INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT INTO THE SUDDEN DEATH OF GEORGE McGARRY

SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES & GALLOWAY

AT AYR

DETERMINATION

by

JOHN MONTGOMERY, Sheriff of South Strathclyde, Dumfries & Galloway at Ayr

Inquiry into the circumstances of the death of George McGarry residing latterly at 59 Ardfin Road, Prestwick

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Parties to the Inquiry:

Procurator Fiscal represented by Mr R Bloomer, Procurator Fiscal Depute.

Ayrshire & Arran Health Board represented by Mrs D Kane, Solicitor.

AYR: 4 April 2006.

The Sheriff, having considered all the evidence adduced, DETERMINES:-

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"), that George McGarry, born 5 September 1931 died at the Ayr Hospital, Ayr around 1015 hours on 15 January 2004.

2. In terms of Section 6(1)(b) of the Act that his death was caused by:-

I. (a) right coronary artery thrombosis;

I. (b) Coronary artery atherosclerosis;

Contributory Causes:-

II. (a) Bronchial carcinoma;

II. (b) Chronic obstructive pulmonary disease.

NOTE

This Inquiry centred around the cause and effect of a fire which occurred in Mr McGarry's room in the Ayr Hospital on 11 January 2004 four days prior to his death.

In the course of the Inquiry the Crown led evidence from 19 witnesses over four days. None of the evidence as to fact was contradicted or in any way seriously challenged. Mr Bloomer, for the Crown, and Mrs Kane, for Ayrshire and Arran Health Board were in agreement as to the determination which I should make in terms of Sections 6(1)(a) and 6(1)(b) of the Act. They both submitted that it was clear from the evidence that there was no causal connection between the fire and Mr McGarry's death. Accordingly there was no accident which had resulted in death. This precluded any determination in terms of Sections 6(1)(c) and 6(1)(d) of the Act which respectively relate to reasonable precautions or defects in any system of working relating to the death or any accident resulting in it. Mr Bloomer submitted that it was open to me to make a determination in terms of Section 6(1)(e) of the Act which relates to "any other facts which are relevant to the circumstances of the death". In Mr Bloomer's view the fire which occurred was a "relevant circumstance".

Although Mr McGarry's death was not causally linked to the fire or any injuries which he sustained thereby or any treatment which he received as a result such is the public interest and of course the interest of Mr McGarry's family in the unusual if not unique circumstances of this case that it is appropriate that the circumstances surrounding the fire are set out in this determination.

Brief History Prior to the Fire

Mr McGarry had a poor medical history of respiratory illness. For many years he had suffered with chronic obstructive pulmonary airways disease and chronic bronchitis. He was diagnosed on 11 November 2003 as suffering from lung cancer. His consultant Dr Elliott estimated that he had two months to live from then.

Mr McGarry was a long term heavy smoker. Despite his respiratory problems he did not cease smoking. He suffered breathlessness to such an extent that he required oxygen. His doctors however refused to prescribe oxygen for use at home because of the well known dangers associated with smoking in an oxygen enriched environment. Mr McGarry was well aware of these dangers.

Following him being diagnosed with lung cancer Mr McGarry refused active treatment such as radiotherapy or drug therapy. Such treatment would in any event have been palliative and not curative. Following his admission to the Ayr Hospital on 2 January 2004 he eventually agreed to submit to a course of palliative radiotherapy. The intention was that he would be transferred to a Glasgow Hospital to receive that therapy. He died before arrangements could be put in place.

At some time after Mr McGarry's admission to the hospital he was transferred from a six bed ward to a single bed side room (room 307) at Nurse Station 8.

He was prescribed oxygen which was supplied from a piped source to a point adjacent to his hospital bed. He received the oxygen by way of mask or nasal cannulae. He was basically immobile.

He continued to smoke after his admission. Generally this occurred under supervision of his relatives who routinely during visits conveyed him to a point outside the front door of the hospital where smoking was permitted.

Nurses suspected that Mr McGarry had on occasions furtively smoked cigarettes in his hospital room although none of them witnessed this. They suspected that he had smoking materials in his room. He had during a previous admission to the hospital in December 2003 on one occasion been permitted to smoke a cigarette in a hospital room under close supervision of an auxiliary nurse. He was not on oxygen when that occurred. The circumstances surrounding that occasion were exceptional. Neither the nursing staff, nor any other members of the hospital staff, were empowered to remove smoking materials from patients without consent.

In January 2004 the hospital had a tobacco policy. The thrust of it was that smoking by patients particularly long term and terminally ill patients, was only permitted in the hospital at the discretion of the nurse in charge of the individual wards. If it was allowed then the patient had to be supervised by a member of staff.

The Fire

On 11 January 2004 around 8.30 p.m. Mr McGarry was given tea and biscuits in his room by Auxiliary Nurse Mabel McLarty. Shortly thereafter Staff Nurse Fiona Scott drew Auxiliary Nurse McLarty's attention to a smell of burning in the corridor off which Mr McGarry's room was situated. The smell of burning increased as they approached Mr McGarry's room. When they reached the room they found the door shut and the room full of smoke described as a misty haze. No flames were noted by them. Mr McGarry was sitting on the edge of his bed facing away from the door. When he was given the tea and biscuits he was seated on top of his bed with his feet pointed towards the bottom of the bed.

Staff Nurse Scott and Auxiliary Nurse McLarty almost immediately entered the room. No more than 15 minutes had lapsed at that point from the time Mr McGarry was given tea and biscuits. They discovered that some parts of Mr McGarry's pyjamas were smouldering, there was limited fire damage to the bed clothes and the mattress beneath was smouldering in places. They saw that Mr McGarry had sustained various burns and that the nasal cannulae supplying the oxygen had melted. They closed the door behind them and opened the window to allow the smoke to escape. They unplugged electrical equipment, and wet the bed clothes and mattress. They were joined by Staff Nurse Arlene Robertson and night co-ordinator Sharon Muir. Mr McGarry reluctantly following encouragement by the nurses moved off the bed and sat on a chair. Cold compresses were applied to his burns.

Mr El-Banna, a surgeon, was quickly summoned and quickly attended to examine Mr McGarry's burns. He examined Mr McGarry and diagnosed that the burns which he received to his face, neck, legs and hands were mainly first degree burns with a small full thickness burn.

In Mr El-Banna's opinion the burns which Mr McGarry sustained were not life threatening and did not require surgery. He was already on antibiotics and

intravenous fluids which are appropriate to treat such burns. Additionally Mr El-Banna prescribed topical soothing agent creams.

Mr McGarry was moved to another room and the nurses tidied up the room in which the fire had occurred. They bagged his clothing and the bed clothes and caused the mattress to be moved by a porter to an equipment room.

When they discovered the fire the nurses did not activate the fire alarm. Neither did they contact the Fire Service or cause it to be contacted. On the night the fire occurred the incident was reported to Ward Sister Frances Kelly and Dr Robert Masterton the hospital duty manger who were both at home. Neither gave instructions for the Fire Service to be contacted. The incident was reported to the hospital's in-house Health and Safety officers and Fire Officer on the day following the fire. They carried out investigations.

There is a smoke detector located a few metres away from the door of the room in which the fire occurred on the ceiling of the corridor leading to the room. It did not activate during the fire because the smoke from the bedroom did not reach it. The day following the fire it was tested and found to be in working order.

Mr McGarry's room was fitted with an emergency push alarm on the wall adjacent to the head of his bed. It was also fitted with a "nurse call" buzzer. Mr McGarry did not operate either in the course of the fire. After the fire both were tested and found to be in working order. The oxygen supply equipment in the room was tested following the fire and found to be in good working order.

There is a manually operated fire alarm located at the Nurses Station in the ward. On the occasion of the fire no one operated it. It was tested on the day following the fire and found to be in working order.

After the fire a lighter, cigarettes and tobacco were found on or in the locker in Mr McGarry's room. They were given to his family.

Mr McGarry admitted that he had caused the fire by smoking while receiving oxygen by way of nasal cannulae. He refused to say who had given him the lighter. Prophetically he told Ward Sister Frances Kelly that he would take that information to his grave. The remnants of a cigarette with some burning at the tip was found inside the damaged bed mattress.

Following the fire Mr McGarry continued to receive palliative care. Prior to the fire he had been on pain relief in the form of morphine. After the fire he continued to be given morphine with doses of diamorphine as necessary for pain relief.

An autopsy on Mr McGarry's body was carried out by Doctor Joyce Lang, Consultant Pathologist, on 18 January 2004. Her conclusion was that the causes of death were as stated earlier in this determination. She was of the view that Mr McGarry's death could not be linked either directly or indirectly to the burns which he sustained in the fire or any smoke inhalation which he endured as a result. Neither was there any evidence that the morphine and diamorphine given to him following the fire had in any way caused his death. Doctor Lang's view on these matters was shared by Mr

McGarry's respiratory consultant Doctor John Elliott. No clinician who gave evidence at the inquiry was otherwise minded.

On 15 January 2004 the Fire Service reconstructed the post fire scene in the room where it had occurred. Fire Officer Lynn concluded that the fire must have occurred when an ignition source, such as a lighter ignited Mr McGarry's pyjamas in an oxygen enriched atmosphere causing his pyjamas to burn. This in turn progressed to the bedding and the mattress. It is likely that immediately prior to the fire Mr McGarry's pyjamas were impregnated with oxygen from the nasal cannulae. In his view the fire would have burned quickly. He estimated that the fire would have lasted a maximum of eight minutes.

At the time of the accident the hospital was fitted with what is known as an L3 fire detection and alarm system which complies with current fire safety regulations. The system was working at the time of the accident. Since the accident the system has been upgraded and funding is presently awaited to convert it to what is known as an L1 system which will have more fire and smoke detection devices than currently exists. At the time of the accident the hospital had a valid Fire Certificate.

The hospital now operate a "No Smoking" policy throughout in line with the Smoking, Health and Social Care (Scotland) Act 2005.

Conclusion

The fire was caused by the action of Mr McGarry in smoking a cigarette in an oxygen enriched atmosphere. No evidence was led at the inquiry which would have permitted a submission that the hospital staff could have acted in any way reasonable to prevent it. No evidence was led which would permit findings as to how such an accident could be prevented in future.

Mrs Kane submitted that the coming into force of legislation banning smoking in Scotland's enclosed public places had usurped any finding or recommendation which this Inquiry could make regarding the hospital's previous tobacco policy. I agree with her.

I am of the view that the hospital's Action Plan following their extensive critical review of this incident deals adequately with some concerns which were exposed during the Inquiry about the desirability of calling the Fire Service to such incidents without delay and the need so far as practicable to leave the locus of such incidents undisturbed.

As Mr McGarry's death was not caused or contributed to by the fire or the burns which he suffered or the treatment therefor I am satisfied that the fire and its effects were not facts which are relevant to the circumstances of his death. I accordingly conclude that there is no scope for a determination in terms of Section 6(1)(e) of the Act.

The Nursing Staff

It is in my view appropriate that I pay tribute to Staff Nurse Fiona Scott and Auxiliary Nurse Mabel McLarty who with scant regard for their own safety instinctively entered Mr McGarry's smoke filled room to protect and care for him. They together with Staff Nurse Arlene Robertson and night co-ordinator Sharon Muir cannot be criticised for not calling the Fire Service at the time of the accident. They were all of the view that the fire had been extinguished much sooner than it would have been if it had been left to the Fire Service to respond and deal with it. In any event they had no instruction at the time of the incident to call the Fire Service in these circumstances. In passing I should remark that that situation has now changed so that all staff within the hospital have now been instructed to summon the Fire Service in all cases where a fire occurs or has recently occurred within the hospital no matter the nature, cause or size of the fire. If the Fire Service had been summoned by the nurses on this occasion no benefit would have been derived as a result by Mr McGarry. Neither can the nurses be criticised for following their natural instinct to clear up the mess in the room, to cause clothing and bedding to be bagged and to have the mattress removed. It would have been better from a post-accident investigative point of view if items had been left undisturbed but the nurses did not know that at the time and were not under instruction not to do what they did. An Action Plan following a critical incident review of the accident is being implemented. Part of it involves instructing hospital staff not to disturb the locus of such incident until fire and health and safety investigations have taken place.

Condolences

I extend to Mr McGarry's family this Inquiry's condolences. Although I have determined that the fire and the burns which he suffered as a result did not in any way contribute to his death it is nevertheless obvious that the incident must have been extremely traumatic and harrowing for Mr McGarry and concerning for his family. It is indeed tragic that Mr McGarry whose life expectancy at the time of the incident was so limited should suffer such a terrible experience in his final days.

Finally I wish to thank Mr Bloomer and Mrs Kane for the professional and sensitive way in which this Inquiry was conducted. It was apparent to me that they fully co-operated where co-operation was appropriate in relation to the evidence led at the Inquiry and the logistics involved in arranging for the attendance of witnesses.