

DETERMINATION
of
SHERIFF ALAYNE E SWANSON
in
FATAL ACCIDENT INQUIRY
into the circumstances of the death of
MRS MARY MACAULEY

**In terms of Section 6 of the Fatal Accidents and Sudden Death
Inquiry (Scotland) Act 1976**

Glasgow January 2012

The Sheriff having resumed consideration determines as follows:

1. Section 6(1)(a)

Mrs Mary MacAuley died in the bedroom of her house at 149 Crowhill Street, Parkhills, Glasgow between 08:19 and 10:05 on 15 January 2008

2. Section 6(1)(b)

The cause of death was ischaemic and hypertensive heart disease.

3. Section 6(1)(c)

A reasonable precaution which might have avoided Mrs MacAuley's death would have been for the call handler at the direct response centre to have alerted the ambulance service immediately upon receipt of the first call from Mrs MacAuley asking for help

4. Section 6(1) (d)

There were defects in the system of working at the direct response centre which contributed to the death of Mrs MacAuley:

(a) the direct response centre's procedure for dealing with no response calls failed to distinguish adequately between nuisance calls and emergency calls

(b) the direct response centre staff had a lack of understanding and lack of familiarity with the way in which the ambulance service would react to no response calls

5. Section 6(1) (e)

There are no other facts relevant to the circumstances of death

Note

Evidence in this fatal accident inquiry was heard on 14, 15, 16 and 17 December 2010 and 6 October 2011. Submissions on behalf of the parties were made on 6 December 2011. The Crown was represented by Mr Ross, Procurator Fiscal Depute. Mr Coll, Advocate represented Glasgow City Council, Mr Hamilton, Advocate represented Greater Glasgow Health Board and Mr Khurana, Advocate represented the Scottish Ambulance Service who only became a party to the Inquiry following the first four days of evidence. This was a result of evidence

given by Ms Kerry Ann Dolan as to the Ambulance Service's likely reaction to a call from the Direct and Care Services alarm service.

The witnesses to the Inquiry were:-

Sharon MacAuley (Mrs MacAuley's daughter)

Steven Campbell (Direct Response Service Centre)

David McCartney (Direct Response Service Centre)

Ashley Findlay (Direct Response Service Centre)

Dr Margaret Craig (Mrs MacAuley's GP)

Angela Shannon (Direct and Care Services Home Care Section, Glasgow City Council)

Dr Julianne McAdam (Consultant Forensic Pathologist)

Gerald Nicol (City Building, Glasgow)

Michelle Clelland (Direct and Care Services Home Care Section, Glasgow City Council)

Pamela Keating (District Nurse)

Diana McNaught (Occupational Therapist)

Hilary Bell (Greater Glasgow and Clyde NHS)

Kerry Ann Dolan (Direct and Care Services Home Care Section, Glasgow City Council)

Gerald Kelly (Cordia LLP formerly Glasgow Independent Living and Equipment Service)

Alison Docherty (Glasgow City Council)

Raymond Hepburn (Scottish Ambulance Service)

In order to explain my determination in this case I think it will be helpful if I recite the factual background and the events of 15 January 2008 as I found them to be established by the evidence. I have also set out briefly

parties' submissions on the additional findings and recommendations proposed by them and my reasons for rejecting those.

1. Background

Mrs MacAuley suffered significant ill health. She had diabetes and peripheral neuropathy or numbness in her feet. This combined with the fact that she was very overweight meant that she was immobile. She had essentially been housebound since 2005. She had an understandable fear of falling given that she had been hospitalised twice in 2007 due to fractures resulting from falls. In the days before her death she had been suffering from panic attacks.

Mrs MacAuley had support from a number of service providers. These were in the main requested by her GP practice, the Allander surgery at 124 Allander Street, Possilpark. Her GP was Dr Margaret Craig. The District Nursing Service was also provided from the Allander surgery.

Following her discharge from hospital on 9 February 2007 Mrs MacAuley received assistance from the Direct and Care Services Home Care Section (DACs). This service was at that time provided by Glasgow City Council hence their representation at the Inquiry. The assistance provided was at the level of 4 visits a day from 9 February 2007 to 29 June 2007 as part of the hospital discharge package.

Mrs MacAuley also received support from the Interdisciplinary Response and Intervention Service (IRIS) on her discharge. This service is provided by the NHS through Greater Glasgow Health Board hence their

representation at the Inquiry. It included the support of an Occupational Therapist.

Mrs MacAuley's need for support had increased in the lead up to her death. The District nurses were attending twice per week. On 11 January 2008 a referral was made to DACS by the District Nurse at the Allander surgery for a tuck in service to assist Mrs MacAuley at bed time. This was provided daily from 11 January until Mrs MacAuley's death. The Community Older People's Team (COPT) were also contacted by the surgery on 10 January 2008 following a visit to Mrs MacAuley by her GP and an Occupational Therapist from that organisation attended on 11 January.

Mrs MacAuley was also a user of the services provided by the DACS alarm service. This was described as a low level support to enable people to stay at home. The service works with other agencies or the families and their carers. I will return to the role of the DACS alarm service later in this note.

2. Mrs MacAuley's death

The events on 15 January 2008 started with an alarm call from Mrs MacAuley to the DACS alarm service at 07:57. The call was taken by David McCartney. The call was categorised as a no response call because Mrs MacAuley was unable to provide answers to any of Mr McCartney's questions and was simply repeating "help". He tried to resolve the call by contacting the relevant key holders who were Mrs MacAuley's daughters. He told Mrs MacAuley that that was what he was doing. He was unable to contact them and so decided to dispatch the

direct response team. A second call from Mrs MacAuley at 08:19 was also categorised as a no response call. That call was taken by Ashley Findlay. She was advised by Steven Campbell that the direct response team had already been dispatched and she closed the call down after telling Mrs MacAuley that.

Angela Shannon was in the office at the time of Mrs MacAuley's first call. The practice was that a no response call could only be attended to by two members of the team. Angela's colleague Michelle was not in the office. She had been allowed to go to Carntyne to pick up her car.

Angela went to collect her and they journeyed together to Mrs MacAuley's house. They arrived there at 09:25 and Steven Campbell, having been advised by them that they could not gain access to the property, contacted a joiner to force entry. They eventually gained entry to the house at 10:05 where they found Mrs MacAuley dead. She was found dead in her bedroom crouched on the floor with her head and neck jammed between the bed and the bed support rail.

I took from the evidence of Dr McAdam that a lady with serious heart disease of the type suffered by Mrs MacAuley could have dropped dead at any time. She said that even serious heart disease can exist without symptoms.

I was unable to establish on the evidence whether Mrs MacAuley had suffered a cardiac event prior to her fall on to the floor thereby becoming trapped between the bed and the grab rail or whether she had fallen between the bed and the grab rail and the stress and uncomfortable position contributed to a cardiac event occurring whilst she was effectively trapped. I understood from Dr McAdam that such stress

would increase both heart rate and blood pressure and that this could place additional strain on an already diseased heart and greatly increase the likelihood of a fatal cardiac event. However the second scenario was no more likely to have occurred on the balance of probabilities than the first scenario.

Dr McAdam said that the post mortem staining would indicate that Mrs MacAuley had been dead for at least half an hour before she was found at 10:05 but that it was more likely that she had died closer to 08:19 than 10:05. This was because Dr McAdam said that if Mrs MacAuley had suffered a cardiac arrest without treatment she would have been dead very quickly. However, what Dr McAdam was unable to say was whether that had been preceded by a period in which Mrs MacAuley felt unwell or whether the event had happened very suddenly. It is possible to have chest pain because of a cardiac event for a period of time but once you actually suffer an arrest, you have to be treated immediately or you have no chance of survival.

Dr McAdam was clear that if Mrs MacAuley had had more rapid medical attention it would have increased her chances of survival. Dr McAdam did stress, however, that you only have a few minutes in which to help someone suffering a cardiac arrest.

Dr McAdam accepted that there could have been a multitude of potential stressors. The evidence from Mrs MacAuley's GP suggested that a fall of any kind even without being trapped would have caused Mrs MacAuley stress given her medical difficulties.

The main question in this Inquiry is whether medical attention could have been available to Mrs MacAuley sooner and if it had been whether that might have avoided the death. In order to answer the question about the speed with which medical attention could have been provided it is necessary to examine the service provided by DACS and the way in which they categorise calls.

2. The DACS service

The DACS alarm service provided Mrs MacAuley with a pendant alarm and a stationary alarm which was placed in the living room of her house. Activation of either the stationary alarm or the pendant would send a call to the call centre where one of the operators would deal with it. The operator would have available on screen a history of that person's previous calls and any other relevant information. When the operator responded the voice would come through the stationary device. This did cause problems as the stationary device could be at some distance from where the client and the pendant alarm were located. The service's procedures remind the call handlers that the speech unit is not necessarily in the same vicinity as the client and encourage them to take care to listen in and provide adequate spacing in between attempts to identify where the client is.

I heard evidence that clients use the alarm pendant to alert DACS to a variety of issues. This ranges from an accidental or inadvertent pressing of the alarm, the client advising about a problem like a power cut or the client having had a fall from which they are unable to recover. The response from the service ranges from contacting a family member or

neighbour, organising repair services for household maintenance to contact with NHS 24 or the ambulance service.

3. No response calls

Both of the calls received from Mrs MacAuley were categorised as no response calls. This was because Mrs MacAuley was unable to provide the call handler with any information. Questions are asked by the call handler in an attempt to elicit information about any injuries sustained. Mrs MacAuley's response to all questions asked on 15 January 2008 was "help".

I was concerned to learn that in terms of the service's procedures the call handler would not automatically telephone 999 to call an ambulance in such a situation. The emergency services would not be contacted until the service's direct response team had visited the property to find out more information. This means that were you able to tell the call handler that you needed an ambulance they would call one for you but if you were in extremis and unable to communicate that would not happen until further information had been ascertained. I found that to be a worrying and illogical distinction.

Mr McCartney the call handler said that it was a judgement call what to do with a call if it could not be resolved from the control centre and you did not believe it warranted emergency services. The judgement call is informed primarily by the information you are getting from the client. If

the client were able to say that they have fallen and hurt themselves then he would call an ambulance. If the client were to say that someone was vandalising their front door then he would call the police. But if he simply got a call requesting help with no information then he would send the direct response team. In his view, 30 to 35 minutes for that to take place was acceptable. If the direct response team cannot gain access on arrival then they will call a joiner from City Building. This could take 45 minutes to an hour. The police would be called to force entry if the direct response team thought that something was seriously wrong.

The procedure in January 2008 whereby a no response call could only be attended to by two members of the direct response team who required to travel to the house together seems unusually cumbersome. If someone had fallen the practice was also that the call could only be dealt with by two members of the team. That was a point highlighted in the critical incident review and I understand that the new procedure is that the team members work individually and only meet up for calls which do require two people. They can now travel separately to a house where they meet up. For that reason I make no comment on that aspect of the working system as any deficiencies appear to have been addressed.

4. The Critical Incident Review

The critical incident review was conducted between January and April 2008 by Hilary Bell of North Glasgow CHCP and Hazel Quinn of the Community Support Team. They examined the services provided to Mrs MacAuley by the various agencies involved. Their recommendations in relation to DACS addressed a number of issues about what happened

after Mrs MacAuley's death. Those that concern this determination as are follows:

- Review DRT shift rota to ensure a minimum cover of 2 staff available for the entirety of each shift.
- Review the process for forced entry and when there is a need to contact other services when pendant activation for assistance is followed by no further contact with the client, there is no emergency contact available and the DRT are unable to attend within a reasonable time
- Review the accuracy and updating of the emergency contact numbers procedure

Nothing in the critical incident review suggested that call handlers should call the emergency services in relation to a no response call.

Kerry Ann Dolan the manager of the DACS was a most unsatisfactory witness. She started by saying that the call handlers understood that if they were in doubt they should phone an ambulance. It then became clear that that assessment could be made at any point in the call or after the home carer or response team gets there. That would mean that it took some time for the no response call to be re-categorised as an emergency as it would involve an assessment being made only at the point the direct response team gained access.

At that point in the evidence I asked Ms Dolan: "Would you never make a decision that no response was urgent enough for an ambulance?" Ms Dolan answered: "There would be few occasions that-----the ambulance wouldn't attend if we didn't submit some other evidence from the ambulance service that told us that if we phoned up and said somebody

came through to us and didn't tell us anything then they wouldn't attend that as an emergency."

That attitude (and as it turned out misapprehension) had been echoed earlier in the evidence of Steven Campbell. He said that control try to get as much information as they can. "Quite often we pass them a call and they can turn round and say--look I don't think a call warrants a 999 or an ambulance, the person will have to wait or you'll need to go through NHS 24. Again, it's only the information we can get from the person in the house that we can decide what they actually need, you know."

Ms Dolan was clear that "for the purpose of following the procedure" it was right to treat the call from Mrs MacAuley, where she said "help" each time she was asked a question by the call handler, as a no response call. She gave clear evidence that the Scottish Ambulance Service had told her that they would not treat a situation like Mrs MacAuley's as an emergency. This was because, she said, "they would not have known how to get access and how do they know that the call wasn't because there was a fire or because they were upset." She was clear that the correct decision had been made on 15 January 2008 in respect of Mrs MacAuley. She re-reiterated that view despite the fact that on the day in question the direct response team were going to take longer than average to get there.

Her evidence both about the decision to allow one of the direct response team to collect her car and about the nature of the direct response service was defensive. She was more interested in telling the Inquiry that other authorities provide this service without any response team and comparing

response times with Edinburgh than answering directly the questions put to her either by the Fiscal or by me.

Her responses to the specific recommendations of the critical incident review were unhelpful. She kept reverting to the lack of definition of terms like reasonable time or the lack of specification in the policy rather than accepting any responsibility for the need for change. At the end of her evidence, having been presented with the eight factors that were at play on 15 January 2008 in respect of Mrs MacAuley, Ms Dolan still confirmed that she would not have contacted emergency services. She said that they “work on the premise that we don’t know and therefore we should go and check”. She remained adamant that the ambulance service would not have attended in all the circumstances because, she said, she had asked them.

Those eight factors were:

- Mrs MacAuley was 72 and lived alone
- she had issued no false alarms in the eleven months for which she had been a service user;
- on 15 January 2008 she activated the alarm and was repeatedly calling for help;
- she could not answer the questions asked and only replied “help”
- the call handler assumed that she had fallen
- the emergency contacts could not be contacted
- the direct response team were delayed beyond the average response time due to a staff shortage created by allowing someone to undertake personal business
- she called again twenty minutes after her first call;

When she was re-called as a witness on 6 October 2011 Ms Dolan said that her understanding that an ambulance would not have attended was based on previous calls where they have not attended, what other authorities use them for and meetings she said she had had with the ambulance service and the NHS. I discounted her evidence on this entirely. I found her generally to be incredible and entirely unreliable. I have given her evidence little weight in my considerations.

The action plan in relation to the critical incident review notes in relation to point 2: “as no definition of reasonable time—review of procedure and feedback from staff, the process has been changed to reflect that no response calls should be passed to response team within 20 minutes.”

This fails to address the categorisation point. A quicker passing of no response calls to the DRT does not, in my view, address the difficulty which arises from the categorisation of no response calls as non-emergency calls. There is an additional internal recommendation about prioritising calls which suggests that no response calls should be treated as the second priority after “client has fallen” calls. I was not satisfied that that meant any change in practice in relation to how such calls were handled.

In my view, there is a problem with the way in which the DACS call handlers react to no response calls. I fully appreciate that some kind of distinction has to be drawn in order to filter out what can be described as nuisance calls. I heard a lot of evidence about the “profile” of the DACS clients and the fact that some of the clients inadvertently press the alarm for any number of reasons. What does not seem to happen, however, is

for the call handler to make any judgement differentiating a call where, for example, the alarm has been pressed and the client can be heard moving about elsewhere in the house and a call where in answer to questions asked the response is “help”. Surely a common sense approach would highlight that there is a difference between the way in which these two calls should be treated.

I have made a finding in respect of section 6 (1)(c) of the Act that a reasonable precaution might have avoided the death because I am satisfied on the evidence which I heard that a different approach to this call for help and a call for an ambulance after the first call was received might have avoided this death.

What is required to improve the system is an assessment of whether an ambulance is required at the time of the first call for help. The suggested new procedure whereby the DRT would be dispatched within twenty minutes of a no response call does not address that point. On arrival to ascertain further information they might still require to seek assistance to gain entry. No thought seems to have been given to treating a no response call as an emergency call and phoning the ambulance service immediately.

I heard evidence from Mr Raymond Hepburn the Head of Service responsible for the Scottish Ambulance Service Emergency Medical Despatch Centre for the West of Scotland. He explained that calls are categorised as Category A (life threatening) Category B (serious but not life threatening) and Category C (neither). A call where there were unknown criteria would be categorised as Category A. He advised that 75% of Category A calls are attended to within 8 minutes. When

presented with the particular circumstances pertaining to Mrs MacAuley and the eight factors listed above he said that she would have been a Category A call. He said that the perception that the ambulance service would not attend such a call as an emergency is wrong. On the basis of the facts as put to him he stated that he had a high degree of confidence that a call at 08:00 would have had the ambulance there by 08:08 and that entry would have been gained with police assistance by 08:13.

Mr Coll for Glasgow City Council put to me in submissions that Mr Hepburn's evidence of possible timing was optimistic. In order for the ambulance to have been in attendance at 08:08 the call handler would have required to call the ambulance immediately upon receiving the call from Mrs MacAuley. There would then have required to be no delay in the attendance of the police to assist with a forced entry for entry to have been gained by 08:19. By then, according to Dr McAdam, it might have been impossible to prevent death.

I am satisfied on the basis of Mr Hepburn's evidence that there was a lively possibility that immediate instruction of the Scottish Ambulance Service might have avoided this death. I do not require to make any finding in fact as to the exact time when assistance could have reached Mrs MacAuley. All I require to find is that had an ambulance crew gained entry to the house at 08:13 the outcome might have been different. As it was, given the delay in the direct response team getting there and the further delay while entry was gained, the possibility of medical intervention at a stage where that might have been of assistance was removed.

3. Parties' submissions

Other matters canvassed by parties in their submissions were:

- (1) the responsibility of family members named as key holders to update their details with DACS.

The critical incident review had recommended a review of the accuracy and updating of the emergency contact numbers procedure.

The position of Glasgow City Council was, to say the least, defensive on this issue. Mr Coll was at pains to point out in submissions and in questioning that with 19,000 users of the service if the alarm centre required to contact key holders every six months to check details this would involved them in making 40,000 calls. His conclusion was that if the Council had to be proactive in approaching relatives on a regular basis to check details the resource simply did not exist to allow them to do this.

I am not persuaded that the failure to update records had any impact on Mrs MacAuley's death. It matters not whether the responsibility for updating should lie with the family or with the Council. The problem which I have identified with categorisation of calls is unaffected by this issue. If a call had been placed with the ambulance service when the first call was made an ambulance would have been dispatched immediately. If further information about access to the property had become available that would have been relayed to the crew. Mr Hepburn gave evidence that the status of a call could change whilst the ambulance was en route. Given Dr McAdam's evidence that there may have only been a few minutes during which intervention would have been successful the most important thing

was to get the ambulance crew into the house not to waste time trying to contact keyholders.

- (2) whether the accident which caused the death was the entrapment of Mrs MacAuley by the neck in the gap between the fixed floor rail and the bed.

The Fiscal submitted that there was no other catalyst to which the cardiac event could be attributed.

As I have discussed above, I do not find on the evidence that Mrs MacAuley's entrapment caused the death. The scenario outlined by the Fiscal was no more likely to have occurred than the scenario in which Mrs MacAuley suffered a cardiac event prior to her fall on to the floor. I therefore make no determination in that respect.

- (3) the issue of whether the hand rail at Mrs MacAuley's bed had been properly and correctly selected, fitted and risk assessed.

The Fiscal suggested that use of a different type of bed rail would have greatly diminished the risk of the accident he submitted had occurred as would instruction from the OTs to the fitting technicians about the fixing of the rail.

Mr Hamilton submitted that the evidence showed that at the time there was no alternative rail available for this purpose and that it was needed to allow Mrs MacAuley the independence she desired. There was, in his view, insufficient evidence to allow me to determine how far from the bed the rail had been fitted. With

respect to the Occupational Therapist's role he invited me to find that Mrs McNaught had acted appropriately in prescribing the rail and in her discussions with Mrs MacAuley about the risks involved. He submitted that it was not part of the OT's role to advise the Greater Glasgow Independent Living and Equipment Service (GGILES) technician where and how to fit the rail.

This point is worthy of some further discussion in order to explain why I have made no determination in this respect.

4. Risk assessment

The role of the occupational therapists provided to Mrs MacAuley by IRIS was raised in submissions with reference to the third point described above. The evidence I heard on this subject was as follows.

Ms McNaught the OT who attended Mrs MacAuley assessed her as requiring a mattress elevator and a support rail to enable her to get in and out of bed independently. Ms McNaught ordered the equipment from an online catalogue provided by GGILES. There is a box on the online order form in which the OT can enter comments and the instructions here were to fit the rail to the right hand side of the bed when lying. This box is routinely used by the OTs to give instructions to the technicians on where to place items or at what height to fix them.

Once the equipment arrived it was taken out to the house by technicians who fitted it within a couple of days. Ms McNaught then went back to the house to view the equipment and check that Mrs MacAuley could use it safely. This was described as a dynamic risk assessment. Ms

McNaught's notes from that assessment read as follows: "OT discussed with patient risks of floor-fixed rail beside bed. However, patient aware of risks but feels both are beneficial. Patient would not be able to transfer in and out of bed independently without these." Ms McNaught was unable to recall what risks had been discussed. She confirmed that if she had been concerned about the equipment or about the size of the gap between the bed and the rail she would probably have uplifted the equipment.

The rail supplied was a toilet assistance rail. The client had previously had a bed stick and an ordinary mattress. At that time in 2008 there was no integrated mattress and rail. The bed stick could not operate with the mattress elevator. Nothing in the GGILES catalogue or elsewhere suggested that the toilet assistance rail should not be used as a bed rail and I heard evidence that the rail was being widely used at that time by both Health OTs and Social Work OTs in a bedroom setting such as this.

It was accepted that it is not possible to fix the rail to the side of the bed without any gap as this would create difficulties for the patient and in practical terms hamper the making of the bed etc. However the size of the gap was inevitably discussed at great length in the evidence. Clearly it had never been addressed as a matter of risk assessment. Ms McNaught when asked about her awareness of the risk of entrapment with the use of rails beside beds confirmed, "It would never have occurred to me before this case."

I am satisfied that the use of the toilet rail was justified in the circumstances at the time and I find no evidence to suggest that a proper risk assessment was not carried out by the OT. Given that I have not

found there was sufficient evidence to determine that the entrapment was the accident which caused the death it is not appropriate for me to make any finding in respect of the use of the bed rail or its fitting.

5. Conclusion

It is the function of a fatal accident inquiry, where appropriate, to establish whether there were any reasonable precautions which might have prevented the death and to examine whether any defects in the system of working were identified which contributed to the death.

Sheriff Kearney, in his determination in relation to the death of James McAlpine, issued on 17 January 1986 and referred to at paragraph 8-99 of the Third Edition of Sudden Deaths and Fatal Accident Inquiries by Ian Carmichael, noted:

“ In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death be satisfied that the precaution was a reasonable one. -----The Phrase “might have been avoided” is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than “would on the probabilities have been

avoided” and rather directs one’s mind in the direction of the lively possibilities.”

It is accepted that this is very much an exercise in applying the benefit of hindsight. However in identifying reasonable precautions I am not required to be concerned with the issue of foreseeability. Reasonableness in this context simply relates to the practicality of the precautions proposed. Where lessons can be learned and steps taken to avoid any future recurrence, these should be identified and brought to the attention of those who are in a position to implement them.

It is clear from this Inquiry that Mrs MacAuley prized her independence and made use of such services as were available to her to enable her to remain living in her own home. One of these was the direct alarm service provided by DACS. It was stressed in the evidence and again in the submissions for Glasgow City Council that the alarm service is not a substitute emergency service. I entirely accept that. However, the promulgation of that view and its permeation into the understanding of staff may significantly restrict the usefulness of the service provided.

The direct response aspect of the service in Mrs MacAuley’s case turned out to be something of a misnomer. I think that Mrs MacAuley’s family were entitled to expect, in her daughter’s words, that when she pressed the alarm “the centre is supposed to come to her response”. That was not in fact what happened on 15 January 2008. It is of course not possible to say that had the ambulance service been alerted immediately that Mrs MacAuley would have survived. Clearly she had many health challenges to face. However, there was a lively possibility that a different reaction to her call by the direct alarm service might have avoided her death.

A review of the procedure for the categorisation of calls by the DACS alarm service may prevent other deaths in the future. I fully appreciate that some distinction has to be drawn in order to ensure that emergency services are not troubled by nuisance calls. However it was a grave defect in the system of working which allowed a call constituting a genuine cry for help to be categorised in the same way as an inadvertent pressing of the alarm or nuisance call.

Alayne E Swanson

Sheriff, Glasgow and Strathkelvin at Glasgow

January 2012