in Switzerland, wanted to ask some supplementary questions after evidence had been led by the Procurator Fiscal Depute. With the assistance of the Depute, certain further questions were put to witnesses on behalf of the Devine family. Mr Devine also asked supplementary questions and was called as an additional witness to give evidence. Obviously, the nature of a Fatal

Accident Inquiry is somewhat difficult for a lay-person to understand and the court is most obliged to the Procurator Fiscal Depute for her assistance in fully engaging with Mr Devine in explaining matters to him, and asking supplementary questions.

I would also like to acknowledge Mr Devine's public announcement that he did not wish to apportion personal blame to Miss Lees, the care worker who was pushing Mrs Devine's wheelchair at the time of the accident. Further, Mr Wilson the Director of the Nursing Home also tendered his apologies to the family for their loss. The court trusts that this is of some comfort to all involved.

In this respect, there are two preliminary matters worth mentioning and these are:-

Firstly, an Inquiry of this nature is not determining any question of civil fault or liability (**Black v Scott Lithgow Limited** 1990 SLT 612) and of course a determination cannot be founded upon in any subsequent proceedings (**Section 6(3)**). Despite the wording of Section 6(1)(c) therefore the Sheriff does not have power to make findings of fault or to apportion blame.

Secondly, in terms of Section 4(7) the rules of evidence shall be as nearly as possible those applicable in an ordinary civil cause brought before the Sheriff. The standard of proof is the balance of probabilities and the facts and circumstances can be established without the necessity of corroboration.

The duties and powers of the Sheriff in respect of her determination are contained in Section 6 of the Act. This section provides as follows:-

“(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:-

- (a) where and when the death and any accident resulting in death took place;
- (b) the cause or causes 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.”

Summary of Events

Mrs Devine was aged 89 at the time of her death. She had been suffering from ill health for a number of years and had been cared for at home for some 12 or 13 years by her two daughters. In March 2002 her health was such that her daughters despite their obvious care and attention, could no longer care for her at home and she was admitted to Greenbank Nursing Home. Her two daughters continued to visit her on alternate days.

Mrs Devine’s medical history included congestive cardiac failure, high blood pressure, diverticular disease, recurrent urinary tract infections, Parkinson’s Disease and dementia. She was wheelchair bound.

On 18th May 2005 Miss Margaret Devine, one of Mrs Devine’s daughters, had been visiting her in the afternoon. In the late afternoon Mrs Devine was transported by wheelchair to the

dining room in the Nursing Home by Miss Nicola Lees. After having her meal and whilst being wheeled back to her room, Mrs Devine fell from her wheelchair and struck her head. She did not lose consciousness but was observed for any deterioration. She subsequently complained of a headache and was transferred to the Accident and Emergency Unit of Wishaw General Hospital. There she was noted to have a large number of bruises on her face, left hand and legs. X-rays at that time revealed no obvious injury and she was returned to the Nursing Home.

On the morning of 19th May following review of her X-rays by Wishaw General Hospital, Mrs Devine was transferred back to the hospital and admitted, as it was felt that she may have suffered a fracture to her neck. It was subsequently confirmed to be a fracture of the first cervical vertebrae. She was treated for this fracture with immobilisation of the neck but over the next eight days her condition steadily deteriorated with developing pneumonia and she died on 27th May 2005.

A Post Mortem was carried out on 1st June 2005 by Doctor John Clark, Forensic Pathologist, University of Glasgow.

Section 6(1)(a) Where and When Death Took Place

Mary Smith Devine died at 05:45 on 27th May 2005 at Wishaw General Hospital. This was recorded in Mrs Devine's medical records (Production 29 page 84), and spoken to by Doctor William McSween, the Consultant Orthopaedic Surgeon in charge of her case.

Section 6(1)(b) The Cause or Causes of Death

Doctor John Clark spoke to his Post Mortem Report (Production 2). He spoke to finding a large number of fading bruises on Mrs Devine's face, arms and legs which he considered to be consistent with a substantial fall. He spoke to the Post Mortem Photographs which were taken (Production 3). He was also referred to the photographs taken at Wishaw General Hospital (Production 31) which he confirmed were consistent with his findings. In his opinion, the forehead injuries sustained by Mrs Devine were typical of those associated with falling out of a wheelchair. In conclusion, Post Mortem Examination confirmed that Mrs Devine died from bronchopneumonia which was well developed and involved both lungs. Doctor Clark concluded that this would have been a natural development for someone of her age with her medical history and with the injury which she had suffered ie. a fracture of the upper end of the cervical spine (broken neck) with her resulting immobilisation. This was confirmed by Doctor McSween.

Although Doctor Clark could not confirm from his Post Mortem Examination that there was a cervical fracture, he was of the opinion that this had been adequately demonstrated in the hospital. He also confirmed that the pattern of injuries would fit with Mrs Devine having fallen from her wheelchair as described, striking her forehead on the ground and landing also on her left wrist and knee. He also stated that despite her fairly lengthy medical history there was remarkably little else to find at Post Mortem, other than coronary artery disease and ageing changes in the brain. He thus found that the cause of death was as previously stated. The family had been advised that Mrs Devine was suffering from MRSA. Doctor Clark stated that MRSA was a type of bacterial infection but was not significant in the cause of death of Mrs Devine. He stated that she had a high risk of developing pneumonia standing that she was elderly, had suffered a broken neck and already had other illnesses. He said that a urinary tract infection was very common in elderly people but did not lead to pneumonia. He said that a

urinary tract infection was not obvious in his Post Mortem Examination. He accepted however that this could affect the balance of the person infected and this could lead to dizziness.

Further, anyone with such an infection would not be “themselves” and could be drowsy and confused. Doctor Clark further stated that he was of the opinion that the broken vertebrae was significant in the cause of death. He was of the opinion that if Mrs Devine had simply fallen out of her wheelchair without having suffered such a break it may not have led to her death.

By and large all of the above was confirmed by Doctor McSween. He confirmed that when he was advised that Mrs Devine had suffered a fracture to her cervical spine, the prognosis was not good for her recovery. He took advice from the Southern General Hospital regarding her future treatment. Surgery was not recommended and soft items were used to support her neck. A surgical collar could not be used as this would have further restricted her breathing. He confirmed that this was a difficult case clinically because of all Mrs Devine’s pre-existing medical condition. He said that the major problem was maintaining her breathing and nutrition. He did not consider that MRSA or a urinary tract infection in any way contributed to her death. Antibiotics given to treat the chest infection from which she subsequently died, would also have been effective in dealing with any urinary tract infection also.

I was satisfied that the Nursing Home and Wishaw General Hospital had taken every possible step to care for Mrs Devine after her fall from the wheelchair. From the evidence led before me, I was satisfied on the balance of probabilities that the cause of the death was bronchopneumonia due to a fracture of the cervical spine due to a fall from a wheelchair.

The family of Mrs Devine raised the question as to whether MRSA or a urinary tract infection had contributed to Mrs Devine’s death. This was ruled out by both Doctor Clark and Doctor

McSween. I accept their evidence. There was nothing to contradict their opinion.

Accordingly, on the balance of probabilities, I do not consider that any such infections contributed to the death of Mrs Devine.

Section 6(1)(c) Reasonable Precautions whereby the Death and the Accident Resulting in the Death might have been avoided

It appears to me that many of the factors regarding what reasonable precautions could have been taken whereby the accident could have been prevented, and the examination of the system of work in place overlap. Further, in terms of Section 6(1)(e) ie. looking at other relevant factors, again there is some overlap.

There was evidence that Mrs Devine's needs had been assessed when she was admitted to the Nursing Home and reviewed every three to six months to see if there was any change needed. (See Production 4 being Mrs Devine's Care Plan). This clearly showed that Mrs Devine was immobile and required the use of a wheelchair when she first came into the Nursing Home. It was stated at page 2 of said Production dated 11/2/05:-

Mobility/Mobilising

“Mary remains immobile but is able to take her weight when transferring. 3 monthly moving and handling assessment carried out refuses to use standaid hoister”.

At page 3 of said report under the heading “**History/Risk of Falls**” it was stated:-

“Poor weightbearing capacity could lead to falls please ensure appropriate moving and handling techniques adopted.

Cot sides in situ potential for falling out of bed due to partial sight”.

Under the heading “**Personal Safety and Risk**” it was stated:-

“Cot sides in situ due to risk of falling out of bed overnight permission sought from both Mary and family”.

Production 4 showed further risk assessments relating to Mrs Devine which had been carried out by the Nursing Home. Page 36 showed the position prior to Mrs Devine’s accident on 18th May 2005. This recorded that she normally used a wheelchair. Further, she suffered from mild dementia. Physical constraints were listed as “previous fracture neck of femur”. Handling constraints were listed as “partially sighted”. Under “**History of Falls**” the box marked “yes” was ticked. Under the “**Assessment of Risk to Resident and Staff**” it was stated that in relation to standing, toileting, bathing, transfers and handling into/out of bed, the assessment of risk to Mrs Devine was “low” and that she required the assistance of two staff members in respect of these matters.

In evidence, which was not disputed, I was advised that the heading “**Transfers**” referred to moving Mrs Devine from a chair to a wheelchair or from a chair/wheelchair to bed and did not refer to transporting her in a wheelchair within the Nursing Home.

All the relevant witnesses accepted that there was nothing in Mrs Devine’s Care Plan prior to her accident as to how she should be transported in a wheelchair and that no risk assessment had been carried out in this respect. Further, her wishes with regard to the conditions of her being transported in a wheelchair had never been recorded nor had the views of her family been canvassed. The evidence from Mrs Hunter, the Manager of the Nursing Home, and Mrs Cassels, a staff nurse at the Nursing Home, was that following upon Mrs Devine’s accident,

they recognised that there was a risk factor of her falling out of a wheelchair and this was appropriately recorded although not actioned as Mrs Devine did not return from Wishaw General Hospital.

A wheelchair provided by the Nursing Home was lodged as a Production in this Inquiry. I was told that the Nursing Home had a pool of wheelchairs which were used by the residents. Mrs Devine used the type lodged in court which was of the wider variety. The wheelchairs were stored in the sluice room and taken to the resident as and when required. The wheelchairs were generally stored in the folded-up position. At the time of Mrs Devine's accident, footplates were not generally attached to the wheelchairs when they were so stored. There was a box adjacent to the wheelchairs which contained the requisite footplates. I heard evidence which I accepted, that the footplates were easily removed and fitted from the wheelchair. Accordingly, there was, in my opinion, no reason for staff not fitting footplates when required.

Staff Nurse Jean Cassels was clearly of the view that her practice and good practice would have been to use footplates on wheelchairs when transporting residents including Mrs Devine. She stated that she had heard from carers that Mrs Devine did not want footplates. However, she said that this would not have affected her own personal practice, and even if a carer had told her that Mrs Devine did not want footplates, she would have tried to persuade her that they should be used as she thought this was good practice.

Mrs Hunter, the Nursing Home Manager, also knew that Mrs Devine did not like footrests on her wheelchair but allowed her to have the choice not to use them although it was not included in her Care Plan. She considered that Mrs Devine was "small" and accordingly her feet did not reach the bottom of the wheelchair and thus it was decided that they would not insist upon her

using footplates although this was said to be against the general policy of the Care Home. However, Mrs Hunter said that an instruction to use footplates on wheelchairs had only been given verbally to staff and had never been put in writing at the time of the accident.

Miss Margaret Devine (Mrs Devine's daughter) stated that she never saw footplates being used on any wheelchair. In particular, she never saw footplates being used on her mother's wheelchair. Miss Nicola Lees spoke to not using footplates on Mrs Devine's wheelchair as she did not like them. It appeared to me from the other evidence led from Nursing Home Staff that this was a generally perceived view. Thus, on the balance of probabilities, I conclude that footplates were seldom used when transporting Mrs Devine in a wheelchair.

On the balance of probabilities, I conclude that footrests were not being used when Mrs Devine was being transported from the dining room in the Nursing Home to her room when she sustained the fall from her wheelchair on 18th May 2008.

On the balance of probabilities I also conclude that footplates were seldom used on wheelchairs when transporting other residents. I reached this conclusion standing that the general practice seemed to be that footrests were stored in a box adjacent to the wheelchairs rather than them being stored on the wheelchairs. It appeared to me from seeing the operation of the wheelchair being folded and stored as shown in court that there was nothing to preclude the footrests being stored on the wheelchairs as wheelchairs could fold readily when footrests were attached. There may have been a slight problem with footrests falling off when being stored but it did not appear to me to be an insurmountable problem to simply reattach them rather than store them in the adjacent box.

Miss Devine also spoke to her mother being frightened of sitting in the wheelchair although Mrs Devine never gave any explanation to her as to why this was. On the balance of probabilities, I did not accept the evidence that Mrs Devine was scared when sitting in the wheelchair. There was no other evidence to substantiate this claim. On the contrary, Mrs Devine clearly used a wheelchair on a daily basis to be transported to and from the dining room and the toilet. Further, she continued to sit in the wheelchair when eating meals and never voiced any disquiet to Nursing Home Staff. There was no evidence that Miss Devine had ever raised this matter with Nursing Home Staff or the rest of the family.

The Use of Pressure Cushions and their Impact on Stability of Wheelchair Users

A pressure cushion was used in Mrs Devine's wheelchair. It was not disputed that the use of such a cushion was totally appropriate given Mrs Devine's condition. However, evidence was led from Ms Joanne Booth a Senior Research Fellow in Gerontological Nursing at Glasgow Caledonian University, Doctor Okunribido, Ergonomics Section of the Health and Safety Laboratory Buxton and Mr Alasdair MacInnes, a Nurse Lecturer at the West of Scotland University Hamilton who all agreed that the use of a pressure cushion in a wheelchair was a contributory factor in the overall stability of Mrs Devine on the day of her accident. This was compounded by the fact that Mrs Devine was said to be tired on the day in question and was slumping forward in her wheelchair at the time of the accident.

All the above witnesses were well versed in the possible effects of the stability of wheelchair users when a pressure cushion was used. I was particularly referred to Ms Booth's Report being Production 5 and Doctor Okunribido's Report Production 36. Production 36 was a report prepared following upon a detailed assessment of the whole circumstances relating to Mrs Devine's death. This involved a large number of tests being carried out both in the

Nursing Home and in laboratory conditions. Tests were carried out using mannequins and test subjects using the wheelchair both in the Nursing Home and in the laboratory. The author of the report also studied various authenticated research papers on matters pertinent to this Inquiry, which assisted him in reaching his conclusions.

Doctor Okunribido stated *inter alia* at pages 17 and 18 of his report that:-

“When the occupant sat on the home pad (ie. pressure cushion) with feet unsupported, it was compressed considerably at the front edge due to the weight of the legs. The occupant’s knees were moved to a lower position than when occurred when they sat on the regular cushion. Thus there is a greater risk of a fall forward when sitting on the pressure cushion.”

However, all the above witnesses considered that such a risk could and would have been countered by the use of appropriate footrests on the wheelchair being used by Mrs Devine. Mr MacInnes in particular confirmed that the use of a pressure cushion would have raised Mrs Devine’s sense of gravity thus making her less stable in the wheelchair. All the above witnesses were of the opinion that the use of footrests in themselves were a reasonable precaution whereby the accident leading to the death of Mrs Devine could have been avoided.

The Fitting and Use of Footrests

On the balance of probabilities, I concluded that a reasonable precaution whereby the death and the accident resulting in the death might have been avoided was primarily the use of appropriately fitted footrests on the wheelchair in which Mrs Devine was being carried. This was very clearly confirmed by the three witnesses previously referred to. It was also clear that Miss Cassels was also of the view that the accident could have been avoided by the use of footrests.

In particular Doctor Okunribido confirmed in his technical report how the lack of footrests would have left Mrs Devine's feet "dangling" or if she was leaning forward with her feet close to the floor, this would have led to the accident. In particular his report at page 18, (under reference to Photograph 9) states:-

"Supporting the feet on footplates causes the whole leg to be raised from the floor and the knee (hip) to be more flexed toward the back of the chair. As a result the extent to which the trunk can be flexed forward from the backrest is thereby reduced. Thus there is a lower risk, that an occupant may fall forward out of the wheelchair when the feet are supported on the footplate than when they are unsupported."

His evidence in court supplemented this report by explaining that the weight of the footrests acted as a counterforce by lifting the feet considerably off the ground which throws back the centre of gravity when the feet are raised by the legs being flexed, and bent closer to the body. It was explained that this reduces the amount a person can lean forward and forces the back towards the backrest of the chair. On the balance of probabilities I accepted this evidence as it was supported by the evidence from Mr MacInnes and Ms Booth.

The Fitting and Use of Seatbelt and Lapbelt Restraints

The evidence showed that in general the wheelchairs used in the pool at the Nursing Home were not fitted with seatbelts at the time of the accident. This practice has since been changed by the Nursing Home but I will deal with this later in my note.

The main evidence in this respect came from the witnesses previously referred to. In particular Ms Booth was quite clear in her view that a seatbelt alone as a preventative measure could not in fact have prevented the accident. She was of the opinion that had Mrs Devine been strapped

into her wheelchair without the use of a footrest this could have in fact had the potential for the whole chair and the occupant to have been tumbled forward. She said that she had seen one such occurrence and that such an accident would have come about as a result of a pivoting motion which would have gathered momentum and taken the chair and the occupant forward resulting in an accident to the occupant.

Doctor Okunribido thought that there were recognised safety benefits from using a seatbelt particularly when transporting residents around the Home. However, he did not envisage the problem identified by Ms Booth and thought that there would have to be a very steep gradient or leaning forward by the occupant of the wheelchair for a safety belt on its own without footrests to cause a topple forward and falling out of the wheelchair. Even in such a scenario, he considered that a carer would be able to hold back the force of the toppling movement. He was of the opinion that if he had to choose only one of the two options, namely the use of footrests alone or the use of seatbelts alone, he would choose the former.

In addition Mr MacInnes also thought that the use of seatbelts was a secondary precaution when used in conjunction with footrests. He considered that seatbelts if fitted were suitable and advisable for use when the wheelchair was in motion.

Mr Wilson, the Director of the Nursing Home stated that in his view this accident would have been prevented if seatbelts had been fitted to Mrs Devine's wheelchair and used at the time of the accident. He further stated that his major change in policy since the accident had not been to use footplates, but to use seatbelts. I did not agree with Mr Wilson's view. On the other evidence available to me, I considered upon the balance of probability that seatbelts alone would not have been a reasonable precaution whereby the death and the accident resulting in

the death of Mrs Devine might have been avoided. However, I did decide upon the balance of probabilities that a secondary reasonable precaution whereby the death and the accident resulting in the death might have been avoided would have been the fitting and use of a seatbelt or lapbelt restraint in the wheelchair when appropriately fitted footrests to the wheelchair in which Mrs Devine was being carried were used.

Defects in the System of Working which Contributed to the Accident Resulting in the Death in terms of Section 6(1)(d) of the Act

My Determination as set out in sub-paragraphs (i), (ii) and (iii) relate to the training of staff in the safe transporting of residents in wheelchairs and the use of footrests and seatbelts or lap restraints. There was clear evidence from Nursing Home management and staff that the moving and handling training of staff prior to Mrs Devine's accident did not include the safe transporting of residents in wheelchairs and the use of footrests and seatbelts or lap restraints. I accepted the evidence of Mr Wilson, Mrs Hunter and Mrs Cassels that it was the general policy of the Nursing Home that footrests should have been used on wheelchairs at all times. However, in my opinion, this policy was not adequately conveyed to all members of staff particularly care assistants such as Nicola Lees. The training that Miss Lees received prior to Mrs Devine's accident clearly did not show that she was trained in how to properly convey a resident in a wheelchair and the necessary safety factors. Miss Lees was obviously not aware of the safety implications in using a wheelchair and the benefits of using footrests and seatbelts.

From the evidence before me it did appear that management and qualified nursing staff were aware of the safety benefits of using footrests on wheelchairs prior Mrs Devine's accident. There was nothing in writing to alert other less qualified staff as to these benefits prior to Mrs Devine's accident. Footrests were not routinely kept on the pool of wheelchairs in my opinion

but were rather stored in a separate adjacent box, and were not used on a regular basis on wheelchairs. This was known by management. In these circumstances, it appeared to me that there was at best a “blind eye” being turned by management of the Nursing Home as to the manner in which residents were being transported in wheelchairs. In particular, Mrs Hunter knew of Mrs Devine’s aversion to the use of footrests but took no steps to redress this problem. She justified this by saying that Mrs Devine was “allowed to have her choice” and further, Mrs Devine was “small” and accordingly her feet did not reach the bottom of the wheelchair. I did not accept this as acceptable, standing she knew the risks involved in not using footrests.

It was clear from the evidence of Mr Wilson, Mr Hunter, Nicola Lees and Mr MacInnes that since the accident a new training regime had been set up whereby all the previous defects in training regarding the proper use of wheelchairs had been addressed. It was confirmed by Mr MacInnes that this had been done without any additional cost to the Nursing Home. Upon the balance of probabilities, it appeared to me that this previous lack of training had not been due to any monetary factor but rather a lack of understanding for the need to provide training in the safe transportation of residents in wheelchairs. I considered that although nursing staff were aware of the problems potentially involved in transporting residents in wheelchairs, this had not been adequately conveyed to other members of staff such as Nicola Lees prior to Mrs Devine’s accident. This, however, has now in my opinion, on the balance of probabilities been adequately addressed by the Nursing Home.

The Health and Safety Executive and the Care Commission were actively involved at all times in supervising the management of the Nursing Home. At all times the Nursing Home complied with their policies and enquiries. Following upon Mrs Devine’s accident the Nursing Home produced a document Production 10 whereby it was stated that the policy of the Nursing Home

was that the Nursing Home would use footrests and seatbelts on all wheelchairs when transporting residents.

Restraint

In relation to Section 6(1)(c), (d) and (e) of the Act, a question raised in respect of the use of seatbelts in wheelchairs related to whether or not such use amounted to “restraint”. In this respect I heard evidence from the Nursing Home staff, Mr MacInnes, Ms Booth and Miss Brimelow of the Care Commission. Evidence was also led from Ms Edgar who had looked at the evidence from an independent point of view.

At the time of Mrs Devine’s accident I considered on the balance of probabilities that residential homes and Greenbank Nursing Home in particular, were extremely reluctant to use safety belts in wheelchairs as this could be considered a form of restraint which would have been against the residents’ human rights.

Greenbank Nursing Home thought that before they could use a seatbelt in transporting Mrs Devine this could only be done after calling a multi disciplinary meeting and recording in her Care Plan special measures for the use of a seatbelt. It was felt at the time of Mrs Devine’s accident that there was no need for such a meeting or use of such a measure. This, in retrospect, had been found to be incorrect and has been addressed by the Nursing Home.

There was evidence before me, which I accepted upon the balance of probabilities, that it was a “grey area” as to whether the use of seatbelts in a wheelchair was a restraint or a safety measure. The guidance provided by various agencies such as the Care Commission did not clearly define what was “restraint” and what was a safety measure. In my opinion at the time

of Mrs Devine's accident, such use of a seatbelt when transporting a resident, may have been considered as a "restraint" with justification standing the above. However, in view of the position which has moved forward since that time, I consider that the additional use of a seatbelt when transporting a resident would not be a "restraint" but rather a safety measure in appropriate circumstances. I consider that this is a matter which individual Nursing Homes would have to assess when carrying out individual risk assessments of residents. However, on the balance of probabilities, I consider that at the time of Mrs Devine's accident, the Nursing Home did not adequately assess the additional benefits of using a safety belt in conjunction with footrests when transporting residents in wheelchairs. In terms of the new policy, this has on the balance of probabilities been adequately addressed by the Residential Nursing Home in terms of their amended policy in the use of seatbelts.

The Lack of any Clear Personalised Risk Assessment in Respect of Mrs Devine being Transported in a Wheelchair

I have previously summarised the risk assessment (Production 4) which showed a basic need assessment in respect of Mrs Devine's poor mobility. Therein it is identified that there was a risk of falls and the use of appropriate moving and handling techniques. However, there is no specific mention of a risk of falls from a wheelchair at any time. Such a risk was not considered until after Mrs Devine's fall from the wheelchair resulting in her death.

In the moving and handling risk assessment (at pages 36/37) Mrs Devine's use of a wheelchair is recorded but is not risk assessed. This in my opinion, is surprising given that the risk involved in her otherwise falling is recorded.

There was clear evidence which I accepted, that the Care Plan had been prepared by an experienced nurse and thereafter supervised by experienced staff. Ms Booth indicated that in

her experience this was a Care Plan which was similar to those prepared by other Nursing Homes. She described it as “adequate”. However, it was significant that the experienced nurse, Miss Cassels, who gave evidence was alert to risks from falling from a wheelchair. Her notes, post accident, is evidence of the fact that she had noticed the risk of Mrs Devine falling from a wheelchair on the day it happened. This was with a view to subsequently reviewing Mrs Devine’s Care Plan. This was in addition to assessing her risks of falling out of bed which had previously been identified.

The Procurator Fiscal Depute submitted that there was a possible argument that had staff in the Nursing Home followed the then verbal instructions regarding the use of footrests then it was not at all foreseeable that Mrs Devine could have fallen out of her wheelchair. This was based upon the premise that management and qualified nursing staff of the Nursing Home were fully conversant with the need to use footrests on wheelchairs and the reasons therefore and assumed staff would carry out verbal directions. As previously stated, I considered that this was a totally misplaced assumption, as lack of training had not made other staff aware of the safety implications. Accordingly, I concluded that no personal risk assessment in respect of Mrs Devine when being transported in a wheelchair had been carried out. However it was, in my opinion, clear that this would have been done following upon Mrs Devine’s accident if she had returned to the Nursing Home.

However, in my opinion, there was clear evidence to suggest that the risk assessment and Care Plan should have recorded the views of Mrs Devine and/or her relatives as to the use by Mrs Devine of the wheelchair. As previously stated there were conflicting views as to Mrs Devine’s preference for the use of footrests. Standing that the Nursing Home was well aware that footrests should have been used, this is a matter I consider should have been fully

canvassed with Mrs Devine and her relatives who were obviously in attendance on a regular basis. The question could have been clearly resolved if the views of Mrs Devine and/or relatives and staff had been clearly canvassed and recorded in her Care Plan. On the balance of probabilities I considered that if this had been recorded in Mrs Devine's Care Plan it would have indicated that she did not wish foot restraints to be used when she was transported in her wheelchair. However, I also consider on the balance of probabilities attempts should have been made to persuade Mrs Devine from this view and that footrests should have been used on her wheelchair when she was being transported within the Nursing Home. There was no evidence in my opinion to suggest there were any attempts made to persuade her that footrests were an important safety measure. As such what should have been a matter of choice for Mrs Devine was not clearly explained to her. Miss Cassels in particular considered that she would have tried to persuade Mrs Devine that the use of footrests was important. However, there was no evidence at all that she had ever tried to do this. In short I do not consider that the Nursing Home ever considered the risks of Mrs Devine falling out of her wheelchair until after her accident.

However it is quite clear that the policy of the Nursing Home is now that footrests are used in all wheelchairs when residents are being transported and further that a seatbelt or lap restraint is also used when residents are being transported. The Nursing Home have, in my opinion, clearly reviewed their position as to what amounts to "restraint" in that now footrests and seatbelts are now used routinely when transporting patients in the Nursing Home.

Accordingly, I consider that all defects in the system of working which contributed to the accident resulting in the death of Mrs Devine have now been addressed. I consider on the balance of probabilities, that if such a consultation had been undertaken, possible defects in the system of working could have avoided the accident resulting in the death of Mrs Devine.

However, I must restate my opinion that the relatives of Mrs Devine did not raise any relevant concerns to the staff of the Nursing Home regarding her transportation in a wheelchair. In my opinion, Mrs Devine's relatives were obviously very caring for her wellbeing and could easily have raised any concerns for her care with the Nursing Home Management. This was never done until after her death. Obviously, this does not absolve the Nursing Home of their primary duties and responsibilities.

In evidence Miss Brimelow from the Health Care Commission stated that they received a complaint from a named person who wished to remain anonymous regarding concerns about the services that Greenbank Nursing Home was providing to users using wheelchairs and staff not using laptop restraints and footrests when transporting users in wheelchairs between the original building and the extension. She stated that they treated such complaints very seriously and were sufficiently concerned, although busy, to investigate this complaint. Her inspectors accordingly made an unannounced visit to the Nursing Home on 24th May 2007 at a busy time namely lunchtime. This unannounced visit totally exonerated the Nursing Home and found that they were totally compliant with all requirements.

There was no other suggestion of any other complaints against the Nursing Home. On the contrary, both the Health and Safety Executive and the Care Commission confirmed that the Nursing Home had complied fully with them at all times and had not been subject to any enforcement action. As a result of the foregoing inspection all transportation of residents was found to be in order. Accordingly, it was deemed that there was no irregularities in the Nursing Home's procedures. I have no doubt at all that the Care Commission investigated a full investigation of this complaint and that there was no subsistence in it whatsoever. Indeed, I cannot see why such a complaint in May 2007 was ever made standing that Mrs Devine died

in 2005 and so far as I could ascertain the family of Mrs Devine had had no contact with the residential home since that time.

Facts which it was suggested may be Relevant to the Circumstances of the Death in terms of Section 6(1)(e)

(a) Gradient of the Ramp within the Nursing Home

I did not find, on the balance of probabilities, that this was relevant in the circumstances of Mrs Devine's death. I only include reference to the evidence as it was a major factor in the investigations and the evidence at the Inquiry. ~Accordingly, I consider it appropriate to summarise the evidence led before me and my reasons for rejecting this as being a contributory cause of the accident leading to Mrs Devine's death. Production 6 was a Book of Photographs showing the ramp which connected the traditional sandstone part of the Nursing Home Building with a single storey extension to the rear accommodating twenty bedrooms. The dining room was in the main building and Mrs Devine's bedroom was in the extension. Basically coming from the main building there is a flat area outside the door to the main building followed by a downward ramp of 2.3 metres in length. There is then a flat area beside a toilet followed by a second downward ramp extending 1.9 metres leading to a level area outside the first bedroom in the extension.

Mr Wilson gave evidence regarding the conversion of the building. He said that the ramp was an afterthought as there were problems regarding the difference in height between the old building and the new extension. He stated that the Architect designed the ramp to comply with building regulations and that a building completion certificate was issued in respect of the work.

Mr Wilson spoke to having a meeting with Miss Edgar of the Health and Safety Executive in about September 2006 when concerns were raised by Miss Edgar regarding the gradient of the ramp. He stated that he had suggested that when a further new extension was built to the Nursing Home the ramp would be changed. The plan was to extend the ramp and make the gradient less. However, this work had not to date been carried out as the Nursing Home had not received planning permission for the new extension.

However, the main evidence in this respect came from Doctor Okunribido. I have previously referred to his very detailed report being Production 36. He carried out extensive tests regarding wheelchair use on the ramp. I do not intend to rehearse his findings as to the gradients and all the tests he carried out as they are somewhat complex and are more specifically set out in his report. Doctor Okunribido also had regard to a considerable amount of technical data when making his assessment. He considered the data in relation to whether the ramp's gradient was suitable for transit of carer propelled wheelchairs and self propelled wheelchairs. He found that there was a difference in what was a safe gradient in respect of the two groups.

Mrs Devine was not capable of propelling her own wheelchair. She required the assistance of a carer to push her wheelchair up and down the ramp. In these circumstances the opinion of Doctor Okunribido was that "the slopes of the two ramps are adequate (not excessively steep) for the carer and wheelchair pushing/pulling tasks that are performed".

Thus, Doctor Okunribido was of the opinion that the gradient of the ramp was not too steep for safe wheelchair use and that Mrs Devine's fall out from the wheelchair was not due to the ramp's gradient. I found Doctor Okunribido to be an impressive witness who had clearly

carried out a great deal of research into this case. Accordingly, upon the balance of probabilities, I concluded that the gradient of the ramp did not in any way contribute to the accident resulting in the death of Mrs Devine.

My opinion with regard to this matter was further reinforced by the evidence given by Miss Brimelow regarding the Care Commission's inspection in May 2007 following upon the complaint I previously referred to from a named person who wished to remain anonymous. Production 39 was the Care Commission's response which found no basis for any concern, regarding the safe use of wheelchairs on the ramp.

One further matter that was raised with regard to the ramp was whether or not the forces used in bringing Mrs Devine's wheelchair to a stop at the bottom of the ramp had in any way contributed to the accident. Doctor Okunribido stated that in his view the momentum of movement down the ramp would not cause the occupant of a wheelchair to topple out. He stated that if the carer was coming to a stop on the level ground and an extra force was applied to the handles of the wheelchair to bring the chair to a stop then that could create an impact on the occupant. However, he opined that the degree of force would have to be a quite extreme stopping/pulling force to have the effect of making the occupant fall out of the wheelchair.

The evidence in respect of how Mrs Devine's wheelchair was brought to a halt prior to the accident came from Miss Lees. Miss Lees said that she had two hands on the handles of the wheelchair as she was coming down the ramp towards the lower flat area. She said that she stopped at the lower area as there were other lady residents walking down the corridor in front of her and she was aware that she had to stop. She said that she stopped the wheelchair slowly. I accept that on the balance of probabilities that this is true and accordingly there was not a

sufficient force on the wheelchair which could have in any way contributed to Mrs Devine's accident.

(b) The use of Pressure Cushions

I have previously addressed this matter.

(c) Interpretation of "Restraint" in the Care Home Setting

I have also previously addressed this matter.

(d) Accident Report

I do not consider that this was a fact which was relevant to the circumstances of Mrs Devine's death. I have only provided a note of the evidence and my findings thereon as it was a matter pursued in evidence and particularly referred to by Mr Tom Devine in his closing submissions to me, who appeared to find this a major concern into the investigation into his mother's death. In this respect, I have previously pointed out the purposes of a Fatal Accident Inquiry which may not have been totally understood by Mr Devine. Accordingly, I do not consider that this is a matter upon which I should make a Determination.

Very shortly after Mrs Devine's accident the Nursing Home prepared an Internal Accident Report (Production 8). This was an extremely brief document which gave minimal information regarding the circumstances of the accident.

In evidence this was criticised by Miss Edgar the Health and Safety Executive (hereinafter referred to as "HSE) who was not initially involved in the case. Although the Nursing Home advised the Health and Safety Executive timeously of the accident as they were required to do,

no investigation was carried out immediately by the HSE for reasons which are unknown.

Miss Edgar was only involved in this investigation in about August 2006 after investigations were being undertaken by the Procurator Fiscal's Office.

Miss Edgar was extremely critical of the lack of specification in Production 8 namely the Accident Report Form. She considered it to be totally inadequate in that it did not give any medical consequences for Mrs Devine and the description of the event was superficial. She stated that she would like to see for example:-

1. Was it connected with a work activity?
2. What equipment was involved and the make of it and the condition of it?
3. Whether or not the equipment ie. the wheelchair had been maintained and could footplates have been easily adjustable or were in place?
4. Was the pressure cushion in use and the type thereof and whether that had slipped during the course of the accident (although it was conceded that this was unlikely to slip)?
5. The condition of the premises where the accident had occurred and for example, the surface type of flooring where the accident occurred.
6. Whether or not there was a link to the ramp where the accident occurred.
7. The name of the person supervising Mrs Devine and what training that person had had.

In other words Miss Edgar suggested that the report should have captured the evidence regarding the accident at the earliest possible opportunity and drawn together all relevant factual information. She also suggested that the Care Plan should have been referred to and in particular whether or not that required to be reviewed in light of the accident. She suggested that there should have been a system of work whereby one member of staff at the Nursing Home dealt with the medical matters relating to the accident and treating Mrs Devine and

someone else dealing with recording the above details as soon after the accident as possible. She suggested that in this particular case the wheelchair for example, could have been taken into a side room soon after the accident so that the relevant details could have been recorded.

I accept that Production 8 was in extremely short compass. However, I also accept that it was completed very shortly after Mrs Devine's accident and on the balance of probabilities I consider that it was an adequate recording of matters taken so shortly after the accident. However, again on the balance of probabilities I agree that Miss Edgar's comments are wellfounded as to how the Nursing Home should have thereafter proceeded in collating the information she suggested.

On the balance of probabilities I considered that this has now been addressed by the Nursing Home. Mr Wilson advised the Health and Safety Executive in Production 8 at .5 of a letter to them dated 22nd November 06 (Production 15) that nursing staff were to fill in Accident Reports more fully and gather more appropriate information.

Mr Devine made some closing remarks which he urged me to consider. He submitted that if the investigation report prepared by Greenbank Nursing Home had been adequate the court and the family would be better able to understand why Mrs Devine fell out of the wheelchair. I accept that the investigation report which was prepared very shortly after the accident was very short. However, standing the evidence led in this three day Inquiry, I am of the opinion that all relevant facts have now been fully canvassed. Mr Devine suggested that "no one knows for sure" why his mother tipped forward. I cannot provide a Determination which satisfies this criteria as our law only allows me to make Determinations upon the balance of probabilities.

Mr Devine also suggested that the accident had been caused by the wheelchair coming to an abrupt halt at the bottom of the ramp because of people in front. However, as previously stated I do not consider on the balance of probabilities, that there was any such abrupt halt. Miss Lees was clearly in a position to see that there were people in front of her and that she would require to stop. Mr Devine suggested that the court had not explored the effect of less extreme stopping. However, I do not consider that this was a relevant complaint standing that, upon the balance of probabilities, I considered that only a controlled stopping of the wheelchair occurred in this accident, and Doctor Okunribido's evidence that extreme force would be required to cause Mrs Devine to fall out of the wheelchair.

Mr Devine also seemed to think that lessons still require to be learned by the Nursing Home Management regarding the proper training of accident investigation. Again, on the balance of probabilities I did not agree with his view that this had not been addressed standing the Nursing Home's Policy (Production 10) and the observations carried out by the Care Commission Staff following the unnamed complaint.

Mr Devine also suggested that there should be a "Audit Programme" set up by the Nursing Home. This he suggested should be a person or persons trained in "safety auditing" who would observe people while they worked and for example, report any person pushing a wheelchair without footplates to a relevant person. It appeared to me that there was no such need for such a programme standing the clear directions which were now in place in the Nursing Home. I was further reinforced in this view standing the observations of the Inspectors from the Care Commission and the Care Commission's strict inspection rules.

Mr Devine also criticised the Health and Safety Executive as being amiss for not carrying out an investigation into Mrs Devine's death shortly after the accident. The reasons for this were not clear but I do not consider that this is part of my remit. What was, however, clear to me from the evidence led, was that the Nursing Home had at all times complied fully with the Health and Safety Executive and the Care Commission.

It was suggested by the Procurator Fiscal Depute that for the care community at large, there were important lessons which could be learned from this accident regarding the use of wheelchairs and the systems in place for training of staff in their safe use and also risk assessment in the transporting of residents in wheelchairs. It was also suggested that this Determination could be of value when the care community when reporting and investigating accidents. It is now more than three years since this unfortunate accident occurred. It may be that many lessons have already been learned. In particular the Care Commission in my opinion, obviously takes an extremely full active role in monitoring Nursing and Residential Homes and keeping abreast of best practice, and advising accordingly. My Determination may be of assistance in avoiding future accidents involving the safe transportation of residents in wheelchairs. However, I do not consider my remit in any way allows me to make any recommendations upon how accidents in Residential Homes should be reported or investigated.