

SHERIFFDOM OF NORTH STRATHCLYDE AT GREENOCK

[2026] FAI 12

GRE-B86-23

DETERMINATION

BY

SHERIFF SHEENA FRASER

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC
(SCOTLAND) ACT 2016

into the death of

ROBERT McPAUL

GREENOCK 17 March 2026

Determination

The sheriff, having considered the information presented at the Inquiry, Determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, (hereinafter referred as (“the 2016 Act”):

(a) In terms of section 26(2) (a) of the 2016 Act (when and where the death occurred):

Robert McPaul died at 1757 hours on 30 March 2018 within Sir Gabriel Wood’s
Mariners’ Home, 67 Newark Street, Greenock.

(b) In terms of section 26(2) (b) of the 2016 Act (when and where any accident resulting in the death occurred):

The accident occurred between 1650 hours and 1713 hours in the dining room within Sir Gabriel Wood's Mariners' Home, 67 Newark Street, Greenock.

(c) In terms of section 26(2)(c) of the 2016 Act (the cause or causes of the death):

The cause of the death of Robert McPaul was choking on food, with a potential contributing cause of Cerebrovascular Disease.

(d) In terms of section 26(2) (d) of the 2016 Act (the cause or causes of any accident resulting in the death):

The cause of the accident resulting in the death was Mr McPaul receiving and consuming a meal that was not suitable for his specified dietary requirements. In particular, the steak pie meal served by carers at the Home, which consisted of stewing steak, gravy, mashed potato and puff pastry was not prepared in accordance with a Texture D diet, and in any event, not the menu choice he had selected. On ingesting this meal, a portion of it, the pastry, became lodged in his trachea, causing him to choke.

(e) In terms of section 26(2) (e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in death, being avoided):

A reasonable precaution which might realistically have prevented the death was to label each patient's plate with their name, such plates to be (i) colour coded according to the patient's specific type of diet and (ii) to be checked prior to leaving the kitchen, and before service to the patient, against a cross checked and colour coded main menu showing the patient's selected meal preference and diet type.

(f) In terms of section 26(2) (f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in the death):

A defect in the system of work which contributed to the death was the failure by the Home to introduce a system of work, including appropriate training to employees as part of that system, which would allow employees of the Home to identify patients with specific diet type, and to cross check that the patient with that diet received the correct types of food.

(g) In terms of section 26(2) (g) of the 2016 Act (any other factors which are relevant to the circumstances of the death:)

There are no other facts beyond the findings set out in this Determination which are relevant to the circumstances of the death of Mr McPaul.

(h) In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

No recommendations are made. After Mr McPaul's death, the management of Sir Gabriel Wood's Mariners' Home introduced a system of colour coded plates on which separate and different types of meals were set out for groups of residents with dietary needs and trained staff members on that. Further the Home has ceased trading and the Trustees are no longer involved in the operation of any other care home. On these bases, there are no further recommendations to be made under this heading.

NOTE

Introduction

[1] This was a discretionary Inquiry held under section 4 (1) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 into the death of Robert McPaul, who died whilst in the care of Sir Gabriel Wood's Mariners' Home on 30 March 2018.

The legal framework

[2] The purpose of the Inquiry in terms of section 1(3) of the 2016 Act is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability,

criminal or civil or to apportion blame or fault. The Inquiry is an inquisitorial process which is fact finding, not fault finding. Section 26 of the 2016 Act requires the sheriff to determine a number of issues: where and when the death occurred; when and where any accident resulting in the death occurred; the cause or causes of death; the cause or causes of any accident resulting in the death; any precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death or the accident resulting in the death being avoided; any defects in the system of working which contributed to the death, and any other relevant factors to the circumstances of death.

[3] In terms of section 26(4) of the 2016 Act specifically, the sheriff can make recommendations as a consequence of the issues determined which might realistically prevent other deaths in similar circumstances.

Proceedings and parties

[4] The notice of Inquiry and Form 3.1 were lodged with the court by the procurator fiscal on 6 April 2023. A preliminary hearing took place on 19 July 2023. Further preliminary hearings were held on 28 August, 25 September and 1 November 2023, before a date for the Inquiry was fixed for 15 December 2023. The hearing was treated as a further preliminary hearing due to difficulties with the joint minute and witnesses not being present on that date. There were a further two preliminary hearings on 21 February and 1 March and evidence was led in the Inquiry on 13 and 14 March,

3 May and 2 and 18 July all 2024, with written submissions being adopted by parties on 18 July 2024.

[5] In the Inquiry, the public interest was represented by Mr Ul-Hassan, Procurator Fiscal Depute. Other participants were Ms McDonald for the Trustees of the Sir Gabriel Wood's Mariners' Home and Ms Blockley, Advocate, for the care worker BM. I am grateful to parties for their assistance at all stages of the Inquiry.

[6] Parties agreed much of the evidence before the court in the form of a joint minute of agreement. The agreed facts are set out in full within the determination. I have changed the wording slightly from what appeared in the Joint Minute to assist the reader.

[7] Due to issues with availability and ill health, the Inquiry also heard evidence by way of affidavit from two witnesses namely Annabelle Stewart, manager at the Home, and RT, head chef there. This meant that their evidence contained therein was not subject to cross examination.

[8] The Inquiry also heard evidence from the following witnesses:

1. MMcG, senior care assistant, employed by the Home
2. BM, care assistant, employed by the Home
3. Dr Julia Bell, pathologist
4. RT, head cook employed by the Home (who also provided additional evidence by affidavit)
5. Kim Wilson, senior care assistant, employed by the Home
6. Catherine Cameron, senior care assistant employed by the Home

7. Tracey Lazenby-Paterson, speech and language therapist, consultant dysphagia practitioner

[9] All the witnesses did their best to assist the enquiry, however to different extents, the efforts of those present to explain what happened on the day of Mr McPaul's death, at the Home and in the days following, were hampered by poor recollection. Ultimately though, I concluded that all were doing their best to be truthful, but their reliability was doubtful in some respects, and I have identified later those areas.

The joint minute of agreement

[10] The parties to the Inquiry agreed as follows:

1. Sir Gabriel Wood's Mariners' Home ("the Home") 67 Newark St, Greenock, PA16 7TQ. It is a Scottish charity registered with the Office of the Scottish Charity Regulator with the charity number SC003763. The home operated as a care home for retired seafarers, those who worked in the maritime industry as well as those who worked at sea in the Merchant Navy, Royal Navy, Royal Marines or WRNS. The Home provided specialist care for those living with Alzheimer's disease, and Korsakoff's syndrome. In addition, the Home operated a separate residential facility for those capable of independent living.
2. The Trustees of the Home ("the Trustees") were responsible for the control, management and operation of the Home from 1968 until 2021. The Sailors' Society (the "Society") is an English charity registered with the Charity

Commission for England and Wales with the charity number 237778. The Society held the title to the care home operated by the Trustees and retained general oversight of the Home.

3. On 1 November 2020, the Trustees decided to close the Home. The decision followed a lengthy review of the Home's future due to a sharp decline in the number of mariner beneficiaries, coupled with concerns over the resources needed to maintain the standards required for the Home. The COVID-19 pandemic placed significant added pressure on the Home and its staff and efforts to increase occupancy were hampered by restrictions on resident movements into the Home. The Home worked closely with health and social care partnerships to ensure that every resident was successfully transferred to suitable alternative care settings. The last residents left the Home in February 2021. The Trustees are not involved in the operation of any other care homes.
4. Crown Production 29 is a copy of the Deed of Trust by Sailors' Society registered with the Books of Council and Session dated 18 February 2014.

Said deed states, *inter alia*, that:

"[i]t shall be competent to the Society to delegate to the Committee of Management aftermentioned to deal with the reception of persons and to delegate to such Committee of Management (the 'Management Committee') all powers requisite for said purposes. The Society will appoint a Committee of Management to supervise the day to day running of the Trust."

5. At the time of Mr McPaul's death, the Management Committee was made up of 11 individuals.
6. The Society provided a general, high-level oversight of the management of the Home. This oversight was in relation to financial matters, such as obtaining quotes for work at the request of the Management Committee. The day-to-day running of the Home was the responsibility of the Management Committee who reported to the Trustees of the Home. The Management Committee was responsible for all operational aspects of the Home including, *inter alia*, all care provision matters, for example, feeding the residents and liaising with the Care Inspectorate. The Management Committee had responsibility for ensuring the Home's compliance with health and safety legislation.
7. The Management Committee aimed to meet monthly, but this was not always possible. The Management Committee discussed, *inter alia*, care related matters. The Board of the Trustees of the Home met three to four times per year. The Board of Trustees discussed, *inter alia*, matters of governance, finance, marketing, fundraising and occupancy of the Home.
8. Robert McPaul, was born in Greenock on 6 February 1948. He joined the Merchant Navy when he was 16 years old where he served for approximately 10 years. After working for various management positions for different companies, he retired in 1988. Robert McPaul was admitted to

the home on 21 July 2009. Crown Production 34 is a copy of Mr McPaul's admission assessment to the home on 21 July 2009.

9. Robert McPaul was 70 years old at the time of his death.
10. Robert McPaul had a past medical history including, *inter alia*, cognitive impairment. He suffered from osteoarthritis and chronic oedema. He had a history of choking.
11. Speech and language therapy guidance was provided to the care home on 01 December 2017. The guidance stated that Robert McPaul should receive a Texture D diet on the basis that he had a history of eating too quickly and storing food in his mouth. That advice was current at the time of Robert McPaul's death.
12. Crown Production 16 is a copy of Robert McPaul's medical records. The contents of those records are accurate. Page 82 of that production refers to a choking incident of Robert McPaul's from 21 March 2015. Page 56 of that production records that Robert McPaul was placed on a Texture D diet from 05 December 2017.
13. BM was a care worker at the Home. She commenced employment at the home on 08 January 2018. At the date of Robert McPaul's death she had worked at the home for under 12 weeks.
14. On 30 March 2018 at about 1645 hours, Robert McPaul was taken to the dining room in the Home for dinner. Robert McPaul began to choke while

eating his meal. Staff members MMcG, BM, Philip Allison and Kim Wilson attempted to assist him. An ambulance was called.

15. The ambulance arrived about 1722 hours. The ambulance was crewed by Thomas McShane (paramedic), Jeffrey Proctor (paramedic), Carol Kelly (ambulance technician), David Millar (ambulance technician), Alan Megahy (retrieval practitioner), Alistair Bell (doctor). The ambulance crew were unable to resuscitate Robert McPaul, and his life was pronounced extinct at 1757 hours.
16. A post mortem examination of Robert McPaul, took place on 10 April 2018 at the Queen Elizabeth University Hospital, Glasgow. A post mortem report was subsequently issued, dated 23 May 2018. It was noted that the primary cause of death was choking on food, with cerebrovascular disease being a potential contributing cause. Crown Production number 13 is a copy of that report.
17. A speech and language therapy report was produced by Tracy Lazenby-Paterson on 18 December 2020. The report details her opinion of the suitability of the meal consumed by Robert McPaul on 30 March 2018, and her opinion about whether this meal was appropriate for Robert McPaul's "Texture D diet". Crown Production 17 is a copy of that report.
18. The death of Robert McPaul was communicated to the Society in June 2018, through a quarterly report.

19. That following the death of Robert McPaul, the Home conducted an immediate review into the circumstances of said death. As a result of this review, the Home implemented a change of process and training. Following the death of Mr McPaul, no enforcement notices were served on the Home and no individuals were prosecuted.

Background to home

[11] I heard from a number of witnesses who worked at the home at the time of Mr McPaul's death, both in person and by way of affidavit. The background circumstances were largely uncontroversial.

[12] The Home was a two-story building with a garden. The exact number of rooms was unclear, as recollections varied between staff members, but it was generally accepted there were up to 40 residents in total over the two floors at the time of Mr McPaul's death. Twelve of the residents, including Mr McPaul were in the Korsakoff Unit. There was also a separate unit for those with mobility problems.

[13] There was a staff room/office to which all members of staff had access. Within that room, was a notice board on which general information would be posted. There was also a folder which was called various names in evidence, including the report book, resident's report book or the shift book. All staff had access to this book. The book contained information about each of the residents, including all their needs, such as medical needs, and any risk assessment carried out in respect of them. This book included a daily report on each resident, which was completed each day with anything

that had happened in respect of individual residents that day. The daily report would be updated at the end of each shift by the care staff and checked by those coming on duty at the start of their shift, to appraise themselves of anything that might have happened in their absence.

Staff training

[14] I heard from a number of the employees about the various methods of training for staff. There was a period of supervision/shadowing with a supervisor/senior member of staff, when the employee first started, then a mixture of online courses and external training supplied by a named individual.

[15] The court also heard excerpts from the training records of a number of employees who gave evidence. Insofar as food and nutrition is concerned they all seemed to have had a degree of training in the types of diet that resident might require. BM, who was the carer who was with Mr McPaul when he began to choke, was a relatively new employee, commencing employment at the Home in January 2018 and had not yet completed any specific training in relation to food and nutrition. She had been trained in First Aid, which included what to do if someone was choking. She was still at the stage of training where she was shadowing a more senior member of staff.

[16] Management within the Home would identify courses that were available and let staff within the Home know about them, by placing the details of the course on the notice board in the staff room/office. The identity of any staff member who was to attend a particular course would also be posted on this board. Individual members of

staff could request to attend a specific course or would be identified by management as being required to attend that course. Some courses were provided online, and some in person by an external agency. As I have stated before, all members of staff had access to the staff room/office where the notice board was.

[17] Food and nutrition training included staff being made aware in general terms of what different types of diets were. Most of the witnesses, both carers and kitchen staff, confirmed they were aware of what a textured D diet was. That is with the exception of the care worker BM, who was with him as he ate the steak pie, she had not yet attended the food and nutrition course.

[18] The head cook, at the time of Mr McPaul's death, RT, gave evidence both in person and at a later stage an affidavit was lodged and read to the inquiry. She described her training in food and nutrition which was a mixture of in person training by the individual whose organisation provided most of the training for the Home, online courses and her own research on the internet. She was aware of the dietary requirements of Mr McPaul and had prepared the foodstuffs on 30 March 2018 accordingly. She confirmed that the steak pie option was not suitable for someone, such as Mr McPaul, on a Texture D diet.

Procedure in relation to ordering meals and in the dining room:

[19] There were two separate dining rooms, one upstairs and one downstairs. Dinner was served in both dining rooms in two separate sittings, with about 45 minutes between the start time of each of the two sittings. Residents whose rooms were on the

upper level ate upstairs and those with rooms on the lower level ate downstairs.

Mr McPaul dined in the dining room on the upper level of the Home.

[20] The kitchen staff consisted of a head cook and an assistant cook. Other members of staff did not enter the kitchen area without the permission of the kitchen staff.

[21] The head cook, RT, decided which meals were to be on the menu. She had identified three distinct weekly menus that rotated every three weeks, changing those weekly menus seasonally. The residents were generally provided with a choice of two or three different dishes for each course of the dinner. On 30 March 2018, chicken paella was on the menu for the first time. It had been prepared to make it suitable for those on a Texture D diet.

[22] RT prepared daily menu sheets in the form of a handwritten table. This table had the names of each of the residents separated into sections according to the type of diet they were on. Mr McPaul was under the section for people requiring a "soft diet". The table also detailed the options for each course of each meal and included details of which dish was suitable for which type of diet, such as, for example, gluten free, diabetic or soft or Texture D. On 30 March 2018 the two options noted on the menu sheet as being suitable for a soft diet were beef stew and chicken paella.

[23] At some point during the earlier part of the day or the day before, a carer would ask each resident which of the options set out on the menu they wished for their dinner and record their selection on the menu by ticking the box under the menu option next to the resident's name. This document would then be returned to the kitchen staff, either the head cook, RT, or her assistant.

[24] The head cook or her assistant would then check that the meal selected was suitable for the type of diet the individual was on. Should the individual have selected a course which was unsuitable for their diet, then it would be returned to a senior carer to speak again to the resident.

[25] The head cook or her assistant then prepared the individual meals, plated them up individually, and covered them either with foil or a lid of some sort. The plates were then put on a heated trolley which was wheeled to the dining room along with the copy of the handwritten menu. This was the menu used by kitchen staff to identify how many meals to make and send to the dining room. There did not appear to be any plan in relation to where on the trolley the different types of meals were placed to assist with identifying them to dining room staff. The head cook and a senior care assistant spoke of such a process, but neither of the individuals in the dining room with Mr McPaul on 30 March were aware of it, so I was not satisfied that such a procedure was universally in place at the time.

[26] It was the staff in the dining room, who were carers, who distributed the meals to the individual residents. The procedure to identify which meal was for which resident, was that before giving the meal to the resident, the staff member would double check the selection by reference to the menu sheet on which each resident's selection was recorded.

[27] Where a resident required supervision or other assistance whilst eating then a carer would sit with him and provide what was necessary.

[28] At any meal there could be up to eight residents in a dining room at any time with two members of staff present.

Robert McPaul

[29] As agreed in the joint minute, Robert McPaul was born in Greenock on 6 February 1948. He served in the Merchant Navy for approximately 10 years, before making his career in management. He resided in the Home from 21 July 2009 until his death.

[30] At the time of his death, he was relatively immobile and required to be taken to the dining room in a wheelchair. He also had difficulty swallowing. He could feed himself but was known to sometimes fall asleep during meals and required prompting to eat. At other times he would eat too quickly. This meant that on occasions he needed to be supervised at mealtimes and sometimes he needed to be fed, with his mouth being checked at the end of each meal to ensure he had not pocketed food.

[31] Mr McPaul had two previous choking incidents recorded in his file. Records in the report book noted his previous choking incidents, the second of which was in May 2017.

[32] As a result of these incidents, he was referred to Speech and Language Therapy (SALT) services on 2 May 2017. An assessment by those services recommended he be placed on a Texture D diet. This information was passed to the Home and recorded in Mr McPaul's records.

[33] He was referred to the SALT services again in December 2017 and on discharge it was recommended that there was mandatory supervision of Mr McPaul at mealtimes. Whilst it appears on the evidence that that did not happen at all times, it did not impact on Mr McPaul's death as he was supervised at the time he began to choke.

[34] Mr McPaul's Resident Care Plan recorded that from 29 November 2017, he was placed on a "soft diet, texture D or E depending on availability or suitability" due to his eating too quickly and putting too much into his mouth. Staff also spoke to him about splitting his meal between two plates to encourage him to slow down, which he agreed to. The Care Plan records that kitchen staff were aware.

[35] BM recalls that the two-plate system was in place on 30 March 2018 but none of the other witnesses spoke to that. I considered she was mistaken about that. This was the first time she had assisted Mr McPaul at a mealtime, and although she had been present when the person she was shadowing had assisted a resident, she had not been present when someone with a Texture D diet had been assisted.

Texture D diet

[36] At the time of Mr McPaul's death, the Dysphagia Diet Food and Texture Descriptors (2011) (Hereinafter "the DDFTD") were in use. These have now been superseded by the International Dysphagia Diet Standardisation Initiative (IDDSI). Within the DDFTD, under the heading "Additional recommendations" it states that " All professional organisation should encourage their members to comply with the

terminology and language used within this document". The different food textures set out in the document, were:

- a) Texture B= thin puree dysphagia diet
- b) Texture C= Thick puree dysphagia diet
- c) Texture D = PRE- mashed dysphagia diet
- d) Texture E + Fork Mashable dysphagia diet.

[37] I heard from Speech and Language Therapist Dr Tracey Lazenby- Paterson who prepared a detailed and helpful report for the Inquiry (Crown Production number 17) in more detail on these diets and I shall refer more to her evidence later.

Events of 30 March 2018

[38] At some point earlier in the day of 30 March 2018, or perhaps the day before, a member of staff spoke with Mr McPaul to ascertain his dinner selection for that evening. He selected chicken paella as his main course for dinner. This was one of two dining options that was suitable for a Texture D diet, the other being beef stew. The member of staff recorded his selection on the menu. A copy of the handwritten menu as completed by this member of staff was available to the Inquiry as Crown Production 2.

[39] This document was set out in a table form, with residents' names listed down the left hand side of the page and the menu options for lunch and dinner set out along the top of the page. The staff member completing the form then ticked the box next to the resident's name below the meal option selected. The resident's names were grouped together on the menu according to the type of dietary requirement they had, such as

“puree diet”, “soft diet” and Ostoma. Steak pie was an option on the menu for other residents but not for those on a soft diet, including Mr McPaul.

[40] Mr McPaul was listed along with two others under the heading “soft diet”. For dinner the options for individuals on that diet was chicken paella or beef stew. In respect of Mr McPaul’s selection, the box under the heading chicken paella was clearly marked with a tick.

[41] Whether or not chicken paella or indeed beef stew is suitable for a Texture D diet depends on how it is prepared. On the evidence, it was not disputed that chicken paella, as prepared on 30 March 2018, would have been suitable for a Texture D diet.

[42] To prepare it, the head cook, RT, made modifications to ensure it was suitable for a Texture D diet, namely by mincing the raw chicken, by removing the skin of the tomatoes before blanching them and removing their seeds, and also by cooking the rice with a thick tomato sauce into which the chicken is added and cook slowly to achieve the necessary consistency.

[43] The menu sheet which showed what each resident was to eat that night clearly recorded that Mr McPaul was to receive chicken paella. He did not.

[44] He was brought to the upstairs dining room in his wheelchair. There were eight or nine residents in total being supervised by BM and MMcG. An unnamed member of kitchen staff brought the heated trolley to the dining room, on which the meals for all the residents were set out. There was no particular order to the way in which the meals were set out over the two levels of the trolley, and there was no name marked on any of the plates.

[45] A copy of the daily menu card which recorded each resident's meal selection was on the trolley.

[46] Whilst the meat element of a steak pie may be suitable for a Texture D diet depending on how it was made, the pastry element is extremely unlikely to be suitable and therefore should not be included on a plate for someone requiring a Texture D diet. I heard no evidence to suggest either the meat element or the pastry was suitable. On the contrary, the menu card did not identify it as being a suitable meal for someone on a Texture D diet.

[47] In any event, there was no dispute in the evidence led that the steak pie dinner served that night was not suitable for someone such as Mr McPaul who was on such a diet.

[48] On the evidence, it was not clear how he came to be fed that meal. The kitchen staff were aware it was not suitable. The menu sheet which was on the Trolley with the plates of food recorded not only that it was not suitable, but it also recorded that it was also not the meal selected by Mr McPaul.

[49] As he ate the steak pie meal, Mr McPaul was supervised by BM, who was herself shadowing a senior carer MMcG. MMcG took the meal from the trolley and handed it to BM who served it to him. This meal was the steak pie option on the menu and consisted of mashed potato, steak, gravy and pastry.

[50] Before serving it to Mr McPaul, either MMcG or BM mashed the meal further and added gravy. At this point the pastry was fork mashed into the gravy. It is not

clear on the evidence which of them did this, as each thought they had done it, but it was clear both accepted that that had been done.

[51] Mr McPaul began to feed himself, but shortly afterwards BM noticed his hand shaking, so she sat down with him to supervise him and helped him feed himself. She was aware that he was known to pocket food in his mouth, and chew on it later. There was no evidence to suggest he did that on this occasion, therefore, on the evidence, I do not consider that that is what happened here.

[52] Mr McPaul was also known to grab foodstuffs from other individual resident's plates and consume it. I do not consider on the evidence that that is what happened here. There was some evidence from BM that she saw him grab something from another plate and put it in his mouth just before he choked, but I do not consider that to be reliable evidence. BM was interviewed shortly after the event by investigators with Environmental Health at Inverclyde Council and said she did not see him take anything from another plate. This leads me to conclude her evidence at the Inquiry was unreliable on that point, having been impacted by her trauma at the events of that day, and consider her recollection nearer the time to be more accurate. There was no evidence that there was anyone eating food sufficiently near to Mr McPaul to enable him to do this.

[53] BM was supervising Mr McPaul as he ate his steak pie meal when she noticed him begin to cough, so she started to feed him to slow him down, but after one mouthful, he was clearly choking.

[54] Although BM and MMcG were the only two members of staff in the dining room at the time as BM attempted to remove whatever was choking him from his mouth, MMcG pressed an alarm button. They removed Mr McPaul to the corridor, and other members of staff quickly attended there. They all attempted to dislodge whatever was choking him. This involved removing him from his wheelchair and employing the “thrust” manoeuvre. All to no avail.

[55] Their attempts continued until the arrival of paramedics who continued to attempt to resuscitate Mr McPaul but he was pronounced dead at 1757 hours.

Cause of death

[56] I conclude on the evidence that Mr McPaul choked on pastry from the steak pie he was given to eat for dinner on 30 March 2018.

[57] An autopsy was carried out at Queen Elizabeth University Hospital Glasgow on 10 April 2010 by Dr Julia Bell, pathologist. Her report was dated 23 May 2018 and was available to the Inquiry as Crown Production 13.

[58] Dr Bell gave evidence at the Inquiry by live link and adopted her report in full. This report recorded that there was no obvious food in Mr McPaul’s mouth and that there was no obvious oral injury. She recorded details of their findings, including finding a large mound of soft material in the trachea and bronchi. This would have caused the blockage which would have prevented Mr McPaul from breathing. The report recorded that the pathologists were unable to identify the foodstuffs that had caused the blockage, describing it as “white and congealed”. That conclusion, however,

was drawn on the information they had at the time of the autopsy and preparation of their report, namely that Mr McPaul was eating stew and potatoes when he choked and the foodstuff did not have the appearance of either meat or mashed potatoes.

[59] However, in evidence, Dr Bell was advised that the information she had at the time of autopsy in relation to the meal was incorrect and that, in fact, he had been eating steak pie which included pastry. She acknowledged that, whilst it was impossible to be definitive about it, the blockage material could have been pastry.

[60] Dr Bell was also asked if the foodstuff in the blockage could have been partially digested and regurgitated, but she confirmed that whilst she could not exclude that, she considered that to be less likely standing the appearance of the foodstuff.

[61] Dr Bell confirmed the cause of death was 1. Choking on food with a potential contributing cause being Cerebrovascular Disease.

Speech and language expert

[62] I also heard from Ms Tracy Lazenby-Paterson, a speech and language therapist, who gave evidence in the capacity of an expert witness. She gave details of her qualifications and expertise, in particular, in the field of dysphagia and swallowing disorders. There was no dispute that she was qualified to give evidence as an expert in her field to the Inquiry.

[63] She had originally received instructions from the environmental health officer at Inverclyde Council who was investigating Mr McPaul's death. She prepared a report which was available to the Inquiry as Crown Production number 17.

[64] She confirmed that dysphagia is a medical term used to describe disorders of eating, drinking and swallowing, which can lead to, *inter alia*, choking.

[65] Prior to writing her report she had access to a number of documents including Mr McPaul's medical records, his care plan from the Home and his SALT referrals and assessments.

[66] She explained the Dysphagia Diet Food Texture Descriptor (2011) as set out above from para [36] and noted that Mr McPaul was placed on a Texture D or E diet, depending on availability and suitability, following a choking incident in May of 2017. It was considered he was eating too quickly and putting a lot of food in his mouth at one time. She described Texture D food as being soft, tender and moist, such that it requires very little chewing before it can be swallowed safely. It is fork mashed before being served to the individual and usually combined with a very thick sauce or gravy in order to add moisture and to achieve a cohesive texture. Any meat is finely minced to approximately 2mm in size, or if that is not possible, it is pureed. Textures that are not permitted on a D diet include, hard, tough, chewy, fibrous, stringy, sticky, dry, crunchy or crumbly textures, as well as pips, seeds, pith, crusts, husks, skin and gristle. Bread is not permitted on a Texture D diet unless assessed and recommended by a speech and language therapist after individual assessment.

[67] In a Texture E diet food is soft, tender and moist. The main difference between Texture D and E diet is that Texture E foods require some chewing and can, but do not necessarily need to, be mashed with a fork. Meat should be tender and pieces should be no larger than 1.5cm in size. E diet foods usually require a thick sauce or gravy in order

to add moisture and to achieve a cohesive texture. Textures not permitted on a E diet are the same as those for a D diet and bread is also not permitted in such a diet without an individual assessment which did not seem to have been carried out in respect of Mr McPaul.

[68] Pastry being considered a bread product would also not be suitable for such diets, as it cannot be easily fork-mashed without binding and becoming solid and sticky.

[69] There was no record of a recommendation by a speech and language therapist that pastry or bread was suitable for Mr McPaul.

[70] Ms Lazenby-Paterson confirmed that chicken paella, could be prepared in accordance with a Texture D or E diet.

[71] She confirmed that staff both kitchen staff and carers should have had training in what foodstuffs were suitable in the various diets, In particular in relation to kitchen staff she would expect that training to be formal training and not simply self taught. I considered this along with the evidence of the cook RT that she did a lot of her own research into types of diets and what meals were suitable. I did not consider this further as she was clearly supplementing her formal training through choice and there is no suggestion that the meal which caused Mr McPaul to choke was considered to be suitable for his diet by the kitchen staff.

[72] Ms Lazenby-Paterson opined that Mr McPaul, choked on the puff pastry as it was not something he should have been fed. She ruled out the likelihood of his choking on partially digested foodstuffs, having regurgitated same, as he appeared to have no history of vomiting around mealtimes.

[73] On this evidence, I accepted that steak pie which included pastry was not a suitable foodstuff for Mr McPaul to eat. In coming to this conclusion I also took into account the evidence of RT, the cook, that the steak pie was not prepared in such a way that it would be suitable for a Texture D or E diet, and the menu card showing that it was not a meal offered to Mr McPaul or other residents on a soft diet as a suitable meal that night.

[74] I had no difficulty in concluding that Mr McPaul should not have been given the steak pie to eat on 30 March 2018.

[75] Ms Lazenby-Paterson consider the introduction of colour coded plates to more readily identify which meals should be served to which resident, to prevent them being served the wrong food and agreed it would be appropriate.

General

[76] Taking all this into account and, given the evidence that he was eating steak pie, including pastry, immediately before he choked, along with the evidence of the pathologist that the foodstuff on which he chokes could be pastry, allowed me to conclude that it was the ingestion of the pastry that resulted in his choking.

[77] The evidence is less clear on why Mr McPaul was fed the steak pie at all. It was agreed he was on a Texture D or E diet. As stated above, there was no evidence led to suggest that the steak pie dinner was one which was suitable for someone on such a diet, and it was not the meal selected by Mr McPaul for his dinner that night.

[78] The food came ready plated from the kitchen on trolleys. The trolley contained a number of plated meals for residents, each plate covered with a type of lid, whether foil or another type of lid.

[79] At the time of the incident, there was no uniformly followed procedure to segregate the different types of meals on the trolley. The plates containing different types of meals were all just stacked together. The carers in the dining room required to remove the lid to check what type of meal was within.

[80] There was some evidence from the head cook that the resident's name would be written in some way on the lids, but I do not find that that was the practice as the carers in the dining room who were distributing the meals from the trolley did not speak to that. There was no evidence the plates were so labelled on 30 March 2018.

[81] Having said that, the meal sheet was clearly marked that Mr McPaul should be given chicken paella to eat. This was a meal that was suitable for a person on a Texture D diet. The only suggestion on the evidence as to why he was given the wrong meal was "human error".

[82] On the evidence of Ms Lazenby-Paterson the probability of experiencing a choking event depends on various factors, and the greater number and severity of risk factors present, the greater the probability of a choking event occurring, and the greater likelihood that the choking event may be severe enough to result in death.

[83] In Mr McPaul's case a number of the risk factors for choking were present including:

- a) a prior history of choking
- b) neurological disease with deteriorating cognition
- c) eating too quickly
- d) overfilling the mouth, and
- e) pocketing food in the mouth

[84] In Mr McPaul's case, on 30 March 2018 there was the additional risk factor of being fed a meal that was not suitable for a Texture D diet. It was therefore foreseeable that this meal would have substantially increased the probability of him suffering a severe choking episode.

Changes since Mr McPaul's death

[85] I heard evidence that after Mr McPaul's death the practice within the Home was changed so that the different types of meals were placed on different coloured plates, and the colour coding was reflected on the meal menu sheet. This ensured the different types of meals were more immediately and readily identifiable, thereby rendering it less likely that the wrong meal would be given to someone on a particular diet, particularly when all members of staff are aware of that individual's diet.

[86] Further I heard that the Home is now closed with the final resident leaving in February 2021. The Trustees are no longer involved in the running of care homes.

Submissions for the Crown

[87] The Crown made a number of submissions in writing:

1. The Crown invited me to make a finding under section 26(2) (a) that that Mr McPaul died at 1757 hours on 30 March within the Sir Gabriel Wood's Mariners' Home, 67 Newark Street, Greenock. This was agreed in the joint minute.
2. In terms of where and when the accident resulting in the death occurred, I was invited to find that this was between 1650 hours and 1713 hours on 30 March 2018. This was on the basis the evidence showed that at 1645 hours on that date, within the home, Mr McPaul, was situated within the dining room where he was served food. After approximately 5 minutes he began to choke. The Scottish Ambulance Service were contacted at about 1713 hours.
3. In terms of the cause or causes of death, I was invited to make a finding that the cause of death was as a result of choking on food, with a potential contributing cause being Cerebrovascular Disease, and I was referred to Crown Production 13 the post mortem report to establish that. That was also an agreed fact in terms of the joint minute.
4. In respect of the cause or causes of the accident, I was invited to find that this was Mr McPaul receiving a meal that was inappropriate to his specified dietary requirements, in particular, the steak pie meal served by

the carers at the home, which consisted of steaking steak, gravy, mashed potato and puff pastry was not the menu choice he ought to have received.

5. In support of this they pointed to the report and evidence of Tracey Lazenby- Paterson, a specialist speech and language therapist. She considered the process by which Mr McPaul was identified as requiring the Texture D diet and made no criticism of that.
6. She set out the various types of diet that patients could be assessed as requiring and described the types of food which were appropriate for each diet.
7. In relation the subsection (e) any precautions that could be taken, and had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths being avoided, I was asked to find that the system of colour coded plates would be a visual precaution particularly if the colour corresponded with a colour coded menu, and the name of the individual being put on the plate, and any mashing required for the diet to be done in the kitchen.
8. In relation to subsection (f) I was asked to find that the defects in the system of working were the absence of a system which had a colour coded menu choice, preparation of any cooked meal to the required standard, delivery of that appropriately prepared meal to its intended recipient vial coloured crockery and supervision of the resident's safe consumption of that meal.

Submissions for The Trustee of the Sir Gabriel Wood's Mariners' Home Charity

[88] Written submissions were also lodged on behalf of the Trustees of the Home:

1. On behalf of the trustees, I was invited to make formal findings in terms of section 26 (2) (a) to (c) on the same basis of the submissions by the Crown and in accordance with the joint minute.
2. Further, on behalf of the Trustees, it was submitted under section 26 (2) (d) I should make a finding that the cause or causes of any accident resulting in death was the entry of food from Mr McPaul's mouth into his trachea causing him to choke. They invite me to make that finding, referring to the evidence of Dr Bell, and to the evidence of BM, that Mr McPaul took food from his own plate and put it in his mouth, at such a speed she was unable to identify what it was he put in his mouth.
3. For the reasons stated above, I do not accept that evidence. I accept the accident includes the entry of food from Mr McPaul's mouth into his trachea, as the evidence was that there was food in his trachea causing him to choke. However, from the evidence of the forensic pathologist that it was unlikely to be vomited or regurgitated food, the absence of evidence that Mr McPaul had pocketed the food earlier (his mouth was checked for pocketed food at the end of any meal) and the evidence that he was eating a meal which was not suitable for his dietary requirements, I find the accident is wider than the blockage of his trachea. From the evidence that he choked as he ate a meal which was not prepared in a manner suitable for

someone on a Texture D or E diet, a meal that included pastry which was a product which would only be considered suitable after an individual assessment of Mr McPaul (which had not taken place), and the evidence of the forensic pathologist (who said the foodstuff could have been pastry), I concluded that it was this meal, in particular the pastry, that caused him to choke. On that basis I find that the accident includes the provision to him of a meal which was inconsistent with his dietary requirements that cause him to choke.

4. On behalf of the Trustees I was invited to make no finding under section 26(2)(e) (reasonable precautions), on the basis that the evidence was that staff were trained in special diets. I do not consider on the evidence that BM was so trained at the time of Mr McPaul's death, as she was a relatively new member of staff and her records show she subsequently undertook the training. However, she was under supervision at the time therefore I do not consider her lack of specific training to be relevant. Moreover, she had a rudimentary knowledge of the types of diet at the time, knowing that Mr McPaul's food should be fork mashed.
5. On the evidence, it appears that MMcG did not check the menu card to identify which meal was the correct meal for Mr McPaul before passing the steak pie dinner to BM to serve to Mr McPaul. This allows me to conclude that any system that was in place, which seemed to rely on individuals checking the menu card before distributing the meal, or relying on a care

worker to identify individual items of foodstuff that was not suitable, was not sufficiently robust. The colour plate system subsequently put in place by the Home was a system that appeared to be more robust, allowing for easier identification of the meals on plates and the intended recipients. I have little difficulty in concluding that a reasonable precaution would have been to operate a system that more readily identified the particular diets required by individual residents such as the colour coding of plates corresponding to a colour coded menu and staff training thereon.

6. For the Trustees I was invited to make no finding under section 26(f), firstly on the basis that Mr McPaul, grabbed some unidentified foodstuff and ingested it, resulting in his choking (which I rejected on the evidence as I said above); secondly because all staff were sufficiently trained, the system was enhanced following Mr McPaul's death, and there is no evidence as to why the steak pie was given to him, or indeed that it was steak pie that he choked on. For the same reasons stated above, I do not accept that submission. There was a clear defect in the system of working in that while the individual staff members were aware of Mr McPaul's dietary requirements, it was not instantly identifiable to those in the dining room that the meal given to him, was not suitable. A system of work relying on a handwritten menu being checked by one individual carer before distributing meals is not sufficiently robust and I consider it to amount to a defect in the system of work. The system was changed after Mr McPaul's

death to have colour coded plates relating to each type of diet, so that the correct type of meal was instantly and clearly identifiable. I have concluded it was being given and ingesting the unsuitable meal, in particular the pastry that resulted in the death. Accordingly, I have made the finding under this section.

Submissions for BM

[89] Written submissions were also made on behalf of BM.

1. On behalf of BM, it was submitted that the means of identifying which meal belonged to any particular resident with a special diet was haphazard, with witnesses giving differing evidence about the methods used, not only for identifying the resident to whom the meal had to be served, but also the means of ensuring it was suitable for that resident. I was asked to find that two members of staff within the dining room at mealtimes was not sufficient staff to deal with the number of residents with the particular vulnerabilities involved. I am not prepared to do so, for two reasons. Firstly, there is no evidence to the effect that more staff within the dining room would have prevented the death or that any deficiency in the staffing level contributed to the death, and secondly, I heard no evidence as to what the appropriate staffing level might be with the number of residents within the home.

2. Thereafter it was submitted that I could find that the choking incident occurred because Mr McPaul was eating too quickly. Whilst I accept that evidence of him often eating too quickly was given by MMcG, and Ms Lazenby-Paterson accepted that eating too quickly was a risk factor in choking, I considered the more likely explanation, based on the evidence of BM herself that she sat beside him because his hand was shaking and was supervising him at the time he began to choke, was that Mr McPaul choked on the food because he was given a meal which was not consistent with his proscribed dietary requirements.
3. Finally on behalf of BM, I was invited to find that because she was relatively new to her job, had shadowed someone who was herself relatively unclear about the requirements of a Texture D diet and having been instructed to feed Mr McPaul a specific meal handed to her by her senior, BM was not at fault for the death of Mr McPaul. This submission misses the purpose of this Inquiry. The purpose of an Inquiry under the Act, is not to attribute fault or blame in any way, rather to identify means by which similar deaths might be avoided.

In terms of section 26(2)(g) of the Act (any other facts which are relevant to the circumstances of the death).

[90] None of the parties invited me to make a finding in relation to this and I consider that to be appropriate.

In terms section 26(1)(b) of the Act, recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working (c) the introduction of a system of working (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

[91] I make no recommendations regarding improvements to how meals are clearly identified as specific types of meals allocated to those who require them. It is a matter of agreement that the home moved to a system of coloured plates, with difference colours for each type of diet. It is accepted that this system would ensure the meals were readily identifiable. Further the Home no longer engaged in the business of care homes.

Closing remarks

[92] In closing this Determination, I would once again join parties in expressing my condolences, to the family and friends of Robert McPaul. His loss will no doubt be keenly felt.