INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRIES (SCOTLAND) ACT 1975 INTO THE SUDDEN DEATH OF JAMES HUTCHISON

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

DETERMINATION

By

SHERIFF ALISTAIR JM DUFF

In Inquiry into the circumstances of the death of

JAMES HUTCHISON

In terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

DUNDEE 7th December 2006

The Sheriff, having resumed consideration of the Inquiry, DETERMINES as follows:

1. In terms of section 6(1)(a) of the Act that James Hutchison, who was born on 11th August 1912, and late of Tullideph Nursing Home, 38 Benvie Road, Dundee died at 11.00 hours on 11th December 2002 at Ninewells Hospital, Dundee, having sustained injuries in an accident which occurred within Tullideph Nursing Home at approximately 20.40 hours on 3rd December 2002,

2. In terms of section 6(1)(b) of the Act (a) that the cause of his death was (1) artherosclerotic coronary artery disease and (2) fractures of left humerus and femur (indoor fall, operated), senile dementia and acute bronchial pneumonia and (b) that the cause of the accident was a fall to the floor immediately following upon James Hutchison having been kicked by Andrew Brown, now deceased but at the time a resident of Tullideph Nursing Home, which fall resulted in the fractures referred to above,

3. In terms of section 6(1)(c) of the Act that the death and the accident resulting in the death might have been avoided if Andrew Brown had been made subject to close supervision when he was in the company of other residents of Tullideph Nursing Home. This precaution would have been reasonable having regard to a number of considerations as follows:-

(a) the acknowledged propensity of some who suffer from senile dementia to behave in an unpredictable and sometimes aggressive or violent manner;

(b) the stated policy of the manager of Tullideph Nursing Home not generally to medicate residents so as to render them incapable of independent movement;

(c) the well documented pattern of violent behaviour towards carers and residents manifested by Andrew Brown prior to his admission to Forebank Nursing Home, Dundee, within Forebank and then at Tullideph;

(d) the terms of the "care plan" for Andrew Brown apparently put in place for him when admitted to Tullideph;

(e) the vulnerability of elderly persons, particularly those suffering from senile dementia.

4. In terms of section 6(1)(d) of the Act there were the following defects in the system of working which contributed to the death of James Hutchison:-

(a) on 3rd December 2002 at 20.40 hours the residents' lounge in Tullideph was unsupervised by staff;

(b) having regard to the characteristics of the residents of Tullideph, the layout of the building and the responsibilities of staff at that time of the day the level of staff numbers was inadequate to maintain supervision of the lounge;

(c) when Andrew Brown was admitted to Tullideph there was apparently an inadequate transfer of information from Forebank, the nursing home from which he was being transferred, about his past violent behaviour. It was also far from clear that the care plan for Mr Brown devised by his social work care manager was timeously provided to the management of Tullideph.

(d) Although, in circumstances which are not clear, a care plan for Andrew Brown was drawn up on admission to Tullideph which plan appeared to recognise his previously violent behaviour and recommended strategies for addressing it the staff at Tullideph did not seem to be aware of the terms of the plan and there seemed to be no reliable method in place for staff to make themselves aware of the terms of residents' care plans;

(e) as a result of (c) and (d) when Andrew Brown began to exhibit violent behaviour in Tullideph the staff were insufficiently equipped with information about his past behaviour and therefore failed to approach the question of his care and management and the safety of other residents with the appropriate level of urgency;

(f) in particular, because of (c), (d) and therefore (e), the staff at Tullideph failed to report timeously the full circumstances of his violent behaviour to Mr Brown's GP, to Patricia Bree, the dementia liaison nurse and community care co-ordinator attached to the GP practice and employed by Tayside Health Board, to Jacqueline Bell, Andrew Brown's social work care manager, employed by Dundee City Council, or to any appropriate psycho-geriatrician. Had such a fully informed and timeous report been made prior to the accident on 3rd December it is probable that an urgent psychiatric assessment of Andrew Brown would have been carried out and probable that he would have been admitted to a psychiatric hospital.

(5) **Recommendations**

I make the following recommendations (where I refer to a nursing home it should be understood that I am referring to a nursing home for elderly and mentally infirm persons, an EMI home) :-

(a) When any elderly and mentally infirm person (probably therefore a person suffering from dementia) is to be admitted to a nursing home there ought to be a full assessment of the needs of that person by the nursing home prior to admission. There should be supplied to the nursing home a copy of the care plan for that person devised by their social work care manager and the nursing home should, in advance of the person's admission, devise a provisional care plan.

(b) The care plan relating to any person, while it will require to address many aspects of the person's needs, should contain a clearly identifiable section detailing all incidents of violent or aggressive behaviour, any measures taken in response and the strategies recommended for avoiding repetition of such behaviour.

(c) The nursing home should, within an appropriate period (perhaps six weeks) refine and finalise the care plan, building on the initial assessment and social work care plan but taking account of the home's experience of the person since admission.

(d) When any elderly and mentally infirm person is transferred from one nursing home to another, whether both homes are run by the same organisation or not, the accepting nursing home should fully assess the needs of that person prior to admission. The accepting nursing home should be supplied with a copy of the social work care plan and the care plan of the previous home in advance of the transfer taking place.

(e) Where the transfer requires to take place as an emergency the accepting nursing home should nevertheless be supplied with a copy of the social work care plan and the care plan of the previous home at the time of the transfer taking place. The accepting home should then expedite a full assessment of the needs of the person.

(f) Following an emergency transfer the nursing home should promptly revise the care plan of the previous home to reflect any needs identified by the assessment process, but in any event within an appropriate period (perhaps six weeks) refine and finalise the care plan, building on the initial assessment and social work care plan but taking account of the home's experience of the person since admission.

(g) The senior nursing management of a nursing home should be aware of the detailed terms of the care plan of every person resident within the home.

(h) On each shift of staff on duty within a nursing home each member of the nursing or care staff, excluding any senior manager on duty, should require to be familiar with the detailed terms of the care plans of a group of residents so that the terms of the care plan of every resident will be known to at least one member of the nursing or care staff. Managers require to put in place systems which will allow staff time to become familiar with care plans and to monitor any changes to the plans.

(i) On a change of shift the staff member going off duty who is familiar with the care plans of a particular group of residents should communicate clearly and effectively to

the staff member coming on duty who is familiar with the same group any relevant information about anything which may have occurred during the shift which bears upon the needs of any resident who is part of the group. This is in addition to any records of such information which the home may maintain.

(j) Communal areas of nursing homes such as lounges and dining rooms should at all times be monitored by a member of staff present in that area.

(k) The managers of any nursing home should have under constant review the level of staffing required to meet the changing needs of residents, regardless of the staffing levels set by the Care Commission for Scotland.

(l) There should be established clear protocols for liaison and exchange of information in relation to client/patient/resident care amongst social work, health professionals and care home managers.

Signed

Sheriff of Tayside Central and Fife

At Dundee

NOTE:

The Crown were represented by Mr Kermode, procurator fiscal depute. Miss Glen appeared for the representatives of the deceased. Miss Fleetwood and then later Ms Foulis represented the Care Commission for Scotland. Miss MacPhail represented NHS Scotland and Miss Bennett represented Four Seasons Health Care.

The following persons gave evidence:-

(a) Catherine Kelly, daughter of James Hutchison

(b) Yvonne Hutchison, daughter of James Hutchison

(c) Robert Livingston, former care assistant at Tullideph Nursing Home

(d) Kathleen Stewart, deputy manager of Tullideph Nursing Home

(e) Dr David Sadler, forensic pathologist, Dundee University

(f) Patricia Bree, dementia liaison nurse, Tayside NHS, Dundee

(g) Manhal Nassif, consultant orthopaedic surgeon, Ninewells Hospital, Dundee

(h) Joan Downie, manager of Tullideph Nursing Home

(i) Elizabeth Smith, former care assistant at Tullideph Nursing Home

(j) James Kilgour, social worker with Falkirk Council

(k) Jacqueline Bell, social work care manager with Dundee City Council

(l) David Gilling, Care Commission

(m) Margaret Semple, consultant psychiatrist, Royal Dundee Liff Hospital

The evidence disclosed the following.

(1) Catherine Kelly and Yvonne Hutchison both gave evidence about their father James Hutchison, his family circumstances and his life up until the accident. They presented a clear picture of their father. This deserves to be expressly recorded.

(2) James Hutchison was born on 11th August 1912 and thus was aged 90 when he died. He married when he was about 21and remained married to his wife for 66 years, until her death. The marriage was a close, loving relationship and resulted in the birth of six children, including five daughters. Throughout his marriage Mr Hutchison was a hard working husband and father supporting his wife and children. He worked for NCR in Dundee and served as a gunner with the Royal Artillery during the Second World War, suffering severe hearing loss as a result.

(3) Mr Hutchison's wife developed Alzheimer's condition in her mid-60's and he cared for her until she was eventually admitted into the care home system. Even then Mr Hutchison visited her every day until his own health became problematic. Around the age of 85 Mr Hutchison's health began to deteriorate and over time he developed dementia. Eventually he had to be admitted to a nursing home in Dundee called St Columba's When he was resident there his family organised taking him to Tullideph Nursing Home, 38 Benvie Road, Dundee to which his wife had been admitted, so that he could visit her.

(4) After about a year or so the family successfully arranged for Mr Hutchison to be himself admitted to Tullideph so that he could be with his wife. They resided there together for about six months before Mrs Hutchison died. Mr Hutchison remained in Tullideph until the accident on 3rd December 2002 and was a resident there for about two years in total.

(5) During his life Mr Hutchison was a very caring person. At the age of 12 his father died and he had to help his mother care for three younger siblings. He cared for and supported his wife and family. He encouraged his children to be respectful to others and to look out for others.

(6) In Tullideph he was well liked by staff and other residents. He enjoyed helping others and assisting staff with chores, when his health permitted. He was a slim, small man and latterly quite frail. He had to be helped to stand up out of a chair but once up was able to walk unaided, albeit slowly. When first admitted to nursing homes he could exhibit verbally aggressive behaviour. In the view of his daughters this was because he was frightened. He would shout and get angry. This was typical of persons with dementia. However after a while in the care system he became very even tempered and placid.

(7) Mrs Kelly stated in her evidence that she and three other daughters took it in turns to visit their father in Tullideph. They tended to go in pairs. Mrs Kelly would visit two or three times per week. Her belief was that there were about sixty residents in the home, thirty in rooms on the ground floor and thirty on the first floor. She took visits with her father in the day room on the ground floor, a communal room for the use of all residents, where residents sat around in chairs and wheelchairs or walked about either unaided or using "zimmer" frames.

(8) Mrs Kelly's evidence was that it was regularly the case that there was no member of the care staff supervising the day room. There never seemed to be enough staff. They were always busy doing chores. It was hard to find anyone to ask about her father. Mrs Kelly thought that this lack of staff was a common feature of all the care homes she had visited when her mother, father and sister were in such homes. Often visitors would assist residents with their needs if they got into difficulty. There would be no staff member in the day room and it would be necessary to set off to find one.

(9) In March 2002 her father had a problem with his heart but the doctors were not too worried about it. On the Saturday before the accident another sister told Mrs Kelly that she had noticed that their father had a "rattle" in his chest.

(10) On 3rd December 2002 Mrs Kelly was contacted by Kathleen Stewart, the deputy manager of Tullideph and was advised that her father had been assaulted by another resident, that it was a "nasty" attack and that her father had been taken to Ninewells Hospital in Dundee. She went to the hospital where she saw her father who was in great pain and was distressed.

(11) Mrs Kelly later learned that the resident who had assaulted her father was an Andrew Brown and that he was a new resident in the home. Mrs Kelly thought she knew who this was. She had noticed a new resident who seemed younger and more mobile than the others. He dressed smartly. He was never accompanied by a member of staff when walking about. Mrs Kelly thought one of the care assistants had told her this person's name.

(12) Mr Hutchison was examined at the hospital and was found to have sustained a broken femur, broken shoulder and massive bruising to his left side. The doctors told Mrs Kelly that he had a bad chest infection and they could not operate until this had been treated with antibiotics. They said he needed surgery for his fractures otherwise he would be constantly in great pain. The operation was carried out two or three days later on a Friday. The doctors knew in advance of the operation that he had had a heart problem but they were happy to operate. They told her that during the operation there had been some kind of heart difficulty but they felt this had been resolved and that Mr Hutchison had come through the operation well. Mrs Kelly thought he was confused and in pain, but he was able to communicate to some extent. He was clearly anxious. At no point did he say anything about what had happened to cause his injuries.

(13) By the Sunday after the operation his condition had deteriorated. He still had the chest infection. Medical staff were doing all they could to "keep him going". Eventually his family said they just wanted him kept comfortable. He was given pain

relief only. He died on 11th December 2002 around noon. Staff felt his pulse not long before he died and said it was strong. Mrs Kelly had no criticism of the staff at Ninewells or the treatment administered.

(14) Mrs Kelly was asked to narrate the concerns she had about the regime and management of Tullideph. The first related to staff and staffing levels. Mrs Kelly was clearly of the view that staff in privately run homes (as opposed to Council run homes) were poorly paid leading to a high turnover of personnel. When gaps in staffing required to be filled at short notice the private homes tended to contact agencies who supplied temporary staff. These were sometimes non-British who spoke English poorly. This was far from ideal for EMI patients who required continuity and stability in those who cared for them. Mrs Kelly also believed that there was a chronic shortage of staff in private homes to meet the significant needs of EMI patients. She explained that when Four Seasons Health Care took over the running of Tullideph in about September 2002 she raised these concerns and was given reassurances. She felt that the standards at Tullideph did improve when they took over. Secondly Mrs Kelly had concerns about Tullideph's approach to the management of the resident Andrew Brown. She discovered in the aftermath of her father's death that Mr Brown had a history of violent behaviour. She felt that this should have been known to staff at Tullideph and, if it was known, steps should have been taken to supervise him closely, assuming Tullideph were prepared to take him at all.

(15) In September 2003 Mrs Kelly raised her concerns with the Care Commission for Scotland. She subsequently had a meeting with a David Gilling of that organisation. He told her that he had visited Tullideph twice on an unannounced basis and on both occasions found no care staff on duty in the day room. He also advised her that the Commission set minimum staffing levels for Tullideph and that they were complying with the minimum. Mrs Kelly's view was that this minimum level was not enough to meet the needs of this particularly demanding type of resident.

(16) In cross examination Mrs Kelly said that her father was diagnosed as suffering from angina in November 1993. In 2002 he was diagnosed as having suffered a heart attack but there was no medical follow up planned at that time. Mrs Kelly was aware that the view of the pathologists after post mortem examination was that his death was associated with his heart. Mrs Kelly did not accept this. She accepted that the Care Commission responded promptly to her concerns, raised in 2003 and that she was advised that the home was going to have to carry out a review of staffing and of care plans. She did not think she was mistaken in identifying Andrew Brown as the smartly dressed, younger resident who walked around easily. She agreed that her general criticisms of EMI homes were not restricted to Tullideph. She agreed that all dementia sufferers could exhibit challenging behaviour including shouting. She was not aware of an episode on 14th June 2002 (mentioned in her father's care plan, a documentary production) when her father was recorded as having been shouting, kicking and pulling.

(17) The next witness to give evidence was Yvonne Hutchison, another daughter of James Hutchison. Without minimising the effect of her evidence I think it can be said that she confirmed much of the evidence of her sister, Mrs Kelly, in relation to her father's history, his death and the concerns about the staffing levels at Tullideph and

the high turnover of staff. In particular Mrs Hutchison had personally experienced the regular failure of staff to supervise the day room. She had often seen to the needs of her father herself as no care assistant was in attendance. If it was necessary to find a care assistant this could be difficult. There might be someone in the office next to the day room. Otherwise one had to trawl the corridors looking for someone.

(18) According to Mrs Hutchison there were very few residents in Tullideph who could move about freely and unassisted. Most remained seated or moved using walking frames. There was one called Gretel who liked to wander around touching hair, clothes, earrings and scarves on residents or visitors. She did this in a friendly way. Mrs Hutchison thought Andrew Brown was a sprightly, younger resident, well dressed and mobile. In cross examination she was shown a photograph of someone, supposedly Andrew Brown. She did not think this was the resident she believed to be Andrew Brown. The man she believed to be Mr Brown did not have impaired mobility and did not use a walking frame. Mrs Hutchison was surprised that the pathologists attributed her father's death to his heart condition.

(19) The next witness was Robert Livingston, now aged 40. He had worked as a care assistant for about ten years and this included two years at Tullideph. He was working there in December 2002. His duties were to look after the care and needs of residents. He had no formal qualifications in this area but got training "on the job", including training in moving and handling residents, fire awareness, restraint and self defence as well as seeing videos about dementia. He stated that in order to become familiar with residents it was necessary to look in their "care plans" for their history. All care assistants had access to the care plans and at Tullideph were required to read them. The care plan set out the residents' needs and any care that was required to meet those needs. It also included a reference to any appropriate medication. There was a staff nurse in charge of each shift and each staff nurse would have the responsibility for preparing the care plans for various residents. A daily report about the patient was also put into the care plans. If a patient arrived in the home without a previous existing care plan, then the staff nurse would have to compile one. New residents to the home would arrive with information about them depending on where they had come from.

(20) Tullideph had 60 residents, one to each room. There were three shifts. The early shift, from 7.30 am to 2.45 or 3 pm, had 6 care assistants and a staff nurse on each of the two floors. The late shift, or back shift, which was from approximately 3 pm to 9.30 pm had, Mr Livingston thought, 5 carers and a staff nurse on each floor. The nightshift from 9.30 pm to 7.30 am had 3 carers and a staff nurse for each floor.

(21) Mr Livingston was on duty on 3 December 2002 when an incident happened in the lounge. He thought he was on the back shift and thought that the incident occurred at about 9 pm. The only other two members of staff that he could remember being on duty were Kath Stewart, the staff nurse in charge on the shift, and Elizabeth Smith, a care assistant. There would have been other members of staff on duty but he could not remember who. His mind was vague since this all had happened three years ago. Mr Livingston was working on the ground floor and was involved in putting a resident to bed and then walking down a corridor to put clothing into a sluice. He then heard a fracas coming from the ground floor dining room which

he described as being "in Area 2". (Note: this was the day room where the accident occurred)

(22) He ran down the corridor to the dining room in Area 2, entered the dining room and saw James Hutchison lying on the floor in a lot of pain. Mr Brown was sitting on a chair. Mr Hutchison was at the bottom of Mr Brown's feet. Mr Brown was trying to kick Mr Hutchison. John O'Hara, another resident, was in the lounge shouting at Mr Brown, having a go at him for assaulting Mr Hutchison. Another resident called William Legge was also there, sitting next to Andrew Brown and also shouting at him, having a go at him for assaulting Mr Hutchison. Another resident called Gretel Clark was lying on the floor close to James Hutchison at the bottom of his feet. She was five or six feet away from Andrew Brown. There were no staff in the room. Mr Livingston jumped in front of Andrew Brown to stop him trying to kick Mr Hutchison and pushed Mr Brown's chair back away from Mr Hutchison. Kath Stewart and Elizabeth Smith then came into the room coming from the nurses' office next to the lounge/dining room. It was necessary to leave the lounge to go to the nursing office. Once in the nursing office it was not possible to see into the lounge, said Mr Livingston.

(23) Mr Livingston and the others tried to calm the situation down, unsuccessfully. Mr O'Hara and Mr Legge were still bawling and screaming, and it was decided that Mr Brown should be removed from the room and taken to his own room. Mr Livingston did this and stayed with Mr Brown in his room for about five minutes. He asked Mr Brown if he knew why he was being put into his room and, according to Mr Livingston, Mr Brown said "Yes - for kicking that bastard". Mr Livingston did not know to whom Mr Brown was referring. Mr Livingston's evidence was that he had not been successful in calming Mr Brown down. Mr Brown was still violent, punching, lashing out and kicking at Mr Livingston. Mr Livingston left him in his room and returned to the lounge. His memory was that Mr Hutchison was being seen to by Kath Stewart and was then taken to hospital. The other residents in the room had calmed down. Andrew Brown was taken to Royal Liff Hospital the next day for assessment, and as far as Mr Livingston knew did not return to the home.

(24) Mr Livingston was then asked for his assessment of various of the residents. In relation to Gretel Clark he indicated that he had been unable to communicate with her. She could understand what was being said to her but could not communicate her own needs. She suffered from dementia. If she spoke at all she tended to speak in German, her native tongue, and no-one in the home could understand her. She was mobile. She mainly wandered around the home touching people all the time. She also liked to pick things up, or at least to pretend to pick things up. She liked to "paw" people, including other residents, but she did this in an inoffensive way and no-one was bothered by her behaviour. There had never been any complaints about her from other residents. William Legge was not very mobile. He was definitely sitting in the chair next to Andrew Brown in close proximity to him when Andrew Brown was "having a go" at Mr Hutchison. Mr Legge could communicate. He could take in what was being said to him and could ask for things. Mr Livingston at no stage asked him what had happened in the lounge. John O'Hara was mobile and could get around fairly easily. He was excellent at communicating. Mr Livingston could not recollect Mr O'Hara saying anything about the incident in the lounge, other than pointing to Mr Brown and indicating that there was kicking going on. James Hutchison was a nice

man. He could walk around reasonably well unaided but sometimes needed assistance. He was able to communicate. He could understand what was being said to him so long as he had his hearing aid in and he was able to give an indication of his needs. Mr Livingston never spoke to him about the incident. Andrew Brown had only moved into the home a month or so before the incident. He could communicate without difficulty. He used an aid to walk, namely a tripod, but was able to get around. Mr Livingston did not know much about Mr Brown's character because Mr Livingston worked in a different area and did not have much to do with him. On most nights when Mr Livingston was on the back shift, Mr Brown would be sitting quietly having a cup of tea, seated in the lounge in Area 2. Mr Brown, when seated, was kept away from the other residents but apart from that had no special seating arrangement that Mr Livingston knew about. He was free to mix with other residents.

(25) Mr Livingston was shown Production 9 (Book 2, page 404), the plan of the upstairs section of the home. He was able to confirm that this was also a reasonably accurate plan of the downstairs section, with two corridors running in a shallow V-shape with the lounge in which the incident occurred being situated where the two corridors met. The downstairs area was divided into three areas with, basically, ten residents in each area and two carers being responsible in broad terms for each area. Mr Brown's room was in Area 3. The lounge where this happened was in Area 2 but was the lounge used by the residents on the ground floor. A different room on the ground floor was used as the dining lounge.

(26) Mr Livingston's understanding of the situation was that at all times there should be a member of staff on duty in the lounge to observe residents. He described this as one of the "big things" of the manager of the home, who he said "goes nuts" if no-one was on duty in the lounge. His evidence was that in general terms he had never seen the lounge unsupervised. If the lounge was unsupervised for any time then this might be towards the end of the back shift when residents were being prepared for bed or having showers etc. At night there might be 15 to 20 residents using this lounge. There would be 5 care staff on duty on the bottom level, but one of these ought to be on duty in the lounge.

(27) On a changeover of shift, the staff coming on duty would get a daily report from the nurse in charge of the outgoing shift, giving any indication of anything significant which had happened during the shift. This might mean at a change of shift that the lounge would be left unattended briefly while this report was given to the incoming staff. Mr Livingston accepted that if a resident from the lounge needed to be taken away to be cleaned, then another carer would have to take over observations in the lounge. If a resident suddenly needed to go to the toilet, then the lounge might need to be left unsupervised. There was a buzzer system used by staff and residents and Mr Livingston thought there was a buzzer situated in the lounge. If there wasn't he would shout for assistance. Mr Livingston thought that if the buzzer was activated then there were boards situated halfway up the two corridors which would display that one of the buzzers had been activated and also make a sound. The nursing stations were unmanned but anyone who was nearby would hear the buzzer and could go to the station, see where assistance was required and then go there.

(28) Eventually Mr Livingston conceded that given the different situations that could crop up, the lounge might be unsupervised on a significant number of occasions. Mr

Livingston's evidence was that the home was never short-staffed in the sense that minimum staffing levels were always maintained, but his opinion was that in the nursing homes in which he had worked including Tullideph, there was never enough staff. He agreed that if more staff were employed then a communal area like the lounge could be supervised without fail at all times, and the home would thus be safer and better for the residents. He thought that to improve safety for residents there ought to be more staff employed and panic alarms ought to be provided. On the back shift it was very busy for staff. If Mr Livingston was on observation duty in the lounge and had to leave the lounge for some reason, he would shout for a nurse or care assistant to come and sit in his place. His view was that none of the residents in the lounge were at risk of falling. Those who might be at risk of falling were not able to get up without assistance. Mr Brown required help to stand up, although once he was up he was mobile. Mr Hutchison on the other hand could stand up and sit down on his own and could look after himself. Mr Livingston was then shown Production 17 (Book 8, page 3058). He identified this as the care plan for Mr Hutchison which he said he had seen before. He was directed to page 3059, an index of the problems faced by Mr Hutchison, and agreed that one of these was mobilising. He explained that Mr Hutchison had problems with his mobility first thing in the morning but would have improved by later in the evening. He was then directed to page 3067 and agreed that in broad terms this part of the care plan had as its objective the need for Mr Hutchison to be safe at all times to prevent injury. Under the heading "Prescribed Care" there was set out a number of "interventions" designed to achieve this objective. He agreed that one of these interventions was to ensure that Mr Hutchison's room was neat and tidy at all times, and free of "clutter". He was directed to page 3097 which related to mobility, and again included the goal to ensure that Mr Hutchison was safe at all times, and included maintaining a safe environment for Mr Hutchison when he was moving. Mr Livingston agreed that if Mr Hutchison was moving about, then if a care assistant was on duty observing in the lounge, that would contribute to his safety. Mr Livingston indicated that he did not have much responsibility for the care of Mr Brown when he was in the home.

(29) In the view of Mr Livingston, the incident leading to Mr Hutchison being injured could not have been prevented even if there had been staff in the room because, he said, "It happened that quickly". He agreed however that if part of what contributed to the incident was Gretel Clark walking towards Mr Brown, then that could have been prevented by someone stopping her approaching. He agreed that if Mr Brown was seated away from other residents, then that would help to prevent the incident.

(30) Mr Livingston could not remember if he was aware of the care plan relating to Andrew Brown. He thought he probably was. He explained that there were specific residents for whom he had responsibility, and he would make sure he was familiar with the care plans of those residents. Mr Brown was not one of those residents. However, he indicated that if he had time then he would try to read the care plans relating to other residents. He seemed to remember that in a daily report setting out things which had happened in a previous shift, mention had been made of aggressive behaviour by Mr Brown.

(31) He was referred to Production 14 (Book 6, page 2430A). He agreed that this was part of the care plan for Mr Brown, and that there was a problem identified in this part of the care plan as Mr Brown having difficulty communicating all of his

needs. He agreed that he was aware that Mr Brown had a painful hand and he noted that in the prescribed care on this page of the care plan, there was a reference to the possibility of Mr Brown becoming physically aggressive towards staff, and the steps that should be taken if this happened. Mr Livingston indicated that he was not familiar with Mr Brown's care plan. He was then referred to page 2432A of the same production, which again was part of the care plan for Mr Brown, specifically relating to the need or problem that Mr Brown would become aggressive and agitated. It was pointed out to him that there was reference in the prescribed care section of this part of the care plan to the possibility that Mr Brown could become aggressive with staff and residents, and that Mr Brown "has to be supervised when he is with other residents because he could push them over or throw items at them". Mr Livingston was quite clear that he was not aware of this part of Mr Brown's care plan. He agreed that staff should be aware of such a possibility if it is in the care plan, and he was also clear that if he had known of this part of Mr Brown's care plan then, for his part, he would not have left Mr Brown in the lounge with other residents unsupervised.

(32) Mr Livingston was cross-examined by Mrs Glen for the family of Mr Hutchison. He stated that of the 30 residents on the bottom floor, a maximum of 10 would need "pressure care" at about 8 pm or 8.30 pm. These were residents who were lying down all day and had to get some relief. Two carers would have to deal with each resident, and this would involve the use of a hoist. The other 20 residents would not be able to put themselves to bed and all would need assistance to some extent. The bedding process would start at about 8 pm or 8.30 pm, but there was no objective to try to have everyone in bed before the nightshift came on at 9.30 pm.

(33) It was up to each care assistant to use their discretion to read care plans. The matron of the home never checked to see if Mr Livingston had read any particular care plans, although he would have been seen reading them. He agreed that it was an essential part of the care of any resident to have read the care plan in full. He was asked to try to make sure he read the care plans, but no check was carried out to ensure he had done so.

(34) He was confident that Mr O'Hara and Mr Legge could be relied upon if giving an account of something that had just happened. In his opinion Mr Brown was quite strong and a lot younger than other residents.

(35) Ms Fleetwood on behalf of the Care Commission cross-examined Mr Livingston. He stated that he never felt over-worked because of staff shortages, and never felt torn between supervising the lounge or seeing to the needs of residents. If he had to leave the lounge there was usually someone there to take over. He was aware that Mr Hutchison had had some falls during his stay in the home.

(36) Mr Livingston was cross-examined by Mrs MacPhail on behalf of Tayside Health Trust. He stated that when he heard the noise of a disturbance in the lounge he was about 20 yards from the door of the lounge. When he got into the lounge Mr Brown was seated and he was quite clear that whatever had happened must have happened with Mr Brown sitting down. He agreed that EMI homes catered for very frail residents who could be a very challenging group to look after. Mr Livingston had had to use his self-defence training while at Tullideph but not with Mr Brown. Most

usually the need had arisen because a resident was lashing out at him or another carer or at another resident. In his opinion residents lashing out was not unusual and happened all the time.

(37) Mr Livingston was cross-examined by Ms Bennett on behalf of Four Seasons, the company running the nursing home at Tullideph. He was sure that he was the first person to get into the dining room. He agreed that he might have said something different to the police but nevertheless was positive he was first there. After further questioning however, he conceded that Kath Stewart, the staff nurse on duty, might have got into the room before him or at the same time as him, but this was not his recollection. He was clear however that while Mr Brown was kicking out at Mr Hutchison the kicks were not connecting with Mr Hutchison. He was adamant that he saw no physical contact at all.

(38) Although the maximum number of residents was 60 the numbers could fluctuate if people died, and for other reasons. The early shift had the most staff because that was the busiest shift. Visitors and relatives visited during this shift. In addition doctors and other experts would come in to see residents. There were quite a few residents who could not communicate well. In relation to the patient Gretel Clark, she liked to touch things. She liked to walk about and stoop as if picking up imaginary flowers off the patterned carpets. She had occasional falls. Mr Livingston had little involvement with Andrew Brown who was not a resident in his area. When sitting in the lounge he would normally be sitting quietly having a cup of tea.

(39) The manager of the home was Mrs Joan Downie. Care assistants knew that they were not to leave the lounge unsupervised. They knew that that was one of the rules. The lounge area was approximately 30 feet by 30 feet. Mr Livingston agreed that if a resident was at one end of the lounge and fell, a care assistant at the other end of the lounge would not be able to stop that happening. Care assistants were expected to read the care plans. They were told this by the nurses. Mr Livingston tried to read all of the care plans but could not recall if he had read Mr Brown's. It certainly seemed unfamiliar to him, but this was not surprising perhaps given that Mr Brown had only been in the home 3 or 4 weeks. Mr Livingston agreed that falling was one of the hazards for residents given that they were all frail. Mr Livingston agreed that for new staff there was a mentoring process. He did not get allocated a mentor but others did. He thought this was for six months but it might have been three months. Training in moving and handling residents was an ongoing process.

(40) In re-examination by the fiscal Mr Livingston indicated that he had managed to stop people falling on a few occasions. He agreed that if he was in the lounge and someone was shuffling towards Mr Brown he would have been able to stop this, but not every incident could be prevented even with someone supervising.

(41) The next witness was Kathleen Stewart. She stated that she was aged 51 and was Deputy Manager of the Tullideph Nursing Home. She stated that she had worked in the home for almost eight years and had been Deputy Manager for three and a half years. She stated that she was a Registered Nurse for the mentally handicapped.

(42) She was on duty on 3 December 2002 at approximately 9 pm. She was in the nursing office next to the residents' lounge (the day room) on the ground floor. She left the nursing office and went towards the door of the lounge which was a few feet away from the door of the nursing office. She was in the company of a care assistant called Betty Smith. She was getting a report from Betty Smith in order to pass it over to the nightshift staff. She was asking Betty Smith if Mrs Smith had anything of note to tell her about any of the residents. When a new shift took over there was provided a written report and a verbal report. Betty Smith was providing her with information for Mrs Stewart to write into the daily update report. When the new shift came on duty the report was given in the nurses' room and could take about 10 minutes to provide depending on how much there was to report. In any event Mrs Stewart was in the process of asking Betty Smith if she had anything to report. Betty Smith said no. Nothing much had happened on the shift so that obtaining the information from Betty Smith only took a matter of a few seconds.

(43) Mrs Stewart explained that that evening there were ten staff on duty on the late shift, namely three trained staff (i.e. nurses) and seven care assistants. On the ground floor there were, out of this total, four care assistants and two trained staff, with the other three care assistants and one trained staff nurse on duty upstairs.

(44) In any event Mrs Stewart came out of the nurses' room into the short corridor approaching the lounge door. Betty Smith came out of the lounge in order to give the report having been asked by Mrs Stewart whether she had anything to report. Mrs Stewart and Mrs Smith were standing at the lounge door. They then heard a thud followed by another thud. At this point both of them rushed into the lounge. Mrs Stewart saw James Hutchison lying on the floor. Gretel Clark was getting up on to her feet having been on the floor. Mr Hutchison was obviously in some discomfort. He was on the floor by the window on the right hand side as one entered the lounge. There was a row of chairs positioned in front of the windows. Mr Hutchison was near to Andrew Brown who was sitting in a chair in the lounge. He was at Mr Brown's feet. Mr Brown seemed to be quite frightened and was kicking out with his feet towards Mr Hutchison. In the opinion of Mrs Stewart it was difficult to say if any contact was being made. She thought there might be slight contact but the distance between them was such that Mr Brown was not close enough to Mr Hutchison to make any "great" contact. Mr Brown was seated in a chair which was in the row of chairs in front of the window but his chair was set further back from the others. There were about nine or ten residents in the room. The other residents on the ground floor had either gone to bed or were in the corridor of the home.

(45) One of the residents in the lounge was Mr O'Hara. Mrs Stewart could not remember what he was saying but he was shouting and was upset at Mr Brown about what was happening. He was pointing at Mr Brown and shouting. Mr Brown was not speaking. Mr O'Hara was shouting something like "They've fallen. It was your feet". Mrs Stewart said that Mr Brown had a habit of sitting with his legs straight out in front of him and that was why his chair was pushed back away from other chairs. She said he was quite a tall man.

(46) Another resident in the lounge at the time was William Legge. He was in a wheelchair on the left hand side just as Mrs Stewart entered the sitting room door. He was shouting for a nurse to come and help. Mrs Stewart checked Mr Hutchison

and made sure that Gretel Clark was OK. Mrs Stewart sat her in a chair. Mr Hutchison was moaning in pain and he was put on to his bed. An ambulance was called and he was taken to Ninewells. Mrs Stewart and Mr Livingstone took Andrew Brown into his room. He was very upset and agitated. She described him as a very nervous man with a very low pain threshold who tended to get nervous and frightened if any care staff were going to carry out any "intervention" with him. It was necessary to explain to him very clearly what was going to happen. In the opinion of Mrs Stewart, Mr Brown was not an aggressive person. When taken to his room after the incident he was agitated and upset. His limbs were moving and if she and Mr Livingstone hadn't moved out of the way they would have been kicked or lashed out at. He was left to calm down.

(47) Mrs Stewart confirmed that she had not seen anything that happened in the room immediately before the thuds which she heard. She said that she asked the other residents what had happened but none was able to give any coherent or reliable account. Mr O'Hara was saying that "it was him" pointing at Mr Brown, but did not say what Mr Brown had done. Mr O'Hara was not asked what had happened. Mrs Stewart thought that Mr Legge had been asked what happened and just said "They were on the floor" pointing at Andrew Brown. Andrew Brown said nothing. There was no formal interviewing of people to find out what happened. When Mrs Stewart left Andrew Brown's room Mr Livingstone was still there.

(48) Mrs Stewart was asked about the staffing numbers in the home. She stated that the rules of the home manager included a rule that there had to be one person in the lounge at all times to supervise. Other staff had to deal with other tasks, such as changing people, assisting residents to get to bed, etc, tidying laundry away, and so on. The backshift was at that time from 3 pm to 9.30 pm, although at some point it changed to 2.30 pm to 9.30 pm. Mrs Stewart was not sure exactly when the hours changed. Bathing of residents was usually done earlier in the evening than 9 pm. The residents had different needs and some only needed one carer to assist them get ready for bed while others needed two, but there was no doubt that as at 3rd December 2002 on the ground floor there was more than one resident who needed two carers to be put to bed. Mrs Downie, the home manager, had been on duty earlier in the evening but she had left before the incident.

(49) Mrs Stewart stated that it was the Care Commission which set the minimum staffing levels, and on this shift the minimum number was six care assistants and three trained nurses. In fact, on the backshift on 3rd December there had been three trained nurses and seven carers on duty. One of the trained nurses had been the home manager, Mrs Downie. She left half an hour early and the night duty charge nurse came in early to let her go. The evidence of Mrs Stewart was that care assistants could move between floors as required during the course of a shift. Mrs Stewart reiterated that the lounge should never be left unattended but stated that when she was speaking to Betty Smith, Ms Smith was at the doorway of the lounge and was therefore still able to supervise. Mrs Stewart could not say that the lounge never went unsupervised, e.g. if a care assistant was in the lounge and a resident got undressed in the corridor or fell, the care assistant would obviously get up and go to deal with an emergency like that, but Mrs Downie was quite insistent that as a general rule there was always a care assistant in the lounge. If a resident in the lounge desperately needed the toilet and could not go independently the care

assistant would take that resident, but would normally try to get another care assistant to take over. The toilet was nearby. If the care assistant in the lounge needed a break then they would get someone to take over. Each care assistant did about an hour at a time in the lounge rather than spend the whole shift there. Each care assistant had a 15-minute tea-break and a 30-minute meal break but the breaks were staggered so the lounge would still be supervised at all times. Mrs Stewart accepted that in an emergency the person in the lounge might have to attend to it. It was put to her that people visiting residents had stated in evidence that more often than not, the lounge was unsupervised. Mrs Stewart stated "That's what they say". She stated that, since 3rd December 2002, a system had been introduced so that at the start of a shift the person who went on duty in the lounge would be given a card acknowledging that they were supervising the lounge, and they would have to hand the card to another person to take over from them. The lounge would not even be unsupervised at the point of a shift changeover, because the oncoming shift trained staff would come on duty ten minutes before the end of the preceding shift, so there was an overlap.

(50) The evidence of Mrs Stewart was that at the time of the incident the care assistant Mr Livingstone was dealing with a resident and was not in the lounge. The recollection of Mrs Stewart was that Mr Livingstone came into the lounge while she was checking the condition of Mr Hutchison. She was not sure whether Mr Brown was still kicking out at this point.

(51) She stated that any visitor to the home, including doctors and experts, had to ring a bell at the front door to be allowed in.

(52) She stated that Tullideph was an EMI home, namely a home for elderly and mentally ill or infirm residents. All residents fell into that category. When a resident was admitted to the home, a care plan was drawn up. The resident was allocated a nurse, and the nurse would devise the care plan after observing the resident and consulting others within the home. If the resident came from another home, there would be a transfer letter explaining something about the needs of the resident and any medication which the resident was on. Information would also be supplied by the Social Work Department care manager, who provided detailed information in a form CCA2.

(53) Mrs Stewart was not sure of the precise dates but thought that Mr Hutchison had been in Tullideph since about 2000. He had certainly been a resident in Tullideph for all the time that she had been there, and she had known him for a couple of years. To begin with his wife was also a resident, and he came to the home to join up with her. In Mrs Stewart's opinion, Mr Hutchison was a nice man. He sometimes did not like to get up in the morning to get washed and dressed, and might get agitated. When the staff were trying to help him to get washed and dressed in the morning, he might strike out at them, but in the opinion of Mrs Stewart, he posed no major problems to staff. He was quite deaf, and if his ear was sore he would not use his hearing aid. He liked to wander around the home. He never caused a problem to any other residents. The type of agitation or grumpiness which he would show in the mornings was fairly typical of EMI residents. Mrs Stewart agreed that persons suffering from dementia could exhibit very challenging characteristics.

(54) In relation to Andrew Brown, Mrs Stewart confirmed that he had only been in the home for a matter of weeks by the time of the incident. He was a very nervous man who had had two or three strokes, which had left him debilitated. He could not speak and his mobility was poor. He had a low pain threshold. He stayed in his room most of the time, although he came to the lounge occasionally, but he did not really mix with other residents. He got frustrated. Mrs Stewart knew that his wife had been unhappy about the care Mr Brown was getting in a previous nursing home, Forebank, and had wanted him moved. This was why he came to Tullideph. When he was admitted to Tullideph, the staff there knew about his low pain threshold and his previous strokes. He was aged 72 and was therefore one of the younger residents in Tullideph. Mrs Stewart was aware that he was a very anxious man and was quite frustrated about his condition. Mrs Stewart was asked to describe any special measures that were used in respect of Mr Brown, to take account of his particular condition and his character. She stated that it was necessary to explain to him in detail, in advance, any intervention that was going to be carried out in relation to him, and not to approach him suddenly, e.g. to wash him or help him get dressed. He had to be given his own space which usually involved simply leaving him in his room, which is what he wanted. Mrs Stewart stated that she was not aware of any warning signs in relation to looking out for other residents.

(55) Mrs Stewart stated that she "would be aware of the content of Mr Brown's care plan". She was asked to look at Production 14 (Book 6, page 2430A), that part of Mr Brown's care plan which related to his difficulty in communication. She agreed that he could only communicate by expression and could not communicate his needs verbally. She explained that he wore a splint on one hand in order to keep his hand straight. This was because of contractions caused as a result of his strokes. She agreed that this hand would be painful. She agreed that at item 4 on page 2430A there was a reference to Mr Brown becoming physically aggressive towards staff. Mrs Stewart understood that this involved him grabbing the wrist of a carer if the carer approached him unexpectedly. She was then referred to page 2432A of the same production, which referred to Mr Brown being "prone to aggression and agitation". Her attention was drawn to numbered paragraphs 3 and 4 on that page, which referred to the possibility of Mr Brown becoming aggressive with staff and residents, and the requirement that Mr Brown should be supervised when with other residents because he could "push them over or throw items at them". Mrs Stewart stated that Mr Brown was not aggressive with residents but only staff, and again explained that this was because of his low pain threshold, which meant that he did not like his hands or feet being touched, and things had to be done slowly. She said that he could form the odd word but was not able to string sentences together. She was adamant that she was not aware of Mr Brown being violent to residents. She stated that she did not write the care plan, although she believed that she would have read it at the time Mr Brown was a resident. She said that she did not read all the care plans. Registered nurses made up the care plans. Mrs Stewart said she would make sure that the care plans were kept up to date. She pointed out that Mr Brown had only been a resident for a very short period of time. She said that she read the care plans when she had the opportunity during shifts.

(56) She agreed that she had responsibility for the home after Mrs Downie went off duty, because she was Deputy Manager. She agreed that she had responsibility to know what the dangers were for the various residents, but commented "Yes, but we

had 60 residents". She said that she would "hopefully" read all of the care plans when they had been compiled, but she could not say whether she had looked at this care plan or not. In relation to numbered paragraph 4 she said that she was aware if Mr Brown was sitting at the dining table and didn't want something he could swipe it off the table, but she had not ever seen him pushing anyone over and was not aware of any such incident. She said that "ideally" she should have been aware of the information on page 2432A. She said that all staff should be aware of the information in care plans.

(57) She was then directed to page 2433A of the same production. Her attention was drawn to three entries on that page. First of all there were two entries relating to incidents on 25 November 2002. In one, Mr Brown was noted as being aggressive and kicking a resident so that she fell to the floor. An accident form was filled in. Also on 25 November it was noted that Mr Brown was very aggressive towards female staff "spitting in their face and kicking out". It was also noted that Mr Brown kicked out at a resident as the resident was passing. The final entry of relevance was one dated 30 November 2002, which narrated that Mr Brown was trying to cover the mouth and nose of a resident "with a towel, forcefully". She also noted that there was an entry on 3 December 2002 relating to the incident involving Mr Hutchison. In any event Mrs Stewart conceded that she was aware of the incident on 30 November, although she only found out about it later, not being on duty herself. As far as the entry for 3 December was concerned which referred to Mr Brown kicking two residents causing them to fall, she felt that this had maybe not been a proper way to record the incident of 3 December. She suggested that this entry made by her was really just her surmising as to what had happened. Gretel Clark used to wander round trying to pick things up. Mrs Stewart had "surmised" that she had either fallen or tripped over Mr Brown's legs, that Mr Hutchison had gone to help her, and that he himself had then either fallen or been tripped. Gretel Clark had not been able to say what happened. Mrs Stewart said that she had been in the lounge shortly before the incident, and Gretel Clark and Mr Hutchison were wandering about.

(58) She was then directed to page 2435A which had an entry dated 28 November 2002 referring to Mr Brown having two falls. She agreed that she remembered Mr Brown falling and that his mobility was very poor. She was then referred to page 2444, part of Mr Brown's care plan which referred to his poor mobility and his risk of falling. She said that he needed to be helped to stand up out of a chair and that he had to use a wheeled tripod to walk, called a mobilator. She was also referred to page 2449, a referral form. This contained a note that on 3 December 2002 contact was made with Mr Brown's GP about his aggression. Mrs Stewart thought this had been done in the morning of 3 December before the incident in which Mr Hutchison was injured at 9 pm. She explained that the home had to contact a GP if the home was concerned about a resident's behaviour. It would be up to the GP to decide whether any particular specialist should be called in to see the resident, or whether medication should be prescribed, such as a sedative. Mrs Stewart recollected that Mr Brown's GP had not wanted to prescribe any sedative for his "anxiety and agitation and aggressive behaviour towards staff during interventions". According to Mrs Stewart she was given this information when she came on shift. She agreed that on 3 December 2002 as a result of the referral to the GP, Mrs Pat Bree and a Jane Meldrum visited the home to see Mr Brown. These ladies were attached to Mr Brown's GP's practice, and Mrs Bree was an expert in dementia. Ms Meldrum was

her assistant. At the time of the handover Mrs Stewart knew that these ladies were to visit, and when they arrived she spoke to them. When they left she understood that they were going to arrange for a Dr Semple, a psycho-geriatrician, to visit Mr Brown. Mrs Stewart's recollection also was that Mr Brown was to be given pain relief on a regular basis.

(59) Mrs Stewart stated that because Mr Brown spent a lot of time on his own in his room, another strategy which was decided upon at this stage was to get the Activity Co-ordinator to visit him to try to get him involved in activities which would help to pass the time and stop him getting bored. In response to her question about whether another strategy was to keep Mr Brown under observation because of his aggression, Mrs Stewart stated that "we were observing Andy at all times, just like all other residents". Mrs Stewart was adamant that she was not aware of any violence towards residents, and that it was "mainly staff, and swiping things off tables". She stated that this was consistent with his condition of dementia and was not abnormal. He was being monitored and was seldom out of his room. The only instruction given to staff was that he was to be observed and his chair was to be kept back from other residents.

(60) Mrs Stewart was then referred to a number of pages of the production, page 2461, an accident report dated 16 November 2002 relating to Mr Brown being found lying on the floor in his bedroom, page 2462, a similar report dated 21 November 2002, and page 2463, a similar accident report relating to Mr Brown falling when moving towards the dining room. Mrs Stewart summarised all of this as indicating that Mr Brown's mobility was not good, that he could get anxious and that in relation to the last incident he must have hurried up and fallen over. He would be checked for bruising, and in relation to the two bedroom incidents would be observed throughout the rest of the night. She was referred to page 2464 which related to an incident in the same sitting room as the incident on 3 December when Mr Brown was trying to grab hold of a chair, his tripod got stuck and he fell. Mrs Stewart pointed out that falls cannot be prevented on a 100% basis. She was then referred to page 2465 which related to the incident of Mr Brown trying to cover a resident's face and nose with a towel "forcefully" on 30 November 2002. Mrs Stewart did not know how this had happened. She was sceptical about whether the incident could have occurred as described in the accident report since Mr Brown had a bad hand, was slow at moving and could not really do anything forcefully. She could not imagine how he was supposed to have done this.

(61) She stated that as soon as Mr Brown came into the home it was realised that when he was sitting he stretched his legs out so the chair was pushed back in order to make things safe for other residents. Everyone was aware on the care side that he should be kept sitting back.

(62) Mrs Stewart was then referred to Production 17 (page 3058) which contained Mr Hutchison's care plan. She was referred to page 3061, a reporting record which noted that on 2 May Mr Hutchison fell, on 14 June he was very agitated, shouting, kicking, pulling and pushing, and that on 19 June he was recorded as being aggressive. All of these notes were in 2002. She was also referred to page 3063, which recorded that on 3 December 2002 Mr Hutchison was "knocked over by a fellow resident". Mrs Stewart described this as an assumption. She was then referred

to page 3097, part of the care plan indicating that Mr Hutchison should be kept clear of "trip hazards".

(63) Mrs Stewart stated that Gretel Clark had reasonable mobility. She was asked whether if several residents were up and moving around at the same time, one care assistant in the sitting room would be enough. She stated that all residents were at risk of falls and that ideally it would be wonderful to have more than one care assistant, but she pointed out that the one on duty could always call for assistance if necessary. She said that a lot of the residents wandered round the whole house and that all of them could not be accompanied at all times. Her view was that Mr Hutchison was as safe as he could be, and that he would need one-to-one supervision to guarantee 100% safety. She could not say that no resident would ever have a fall. She agreed that Mr Hutchison was at risk of falling and that Mr Brown was also at risk of falling, as well as at risk of showing aggression. She agreed that it would always be helpful to have more staff; but that the home always made sure it worked with the minimum number of staff requested by the Care Commission. While it would be nice to have more staff, she did not complain about staff numbers to her bosses. She agreed that there was a high turnover of care assistants in the home, and that this was not good for dementia sufferers who needed continuity of care. The care assistants had to be able to read the signs when a resident was trying to communicate. She said that some of the care assistants in the home had been there for over eight years, and some had been for two or three years, some had been for a year or so but some people were leaving after a week.

(64) In relation to the care plans, all she could say was that these were available for care assistants to read but she could not say whether the care assistants had read them. All care assistants were aware that they could read the care plans and should read the care plans. They should read the care plans when they had the spare time to read them. There were quieter periods when they could be read and the care assistants were instructed to read the care plans when they could.

(65) Mrs Stewart described how when someone started working for the first time as a care assistant at Tullideph, they spent their first day between 9 am and 4 pm being taken round the home to become familiar with it. There was then an induction process lasting some three months. They were provided with a handbook giving details of their responsibilities, and they were also allocated a mentor. On day one they were shown where the care plans were kept and were told to read them when they could. Only nurses made entries in the care plans. The care assistants kept their own records in their own files.

(66) Mrs Stewart was adamant that even having seen the care plans in court, she did not think that any more could have been done to maintain Mr Hutchison's safety. She stated that the home made sure someone was in the lounge at all times and that this person watched out what happened in the lounge. Mrs Stewart agreed that she could not see into the lounge but denied that Betty Smith was not able to keep matters under observation, since she was standing at the lounge door. Mrs Stewart had been in the lounge only five or ten minutes before the incident happened. She did not think the incident could have been prevented even with more staff. She did agree however, that if Gretel Clark and Mr Hutchison had been seen to be walking towards Mr Brown, then a care assistant could have, indeed would have, steered

them away from Mr Brown. So ultimately she agreed that if someone had been there and seen this happening then the accident could have been prevented.

(67) She was then cross-examined by Ms Glen. With hindsight, she thought that probably she should have gone into the dining room/lounge to speak to Betty Smith rather than call her out. She said that before the incident Mr Hutchison had been "wandering about" in the lounge, in the area of the wall on the left hand side opposite the side of the room where Mr Brown was seated. She was sure that Betty Smith was the first person to get into the lounge when the noise broke out. There was a lot of noise.

(68) She said that when Tullideph received a new resident from another care home, then Tullideph would receive a transfer letter from the previous home providing information about the resident, who his or her GP was, etc. Any resident would have a social work care manager dedicated to their case and Andrew Brown's care manager was Josephine Bell. Patricia Bree was a person attached to Andrew Brown's GP practice and had been dealing with his mental health problems before Andrew Brown came to Tullideph. Mrs Stewart was aware that Andrew Brown had been in Forebank before coming to Tullideph. She understood that his family was unhappy with the care that he was getting there, that items of his property had gone missing, etc. Mrs Stewart was not involved in deciding to accept Andrew Brown as a resident. She did not know if Tullideph received a report from his social worker when Andrew Brown was admitted. Normally Tullideph would visit the resident and carry out an assessment, and also obtain the social work care plan devised by the social worker before accepting a resident, but in Andrew Brown's case it was an emergency and any assessment had been done at Forebank.

(69) Mrs Stewart was shown production 12 (at numbered page 2149) and confirmed that this was the social work care plan prepared by Josephine Bell, the social work care manager, and according to Mrs Stewart it was provided to Tullideph on the day he was admitted as a resident, namely 13 November 2002. She explained that Mr Brown would have been received at Tullideph, either by the manager, Mrs Downie, Mrs Stewart herself or a staff nurse, and Mrs Stewart indicated that while she could not recollect precisely she would have thought that she probably did see this document when he was admitted. She said that her understanding of Mr Brown's situation was that, apart from anything else, he would have to have explained to him by staff any interventions they wanted to carry out in relation to him because he was easily startled and could lash out. She was referred to page 2151 of the same production and confirmed under the heading "Behaviour" there was a reference to this possibility and a recommendation that Mr Brown should be seated on the periphery of any room so that he was not in the path of other residents. According to Mrs Stewart the staff at Tullideph tried to implement this recommendation. She said Mr Brown did not spend much time in the lounge but when he did he was put on the periphery of the room, and every effort was made to make it safe for him.

(70) Mrs Stewart was adamant that Tullideph was during November and into December carrying out their own assessment of Mr Brown but that staff took on board the information contained in the social work care plan and made sure that all carers in the home knew about this situation and that Mr Brown was seated well out of the way if he was in a communal area. She said that residents lashing out at staff

was just something that happened in EMI units, and if this becomes a problem then at Tullideph the staff would consult the resident's GP or a psycho-geriatrician to get advice.

(71) On 3rd December 2002 once they got into the room and calmed things down, Betty Smith was left in the room with the residents. She was employed as a care assistant. Mrs Stewart was the only qualified person in the room. Mr Hutchison was taken to his own room for his own safety, away from what was going on. Mrs Stewart and one of the care assistants moved Mr Hutchison. Mrs Stewart wasn't sure if Mr Hutchison had any fractures but thought it was a possibility, but she felt it was not safe to leave him in the lounge where people were agitated and there was a lot of movement.

(72) Mrs Stewart was then referred to production 14, page 2450, part of Mr Brown's care plan records. She noted that Mr Brown's admission to Tullideph was recorded dated 13 November 2002, and that then there was an incident recorded on 14 November 2002 in the afternoon where it was noted that Mr Brown had been aggressive towards a fellow resident for no apparent reason, kicking out at this person when the person was passing. She confirmed that this record had been made by a member of staff called Elizabeth Johnston. Mrs Stewart confirmed that anything of note in relation to a patient was recorded in various parts of his Tullideph records. She stated that if the staff had any concerns about a resident, then staff would have a meeting with the resident's family and care manager, and if someone was being aggressive and could not be dealt with, then the GP or a psycho-geriatrician would be contacted. Once someone had been admitted to Tullideph there was a 6-week review period during which family members, GPs etc would be consulted while the resident's needs were assessed.

(73) The residents John O'Hara and Willie Legge had died since the incident in December 2002. Mrs Stewart indicated that when she went into the room Mr O'Hara was pointing and shouting "It was him" but was not saying what had happened. She saw Mr Brown kicking in the direction of Mr Hutchison and said that if there was any contact it was slight. Mr Legge was pointing at the floor and at Andrew Brown, and was shouting, but Mrs Stewart could not say what he was shouting. Mrs Stewart was then asked whether she had given a statement to the police on 12 December 2002 to a Detective Sergeant Ewan Cameron. She confirmed that she did and that she had signed the statement. She confirmed that her recollection then would be better than at the point of giving evidence. She was asked if she had told the police that when she went into the room she saw Mr Brown still in his chair kicking Mr Hutchison. She confirmed that she had said this, but said that what she really saw was kicking out rather than actually kicking Mr Hutchison. She said she could not remember now what Mr O'Hara said at the time but that he was pointing and saying "It was him". She thought this was Mr O'Hara trying to tell her what had happened. She was asked about her police statement where, it was said, she told the police that Mr O'Hara told her that Mr Brown had kicked Mr Hutchison. She said that Mr O'Hara might have said this but she could not now remember precisely what he had said.

(74) She said that Mr Brown was definitely kicking out as if he wanted to move Mr Hutchison away from near his feet. She thought there was probably some contact

but she felt Mr Brown was not really close enough to Mr Hutchison to make any real contact. She was asked about her statement to the police where it was alleged that she had said that William Legge told her that Mr Brown tripped up Gretel Clark and then kicked Mr Hutchison. She did not recall now that that was what had happened, but she agreed that Mr Legge might have been shouting that if that was what she had told the police at the time.

(75) She said she called 999 right away and then wrote up a report later in the same day. She would have written it up in her office and written it up in Mr Brown's care plan and Mr Hutchison's care plan, as well as putting it into an accident report. She was referred to production 17, page 3142 of book 8, where she confirmed that this was the accident report relating to the matter in respect of James Hutchison on 3 December, and she agreed that it was recorded there "Jim was kicked and pushed over by resident Andrew Brown. He fell to the floor on his left side." She confirmed that she definitely saw Mr Hutchison lying on his left side. She was then referred to production 14, page 2433A of Book 6 where it was recorded at 3 December - "kicked two residents causing them to fall". These were the care notes for Andrew Brown, and she agreed that while she didn't see this happening she might have written it if Mr Legge and Mr O'Hara told her that that was what happened. She was then referred again to production 17 at page 3063 of Book 8, the care plan for Mr Hutchison, and agreed that it was recorded at 3 December that he had been knocked over by a fellow resident.

(76) Mrs Stewart was then cross-examined by Mrs Fleetwood on behalf of the Care Commission. She stated that at all times Tullideph Nursing Home was staffed to at least the minimum level required by the Care Commission. She was referred to production 25, a production lodged on behalf of the Care Commission (no 6 of their Inventory of Productions). She agreed that this was the staffing schedule for Tullideph effective from December 2001 and agreed that it was stipulated there that on the late shift between 2.45 pm and 10 pm there were to be a minimum of six care assistants and three trained nurses on duty. Her position was that she accepted that this was only the minimum level and that if more staff were needed then they would be recruited. She said that there were in fact seven carers on duty on the evening of the shift when the accident happened. The carers on duty would transfer between the two floors of Tullideph as and when the needs of residents required that.

(77) She indicated that in relation to the accident none of the residents were interviewed about what had happened because of their dementia. While someone with dementia might have lucid moments her view was that none of the residents in the room when the incident happened were at a stage of their illness where they would have been able to give an account of anything, since they all suffered from severe advanced dementia and all required intensive care.

(78) She agreed that with a group of residents all requiring intensive care then raised levels of staffing would certainly have helped, but there was no question of the home being "short staffed". The right numbers were in place as far as the staffing schedule set by the Care Commission was concerned.

(79) Mrs Stewart said that she did not have time every day to read the care plans for every resident. She said that she was not aware as at 3 December 2002 that Mr

Brown had previously attacked other residents. She said that it was decided after the accident to move him for his own safety and this had involved an exercise of professional judgement. She did not think that Tullideph Nursing Home could be described as generally unsafe. Because of the type of residents in the home accidents could happen, and her view was that one or two more staff members would not have made a difference. She then confirmed that because of complaints made about Tullideph Nursing Home there had been approximately 12 investigations by the Care Commission as well as the 6 regular scheduled inspections.

(80) Mrs Stewart was then cross-examined by Mrs MacPhail on behalf of Tayside Health Board. She said that EMI residents posed a number of challenges in terms of their care. They could become confused. They could be obstinate such as refusing to get dressed. They could also strike out if they did not understand what was going on. She said that Mr Hutchison himself was capable of lashing out in certain circumstances. In her view Mr Brown's behaviour was not markedly different from other EMI residents. She said that it was common for residents to fight with one another, push one another and get involved in altercations. This was partly why EMI residents required close observation.

(81) In her view it would be hard to say whether Mr O'Hara and Mr Legge could distinguish verbally between kicking as against kicking out. Even if what they saw was someone kicking out they might well describe it as actual kicking.

(82) When Mr Brown was admitted to Tullideph the staff were confident that they would be able to meet his needs. If the home had not been able to meet his needs because of his dementia then he would have to have been admitted to a psychiatric hospital.

(83) She was referred to production 14 at page 2433A of Book 6 and in particular an entry for 30th November 2002 where it was recorded "Andrew was trying to cover one of the residents' mouth and nose with a towel, forcefully. No injury to victim." Her view was that she could not imagine how Mr Brown could have used his hand in this way to put it forcefully over a nose or mouth. He had a deficiency in his hand and could not have done anything forcefully with it. Also he could not move out of his chair to stand up and therefore could not have got to another resident. If staff at Tullideph had not felt confident about being able to cope with Mr Brown's care and needs, then his GP would have been contacted. She was referred to production 13 at page 2325 of Book 6 and confirmed that these were the medical records of Mr Brown, retained by his GP, and stated that the entry for 3rd December 2002 was a record of the GP noting that nursing staff at Tullideph had been in touch requesting a visit to Mr Brown. It had been noted that he was agitated, aggressive and moody at times. It was noted that Pat Bree was to visit and that Mr Brown was behaving in an aggressive way. She was then referred to production 14 at page 2449 of Book 6 and confirmed that this was the other side of the telephone record just mentioned. These were the care notes of Mr Brown held by Tullideph and they recorded that on 3rd December 2002 the GP had been contacted about Mr Brown behaving in an aggressive way and that Pat Bree and Jane Meldrum had visited that same day as part of the GP response.

(84) Mrs Stewart was asked about Andrew Brown's ability to communicate and said that he could only say single words, usually yes or no, and if distressed would make a moaning sound and roll his eyes. She would be surprised if Mr Brown could have said "Yes, for kicking that bastard", the comment spoken to by Mr Livingstone.

(85) Mrs Stewart was then cross-examined by Mrs Bennett acting for Four Seasons Healthcare. She indicated that she only spoke to Betty Smith for seconds at the door of the lounge, long enough for Mrs Stewart simply to say "Is there anything to report?" and for Ms Smith to reply "No, everything's been quiet." After the incident Mrs Stewart and Ms Smith went into the lounge and Mrs Stewart was adamant that Mr Livingston came in last.

(86) Mrs Stewart described the philosophy of the nursing home with regard to the mobility of residents. She said that residents were free to walk about and treat the house as their own house. There was a policy of not using sedation on residents but rather allowing them to be free to wander as they chose. Walking about was encouraged. This meant that residents were at risk of falls and falls could never be absolutely prevented without one-to-one care. Mrs Stewart made sure that residents wore safe footwear and that the environment was free of hazards. This also included observation and supervision, but even with all of this falls could not be excluded. It was Andrew Brown's right to sit in the lounge because it was his house.

(87) She stated that people with dementia presented with challenging behaviour, and in the past she had had to deal with residents behaving aggressively towards other residents in the nursing home. She was referred again to production 14 at page 2433A of Book 6 and she agreed that the entries there appeared to be alarming in isolation but she was adamant that these were not unfamiliar entries to see and that people with dementia often displayed aggression. She was referred to production 17 at page 3149 of Book 8 which was an accident report relating to Mr Hutchison having been pushed off his chair falling to the floor on his face. This happened on 23 March 2002 and resulted in severe bruising to his nose and the side of his left eye. This was an example, said Mrs Stewart, of a typical incident. She was then referred to production 8, Andrew Brown's care plan at the Forebank Nursing Home, contained in page 21 of Book 1. In particular she was referred to the entry for 8 November 2002 at page 30, where there was a reference to Andrew Brown having been punched by a resident, and that Andrew Brown himself then kicked another resident. She said again that this was an example of challenging behaviour. In general terms she said that it was not uncommon for persons suffering from dementia to be aggressive to others.

(88) Mrs Stewart was asked about care plans relating to residents, and indicated that one of the nurses completed the care plan for a new resident with input from the care assistants, nursing staff and the Social Work Care Manager. The family would also have some input and the care plan would be reviewed every 6 months. It would normally be expected that the Social Work Care Manager would visit the home once per year.

(89) She was then referred to production 17 at page 3058 of Book 8 and confirmed that this was the care plan relating to James Hutchison. She was directed to page 3067 which concerned ensuring that Mr Hutchison had a safe environment round

about him, and also page 3071 which related to Mr Hutchison's communication needs. She said that in general all residents would have a care plan relating to being in a safe environment. This is a form of risk assessment. The care plans were updated on a monthly basis because the needs of the patient could change.

(90) She indicated that before the admission of a resident there would be a pre-admission assessment carried out either by her or Mrs Downie, but she was not involved in assessing or admitting Andrew Brown. She had no idea what documentation accompanied him to Tullideph from Forebank. At Tullideph they would have carried out their own care plan assessment over a 6-week period.

(91) She was referred again to production 12 at page 2149 of Book 5 which was the Social Work Care Plan for Andrew Brown. She had no recollection of ever having seen this document. She was referred to page 2151 of the document in which it was indicated that Mr Brown could lash out if he was upset, and that he would have to be seated away from other residents. She indicated that she would have been aware of this. She pointed out that the document was not dated. She noted that a report from Josephine Bell at pages 2153-2155 within production 12 was dated 3 December 2002 and therefore agreed with the suggestion that this could not have been handed over at the time of Mr Brown's transfer from Forebank. This document contained information about his low pain threshold etc.

(92) She was referred again to production 8 at page 21 of Book 1 and confirmed that this seemed to be the Forebank Nursing Home file relating to Andrew Brown. She was referred to page 43 of that file and agreed that this seemed to be the Social Work Department assessment of needs carried out in relation to Andrew Brown between 17 September 2002 and 20 September 2002 prior to his admission to Forebank. This would have been carried out by Josephine Bell. She was referred to page 53 of that document which contained an entry reading "Mr Brown has had recent outbursts of anger and has gripped a carer's wrist and sworn at her".

(93) She was then referred to other documentation within production 8, the records from Forebank Nursing Home, and she agreed that at page 41 there was a reference to Mr Brown possibly becoming agitated or angry and giving verbal or physical abuse. She noted that Mr Brown was recorded as being close to 6 feet tall and weighing less than eight-and-a-half stone. She said that Mr Brown was not sprightly, but was unsteady on his feet and his mobility was poor. She said that he was frail because he was very thin. He could grip with his hand. His verbal skills were very poor and he could really only say yes or no. She was referred again to Production 14 at page 2433A of Book 6 which contained a reference to the incidents on 25 and 30 November 2002. She insisted that she did not know about these incidents but that if she had been present at a shift handover she would have found out about them. She noted that at page 2465 of the record that it was noted that the latter incident was not reported to her but to an Elizabeth Johnston.

(94) She knew that Mr Brown had to be seated away from other residents and she saw him 10 minutes before the incident with Mr Hutchison and he was seated away from other residents. At that time his 6 week assessment had not concluded and it was not clear if Tullideph would be able to meet his needs.

(95) On 3 December 2002 someone contacted his GP and requested assistance and Pat Bree attended.

(96) She was then asked about record keeping within the home, and confirmed again that every resident had a care plan and that care assistants were required to read these. There was also a daily update diary and a communications book. There were also handover meetings at which the oncoming shift was told of anything that had happened. Care assistants also kept their own records. In Mrs Stewart's opinion however the handover meeting was the most important way of transferring information and usually lasted for 10 or 15 minutes.

(97) Mrs Stewart was asked about the records made after the 3 December incident. Her view was that Mr O'Hara and Mr Legge were not capable of giving an accurate account of events, whatever they might have said at the time. Whatever they said could not be relied on as accurate. They were confused men.

(98) She was then asked about staffing and supervision. She said that Mr Hutchison's family never complained about there being no supervision in the lounge. She agreed that recruiting and retaining care assistants was a problem, but in her view having more staff on duty could not have ruled out this incident, although she agreed that having more staff would help.

(99) She said that looking after people with dementia was a challenging task but that there were many positive moments in Tullideph. She said some people were pleasantly confused while others could be more aggressive. There was entertainment for residents as well as theme days and celebrations of all sorts of different occasions. There was a family support group.

(100) She also said that there was regular training at Tullideph, both in-house, at a college in Aberdeen and at a college in Edinburgh. This included courses in dementia and in dealing with challenging behaviour.

(101) She said that the staffing requirements had been reviewed and the skill mix had changed so that now 2 trained staff and 8 carers were required, whereas on the day of the incident on the particular shift it was 3 trained staff and 7 carers.

(102) In re-examination to the Procurator Fiscal she indicated that in her view in the private sector salaries for care assistants were not as good as in the public sector, and the same could be said for holiday entitlement. There was no pension in the private sector. She was aware that care assistants were fairly low paid but the same was true everywhere.

(103) In her view the handover was a very thorough way of passing on information but she agreed that she had never heard of the towel incident. In her view it was impossible to read every care plan.

(104) With reference to the incident where Mr Brown had kicked out at people in November she believed that this was possible if someone had come close to his feet. She did not think that there was any problem in Tullideph with care staff not speaking English. Sometimes when they came from agencies this was inevitable.

She referred again to Production 12 at page 2149 of Book 5, the Social Work Care Plan. She agreed that it was undated but said that she was aware of some of the content.

(105) She was asked by me about Mr Livingstone's suggestion that care assistants were allocated about 10 residents and read their care plans carefully. She said that this was not the system and appeared never to have heard of it. Again in response to a question from me she agreed that she had never agitated for extra staff.

(106) The next witness to give evidence was Dr David Sadler, a forensic pathologist with the Department of Forensic Medicine at Dundee University. Dr Sadler was an experienced pathologist. He was referred to Production 2, his post-mortem report dated 13 December 2002, relating to James Hutchison. He agreed that he had access to hospital records and a preliminary police report. He went through the report. The cause of death was given as atherosclerotic coronary artery disease with as what he described as a trigger factor the fractures of the left humerus and femur described as being caused by an indoor fall resulting in an operation, as well as senile dementia and acute bronchial pneumonia. In his post mortem report he reviewed the medical history of Mr Hutchison, referring in particular to the fractures of the left hip and left upper arm. In his view the fracture to the left hip would not be as a result of a kick but more likely a fall. A twist could also cause a fracture which could then lead to a fall. Both fractures were on the same side and were therefore likely to have been caused by a fall. There was nothing to indicate a violent, assaultative death. The bruising that he found could have arisen because of fractures.

(107) Dr Sadler found severe hardening and narrowing of the blood vessels supplying the heart with evidence of a previous heart attack and resultant scarring of the heart muscle. This heart disease was severe enough to account for death. There was no visible evidence of a fresh heart attack, but if there was a fresh heart attack with death occurring very soon after it then there would be no sign of that heart attack. His heart disease would account for the atrial fibrillation which had been noticed by surgical staff during his operation, but this was not a particularly significant matter on its own.

(108) As far as the pneumonia was concerned, in the view of Dr Sadler this was moderate in severity. It could have been caused by his immobility following upon the fracture, but in the opinion of Dr Sadler it looked as if it was pre-existing and then got worse after the surgery. This could have contributed to his death and could have caused death but the severe heart disease was a better explanation.

(109) Mr Hutchison could have been expected to die virtually at any time because of his heart disease, but commonly there was a trigger of some sort and this could be the fall resulting in the fractures on 3 December with the resultant stress caused by pain, being in hospital and the operation. In the view of Dr Sadler Mr Hutchison was essentially always on a knife-edge because of the heart disease. He would have survived for longer if he hadn't fallen. The fall essentially tipped the balance.

(110) Dr Sadler was referred to Production 7, the death certificate, which was issued immediately following upon Mr Hutchison's death. This was at page 20A of Book 1.

The cause of death there was given as primarily pneumonia with dementia as a secondary cause and then the fractured femur. In the view of Dr Sadler there could be a difference between the clinician's view of the cause of death and the pathologist's. A pathologist would be able to find, for example, the severe heart disease which existed in this case, whereas the clinician would not necessarily know anything about it. Dr Sadler was referred to Production 16 at page 2487 of Book 7. This was a letter in April 2002 from Ninewells Hospital to Mr Hutchison's GP referring to Mr Hutchison suffering from heart disease and suffering a small heart attack in March 2002 from which he made an uneventful recovery. Dr Sadler agreed with all of this but indicated that where there had been such an event there was always a likelihood of another attack.

(111) The next witness was Patricia Bree, aged 55. She was employed as a dementia liaison nurse by Tayside NHS. She had been a nurse since 1968 and had been involved specifically in looking at the care needs of the elderly between 1993 and 2004. Eventually she became the community care co-ordinator with Downfield Medical Practice, initially looking at the care needs of older people generally then this developed into looking at the specific needs of dementia sufferers. She had a Masters Degree in Dementia Studies from Stirling University.

(112) Her first contact with Andrew Brown was in 1997. He had a long history of strokes during his 50s and she had been involved in looking at his needs in a home setting. She saw him a few times at the request of either his wife or GP or Social Work Care Manager Josephine Bell, and Mr Brown had undergone a multi-disciplinary assessment.

(113) Concerns arose around 2000 or 2001. Up until then his care package had been working well but then there were two incidents, the first where he pushed a care assistant and then secondly when he lashed out at staff at a day centre when a member of staff tried to clean his face. Mrs Bree thought that his lashing out may have been an effort to communicate but in a non-verbal way.

(114) Mr Brown was admitted to Forebank Nursing Home eventually. Mrs Bree took him in the company of Josephine Bell. Mrs Bree's opinion was that Forebank would have been told about his aggressive behaviour by Josephine Bell. In the opinion of Mrs Bree it was vital to pass on such information since staff in care homes had to know about a resident's previous aggressive behaviour, the triggers which led to it and the non-verbal indications which there might be of an onset of an aggressive episode. Andrew Brown had a sore hand and a low pain threshold and when carrying out any intervention in relation to him it was necessary for a carer to speak to him, maintain eye contact and touch him in an appropriate way.

(115) In the opinion of Mrs Bree, care had to be taken not just in relation to care assistants but also in relation to other residents. If they were to approach or touch Mr Brown, particularly in an uninhibited way, this could lead to aggressive behaviour on his part. This was something that would have to be watched out for.

(116) Mrs Bree was not aware that Mr Brown had been transferred from Forebank to Tullideph until 3 December 2002 when the GP's surgery was contacted because Mr Brown was behaving in an agitated and aggressive way and was also refusing food.

As a response to this contact Mrs Bree attended at Tullideph Care Home at 3.30 pm on 3 December. She found Mr Brown sitting in the dining room. She had been told by a member of staff that Mr Brown had put a towel over another resident's face and had forcefully held it there with both hands. Mrs Bree noticed that Mr Brown seemed to have food on his face from a meal so she cleaned him. She asked if he was in pain and he indicated that he was. She asked if he wanted to hurt people and he indicated that he didn't. He appeared calm but was crying silently. She left some time after 5 pm. She returned to the practice and spoke to the GP, and the decision was made first of all that Mr Brown should be given pain relief regularly, rather than as required since he was not always able to ask for pain relief. Next it was decided that he would be seen by a psychiatrist, and then finally it was decided to make sure that there were no physical health problems leading to his behaviour. Mrs Bree was not in a rush however to proceed to prescribing any sort of sedatives for Mr Brown without a full assessment.

(117) Mrs Bree was asked to comment about residents in EMI homes. She said that such residents were quite demanding from the perspective of nursing and general care. They had complex physical, psychological and emotional needs. In the experience of Mrs Bree, EMI units would normally contact her or the GP practice if they needed advice or support in relation to a resident.

(118) Mrs Bree was cross-examined by Ms Glen. She confirmed that prior to Mr Brown being admitted to Forebank she was aware of two incidents of aggression which she thought were around 2001 and 2002. Because of the aggressive behaviour in Menzieshill Day Centre, Mrs Bree had been led to believe that his placement in the day centre might be in jeopardy.

(119) Mrs Bree was referred to Production 11, described as the care plan and notes relating to Andrew Brown, and in particular page 1766 in Book 4, where there was an entry dated 8 October 1997, which referred to Mr Brown being physically and verbally abusive to a member of staff. Mrs Bree thought that this might refer to Menzieshill House, a respite centre. She thought that she might have been given this information at the time it occurred. She was then referred to the same production at page 1531 where there was an entry dated 16 November 2000, where there was a reference to Mr Brown being cleaned by a carer but becoming very aggressive and punching. The reason for this was noted as his hand being very painful. Mrs Bree was then referred to Production 12, Social Work records relating to Andrew Brown, and in particular pages 2233-2234 in Book 5 where there was a reference to an incident on 28 February 2001 at Menzieshill Day Centre where Mr Brown was recorded as lashing out at a carer and striking her on the throat with his fist at the point when the carer was going to be helping him with exercises. She was then referred to Production 11 again in Book 4 at page 1446 where there was a note of an incident on 10 May 2001 at Menzieshill Day Centre where Mr Brown was recorded as lashing out "at the nearest person" and scratching a Social Care Officer on the arm. This was when there was an exercise underway with a parachute and a ball, and the ball accidentally hit Mr Brown on the head waking him up. Mrs Bree was then referred to another page of Production 12 at page 2235 of Book 5 where again an incident was recorded as taking place on 6 June 2001 at Menzieshill Day Centre when Mr Brown was being helped to sit in a chair but stumbled and lifted his fist as if he was about to strike a Social Care Officer. In general terms Mrs Bree indicated that

she was not aware of any of these reports going to the GP practice. She agreed that collaboration between different agencies was necessary and that communication was an essential part of anyone's care package.

(120) Just before Mr Brown was admitted to Forebank there had already been an arrangement made for Mr Brown to be assessed for a psychiatric day hospital to look at his mood and mental state. He was due to attend this but was admitted to Forebank instead. Mrs Bree was referred again to Production 12 at page 1980 of Book 5, the Social Work Records, and agreed that on that and the subsequent page there was a minute of meeting dated 29 August 2001 at which Mr Brown's aggressive behaviour at Menzieshill Day Centre was discussed. Mrs Bree indicated in general terms that she remembered the meeting and agreed that the question of his pain relief was discussed as the way forward.

(121) Mrs Bree said that she went with Andrew Brown to Forebank to reduce his distress and assist him to walk. She was not contacted by Forebank before his admission, but there was no need for this unless they wanted advice or assistance, for example if his behaviour had altered while they were looking for advice or training on how to handle him. Normally his situation would have been reviewed after six weeks but he didn't stay in Forebank long enough.

(122) Mrs Bree was then referred to the records of Forebank Nursing Home namely Production 8, Book 1 at page 24. She agreed that Mr Brown was admitted to Forebank on 20 September 2002 and her attention was then drawn to an entry for 22 September 2002 referring to Mr Brown becoming aggressive when his personal hygiene was being attended to and punching a care assistant twice on the head. She was then referred to an entry on the same page for 27 November describing Mr Brown as pushing people away, and then a further entry on page 25 for the date 1 October 2002 referring to him kicking a fellow resident in the stomach when the resident was passing him, and the resident falling heavily to the floor. When another resident went to assist Mr Brown was noted as telling her to watch or she would get the same. Mrs Bree indicated, her attention having been drawn to these entries, that she would have liked to have known about them at the time that they happened because if a resident was behaving in this way then there was a need for a risk assessment, a psychiatric assessment which might have led to his being assessed within a psychiatric unit.

(123) She was then referred to page 29 of the same production where there was noted at the foot of the page for 4 November 2002 that Mr Brown kicked another resident in the stomach, and then on page 30, on 8 November 2002 it was noted that Mr Brown was punched in the head by one resident for no reason, and that a few moments later another resident was walking past Mr Brown when Mr Brown kicked this person in the stomach. The view of Mrs Bree was that Mr Brown should have been re-assessed as a result of these incidents. Her attention was then drawn to an entry for 10 November relating to Mr Brown throwing hot soup over a fellow resident for no obvious reason, and then on 10 November a reference to Mr Brown kicking his table over after lunch. Again Mrs Bree indicated that she had never been informed of any of these incidents.

(124) Mrs Bree then repeated that she was not told about Mr Brown's move from Forebank to Tullideph, which took place on 13 November 2002. Mrs Bree's opinion was that she should have been told about the move.. She was referred to Production 14 at page 2450 of Book 6, the Tullideph Care Plan and notes in relation to Mr Brown. Her attention was drawn to an entry for 14 November 2002 in the afternoon, where there was a reference to Mr Brown being aggressive towards fellow residents and kicking out at them when they were passing.

(125) She was then asked to look at page 2433A of the same records. First of all there was an entry for 24 November 2002 noting that Mr Brown had been very aggressive towards female staff. There was then an entry for 25 November 2002 where it was recorded that Mr Brown had been aggressive and had kicked a resident as a result of which she fell. He was described again as being very aggressive in the morning towards female staff, spitting in their face and kicking out at them, and also kicking out at a resident as the resident passed. There was also a reference on 30 November 2002 to the towel incident mentioned before. Mrs Bree remembered that it was this last incident which triggered a call to the GP, however she was quite clear that she had not been told about any of the earlier incidents and her clear evidence was that she should have been, and that if she had known that the towel incident was coming at the end of all of these other incidents then she would have taken a different view of his care. When she attended at the care home on 3 December she was only told about the towel incident. She was not asked to look at his care plan where, had she looked, she would have seen these references. All she was told was about the towel episode and that in general terms Mr Brown had been more aggressive and agitated, and that he had not been eating well. She found it difficult to imagine the towel incident, given what she knew about Mr Brown's physical capabilities. When she saw Mr Brown he was not aggressive but passive. He was crying. What she felt at the time was that his care needed to be reviewed and he needed to be seen on a daily basis. She would have arranged for a GP or consultant psychiatrist to review him. On the information available to her at that time she could not have had him admitted to a psycho-geriatric ward. If she had known about these other incidents she certainly would have suggested that he had someone with him all the time.

(126) Mrs Bree was cross-examined by Mrs MacPhail. Mrs Bree confirmed that her involvement with Mr Brown first began in 1997 when she was one of those who carried out a multi-disciplinary assessment of him in his own home. It was between 2000 and 2001 that she became aware that he was less tolerant to intervention and that he suffered from low mood. She confirmed again that she attended a review meeting in August 2001 when his placement at the Menzieshill Day Centre was at risk, and she agreed that at the review meeting it was decided that he would be re-assessed by a psychiatrist.

(127) She was then referred to various productions making it clear that following upon the meeting on 29 August 2001 she wrote to Dr Cuthill, consultant psychiatrist at Dundee Royal Liff Hospital, who was due to be seeing Mr Brown at his doctor's surgery. In the letter she explained her most recent assessment of the deterioration in Mr Brown's behaviour. She was then referred to page 2300 of the same Production which was Dr Cuthill's letter of 5 October following upon his assessment of Mr Brown. This letter suggested assessing Mr Brown at the Ashludie Day

Hospital, which was what Mrs Bree had suggested might be appropriate. Like Mrs Bree, Dr Cuthill obviously did not feel that the situation was an emergency one requiring immediate admission to a psychiatric hospital. Mrs Bree then explained that Mr Brown was not admitted to the day hospital because he developed dehydration and had to be admitted to hospital. Page 2362 of the same Production was a letter from Dr Sheila McLean , Senior Clinical Medical Officer at Dundee Liff Hospital, explaining that she had assessed Mr Brown's situation in Royal Victoria Hospital, and clearly from the terms of the letter did not conclude that he had to be transferred to a psychiatric hospital at that stage. What Dr McLean suggested was that a community psychiatric nurse might monitor his progress once he returned home. Page 2357 of the same production was a letter to Dr McLean from the community mental health nurse dated November 2001 indicating that she had visited Mr and Mrs Brown at home in late November 2001. In that letter his periods of physical aggression were described as "usually minimal".

(128) Mrs Bree had difficulty remembering when her next involvement with Mr Brown was but she was directed to the same production at page 2327 where there was a note dated 17 September 2002 in her handwriting, indicating that Mr Brown had physically assaulted a carer who came into his home to look after him, and that there was a crisis and that his wife was requesting his admission, possibly to the care setting of a nursing home rather than a psychiatric unit. The note recorded that Mrs Bree contacted Josephine Bell the Social Work Care Manager who would try to see Mr Brown urgently.

(129) Mrs Bree was then referred to page 2298 of the same production, a letter from the consultant psychiatrist David Findlay dated 9 September, explaining that he assessed Mr Brown at his home on 6 September. The letter was suggesting a referral to a day centre. Mrs Bree explained that this in fact never happened because Mr Brown was admitted to Forebank.

(130) He was admitted to Forebank on 20 September. He could be assessed at Forebank. His wife really needed 24-hour care for him because she could no longer meet his needs. Mrs Bree had no doubt that at that time given her state of knowledge she believed that this was the most appropriate course for Mr Brown.

(131) Mrs Bree explained in general terms that Forebank and Tullideph were privately managed care homes outwith the authority of Tayside Health Board. Tayside Health Board had previously been involved in monitoring such care homes but for some time they had been monitored by the Care Commission for Scotland. Once a patient was admitted to a care home Mrs Bree would expect the staff at the care home to contact her if there was a problem, but not otherwise. She explained that she had only rarely been involved in a pre-admission assessment and was not involved in any assessment of Mr Brown prior to his admission to Forebank. She would have been contacted during the 6-week assessment period thereafter but only if the care home thought it appropriate. There was no mechanism for her to know what was going on in Forebank or Tullideph unless the staff there got in touch with her. If she had known then she would have consulted the GP and Dr Findlay to consider a further risk assessment. The needs of people with dementia could change quite rapidly from hour to hour and had to be re-assessed constantly. She had no dealings with Andrew Brown at Forebank after he was admitted.

(132) As already explained she did not know that Mr Brown was transferred to Tullideph and she would have hoped that someone would have let her know. As far as she was aware, any care home would undertake an outreach visit prior to admission to see whether they could meet the needs of the patient. 3 December was the first time Tullideph contacted the GP practice about any problem.

(133) She was referred to records relating to 3 December, namely page 2325 of Production 13, the medical records of Mr Brown. On that page there was an entry dated 3 December, referring to contact from the nursing staff at Tullideph requesting a visit because Mr Brown was agitated, aggressive and moody, as well as not eating. When Mrs Bree attended at Tullideph she spent one and a half, or slightly more, hours with him and then went back to the GP's practice and asked for an urgent psychiatric assessment. She was referred to page 2340 of the same production, a letter dated 4 December 2002 from her GP practice to Dr Semple, a consultant psychiatrist, asking for Mr Brown to be assessed urgently.

(134) When Mrs Bree left the nursing home on 3 December she did not believe that Mr Brown needed to be urgently assessed that evening, nor that he had to be kept in his room until he was assessed. If however she had known the truth of all of the incidents of aggression displayed by him in Forebank and Tullideph she would have acted differently.

(135) Mrs Bree explained that she had now become part of a community mental health team for old people, and that she was now involved in developing services for people with dementia. This was happening on a nationwide basis and there were now LINK nurses attached to each of the nursing homes within Dundee City. If there was a crisis in relation to a resident in a care home then the LINK nurses would work with staff to try to resolve the problem. The system still depended however on staff contacting the LINK nurses to explain that there is a problem.

(136) She was then cross-examined by Mrs Bennett and explained that the care package developed by Mr Brown's care manager was to address his social and health needs. When Mr Brown was at home his wife had assistance, commissioned by the Social Work Department, as well as support with his physical care and emotional support. Mr Brown's admission to Forebank on 20 September was something of an emergency. Page 41 of Production 8 in Book 1, his pre-admission assessment for Forebank, showed that Forebank was aware that he was going to be assessed at the day hospital, albeit this did not take place. Forebank were also aware of Mrs Bree's involvement with him. Mrs Bree agreed that nurses in an EMI home were not dissimilar to nurses in psychiatric hospitals. She was referred to page 49 of the same production, Mr Brown's care plan, which showed that it was clearly noted that staff were to monitor Mr Brown's mental health and contact his GP if concerned. Page 53 of his care plan also showed that Forebank were aware of his outbursts of anger. This care plan was technically known as a "CCA2" form which was compiled by his Social Work Care Manager, and at page 43 it was clearly stated as having been compiled between 17 and 20 September 2002.

(137) Mrs Bree agreed that aggressive behaviour was not unusual in dementia sufferers. She felt that perhaps Forebank developed strategies to deal with the aggression and perhaps thought they could cope with it. If the aggression was

predictable one could try to avoid the triggers which set it off but if it was unpredictable then it was more difficult and assessment was required. Dementia sufferers liked familiarity and routine. This period in Forebank was Mr Brown's first time away from home, and Mrs Bree might have expected a period of lack of settlement. Mrs Bree had no doubts about the appropriateness of admitting Mr Brown to Forebank.

(138) Mrs Bree was referred to page 37 of the Forebank Care Plan where there was a reference to a review meeting on 23 October 2002. Mrs Bree was not invited to be involved in that review.

(139) The view of Mrs Bree was that the strategies adopted by Tullideph in relation to Mr Brown, namely to sit him away from other residents and not to intervene with him suddenly, were perfectly sensible. Her feeling was that their policy of allowing residents to walk about and use communal areas without interference was a perfectly good policy. She also agreed with avoiding the use of sedation unless absolutely necessary. She was referred to certain guidelines designed by the Scottish Intercollegiates Guideline Network in relation to dementia sufferers and these guidelines suggested that there should be behavioural interventions with residents, rather than pharmacological. In particular it was always a good idea to look into the physical causes of bad behaviour rather than immediately resort to pharmacological intervention. She agreed with this.

(140) The next witness to give evidence was Dr Manhal Nassif, aged 44. He was a consultant orthopaedic surgeon from Ninewells Hospital, with appropriate professional qualifications and experience. He was referred to Production 16 at page 2483 in Book 7, namely the Ninewells medical records relating to the care of Mr Hutchison, and in summary he indicated that given the injuries which Mr Hutchison had when admitted to Ninewells, there was no alternative but to operate on his hip fracture. The operation had to be delayed because of his chest infection and therefore high temperature so antibiotics were prescribed. He also had a urine infection. By 6 December his condition seemed to have become satisfactory and therefore the operation took place, but Mr Hutchison died on 11 December 2002 at 11 am. Dr Nassif was clearly of the view that delaying the operation to treat the infection was in the best interests of Mr Hutchison.

(141) In the opinion of Dr Nassif the injuries sustained by Mr Hutchison were likely to be the result of a fall mechanism rather than a kick. Both injuries were on the same side of the body. The mortality rate in the elderly after fractures like this was unfortunately fairly high, and increased where there was a pre-existing heart condition and where the victim was over 90.

(142) The next witness to give evidence was Mrs Joan Downie, aged 61. She explained that she was the manager of Tullideph Nursing Home and had been the manager for almost 9 years. She confirmed that the home was an EMI unit with 60 residents and was usually 98% full. She believed that in December 2002 the home was likely to have been full.

(143) She explained that when consideration was being given to a resident to be accepted into Tullideph as an EMI home, that person's care manager would be

involved in the process. Mrs Downie would try to obtain as much information as possible about the potential resident in relation to their physical and mental health, whether they had been seen by a geriatrician, whether they were for example blind or in some other way incompetent. The idea of the assessment was so that the home would be able to consider if it could meet all the needs of the resident.

(144) Four Seasons Health Care took over Tullideph Nursing Home from a different company called Tamaris in 2002, but Mrs Downie was manager of the home under both organisations. Tullideph was a private home and the cost of residents' care there was either paid for privately or by the local authority. There was a flat fee for each resident which did not alter according to the needs of the resident.

(145) The minimum staffing levels were set by the Care Commission. On the early shift Mrs Downie would be on duty as well as three trained staff and eight carers. On the late shift there would be three trained staff and six carers and on the nightshift two trained staff and four carers. The home did not function below these levels. If there was a particular need because of a situation in the home to have extra staff then it would be possible to approach the Regional Manager of Four Seasons and ask for authority.

(146) There was a high turnover of care assistants because the job of a care assistant in an EMI home was hard and demanding. Tullideph was a particularly busy home because of the complex needs of the residents and the geographical layout of the home with 60 single rooms spread over two floors. Mrs Downie conceded that it was difficult if not impossible for there to be total observation of all the residents at all times.

(147) As far as pay was concerned Mrs Downie did not set the wages and thought that all carers in private nursing homes in Dundee were paid the same amount. She thought that the pay levels were low and that that had something to do with the high turnover of staff. She agreed that a high turnover of staff was not ideal for residents because of the lack of continuity of care.

(148) Mrs Downie then described the process for recruiting and training new staff, and also explained that if there was a member of staff ill at short notice then the home could contact an agency to get a temporary care assistant.

(149) On the changeover of one shift to another there was a handover at which the staff coming on duty were told of anything significant that had happened during the previous shift. This normally took 15-20 minutes. The outgoing trained staff gave a report to the incoming trained staff and then one member of the trained staff who was coming on duty gave a report to the care assistants coming on duty. There was also a diary and a communications book in which notes were kept of any significant matters and all staff had access to these records.

(150) The care plans for all residents were available 24 hours per day. The staff were not required to read the care plans every day. The staff nurse was expected to fill in at least one entry every day on each resident's care plan indicating how the day had gone. Care assistants were required to read the care plans if they are unfamiliar with the care which was to be given to any particular resident on a given day.

(151) The home was divided into four areas and each area was allocated a trained nurse who was responsible for formulating the care plan for the residents in that area. The staff knew every resident because they were long-stay residents and staff tended to get to know them well over a period of time. The trained staff were fairly static and had been there for a while. The care assistants would not necessarily know the residents as well as the trained staff.

(152) When a new resident was admitted a staff nurse would formulate a care plan based on information from the family, the pre-admission assessment and any information coming from a community psychiatric nurse or GP and also from the Social Work Care Manager. The Social Work Care Manager sent a copy of his or her own care plan for the person to the home. This usually addressed social needs rather than nursing needs. When the pre-admission assessment was done by the home, the home did not have access to medical records but would sit down with family and staff from any other hospital or institution or a staff nurse at another care home, depending on where the resident was coming from, and discuss the resident's needs. The pre-admission assessment took about an hour and went into all aspects of the care plan. The staff nurse responsible for that resident in the care home would be expected to have read the care plan and pre-admission assessment, but care assistants would not be expected to have read this assessment.

(153) There were certain portions of the care plan in the nursing home which carers had to complete about the day-to-day care of the patient, and the care staff knew that they could come into the office at any time and read the care plans for any resident. They were told that if there was a new admission they had to come and familiarise themselves with the care plan for that person. Mrs Downie indicated that she personally made herself familiar with the care plans for the 60 residents, and said that she had "probably" read all of them.

(154) On 3 December 2002 Mrs Downie had been on duty during the day but left at about 8.30 pm or so. She described the downstairs lounge as being like the hub of the home and very popular for residents to be in. The residents tended to wander all over the house. At all times there should be one member of staff in the lounge. The other members of staff could be bathing residents, helping them to go to the toilet or putting them to bed. Mrs Stewart, the Deputy Manager, would be checking that all residents were comfortable and asking if there was anything to report, and then would be writing up the care plans for the residents.

(155) Mrs Downie agreed that it might take two people to bathe a resident depending on the circumstances of that resident, and if two people were away doing that then there would be three assistants left. One could be in the lounge, one writing up the care plans and then somebody else giving out drugs or changing dressings or whatever. If a resident needed to go to the toilet then some people were able to do that themselves but others required assistance, possibly even of two care assistants.

(156) Mrs Downie agreed that if someone needed to go to the toilet then the person supervising the lounge might have to leave the lounge for a few minutes. If the person supervising the lounge had to leave to go to the toilet themselves or something of the sort then that person would be expected to get somebody else to take over the supervision of the lounge. Mrs Downie could not guarantee that there

would be somebody in the lounge observing residents all the time, but this was the objective. She agreed that it might well be correct that visitors to the home might very occasionally find that there was no member of staff in the lounge. She agreed that probably every manager of a care home wished that he or she had more staff and she agreed that ideally there would be someone in the lounge at all times for observation of residents, for their safety, to observe their behaviour and that they were enjoying their activities, but her view was that even if there was no-one actually in the lounge at a given moment, the safety of the residents was not diminished as there would always be a member of staff in close proximity. She was not aware of visitors having to go searching for members of staff to come to meet the care needs of a resident in the lounge.

(157) She agreed that the safety of residents could be compromised if there was no member of staff in the lounge and then someone whose mobility was poor got out of their chair and started moving around, or if someone whose behaviour was challenging was not seated away from other residents. Challenging behaviour was however common in EMI homes.

(158) Mrs Downie said that James Hutchison had been in Tullideph for a long time. His wife had also been in the home at the same time as him at one point. The staff at Tullideph had a good relationship with the Hutchison family. Mrs Downie was aware that he had previously had a heart attack and had recurrent chest and ear infections. He was usually an agreeable man but could be aggressive in the mornings when getting bathed or toileted. She thought that he had been in the home for about three years.

(159) She was asked what risks there were to the safety of Mr Hutchison and she indicated that he was a frail man but that he enjoyed walking around. He had befriended another female resident who he thought was his late wife. Mrs Downie agreed that he was at risk of falling because of his frailty and that he was also deaf.

(160) As far as Andrew Brown was concerned Mrs Downie stated that he came to Tullideph as a transfer from another Four Seasons home. That home had done a pre-admission assessment. Mrs Downie was asked to take him at Tullideph because of a breakdown of communication between his family and the staff at Forebank, the previous home. Tullideph therefore did not do a pre-admission assessment. They simply accepted the conclusions of the Forebank assessment. There would have been a six-week period of assessment at Tullideph anyway to review his precise care needs.

(161) Mrs Downie was asked what documentation accompanied Mr Brown from Forebank and she said that there was a transfer letter. She said that this letter raised issues about his mobility, his dietary needs and the fact that he had to use a special kind of a spoon for eating. There was also, she said, a reference to an incident of him trying to trip someone up and an incident of him being aggressive to a member of staff by gripping this person's wrist when an intervention was being done with him. Forebank had not asked for any psychiatric assessment of Mr Brown following upon all of this, and Mrs Downie would have expected this to happen if his behaviour had been so bad that it gave cause for concern. If his behaviour had been worse than what was being described to her, then she would have expected psychiatric re-

assessment of him, but she did not think that things were so severe that he could not be cared for within Tullideph.

(162) In trying to arrange for Mr Brown's transfer to Tullideph his care manager was emphasising the breakdown of communications at Forebank. Mr Brown was very frail and could not walk without the use of a tripod. He wore splints on one hand and had a very low pain threshold. Any proposed intervention had to be explained to him.

(163) His wife was extremely upset at the point of his transfer and Mrs Downie tried to reassure her that there would be a full assessment of Mr Brown and a detailed care plan devised. Mrs Brown told Mrs Downie that her husband was a lovely man and not aggressive. He liked to read a newspaper each day and follow sport. He liked his own space. His wife said that care assistants should be careful with interventions because of Mr Brown's low pain threshold. He was not able to wear shoes but wore felt boots instead.

(164) Mr Brown was administered pain relief if he seemed to be in pain. He was not prescribed regular pain relief.

(165) Mrs Downie was referred to Production 29, the transfer letter which accompanied Mr Brown from Forebank on 13 November 2002 when he was admitted to Tullideph, and agreed that there was a reference to Mr Brown requiring assistance of two members of staff in all aspects of his care, and there was also a reference to Mr Brown becoming "aggressive with staff and residents - care should be taken when residents are passing as he may push them over or throw items at them".

(166) Mrs Downie stated that in relation to Mr Brown behaving aggressively, she had phoned the manager at Forebank, a Mr McDonald, and discussed this specifically with him. She was told that he had on one occasion grabbed a care assistant by the wrist and on another occasion had put his foot out when seated and had tried to trip someone up. Mrs Downie said that she spoke to Mr Brown's Social Work Care Manager who also said there had been an incident of him putting his foot out and tripping someone up. According to Mrs Downie nothing else had been said about aggressive behaviour. It was not out of the ordinary for EMI residents to behave in an aggressive way.

(167) According to Mrs Downie, Mr Brown spent 95% of his time in his own room. This was his wish and that of his family. He liked his own space. If he did want to sit in the lounge then the furniture was always rearranged so that he was over by a window with plenty of space round about him, and seated well away from other residents. The member of staff supervising the lounge would have the responsibility of making sure that no other residents wandered near him. In an EMI home a care assistant carrying out this kind of observation could turn to put a kettle on and a resident could wander. The only additional precaution taken when Mr Brown was in the residents' lounge was to seat him away from other residents.

(168) Mrs Downie's view was that if Mr Brown's social work care manager or his GP or any psychiatrist had detailed information about Mr Brown's previous behaviour then this should have been passed to her. Mrs Downie assumed that the information

she got from the care manager was everything relevant that there was to be told about Mr Brown. All she knew about his background and behaviour in Forebank was the information contained in Production 29, the Transfer Letter.

(169) Mrs Downie described the resident Gretel Clark and said that she suffered from advanced dementia. She spoke in German although she could speak perfect English, and no-one could understand her. She liked to wander round constantly picking up imaginary objects and touching people. She was a very friendly and gentle lady. Mrs Downie agreed that because of Gretel Clark's habit of wandering around constantly it would be sensible to keep a close eye on the lounge if she and Mr Brown were both in the lounge together. Ideally any care assistant should have made sure that she did not wander into Andrew Brown's area. He could not move from his chair. From a safety point of view he really had to be observed all the time, although he was relatively safe once he was seated. The care assistant on duty in the lounge would be expected to sit and chat with residents, possibly sing songs and make cups of tea.

(170) Mrs Downie was made aware of the incident on 3 December when Mr Hutchison was injured when she came on duty the following morning. Mrs Stewart gave her an account of what had happened, and as far as Mrs Downie could remember what she was told was that there had been an incident in the lounge, that Mr Brown had attacked Mr Hutchison who sustained injuries, that Gretel Clark had been there picking things up and had been knocked over or had fallen over, that Mr Hutchison had gone to help her and that Mr Brown had then kicked or knocked over Mr Hutchison. Mrs Downie contacted Mr Brown's care manager and GP. She wanted Mr Brown to be referred to a psycho-geriatrician. In fact the GP had been contacted the day before the incident on 3 December because the home wanted to have Mr Brown re-assessed. This was because one of the "overseas" staff nurses had reported that Mr Brown had put a towel over a resident's face and had held it there. This was mentioned in an accident report. Mrs Downie found it hard to imagine how Mr Brown could have behaved in this way and she spoke to members of staff but could not find out how this incident was supposed to have happened. She never got to the bottom of it but was sceptical about whether it had happened as described.

(171) Mrs Downie was then referred to Production 12 at page 1902 of Book 5, and agreed that these were the Social Work records relating to Andrew Brown. She confirmed that Mr Brown had died on 28 November 2003 in Ashludie Hospital, Monifieth. She was referred to pages 1963 and 1964 which appeared to be a summary of contacts and action taken in relation to Mr Brown. There was an entry dated 19 September 2002 indicating that Mr Brown was to be admitted to Forebank Nursing Home and then an entry dated 17-20 September 2002 reading "New CCA2 done - see file." She agreed that this was a reference to the Social Work Care Manager's care plan for Mr Brown. She was then referred to page 164 of the form which disclosed that Mr Brown was admitted to Forebank on 20 September 2002 but that as at 31 October 2002 Mrs Brown wanted her husband moved from there. She was then referred to page 1971 which was described as a "detail record" dated 4 December 2002. This made reference to a telephone call from Mrs Downie about the incident involving Mr Brown and Mr Hutchison on 3 December and included a reference to Mr Brown attacking another patient and also Mr Brown carrying out "a vicious attack on two residents and three members of staff." There was detail about

him kicking Gretel Clark and another patient who went to the aid of Gretel Clark who was, the report said, kicked several times. The report went on to say that Mr Brown continued to kick this man after he had fallen. Mrs Downie stated in evidence that what she told Josephine Bell was simply what had been reported to her. Mrs Downie said that it was "possible" that Mrs Stewart had contacted the GP about two days before, "possibly" in relation to the so-called towel incident.

(172) Mrs Downie was then referred to page 1974 of the Social Work records which related to 13 November 2002 and the move by Mr Brown from Forebank to Tullideph. In that note the discharge of Mr Brown from Forebank was described as "very traumatic" and it was noted that during the discharge Mr Brown kicked another resident. The note was in the handwriting of Josephine Bell and signed by her. Jacqueline Bell noted that she spoke to the manager of Forebank about the assault by Mr Brown on the resident and the manager told her that Mr Brown had assaulted "other staff". Miss Bell recorded that she had never been advised of this. The note also read that on arrival at Tullideph "a full care plan was given to J Downie, Matron". The note went on "She was advised that Mr Brown had assaulted a resident at Forebank and also members of staff". The note also recorded Mrs Downie as saying that she would ensure Mr Brown was seen by a GP in relation to pain because it was believed he lashed out whenever anyone came near him because of his low pain threshold and a fear of being hurt. The note disclosed that staff were advised on how best to approach him by Mrs Brown. In evidence Mrs Downie had her attention drawn to the terms of this note and stated that Mrs Brown did give her information about how to approach him because of the pain, and she stated that it was Mr McDonald at Forebank who told her about Mr Brown grabbing a worker by the wrist. Mrs Downie insisted that she only received a transfer letter from Forebank when Mr Brown arrived at Tullideph. She confirmed that she had spoken to Mr McDonald, Mrs Bell and Mrs Brown as part of the pre-admission assessment, but she insisted that the only information she got was that he had grabbed a member of staff by the wrist and had put his legs out to trip somebody up. She then said however that Mrs Bell had told her about the incidents at Forebank. She related a discussion with Mrs Brown about how to approach Mr Brown and about how he was a frightened man. She said she spent 5 or 10 minutes on the telephone to Josephine Bell and also had a telephone call with Mr McDonald, the manager at Forebank. She said that she spoke to Mrs Brown on the day that Mr Brown was admitted and that this discussion lasted "a good half hour".

(173) Mrs Downie was referred to page 1978 of the Social Work Records where Josephine Bell had noted that on 20 September 2002 when Mr Brown was admitted to Forebank Nursing Home a full care plan was given to the nursing home. Mrs Downie said that it was the care manager's duty to give over the information they had. Mrs Downie said she was not involved in the handover process and that a staff nurse was involved when Mr Brown was admitted to Tullideph. Mrs Downie thought that she "probably" did ask for the care plan since she would usually have asked for that and the relevant contract, but she did not always get these on the day of admission.

(174) She was then referred to page 1980 of the Social Work Records which contained the note of the review meeting on 29 August 2001 in relation to Mr Brown where there was a reference to 3 episodes of aggressive behaviour. Mrs Downie

said that she had not been told about these. She felt that she should have been made aware that he was capable of lashing out at other residents. She was then referred to page 2011 of the Social Work Records and the letter from the consultant psychiatrist Dr Findlay to Mr Brown's GP practice in which there was reference to Mr Brown's behaviour as being "increasingly aggressive in recent weeks". Mrs Downie insisted that she knew Mr Brown had been aggressive. She was then referred to page 2035 of the same production which was a functional assessment report carried out at the Royal Victoria Hospital in late 2001, and it referred to Mr Brown at that time requiring "supervision of one" in relation to mobility, climbing stairs, transferring to and from bed, chair or toilet, and during personal care. Mrs Downie's response to this was that the EMI nursing home tried to provide what amounted to 24-hour supervision. She was then referred to page 2113 of the Social Work Records, being the care plan for Mr Brown devised between 17 and 20 September 2002 by Josephine Bell. In the first instance she was referred to page 2116 which related to the need to communicate carefully to Mr Brown before carrying out any intervention and referred to his having been aggressive to carers on a few occasions. Mrs Downie said that she knew about this. She was then referred to page 2118 which contained a reference to Mr Brown lashing out if upset and being seated away from other residents etc. Her response to this was that Mr Brown spent a lot of time in his own room, and when he came to the lounge he was kept on the periphery away from other residents. He was also constantly reassured.

(175) Mrs Downie insisted that she had never been made aware of any of the incidents of aggression that had occurred while Mr Brown was attending the Menzieshill Day Care Centre. She felt it might have been helpful to have known about these, and if she had known, then the staff at Tullideph would have looked at the possibility of providing drug therapy or getting psycho-geriatricians involved in the care of Mr Brown and assessing him.

(176) Mrs Downie was then referred to Production 14, the care plans and notes for Mr Brown in Book 6 at page 2430A where there was a reference to the steps to be taken if Mr Brown became physically aggressive towards staff. She appeared to think this related to the care plan for Forebank and not Tullideph. She was referred to page 2432A of the same document where there was reference to Mr Brown becoming aggressive towards staff and residents and how to deal with that and also a reference to Mr Brown requiring to be supervised because when he was with other residents he could push them over or throw items at them. She was asked when care assistants were supposed to read the care plans and she said that they were available at all times for staff to read. She also said that when Mr Brown was admitted staff would have had a briefing about the possibility that he could be aggressive. Mrs Downie said she was confident that all this information would have been passed on.

(177) She was then referred to page 2433A of the same document where there was a reference, already mentioned, to Mr Brown kicking a resident on 25 November. She said she was aware of this although she did not witness it. She was asked whether any additional steps had been taken to supervise Mr Brown because of this and she replied that the staff would have been reminded of the steps necessary and if possible a member of staff would have been in the company of Mr Brown at all times, but such 24-hour supervision was very difficult. Mrs Downie said she would

have told staff that someone should be in the vicinity of Mr Brown at all times. She was then reminded of the recorded incident on 30 November relating to the use of a towel and was asked if any additional steps had been taken after this incident. Her response was that one-to-one supervision was not possible. She said that someone from the Activities Co-ordinators Area was asked to involve himself so there would be one-to-one some of the time. She stated that she discussed the incident with her two deputies and reiterated that someone should be in the area of Mr Brown at all times but again she said that one-to-one supervision was not possible because there was not enough staff. She stated that on 3 December Mr Brown's GP was contacted to be told about the incident and to provide advice. She was referred to page 2435 of the same document recording that on 28 November Mr Brown had tripped and fallen. She indicated that when he was "on the move" there would be a nurse escort with him. She pointed out that he was not able to get out of chairs by himself and therefore would be supervised when walking around.

(178) Mrs Downie was adamant that Mr Brown's GP was contacted because of the towel incident and "his general behaviour". Depending on when the towel incident happened there might have been a delay of a day or two before the GP was contacted, but the GP would definitely not have been contacted out-of-hours. She phoned Dr Semple, a psychiatrist, on the morning of 4 December to say what had happened in relation to Mr Brown and Mr Hutchison. When the GP was contacted on 3 December the home were suggesting assessment by a psycho-geriatrician but the doctors' practice decided to send in Mrs Bree first.

(179) Mrs Downie was referred to Production 17 at page 3058 of Book 8, namely the Tullideph Care Plan for Mr Hutchison, and agreed with reference to various recorded information that Mr Hutchison required a safe environment, that although he was frail he was able to mobilise independently around the home, but that he would have to be reminded to avoid trip hazards. He was doing well in getting around properly. She agreed that there were a number of falls recorded in relation to Mr Hutchison. She said that given more staff there could clearly be more supervision but greater supervision would never necessarily prevent falls and accidents. The policy of the home was that everyone was under observation at all times. Mr Hutchison wandered the corridors with his friends day in and day out. Residents were encouraged to wander.

(180) There were domestic and catering staff around. They were not aware of what was in the care plans in detail but they were able to watch out and see if anyone was in difficulty. The nurse in the lounge could also look down both corridors, since the lounge was at the meeting point of the two corridors, and see what was happening.

(181) Mrs Downie stated that staffing levels were set by the Care Commission. If she felt she didn't have enough staff she could ask for more. She was responsible for the budget of the care home and had to work within the budget. She was an extra staff nurse on 3 December and there was also an extra carer. She felt she could probably do with more care staff because it would help to meet the goals in the care plans more easily.

(182) She said that there had been several complaints from relatives of residents about levels of staffing but most were not upheld and investigated, although some

may have partly been upheld. She felt that there was a high turnover among care assistants and that that had been a cause for complaint, but the trained staff were fairly stable.

(183) Since 3 December there had been an increase in the skill mix and the staffing levels. There were two extra staff on the morning shift and an extra carer on the late shift. She had no doubt that all nursing home managers would say that they could do with more staff.

(184) She was then referred to Production 9 at page 101 of Book 2 which was a history of complaints to the Care Commission about Tullideph between April 2002 and April 2004. It was noted that the complaint about shortage of staff on 12 June 2002 was upheld. This must have been an emergency situation with people calling off and the agency being unable to provide cover, Mrs Downie believed. Mrs Downie commented that sometimes when staff were very busy it could appear as if the care home was short-staffed when it was not. If staff were bathing a resident or seeing to the care needs of other residents then there might be a shortage of staff in the communal areas. Her attention was drawn to the document commencing at page 108 of Book 2 which was an inspection report dated 4 November 2003 when just such a problem was identified by the Care Commission Inspection Team. She was then referred to a similar inspection report for three dates in January 2003 at page 116 of the same book. In September 2003 the family of Mr Hutchison wrote to the Care Commission to raise concerns about the circumstances surrounding the death of Mr Hutchison, and Mrs Downie was referred to page 124 of the same production which was a note of a meeting with the family. Within this note the Care Commissioner was recorded as informing the family that although the home was probably meeting the minimum staffing numbers, the home was required to review the number and skill mix of staff to ensure that the residents' needs were being met.

(185) Mrs Downie was then referred to page 129 of the same production which was a note of a complaint made by a care manager in relation to visiting Tullideph. Various complaints were noted at page 132 including a complaint that when the doorbell was rung the complainer had to wait for ten minutes before eventually she was allowed in by a visitor who was leaving. She then went up a lift and along a corridor to visit a resident without on the way seeing any member of staff. Mrs Downie commented that there would have been five staff on duty at the upper level, and since this visit happened in the evening, if one member of staff was in the lounge, one was on a break and the other three were doing things then the corridors might seem to be deserted. The corridors were not under observation all the time. Mrs Downie made it clear that a resident should not be left unattended in order that the door could be answered. Mrs Downie also commented that at the time of this incident the home was already looking at the question of increasing staff numbers and altering the skill mix.

(186) Mrs Downie was referred to page 154 of Production 9 in Book 2 which related to a visit by the Care Commission to Tullideph on 19 June 2002 to investigate a complaint, part of which related to a shortage of staff, apparently caused by a high rate of sickness amongst staff. She was also referred to page 159 of the same production which was a letter from the Care Commission dated 14 July 2003 and, amongst other things, related to concerns expressed by a Social Work Care

Manager and a Specialist Registrar in Psychiatry. One of those concerns was that a nurse on duty in relation to a patient had little knowledge of the mental health needs of that patient. Another complaint was that there seemed to be very few staff present and it was some time before the registrar was approached by a member of staff. The staff appeared not to be regular staff but agency. The staff also seemed to be inexperienced and unable to provide a detailed background history in relation to the physical and mental state of the same patient. At page 162 of the same letter the response of Tullideph to these concerns was noted and in particular the home seemed to express concern about the information received by them in relation to the medical history of residents. The Care Commission noted that the home had a responsibility to ensure that they had sufficient detail of residents' needs to deliver adequate and safe levels of care. At the conclusion of the letter the Care Commission was noted as requiring Tullideph to ensure that all appropriate health and social care information about a resident was received into the home from relevant services, and also to organise staff in such a manner to ensure that adequate levels of observation were maintained within care areas.

(187) Mrs Downie confirmed that over a period of time there had been discussion with the Care Commission about the skill mix of staff within the nursing home, and that the whole procedure took 18 months before the current arrangements were finally in place.

(188) Mrs Downie was then referred to page 205 of the same production, a letter from the Care Commission dated 8 October 2003 to a lady who had made a complaint about Tullideph which partly related to the question of staffing levels and supervision of communal areas. This investigation led to an unannounced visit to Tullideph on 29 August 2003. What was discovered was that the home was in compliance with regulations in respect of the number of staff and in fact had staffing levels beyond the minimum number required. It was noted however that the lounge on the ground floor was not supervised by staff. It was thought that this might be because a number of agency staff were on duty. It was also noted that because of the layout of the home, and in particular the long corridors on the two floors, that observation of communal areas was difficult. Because staff were involved in direct care duties within residents' rooms etc they were out of direct contact with residents in corridors and communal areas. It was noted that a pilot project was about to begin to improve staff numbers and care delivery, and that the home was aware of these issues. The conclusion of the letter was to the effect that the home had to review immediately the provision of staff in terms of number and allocation of duties to ensure that all care areas were adequately observed and to make sure that staff were aware of their duties in this regard. Mrs Downie's comment on all of this was that the home's policy was that there should be a member of staff allocated to the lounge at all times, but she conceded that "obviously" there were times when there was no-one there.

(189) Mrs Downie was referred to a note of a meeting held on 20 March 2002 involving herself and representatives of Tayside NHS Board. This meeting highlighted the fact which Mrs Downie conceded that staffing numbers need to be in accordance with the needs of residents, that the needs of residents could change and that this might lead to increase in cost.

(190) Mrs Downie was then referred to page 672 of the same production which related to an anonymous complaint by a member of staff relating to staffing levels and staffing problems. Mrs Downie did not agree that residents had suffered because of lack of staff.

(191) In summary Mrs Downie conceded that there would be occasions when there was not enough staff to have a member of staff on duty in the lounge. She conceded that she did not at all times have enough staff to see to the care needs of all residents and their care plans. She said that she had asked her superior to increase the minimum levels of staffing but the response had been that if the Social Work Department was only funding the minimum level of fee then Mrs Downie had to work with the minimum level of staff. She indicated that she had no power to go to the local authority and increase fees. She indicated that her superior had increased staffing levels above the previous minimum since 2004 but that with the complex needs of residents she could always do with more staff to be able to see to the needs of residents with less stress.

(192) Mrs Downie was cross-examined by Mrs Foulis who had by this point taken over representation for the Care Commission. She confirmed that between 2002 and 2004 there had been a great deal of liaison between Tullideph and the Care Commission to consider the skill mix of staff and increasing staff numbers. A new staffing schedule was eventually put in place dated 11 March 2005, following upon a pilot scheme, and Mrs Downie confirmed that the Care Commission were happy with the changes made. She was referred to Production 22 (Production 3 on the Inventory of Productions for the Care Commission), an inspection report by the Care Commission dated August 2004. At page 7 of the report the Care Commission expressed its satisfaction with the situation.

(193) Mrs Downie was also asked about the information received when Mr Brown arrived at the home with a view to formulating a care plan. Mrs Downie indicated that she received a verbal report from his care manager to the effect that Mr Brown and his wife were not happy at Forebank. She was told that he had a low pain threshold and used a tripod to move around. She was told he had a splint on one hand, that he liked to spend most of the time in his room, and that he did not like curry. She was also told he had a history of grabbing the wrists of care assistants. She was anxious to emphasise that this was not an unusual feature of dementia residents and she was confident that Tullideph could cope with people with such challenging behaviour. There was no basis to change staffing levels in the light of the information received about Mr Brown. She also emphasised that at every changeover of staff there was an exchange of information between the outgoing staff and the incoming staff. The detail of every individual resident would be gone over and everything of significance would have been recorded in the daily diary.

(194) Mrs Downie was then cross-examined by Mrs MacPhail on behalf of Tayside NHS Trust. She confirmed again that no formal care assessment of Mr Brown was carried out but information was received verbally from his care manager Josephine Bell who said only that Mr Brown had grabbed the wrist of a care assistant when getting personal care. She confirmed that she also had the information in the Transfer Letter from Forebank (Production 29). She had no reason to doubt that Tullideph could meet Mr Brown's needs. If she had felt it wasn't possible to meet his

needs she would have refused to accept him. She did not feel there was any need for Mr Brown to be formally assessed by a psychiatrist. If things were as bad as that she would not have accepted him. Once he had been admitted, if there had been any concerns she could have asked for an assessment by psychiatric services. Dr Semple the consultant psychiatrist was excellent at returning calls and dealing with requests for assessments. Normally any request would go through the resident's GP or Community Psychiatric Nurse, although sometimes a psycho-geriatrician would be contacted direct.

(195) Mrs Downie was asked about various incidents of aggression manifested by Mr Brown when he was in Tullideph, according to the records, but she could not remember whether the GP had been contacted after these incidents. She was confident that the only point at which the GP was contacted was on 3 December 2002 before the incident with Mr Hutchison. At any point prior to that she suspected that discussion about Mr Brown had focussed around his boredom and the need to alleviate his pain. She was confident that there had been a discussion about Mr Brown's aggressive behaviour. She did not see Mrs Bree on 3 December. Because Mrs Bree was technically a visitor to the home she would have no access to Mr Brown's records as of right but would have to rely on staff for information. Mrs Downie could not account for why Mrs Bree was only told about the towel incident rather than all the other incidents. Mrs Downie agreed that after Mrs Bree's visit there was still no question of immediate emergency psychiatric assessment.

(196) Mrs Downie was then cross-examined by Mrs Bennett on behalf of Four Seasons Health Care. She recounted her experience as a nurse and in particular experience working with dementia sufferers. She agreed that dementia sufferers could exhibit challenging behaviour including aggression. The aggressive behaviour could cover many types of behaviour. Kicking out could be a form of communication. Tullideph was one of five EMI units in the Dundee area, and there was no NHS home providing the same sort of care. Places were funded by the local authority irrespective of the needs of the individual.

(197) She was referred to Production 25, the staffing schedule at the time of the incident. Mrs Downie indicated that the home never functioned below the minimum levels of staff required and occasionally had more staff on duty. She suggested that the morning shift tended to be the busiest and any shift was busy where there was a meal to be served. On the afternoon or late shift there was only one meal to be served, and in her view there tended to be less demands on this late shift. She confirmed that Productions 23 and 24 were the later staffing schedules set out by the Care Commission which resulted in two extra staff on the morning shift and one extra on the late shift. There was also a change in the skills mix.

(198) She did not think that a high turnover of staff was peculiar to Tullideph or the Four Seasons company. There were some staff at Tullideph who had been there as long as her. She then went through the training which a new care assistant received at Tullideph and explained that there was now a Training Manager who organises training for staff both internally and externally. 60% of the budget at Tullideph was expended on staff wages.

(199) She agreed that there had been complaints about Tullideph and that the Care Commission had had to investigate these but she did not think that the problems identified were peculiar to Tullideph but were common to many care homes. There was subsequently, however, a pilot project which took some time to put in place but eventually led to the new staffing levels. She did not agree that residents' needs had been neglected because of any issues related to staffing.

(200) Mrs Downie was then asked about the admission of a new resident and the design of care plans. She indicated that normally there was a pre-admission assessment and then after admission there would be a six-week assessment period during which a care plan would be written up. At the point of admission there would be received from the Social Work Care Manager a form CCA2 being the Social Work Care Plan for the resident. The resident's family and friends would also provide information. A specific nurse would be appointed to the resident with the responsibility to write up the care plan. The care plans were available for all staff to read. Each trained nurse was allocated about 8 residents and had to make an entry in the care plan every day in relation to each resident under his or her care. A daily diary was kept in which any relevant information was recorded and all had access to. There was a communications book which allowed any member of staff to write down observations at any time. There was a diary kept to record visits by GPs etc and then there was the handover meeting which would last for 15-20 minutes between shifts, and at which all care assistants were present to receive any relevant information. An innovation since December 2002 was that the Personal Care section of care plans had now been extracted from the care plan and was kept separately for ease of reference. Mrs Downie felt that the key element in the passing on of information was the handover meeting.

(201) In relation to the transfer of Mr Brown from Forebank this was done as an emergency in a rush, and Tullideph relied on the pre-admission assessment which had been done for Forebank. Mrs Brown was not seen before the point of admission although Mrs Downie had spoken to the Social Work Care Manager, Josephine Bell. On the day of admission Tullideph was given only the transfer letter and no other document apart from perhaps the contract relating to issues of payment and so on. Josephine Bell phoned Mrs Downie and "put her in the picture" in relation to Mr Brown. Mrs Bell told Mrs Downie about the incident of aggression when Mr Brown was actually leaving Forebank and Mrs Downie spoke to the manager at Forebank to get more information. It was not the policy that the Forebank file in relation to Mr Brown would be transferred to Tullideph. Mrs Downie did not know why this was not the policy. She insisted that the only document received by her relevant to the care of Mr Brown was Production 29, the Transfer Letter. She received other information from which she concluded that Mr Brown could become aggressive. The most she was aware of was the incident when he left Forebank and that he had exhibited challenging behaviour in the past. She had no basis for thinking that his behaviour was something that Tullideph could not cope with. Once admitted he was on a six-week period of assessment, and after the six weeks there would have been a review meeting at which his care plan would have been examined to see if all his care needs were being met. Sometimes it was decided at that stage that Tullideph could not cope with a particular resident.

(202) Mrs Downie was referred to Production 12, the Social Work records for Mr Brown, where it was recorded at pages 1974-1975 that on 13 November 2002 when Mr Brown was transferred to Tullideph "a full care plan was given to J Downie, Matron". Mrs Downie was absolutely adamant that the care plan was not handed over and that all she received was the transfer letter and perhaps the contract. Mrs Downie said that eventually around the time of the incident in December 2002 she received a handwritten copy of the care plan, but that it was not up-to-date. It was dated September 2002 when he was still at home. She was then referred to Production 14 at page 2430A of Book 6 and confirmed that this appeared to be the Tullideph care plan for Andrew Brown. She said that it was devised in consultation with Mrs Brown, Josephine Bell and Mr McDonald the manager at Forebank. She was adamant that she did not have the Social Work Care Plan at this point and therefore the Social Work Care Plan was not part of the Tullideph Care Plan. She was referred to Production 8 in Book 1 between pages 43 and 53 and confirmed that this was the Social Work Care Plan (Form CCA2) in relation to Mr Brown, but she was adamant that she only received this later.

(203) The question of Mr Brown's pain control was something which staff at Tullideph had very much in mind. It was believed that issues of pain control lay at the root of Mr Brown's behavioural problems. These were being addressed, not ignored. In addition Mr Brown liked to stay in his room. On the few occasions that he was in the lounge he was put by the window overlooking the garden to give him room and space and to keep him away from other residents. Mrs Downie was referred to the care plan, Production 14 in Book 6 at page 2432D and confirmed that it was noted that Mr Brown could become aggressive with staff and residents, in which case he should be settled in a quiet place and given time to settle down. It was also noted that Mr Brown had to be supervised when with other residents because he could push them over or throw items at them.

(204) Mrs Downie confirmed that Mr Hutchison had been in the home for several years and that he was mobile although he had had occasional falls. This was not uncommon in EMI homes.

(205) Tullideph did a Risk Assessment for all residents. Their philosophy was to try if possible to have residents walking around and using the home in freedom. The home preferred not to give strong medication to residents unless necessary. The home encouraged residents to mobilise, socialise and interact. Tullideph did not offer one-to-one care. In the view of Mrs Downie it was necessary to balance the individual freedom to walk around against a 100% guarantee that the resident would not fall. Such a guarantee cannot be achieved without taking away freedom.

(206) She confirmed again that the rule was that there should be somebody in the lounge at all times supervising, but she conceded that this could not be adhered to 100% of the time because so many things could happen. A resident might need the toilet or there might be some sort of commotion, but she was adamant that the lounge was being supervised on the night of the incident. Her position was that it was more common that somebody would be in the lounge than not.

(207) In re-examination to the Procurator Fiscal, Mrs Downie indicated that staffing levels and the mix of staff had been reviewed following upon the pilot project. There

had been substantial discussion with the Care Commission. Working conditions had improved and wages were better. There would always be a difficulty retaining staff however. The working conditions were not as good as the public sector and often care assistants left when they saw how busy the home was. A percentage of them would not stay long enough to get to know residents and would not get to know the residents' care plans, but the care plans were available at any time for care assistants to read. Between 1 pm and 2.30 pm it was part of the policy that the care plans were completed. During induction the care assistants were all instructed to the effect that care plans were there to be read especially in relation to new residents, and at staff handovers they would be told if there was a new care plan in place.

(208) She was perfectly satisfied that the move to Tullideph was the right move for Mr Brown. She was adamant that the care plan from Josephine Bell was only received later. Production 29, the transfer letter, essentially summed up the information available to Mrs Downie when Mr Brown was transferred.

(209) She was prepared to accept that the care needs of Mr Brown and Mr Hutchison were not being met at the point of the incident because the lounge was at least momentarily not supervised.

(210) The next witness to give evidence was Elizabeth Smith, aged 44. As at December 2002 Mrs Smith was employed as a care assistant at Tullideph. She had worked there for just over 2 years. Her duties involved caring for the elderly residents, mainly seeing to their personal hygiene and their eating requirements. Mrs Smith confirmed that each resident had a care plan and that the care assistants knew what the needs of the residents were. Sometimes she read the care plan for a resident but most of the time the care assistants had the necessary information simply because the nursing staff explained to them what the residents' needs were.

(211) She was on duty on 3 December 2002 when the incident involving Mr Brown and Mr Hutchison occurred, and she could remember the incident. She was working on the ground floor. Mr Livingstone and Mrs Stewart were also on the ground floor. The incident happened late on in the shift. Mrs Stewart was doing her report and had called Mrs Smith into her office to see if she had anything to report. Mrs Smith thought that she was just coming down the corridor. About that time she was involved in putting residents to bed. It was usually the frail ones who were put to bed at this point because a lot of them wanted to go after their supper. They normally sat in the lounge after their supper. Some of the very frail ones would sit falling asleep so they would be put to bed. Mrs Smith was working with Mr Livingstone. Some residents needed two care assistants to put them to bed whereas some needed just one.

(212) It was Mrs Smith's recollection that there was no care assistant in the lounge. As she was passing the nursing office Mrs Stewart called her in to see if there was anything to report. At this point Mrs Smith had been engaged in the process of putting people to bed for about half an hour. This involved her going to and from the lounge escorting residents to their rooms and helping them get to bed. She and Mr Livingstone were both doing this.

(213) She suddenly heard a thud and heard the resident Mr O'Hara bawling and shouting.

(214) She and Mrs Stewart ran through and saw the resident Gretel Clark lying on the floor. Mr O'Hara was shouting that Andrew Brown had knocked Gretel onto the floor and was saying that Mr Brown had kicked Mr Hutchison. Mrs Smith said that the picture she had in her head from what Mr O'Hara was shouting was that Hutchison had gone to help Gretel Clark and had been knocked over.

(215) Andrew Brown was sitting on a chair, sitting by the window. All the chairs were in a row. Mr O'Hara was standing beside where Gretel Clark was lying, and she in turn was lying just at Andrew Brown's feet. Mr Hutchison was lying further over. Mr O'Hara said that Mr Hutchison had "gone flying". Mr Hutchison was quite a distance away from Mr Brown, not within touching distance. It was all very confused.

(216) Mrs Stewart ran over and assessed Mr Hutchison, and Mr Livingstone came in after that. He went and phoned for an ambulance. Mrs Smith was sure that Mr Livingstone took Mr Brown to his room. Mr Brown was just sitting when Mrs Smith went into the room.

(217) Mrs Smith stated that Mr Brown "always kicked everybody - patients and staff". He had kicked Mr Livingstone before and sent him flying across the room.

(218) Mrs Smith stated that she had never read Andrew Brown's care plan.

(219) Gretel Clark was picked up and put on a seat. Mrs Smith did not remember Willie Legge being present. She could not remember who precisely was there out of the residents. There were only a few residents in the lounge. The others were in bed.

(220) Mrs Stewart was in charge in the absence of Mrs Downie who usually finished at about 4.30 or 5 pm.

(221) Mrs Smith stated that there was always meant to be a care assistant in the lounge at all times, but sometimes on the late shift the home was quite short-staffed, perhaps because of agency or other staff not turning up. It did happen that the lounge was left unsupervised during the late shift because the late shift was very busy.

(222) The opinion of Mrs Smith was that Mrs Stewart and Mrs Downie must have appreciated that sooner or later something like this would happen because there was so much work to be done on that shift and so few care assistants.

(223) Mrs Smith said again that she was first on the scene in the lounge and that Mrs Stewart was right behind her. Mr Livingstone came after the two of them because he had been at the top of the corridor putting a resident to bed Mrs Smith thought.

(224) She was quite clear that the chairs were set out in a row and that Mr Brown was in one of the chairs in a row. He was a new resident at that time and Mrs Smith had not read his care plan. The only thing she was aware of was that if any interventions were to take place in relation to Mr Brown, then two members of staff

had to do it because he had previously got aggressive with staff. She was not aware of any special arrangements about where he was to be seated in the lounge.

(225) She supposed that the care plan for Mr Brown might have information about special seating arrangements for him. She never read any of the care plans although they were there to be read. Care assistants were not told they had to read the care plans, simply that they were there if the care assistants wanted to read them. There were 60 residents and Mrs Smith would not have had time to read the care plans. No time was allocated for the reading of care plans.

(226) When coming on to the morning or back shift as a care assistant, Mrs Smith would be given a daily report about anything she had to know. She had a recollection that Mr Brown was waiting to be "sectioned" to go to the Royal Liff Hospital.

(227) She remembered that when Mr Brown first came into the home he was very quiet but then he started kicking staff. She never saw him kicking residents. She did not recall being told anything about him sticking his leg out and tripping people up. She agreed that all residents could hit out at people and that this was part of their dementia, but she did not recollect being told that Mr Brown had to be treated in a particular way. She certainly was never told to keep him seated away from other residents. All residents could have bad days and get aggressive but not to the extent that Mr Brown got aggressive. He tried to kick staff and tried to strangle them. He had a firm grip even though he had a splint on his hand. Mrs Smith had not heard about the towel incident but accepted that he could have done that. Mrs Smith was only aware of one other resident as aggressive as Mr Brown. Her view was that she had not been trained to deal with people who behaved as aggressively as that.

(228) In cross-examination by Mrs Bennett on behalf of Four Seasons Care Homes, Mrs Smith was asked about being interviewed by the police. She agreed that she had been. She was shown a police statement dated 13 December 2002 and agreed that she had signed that statement and that the statement appeared to be hers. She was asked about page 2 of the statement where it was noted that she had told the police that on the evening of 3 December she was in the sitting room along with two residents, and was playing Christmas tapes for them. She indicated in her evidence that perhaps it was right that she was sitting in the lounge. She could not remember where she was before the incident. Perhaps she was thinking when she gave her statement to the police about what she would usually do rather than what she was actually doing. She also indicated that she might have been trying to make things better for Tullideph by saying that she was in the lounge before the incident. She then said in her evidence that she stood by what she had said earlier, namely that there was never anybody in the lounge on the late shift. This was in reference to it being pointed out to her that in her police statement she was recorded as saying "There is normally a member of staff there at all times, apart from going out of the room for a few minutes to maybe get something". Mrs Smith made it clear that she was not suggesting in her evidence that anybody from Tullideph had told her what to say to the police. She agreed that Mr Hutchison was lying quite far away from Mr Brown's feet when she went into the lounge and that she did not see Mr Hutchison lying at Andrew Brown's feet and Andrew Brown kicking out at him.

(229) Mrs Smith said that she read care plans when she got the chance but usually she was too busy and she had never read Mr Brown's care plan. She said she read other care plans when she worked on the first floor of the home, when she first started. She indicated that she knew she was required to read the care plans but relied on the hand-over meeting at the end of each shift, which she thought was an effective form of communication.

(230) Her view was that if she had been in the lounge when the incident happened she would have been able to stop it.

(231) The next witness to give evidence was James Kilgour, aged 54, a Senior Social Worker. He was employed by Falkirk Council, and apart from being a trained social worker was also a registered nurse for people with learning disabilities. He was the team manager for a specialist team employed by the Social Work Department for dementia sufferers, for delivering services to such persons and their families. This included respite services, day care services and outreach services.

(232) He was familiar with EMI homes. For four years he had been an inspector with the Inspections Unit of Falkirk Council and inspected such homes. He had also worked in residential care homes for older people for over 20 years, particularly in specialist units for those with dementia.

(233) He indicated that he had been asked to consider the circumstances of Mr Brown and to prepare a report. He was referred to Production 4 at page 9 of Book 1. He indicated that to prepare the report he had been granted access to certain files plus witness statements taken by the police and statements from medical staff. Mr Kilgour was then asked to go through his report.

(234) In relation to the question of supervision of Mr Brown and his care, he confirmed his report that in deciding whether or not to accept Mr Brown the home had to consider whether they could adequately meet his needs and what effect he would have on the life of the home and other residents. They would have to have decided whether he needed his own support worker who would be able to supervise Mr Brown and therefore protect other residents. In the view of Mr Kilgour if Mr Brown was being left alone then his needs were not being met and others were being put at risk. In his view this was not an unknown risk given the information available about Mr Brown's behaviour in the past. Mr Kilgour conceded that one-to-one supervision would be difficult to maintain from the point of view of a care manager who would have to make sure that there were adequate levels of staff at all times, and in particular at the start of every shift. A balance would have to be struck between supervising Mr Brown and still ensuring that he had a reasonable quality of life.

(235) In Mr Kilgour's opinion the supervising member of staff in the lounge should never have been removed from the lounge. Any nurse seeking information from that member of staff should have come to the lounge or cover should have been obtained. In his view it created a high risk situation for the supervising care assistant to leave the lounge even for a short period of time.

(236) On the question of the level of staffing Mr Kilgour was very clear that whatever was set by the Care Commission as minimum levels of staffing, these levels would

have to be adjusted to meet the changing needs of residents. The use of agency staff could well unsettle residents. Such staff might well have insufficient knowledge about the residents. EMI residents needed familiarity and to build up trust which was not helped by changing staff.

(237) In the view of Mr Kilgour the support needs of residents increased as the day progressed. He accepted that mornings were busy and he accepted that as the evening went on the workload would become less, but dementia sufferers in the evening might well need more support because it took more time to deal with their needs. In his view ideally staff would not be decreased on the evening shift.

(238) Care staff needed to be trained in dementia, and in the opinion of Mr Kilgour it was not good for any person to have been employed in a home for two years and have no training in dementia.

(239) In Mr Kilgour's opinion the care needs of Mr Brown were not being met at the time of the incident, nor were the care needs of Mr Hutchison.

(240) In cross-examination by Mrs Foulis on behalf of the Care Commission Mr Kilgour on being shown Production 29, the transfer letter from Forebank, offered the view that even on the basis of that letter one-to-one supervision was required. That supervision might reduce if he behaved well in Tullideph.

(241) He agreed that staffing levels having been set by the Care Commission according to national care standards, it was still up to the provider of the care service to respond to the needs of a new resident, possibly by changing staffing levels.

(242) On the information available to him about Mr Brown, Mr Kilgour acknowledged that one-to-one supervision could well have restricted his choices and invaded his privacy and could have ended up agitating him but in terms of protecting others his feeling was that one-to-one supervision was required.

(243) Under cross-examination by Mrs Bennett on behalf of Four Seasons Healthcare Mr Kilgour agreed that if what Mr Brown wanted was to be left alone in his room, then there was no reason not to abide by that. Mr Kilgour would not expect that if Mr Brown had one-to-one supervision that he would be supervised in his room if he was on his own, but the one-to-one supervision would have to be available if Mr Brown was coming into communal areas. Mr Kilgour was aware of homes where there was one-to-one supervision because that was necessary to meet the needs of a resident. Such one-to-one supervision could be privately funded or funded from public resources, and he thought most local authorities would have some flexibility to negotiate the funding necessary to meet the needs of a particular resident. He did not think it was reasonable to wait till the end of a six-week assessment period to bring up the question of one-to-one supervision.

(244) Staffing levels had to be constantly assessed to ensure that the needs were being met not only of new residents coming into the home but also those already in the home having regard to these new residents being admitted.

(245) Mr Kilgour agreed that working with people with dementia was very challenging. He found that staff in EMI homes often did not have sufficient training. He agreed that the problems of getting and keeping trained staff was not unusual to Tullideph. He also was not critical of any EMI home which allowed people to move about freely because he felt a balance had to be struck between surveillance and protection.

(246) In re-examination to the Procurator Fiscal, Mr Kilgour offered the view that having regard to Mr Brown's history of aggressive behaviour he undoubtedly needed constant supervision when in Tullideph. In the opinion of Mr Kilgour the incident involving Mr Hutchison was predictable.

(247) The next witness was Josephine Bell, aged 57, a Social Work Care Manager with Dundee City Council. She had been a care manager since 1993 and before that a social worker involved with older people.

(248) On 29 October 2001 she took over as care manager for Andrew Brown at a point where he had been admitted to the Royal Victoria Hospital and his previous care manager had gone on maternity leave. Mrs Bell set up a care plan for Mr Brown and had access to previous records from when he had come to the attention of the Social Work Department.

(249) He had had several major strokes and was quite impaired physically. He used a walking aid and was not able to get up from a chair without assistance. He also needed help with toileting. His strokes had resulted in impairment to his memory and his speech. He had very little speech and could only respond with single words.

(250) Mrs Bell found it difficult to say what he was like as a character because of the communication problem, but understood from his wife that when well he had been very athletic, very clever and hard-working and was also well respected. His wife described him as a very gentle person.

(251) His first stroke had been in 1993 and had resulted in a complete change of character. Mrs Bell was aware of a number of incidents of aggression manifested by Mr Brown before his admission to Forebank. They started when he was in day care centres and were relatively minor to begin with but they got worse. There were incidents when he attended a day care centre at Menzieshill House. He was then referred to the organisation Alzheimer Scotland. In September 2002 there was a difficulty with a care assistant who visited him at home when he grabbed this person's wrist and subjected the person to verbal abuse. It was following upon this incident that he was admitted to Forebank Nursing Home.

(252) He was admitted on 20 September. Mrs Bell and Mrs Bree accompanied him to Forebank. A pre-admission assessment had been done and a care plan had been devised. Before his admission to Forebank he had been assessed by a psycho-geriatrician who had recommended that he attend a psychiatric day hospital, but Mrs Brown became unable to look after him and therefore the admission to Forebank was undertaken. The care plan devised by Mrs Bell was given to Forebank.

(253) Mrs Bell was under no doubt that she subsequently gave the same care plan to Tullideph when he was admitted there about two months later.

(254) Mrs Bell talked through the care plan with staff at Forebank and also with Mrs Downie at Tullideph in due course. Mrs Brown and Mrs Bell spoke at some length to Mrs Downie about Mr Brown's needs. Mrs Downie was confident that she could meet these needs.

(255) On 13 November 2002 he was admitted to Tullideph and his care plan was handed over. Mrs Brown advised staff of his needs.

(256) Mrs Bell remembered that in the process of leaving Forebank there was a dreadful atmosphere and while she and Mr Brown and Mrs Bree were waiting in a communal area Mr Brown kicked a resident who had got close to his feet. Mrs Bell spoke to the manager of Forebank about this and was horrified because she was unaware that he could behave in such a way. Mrs Bell was aware of the incident with the care assistant at home and was aware of the Menzieshill Day Care Centre incidents. She knew that Mr Brown could react if something was thrown and struck him or if there was a loud noise. However the manager of Forebank, Mr McDonald, then told Mrs Bell that Mr Brown had attacked other members of staff. Mrs Bell told Mrs Downie about this. It seemed to Mrs Bell that it was unprovoked behaviour.

(257) Mrs Bell was confident that in the original care plan which she had devised in September 2002 it had been provided that one way to avoid triggers for aggressive behaviour was that people should be kept away from Mr Brown's feet as he was sensitive to pain.

(258) Mrs Bell and Mrs Bree accompanied Mr Brown to Tullideph in a taxi. On arrival Mrs Bell spoke to Mrs Downie who said she was willing to give Mr Brown a chance and that she would contact his GP to see about getting pain relief for him and making him more comfortable. Mrs Bell did not recollect specifically telling Mrs Downie about the incidents at Menzieshill House but definitely did tell her what had happened at Forebank in the past and what had happened with the other resident that day. Mrs Bell recollected going to visit Mr Brown a few days later and felt that he was settling in OK.

(259) On 4 December Mrs Bree phoned Mrs Bell to say that she had visited Mr Brown on 4 December and that he was complaining about being bored. Mrs Bree said she had found him in the dining room on his own. There was a discussion about trying to improve his quality of life. Later however Mrs Bell got a phone call from Mrs Bree indicating that she had spoken to Mrs Downie about an incident which had taken place and that Dr Semple was going to see Mr Brown.

(260) In a subsequent conversation with Mrs Downie, Mrs Bell was told that Mr Brown had carried out an attack on another resident when this other resident had gone to help a woman who had got into some difficulty with Mr Brown. This other resident had been kicked, had fallen and had ended up with fractures. Mrs Bell was also told that three members of staff had been attacked. She was aware that Mr Brown was to be seen by Dr Margaret Semple, a consultant psychiatrist.

(261) Mrs Bell was not sure whether the Social Work Department would have funded one-to-one care for Mr Brown if asked, but the home never approached and asked for such a thing to take place. Mrs Bell was not in any doubt that when admitted to Tullideph, and indeed Forebank, Mr Brown's care needs would be met, and she took into account the care needs of other residents.

(262) She would have expected Mr Brown to be kept well apart from other residents, and there would be a member of staff in a communal area such as the sitting room supervising all the time. If she had known that Mr Brown would be in a communal area unsupervised with other residents then she would not have been happy to let him go to Tullideph.

(263) On the information available when he went into Forebank and indeed Tullideph, there was no basis for admitting Mr Brown to a psychiatric hospital.

(264) When Mrs Bell was precognosced by the Procurator Fiscal's Office she then was shown a list of incidents which had taken place at Forebank and was horrified. She knew that Mrs Bree was unaware of these incidents and the GP practice was unaware of these incidents. If she had known about what happened at Forebank she would have called a psycho-geriatrician and would have had Mr Brown re-assessed. In cross-examination by Mrs Glen on behalf of Mr Hutchison's family, Mrs Bell went over the incidents which had happened in Menzieshill and was quite clear that these incidents were sporadic and occurred against a background of either care interventions which were taking place or when he was struck by an object. It was entirely right that the GP practice and Mrs Bree would be aware of these incidents to decide what was best. If these incidents had been more violent or occurring on a day-to-day basis, then there might have been a different approach taken, but Mrs Bell had no doubts that when Mr Brown was admitted to Forebank and then Tullideph, on the basis of the information available, the staff including psychiatric nurses in these homes should have been able to cope with a certain level of violence and be in a position to monitor his behaviour.

(265) Mrs Bell was then taken through the various violent incidents which had occurred when Mr Brown was in Forebank, and was of the view that she should definitely have been told about these incidents because it was a different level of aggression and it was being directed towards residents as opposed to care staff. Mrs Bell would have contacted Mrs Bree, told her about the incidents and discussed the question of whether Mr Brown required psycho-geriatric assessment.

(266) Mrs Bell was then taken through other incidents of violence which occurred in Forebank and indicated that she should have been told about all of them. When she conducted a review of Mr Brown's case on 23 October 2002, the only incident she knew about was him kicking a table.

(267) She was shown Production 29, the Transfer Letter from Forebank to Tullideph, which she had never seen before, and it was quite clear that the information provided did not tell the whole story. By that stage she would have had him re-assessed by a psycho-geriatrician and probably admitted to a psychiatric hospital if that were possible. In Mrs Bell's view on the information available, by that stage Mr Brown needed treatment and was a danger to others.

(268) Mrs Bell was then referred to the various incidents of violence which had taken place within Tullideph. Her view was that in the early stages of being at Tullideph, some problematical behaviour might have been expected because of the settling in phase, but in relation to the incidents on 25 November and 30 November 2002 involving violence towards residents, she was in no doubt whatsoever that she should have been told about these. Mrs Bree and the GP should have been told about them, and a psycho-geriatric assessment would have been urgently required.

(269) She confirmed that social work care notes were never transferred to care homes but she would have expected full information to go from one home to another. In cross-examination to Mrs Foulis Mrs Bell indicated that she and the other health professionals depended on the home taking the view that in relation to a particular resident the situation could not be managed. The Social Work Department paid for care and had responsibility for that care.

(270) In response to cross-examination by Mrs MacPhail on behalf of Tayside National Health Trust Mrs Bell indicated that in her view the incidents in the Menzieshill Day Care Centre were different in character and degree from many of the subsequent incidents. When these incidents had taken place it had been arranged for Mr Brown to be assessed by a psychiatrist and the result was that he was to go to a day centre but this was cancelled because he was admitted to Forebank.

(271) In cross-examination by Mrs Bennett on behalf of Four Seasons Mrs Bell indicated that if she had known about the Forebank incidents she would have undoubtedly asked for a psycho-geriatric assessment of Mr Brown and would have been of the view that he was not suitable for even an EMI nursing home. Having said that however, all she could have done was allowed him to go to Tullideph and then tried to get an emergency assessment done.

(272) She agreed that Mr Brown's behaviour was not untypical of dementia sufferers and that EMI staff were qualified to deal with people like him, but she would have hoped that staff would alert her to the fact that his behaviour had undergone a major change and was impacting on other people. The aggressive behaviour had not just been a one-off. It was a series of incidents.

(273) In relation to the incidents at Tullideph she accepted that the staff at Tullideph made a judgement which was to refer Mr Brown to an occupational therapist and try to address issues relating to pain and boredom. In her view however, this did not take away from the fact that Mr Brown's behaviour was a danger to others. She agreed that after the towel incident the home had contacted the GP but her view was that the GP and Mrs Bree should have been told about everything else that had taken place.

(274) Mrs Bell still placed people at Tullideph. She agreed that there could be a shortage of EMI places within the Dundee area and that there was no public sector provision in Dundee.

(275) In re-examination by the Procurator Fiscal Mrs Bell was referred to Production 12 at page 2158 of Book 5, the contract between Dundee City Council and Forebank

Nursing Home in relation to Mr Brown's residence there. At page 2159 of that contract the care manager was described as the member of the Social Work Department staff responsible for assessing and "monitoring" the care of the resident. At page 2159 to page 2160 it was provided that the service provider (the care home) could only give notice of termination of the contract if in the opinion of the care home the resident's condition had deteriorated and the home could not provide the appropriate long-term care or the resident's behaviour was so unsociable that it affected the well-being of other residents. The view of Mrs Bell was that having regard to the terms of the contract she would undoubtedly expect to be informed of the type of incidents which had taken place. It was not good enough to wait until the end of the 6-week review period.

(276) In relation to the incident which she personally witnessed at Forebank on the day of transfer she was unable to prevent it. She had not expected Mr Brown to kick out at anyone. She had never known him to do this. The only thing she knew about was that he had kicked a table. She was not therefore paying particular attention to him. If she had known about the earlier incidents of violence in Forebank she would have been wary about letting people approach him and would have tried to prevent it.

(277) The next witness to give evidence was David Gilling who was a Registered Mental Nurse with an Honours Degree in Science and a Post-Graduate Diploma in Social Sciences, but who since December 2002 had been a Care Commission Officer. His particular area of interest was Acute Adult Intensive Care Psychiatry. As a Care Commissioner his role involved four main components in relation to care homes in Scotland. Firstly the regulation of services, secondly the inspection of services, thirdly the investigation of complaints and fourthly the enforcement of regulations. This responsibility included EMI homes in Dundee and therefore Tullideph Care Home.

(278) The inspection routine involved a minimum of two inspections in any given year, one of which would be announced by giving at least 28 days' notice and the other was unannounced.

(279) One of the responsibilities of the Care Commission was to establish a staffing schedule for a nursing home, in other words to set a minimum level of staffing and specify the skill mix for the home. The level of staff and skill mix set would be based upon the degree of dependency of the various residents. Usually staffing levels were decided by agreement with the nursing home, although the Care Commission could enforce a particular level regardless of the home's consent.

(280) Mr Gilling agreed that the needs of residents within EMI care homes could vary. There could be a high turnover of residents, leading to variation in need, or the level of need might remain static for a significant period of time, but the care provider, that is the nursing home, undoubtedly had the responsibility to monitor the changing needs of residents and to increase the levels of staffing and vary the skill mix if the needs of the residents required it.

(281) In relation to complaints Mr Gilling indicated that complaints about care homes could come from any source. The Care Commission would log any complaint and

then investigate it. Usually a complainer would be referred to the care provider to try to resolve the difficulty, but sometimes this was not possible and the Care Commission had to carry out an investigation. Mr Gilling confirmed that there were over time complaints about Tullideph and some of these related to staffing levels. Some of the complaints about staffing levels were upheld or partially upheld.

(282) Mr Gilling emphasised again that any care home had the responsibility to adjust its staffing levels to meet the needs of residents which might change on a daily basis. If the Care Commission had ongoing concerns about staffing levels in a particular home, then the Commission would work with the home to try to establish a new staffing profile. This was done over time at Tullideph where a pilot project was put in place to try to change the skill mix. This pilot project was ultimately successful and led to a change in the skill mix over the early and late shifts at Tullideph so that there was one less trained nurse but two more senior care assistants trained to a high level. Mr Gilling's recollection was that this new scheme was in place by 2004.

(283) Mr Gilling was referred to Production 9 at page 98 of Book 2, described as Care Commission Reports and Notes. In particular he was directed to page 201 which contained a history of complaints about Tullideph between April 2002 and September 2003, although the document itself was dated April 2004. In particular there were complaints about shortage of staff at Tullideph in June 2002, May 2003, August 2003 and September 2003. Mr Gilling could not remember what the June matter was about. He recollected the May 2003 complaint because that involved quite a complex investigation covering a number of different issues. The August 2003 complaint was an anonymous complaint about the numbers of staff and turnovers of staff. The September 2003 complaint was the complaint by the family of Mr Hutchison about the incident in December 2002.

(284) Mr Gilling was then referred to various inspection reports. The first was at page 102 and related to an inspection in February 2004. Within that report at paragraph 9 it was recorded that the home was implementing a robust and proactive approach to staff training and development. It was also noted that there had been no formal complaints about the home since the last inspection in November 2003.

(285) Mr Gilling was then referred to page 108 of the production, an inspection report relating to an inspection which took place on 4 November 2003. At page 111 it was noted that a number of the care plans for the residents failed to demonstrate that there had been ongoing assessment of their care needs, although the Commission was satisfied that there had in fact been such assessment. It was also noted at page 112 that during the inspection staff appeared to be extremely busy and that this led at times to a scarcity of staff being able to observe and interact with residents in general circulation areas. Reference was made again to the large geographical area of the home and the complex care needs of the residents which place a high demand on staff time. It was noted that the home was engaged in reviewing the number and skill mix of staff to ensure that residents' needs were met and that an adequate level of observation was maintained at all times. The report required that this review should be concluded as quickly as possible and in particular within one month.

(286) Mr Gilling was then referred to page 116 of the production, an inspection report relating to an inspection which took place over three dates namely 13th , 16th and 21st January 2003. There did not however appear to be any particular issues raised in this document.

(287) Mr Gilling was referred to pages 132 and 143 of the production which related to a complaint made in April 2003 by the care manager of a resident who complained in particular that she had to wait at the front door of the nursing home pressing the bell several times for 10 minutes before she was allowed entry by a visitor who was leaving. The visitor told the care manager she had similar difficulties gaining access. The care manager was then able to enter the home, go into a lift and get to the resident's room at the end of a corridor without seeing any member of staff and without being challenged about her entry into a home.

(288) Mr Gilling was then referred to page 154 of the same production which related to an unannounced visit made to Tullideph Nursing Home on 19 June 2002 after an anonymous complaint had been received on 12 June 2002 raising various concerns including shortage of staff. That inspection disclosed that the home was meeting the then current staffing notice the majority of the time, but that there had been two days when there were shortages.

(289) Mr Gilling was referred to page 159 of the same production which was a letter from the Care Commission to Mrs Downie, the manager of Tullideph, in relation to the complaints made by the care manager referred to above and also complaints made by Dr Cuthill following his visit to the home in February 2003 in relation to the same resident, when he also encountered very few staff on duty. Both the care manager and Dr Cuthill also found that staff appeared to be unable to provide a detailed background history in relation to the resident. Mr Gilling confirmed that the part of the complaint relating to a lack of staff was partially upheld and the complaints about staff being unaware of the resident's medical background was fully upheld. The home was required by the Care Commission with immediate effect to organise staff in such a manner to ensure that communal areas were properly observed. The other relevant requirement was that staff should be conversant with the needs of all residents under their care, and that all appropriate health and social care information should be received into the home from relevant services.

(290) Mr Gilling indicated in general terms that he would expect staff coming on duty on a shift to get a clear and thorough report on the care needs of residents as they might have been affected by any events during the preceding shift or shifts. He would also have expected any nursing home to be told if an incoming resident had a history of attacking other people.

(291) Mr Gilling was then referred to a letter from the Care Commission to a complainer dated 8 October 2003 which related to a complaint made in August 2003, in particular relating to the absence of staff in attendance when residents were sitting in lounges on the ground and upper floors. The letter noted that this had led to an unannounced inspection of Tullideph on 29 August 2003 when it was noted that the lounge was not supervised by staff. Reference was made also to this perhaps being because agency staff were not fully aware of their duties, and also the difficult layout of the home. It was noted on page 207 of the productions as part of the same letter

that as expected action the home was due to commence a pilot project aimed at improving staff numbers and care delivery.

(292) Finally Mr Gilling was referred to production 10 at page 827 of Book 3, described as a note of a meeting which took place on 15 April 2004 in relation to the Tullideph staffing pilot. It was noted there that the pilot had commenced on 19 January 2004 and the observation made was that there were now additional staff present in the home who were circulating and were more obvious in their presence. There was a reference to better training and induction leading to an increased understanding of the needs of the residents, and also a card system identifying staff to particular duties such as observation of residents.

(293) Mr Gilling confirmed that the ultimate sanction of the Care Commission if a nursing home was not improving was to issue improvement notices which could ultimately lead to closure of a home. The Care Commission had never felt it necessary to issue improvement notices in respect of Tullideph.

(294) In cross-examination by Mrs Glen, Mr Gilling was clearly of the view that if a resident transferred from one home to another, then the key components in the care plan should be communicated by the first home to the second.

(295) In cross-examination by Mrs Foulis on behalf of the Care Commission Mr Gilling was referred to Production 31, the National Care Standards for Care Homes for Older People, dated March 2005, in particular at page 50 of that document which informed a potential resident that if moved from one home to another then the resident's records would be passed on quickly to the new home and would be complete and up-to-date. Mr Gilling was shown Production 29, the Transfer Letter from Forebank to Tullideph, and was quite clear that this was not a comprehensive survey of Mr Brown's care needs, and in particular that any change in his behaviour during his time at Forebank should have been clearly communicated. He would have expected repeated acts of aggression to be highlighted. In Mr Gilling's view it would be easier to transfer the whole care plan from one nursing home to the next. The provision of the "old" care plan would be a useful tool to the new home in devising their care plan. A detailed summary of the care plan would also be useful.

(296) Mr Gilling was then asked what the main issues were in relation to staffing within Tullideph and he indicated that one of the principal issues was the question of observation of residents. It was important to have staff in communal and corridor areas, and as a result of observations at Tullideph, this type of observation appeared to be lacking. Mr Gilling was not aware of Tullideph causing concerns before the point at which he took over in April 2003, which was when formal discussions started about changing staffing levels and a mix of staff.

(297) Mr Gilling indicated that there was a tool used by the Care Commission to assess staffing levels. This involved assessing the number of hours of care that individual residents would require within a 24-hour period. This was then translated into the number of staff. This tool was perceived as being imprecise and it was Mr Gilling's understanding that the Scottish Executive was currently looking at alternatives to the use of this tool. At the moment the assessment process did not cover the question of the complexity of the environment, nursing homes with a

difficult geographical layout or residents with very complex needs. Mr Gilling was not sure where the Scottish Executive had reached in its consideration of alternatives. He believed that a representative of the Care Commission had been seconded to work with the Executive in developing a new tool.

(298) In April 2003 the Care Commission discussed with the home a joint approach to try to devise a system which would then be piloted to see how it operated in practice. The pilot started in June 2004 and led to a new staffing schedule being issued in October 2004. This was production no 24 or production 5 in the Inventory of Productions lodged for the Care Commission.

(299) The new schedule involved a reduction in the number of qualified nurses in an effort to see whether care could be delivered more effectively through re-structuring the staffing and having more care assistants "on the shop floor". The decision was also partly driven by a difficulty in recruiting nursing staff. The reduction in nursing staff would be met by appointing two senior care assistants trained to SVQ3 level, and these senior carers would effectively lead the care assistants.

(300) A new staffing schedule was agreed as at March 2005. This was production 23 or production 4 in the Inventory of Productions lodged for the Care Commission.

(301) The Care Commission never got to the stage with Tullideph of issuing an improvement notice. It was considered at certain points but it was felt that Tullideph was working with the Care Commission to try to move things forward.

(302) Mr Gilling reiterated again that in his view Production 29 - the Transfer Letter from Forebank to Tullideph - was a clear breach of national care standards. The receiving home and the delivering home were both responsible to ensure that proper information was passed. In cross-examination by Mrs Bennett on behalf of Four Seasons Care Homes Mr Gilling confirmed that in his view Tullideph was co-operative in working with the Care Commission during the process of re-assessment from April 2003 onwards. While there were some difficulties his view was that Tullideph did move matters forward reasonably quickly. He confirmed again that in his view the current tool used for assessing staffing levels was not by any means perfect.

(303) He had no doubt on the basis of inspection of Tullideph that the staff there were caring towards residents. He had dealt with complaints in relation to other care homes. He was asked whether there were any common themes that tended to crop up in complaints about care homes. He confirmed that issues of staffing and the skill mix of staff did come up occasionally in relation to other care homes but he had never dealt with other homes which threw up complaints in the same consistent way that Tullideph did in relation to issues of staffing.

(304) The final witness to give evidence was Margaret Semple, aged 48, a consultant psychiatrist at Royal Dundee Liff Hospital. She confirmed that she had prepared a report, namely Production 6 at page 15 of Book 1, and had also subsequently written a letter to the Procurator Fiscal which was Production 5 at page 14 of Book 1. The report and letter addressed issues relating to the incident on 3 December 2002 and the particular circumstances of Mr Brown and Mr Hutchison.

(305) Firstly Dr Semple was referred to her report. She confirmed that in preparing the report she had had access to Mr Brown's medical and local authority records. The first question she was asked to address was "What was Mr Brown's psychiatric condition at the time of his admission to Tullideph?" Her report addressed the history of Mr Brown's condition, and I do not feel it necessary to go into that in detail, but her conclusion was that at the point of admission to Tullideph on 13 November 2002 it was clear from his records that Mr Brown had escalating behavioural problems associated with vascular dementia and a painful hand, and that he had been physically aggressive towards several other residents between 4 and 13 November while in Forebank. Dr Semple felt there was no clear evidence that he had been suffering from hallucinations or delusions. His expressive language skills were impaired and his capacity to understand the spoken word was also restricted. In evidence she indicated that in her view it would have been helpful if staff at Forebank had contacted Mr Brown's GP practice in the first instance so that the GP could assess the situation arising from his deteriorating aggressive behaviour. In particular consideration could have been given as to whether it would have been appropriate to refer Mr Brown for psychiatric services.

(306) Next Dr Semple was asked whether the care supplied to Mr Brown was adequate, including the provision of medication. Dr Semple concluded that while there were several references to episodes of physical aggression perpetrated by Mr Brown at Forebank and then at Tullideph, it appeared to her that the care staff dealt with these appropriately. At the time Mr Brown was admitted to Tullideph he was on various drugs but was not prescribed any psychotropic medication. Dr Semple noted that there was no record of care staff contacting the GP to ask for a review of his medication even after several acts of physical aggression by Mr Brown. In her opinion this should have been considered. In her evidence however Dr Semple confirmed that her view was that there should have been an assessment of Mr Brown before moving to such medication. Those carrying out any assessments should have had all available information. She felt that it was entirely appropriate that after the towel incident Patricia Bree was asked to visit Mr Brown and assess the position, but on arrival Mrs Bree should have been given the whole history of aggression.

(307) In the view of Dr Semple, given what ought to have been known about Mr Brown when Mr Brown was in the presence of other residents, he should have been kept under supervision within the eyesight of a member of staff.

(308) Dr Semple was then asked to consider whether Mr Brown in the whole circumstances should have been admitted to Tullideph at all, and her conclusion was that the decision to transfer him to another EMI nursing home was not inappropriate. She emphasised that having regard to the Tullideph Care Plan which had been devised during November 2002, his behavioural and psychological needs appeared to be recognised at the time of admission, and staff were appropriately advised on how to manage them.

(309) It was also noted that his care manager and his wife visited him shortly after his admission to Tullideph and he appeared to be settling in well.

(310) In evidence Dr Semple confirmed that many residents of EMI homes behaved like Mr Brown as far as aggressive behaviour was concerned. Her clear view was that if a home could not meet the level of needs of such a resident, then they should not accept such a person for admission. In EMI homes the residents were not generally constantly under supervision, but Mr Brown's needs were changing and there should have been constant re-appraisal of his needs. In her view most EMI homes adopted a high level of observation of new residents until the resident had been fully assessed.

(311) Next, Dr Semple was asked to consider whether the events which led to Mr Hutchison's death were foreseeable. The conclusion of her report was in the following terms: *"It is difficult to state that the events which led to Mr Hutchison's death were foreseeable. There were a number of incidents both before and after Mr Brown's transfer to Tullideph Nursing Home which indicated that he presented a risk to others, both care staff and fellow residents. Mr Brown had not threatened to kill anyone. There was no record of Mr Brown specifically targeting any other resident, particularly on a repetitive basis. I could find no evidence of Mr Hutchison being assaulted by Mr Brown prior to the incident on 3 December. The incident on 30 November 2002, during which he pulled a towel around a fellow resident's head, was particularly concerning. This incident was only terminated by the prompt action of a member of staff. It might have been helpful to have sought an urgent opinion that day from Primary Care Medical Staff, in the first instance. In turn due consideration might have been given to contacting the Psychiatry of Old Age Service for a review of Mr Brown's health needs in the light of his severe behavioural problems in the setting of dementia. Advice could have been given on the continuing appropriateness of Mr Brown's treatment plan. Unfortunately on 3 December 2002 Mr Hutchison appears to have approached Mr Brown when he (Mr Brown) was already in an aroused state. Mr Brown lashed out at Mr Hutchison and caused a severe injury. It is not possible to state exactly why Mr Brown behaved this way."*

(312) In evidence Dr Semple was of the view that it was not appropriate to leave Mr Brown alone without supervision. In her view the situation with regard to his aggressive behaviour was escalating as at 3 December and the home should have been reviewing his treatment plan and considering pharmacological and non-pharmacological approaches to his aggression. While Mr Brown's behaviour towards Mr Hutchison on 3 December was in a sense not foreseeable, it might have been prevented if someone had been in the room at the time. In particular, if someone in the room had known of the information in the care plan, that person could have been more vigilant. If that person had been aware of Mr Brown's full history, then the approach to Mr Brown might have been coloured.

(313) In general terms, if staff were to supervise Mr Brown, then they should have considered whether they could meet his needs and also the needs of other residents for safety.

(314) Even taking account of the aggressive behaviour there had been at Tullideph, let alone Forebank, the staff at Tullideph should have been keeping him under clear observation.

(315) Dr Semple was asked to consider Production 29, the Transfer Letter between Forebank and Tullideph, and she felt the terms of the Transfer Letter constituted a clear warning to the staff at Tullideph, and that even on that basis alone they should have kept Mr Brown under close observation, particularly having regard to the fact that he would then be in a changed environment with a whole new set of carers which was likely to impact on his behaviour.

(316) In cross-examination by Mrs MacPhail on behalf of Tayside NHS Trust, Dr Semple agreed that following the aggressive incidents at the Menzieshill Day Centre in 2002, a referral to the Orleans Day Centre was perfectly appropriate. The incidents at Menzieshill were of a different calibre to what eventually took place at Forebank and Tullideph. Given that Mr Brown ended up being admitted to Forebank before he was due to attend at the Orleans Day Centre for assessment, it would have been quite normal to cancel the day hospital placement.

(317) Normally the Social Work Department informed the psycho-geriatricians if a patient had been admitted to an EMI home. It would not be routine for the psycho-geriatricians to screen all admissions to EMI homes. They would have to be asked specifically to carry out assessment. The psycho-geriatric service was not contacted until 4 December, after the incident between Mr Hutchison and Mr Brown.

(318) In cross-examination by Mrs Bennett on behalf of Four Seasons Healthcare Dr Semple reiterated again that she had no criticism of the move of Mr Brown from Forebank to Tullideph. She also agreed that Tullideph's decision to have an occupational therapist assess Mr Brown rather than move to medical intervention was entirely appropriate. After the towel incident on 30 November which appeared to have happened at 6.30 pm, Dr Semple confirmed that there would be a GP out-of-hours service and that psychiatric assistance could have been sought even at that time, but while she thought it might have been helpful to have had Mr Brown assessed more quickly rather than a few days later, this was still a judgement call to be made by the psychiatric nurse and she would not criticise that nurse for not treating it as more of an emergency.

(319) At Royal Liff, Dundee, when someone was admitted there was usually a 6-week assessment period. The hospital did not wish to rush to give medication to people but rather assess them and take account of their history and then decide whether medication was appropriate and safe. She could not recall whether Mr Brown was prescribed medication on his admission to the hospital. She agreed that many residents in EMI homes displayed aggressive behaviour and that Mr Brown's behaviour was not untypical.

(320) Had Mr Brown not been admitted to Tullideph in November 2002 it would have been up to his care manager and family to decide what to do next, but he certainly could not have been managed in anything less than an EMI home. It was extremely unlikely that he could have gone home. It could not be said that a bed in a hospital could have been guaranteed that day on 13 November 2002, and Dr Semple could not say whether he would have been admitted somewhere.

(321) In psychiatric hospitals one-to-one care for residents was not provided. Dr Semple did not know the ratio of staff to patients but was able to confirm that

patients in psychiatric hospitals had assaulted other patients despite being in a ward environment.

(322) Mr Brown continued to display aggressive behaviour in Liff Hospital. Dr Semple believed he assaulted someone in the Liff Hospital. This happened even though those staff caring for him knew about his background history of aggression. Dr Semple confirmed that there was a known risk of managing people with dementia that aggressive behaviour could take place. Aggression could happen and it could be difficult to react quickly enough to stop it.

(323) She agreed with the general policy of Tullideph to encourage people to move around.

(324) Finally she indicated that whether someone suffering from dementia could be described as a reliable witness would depend on the degree of their dementia.

Decision

Firstly I wish to deal with two preliminary matters.

(1) I wish to explain why I will not be addressing in detail certain issues. All witnesses who gave evidence on the matters were agreed about certain things. There is no provision within the public nursing home sector in Dundee for care of EMI residents. The only option between "ordinary" nursing homes (which may be public or private) and psychiatric hospitals is a private EMI home, of which there are about 5 in the Dundee area. The task of caring for EMI residents is onerous and demanding. Care assistants within the public sector are paid more than those in private homes and have other enhanced employment conditions. Private homes have difficulty retaining staff for this reason, coupled with the demanding nature of the job. Private homes therefore often require to rely on staff recruited from external agencies. Such staff may not have English as their first language. EMI residents require continuity in their care staff. Constant changes in personnel are likely to unsettle residents and can lead to staff being unfamiliar with the care needs of residents or insufficiently familiar with their detailed duties. On the evidence led before me none of these considerations had any bearing upon the death of Mr Hutchison, the circumstances surrounding the incident on 3rd December 2002 or the system of working relevant to those circumstances. I do not therefore propose to address them further, which is not to say that these issues should not be of concern to those with responsibility for regulating the care "industry".

(2) The first two witnesses were Catherine Kelly and Yvonne Hutchison, two daughters of James Hutchison. I wish to acknowledge the dignified way in which they gave evidence and the responsible manner in which, in the aftermath of their father's tragic death, they sought to ventilate their perfectly legitimate concerns about the circumstances. In addition I wish to emphasise the compassionate attitude which they exhibited towards Andrew Brown. Evidence was led about the character of Mr Hutchison and Mr Brown during their life. It was clear that, before being transformed by dementia, they were similar men - loving husbands, good fathers and hard

workers. Both had been of a gentle disposition. After becoming ill they each manifested different personalities. Part of Mr Brown's behaviour involved his showing aggression towards carers and fellow residents. This arose from fear, pain and frustration rather than malice. Mrs Kelly and Ms Hutchison recognised this in their evidence and took pains to articulate that they did not blame Mr Brown for the part they saw him as playing in their father's death. For this they deserve credit. I should also say this. At the outset of the inquiry my attention was drawn, for various reasons, to certain press reporting of the death of Mr Hutchison and the accident in the home on 3rd December. It seems to me that this coverage presented a wholly distorted picture of the circumstances, giving the impression that Mr Brown was a maliciously violent man who had perpetrated a wicked assault on Mr Hutchison. The view I have formed on the evidence was that Mr Brown was not capable of behaving in a deliberately wicked manner. No great deal of force would have been required to cause Mr Hutchison to fall. His injuries were sustained in the act of falling, rather than through any blunt force used by Mr Brown. Given Mr Hutchison's age and frailty the injuries he sustained were predictable. Given his heart condition the likelihood of his dying was unfortunately substantial. Both men were essentially victims of their illness.

Turning to the credibility and reliability of the witnesses in general terms, with certain exceptions I felt that all of the witnesses were doing their best to recollect facts and gave a reliable account of the facts within their knowledge. The principal exceptions to this were, in my view, Joan Downie and Kathleen Stewart. My assessment of these witnesses was that they sought where possible (a) to exaggerate the efficiency of the systems in place within Tullideph as at December 2002, particularly as regards supervision of communal areas and sharing of information and (b) to avoid responsibility for forming a clear understanding of Mr Brown's needs based upon his care plan. My view on the evidence was that staff at Tullideph were not given the information they should have been given by staff at Forebank about Mr Brown's aggressive behaviour there. Nonetheless, even when confronted with that information during examination, Mrs Downie and Mrs Stewart, in my opinion, sought to "downplay" its significance in an effort to characterise the behaviour as no more than would be expected from a dementia sufferer. This flew in the face of all other expert opinion which I heard and seemed to me to be an attempt to deflect what they saw as an effort to attach to them responsibility for not addressing his conduct more quickly. Mrs Downie also denied that when Mr Brown was transferred to Tullideph she received a copy of his social work care plan from Jacqueline Bell. This was contradicted by Mrs Bell, contradicted by Mrs Bell's records and contradicted by the production of Tullideph's care plan for Mr Brown dated during the days immediately following his admission and clearly demonstrating that it had been informed by the social work care plan. I therefore did not find them to be credible and reliable witnesses. Questions were raised as to the credibility and reliability of the witness Elizabeth Smith with particular reference to the question of whether she was in the lounge seconds before the incident, only leaving for an instant to stand at the threshold of the room to speak to Mrs Stewart, as she apparently told the police, or whether, as she said in evidence, she was putting residents to bed and had not been in the lounge for a while, so that it was unsupervised at the critical time. The evidence of Robert Livingston on this important matter, in certain respects, tended to support the evidence given by Mrs Smith to the effect that the room was unsupervised, albeit at other points their evidence was contradictory. On a balance

of probability, the view I reached was that the lounge was completely unsupervised at the critical time and had been unsupervised for some time before. The evidence of Smith and Livingston about the need at that point in the shift to be heavily engaged in seeing to the bedding and toileting needs of residents was consistent *inter se* and consistent with the evidence of Downie and Stewart. There was also general evidence about the lounge frequently being left unsupervised because staff were busy. This came from Mrs Kelly and Mrs Hutchison as well as Mr Gilling from the Care Commission. All of the witnesses to the incident inevitably suffered in their recollection by the passage of time since the events, but I decided that I was prepared to rely on the evidence of Smith and Livingston on this point.

There was no great dispute about the medical and forensic evidence of Dr Sadler and Mr Nassif whom I found to be credible and reliable. James Kilgour, Dr Margaret Semple and David Gilling were essentially purely expert witnesses all of whom I found to be credible and reliable. Patricia Bree and Josephine Bell were both witnesses to fact but also able to give evidence of opinion in relation to facts which were not within their knowledge at the time of the events. I found them to be credible and reliable witnesses.

I turn now to my specific determinations and recommendations.

Section 6(1)(a) of the 1976 Act - where and when the death and any accident resulting in the death took place

There was no dispute about the time and place of death. The fact that the accident on 3rd December 2002 "resulted" in the death was clearly spoken to by Dr Sadler and Mr Nassif. Because of his existing heart disease, the extent of which was only ascertained *post mortem*, Mr Hutchison was unfortunately liable to die at any time. However the injuries sustained in the accident and the trauma of the resultant hospitalisation and operation alongwith the existence of acute bronchial pneumonia were clearly identified by Dr Sadler and confirmed by Mr Nassif as the triggers or surrounding circumstances which led to the fatal episode of heart failure. I acknowledge that my findings, which reflect the evidence of Dr Sadler, are at odds with the cause of death as assessed at the time of death and as registered with the Registrar of Births, Deaths and Marriages, namely pneumonia, dementia and (as a significant contributing condition) fractured femur. However I was impressed by the evidence of Dr Sadler and Mr Nassif as to the part played by coronary artery disease in the death and their explanation that it is in no way unusual for the attending clinician's view of the cause of death to be found to be wrong following upon *post mortem* examination.

Section 6(1)(b) of the 1976 Act - the cause or causes of such death and any accident resulting in the death

I have already referred to my view of the causes of death. The cause of the accident was a more difficult area, there being virtually no evidence from any eye witness as to the circumstances leading to Mr Hutchison's undoubted fall to the floor of the residents' lounge. However, on analysis of the circumstantial evidence a compelling picture emerges. Mr Brown was seated in the lounge where there were other residents, including Mr Hutchison, Gretel Clark, Mr O'Hara and Mr Legge. All

suffered from differing degrees of dementia. Mr Brown was someone who had in the past manifested a propensity for behaving violently including kicking out at and thus knocking over fellow residents. He had a fear of pain and was liable to act aggressively if someone, even a carer, came close to him unexpectedly. He could not articulate his fears verbally. Once seated in a chair Mr Brown could not rise from the chair unaided. Gretel Clark was mobile. She liked to wander around, picking up imaginary objects and touching the garments, jewellery or hair of residents or others. Mr Hutchison was mobile. He was a caring person who liked to help others. When staff got into the lounge after the incident they found Mr Brown still seated and kicking out in the direction of Mr Hutchison who was lying on the floor near to, but out of range of, Mr Brown. Mr Hutchison was clearly in pain. Gretel Clark was also lying on the floor near Mr Brown. Mr O'Hara and Mr Legge were pointing at Mr Brown and shouting remarks suggestive of Mr Brown having just kicked Mr Hutchison. When removed to his room Mr Brown, on being asked if he knew why he had been removed, said to Mr Livingston "For kicking that bastard". All of Mr Hutchison's injuries were on his left side and were consistent with having resulted from one fall. On a balance of probabilities I am satisfied that Mr Brown kicked Mr Hutchison, causing him to fall to the floor and that Mr Hutchison sustained his injuries as a result of that fall, rather than as a direct result of the initial kick. I do not believe that there was any further contact between Mr Brown and Mr Hutchison after the fall. I think that it is probable that Mr Hutchison had got close enough to Mr Brown to be kicked because Gretel Clark had done the same, Mr Brown had knocked her over and Mr Hutchison went to assist her. This scenario was noted in certain Tullideph records as what had happened. However it is hard for me to see how this could have been positively asserted to be the case, rather than being the same deduction which I have made from circumstantial evidence.

Section 6(1)(c) of the 1976 Act - the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided

I acknowledge that with the benefit of hindsight we all have perfect perception of events and their causes. However, my view is that, for reasons which I will set out, it would have been a reasonable precaution which might (my emphasis) have resulted in the accident being avoided if in Forebank or in Tullideph staff had arranged an urgent reassessment of Mr Brown after his aggressive behaviour towards residents. They should have contacted his GP practice, his social work care manager and (perhaps) made direct contact with a psychogeriatrician so that an assessment could be made. The likely (but not inevitable) outcome of such an assessment would have been that Mr Brown would not have been resident in Tullideph on 3rd December 2002.

Further I recognise and accept the evidence which came from a number of witnesses, not only Mrs Stewart and Mrs Downie, that (a) no care home or psychiatric hospital routinely provides 1-1 care and supervision for residents; and (b) even with supervision, perhaps even with very attentive supervision, all accidents cannot be eliminated within care homes and psychiatric hospitals. However I am asked to determine at this stage whether there was any reasonable precaution which could have been taken which might have resulted in the accident being avoided. As already explained, I am satisfied on the evidence that, at the time of the accident and for some time before, the residents' lounge in which there were a number of

residents including Mr Brown, Mr Hutchison and Mrs Clark had been wholly unsupervised by any member of staff. My view is that, for reasons which I will set out, this created a clear risk of occurrence of the type of incident which did occur and thus the safety of Mr Hutchison and the other residents was compromised. However I would go further. My view is that, for those same reasons, not only would it have been a reasonable precaution to have the lounge constantly supervised but Mr Brown himself, as an individual resident posing a specific risk of harm to the other residents, should have been subject to close supervision from the moment of his admission to Tullideph and certainly once he began to show aggression to residents, until such time as he could be urgently assessed by a psychogeriatrician with a view to determining whether his needs could be met in Tullideph without compromising the safety of other residents and staff.

I have set out in my determination the considerations which, in my judgement, make reasonable the precaution of close supervision of Mr Brown when he was with other residents.

Firstly, there was ample evidence from a number of witnesses to the effect that dementia sufferers commonly exhibit challenging behaviour, including behaving aggressively towards those providing care to them and to others. Such behaviour could occur unpredictably or, having regard to the circumstances of the particular resident and the background against which previous acts of aggression had occurred, there might be identified triggers for or causes of the aggressive behaviour. If the risk of aggressive behaviour was predictable then strategies could be developed, tailored to the individual resident, which could either minimise the risk of the behaviour taking place or at least minimise the risk of harm. Mrs Downie and Mrs Stewart both recognised that in caring for the particular type of resident housed in Tullideph they were dealing with persons some of whom could and probably would behave aggressively.

Secondly, Mrs Downie and Mrs Stewart stated in clear terms that one of the policies of management at Tullideph was that it was the home of the residents and that they should therefore be free to enjoy their home as anyone in the community can enjoy theirs. This included having the "right" to wander around communal areas insofaras their motor ability permitted. This "right" was extended to residents who exhibited challenging behaviour and so, rather than medicate such residents to the extent that they were virtually immobile, the philosophy of the home was to try to identify the causes of or triggers for the challenging behaviour and address it that way. Triggers could be pain, boredom, fear or frustration with an inability to communicate verbally. Rather than rush to the resident's GP to seek a prescription for sedative medication the staff at Tullideph would tend to consider, for example, a new regime of pain relief or the engagement of an occupational therapist to combat boredom. Other witnesses agreed that this approach could be perfectly appropriate. However, in my view the result of this laudable attitude to the freedoms of residents was that at any given moment it was entirely likely that a significant number of residents in Tullideph might be in communal areas moving around rather than confined to static sites, such as a chair. Given Mr Brown's lack of mobility there was no risk of him moving anywhere, but there was a clear risk of others moving close to him.

Thirdly, there was available in the historical records relating to Mr Brown, clear evidence of his propensity to behave aggressively towards staff and other residents. My view, which I will articulate in more detail, is that there was a failure of communication of this information to those who required to have it in order to make informed decisions about the care needs of Mr Brown and the risk of harm to others.

The evidence disclosed that Mr Brown had exhibited aggressive behaviour in October 1997, November 2000, February 2001, May 2001, June 2001 and August 2001. All of this conduct was relatively mild, was directed towards carers and usually, but not always, occurred when some care intervention was taking place. Mr Brown's social work care manager and Mrs Bree, the dementia expert attached to his GP practice, were aware of this conduct. Details of his propensity were recorded in his social work care plan and strategies to deal with it were set out. This conduct was well within the range of predictable behaviour of dementia sufferers. There was a review of Mr Brown's case on 29th August 2001, attended by Mrs Bree and his then care manager. Mr Brown's needs could not be met by the Menzieshill Day Centre where most of these incidents had taken place. There was a psychiatric review of Mr Brown and he was referred to Alzheimer Scotland. There was then a period of calm before a further episode of aggression towards a care assistant attending to Mr Brown within his home. It involved gripping the carer's wrist when she tried to bathe him. This was on 17th September 2002 and was notified to Josephine Bell and Mrs Bree. Mr Brown was admitted to Forebank Nursing Home on 20th September 2002 as his wife could no longer cope with his care. He had been due to be assessed at the Orleans Psychiatric Day hospital but this was cancelled because of his admission.

On admission to Forebank Mrs Bell provided to Forebank the social work care plan which she had devised over time and which she revised between 17th and 20th September 2002. This care plan referred in terms to Mr Brown's aggressive behaviour towards carers, his sensitivity to pain, the need to explain all care tasks to him before commencing and the need to explain things to him generally.

Once in Forebank there were further acts of aggression. On 22nd September he punched a care assistant when his personal hygiene was being attended to. On 27th September he pushed "people" away. On 1st October he kicked a resident in the stomach, resulting in that person falling heavily to the floor. He also threatened another resident who came to assist that she should "watch or she would get the same". On 4th November he kicked a resident in the stomach twice. On 8th November he was punched by a resident. A few minutes later a different resident walked past him. Mr Brown kicked him in the stomach. On 10th November he threw soup over a resident and later kicked over his table.

Not one of these incidents was reported to Mrs Bell or Mrs Bree, although they were all clearly recorded in his Forebank care notes. The first two incidents might have been perceived as resulting from Mr Brown coming to terms with his new surroundings and, even if they had been reported, might not have led to any sense of urgency in having Mr Brown assessed by a psychogeriatrician, but the other incidents were of a different quality entirely, in the view of Mrs Bree and Mrs Bell. They exhibited a clear escalation in Mr Brown's aggressive behaviour, both in terms of severity and also in terms of it being directed towards residents. Mrs Bree and Mrs

Bell had no doubt that these incidents should have been reported to them so that consideration could be given to how to proceed.

On 13th November 2002 Mr Brown was admitted to Tullideph. Mrs Bell and Mrs Bree accompanied him. While waiting to leave Forebank Mr Brown kicked a passing resident who had got close to his feet. Mrs Bree and Mrs Bell witnessed this but, while concerned, did not know about the earlier incidents in Forebank and therefore could not put it in the context of his escalating aggression.

Initially in their evidence both Mrs Stewart and Mrs Downie offered the same assessment of Mr Brown as at the date of his admission to Tullideph, namely (1) that he had in the past gripped the wrist of a carer and therefore care had to be taken by care assistants in administering to him; (2) that the strategy for dealing with this was to explain interventions to him in advance, not to approach him suddenly and to monitor the issue of pain relief for his hand; (3) that he tended when seated to have his legs stretched out creating a danger of tripping others; (4) that the strategy for dealing with this was to seat him in communal areas well away from others. They insisted that this view of the risks posed by Mr Brown essentially remained the same throughout his residence in Tullideph

.The evidence of Mrs Downie was that there had been no formal pre-admission assessment of Mr Brown by Tullideph. The transfer had been an emergency and time did not allow for an assessment. On admission Mrs Downie received from Forebank a "transfer letter" containing, in my view, the scantiest of information, although it did refer to the following under "Other Information":- *"Andy can become aggressive with staff and residents - care should be taken when residents are passing as he may push them over or throw items at them".* Mrs Downie also claimed that she spoke to a Mr McDonald, the manager at Forebank, Mrs Bell and Mr Brown's wife. She said in evidence that she was told about the incident at Forebank on the day of transfer. She denied receiving a copy of the social work care plan. As I have already explained, I prefer the evidence of Mrs Bell that she handed over a copy of the social work care plan dated September 2002 on the day of admission. Mrs Bell also told Mrs Downie about the incident at Forebank that day. In accordance with what was apparently normal practice the records of Forebank, which detailed all his acts of aggression there, were not passed to Tullideph and there was no evidence that anyone at Tullideph was told about them. Mrs Bell and Mrs Bree did not themselves know about these incidents.

Despite Mrs Downie's evidence about not receiving a copy of the social work care plan, there was prepared at Tullideph a care plan for Mr Brown. This care plan followed a standard form. There were individual sections focusing on different aspects of care such as mobility, continence, hygiene, sleep, nutrition, communication. Each section identified the need or problem, then the objective, then the strategy for achieving the objective. Each section of the care plan had a commencement date. The date for most sections was 13th November 2002. Some sections were dated 18th November 2002, including a section dealing with Mr Brown's aggressive behaviour which contained the following strategies :- *"Andy can become aggressive with staff and residents. If it happens settle him in a quiet safe area and give him time until he feels better (ensure regular checks)"* and *"Andy has*

to be supervised when he is with other residents because he could push them over or throw items at them".

To summarise then...at the point of admission to Tullideph there was ample evidence of his ability to be very aggressive towards residents as well as staff. This information was not given to his care manager or the GP practice dementia expert. Detailed information was not given to staff at Tullideph albeit there was a general description given in the transfer letter. Despite the very restricted assessment of his capacity for violence spoken to by Mrs Downie and Mrs Stewart, the care plan devised for Mr Brown at Tullideph referred to the possibility of Mr Brown being aggressive towards residents and pushing them over and the need to supervise him when he was with other residents.

I turn now to consider how Mr Brown behaved in Tullideph. The records disclose some incidents of Mr Brown apparently falling out of his bed or, on one occasion and falling in a lounge when his mobilator (walking frame) got stuck There are no episodes of aggressive behaviour noted until 24th November 2002 when he is recorded as being "very aggressive toward female staff" and then on 25th November "Aggressive and kicked off one of the residents and she fell down on the floor" and then later the same day "Andy was also very aggressive towards female staff spitting in their face and kicking out. Andy was also noted to kick out at [a] resident as they passed. Reminded same behaviour unacceptable". On 30th November he is recorded as having tried "to cover one of the residents face and nose with a towel forcefully". On 3rd December (the day of the incident with Mr Hutchison) the following is noted "Aggressive at first but settled after 30 minutes".

Contact was made with Mr Brown's GP following the incident on 30th November with the towel. This was why Mrs Bree attended to see him in the afternoon of 3rd December, the same day the practice was informed. However no effort was made to seek advice or notify Mrs Bree after any of the earlier incidents. No extra measures of supervision were put in place. The clear evidence of Mrs Bree and Mrs Bell was that they should have been notified of the 25th November incident, even allowing for the fact that the staff at Tullideph had not been told in terms about all of the Forebank incidents and thus could only assess the Tullideph incidents in isolation.

Fourthly, I have already referred to the terms of the care plan for Mr Brown. There was no clear evidence led before me as to how this care plan came to be devised. It can be seen to draw to some extent from the transfer letter from Forebank, the social work care plan and perhaps from an assessment of Mr Brown carried out immediately on admission. There may well have been input from Mrs Brown. There may be aspects drawn from what would be expected in relation to the care needs of any elderly person with dementia. However it came to be drafted there can be no doubt that the plan recommends in terms that, because of his prior aggression to staff and residents (my emphasis) Mr Brown should be supervised "when he is with other residents" (my emphasis). In my view this was an entirely appropriate strategy to recommend, albeit the plan seems to have been drawn up without any detailed information about the aggressive incidents in the past. I heard evidence from four members of the staff at Tullideph and not one of them appeared to be aware of this aspect of Mr Brown's care plan.

Finally, there is the question of the risk of harm posed by Mr Brown. I have already addressed the policy of Tullideph to allow residents as much opportunity as possible to move around the home and the risk this created of residents wandering close to Mr Brown, frightening him and thus provoking an aggressive outburst. In my view, having regard to the age and frailty of many of the residents the risk of serious harm to them if Mr Brown did lash out was high and therefore the need for supervision of him in communal areas was underlined.

In summary, my view is that, even on the limited information available to staff at Tullideph as to how Mr Brown had behaved before admission, how he had behaved in Tullideph and the risk of his causing serious harm to residents who might inadvertently get close to him and taking account of the terms of the care plan actually devised for him, it would have been a reasonable precaution to take for him to be closely supervised when in the company of other residents. Had all of the available information about Mr Brown's previous conduct been available (and I will shortly express the view that it should have been) then in my view the need to supervise him closely would have been established *a fortiori* and, had he been so supervised the risk of his assaulting Mr Hutchison would have been reduced.

The evidence of Mrs Bell and Mrs Bree was clear. They should have been informed of his aggressive behaviour towards residents in Forebank. They would probably have arranged for him to be assessed by a psychogeriatrician. They should have been informed about the incident on 25th November in Tullideph. Even without knowing of the Forebank episodes they might have arranged for him to be assessed by a psychogeriatrician on the strength of that incident alone. On 3rd December when Mrs Bree visited him after the towel incident, if she had been told of the other aggression in Tullideph and still knew nothing of the Forebank behaviour she would have considered such an assessment. It is hard to avoid the conclusion that the transfer of Mr Brown from Forebank to Tullideph on 13th November 2002 was unlikely to be a success. He should have been reassessed before that point was reached. However, as matters actually developed, by that time there was no obvious option for his care other than Tullideph, given the limited information available to Mrs Bree and Mrs Bell. However my clear view is that sufficient information was in fact available to conclude that in Forebank or later in Tullideph staff should have formed the professional judgement that an urgent reassessment of Mr Brown was required. They should have contacted his GP practice, his social work care manager and (perhaps) made direct contact with a psychogeriatrician so that an assessment could be made. The likely (but not inevitable) outcome of such an assessment would have been that Mr Brown would not have been resident in Tullideph on 3rd December 2002.

Section 6(1)(d) of the 1976 Act - the defects, if any, in any system of working which contributed to the death or any accident resulting in the death

I do not propose to repeat the evidence which founds my conclusions under this head, unless new issues are relevant.

As already stated, I am of the view that at the time of the accident the residents' lounge was unsupervised and had been so for some time.

I have already referred to the particularly challenging behaviour which can be exhibited by EMI residents. Such persons are also elderly and can be of limited mobility. They may be physically frail. They will often require assistance, perhaps from two carers, with personal hygiene, toileting, getting undressed and getting into bed. Tullideph Nursing Home housed at the time of the accident 60 residents, divided over two floors. Each floor had two long corridors leading off at an angle from a central point. During the latter stages of the late shift carers would normally be intensely occupied in getting residents to bed. The result of this was that at the time of the accident there was no supervision of the lounge. The evidence of Mr Gilling from the Care Commission established that the Commission has the responsibility to specify a minimum staffing schedule for any care home. This had been done for Tullideph. There was no evidence that at the time of the accident the home was operating with fewer than the minimum staff. However, Mr Gilling emphasised, and Mrs Downie accepted, that whatever the minimum staffing schedule specified it was up to the management of the home to review constantly the care needs, including safety, of residents and utilise additional staff if required. In my view it was clear on the evidence that, having regard to the needs of Mr Brown, the safety of other residents and the terms of his care plan, the home was under a clear obligation to employ sufficient staff so that, whatever the exigencies of the late shift, there was a member of staff with the sole responsibility to supervise him when with other residents.

There was evidence from Mr Gilling that the analysis tool currently used by the Commission to set the staffing schedules is rather crude and is under review by the Scottish Executive, including consideration being given to having as a component assessment of the complexity of the environment (ie the layout of the home) and the complexity of the needs of the particular residents of the home. I make no recommendation about this issue, but express the hope that this review proceeds to a conclusion expeditiously and that these particular issues, which clearly impact on staffing requirements, be considered.

I am clearly of the view that when Mr Brown was transferred to Tullideph the management of Forebank should have provided, and Tullideph should have sought, a copy of his care plan and records compiled during his residence at Forebank. There should also have been provided a detailed summary of the issues relevant to compiling a care plan at Tullideph, to be applicable until such time as Tullideph could independently assess his needs. I would comment that Forebank and Tullideph were at the time homes run by the same company.

A care plan was, somehow, devised at Tullideph. Mrs Downie and Mrs Stewart claimed to be familiar with the care plan. They patently were not. They claimed that their understanding was that the risks posed by Mr Brown could be assessed by reference to his having (1) previously grasped the wrist of a carer and (2) previously sat with his legs stretched out thus posing a trip risk. Their own care plan stated in terms that he posed a risk of pushing over residents or throwing items at them and should be supervised when with other residents. Mrs Downie and Mrs Stewart claimed that all care assistants were told to read the care plans of all residents. This was not the understanding of Mr Livingston who thought he only had to be familiar with the care plans of certain residents. Mrs Downie and Mrs Stewart denied this. Mrs Smith understood that she was supposed to read the care plans of residents but

she had no time to do so. Neither Mr Livingston nor Mrs Smith appeared to be familiar with the care plan of Mr Brown. None of the four "Tullideph" witnesses were aware of the need for Mr Brown specifically to be supervised when with other residents. If there was a policy, articulated to all care assistants, that they should read all care plans (which I doubt) then there was no consideration given to when during a shift they might do so and no system in place to check that they had done so.

As a result of staff at Tullideph having inadequate information about Mr Brown's previous violent behaviour and being insufficiently familiar with his care plan, when he did exhibit aggressive behaviour on 25th November staff were not equipped to make an informed decision about what to do. Similarly, when he behaved aggressively on 30th November, although contact was made with his GP on 3rd December, there was an insufficiently urgent approach taken.

In particular, in my view after the incident on 25th November and *a fortiori* after the incident on 30th November staff at Tullideph should have contacted as a matter of emergency Mr Brown's GP practice and his social work care manager and (perhaps) a psychogeriatrician so that Mr Brown's mental condition and needs could be reassessed with a view to establishing whether Tullideph could continue to meet those needs.

I have made no comment in this connection about any defects in the system of work in place at Forebank. No evidence was led from any staff at Forebank but in my view certain of the criticisms which I have made of the procedures at Tullideph apply with equal force to Forebank. In particular, the failure to inform the GP practice and Mrs Bell when Mr Brown showed high levels of aggression and the failure to contact direct a psyochgeriatrician for assessment. Had these steps been taken I doubt whether Mr Brown would have been transferred to Tullideph.

Recommendations

I have made certain recommendations. I do not believe that I require to explain these having regard to the analysis of the systemic defects which I have set out above.