SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2025] FAI 46

EDI-B1740-24

DETERMINATION

BY

SHERIFF C A WALLS

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

into the death of

ANNE AMOS

EDINBURGH, 4 December 2025

DETERMINATION

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") that:

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

Anne Amos died shortly before 12.15pm on 13 September 2021 in room 13A at Pine Villa Nursing Home, 4 Hawthorn Gardens, Loanhead EH20 9EE.

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

The accident resulting in the death of Anne Amos occurred on 13 September 2021 between approximately 10.15am and 12.00pm in room 13A at Pine Villa Nursing Home, 4 Hawthorn Gardens, Loanhead EH20 9EE.

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

The causes of Mrs Amos' death were (i) choking on food; and (ii) Alzheimer's disease and Atherosclerotic cardiovascular disease.

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

The cause of the accident is unknown.

5. 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 death, or any accident resulting in death, being avoided):

The precaution of supervision of Mrs Amos while she was eating could reasonably have been taken.

6. 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 death):

There was no adequate system whereby important information about residents' care needs was shared with staff, and in particular the identified requirement for Mrs Amos to be supervised while eating.

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

Other facts which are relevant to the circumstances of the death are discussed in the Note below.

RECOMMENDATIONS

Mansfield Care Ltd, the owners of Pine Villa Nursing Home have introduced a digital system whereby each staff member has a handheld device which contains key information on each resident. Given that the system of recording and sharing residents' care needs which was in place at the time of Mrs Amos' death has been replaced, there are no recommendations to be made in relation to how residents' care needs are shared with staff.

However, there was no evidence regarding any changes to the admission process at Pine Villa or the establishment of a choking policy and pathway. I make the following recommendations under section 26(1)(b):

1. That any pre-admission form designed to elicit information regarding a resident's care needs, issued to the family or legal guardian of a resident, contains a series of questions, worded in laypersons' language, sufficient to highlight the presence or potential risk of dysphagia or choking.
2. That a choking policy and pathway is put in place to identify and manage symptoms of dysphagia and the risk of choking, and that appropriate staff training is given in relation to any such policy and pathway.

NOTE

Introduction

[1] This inquiry concerns the death of Anne Amos who died whilst in the care of Pine Villa Nursing Home on 13 September 2021. It is a discretionary inquiry called for by the procurator fiscal under section 4(1)(a)(ii) and (b) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. It is not the purpose of the inquiry to establish criminal or civil liability for the death, or to attribute blame. Rather,

its purpose is to establish the circumstances of the death and to consider what measures might be taken to prevent deaths in similar circumstances.

[2] A preliminary hearing was held on 20 January 2025 by Webex. At this hearing, Mansfield Care Ltd, the owners of Pine Villa Nursing Home, appeared and indicated that they wished to be a participant in the inquiry. The family of Mrs Amos attended the hearing as observers as they did not wish to formally participate. It was agreed that the Crown would submit affidavit evidence from witnesses in lieu of evidence in chief. A further preliminary hearing was assigned for 10 March 2025. Prior to that hearing I had expressed concerns regarding the state of the Crown productions which contained duplicate versions of documents and an expert report which was unpaginated and had no paragraph references. In advance of the hearing a core bundle of papers was lodged, including affidavits and a paginated expert report. The Crown and Mansfield Care Ltd confirmed that they were ready to proceed with the inquiry.

[3] I heard evidence on 20 May, 21 May and 30 June 2025. Written submissions were lodged by parties and a hearing on the submissions took place on 10 October 2025. The Crown were represented by Ms Stewart, procurator fiscal depute. Mansfield Care Ltd were represented by Mr Henry, advocate (instructed by Kennedys).

[4] The following was agreed in a joint minute:

i. Anne Amos was born on 8 January 1949 and was 72 years old at the time of her death on 13 September 2021. She was married

to Robert Amos and had two daughters, Joanne Holmes and Ruth Wyatt.

ii. Prior to her admission to Pine Villa Nursing Home ("Pine Villa"), she lived with her husband at home, with support from her daughters and carers.

iii. Mrs Amos was diagnosed with frontotemporal dementia in 2016.

iv. Following a decline in her condition, in July 2021, Midlothian Council assessed her as requiring admission to a setting which could offer 24-hour care. It was no longer possible for family and carers to provide safely the level of care she required at home.

v. Mrs Amos was admitted to Pine Villa, 4 Hawthorn Gardens, Loanhead, on 12 August 2021.

vi. At the time of her admission to Pine Villa, she was non-verbal due to the progression of her condition. Mrs Amos also suffered from recurrent urinary tract infections and osteoarthritis.

vii. Prior to her admission to Pine Villa, on 9 August 2021 a Personal Care Plan was completed by Joanne Holmes and Mrs Amos' carer. This plan was provided to Pine Villa.

viii. Mrs Amos was prescribed one 20mg tablet of Memantine daily, paracetamol 250mg/5ml oral suspension to be taken three times a day,

one 50mg tablet of trazadone daily and one 5mg tablet of folic acid daily.

ix. On 12 August 2021, staff at Pine Villa completed an Eating and Drinking Care Plan for Mrs Amos. This plan indicated that when eating, Mrs Amos "requires close supervision e.g. in small groups" and "requires some assistance." The plan also recorded that Mrs Amos "Needs support/prompting/encouragement but can also feed herself at times." Mrs Amos' IDDSI score was assessed as 7 for foods and 0 for fluids.

x. On 10 September 2021, staff at Pine Villa recorded that Mrs Amos was unwell and appeared to be developing a UTI or chest infection. On 11 September 2021 she was noted as being "quite chesty." A lateral flow test was carried out which was negative for COVID-19.

xi. On 12 September, Mrs Amos engaged in activities in the communal dining area. A PCR COVID-19 test was carried out.

xii. On 13 September, two care assistants and one nurse were on duty at Pine Villa. On the morning of 13 September Mrs Amos' care needs were met by two care assistants. One of them, Diane McIntyre, gave Mrs Amos toast and a cup of tea and left her alone in her room.

xiii. When Diane McIntyre returned, Mrs Amos was sitting in her chair and was unresponsive. She was pronounced life extinct at 12.15pm.

xiv. The GP was unable to issue a death certificate and reported the death to the procurator fiscal. Further information was requested from the Police Service of Scotland and a postmortem instructed.

xv. On 22 September 2021 Dr Thomas Prickett (then a trainee forensic pathologist under the supervision of Dr Ian Wilkinson, consultant forensic pathologist) carried out a postmortem. The cause of death was recorded as being unascertained, pending investigations.

xvi. On 9 February 2022 a final postmortem report confirmed the cause of death as being:

1(a) Choking on food

2 Alzheimer's disease

Atherosclerotic cardiovascular disease.

xvii. At the time of her death Mrs Amos resided at Pine Villa Nursing Home, 4 Hawthorn Gardens, Loanhead.

[5] The joint minute also contained an agreement regarding the use of a choking screen - the Mersey Care NHS Foundation Trust Choking Risk Screen. However, the terms of the joint minute did not reflect the evidence I heard in relation to this document and its use. This is discussed later in this determination. In addition to the agreed

evidence, there were affidavits submitted by witnesses, who also gave evidence in court. Over the course of the inquiry evidence was heard from the following witnesses:

(i) Joanne Holmes, the daughter of Mrs Amos;

(ii) Elaine Finlayson, Mrs Amos' carer prior to her admission to Pine Villa;

(iii) Diane Suddaby, care assistant at Pine Villa;

(iv) Diane McIntyre, care assistant at Pine Villa;

(v) Dolly Austin, nurse at Pine Villa;

(vi) Amanda Buick, nurse at Pine Villa;

(vii) Denise Williams, manager of Pine Villa;

(viii) Tracy Lazenby-Paterson, speech and language therapist, consultant dysphagia practitioner.

[6] All of the witnesses did their best to assist the inquiry. However, to different extents, their efforts to explain what happened in the period between Mrs Amos' admission to the home and her death were hampered by the lack of detailed records and poor recollection. I also had some concerns regarding the reliability of the evidence of Dolly Austin, principally because it appeared to me that she struggled to understand the questions asked of her and had a very poor recollection of the events which concerned the inquiry. Ultimately, in so far as the witnesses were able to recall events, other than in relation to one issue regarding the lead up to Mrs Amos' admission to the home, their evidence was broadly consistent.

Summary of the evidence

Mrs Anne Amos

[7] Mrs Amos was diagnosed with Alzheimer's dementia shortly before her 65th birthday. Although she was initially able to take care of her own personal needs, her condition continued to deteriorate. She was loved and cared for at home by her husband and daughters, but gradually the level of care she needed increased to the point where in addition to family support, carers were appointed, and she attended a day centre.

[8] Her daughter, Joanne Holmes, explained that there would always be someone with her mother when she was eating although by 2019/2020, she would sometimes forget to swallow food and might "pocket" it in her cheeks. She would sometimes cough or choke on food, but the family treated this as if she had swallowed food the wrong way - they were not thinking in terms of a "choking risk" as Mrs Amos was never alone when eating. Elaine Finlayson, her carer, gave similar evidence.

Admission to Pine Villa

[9] Following a fall in the shower, and further deterioration in her condition, it was no longer sustainable for Mrs Amos to be looked after at home. On 21 July 2021, Midlothian Council, following discussions with the Amos family, identified a critical need for Mrs Amos to be admitted to a nursing home. Pine Villa was chosen as a facility which would meet her care needs. Prior to being admitted to Pine Villa, Mrs Amos'

family met with the manager, Denise Williams. Ms Holmes explained in her affidavit that she told Ms Williams that she would be concerned about her mother eating alone, but that her worries were allayed when she was told that there was a communal dining room and that there would always be someone on hand. In her evidence to the inquiry, Ms Holmes said that she had specifically told Ms Williams and Amanda Buick (a nurse at Pine Villa) that her mother was prone to choking on food. Ms Williams and Ms Buick had no recollection of any such concerns being raised.

[10] Prior to admission, a Mansfield Care document ("Personal Care Plan") was issued to Mrs Amos' family for them to complete. This document would ordinarily have been completed in conjunction with Pine Villa. However, due to the ongoing impact of the COVID-19 pandemic, Ms Holmes and Ms Finlayson (Mrs Amos' carer prior to admission) completed it together on 9 August 2021. The purpose of the form was to document the care needs of a new resident.

[11] The form contained boxes in relation to the following matters - communication and understanding, personal choices (hygiene, bathing, sleeping), mobility, special equipment, elimination, skin care, nutrition likes and dislikes, social/leisure, health and wellbeing, cultural and spiritual matters, family/advocate involved in care, and additional comments. There was no specific question in relation to choking.

[12] In relation to nutrition, a handwritten entry confirmed Mrs Amos' preference for black tea and diluted juice and recorded that she would eat most foods other than lentils. A paper apart was submitted with the form in which Ms Holmes recorded that

her mother "Can eat unsupervised but will need prompted to drink." In her evidence to the inquiry, Ms Holmes accepted these were her words, but she was not sure why she chose them. She explained that what she meant was that her mother could eat unassisted in that she could move food into her mouth but would need prompted to drink to wash it down as she would sometimes store food in her cheeks. She said this form was completed after the discussion with Ms Williams regarding the communal dining area.

[13] On 12 August 2021, the day Mrs Amos moved into Pine Villa, Ms Holmes said she had a detailed discussion with Amanda Buick, a nurse at Pine Villa, about her mother's habit of pocketing food, occasional choking and the need to be prompted to drink. Ms Buick recalled having a discussion with Mrs Amos' family at the time of admission but did not recall any discussion about a choking risk. If this had been brought to her attention, she said it would have been included in the care plan for Mrs Amos.

Assessment on admission to Pine Villa

[14] Ms Buick was working as a nurse at Pine Villa in August 2021. She qualified as a nurse in 1985 and since 1999 has worked solely in nursing homes. She had previously worked with Ms Williams at another home.

[15] As a nurse, she was responsible for preparing care plans for patients. She prepared an "Eating and Drinking Care Plan" for Mrs Amos on 12 August 2021. She

said she had completed this form based on information provided by the family and her own observations of Mrs Amos. She also had sight of an assessment of Mrs Amos dated 27 July 2021 prepared by Midlothian Council social work department which although detailed made no reference to a choke risk.

[16] In relation to supervision while eating, boxes had been ticked indicating that when eating, Mrs Amos required (i) "close supervision e.g. in small groups"; and (ii) "some assistance." There was an option for "Constant supervision: high risk of choking/aspiration" but this had not been selected. There was no pro-forma option to tick to highlight a choke risk.

[17] Ms Buick said that when she started at Pine Villa, she had been asked by Ms Williams to review procedures relating to eating and drinking and to develop a "dignity in dining" system for residents. In previous posts, she had received training in the International Dysphagia Diet Standardisation Initiative (IDDSI) and introduced this at Pine Villa by adding a further page to a resident's Eating and Drinking Care Plan in the form of a template from a previous home with an image of a plate with cutlery where the resident's needs could be recorded. For Mrs Amos, this recorded her dietary preferences, IDDSI score of 7 for food and 0 for fluids (essentially normal food and drink types) and a statement that "Annie eats well and enjoys her food…staff need to support/prompt/encourage but Annie can also assist herself at times and enjoys snacks."

[18] The information in relation to a resident was kept in a folder in a cupboard in the dining room for Pine Villa nurses and care staff to access and review.

[19] Ms Buick was aware of the need for SALT (Speech and Language Therapy) referrals if patients were identified as being at a choking risk. The only existing policies regarding eating and drinking were the Mansfield Care Mealtimes Policy 2019 and the Mansfield Care Nutrition Policy 2019. Neither expressly addressed the risk of choking. The Mealtimes Policy was concerned primarily with the timing and structure of meals although it does note that some residents may require "encouragement, assistance or special equipment." The Nutrition Policy refers obliquely to choking in the context of a soft food diet (such as pureed food or thickened drinks) being recommended after a SALT referral for those with a risk of aspiration or choking. In the "Providing Assistance" section it also states that people with dementia require different levels of assistance, although there is no express reference to choking.

[20] She felt there was a gap in the Pine Villa procedures and so searched the internet to find an assessment tool for choking risk, similar to that which she had used in previous homes. The document she found and subsequently began to use was the "Mersey Care NHS Foundation Trust Choking Risk Screen 21.06/2017" ("The Mersey Choke Screen").

[21] She accepted that she had no training specific to the use of Mersey Choke Screen, the terms of which stated that it was "…to be read in conjunction with the MCT Choking Risk Management Policy" which she had not seen, and which had not been lodged as a production for either the Crown or Mansfield Care Ltd. (At my request, parties were invited to search for and produce the MCT Choking Risk Management Policy.

Mansfield Care Ltd located and lodged a document called "NHS Mersey Care Assessment and Management of Choking (Adults) Policy" but the version produced was a revision from 2023 and the first iteration appears to have been in 2018).

[22] She explained that she only used two pages of the overall document and accepted that it was intended to be choking screen rather than part of a care plan. Put another way, the intention of the Mersey Choke Screen appears to be that if there was a "yes" answer to one question suggesting a risk of choking, it would trigger further action. However, at Pine Villa it was used to record information and was kept with the resident's care plan. She described it as "tool" for the staff to refer to. This information was then placed with other information relevant to the resident in question, which was available for all staff to review in the dining room cupboard.

[23] The person completing the Mersey Choke Screen is required to answer various yes/no questions. If "yes" is answered to any of the questions, then the form states "…immediate action is required as there is likely to be an increased risk of choking." The questions were:

> "1. Has there been a choking incident in the past 12 months?
>
> 2. Are there any chewing or swallowing problems? Symptoms may include
>
> - Coughing during or after eating
> - Effortful or repeated attempts to swallow mouthfuls
> - Changes to breathing during or immediately after food/drink
> - Voice sounds gargly or wet after swallowing
> - Poor dentition and chew
> - Poor control of food/drink in the mouth e.g. food pocketing, food remaining in mouth after swallow

- The Service User needs 1:1 support to eat/drink
- Service User or Caregiver reports choking or problems swallowing
- Service User shows or describes distress or pain when eating, drinking or swallowing
- Repeated or prolonged chest infections/recent aspiration pneumonia
- Physical changes or abnormalities of mouth/throat
- Reports of food or drink 'going down the wrong way' or into the nose

[3. not used]

4. Is there anything about the person's behaviour that puts them at risk of choking? This may include
   - PICA – compulsive eating of non food items or materials
   - Rushing or cramming food
   - Grabbing from others plates
   - Overfilling the mouth
   - Leaving the table during the meal/moving around when eating
   - Trying to lie down or recline immediately or soon after eating
   - Not chewing their food
   - Holding food in their mouth
   - Talking with food in the mouth
   - Poor attention/concentration
   - Self-harm or other physical damage to face and/or neck
   - Reluctance to eat or refusal of certain foods (e.g. tougher/chewy items or liquids) change in medical conditions such as CVA/neurological condition

……

6. Any additional factors that may increase risk of choking such as varying levels of alertness."

[24] The assessment was based on supplied information and her own observations of Mrs Amos eating on at least three occasions. The form was signed on either 13 or 15 August 2021.

[25] All questions were answered by Ms Buick in the negative other than "...Service User needs 1:1 support to eat/drink." This was answered "yes" although Ms Buick wrote "prompting" next to the question and at the end of the form wrote "Annie does need support and prompting to begin eating but eats independently once started."

[26] Ms Buick explained that her answers were based on her observations of Mrs Amos in her first few days at Pine Villa and the available information on admission. She could not recall a discussion with the family about Mrs Amos pocketing food. In relation to the question about 1:1 support she said she did not believe the form had posed the correct question and that there was no opportunity on the form to elaborate. This was why she had written "prompting." She explained that some of the questions on the form were in her view unclear, but after discussion with Ms Williams did not feel there was a high choking risk as Mrs Amos just needed prompting to go back to her food. In any event, the document was being used as a tool for staff rather than as a screen.

[27] The care plans for residents were updated and reviewed monthly, although a daily record (known as a "daily wellbeing record") was kept regarding a resident's activities. The plans would be updated prior the end of the month if required. The plan for Mrs Amos would have been updated 1 month after she moved into Pine Villa.

[28] Ms Williams explained that there was no specific choking risk assessment at Pine Villa until she and Ms Buick began using the Mersey Choke Screen. When asked about the questions and how they might apply to Mrs Amos, she said that on reflection a "yes"

answer could have been provided in relation to question 6 (levels of alertness) and that any "yes" answers ought to have prompted more vigilance in relation to Mrs Amos. However, their own observations had not shown any difficulties with eating or swallowing. They had established that prompting was needed as opposed to her being a choke risk.

[29] Ms Williams said that all staff knew where the information in relation to residents was stored. There was a board in the kitchen where the chef recorded which residents needed assistance with eating, although Mrs Amos' name was not on the board as it ought to have been.

Care plans and post admission

[30] All of the witnesses from Pine Villa spoke in similar terms regarding the system for collating and sharing relevant information concerning residents. The care plans for residents were generally prepared by Ms Buick. These folders were kept in a cupboard in the dining room. Everyone knew they were there. Details regarding patients were also recorded in the daily wellbeing records, which were also available for all staff to review. However, there was no system whereby the information regarding residents was shared formally with staff.

[31] Diane Suddaby and Diane McIntyre gave evidence. They were both care assistants at Pine Villa and at the time of Mrs Amos's death had worked there for 4 and 5 years respectively. They were on duty when Mrs Amos died. Their duties included

assisting residents with getting out of bed and dressed, personal hygiene, meals and various elements of daily life. Both were aware of the cupboard where information about residents was stored, but explained they rarely looked that the folders. They relied on hand-over information shared verbally by staff at the change of shifts. Both said they had not seen the Eating and Drinking Plan for Mrs Amos or the completed Mersey Choke Screen before it was shown to them in these proceedings. Neither made any reference to the board in the kitchen referred to by Ms Williams.

[32] Dolly Austin qualified as a nurse in 1968 and at the time of the accident had worked at Pine Villa for 18 years. Latterly, she was working 2 days 1 week and a single day the following week. By the time she gave her evidence she was 80 years old. She had not seen the Eating and Drinking Plan or Mersey Choke Screen for Mrs Amos either.

[33] The position of all three of these witnesses was that although they had not seen the documentation in relation to Mrs Amos, based on their own experience and observations, they did not regard her as being at risk of choking.

[34] Ms Williams, Ms Buick and Ms Austin all appear to have assumed that the care staff were regularly accessing the care plans, but that was not the evidence of Ms Suddaby and Ms McIntyre. Their evidence was that although they knew where care plans were stored if they needed to look at them there was no procedure by which they were mandated to do so. They relied on information being informally shared at the

handover from one shift to another. No written procedure regarding the collation, storing and sharing of care plans was referred to in evidence.

[35] The system whereby care plans were on paper and kept in a cupboard has been replaced by a digital system whereby staff have handheld electronic devices which contain all relevant up to date information regarding residents' needs.

[36] The daily wellbeing records contain handwritten entries by nurses and care staff, recording matters such as visitors, sleep patterns, hygiene and toileting, eating and drinking, engagement in activities and any health concerns. Mrs Amos's daily wellbeing record was lodged as a Crown production. It begins with her admission to Pine Villa on 12 August 2021 and ends with her death on 13 September 2021. There are no recorded instances of Mrs Amos choking on food. The entries vary in detail. On some days, there is a general entry in relation to food eg "good food intake" (13 August 2021); "ate well at breakfast but less at lunch" (15 August 2021). On other occasions, the entries are more detailed eg "good dietary and fluid intake with prompting" (16 August 2021); "Anne has again managed to eat her meals independently today - please allow Anne to eat herself before assisting her with meals - please observe" (24 August 2021).

[37] The COVID-19 pandemic was still a feature of life in Scotland in August 2021. The daily wellbeing record confirms that on various days during her brief time at Pine Villa, Mrs Amos was required to isolate in her room while results of PCR tests were awaited. On these days, it appears that she ate in her room. There is no consistent

description of how she took her meals on those days. On 30 August 2021 the entry for the day records "Anne has had a day in her room - good dietary intake - PCR NEG - Anne can now come out of her room." However, the entry for the following day is

> "Anne still remains in isolation until a second negative test is obtained she has been given assistance with all aspects of daily living throughout the day - regular checks carried out."

On 1 September 2021 she was still in isolation and was "Assisted with food and drinks which were taken well." Mrs Amos remained in isolation, in her room until 6 September 2021 when she provided a second negative PCR test. The entries for the period 2-6 September 2021 record good food and fluid intake, but do not disclose whether Mrs Amos was left to eat alone in her room or was supervised. On 7 September 2021, now out of isolation, she was noted as "…managing to eat all her meals independently."

[38] Between 8 and 10 September 2021 there are general references to good food and fluid intake. On 11 September 2021 there were concerns Mrs Amos had a chesty cough, and unsuccessful efforts were made to contact NHS 24 although she appears to have rallied and is said again to have had good food on fluid intake. The entry for 12 September 2021 records that she was "Eating & drinking very well."

[39] None of the witnesses from Pine Villa said they had ever witnessed Mrs Amos pocketing food.

The death of Mrs Amos

[40] On 13 September 2021 Ms Suddaby and Ms McIntryre were on duty as care assistants. Both explained that at around 10.15am they were taking Mrs Amos downstairs for breakfast. Ms Austin saw them and insisted that they take her back to her room as she was waiting for the results of a Covid test.

[41] Ms Austin had no recollection of this or any interaction with the care assistants. Her evidence was that at 08.30am on 13 September 2021 she had called for a doctor to come and visit Mrs Amos, who had been unwell with a chesty cough.

[42] In any event, Mrs Amos was given two slices of toast and a cup of tea by Ms McIntyre and left to have breakfast alone in her room. Ms McIntyre's recollection was that she found Mrs Amos unresponsive in her room at around 11.25am. She could see that one slice of toast had been eaten. She said that Ms Austin, as the nurse, was summoned and the GP was called, who pronounced life extinct at 12.15pm.

[43] Ms Austin's recollection regarding the times was slightly different. She thought that Ms McIntyre had summoned her at around midday.

Expert evidence

[44] Tracy Lazenby-Paterson was instructed by the Crown to prepare an expert report, offering her opinion on various matters relating to the death of Mrs Amos. She is a speech and language therapy expert with extensive experience of speech therapy and of eating, drinking and swallowing disorders (dysphagia). She is a specialist speech

and language therapist and team co-ordinator of the NHS Lothian Community Learning Disability Service. She provides evidence-based assessment, diagnosis and treatment of highly complex communication and eating, drinking and swallowing disorders in adults with an intellectual disability. She has published various book chapters, academic papers and dysphagia guidance papers.

[45] She adopted the terms of her report, dated 29 July 2024. She had been provided with the various records relating to Mrs Amos that were lodged as Crown productions in the inquiry, and summaries of the evidence of Crown witnesses which were, in most critical respects, consistent with the evidence given to the inquiry. Dysphagia is the medical term to describe difficulties with eating, drinking and swallowing. Signs of the condition include problems with chewing and moving food in the mouth, difficulty swallowing, and gagging, coughing or choking on food, drink, medication and saliva. Changes to a person's ability to eat and drink can occur due to the aging process. Frail older adults are more likely to experience dysphagia and choking because the swallowing mechanism may be unable to compensate for the added stresses of comorbid conditions that often accompany advancing age, like dementia or stroke.

[46] Appropriately experienced and qualified speech and language therapists assess, diagnose and manage dysphagia. The assessment of an individual's condition will involve taking a case history from the individual, their family, carers and other health professionals. Physical examination may be required. Treatment can range from rehabilitation exercises to altering the texture of food and drink. Treatment must also

respect the autonomy of the patient, as many interventions to eating and drinking routines can impose a significant burden on the individual and the impact on quality of life can outweigh any resolution of the swallowing problem.

[47] I summarise below the questions she was asked to address by the Crown in her report, and her answers.

Was the choking risk assessment ("Mersey Care NHS Foundation Trust Choking Risk Screen 21/06/2017") sufficient to address the risks to the deceased and her care needs?

[48] The Mersey Choke Screen identified that she had an increased likelihood of choking due to her Alzheimer's condition. The evidence suggested that there were appropriate factors that could have resulted in a "yes" answer to question 6 such as Mrs Amos' limited understanding of instructions, cognitive impairment, confusion and unpredictable behaviour and the need for assistance when eating. In her opinion, staff completing the form may have had limited awareness on how factors seemingly unrelated to obvious problems and mealtimes could increase the risk of choking.

[49] She noted that the Mersey Choke Screen recorded "Annie does need support and prompting but eats independently once started." If "yes" was answered to any question then, as noted above, immediate action was needed and the choking pathway was to be consulted to develop an action plan for the at individual at risk. In her report she expressed the opinion that while it was likely that supervision was instigated to address the risks identified in the choke screen, there was no choking pathway to be

implemented if the screen highlighted a choking risk. She had reviewed the Mansfield Care Mealtime Policy 2019 and concluded that this was not a choking policy, as choking was mentioned only once as a risk factor associated with dementia. A choking policy would include detailed information about identifying choking hazards and risks, and a pathway would contain steps for screening, identification and management of choking. It was not clear whether the other documents referred to in the Mersey Choke Screen had been available to Pine Villa staff. Further, an individual's family should be consulted when completing the screen.

[50] However, in her parole evidence, she explained that for the Mersey Choke Screen to be properly deployed, the person carrying out the screen must be trained in its use - particularly as it is to be read in conjunction with a choking and risk management policy. The screen is part of the overall suite of measures, but is not a choke policy in and of itself.

Should Mrs Amos have been referred to SALT on her admission to Pine Villa?

Her medical history available to the care home

[51] In her opinion, the available information did not indicate that a SALT referral was mandated. While SALT assessments are not typically conducted as a matter of routine on admission, if Ms Holmes had told nursing home staff that her mother stored food in her mouth and would occasionally choke these statements may have warranted a referral for assessment and guidance. However, the Midlothian Council assessment

and plan and the personal care plans completed by Ms Holmes herself did not reference any concerns about choking.

[52] Ms Buick had assigned Mrs Amos IDDSI scores of 7 for food and 0 for fluids ie ostensibly the same as a normal diet. An IDDSI assessment is normally part of a comprehensive assessment by a clinician trained in dysphagia assessment. There was no evidence that a SALT clinical assessment was required on admission, and so the rationale of assigning IDDSI levels to Mrs Amos' diet was unclear.

The content of the completed Mersey NHS Foundation Trust Choking Risk Screen

[53] Ms Lazenby-Paterson concluded that the content of the completed Mersey Choke Screen did not suggest a referral to SALT was necessary, given there were no recorded difficulties with eating, drinking, swallowing or choking. The screen had identified an increased risk of choking, but a SALT referral would only be made if problems such as coughing and choking on food had been observed.

Were there any "red flags" which ought to have prompted a SALT assessment?

[54] If Ms Holmes had told care home staff that Mrs Amos had choked on food, this ought to have prompted a SALT assessment, but the documentation alone did not contain any red flags.

Does the available evidence show what a SALT assessment, had one been done, would have or may have recommended at any particular point in time?

Eating food

[55] Chopping up food into small pieces or pureeing it can reduce the choke risk and need for chewing. However, modified texture diets can reduce choice, make meals unpalatable and reduce quality of life. If concerns had been raised about choking, staff would have been asked to supervise her at mealtimes. After meals, Mrs Amos' mouth would have been inspected and a drink offered. If there were no concerns about coughing or choking, she thought it unlikely that special arrangements would have been recommended. However, a SALT assessment would have advised watchful waiting, reminding staff to be vigilant for deterioration in Mrs Amos' condition and of the need to refer for assessment if there were any signs of dysphagia.

Special dietary requirements

[56] Given the lack of evidence of problems with Mrs Amos eating, drinking and swallowing, it was unlikely that any SALT assessment would have recommended chopping food into small pieces.

Supervised eating

[57] Supervision can occur in various ways: sitting at a table face to face with an individual or watching an individual from a short distance or further away in the

same room. It can vary from watching an individual take every mouthful to occasional checking. If concerns had been raised about Mrs Amos frequently choking on food, then supervision would likely have been recommended. Even if no concerns had been raised about Mrs Amos choking on food, a SALT referral would likely have recommended that a staff member be in the same room as Mrs Amos when eating, due to her level of cognitive impairment and fluctuating need for prompting and assistance.

[58] Overall, her evidence was that the available Pine Villa documentation indicated an awareness of the need for varying levels of prompting and assistance at mealtimes. However, in the absence of dysphagia symptoms, Mrs Amos did not appear to have required at SALT referral at the time of her death.

[59] In terms of choking generally, any person of any age can choke, although those over the age of 65 are seven times more likely to choke than a child of between 1 and 4 years. Alzheimer's dementia is associated with a higher risk of choking.

[60] Even with supervision, and prompt and appropriate first aid, it may not be possible to prevent a fatal outcome from choking due to a range of factors including the individual's age and health, the nature of the food obstruction and the circumstances surrounding the incident.

Submissions for the Crown

[61] The time of death was agreed in the joint minute as being 12.15pm on 13 September 2021. This was broadly supported by the evidence, and I was asked to reflect this in a finding under section 26(2)(a).

[62] In terms of the when and where the accident resulting in death occurred, I was invited to find that it took place between 10.00am and midday on 13 September 2021. Ms McIntyre's memory of the time was unclear and the daily wellbeing records were to be preferred as contemporaneous evidence. During the hearing on submissions, I asked the procurator fiscal depute to define what she said the accident was. She said the accident was "being given toast to eat while unsupervised while being at a risk of choking." If that were the case, then the accident would have happened closer to 10.00am, rather than between 10.00am and 12.00pm as submitted by the Crown.

[63] The causes of the death were agreed in the joint minute, under reference to the final postmortem report.

[64] The Crown submitted that the evidence of Ms Austin should be preferred over that of the care assistants in relation to why Mrs Amos was left to eat breakfast alone in her room. There was no evidence that Mrs Amos was awaiting a further Covid test result. However, there was evidence from the daily wellbeing records that Mrs Amos was unwell, and that Ms Austin had arranged for a GP to visit.

[65] Detailed submissions were made regarding whether the chain of events leading to Mrs Amos being left alone in her room were as described by Ms McIntyre (being

instructed to return her to her room due to pending covid test results, as directed by Ms Austin) or by a combination of a reading of the records and evidence of Ms Austin (Mrs Amos being unwell and waiting for a doctor's visit.) Ultimately, however, this makes no material difference as the critical fact was that Mrs Amos was given tea and toast to eat in her room unsupervised. The Crown submitted that the finding under section 26(2)(d) should be that the cause of the accident resulting in the death of Mrs Amos was that she was left unsupervised in her room to eat breakfast, on which she choked.

[66] Regarding section 26(2)(e), there were precautions which could reasonably have been taken, and which might, realistically, have resulted in Mrs Amos' death being avoided. These precautions were (i) for Mrs Amos to have been supervised while eating; and (ii) for Mrs Amos' care plan details to have been provided to staff.

[67] Ms Lazenby-Paterson's evidence was that choking is one of the leading causes of preventable deaths in a care home setting. It is not guaranteed that a person would survive a choking episode even with prompt first aid, but supervision is a reasonable first step. The Eating and Drinking Care Plan for Mrs Amos had identified a need for "close supervision." Further, Ms Holmes and Ms Finlayson had given evidence that Mrs Amos pocketed food and was supervised when eating at home, prior to admission. It was acknowledged, however, that Ms Holmes had also provided written information to say that her mother could eat "unsupervised."

[68] Both care workers gave evidence that they had not seen the Eating and Drinking Care Plan for Mrs Amos. The information they got about Mrs Amos' needs was provided verbally. Ms Austin thought she had read the care plan but said finding time to read care plans was an issue. She did not direct care assistants to supervise Mrs Amos, as she assumed they knew what was required of them. Although Ms Buick and Ms Williams said that staff knew about the care plans, there was no system in place to ensure information was appropriately shared with staff. Had staff known about the requirement for supervision, Mrs Amos would not have been left alone to eat, and her death might have been realistically avoided.

[69] The Crown also invited me to make a finding under section 26(2)(f) that there were defects in the Pine Villa system of working which contributed to the death.

[70] There were defects in the pre-admission process. The forms sent to Mrs Amos' family contained only one box in relation to eating and drinking and that was concerned with likes and dislikes. There were no questions concerning difficulties with eating generally or choking specifically. Ms Holmes in her evidence said that she had tried to describe her mother's eating issues, but that she had not been thinking in terms of "choke risk."

[71] Related to the lack of focus in the forms, was a lack of guidance from Pine Villa staff about how the forms ought to have been filled in and discussions with family members prior to admission were not documented.

[72] Once Mrs Amos had been admitted, the plans prepared by Ms Buick were based on inadequate observation and ought to have completed after discussion with the family. The lack of adequate information contributed to the decision by staff to leave Mrs Amos unsupervised and ultimately resulted in the accident which caused her death. Ms Holmes and Ms Finlayson were taken through the questions on the Mersey Choke Screen and both indicated that they would have provided "yes" answers to some questions, highlighting a choke risk. Ms Lazenby-Paterson's evidence was that diagnosis and management of dysphagia should involve the family of the individual in question.

[73] Finally, the Crown invited me to make certain recommendations. These were that Mansfield Care Ltd, the owners of Pine Villa:

(i) implement a clearly defined choking risk policy which includes a reference to a choking risk pathway and action plan;

(ii) implement a choking risk screen document and provide training to staff on how it should be completed; and

(iii) amend pre-admission documentation to specifically request details on difficulties a person may have with eating, and the level of required supervision.

[74] The Crown had initially submitted that the absence of a choking policy or screen was a cause of Mrs Amos' death. However, it was accepted at the hearing on

submissions that there was insufficient evidence to allow the court to conclude what the outcome of any choke screen assessment, properly carried out, would have been.

Submissions for Mansfield Care Ltd

[75] Mansfield's position in relation to when and where the death and the accident occurred was essentially the same as those of the Crown. The accident was "choking." The cause of death was a matter of agreement between parties.

[76] However, the cause or causes of the accident resulting in death were unknown, because it was not known what had caused Mrs Amos to choke on her food. Ms Lazenby-Paterson's evidence was that any person of any age could choke. Even with prompt intervention, a person might still die from choking. Although the deceased had an increased risk of choking due to her condition, it could not be said, on the balance of probabilities, whether it was the lack of supervision that caused her to choke or whether it was an event that could have occurred in anyway.

[77] Regarding precautions, any finding under section 26(2)(e) requires to have a casual aspect. This section relaced the statutory question posed in section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Considerations of the previous provision are relevant to the question posed by section 26(2)(e).

[78] I was referred to *Sutherland* v *Lord Advocate* 2017 SLT 333 where Lord Armstrong stated:

> "[29] It was not in dispute before me that the conduct of an FAI is not a fault-finding exercise. It is a process which is entirely separate and distinct from the determination of any question of civil liability. Thus, reasonable foreseeability is not a relevant consideration. Rather, the aims of the process are to identify the circumstances of the death and, to the extent that it is possible, to inform any subsequent actings with a view to avoiding such a death in future. Such a process necessarily involves use of the benefit of hindsight, without reference to the state of knowledge at the time of death. Were it otherwise, the utility of the enquiry into the facts, necessarily after the events, would inevitably be undermined.
> [30] The statutory provisions of the 1976 Act are intended to permit retrospective consideration of matters with the benefit of hindsight.
> [31] In determining whether the death might have been avoided by a reasonable precaution, the appropriate test has been described as that of a 'lively possibility'. Such a description is entirely apt and is consistent with the language of section 6(1)(c). According the provision its ordinary meaning, certainty or probability are not relevant considerations in determining whether the death might have been avoided. Further, given the nature of the process as I have described it, in considering whether a precaution is reasonable, foreseeability has no part to play. That question falls to be determined with the benefit of hindsight, and a finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the precaution was negligent or unreasonable. Whether or not a precaution was reasonable does not depend on foreseeability of risk, or whether at the time the precaution could or should have been recognised."

[79] I was also referred to the following passage of Lady Haldane's judgment in *Duncan, Petitioner* 2025 SLT 47:

> "[49] In that regard, although neither party made explicit reference to it, the comments of the then Sheriff Braid at para [46] of his determination in Bellfield are instructive. He said the following:
> > '46. The next question which arises is whether it was in this case a reasonable precaution. In deciding that question, I must deal with the submissions presented to me to the effect that it would be open

> to me to find that a CT scan was reasonable only if I reached the view that what was done was unreasonable. With respect, I do not consider that to be correct. I have already pointed out that negligence is not in issue and that it is not the function of this Inquiry to attribute blame. It is therefore nothing to the point to inquire as to whether what was done was reasonable, and it seems to me to involve a non sequitur to hold that a precaution which was not taken can be held to have been reasonable only if what was done was not reasonable. To take that approach respectfully seems to me to apply the principles and language of negligence, which are irrelevant for the purposes of this Inquiry. I do not see why it is not open to me to hold that, even though what was done was reasonable, other reasonable precautions might also have been taken which might have prevented the death'
>
> [50] Although that analysis is not binding on me, it encapsulates entirely correctly the proper approach and I respectfully adopt and endorse it. That analysis was of course contained in a determination that pre-dated the coming into force of the 2016 Act but having regard to the more expansive language of section 26(2)(e) it is entirely consistent with the language of the statute as now framed. Applying that approach to the present case, the evidence of Dr Wallace that he could understand why the petitioner felt reassured by the earlier referral and that he would not be critical of her in so feeling, has to be seen in its' proper context. That context is a passage of evidence in which he is moving between the statutory test and the test employed in litigation, with which he is clearly familiar (see the passages of evidence quoted in para [23] above). He is not, viewed fairly, departing from his view that referral would have been a reasonable precaution. He is simply saying that he would not be critical of the petitioner, employing the test of a doctor exercising ordinary skill and care, for having been falsely reassured in all the circumstances. It was not in dispute that, that test is not one that is relevant for the purposes of a determination in an FAI."

[80] Mansfield submitted that the possibility that the death might realistically have been avoided by the reasonable precaution requires there to be a possibility of substance and genuine potential, rather than a mere fanciful possibility.

[81] In view of this, the correct approach does not involve consideration of what staff knew or did not know about the care plan or pocketing of food. Rather, the court is to

consider whether, if the deceased had been supervised by employees who knew details of the care plan, was there a lively possibility that the death could have been avoided. It was submitted that there was insufficient evidence about the effect the precautions identified would have had. Ms Lazenby-Paterson's evidence was that even with close supervision, a choking person might still die.

[82] Further, in the absence of evidence regarding how long Mrs Amos may have taken to die, whether it would have been possible for the food to be dislodged from her throat and whether any resuscitation efforts may have been successful, it cannot be said that there is a lively possibility that had the precautions been taken, her death could have been avoided.

[83] It was also submitted that there was no basis for a finding under section 26(2)(f) that a defect in a system of work contributed to the death or any accident resulting in the death. Any finding under this section requires there to be a causal connection between the defect and the accident or death as a matter of fact. Mansfield's primary position was that there were no defects in the system of working. The defects suggested by the Crown were largely predicated on information which should have been available from Mrs Amos' family in relation to her eating and drinking problems, which should have been available during the admission and pre-admission process. However, there is an evidential problem for this hypothesis. Although Ms Holmes' evidence in court and affidavit was that she had discussions with Ms Buick and Ms McIntyre regarding pocketing of food and needing prompting to drink as she would occasionally choke,

this was not consistent with the documents prepared by Ms Holmes on admission or with the evidence of the Mansfield witnesses. The clear terms of Ms Holmes' note at the time of admission, where she stated Mrs Amos could "eat unsupervised by will need prompted to drink" should be preferred to her subsequent evidence. None of the Mansfield witnesses who gave evidence said they had ever seen Mrs Amos pocket food or identified any other issues with her eating and drinking.

[84] Further, the daily wellbeing records for Mrs Amos did not indicate any observed issues with eating and drinking. The Mersey Choke Screen gave sufficient information for the choking risk to be considered. Ms Lazenby-Paterson's opinion was that it was not possible to conclude from the evidence that Mrs Amos should have been the subject of a SALT referral.

[85] *Esto* there was a defect in the system of work, there was no causal connection between that the death.

[86] Finally, as a new system of work had been implemented, whereby staff had the benefit of handheld devices with all relevant information on residents, no recommendations were required.

Discussion and findings

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[87] It was a matter of agreement that life was pronounced extinct on 13 September 2021 at 12.15pm at Pine Villa Nursing Home, 4 Hawthorn Gardens, Loanhead, Midlothian EH20 9EE.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[88] There is a difference of approach between parties in relation to this finding. The Crown's position is that the accident was Mrs Amos "being given toast to eat while unsupervised while being at risk of choking." Mansfield's position is that the accident was Mrs Amos choking. The logic of the Crown's position, is that the accident occurred the moment that Mrs Amos was left alone.

[89] The Crown's definition of the accident conflates the accident and the potential causes of the accident. It also proceeds on the assumption that the deceased was at a risk of choking. The accident was Mrs Amos choking. It is impossible to say when this occurred and so the appropriate finding is that suggested by Mansfield.

[90] I find that the accident resulting in the deceased's death occurred on 13 September 2021 between approximately 10.15am and 12.00pm in room 13A at Pine Villa Nursing Home, 4 Hawthorn Gardens, Loanhead, Midlothian EH20 9EE.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[91] It is a matter of agreement that the cause of death is confirmed in the final postmortem report as:

1(a) Choking on food

2 Alzheimer's disease

Atherosclerotic cardiovascular disease.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[92] I have already determined that the accident resulting in death was Mrs Amos choking. The Crown's description of the accident is more apt to describe what they submit caused the accident. There were competing accounts of why it was that Mrs Amos was left alone, but as I understand the Crown's submission, it is ultimately that the accident was caused by Mrs Amos being left alone in her room to eat, meaning that she choked.

[93] The Eating and Drinking Care Plan prepared by Ms Buick provides that Mrs Amos "…requires close supervision e.g. in small groups" and "requires some assistance." Other documents prepared by Pine Villa record the need for "support." Notwithstanding the discrepancy between the evidence of Ms Holmes and Pine Villa witnesses regarding what was or was not said about supervision and choking, it is abundantly clear from the evidence that Mrs Amos ought to have been supervised

when eating. Pine Villa had determined that Mrs Amos should be supervised but failed to ensure that this was done.

[94] However, the expert evidence of Ms Lazenby-Paterson was that choking can happen to anybody and could occur even under close supervision. If, as I have concluded, the accident which caused death was choking, there was no evidence to allow me to determine the cause of choking. Accordingly, I am unable to make a finding under this section.

[95] During the hearing on submissions, the Crown initially suggested that a further cause of choking was Mrs Amos being given toast, which it was submitted was a risky food for someone with Alzheimer's and that she ought to have been fed alternative, softer foods. Ultimately, the Crown did not insist on this submission as it was not supported by any evidence.

[96] For completeness, although Ms Lazenby-Paterson addressed food texture in her report, it was at a general level and with the caveat that a change to soft food can often be at a significant detriment to quality of life. There was no evidence to suggest that Mrs Amos required such a diet. Indeed, the evidence from her family, Pine Villa witnesses and the daily wellbeing records was that she was coping with what might be described as a normal diet.

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 death, or any accident resulting in death, being avoided)

[97] There is a distinction between precautions which might have realistically resulted in avoiding death and the accident resulting in death. Standing the unchallenged evidence of Ms Lazenby-Paterson that choking can happen to any person at any time and that even a change in food texture would only reduce the risk of choking, I am not satisfied on the evidence available that there was any precaution which could reasonably have been taken to avoid the accident, that is to say Mrs Amos choking.

[98] That leaves whether there were any precautions which could have been taken to avoid a death from choking. I agree with Mansfield that the correct way for me to approach this question is by considering whether the precautions suggested by the Crown (or identified by me based on the evidence), if implemented, would have had a lively possibility of avoiding the death. The Crown submit that the precautions which could have avoided the death were (i) for Mrs Amos to be supervised during meals; and (ii) for the Eating and Drinking Care Plan requirements to have been provided to staff. I consider that these two precautions amount to essentially the same thing - implementation of the measures assessed as being appropriate for Mrs Amos.

[99] Mansfield's position is that given Ms Lazenby-Paterson's position that not all resuscitation efforts are successful in choking incidents due to a range of factors, the lack

of evidence regarding how long it may have taken Mrs Amos to die, whether food could have been removed from her throat and whether any resuscitation would have been successful, there is insufficient evidence to conclude that there was a real or likely prospect of death being avoided by supervision.

[100] The explanatory notes to the 2016 Act, at paragraph 72 state that "a precaution might realistically have prevented a death if there is real or likely possibility, rather than a remote chance, that it might have done so."

[101] Since hearing submissions, the Inner House has issued a decision in *Duncan* v *The Lord Advocate* [2025] CSIH 27 following an appeal against the judgment of Lady Haldane cited above. Delivering the opinion of the court, the Lord President stated that:

> "If the evidence presented at the FAI shows that a precaution could reasonably have been taken and that had it been taken it might realistically have resulted in the death or any accident resulting in death being avoided then the sheriff must set out such a precaution in his or her determination. The duty to do so is a mandatory one created by the statutory provision. The sheriff has no discretion not to make such a finding where the evidence satisfies the statutory criteria. It is notable that the provision does not say that a precaution should be set out only if the sheriff considers that it *ought* to have been taken or that it *should* have been taken. The threshold for making a finding under section 26(2)(e) has been deliberately placed at a lower level than would be the case if the provision required the sheriff to be satisfied that a precaution ought to have been taken or that it should have been taken. It is sufficient that the sheriff is satisfied that the precaution <u>could</u> have been taken." (paragraph 51)

[102] The Mansfield approach is overanalytical. It would require the court to be persuaded almost as a matter of certainty, rather than "lively possibility", that

supervision of Mrs Amos could have avoided death from choking. Taken to its logical conclusion, it would suggest that even if Mrs Amos (or another individual) was assessed as being at high risk of choking and was intended to be the subject of close and intense scrutiny while eating, it could not be said that supervision might have realistically resulted in death being avoided.

[103] There was no medical evidence regarding how long a person takes to die from choking, or how long Mrs Amos specifically may have taken to die. However, it is reasonable to infer that in a nursing home setting, supervision might realistically have avoided death from choking, when nursing assistance was available and could have been sought promptly by whoever was supervising Mrs Amos. This was consistent with the evidence of Ms McIntyre when she said that she sought immediate nursing assistance from Ms Austin when she found Mrs Amos unresponsive.

[104] The two Pine Villa care assistants gave evidence regarding their training in dysphagia. Although the evidence in relation to the nature of the care assistants' training regarding choking was limited, I am satisfied that had Mrs Amos choked while being supervised eating, steps would have been taken which had a realistic possibility of avoiding her death.

[105] The question posed by this section is whether precautions could reasonably have been taken. Supervision of Mrs Amos while eating had been identified as necessary to prompt her to eat and drink, rather than because of any concerns about choking. Given the evidence that any person can choke at any time, it follows that supervision of every

resident while eating could be a measure which might realistically prevent a death from choking. However, there was no suggestion in the factual or opinion evidence that blanket supervision of every person residing at Pine Villa while eating would be a reasonable approach. Indeed, the purpose of SALT referrals and a choking screen and policy is to identify those individuals who *are* at a risk of choking and who require that risk to be managed by, eg a change in texture of food and/or supervision. In relation to Mrs Amos specifically, there was conflicting evidence regarding whether care staff were advised by Ms Holmes that her mother had on occasion choked. There was evidence from all the care home staff that their observations of Mrs Amos disclosed no pocketing or choking on food. Ms Lazenby-Paterson's opinion, on review of the documentary evidence available at the time of admission, was that a SALT referral was not required. Significantly, even if concerns about Mrs Amos choking had been shared with staff on admission, there was no evidence regarding what the outcome of any SALT referral would have been.

[106] However, applying the test for making a finding under section 26(2)(e) set out by the Lord President in *Duncan,* it is sufficient for me to be satisfied that a precaution *could* have been taken. There is no requirement for me to be satisfied that a precaution *ought* to or *should* have been taken. If I am so satisfied, then I am mandated by the legislation to make a finding under this section.

[107] Pine Villa had identified - albeit for a different reason - that she ought to be supervised whilst eating. Accordingly, I am satisfied on the evidence that Mrs Amos

could have been supervised while eating and that this precaution could reasonably have been taken. Of course, taken to its logical conclusion, given that any person can choke, it might be suggested this means that a reasonable precaution to avoid deaths by choking would be to supervise every resident of a nursing home while eating. I wish to be clear that there was no evidence before me to support this conclusion and that the finding I make under this section is specific to Mrs Amos, in circumstances where she had already been identified as in need of supervision while eating.

[108] I find that supervision of Mrs Amos while eating was a precaution which could reasonably have been taken, and had it been taken, might realistically have resulted in the death being avoided.

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 death)

[109] This is closely related to my finding under section 26(2)(e). Mansfield contended that there were no defects in the system of work and *esto* there were defects, they were not causative or contributory to the death. This latter point was made under reference to essentially the same causation arguments advanced in relation to section 26(2)(e).

[110] The Crown highlighted alleged deficiencies in the pre-admission process, the preparation of the Eating and Drinking Care Plan, the use of the Mersey Choke Screen and that Pine Villa had no clear choking risk policy or pathway.

[111] In terms of the pre-admission process, drawing the Crown's submissions together, the point being advanced is that it did not bring out the family's concerns about Mrs Amos and that she had previously pocketed food and choked. The evidence of Pine Villa staff regarding their own observations of Mrs Amos when eating and drinking was that they had not witnessed any pocketing of food or choking. Ms Lazenby-Paterson's position, on the hypothesis that the family had expressed concerns, was that this would warrant a SALT referral.

[112] The Mersey Choke Screen was not properly utilised. Ms Buick was, in my view, well intentioned in deploying it, but she was not trained in its use and it was deployed as a "tool" not a screen. However, there was no evidence as to what form an appropriate choke screen would have taken, whether appropriately completed the screen would have mandated further investigations or measures, and what those investigations and measures (including the outcome of a SALT referral) might have been. Further, the Crown accepted that there was no evidence to show that the absence of a choke screen and policy was something which had contributed to Mrs Amos' death (paragraph 74, above).

[113] Similarly, with regard to the Crown's criticism of Ms Buick's Eating and Drinking Care Plan, there was no evidence that the IDDSI categorisations for Mrs Amos were incorrect, or if they were, what alternative categorisation was appropriate. The basis for this submission was not explored with any witnesses. Ms Lazenby-Paterson discussed the categorisation of food and drink in her report in the abstract. Her opinion

was that there is often a significant trade-off between offering a person a softer diet and their general wellbeing. There was no suggestion that Mrs Amos was struggling to eat the food provided.

[114] Accordingly, in relation to the admission process, the absence of a choke screen and the assessment of Mrs Amos' IDDSI categorisation, there is no basis for a finding that any defects in the system of work contributed to the death.

[115] However, Pine Villa *had* determined that Mrs Amos required "close supervision e.g. in small groups" when eating. The evidence of Ms Williams, Ms Buick and Ms Austin was that they assumed care workers had taken the trouble to read the plans and so knew of the supervision requirement. However, Ms Suddaby and Ms McIntyre said that although they knew where care plans were stored, they did not look at them. The daily wellbeing records show that Mrs Amos spent a number of days in isolation in her room and that she ate there. However, it is far from clear that on these occasions she was supervised.

[116] I am satisfied on the evidence that there was no adequate system whereby important information about residents' care needs was shared with staff, and in particular the identified requirement for Mrs Amos to be supervised while eating. This was a defect in the Pine Villa system of work which contributed to the death.

Recommendations

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)

[117] I make no recommendation regarding improvements to how critical information regarding residents is communicated to staff. It is a matter of agreement that Pine Villa moved to an electronic system shortly after the death of Mrs Amos.

[118] However, there are other recommendations which might realistically prevent the deaths of others in similar circumstances.

The admission process

[119] The only meaningful discrepancy in evidence was between Ms Holmes, Ms Buick and Ms Williams regarding whether anything was said prior to or post admission regarding Mrs Amos pocketing food and occasionally choking. I was invited by Mansfield to reject Ms Holmes evidence on the basis that her written note to Pine Villa stated that Mrs Amos could eat "unassisted." However, I found all the witnesses to be both credible and generally reliable. They were all doing their best to assist the inquiry. Ms Holmes evidence was that the questions she was asked did not specifically address choking and that she was not thinking in terms of "choke risk" when she completed the questionnaire. Any subsequent discussions between her and

Pine Villa staff, in my view, are likely to have suffered from a similar lack of clarity. Ms Buick and Ms Williams may have forgotten or misinterpreted what was said.

[120] However, the pre-admission process ought to have left no room for doubt or confusion. Leaving aside the problems presented by the COVID-19 pandemic, the Personal Care Plan pre-admission form is inadequate to properly highlight any concerns regarding dysphagia. The only reference to eating and drinking is in respect of nutritional likes and dislikes. There is an "Additional Comments" section at the end of the form, but there is too heavy an onus on family members completing this form to highlight matters whose potential significance they may not understand eg pocketing food or other symptoms of dysphagia. While nursing home staff will carry out their own assessment of a new resident, they would be better informed in doing so with properly focused information from the resident's family.

[121] I therefore recommend that:

> "Any pre-admission form designed to elicit information regarding a resident's care needs, issued to the family or legal guardian of a resident, contains a series of questions, worded in laypersons' language, sufficient to highlight the presence or potential risk of dysphagia or choking."

Choking policy

[122] The identification and use of a choke screen by Ms Buick was well intentioned. Her own evidence was that it filled a gap in the Mansfield policies.

Ms Lazenby-Paterson's expert opinion was that the Mansfield Care Mealtimes Policy (2019) and Nutrition Policy (2019), while recognising the risks associated with

dementia, were not adequate choking policies. There was no formal pathway regarding what ought to be done if a choke risk was identified. There was evidence that staff were aware of when SALT referrals were appropriate, but there was no policy.

[123] Accordingly, I recommend that:

> "A choking policy and pathway is put in place to identify and manage symptoms of dysphagia and the risk of choking, and that appropriate staff training is given in relation to any such policy and pathway."

Conclusion

[124] Ms Holmes attended court each day of the inquiry and at times was accompanied by other family members. At the conclusion of submissions, I expressed my condolences and thanked the Amos Family for the dignified way they conducted themselves throughout these proceedings. It will have been difficult to hear evidence and legal argument about the death of a much-loved wife and mother. I take this opportunity to renew my condolences.