

Fatal Accident Inquiry

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Case No: B3021/10

DETERMINATION

by

SHERIFF W J TOTTEN

**following an Inquiry at
Glasgow and Strathkelvin Sheriff Court
into the circumstance of the death of**

Elizabeth McGaw

Formal Findings

1. This was an Inquiry into the circumstances of and surrounding the death of Elizabeth McGaw, born 5 February 1920 who died at Southern General Hospital, Glasgow on 25 February 2007, just a few weeks after her 87th birthday as determined in terms of *The Fatal Accident and Sudden Deaths Inquiry (Sc) Act 1976, section 6 (a)*.

2. Cause of death was certified as

1a. Ischaemic heart disease (primary cause of death)

and

2. Cachexia, Dementia, Amyloidosis.

3. In my view the evidence did not establish any basis to amend those findings. Nor, as explained below, did the evidence establish that death resulted from any act, omission, failure or other accident during the time she was resident in Heatherbank

Care Home or Southern General Hospital. In particular the evidence did not establish that any lack of oral care of Mrs McGaw contributed to her death.

4. Death in this case was due to heart disease and Mrs McGaw's dementia. I so determine in terms of *The Fatal Accident and Sudden Deaths Inquiry (Sc) Act 1976, section 6 (b)*.

5. The evidence did not establish any reasonable precautions whereby her death from those causes might have been avoided in terms of *The Fatal Accident and Sudden Deaths Inquiry (Sc) Act 1976, section 6 (c)*.

6. Accordingly no formal recommendations are made in this determination.

7. Although the evidence did not establish that lack of oral care while she was a resident in the Heatherbank Care Home for the Elderly contributed to her death, it is clear that her transfer from there to hospital was precipitated by the condition of her mouth through lack of oral care. The issues of the standard of oral care provided to her and to other residents was accordingly identified as a relevant fact in terms of *The Fatal Accident and Sudden Deaths Inquiry (Sc) Act 1976, section 6 (e)*.

8. In summary, the evidence confirmed the important role which good oral care has in maintaining the health of elderly residents of Care Homes and the need for those in charge of Care homes to have an up-to-date policy for maintaining oral care and hygiene of their residents. This case also established that there has to be an effective system of operating such a policy. That requires adequate training to ensure that staff know the importance of oral care, how to administer that to elderly residents, including those who are affected by dementia and what action to take if a resident refuses to allow adequate oral care. There has also to be a clear allocation of responsibility for both administering and recording oral care.

Note

Background

[1] Evidence was first led on 14, 15 and 16 November 2011 when the Inquiry was adjourned following concerns regarding intimation to, and representation of, certain professional parties who might face criticism. Following further procedural callings evidence was resumed between 16 and 27 April 2012 and closing submissions were on 11 May 2012.

[2] I am not in a position to criticise the apparent delay in the Inquiry proceeding since I did not enquire into the reasons for that. However, objectively, it is clear on a number of levels that such a delay is far from ideal. In the present case a substantial amount of the evidence came from eye-witnesses who were testifying about events of some five years ago. Their attempts to recollect those events, and the ability of the court to reach safe findings in fact were hampered by the lapse of time and the frailty of memory.

[3] Mrs McGaw had a great, long and happy life. It was clear from the evidence of various of her carers that even in the twilight of her life she continued to radiate a happiness which brightened the lives of those around her. I heard evidence from a son and a daughter and was enormously impressed by both of them: she must have been very proud of her family who were a credit to her. Sadly she was affected by a progressive dementia in her latter years. As it became worse it imposed enormous burdens upon her children who were looking after her.

[4] My words cannot adequately convey my admiration for the care they provided for her. Although it became more and more difficult they continued to look after her and did that so well she was able to continue living in her own home well past a time and stage where that would have been impossible for all but the most dedicated carers. One of the features of her dementia led Mrs McGaw to have an irrational fear of being moved to any kind of care home: her opposition to that was much more than an understandable desire to remain independent. Eventually the toll upon the health of her daughter and other family members became so great that they could

not on any view have continued to care for her at home and she was admitted to Heather Bank Nursing Home on 30 November 2005. It is abundantly clear that this was not only inevitable but was in her best interests as to have maintained the status quo would have been very harmful to her daughter's health and her own well being.

[5] Happily, she settled in to Heather Bank much better than might have been expected from that beginning. Staff who gave evidence confirmed how it was a pleasure to care for her in view of her smiling, contented disposition, especially in the early period after her admission. However it is also clear that her dementia continued inexorably to take toll of her and her condition continued to deteriorate despite the good standard of care she was receiving both from the professional staff and her family who were constant visitors. In January 2006 she had a fall within the Home, fracturing her right arm, which left her very much less mobile than she had been and from this point there was a marked deterioration in her dementia. For the avoidance of doubt it was at no time suggested in evidence that the fall had been as a result of any lack of care. Since there is public concern regarding the possibility of deliberate or callous ill-treatment of elderly residents of Care homes it is worth recording at this stage that on no view of the evidence before me was this such a case. It was not suggested at any time that any individual or body could be accused of that in this case.

Oral Care at Heather Bank

[6] Her dementia was one of the important factors in her time in the Care Home and in her death and accordingly much of the evidence in the Inquiry dealt with that. The other important fact which was the subject of much evidence was her oral care. When she was admitted to the Care Home she had partial upper and lower dentures but still had some of her own teeth.

[7] Oral and dental hygiene is a particularly difficult but important area of providing adequate care for the elderly, especially those residents with forms of dementia. Residents can and frequently do reach a stage where they cannot provide their own oral care. It is essential that Care homes for the elderly have an effective system to ensure that proper oral care is received by residents. That will usually take the form of removal and cleaning of dental plates each evening and replacement the following morning together with adequate cleaning of natural teeth morning and night. In other words the usual standards of care a fit and well person would observe in their own oral hygiene. It has been recognised for some years that the importance of a high standard of oral care in elderly residents of care homes cannot be overlooked. In addition to leading to pain and discomfort, poor oral hygiene can lead to serious illness. The difficulty of providing oral care for dementia sufferers is increased because, for reasons which are not wholly understood, it is a frequent effect of dementia that sufferers become unwilling to open their mouths either to take nourishment or to allow oral care.

[8] Leaving to one side those additional difficulties, what is absolutely required is a properly set up and strictly observed system to ensure that every resident receives appropriate oral care morning and night. By definition that will entail a system which clearly identifies who is responsible for providing that care together with an accurate record that it has been provided or not. To be effective a good system will record the reasons for any failure or refusal of oral care and have in place an appropriate response. In extreme cases that may mean calling a dentist to attend and in chronic cases may require the permanent removal of denture plates. Any such system will in practice be more effective if it operates in a climate of understanding of the real importance of oral hygiene in the overall health of residents.

[9] It is one of the unfortunate ironies of this case that as at the time of Mrs McGaw's admission to Heatherbank, Southern Cross who owned and operated it throughout the time she was there appeared to recognise the importance of twice daily oral care. Their system, if operated effectively, was a good one certainly by the standards of

2006. Dr Gibson, mentioned below, described the policy statement of Southern Cross as a “national exemplar”.

[10] However it is clear that the system was defective in operation. Counsel who appeared for the Care Home operators in the earlier part of the inquiry expressly intimated that his clients did not dispute that the system was clearly defective.

[11] One of the issues was what training was received by the Care Assistants in administering oral hygiene. Somewhat surprisingly perhaps, there was some divergence of testimony: some thought they had received some more or less formal training in oral care of the elderly, the recollection of others was that they had simply learned and been shown what to do “on the job”. As indicated above, the witnesses were recalling events of many years ago. Be that as it may, whether or not the individual care assistants had a full understanding of the consequences of poor oral hygiene, they gave evidence which I accepted that they did know that each resident was to receive oral care including, where appropriate, removal and cleaning of dentures each night and replacement each morning in addition to brushing of natural teeth.

[12]The aspect where the failings are obvious was in the system of allocating responsibility for provision of oral care to individual residents and the record of that. In any given period of 24 hours a number of different people might have the responsibility to provide, or actually provide, the oral care of a resident. It would normally be one of the care assistants, but could be a nurse; depending upon when the resident went to bed and got up it might be done by a member of the day staff or the night staff. It was not the responsibility of the person providing the oral care to record either that it had been successfully completed or refused. The record of oral hygiene was completed by a nurse. Where, as was usually the case, the person providing it was a care assistant, the nurse would rely upon the information provided by the care assistant. The obvious division of responsibility clearly gives rise to a risk of inaccuracy together with failing to identify who administered oral

care on any given occasion. In practice the haphazard way in which it was operated had still more glaring difficulties. Sometimes a resident would resist oral care at the due time but a further attempt, which may or may not succeed, was made to provide it later; the records were made later in the day and the forms used did not have provision for different entries at different times of the day in question; the nurse recording, *inter alia*, oral care would do so by filling in a batch of forms for up to 17 or 18 residents on the corridor; the nurse was dependent upon the memory of the information provider in relation to a number of different residents; in practice the system came to, or very close to, an assumption that oral care had been provided unless specifically informed that it had not; mistakes were commonly made, including entering the information on the wrong resident's form. The clearest evidence that the system was wholly unreliable emerged from entries on Mrs McGaw's file appearing to suggest she had received oral care for the two days after she had left the care home and was in hospital in December 2006. I was initially concerned that the appearance of those entries might be sinister. By the conclusion of the evidence I was entirely satisfied that they are innocent mistakes but they do highlight that as an accurate record of whether any resident has actually received oral care these records are worthless.

[13] In my view it was, and should have been, obvious that this system in operation gives rise to gaps which might allow a resident to miss essential oral hygiene. Perhaps the most obvious gap being that night shift staff might believe oral care has been provided by day staff and vice versa. The evidence disclosed that there was no formal provision for overlap of shifts and briefing which might have ensured the incoming shift knew the position. The staff themselves usually informally arrived in (unpaid) time to conduct the handover but that was a loose arrangement which did not fill this gap. The forms used to record oral care were clearly not fit for purpose. In particular the forms contained one box to record oral hygiene record on any given day when clearly there ought to be recorded in separate boxes whether it has been completed or refused in the morning and in the evening.

[14] Thus a resident like Mrs McGaw, with a partial denture, could easily slip through a gap whereby she does not receive oral care at night time if each shift believes it has or will be provided by the other shift. If as a result her dental plate remains in her mouth overnight, the following day there is no plate to be 'replaced' leading to an assumption that she is no longer using her denture and/or a failure which persists to remove and clean the denture. Whilst that may not seem an obvious defect if one were dealing with residents with their faculties intact, any insight into dealing with geriatrics and dementia sufferers makes it abundantly clear. The well documented resistance of many dementia sufferers to oral care or even opening their mouths can make it very difficult for the frontline carers to appreciate that a denture has been left in place or a resident has not been receiving adequate oral care.

[15] I was informed through a combination of submissions and evidence that the Care Home owners recognised at least some of the defects in the system soon after Mrs McGaw's death and took steps to remedy that. One important change requires the person actually administering oral care to make a contemporaneous record of that fact or that it has not been possible to provide oral care for the resident.

[16] The irresistible conclusion from the evidence was that the gaps and defects in the system at that time led to precisely the result that Mrs McGaw's upper denture was left in her mouth for some time. That was discovered on 27th December 2006. It is not possible to be certain how long they had been there without removal and cleaning. The condition of the denture and Mrs McGaw's mouth can only mean that the plate had been there for at least some days. Opinions ventured by experts varied. One thought they might have been there for a period in excess of two weeks. The preponderance of medical opinion was towards a period of up to two weeks. That is consistent with her daughter's observations of her appearing increasingly unwell and having discomfort in her mouth over the two weeks or so prior to 27th December. Evidence from the staff at Heatherbank and her records while there would suggest that it is unlikely it was left in place for fully two weeks. That evidence suffered

from the lapse of time and efforts were made to reconstruct the position by reference to the records. The situation is therefore not abundantly clear but there are records of medication being administered orally as well as food and liquids being provided orally. However those processes did not call for a close examination of inside Mrs McGaw's mouth, which she was not readily opening for any purpose. Additionally visible discolouration of her teeth as a result of taking iron tablets may have disguised the true condition of her mouth. That evidence does not exclude completely the possibility of a two week time scale and certainly does not refute the suggestion that the denture had not been removed for a number of days prior to 27th December. During that time it is likely she would have suffered increasing pain and discomfort but would not have been able to vocalise that or probably even understand the cause of her discomfort. There was some evidence of her recoiling from contact when she was being fed. It is highly likely that provision of adequate oral care would have become increasingly difficult and she would have become increasingly reluctant to open her mouth for any reason. That may provide some explanation for the condition of her mouth not becoming apparent earlier during routine care. There was some evidence that, at a meeting after the events, some care staff admitted that particularly latterly they had found it difficult to administer oral care to Mrs McGaw. This had not been reported at the time due at least in part to reluctance to admit they were finding it difficult. It is probable that they were wholly unaware the denture had not been removed and did not recognise the seriousness of the situation. There was some evidence which was far from clear that at least some members of staff thought wrongly that her family had taken the denture away.

Transfer to Southern General

[17] On 27th December it was clear that she was not well. Dr Sweeney, a GP from the practice which served Heatherbank was called to attend and examine her. She was concerned when she saw the condition of her mouth and advised that she had to be seen by a dentist. Contact was made with the dental practice which served Heatherbank but the practice was closed due to the festive period and it was left that

a message had been placed on the answerphone of the practice. Without further intervention, that would have meant that she would not be seen by a dentist for a further eight days. Dr Sweeney had noted swelling and inflammation in her mouth. By lifting her lips she was able to see the dentures. They were very dirty and “needed to come out”. Significantly perhaps, she noted that they were black due to the effect of iron tablets she had been taking. This is an effect of that medication where elderly patients do not swallow iron tablets, and, as mentioned above, it may to some extent have disguised the generally poor condition of her teeth and mouth. Dr Sweeney did not view her case as an emergency but clearly and correctly intended that she be seen promptly by a dentist. She was not aware that it would be eight days before she would be seen by a dentist. The Inquiry touched only tangentially on the issue of out of hours provision of dental treatment and I do not make any formal comment regarding that. I observe in the passing that, if Mrs McGaw had in fact remained in Heatherbank without being seen by a dentist for a further eight days that would clearly not be satisfactory. A combination of different understandings about Mrs McGaw’s condition, when she should or could be seen by a dentist visiting Heatherbank and what alternative steps might be appropriate over the holiday period led to her not being seen by a dentist.

[18] During the course of 27th December Mrs McGaw’s condition worsened and it became necessary to call the out of hours GP service. Dr Ferguson attended and examined her. I was very impressed by his response to the situation. He found her presenting with symptoms of what he diagnosed as Cellulitis and possibly Necrotising Gingivitis, very serious and potentially life-threatening infections of the mouth, face and neck regions. Subsequent evidence and hindsight suggested that he may not in fact have been correct in his diagnosis but it is without doubt that he responded quickly and correctly to the presenting patient. He administered a loading (ie high) dose of appropriate antibiotics and arranged for her admission to the maxillo-facial unit of Southern General hospital. Even if his diagnosis was not accurate he cannot be faulted for reaching it or for his actions in response. He had a perfectly proper basis for arriving at that diagnosis. On any view he responded

correctly by administering a high dose of antibiotics which helped fight infection and it remains at least possible that his diagnosis of Cellulitis was correct. It was clear that his patient required immediate, albeit not emergency, admission to hospital. He tried to have her admitted forthwith to the maxillo facial ward at Southern General but admission had to be postponed until the following morning due to non-availability of a bed. Whether or not the infection was Cellulitis, his actions in administering the loading dose of antibiotics helped her recovery and may have saved her life. He was an impressive witness and his response to this very ill patient was equally impressive.

Treatment at Southern General

[19] Mrs McGaw was initially an inpatient at the maxillo-facial unit under the care of Dr Devlin, consultant of oral and maxillo-facial medicine. She was then transferred to the care for the elderly ward at Southern General under the care of Dr Reeves, consultant in geriatric medicine where she remained until her death on 25 February 2007. Both Dr Devlin and Dr Reeves were impressive witnesses and I am satisfied that their expertise and the care and treatment they provided for Mrs McGaw is above criticism.

[20] There was a substantial amount of evidence examining the care and treatment Mrs McGaw received in the Southern. It would appear that this may have been precipitated by two things: concern on the part of her family regarding how the impacted denture was removed and whether that might have resulted in further trauma contributing to continuing discomfort and/or her death; and a report prepared by Dr Gibson an eminent expert in dentistry. That report is extremely comprehensive and thorough and gave rise to various possibilities including that ongoing infection and/or abscess might have been present and were missed by the doctors in the Southern.

[21] As stated above, I am completely satisfied that no criticism can or should be made of the Doctors in the Southern or of the care and treatment they provided for

Mrs McGaw. Dealing firstly with the removal of the impacted denture, it was not easy for the surgeon to get her to open her mouth fully or to co-operate with the removal. Clearly it could not be left in place and the surgeons were coming to the view that it might be necessary to do so under a general anaesthetic. As was explained, however, any general anaesthetic carries a considerable risk of death for an elderly, infirm patient like Mrs McGaw and the surgeons did not wish lightly to take that course. In my view they were entirely correct in exercising that caution. They were prepared if necessary to do so but two consultants together were able to get the patient to open her mouth sufficiently to be able to take hold of the denture and dislodge it by hand. The evidence, which I have no hesitation in accepting, is that only a modest amount of force was required and no further particular trauma was caused to the inside of her mouth. I deal at paragraph [29] below with the possibility raised by Dr Gibson that there may have been present along with the impacted denture some other infection which the Doctors at the Southern failed to detect or recognise.

[22] Following the removal of the denture she showed some improvement in her condition. She was transferred to the Care for the elderly ward and within a few days, Mr Reeves, the consultant there felt she might be fit to be returned to Heatherbank. Prior to doing so he had discussions with her family who had for reasons one can understand concerns about that and he was persuaded that her continuing frailty justified her being kept in the hospital. With the benefit of hindsight that can clearly be seen as the correct decision. She very quickly reverted to not eating or drinking well in the Southern. It was apparent that she was entering the final stage of her life and it was agreed that she should not be resuscitated in the event of any critical failure. She passed away a little under two months later.

[23] Post mortem autopsy was carried out and the cause of death found to be:

- 1a. Ischaemic heart disease (primary cause of death) and
2. Cachexia, Dementia, Amyloidosis (potential contributing causes).

It is not disputed that cause of death was correctly certified and in a joint minute at paragraph four parties helpfully agreed much of the meaning and detail of the certified causes.

Consequences of lack of oral care at Heather Bank

[24] The crucial fact for this inquiry is whether the events surrounding the oral care in Heatherbank and/or her subsequent care in the Southern General contributed in any way to her death. After careful consideration I have come to the view that it is not established to any degree of certainty or probability that her (lack of) oral care or the effect of the denture being left in her mouth contributed to her death. As indicated above I am entirely satisfied that there were no failings in her care and treatment in Southern General hospital and that nothing in her treatment there contributed to her death.

[25] On the evidence led in the Inquiry, the overwhelming feature affecting Mrs McGaw's last years and her death was her dementia. The agreement in relation to the cause of death at paragraph four notes that a cause of her dementia could have been due to the age related amyloid deposits within the brain. It is significant that she was found to be cachectic, ie thin, consistent with long-term loss of appetite and gradual deterioration in health which, in the opinion of the pathologist, possibly reflected her dementia. That is amply supported by the direct evidence describing the deceased in the period of at least 15 months prior to her death.

[26] A sharp issue of fact to be determined is whether the continuing effect of retained memory of the discomfort and pain in her mouth caused her continuing reluctance to eat and drink after the denture was removed. In other words whether her dementia was so severe that she had no proper understanding of what had caused her discomfort and continued over the next two months to react as if any contact with her mouth or opening it to take nourishment would be painful. There was a body of opinion from the medical witnesses who felt this to be quite likely and therefore that the denture did indeed contribute to her death. It was not suggested

that this was clearly established from any particular scientific finding during her lifetime or at post mortem and of course, by definition, Mrs McGaw could not have explained it in that way.

[27] Against that background the Inquiry had evidence from Dr Davie, a vastly experienced and highly regarded expert in geriatric care. He has had considerable experience of dementia patients refusing to eat or drink sufficiently. It is a widely acknowledged feature of dementia. He was aware that in the USA there had been for a while a policy of trying to manage this common problem amongst dementia patients by feeding intravenously but paradoxically that appeared to actually shorten life expectancy. Having looked at the whole circumstances of Mrs McGaw's latter stages of life and her death it was clear that he sees her case as a classic one of death supervening after a prolonged period of deteriorating dementia causing, *inter alia*, a not uncommon reluctance to eat or drink. He was aware of the theory of "retained memory" but felt that it is not free from controversy: while he felt that no-one could completely exclude it, he very much doubted it. Based upon his long experience he considered it was much more likely that this was a classic case of severe dementia leading to reluctance and refusal to eat or drink sufficiently.

[28] I consider that the greatest weight has to be accorded to the view of Dr Davie with his experience and expertise in geriatrics. Particularly where he is able to reference the frequent connection between dementia sufferers and loss of appetite. It should also be borne in mind that Mrs McGaw lived for some two months after the denture was removed. Accordingly, although it *may* have done, in my view it cannot be safely concluded even on the balance of probabilities that the denture or other lack of oral care did in fact contribute to death at that time.

Quality of treatment in Southern General

[29] I return to her medical treatment in the Southern and the possibilities raised by Dr Gibson of unrecognised or undiagnosed problems including abscess and ongoing infection (perhaps initially masked by the short-term effects of the loading dose of

anti-biotics administered by Dr Ferguson) which may or may not have contributed to her death. It is clear that Dr Gibson had taken a great deal of care to thoroughly look at any such possibility for which the Inquiry should be grateful. I do not, nor would I wish to, dismiss lightly those concerns. However, as indicated above, I was very impressed with the Doctors from the Southern who gave evidence and were in charge of her care. There was substantial support for the view that their treatment was above criticism in the evidence of Dr Currie. In my view great weight should be properly attached to their expertise as clinicians and their first-hand involvement with the patient. There was nothing found in her records at Southern General or at post-mortem to contradict their assessment that there was no abscess or other cause of underlying infection which went undetected. The whole evidence, including that assessment of the expertise of the clinicians, does not in my view support the possibility raised by Dr Gibson of these alternative causes of infection and illness. There is no basis whatever on the evidence to make any criticism of the medical treatment or the Doctors at the Southern General, much less to reach any finding that any act or omission on their part contributed to the death. I formed the impression that there is room for some, more or less, academic, disagreement about the prevalence of Staphylococcal Mucositis. That is a potentially life-threatening infection which can enter the system from oral infection. Dr Gibson from his position of expertise in the field and based upon research has a concern that this may be a more common killer than is recognised and that it may have contributed to death here. I accept Dr Devlin's evidence, supported by Dr Currie, that it was not present here and was reassured by Dr Devlin and Dr Currie that, albeit they may not agree with Dr Gibson about its prevalence they are well aware of this condition, its seriousness and how to treat it.

Required Standard of Oral Care in Care Homes

[30] I viewed Dr Gibson's evidence as falling into two sections: I have dealt with the section in which he reviewed the treatment at the Southern. In my view what he had to say about oral care within Care homes was of much greater general significance. I am satisfied that the cause of death was heart disease and contributed to by Mrs

McGaw's dementia and associated health problems but was not as a result of the lack of oral care and the denture being left in her mouth. However his evidence highlighted the importance of providing adequate oral care in Care homes for the elderly, particularly dementia sufferers. Dr Gibson's evidence makes it clear that, however difficult, maintaining good oral hygiene is essential. He was in an academic, professional and reasoned way passionate and impressive about the importance of dental care for all, including the elderly residents of Care Homes. He clearly sees a need to reinforce the message that dental and oral hygiene is as important as overall health and is concerned that even today not all health and elderly care professionals have fully embraced that. He was at pains to emphasise that in addition to avoiding pain and discomfort, oral hygiene is important to reduce the risk of a direct link which has been documented between poor oral hygiene and potentially life threatening infection.

[31] I am happy to endorse his view. Paragraphs 7 to 15 above are informed by Dr Gibson's evidence in tandem with my own interpretation of the facts in this case. There is already in existence a Scottish Government Code of Practice for oral care of residents in Institutions including care homes. It has been revised and updated recently. Dr Gibson spoke highly of the excellence of the standards set in that code of practice and I do not consider there is any need to make any formal recommendation regarding that. This Inquiry highlights the importance of Care Homes adopting and applying that code. It is important that all persons who care for the elderly know and apply up to date thinking in oral care. There should not be a climate in which dental health is seen as less important than general medical health. Nor should residents of Care Homes receive any lower standard of oral care than those able to do so would provide for themselves. Care Homes require to institute and operate a system for oral care which is fit for purpose. Those operating Care Homes have the benefit of that Code to inform best practice. The evidence in this case demonstrates, as the Home owners have accepted, that there were gaps in the system at Heatherbank in 2006 which allowed Mrs McGaw's oral hygiene to be overlooked. That was despite an oral care policy which appeared to be satisfactory at

the time. As stated above, those running the Home put in place improvements in that system soon afterwards. There is strong public interest in the elderly and infirm who become residents in Care Homes receiving good care. That interest will continue to grow as the growing numbers of elderly who spend their twilight years in care increases. This case serves to emphasise for the residents and their families that practice as well as policy has to ensure that residents do not suffer from poor oral care leading to not only pain and discomfort but also life threatening illnesses. When it is known that those with dementia in particular may suffer loss of appetite it is important to avoid adding to that because of poor oral hygiene.

Conduct of Nursing and Care staff in Heather Bank

[32] This Inquiry took many days of evidence. However, although it was necessarily time-consuming, much of the evidence in reality was not the subject of serious dispute. It is of course the case that a Fatal Accident Inquiry is not, and should not be, a process of seeking to blame individuals. However, necessarily an Inquiry such as this one gives rise to the possibility that individuals may be criticised either in the evidence, cross examination or incidentally in the course of findings of wider public concern. That possibility is important to individuals particularly where there may be professional implications for persons such as Registered Nurses and Doctors. Inevitably that gave rise to much questioning and cross-examination regarding the actions and possible omissions by the Care Assistants and Nurses who dealt with Mrs McGaw. That being so, I consider I should deal briefly with that aspect. Although it is unfortunate that neither a carer nor a nurse found the denture sooner, I do not consider that the evidence justifies criticism of any named individual. The ability of this Inquiry to arrive at a complete picture was hampered by the passage of time and to an extent the absence in the system of a record identifying precisely who did or should have provided oral care at any given time. The care assistants and nurses who testified were having to recall events of many years ago, including matters which may not have appeared important at the time. Naturally they wished to see and portray themselves as having done everything they were personally required to do. Some made more impressive witnesses than others but that might be

referable to a better ability to remember and/or the effect of nerves when giving evidence in court. I also recognise that in human affairs people do not wish to feel that, either personally or professionally, their failings may have led to this kind of situation. That having been said, and recognising that any individual nurse or carer might be capable of portraying themselves as more thorough than they actually were, I was satisfied of an overall good level of care and concern on the part of all the staff at Heatherbank towards their residents. Their task was not an easy one, dealing with as many as 17 or 18 residents between a team normally comprised of two or three care assistants and at most two nurses.

[33] It is my clear view that had the system for oral care within Heatherbank avoided the gaps which are documented, it is likely that the care staff and qualified nurses there would have ensured that Mrs McGaw did not “fall through a gap” and miss out on oral care including removal of her denture however difficult that might have been in her case. It was gaps in the system which allowed this to happen, not individual failure. That system has been improved and I trust this case will help to highlight to all Care Homes the importance of applying effectively a system for oral care as set out by the Scottish Government.

Conclusion

[34] Ultimately this document setting out my Determination in this case has been shorter than it might otherwise have been for a number of reasons. There was less controversy about many issues than at first appeared. Parties helpfully reached an extensive agreement regarding matters which I may have otherwise required to reach a view and set out at length here. The agreed matters should be read as incorporated into the Determination. With that assistance and in the absence of any finding that Mrs McGaw’s care in Heatherbank, the denture being left in her mouth or her treatment in Southern General Hospital contributed to her death I have felt able to summarise the evidence and conclusions in a way which I hope is both clear and helpful to interested parties. I consider the requirement of Care Homes operating an adequate system of oral care is irrefutable and wholly reasonable. Had

I been satisfied that lack of oral care did in fact contribute to Mrs McGaw's death I consider I would have been bound to make the same comments in the form of reasonable precautions which might have avoided her death in terms of section 6 (c) of the Act.

[35] I wish to record my thanks to the Counsel and solicitors who appeared including Mr Brown, who appeared in the early stages for the Care Home owners and withdrew with the appropriate courtesies when those instructing him declined to be further represented. I was greatly assisted by the careful and considered presentation of the evidence in this case by the Procurator Fiscal and each of the professional representatives.

[35] Mrs McGaw's daughter and other family members faithfully attended with quiet dignity throughout the Inquiry. It is my earnest hope that they will have arrived at the same impression of their late mother's carers or at least understand my conclusions about them. I hope that the determination of this Inquiry will allow them to draw a line under the circumstances of her death and, having discharged their final duty to her, move forward in the knowledge that lessons have been learned from their mother's case and with the abiding memory of their mother's long and happy life which is to be a source of celebration after an initial period of grief at her passing.

Glasgow

June 2012