HMA v Central Scotland Healthcare (St Andrews) Limited.

S. 76 Diet

Dundee Sheriff Court

On the 26th of September 2025 Central Scotland Healthcare (St Andrews) Ltd (who I shall refer hereinafter to as "the Company") pled guilty to the following charge ;-

"On 06 April 2024 at the premises owned and operated by the company at St Andrews Care Home, 1 James Foulis Court, St Andrews, that the company, being an employer within the meaning of the aftermentioned Act did fail to conduct their undertaking in such a way as to ensure, so far as reasonably practicable, that persons not in their employment who may be affected thereby , and in particular Katherine Bailes, aged 94 years, then resident within the said care home, were not exposed to risks to their health and safety in that they did fail to have in place a safe system of work to ensure that any meals prepared and provided by them contained foodstuffs that were suitable to eliminate or minimise the risk of choking by persons consuming them and had been prepared, where necessary, in accordance with the requirements of the International Dysphagia Standardisation Initiative and in consequence whereof while said Katherine Bailes was eating a meal prepared and provided by you which failed to meet her dietary requirements, which had been determined on 18th December 2023 by a speech and language therapist, she choked and died;

CONTRARY to sections 3(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974"

Background

Mrs Katherine Bailes was a 94 year old lady who was a mother, grandmother and aunt to family both near and living a little farther

away. The Court has been told that she was well liked by everyone within the care home. Whilst she suffered from a range of age-related conditions, as anyone might having reached such a grand age, the Court was told that she was well liked by everyone in the home, and was described as being still a fiercely independent lady.

In December 2023, she was seen by a speech and language therapist who assessed her ability to swallow on three occasions over a two-week period. Her conclusion was that Mrs Bailes was able to swallow food that was of a mashed consistency, noting that when trialling foods with increased texture, they tended to enter her airway and cause choking.

No direction or instruction was given by the therapist that she should be supervised when eating.

Having concluded that Mrs Bailes was at risk of choking or aspiration on foods of increased texture, she recommended that Mrs Bailes continue on an International Dysphagia Diet Standardisation Initiative (Known as IDDSI) level 5 'minced and moist diet'. The letter sent to Mrs Bailes recording this recommendation was also sent to Mrs Bailes niece and was within her records at the care home.

Mrs Bailes had moved into the home on 18 January 2024 from St Andrews Community Hospital.. On beginning to reside there her individual needs had been assessed by the home. It was noted by staff at the home that Mrs Bailes had short- and long-term memory problems. It was also noted that Mrs Bailes had a poor appetite along with type 2 diabetes which required to be controlled by way of diet. Her meals were to be prepared in accordance with a level 5 minced and moist diet.

Incident

On 6 April 2024, Mrs Bailes was alone, within her room in the home at around 1800 hours. At that time, she was provided with a meal of scrambled egg on toast.

The scrambled egg would have caused no issues with her specific requirements in terms of IDDSI, meeting the requirements of Level 5. However, the toast would not have been, bread products not capable of being rendered 'minced and moist' and therefore unsuitable for someone on a level 5 IDDSI requirement.

Even though the toast had been soaked in butter, scored on both sides to allow the butter to soak in and cut into small pieces with the crust removed it could not be compliant with the requirements of level 5. This can be seen from page 13 of the IDDSI which clearly states under the heading of "Bread" that while presoaked bread might be suitable, that no sandwiches, dry bread or toast of any kind should be used.

Mrs Bailes was alone in her room when this meal was served but at the time she began to cough, one of the carers was with her and alerted a member of the nursing staff for assistance.

First aid was administered, and an ambulance was called for although the ambulance did not ultimately attend because by the time it was able to, Mrs Bailes had passed away. Nursing staff, conscious that this was an unexpected death, called the Police. Mrs Bailes was pronounced dead at 1815 hours. Her death was reported to the Crown and a post mortem examination was instructed. The cause of death, per the certificate, was recorded as 'Food bolus tracheal obstruction of bifurcation'.

The Health and Safety Executive initiated an investigation. The company has cooperated and engaged with the investigation throughout.

By its guilty plea today, the company accepts that its system of work, in place at the time, was not sufficiently robust to ensure that Mrs Bailes, with her particular dietary requirements in terms of the IDDSI scheme, was provided with food that was complaint with that framework.

Remedial Action

I note that since the incident, the company has put in place a number of remedial actions.

1) Choking risk assessments are completed for all residents within 48 hours of admission and reviewed monthly along with other care plans. In addition a further choking and dysphagia risk assessment is also carried out, again within 48 hours, and reviewed monthly thereafter.

2) All kitchen and care staff have had mandatory training implemented to cover the IDDSI Framework. The training is being updated on an annual basis.

3) The company has also implemented a system for auditing whereby it audits a selection of the meals it prepares each day. The audit system was implemented shortly after the incident and prior to the HSE investigation commencing.

4) The company recognised that training on the IDDSI framework required improvement. Dysphagia training is now mandatory for all staff as part of their introductory training, completed on their first day. Staff undergo refresher training on an annual basis. The Court was advised that this has not been a straightforward undertaking on the part of the company. The relevant IDDSI training modules are available via NHS England resources which the company have experienced difficulties in accessing. Following persistence and liaison with NHS colleagues, the home has gained access to the relevant resources. The Court was advised, somewhat disappointingly, that currently there is no equivalent training resource provided by the relevant Scottish healthcare authorities.

5) The company has arranged for their computer system, to be updated and has inserted an extra "risk to be aware of" section in handheld devices used by staff. There is now a text which runs along the top of the screen highlighting precautions to be taken when serving residents food and drink. If a resident requires food or drinks to be prepared in line with the IDDSI framework, this is now clearly visible.

6) Rather than marking food for pureeing or liquidation with stickers, meals are now served on plates colour coded to each level of the IDDSI framework. In addition, the plates are labelled with details for the relevant level of diet they are for.

7) All meals are now plated in the kitchen to reduce errors taking place during service.

8) To assist with the extra kitchen duties, a further chef has been employed. The home has introduced a process for auditing compliance with the IDDSI framework. The audits took place initially daily for both lunch and dinner service. Once the new procedures were embedded, the home elected to continue the audit process. Lunch meals are audited daily to make sure they fit

with resident's requirements and the guidelines. All risk assessments were reviewed and updated

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The Health and Safety Executive were content that an Improvement Notice served on the company on 24 June 2024 was complied with by 2 September 2024.

The Company

The company is owned and operated as a single care home by a husband and wife team. They have worked in care settings since the early 1980s. The home opened in 2004 and has an unblemished health and safety record. It is dedicated to providing high quality, personalised care. All of its Healthcare Assistants are registered with the Scottish Social Services Council (SSSC). All staff employed within the home are members of the Protecting Vulnerable Groups (PVG) Scheme. It is dedicated to providing residents with the highest quality of care. The company has no previous convictions.

Sentencing

I turn now towards sentencing in this case. Let me first state at the outset of the sentencing process that no size of penalty can adequately reflect or compensate for the loss suffered by Mrs Bailes' family as a result of this tragic incident. They ought reasonably to have been able to assume that Mrs Bailes was safe in the care home from the risk of being provided with unsuitable food. It is difficult to comprehend the devastation they must have felt on learning of the distressing circumstances of her death and they must continue to feel at her loss, the manner of which was so clearly avoidable.

I have considered, as I must, the Scottish Sentencing Council's guidelines on the sentencing process and on the principals and purposes of sentencing that all sentences must be fair and proportionate. I have

also, as the High Court has advised we should do, had regard to the guidelines in relation to Health and Safety cases promulgated by the sentencing council of England and Wales.

I am grateful for, and I have given careful consideration to, the helpful submissions from Miss Duffis on behalf of the Crown and Miss Smith, Counsel for the company in this sad case.

There is no dispute as to the applicable law. The relevant principles were summarised in *Scottish Sea Farms Ltd* v *HM Advocate* 2012 SLT 299 at paragraph 18 as follows:

> (a) where death occurs as a consequence of the breach, that is an aggravating feature, multiple deaths being viewed even more seriously than single deaths;
> (b) a breach with a view to profit is a serious aggravation;
> (c) the degree of risk and extent of the danger and in particular whether this was an isolated incident or one continued over a period;
> (d) mitigation will include (1) a prompt admission of responsibility; (2) steps taken to remedy deficiencies; and (3) a good safety record; and
> (e) the resources of the offender and the effect of a fine on its business are important. Any fine should reflect the means of the offender but could not be said to stand in any specific proportion to turnover or profit. The objective of the fine should be to achieve a safe environment for the public and bring that message home, not only to those who manage a corporate offender, but also to those who own it as shareholders.

Applying those considerations to the case at hand, it has been accepted that

a) Mrs Bailes death is an aggravating factor, but the case concerns a single death.
b) The breach was not committed with profit in mind, and,
c) The incident was an isolated one.

Turning to the issues raised at (d), there has been

1) a prompt admission of responsibility.
2) as I have already noted active steps have been taken, and continue to be taken, to remedy the defect in the system of work, and
3) there is a good safety record.

Finally, in considering the resources of the offender I found the case of ***HMA v Tigh-na-murin Limited*** **[2023] HCJAC 30** to be of particular assistance and guidance in that it also concerned a care home of similar size and in a similar financial position. That case resulted in a starting point for the financial penalty imposed of £90,000. As the breach in that case was ongoing over a period of a little over two months and in this case the breach was on a single day then an adjustment down from that starting figure is indicated. I am also much obliged to parties for the outline facts they were able to provide to a not dissimilar case of Lister House Fife, in which there sentenced was passed earlier this week.

I turn now to the cross check that is to be done with the assistance of the sentencing guidelines issued by the Sentencing Council for England and Wales. I agree with the submissions and analysis of Miss Smith on behalf of he company that after carrying out the first two steps of the process that this offence is one within the harm category of 2 and I agree that the culpability is within the medium range which gives a starting point for an offender of the size of the company of £54,000.

Moving on to step 3 of the process. The company does not have convictions nor were any other aggravating factors present in this case. On the other hand there is substantial mitigation in the actions taken by the company in the aftermath of this tragic incident all designed to prevent any repeat of such a tragedy.

Finally, looking at step 4. I must have regard to the fact that the company is a commercial organisation. It exists as a business to provide health care to residents and reassurance to families that loved ones are safe and properly cared for in return for payment. The penalty must suitably reflect the level of culpability and underline the importance, in

particular in an organisation which is relied on to protect life and health, of the need to comply with Health and Safety Legislation and the protections it seeks to provide. I have decided, in all these circumstances, that the headline sentence in this case should be £67,500.

In assessing whether the fine is proportionate to the overall means of the company, I take into account that, the company is now returning to profit after the pandemic and last years profit figure is £461,000.
I consider that the level of fine should not adversely affect the company, in addition, I consider that there should be no significant impact on staff, customers or other third parties. Accordingly, no adjustment will be made to this headline figure.
Thereafter the fine will be reduced by one third, in light of the timing of the plea under the section 76 procedure, giving a final figure of £45,000.

There is also an associated victim surcharge which will require to be paid by the company. That sum shall be paid to the clerk of the court here in Dundee at the rate of £7,500 per month and will also be recoverable by civil diligence.

That is the sum which the company will pay as the fine in this case. It is a figure which will no doubt remind the company's directors of the gravity of this offence.

I must stress, once again, that this is not, and can never be, a figure which in some way represents compensation or consolation for the loss suffered by Mrs Bailes family.