

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES & GALLOWAY
AT AIRDRIE**

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

INTO THE DEATH OF

GRAHAM RATTRAY

**DETERMINATION by PETRA M. COLLINS, Sheriff of the Sheriffdom of
South Strathclyde, Dumfries & Galloway following an Inquiry held at AIRDRIE
on 26-30 November 2007 and 10-11 December 2007**

Airdrie: 11 January 2008

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

1. that in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Graham Rattray, born 13 September 1963, who resided at 49 Dunellen Drive, Moodiesburn, Glasgow died on 26 December 2005 at said address;
2. that in terms of section 6(1)(b) of the said Act the cause of death was asphyxia due to aspiration of food;
3. that in terms of section 6(1)(c) of the said Act the reasonable precautions whereby his death might have been avoided are that:-

(i) those responsible for his daily care should have ensured that, in the light of his known risk of choking, his care team knew and understood that he had to be watched whilst eating or when he had access to food, in order to prevent him putting too much food into his mouth at the one time;

and

(ii) those responsible for his daily care should have ensured that, in the light of his known risk of choking, his care team knew and understood what first aid to administer in the event that he in fact choked.

NOTE

This Inquiry into the circumstances of the death of the late Graham Rattray proceeded before me at Airdrie Sheriff Court on 26 to 30 November 2007 inclusive. Evidence was concluded on 10 December 2007 and I heard submissions on 11 December 2007. Mrs. Donaldson, the Procurator Fiscal, represented the public interest. Mrs. Howson appeared for North Lanarkshire Council. Miss Kaney appeared for Dr. Neill Simpson. Mr. Wightman appeared for Greater Glasgow Health Board and Mrs. Martin-Brown appeared for Quarriers.

Mr. Rattray was a severely learning disabled adult who had lived in institutionalised care for most of his childhood and adult life. He was discharged from Kirklands Hospital, Bothwell, in September 2003 and accommodated in 49 Dunellen Avenue, Moodiesburn as part of the national “care in the community” policy. He was directly supported in 49 Dunellen Avenue and the community by Quarriers. Amongst other difficulties Mr. Rattray had a recognised risk of choking. He suffered a serious choking incident in his home on 5 March 2005. He died in his home, having choked on toast, on 26 December 2005.

In this Inquiry evidence was led exploring whether the level of care Mr. Rattray was afforded was reasonable and appropriate, given his known difficulties, and in

particular whether there were any reasonable precautions whereby his death might have been avoided.

Those who gave evidence to the Inquiry were Mr. Alan Rattray, (the deceased's brother), Morag Dendy, Service Manager for Adults with Disabilities, Carol Ann Langford, Social Worker, Anne Early, Support Worker, Wendy Graham, Support Worker, May O'Byrne, Paramedic, Michael Doherty, Student Nurse, Alistair Welsh, Service Manager, Irene Brown, Team Leader, Dr. Krishna Singh, Police Casualty Surgeon, Todd Coster, Project Manager, Dr. Stanford Mathe, Consultant Pathologist, Paul Brady, Community Psychiatric Nurse and Dr. Neill Simpson, Consultant Psychiatrist in Learning Disability.

The Evidence

I heard evidence that Graham Rattray was a severely learning disabled adult who died aged 42. He lived in a hospital setting from about the age of seven until he was about forty. In September 2003 Mr. Rattray was discharged from Kirklands Hospital, Bothwell, where he was then living, to 49 Dunellen Avenue, Moodiesburn. His discharge was in accordance with the "care in the community" programme and had been planned for about a year prior to taking place.

The preparatory work for Mr. Rattray's discharge was undertaken by his social work and health professionals in consultation with his parents. As a result of this process North Lanarkshire Council produced an Essential Lifestyle Plan (Production 1), a Risk Assessment (Production 2), a Service Design (Production 3) and a Service Specification (Production 16) all of which were designed to inform as to how best to care for Mr. Rattray in the community. These are the core documents prepared for every person discharged from institutionalised care into the community, and are accordingly very important. In particular, the Essential Lifestyle Plan is intended as a living document which defines and determines care on a day to day basis, and which is kept up-to-date through a review process.

Mr. Rattray had a loving and supportive family, in regular contact with him. Whilst at Kirklands Hospital Mr. Rattray went home most weekends. There his

family were completely responsible for all aspects of his welfare and ensured he was supervised. There were always two adults present, one to watch and one to “do”. After his move to 49 Dunellen Avenue his family saw him as frequently as before. In his family’s view he loved being amongst people and detested being on his own. Despite the fact his verbal communication was limited to some three or four words, Mr. Rattray was able to communicate his mood by his facial expressions, by making noises appropriate to his mood, and by his body language. He had a degree of comprehension. For example, he loved travelling and would let out a shout of happiness if told the family was going for a trip in the car. Contrary to what might be expected, he had a developed, almost devilish, sense of humour. He was able to see irony and enjoyed slapstick.

Mr. Rattray’s condition was such that he was incapable of independent living. He required assistance with all aspects of daily life. Of his many difficulties, in particular he had no awareness of dangerous situations. He was doubly incontinent and wore incontinence pads. He had an identified risk of choking. He had a condition known as “pica”, whereby he would pick up and eat objects indiscriminately, including his incontinence pads and the contents thereof. He could present challenging behaviour, including agitation and aggression. He experienced periods of insomnia. By the time of his death he had been diagnosed as profoundly learning disabled, with Attention Deficit Hyperactivity Disorder, anxiety and depression and episodes of intense behaviour. He was on a variety of drugs.

Learning disabled adults discharged from hospital into the local community have to be provided with suitable housing and support for their needs. The housing provided by North Lanarkshire Council depends upon what housing is available and the needs of the individual concerned. The decision as to what can be provided is ultimately one for the Council, taking into account in so far as possible the views of the family. North Lanarkshire Council provided Mr. Rattray with 49 Dunellen Avenue, Moodiesburn being a two storey, three-bedroom detached house with a garage. It is located about two miles from his parents’ home. Whilst it is possible to criticise the design of this house as not wholly suited to Mr. Rattray’s needs, there was no evidence that the design of this house had a material bearing upon the circumstances of his death.

In so far as support is concerned, North Lanarkshire Council provide support through the Social Work Department, and day to day living support through a Supported Living Provider. The learning disabled adult is allocated to a social work team, and usually will have an allocated social worker, described as a Care Manager. Four weeks after discharge into the community there is an initial social work review of the care arrangements in place, followed by a second review within six months, with six monthly reviews thereafter. This review process provides an opportunity for up-dating the Essential Lifestyle Plan, if necessary.

Mr. Rattray had an allocated social worker prior to his discharge from Kirklands Hospital until March 2004. He was without an allocated social worker, due to national staff shortages, for some fifteen months until June 2005. From June 2005 until his death Mr. Rattray had an allocated social worker, Carol Ann Langford. His first Social Work Department Community Care review took place on 22 October 2003. Thereafter there were no reviews until 30 November 2005.

North Lanarkshire Council provides direct support in the home and community through a Supported Living Provider. The Supported Living Provider is required to demonstrate an ability to provide good quality service, dedicated to the principles of supported living, and geared to the needs of the individual. The latter requirement necessitates training specific to the needs of the individual. The level of supervision to be provided is driven by need, rather than budgetary considerations. For any situation where a risk is involved the level of supervision should be 2:1.

The level of support deemed necessary in any individual case is described in the Service Specification, but over and above that the Supported Living Provider has a discretion as to what support is required when, in any one week, and is delegated the authority to decide if more or less support is needed. If more support is needed, North Lanarkshire Council undertake to honour what is required.

In Mr. Rattray's case North Lanarkshire Council contracted Quarriers as the Supported Living Provider. North Lanarkshire Council has a well-established working relationship with Quarriers dating back to the late 1990's. It was the responsibility of Quarriers to provide Mr. Rattray's day to day care and to ensure in so far as

reasonably possible his safety. Quarriers first became involved in supporting Mr. Rattray in April 2002, prior to his discharge from Kirklands Hospital.

Mr. Rattray's parents had very strong reservations about their son's proposed discharge into the community. They were worried about his future care and safety. However, their involvement in the preparation of Mr. Rattray's Essential Lifestyle Plan, Risk Assessment and Service Design allayed some of their fears. These documents set out what Mr. Rattray required for safe and healthy living. In particular, the Essential Lifestyle Plan is the guide by which Mr. Rattray was to be supported for a safe and enjoyable life once in the community. The family were of the view that, if followed, the Essential Lifestyle Plan would have kept Mr. Rattray safe.

The Essential Lifestyle Plan was prepared in August 2002. Pages 7 and 8 thereof are headed "Essential Things in Graham's Life. The Following things must happen:" These things include specifically:-

- "For staff to be aware of Graham's whereabouts at all times",
- "Foods have to be cut up into small pieces to ensure Graham can manage to eat his meal, less chance of choking" and
- "Support staff to be with Graham while he is eating his meal, to offer him support and reassurance on how well he is doing, and also prevent him from putting too much food into his mouth at the one time."

Page 10 of the Essential Lifestyle Plan is headed "Essential Things in Graham's Life. The Following things must NOT happen". These things include specifically:-

- "Being left unsupervised" and
- "His food not being cut up into small pieces".

Page 11 of the Essential Lifestyle Plan is headed "To be successful in supporting Graham we should:" There then follows a list of specific items, including:-

- "Understand that Graham cannot be left unsupervised for any length of time and
- "People who care for Graham should be aware that Graham will eat any objects that are lying about him (pins, paper, buttons, material, curtains faeces)"

Page 12 continues that list, under the subheading “Eating and Drinking” and includes:-

“Understand that Graham likes most types of foods however requires his food to be cut up into small pieces” and

“Graham has in the past choked on food, because he puts more food into his mouth before he has chewed and swallowed the contents of his mouth”.

Page 20 of the Essential Lifestyle Plan is headed “To be successful in keeping Graham Health and Safety” and includes:-

“Know that Graham can put too much food into his mouth at one time, thus running the risk of choking. People who care for him should sit beside him while he is eating, ensuring that his meal has been cut into small pieces. (See Risk Assessment)”

As Mr. Rattray’s Essential Lifestyle Plan had identified areas of specific risk, a written Risk Assessment was completed following consultation between his parents, his then allocated social worker, and his named nurse and occupational therapist at Kirklands Hospital. Page 2 of the Risk Assessment is headed “Clarity around issue. Safe environment (in the home)”. There then follows a number of bullet points, the first of which is:-

“Eating and drinking of harmful/hazardous substances (this could be anything that is lying around i.e. paper, objects, contents of incontinence pads, bleach, shampoo etc)”.

The second bullet point is:-

“Choking when eating his meals”.

Page 3 of the Risk Assessment is headed “Occurrence” and makes clear that the identified areas of concern “could happen at any time”.

Page 6 of the Risk Assessment is headed “Strategies to reduce/manage issue. Safe Environment (within the home)”. There then follows a number of bullet points, the first of which is:-

“1-1 support at all times, (carer to be able to observe Graham).”

The fifth bullet point is:-

“Carer to sit with Graham while he is having his meals.”

The sixth bullet point is:-

“Meal to be cut into small pieces and Graham encouraged not to put too much food into his mouth at the one time”.

The Service Design document followed on from the Essential Lifestyle Plan and looked at the detail of Mr. Rattray’s needs. Thus in the context of “Someone who Graham may like to live with” it was noted that Mr. Rattray would not have been able to cope with sharing or living with, for example, a family member or another learning disabled adult, and needed his own space.

The Essential Lifestyle Plan, Risk Assessment and Service Design informed the Service Specification. This latter document summarised Mr. Rattray’s difficulties and needs, and anticipated that he would require twenty four hour support. At page 2, in relation to support for Mr. Rattray when awake, it is stated

“Careful attention must be paid by carers with the realisation that Graham relies on others to provide him with a safe environment. Staff must understand that Graham must not be left unsupervised for any length of time.”

His choking risk was reiterated, including that carers should remain with him at mealtimes.

The policy of North Lanarkshire Council is to pass paper copies of the Essential Lifestyle Plan, Risk Assessment and Service Specification to the family of the learning disabled adult, to the adult himself if he has the capacity to understand the documents, and to the Supported Living Provider. The expectation is that a copy of these documents is kept securely in the offices of the Supported Living Provider, and in the adult’s home. Everyone working with the adult is expected to be fully familiar with these documents. The Service Design is not necessarily disseminated.

In Mr. Rattray’s case North Lanarkshire Council passed paper copies of the Essential Lifestyle Plan, Risk Assessment, Service Specification and Service Design (hereinafter the “core documents”) to Quarriers.

The care provided by Quarriers for Mr. Rattray

Quarriers began to provide support to Mr. Rattray in April 2002, when he was still a long-stay patient in Kirklands Hospital. His team of carers was recruited from about July 2003, although some team members, such as Michael Doherty, were in fact involved in his care from as early as January 2003. The time at Kirklands Hospital prior to Mr. Rattray's discharge to 49 Dunellen Avenue was an opportunity for his team to get to know Mr. Rattray and learn about his needs. The level of experience in Mr. Rattray's team was variable, and ranged from none to a great deal. Induction training was undertaken en bloc. First Aid training was not a mandatory component of the Induction training. The expectation of Quarriers was that all support staff would have undertaken first aid training within the first six months of their entry to Quarriers.

At the time of his death Mr. Rattray's Quarriers' team consisted of six carers led by Team Leader Irene Brown. The six carers included Anne Early and Wendy Graham. Anne Early joined Mr. Rattray's team about four months after his move to 49 Dunellen Avenue, Moodiesburn. Wendy Graham joined Mr. Rattray's team whilst he was still in Kirklands Hospital in the Summer of 2003. It was her first job in social care. As Team Leader, Mrs. Brown was responsible for the day-to-day management of the team, staff supervision, health and safety in the home and liaison with external agencies. Where team members were untried and inexperienced there was an increased responsibility on the Team Leader to ensure that guidance was given.

Mrs. Brown was immediately responsible to her Project Manager, Todd Coster. Mr. Coster was responsible for over-seeing the Team Leader, and to ensure that she followed through the tasks she was charged with. Mr. Coster in turn was responsible to his Service Manager, Alistair Welsh. Alistair Welsh gave evidence that it was the expectation that Mr. Rattray's team, including any new members to the team, should have a very clear working knowledge of Mr. Rattray's Essential Lifestyle Plan and Risk Assessment. It was the responsibility of the Project Manager and Team Leader to ensure this.

In addition it was the responsibility of the Team Leader to call Team Meetings and it was the expectation that these core documents would be referred to on an on-going basis at Team Meetings. The aim was to have monthly Team Meetings, with minutes taken and properly stored. In the event it seemed on the evidence that the monthly Team meetings were on occasion cancelled. No minutes for any Team Meetings were produced as these had gone missing.

Mr. Coster gave evidence that shortly after Mr. Rattray's team was recruited he produced a copy of the Essential Lifestyle Plan, Risk Assessment and Service Design for each team member and went through it with the team, probably during the first week of their Induction training. In Mr. Coster's view the Risk Assessment was the most important document for the team. Mr. Coster had no recollection of going through the same exercise with Anne Early, who did not join the team until after Mr. Rattray's move to 49 Dunellen Avenue. Copies of the core documents were stored both in Quarriers main office and at 49 Dunellen Avenue in the spare bedroom.

Ms. Early said that when she joined Mr. Rattray's team she was told about his pica and that he had no verbal communication. She knew a bit about Mr. Rattray from Kirklands Hospital. She wasn't aware at first of his choking risk, and only became aware of this through other staff telling her at handovers and in conversation that his food required to be cut up because of this risk. She had direct experience of Mr. Rattray trying to cram his mouth full of food on occasions. She said the food was sometimes bulging out of his mouth.

On being asked if she had been given Mr. Rattray's core documents to read Ms. Early said "No, not really". She said the staff filled her in and told her about the "stuff" in the back bedroom. She said she was sure she'd read the whole of the Essential Lifestyle Plan and "other bits and stuff". On being shown the Risk Assessment she said she didn't recognise that document. She said that the Team Leader, Irene Brown, encouraged them to read the documents themselves.

Wendy Graham gave evidence at the Inquiry that she thought she had seen Mr. Rattray's Essential Lifestyle Plan before. She thought she had read it in 49 Dunellen Avenue. She thought it would have been drawn to her attention by the

Team Leader or Project Manager “because this is what I need to know about Graham”. She thought the Essential Lifestyle Plan was talked about at Team Meetings although she didn’t remember it being “actually physically taken out and referred to”. On being shown the Risk Assessment Ms. Graham thought she had seen it before, possibly after Mr. Rattray’s death when she attended the Procurator Fiscal’s Office. She thought she might have seen it before that, but couldn’t remember. She had no recollection of the Risk Assessment being taken out and discussed at Team Meetings.

In addition to Mr. Rattray’s core documents, by October 2005 a Support Plan (Production 6) had been prepared by Mr. Rattray’s team in conjunction with Irene Brown for use by the team on a daily basis. It covered such things as health and medical information, Mr. Rattray’s daily routine, including activities outside his house, and support at meal times. In relation to support at meal times it is stated:-

“STAFF SHOULD CUT MY FOOD INTO MANAGEABLE PIECES FOR ME”

and

“I REQUIRE STAFF TO SIT WITH ME AS I OFTEN CRAM ALL THE FOOD INTO MY MOUTH AT THE SAME TIME.”

In relation to a section headed “How to support me when I am unhappy” it is stated:-

“Sometimes I enjoy my own company and go off to my bedroom for a while. At these times staff will encourage me to come back downstairs but perhaps will realise I want to be on my own and will let me come back down when I am ready.”

Mr. Rattray’s known risks, in particular his pica and his risk of choking, were not mentioned in this Support Plan. This Support Plan was not a risk assessment carried out by Quarriers.

Mr. Rattray presented challenging behaviour at times. He could act impulsively and aggressively. Staff were aware of this, and also aware of the need to ensure their own safety. Staff had to be safe in order to keep Mr. Rattray safe. Mr. Coster gave evidence that on the occasions when he was called out to 49 Dunellen Avenue when Mr. Rattray was presenting challenging behaviour and staff felt at risk, he directed

staff to give Mr. Rattray his own space, but still to be in a position where they were able to observe Mr. Rattray safely.

Staff recorded Mr. Rattray's daily activities, personal care, medication and household chores in a Daily Log (Production 8 Appendix 6). In addition information about his general behaviour and wellbeing was noted in a Daily Communications Log (Production 8 Appendix 5).

Mr. Rattray's medication was pre-packed by a qualified pharmacist. In addition to his daily medication he had "PRN" or "as required" medication, to be given in the event that he became agitated. A Protocol (Production 12) had been prepared by Irene Brown to assist staff in judging when to administer this additional medication. All medication was clearly labelled as to the appropriate dosages.

Staff worked a rota system. The level of support provided at the time of Mr. Rattray's death was 2:1 for seven hours per day including any time spent out the house, and otherwise was 1:1. At night Mr. Rattray was supported by a wakened member of staff. If Mr. Rattray got out of bed and crossed to the bedroom door, his movement would break an alarm beam, thus alerting his carer. However, it was possible for him to get out of bed on the other side, without activating the alarm, and without his carer being aware he was out of bed.

On Mr. Rattray's move to 49 Dunellen Avenue Mrs. Brown's time was divided between him and another learning disabled adult. Mrs. Brown did not think that her supervision of Mr. Rattray's team was compromised by this other commitment. Mrs. Brown said she monitored Mr. Rattray's team by "popping in" and observing that they were adhering to the guidance in his core documents. She popped in one to three times a week for 15 minutes up to an hour. She was also contactable by phone. By about the Summer of 2004 her other commitment ended and she was able to start working in Mr. Rattray's shift pattern. At this stage, Mrs. Brown did not carry out any formal review of Mr. Rattray's care, but "took in a lot of information from staff". She did not make any changes to his care. She felt a lot of staff had done a very good job.

In so far as eating food was concerned Mrs. Brown said that if Mr. Rattray left the table with food and tried to go upstairs “staff would definitely follow him. If staff were unsure if he had food in his mouth they would definitely follow him up.” It was her experience of staff that if, on those occasions, Mr. Rattray wanted his own space or privacy, *if he was safe*, staff respected his choice to have his own privacy. She did think that it was clear to staff that Mr. Rattray was not to go upstairs with food in his mouth.

There did not appear to be any *instruction* about what to do should Mr. Rattray leave the table with food, either in his hands or in his mouth. Miss Early said that in such a situation she would follow him to keep an eye on him because of her concern that he might choke. However, this was something which she did personally, and not something which she had been instructed to do. As will become apparent, Wendy Graham, on Boxing Day 2005, did not follow Mr. Rattray upstairs when she knew he had food, or at the very least suspected he had food with him.

As noted, Mr. Rattray’s required initial Social Work Department Community Care Review took place on 22 October 2003. It was noted that there were no issues with his Quarriers team at that time.

There was oral evidence that in about November 2003, in daylight, Mr. Rattray, whilst alone and unobserved, managed to climb out his bedroom window and drop onto the garage roof. Thereafter he dropped some eight feet to the ground and ran off. Meanwhile three Quarriers’ carers, including Wendy Graham, were in the house in the living room. Fortunately Mr. Rattray suffered no more than light bruising.

In her evidence to the Fatal Accident Inquiry Wendy Graham accounted for the fact that Mr. Rattray had gone out the window by saying that the window was not alarmed. She then said she had never been told to sit with Mr. Rattray whilst he was sleeping and that to her knowledge he was sleeping. She said that she wouldn’t check Mr. Rattray if he was sleeping unless the alarm went off. She said that someone was usually up every twenty minutes anyway to check.

After this incident there was evidence that it was emphasised to Mr. Rattray's carers that they had to be aware of his whereabouts at all times. Locks were put on the windows. This incident did not trigger any formal review of Mr. Rattray's Risk Assessment. Nor did it appear to trigger any review of his existing levels of supervision in order to determine if they were adequate or indeed if the requirements of his Essential Lifestyle Plan were in fact being followed by staff.

It was Mrs. Brown's evidence that if Mr. Rattray was alone in his room staff would "pop up and down". She observed they would go "frequently" to check that he was ok. She did not remember giving any guidance to staff as to the level of frequency. From the evidence it appeared that it was not unusual for Mr. Rattray to be on his own, out of sight of a carer. It appeared that he spent quite a lot of time in his room. Ms. Early said that when in a "sombre mood he could crouch in his room for hours and stay there". Staff would "have to go up" and encourage him, although that sometimes made him agitated if he did not want the staff member there. Ms. Graham said that when he was out of sight, staff checked on him "regularly". She offered 15-20 minutes as a time span in this regard, although said she couldn't honestly remember. She said "Graham was checked on, but we didn't follow him about".

Mrs. Brown said that at night time Mr. Rattray was "checked on frequently to see if he was ok". She knew that Mr. Rattray could eat his incontinence pads. She said "I do believe that at night he chose not to wear his incontinence pads. I think sometimes he did and sometimes he didn't." She didn't give any guidance to staff on how often Mr. Rattray should be checked at night. She thought he was checked more frequently than every 15 to 20 minutes.

Anne Early worked on Mr. Rattray's night shift. If Mr. Rattray wasn't up out his bed, Miss Early would go up "to check every couple of hours". She said that this time period was "something that was just agreed", she thought at a team meeting with her colleagues. If Mr. Rattray was in an agitated mood or was unwell, she would check him more often.

It became clear during Miss Early's evidence that Mr. Rattray went to bed wearing incontinence pads. Miss Early knew about Mr. Rattray's pica, and in particular had

personal experience of Mr. Rattray eating his incontinence pads. She said that on quite a few occasions she had physically taken “stuff” out of his mouth. She said that sometimes Mr. Rattray’s mouth would be full. She indicated this by puffing her own cheeks out. She said that if Mr. Rattray was in an approachable mood he’d let her take out the contents of his mouth, but sometimes he would slap her and not let her near him. There had apparently been some discussion about how to stop Mr. Rattray eating his incontinence pads, for example by wearing drawstring pyjamas, but despite this he “still occasionally got to his pad”.

Miss Early conceded that it was possible for Mr. Rattray to be at risk in his bedroom if he was quiet and hadn’t activated the alarm beam.

The Choking Incident of 5 March 2005

On 5 March 2005 at about 6.10pm Michael Doherty was caring for Mr. Rattray. Michael Doherty was an experienced member of Mr. Rattray’s team, and had worked with him for about nine months prior to his discharge from Kirklands Hospital until about September 2005 when he left Quarriers to train as a Nurse. Prior to joining Quarriers Mr. Doherty had trained in first aid and worked for several years with St. John’s Ambulance service. He had also received first aid training with Quarriers.

Mr. Doherty knew about the Essential Lifestyle Plan. He was fully aware of and understood Mr. Rattray’s choking risk. He said “the way I worked and learned from my peers, I felt it appropriate to keep an eye on Graham when he was eating, to ensure he swallowed and was not choking.”

On 5 March 2005 Mr. Rattray and Mr. Doherty were sitting at the kitchen table and Mr. Rattray had his food cut up for him. Mr. Doherty got up to get something, and turned to look at Mr. Rattray to check on him. Mr. Rattray made no noise. However, he got up, his face changed colour, his eyes were protruding and his pupils were dilating, his hand went to his throat and his lips turned blue. From these visual signs Mr. Doherty fully realised Mr. Rattray was choking and that he was in serious trouble. Mr. Doherty slapped Mr. Rattray’s back about three times in an effort to dislodge the obstruction. Mr. Rattray was walking round in a circle. Mr. Doherty tried to keep

him calm. Mr. Doherty then used the Heimlich manoeuvre three times. Before the third time, he had already decided to call 999. Fortunately the third abdominal thrust did dislodge the obstruction, which Mr. Rattray swallowed.

That same day Mr. Doherty completed sections A to F of the first part of Quarriers' Accident Report (Production 8 Appendix 4) and contacted and subsequently met with his Team Leader, Irene Brown the next day. The "Follow-Up" and "Staff Support" section of the Report was then completed with Irene Brown. Irene Brown noted "Emergency First Aid Refresher Course" as required further action for Mr. Rattray's team, together with "Staff to make sure food is suitable size/texture. Also prompt GR to eat slowly" as further action required to support Mr. Rattray.

Mr. Doherty verbally told his team colleagues about the incident. He was fully aware of the need to highlight the incident. So far as he could remember after this incident the team were all made aware that they had to be extra vigilant with Mr. Rattray when he was feeding. He couldn't remember whether there was first aid training in the period after the incident until he left Quarriers in September 2005.

As required, the Accident Report was submitted by Irene Brown to the Project Manager, Todd Coster and from him to the Service Manager, Alistair Welsh for "Senior Management Follow-Up" on 22 March 2005. Alistair Welsh recommended the completion of a risk assessment by Mr. Rattray's team with management support "given that the risks involved in such an incident are very high". He also mooted the possibility of referral to Occupational Therapy or Speech and Language Therapy. He regarded the incident to be of such severity that he reported it to Quarriers' Service Director. The Accident Report was thereafter returned to Todd Coster for the recommended action to be taken.

In fact, none of the highlighted issues arising from Mr. Rattray's choking incident were addressed to completion. The choking incident was an event which should, under Quarriers' own practices, have automatically triggered a review of his Risk Assessment (Production 2). There was no evidence that a review of Mr. Rattray's Risk Assessment took place. There was no evidence that a review of the existing risk control measures took place to determine whether those measures were adequate or if

they were actually being followed by staff. Additional staff training in first aid was not arranged. Quarriers does in fact provide an Emergency First Aid course but at the time of Mr. Rattray's death it appeared that no-one on his then team had attended it. Certainly neither Wendy Graham nor Anne Early had received any first aid training at the time of Mr. Rattray's death.

Quarriers is also able to arrange specific training on request, which can be taken out to the point of need. There was no evidence that this option was explored following Mr. Rattray's choking incident.

Irene Brown contended that the choking incident was discussed at a Team Meeting but no minutes of that meeting were found. Irene Brown also contended that she had phoned Quarriers Training Department to request first aid training, but there was no record of such a request and no follow-up when the lack of action in this respect must have become apparent. In any event she was not aware of which staff, if any, in Mr. Rattray's team in fact had first aid training. In addition, Irene Brown contended that she had phoned Paul Brady, Mr. Rattray's Community Psychiatric Nurse, for a referral for Speech and Language assessment, but there was no record of this phone call, or of any response from Paul Brady. Paul Brady had no recollection or record of this call. If the call was ever made, there was certainly no follow-up when the lack of action in this respect must have become apparent. Irene Brown said she could not remember doing a risk assessment, but that that didn't mean that she or Todd Coster hadn't done one.

It was the responsibility of Mr. Coster, as Project Manager, to monitor and check the follow-through of the highlighted issues. Mr. Coster, with refreshing honesty, very fairly conceded that he had not fulfilled that responsibility.

The fact of this choking incident was not conveyed to Miss Langford, Mr. Rattray's allocated social worker, or the Social Work Department. Mr. Coster accepted that it was part of his responsibility to ensure that this was done. As a result of this failure Mr. Rattray's social work team was not in a position to re-evaluate the support Mr. Rattray was provided with in his home in relation to eating and his known choking risk.

In addition Mr. Rattray's Psychiatrist, Dr. Simpson, was not made aware of this choking incident.

Quarriers own internal investigation Report (Production 8), completed in February 2006 subsequent to Mr. Rattray's death, found that the information gained from this choking incident "did not result in a revision of risk assessment in conjunction with relevant professionals" and that "it is questionable how this incident and its potential was conveyed to the entire staff team" in the sense of ensuring that all knew of Mr. Rattray's choking risk to the extent that they needed to.

Carol Ann Langford took over as Mr. Rattray's allocated social worker in June 2005. She did not hold an immediate review of Mr. Rattray's case as she required to contact all those involved in his care to get a full understanding of Mr. Rattray's complex needs and of all the issues involved. She had no concerns about the level of care that Quarriers were providing. As noted, a review was in fact held on 30 November 2005, the purpose of which was to gain an understanding of the support package provided by Quarriers. Mr. Rattray's parents attended that review and advised that they were satisfied with the staff working with their son at that time. Mrs. Rattray also reported that her son liked to "have his own space". Production 4 is the minutes of this review.

Towards the end of his life Mr. Rattray's team had noticed a change in his behaviour. He was described as more agitated, more aggressive and more solitary. He was having more bad days than good. Throughout his care in the community Mr. Rattray was allocated a Community Psychiatric Nurse and a Psychiatrist. At the time of his death these were Paul Brady and Dr. Neill Simpson respectively. Paul Brady provided support to Quarriers on a "needs-led" basis. Dr. Simpson monitored Mr. Rattray's mental health.

Efforts had been made for some considerable time to find the best combination of drugs to suit Mr. Rattray and provide him with a better quality of life. He had been prescribed anti-psychotic medication whilst in Kirklands Hospital where the possibility of a psychosis had been raised, but there was no diagnosis of a condition requiring long-term prescription of anti-psychotic medication, and efforts were being made to rationalise his anti-psychotic medication, with the aim in the first place of

removing the anti-psychotic drug Amisulpride from his regime. The difficulty was that every time attempts were made to reduce Amisulpride Mr. Rattray experienced a period of instability.

Despite the efforts made to rationalise Mr. Rattray's medication, on 10 December 2005 Dr. Simpson in conjunction with Paul Brady noted that the situation was not improving. Dr. Simpson decided to place Mr. Rattray on the elective waiting list for admission to an in-patient facility for the learning disabled where he could be properly managed whilst his medication was reviewed. Dr. Simpson assessed Mr. Rattray as requiring admission, but there were no additional risks if there was a delay in admission. Dr. Simpson envisaged that Mr. Rattray would require a short-stay admission of from 6 weeks to 3 months for review of his medication. In the interim Dr. Simpson reduced Mr. Rattray's Amisulpride and amended his dose of the anti-depressant Lofepramine.

On 16 December 2005 Paul Brady advised Dr. Simpson that Mr. Rattray's mental health had declined. He was throwing furniture about. To manage Mr. Rattray safely, he needed to be supervised, but in addition his carers needed to be kept safe. Dr. Simpson placed Mr. Rattray on the "urgent" waiting list for admission to Pineview, Canniesburn Hospital, where specialist beds for learning disabled patients are provided. "Urgent" in this sense indicates that there were associated risks if his admission was delayed. Admission within a month is what is expected in relation to those on the "urgent" waiting list in this particular service.

The next day, 17 December 2005, the situation deteriorated further and Mr. Rattray was in fact admitted as an emergency to a general psychiatric ward in Stobhill Hospital. Whilst in Stobhill, Mr. Rattray continued to be supported by his team. Dr. Simpson saw him there on 19 December 2005 at which time he expected Mr. Rattray to be transferred to Pineview by the end of the week. However, when Dr. Simpson saw Mr. Rattray on 22 December 2005 he was back to his normal self and the immediate emergency had settled. Mr. Rattray's name remained at the top of the urgent list for admission to Pineview, with the expectation that he would be admitted in January 2006, but he was able to return to his house in the interim.

Dr. Simpson felt that admission in January 2006 was reasonable in Mr. Rattray's circumstances. He would not have recommended Mr. Rattray's discharge if Mr. Rattray had not been safe to be discharged. He opined that in his view the degree of risk that Mr. Rattray presented was best managed by carers who were familiar with him, in a familiar setting, especially where over the Christmas period Stobhill's Christmas rota meant that there would be no continuity in the hospital staff caring for him. Mr. Rattray returned to 49 Dunellen Avenue on 22 December 2005.

Christmas Night and Boxing Day 2005

Mr. Rattray spent Christmas Day with his family and was returned to 49 Dunellen Avenue in the early evening. Anne Early was Mr. Rattray's carer on Christmas night. It was a difficult night. Mr. Rattray was given his PRN medication at 8.30pm with little effect. He was unsettled and agitated. He slept for some hours then awoke. He kept tearing his incontinence pad off and eating it. He would not go back to bed. He eventually slept downstairs on the sofa but awoke between 5am and 6am. His agitation continued. He had some toast at about 6am, but left most of it and pushed the table away. He paced the floor. He went upstairs and Miss Early followed him and attended to his personal care. He then fell asleep on the sofa at 7.45am.

Wendy Graham arrived at about 7.50am. Miss Early gave her a run-down, before leaving at about 8.10am. Ms. Graham described Mr. Rattray as agitated and distressed. She gave him his PRN medication. There wasn't an instant improvement. She managed to attend to his personal care. She then decided to make him tea and toast.

Ms. Graham's evidence to the Inquiry was that she made Mr. Rattray two slices of toast, each cut into four pieces. Mr. Rattray was sitting at the table with a piece of toast in each hand. The remaining six pieces were on a plate in front of him. She saw him eat the first two pieces. Then he left the table and started to pace. He then started to eat the second slice of toast, but wouldn't sit at the table. Ms. Graham tried to guide him back to the table, but he pushed her away. Whilst he had toast with him, he went upstairs, then came back downstairs, eating toast. He went into the livingroom. Ms. Graham was in the kitchen making tea. She thought he came into the kitchen.

She thought there could have been another two pieces of toast left at this stage, although after his death there was only one piece remaining. Mr. Rattray then went upstairs. He didn't come back down.

Ms. Graham said that Mr. Rattray may have had toast in his hand when he went upstairs this second time. Her evidence as to whether or not she knew Mr. Rattray had toast with him when he went upstairs was inconsistent. At first she denied knowing if he had toast with him. This account to the Inquiry did not wholly square with the account Ms. Graham gave at the internal investigation held by Quarriers in the two months following Mr. Rattray's death (Production 8 Appendix 8). The minute of her account, dated 16 January 2006, records that Mr. Rattray started to eat toast in the kitchen and then "left with it", clearly thereafter going upstairs. The inference is that when Mr. Rattray went upstairs Ms. Graham knew that he had toast with him. At the Inquiry this account was put to Ms. Graham and specifically the question "The last time he went upstairs, did you know he had toast with him?" She replied "Yes. Well, he may have done. Yes."

When asked why she didn't follow him upstairs, Ms. Graham said "because I'd to keep myself safe". When asked if she had something in mind that she was to be kept safe from she replied "well, he pushed me." She elaborated that if something happened to her, there would be no-one there to look after Mr. Rattray. She also said that by giving him space, she felt Mr. Rattray would calm down. She went on to say that she was leaving Mr. Rattray to calm down upstairs and that "that was why I didn't go up".

Ms. Graham could hear him walking, but eventually it went quiet. She assumed that he had calmed down. She thought he was upstairs for a maximum of five minutes. She shouted on him to come down for his tea. On getting no reply she went upstairs and found Mr. Rattray lying curled on the floor in the spare bedroom. He was unresponsive. She collected the phone from downstairs and called 999. She was instructed in resuscitation techniques via the phone and carried those instructions out, including removing some food from each of Mr. Rattray's cheeks.

The 999 call was received by ambulance personnel at 10.11am. They attended at 10.18am. Mr. Rattray was found to be lying on the floor. The toast which Ms. Graham had removed from his mouth was lying on the floor. More toast was found in his mouth. His airway was blocked with masticated toast to a degree that the ambulance personnel were not able to remove it properly. No sign of life was detected.

Dr. Singh, a Police Casualty Surgeon, attended at 11.30 am and formally pronounced life extinct at 11.35am.

On 29 December 2005 a post-mortem examination was carried out by Dr. Stanford Mathe, Consultant Pathologist. The post-mortem report is Production 5. Dr. Mathe certified the cause of death as asphyxia due to the aspiration of food. Blood and urine samples were retained for drug and alcohol analysis. The results of that analysis showed nothing untoward, with all drugs prescribed and found to be within the therapeutic range.

On post-mortem a lot of food was found in Mr. Rattray's mouth. His pharynx and larynx contained chewed up bread compacted into a large ball of 4cm dimension and aspirated down below his vocal chords. More bread particles were found in his trachea, continuing down to his two bronchi, which were both completely obliterated by food. Similar food particles were found in the oesophagus. From his findings Dr. Mathe opined that Mr. Rattray appeared to have had "quite a substantial amount of food in his mouth at one time". He explained that there is both a voluntary and reflex component in the action of swallowing. Thus, a conscious decision is made to chew and swallow, then the reflex action takes over in the actual swallow. He commented that for those who are mentally impaired their judgement of food selection and how much to chew at one time can be impaired. He described this as a "known risk" for the mentally impaired. In Mr. Rattray's case Dr. Mathe posited that his voluntary aspect of swallowing was probably impaired. It was very unlikely that his swallowing mechanism was affected by his drug regime.

Dr. Mathe gave evidence that where the airway was completely obstructed – which was quite likely in Mr. Rattray's case – consciousness would be lost in three to five

minutes, and death would ensue in six to eight minutes. The body's normal mechanism for coping with an obstruction of the airway is the cough reflex, but if a sizeable ball lodges below the vocal chords, the vocal chords can go into spasm, contracting to close the larynx and prevent the entry of more foreign bodies. However, that in turn means that the blockage cannot come out. The only resuscitation procedure in such an event is the Heimlich manoeuvre. The problem is that the victim cannot speak to draw attention to his plight. Dr. Mathe described this silent aspect of laryngeal spasm as probably its most dangerous aspect. Those in a position to administer help would have to be in a position to see the victim had got into difficulties.

Following Mr. Rattray's death Quarriers notified the Mental Welfare Commission, the Care Commission and the Health and Safety Executive. Quarriers also carried out their own internal investigation and provided a copy of the resultant report, dated 8 February 2006, to North Lanarkshire Council. This report is Production 8. During the investigation Todd Coster, Irene Brown, Anne Early and Wendy Graham were interviewed.

The investigation found that there was no evidence that Mr. Rattray's Risk Assessment (Production 2) was reviewed or reassessed during his support by Quarriers. This was contrary to Quarriers own "Risk Assessment Standard" which requires that risk assessments are carried out where risks are identified or any aspect relating to the previously known level of risk changes. It also requires that all risk assessments are reviewed on at least an annual basis in order to evidence reductions or increases in risk, thereby informing methods of work, staffing levels, equipment used and such like. In Mr. Rattray's case it was therefore to be assumed that his support team should have been working to the requirements of the Risk Assessment (Production 2) at all times in the lead up to his death.

The investigation also found that following Mr. Rattray's choking incident in March 2005 it appeared that there were no changes made to his support while eating. The report continues:-

“This seemed to be backed up by the staff who were interviewed, who, although they were aware of this incident, demonstrated no obvious increased perception of risk in relation to the normal eating of food.”

The investigation found that staff concerns focused on Mr. Rattray’s pica, and guidelines on being supervised whilst eating at the table had been interpreted by some staff as relating to the promotion of social skills.

The “Summary of Investigation Findings” records

“The real and known risk of Graham choking on ordinary food had not adequately been conveyed to staff. There was little perception of this risk, despite an earlier choking incident. Senior Manager’s instructions following the earlier accident were not followed through to completion, or monitored. Organisationally, systems were already in place to carry out and review risk assessments but the systems were not applied or monitored at local level. First Aid training had not been provided to staff despite the risk of medical emergency being known at the outset of Graham’s support, and despite being recognised as required following the earlier choking incident.”

The investigation made a number of recommendations, all of which have now been implemented and which were followed on in Quarriers’ subsequent Report into Practice and Management Issues (Production 9) dated July 2006. Production 9 made various recommendations all of which have now been implemented. Of particular importance are the instructions that:-

“all staff in all Quarriers services need to be fully aware of and cognizant with the specifics of care plans and risk assessments from the onset of their involvement with the people Quarriers support. Responsibility for ensuring this in each service is the first line manager for that service. Monitoring of this is the responsibility of the Project Manager....”

and

“where changes in care are provided through time, that this is reflected fully in appropriate documentation, dated and signed off by respective decision makers.....involved, and kept easily accessible within the relevant individual’s

file. This will ensure that whatever documents are kept in live files are valid and worked to.”

This Report also made recommendations to identify and address the training needs of staff, particularly in relation to First Aid training, the review of all risk assessments to confirm their current applicability and the review of all accident reports to ensure that any follow-up actions had in fact been undertaken. Specific recommendations were made to improve the performance of both Todd Coster and Irene Brown.

Finally the Report concluded that some of the systems and processes that Quarriers would expect to be followed in relation to its standards and policies had not been followed in Mr. Rattray’s case, particularly that of risk assessment. In addition some key parts of his core documents in relation to managing risks had become “diluted or disregarded”, particularly in relation to the need for people to sit at the table with him and for him not to be wearing incontinence pads at night.

Mr. Rattray’s death resulted in the production of new Health and Safety standards for Quarriers which tie into the Care Commission and National Standards and the general tightening up of the recording and storing of information.

Paul Brady said that he first learned of Mr. Rattray’s choking incident of 5 March 2005 subsequent to Mr. Rattray’s death, when he attended the Procurator Fiscal’s office for precognition. Dr. Simpson only became aware of this choking incident when told by Paul Brady, and prior to that Mr. Rattray’s choking risk had not specifically been drawn to his attention. There was no evidence to suggest that Mr. Rattray’s choking risk had its origins in a physical condition, such as dysphagia, and no indication that his choking risk required or would be amenable to any invasive medical intervention, such as a feeding tube. Dr. Simpson would have expected to have been informed about the choking incident as it had a bearing on the safety aspect of Mr. Rattray’s care plan, although Dr. Simpson didn’t believe he would have prescribed different medication had he known. He had no reason to believe that the prescribed drugs, none of which were identified as carrying a choking risk, impacted on either this choking incident or indeed upon Mr. Rattray’s death. There was very little research to indicate that in general learning disabled adults were more prone to

choking than the general population. It was known that learning disabled adults had a higher incidence of death by choking than the general population, but at the time of Mr. Rattray's death there was no research available to specifically identify choking as a risk for learning disabled adults.

Submissions of the reasonable precautions, if any, whereby the death might have been avoided

Parties submitted written submissions, fully rehearsed at the Fatal Accident Inquiry, on the evidence as it impacted upon their various interests. One of the main issues at this Inquiry related to the reasonable precautions, if any, whereby Mr. Rattray's death might have been avoided (section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976).

The Procurator Fiscal emphasised that Mr. Rattray's risk of choking was a real risk, which was fully flagged up in the core documents and from which it was clear that a very high level of supervision was required. In addition, she pointed out that not only was food a risk to Mr. Rattray, but indeed as a result of his pica, any other item such as his incontinence pads. His known and well-established risk of choking had to be managed. It was the quality of supervision, rather than the number of carers on duty, which was of importance and in this respect the overriding responsibility of those caring for Mr. Rattray was his safety, as he was completely incapable of having regard to this himself. Whilst his carers were clearly well-meaning, there was a real lack of guidance from the Team Leader to the staff on the ground, some of whom had very little experience. The Team Leader's supervision appeared less than robust and there was no real steer on how often Mr. Rattray should be checked on if out of sight, or what would be an acceptable size of food. In highlighting failures of supervision, the Procurator Fiscal did not minimise the real issues for staff in terms of ensuring their own safety, but never the less the duty to secure Mr. Rattray's safety was there.

The Procurator Fiscal concluded that a reasonable precaution whereby Mr. Rattray's death might have been avoided would be to ensure that he was not left unsupervised in possession of toast. A further reasonable precaution would have been for all staff

working with Mr. Rattray to have undergone first aid training in order that in the event that a serious situation arose, they would be equipped to deal with it.

Mrs. Howson for North Lanarkshire Council highlighted the significant preparatory work undertaken by social work and health professionals in conjunction with Mr. Rattray's parents, which resulted in the Council producing the core documents. The importance of these documents as informing Mr. Rattray's safe care and minimising risks to him whilst in the community was emphasised. It was argued that Mr. Rattray's discharge programme was well prepared and planned.

After his discharge, as noted, Mr. Rattray was without an allocated social worker and case reviews for a significant period. Mrs. Howson conceded that this situation was not desirable, but submitted that there was no evidence before the Inquiry that it had any detrimental impact upon Mr. Rattray's care. The Council has a well-established working relationship with Quarriers and there was evidence that if any care issues had arisen Quarriers knew that they could contact the Social Work Department. In the absence of contact, the Social Work Department had no reason to believe that the system wasn't working.

On the evidence the very serious choking incident of 5 March 2005 was not reported to the social work authority. Given the Council's statutory responsibility for Mr. Rattray's care, Mrs. Howson submitted that that was astonishing. The choking incident was not a health issue, but a care issue. In his evidence Mr. Welsh conceded that with hindsight both health and social work should have been told. He accepted that if the social work authority had been advised this would have allowed them the opportunity to monitor whether his proposed recommendations were followed through. As no report was made this opportunity for the Council to review the core documents was lost.

Mrs. Howson submitted that there was no evidence before the Inquiry of any reasonable precautions that could have been taken by the social work authority whereby Mr. Rattray's death might have been avoided.

Ms. Kaney submitted that in relation to Dr. Simpson there were no reasonable precautions which could have been taken whereby Mr. Rattray's death might have been avoided. Dr. Simpson was responsible for Mr. Rattray's psychiatric, as opposed to his general, health. On the evidence Mr. Rattray's drug regime did not impact on the choking incident of 5 March 2005, and did not impact upon his eventual death. At post-mortem all drugs were found to be at therapeutic levels. Dr. Simpson's management of Mr. Rattray's psychiatric condition, in particular his decision to discharge Mr. Rattray from Stobhill Hospital on 22 December 2005, was entirely reasonable and appropriate. There was no evidence that any different action on the part of Dr. Simpson would have made any material difference to the tragic outcome in this case.

Mr. Wightman for Greater Glasgow Health Board, the employer of Dr. Simpson and Paul Brady, adopted a similar stance to that of Ms. Kaney in relation to Dr. Simpson. In relation to Mr. Brady, his role was "needs-led" regarding Mr. Rattray's health, rather than a "care management" role. Other Health Board functions were available by referral. If there was to be a referral in respect of swallowing it should be made initially to speech and language therapists to assess and ensure that Mr. Rattray's care plan preserved his airway. There was little or no evidence before the Inquiry that Mr. Rattray had a problem with the *physical* act of swallowing. His difficulty did not merit the insertion of a feeding tube. Rather the evidence showed that Mr. Rattray had a problem with food selection (for example his pica) and volume selection.

Neither Dr. Simpson nor Mr. Brady was present on Boxing Day 2005. Further, on the evidence neither knew of the choking incident of 5 March 2005 until after Mr. Rattray's death. Mr. Wightman contended that Irene Brown did not make a good witness, and her evidence of contacting Mr. Brady about the choking incident could not be relied upon. In any event the choking incident raised issues of the implementation of Mr. Rattray's care plan, rather than health issues.

Thus in so far as Greater Glasgow Health Board was concerned it was submitted that there were no reasonable precautions whereby the death might have been avoided.

Mrs. Martin-Brown for Quarriers submitted that the Inquiry had heard no evidence of any reasonable precautions whereby the death might have been avoided. I was urged to avoid making any findings in this case with the benefit of hindsight. If it was suggested that Wendy Graham should have forced Mr. Rattray to remain at the table with her, or that she ought to have followed him upstairs when he left the table, in Mrs. Martin-Brown's submission neither of these precautions were reasonable, nor had it been shown in evidence that they might have prevented the death.

Submissions on the defects, if any, in any system of working which contributed to the death

Another issue at this Inquiry was whether there were any defects in any system of working which contributed to the death, in terms of section 6(1)(d) of the 1976 Act.

The Procurator Fiscal submitted that the defects in Quarriers' systems of work which contributed to Mr. Rattray's death were (i) the fact that first aid training was not a mandatory component of induction training, (ii) the fact that no-one in a managerial capacity made arrangements to ensure first aid training was provided to staff either as part of the induction training or thereafter, (iii) the apparent lack of system relating to the auditing of training, (iv) the failure to follow the Essential Lifestyle Plan and Risk Assessment, (v) the failure to ensure that staff had a heightened perception of Mr. Rattray's choking risk after the choking incident on 5 March 2005 and (vi) the break-down of the system of recommendations.

For the arguments already advanced Mrs. Howson, Ms. Kaney and Mr. Wightman all submitted that on the evidence there were no defects in any system of working operated by the Council, Dr. Simpson and Greater Glasgow Health Board which did in fact contribute to Mr. Rattray's death.

Mrs. Martin-Brown for Quarriers conceded that it was clear from the evidence that the choking incident of 5 March 2005 should have automatically triggered a review of the Risk Assessment and all related procedures. In addition some of the systems and processes Quarriers would expect to be followed in relation to standards and policies were not followed in Mr. Rattray's case, particularly in relation to risk assessment.

It was submitted that the systems in place for caring for Mr. Rattray at the time of his death were adequate, but were not followed appropriately. In an effort to minimise the risk of such a tragic event reoccurring Quarriers had taken steps to improve their systems in relation to risk assessment, delegation and checking to ensure that actions have been completed. However, there was no evidence that the system of working at Quarriers contributed to the death in any way.

Determination

In reaching my determination I have had full regard to the submissions, both written and oral, presented by parties.

In my view it is important to bear in mind at all times the scope of any Fatal Accident Inquiry. That scope is statutorily defined in section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter “the Act”). Thus it is provided that the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his or her satisfaction, namely:-

- (a) where and when the death....took place;
- (b) the cause or causes of such death....;
- (c) the reasonable precautions, if any, whereby the death....might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death....; and
- (e) any other facts which are relevant to the circumstances of the death.

Accordingly, the essential purposes of the Inquiry are to inform the family as to the cause of death, and to inform the public at large, including the family, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided in order that lessons may be learned for the future. In fulfilling those purposes fault may be disclosed, but the Inquiry is not the proper forum for the

determination of any questions of civil or criminal liability, and it is not the function of the Inquiry to make any findings of fault or to apportion blame.

At this Inquiry there was no real dispute on the evidence as to where and when the death took place, and the cause of death. Accordingly I have set out those circumstances of the death in terms of section 6(1)(a) and 6(1)(b) of the Act.

I turn now to the reasonable precautions, if any, whereby this death might have been avoided.

It was clear at the Inquiry that Mr. Rattray's character was such that he endeared himself to all those involved in his care. In particular, I am in no doubt that the Quarriers' staff responsible for his daily care were all individually very fond of him and dedicated to him. There was no evidence that they acted with anything other than the best of intentions. Moreover, it has to be accepted that in life it is not possible to eliminate *all* risk. However, where the care of a highly vulnerable individual with identified risks is concerned, those responsible for his care must ensure that those directly involved in his care know and understand the identified risks, know and understand agreed strategies to minimise those risks, and know and understand what to do in the event that the risks in fact manifest themselves.

Mr. Rattray's core documents were all passed by North Lanarkshire Council to Quarriers to inform his care.

The risk of Mr. Rattray choking was fully flagged up in the Essential Lifestyle Plan, the Risk Assessment and the Service Specification. The risk of choking was not just a theoretical risk, but a real risk. The Essential Lifestyle Plan and Service Specification made clear that Mr. Rattray had in fact choked in the past. In addition the Essential Lifestyle Plan and Service Specification explained the mechanism by which Mr. Rattray choked, specifically by putting more food into his mouth before he had chewed and swallowed the contents of his mouth. The risk having been identified, strategies to minimise the risk of choking were clearly set out in all three documents. Thus, Mr. Rattray's food had to be cut up into small pieces. Support staff had to be with Mr. Rattray whilst he was eating, not only to offer positive encouragement, but

also to “*prevent him from putting too much food into his mouth at the one time*”. The latter strategy in particular necessitated that when eating, or when he had access to food, Mr. Rattray had to be *watched*. It is not possible for a carer to prevent someone from putting too much food into his mouth if the carer is not in a position to see him overload his mouth.

Given the importance of Mr. Rattray’s core documents it was of concern that members of his Team were not as familiar with them as they might have been. In particular, the Essential Lifestyle Plan, which was the guide by which he could be supported for a safe and enjoyable life, did not appear to be the “living document” which it was intended to be. His Risk Assessment, which had not been reviewed since its inception, was the document which should have informed his level of supervision given his known risks. However, my impression was that his Quarriers’ Support Plan of October 2005 was the document with which staff were in fact most familiar. It was not clear on the evidence as to how this Support Plan, prepared by his Team Leader in conjunction with his team, had evolved. In particular the relationship that this document bore to Mr. Rattray’s Essential Lifestyle Plan and Risk Assessment was not clear. None of Mr. Rattray’s known risks were mentioned in the Support Plan, in particular his pica and risk of choking.

At the Inquiry there was evidence that Mr. Rattray needed, on occasion, to have “his own space”. Mr. Rattray’s Service Design (Production 3) describes him as needing “his own space” in the context of having his own accommodation and not living or sharing with anyone else. In Quarriers’ Support Plan staff are asked to give Mr. Rattray his own space when he becomes angry looking and distressed. In addition the Support Plan states:-

“Sometimes I enjoy my own company and go off to my bedroom for a while. At these times staff will encourage me to come back downstairs but perhaps will realise I want to be on my own and will let me come back down when I am ready.”

It appeared that the situation had evolved where his team perceived that giving Mr. Rattray “his own space” meant leaving him alone, provided that “regular” checks were made. It was my impression from the evidence that for Mr. Rattray to be in another part of the house from his carer, unobserved by his carer, was not an

infrequent occurrence, all be it that that was for short periods. He was certainly alone and unobserved by his carers when he jumped out his bedroom window in November 2003. He was alone and unobserved by his carer when he choked on Boxing Day morning.

Mr. Rattray's Essential Lifestyle Plan made clear that Mr. Rattray was not to be left unsupervised for *any* length of time. His Risk Assessment made clear he was to have 1-1 support at all times, *with his carer able to observe him*. There was no evidence from the authors of Mr. Rattray's core documents as to the precise interpretation of these requirements. However, a careful reading of the Essential Lifestyle Plan, Risk Assessment and Service Specification can leave the reader in no doubt that Mr. Rattray was a very vulnerable man, for whom everyday life was a hazard, and who relied entirely on others to provide him with a safe environment. Nowhere in any of the core documents is it positively stated that Mr. Rattray, *when awake*, was capable of being left *safely* on his own, out of sight of a carer.

I fully accept that there is always a balance to be struck between allowing someone personal space, and hovering over them, watching their every move. I also accept that those directly responsible for Mr. Rattray's day-to-day care were of course best placed to assess the degree of supervision that his vulnerability demanded. However, it seemed to me that on the evidence there was no positive direction in this respect. As the Procurator Fiscal put it, there was no real steer on how often Mr. Rattray should be checked on if out of sight. Whilst Mrs. Brown said in evidence that Mr. Rattray being left on his own was subject to his team being sure he was safe, it was not clear to me that all of his team fully understood this or were directed to that effect. There seemed to be a lack of appreciation that the courtesy of allowing Mr. Rattray his personal space could never be allowed to override his personal safety, in particular, when eating or with access to food given his known risk of choking. This was alluded to in Quarriers own internal investigation report where, at page 14, it is stated:-

“There is a balance between supervision and time alone which must be struck in order to enable people we support to enjoy privacy, *but in this case, the risks for Graham of eating food out of sight were already known to be high,*

(my emphasis) and staff could all recall situations where he had crammed his mouth full of food.”

There was in fact ample evidence that Mr. Rattray’s care staff were aware of his choking risk. In addition there was evidence that the team knew he was capable of grabbing food quickly, and that he was capable of hiding food in his mouth or hand. However, on the evidence it appeared that not all his team fully *understood* his choking risk and its implications.

Mr. Rattray’s choking risk was emphasised by his choking event on 5 March 2005. If his risk of choking was not fully understood before, this event was the trigger to alert all those involved in his care to the reality of that risk and to a reappraisal of the strategies in place for minimising that risk. As Quarriers made clear in their Report of July 2006 (Production 9)

“If there had been any misunderstanding of whether Graham needed staff with him at the table for social or safety reasons, this incident would have given the opportunity to make that very clear.”

Although the process of recording the choking incident and action to be taken was begun, none of the recommended actions were followed through to anything near completion. There was a general awareness in Mr. Rattray’s team that the choking incident had taken place. However, awareness is not enough. What was required, and obviously so, was to ensure that the team understood how the choking incident arose, how to minimise the possibility of it happening again, and what to do in the event that it did happen again.

In saying that, I have nothing but praise for how Mr. Doherty reacted that day. He was appropriately watching Mr. Rattray whilst the latter was eating, and thus in a position to see the risk arising. He understood immediately that Mr. Rattray was in fact choking. He knew what to do in response. It can properly be said that Mr. Doherty saved Mr. Rattray’s life that day, and for that he is to be commended.

Observations were made of Mr. Doherty’s vast experience in first aid. That experience is undoubted. It is possible that if Mr. Doherty was not as experienced his efforts would have been in vain. However, that is beside the point. The point is that

Mr. Doherty was only able to save Mr. Rattray because firstly he was in a position to see Mr. Rattray choke and secondly he *knew* what to do when Mr. Rattray in fact choked. It seems to me that the choking incident highlighted the necessity of ensuring that Mr. Rattray was always watched when he was eating, by a person who knew what to do in the event that his known risk of choking manifested itself. A risk assessment would have made that necessity patent.

The lack of action after Mr. Rattray's choking incident was a lost opportunity to ensure that all team members were fully conversant with and able to respond to his choking risk. Rather than directing her team, my impression was that Irene Brown was prepared to assume, on the basis of her observations, that her team would automatically know what to do to keep Mr. Rattray safe. Her response to what procedures, if any, were in place as to how staff should react if Mr. Rattray did in fact choke was that there were no "written headlines" that she was aware of, but her team had general experience and were "always aware of incidents" and were "best prepared by taking the best course of action at the time". This assumption was made where Mrs. Brown, by her own admission, was not aware of what, if any, first aid experience the members of her team had. By the time of Mr. Rattray's death it appeared that none of his then team had in fact undergone Quarriers' Emergency First Aid training.

The reliability of Ms. Graham's evidence to the Inquiry on the exact events of Boxing Day morning 2005 is questionable. In particular, her evidence about whether she knew Mr. Rattray had toast with him when he went upstairs that last time I found unsatisfactory. The clear understanding of those who carried out the Quarriers investigation after Mr. Rattray's death was that when Mr. Rattray went upstairs for the last time he was eating toast. The source of that understanding was Ms. Graham. Even on her account to the Inquiry Ms. Graham allowed Mr. Rattray to go upstairs "with toast", all be it that he came back downstairs again safely, actually eating the toast. He was thus clearly out of her sight, with her knowledge, with ready access to food. When he went upstairs that last time, if she did not know he had toast with him, at the very least she suspected it.

On the evidence it appeared that Ms. Graham did not fully understand the implications of Mr. Rattray's choking risk. It did not appear to have been made clear

to her that, given Mr. Rattray's known risk of choking, she should have been in a position to observe Mr. Rattray eating, and thus in a position to attempt to prevent him from putting too much food into his mouth at the one time. In my view it would have been entirely reasonable for Mr. Rattray to be followed up stairs when it was suspected he had food with him, to keep an eye on him. Whilst I appreciate that staff had to keep themselves safe in order to ensure the safety of Mr. Rattray, on the evidence it is difficult to see how the act of following Mr. Rattray and keeping an eye on him could in any way have jeopardised Ms. Graham's safety that morning.

If she had been in a position to see Mr. Rattray choke, it can be inferred from the evidence that it is likely that given her lack of first aid training Ms. Graham would not have been in a position to positively intervene. Of course, had she been given first aid training it is possible that she wouldn't have been able to save Mr. Rattray. However, she would have known how to react to the emergency. It is not necessary in terms of the Act that I have to be satisfied on a balance of probabilities that Mr. Rattray's life *would* have been saved, only that it *might*. It is possible that Mr. Doherty, on 5 March 2005, might not have saved Mr. Rattray's life. He was able to do so first and foremost because he knew what to do. If Ms. Graham had had first aid training she would have been in a position where there was a real possibility she might have saved Mr. Rattray's life. In my view to argue thus is not an exercise in hindsight. Choking for Mr. Rattray was not an unanticipated event. It was a known risk which had in fact manifested itself before, and indeed had manifested itself fairly recently with near fatal consequences.

In my view the reasonable precautions whereby Mr. Rattray's death by choking might have been avoided are:-

1. that those responsible for Mr. Rattray's daily care should have ensured that his care team knew and understood that he had to be watched when eating or when he had access to food, to prevent him from putting too much food into his mouth at the one time; and
2. that those responsible for Mr. Rattray's daily care should have ensured that his care team knew and understood what first aid care to administer in the event that he in fact choked.

In so far as North Lanarkshire Council, Dr. Simpson and Greater Glasgow Health Board are concerned I am unable to discern any reasonable precaution that could have been taken whereby Mr. Rattray's death might have been avoided. I reach that conclusion on the evidence and on the basis of the submissions made on behalf of these parties.

In particular, in so far as Dr. Simpson is concerned I am entirely satisfied that the decisions he made as to Mr. Rattray's psychiatric care were both reasoned and reasonable exercises of his clinical judgement. That includes his decision on 22 December 2005 to discharge Mr. Rattray to 49 Dunellen Avenue. I can understand how it might be argued that if Mr. Rattray had remained in hospital or been transferred to Pineview he wouldn't have been at 49 Dunellen Avenue on Boxing Day 2005. However, that argument does not render Dr. Simpson's decision to discharge him an unreasonable one, and hindsight does not make the alternative of remaining in hospital a "reasonable precaution".

I now turn to consider the defects, if any, in any system of working which contributed to the death, in terms of section 6(1)(d) of the Act. As a precondition to making any finding under section 6(1)(d) the court must be satisfied that the defect in question *did* in fact cause, or contribute to the death.

In this regard the Procurator Fiscal focused firstly on the provision and monitoring of first aid training.

On the evidence Quarriers did have an existing system whereby first aid training was available, although not mandatory, and where a trainer was available to visit projects to deliver relevant aspects of the course where specific needs were identified. The difficulty in this case was that the existing system was not applied or monitored as it should have been by management. Despite the risk of medical emergency being known at the outset of Mr. Rattray's support, and despite first aid training being recognised as required following his choking incident of 5 March 2005, first aid training was not provided. In my view the need for first aid training in the face of Mr. Rattray's known choking risk should have been identified and delivered for Mr. Rattray's care staff at the outset in order that he was always supervised by at least

one carer who knew what to do in the event that his choking risk manifested itself. However, that is a failure in utilising an existing system, not a defect in the system itself. As a result of Mr. Rattray's death, matters have been tightened up. First Aid training is now a mandatory component of induction training. Todd Coster gave evidence that now where there is an identified risk there will not be a team member with that person who is not trained to deal with that risk in the event that it arises.

The Procurator Fiscal thereafter focused on the failure to follow Mr. Rattray's core documents, and the breakdown in the system of recommendations following the choking incident of 5 March 2005. These are important matters, but again they are issues of human failure in following existing systems, rather than defects in the systems themselves. A "heightened perception" of Mr. Rattray's choking risk should have been one of the end results of the choking incident reporting process. Again, the fact it didn't happen is a failure of implementation of the system, rather than a defect in the system itself.

It follows that on the evidence I am not satisfied that the matters raised by the Procurator Fiscal properly fall within the confines of section 6(1)(d) of the Act. These are matters which in my view fall to be considered under section 6(1)(c) of the Act, which I have done.

On consideration of the evidence I am not satisfied that there were any defects in North Lanarkshire Council's system of working which in fact contributed to Mr. Rattray's death. Whilst it is unsatisfactory that Mr. Rattray was without an allocated social worker for some fifteen months, and that no social work department community care reviews took place for just over two years, there was no evidence before me that the absence of an allocated social worker and the absence of regular case reviews impacted negatively upon Mr. Rattray's care, or had any bearing upon the circumstances of his death.

In so far as Dr. Simpson is concerned the reasoned decisions he made as to the psychiatric care of Mr. Rattray cannot properly be characterised as "defects in any system of working". Further, on the evidence I am satisfied that his decisions did not in fact contribute to Mr. Rattray's death. Turning to Greater Glasgow Health Board in

general, there was no discernible evidence that there was any defect in the Board's systems of working which in fact contributed to Mr. Rattray's death.

It is right and proper that in the light of Mr. Rattray's death Quarriers have implemented a series of recommendations designed to improve their systems of risk assessment, monitoring, delegation of responsibility, and recording and preservation of information. However, on the evidence I am not able to say that there was any defect in any system of working which *did* cause or contribute to the death. Accordingly in my view it would be inappropriate to make any finding in terms of section 6(1)(d).

In terms of section 6(1)(e) of the Act I have to consider, so far as established to my satisfaction, any other facts which are relevant to the circumstances of the death. It is not necessary that there be a causal link between such facts and the death. However, in my view to be relevant the facts must have some evidential bearing upon the circumstances of the death.

I have fully rehearsed the evidence in my Determination and on a careful consideration of that evidence I do not propose to add anything in terms of section 6(1)(e). The Procurator Fiscal has asked me to make recommendations, but in my view I am confined by the Act to setting out the circumstances of the death as described in section 6(1).

In conclusion, in my view Mr. Rattray's death has given rise to serious public concern. Whilst it is not the purpose of this Inquiry to examine the policy of "care in the community" in general terms, obviously in implementing that policy there is a responsibility to ensure, in so far as possible, the safety of those cared for. The vulnerable adult's core documents have a fundamental purpose in informing as to what is required to ensure in so far as possible a life which is not only enjoyable, but above all safe.

It seems to me that where risks are identified those responsible for the daily care of the vulnerable adult must ensure that carers know and *understand* the identified risks,

know and understand *agreed* strategies to minimise those risks and know and understand what to do in the event that the risks in fact manifest themselves.

The incident in about November 2003 when, whilst alone, Mr. Rattray jumped out his bedroom window, and his access to his incontinence pads and their contents when alone in bed at night, are not circumstances related to his death on 26 December 2005. As such I am not in a position to make any formal finding in respect thereto. However, I feel that they are matters of sufficient concern that I cannot let them pass without some comment. In my view these incidents indicated a lack of true understanding on the part of his carers of what was required to keep Mr. Rattray safe, as indicated in his core documents.

I found it particularly worrying that, despite ample evidence that his carers were aware of his choking risk and his pica risk, no real thought seemed to have been given to the link between the two. Despite the knowledge that Mr. Rattray had in the past eaten the contents of his incontinence pads and the pads themselves, that awareness did not inform his care whilst in bed at night with ready access to his incontinence pads.

Mrs. Brown seemed to think that wearing or not his incontinence pads was a matter of choice for Mr. Rattray. The Essential Lifestyle Plan and Service Specification make clear that Mr. Rattray didn't wear incontinence aids at night as in the past he had eaten the pads. Quarriers' own investigation picked up that this aspect of Mr. Rattray's core documents had been "disregarded".

In my view this chapter only serves to emphasise that those responsible for the care of the vulnerable must ensure that awareness of known risks is accompanied by understanding of the implications thereof. I am encouraged that Quarriers have carried out a full internal investigation into the circumstances of Mr. Rattray's death and have implemented a series of recommendations designed to reduce the risk of such a death happening again. It is only right that the very sad circumstances of Mr. Rattray's death should prompt a reappraisal of how best to care for our most vulnerable members of society.

Finally, I wish to take this opportunity to formally convey my sympathy to Mr. Rattray's family.

