INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF GEORGE JAMIESON FAIRLIE

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

Inquiry into the circumstances of the death

of

George Jamieson Fairlie

Determination

By

Sheriff David James Pender

Paisley, 22 June 2006

In terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the Sheriff determines as follows:

In terms of Section 6(1)(a)

George Jamieson Fairlie (d.o.b. 24.12.1927) died at the Royal Alexandra Hospital, Paisley, at 9:50 hours on 27 November 2002.

In terms of Section 6(1)(b)

The cause of Mr Fairlie's death was

Ia Bronchopneumonia and lung abscess

due to

Ib Immobility, ischaemic left foot and infected sores.

Conditions contributing to his death:

II Ischaemic heart disease, cerebral vascular disease, diabetes mellitus and cirrhosis of the liver.

In terms of Section 6(1)(c)

Mr Fairlie's death might have been avoided had the following reasonable precautions been taken: -

a(i) If there had been an adequate level of staffing in the St Mirren Wing of the Alexandra Nursing Home, Paisley in the period of ten days or so leading up to Mr Fairlie's final admission to hospital on 26 October 2002; and

(ii) That it was reasonable for the foregoing precaution to have been taken because if there is a breach of the guidelines which stipulate the minimum levels of staffing there is a probability that the care of residents in the Home will be compromised.

b(i) If there had been proper Nursing care given to Mr Fairlie by the staff of the Alexandra Nursing Home in the period of ten days or so leading up to his said final admission to hospital; and

(ii) That it was reasonable for the foregoing precaution to have been taken because if proper nursing care is not given to a patient that patient's health may deteriorate.

c(i) If there had been a comprehensive and accurate completion of Mr Fairlie's medical notes particularly in relation to the wounds to his ankles; and

(ii) That it was reasonable for the foregoing precaution to have been taken because if the details of the serious wounds to Mr Fairlie's ankles had been properly noted steps could have been taken to treat them in the hope of preventing them deteriorating.

d(i) If Mr Fairlie had been given sufficient food and fluid in the ten day period prior to his said final admission to hospital; and

(ii) That it was reasonable for the foregoing precaution to have been taken because Mr Fairlie's blood pressure might not have dropped to the very low level of 60/40 and he would probably not have developed problems with the ischaemic leg at the time he did.

e(i) If Mr Fairlie had been admitted to hospital four or five days earlier than he was admitted; and

(ii) That it was reasonable for the foregoing precaution to have been taken because Mr Fairlie's blood pressure might not have dropped to the very low level of 60/40 and he would probably not have developed problems with the ischaemic leg at the time he did.

<u>In terms of Section 6(1)(d)</u>

The failure by the Alexandra Nursing Home to ensure that Mr Fairlie's medical records were fully and accurately completed was a defect which contributed to his death.

<u>In terms of Section 6(1)(e)</u>

1. Care Homes which offer a dedicated dementia Unit should ensure that trained nursing staff and staff who work as care assistants have training in the treatment of patients with dementia.

2. All nursing and care staff employed in Care Homes should be given a proper induction at the commencement of their employment and unqualified staff should be given relevant training throughout their employment.

3. Care Homes should be obliged to keep records for each member of staff detailing the nature of, and the extent of, the training which is given, and these records should be available for inspection by Officers of the Care Commission.

4. Since a proper and adequate level of staffing is fundamental to the efficient running of a Care Home, Officers of the Care Commission, when inspecting a Home, should always examine staff schedules and rotas, and where necessary interview staff, to ensure compliance at all times with the recommended staffing guidelines.

"David J Pender"

Note/

Note:

This Inquiry was conducted over a total of 33 days in June and November 2005 and January 2006 when I heard evidence from the witnesses detailed in the Appendix hereto. On 4 and 5 May 2006 I heard representations and submissions from the various interested parties who were:-

For the Crown: Mr D Kelly Depute Procurator Fiscal (and who replaced Miss G Climie, Depute Procurator Fiscal after day 10 of the Inquiry).

For the Family of the Deceased: Mrs L Sutherland, Advocate.

For Renfrewshire Council: Mrs D McGowan, Solicitor.

For the Care Commission: Mr K McClure, Solicitor

For Four Seasons Health Care Limited: Mr A.W.D MacLean, Advocate.

The late Mr Fairlie died in the Royal Alexandra Hospital Paisley. I accept the views of several of the expert medical witnesses who gave evidence before me that the care given to Mr Fairlie while he was in that Hospital was exemplary.

Mr Fairlie was admitted to Hospital on 26 October 2002 having resided at the Alexandra Nursing Home, Paisley since May 2000. At the time of his admission Mr Fairlie was a widower. His four children were so concerned about his condition that they contacted the Police, the Press and the Care Commission.

It is important in my view to appreciate the objectives of a fatal accident inquiry. An essential feature of the procedure is that evidence is given in public so that the

knowledge of those responsible for investigation of the death is shared with the public and in particular with legitimately interested parties. The inquiry therefore fulfils the important purpose of enlightening those with a legitimate interest in the death, for example the relatives of the deceased, as to the cause of death. It also serves the purpose of enlightening the public at large, including the relatives, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided. There may be lessons to be learned from the facts which emerge at an inquiry. If so, the sheriff may in his Determination set out the circumstances under one or more of paragraphs (c), (d) and (e) mentioned above. He may also make "recommendations", for instance directing attention to ways whereby practices which may have contributed to the death can be improved. Moreover the provisions of section 6(1)(e) entitle the Court to comment upon, and where appropriate, make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry, as a circumstance surrounding the death, if it appears to be in the public interest to make such comments or recommendations.

It is also important, however, that the limitations of this form of inquiry should be borne in mind. An inquiry of this type is essentially an exercise in fact finding, not in fault finding, and it is not the function of the Court to make findings or express opinions on questions of fault or liability, or to attempt to apportion blame. This does not mean, of course, that the evidence led at an inquiry may not disclose fault. In that event, a finding implying or imputing fault is competent and where the evidence is sufficiently compelling, the responsibility of exposing and finding fault should be accepted. The whole object of impartial public inquiry is to get at the truth, to expose fault where fault is proven to exist, and in all cases to see to it so far as humanly possible that the same mistake, whether it arises through fault or some other reason, is not made in the future.

The very wide power given to a Sheriff in a fatal accident inquiry must also be exercised with caution, bearing in mind the summary nature of the proceedings and the lack of formal pleadings. It is no doubt partly at least for this reason that section 6(3) of the Act provides that the Sheriff's determination in a fatal accident inquiry may not be founded upon in any subsequent proceedings.

In the course of his final submission Mr MacLean, counsel for Four Seasons Health Care Ltd, submitted that it would have been better had this inquiry not taken place. He suggested that it is better that the practical management of all the issues raised by this inquiry should be left to the Care Commission. I think that is going too far. Mr Fairlie's family were so horrified by his condition on 26 October that they contacted the Police, the Press and the Care Commission. The prime mover for this seems to have been Alison Fairlie, Mr Fairlie's eldest child, who by her own admission is a very emotional person who on occasions does things on the spur of the moment. She readily accepted with the benefit of hindsight that it was unnecessary to contact the Press. There is no doubt, however, that there were several important issues arising from Mr Fairlie's death and I do not think that the Crown should be criticised for initiating this inquiry.

The transcription of the evidence runs to more than six thousand two hundred pages of notes. The documentary productions, to which reference was made, amount to

several hundred pages. I heard thousands of facts. I have not endeavoured to make findings in fact in relation to all of these. To do so would have needlessly extended the length of this Determination. I have therefore restricted the findings in fact to those which I consider are important, concentrating on the few months leading up to Mr Fairlie's death, and to those where an Agency such as the Care Commission has been involved.

It is therefore axiomatic that my findings in fact are not comprehensive. This Determination can only be regarded as a summary of what I consider to be the salient facts which were established in evidence.

A number of expert witnesses were led in relation to various issues and I have treated the evidence from these witnesses as truly opinion evidence and I have made no factual findings thereon.

I have divided my findings in fact into various chapters, more to facilitate easy reading of this Determination, than for any other purpose. There will be occasional duplication of facts. This is deliberate to provide the logical sequencing of facts.

I found the following facts proved: -

I. Brief Personal History and Medical History (1985 - 2001) of George J Fairlie

1. George Jamieson Fairlie was born on 24 December 1927. He was married to Grace Fairlie and they had four children, Alison, Ann, James and Stewart. Towards the end of their married lives together Mr and Mrs Fairlie lived in Heriot Court, Foxbar, Paisley and then in a form of sheltered accommodation at Clavering Street East, Paisley. This was accommodation with a warden.

2. As their health deteriorated further they moved on 20 September 1999 to Montgomery Court, Paisley. This was "very sheltered" accommodation. They had their own private accommodation with a communal dining room within the building where they could eat if they chose to do so. Their meals were made for them. A home help came in to help with their toileting. There was 24 hour cover in case of emergencies.

3. By the year 2000 Mr and Mrs Fairlie were both disabled but managed to help each other, with assistance as required, on a day to day basis.

4. At the beginning of May 2000 Mrs Fairlie was due to go into hospital for a blood transfusion. It was realised that Mr Fairlie could not live in Montgomery Court on his own and it was decided that he should go into a Nursing Home for respite care while his wife was in hospital. After consultation with social services Mr Fairlie was admitted on or about 3 May 2000 to the Alexandra Nursing Home. The following day, 4 May 2000, Mrs Fairlie died unexpectedly.

5. Mr Fairlie then returned to his home in Montgomery Court where he was looked after by his daughter Ann Cook who stayed with him for a while following upon Mrs Fairlie's death.

6. It was realised by the family, however, that Mr Fairlie could not remain in this form of sheltered accommodation on his own and it was arranged that he should return to reside at the Alexandra Nursing Home.

7. On 26 May 2000 Mr Fairlie was admitted to the Tannahill Wing of the Alexandra Nursing Home. He was naturally upset at the loss of his wife of 47 years and did not settle. This was not a secure ward and Mr Fairlie left the ward without permission, or attempted to do so, on several occasions. At the time of admission to the Home, Mr Fairlie was able to walk unaided.

8. For his own safety Mr Fairlie was then transferred to the St Mirren Wing of the Alexandra Nursing Home. This was a secure ward and a dedicated dementia unit. Item 75 of Crown Production 22 is a Report by Mr Joe White, a Registered Mental Health Nurse, which was prepared in relation to Mr Fairlie at the time of his admission to the St Mirren Wing.

9. Item 19 of Process comprises copies of the Royal Alexandra Hospital Records. Item 21 of Process comprises copies of Mr Fairlie's General Practitioner Records. These disclose that he suffered inter alia:-

a) 24.8.85 Acute Myocardial Infarction

b) 25.8.85 Angina Pectoris

c) 7.2.90 A CT scan showed signs of a very large stroke

d) 4.12.90 Grand Malseizure and Myocardial Infarction

e) 19.12.90 Ventricular Tachycardia

f) 1.1.93 Ventricular Tachycardia

g) 20.6.93 Ventricular Tachycardia

h) 1993 and 1995 Myocardial Infarction

i) 1.1.96 Right Hemiparesis

j) 1.1.96 Atrial Fibrillation

k) 1.2.99 Stroke and Cerebrovascular accident unspecified

l) 10.8.01 Diabetes

As a consequence of his stroke Mr Fairlie was unable to speak. The stroke had affected the right side of his body, and his right arm and right leg did not function properly.

10. In May 2000, at the request of his General Practitioner, Mr Fairlie was referred to Doctor H.M Livingston, Consultant in Geriatric Psychiatry, Paisley. Her Report is

contained in a letter dated 6 June 2000 which is Items 120/1/2 of Production 21. Because of his difficulty in communicating, Mr Fairlie was seen by Doctor Livingston in the presence of a Nursing Sister from the Alexandra Nursing Home and Mr Fairlie's District Nurse. They provided Doctor Livingston with useful background information. Doctor Livingston concluded that Mr Fairlie had a long history of cerebrovascular dementia, that he was irritable and aggressive because of his global cognitive impairment and more specifically because of his difficulties with comprehension and expression and that he needed 24 hour care in a Nursing Home setting.

II. Alexandra Nursing Home: The Treatment and Care of George Fairlie

1. When Mr Fairlie moved to the St Mirren Wing at first he was allocated a nurse, Joe White, who was designated his key worker.

2. Initially the nursing care was basically fine. The family had no major issues about the quality of care offered to Mr Fairlie. The staff members seemed to be the same and there was a consistency and continuity of care.

3. Of Mr Fairlie's 4 children, James Fairlie lived in Renfrew and he was a regular visitor. He is now deceased. Alison Fairlie lives in Bradford, Ann Cook lives in Reigate, Surrey and Stewart Fairlie resided in Cumbernauld until 2002 but often worked away from home. They visited less frequently.

4. When Mr Fairlie went into the Alexandra Nursing Home at first it was unnecessary for members of his family to make an appointment if they intended to visit him. They just turned up, usually in the late morning or after lunch and Mr Fairlie was always ready for them. His hair was combed and he was shaved and dressed.

5. From a date sometime in 2001 things changed in the Home. The family were asked not to arrive unannounced but to telephone in advance to advise when they would be calling for Mr Fairlie. Despite this, on many occasions when a family member turned up to visit Mr Fairlie or to take him out he was not ready. He was not shaved. His hair would not be combed, his face would be covered in food and (since he was incontinent) he was sitting in a pad, which was often soaking wet.

6. This deterioration in the standard of Mr Fairlie's cosmetic care coincided with what appeared to the family members to be a reduction in staffing levels. When they telephoned the wing for information about their father there were occasions when the telephone was not answered. When they attended at the Home there was invariably a long delay in the secure buzzer entry system being answered and when they were admitted to the wing there were many occasions when there were no members of staff immediately obvious.

7. This deterioration in the quality of care and the absence of staff members coincided with the departure of Joe White as a member of the nursing staff. He left in August 2001.

8. Such were Stewart Fairlie's concerns for his father around this time that he would often arrive at the Home without a prior appointment. Invariably his father was

generally unkempt and wearing a heavily sodden pad. Often a member of Mr Fairlie's family would arrive to find him in his room with the television blaring. The window often seemed to be jammed open and the room was very cold. On one occasion the wash hand basin in Mr Fairlie's room leaked on to the carpet. It was only when Stewart Fairlie complained that the window and the leak were repaired. The carpet was not replaced.

9. On 9 October 2001 Stewart Fairlie and his partner Janet Bruce had a meeting with Mrs Grogan, the Home's Manager, at which they expressed concern about the poor cosmetic care of Mr Fairlie. They also complained that it was a regular occurrence for Mr Fairlie to be wearing another resident's clothes. Item 1 of the Home's Productions contains a "review form" for this meeting.

10. On conclusion of the meeting Mrs Grogan promised that the matters raised on behalf of the family would be dealt with. Nothing appears to have been done to address these concerns. She also said that efforts would be made to improve things for the residents including Mr Fairlie. She said recreational therapists and physiotherapists would come in to see Mr Fairlie. Nothing appears to have happened. In fact, quite early on in Mr Fairlie's stay at the Home two staff members were employed to provide entertainment for the residents but often they were employed on the Wings as care assistants when the Home was short-staffed. They then left and were not replaced.

11. Said last mentioned Production contains a section requiring the person chairing the Review Meeting to note any areas of disagreement amongst the participants at the Review. This section of the form has been left blank. This Production (on page 10) has a heading "Specialist nursing needs" to which has been added the comment "none". This was incorrect. At that time Mr Fairlie had a substantial number of nursing needs.

12. This review was the first review which had been carried out by the Home. There should have been a review 4 weeks after Mr Fairlie was admitted to the Home with a review six months after that first review, with further reviews annually thereafter.

13. The quality of care in the Home did not improve following upon said meeting. The family continued to have reservations about the wisdom of their father remaining in the Alexandra Nursing Home.

14. Mr Fairlie's children continued to visit him as and when they could. Those members of the family who had to travel a distance to visit Mr Fairlie saw him at Christmas 2001 and Easter 2002 and while there were always concerns about Mr Fairlie's physical health, there was no obvious deterioration in his health over this time.

15. On 24 June 2002, Mr Fairlie's son James Fairlie attended at the Home to visit his father. He found him slumped in a wheelchair in a corridor of the Home. He appeared to be weak and withdrawn. The staff did not seem to have noticed Mr Fairlie's condition and at the insistence of James Fairlie a Doctor was called and he arranged for Mr Fairlie to be admitted to Hospital. He was found to be suffering from a chest infection.

16. It was also noted by the Hospital on 24 June that Mr Fairlie had MRSA in a foot wound. Tests also disclosed that Mr Fairlie's nutrition was satisfactory at this time.

17. On 26 June 2002 while Mr Fairlie was still in Hospital Mr James Fairlie telephoned the Hospital Social Work Department complaining about the standard of his father's care while in the Alexandra Nursing Home. It was suggested to him that he speak to the Manager of the Home about his concerns and utilise the Complaints Procedure which would be in operation in the Home. It was also suggested he could speak to the Area Team of the Social Work Department about transferring Mr Fairlie to another Nursing Home.

18. Ann Cook travelled from her home in Reigate at this time to visit her father after receiving a telephone call from James Fairlie expressing concern about their father's health. Mrs Cook had not seen her father since Easter and when she saw him she thought he had lost a lot of weight.

19. Mr Fairlie was discharged from Hospital on 26 June 2002 and returned to the Alexandra Nursing Home.

20. The Home's records from around January 2002 contain notes that Mr Fairlie became difficult to manage and would often lie on the floor or slip off his chair onto the floor. Crown Production 12 page 96 contains an entry for 1 May 2002 to the effect that Mr Fairlie was settled on a mattress on the floor "for safety". There are similar entries dated, for example, 25 May and 2 June 2002.

21. While Mrs Cook was in Scotland she took the opportunity, along with James Fairlie, to visit the Alexandra Nursing Home to have a meeting with Mrs Grogan. At this meeting Mrs Cook and Mr Fairlie expressed grave concerns about their father being nursed on a mattress on the floor.

22. James Fairlie had requested that cot sides be put around Mr Fairlie's bed to stop him falling out of bed but the Home had been reluctant to do this in case Mr Fairlie hurt himself. They considered the better option was to nurse him on the floor. James Fairlie agreed to his father being nursed on a mattress on the floor as a short term measure. Although Mrs Josephine MacDonald was the Mental Health Link Nurse she was not consulted about this practice.

23. At one point when there were cot sides in place Mr Fairlie was found on the floor in a position which suggested he had been attempting to climb out of bed over the cot sides and had fallen on to the floor.

24. Mrs Cook also mentioned to Mrs Grogan that when she had taken her father out of the Home for lunch at Easter, he had drank pints of orange and water. She asked that fluid charts be kept to monitor Mr Fairlie's fluid intake and Mrs Grogan agreed that this would be done. It was not the Home's practice to provide jugs of drinking water in the residents' rooms.

25. After Mr Fairlie was released from Hospital in June 2002 Mrs Cook and other family members took their father out for lunch. He still had an appetite. He was able to drink and feed himself provided his food was cut up for him.

26. When Mrs Cook went into the Home on this visit to Scotland to say goodbye to her father she found him lying on the floor in the corridor. She was told by staff that they had put him there because he was sliding out of his chair. There was no pillow under his head and he was lying in the foetal position.

27. On 29 June 2002, Nurse Kathleen Harvey discussed using cot sides with Mr Fairlie's family. All avenues of danger and risk of injury were discussed and explored and permission was given for cot sides to be used. Item 129 of Production 12 is the consent form signed by Stewart Fairlie. Mr Fairlie would often thrash about in bed and try to put his legs through the cot sides even when they were protected with bumpers. Although certain members of staff were aware of this they did not take any steps to review their decision that cot sides should be used.

28. On 4 July 2002 Dr Karl Philips attended at the St Mirren Wing and met with Mr Fairlie in the presence of Mrs Josephine MacDonald, a senior Nurse. After being involved in this referral Mrs MacDonald maintained an interest in Mr Fairlie. She would go into the St Mirren Wing to see how he was from time to time. The last time she saw him was in late August 2002 when he seemed more settled.

29. On 25 August 2002, Stewart and James Fairlie, Stewart's partner and James' wife and their children took Mr Fairlie out for lunch and he was fine. He ate well and no one was concerned about his physical well-being. He was able to interact with his children and grandchildren. On these occasions when the family took Mr Fairlie out they usually were with him for several hours, not returning him to the Home until the early evening.

30. Until August 2002 or possibly later Mr Fairlie still had some degree of comprehension. If he passed a landmark while in the car he would point it out. He was able to show happiness when his family came to see him and sadness or disappointment when he realised he was being taken back to the Home after a day out with his family.

31. On 24 September 2002 James Fairlie contacted the Home expressing concern about his father's weight loss. He was told that Mr Fairlie was weighed regularly and that the times when he did not eat were documented and that he was offered supplements on a daily basis. When James Fairlie asked to speak to a member of the medical staff he was advised to contact his father's General Practitioner.

32. On 13 October 2002 James Fairlie and his uncle William Barr took Mr Fairlie out for lunch. He seemed well and James Fairlie had no cause for concern.

33. On 23 October 2002 James Fairlie visited his father after receiving a telephone call from the Home advising that Mr Fairlie had a chest infection. When James arrived his father was asleep in bed. James thought his father had lost weight and that there was a dramatic change in his appearance. James pulled down the bedcover and noticed sores on the tops of his father's feet and his left knee. He also had a small square bandage on his left ankle.

34. The Home's notes (Production 12) pages 63, 115, 116, 117 and 118 contain the following critical entries:

(a) 16 October 2002 07:40 "vocal overnight? Responding to auditory/ visual hallucinations - requested GP advice"

(b) 16 October 2002 21:30 "Appears to be responding to auditory and visual hallucinations. Very restless throughout the day, appears agitated. Nursed in bed to maintain safety"

(c) 17 October 2002 Night shift "Sweating profusely on commencement of duty, no temp, - fan in situ overnight, taking fluids well as charted, has had a settled nights sleep"

(d) 17 October 2002 13:30 "Restless and agitated again, appears to be responding to auditory and visual hallucinations. Taking diet and fluids with assistance"

(e) 19 October 2002 07:30 "Extremely vocal and difficult to manage..."

(f) 19 October 2002 Nightshift "Eating and drinking well with staff assistance, slept on his bed most of the time; no auditory or visual hallucinations noted whenever awake"

(g) 21 October 2002 07:30 "Taking fluids well, assisted with personal hygiene, very difficult to deal with"

(h) 21 October 2002 14:00 "Bed bath given this morning. GP contacted regarding referral to dietician. Weight has to be taken weekly for next four weeks and reviewed later. Taking diet and fluids well"

(i) 21 October 2002 22:30 "temperature 39.3 C. Patient sweating +++, shaking uncontrollably BM 11.8. BP and pulse unrecordable due to lack of co-operation from George. GP contacted, awaiting visit"

(j) 21 October 2002 23:50 "GP confirmed - chest infection. Commenced on Amoxicillin 500 mg immediately"

(k) 22 October 2002 "Temperature is 37.2 C at 1:30pm. Family has been phoned to inform them of George's condition. Dressing on both ankles has been renewed. The left outer aspect of the ankle looks really bad, septic, query infection. The left inner aspect is sloughy, nu-gel applied to de-slough both sides of the left leg. The right ankle has been sprayed with povidore and a dry dressing applied mepore."

(l) 22 October 2002 21:30 "Position changed regularly, temperature taken and was 37.2C, fan in situ for a while, temperature remains at 37.2C. Please observe overnight"

(m) 25 October 2002 14:00 "Remains frail. Position changed regularly but continues to lie on left side. Taking diets and fluids well with assistance ...".

(n) 26 October 2002 13:00 "George's condition poorly, attended to his personal hygiene. BM before breakfast 9.1. Condition remains the same. Family came in and also expressed concern at his poor condition. 12:00 I phoned the emergency GP and talked to a nurse who said Shall get in touch with his GP ...".

35. The entry of 22 October 2002 (Paragraph 34(k) hereof) by Florence Mtermende in relation to the wounds on Mr Fairlie's ankles appears in isolation. These injuries would have been present for several days. Miss Mtermende "renewed" the dressings. There are no entries in the Home's records for several days before or after 22 October 2002 relating to the care and treatment of these injuries. There should have been a nutritional assessment along with a plan detailing Mr Fairlie's tissue viability needs.

36. Mr Fairlie's temperature and pulse should have been taken four hourly after he was prescribed the antibiotic for the chest infection. This is good nursing practice.

37. On Saturday 26 October 2002 Stewart Fairlie and his partner Janet Bruce arrived at the Home at about 12:30pm to visit Mr Fairlie. It was their intention to take him out for a meal. They were horrified by what they saw. Mr Fairlie was lying in bed in an emaciated state. He was contracted and lying in the foetal position. He also appeared to have lost a substantial amount of body weight. He was making a clicking sound with his mouth.

38. On a set of drawers in Mr Fairlie's room there was a plastic cup with water in it and a syringe. There was also a piece of paper with various numbers, such as "20", "30" written on it. The water in the glass looked stale and the glass had a lot of dirty fingerprints on it.

39. Miss Bruce, a nurse, concluded that he was showing all the signs of dehydration. He had sunken eyes. His skin turgor was gone, his skin seemed dry, the mucous membranes of his mouth were dry and crusted and his lips were dry crusted.

40. Miss Bruce pulled back the sheet covering Mr Fairlie. He was wearing only a pyjama jacket and an incontinence pad.

41. When Mr Fairlie and Miss Bruce saw Mr Fairlie's condition they asked a care assistant to call for the nurse in charge. She arrived. She spoke very poor English and appeared to have no comprehension of the poor state of Mr Fairlie's health. At the request of Mr Fairlie and Miss Bruce a Doctor was called and Doctor Ismail arrived at about 13:55 hours. She examined Mr Fairlie and then arranged for him to be admitted by ambulance to the Royal Alexandra Hospital. Production 21 page 80 is a record of Doctor Ismail's visit. Her diagnosis is recorded as "frail and bedridden with dehydration".

42. Prior to being taken into Hospital Mr Fairlie was given two scoops of ice cream which he managed to eat with assistance.

43. The ambulance arrived at about 4.00pm. In the three hours or so that Stewart Fairlie and Miss Bruce were in the Home no one changed Mr Fairlie's position in bed.

44. Production 12 Item 116 contains an entry dated 13:00 hours on 26 October 2002 which records Mr Fairlie's blood pressure at 60/40.

45. After Mr Fairlie was admitted to Hospital the Home carried out its own internal investigation into the complaints by Mr Fairlie's family. Mrs Grogan provided a brief report for this investigation. This is item 231 of Production 17.

46. The Home had no proper Complaints Procedure in place. When the Care Commission was investigating the complaint by Mr Fairlie's family after his admission to Hospital on 26 October 2002 Mrs Grogan advised the Care Commission Officers that the Home "never received a formal complaint from the family". The true position is that the family had made several complaints about the running of the Home and the lack of care of their father.

47. Production 1 for the Four Seasons Health Care Limited comprises two fluid charts relating to Mr Fairlie covering approximately two weeks or so from 1 October 2002. The days and dates on these charts do not correspond with the calendar for October 2002. These documents also show (if accurate) that on some days Mr Fairlie was given no food and drink and very little food and drink on other days.

48. Production 12 Item 27 is a daily fluid balance chart for 16/17 October 2002. This chart contains no totals for input and output of liquid. Item 28 is a daily fluid balance chart covering the period 22 to 25 October 2002. Item 29 is a daily fluid balance chart for 26 October 2002. This last Production shows that liquids were given to Mr Fairlie at the Home at a time when he had been admitted to the Royal Alexandra Hospital.

49. Four Seasons' Policy for the assessment and management of wounds stipulates that in all cases the initial assessment will include photographing and measuring the wound. There was no evidence that this procedure was followed in the case of Mr Fairlie's ankle wounds.

50. There was a possibility when staff were distributing teas, coffee and drinks in the mornings and afternoons that they would omit residents, such as Mr Fairlie, who were in their rooms.

51. For an unspecified period of time, but certainly for a period of several weeks prior to 26 October 2002, Mr Fairlie was nursed in bed. He spent most of the day in the bed. There was no medical reason for this.

52. When Mr Fairlie was admitted to the Alexandra Nursing Home in May 2000 he weighed 94.5kgs. In October 2001 his weight had dropped gradually to 78.5kgs and then stabilised about 80-81kgs until May 2002 when he weighed 79kgs. On 6 August 2002 Mr Fairlie weighed 71kgs and on 6 September 2002 he weighed 70kgs.

53. At this time (September and October 2002) the St Mirren Wing of the Home constantly operated with staffing levels below the requirement agreed with Argyll and Clyde Health Board (and which is deemed to apply to the Care Commission by virtue of The Regulation of Care (Scotland) Act 2001 (Commencement No.2 and Transitional Provisions) Order 2002).

54. Mr Fairlie's children were so upset at the condition in which he was found on 26 October, they contacted the Police, the press and the Care Commission.

55. After Mr Fairlie was admitted to Hospital there were many improvements in the Home. The staffing levels increased, on occasions exceeding the minimum requirement, and there was no shortage of supplies.

56. The Alexandra Nursing Home closed sometime in July 2005.

III. Alexandra Nursing Home - Staff and Staffing

Ruth Grogan

1. Mrs Ruth Grogan, aged 58 years, was employed as the Manager of the Alexandra Nursing Home from 1998 until December 2002, firstly by Scotcare Group Limited, the previous owners of the Home, and then by Four Seasons Health Care Limited.

2. Mrs Grogan terminated her employment with Four Seasons Health Care Limited in December 2002 having been absent due to illness from the end of November 2002. At the beginning of December Mrs Grogan received a letter summoning her to a disciplinary hearing but this did not proceed because she resigned.

3. Production number 4 for Renfrewshire Council is a contract performance report dated 20 November 2002 following upon a visit to the Home on 4 November 2002.

4. The Manager of the Home was obliged to notify the Council of the outcome of any serious complaints about the Home, and at the said visit on 4 November Mrs Grogan accepted that this procedure had not always been followed by her.

5. It was also ascertained that at the date of the visit on 4 November 2002 there were 11 whole time equivalent vacancies within the Home.

6. Crown Production 2 is a memorandum dated 5 April 2001 to all Home Managers from the Regional Manager of Four Seasons Health Care Limited reminding them to ensure that all residents' skin integrity is carefully checked and that nursing documentation should clearly demonstrate the assessment of care needs, intervention, inspection and regular review of progress, and that this applies not only to tissue viability but to all care needs.

7. Crown Production 3 is a memorandum from the Regional Manager of Four Seasons Health Care Limited to all Home Managers dated 8 October 2001 regarding Wound Notification. This memorandum enclosed a new Wound Reporting form. This memorandum stressed that it was the responsibility of the Home Manager to ensure completion of the form and it was stressed that to ensure that good practice was promoted and maintained, Home Managers should complete the form at all times except during annual leave or sickness. It also directed that to ensure accurate completion of the form Home Managers should observe all wounds in the 72 hours prior to completion of the form and should document if they have not done so.

8. Although Mrs Grogan had no power to delegate Wound Notification and Reporting Mrs Karrim was given this responsibility during her tenure as Deputy Manager of the Home. When Mrs Karrim left on 7 June 2002 no member of staff, including Mrs Grogan, assumed responsibility for completion of this task until Mrs McDonald

accepted the post of Deputy Manager at the end of July or beginning of August 2002.

9. Four Seasons Production 13, the Care Manual, provides a policy for the assessment, photographing and constant re-assessment of wounds. It is the Manager's responsibility to collect the wound forms each Monday and to forward these to Head Office. The Wound Notification form which accompanied Crown Production 3 is the form which should have been completed and sent to Head Office.

10. There were no wound photographs with Mr Fairlie's medical notes in the Home. The wounds on Mr Fairlie's ankles which were evident when he was admitted to Hospital on 26 October 2002 were not properly and adequately recorded by the Home. There was also no note in Mr Fairlie's records that he suffered from peripheral vascular disease. Consequently any person attending to his wounds would not be aware of the fact that any bandages should not be applied tightly.

11. The Four Seasons' Care manual at page 115 lays down the policy and procedure in relation to complaints. It was the responsibility of the Home Manager, or in his or her absence, the senior person in the Home, to record details of each complaint on a complaint form "regardless of the nature of the complaint". This was not done in relation to complaints made by Mr Fairlie's family. No such forms were available for this Inquiry.

12. Crown Production 22 is the Social Work case file for Mr Fairlie. This contains details of various telephone calls from members of Mr Fairlie's family complaining about the quality of his care. Some of these complaints were communicated to Mrs Grogan but she did not record these in Mr Fairlie's file.

13. In terms of the Four Seasons' Care Manual the Managers of each Home were responsible for ensuring that a continence assessment was carried out for any resident who was incontinent. Mrs Grogan took no positive steps to implement this policy.

14. The Care Manual stipulates that the Manager should review in detail 25% of the Care Plans each month selected on a random basis. Mrs Grogan did not do this from, at least, June 2002 onwards.

15. Crown Production 27 comprises a series of letters between the Home and the Care Commission in relation to a request by the Home to reduce the level of staffing throughout the Home. Within Production 27 there is a letter dated 18 September 2002 written jointly by Mrs Grogan and Mr John Murphy, Managing Director of Four Seasons Health Care Ltd, in which it is stated that on the St Mirren Wing the early shift had an existing complement of two trained and two untrained staff. At the time this letter was written there was only one trained member of staff on the early shift and this had been position since at least the date when Mr Rossi began employment at the Home on 8 July 2002.

16. Crown Production number 5 is a letter dated 18 November 2002 to Mrs Grogan from the Care Commission reporting on an unannounced monitoring visit which was conducted at the Home on Tuesday 12 November 2002. This letter records that at

the date of said visit the St Mirren Wing had two trained and three untrained staff on duty.

17. Crown Production 4 is a letter to Mrs Ruth Grogan from the Care Commission dated 20 November 2002 following upon a monitoring visit carried out on 20 November 2002. At the time of that inspection the St Mirren Wing had two trained and three untrained staff on duty. This was in excess of the minimum requirement laid down by Argyll and Clyde Health Board (and which is deemed to apply to the Care Commission by virtue of The Regulation of Care (Scotland) Act 2001 (Commencement No.2 and Transitional Provisions) Order 2002).

18. Mrs Grogan was unaware that at least one member of staff in the St Mirren Wing was using a syringe to give Mr Fairlie water.

19. Several members of the nursing staff and several care assistants found it difficult to do their jobs properly in ensuring the care of the residents because they were short of basic supplies. When Mrs McDonald, a very experienced nurse, complained to Mrs Grogan about the shortage of supplies she received an unsatisfactory response and felt her concerns were not being taken seriously. Other staff members who complained to Mrs Grogan received a similar reaction.

20. The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 stipulate, *inter alia*, that it is the provider's responsibility to ensure that there is an adequate number of staff on duty with the skills and experience as are appropriate for the health and welfare of the residents. Mrs Grogan, as manager of the Home, failed to ensure compliance with this provision on many occasions.

21. Under the Regulation of Care (Scotland) Act 2001 the Home was obliged to keep a record of the staff on duty at all times. On 26 October 2002 the Home failed to do so.

Isabella Karrim

1. Isabella Karrim was appointed Deputy Manager of the Alexandra Nursing Home. She started in December 2000 and resigned in June 2002.

2. When Mrs Karrim started she believed she was to have a Supervisory Clinical Role, that is, she believed that she would be responsible for supervising the clinical care of all the residents throughout the Home. As time progressed, however, she realised that she was expected to have clinical responsibility for one of the five units within the Home. If a Charge Nurse failed to turn up for work for a shift Mrs Karrim was expected to fulfil that person's role. This was a regular occurrence and applied in any of the Wings in the Home. After Joe White left the St Mirren Wing in August 2001 Mrs Karrim was required to be the Nurse in charge of that Wing on a regular basis. She was, however, expected also to perform the duties of Deputy Manager.

3. On days when Mrs Karrim was expected to perform the aforesaid dual role she would only be on the Wing for a short period of time before she required to leave to carry out managerial tasks. This meant, however, that Mrs Karrim was included on the staff rota as the Registered Nurse in charge of the particular Wing when, in fact,

she was not there for a very large proportion of that particular shift, and this Wing was operating without a qualified Nurse. After August 2001 Mrs Karrim was required to stand in as the Nurse in charge of the St Mirren Wing, albeit nominally, two, three or four times each week.

4. Such were the pressures put upon Mrs Karrim that one day in December 2001 she collapsed. Her blood pressure was elevated through physical and mental exhaustion and worry and she was taken from the Home by ambulance to hospital.

5. Mrs Karrim was concerned that the residents in the Home were not being given the proper care and attention they needed and she also considered that her nursing registration might be at risk. She therefore tendered her resignation in December 2001 giving four weeks notice of her intention to leave the Home.

6. Mrs Karrim's letter of resignation was ignored by Mrs Grogan. It was not forwarded by her to her immediate superior, Mrs Bandeen, or to the Management of Four Seasons Health Care Limited. Mrs Karrim then drafted a letter which she intended to send to Mrs Bandeen the Regional Manager of Four Seasons Health Care Limited in Kirkcaldy. Before she could post the letter, however, she broke down in tears to Mrs Grogan. Mrs Karrim was then told that a new Sister was starting soon in the St Mirren Wing and on that assurance Mrs Karrim withdrew her resignation.

7. Marie Gilchrist started as a Nursing Sister in the St Mirren Wing in January 2002. Her background was academic, having at one time been a researcher, but she had considerable practical experience as a Nurse.

8. In April 2002 Mrs Gilchrist decided to leave. Mrs Karrim was expected to cover the St Mirren Wing again although she was still Deputy Manager of the Home. When Mrs Gilchrist left Mrs Karrim feared that she would again encounter the problems which had resulted in her health difficulties in December 2001. She therefore applied for another job and left the Alexandra Nursing Home on 7 June 2002. When she left no one had been recruited to be the Nurse in charge of the St Mirren Wing.

9. Three weeks after Mrs Karrim left nine Filipino staff left the Home at the end of June 2002. These were eight trained Nurses, male and female, and a maintenance man. Three of the staff who left were qualified Nurses from the St Mirren Wing.

Michelle King

1. Michelle Peters or King was employed at the Alexandra Nursing Home as a Care Assistant from October 2000 until December 2002. For the first six weeks she was employed as a Bank worker, working as and when required. She was then given a full time contract as a Care Assistant working on the St Mirren Wing. She worked from 37 to 55 hours per week.

2. Mrs King's employment with the Home was her first job in the Health Care Sector. She had no previous experience. She was given no training other than to be told to shadow another carer for her first shift. She was not sent on any courses. She was not given any on site training.

3. About 6 months after Mrs King started working in the Home about 11 trained nursing staff left over a short period of a few weeks. Some of these trained staff normally worked on the St Mirren Wing.

4. Four Seasons' Production 2 is a "staff orientation" form in relation to Michelle King. This form purports to show that Mrs King received training in various aspects of her work. Various boxes have been ticked confirming that she was given this sort of training. Other boxes have been ticked which have no application to her. Mrs King has signed this form and it has been countersigned by Joe White. The form is dated 26 June 2001, approximately nine months after Mrs King started working at the Home.

5. Mrs King was absent due to illness for two weeks in October 2002 and returned to work to start the early shift at 8.00am on 26 October 2002. She was present when Mr Stewart Fairlie and Jan Bruce arrived to visit Mr Fairlie's father. Before she went off on sick leave Mr George Fairlie had been reasonably well.

6. There were many occasions when Mrs King was on duty on the St Mirren Wing when it was understaffed (that is, it was below the minimum requirement stipulated by Argyll and Clyde Health Board and deemed to apply to the Care Commission).

7. Sometime in the summer of 2002 Mrs King lodged an anonymous complaint with the Care Commission regarding the Home. She was concerned that the residents' personal hygiene was not up to standard, the rooms were dirty and the food was poor.

John Rossi

1. Mr John Rossi began employment at the Alexandra Nursing Home as a Charge Nurse on the St Mirren Wing on 8 July 2002. He is a qualified Mental Nurse and although he had had some experience in nursing elderly people this was his first job in the Home Care Sector.

2. Mr Rossi has been a qualified Nurse since 1986 and in 1999, when he was subject to a complaint to the Nursing and Midwifery Council, he took a three year break and worked in the catering industry. His first job on his return to the nursing profession was at the Alexandra Nursing Home.

3. Mr Rossi was interviewed for the post of Deputy Manager some three or four weeks prior to his starting at the Home. He was telephoned later on the day of the interview to be offered the job of charge nurse on the St Mirren Wing, a job which he took. He was interviewed by Mrs Grogan the Home Manager and Mrs Brenda Bandeen the Regional Manager of the company. Mr Rossi was not asked to complete a disclosure form. A Mrs Marie Cole started at the Home as Deputy Manager at the same time as Mr Rossi started but she only stayed a few weeks.

4. Mr Rossi turned up to start his first day at 9.00am, it being his understanding that this for "orientation", that is for him to go through the fire procedures, statutory regulations and the like. When he arrived he was told that someone on his Wing had telephoned in sick, he was given a uniform and was expected to start work

immediately. He was then asked to do a double shift on his first day since he was the only Nurse on duty. As the Nurse in Charge, Mr Rossi expected to be in charge of a team. There was, in fact, no team to lead.

5. When Mr Rossi started at the Home he expected the Manager, Mrs Grogan, to be his mentor. She simply gave him the induction sheet and told him to fill it in as he went along. Mr Rossi complained to Mrs Grogan that since he had been out of Nursing for three years he needed some support. Mrs Grogan said that she would endeavour to get help, but none materialised. Mrs Grogan did not spend a good part of his first day with him.

6. When Mr Rossi worked a morning shift there should have been two trained Nurses on duty along with two Care Assistants. At best there was only ever one trained Nurse and three Care Assistants on duty, but on occasions there were only one Nurse and two Care Assistants on duty on the morning shift.

7. On the afternoon shift there should have been a trained Nurse and two Care Assistants. Occasionally this shift was also short staffed and Mr Rossi had to work the afternoon shift with only one Care Assistant.

8. When Mr Rossi started at the Home he was the only qualified Nurse on day shift for the St Mirren Wing.

9. Mr Rossi was the only qualified Nurse on the day shift (apart from Bank or Agency staff) who had the care of Mr Fairlie from July until October 2002.

10. On many occasions when Mr Rossi was working a late shift (2.00pm - 10.00pm) he would also be the Nurse in charge of the Home once Mrs Grogan had left for the day. If any member of staff telephoned in sick for the next day it was Mr Rossi's responsibility to endeavour to obtain cover for that person. When carrying out this task Mr Rossi was unable to attend to the necessary nursing duties to which he was assigned in the St Mirren Wing and he was often absent from the Wing for a substantial part of his shift.

11. Mr Rossi was married on 27 September 2002. He stopped work on or about 24 September and did not return to work until 16/17 October 2002. During his absence the role of the Nurse in charge of the St Mirren Wing was covered by Bank or Agency staff.

12. When Mr Rossi returned from his honeymoon on or about 16/17 October 2002 Mr Fairlie had lost weight. He therefore decided not to consult the dietician but to invoke what he described as a "six week protocol" whereby he sought to fortify Mr Fairlie's diet. He did not, however, prepare a care plan for this and other staff would therefore not know that Mr Fairlie's diet was to be fortified.

13. Mr Rossi was unaware that Mr Fairlie had bad pressure sores on his ankles. He claimed that every time he came on duty another nurse had changed Mr Fairlie's dressings and he did not wish to undo them. He also claimed not to have read Miss Mtermende's entry of 22 October

which detailed her concerns about Mr Fairlie's ankles, although the next entry on Production 12 item 115 is his. He also has no recollection of Miss Mtermende specifically drawing his attention to her concerns about these wounds when he came on duty.

14. Mr Rossi was working on 23 October 2002. He wrote an entry in the fluid chart for that day. He has not, however, written any entries in Mr Fairlie's medical notes for that day.

15. Mr Rossi has written an entry in Mr Fairlie's records for 25 October 2002, viz "remains frail, taking diet and fluids well with assistance". Mr Rossi did so on the basis of information given to him, not as a result of his visual examination of or physical involvement with Mr Fairlie.

16. Mr Rossi was not working on 26 October 2002, the day Mr Fairlie was taken into Hospital but he was on duty the previous day. He did not think Mr Fairlie was showing any signs of dehydration.

17. Mr Rossi remained in employment at the Home until July 2004. After Mr Fairlie was taken to Hospital on 26 October there was a dramatic improvement at the Home. Any equipment which was needed, such as special pressure relieving mattresses, was provided. Staffing levels improved and the quality of the food was better. The care assistants were given training by Clinical Nurse Specialists in incontinence, Dieticians and Nurses gave them lectures and training in various aspects of nursing.

18. One week or so after Mr Fairlie was taken into Hospital Mrs Anne Walker became the Regional Manager and other staff were brought into the Home. Considerably more support was given from management to nursing staff and Mr Rossi felt that he was now being given the support and the time to do things which he had not been able to do in the past.

19. Sometime after Mr Fairlie was taken into Hospital on 26 October Mr Rossi was disciplined because of his failure to keep up to date and accurate written records. He was given a written warning. The discipline panel took into account the fact that he had not been given a proper induction, the pressure of work and the fact that he had been the only trained member of staff on duty.

20. Throughout Mr Rossi's time in the Home while Mrs Grogan was the Manager, the duty rota often bore no resemblance to the staff who were actually working on the Wing at any particular time.

21. As the named Nurse for the 18 residents in the St Mirren Wing Mr Rossi was responsible for the preparation and review on a monthly basis of the care plans for each resident. If Mr Rossi, when completing a care plan, identified a specific problem he was required to prepare a separate sheet with goals and expected outcomes for that problem. It was also the responsibility of the Nurse in charge to complete the daily entries in the progress sheets and to keep accurately the medication sheets for each patient, and to dispense the medication. It also would be the Charge Nurse's responsibility to complete pressure sore assessments, nutritional assessments and

moving/handling assessments, and to order drugs and telephone the residents' General Practitioners.

22. It was also the responsibility of the Charge Nurse to record patients' blood pressure rates, temperature, pulse and the like, and to prepare other documentation such as wound charts and to take photographs of any wounds and to prepare relative care plans to deal with the management of such wounds. It was also the responsibility of the Charge Nurse to assess such wounds and to dress them appropriately.

23. Mr Rossi prepared a detailed Care Plan for Mr Fairlie on 6 September 2002. In this he stated that the next review would be on 6 October 2002. Mr Rossi was on holiday at this time. The Bank or Agency Nurses who were in charge of the Wing in his absence did not complete any new Care Plans or renew any existing plans. Accordingly when Mr Rossi came back from holiday on 16/17 October it would have been necessary for him to write out a review of the Care Plans for 19 residents. In particular the deterioration in Mr Fairlie's condition which was noted by Mr Rossi on his return from holiday should have triggered a review, but this was not done.

24. The day before Mr Fairlie was taken into Hospital Mr Rossi put in a request to Mrs Grogan for a pressure relieving mattress for Mr Fairlie. (He had previously requested this in September 2002). This had not become available by the time Mr Fairlie went into Hospital. There was no good reason why this mattress should not have been obtained immediately. Its purchase did not come out of the Home's budget since it was an item of capital expenditure.

Kathleen Federer or Harvey

1. Kathleen Federer or Harvey qualified as a Mental Health Nurse in September 2000 and after taking maternity leave she started work as a Staff Nurse at the Alexandra Nursing Home in April 2001. She worked, and at the date she gave evidence to this inquiry (June 2005) she continued to work 28 1/2 hours per week nightshift. She worked a weekend shift of Friday, Saturday and Sunday nights.

2. Mrs Harvey's first post was in the Sir Matthew Goodwin Wing of the Home and she moved to the St Mirren Wing in November 2001.

3. When Mrs Harvey started at the Home she received no induction. Her first night's duty was as the only nurse on the Wing along with a carer. At that time there was a male Charge Nurse in charge of the Home at nights and on Mrs Harvey's first night he came down to the Sir Matthew Goodwin Wing to ensure that she was coping.

4. Between the weekend in June 2002 when nine members of staff left and Mr Rossi starting on 8 July 2002, Mrs Harvey was the only permanent Staff Nurse working on the St Mirren Wing.

5. Mrs Harvey was due to go on annual leave after finishing her shift on the morning of Monday 21 October 2002. She did, however, work an extra nightshift from 23 to 24 October. She said that she had no cause to renew any of Mr Fairlie's dressings.

She would only renew a dressing if it was dirty or had fallen off. She did not return to work until Friday 1 November 2002.

6. When Mrs Harvey finished her shift at 8 o'clock on the morning of 24 October she remembered Mr Fairlie having a dressing on his left ankle and a scuff-type mark on his right hip. He did not appear to be suffering from dehydration.

7. Mrs Harvey recollects seeing water and a syringe in Mr Fairlie's room but cannot remember when this was.

8. Mrs Harvey has completed a substantial number of entries regarding Mr Fairlie's agitation and has noted the many occasions when he has been found on the floor or has put himself on the floor.

9. Prior to Mr Fairlie being admitted to hospital on 26 October 2002 Mrs Harvey had concerns about the Home. There was a shortage of resources, pads, wipes etc and a lack of consistency of care of the residents. She considered finding other employment. After October 2002 there were many improvements. There were fresh sandwiches for the residents to eat between meals, there were plenty resources and no shortages.

10. As a Mental Health Nurse Mrs Harvey did not consider she had an expertise in the care and dressing of wounds. If she had to dress a wound she would follow the Care Plan (if, of course, there was one), failing which she would take advice.

Josephine MacDonald

1. Josephine MacDonald, date of birth 28 March 1943, qualified as a Registered Nurse in 1983, starting in the profession as an Enrolled Mental Nurse. She worked as a Nurse in the public sector and retired from the Royal Alexandra Hospital at Christmas 1999. It was her intention to finish her nursing career in the private sector and sometime in mid 2000 she began work at the Alexandra Nursing Home as a Night Staff Nurse. Until that point she had spent most of her nursing career dealing with people suffering from mental health problems and with dementia.

2. When Mrs MacDonald began employment at the Alexandra Nursing Home she worked on a full time basis, four nights per week, in the Abbey Wing. The Abbey Wing is for the care of the elderly suffering from dementia, in effect a dedicated dementia unit.

3. After about a year or so at the Alexandra Nursing Home Mrs MacDonald left that employment to take up a Sister's post, working night duty in a BUPA Home. She remained there until early 2002 when she returned to take on the post of Sister in overall charge of the Abbey Wing. She also agreed to become the Mental Health Link Nurse for the whole of the Home.

4. In July 2002 Mrs MacDonald was asked by Mrs Grogan to meet Mr Fairlie's family as they had voiced concerns about Mr Fairlie. In particular they said that he was very restless and they pointed out that a member of the family had gone into the Home to visit Mr Fairlie and had found him sitting on the floor.

5. That day Mrs MacDonald went to see Mr Fairlie. She agreed that he seemed more restless and she considered that it would be helpful if he were to be assessed by a Consultant Psychiatrist. Mrs MacDonald arranged for Doctor Karl Philips to see him.

6. Several days later, on 4 July 2002, Doctor Philips attended at the St Mirren Wing and met with Mr Fairlie in the presence of Mrs MacDonald.

7. Doctor Philips was of the view that admitting Mr Fairlie to a psycho-geriatric ward within a specialist psychiatric hospital would not be of benefit to Mr Fairlie. Doctor Philips considered that a change in medication might be of value and he arranged this. Item 84 of Crown Production 21 is Doctor Philips' report to Mr Fairlie's General Practitioner dated 8 July 2002.

8. One of the changes recommended by Doctor Philips was a prescription for Respiradol but this was over sedating Mr Fairlie and it required to be stopped after only a few weeks.

9. In late July or early August 2002 Mrs MacDonald was prevailed upon by Mrs Grogan and Mrs Bandeen to take on the job of Deputy Manager along with her existing role as Sister in Charge of the Abbey Wing. Mrs MacDonald only agreed to do so, however, on the basis that it was a temporary appointment until the Home managed to employ a Deputy Matron.

10. No additional Nurses were taken on to enable Mrs MacDonald to perform this dual role. Consequently, when she was away from the Abbey Wing in her role as Deputy Manager she was not replaced by another Nurse on that Wing. Mrs MacDonald, however, endeavoured to prioritise her work as the Nurse on the Abbey Wing and would only leave the Wing once the residents had been attended to and supplied with medication, breakfast and the like.

11. Mrs MacDonald was the Senior Nurse in Charge of the Home on the weekend in June 2002 when nine staff left.

12. Mrs Grogan was at the Wimbledon Tennis Championships that weekend. While she was away she was contacted by the Nurses' landlord to say he suspected something was about to happen. The next day nine staff left the Home without working their notice. Mrs Grogan did not telephone the Home while she was away to find out if there were any developments.

13. Mrs MacDonald managed to retrieve the situation by employing agency staff. When Mrs Grogan came back to work on the Monday morning she did not seem to Mrs MacDonald to be unduly concerned about the situation which had occurred in her absence.

14. As a consequence of a family bereavement Mrs MacDonald ceased working about 21 September and did not return until 28 October 2002. Mrs MacDonald, in fact, was due to start another job on 13 or 14 September but due to the bereavement she did not take this other job. Mrs MacDonald had become very attached to the residents in Abbey Wing but she had become disheartened by the Home.

15. Before going off on leave Mrs MacDonald would go into the St Mirren Wing from time to time to see Mr Fairlie. She last saw him some time towards the end of August 2002 and it was her opinion that he had become much more settled.

16. As part of Mrs MacDonald's duties as Deputy Manager she required to review the weekly wound report forms which were to be submitted to her each Monday morning. Mrs MacDonald was then obliged to complete an audit form which was sent to Four Seasons' Central Office.

17. Not only did Mrs MacDonald complete this wound audit but it was her practice to visit a resident who had a lot of wounds or one who had a wound reported with a grade of 3 or 4. She made it her practice to enquire of the staff what steps they were taking in regard to the wound, and she would ask if it had been referred to the Tissue Viability Nurse or the GP.

18. Had Mrs MacDonald been the Nurse in charge of the St Mirren Wing on 22 October 2002 she would have been very concerned about the note of Mr Fairlie's wounds and his condition as recorded in Miss Mtermende's entry on that date. Mrs MacDonald would have inspected Mr Fairlie's ankle wounds each day (until the wounds were clean and every two or three days thereafter) and ensured that wound forms were completed and a wound assessment carried out. In view of the fact that Mr Fairlie had a raised temperature Mrs MacDonald would have ensured that he was given fluids of at least 150-200 mls every hour and at appropriate times during the night.

19. It would also have been good nursing practice to chart Mr Fairlie's temperature and pulse four hourly. This was not done.

20. While Mrs MacDonald was in charge of Abbey Wing it was very homely with a pleasant environment. At her expense she bought dishes and ornaments. She brought in flower arrangements. She improved the décor of the ward and brought in furniture.

21. During the time Mrs MacDonald was Nurse in Charge of the Abbey Wing none of the residents had pressure sores.

Julie Anne Wilson

1. Julie Anne Wilson, date of birth 2 November 1977, is a registered Mental Health Nurse. She qualified in September 2001.

2. After taking some time out to have a baby Mrs Wilson started work in February 2002, initially in Castlehead Nursing Home and she then joined the Alexandra Nursing Home some time in August 2002.

3. Mrs Wilson worked two night shifts each week, usually Monday and Tuesday nights or Tuesday and Wednesday nights.

4. When Mrs Wilson started in the Home she was assigned to work in the St Mirren Wing. She started at 10.00pm for her first shift and was the only Nurse on the Wing,

assisted by a Care Assistant. Mrs Wilson had no proper induction. She voluntarily shadowed Mr John Rossi the day shift Charge Nurse, on an unpaid basis for a few hours earlier that day.

5. Mrs Wilson did not enjoy working at the Home and she left a few weeks after Mr Fairlie was admitted to Hospital. She felt the Home was disorganised, very short staffed and there was no consistency of staff. Furthermore, she could not get essential equipment such as thermometers and the like and basic things such as gloves, aprons and wipes. It was often necessary to go to other Wings to borrow equipment but often they were short too.

6. While Mrs Wilson worked with the same Care Assistant, Mrs Elizabeth Grant, she was concerned that she always seemed to take over her shift from a Nurse she had not met before, usually an agency or bank Nurse. There was no continuity of staff.

7. Mrs Wilson came on duty on Monday 21 October 2002 at 9.45pm to start her shift at 10.00pm. There was no adverse report from the Nurse going off duty in relation to Mr Fairlie. At one point, as part of her normal routine, Mrs Wilson went into Mr Fairlie's room and became very concerned about him. He was very flushed. He was suffering from rigors. He was shaking. His temperature was very high and his blood sugar level was very high (Mrs Wilson had to go to another Wing to borrow the equipment to carry out a BM check). Item 117 of Crown Production 12 is Mrs Wilson's entry recording Mr Fairlie's temperature at 39.35 C and his BM level at 11.8.

8. Mrs Wilson telephoned the NHS 24 helpline and Doctor Ezebuiro, an on call Doctor, was sent out. Doctor Ezebuiro examined Mr Fairlie. He gave Mrs Wilson one dose of an antibiotic to give to Mr Fairlie and a prescription for amoxicillin.

9. When Mrs Wilson came on duty on 21 October she was not told that Mr Fairlie had any pressure wounds. He often wore bed socks in bed and she did not notice any injuries to his ankles.

10. Mrs Wilson started a fluid balance chart the night of 21 October because of Mr Fairlie's infection. When she was working on that particular shift she did not notice any signs of dehydration. Had she been concerned about his state of hydration, she would have mentioned it to Dr Ezebuiro.

11. When Mrs Wilson came on duty at 10.00pm on 22 October, she took over from Mr Rossi the Nurse in charge of the St Mirren Wing. She has no recollection of reading the entry of 22 October by Miss Mtermende regarding the wounds on Mr Fairlie's ankles and Mr Rossi, in his end of shift report, made no mention of any such injuries. Had she been aware of these wounds on 21 October she would have brought them to the attention to Doctor Ezebuiro.

12. Such were the time pressures on Mrs Wilson she often did not have time to read the patients' case notes before or during her shift.

13. In the two week period leading up to Mr Fairlie's admission to Hospital on 26 October Mrs Wilson saw a cup and a syringe on the unit beside Mr Fairlie's bed. Mrs Wilson never used a syringe to give a resident water. Mrs Wilson particularly

recollected seeing a syringe in Mr Fairlie's room when she came on duty on 14, 21 and 22 October. On each occasion when she saw a syringe in Mr Fairlie's room she would discard it. The next time she came on duty there was another syringe in his room. She brought her concerns to the attention of Mr Rossi but he seemed know that a syringe was being used.

14. Mrs Wilson conscientiously used the Home's diary (Crown Production 14) and the communications book (Crown Production 16) as a means of communicating her concerns and information to staff coming onto the day shift.

Maxine Beveridge

1. Maxine Beveridge was employed by Four Seasons Health Care between February 1994 and September 2005. In the year 2000 she was employed as a Home Manager and was promoted to Regional Manager in May 2001 with responsibility for the eastern side of the country.

2. Her duties as Regional Manager included the overall monitoring of the performance of all the Homes owned by the group involving monthly visits and generally looking at questions of occupancy, care standards, disciplinary issues and the like. The Alexander Nursing Home was not one of the Homes for which she had responsibility within the group.

3. The Care Home manual, number 13 of Process, was introduced to all the Homes within the Four Seasons Group in May 2002. There had been a manual in the Alexandra Care Home prior to that. There were Homes which had been in the Four Seasons Group for some considerable time, there were Homes which had previously been owned by Scotcare Limited and there were other private Nursing Homes which had been bought over by Four Seasons Health Care Limited. One of the reasons for issuing the manual was to provide uniformity in the documents used within the Homes in the Group for the monitoring of residents' care.

4. Mrs Beveridge had no direct involvement with the Alexandra Nursing Home other than to chair the disciplinary hearing in relation to Mr Rossi.

5. In 2002 Managers of Care Homes within the Four Seasons Health Care Group were paid a bonus if they managed to keep financial spending within the allocated budget.

6. While Mrs Beveridge was Regional Manager none of the Homes under her control had any difficulty providing sufficient food for residents and items such as gloves, wipes and the like, or in providing capital expenditure items such as pressure relieving mattresses. According to Mrs Beveridge the Alexandra Nursing Home should have had no difficulty obtaining incontinence pads because these were provided by the local Health Board and would come in different sizes based on the residents' individual assessments.

7. According to Mrs Beveridge if a new member of staff joined Four Seasons Health Care the induction period should have lasted up to twelve weeks.

8. Posts, even for care assistants, should not be filled without references being obtained and after the Care Commission came into existence, a disclosure check was also necessary. A registered nurse should not be employed without a disclosure check being obtained in advance. A care assistant could be taken on to work under supervision until the disclosure check was received.

Marie Gilchrist

1. Marie Gilchrist, aged 43 years, qualified as a Nurse in 1980. She holds a dual qualification in general and mental health. From 1990 until 2002 she worked exclusively in mental health. Since then she has been involved in education and at the date of this Inquiry was employed as an SPQ Assessor Verifier and Lecturer on Health and Social Care. She is, however, an experienced practical Nurse.

2. Mrs Gilchrist was employed at the Alexandra Nursing Home in the St Mirren Wing as a Nursing Sister from January until April 2002.

3. When she started work at first Mrs Gilchrist worked from 9.00am to 5.00pm and after an assessment she was employed mainly working backshift or on night duties. When she worked the early shift she also had another trained member of staff on duty.

4. When Mrs Gilchrist started on the St Mirren Wing she received only a very basic induction involving fire safety procedures. She did not shadow another Nurse.

5. At that time the other trained staff working on the St Mirren Wing were three Filipino Nurses, Orsis, Ruby and Randy. Mrs Gilchrist left the Home because she disapproved of the way Mrs Grogan and Mrs Karrim treated these staff members. She was also unhappy about the unavailability of certain supplies particularly in relation to personal hygiene.

6. Mrs Gilchrist was concerned about the number of times Mr Fairlie was falling when he tried to walk unaided. She started a falls chart to document the times he fell and what injuries, if any, he suffered. Production 17 pages 209, 210 and 211 are examples of these charts instigated by Mrs Gilchrist. One of the objectives of these charts was to enable Mrs Gilchrist to see if there was a pattern emerging and also to obtain an overall picture of Mr Fairlie's mobility.

7. From time to time Mrs Gilchrist observed Mr Fairlie simply putting himself down on the floor so that he would attract the attention of one of the staff.

8. On 17 March 2002 Mrs Gilchrist was concerned about Mr Fairlie's state of health and noted in the Home's medical records, "GP to be contacted tomorrow for review of medical condition and medication. Physical condition deteriorating - evidence of involuntary muscle movement (tardive diskinsia). Discuss with GP. Mobility very poor. Appetite decreasing. Appointment to be made for his family to discuss prognosis." This entry is contained within Production 12 page 107.

9. Production number 12 pages 115 to 160 comprise care plans for Mr Fairlie which were prepared by Mrs Gilchrist. These care plans were implemented by Mrs Gilchrist and the staff working for her.

10. Mr Fairlie was not nursed on a mattress on the floor when Mrs Gilchrist worked on the St Mirren Wing.

11. When Mrs Gilchrist was on duty in the St Mirren Wing she did not see Mrs Grogan visiting the Wing each day.

12. After she left her employment at the Home Mrs Gilchrist made an anonymous telephone complaint to the Care Commission. She did so because she was unhappy with the level of care, the standards and the staffing levels within the Home. She also thought that the Filipino staff were being bullied. She also considered that the initial assessments of potential residents were being carried out by Mrs Karrim without any discussion with the Registered Mental Nurse, and accordingly on one occasion a resident was inappropriately placed within the Home.

13. Production number 26 is the Complaint Log prepared by one of the members of the Care Commission for her own use detailing the complaints received for the Alexandra Nursing Home between April and November 2002. It was likely that the second complaint on the Log which is logged as number 20, received on the 2 May 2002, is Mrs Gilchrist's complaint.

Mary Jude Garganta

1. Mary Jude Garganta, aged 32 years, qualified as a Nurse in the Philippines in 1994. She came to the United Kingdom in 2002 and began work as a carer in the St Mirren Wing of the Alexandra Nursing Home on 17 June 2002. At this time Mr Fairlie was nursed on a mattress on the floor.

2. In March 2004 Mrs Garganta qualified to work as a Nurse in the United Kingdom.

3. When Mrs Garganta started as a carer she was assigned to work with two other carers, Michelle Peters and Anne-Marie Bell.

4. Mrs Garganta recollects Mr Fairlie having a very good appetite, eating everything that was given to him. When she started at the Home he took his meals in or near the dining room and latterly he was fed in his room. While he always looked frail to her, she recollected that he became thinner before he was finally admitted to Hospital.

5. She also recollected that he was a very agitated person, constantly kicking out.

6. Mrs Garganta was involved in nursing Mr Fairlie in bed for a few weeks before he went into hospital on 26 October 2002. She was involved in turning him every two hours. She would put him in a particular position and often he would then turn himself back to his original position.

7. Mrs Garganta was not on duty on 26 October 2002 although Mrs Grogan advised the officers of the Care Commission that she was working that day. Enquiries by the Care Commission would tend to support Mrs Garganta's position.

8. When Mrs Garganta worked as a carer on the St Mirren Wing there were occasions when there was no Nurse working on the Wing.

Elizabeth Grant

1. Elizabeth Grant, aged 51 years, was employed as a Care Assistant in the St Mirren Wing of the Alexandra Nursing Home from sometime in 2001. Before that, from about 1999, she worked in a different Wing within the Home. She was employed on the nightshift from 10.00pm until 8.00am on a full time basis. This was Mrs Grant's first job.

2. When Mrs Grant started at the Home she was in a Ward for the frail elderly. When she moved to the St Mirren Wing she had no previous experience of dealing with people suffering from dementia. She was given no particular training to assist her in dealing with people suffering from dementia.

3. Mrs Grant also recollects Mr Fairlie being a very agitated person. He kicked out in bed, kicking off the cot sides and the bumpers which were put in place to protect him. If Mr Fairlie needed changed because of his incontinence Mrs Grant needed help. She could not change him on her own.

4. Mrs Grant was also involved in turning Mr Fairlie but he often would just "turn back again".

Florence Mtermende

1. Florence Mtermende, aged 33 years, is a Staff Nurse presently working in Dykebar Hospital, Paisley. She qualified from Paisley University in 2000.

2. Miss Mtermende worked as a Bank Nurse from time to time at the Alexandra Nursing Home, starting there in May 2001.

3. When Miss Mtermende worked as a Bank Nurse in the Home she could work any shift and in any Wing.

4. From time to time she worked in the St Mirren Wing and nursed Mr Fairlie.

5. Production 14 (the appointments diary) page 192 contains an entry for Friday 28 June 2002 written by Miss Mtermende, viz, "Please contact G Fairlie's family re cotsides permission, only use them in an emergency situation without their consent". Beside this entry another member of staff has written Mr James Fairlie's name and telephone number and a note "to come up tomorrow".

6. Production 12 page 115 contains an entry dated 22 October 2002 written by Miss Mtermende. This entry states, inter alia, "Temp is 37.2C (at 1.30pm). Family has been phoned to inform them of George's condition. Dressing on both ankles has

been renewed. The left outer aspect of the ankle looks really bad, septic, query infection. The left inner aspect is sloughy, nu-gel applied to de-slough both sides of the left leg. The right ankle has been sprayed with Povidore and a dry dressing applied Mepore". Miss Mtermende had not seen Mr Fairlie for about 3 weeks or so prior to this date as she had been on annual leave.

7. Because Miss Mtermende is a Mental Health Nurse she does not consider herself to have any expertise in wound management. When she completed her shift, at handover, she expressed her concerns to the Nurse coming on duty (John Rossi) and asked him for a second opinion.

8. Production 16 (the Communications Book) page 41 contains an entry written by Miss Mtermende on 22 October 2002 in relation to her treatment of Mr Fairlie's ankle wounds.

She specifies the products she has used. The purpose of the entry in the Communications Book was to warn staff that one of the products, Imodine Dressing, cannot be used for more than one week since it is only "appropriate for short term". Prior to treating Mr Fairlie's wounds Miss Mtermende took advice from the District Nurse.

9. When Miss Mtermende came on duty on 22 October she was given a verbal report from the Nurse from whom she took over but does not remember being told about wounds on Mr Fairlie's feet.

10. Although she was not a permanent member of staff, she was aware of Mr Fairlie's state of health and ensured he was given fluid regularly. In the main she did this personally, but if she asked a care assistant to do it she always checked that it had been done since Mr Fairlie was "on a fluid chart".

Brenda Bandeen

1. Brenda Bandeen, aged 55 years, started employment with Four Seasons Health Care as a Home Manager in 1987. In 2000 she was promoted to the post of Regional Manager. There were two Scottish Regional Managers, Mrs Bandeen basically covering the western side of the Country and another Manager Maxine Beveridge, covering the eastern side. Mrs Bandeen had responsibility for ten Care Homes varying in size from between 43 beds to 122 beds.

2. Mrs Bandeen ceased employment as Regional Manager in September 2002. She was in fact made redundant and between that date and March 2003 she was a peripatetic Manager filling in as a Home Manager where there was a vacancy.

3. Four Seasons Health Care Limited had amalgamated with another company. There were more Regional Mangers than were needed. Mrs Bandeen was replaced by Mrs Anne Walker who became Regional Manager in the west but she had a smaller geographical area to cover.

4. As part of her duties as Regional Manager Mrs Bandeen was expected to visit each of the Homes in her area. These visits could be announced or unannounced.

She was expected to visit each Home each month but because of the extent of the geographical area and her workload this was not possible and she tended to visit each Home about every 6 to 8 weeks. She visited the Alexandra Nursing Home in accordance with this approximate timetable.

5. As far as Mrs Bandeen was concerned the Alexandra Nursing Home should have had no difficulty in obtaining supplies and in ensuring that there was an adequate stock of supplies for use by the staff. She was also of the view that the Home should have had no difficulty obtaining an adequate supply of pressure relieving mattresses since these were an item of capital expenditure.

6. Mrs Bandeen also could not understand why the Home had difficulty obtaining replacement staff. She said it was possible to block book bank staff to try to ensure there was some continuity of staffing.

7. Item 2 of Renfrewshire Council's Productions is a contract performance report dated 27 April 2001 following upon an earlier visit by council staff. The report concludes by itemising 14 "requirements" to be carried out by the Home including important matters such as the preparation of accurate client records, proper care plan reviews and the keeping of accurate complaint records. Mrs Bandeen on her periodic visits to the Home did not pick up on the fact that these deficiencies existed.

8. As part of these monthly performance reviews Mrs Bandeen was expected to complete a sheet detailing the way in which the particular Home was being run, and this sheet was then submitted to Head Office.

9. In relation to the question of staffing the purpose of the review was to ascertain if there was a shortage of trained staff, or of untrained staff, and if there were shortages what the Manager was doing about it and how she was endeavouring to recruit replacement staff.

10. Mrs Bandeen did not carry out a review of the Home in September 2002 as she was on holiday. She could not recollect if she had carried out a review in August 2002.

11. It was part of Mrs Bandeen's duties to check the care plans for the individual residents and to ensure these plans were up to date and completed properly. She should also have checked the Communication Books the Complaints Books and the Duty Rotas to ensure that the minimum staffing requirement was being complied with. Mrs Bandeen also required to check staffing, budgeting levels, occupancy levels and the like.

12. The Four Seasons Care Manual, Production 13, stated that the Home Manager had a responsibility to check that records were being kept properly. So far as Mrs Bandeen was aware Mrs Grogan was complying with this requirement.

13. Similarly the Care Manual provides for the treatment and recording of wounds and general wound management. Wound assessment forms should have been sent by the Home to Head Office every Monday. As far as she was aware Mrs Bandeen thought this requirement was being complied with.

14. Mrs Bandeen was not aware of any complaints by Mr Fairlie's family.

15. Mrs Bandeen was not aware that Mrs Karrim had handed in her resignation in December 2001.

16. Four Seasons Production 8 is a fax dated 28 June 2002 to Ms Una Duffy at the Care Commission advising the Commission that nine Filipino Registered Nurses had left the Nursing Home without notice on Wednesday 26 June leaving the Home in crisis. Mrs Bandeen was the co-author of that memorandum.

IV. Doctor Uzoije Ezebuiro

1. Production 12 page 81 is the R.E.M.S Emergency Service's record of a telephone call from Julie Wilson at the Alexandra Care Home on the evening of 21 October 2002. The complaint from the Home as disclosed in the triage notes within the Production is that Mr Fairlie seemed very chesty, is sweating ++, seemed confused and with a very high temperature.

2. Doctor Ezebuiro, a General Practioner based in Erskine, but who has worked for the Emergency GP Services for 20 years was on duty that evening and he responded to the call. He attended at the Alexandra Nursing Home at 11.36pm.

3. After examining Mr Fairlie Doctor Ezebuiro concluded that he was suffering from a chest infection and he prescribed amoxicillin.

4. When Doctor Ezebuiro visits a Care Home in his capacity as an Emergency GP to see a resident he normally reads the Home's notes for several days prior to the date of his attendance, with a view to obtaining a general picture of the state of health of the particular resident.

5. Doctor Ezebuiro thinks that he read the Home's notes for Mr Fairlie. Production 12 page 117 contains an entry for 21 October 2002 for 2.00pm which states "bed bath given this morning. GP contacted regarding referral to dietician. Weight has to be taken weekly for next 4 weeks and review later. Taking diet and fluids well". This is the entry in Mr Fairlie's notes immediately before Julie Ann Wilson's entry at 22.30 on that date where she states that the GP had been contacted (and Doctor Ezebuiro attended).

6. Doctor Ezebuiro is able to recognise the clinical signs of dehydration. It is likely if he had been concerned that there was a problem with dehydration that he would have arranged for Mr Fairlie to be admitted to Hospital.

V. Involvement of the Social Work Department

1. Peter James McCulloch, aged 48 years, is the Principal Officer for Older People Services within Renfrewshire Council Social Work Department and has been in that post since August 2000. He began his Social Work career as a trainee Social Worker in 1980.

2. His responsibilities are in relation to Older People Services. He has responsibility for Renfrewshire Council's Care Homes, for Day-Care Services, for Home Care Services, and Hospital Services and he also has a role in overseeing the standards of care in all Renfrewshire Council's Care Services.

3. Prior to Mr Fairlie's admission to the Royal Alexandra Hospital in October 2002 Mr McCulloch had no personal involvement with Mr Fairlie.

4. Crown Production 22 is a Social Work Case File relating to George Fairlie. A file, such as this, would hold all relevant information on a client including case notes, correspondence and other relevant matters.

5. Crown Production 24 is a file of Social Work notes from the Royal Alexandra Hospital, Paisley relating to George Fairlie. Files such as this would generally deal with specific incidents relating to a person's admission to Hospital.

6. Renfrewshire Council Social Work Department was involved with Mr Fairlie and his wife from about 1996 onwards in providing a substantial amount of home care while they still resided in the community.

7. The Social Work Department was also involved in the placing of Mr Fairlie in the Alexandra Care Home in May 2000.

8. At that time the procedure was that when a person, such as Mr Fairlie, was admitted to a Care Home the placement was normally considered to be temporary and for a period of four weeks or so. At the end of that period a review should have taken place to confirm the placement as permanent or not. Thereafter there should have been continuing contact between the individual and the allocated Social Worker, including contact with the person's family and the Care Home for a further period of six months. At the time of his admission, Renfrewshire Council required to make various enquiries regarding a flat Mr Fairlie had once owned, and it took some time for this issue to be clarified.

9. Production 1 for Renfrewshire Council is an agreement between Renfrewshire Council and Scotcare Group Ltd the previous owners of the Alexandra Nursing Home dated 28 January and 4 March 1999. This agreement regulates the running of the Home and sets out the standards and rules with which the Home is expected to comply in looking after its residents. Paragraph F4 of that agreement deals with the "monitoring and review" of residents within the Home. This document confirms that a placement, such as Mr Fairlie's, should have been reviewed at the end of the four week period with a further review at the expiry of a further period of six months, and annually thereafter. His four week review should have taken place somewhere about the end of June 2000 and the six month review should have taken place about the end of December 2000.

10. In terms of the contract between the Social Work Department and the Home it was the responsibility of the Social Work Department to arrange the four week review for Mr Fairlie. They failed to do so. It was the responsibility of the Care Home to arrange the 6 month review and to invite a representative of the Social Work Department to attend. The Manager of the Home failed to do so.

11. At that time there were approximately nine hundred or so people residing within Care Homes in Renfrewshire and it was not possible for a representative of the Social Work Department to attend every such review. Accordingly it was the Department's practice either to attend a percentage of reviews or to call a review if there were particular circumstances of concern which had been brought to the Department's attention.

12. At the end of that six month period Mr Fairlie's file would have been considered by a senior member of the Social Work Team and if everything was in order the file would have been closed as an active Care Management case. There would of course still be a contract between Renfrewshire Council and the Home, and the Social Work Department would continue to be responsible for the contractual aspects of the resident's care. The Home would assume responsibility for ensuring his care. Thereafter, Mr Fairlie's case would be reviewed on an annual basis.

13. In Mr Fairlie's case the file was not examined by a Senior Social Worker. If it had been so examined the Social Worker should have noticed that there had not been a review.

14. Once a review has been completed a copy of the minute of the review should be sent to the Social Work Department by the Home.

15. For reasons unknown to the Social Work Department the case was not closed by them, that is, Mr Fairlie was not regarded as a permanent resident of the Home, until February 2001.

16. Four Seasons' Production 4B is the minute of the review carried out by the Home on 9 October 2001. This was the first (and only) formal review to be conducted in relation to Mr Fairlie's case. This Production indicates that the Social Work Department was invited to attend the review. Mr McCulloch was unable to find such an invitation in his Department's files, although he accepted that the invitation may have been verbal.

17. By the time of this review there had been several telephone calls to the Social Work Department from members of Mr Fairlie's family expressing concern about his care. Production 22 page 37 contains an entry dated 12 July 2000 of a telephone call from Alison Fairlie to the Social Work Department in which she specified seven matters of concern ranging from matters such as missing laundry, the quality of Mr Fairlie's care and insufficient food to eat.

18. Page 36 of said Production contains an entry of a telephone call on 12 July 2000 from the Social Worker to Mrs Grogan, Manager of the Home repeating these matters of concern. The Social Worker concludes the entry by stating "will monitor this at review". There does not appear to be any evidence of a monitoring or review of the subject matter of these complaints. Mrs Grogan should have noted these complaints in Mr Fairlie's records but she failed to do so.

19. Production 22 page 4 contains an entry dated 20 February 2002 of a telephone call to the Social Work Department from James Fairlie voicing concern over the care

of Mr Fairlie at the Alexandra Nursing Home. He is advised to speak to the Manager and thereafter to write to Laura Harrigan of the Social Work Department.

20. The same Production contains an entry dated 18 March 2002 of a telephone call to the Social Work Department by Mr Fairlie's daughter Alison Fairlie expressing concern about the standard of care of her father in the Alexandra Nursing Home and enquiring how she can arrange for Mr Fairlie to be transferred to Bradford where she resides. Unfortunately the Duty Social Worker who took this call did not take a note of Alison Fairlie's telephone number and he was unable to return her call.

21. Production 24 page 5 is a Royal Alexandra Hospital Social Work referral form relating to a telephone call received from James Fairlie on 26 June 2002. The complaint was that the family was not happy with the Nursing Home and the care that was being received. It was said that there were language problems with foreign staff members, a failure to help Mr Fairlie shave and more general concerns about his health care. The caller was advised by the Social Worker to speak with the Manager of the Home who would advise as to the formal complaints procedure in place there. He was also told that he could also speak with a member of the Paisley area team regarding his unhappiness.

22. Said last mentioned Production also records that Mr Fairlie was discharged from Hospital on 27 June 2002 and that "no further action" be taken.

23. The Social Worker who took the telephone call on 26 June would not have been aware of the earlier telephone calls from the family. At that time the Social Work Department did not have a computer system which enabled a Social Worker to marry up complaints to the Social Work Department with complaints to the Hospital Social Work Department.

24. Between May 2000 and October 2002 members of the Social Work Department carried out various contract compliance visits at the Home, but they did not attend the Home specifically to monitor or assess Mr Fairlie's case. Such a visit involved the Contract Monitoring Officers calling at the Home and selecting a sample of cases to check if reviews were taking place, to ascertain if there were any particular problems in a case and, generally, to ensure compliance by the Home with their contract.

25. There had been a contract monitoring visit carried out by Renfrewshire Council at the Alexandra Care Home on 8 August 2000 and following upon that inspection a contract performance report dated 27 April 2001 was prepared. This is Production 2 of Renfrewshire Council's Productions. A follow up letter was sent to Mrs Grogan, Manager of the Home, on 2 August 2001. This is item 3 of Renfrewshire Council's Productions.

26. The said contract performance report specified fourteen issues which required to be addressed by the Home. It pointed out, *inter alia*, that the Home's complaints procedure did not comply with Renfrewshire Council's requirements in several respects and that the record-keeping in the home was poor. The Home was therefore in breach of the agreement with Renfrewshire Council.

27. Item 2 of Renfrewshire Council's Productions (the Contract Performance Report dated 27 April 2001) contains a letter dated 5 February 2001 from Renfrewshire Council to the "provider" (that is, the Home) pointing out that the Home should advise the Social Work Department of any complaints (either verbal or written) and the details thereof and that within 3 days of receipt of same. It also informs the Home as to how it should record and deal with such complaints and the timescale for doing so.

28. Paragraph D.5.4 of the Agreement between Renfrewshire Council and Scotcare Group Ltd (Item 1 of Renfrewshire Council's Productions) also provides that the Home should inform the Council of the outcome of any serious complaints including any which have been the subject of investigation by the registration authority. A "serious complaint" is defined as one which contravenes any of the requirements of said Agreement. At a contract performance visit to the Home on 4 November 2002 Mrs Grogan accepted that she had not always done this.

29. Renfrewshire Council Social Work Department has no record of the intimation to it by the Home HioHH of any complaints made directly to the Home by or on behalf of any individual.

30. The complaints referred to in Crown Production 26, the Care Commission's log, were not intimated either by the Home or the Care Commission to Renfrewshire Council.

31. After Mr Fairlie's admission to the Royal Alexandra Hospital on 26 October 2002 the Social Work Department became aware of the allegations of Mr Fairlie's lack of care and they initiated an investigation of the Alexandra Nursing Home. They obtained from the Home a list of all residents (approximately 83 in number) and they then contacted the families of these residents to ascertain if there were any similar concerns about lack of care. Only one family expressed concern about the care of a resident.

32. A further contract performance inspection was carried out and a report was issued on 20 November 2002. This is Item 4 of Renfrewshire Council's Productions. This inspection was carried out as a consequence of the complaints regarding Mr Fairlie's care. Paragraph 1 of the issues raised in the inspection in November 2002 related to the fact that the complaints procedure within the Home required to be addressed. This issue was also highlighted in the inspection carried out in August 2000 and referred to in the report of 27 April 2001. The issue was also raised in the letter to Mrs Grogan dated 2 August 2001.

33. The contract performance report dated 20 November 2002 which was issued following upon the visit by members of Renfrewshire Council Social Work Department to the Home on 4 November 2002 provides, inter alia, that all admissions to the Home were to be suspended pending the outcome and recommendations of the contract compliance visit, care manager's interviews with residents and relatives and the Care Commission investigation. Renfrewshire Council also contacted the relatives of all residents of the Home to ascertain their views about the quality of care and prioritised cases where there were no relatives or next of kin and where visits from relatives or next of kin were infrequent.

34. Following upon Mr Fairlie's treatment at the Home the Social Work Department put new procedures in place to ensure that they were present at a greater number of reviews of clients residing in Care Homes. For this purpose a Headquarters-based review team was established in 2003 as part of Mr McCulloch's Department for the routine monitoring of a greater number of cases and to ensure a proactive involvement in cases where there were concerns.

35. This Team works closely with the Care Commission in the monitoring of cases. Communication between the two agencies is covered by a Memorandum of Understanding (which, as at November 2005, had not been signed).

36. The Social Work Department is entitled to a copy of a Care Commission Report on a particular resident or issue, but the Care Commission is not obliged to disclose the outcome of a complaint to the Social Work Department even in cases which are funded by the Local Authority.

37. Renfrewshire Council's Social Work Department carried out a further follow up contract compliance visit to the Home on 17 December 2002 and confirmed the outcome of this visit in a letter to the Regional Manager of Four Seasons Health Care dated 21 January 2003. This is Item 5 of Renfrewshire Council's Productions. This letter recorded, inter alia, that the Care Commission's requirements for staffing levels had been met.

38. The Social Work Department continued to monitor the Home at a fairly high level throughout the beginning of 2003 and the embargo on admissions was not lifted until May 2003.

VI. Involvement of the Care Commission

1. The Scottish Commission for the Regulation of Care ("the Care Commission") was established by the Regulation of Care (Scotland) Act 2001. With effect from 1 April 2002 it took over the functions of a variety of Regulators, for example Social Work, Education, and Health Boards. It now has jurisdiction in connection with the running of, inter alia, Children's Homes, Homes for the Elderly and Hospices. Generally, the ethos of the Care Commission is to approach each provider and to work towards improving the services for the benefit of the service user. The core activities of the Care Commission are the Registration of Services, Inspection of Services, a Complaints Function and an Enforcement Function.

2. In relation to Residential Care Homes for the Elderly, the Care Commission decided it would inspect these on a twice a year frequency, one of which was to be unannounced. The purpose was to inspect the establishment against the national care standards, to consider the regulations under the 2001 Act and to report on the establishment's compliance with these standards.

3. In 2002 it was decided by the Care Commission that once it had inspected an establishment a draft report would be sent to the service to give it the opportunity of checking for factual inaccuracies. This would be sent within 10 working days of the completion of the inspection (to give the service provider the opportunity of accepting or challenging the contents), and within 15 or 20 working days thereafter the final

document would be issued to the service provider. It has since been decided that the 10 day period for issuing the draft report was too ambitious. A draft is now sent out to the service provider within 20 days of the inspection and if there is no response with proposed amendments or challenges to factual inaccuracies within 15 days thereafter, the draft becomes final.

4. Crown Production 11 is a document entitled "National Care Standards: Care Homes for Older People" published by the Scottish Executive (since revised in March 2005). It is produced for the benefit, firstly, of Care Home owners and managers so that they know what they should be providing to residents of Care Homes, and secondly, of residents so that they know what level of service they should expect from a Care Home. The document sets out 20 core standards. In the first year of its existence the Care Commission decided when inspecting a Care Home that it would investigate any five of these core standards but it had the flexibility to consider other standards of inspection. .

5. Prior to the Care Commission assuming responsibility for the Alexandra Nursing Home, it had been the responsibility of Argyll and Clyde Health Board. It had carried out an inspection of the Home on 8 January 2002 and the Care Commission obtained a copy of its report. This report highlighted a number of recommendations including a recommendation that there was to be adherence to the staffing schedule issued by the Health Board. The Care Commission was also provided with a copy of the staffing schedule. At the time of transfer of responsibility to the Care Commission, the recommendations contained in the January 2002 report had not been implemented by the Home.

6. The Alexandra Nursing Home was inspected by Officers of the Care Commission on 10 and 11 September 2002. Item 6 of the Crown's Productions is the draft report prepared by the Care Commission following upon its inspection. Item 25 is its final report. On conclusion of the inspection Care Commission Officers met with the Manager of the Home and informed her of the likely contents of the Report.

7. Prior to the said inspection on 10 and 11 September 2002 the name of the Alexandra Nursing Home was fairly well known to Officers of the Care Commission as there had been a number of complaints.

8. During the course of this inspection the Care Commission Officers were advised by the Home's Manager that she had 11.5 vacancies for trained staff.

9. The Care Commission Officers concluded that this shortage of staff impacted upon the record keeping, the medicine management, the promotion of continence and the general care of the residents. At this time the St Mirren Wing should have had two trained and two untrained members of staff on the early shift. Regularly this unit was operating with a maximum of one trained and three untrained members of staff on the early shift. The Care Commission Officers also concluded that there was a problem with staff training and that Care Assistants had not been given training to the appropriate level.

10. This inspection also concluded that the St Mirren Wing, which was a dedicated dementia unit, was not run properly as such. There was insufficient stimulation provided for the residents and there did not seem to be any specialist care.

11. Environment, signage, lighting, and use of colour in décor can be important to people suffering from dementia. They can be conducive to a contented existence. The St Mirren Wing, on the contrary, was cold (environmentally), uninviting and with poor décor.

12. Ms Una Duffy of the Care Commission was the team leader in charge of the inspection of the Alexandra Care Home on 10 and 11 September 2002. She left the organisation about 24 or 25 October 2002 at which time it was ascertained that the draft report had not been sent out to the Home. This was issued to the Home shortly thereafter.

13. Item 26 is a summary of complaints received by the Care Commission in relation to the Alexandra Nursing Home between 17 April and 10 October 2002. This shows eight complaints having been received. "Staffing levels" was a recurring complaint. In general these complaints were not substantiated in relation to the number of staff on duty but the Commission accepted that there were concerns about "the staff mix," that is, the absence of trained staff being compensated by the provision of untrained staff. This was at variance to the staffing schedule approved by Argyll and Clyde Health Board and which was deemed to apply to the Care Commission.

14. For a unit the size of the St Mirren wing there should have been on the early shift two trained and two untrained staff; for the afternoon shift one trained and two untrained staff and the night shift one trained and one untrained staff.

15. On 28 October 2002 a complaint was received by the Care Commission from the family of Mr George Fairlie following upon his admission to the Royal Alexandra Hospital on 26 October 2002.

16. Two Officers of the Care Commission, namely Marie McKerry and Andrea Fitzgerald-Gee, were assigned to investigate the complaint and they carried out an unannounced inspection of the Home on Tuesday 29 October 2002 when they were met by Mrs Ruth Grogan, the Manager of the Home, and Mrs Anne Walker the Regional Manager of Four Seasons Health Care Limited. She had attended at the Home having been made aware of the nature of the complaint by Mr Fairlie's family.

17. Item number 4 of the Care Commission's Productions is the typed version of contemporaneous notes made by Marie McKerry during her visit on 29 October 2002.

18. This Production shows, inter alia,:

a) The Manager advised the Officers from the Care Commission that Mr Fairlie had been admitted to hospital in June 2002 with dehydration. This was incorrect. He was admitted for a chest infection;

b) It was alleged by Mr Fairlie's family that when he was admitted to hospital in October 2002 he had pressure sore damage to his ankles and also to his hip and buttocks. The Care Staff in the Home disputed the latter and said that there was no damage to Mr Fairlie's hip "other than a bit of discolouration". Examination of the Hospital Records (Crown Production 19 page 630) discloses that on Mr Fairlie's admission to Ward 14 of the Royal Alexandra Hospital on 26 October 2002 he had pressure sores, inter alia, to his left hip, and further, "Bruising over various parts (left) hip quite extensive will need pressure relieving mattress". When Mr Fairlie was seen by Elizabeth Wilson the Tissue Viability Nurse Specialist on 28 October 2002 she recorded that Mr Fairlie had Stage 1:2 areas of damage along the left iliac crest, sacral areas and left hip.

c) Mrs Grogan advised the Officers that an agency nurse was in charge of St Mirren Wing on Saturday 26 October 2002 at the time Mr Fairlie was admitted to the Royal Alexandra Hospital. Having consulted the off duty rota in her office, Mrs Grogan advised the Officers that three care workers were also on duty and she named them. One of these workers was interviewed and advised the Officers that she was not on duty. She checked the duty rota on the unit and named another care worker whom she claimed was on duty. This named care worker was also interviewed and she stated that she was not on duty either. Further investigation by the Care Commission Officers ascertained that only two care workers were on duty, Michelle (surname unknown) and Anne Leitch. When this information was put to Mrs Grogan she claimed the rota in the unit was incorrect and that Michelle and Anne Leitch had been on duty with the agency nurse and also with a bank care worker, whom she could not name;

d) Mrs Grogan advised the Officers that John Rossi was Mr Fairlie's key worker. This appeared to be incorrect. The Home did not have a proper key worker system in operation. There was not a sufficient number of staff to operate it;

e) Mrs Grogan advised the Officers that she had never received a formal complaint from the family and that all previous verbal complaints had been resolved. Mrs Grogan also claimed that a new complaints book was in the unit replacing a book with missing pages. This book, apparently, had previously been used for another purpose and when it was decided to use it as a complaints book completed pages were removed;

f) The Care Commission Officers asked for Mr Fairlie's Records during the course of their investigation of the complaint and various documents were produced.

g) Examination of the Records disclosed that Mr Fairlie was a type two non-insulin dependent diabetic, diet controlled. Two of the care workers with whom the Officers spoke on 29 October 2002 were unaware of this. Mr Fairlie also suffered from peripheral vascular disease. The Home's records did not disclose this. The Care Workers with whom the Officers spoke did not know he suffered from this;

h) The members of the family who attended the Alexandra Nursing Home on 26 October 2002 complained that they found Mr Fairlie in bed wearing only a pyjama jacket and an incontinence pad. One of the care workers interviewed by the Care Commission Officers advised that Mr Fairlie did not like pyjamas because he

sweated so much. This view is not shared by members of Mr Fairlie's family. No documentation could be found to show that this issue had ever been raised and discussed;

i) This care worker also advised the Officers that Mr Fairlie had been in bed for four months "for his own safety" and that his family knew he was confined to bed. This information was inaccurate;

19. The complaint made by members of Mr Fairlie's family related to (1) the standard of nursing care received by Mr Fairlie; (2) his physical appearance, health and well-being on Saturday 26 October 2002, particularly in relation to weight loss, dehydration and pressure sores and dressings to both legs; (3) unsatisfactory communication with the Home; (4) that the Alexandra Nursing Home had failed to seek medical assistance for Mr Fairlie until requested to do so by a family member.

20. This complaint was upheld by the Officers of the Care Commission. Production 1 of the Care Commission's Productions is a copy letter of 12 December 2002 addressed to James Fairlie from the Regional Manager of the Care Commission advising that the Commission had concluded that the impact of staffing levels and skills mix in the Home had been significant and had affected the care given to his father, that his father's care plan had not been systematically updated and his unexplained weight loss did not appear to have been investigated, and that communication with the family had been poor.

21. Item 8 of the Commission's Productions is the Complaint Investigation Report dated 4 November 2002 issued by the Care Commission to the Alexandra Nursing Home. This document contains a summary of the nature of the complaint, the process of the investigation and the Care Commission's findings on various matters. This document also specifies six Requirements, which are mandatory, and the time-scale for implementing these. The Home was obliged to implement these Requirements, within the time scale provided, to comply with the 2001 Act and to ensure it maintained its registration with the Care Commission.

22. The Report also contains sixteen recommendations, which are not mandatory, but which are deemed by the Care Commission to be helpful in improving standards.

23. As a consequence of the fact that various complaints had been received about the Home, Officers of the Care Commission decided to serve a Section 10 Notice under the Regulation of Care (Scotland) Act 2001. Care Commission Production number 3, a letter of 7 November 2002, is a copy of said Notice. A Section 10 Notice is, in effect, an Improvement Notice calling upon the owners of the Home to comply with various specified requirements within a specified period of time.

24. Crown Production 5 is a letter dated 18 November 2002 from the Care Commission to Mrs Ruth Grogan in relation to an unannounced monitoring visit conducted by two Care Commission Officers on 12 November 2002. This letter records, inter alia, that at the date of said visit the staffing schedule issued by Argyll

and Clyde Health Board was generally being adhered to. In relation to the St Mirren Wing there were two trained and three untrained members of staff on duty.

25. Crown Production 4 is a letter dated 20 November 2002 from the Care Commission to Mrs Grogan in relation to a visit carried out by two Officers on 20 November 2002. This letter records, inter alia, that at the time of the said inspection the St Mirren Wing had two trained and three untrained members of staff on duty, in excess of the minimum requirement laid down by Argyll and Clyde Health Board.

26. After said Section 10 Notice was served Care Commission Officers were involved in monitoring the Home. They carried out unannounced visits at different times of the day and on different days of the week over a period of approximately 11 weeks. The Home had difficulty complying with the Notice for quite a period of time because of inherent staffing difficulties. There was a lack of permanent staff. There was also a change in management and a change in other key personnel.

27. Towards the end of this 11-week period of monitoring, another complaint was received in respect of the same Home and another Improvement Notice was served. Officers from the Care Commission continued to monitor the Home until about December 2003.

28. Production 27 comprises a series of letters between the Home and the Care Commission in relation to a request by the Home to reduce the level of staffing throughout the Home. An agreement was eventually reached some time in May 2003. There is a letter within this Production dated 18 September 2002 jointly written by Mrs Grogan the Home Manager and John Murphy, Managing Director of Four Seasons Health Care Limited, in which it is stated that on the St Mirren Wing the early shift had an existing complement of two trained and two untrained staff with a proposal that this be changed to one first level Nurse and 3 untrained members of staff. At the time this letter was written there was only 1 trained member of staff on the early shift and this had been the position since at least the date when Mr Rossi began employment at the Home on 8 July 2002.

29. Enquiries by the Officers of the Care Commission disclosed that the nurse on duty on the St Mirren Wing on 26 October 2002 was an Agency Nurse called "Rachel" (surname unknown). There was no attempt to interview this nurse.

VII. The Royal Alexandra Hospital Paisley from Admission on 26 October 2002

1. Page 262 of Production 19 (the Hospital Records) is the Admission Form relating to Mr Fairlie's admission to the Accident and Emergency Department at about 16:07 hours on 26 October 2002.

2. At about 5.00pm that day Mr Fairlie was seen by Dr Fraser, a Junior House Doctor, who took a brief social and medical history of Mr Fairlie who was then medically examined. Pages 270, 271, 272 and 273 of Production 19 relate to this examination.

3. It was noted, inter alia, that Mr Fairlie had flexion contractures and was thin. He had some crepitations or crackles in his lung on chest examination, suggestive of a chest infection. The oxygen level in his blood was low, but not critically so, and his conscious level was reduced. Dehydration could be one cause of his conscious level being reduced. A chest infection could also cause a loss of consciousness.

4. Mr Fairlie was then seen by Doctor Manning. He records his impression of Mr Fairlie upon seeing him as "dehydration. General deterioration".

5. Doctor Manning also describes Mr Fairlie as "Cahectic +++". This means Doctor Manning considered Mr Fairlie to be very very thin, so thin to be concerning.

6. The following day, 27 October 2002, Mr Fairlie was seen by Doctor Martin McIntyre, the Consultant on call for all medical admissions that particular weekend.

7. Page 273 of Production 19 contains Doctor McIntyre's notes on his examination. He has noted the results of blood tests taken on 26 October and which are contained in page 516 of Production 19. Mr Fairlie's urea was recorded at 44.1 millimols per litre. The normal range is 2.5 to 7.5 millimols per litre. This reading was uncommonly high. The blood tests also disclosed a reading for creatinine at 245. The normal reading for creatinine is between 82 and 124.

8. Urea and creatinine are normally excreted from the human body in the urine. The combination of these two figures suggested to Doctor McIntyre that Mr Fairlie had a dehydration problem.

9. The blood test results also disclosed that Mr Fairlie's blood sugar level was 11.6 millimols per litre. This was a high reading, a reading up to 6 being a normal fasting blood sugar level.

10. Doctor McIntyre also recorded on page 273 of Production 19 that Mr Fairlie might be suffering from "honk", that is hyperosmolar non-ketotic diabetic decompensation, a complication of Type 2 diabetes. To correct this "honk" Mr Fairlie was given insulin intravenously. By 30 October his blood sugar level was back to normal.

11. Page 514 of Production 19 comprises blood test results for 28 October 2002. The albumen result shows a reading of 28.5 grammes per litre. The normal range is 37 to 50. Albumen is an indicator of protein in the blood stream and this low reading was indicative of either Mr Fairlie not getting enough protein into his body or that he was losing protein excessively. Since at that date he did not appear to have any urinary or bowel problems to cause him to lose protein excessively Doctor McIntyre concluded that the low albumen reading was probably a consequence of malnourishment.

12. Item 507 of said Production is the last record of Mr Fairlie's albumen level which was taken on 11 November 2002. On said date the level was 15.5. This was still not very good and in fact it was down on his level on admission.

13. Various entries within Production 19 for the period from about 29 October to 8 November show that Mr Fairlie's condition improved. He seemed brighter and he

was taking his fluids and diet well. After a temporary decline about 9 or 10 November, he seemed brighter by 12 and 13 November and his oral intake improved.

14. On 14 November 2002 Mr Fairlie was seen by a Consultant, Doctor Hinny who recorded on page 278 of said Production 19 "being transfused. Sores are healing but his left foot is ischaemic and toes are mummifying". The ischaemia was a new development and indicative of a vascular problem.

15. It took the Hospital some time to get Mr Fairlie's dehydration problem back to normal. Item 279 of said Production contains an entry from Doctor McIntyre on 18 November 2002 commenting that his urea and creatinine levels were almost back to normal.

16. On 18 November Doctor McIntyre recorded at page 279 that Mr Fairlie's infected pressure sores were deteriorating and that his ischaemic gangrenous left foot was not fit for intervention, that is, for amputation or surgery of some type to debride or revascularise the blood supply to the foot.

17. Item 280 recorded the Doctor McIntyre had a discussion with Mr Fairlie's "2 daughters in law" on 20 November 2002. He also noted that the family is happy for the Hospital to continue with intravenous fluids and antibiotics while venous access is still possible, together with subcutaneous fluids and diarmorphine (as a painkiller) as required.

18. In view of the condition of Mr Fairlie's pressure sores and the fact that on admission to Hospital Mr Fairlie was dehydrated and malnourished, Doctor McIntyre was of the view that Mr Fairlie should have been admitted earlier to Hospital.

19. Item 593 of Production 19 discloses that Microbiology swabs taken on 28 October 2002 from Mr Fairlie's left inner and outer ankle showed the presence of MRSA.

20. Mr Fairlie died at 9:50 hours on 27 November 2002.

VIII. Tissue Viability from 26 October 2002

1. At the Royal Alexandra Hospital on 26 October 2002 it was noted that Mr Fairlie had "Extensive pressure area damage on admission." He was referred to Nurse Elizabeth Wilson a Tissue Viability Nurse Specialist. Mrs Wilson has held this post for eight years and, in fact, is the only Tissue Viability Nurse Specialist within the Royal Alexandra Hospital.

2. Item 681 of Production 19 is a Risk Assessment and Pressure Area Management Chart. This is used to give patients a Waterlow score to determine their susceptibility to pressure sores. Mrs Wilson completed this on 28 October 2002. Mr Fairlie had a Waterlow score of 27. A score of 20 plus indicates a patient is at very high risk of having pressure sores. (On admission to the Royal Alexandra Hospital on 26 October 2002 Mr Fairlie's Waterlow score was 24).

3. Mrs Wilson examined Mr Fairlie on 28 October 2002. Production 23 is a "Tissue Viability Referral/Progress Chart" prepared by Mrs Wilson in relation to Mr Fairlie covering the period 28 October to 26 November 2002.

4. In the course of her examination of Mr Fairlie, Mrs Wilson noted details in Production 23 of the following pressure sores.

a) Areas of damage along left iliac crest, sacral areas and left hip. Stage 1:2.

b) Sores at lateral and medial left malleolus (the outside and inside of the left ankle). Stage 4:1.

c) Grazes and abrasions over dorsal area and toes of the right foot

d) Areas of damage along tendons on the front and back of the right foot at the bony prominences. Stage 1:2.

5. Pressure sores are graded according to their degree of severity on the basis of the Stirling Classification. The classification ranges from 0 (skin intact and healthy) to stage 4, and stages 1 to 4 inclusive have various sub divisions.

6. Stage 1.1 is a redness in the skin which does not blanch on finger pressure, suggesting that there is damage to circulation. Stage 1:2 is similar but there is more discolouration noted, a sort of blue/purple type of discolouration. The skin is intact but the darker discolouration is indicative that the oxygen supply in the area in question is more compromised than Stage 1:1.

7. Sores which are categorised as Stage 4:1 have visual exposure of the bone or tendon. In Mr Fairlie's case there was total tissue destruction visible on both sides of the left ankle and the dead tissue could be pulled away.

8. In relation to the areas of damage noted along the tendons on the front and back of the right foot at the bony prominences Mrs Wilson wondered if this was due to too tight bandaging.

9. In relation to the ulcer to the inside of Mr Fairlie's left ankle Mrs Wilson noted that the tendon was exposed and dry. She was anxious that the tendon should not be allowed to dry out and she recommended the use of a gel to keep it moist.

10. In relation to the ulcer on the left outer ankle Mrs Wilson noted that the bone was evident in the centre but the ulcer was covered with necrotic tissue. Mrs Wilson recommended an antiseptic type of dressing for this wound.

11. Mrs Wilson recommended that Mr Fairlie be given a "breeze" low air loss mattress.

12. Despite using a doppler Mr Fairlie's pedal pulses were not audible, an indication of poor arterial circulation to the feet.

13. When Mrs Wilson first saw Mr Fairlie on 28 October she considered that he was emaciated. She noted he was suffering from leg contractures.

14. Mrs Wilson was of the opinion that Mr Fairlie's pressure sores were a cause for concern, particularly since he had been admitted from a Nursing Home, and she therefore reported Mr Fairlie's injuries to the Director of Nursing at the Royal Alexandra Hospital. Mrs Wilson considered that the majority of these pressure sores were preventable.

15. Production 23 also records that on 31 October 2002 the superficial stage 1 damage around the bony prominences on Mr Fairlie's left foot was resolving. The stage 4:1 damage to the left ankle was about the same as when seen on 28 October and there was still no skin coverage over the left ankle. The area of damage to the hip appeared to be deteriorating.

16. Production 23 records that on 5 November 2002 Mrs Wilson noted, inter alia, that the blood supply to the left foot was poor. For her to come to this conclusion it is likely she noticed a difference in the colouration of the foot.

17. Same Production also records Mrs Wilson's penultimate visit on 14 November 2002 when she noted a major deterioration in Mr Fairlie's left foot. It was totally ischaemic. Mr Fairlie had been prescribed diamorphine to relieve the pain. Mrs Wilson was of the view that the wounds to the left foot could not be healed. Mr Fairlie's general state of health was so poor that he could not cope with an amputation and she recommended that the wounds did not need to be disturbed daily and he should be given "*TLC*" (Tender Loving Care).

18. On 15 November 2002 Mr Fairlie's Waterlow score was 31.

19. Mrs Wilson saw Mr Fairlie for the final time on 26 November when she records, *inter alia*, that his left foot was totally gangrenous. Mrs Wilson also noted that the damage to Mr Fairlie's hip which was at Stage 1:2 on admission had deteriorated to Stage 3:4, indicative of deep damage covered in dead tissue. There were also two additional areas of ulceration on the left hip which were categorised as Stage 2:3 and Stage 2:4. It was also noted that there were two additional areas of damage at Stage 2:3 above the sacrum. Additional areas of damage were also noted, all as detailed in said Production, and were indicative of the fact that Mr Fairlie's peripheral circulation by this time had become extremely compromised.

IX. Post-Mortem Examination

1. At 0945 hours on 29 November 2002 Doctor Marjorie Black, Consultant Forensic Pathologist, and Doctor John Clark, Senior Lecturer in Forensic Pathology, both of the University of Glasgow, carried out a Post-Mortem Examination of the body of George Jamieson Fairlie.

2. Production number 20 is a copy of the Post-Mortem Report

3. The body weighed approximately 53 kilograms.

4. External examination of the body disclosed inter alia the following:

a) There were hospital dressings covering the top of Mr Fairlie's right foot around the inner aspect of the right heel, around his lower left leg and foot and on both buttocks and sacrum.

b) There was a further dressing around the left middle finger and there was a small number of very superficial abrasions around the left cheek and around the chin.

c) There were one or two superficial abrasions on the back of the left wrist and hand with some bruising across the knuckles on the left hand.

d) On the proximal interphalangeal joint of the left middle finger there was a deep ulcerating lesion, almost down to the bone, 1 cm across. This is like a pressure sore or ulcer but it is uncommon to find a pressure sore on that part of the body.

e) Over the left knee there was an area of almost healed ulceration measuring 7.5cms x 6.0cms surrounding which were a number of small superficial ulcers/abrasions, measuring up to 1.5cms x 0.5cms. There was extensive ischaemic change and infarction of the lower left leg and the entire foot, extending maximally up the sides of the leg to 19cms above the base of the heel. In layman's terms, the left leg was gangrenous; it was black and the tissue was dead.

f) There were flexion contractures of the right leg at the hip and knee. Over the lower outer knee there was a dried parchmented abrasion, 2cms by 1.3cms with around it a number of smaller more superficial abrasions up to 1.5cms by 0.7cms. There were extensive ulcers on the right foot ranging from an almost completely healed ulcer below the outer ankle, 0.7 cms by 0.3cms. Along the inner aspect of the foot and the big toe were ulcers up to 3.5cms by 2.0cms, one deeply eroding down almost to the bone. There also were multiple ulcers over and between the toes and immediately proximal to them up to 1.5cms by 1.0cm and over the dorsum of the foot, there was a superficial ulcer measuring 2cms by 1.5cms. "Contractures" occur if a limb remains in the same position for a long period of time. The ulcers on the right foot were not concentrated on the one area of the foot.

g) Above the sacrum over the lumbar spine there was an area of ulceration measuring in total 10cms by 8cms, the largest individual ulcer with a purulent base measuring 4.5cms by 2.5cms. Below the sacrum and to the right there was a more superficial ulcer measuring 2.5cms by 1.5cms with surrounding reddening in an area 5 cms across. There were also a few very small superficial lesions over the mid-thoracic spine averaging 1.5cms by 1.0 cm. Over the right buttock/upper femur area were two ulcers, 5cms by 3cms and 1.0cm across. On the left buttock over the bony prominence there was an ulcer measuring 4.5cms by 4cms. 4cms above that ulcer was a further ulcer measuring 7cms by 4cms. Generally, these ulcers were located on typical pressure points of the body.

5. Internal examination of the body disclosed the following: -

a) The brain showed an extensive old infarction occupying the majority of the left frontal and parietal lobes. There was also a separate infarct over the left occipital

lobe. Sectioning revealed that the parieto-frontal infarct extended deeply into white matter virtually to, and perhaps including, the internal capsule.

b) There were scattered adhesions and approximately 500mls of straw coloured fluid in both pleural cavities. Both lungs showed bronchopneumonic change in the lower lobes. There was an abscess measuring 4cms by 2cms by 2cms in the lower lobe of the right lung.

c) The pericardial sac was stuck down to the heart at the apex. There was approximately 90% occlusion by atheroma of both the left anterior descending and left circumflex coronary arteries. There was extensive fibrosis and marked thinning and calcification virtually amounting to early aneurysmal formation of the left ventricle.

d) The peritoneal cavity contained approximately 2 to 3 litres of straw coloured fluid. The spleen was enlarged and soft, consistent with sepsis. The liver was cirrhotic.

5. Doctor Black and Doctor Clark concluded that the cause of Mr Fairlie's death was bronco-pneumonia and lung abscess caused by his general immobility following upon a number of problems including acute ischaemia of the left foot and infected sores; and that the Conditions contributing to death were ischaemic heart disease, cerebral vascular disease, diabetes mellitus and cirrhosis of the liver.

X. Police Involvement

1. On or about 18 November 2002 Mr George Fairlie's daughter, Alison Fairlie, contacted Paisley Police Office complaining that her father had been mistreated while a resident at the Alexandra Care Home.

2. Detective Sergeant Andrew Dunn carried out various enquiries.

3. Family Production number 6 is a witness statement taken by Detective Sergeant Dunn on 26 November 2002 from the now deceased James Thompson Fairlie.

XI. Submissions in Relation to Section 6 of the 1976 Act

Mr Kelly for the Crown and Counsel and the Solicitors for the other parties to this Inquiry were in agreement as to the findings I should make in terms of section 6(1)(a) and (b) of the Act.

Mr Kelly made no further submissions.

Mrs McGowan specifically invited me to make no findings in terms of section 6(1)(c), (d) or (e) in relation to Renfrewshire Council. She submitted that the evidence presented to the inquiry neither required nor justified any such findings. I agree with this submission.

There was a failure by the Social Work Department to hold a review of Mr Fairlie's case within four weeks of his admission to the Home. There was a failure by the

Home to hold a review within six months after the first review, and this failure ought to have been picked up by the Social Work Department. There was evidence that the Council required to make various enquiries regarding a flat Mr Fairlie had once owned, and it took some while for his financial position to be clarified. During this time his status remained unclear, and I suspect that by the time this issue was clear the question of the review was overlooked. I accept Mrs McGowan's submission, however, that irrespective of the category or status of Mr Fairlie's residence in the Home he received, initially at least, the same level of care as the other residents in the Home, and his position there was confirmed as permanent in February 2001, some 21 months or so before he died.

There was a review in October 2001 which the Social Work Department did not attend. Mr McCulloch from the Social Work Department could not advise the inquiry if a member of his department had been invited to attend but there is no doubt that there was no such representation by the department at the review. As Mr McCulloch pointed out, however, at that time there were 900 people in care homes within the Renfrewshire Council area and it was not possible for a representative of the department to attend every review.

I accept the evidence that, in the intervening six years or so since Mr Fairlie's admission to the Home, the Council's computer technology has advanced to the extent that the Council now has a system in place which should enable the department to be aware of a failure to hold a four-week or six-month review.

While it is still not possible for a member of the department to attend every review the creation, in 2003, of the older person's review team, led by Mr McCulloch, should ensure the proper monitoring of visits to care homes and the examination of relevant files.

There had been considerable social work involvement in the lives of Mr Fairlie and his wife while they resided in sheltered and then in very sheltered accommodation. The Social Work Department was also very much involved in the placing of Mr Fairlie in the Home in May 2000. While a social worker by the name of Frances Levak had been the main person dealing with Mr Fairlie's case prior to his admission to the Home she left the department and thereafter it does not appear that there was a system in place whereby a particular member of the Social Work Department was responsible for Mr Fairlie's case. Accordingly, telephone calls by the family to the Social Work Department were dealt with, not by a particular individual, but by whichever person happened to answer the telephone. There was a system in place whereby the social worker could access details of prior telephone calls about a particular resident, provided the call was to the same department. While there was criticism by the family as to the way one telephone call from Alison Fairlie was dealt with my impression is that, generally, the members of the family who telephoned were not dissatisfied with the way in which the calls were handled.

One of the telephone calls from James Fairlie in June 2002 was to the Social Work Department based at Royal Alexandra Hospital. At that time the computer system within the Social Work Department was not sufficiently sophisticated to enable the recipient of the telephone call in the hospital Social Work Department to link up that complaint with earlier telephone complaints from the family. It was accepted that had

that facility been available this may have prompted a more proactive approach. This difficulty has now been cured.

Mr Brian Kerr, a Consultant in social work and social care, was led by the family. He suggested in evidence that the various social workers who took these telephone calls could have been, and should have been, much more proactive in their response. I think this is a matter of degree. On all occasions the complaint was noted and advice given. The lines of communication were never closed to the family.

Mr Kerr was extremely critical of the department in other ways. He suggested, for example that there should be social work representation at every review of every individual in a care home until he or she died. He accepted in cross-examination, however, that it was extremely unlikely that local authority resources would enable this to be achieved in practice, and in fact he accepted that when he had been in local government that ideal had not been achieved. As Mrs McGowan pointed out in her submissions, Mr Kerr did not attempt to argue that Mr Fairlie would have lived longer or that his death would have been avoided if the proper review procedures had been followed.

Mr MacLean submitted that I should place little reliance on Mr Kerr's evidence suggesting that it was over-critical and that he was prone to stipulate vague, impractical and idealised requirements for the care of the elderly. Certainly, I would say that Mr Kerr advocated a counsel of perfection which would be difficult to achieve in a situation where the harsh realities of budgets and a lack of resources play an ever increasing role.

Mr McCulloch, in the course of his evidence, accepted that there had been failures on the part of his department. He told the inquiry what steps had been taken to eliminate or reduce the possibility of these happening again. I agree with Mrs McGowan's submission that these justifiable criticisms of the department relate to events so much prior to Mr Fairlie's death that they could not be relevant to his death.

On the basis of this submission I accept it would not be appropriate for me to make any findings in relation to the Social Work Department in terms of subsections (c) (d) and (e) of section 6(1) of the Act.

In relation to the involvement of the Scottish Commission for the Regulation of Care, Mr McClure submitted that in the event of my making a finding in relation to the involvement of the Home in terms of subsections (c), (d) or (e) of Section 6(1) then, theoretically at least, it would be open to me to make similar findings in relation to the Care Commission. He submitted, however, that if I were inclined to that view then any such findings should, more appropriately, be made in terms of section 6(1)(e) of the Act.

The Care Commission came into existence on 1 April 2002 and there was evidence that its system of inspection of Homes commenced sometime around June 2002. As a consequence of the number of complaints which had been received (some of which were not substantiated) the Commission decided to carry out a fairly early inspection of the Home and this was done on 10 and 11 September 2002. I was

invited to accept, and I do, that this was a thorough inspection. It is extremely unfortunate, however, that the Commission then failed to comply with its own timetable by not sending out its draft report timeously. In fact it did not send out the draft report at all until an employee of the Commission became aware of this failure when Mr Fairlie's family complained on 28 October about the condition in which he had been found in the Home two days earlier.

It was pointed out by Mrs McKerry, one of the Care Commission Officers, that at the end of the second, and final, day of the inspection the Officers would have discussed the likely contents of the report with the Manager of the Home so that she would be aware of the likely areas of criticism.

Mr McClure accepted that the report highlighted certain areas of concern but he submitted that it was clear from the evidence of Mrs McKerry that these were typical of Care Homes of this type and did not suggest the existence of a major problem.

Mr McClure invited me to reject the criticism of the Care Commission by Mr Kerr. He submitted that it was totally unrealistic to expect a newly established statutory regulator to issue an improvement notice following upon the inspection of 10 and 11 September 2002 and, even more particularly, to expect the Care Commission to demand that the Home should suspend admissions to the Home. Unless the Home consented, this would have involved the taking by the Commission of enforcement action. I agree, standing the terms of the inspection report of 10 and 11 September, that this would have been a draconian step to take. As Mr McClure pointed out, the Commission is accountable for its actions, in the Sheriff Court and elsewhere, and has to proceed on the basis of evidence.

It is unfortunate that Mr Kerr's report, which was so highly critical of the Care Commission (and also of the Social Work Department) was not lodged at a time when the witnesses from the Care Commission and the Social Work Department were giving evidence. The terms of Mr Kerr's report were therefore not put to them and they were denied the opportunity of commenting thereon.

Mr Kerr also took issue with the fact that the Care Commission was under no obligation to provide a local authority, such as Renfrewshire Council, with a copy of its findings in relation to a complaint to the Commission. Mr McClure pointed out that the local authority is in no different a position in law to any other purchaser of a Care Home place. There was, however, evidence from Mr McCulloch that Renfrewshire Council and the Care Commission had entered into a "memorandum of understanding" with a view to facilitating better communication between the two bodies.

I am mindful of the fact that earlier this year a Member of the Scottish Parliament raised this matter in relation to a death in a Care Home in Lanarkshire. Since no criticism was made in submissions to me in relation to this point, I am content to leave matters as they stand.

I agree with Mr McClure that it would be entirely inappropriate for me to make any finding in relation to the involvement of the Care Commission in terms of Section

6(1)(c) or (d) of the Act. I have, however, made certain recommendations in terms of Section 6(1)(e).

In the course of her submission on behalf of the family of the late Mr Fairlie Mrs Sutherland criticised the Care Commission for, *inter alia*, not taking immediate action in relation to staffing problems. When the Care Commission inspection was carried out in September 2002 the officers were advised by the management of the Home that there were vacancies for 11.5 qualified nurses. Crown Production 25 (the Care Commission Report) records "in the meantime, agency staff are being deployed as necessary to ensure minimum staff cover is available on all shifts". In the course of her evidence Mrs McKerry assured the inquiry that the Officers did not accept the duty rotas at face value and that staff were questioned in an attempt to check the veracity of staff rotas presented to them.

The "robust examination" as it was described by Mr McClure of the Manager of the Home and of the staffing schedules by Care Commission Officers at the inspection on 29 October disclosed that the duty rotas for 26 October could not be relied upon. We now know after a substantial amount of evidence that the St Mirren Wing was under-staffed by one trained Nurse on the early shift from at least July 2002.

Crown Production 11 the document, "National Care Standards: Care Homes for Older People," sets out twenty core standards. The inquiry heard that in the first year of its existence the Care

Commission decided that it would investigate five of these core standards although it had the flexibility to consider other standards of inspection. I am unaware whether this approach still applies at the present time but it does seem to me that while matters such as environment and the choice of menu and diet are important the question of staffing should be given priority as this underpins, and is integral to, the proper running of any Care Home. Without a proper level of staffing it is difficult for a Home to accomplish many of the standards which it is expected to achieve and maintain. Several witnesses spoke of the difficulties in recruiting Nurses to the profession and it seems to be more difficult to recruit qualified staff to the Care Home sector. I therefore recommend that staffing schedules and duty rotas should always be inspected and staff interviewed to ensure the accuracy of the schedules.

Mr MacLean, counsel for Four Seasons Health Care Ltd invited me to make no findings in relation to paragraphs (c), (d) and (e) of section 6(1). I do not think this is appropriate. I shall elaborate later in this Determination.

In the course of his submission Mr McLean suggested that the family's approach was that Mr Fairlie's death was the inevitable result of his condition on reaching the Hospital on 26 October and "that in turn was caused by multiple failures on the part of the Alexandra Nursing Home stretching back, it seemed at times, almost to the moment of admission".

I think that is an unfair interpretation of the family's position. There is no doubt that from time to time the family members were concerned about various matters, all of which I have detailed in my findings and fact. It cannot be said, however, that they have attempted to blame Mr Fairlie's death on anything which occurred in the early

part of his residence in the Home. I think their evidence can be interpreted as suggesting that from sometime in the Summer of 2002 there were real concerns about the lack of proper nursing (as opposed to cosmetic) care given to their father.

I accept Mr McLean's submission that Mr Fairlie had not kept good health for many years prior to his death. He had complex care needs and I agree that the staff responded to these needs "most of the time". It has to be said, however, that they did not respond to these needs all of the time and there have to be concerns about the adequacy of their efforts from time to time.

Mr McLean also submitted that Mr Fairlie was likely to suffer terminal events, and "even if he had survived this one in October 2002, his life expectancy was measured in months". That may well be so but the consensus of the expert medical opinions is that if Mr Fairlie had been taken into hospital five days or so earlier it is likely he would have survived. No one lives forever, but if Mr Fairlie could have had a few months more to interact with his family and enjoy their company, then surely he was entitled to that.

I accept Mr McLean's submission that after Mr Fairlie was taken into Hospital immediate steps were taken by Four Seasons Health Care Limited to deal with the various failures on the part of the management of the Home. Additional staff were brought in to the extent that on occasions the minimum staffing levels were exceeded. There were no longer difficulties in staff obtaining supplies. It is, perhaps, a sad fact of everyday living that it takes a death or similar tragedy before steps are taken to eliminate a problem which has usually existed for a while.

Mrs Sutherland, invited me to make ten findings in terms of sub paragraph (c), two findings in respect of sub paragraph (d) and she raised eight issues which she considered to be relevant in terms of sub paragraph (e).

The relevant section of the Act is in the following terms:

"6-(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 the 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".

It is clear in relation to section 6(1)(c) that it is not necessary for the Court to be satisfied that the proposed precaution would in fact have avoided the accident or the

death, only that it might have done; but the Court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one.

I accept Mrs Sutherland's submission in relation to findings in terms of section 6(1)(c) on three matters, viz, (in short) inadequate staff numbers, poor note-taking and inadequate nutrition and hydration. I shall elaborate later.

In relation to the remaining matters, I agree that there does not appear to have been consistency of staff in the period prior to Mr Fairlie's final admission to hospital. Reliance was placed on bank and agency staff but there is no clear evidence as to whether the same bank and agency staff were used or whether they were often different. Admittedly, there was a little evidence from some of the permanent staff that from time to time they were handing over to or from a person they had not met before. Had there been an adequate level of staffing with proper note-taking then, it seems to me, it would not or should not have mattered if it was the same or different bank and agency nurses who were working on the Wing.

I do not consider that the fact that Mr Fairlie was nursed in bed for a number of weeks prior to developing a chest infection should form a ground in terms of section 6(1)(c).

Two of the proposed grounds relate to the involvement of the Care Commission and I have already dealt with these points. The remaining grounds suggested by Mrs Sutherland in terms of this subsection can be subsumed into the general criticism of poor record keeping and inadequate staffing.

It is clear that in deciding whether to make any determination under section 6(1)(d) as to the defects, if any, in any system of working which contributed to the death or any accident resulting in the death the Court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. There is an obvious distinction in that a finding under section 6(1)(c) can be made if the reasonable precaution "might" have prevented the accident whereas in terms of section 6(1)(d) the defect in the system "must" have contributed to the death.

Mrs Sutherland suggested two grounds in terms of this subsection, viz (in short) lack of proper communication among staff members at handover and poor record keeping. There was some evidence from one of the permanent members of staff that if she was being given a report at the commencement of her shift from an agency or bank nurse the information could be "more basic". The problem is more fundamental in my opinion and, if resolved, communication should not present a difficulty.

If a bank or agency nurse is a complete stranger to the eighteen or so residents in the St Mirren Wing it must be difficult if not impossible for him or her to retain all the relevant points of information in relation to all of these residents. This information must be committed to writing so that staff, when coming on duty, can take a few minutes to peruse what should be the contemporaneous notes for all of the residents. If these notes are accurate, it should not be difficult for staff to pass on to the next shift all necessary, relevant information. There is no doubt that the quality of

record keeping was extremely poor and I am satisfied that inadequate and inaccurate record keeping was a defect which contributed to the death of Mr Fairlie.

Findings in terms of section 6(1)(e) of the Act should relate to facts which are relevant to the circumstances of the death. The general view seems to be that these findings should relate to the circumstances of the death as they may affect the public interest.

Of the findings proposed by Mrs Sutherland in terms of section 6(1)(e) the majority relate to the involvement of the Social Work Department and of the Care Commission, and also of their relationship *inter se*. I have dealt with these matters. I have also considered the question of staffing.

I agree with Mrs Sutherland that Care Homes which offer a dedicated dementia unit must employ staff who have had training in dealing with people suffering from dementia. Mr Fairlie was described by some staff as "difficult" and "uncooperative", and I agree with Mrs Sutherland that it seems that these staff members did not try, or were unable, to understand that there might be an underlying reason for his conduct. Skilled employees like Mrs McDonald were able to cope with him.

I also agree that all nursing and the care staff who are employed in Care Homes must be given proper induction and training.

One matter which was of considerable concern to the family of Mr Fairlie was the fact that at one stage he was nursed on a mattress on the floor. I accept wholeheartedly the fact that Mr Fairlie's family were horrified when they discovered that this was being done. It is clear, however, from the evidence of some of the witnesses, including expert witnesses, that this practice does exist.

I was referred by Mr McClure to guidance produced by the Mental Welfare Commission for Scotland dated April 1998 entitled "Restraint of Residents with Mental Impairment in Care Homes and Hospitals (Care Commission production number 2) where it states at paragraph 3.15 "The alternative of putting the resident's mattress on the floor may be perfectly reasonable if it can be done in a way which is not demeaning to the resident."

I accept Mrs Sutherland's submission that if a decision is taken to nurse a resident on the floor it should be done after a proper assessment has been carried out with the appropriate health professionals having an input and after consultation with the family of the resident. As a consequence of the paucity of records in the St Mirren Wing it is impossible to say if there was a proper assessment and if there was input from health professionals. Certainly there does seem to have been consultation with the late James Fairlie although, because of the poor records, it cannot be said if he gave his consent prior to Mr Fairlie being nursed on a mattress on the floor or retrospectively when he arrived at the Home one day and discovered that the decision had been taken.

I do not think that this is a matter which I should properly consider in terms of this subsection. It does seem to be acceptable practice in certain circumstances and I

cannot be certain that the proper procedures and consultation with James Fairlie were not carried out.

XII. Conclusions

Evidence was adduced from a number of witnesses as to the state of Mr Fairlie's health for a number of years before his death. There is no doubt that he was not a well man for at least a decade, and possibly longer, prior to his death. Most of the major medical events in his life, however, occurred prior to the year 2000 and, thereafter, until his death, he does not appear to have had any major medical crises.

Although there was evidence from Mr Fairlie's family that from about August 2001 (when Joe White left the Home) there was a decline in standards within the Home, the care given to Mr Fairlie appears to have been reasonable (and I put it no higher than that) until the summer of 2002. His health appears also to have been reasonable until that time.

Mr Fairlie's family and some of the employees from the Home said that throughout his time at the Home Mr Fairlie had a very good appetite. When he was out with his family on 25 August 2002 he ate well and gave no cause for concern. On 13 October James Fairlie and William Barr took Mr Fairlie out for a meal. Again, there did not appear to be any cause for concern. There was no evidence to suggest that any family members saw him again until James Fairlie went to the Home on 23 October in response to a telephone call that his father had a chest infection. When James saw his father he thought there had been a dramatic change in his appearance and that he had lost weight.

At the time of his admission to hospital Mr Fairlie had lost a substantial amount of weight. A weight loss in a person can be caused by not eating. If, as seems to be the case, Mr Fairlie was nursed in bed in the days leading up to his admission to hospital then he would have taken his meals in bed. This would have involved probably two members of staff spending at least twenty minutes or so to give him his lunch or dinner. In the days when the Wing was short staffed I wonder if from time to time he was simply overlooked.

It was suggested by Mr MacLean that Mr Fairlie's dementia might have caused him not to eat and there was evidence that dementia can affect the part of the brain which prompts a person to eat. The difficulty with this submission is that in the 10 days or so leading up to his final admission to hospital no member of staff appears to have recorded that Mr Fairlie refused food. If, however, he was not eating because of dementia, the chest infection, or for any other reason the Home should have done something about it by having him admitted to hospital.

Equally, it is clear that on 26 October Mr Fairlie was severely dehydrated. Dr McIntyre was of the view that the degree of malnutrition and dehydration exhibited by Mr Fairlie on his admission to hospital could not have happened in just a few days. It was accepted by the various medical experts that the early signs of dehydration are difficult to detect. When Dr Ezebuiro visited the Home on the late evening of 21 October he did not detect any sign of dehydration. Nurse Kathleen Harvey said Mr

Fairlie was not dehydrated when she was on duty from 23 October until she finished her shift at 8 am on 24 October.

I find the evidence of Dr Paterson very persuasive on this issue. He stated that even if there had not been a complete withdrawal of fluid, if Mr Fairlie was not given sufficient fluid each day this would result in Mr Fairlie becoming slowly but progressively dehydrated. It was his view that it was possible that Mr Fairlie was normally hydrated when he was out with his family on 13 October and that the reduction in his fluid intake started after that.

The fluid charts which were put to various witnesses demonstrate that Mr Fairlie was not given enough fluid on most days. It was suggested to these witnesses by Mr MacLean that human nature being as it is there was every likelihood that Mr Fairlie was given fluid and the staff member failed to record it. I am sure this is correct. Dr Paterson said that this type of omission can occur even in hospitals. The difficulty for the Home, however, is that the tests conducted by the hospital on Mr Fairlie's admission show that he was grossly dehydrated at the time of admission.

It was suggested by Mr MacLean in his submissions that by 21 October or so it would have been particularly difficult to get Mr Fairlie to take fluids. Even if that were so, if Mr Fairlie was refusing, or was unable to take, fluids, arrangements should have been made by the Home for his urgent admission to hospital.

I agree with Mrs Sutherland's submission that there was no evidence to suggest that Mr Fairlie was refusing fluids in the week or so prior to his admission to Hospital. On the contrary, the "critical entries" which I have listed earlier within "the Treatment and Care of George Fairlie" make it clear that he was "taking diet and fluids well". This, of course, does not support Mr McLean's submission that Mr Fairlie was not eating, and this failure to eat was as a consequence of his dementia, and is supportive of Mrs Sutherland's submission that an inference can be drawn that the staff simply failed to give him sufficient fluids and failed to feed him properly.

It also suggests that some of these entries may not be accurate (Mr Rossi accepted that his entry of 25 October "taking diets and fluids well with assistance" could not be accurate).

Doctor Paterson considered, and rejected, any other medical cause for Mr Fairlie's dehydration, and I accept his evidence.

Professor Ruckley, Doctor Paterson and Doctor Chapman, the three medical experts called by the family of Mr Fairlie, were also of the view that this lack of hydration had another serious implication for Mr Fairlie's state of health. His blood pressure dropped to 60/40, a reading which according to Dr Paterson is at the limits with what is compatible with life. They all opined that the dehydration caused Mr Fairlie's blood pressure to drop to that low level and for a person to have that level of blood pressure even for a few hours would lead to long term consequences.

On the basis of these medical opinions, which I accept, there can be no doubt that poor nursing care led to Mr Fairlie's state of malnutrition and dehydration and to his

poor state of health which necessitated his urgent admission to hospital on 26 October. To attempt to advance a contrary view is, in my opinion, quite untenable.

These three experts were also of the view that the drop in blood pressure to that level combined with Mr Fairlie's dehydration and his general condition contributed to the development of the ischaemic leg. It was their view that the drop in blood pressure combined with dehydration would make his blood more viscous and this would lead to sludging in the peripheral circulation. The slow flowing blood would then start to clot within the peripheral circulation and would lead to the ischaemic leg which developed several days later. Mr Fairlie appears to have been almost constantly in bed, certainly in the days leading up to his admission to hospital, and this inactivity would increase the risk of ischaemia.

Dr Davie, the medical expert called by Four Seasons Health Care Ltd, was initially of a different view. He suggested that a blood clot may have formed in Mr Fairlie's heart, passed round his body and lodged in his leg, thus blocking off the blood supply and causing the ischaemia to develop. Initially in cross examination by Mrs Sutherland, Dr Davie did not suggest that Professor Ruckley's theory was incorrect; he simply said there were other possibilities which could not be discounted. He also suggested a third possibility, namely, that Mr Fairlie had a spontaneous thrombosis in his leg which occurred after his admission to hospital due to his continuing poor circulation and continuing illness.

This theory of the spontaneous thrombosis was not put to Professor Ruckley for his comments but in relation to the theory of the clot from the heart Professor Ruckley thought this was very unlikely, "virtually zero". Dr Paterson thought it was 95% likely that the ischaemia was caused by peripheral sludging rather than a clot from the heart. He was not prepared to completely discount Dr Davie's theory, however, particularly since the post mortem examination did not include the vessels of the leg.

Dr Chapman also could not discount it completely although his view was that it was 95% more likely to be peripheral sludging. He conceded, however, that it was known that Mr Fairlie had a small aneurysm and he had an irregular heart and both of these predisposed him to develop a clot in the heart.

Later in his cross examination by Mrs Sutherland, Dr Davie altered his stance and accepted that Professor Ruckley's theory for the development of the ischaemic leg was the most probable, suggesting that this theory was 70% likely.

One significant aspect of the evidence of Dr Paterson and Dr Chapman was their view that if Mr Fairlie had been admitted to hospital on or about 21/22 October before his blood pressure dropped to that critical level, the ischaemic leg might not have developed at all. Dr Chapman said in evidence "I think the ischaemic leg took over basically and I think once that happened there was really very little more the hospital could do".

In relation to this issue, therefore, in summary I think it can be said that the lack of proper nursing care in the days leading up to 26 October 2002 resulted in Mr Fairlie having to be admitted to hospital. Professor Ruckley was 99% certain, Dr Paterson and Dr Chapman 95% certain and Dr Davie 70% certain that the drop in blood

pressure caused the sludging in the blood which led to the ischaemia. The three experts for the family considered that the drop in blood pressure was caused by dehydration due to the insufficient fluid he was given in the Home. Doctors Paterson and Chapman also thought that if he had been admitted to hospital about five days earlier, Mr Fairlie's blood pressure would have remained at a normal level and if it had remained at a normal level the ischaemia might not have developed at all. I therefore think it can be said on the balance of probabilities that there is a causal link between the poor quality nursing care in the days leading up to Mr Fairlie's admission into hospital and his subsequent death.

Professor Ruckley and Doctor Paterson had already given their evidence when the report from Doctor Davie, the medical expert for Four Seasons Health Care Limited, was lodged. Doctor Chapman was critical of a substantial part of this report.

In relation to the question of whether Mr Fairlie's death could have been avoided Doctor Davie states in his report "I feel that when Mr Fairlie developed his chest infection (pneumonia) in October 2002 the writing was on the wall and it was unlikely that he was going to survive for long as he was already by this time quite malnourished due to his inability to eat and at huge risk of dehydration and these two factors in addition to his poor circulation were always likely to cause the development of bed sores".

I do not accept this view. It seems to me that Mr Fairlie did not have "an inability to eat"; he just needed assistance to eat by having his food cut up for him. He should not have been "at huge risk of dehydration." He was on a fluid monitoring chart. The staff in the Home should have been aware of this. The staff should have ensured he was sufficiently hydrated by giving him fluid and if he could not physically take the fluid he should have been admitted to hospital.

The consensus of the medical and nursing witnesses who gave evidence to the inquiry was that if Mr Fairlie had been properly nursed and turned, with this being recorded on a turning chart, then the pressure sores would have been preventable. Doctor Paterson and Doctor Chapman were both of the view that Mr Fairlie's chest infection was treatable if his blood pressure had not dropped so low and if the ischaemic limb had not developed. I accept their evidence and reject the view expressed by Doctor Davie.

It also has to be said that the staff would be unaware Mr Fairlie was not being given sufficient fluids because his medical notes and fluid balance charts were deficient and inaccurate.

There was also a difference of opinion as to the source of the bacteria in the chest infection. Doctor Black could not identify the bacteria at the post-mortem. Doctor Paterson and Doctor Chapman thought it was likely there was a link between the bacteria in the ankle wound and the lung abscess. Doctor Davie did not think so. There are no factors which enable me to conclude which opinion is more likely to be correct.

There are other matters which merit comment.

In relation to the injuries to Mr Fairlie's ankles, feet and hips as recorded by the tissue viability nurse at the hospital on 28 October 2002 I accept Mr MacLean's submission that these must have deteriorated quite rapidly as they do not match the description of the wounds while Mr Fairlie was in the Home.

Jan Bruce, Stewart Fairlie's partner, and a skilled, experienced nurse was very firmly of the view that these injuries were pressure sores. In particular, she was adamant that the injury to Mr Fairlie's right ankle was not caused by his knocking his legs off the cot sides.

No turning charts have been produced although some of the nursing staff thought that they were used. Several members of staff gave evidence that they were involved in turning Mr Fairlie. They also spoke of Mr Fairlie having a favourite side and the difficulties of ensuring that he also lay on the other side. Obviously the production of charts would have enabled the inquiry to see in what way turning was carried out and for expert evidence to be given as to whether or not it was done properly.

On the other hand, there is also evidence that when Mr Fairlie was in bed he was very restless and agitated. He would thrash about in bed. He tried to push his legs through the cot sides even when they were protected with bumpers. It seems to me that it is just as likely that the injuries recorded by Miss Mtermende on 22 October were caused by Mr Fairlie striking his ankles against the cot sides as by pressure damage. Certainly Elizabeth Wilson, the tissue viability nurse, was unable to say how they started.

Item 122 of production 12 is a Waterlow Chart prepared by John Rossi in relation to Mr Fairlie on 6 September 2002. This chart gives Mr Fairlie a score of 20. If a patient has a score of 15 plus they are at high risk of pressure sore damage; a score of 20 plus means that they are at very high risk. Mr Fairlie was clearly at very high risk, irrespective of the mechanism which caused the wounds in the first place.

Mr Rossi asked Mrs Grogan for a pressure relieving mattress on 6 September. The request was ignored. He asked again the day before Mr Fairlie was admitted finally to hospital, but by the time of his admission it was still not available.

I cannot understand why this mattress was not available for Mr Fairlie. I accept the submission by Mr MacLean that the Waterlow Score in isolation does not determine if a pressure relieving mattress is required. There can be no argument with that, but the evidence showed that such a mattress was required by Mr Fairlie and it was just not obtained. There can be no doubt that the failure by the Home to provide a pressure relieving mattress made it much more likely these wounds, however caused, would be more difficult to treat.

Both Mrs Bandeen and Mrs Beveridge stated in evidence that these mattresses were an item of capital expenditure and one should have been obtained easily. Mrs Josephine MacDonald was told by Mrs Grogan that a mattress could not be hired. It seems that Mrs Grogan had a blind spot about this and about the obtaining of other supplies which Mrs Beveridge said were easily obtainable.

Mrs Beveridge was a breath of fresh air in contrast to Mrs Grogan. She could not understand why there was a problem with supplies. She could not understand why the staff complained about lack of incontinence pads since these were provided by the local health board after a resident's individual assessment was carried out. It may well be, of course, that there were no individual assessments carried out in the St Mirren Wing. Certainly I heard no evidence of these being done and Mrs Karrim was horrified when she started at the Home and discovered that there were no individual continence assessments and that the same size of pad was being used for all the incontinent residents. It seems that by the time Jude Garganta worked in the Home different sizes of incontinence pads were available.

The question of staff, staffing and training is of considerable importance in relation to the care which was given to Mr Fairlie.

The view was expressed that the Home was in crisis when the nine Filipino nursing staff left at the end of June 2002. The Home had difficulty replacing these nurses with permanent members of staff.

The staffing difficulties were then compounded. On 14 September 2002 Josephine MacDonald suffered a family bereavement and was on sick leave until after Mr Fairlie was admitted to hospital on 26 October. While she did not work on the St Mirren Wing she was a very important member of staff who would have had to be replaced.

On 24 September Mr John Rossi went off on leave for his honeymoon and did not return until 16/17 October. In his absence there were no full time members of nursing staff on the St Mirren Wing. The only permanent members of nursing staff who were employed on the Wing at this time were Kathleen Harvey and Julie Ann Wilson. They both worked part time night duty. Prior to Mr Fairlie's admission to hospital Mrs Harvey last worked until 8 am on 24 October and Mrs Wilson until 8 am on 23 October.

Some time about 12 October Michelle King, a permanent member of the care staff on the St Mirren Wing, went off sick and did not return until 26 October.

In the period of ten days or so prior to Mr Fairlie being admitted to hospital, the St Mirren Wing had a shortage of staff and a large proportion of the staff on duty were bank or agency nurses. The combination of poor, incomplete nursing records and the constant use of bank and agency staff had a direct impact on the ability of the staff to provide an adequate level of nursing care and, in relation to Mr Fairlie, they failed to do so.

The Alexandra Nursing Home was not a modern purpose built Home but a converted former hospital. The St Mirren Wing was not rectangular or some other uniform shape but an irregular shape in which it was not possible to see from one end of the unit to the other. Several experienced nurses expressed the view that because of the layout of the Wing the minimum staffing level laid down by Argyll & Clyde Health Board was not sufficient. The problem from the point of view of the proper running of the St Mirren Wing was that there were very many occasions when the minimum staffing requirements were not met.

I accept the evidence of Mrs Karrim that from about August 2001 (when Joe White left the Home) she was expected to perform the dual role of deputy manager of the Home and the nurse in charge of the St Mirren Wing. It is clear that such were the pressures put upon her to manage the Home she spent very little time on the Wing.

I believe that Mrs Grogan attempted to mislead the inquiry in regard to the problems of staffing the St Mirren Wing. She said that the Wing was below the minimum staffing level for "maybe a couple of hours". That is blatantly untrue.

She also said that when Mrs Karrim was the nurse in charge of the Wing she would be "predominantly on the Wing" and would only be absent from the Wing "from time to time" for her teabreak. This contrasts markedly with the evidence of Mrs Karrim which I accept and whose evidence is corroborated by Michelle King (although corroboration is not required).

I also accept the evidence of Mr Rossi, which is corroborated from several sources that from the time he began employment at the Home in July 2002 he was the only trained nurse on the St Mirren Wing. When this situation existed on the early shift this was in breach of the minimum staffing requirements. There is also the evidence of Jude Garganta, which I accept, that on occasions there was no nurse on the Wing at all.

I have some difficulty with Mr MacLean's submission that to give training to staff to enable them to communicate with those with dementia is desirable "as a gold standard". It seems to me that if a Home intends to run a dedicated dementia unit then it is essential that the staff have training in dealing with people with dementia.

In relation to the St Mirren Wing, however, it is not just the case that some of the staff had no training in the care of people with dementia. Some of the staff had no training at all. It is clear that the Home had no proper training regime in place. Qualified staff who had had no training in dementia, and unqualified staff, who had never worked in a Care Home setting before, were just told to start their shifts with no proper training or induction and, in a lot of cases, without the Home carrying out a disclosure check or even taking up references.

There was evidence that the staff should have been given "in house training". Considering that the St Mirren Wing was so understaffed I cannot see that staff would be given time away from the Wing to attend courses (and there was no evidence that they were) and I think it highly unlikely that staff would come in to the Home on days off to attend courses (and again there was no evidence that they did this).

After Mr Fairlie's family complained about his lack of care, Mr Rossi was disciplined by his employers for his failure to keep proper records. He did prepare detailed care plans for Mr Fairlie on 6 September 2002. These should have been updated one month later at a time when Mr Rossi was on leave. During the three week period of his absence the nurse in charge of the Wing was either an agency or a bank nurse and the care plans were not updated in his absence.

By the time Mr Rossi returned from leave Mr Fairlie was spending an increasing amount of time in bed. He had an "unexplained weight loss". Mr Rossi said that when he came back from leave he thought Mr Fairlie had lost some weight and that he did not think this was a healthy loss of weight. He decided to start a six week feeding protocol. He did not immediately involve the dietician because, on an occasion in the past, he had been given a row by the dietician for calling her in too early.

The protocol involved fortification of Mr Fairlie's diet. Unfortunately Mr Rossi did not prepare a care plan for this or record it anywhere in Mr Fairlie's records. Consequently, no other member of the nursing or care staff would have been aware of this unless, of course, Mr Rossi happened to mention it to them.

Dr Chapman suggested in evidence that such was the extent of the weight loss that the Home should have called in Mr Fairlie's General Practitioner. Mr Rossi was asked about this and his evidence was completely unclear. At one point in his evidence he said that he called in the doctor and at another point in his evidence he said that he did not.

In the course of this particular piece of evidence Mr Rossi explained that it was difficult to weigh Mr Fairlie because he was agitated. This was contrary to the information given to James Fairlie when he contacted the Home on 24 September to be told that his father was being weighed regularly. There is no documentary evidence to support the assertion that Mr Fairlie was weighed regularly. Item 137 of production 12 shows the last recorded weights were taken in the Home on 10 May, 6 August and 6 September 2002.

Linda Johnston, the nursing expert called by the family, did not accept that it would have been difficult to weigh Mr Fairlie. She said there were special scales and slings available which could be purchased to weigh residents. In fact, Mr Rossi also said that the Home had a scale onto which the wheelchair could be pushed to give the total weight of the resident and the chair, and the weight of the chair could then be deducted.

Mr Rossi stated that care staff had no responsibility for dressing wounds. This was the responsibility of the trained staff. Mr Rossi was the nurse in charge and had never looked at the wounds on Mr Fairlie's ankles in the week or so leading up to his admission to hospital. He said that when he came on duty whoever was handing over to him said that they had done the dressings and he did not wish to disturb them. Given that he would be taking over from a night shift nurse when he started his early shift and since Julie Ann Wilson and Kathleen Harvey rarely changed dressings (and did not do so at the critical time) it is difficult to ascertain who actually did anything with these wounds (apart from Miss Mtermende).

Mr Rossi also explained that some of the dressings used were intended to be in place for three days or so. The Four Seasons Care Manual recommends that wounds be reviewed daily. Mr Rossi was unaware of this. Interestingly, Mrs MacDonald, having been given the opportunity to read Miss Mtermende's entry of 22 October, said that wounds like those described should have had the dressings renewed each day until the wounds were clean.

It was Doctor Paterson's view that alarm bells should have rung about the ankle wounds as recorded in the entry of 22 October. It was his view that a swab of the wound should have been taken. While the presence of slough did not necessarily mean the wound was infected, it meant that it was exudating and inflamed and the commonest cause of exudation and inflamation is an infection in the wound. It needed an antibiotic, and any Nurse should have known that the amoxicillin antibiotic which was prescribed for the chest infection would not have had any effect on the bacteria in the ankle wound. Doctor Paterson conceded to Mr MacLean that to apply an antibiotic dressing was reasonable, but he was not satisfied that that was enough.

The apparent seriousness of the wound combined with the fact that on 21 October Mr Fairlie had had a rigor suggested to Doctor Paterson that there was a serious infection which probably warranted admission to Hospital.

Doctor Paterson also stated that it would have taken several days for the amoxicillin to take effect. There would have been no obvious sign Mr Fairlie was getting better within 24 hours, but the failure by the Home to take Mr Fairlie's temperature four hourly meant that the nursing staff would not know if the antibiotic was having an effect. Unfortunately this basic nursing step was not taken.

Doctor Chapman was of the view that when these bad ulcers were noted Mr Fairlie's General Practitioner should have been called in, and admission to Hospital considered. He was also very surprised that on 23 October when it was documented that Mr Fairlie was "deteriorating" that nothing seems to have been done about this.

I find it hard to believe that when Mr Rossi was writing the entry of 22 October 2002 at 2130 hrs he did not read the bold entry by Miss Mtermende immediately above it which expresses clearly and articulately her concerns about Mr Fairlie's ankle wounds. Mr Rossi explained that he did not always have time to read previous entries.

On 25 October Mr Rossi wrote an entry in Mr Fairlie's records "Remains frail, taking diets and fluids well with assistance". In re-examination by the procurator fiscal Mr Rossi said that this entry was completed by him, not after a physical or visual inspection of Mr Fairlie, but on the basis of information given to him. When faced with a description of Mr Fairlie's condition on 26 October Mr Rossi was constrained to accept that the information given to him must have been incorrect. This is a very unsatisfactory state of affairs. As the only trained nurse on duty it was Mr Rossi's responsibility to distribute the residents' medicines. Did he not notice when he gave Mr Fairlie his medicine on 25 October how ill he was? Surely he should have noticed that the report given to him could not possibly have been accurate.

Mr Rossi also did not know that Mr Fairlie had peripheral vascular disease.

I suspect that Mr Rossi might have had more time to do his job properly if the Home had complied with the minimum staffing requirements and had had two trained nurses on the early shift. Mr Rossi's difficulties would be exacerbated further, at least when he was working on the backshift, by the fact that when Mrs Grogan left the Home at 5 pm he was the nurse in charge of the Home and would have the dual

responsibility of being the nurse in charge of the Wing and ensuring that there was a full complement of staff for the Home for the following day.

It is appropriate at this stage to make reference to the involvement of Miss Mtermende. It was suggested that after noting the details of the wounds on 22 October she should have prepared a care plan. That may well be true but it has to be said that she was not a permanent member of staff. She was a bank nurse who had not been on the St Mirren Wing for some weeks previously as she had been on leave. She is the only nurse who has noted anything about these very serious wounds. It is accepted that these wounds must have been present for several days before 22 October and they were still there on Mr Fairlie's admission to hospital, yet her entry appears in complete isolation.

Because she is a mental health nurse she did not consider that she had any expertise in the care of wounds. Before treating the wounds on 22 October she took advice from the district nurse and I accept her evidence that when she completed her shift that day she advised Mr Rossi, to whom she was handing over, about her concerns. He did nothing about this.

Another part of Miss Mtermende's evidence is worthy of note. She said that usually most residents are described in the notes as "settled". She suggested that if a Wing or ward had 30 residents and 28 are "settled" then one should prioritise the other two. We know that Mr Fairlie had a chest infection and wounds to his ankles in the days leading up to his admission to hospital. Miss Mtermende stated that he should have been a priority. That seems to me to be only common sense but it is clear that his treatment was not given any priority.

Miss Mtermende seems to have had little difficulty giving Mr Fairlie fluids. She gave him fluids four hourly. She also said that if she was busy she would ask another member of staff to give Mr Fairlie fluids. Because she was not a permanent member of staff some of the assistants had "an attitude" which, I took to mean, a resistance to being asked to do something. In this situation, particularly if the resident was on a fluid chart, she always tried to check that her instruction had been carried out.

While, as I have said, Mr Rossi must accept a certain amount of culpability for Mr Fairlie's poor care he should not be singled out. The responsibility for the deficiencies of the Home must rest with the manager Mrs Grogan.

My impression of staff like Mrs Karrim, Mrs MacDonald and Mrs Gilchrist is that they were dedicated, committed and very proactive when carrying out their tasks. That is not my impression of Mrs Grogan. She said that she was a fairly regular visitor to the St Mirren Wing. Stewart Fairlie, Alison Fairlie and Ann Cook (who of course did not visit very often) said that they did not see her on the Wing. That perhaps is unsurprising, but Mr Rossi said that Mrs Grogan did not visit when he was on duty, Marie Gilchrist said that Mrs Grogan did not visit the Wing each day and Michelle King said that Mrs Grogan was rarely there. I prefer their evidence.

There was no review of Mr Fairlie's case four weeks after he was admitted to the Home and six months thereafter. The failure to hold the latter was the responsibility of Mrs Grogan. Eventually a review was held in October 2001, some nineteen

months or so after Mr Fairlie was admitted. Mrs Grogan led the review. It seems to have been a pointless exercise. The review form had a section dealing with "specialist nursing needs" to which was added the comment "none". This was incorrect. At the end of the meeting Mrs Grogan promised that matters of concern raised by the family would be attended to. This did not happen.

The duty rotas could not be relied upon. Mr Rossi said that he could not rely on the rotas to ascertain which members of staff would be on duty with him at any particular time. The evidence from the officers of the Care Commission as to their discussions with Mrs Grogan about the duty rota on 26 October supports the conclusion that these rotas were inaccurate. Mrs Grogan had difficulty identifying which members of staff were on duty that day. Under the Regulation of Care Act 2001 the Home was obliged to keep a record of staff on duty and failed to do so.

Stewart Fairlie and Jan Bruce spoke of finding a dirty glass and a syringe in Mr Fairlie's room on 26 October. It was the evidence of several of the nursing staff that at least one member of staff was trying to give Mr Fairlie fluids using a syringe. Mrs Grogan said in evidence that she would not have allowed that to happen if she had known about it. If, as she said, she was a regular visitor to the Wing then presumably this is something which she should have noticed.

Four Seasons' Care Manual specifies the way in which complaints should be dealt with "regardless of the nature of the complaint". In terms of the contract between Renfrewshire Council and the Home, the Home was obliged to inform the Council of any complaints it received. This was the responsibility of Mrs Grogan and she failed to do so. In my view she was disingenuous in her evidence when she attempted to explain away her failure to deal with complaints properly by describing these as "a general discussion".

It is also difficult to get to the bottom of the situation of the complaints manual. The inquiry heard evidence about missing books and a book with pages torn from it. If there had been a proper complaints procedure in place presumably the evidence would have been quite straightforward and a proper complaints book would have been produced.

In the course of her evidence Mrs Grogan was asked to look at the fluid charts. She accepted that they were completely inadequate. She said that if she had seen the charts she would have spoken to the staff to ensure they were aware of their importance. It is axiomatic that if the staff had been properly trained they would have been aware of the importance of keeping accurate fluid charts. Mrs Grogan, as the manager, has to accept responsibility for the fact that these charts were not completed properly and she surely should have been checking that documents, such as fluid charts, were completed properly.

In relation to the question of wounds, the Four Seasons Care Manual specifically puts the onus of completing the wound assessment forms on the manager of the Home. Mrs Grogan delegated this task to Mrs Karrim. The manual also specifies what steps have to be taken in regard to the measuring and photographing of wounds. I have already found in fact that this instruction was not followed.

When Mrs MacDonald was prevailed upon to take on the role of deputy manager in late July or early August 2002 she took on the task of completing the wound assessment forms, and obviously did it properly. This means, of course, that between 7 June when Mrs Karrim left the Home and Mrs MacDonald becoming deputy manager there was a hiatus of seven weeks or so when the wound forms were not completed. Since this task was the specific responsibility of the manager, any responsible manager, in my view, would have ensured that these important forms were completed. Mrs Grogan in evidence accepted that she did not take much to do with these forms.

Mrs Grogan as manager of the Home was responsible for ensuring that a continence assessment was carried out for any resident who was incontinent. There was no evidence that she took any steps to implement this policy.

Several of the staff complained about the shortage of supplies and in fact this was one of the major issues in causing low moral among the staff. In her evidence to the inquiry Mrs Grogan attempted to minimise the problem suggesting that on one occasion there had been a problem when the wrong box of gloves was sent and "basically there was no problem getting supplies". It is clear that the shortage of supplies was a major issue to the staff who were frustrated by the shortages and by Mrs Grogan's inability or unwillingness to tackle the problem. In fact this seems to have been a factor in several staff leaving the Home and finding employment in other care Homes.

Mrs Bandeen and Mrs Beveridge seemed to me to be reasonable people. They could not understand the difficulties about supplies and the failure to obtain pressure relieving mattresses. Mrs Bandeen, as the regional manager responsible for the Home, said that she did not know of the substantial number of problems within the Home and that clearly must be due to the fact that Mrs Grogan kept all of these difficulties to herself. Mrs Grogan said that she advised Mrs Bandeen on the telephone and when she visited about all the problems in the Home, but I do not accept her evidence. I prefer Mrs Bandeen's evidence that if she had known about these problems she would have done something about them.

The very many difficulties and problems in the Home which I have narrated are, in my opinion, due in no small way to the dereliction of duty on the part of the manager. There was no evidence that she had a "hands on" approach. There was no evidence that she was proactive in trying to get to grips with the difficulties in the Wing. In fact, there was no evidence from any source that she did anything at all. It was the evidence of Mrs MacDonald, which I accept, that she was left to resolve the major staffing problems when the nine staff left the Home in June 2002. She also said that Mrs Grogan did not appear unduly concerned about the problems and really showed little interest on her return from Wimbledon.

Mrs Beveridge said that Home Managers were paid a bonus in 2002 if they kept their spending within a budget. This was not put to Mrs Grogan and I therefore make no comment.

Mrs Grogan resigned before disciplinary proceedings could be initiated.

The issue of Mr Fairlie's diabetes was raised during the course of the inquiry. His diabetes was diagnosed on 16 August 2001. It was not insulin dependent diabetes, but type 2 diabetes, diet controlled. Dr Paterson is a consultant physician with a specialist interest in diabetes. He had examined the records for the Home when Mr Fairlie's blood sugar levels were recorded and it was his view that his diabetes was well controlled. I suspect this was more by accident than design. Mr Fairlie's medical records in the Home did not disclose he was diabetic. Some of the staff who looked after him on a daily basis did not know he was diabetic.

Dr Paterson's view was that Mr Fairlie's diabetes was very mild in any event but because he was losing weight in the last months of his life this would also have controlled his diabetes. If his diet was short on calories this would lead to good overall blood sugar control (although, of course, it could have, and in Mr Fairlie's case, did have, other ramifications for his good health and care, and his ability to cope with infection).

Dr Paterson's opinion was that any loss of diabetic control at the time of his admission to hospital played no more than the most trivial of parts in the biochemical abnormalities which were seen. He was also of the opinion that Mr Fairlie's diabetes was not responsible for his weight loss in the months prior to his death. It was much more likely, he thought, that the weight loss was due to poor nutrient intake.

Significantly, Dr Paterson also opined that diabetes did not play any significant part in Mr Fairlie's acute deterioration in October 2002. It may well be, therefore, that the post mortem findings of Dr Black that diabetes mellitus contributed to the death have to be read in the light of Dr Paterson's findings.

"Honk" or hyperosmolar non-ketotic diabetic decompensation is a potential complication of type 2 diabetes mellitus. If the blood sugar becomes elevated and if the kidney threshold for glucose is exceeded a patient will start to show evidence of glucose in his urine. If the patient does not maintain a high fluid intake dehydration becomes a possibility. The dehydration then causes the blood sugar level to become even more elevated increasing yet further the amount of glucose in the urine, inducing further water excretion and aggravating the dehydration yet further.

Dr McIntyre who saw Mr Fairlie the day following his admission to hospital concluded, on the basis of preliminary tests, that Mr Fairlie had honk and appropriate steps were taken to alleviate this. I prefer the evidence of Dr Paterson, Doctor Chapman and Dr Davie that there was no honk. It was their opinion that the blood glucose results on 26 and 27 October showed the blood glucose within a reasonable range, insufficient to exceed significantly the renal threshold for glucose and thus lead to glucose in the urine which would produce hyperosmolar decompensation.

The issue of Mr Fairlie being nursed on a mattress on the floor was raised during the course of this inquiry. While it clearly had no bearing on the causes of Mr Fairlie's death it caused his family considerable anxiety. I have already discussed this issue in relation to Mrs Sutherland's submission in terms of Section 6(1)(e) of the Act.

It is difficult to be precise about when this practice started and finished. Yet again, the absence of precise records from the Home makes this task difficult. It is linked to the use of cot sides and it is also unclear when these were used.

It seems to be the case that cot sides were used possibly to stop Mr Fairlie falling out of bed, although there is also a suggestion that they were used to stop him getting out of bed at night. He attempted to climb over the cot sides and the decision was then taken to remove these and put him on a mattress on the floor. When Mr Fairlie's family expressed concern about this, the cot sides were reinstated. Since Mrs Gilchrist recalled cot sides being used before she left in April it is clear that the consent form which was signed by Stewart Fairlie for Kathleen Harvey on 29 June was a retrospective consent.

It is clear that the policy for the use of cot sides (or "bed rails") in the care manual was not followed.

I accept the evidence of Linda Johnston that if the purpose in using cot sides was to keep Mr Fairlie in bed against his will, this was a form of restraint. If he wished to get up and could not, this was likely to increase his agitation and frustration and might well cause him to thrash about in bed kicking at the cot sides and bumpers. Mrs Johnston suggested that if a resident wished to get out of bed he should be allowed to do so, and perhaps given a drink and taken to the toilet. It would appear that it did not occur to some of the staff that this thrashing about was a desire to get out of bed, and is another indication of the lack of training and a lack of awareness on the part of some of the staff.

Sadly the inquiry was denied the opportunity of hearing from James Fairlie who died after his father and before the inquiry started. I think it is likely James Fairlie was aware that his father was nursed on a mattress on the floor although, as I have said, this may have been retrospective. There was no consent form signed by James Fairlie produced to the inquiry.

If he had been aware of the situation, or even had consented to it, there is nothing to show for how long each day, or over what period of time, Mr Fairlie was nursed on a mattress on the floor. While it was the unanimous view of all who were asked about it that it was undignified it seems to me that to put a severely disabled man on a mattress on the floor, and who could not get up unaided, for eighteen hours a day (as suggested by Mrs Karrim) is not just undignified but cruel, particularly when regard is had to the fact that the Wing was constantly understaffed and no doubt the staff would be inclined, perhaps, from time to time, not to go in to see how he was, when undoubtedly they had many other things to do.

There was mixed nursing opinion as to whether or not this was an acceptable practice. Jan Bruce considered that it demonstrated a lack of imagination on the part of nursing staff. Mrs Josephine MacDonald, who of course was the mental health link nurse, was against the practice and she does not appear to have been involved in the discussion, if there was one, in relation to putting Mr Fairlie on a mattress on the floor.

No member of the nursing staff accepted responsibility for taking the decision to nurse Mr Fairlie on a mattress on the floor. Mrs Karrim suggested in evidence that the decision was taken by Marie Gilchrist. That cannot be correct. Mrs Gilchrist had left the employment of the Home by the end of April, and it seems likely that this practice did not start until sometime in May 2002. I also accept the evidence of Mrs Gilchrist that she disapproved of the practice and refused to allow Mrs Karrim to put a pillow below Mr Fairlie's head when he was found lying on the floor.

Mrs Grogan claimed in evidence that she was not aware of the family's concerns at the time and only discovered that Mr Fairlie was nursed on the floor "after the event". I suspect that is probably correct. It also adds support to my conclusion that Mrs Grogan was rarely in the St Mirren Wing. If, as she said, she visited the Wing each day then she would have seen Mr Fairlie on a mattress on the floor.

I am of the view that this decision was taken by Mrs Karrim. She claimed in evidence she was not consulted (which, since in my view it was her decision, is likely) but she knew that Mr Fairlie was nursed on a mattress on the floor "for safety reasons". In the course of her evidence she justified the decision, and in fact agreed with it. As the deputy manager and the person in charge of the St Mirren Wing after Mrs Gilchrist left she had the power presumably to overrule a decision taken by a subordinate, but she accepted the situation.

Mrs Karrim also seemed content with the decision because, coincidentally, at the same time as she saw Mr Fairlie on the floor his GP, Dr Ip, was in the Wing and he "didn't disapprove of it". It was, of course, nothing to do with the GP. It was a matter between Mr Fairlie's family and the Home.

As it happened Mrs Karrim did not give evidence on successive days and she may have been disadvantaged by this. She contradicted herself not only in relation to the number of times she had apparently seen the practice before, but more particularly, in her approach to the idea of nursing on the floor. She claimed initially that she was horrified. She said it was like "treating somebody like a dog" but two days later in evidence when cross-examined by Mrs Sutherland she described it as a perfectly acceptable practice through many Homes. Although she was "horrified" she did not endeavour to ascertain which member of staff must have taken the decision. For these various reasons I am perfectly satisfied that the decision was Mrs Karrim's.

I should also say, in relation to the evidence of Mrs Karrim, that I do not accept that Marie Gilchrist's appointment made things "ten times worse". My impression of Mrs Gilchrist is that she is a very experienced and a very good and practical nurse. She took an interest in Mr Fairlie. She charted his falls. She was very diligent in dealing with residents' wounds and in applying the correct approach to residents with MRSA. She had a "no nonsense" approach to things. She refused to work on the morning shift without another qualified Nurse and, although she was concerned about the unavailability of certain supplies, she usually managed to obtain these.

I think it is unnecessary that I give a view on the dispute between Mrs King and Mrs Karrim as to whether the latter refused to allow Mrs King to go home when she suffered a miscarriage. I am sure this is not a matter of great interest to the family.

I have already mentioned several members of staff whom I regard as being excellent members of their profession, Mrs Josephine MacDonald in particular. I think at one point she was described by Mr MacLean as "a star" and no one would argue with that. I accept Mr MacLean's submission that no member of the staff did anything deliberately to harm Mr Fairlie. On occasions the care was very poor as a consequence of the difficulties I have mentioned. Caring for elderly people in a Care Home setting is not an easy task and I am satisfied that most of those who gave evidence before me carried out this task as well as they could.

I thank the procurator fiscal depute, Counsel and the Solicitors involved in this case for their assistance throughout and for the detailed comprehensive submissions which were made. Some were obviously longer than others depending on the nature of the representation.

Finally I extend my deepest sympathy to the family of the late Mr Fairlie. The three surviving children listened to several days of evidence. On occasions they must have been extremely saddened by what they heard.

APPENDIX/

APPENDIX

Witnesses called to give evidence at this Inquiry.

1. The family (a) Mr Ross Cook, son in law of George Fairlie;

(b) Mrs Ann Cook, daughter of George Fairlie;

(c) Mr Stewart Fairlie, son of George Fairlie;

(d) Miss Alison Fairlie, daughter of George Fairlie;

(e) Ms Janet Bruce, partner of Stewart Fairlie.

2. Employees of Four Seasons Health Care Ltd

(a) Mrs Isabella Karrim;

(b) Mrs Michelle King;

(c) Mr John Rossi;

(d) Mrs Kathleen Harvey;

(e) Mrs Josephine MacDonald;

(f) Mrs Julie Ann Wilson;

(g) Mrs Ruth Grogan;

(h) Mrs Marie Gilchrist;

(i) Mrs Jude Garganta;

(j) Mrs Elizabeth Grant;

(k) Miss Florence Mtermende (temporary - bank worker);

(l) Mrs Maxine Beveridge;

(m) Mrs Brenda Bandeen.

3. Medical (a) Dr Marjorie Black, consultant forensic pathologist; the University of Glasgow;

(b) Dr Martin McIntyre, consultant in the department of medicine at the Royal Alexandra Hospital, Paisley;

(c) Dr Hilary Livingston, consultant psychiatrist, the Royal Alexandra Hospital, Paisley;

(d) Dr Karl Philips, consultant psychiatrist, the Royal Alexandra Hospital, Paisley;

(e) Dr Uzoije Ezebuiro, General Practitioner with Primary Care Emergency Service;

(f) Mrs Elizabeth Wilson, tissue viability nurse, the Royal Alexandra Hospital, Paisley.

4. Other agencies (a) Mr Peter McCulloch, Renfrewshire Council Social Work Department;

(b) Mrs Catherine Agnew, The Care Commission;

(c) Mrs Marie McKerry, The Care Commission;

(d) Detective Sergeant Andrew Dunn, Strathclyde Police, Paisley.

5. Opinion evidence (a) Mrs Linda Johnson, a graduate registered nurse and care expert;

(b) Mr Brian Kerr, consultant in social care and social work;

(c) Professor CV Ruckley, emeritus professor of vascular surgery, the University of Edinburgh;

(d) Dr Brian Chapman, consultant in general medicine and geriatric medicine at the Royal Infirmary, Edinburgh;

(e) Dr Kenneth Paterson, consultant physician and diabetologist, the Royal Infirmary, Glasgow;

(f) Dr James Davie, consultant physician in general medicine and medicine for the elderly, Stobhill Hospital, Glasgow.