Glasgow care home provider fined after death of patient

- Vulnerable man walked more than 300 steps from his room to a carpark.
- Care home staff did not notice he had left and falsified records.
- HSE guidance is available on vulnerable residents

A care home provider has been fined more than £50,000 after an elderly patient died in the early hours of Boxing Day in 2022.

Hugh Kearins, 77, had managed to leave the Chester Park Care Home in Glasgow via a series of stairways and fire doors. An inspector from the Health and Safety Executive (HSE) counted 320 steps from the Mr Kearins room to the care home's car park just off Lambhill Street, where his body was found at around 7am.

Mr Kearins, who had dementia, had been living in a room within the Clyde Unit of the home since 2012. As part of its investigation, HSE made enquiries regarding the use of an internal fire door and was unable to obtain corroborated evidence of who was last to use the door prior to Mr Kearins, who is thought to have exited through it just before 1am. The same door was closed about an hour later by an unknown member of staff carrying out routine checks.

A HSE inspector counted 320 steps from Mr Kearins' room to where his body was found

It was confirmed by the care home manager that once the door was noted to be insecure, the member of staff should have initiated a head count of all of the residents to ensure their safety. However, this was not carried out.

The HSE investigation found the company had failed to have a safe system of

work in place. Records held by the company in relation to Mr Kearins, extensively noted the clear risk that he might abscond or ‘wander’. It was part of his care plan that he be checked or monitored every hour.

HSE guidance acknowledges that vulnerable people can enjoy the outdoors. However, it also states that, “you should consider ways of managing the risks to vulnerable people so they can still enjoy the outdoor environment”.

He managed to leave the building through a fire door

A senior care assistant and a care assistant who had responsibility for Mr Kearins’ care were also found to have falsified records, stating that they had performed tasks involving him at a time when he was in fact no longer in the home. Both were unaware he was no longer in his room until news of his death became known following the discovery of his body in the car park.


The red cross indicates where Mr Kearins’ exited the home, with the white cross showing where his body was found the next morning

The management failures in respect of the alarm door reactivation were not causative of Mr Kearins’ death and would likely not have even come to light but for four individual errors:

- The unidentified member of staff who closed the internal fire door without further action;

- The fire alarm for the internal fire door which had been deactivated
- The unidentified member of staff who left the unalarmed external fire door insecure; and
- The actions of both the senior care assistant and the care assistant.

Oakminster Healthcare Limited, of Lambhill Street, Glasgow, pleaded guilty to breaching Sections 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined £53,750.

HM Inspector Amna Shah said: “This incident was completely avoidable.

“It is hugely concerning that a vulnerable man was able to walk so far and through so many doors without being noticed.”

“We counted he had walked more than 300 steps.”

“The fact this incident happened at Christmas time makes it all the more tragic.”

“We will always take action against those who fail in their responsibilities.”

Further information:

1. The Health and Safety Executive (HSE) is Britain’s national regulator for workplace health and safety. We are dedicated to protecting people and places, and helping everyone lead safer and healthier lives.
2. More information about the legislation referred to in this case is available.
3. Further details on the latest HSE news releases is available.
4. HSE does not pass sentences, set guidelines or collect any fines imposed. Relevant sentencing guidelines must be followed unless the court is satisfied that it would be contrary to the interests of justice to do so. The sentencing guidelines for health and safety offences in Scotland can be found here.
5. HSE guidance about health and safety in care homes is available.
6. Both carers were subsequently dismissed from their employment following disciplinary interviews a few days later. They are now subject to investigation by the Scottish Social Services Council.