SHERIFFDOM OF SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY AT HAMILTON

[2026] FAI 58

HAM-B369-25

DETERMINATION

BY

SHERIFF MICHAEL J HIGGINS

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

into the death of

DAVID AINSWORTH

Hamilton, 16 September 2026

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, (hereinafter referred to as "the Act") that

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

David Ainsworth (hereinafter referred to as "Mr Ainsworth") was pronounced dead by Dr Emma Goodall at 10.00am on 22 January 2020 at Hairmyres Hospital, East Kilbride.

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

The death of Mr Ainsworth was not due to an accident.

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

The cause of Mr Ainsworth's death was as follows:

1. Complications of severe leg ulcers

with potentially contributing causes:

2. Interstitial lung disease

Ischaemic heart disease

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

The death of Mr Ainsworth was not due to an accident.

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

There were no precautions which might realistically have resulted in the death of Mr Ainsworth being avoided.

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

There were no defects in any system of working which contributed to the death of Mr Ainsworth.

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

In relation to Mr Ainsworth's care, the following facts are relevant to the circumstances of Mr Ainsworth's death.

In relation to South Lanarkshire Council Social Work Department ("SLC SWD")

(i) there was a failure to take appropriate steps to satisfy professional curiosity in respect of Mr Ainsworth's care. In particular Social Workers did not take any steps to investigate or challenge things Mr Ainsworth said about his care arrangements/health and simply took them as facts without investigation or challenge.

(ii) there should have been a more assertive approach in relation to Mr Ainsworth appearing to remain in the same position for long periods of time which could have led to an earlier intervention in that regard. Mr Ainsworth should have been asked to walk across the room so as to obtain an indication of his mobility.

(iii) there was a failure to sufficiently include Mr Ainsworth's daughter in his care.

(iv) there was a failure to trigger consideration of Mr Ainsworth as being an adult at risk of harm which may have led to intervention into his care and condition.

(v) there was a failure to have a sufficiently complete, clear and detailed care plan for Mr Ainsworth;

(vi) there was a failure to undertake a falls assessment as part of Mr Ainsworth's care plan;

(vii) there was a failure to have an understanding of the danger of Mr Ainsworth smoking in his home whilst there were oxygen cylinders there;

(viii) there was a failure to carry out a skin review when Mr Ainsworth reported to Social Work that he was in pain and was crawling to the toilet and couldn't walk there;

In relation to South Lanarkshire Council Hamilton Home Care Service ("SLC HHCS");

(i) there was a failure to undertake an individual risk assessment on Mr Ainsworth before his care plan and visits started;

(ii) there was a failure to carry out a visual skin assessment when carers reported concerns that Mr Ainsworth was not moving.

(iii) there was a failure to carry out a skin review when Mr Ainsworth reported to Social Work that he was in pain and was crawling to the toilet and couldn't walk there;

(iv) there was a failure by home care workers ("carers") to recognize and escalate to co-ordinators the "soft signs" of a deterioration and change in Mr Ainsworth's presentation during the period from 7 January 2020 to 20 January 2020;

(v) carers should have had the competence to recognize these signs and the ability, confidence and support to escalate their concerns to their co-ordinators but did not.

(vi) there was a failure by carers to take appropriate steps to satisfy their professional curiosity in respect of Mr Ainsworth's care. In particular some carers did not take any steps to investigate or challenge things Mr Ainsworth said about his care arrangements/health and simply took them as facts without investigation or challenge;

(vii) carers did not have the skills to identify soft signs of self-neglect nor the knowledge of the escalation protocol in respect of same;

(viii) there was a failure by carers to follow the systems and processes for the escalation of concerns despite there being a protocol in place that clearly defined self-neglect and the processes to be followed;

(ix) there was a failure by carers to report the changes and notable concerns in Mr Ainsworth's health and wellbeing timeously;

(x) there was a failure to trigger consideration of Mr Ainsworth as being an adult at risk of harm which may have led to intervention into his care and condition.

(xi) there was a lack of detailed notes in Mr Ainsworth's Home Care Diary system and mCare app and some detail that was included was possibly inaccurate. These should have been more detailed so that all carers and family members could see what Mr Ainsworth's day to day situation/condition was and were kept up to date and so that Home Care Management could see what was happening with their service users.

The following facts are also relevant to the circumstances of Mr Ainsworth's death;

(i) Mr Ainsworth's concealed his deterioration in health and self-neglect from carers;

(ii) there was a lack of information sharing between NHS Lanarkshire and SLC SWD about the following:

(a) Mr Ainsworth's alcohol use. In his first hospital admission in July 2019, NHS Lanarkshire noted that it was a direct result of a fall at home whilst intoxicated but this was not shared with SLC SWD until after his death. Moreover, SLC HHCS had noted that he had been admitted then due to breathing issues and not because of a fall; and

(b) Mr Ainsworth smoking whilst having oxygen cannisters in his house. His Consultant had threatened to remove the oxygen on safety grounds but that was not disclosed to SLC SWD and carers continued to attend his home regardless.

RECOMMENDATIONS

(h) In terms of section 26(1)(b) (such 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 present other deaths in similar circumstances).

No recommendations are made.

NOTE

Introduction

[1] This Inquiry was a discretionary Inquiry held in terms of section 4(1)(a)(ii) and 4(1)(b) of the Act as the Lord Advocate considered that the death of Mr Ainsworth occurred in circumstances giving rise to serious public concern and that it would be in the public interest for an Inquiry to be held into the circumstances of Mr Ainsworth's death.

The legal framework

[2] The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[3] The purpose of the Inquiry is set out in section 1(3) of the Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[4] The Inquiry is an exercise in establishing facts and not in establishing fault. Its purpose is not to establish civil or criminal liability. The Inquiry is an inquisitorial process and the Procurator Fiscal represents the public interest on behalf of the Crown.

[5] In terms of section 26 of the Act, the Inquiry must determine the following matters:

(i) when and where the death occurred;

(ii) when and where any accident resulting in the death occurred;

(iii) the cause or causes of death;

(iv) the cause or causes of any accident resulting in the death;

(v) any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(vi) any defects in any system of working which contributed to the death or any accident resulting in the death;

(vii) any other facts which are relevant to the circumstances of the death.

[6] In terms of section 26(4) of the 2016 Act, it is open to the sheriff to make recommendations as a consequence of the issues determined which, in relation to the following matters:

(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;

might realistically prevent other deaths in similar circumstances.

Proceedings and parties

[7] The notice of Inquiry and Form 3.1 were lodged with the court by the procurator fiscal on 25 April 2025. The first preliminary hearing took place on 13 June 2025 and, at the request of parties, there followed a further four preliminary hearings to allow parties to continue with their preparation for the Inquiry.

[8] Suitable dates for the Inquiry to take place were subsequently identified and evidence was led over two days on 8 and 11 June 2026.

[9] On conclusion of the evidence on 11 June 2026 a hearing on submissions was subsequently fixed for 20 August 2026.

[10] In the Inquiry, the public interest was represented by Ms Brown, procurator fiscal depute and South Lanarkshire Council were represented by Mr Donaldson, solicitor advocate.

[11] Mr Ainsworth's daughter, Marion Gillan, and step-daughter, Maureen Galloway, each attended various hearings as observers.

[12] I am grateful to parties for their assistance at all stages of the Inquiry.

Summary

The evidence

[13] The Inquiry took place on 8th and 11th June 2026. The Inquiry heard from a number of witnesses, either by way of written statement, report or orally in person.

[14] The following witnesses gave oral evidence at the Inquiry:

1. Eleanor Wakenshaw, Tissue Viability Nurse
2. Dr Martin Kettle, Expert Witness for the Crown
3. Dr Jane Douglas, Expert Witness for the Crown
4. Deborah Finlay, Care Inspectorate
5. Scott McNeill, South Lanarkshire Council.

[15] Police Statements were lodged for the following witnesses, and it was a matter of agreement between parties that the evidence contained within the said police statements should be admitted in evidence and treated as if it were the parole evidence of the witnesses, namely:

- AB
- CD
- EF
- GH
- IJ
- KL
- MN
- Dr OP
- QR
- ST
- UV
- Dr WX
- Dr YZ
- AA
- BB

[16] In addition, it was very helpful to the Inquiry that parties agreed a substantial amount of the evidence before the court in the form of two joint minutes of agreement.

The first joint minute of agreement

[17] The relevant facts agreed in the first joint minute are set out within this determination and using the paragraph numbers used in that joint minute as follows:

> **"Introductory Matters**
> 1. David Ainsworth was born on 4 January 1961 and was 59 years old at the date of his death. At the time of his death Mr Ainsworth lived alone at X. Mr Ainsworth had previously been married and had one daughter from this marriage, Marion Gillan. Ms. Gillan and her family recently emigrated to Australia. Ms Gillan also had a stepsister, Maureen Galloway, who is the daughter of Ms. Gillan's mother.
>
> **2017**
> 2. Mr Ainsworth was diagnosed with Pulmonary Fibrosis in October 2017 by Respiratory Consultant, Dr EEE at Hairmyres Hospital. Mr Ainsworth was prescribed two inhalers and a steroid tablet, prednisolone by the respiratory team at Hairmyres Hospital who were responsible for Mr Ainsworth's treatment. Following his discharge from Hairmyres hospital, Mr Ainsworth was given long term oxygen therapy within his home address.
>
> 4. On 3 October 2017 Mr Ainsworth was discharged from hospital. On 9 October 2017 Mr Ainsworth was visited within his home by a Social Worker who noted that Mr Ainsworth had refused a care package. At that time Mr Ainsworth lived within an upper flat in a 4 in a block property. The social worker described the home environment as, '*the home was unclean and untidy to standard of neglect……..David was lying in his bed in the bedroom, the floor was covered with full bin bags, rubbish, out of date food stuffs, alcohol bottles and cigarette ends/ash.*'
>
> **2019**
> 5. On the 23 July 2019 Mr Ainsworth tripped on a rug within his property and fell onto his left side. He reported pain in the groin area and at the lateral hip on his left side. X-rays were inconclusive but a CT scan showed a pubic rami insufficiency fracture in the inferior pubic ramus on the left side. Mr Ainsworth was also reviewed by the respiratory team due to low oxygen saturation. Mr Ainsworth was advised by the respiratory doctor that regular reviews of both Mr Ainsworth and the oxygen equipment were required as part of the contract for supplying oxygen to his property. Mr Ainsworth indicated his compliance with the reviews to the respiratory doctor. It was decided by the respiratory team that Mr Ainsworth had been subject to steroid therapy for a significant period of time and that a reduction of prednisolone was required. A plan was

made for this reduction prior to Mr.Ainsworth's discharge from hospital care. Mr Ainsworth did not adhere to this reduction plan.

6. On 14 August 2019 Mr Ainsworth was readmitted to Ward 4 at Hairmyres Hospital at approximately 23:45 hours as he had been feeling more breathless even with minimal exertion. It was noted that Mr Ainsworth lives alone and felt that he was not coping and that there was no care plan in place. On examination Mr Ainsworth was audibly breathless, in terms of circulation slight pitting oedema was visible up to his mid shins. It was noted that a plan of care would likely need to be started.

7. On 15 August 2019, Mr Ainsworth was seen by a physiotherapist who noted, '*David is well known to me from previous admissions. Unfortunately, he does not accept recommendations from rehab teams regarding POC (package of care) /self-management. Despite LTOT (Long Term Oxygen Therapy) he continues to smoke at home. I have had multiple discussions with him regarding the risk to his own life and the lives of others'*. Mr Ainsworth was thereafter discharge from Physiotherapy for referral for a full care package.

8. The package of care was noted to commence on 22 August 2019 at tea-time. Under the care package Mr Ainsworth was to receive a visit in the morning for personal care, breakfast and lunch was to be made and left for him. In the afternoon the evening meal was to be prepared. Mr Ainsworth was discharged from Hairmyres Hospital on 22 August 2019.

9. That Mr Ainsworth failed to attend at Hairmyres Hospital for a follow up chest x-ray.

10. That Dr EEE advised Wellhall Medical Centre of Mr Ainsworth's failure to attend the respiratory clinic with four missed or cancelled appointments since his discharge from Hairmyres Hospital. In particular at page 21 of Mr Ainsworth's GP notes Dr Patel discloses that Mr Ainsworth was still smoking within his home address with the oxygen canister in situ stating: -

'*The Respiratory Nurses have attended him in his house. It appears he is still smoking with oxygen in situ. At the last visit, he threatened the Police if they would try and take the oxygen away which is interesting since we would indeed have to call the Police in order to gain entry to his house to remove the oxygen equipment in the context of ongoing cigarette smoking in a block of flats. This is on the basis of the oxygen equipment being the property of NHS Lanarkshire*.'

11. Mr Ainsworth failed to attend at two orthopaedic appointments on the 18 September 2019 and 16 October 2019.

12. Dr CC, Department of Respiratory Medicine wrote to Wellhall Medical Centre on 12 August 2019 to advise them that Mr Ainsworth was to be weaned from prednisolone.

GP Practice

13. Mr Ainsworth was a registered patient at Wellhall Medical Centre, Hamilton.

14. That the Police Statement of Doctor OP, obtained by DC Calvin Lawrie on 7 February 2020, Production 103 for the Crown is to be admitted into evidence and treated as if it were the parole evidence of Dr OP.

15. Dr. OP noted that although the plan from the Department of Respiratory Medicine was to wean Mr Ainsworth from prednisolone, however Mr Ainsworth did not engage with the respiratory team and therefore the plan to reduce the prednisolone was not adhered to.

16. That Dr OP's statement highlights Mr Ainsworth's use of oxygen cylinders within his home whilst continuing to smoke and a continual non-attendance at appointments with the respiratory nurses and the orthopaedic clinic. That records indicate Mr Ainsworth had a history of not looking after himself and not engaging with offered support despite multiple opportunities to do.
Mr Ainsworth was reluctant to allow medical staff into his home as, due to his continued smoking the medical staff had advised him they wanted the oxygen cylinder to be returned.

17. That Mr Ainsworth was last seen, on a home visit, by Dr. DD (now retired) on 6 October 2017.

Home Care Involvement

18. At the time of his death Mr Ainsworth was in receipt of home support by Hamilton Home Care Services, a subsidiary of South Lanarkshire Council following his release from hospital on 22 August 2019. South Lanarkshire Council carried out an assessment of the care required by Mr Ainsworth.

20. That the initial care package started on 22 August 2019 with the service provision timetable as noted below: -

Morning
Breakfast Provision
Getting Dressed
Personal Hygiene (Wash Shave)
Preparing Food Snack

Afternoon
Cook Main Meal/Pre Prep. Meal

The service provision was for 7 days a week.

21. The contents of the following statements is agreed and can be admitted into evidence and treated as if it is the parole evidence of: -

i. AB, Home Carer
ii. CD, Home Carer
iii. EF, Home Carer
iv. GH, Home Carer
v. IJ, Home Carer
vi. KL, Home Carer
vii MN, Home Carer

22. That Crown Production 9 is a computer printout of the care provided to Mr Ainsworth between 22 August 2019 and 20 January 2020. Said computer printout can be entered into evidence without the need to be spoken to by a witness.

23. Between 22 August 2019 and 20 January 2020, it is noted on the computer printout that Mr Ainsworth declined support on 124 occasions. The majority of the visits related to assisting Mr Ainsworth with his personal care during the morning visit. On 14 occasions Mr Ainsworth was already dressed and washed when the home care workers attended at his property. On two occasions Mr Ainsworth's family were providing support and on seven occasions there were other reasons noted for Mr Ainsworth declining support from the home care workers.

24. Between 1 January 2020 and 7 January 2020, the following visits were made by Home Care workers: -

1 January 2020 –	AM visit – AB
	PM visit – CD
2 January 2020 –	AM visit – GH
	PM visit – IJ
3 January 2020 -	AM visit – GH
	PM visit - IJ
4 January 2020 –	AM visit – AB
	PM visit – CD
5 January 2020 -	AM visit – AB

PM visit – CD
6 January 2020 – AM visit – GH
PM visit – CD
7 January 2020 – AM visit – GH
PM visit – CD

The first indication to the Home Care Workers that Mr Ainsworth was unwell was noted on the 8th January 2020. Between the 8th January 2020 and the 20th January 2020 the following visits were made:

8 January 2020 – AM visit – GH
Actual visit start time – 07:34 hours
Actual visit end time – 07:47 hours
Visit Status – incomplete – Declined Support
Visit Comments – David not wanting anything today he has a bug, doctor said to drink plenty.

8 January 2020 – PM visit – CD
Actual visit start time – 17:50 hours
Actual visit end time – 17:57 hours
Visit Status – Complete

9 January 2020 – AM visit – AB
Actual visit start time – 07:37 hours
Actual visit end time – 07:44 hours
Visit Status – Incomplete other
Visit Comments – not feeling well

9 January 2020 – PM visit – CD
Actual visit start time – 17:37 hours
Actual visit end time – 17:42 hours
Visit Status – Complete

10 January 2020 – AM visit - AB
Actual visit start time – 07:50 hours
Actual visit end time – 07:50 hours
Visit Status – Incomplete Declined Support

10 January 2020 – PM visit – CD
Actual visit start time – 17:00 hours
Actual visit end time – 17:00 hours
Visit Status – Complete

11 January 2020 – AM visit – AB
Actual visit start time – 07:43 hours
Actual visit end time – 07:44 hours
Visit Status – Incomplete Declined Support
Visit Comments – got noro virus

11 January 2020 – PM visit – IJ
Actual visit start time – 17:24 hours
Actual visit end time – 17:52 hours
Visit Status – Incomplete Declined Support

12 January 2020 – AM visit – AB
Actual visit start time – 08:04 hours
Actual visit end time – 08:04 hours
Visit Status – Incomplete Declined Support

12 January 2020 – PM visit – IJ
Actual visit start time – 17:26 hours
Actual visit end time – 17:54 hours
Visit Status – Incomplete Declined Support

13 January 2020 – AM visit – AB
Actual visit start time – 07:40 hours
Actual visit end time – 07:41 hours
Visit Status – Incomplete Other
Visit Tasks – Getting Dressed - Incomplete,
Personal Hygiene (Wash/Shave) -Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete
Visit Comments – unwell not wanting anything to eat

13 January 2020 – PM visit – CD
Actual visit start time - at 17:38 hours
Actual visit end time – at 17:45 hours
Visit Status – Complete
Visit Tasks – Cook Main Meal/Pre Prep Meal – Complete

14 January 2020 AM visit – AB
Actual visit start time - at 07:36 hours
Actual visit end time - at 07:47 hours
Visit Status – Incomplete – Declined Support
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) - Incomplete

Preparing Food Snack – Complete
Breakfast Provision- Complete

14 January 2020 PM visit – CD
Actual visit start time - at 17:14 hours
Actual visit end time – at 17:30 hours
Visit Status – Complete
Visit Tasks – Cook Main Meal/Pre Prep Meal – Complete

15 January 2020 AM visit – AB
Actual visit start time - at 07:44 hours
Actual visit end time – at 07:44 hours
Visit Status – Incomplete – Declined Support
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete.

15 January 2020 PM visit – IJ
Actual visit start time - at 17:51 hours
Actual visit end time – at 17:52 hours
Visit Status – Incomplete Task Already Completed
Visit Tasks – Cook Main Meal/Pre Prep Meal – Incomplete

16 January 2020 AM visit – GH
Actual visit start time - at 07:35 hours
Actual visit end time – at 07:49 hours
Visit Status – Incomplete – Declined Support
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision- Incomplete
Visit Comments – Davie not having anything to eat, declined personal care

16 January 2020 PM visit – IJ
Actual visit start time - at 17:32 hours
Actual visit end time – at 18:08 hours
Visit Status – Complete
Visit Tasks – Cook Main Meal/Pre Prep Meal – Complete

17 January 2020 AM visit – GH
Actual visit start time – at 07:35 hours
Actual visit end time – at 07:51 hours

Visit Status – Incomplete - Declined Support
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete
Visit Comments – declined personal care and breakfast still not feeling well

17 January 2020 PM visit – IJ
Actual visit start time - at 17:05 hours
Actual visit end time – at 18:02 hours
Visit Status – Complete
Visit Tasks – Cook Main Meal/Pre Prep Meal – Complete

18 January 2020 AM visit – AB
Visit start time - at 07:30 hours
Visit end time – at 08:00 hours
Visit Status – New
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete

18 January 2020 PM visit – EF
Actual visit start time – at 17:24 hours
Actual visit end time – at 17:55 hours
Visit Status – Incomplete – Declined Support
Visit Comments – not wanting anything as stomach is playing up, has soup and left buttered bread, commode emptied by friends prior to my arrival.

19 January 2020 AM visit – AB
Visit start time - at 07:30 hours
Visit end time – at 08:00 hours
Visit Status – New
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete

19 January 2020 PM visit – EF
Actual visit start time - at 17:23 hours
Actual visit end time – at 17:55 hours
Visit Status – Incomplete – Declined Support
Visit Tasks – Cook Main Meal/Pre Prep Meal – Incomplete

Visit Comments – daughter coming up for dinner later

20 January 2020 AM visit – GH
Actual visit start time – at 07:37 hours
Actual visit end time – at 07:54 hours
Visit Status – Incomplete – Declined Support
Visit Tasks – Getting Dressed – Incomplete
Personal Hygiene (Wash/Shave) – Incomplete
Preparing Food Snack – Incomplete
Breakfast Provision – Incomplete
Visit Comments – Davie declined personal care

20 January 2020 PM visit – IJ
Actual visit start time - at 17:21 hours
Actual visit end time – at 20:48 hours
Visit Status – Incomplete – Other
Visit Tasks – Cook Main Meal/Pre Prep Meal – Incomplete
Visit Comments – Phoned ambulance for David as feet all infected, phoned David's Doctor to see if he had any doctor visits and was told no but David had said Doctor was out and gave antibiotics for leg and that Doctor said he had norovirus, David taken to hospital.

25. That Home Care Workers received information in relation to Mr Ainsworth to their Samsung work mobile telephones via the mCare App. The app contained the schedule for the individual worker. If the Home Care Worker clicked on Mr Ainsworth's name, it would bring up his risk assessment and care plan. Mr Ainsworth's front door key was kept in a keysafe that Home Workers would access in order to obtain the key and access the property.

26. That Crown Production 84 is a true and accurate copy of the user instructions in relation to the mCare App, which can be entered into evidence without the need to be spoken to by a witness. In particular, point 15 of the user instructions notes as follows: -

'*Tap each task to indicate that it has been completed.*
A green tick will appear alongside the task.
If you have not completed a task DO NOT tap the task. It will remain un-ticked.
If you have not managed to complete all the tasks, tap the Incomplete Visit button.
A list of reasons will be displayed.
Choose a relevant reason from the list by tapping on it or tap other where you can enter details of why the task could not be completed.
If ALL tasks have been completed then tap the End Visit button.
The following message will then appear.

Ending Visit
Are you sure?
Tap YES'

28. That Crown Production 85 contains true and accurate copies of the following South Lanarkshire, Health and Social Care, Social Work Resources documents, said documents can be entered into evidence without the need to be spoken to by a witness: -

'Tasks and activities not to be undertaken by Home Care Workers'
It is noted that the above document should be read in conjunction with the Job Description for the position of Home Care Worker and emphasise specific tasks which the Home Care Worker is not permitted to undertake.

'Food Preparation at the service user's home'
'This document outlines the procedures and precautions which should be followed to ensure the safe and hygienic preparation of food at the service users' home'.

'Suspected Service User Self-neglect'
'This document outlines the actions to be followed if the home care worker has a concern about a service user and what to do when the service user continually declines offers of support which could be attributed to service user self-neglect.'

Under the heading '**What is self-neglect'**, the document notes the following information: -

'*Self-neglect occurs when an adult or older person, by choice or due to a lack of awareness or ability lives in ways that disregards his or her own safety. This can also happen when he/she refuses support with care needs or help with daily activities.*

Examples of self-neglect include inadequate personal hygiene, not taking prescribed medication, poor and unsafe living conditions, lack of heat and proper nutrition.

Self-neglect may occur in conjunction with other issues such as alcohol or drug problems, mental health challenges and/or dementia.

Self-neglect can also occur when a person suffers a temporary inability to manage their self-care or environment. They may be embarrassed to seek help or accept help because they see it as a personal failure to manage for themselves. Situations such as this need a sensitive response from agencies to support the person, maintaining their dignity, whilst restoring them to their previous standards.'

One of the points noted under the heading 'Indicators associated with self-neglect' reads: -
'*refusing to allow access to health and/or social care staff in relation to personal hygiene and care'*

29. AB and GH were first assigned to Mr Ainsworth in August/September 2019. In relation to the tasks allocated to the home care workers Ms. AB noted the following, *'the daily tasks each day would be in relation to personal care. I used a keysafe and would let myself in. Daily tasks included in the morning would be bathing or showering, breakfast provision which would be his breakfast left for him to eat and also a lunch left for him that was all morning and in the afternoon was different Carers*.'

'*The tasks that I have detailed were the ones we were supposed to do on our schedule but David would never let me help with bathing or showering, he always declined, he said he would do it himself. When I would attend it would be half past seven in the morning, he would always be sitting on the couch, sometimes he would be awake and sometimes he would just wake up when I went in. I never seen him on his feet. I never saw any signs that he wasn't capable of washing himself like he told me he would. He appeared clean to me, nothing that I seen or could smell to show that he wasn't washing himself. I thought he didn't want me to help wash because it was early morning and he was a young guy. Each day I updated the app to show that David wasn't wanting help with bathing/showering. He had refused this each time from me*.'

'……..*I visited David about half past seven in the morning. David was always on the sofa, he never used a bed but that is quite common with service users. David said he was more comfortable on the couch, as far as I was aware David was mobile there was nothing to tell me otherwise, there was nothing in the care plan to suggest this.'*
'*Each day I'd always ask if he wanted to wash and he would always say he would do it later. I'd talk to him and find out what he fancied for his breakfast and lunch. He would always stay on the sofa and have a blanket covering him. I couldn't see any of him apart from his shoulders upwards, I can't remember exactly what he would have on his top half, I think it was just T-shirt. Sometimes he would be shaved and other times he would have stubble*.'

30. That Crown Production 99 is a redacted copy of GH's police statement. In her statement GH confirmed the evidence of AB and stated, '*David always slept in his living room on a corner couch. That was his choice, he preferred that……On entering the house, I would say his name loudly to waken him up. That is the protocol. David would have a T-shirt on and his duvet over him and he would it up with his feet on the floor. I have never seen David walking or standing up, anything like that. I have only seen the upper part of his body. The only thing I noticed about recently was he seemed to be growing some stubble.*

'David did his own Personal Care. I never at any time thought he needed a wash. I certainly never smelled any odour from him. As I say, the commode was the main smell in his house. Breakfast, which would be his choice, and we would make what he wanted cereal or sandwich but he would never eat it in front of you, he would say he would eat it later.'

31. In AB's view Mr Ainsworth was getting lazy, allowing packages that he'd ordered and other items to lie on the floor etc but other than that she had no concerns for him and had reported her views on his laziness to the office in December 2019 and suggested that it might assist if Mr Ainsworth was reviewed by an Occupational Therapist. In relation to his health, AB noted she had no concerns apart from the time Mr Ainsworth had a 'tummy bug'. Mr Ainsworth had told her that the Doctor had phoned him and that he (Mr Ainsworth) had norovirus. However, Mr Ainsworth was still eating and referring to his medical condition as '*a wee tummy bug*'. AB had noted the issue of the 'tummy bug' in Mr Ainsworth diary on the second day he had mentioned it to her. AB noted in her statement, '*he didn't seem that ill with it, he was chatty enough. I think at the same time as the tummy bug I noticed that the commode was empty each morning, I asked David about it and he said his friend and his wife had been in on the way to work and emptied it. I didn't ask their names, I've never met them. I didn't see them there, I assumed they had been in before I started. I noted it in the diary that the commode had been emptied by friends.'*

32. AB thought it strange that Mr Ainsworth had only phoned the doctor and hadn't seen the doctor and had noted in Mr Ainsworth's diary that he could have norovirus but was still eating. The last me AB saw Mr Ainsworth was the morning visit on Sunday 19 January 2020. In AB's view he presented to her the same as he had at all her previous visits. Mr Ainsworth was still eating and had no complaints.

33. The last time GH saw Mr Ainsworth was Monday 20 January 2020 for the morning visit. GH noted in her statement, '*I let myself in as I usually do and as I entered carried out the usual Protocol saying loudly "Morning David, it's G, your carer."*

34. GH went on to describe the visit as follows: -

'*On entering the living room, David was sitting up on the couch. The way he always is. He had on a T-shirt and his duvet was round him. I couldn't see any of his body apart from his upper half which was partially covered by the quilt. I asked him how he was and he said he had been in contact with the Doctor as there was a virus going about, he was advised to drink plenty of water. I then asked him what he wanted for eating and he said*

not much, but I heated him up a tin of soup which I put into his flask. He said to me, " ***Did you notice ma hall smelling nice****". I said I did and he pointed to a fragrance device he had sitting on the mobility scooter in his hall. He didn't mention where he got it, he didn't ask me to do anything else, apart from giving him a black throw. That was lying on the end of his couch. I lifted it and placed it beside him. I then put my jacket on and left"*

35. That Crown Production 98 is EF's redacted police statement. EF visited Mr Ainsworth on 4 occasions, in particular on 18th and 19th January 2020, when she covered the evening visit to Mr Ainsworth's home. EF noted that Mr Ainsworth would usually be sitting on a settee in the living room. When sitting on the settee, EF noted that Mr Ainsworth would have a blanket around him covering him from the waist down. Additionally, EF noted that she was aware that Mr Ainsworth was a smoker and that he would stand at the back door smoking. EF knew Mr Ainsworth should not have been smoking as he was on oxygen and gave him a row.

36. On Saturday 18th January 2020, EF attended Mr Ainsworth's property for the evening visit. EF stated in her statement that the first thing that struck her was the smell as she entered the property. Mr Ainsworth was sitting in his usual place on the settee and EF noticed brown markings on the settee, which Mr Ainsworth explained to her was chocolate. He told EF that his daughter would be coming to the house later to clean it. EF noted in her statement, '*I remember having a conversation with him regarding the terrible smell in the house, it was actually sickening. David said he couldn't smell it. He said if there was a smell it must have come from the commode that had been emptied as he said by his pals who had just left. I had a conversation with him about getting some air fresheners. He said he would tell his daughter to bring some up as she was getting his shopping that night. The only thing David complained about was having a sore stomach*'.

37. The last time EF saw Mr Ainsworth was on 19th January 2020 when she attended his property for the evening home care visit. EF noted this was basically a repeat of the previous evening and the smell in the living room was still there. EF was told that Mr Ainsworth daughter had not come to visit on the Saturday evening as his granddaughter had hurt herself. Mr Ainsworth refused his dinner and told EF that there was nothing in the commode to be emptied and that his daughter was coming over to visit on the Sunday night and would take care of things. EF told Mr Ainsworth to press the alert to activate home care emergency services if his daughter didn't attend that night. EF updated the diary and left the property.

38. That Crown Production number 100 is the police statement of IJ It is noted that IJ's first home care visit to Mr Ainsworth was on 12 September 2019. In her

statement IJ noted she was always rostered for the evening visit to Mr Ainsworth. Prior to attending at Mr Ainsworth's property for her first visit, IJ was provided with information regarding Mr Ainsworth's health, which included reference to his diagnosis of COPD and having breathing difficulties. The information also referenced his recent hospital admission. In her statement, IJ provided the following description of Mr Ainsworth property at the date of her first visit to him :-

'*the house seemed okay, not too untidy but it was like a house of a man living on his own. There was a fish tank in the living room but no fish in it. he had things roundabout him, a table near the couch, a commode, his television on a unit, a quilt over him. There were clothes and some pillows near to him, a shaver, some letter, he had a kettle near to him too. He also kept boxes of crisps on the couch*'

39. IJ noted that over time, '*the pile of things got bigger'* with Mr Ainsworth ordering goods online which resulted in boxes, '*lying about'*. When she first started her caring role with Mr Ainsworth, IJ would encourage him to get up and making something to eat but he told her he had COPD. Mr Ainsworth had a Zimmer, but did not use it and, despite encouragement from IJ would remain sitting on the couch when IJ attended for the evening visits. Mr Ainsworth would use the commode instead of using the toilet which was situated upstairs.

40. Mr Ainsworth ordered microwave meals which IJ and the other evening carers would heat up for him and leave for him to eat. Mr Ainsworth would wait until the home care worker had left before he would eat his meal. The evening care worker would clear away and clean the dishes used during the day. Although this was not one of their duties the home care workers who assisted Mr Ainsworth would clean dishes and tidy up the kitchen. IJ would also take clothes off of the radiators and fold them, which was in addition to her allocated duties.

41. In terms of Mr Ainsworth's mobility IJ was aware of the information on her phone noted COPD. Mr Ainsworth was given a trolley to assist him with accessing the kitchen and to transport items between the kitchen and living room.

However, when the trolley was provided Mr Ainsworth stated to IJ that, '*his knees were sore'* and never used the trolley which had been provided to assist him. IJ escalated this issue to her co-ordinator.

42. IJ had not been aware of Mr Ainsworth smoking within his property until on 20th January 2020 she saw all the '*used ends of rolled cigarettes under the quilt where David had been sitting, there would have been about a hundred cigarette ends that had*

been smoked.' IJ was aware of the dangers of smoking in close proximity to oxygen tanks and would not have allowed Mr Ainsworth to smoke in the house if she had known what he was doing and she would have escalated to her coordinator.

43. IJ was unaware of Mr Ainsworth's previous issue with alcohol. She had never seen smelt alcohol on Mr Ainsworth's breath, nor had she seen empty alcohol bottles or any alcohol bottles in the cupboards at Mr Ainsworth's home.

44. In January 2020, in her capacity as a home care worker, IJ attended Mr Ainsworth's property, for the evening visit, on the 2nd, 3rd, 11th, 12th, 16th and 17th. IJ noticed a change in Mr Ainsworth's appearance on the 11th. Mr Ainsworth explained he'd had norovirus, which had been diagnosed by his doctor, and that the doctor told him not to eat and consequently Mr Ainsworth only want water. IJ noted the lower half of Mr Ainsworth's body to be covered by a quilt, and that Mr Ainsworth was wearing a t-shirt on the top half of his body.

45. Mr Ainsworth continued to refuse food on the 12th January and only wanted his water bottles filled. IJ noted Mr Ainsworth was wearing the same tshirt as the previous day.

46. CD worked the evening home care visit as job share with IJ. During her time looking after Mr Ainsworth CD never smelt either alcohol or smoke, although she noted the living room window was always open. On one occasion on either the 6th, 7th or 8th January 2020 did CD smell and odour emanating from the hallway of Mr Ainsworth's home. Mr Ainsworth told her that the morning visit home care worker had spilled the contents of the commode and his daughter had cleaned it up. CD noted there was an air freshener in the living room. The support plan did not include emptying the commode, but CD stated, '*I would never as a carer leave anyone with a full commode whether or not it was on my task sheet. That's just basic duties as a carer, it's about looking after everyone.*'

47. On or around week commencing 6th January 2020 Mr Ainsworth told CD he had had Norovirus and that the Doctor had been out to diagnose him. Mr Ainsworth refused his evening meal and CD noted, *'I didn't think David looked well facially'*. The next time CD visited Mr Ainsworth was the 13th and 14th January 2020. Mr Ainsworth was looking better and was more 'chatty'. At the evening visit on 14th January, CD offered to assist Mr Ainsworth with showering but he refused her offer of assistance. CD had experience of caring for people who had bed sores and gangrene and noted, '*I never once smelled open sores from David. He was never out of breath, which I thought strange if he had COPD, as I know it's very tiring and you wheeze, which he didn't do.*'

48. CD confirmed she had never seen Mr Ainsworth get up or walk about and that he preferred the carers to leave the food covered in tinfoil once they had heated it up. CD was aware that Mr Ainsworth lived in the living room. She described the living room as follows, *'the only light in the living room was his fishtank, he didn't have the ceiling light working so the room wasn't well lit. There weren't any fish, just water in the tank.*'

49. On 15th January there was a 'Patch' meeting which was attended by carers and co-ordinators. At the meeting IJ advised everyone that Mr Ainsworth had norovirus and was told she shouldn't have attended at Mr Ainsworth's property and that she should have advised the co-ordinators of Mr Ainsworth's illness. IJ had been unaware that she should have reported Mr Ainsworth's illness to the co-ordinators or that she should not have attended at Mr Ainsworth's property.

50. When IJ attended at Mr Ainsworth's property on 16th and 17th January, she noticed he was still wearing the same t-shirt he had worn at her previous visit on 12th January. Mr Ainsworth told her he was feeling better, but he was still on the couch with the quit over the bottom half of his body. He said his friends had emptied the commode and that his daughter and her husband would be attending and they would help him get a shower. He refused IJ's offer of assistance to freshen up. Although he agreed to having food prepared IJ did not see Mr Ainsworth eat anything. When IJ commented on Mr Ainsworth wearing the same t-shirt as her last attendance on the 12th January, he told her he would get changed when his daughter arrived. IJ noted, '*He seemed okay, like he was getting over the virus, he was asking for a meal, he was talking away and didn't seem any different. The only thing was his personal hygiene, he still had the same t-shirt on and said he had been showering but to me it seemed like he hadn't been washed. He was insistent that his daughter was coming to help him"*.

51. IJ was next on shift on 20th January 2020. IJ telephoned the home care co-ordinator and asked her to contact Mr Ainsworth's daughter, Marion Gillan, to advise her that Mr Ainsworth's personal hygiene seemed to be slipping and to ask her to visit him.

52. When IJ arrived for the evening visit to Mr Ainsworth's property, Mr Ainsworth told her he wasn't feeling too good and told her he wanted to go to the hospital. Mr Ainsworth told IJ that the doctor had been out to his property that morning as he had a sore foot. IJ asked Mr Ainsworth if she could look at his leg, although reluctant Mr Ainsworth, pulled back his quilt. IJ noticed there were tartan checked shirts wrapped around both legs. On lifting the shirt from his right leg, IJ noticed the right leg was bare, but the left leg was in the leg of Mr Ainsworth's jeans. On the right leg IJ at approximately three to four inches

above the right ankle, something moving. The lighting in the living room was very poor and IJ was uncertain but thought it might have been ants she saw on Mr Ainsworth's ankle. There was no odour emanating from Mr Ainsworth's leg and Mr Ainsworth did not appear to be in pain.

53. IJ contacted the out of hours social work service and explained what had happened and obtained Mr Ainsworth's GP practice telephone number. On telephoning the GP surgery and speaking with the receptionist IJ discovered that there had been no previous doctor visits to Mr Ainsworth's property. As there were no doctors available for home visits at that me, the receptionist suggested IJ telephone an ambulance, which she did. The call handler advised IJ that the details of the call would be passed to NHS 24. IJ then telephoned the home care team who worked as a pair and asked them to attend to assist her in clearing around where Mr Ainsworth was sitting.

54. On arrival at the property of the double team, the three home care workers set about moving tables, boxes and other items away from Mr Ainsworth. They then removed the other shirts from around Mr Ainsworth's right foot and put the shirts in bin bags. IJ had the experience to realise that Mr Ainsworth's foot was badly infected and there was a smell of urine. It became obvious to IJ that Mr Ainsworth had been passing urine onto the seat of the couch.

55. Due the extent of damage to the right foot, IJ telephoned 999 and advised the operator that she needed an ambulance as this was now an emergency situation.

56. Whilst awaiting the ambulance the three home care workers cleared the shirts from around Mr Ainsworth's left leg. He still had the left leg in the leg of his jeans and was wearing a black sock. As his foot looked swollen the care workers did not remove the sock. The shirts on Mr Ainsworth's left leg were also wet. Mr Ainsworth said he was sorry and told the workers that he shouldn't have hidden his condition from them. The paramedics arrived approximately an hour after IJ's first phone call.

57. When Mr Ainsworth was discharged from hospital in August 2019 the Rapid Response Team provided care to Mr Ainsworth until regular home care workers were identified. These team members: -

EE
FF
GG

None of the Rapid Response Team had concerns for Mr Ainsworth. They saw him mobilise with his zimmer or standing. Mr Ainsworth would have already washed prior to the team members arriving at his property. None of the response team saw Mr Ainsworth smoking within his property.

58. Between August 2019 – 17 January 2020 the following home care workers a ended at Mr Ainsworth's property:-

HH
II
JJ
KK
LL
MM
NN
OO
KL
MN
PP
QQ
RR
SS
TT
UU
VV
WW
XX
IJ
CD
GH
AB
EF

Apart from JJ who visited Mr Ainsworth on two occasions, 30th November 2019 and 1 December 2019 and saw him walking out of the bathroom, the aforementioned home care workers did not see Mr Ainsworth on standing or mobilising with his zimmer. When the home care workers attended Mr Ainsworth would be sitting on the couch and would usually have a quilt over him. None of the workers were aware that he smoked and none of them saw him eating within their presence. Mr Ainsworth always refused personal care but was always dressed and clean. There was never any unusual smell within the property apart from the usual smell from a used commode. The house was

described as clean and tidy and there were no concerns for Mr Ainsworth until January 2020, as noted above.

Social Work

60. That Crown Production 14 is a reflection and planning document in relation to the care package completed by AA, South Lanarkshire Council, (hereinafter referred to as Social Worker AA) Social Work Department following a meeting in person with Mr Ainsworth on 20 September 2019. Said document is agreed and can be into entered into evidence without the need to be spoken to by a witness.

61. In particular Social Worker AA has noted the following at electronic page 239: -

'*Personal car/hygiene - Wet floor and shower chair in place to support when showering. Homecare do not support with this and David does not feel he needs assistance in this regard. He is able to mobilise to the bathroom with the zimmer, transfer to his shower chair independently, and then mobilise to a seat to dry himself. David has noted there has been occasions in the past that the joint pain in his knees has increased and he has crawled to that bathroom, or gone without showering, but he is unable to clarify how frequently this occurs.*

Health and wellbeing – David is mood is generally positive and he retains full capacity to make decisions regarding his wellbeing. He can become frustrated at his current health situation and his inability to access the community at present. David confirmed during a homecare assessment that he continues to smoke occasionally in his back garden, despite the presence of his home oxygen tank. He reports that he is aware of the risk and turns the oxygen off before going into the garden, closing the kitchen door and the back door behind him.

Skin care – David has no skin care issues currently.

Nutrition – David is currently supported in preparation of all meals by the homecare staff, as David was not able to stand to prepare a meal and transfer it to his living area. A kitchen trolley was ordered to assist with this and encourage David to regain his independence, however to date he does not feel able to use this due to joint weakness in his knees. An occupational therapy assessment is planned to identify further areas of support in relation to David's ability in the kitchen. Homecare staff make breakfast during the morning visit and prepare a lunch for the afternoon, then visit again in the evening for his main meal. They also leave lots of fluids for David throughout the day.'

At electronic page 240 Social Worker AA has noted: -

'In August 2019, David had a fall in his home and suffered a pelvic fracture to his pubis bone. He spent 2 weeks in hospital before being discharged with homecare assistance from South Lanarkshire Council carers whilst he attempts to regain his mobility. He currently states he is unable to access the community using his mobility scooter and as a result spends all of his time in his home'

Under 'Reflection on Practice' Social Worker AA has noted: -

'L10 assessment not completed as David reported a change in his circumstances (decrease in mobility) after the information had been gathered. Referral made to Occupational Therapy to identify other potential supports in relation to daily living tasks.'

At that date the plan identified by Social Worker AA was noted as: -

'*Prior to David's admission for his pelvic fracture he was independent in relation to all aspects of daily living and he has expressed a hope that he will be able to return to this. Initially it had been felt that the use of a kitchen trolley would remove the need for homecare. Unfortunately, the provision of the kitchen trolley coincided with a decrease in David's mobility and he no longer felt that would be sufficient to allow him to prepare meals independently.*

Future plan will involve:
- An assessment by an occupational therapist to identify further supports to enable David to regain his independence
- Should no further suitable support be identified and David remains unable to complete meal prep independently, L10 assessment required".

62. That further reviews were carried out in relation to Mr Ainsworth by Social Worker AA on 25 October 2019. This was a visit to Mr Ainsworth's home address to begin the process for self-directed support which would determine the level of support required by Mr Ainsworth. On completion of the assessment Mr Ainsworth advised Social Worker AA of his ability to support himself with the exception of moving his meals from kitchen to the living room and also the preparation of meals and snacks. He advised Social Worker AA that he ordered his food shopping online and that his daughter (Marion Gillan) would collect it and deliver it to his home address. Mr Ainsworth also advised Social Worker AA that Ms. Gillan would come to the house once or twice a week to tidy up. Mr Ainsworth disclosed he was independent for washing and showering and would use the shower seat. Mr Ainsworth advised Social Worker AA that he would use the commode during the night if he felt he couldn't make the bathroom in time.

63. On the 22 November 2019 a review was carried out by YY, Community Support Co-ordinator, South Lanarkshire Council. This review included an individual risk assessment.

64. That Crown Production 23 is a redacted copy of Mr Ainsworth's service user's diary which was retained within his home. A copy of the signed service user agreement dated 24 December 2019 and signed by Mr Ainsworth and YY is found at electronic page number 389 of the production.

65. In her statement AB noted, '*Each service user has a diary at their house which each Carer completes at each visit. It is a folder with the service users details in it and their detailed care plan and there are printed South Lanarkshire Council diary sheets that me as a Carer will complete with the tasks that I done, the time I'd go in and the time I'd leave and maybe mark down if they weren't feeling too good so that the Carer can see it for the next visit, the details of the tasks would include if we had given meals. The diary is for everyone to help out the next Carer and can let the family know what has been done.*'

66. In terms of any concerns AB may have for a service user she noted, '*Concerns raised are normally always done by phone. I don't record them anywhere, minor concerns would be noted in the service user's diary mostly just felling a bit under the weather, just minor things"*.

Care Inspectorate

67. In November 2019 Hamilton Home Care Services received a Type 1 inspection from the Care Inspectorate. As part of the inspection 54 service users were visited, including Mr Ainsworth. On 28 November 2019, Deborah Findlay, Care Inspector (hereinafter referred to as Care Inspector Findlay) with the Care Inspectorate, visited Mr Ainsworth at his home in conjunction with his assigned allocated carer for that day, TT. On conclusion of that visit Care Inspector Findlay aired concerns she had about Mr Ainsworth's care with South Lanarkshire Council by email dated 28 November 2019.Due to the concerns raised by Care Inspector Findlay further review was carried out by YY on 29 November 2019. The issues raised by Care Inspector Findlay were discussed with Mr Ainsworth and adaptations to his home care arrangements were made to address those concerns. Social Worker AA visited Mr Ainsworth again on 12 December 2019 and further discussion were held in relation to his care package.

68. Operations Manager ZZ was never asked by any Care Inspectorate staff members to complete and submit an Adult Protec on Form ("AP1").

69. On 8 January 2020 Mr Ainsworth indicated to social workers and carers that he had a stomach bug/norovirus and had been prescribed medication by his general practitioner following a home visit.

70. On Friday 17 January 2020 IJ, Home Carer, noted that Mr Ainsworth to be wearing the same t-shirt as at her previous visit. Mr Ainsworth insisted he had been washing and that his daughter had been coming to his property to assist him. On 20 January 2020 Home Carer IJ telephoned care co-ordinator AAA to ask if Mr Ainsworth's daughter could be contacted and made aware that his personal hygiene seemed to be slipping.

Views of Mr Ainsworth's Next of Kin

81. That the redacted police statement of Marion Annette Gillan, obtained by Police Constable Jennifer Given on 21 January 2020 at 16:16 hours, Production 96A for the Crown is to be admitted into evidence and treated as if it were the parole evidence of Marion Annette Gillan.

82. In particular Ms. Gillan noted in her statement dated 21 January 2020 the following:

"In the past I have raised my concerns with dad regarding his care and general health, however dad has an ability to dress up the truth to suit himself and is a compulsive liar and has told me he has sorted things himself and/or has contacted the doctor himself but I've found out this hasn't been the case"

"In my opinion at that time dad's house was bad very bad. It was unhealthy for him to live like that. I actually think dad has played a part in this via self-neglect. I say this as 3 weeks ago and even yesterday he told me he didn't want to be here anymore."

83. That the redacted police statement of Marion Annette Gillan, obtained by DC Shona Baird on 3 February 2020 at 10:55 hours, Production 96B for the Crown is to be admitted into evidence and treated as if it were the parole evidence of Marion Annette Gillan.

84. In particular Ms. Gillan stated the following:
"I last saw my dad about 10 o'clock at night on Sunday 19th January 2020. I always visited my dad at the weekends, every Saturday or Sunday and usually took my ….year old daughter …..with me. I usually spent an hour or two with him."

"I dropped off his shopping to him which is normal and gave him a bottle of water. He was just acting normal and he was quite upbeat. I asked him if he was ok, which is normal and he said he was fine."

"There was a strong smell of urine in the living room but that is not unusual because the commode was always sitting in front of him"

"……..I didn't smell any faeces in the living room."

20 January 2020

85. On 20 January 2020 Scottish Ambulance Service received a call at approximately 18:07 hours to attend at X, the home address of David Ainsworth. The complaint was noted as *'Male – not been eating or drinking – foot is infected*' with the call being allocated at 18:52 to paramedic UV, who was working night shift on the Paramedic Response Unit (PRU). This is a first response service, in a single manned car. The call in relation to David Ainsworth was classified as a 'yellow call'. The information given to Paramedic UV was of a 59 year-old man with white feet.

87. On attending at Mr Ainsworth's home address and assessing Mr Ainsworth's medical condition, Paramedic UV asked for an ambulance to attend the property. Paramedic UV advised SAS control that the crew attending should wear personal protective suits. At approximately 19:00 hours Ambulance Technicians QR and ST were tasked to attend at Mr Ainsworth's home address to assist Paramedic UV and to transport Mr Ainsworth to hospital.

90. Whilst on route to assist Paramedic UV, the Ambulance Technicians were updated by SAS control and advised that Mr Ainsworth had severely ulcerated feet that were necrotic and that maggots and flies were on the wounds and that the living conditions within the said property were poor.

91. The Ambulance Technicians brought the trolley bed from the ambulance into the living room at the said property. Technician QR donned his personal protective suit prior to entering the said property. He observed Mr Ainsworth's legs to be necrotic, discoloured and there were maggots and flies around the wounds on his legs. Mr Ainsworth was covered in faecal and urine around his waist area with his t-shirt being stuck to his skin due to this. SAS staff required to cut Mr Ainsworth's clothes off to protect his skin.

92. All three SAS staff were required to lift Mr Ainsworth onto the trolley bed as he was unable to stand. He was then taken into the ambulance. As Mr Ainsworth was being put into the back of the Ambulance, Paramedic UV telephoned Hairmyres Hospital to let them know they were bringing Mr Ainsworth to A&E. On arrival at Hairmyres Hospital the Ambulance Crew transferred Mr Ainsworth onto the hospital trolley whilst Paramedic UV spoke to the hospital staff and completed the paperwork. On returning to their base

station the Ambulance crew required to decontaminate the vehicle and equipment before showering and changing prior to resuming their shift.

Attendance at Hairmyres Hospital

94. Mr Ainsworth was registered at Hairmyres Hospital, A & E Department on 20 January 2020 at 20:15 hours. The presenting complaint was noted as 'Self neglect. Ulcerative legs and both feet. Maggots and flies to both feet necrotic flesh evident. Appears unkempt and in pain. Carers x 2 a day but has been refusing help.'

95. That Crown Production 107 is a statement taken from Dr WX, Physician Associate by Police Officers DC Caroline Howatt and DC Gary Marshall on 31 January 2020 at 11:49 hours. Said statement can be entered into evidence without the need to be spoken to by a witness and should be taken as Dr WX's evidence. In particular Dr WX's statement notes: -

'I was aware that Mr Ainsworth was brought to hospital by ambulance earlier that day. This was due to concerns raised by one of his carers regarding wounds to both of his legs and feet and according to Mr Ainsworth he had been concealing those. It was Mr Ainsworth who told me that he had been concealing the wounds to his legs and feet. He told me that he felt he had made a big mistake by concealing these from his carers and his daughter.'

96. Dr WX noted that Mr Ainsworth seemed generally 'very well apart from the obvious odour from his legs'. In relation to the wounds on Mr Ainsworth's leg, Dr WX was noted as stating: -

'Mr Ainsworth was quite vague when speaking about the wounds on his legs. He couldn't say how long they had been there, he just said they had been there for a while. It appeared they had just been getting progressively worse, Mr Ainsworth wasn't aware how the wounds had started but they were becoming more painful which is why he raised this problem to the carer that day. Mr Ainsworth didn't mention anything about his personal hygiene care or what he had been doing about these wounds. From my impression I believe he was quite embarrassed about letting the wounds get to this stage.'

Mr Ainsworth was referred for Vascular Surgical assessment for a viability assessment of his limbs.

97. Mr Ainsworth was admitted to Ward 3 from A&E at 01:30 hours on 21 January 2020. The reason for admission was noted as 'Self-neglect'.

98. Dr YZ, Consultant Vascular Surgeon at Hairmyres Hospital, provided

a statement, dated 14 May 2020 to DC Lynne Begg, Major Investigation Team in relation to his review of Mr Ainsworth on the morning of 21 January 2020. Crown Production 108 is a copy of this redacted statement and can be entered into evidence without the need to be spoken to by a witness. Said statement should be taken as the evidence of Dr YZ. The medical notes Dr YZ refers to within his statement are contained within Crown Production 26 at electronic pages 498 and
501.

99. In particular Dr YZ noted in his statement: -

"I reviewed the patient on the morning of 21.01.20, along with my colleague BBB (Consultant Vascular Surgeon). Our impression was that Mr Ainsworth was extremely unwell with significant bilateral ulceration which was extremely extensive, circumferential and with evidence of larvae within the wound. This was in keeping with a picture of severe ulceration, infection and neglected wounds. It was clear that Mr Ainsworth's lower limbs were not salvageable and therefore our impression was that the only treatment we would be able to offer him would be bilateral transfemoral amputation. However, in view of his significant unwell condition, he required optimisation on and anaesthetic review prior to any consideration of surgery. Mr Ainsworth was subsequently reviewed by one of the physicians Dr CCC (CT2) at 11:35 who felt that the deranged electrolytes were due to adrenal insufficiency due to chronic steroid use and he was reviewed by the Anaesthetic Team as to whether he would be fit for surgical intervention. The opinion of Dr DDD (Consultant Anaesthetist) was that Mr Ainsworth was not a candidate for an anaesthetic in any form and therefore not for any surgical intervention, and he would not be a candidate for escalation to intensive care.

Mr Ainsworth's condition continued to deteriorate, and I discussed with his next-of kin that his condition was extremely poorly and he was unlikely to survive this presentation. They agreed to a Do Not Attempt Cardiopulmonary Resuscitation Order and in the meantime, we would continue with antibiotics and maintain comfort with analgesia. Mr Ainsworth remained unwell and in significant pain and he received opiate analgesia. We subsequently received information from the Microbiologist that he had grown Morganella morganii in blood cultures consistent with severe infection and he was converted to appropriate antibiotics".

100. Dr Emma Goodall was informed by a member of staff on Ward 8 that Mr Ainsworth had passed away and that this would need verified. Dr Goodall verified Mr Ainsworth's death at 10:00 hours on 22 January 2020.

Post Mortem

101. A post-mortem examination was conducted on 7 February 2020, at the

Queen Elizabeth University Hospital, Glasgow, by Forensic Pathologists Dr Julie McAdam and Dr Marjorie Turner. Crown Production number 1 is a true and accurate copy of the said post mortem report which can be entered into evidence without the need to be spoken to by a witness.

102. The cause of David Ainsworth's death was recorded as:

1a: Complications of severe leg ulcers
With potentially contributing causes:

2: Interstitial lung disease
Ischaemic heart disease

103. The Post Mortem report conclusions are contained at page 5 and are summarised as follows: -
'Post mortem examination confirmed the presence of severe full-thickness necrotic leg ulcers, more pronounced on the right. In admission to hospital this man was hyponatraemic and hypercalcaemic (i.e. low sodium and high calcium) and investigations revealed acute kidney injury, thought probably secondary to sepsis. Blood culture in life yielded gram negative bacilli, consistent with systemic infection. The presence of such extensive leg ulcers with associated systemic infection is considered to be the major factor in this man's death.

There are many risk factors in the development of leg ulcers, including severe atherosclerosis (lack of blood flow to the legs) and diabetes mellitus. There is no indication in the clinical history that this man was diabetic and no pathological finding to suggest this diagnosis. Regarding the possibility of chronic leg ischaemia, the abdominal aorta and iliac arteries (in the pelvis, supplying blood to the legs) showed only mild atheromatous disease, but the possibility of severe atherosclerosis (narrowing of the arteries) involving smaller vessels within the legs cannot be excluded. Pressure and chronic immobility are also risk factors.

Elsewhere, there was severe heart and lung disease comprising widespread fibrosis of the lungs consistent with the history of interstitial lung disease and severe atheromatous narrowing of one of the three major coronary arteries. The presence of these pre-existing conditions would have rendered this man more susceptible to the adverse physiological effects of severe leg ulcers with systemic infection.

The adrenal glands were of normal size at post mortem, but it is noted in the clinical history that this man had possibly been taking prednisone daily for a prolonged period of me and, on admission to hospital, the clinical impression was of adrenal insufficiency second to chronic steroid use. It should be noted that chronic steroid use can increase the likelihood of infection.

In summary, the major factor in this man's death is regarded as complications of severe leg ulcers, though pre-existing interstitial lung disease and ischaemic heart disease would have rendered him more susceptible to the adverse effects of such ulcers and resultant systemic infection. Adrenal insufficiency secondary to chronic steroid use may also have been a factor, but this cannot be reliably diagnosed at post mortem.'

Independent Expert Review

106. Crown Office and Procurator Fiscal Service instructed independent expert reviews to be carried out in relation to the death of David Ainsworth and the care provided to Mr Ainsworth by South Lanarkshire Council. Expert reports were commissioned and obtained in relation to health and social care nursing specialities and interventions by South Lanarkshire Council, Social Work.

107. Dr. Jane Douglas, registered nurse, provided an independent report in relation to the Health and Social Care interventions provided to David Ainsworth. Her report dated 21 July 2022, is contained at Crown Production 77.

108. South Lanarkshire Council responded to the above noted report in a letter dated 1 September 2022 from Soumen Sengupta, Director, Health and Social Care. The aforementioned letter is contained at Crown Production 78.

109. Crown Office and Procurator Fiscal Service instructed Dr. Douglas to provide a response to Crown Production 78. Her response dated 23 September 2022 confirmed she was '*satisfied that South Lanarkshire have addressed any concerns raised in the report, and that remedial steps have been taken and these are ongoing and being reviewed to prevent something similar happening again.*' Dr. Douglas's response is contained at Crown Production 79.

110. Crown Office and Procurator Fiscal Service instructed an independent expert review to be carried out in relation to the death of David Ainsworth. An expert report was commissioned and obtained in relation to social work specialities.

111. Dr Martin Kettle, qualified social worker, provided an independent report in relation to the social work interventions provided to David Ainsworth. His report dated 22 August 2024 is contained at Crown Production 80.

112. A response to Dr Kettle's report was received in a letter dated 7 October 2024 on behalf of Professor Soumen Sengupta, Director Health and Social Care, South Lanarkshire Council. This response is contained at Crown Production 81.

113. Dr. Kettle was instructed by Crown Office and Procurator Fiscal Service to consider the Care Inspectorate Report published 3 December 2024 in relation to Hamilton Home Care Service. Dr Kettle produced a supplementary report dated 20 September 2025 which is contained at Crown Production 93.

114. A further instruction was issued by Crown Office and Procurator Fiscal Service to Dr. Kettle to engage him to consider the changes made by South Lanarkshire Council since the death of Mr Ainsworth, to ascertain if the issues raised in Dr. Kettle's original report, dated 22 August 2024 had been addressed in terms of the issue of professional curiosity in South Lanarkshire Council's care of Mr Ainsworth. The supplementary report dated 1 February 2026 is contained at Crown Production 95.

115. Eleanor Wakenshaw, Clinical Nurse Specialist, was instructed by Crown Office and Procurator Fiscal Service to provide an independent report in relation to the wounds and timeframe involved in the development of the aforementioned wounds sustained by David Ainsworth. Her report dated 7 January 2025 is contained at Crown Production 83.

116. In particular in Ms. Wakenshaw's opinion: -

'*It could be considered the reason no odour was detected from Mr Ainsworth's wounds may have been due to the shirts wrapped round his legs, as a barrier which was likely absorbing any odour, and fluid from the wounds.*

After my assessment if the photos and reviewing all the information I received, I agree that Mr Ainsworth had lower limb ischemia. Wet gangrene had developed on the dorsum of both feet, and this was worse on his right foot compared to the left; this can progress quickly i.e. 4 weeks in the presence of any wounds. Medical intervention should be sought immediately as if left intreated, sepsis will almost always develop.

What's more, it was evident from the photos that Mr Ainsworth had developed bi-lateral black heels, which identify as ungradable pressure ulceration, and an ungradable tip of the distal fourth phalanges. Pressure ulcers result from unrelieved pressure over a bony prominence causing cellar death (EUPAP 2023).

Mr Ainsworth also had an ulcer to lateral malleolus of his right lower limb as well as a skin tear identified to the left thigh, which may have occurred when Mr Ainsworth stood from the sofa as reported in a carer's report that his skin was stuck to the sofa.

Finally, he had a deep tissue injury to his left ischial tuberosity, multiple skin breaks on his sacrum likely caused Mr Ainsworth scratching his skin.

> *In general, given the catalogue of evidence, Mr Ainsworth would almost have had some degree of wound/wounds, due to his lack of engagement and equipment, however the timeframe was paramount in these wounds being assessed and cared for appropriately by e.g. the district nursing service, pressure relieving equipment put in place. These wounds may have been less serious or certainly acted on quicker. Although, it was evident that Mr Ainsworth went to great lengths to hide these wounds. Nevertheless, red flags had be raised and should have been investigated in depth, this may have led to a potentially different outcome.'*

[18] Parties agreed that all statements within the Crown Productions are to be afforded the status of a "witness statement" as defined in Rule 4.13 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[19] The Inquiry also had the benefit of productions lodged by South Lanarkshire Council all of which were considered by the Inquiry.

[20] The Inquiry heard oral evidence from five witnesses on 8 and 11 June 2026, namely Eleanor Wakenshaw, Dr Martin Kettle, Dr Jane Douglas, Deborah Findlay and Scott McNeill. I considered them all to be both credible and reliable. Their evidence was not disputed and they gave same in what seemed to me to be a straightforward and balanced way. I accordingly accepted their evidence as credible and reliable.

[21] The evidence of the other witnesses was agreed by way of joint minute and without challenge or dispute as to their credibility or reliability. I accordingly accepted their evidence also as credible and reliable.

Dr Martin Kettle

[22] Dr Martin Kettle, expert in Social Work, gave oral evidence in addition to his written reports to the Inquiry.

[23] In his opinion, a lack of professional curiosity was shown by Social Work in respect of Mr Ainsworth's care. There were a few strands to this. Firstly, Social Workers did not take any steps to investigate or challenge things Mr Ainsworth said about his care arrangements/health and simply took them as facts without investigation or challenge. For example, on 29 November 2019 when YY visited Mr Ainsworth at his home, he told her that he wasn't using the hospital bed he had been given because the bedroom it was in was too dusty. YY simply accepted that and made no effort to go into the bedroom to satisfy herself as to the condition of the room. Dr Kettle's evidence was that she should have asked if she could do so. If Mr Ainsworth agreed, and she saw the condition of the room, she could have satisfied herself as to what he had said and, if he refused, that could have been noted as information for others and for future reference. Secondly, the evidence of health staff at the point of admission to hospital was that Mr Ainsworth's condition at that point had probably developed over a period of time and had not suddenly emerged. It was noted by carers that Mr Ainsworth had often refused parts of his care plan and, in the weeks leading up to his hospital admission, during home visits, carers had observed him to be in the same position ie sitting on the settee. No carer had seen him move during those weeks. Dr Kettle's evidence was that a more assertive approach by carers could have led to an earlier intervention. For example, someone should have asked Mr Ainsworth to walk across the room so that they could get an indication of his mobility. That was not done. Thirdly, in Dr Kettle's opinion, Mr Ainsworth's daughter, who was a significant presence in his life, was not

sufficiently involved by Social Work in his care. She was not involved by them other than on the margins of Mr Ainsworth's care.

[24] In Dr Kettle's opinion, these three issues taken in combination should have triggered consideration of Mr Ainsworth as being an adult at risk of harm which may have led to intervention into his care and condition. However, Dr Kettle's evidence was also that Mr Ainsworth would have needed to consent to being assessed as to whether he was an adult at risk of harm and there was no guarantee that he would have done so.

[25] Dr Kettle accepted that his evidence, at its highest, was that, had consideration been given to assessing Mr Ainsworth as an adult at risk of harm, whilst there was no guarantee that further action would have been taken or led to measures to protect Mr Ainsworth, the likelihood would have been significantly increased. His evidence was that for him to go any further on this point would have been speculation on his part.

[26] Dr Kettle was unable to say that, had Social Work taken all appropriate steps as above, Mr Ainsworth's death could have been prevented. He could only go as far as to say that if all measures been in place, and if Mr Ainsworth had co-operated with his care plan and said assessment, it would have reduced the likelihood of him dying.

[27] Dr Kettle was satisfied that, by virtue of the changes SLC HHCS have made to their service they have sufficiently addressed the concerns raised by Dr Kettle in his Reports.

Dr Jane Douglas

[28] Dr Jane Douglas, expert in Health and Social Care, gave oral evidence in addition to her written reports to the Inquiry.

[29] Mr Ainsworth's care visits began in August 2019. Dr Douglas' evidence was that she would expect an individual risk assessment of the service user to be done before the first visit as it informs the support plan for that person. The individual risk assessment for Mr Ainsworth was not done until 22 November 2019 when it was done by YY of Social Work. On 6 November 2019 TT, carer, reported a concern that Mr Ainsworth was not moving about. In Dr Douglas' opinion, that reported concern should have resulted in a visual skin check being done on Mr Ainsworth. This would also have had an impact on his mobility and therefore also on his skin and should have prompted a skin review being done. Mr Ainsworth had earlier told AA Social Worker that he was in pain and was crawling to the toilet as he couldn't walk there. In Dr Douglas' opinion, this should have triggered a skin review being done.

[30] Dr Douglas' opinion was that, from the carers' notes in Mr Ainsworth's Home Care Diary, there were "soft signs" of a deterioration and change in Mr Ainsworth's presentation during the period from 7 January 2020 to 20 January 2020. Some examples were that although Mr Ainsworth refused the personal care aspect of his care plan and said he was attending to same himself, he was observed to be unkempt, unwashed, he hadn't moved from the settee for some days, and a terrible smell in his property was noted by EF when she attended on 18 January 2020. In Dr Douglas' opinion, it was difficult to understand how some of these soft signs were missed by carers. In

Dr Douglas' opinion, some of these observations should have been escalated by the carers to their co-ordinators but were not. In Dr Douglas' opinion, there was a lack of awareness of these soft signs by the carers. In her opinion the non-escalation of the soft signs by the carers was down to two things, firstly, a lack of training as to recognizing the soft signs and, secondly, a lack of knowledge and or confidence on their part to actually escalate these issues.

[31] In Dr Douglas' opinion, there was a lack of confidence and or competence on the part of the carers to have a conversation with Mr Ainsworth to ask him questions challenging his assertion that he didn't need the personal care part of his care package and that he was attending to same himself. Had these questions been asked, and had Mr Ainsworth co-operated in the discussion, matters may have been escalated and measures taken to benefit Mr Ainsworth.

[32] Dr Douglas did accept that Mr Ainsworth concealed the true position of his self-neglect form his carers and that it is known that self-neglect is challenging for those who are supporting the person and balancing the rights of the person to live the way they choose to live.

[33] In Dr Douglas' opinion, during the period of his illness, Mr Ainsworth was an adult at risk and that his carers should have recognized this from the soft signs of his deterioration and should have raised this with Social Work who should then have carried out that assessment.

[34] Dr Douglas was satisfied that, by virtue of the changes South Lanarkshire Council's Hamilton Home Care Service have made to their service they have sufficiently addressed the concerns raised by her in her Report.

Nurse Eleanor Wakenshaw

[35] Nurse Eleanor Wakenshaw, expert in skin care and pressure ulcers, gave oral evidence in addition to her written report to the Inquiry.

[36] Nurse Wakenshaw was unable to be precise as to the timescale of the development of the pressure ulcers on Mr Ainsworth's sacrum, legs and feet because of his co-morbidities which would also have had a bearing on the developments of the ulcers.

[37] Her evidence was that, also because of his co-morbidities, it would be difficult to say when Mr Ainsworth would have become aware that there was an issue with his legs and feet.

[38] Her evidence was that a pressure ulcer normally starts developing within two hours of sitting in the one position. Once Mr Ainsworth became incontinent or became unable to get up to use the toilet or the commode, the conditions would have sped up the process of infection.

[39] So far as the carers not noticing the smell from the wounds on Mr Ainsworth's legs is concerned, Nurse Wakenshaw said that the smell would have been masked by the shirts that Mr Ainsworth had wrapped round his legs and concealed same from the

carers and that unless the carers had been a healthcare professional like herself, they would not have picked up that there was an issue there.

[40] Nurse Wakenshaw's evidence was that because no skin assessment seemed to have been done whilst Mr Ainsworth was an inpatient in hospital and before his discharge, this meant she had no starting position from which to judge the onset of deterioration and of his skin condition, so she was unable to say whether any intervention could have been made to give a different outcome for Mr Ainsworth.

[41] Nurse Wakenshaw said that whilst she did not know if Mr Ainsworth had any wounds when he left hospital she would have expected that he would have needed equipment for use at home. She did see such equipment in the photographs of the inside of his home she was shown but from those photographs it appeared that he was not using same and so may have been sitting in the same position for long periods of time. This together with other "red flags" such as reports of him not feeling well, of being unkempt etc would have caused her to involve the services of District Nurses in Mr Ainsworth's care.

[42] In Nurse Wakenshaw's opinion, in terms of any intervention, it would have been a case of the quicker the better for Mr Ainsworth but because of the lack of any skin assessment on discharge from hospital, she was not able to say with accuracy when Mr Ainsworth's ulcers developed or when any intervention would have had a difference for his outcome.

Deborah Findlay

[43] Ms Findlay is an Inspector at The Care Inspectorate. The Inspectorate's role is to inspect then inform the public upon the quality and availability of care services. She was involved in that capacity in relation to the care of Mr Ainsworth.

[44] Her involvement began in November 2019 when the Inspectorate carried out an unannounced inspection of SLC HHCS. The Inspectorate chose 52 cases that SLC HHCS were dealing with to inspect. This was from a larger number and Mr Ainsworth was one of the 52 chosen.

[45] On 28 November 2019 she accompanied Mr Ainsworth's carer on a visit to his home. She then had some concerns about Mr Ainsworth's care. There was no copy of his care plan or risk assessment in his home. His carer had a copy on her mobile phone but this lacked detail and some of the detail it did have was incorrect according to the information she had been given by Mr Ainsworth. It seemed from the notes that SLC HHCS understood that Mr Ainsworth's previous admission to hospital (which resulted in them being involved following his discharge) was due to a shortness of breath whereas he had actually been admitted as a result of a fall in which he sustained a fracture. He was sitting on his settee. There were cigarettes on the settee and he had oxygen cylinders. There were cables on the floor from the oxygen equipment which were a trip hazard. He had a kettle next to the settee and next to the commode which was unhygienic. He told her he used his zimmer frame to walk to the back door to smoke there and, although she found that reasonable, it concerned her that the carer did not know he smoked and that he managed his own oxygen.

[46] He told her he was happy with the care he was getting and with his carers. He told her he had support from family. She had no concerns about his vulnerability. She had no concerns about the rooms in the house she went into. Her concerns from this visit were the lack of paperwork that ought to have been in his home about his risk assessment and care plan that wasn't there and the lack and accuracy of some of the detail that was present in the notes. She passed these concerns on to her manager as part of this Inspection.

[47] As a result of the Inspection of the 52 cases, in December 2019 the Care Inspectorate issued an Improvement Notice to SLC HHCS advising of what improvements in they were required to make across their service.

[48] The Inspectorate carried out monitoring visits thereafter to see what progress SLC HHCS had been made in improving their service.

[49] The Inquiry heard evidence that the Care Inspectorate thereafter were satisfied as to the improvements SLC HHCS had made to the service they provided to service users.

Scott McNeill

[50] Scott McNeill is the Service Manager of South Lanarkshire University Health and Social Care Partnership. As such he is the Strategic and professional lead for South Lanarkshire Council's Care at Home Services for adults and older people.

[51] South Lanarkshire Council operate their own Home Care Services for service users and employ other third party providers to do so as well.

[52] When he came into that role in 2019 South Lanarkshire Council were under a high level of scrutiny from the Care Inspectorate following their review in early 2019 of their Hamilton Home Care Services where they were assessed by the Inspectorate as performing poorly. At that time the services given by SLC HHCS was not of a standard that he would have expected them to be.

[53] During the period early 2019 to late 2020 there were a number of Care Inspectorate inspections where their progress was monitored and assessed. The Care Inspectorate served South Lanarkshire Council with an Improvement Notice in that regard on 17 December 2019. Following the poor results in early 2019, South Lanarkshire Council, in close conjunction with the Care Inspectorate, made very significant changes to their working systems to address the Inspectorate's concerns. This task was made all the more difficult by the challenges that the COVID pandemic presented at the time. South Lanarkshire Council, from its highest levels, was fully committed to making the necessary improvements in their Home Care Service including Hamilton Home Care Service. By October 2020 the Care Inspectorate decided that they had fully complied with the Improvement Notice.

[54] The changes made by South Lanarkshire Council were numerous. Some of them are as follows. He was appointed as Service Manager and brought considerable experience to the role. Further significant changes were made in personnel in the management team. Managers who were high performing in their other services were moved into Home Care. Significant retraining of Managers was undertaken. The

Council commissioned an independent review of their Home Care service and had regard to the outcome.

[55] He invited the cares involved with Mr Ainsworth to attend a reflective learning review following Mr Ainsworth's death. Colleagues from other agencies such as Housing and Health were also involved. The review was an opportunity for those involved to go through the chronology of events in a supported way and to identify learning opportunities as a result all with a view to improving the Home Care model.

[56] Home Care staff were retrained in dealing with non-engaging adults with a focus on self-neglect. New protocols were introduced to ensure that staff can spot same and are aware of their responsibilities about escalating any concerns they have and how to escalate those concerns in a supported way to co-ordinators.

[57] Staff were trained on a much wider and detailed way on the issue of adult support and protection and a protocol for assessing and reporting such concerns was introduced. The management was restructured to ensure that a manager was available from 6.30 am to 11.00 pm every day of the year for Home Care staff to reach out to with any such concerns whereas staff had previously to report such concerns to the out of hours emergency social work service which had been established to address public protection concerns at large and who often couldn't cope with the calls they were getting from Home Care given the volume of calls they were getting about their general public protection concern commitments.

[58] They developed an App which was put on the Home Carers' mobile phones which allowed them quick and easy access to information, support and guidance on

adult support and protection. This was rolled out across Home Care staff and it has proved to be so successful that it is now used all over Scotland.

[59] Home Carers also now use a different App produced by the Scottish Social Services Council about Skin Breakdown which also gives quick and easy access to Home Carers on their mobile phone about this issue.

[60] Systems were altered to a collaborative approach with other agencies when dealing with matters such as Occupational Therapy Assessments.

[61] Dr Douglas' Report on Tissue Viability was very helpful to South Lanarkshire Council and they endorsed and accepted her findings. It showed that the Council's approach to skin care was superficial. Dr Douglas referred to the need for risk assessments to be done and, in hindsight, South Lanarkshire Council recognize that they did not have that in their armoury. As a result, they adopted the Waterlow process referred to by Dr Douglas and staff now have the ability to identify risks re tissue viability and to escalate any concerns.

[62] The Council have introduced a Safety Huddle each day where managers from various services such as Home Care, Social Work, Fieldwork and District Nurses come together to discuss any concerns about any service user eg about lack of mobility, so that regardless of whether the individual involved is known to every service, discussion about them by one service can trigger others becoming involved with that individual.

[63] The Council now place a great deal of focus on staff being able to recognize "soft signs" of deterioration in service users' health/condition and the need and confidence in

them asking the necessary questions to properly satisfy their duties of professional curiosity in that regard.

[64] In May 2026 the Council introduced a new electronic case management system which covers assessment, review, service delivery and case recording for all service users. It covers every service area such as children's, adult's, criminal justice and other service areas. It has introduced a significantly better inter-agency channel of communication between agencies which are involved with the service user.

[65] Home Care are also in the process of rolling out a system of family involvement in service user's care so that family members can be involved and can access information about the service users' care to help them understand eg who has visited them and when.

[66] South Lanarkshire Council have never done anything other than accept their failings in their Home Care Service as identified by the Care Inspectorate and experts involved and have tried their best to address same. During the process they have been very keen to demonstrate their compliance and collaboration with the Care Inspectorate and the Procurator Fiscal to show the breadth and depth of the improvements they have made in their Home Care Service and that the service they now operate both from their own Home Care Services and the external third party contractors they employ is very different from that operated in 2019.

[67] The changes South Lanarkshire Council have made to its Hamilton Home Care service is such that both Dr Kettle and Dr Douglas have confirmed that they have sufficiently addressed the concerns they raised in their Reports and, in the most recent

Care Inspectorate Report dated 5 December 2025, Hamilton Home Care Services have been assessed as "very good" across all areas of assessment as have the other geographical divisions of Home Care within the South Lanarkshire Council area.

[68] From all the evidence I have seen and considered, I have no difficulty in holding that the essential facts are as I have set them out in the foregoing paragraphs.

Discussion and conclusions

Parties' submissions

[69] The parties lodged detailed written submissions in advance of the hearing on submissions on 20 August 2026. These were most helpful and I thank and express my gratitude to agents in that regard. In addition, I also heard supplementary oral submissions at the hearing on submissions.

[70] I do not intend to narrate the submissions in detail, but I did take account of them when preparing this Determination.

[71] However, I think it might be helpful simply to record, in the brief terms, what the submissions were with reference to the relevant parts of sections 26(2) of the 2016 Act.

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

[72] Both parties invited me to find that Doctor Emma Goodall verified that Mr Ainsworth had died at 10:00 am on 22 January 2020 within Ward 8 of University Hospital Hairmyres, East Kilbride.

[73] This was in accordance with the evidence and I make a finding in these terms.

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

[74] Neither the Crown or South Lanarkshire Council made any submission in this regard and neither proposed any formal finding as Mr Ainsworth's death was not the result of any accident.

[75] This was in accordance with the evidence and I make a finding in these terms.

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

[76] Both the Crown and South Lanarkshire Council invited me to find that the causes of Mr Ainsworth's death were:

1a: Complications of severe leg ulcers

With potentially contributing causes:

2. Interstitial lung disease

Ischaemic heart disease.

[77] This was in accordance with the evidence and I make a finding in these terms.

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

[78] Neither the Crown or South Lanarkshire Council made any submission in this regard and neither proposed any formal finding as Mr Ainsworth's death was not the result of any accident.

[79] This was in accordance with the evidence and I make a finding in these terms.

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

[80] The court requires to apply a two-part test in respect of any finding under section 26(2)(e) of the 2016 Act.

[81] Firstly, to identify any precautions which could reasonably have been taken.

[82] Secondly, to determine whether any such precaution, had it been taken, might realistically have resulted in the death being avoided.

[83] It is a two-part test and so both parts of the test must be satisfied before the court can make a finding under section 26(2)(e) of the Act.

[84] As far as the first part of the test is concerned, the term "reasonably" relates to the reasonableness of any precaution that could have been taken in itself rather than to the foreseeability of the death or accident resulting in the death.

[85] As far as the second part of the test is concerned, the correct approach was laid down by Sheriff Kearney in his Determination following the Inquiry into the death of James McAlpine (Glasgow, 17 January 1986) as follows:

> "… the phrase 'might have been' avoided is a wide one … it means less than 'would on the balance of possibilities have avoided' and rather directs one's mind in the direction of lively possibilities".

[86] On the same issue, in the Inquiry into the death of Kathryn Beattie (Glasgow, 4 July 2014) Sheriff Ruxton stated as follows:

> "…. the term 'might' should be applied in the sense that it incorporates a notion of something qualitatively more than a remote possibility: a possibility with some substance or potential rather than a fanciful or notional possibility".

[87] The Crown submitted that I find the actions identified by Dr Kettle as having not been taken by Social Work as being precautions which could reasonably have been taken and, had they been taken, might realistically have resulted in Mr Ainsworth's death being avoided.

[88] These were:

(i) taking appropriate steps to satisfy professional curiosity in respect of Mr Ainsworth's care. In particular Social Workers did not take any steps to investigate or challenge things Mr Ainsworth said about his care arrangements/health and simply took them as facts without investigation or challenge.

(ii) A more assertive approach by carers in relation to Mr Ainsworth appearing to remain in the same position for long periods of time could have led to an earlier intervention in that regard. Someone should have asked Mr Ainsworth to walk across the room so that they could get an indication of his mobility.

(iii) Mr Ainsworth's daughter, should have been involved by Social Work in Mr Ainsworth's care.

(iv) Social Work should have triggered consideration of Mr Ainsworth as being an adult at risk of harm which may have led to intervention into his care and condition.

[89] The Crown submitted that I find the actions identified by Dr Douglas as having not been taken by carers as being precautions which could reasonably have been taken and, had they been taken, might realistically have resulted in Mr Ainsworth's death being avoided.

[90] These were;

(i) The individual risk assessment of Mr Ainsworth should have been done before Mr Ainsworth's care plan and visits started.

(ii) A visual skin assessment should have been carried out when carers reported concerns that Mr Ainsworth was not moving.

(iii) A skin review should have been carried out when Mr Ainsworth reported to Social Work that he was in pain and was crawling to the toilet as he couldn't walk there.

(iii) The "soft signs" of a deterioration and change in Mr Ainsworth's presentation during the period from 7 January 2020 to 20 January 2020 should have been recognized and escalated by carers to their co-ordinators.

(iv) Carers should have had the competence to recognize these signs and the ability, confidence and support to escalate their concerns to their co-ordinators.

(v) Carers taking appropriate steps to satisfy professional curiosity in respect of Mr Ainsworth's care. In particular carers did not take any steps to investigate or challenge things Mr Ainsworth said about his care arrangements/health and simply took them as facts without investigation or challenge.

[91] The Crown submitted that, taking the totality of the evidence as a whole, and at its highest, on balance of probabilities, it was open to the Inquiry to find the above were precautions identified by Dr Kettle and Dr Douglas which could reasonably have been taken and had they been taken, might realistically have resulted in Mr Ainsworth's death being avoided.

[92] The Crown also accepted though that the Inquiry might find that it has some difficulty accepting that the second part of the test under this heading has been met.

[93] The Crown recognized that Dr Kettle's evidence was that Mr Ainsworth would have needed to consent to being assessed as to whether he was an adult at risk of harm and there was no guarantee that he would have done so. Dr Kettle accepted that his evidence, at its highest, was that, had consideration been given to assessing Mr Ainsworth as an adult at risk of harm, there was no guarantee that further action would have been taken or led to measures to protect Mr Ainsworth, but the likelihood would have been significantly increased. His evidence was that for him to go any further on this point would have been speculation on his part.

[94] Dr Kettle was unable to say that, had Social Work taken all appropriate steps as above, Mr Ainsworth's death could have been prevented. He could only go as far as to say that if all measures been in place, and if Mr Ainsworth had co-operated with his care plan and said assessment, it would have reduced the likelihood of him dying.

[95] The Crown also recognized that Dr Douglas did accept in evidence that Mr Ainsworth concealed the true position of his self-neglect form his carers and that it is

known that self-neglect is challenging for those who are supporting the person and balancing the rights of the person to live the way they choose to live.

[96] South Lanarkshire Council submitted that no finding is made.

[97] South Lanarkshire Council submitted that whilst the precautions identified by Dr Kettle and Dr Douglas above were precautions which could reasonably have been taken, it could not be said that, had they been taken, they might realistically have resulted in Mr Ainsworth's death being avoided.

[98] Having considered the matter, I have reached the conclusion that it cannot be said that there is a lively possibility that, had the precautions identified by Dr Kettle and Dr Douglas been taken, Mr Ainsworth's death might have prevented.

[99] Both Dr Kettle and Dr Douglas recognized that Mr Ainsworth would need to have consented to being assessed as being an adult at risk of harm The Inquiry did not hear any evidence to confirm that he would have done so. The evidence that was heard was to the effect that Mr Ainsworth had refused to accept personal care, that, in the weeks leading up to his admission to hospital, he had misled his carers as to what was actually happening with his daily hygiene tasks and toileting and that he had actively hidden the condition of his legs and feet from carers.

[100] Moreover, even if he had co-operated with such an assessment, albeit that the evidence the Inquiry heard pointed to the outcome of the assessment being that he may positively have been assessed as being an adult at risk of harm, the Inquiry did not hear evidence that that would definitely have been the outcome.

[101] Furthermore, even if such evidence was heard, the Inquiry did not hear any evidence as to what specific measures, if any, would have been taken by Social Work and or carers or whether Mr Ainsworth would have co-operated with same or what the outcome of same would have been.

[102] Whilst I accept that the precautions identified by Dr Kettle and Dr Douglas were precautions which could reasonably have been taken, I consider that there was no evidence available to the Inquiry to fill the evidential gaps identified above so as to enable the Inquiry to find that, had they been taken, they might realistically have resulted in Mr Ainsworth's death being avoided.

[103] Accordingly, I do not consider that it could be reasonably concluded that the taking of these precautions might realistically have resulted in Mr Ainsworth's death being avoided.

[104] So, I find that there were no precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in Mr Ainsworth's death being avoided and I make no finding under section 26(2)(e) of the Act.

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

[105] In order to make a finding under section 26(2)(f) of the 2016 Act, the court must not only be satisfied of the existence of a defect in a system of working, but must also find, on the balance of probabilities, that the defect contributed to the death. Finding

that, on balance of probabilities that the defect contributed to the death is a higher demand than the "lively possibility" test mentioned under section 26(2)(e).

[106] The Crown submitted that, if I made no finding in respect of the issues they raised under section 26(2)(e) above, then I could make findings in respect of those issues under section 26(2)(f). For the sake of brevity, I do not repeat what is said above in that regard.

[107] Separately, and in addition, the Crown submitted that I find the following issues identified by Dr Kettle as defects in the system of working which contributed to Mr Ainsworth's death:

(i) The lack of adult support and protection assessment and failure to identify Mr Ainsworth as an adult at risk;

(ii) The care plan being unclear and incomplete;

(iii) That there had been no falls assessment made;

(iv) The lack of understanding of the danger of Mr Ainsworth smoking whilst there were oxygen cylinders in his home.

[108] Separately, and in addition, the Crown submitted that I find the I find the following issues identified by Dr Douglas as defects in the system of working which contributed to Mr Ainsworth's death;

(i) Mr Ainsworth's concealment of his deterioration and self-neglect not being recognized by carers;

(ii) Home Carers did not have the skills to identify signs of self-neglect nor the knowledge of the escalation protocol;

(iii) The systems and processes for escalation of concerns were not followed despite there being a protocol in place that clearly defined self-neglect and the processes to be followed;

(iv) the failure to report the changes and notable concerns in Mr Ainsworth's health and wellbeing timeously.

[109] The Crown submitted that the evidence of both Dr Kettle and Dr Douglas was that these were systematic defects of working rather than defects relating to individual carers.

[110] The Crown submitted that, taking the totality of the evidence as a whole, and at its highest, on balance of probabilities, it was open to the Inquiry to find the above defects in the system of working which contributed to Mr Ainsworth's death.

[111] The Crown also accepted though that the Inquiry might find that it has some difficulty accepting that the second part of the test under this heading has been met ie that the defects in the system of working contributed to Mr Ainsworth's death. This is notably since Dr Douglas and Nurse Wakenshaw were both unable to give a timeline as to when an intervention could have made a difference to the outcome for Mr Ainsworth especially given that he concealed the true position of his wounds and condition.

[112] South Lanarkshire Council submitted that whilst the issues identified by Dr Kettle and Dr Douglas above were defects in the system of working, it could not be said that, had they contributed to Mr Ainsworth's death.

[113] South Lanarkshire Council submitted that no finding is made.

[114] Having considered the matter, whilst I accept that the above issues identified by Dr Kettle and Dr Douglas were defects in the system of working, I do not consider that the Inquiry heard any evidence from which it could reasonably be concluded, on balance of probabilities, that these defects causally contributed to Mr Ainsworth's death. I consider there was a lack of evidence to show a causal connection between the defects and the death.

[115] I did not consider that there were any defects in any system of working which contributed to Mr Ainsworth's death and I make no finding under section 26(2)(f) of the 2016 Act**.**

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

[116] In determining whether any findings should be made under this section of the 2016 Act the court does not require to be satisfied that the facts in question are causally connected to the death, rather the question for determination is whether those facts are relevant to the actual circumstances of the death.

[117] The Crown submitted that, if I made no finding in respect of the issues that they raised under section 26(2)(e) or (f) above, then I should make findings in respect of those issues under section 26(2)(g). Again for the sake of brevity I do not repeat same here.

[118] Separately, and in addition, the Crown submitted that I find the I find the following as other facts which are relevant to the circumstances of Mr Ainsworth's death;

(1) That there was a lack of information sharing between NHS Lanarkshire and SLC SWD about the following:-

(i) Mr Ainsworth's alcohol use. In his first hospital admission in July 2019, NHS Lanarkshire noted that it was a direct result of a fall at home whilst intoxicated but this was not shared with SLC SWD until after his death. Moreover, SLC HHCS had noted that he was admitted then due to breathing issues and not because of a fall; and

(ii) Mr Ainsworth smoking whilst having oxygen cannisters in his house. His Consultant had threatened to remove the oxygen on safety grounds but that was not disclosed to SLC SWD and carers continued to attend his home regardless.

(2) There was a lack of notes in Mr Ainsworth's Home Care Diary system and mCare app and some details that were included might possibly have been inaccurate. Dr Douglas expected cares should have made more notes in the Diary so that;-

(i) all carers and family members could see what Mr Ainsworth's day to day situation/condition was and were kept up to date; and

(ii) so that Home Care Management could see what was happening with their service users.

[119] South Lanarkshire Council submitted that it was open to the Inquiry to find that the failings of South Lanarkshire Council in relation to the training and instructions

provided to carers in relation to skin care, lack of professional curiosity and Adult Support Protection were factors which were relevant to Mr Ainsworth's death.

[120] I agree with the submissions of the Crown and South Lanarkshire Council and consider that the above matters identified by Dr Kettle and Dr Douglas are facts which are relevant to the circumstances of Mr Ainsworth's death. I accordingly make such findings.

Recommendations

[121] Both the Crown and South Lanarkshire Council submitted that no recommendations be made in light of the changes which have been made by South Lanarkshire Council in its Home Care Service since the date of Mr Ainsworth's death.

[122] I am satisfied that the Inquiry heard compelling evidence about the significant changes South Lanarkshire Council have made in respect of the provision by it of Home Care Services and the training and monitoring of its staff therein which successfully and adequately address the shortcomings disclosed in evidence in their Service at the time of Mr Ainsworth's death.

[123] I do not consider that the evidence led in the Inquiry was such as to justify or require any recommendation being made by me in relation to any matter raised in the Inquiry.

[124] Accordingly, I make no recommendations.

Closing remarks

[125] I conclude by offering my condolences to Mr Ainsworth's family and friends.