SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY

[2026] FAI 5

AIR-B311-24

DETERMINATION

BY

SHERIFF P A HARAN

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

into the death of

DAVID McCLENAGHAN

Airdrie, 5 January 2026

FINDINGS

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 ("The Act") that:

1. In terms of section 26(2)(a) of the Act, David McClenaghan, born 14 April 1961, died at approximately 1746 hrs on 26 August 2018. His death occurred at Park's Kia, Dundyvan Road, Coatbridge.

2. In terms of section 26(2)(b) of the Act, no finding is made as Mr McClenaghan did not die as a result of an accident.

3. In terms of section 26(2)(c) of the Act, Mr McClenaghan died after suffering a cardio pulmonary arrest with the cause of death being a pulmonary thrombo-embolism following a right calf deep vein thrombosis.

4. In terms of section 26(2)(d) of the Act, no finding is made as Mr McClenaghan did not die as a result of an accident.

5. In terms of section 26(2)(e) of the Act, there are no precautions which could reasonably have been taken that would have prevented the death of Mr McClenaghan.

6. In terms of section 26(2)(f) of the Act, there were no defects in any system of working that contributed to the death of Mr McClenaghan.

7. In terms of section 26(2)(g) of the Act, the facts relevant to the circumstances of Mr McClenaghan's death are:

i) The telephony systems used by the Scottish Ambulance Service's emergency call handlers does not enable call handlers to readily identify when a call has been disconnected.

ii) The call handler dealing with Mr McClenaghan's call required to use a malicious code to progress the call to enable dispatch of an ambulance.

iii) Pre-entry questions could not asked until a call handler had confirmed the caller's location.

iv) There was only one dispatch supervisor on shift within the Ambulance Control Centre West control room at the time of Mr McClenaghan's call.

v) There was a lack of clear policy or guidance in place detailing how dispatch staff should respond when a patient cannot be located by an ambulance crew.

vi) There was a lack of clear policy or guidance outlining how an ambulance crew should manage a situation where a patient cannot be located by the crew.

vii) The call from Mr McClenaghan was recorded as an unconfirmed location.

viii) The first ambulance crew elected not to exit their vehicle when they attended at the Kia garage.

RECOMMENDATION

That the Scottish Ambulance Service investigate whether a telephony technology solution could be introduced that would assist emergency call handling staff in distinguishing between a silent call and a disconnected call. If such a solution can be identified, it is recommended that it is implemented as soon as possible.

NOTE

Introduction

[1] The Crown Office and Procurator Fiscal Service gave notice of their intention to hold a Fatal Accident Inquiry on 5 July 2024.

[2] Following several preliminary hearings, the Inquiry commenced on 1 October 2025, with evidence being heard over 3 days between 1 and 3 October 2025. There was a

further day of evidence on 24 October 2025 followed by a hearing on submissions on 25 November 2025.

[3] Parties to the Inquiry were represented as follows:

(i) The Crown – Ms Carey, Procurator Fiscal Depute

(ii) Scottish Ambulance Service – Mr Hamilton KC, Senior Counsel

(iii) Park's Of Hamilton – Ms Anderson, Solicitor

(iv) Next-of-kin – Mr Nelson, Uncle of Mr McClenaghan

[4] The following witnesses gave evidence to the Inquiry:

(1) Georgina McClenaghan – Wife of Mr McClenaghan

(2) Louise Millar – Assistant Strategic Ops Manger, Scottish Ambulance Service

(3) David Shaw – Ambulance Technician, Scottish Ambulance Service

(4) Karen Kidd – Paramedic, Scottish Ambulance Service

(5) Luke Mariner – Consultant Paramedic (Expert Witness)

(6) David Strachan – Ambulance Dispatcher (retired), Scottish Ambulance Service

(7) Karen Panton – Duty Manager, Scottish Ambulance Service

[5] Crown Witness number 3, referred to as Call Handler 1 ("CH1"), was unable to give evidence in person to the Inquiry. Two affidavits sworn by this witness were received into evidence by the Inquiry.

[6] I make no adverse findings in relation to the credibility or reliability of any witness. I am satisfied all witnesses were doing their best to assist the Inquiry by recalling events which were, by then, more than 7 years ago.

Legal Framework

[7] This Inquiry was held under the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"). It is a discretionary Fatal Accident Inquiry in terms of section 4 of the Act. The Inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[8] In terms of section 1(3) of the Act, the purpose of the Inquiry is to establish the circumstances of Mr McClenaghan's death and to consider what steps (if any) could be taken to prevent other deaths in similar circumstances.

[9] Section 26 of the Act sets out the matters to be covered in the determination. These include setting out findings on the following:

a) when and where the death occurred,

b) when and where any accident resulting in the death occurred,

c) the cause, or causes, of the death,

d) the cause, or causes, of any accident resulting in the death,

e) 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;

f) any defects in any system of working which contributed to the death or any accident resulting in the death,

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

Furthermore, the determination must set out such recommendations (if any) in relation 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 other steps,

which might realistically prevent other deaths in similar circumstances.

[10] The Procurator Fiscal represents the public interest in investigating, arranging and conducting an Inquiry. An Inquiry is inquisitorial and not adversarial. It is not the purpose of an Inquiry to establish civil or criminal liability. Further, it is not the Inquiry's purpose to apportion blame.

Summary of Evidence

[11] The following facts were established in evidence and by joint minute of agreement:

Background of Mr McClenaghan

[12] Mr McClenaghan was born on 14 April 1961. At the time of his death, Mr McClenaghan was 57 years of age. He was married to Mrs Georgina McClenaghan, with whom he had two children, a daughter Rachel and a son Joshua. The family resided in the Stirling area.

[13] Mr McClenaghan had no significant medical history until the year preceding his death. Mr McClenaghan attended at Viewfield Medical Practice in Stirling on 22 September 2017 and was examined by Dr Scott Williams. Mr McClenaghan explained he had been suffering from shortness of breath. Upon examination by Dr Williams, Mr McClenaghan was found to be significantly short of breath after going up and down the stairs at the medical practice. His oxygen saturation levels were observed to drop to 85% and his pulse was 130bpm during this exercise. Following the examination, Mr McClenaghan was referred originally to the Cardiology Department at Forth Valley Royal Hospital by Dr Williams. The referral was redirected to the General Respiratory Medical Department on 27 September 2017. Dr Williams recorded that the reason for the referral was due to Mr McClenaghan suffering from shortness of breath, a persistent cough and muscular pain in his right arm.

[14] Whilst under the care of Mr Douglas Morrison, a Consultant at Forth Valley Royal Hospital, Mr McClenaghan underwent a computed tomography pulmonary angiogram (CTPA) lung scan on 17 November 2017. There was no pulmonary embolism (blood clot) identified by this scan. However, the scan was deemed to be "suboptimal", meaning that, although acute pulmonary embolism could be excluded, smaller blood clots could potentially have been missed. A bronchial challenge test was organised, but Mr McClenaghan did not attend the appointment, and it was not rearranged.

[15] Mr McClenaghan was employed by Park's of Hamilton as a General Sales Manager based at their Park's Kia premises located on Dundyvan Road in Coatbridge ("the Kia garage"). The Kia garage was a car dealership selling new and used cars as

well as providing a full range of vehicle servicing and repairs. As the General Sales Manager, Mr McClenaghan was responsible for overseeing sales, service, parts, accounts, drivers, body shop and sales administration.

[16] In August 2018, the procedure for locking up the Kia garage premises involved an employee locking the buildings and setting the alarm system for the premises. If the alarm system was not set by a pre-determined time each day, a notification was made to the alarm monitoring company who would then contact the Park's security team to alert them to the fact that the alarm had not been set. If such an alert was received, a member of the Park's security team would attend the premises.

Scottish Ambulance Service emergency call handling in August 2018

[17] In 2018, the Scottish Ambulance Service ("SAS") operated a priority-based system of dispatch to try to ensure that emergency ambulances are available to respond to the most serious and life-threatening cases in the first instance. Call handlers utilised a software system called the Medical Priority Dispatch System ("MPDS") to prioritise all requests for emergency ambulances. This was a computerised system that, in response to information provided by the caller, determined a coded response level for the call.

Pre-Entry Questions

[18] The term "pre-entry questions" refers to the practice of a call handler confirming if a patient is conscious and breathing before obtaining any detailed information from the caller. Front loading this question, allows for an ambulance to be dispatched as

quickly as possible in a situation where a patient is not breathing. In 2018, the MPDS system required call handlers to confirm the location for the call before asking the pre-entry questions.

Address Search

[19] MDPS utilised the Ordnance Survey Gazetteer database to enable call handlers to search for an address. This was integrated into the MDPS software. The Gazetteer database was often slow to be updated. SAS call handlers had internet access that enabled them to utilise Google search functions and Google Maps to assist them in searching for a location. The use of Google was an informal but common practice at the time.

Confirmed or Unconfirmed location

[20] In 2018, SAS call handlers required a caller to repeat back the address for the call before the location could be regarded as confirmed. If a caller was not able to repeat back the address, the address would be recorded in MDPS as "unconfirmed".

Response Categories

[21] SAS implemented the New Clinical Response Model ("NCRM") for emergency 999 calls in November 2016. The NCRM included changes to the response categories utilised within MDPS. The categories relate to the level of acuity with triage-determined response levels. These categories were based on an internal SAS review of

approximately 500,000 incidents and analysis of interventions and outcomes experienced by patients. The response categories are:

(i) **Purple** – This is where a patient is identified as having a 10% or more chance of having a cardiac arrest. The actual cardiac arrest rate across this category is >50%.

(ii) **Red** – This is where a patient is identified as having a likelihood of cardiac arrest between 1% and 10%. In fact the mean rate is 1.3%.

(iii) **Amber** – This is where a patient is identified as having a likelihood of cardiac arrest less than 1%, but a high likelihood of need for definitive care. For example, this may include patients affected by stroke who need to go to a specialist stroke unit or patients with chest pains who may be experiencing a heart attack and needs to go to a primary coronary intervention centre for emergency care.

(iv) **Yellow** - This is where a patient is identified as requiring an emergency ambulance response but have a range of conditions that are not life threatening and whose care requirements can be met either in a local Emergency Department or by treatment at the scene.

(v) **Green** – This is for all remaining patients.

[22] The NCRM introduced a move to a dispatch on disposition model, where assessment and management of 999 calls allows for the allocation of an appropriate resource when disposition is reached. "Dispatch on disposition" means dispatch when

the triage system has reached the final dispatch code and thereby determined the priority of the call.

Designation of caller

[23] A "first party caller" is the patient themselves. A "second party caller" is an individual who is directly with the patient. A "third party caller" is explained within "Principles of Emergency Medical Dispatch – Fifth Edition" as:

> "These people are not directly involved with, or in close proximity to the incident but are helping by calling. They are the people who heard a crash, glanced out the window, and saw that an accident had occurred, but did not actually go to the scene. They are the ones who work as security guards and can only tell you that someone rushed up to the desk yelling 'Call an ambulance!' and then rushed off. Third party callers tend to know fewer specific details (but rarely nothing) about the situation"

ProQA

[24] The ProQA is an evidence-based Emergency Medical Dispatcher (EMD) software package that was part of the MDPS and was used in SAS Control Centres at the time of the death of Mr McClenaghan. During the course of a 999 call, the ProQA software guided the call handler through the process of collecting vital information from the caller, enabling the software to identify and select an appropriate response level and dispatch code. In addition, the ProQA would guide the call handler to provide the caller with medically approved protocols that they could follow to assist the patient whilst waiting for the ambulance to arrive at the scene.

Unknown information and Malicious Coding

[25] The term "malicious code" refers to the situation where a call handler is unable to answer specific questions within ProQA and requires to enter "unknown" in response to questions. The MPDS software will then generate a final code that cannot be relied upon. The ProQA does not allow the call handler to select a different code. In 2018, the ProQA did not allow a call handler to process a 1st or 2nd party call with "unknown" responses. The only method of processing such a call was to proceed as a 3rd party call within ProQA.

Sudden Arrest Tool

[26] The MDPS had a Sudden Arrest Tool available to call handlers as part of the ProQA. It was available at any time within the ProQA and accessed by clicking on an on-screen sudden arrest icon within the software. This provided a pathway for medical situations where a patient was reported, or suspected, to be in cardiac or respiratory arrest. Use of the Sudden Arrest Tool would immediately upgrade the call to a **purple** response category. If a patient deteriorated into cardiac or respiratory arrest during a call, following a dispatch code having been generated earlier in the call, the use of the Sudden Arrest Tool by the call handler would upgrade the previous response category to purple (if necessary). The use of the Sudden Arrest Tool would also be immediately communicated to the dispatcher and ambulance crew.

[27] In August 2018, guidance was available to call handlers on the use of the Sudden Arrest Tool that indicated that if a first party caller suddenly goes silent and stops

responding, the call handler should "gauge the situation yourself" to determine whether to use the Sudden Arrest Tool. An operational alert issued to SAS call handling staff in April 2018 discussed the use of the Sudden Arrest Tool where a patient deteriorates **after** the chief complaint selection has been made within MDPS. This alert did not address the situation where a patient deteriorates prior to the chief complaint selection having been made.

Silent and Disconnected Calls

[28] A silent call is one where the call remains connected, but the caller has gone silent. This can occur for a number of reasons, eg the caller is unable to speak due to their medical condition, or the caller may be in a dangerous situation and unable to make any noise. In the event that the call handler did not form the view that use of the Sudden Arrest Tool was appropriate for the call, the call handler was advised to adapt their questioning approach to identify whether the caller was able to respond in an alternative way, such as by pressing buttons on the phone. Call handlers were advised to notify their supervisor of any calls of this nature.

[29] A disconnected call is one where the caller has hung-up the call or the call has been terminated for other reasons, such as poor mobile signal, etc. In the event of a disconnection, the call handler would ask the BT operator to come back on the line to ascertain whether they can provide any further information. Call handlers would also be expected to call back the caller 3 times and leave a voicemail, if that option was available. This would all be recorded by the call handler on the MDPS system.

[30] When a 999 call disconnects, the call handler is met with silence on the line. There is no audible disconnection tone on the line when a call is disconnected. There is no technology based system or process that enables a call handler to identify when a call has been disconnected, as opposed to a silent call.

Replaying 999 calls

[31] Call handlers do not have access to replay a 999 call received by them. Only supervisors have access to the recording of a call. A supervisor can review a call and access the recording of a 999 call within a few minutes.

Patient not found

[32] In August 2018, there was no formal guidance for ambulance crews or ambulance control centre ("ACC") dispatch staff on what actions to take or processes to follow in the event that a patient could not be located. Ambulance crews had no training on how to conduct a search for a patient.

26 August 2018

[33] On the morning of 26 August 2018 Mr McClenaghan complained to his wife that he was feeling faint and struggling to breathe. Notwithstanding this, Mr McClenaghan took the decision to go to work that day. Mr McClenaghan was due to work from 11am to 5pm that day. He travelled to work and arrived at the Kia garage shortly before

11am. There were a number of other Park's staff on duty that day. All staff in attendance that day were likewise working from 11am to 5pm.

[34] At 5pm the premises closed and all other staff members left the premises, leaving Mr McClenaghan alone in the premises.

1st Telephone Call to Emergency Services

[35] At 1745 hrs Mr McClenaghan called emergency services by dialling 999 from his mobile phone. The call was routed to call handler, CH1.

[36] The transcript of the call was as follows:

CH1: Ambulance emergency – What is the telephone number you are calling from?

Mr McClenaghan: Eh 07*** (* = number redacted)

CH1: Yes

Mr McClenaghan: Sorry – 07***

CH1: Yes

Mr McClenaghan: ***

CH1: Yes

Mr McClenaghan: ***

CH1: What is the address of the emergency?

Mr McClenaghan: Park's Coatbridge

CH1: What was that – Parks?

Mr McClenaghan: Parks – Ahhh

CH1: Have you got the street name?

Mr McClenaghan: Kia – Dundyvan Road

CH1: Sorry I can't hear what you are saying

Mr McClenaghan: Em – Parks Kia, Dundyvan Road

CH1 – Right what was the postcode?

Mr McClenaghan: Eh – ML5—1DB

CH1: 1?

Mr McClenaghan: DB – ahh – ahh – ahh

CH1: And is there a door number?

Mr McClenaghan: Ahhhh – No (garbled speech) Ahhhh – Ahhhh – Ahhhh

CH1: I am really sorry I can't make out what you are saying

Mr McClenaghan: Ahhhhhh

CH1: So it is ML5

CM: Ahhhhh – Ahhhhh – Ahhhhh

CH1: So ML5 is coming up as Dundonald Road – is it Dundyvan you said?
Mr McClenaghan: (silent – no reply)

CH1: Hello-----Hello-----Hello-----Hello-----Hello-----Hello-----Operator can you come back to the phone for me?-----Hello-----Operator. Hello-----Operator-----Hello -----come back to the phone for me please?----Hello

[37] The total length of the call was 2 minutes and 35 seconds. Mr McClenaghan stopped responding 1 minute and 8 seconds into the call.

[38] CH1 did not initially appreciate that when Mr McClenaghan stated "Parks Coatbridge", he was referring to the Park's business premises. Furthermore, CH1 did

not fully understand that Mr McClenaghan was saying "Dundyvan Road". CH1 therefore undertook a number of searches on MDPS using partial search parameters such as "DUND" and "COAT" and "ML5 1" in an effort to identify the location of Mr McClenaghan. CH1 undertook a search for "Kia" which returned a different postcode and street name. CH1 utilised the Gazetteer function within SAS systems along with a Google search in her efforts to identify the location of Mr McClenaghan. CH1 was assisted in searching by her supervisor, Karen Panton.

[39] At 1749 hrs, CH1 identified the location of the Park's premises on Dundyvan Road. The address was recorded on the dispatch system software as an "unconfirmed" address as it had not been repeated back to CH1 by Mr McClenaghan. It remained unknown to CH1 whether Mr McClenaghan was nearby the location of that address, within the car park, within any of the multiple buildings at the location or elsewhere.

[40] CH1 was thereafter required to enter further information into the dispatch software to enable the system to generate a response category. This was done by CH1 answering a number of questions within the ProQA software. As a consequence of the limited information available, CH1 was required to answer a number of questions as "unknown" to enable the call coding process to progress. CH1 required to process the call as a 3rd party call. The system generated a code 32B03 and allocated a YELLOW response category. This was an example of a "malicious code".

[41] CH1 was able to enter free text information into the software during the coding process. CH1 entered the following free text:

- MALE MOANING SOUNDED LIKE HE WAS IN PAIN

- THEN THE LINE CLEARED
- OPERATOR WOULD NOT COME BACK ON THE LINE
- THEN CONFIRMED WITH SUP KP TO CLEAR AND
- CALL BACK BUT JUST GOING TO VOICEMAIL
- LEFT MESSAGE

[42] In response to the question "What's the problem:", CH1 entered:

- MALE – MOANING LIKE HE WAS IN PAIN THEN LINE CLEARED – UNKNOWN ISSUE

[43] When Mr McClenaghan stopped responding during the call, CH1 believed that the call had been disconnected. CH1 did not consider that Mr McClenaghan may have deteriorated into cardiac/respiratory arrest and therefore did not utilise the Sudden Arrest Tool.

1st Ambulance attendance

[44] An ambulance was allocated and dispatched at 1749 hrs in response to CH1 entering the address for the Park's premises. The ambulance was dispatched prior to CH1 completing the call coding process. The ambulance that was allocated to the call was staffed by Karen Kidd and David Shaw. Karen Kidd was driving the ambulance. The ambulance arrived at the Park's premises at 1752 hrs. The ambulance arrived in less than 3 minutes from being allocated. The ambulance arrived 7 minutes after Mr McClenaghan called 999.

[45] On arrival, the ambulance turned right on Dundyvan Road, into the Park's premises. The Ambulance was driving slowly as it entered the large forecourt area. There was no one seeking to attract the attention of the ambulance crew or to direct

them to a patient. The ambulance crew had a clear view of the building. Karen Kidd observed the building had no lights on. The security barrier at the entrance to the forecourt was open. The ambulance drove slowly around the large forecourt/parking area. The ambulance crew did not alight from the vehicle.

[46] At 1755 hrs, David Shaw contacted Emergency Dispatcher, David Strachan, seeking any additional information to assist them in locating a patient. David Strachan advised the crew that there was no additional information available. Karen Kidd and David Shaw were advised to standby whilst David Strachan made attempts to contact Mr McClenaghan on his mobile number. Whilst waiting for David Strachan to get back to them, Karen Kidd and David Shaw decided to search the area surrounding the Kia garage. They were aware from knowledge of the local area that there were often calls from the vicinity of a set of stairs behind the Kia garage. They decided to leave the car park of the Kia garage onto Dundyvan Road, turned right and right again onto Buchanan Street heading towards the Time Capsule. They then drove into Henderson Street from there they could see the back of the Kia garage and looked around the to see if they could identify anyone in need of assistance or seeking to draw their attention.

[47] After failing to identify anyone, Karen Kidd and David Shaw drove back onto Dundyvan Road and then crossed over into Hutchison Place, directly opposite the Kia garage. Again, they did not see anyone flagging the ambulance or drawing attention to themselves. They drove to the end of Hutchison Place, performed a turn in the road and were proceeding back towards Dundyvan Road when at 1800 hrs they received a stand down message. Had the stand down message not been received, both Karen Kidd and

David Shaw indicated that they would have returned to the Kia garage to undertake a more thorough search of the premises.

Ambulance Control Centre ("ACC")

[48] As the ambulance crew were undertaking a search of the area surrounding the Kia garage, as noted above, David Strachan made efforts to contact Mr McClenaghan on his mobile number. David Strachan called the mobile number three times but received no answer. He was instead diverted to voicemail where he left the following voicemail message: "This is the ambulance service, please phone back on 999"

[49] David Strachan then spoke with his supervisor, Louise Millar, and explained to her that he had attempted to make contact with Mr McClenaghan on the mobile number and informed her that the crew were unable to locate the patient. Lousie Millar was at that time dealing with an ongoing call in the Glasgow area. She logged into the call briefly on MDPS to confirm that David Strachan had recorded that call backs had been made by him. She noted that it was a 3rd party call and that it was an unconfirmed address at a public location. She thereafter made the decision to stand down the ambulance crew. Louise Millar did not fully review the call history or listen to the original 999 call. Louise Millar did not see the free text entries made by CH1 or the dispatch message sent to the crew advising of a "male moaning". The fact that the call was recorded as a 3rd Party call and an unconfirmed address influenced the decision of Louise Millar to stand down the ambulance.

[50] As a supervisor, Louise Millar had the ability to listen back to the original 999 call from Mr McClenaghan. In evidence, she estimated that it would have taken her 5 minutes to review all of the information relating to the call, including listening back to the original 999 call. Lousie Millar was the only supervisor on shift that day and was busy dealing with another matter when David Strachan approached her to discuss the call. There should have been two additional supervisors on shift that day, including a Call Handling supervisor.

2nd Telephone Call to Emergency Services

[51] At approximately 1830 hrs, Scott Aitken, a member of the Park's security staff, received a telephone call from the alarm company that monitored the alarm system at the Kia garage. Scott Aitken was advised that the alarm system had not been activated at the Kia garage after the premises closed that evening. Scott Aitken thereafter made his way to the Kia garage, arriving shortly before 1850 hrs. Upon arrival, Scott Aitken saw that the barrier permitting access to the forecourt was open and found that the main door to the car showroom was unlocked. Scott Aitken entered the premises and found Mr McClenaghan lying face down on the floor within his office.

[52] Scott Aitken turned Mr McClenaghan around onto his back. He found that Mr McClenaghan was not breathing. He attempted CPR on Mr McClenaghan but could not get a pulse. Scott Aitken then called 999 at 1853 hrs. An ambulance was immediately dispatched with a Purple priority, arriving at the Kia garage at 1858 hrs.

2nd Ambulance attendance

[53] Upon arrival, the ambulance crew, consisting of James McSherry, Brian Morris and David Meikle could see no obvious signs of activity outside the Kia garage or in the forecourt. They conducted an initial search of the premises from within their respective vehicles for approximately 2 minutes. The three then discussed what to do next. Brian Morris' attention was then drawn to a van with "Park's of Hamilton" livery as it looked as though it had been abandoned close to the entrance of the Kia garage, and it was not parked in a marked parking bay. Brian Morris proceeded to investigate further by alighting his vehicle, looking into the window and banging on the glass entrance doors to the Kia garage. He noted the doors were locked. He shouted to draw attention to himself. Scott Aitken responded to the shout and directed Brian Morris to an open door on the left side of the building. James McSherry and David Meikle then joined Brian Morris in the showroom.

[54] Mr McClenaghan was located by the ambulance crews in an office to the rear of the car showroom. Scott Aitken was carrying out CPR when the ambulance crews entered the office. James McSherry took over CPR whilst Brian Morris attached a defibrillator to Mr McClenaghan's chest. Mr McClenaghan was found to be asystolic, meaning that he had no pulse and a defibrillator would be of no assistance to him.

[55] The decision was taken by James McSherry and David Meikle to stop resuscitation efforts and life was pronounced extinct at 1910 hrs on 26 August 2018. David Meikle contacted Ambulance Control at 1911 hrs and spoke with David Strachan, confirming that the deceased had been located, and life had been pronounced extinct.

He also requested that David Strachan contact officers from the Police Service of Scotland to ask them to attend at the Kia garage.

Post Mortem Examination

[56] A post mortem examination of Mr McClenaghan was carried out on 29 August 2018 by Dr Sarah Bell at the Queen Elizabeth University Hospital, Govan Road, Glasgow and the cause of death was recorded as:

1. Pulmonary thrombo-embolism

1b. Right calf deep vein thrombosis

The conclusions contained within the post mortem report are as follows: -

> "The background circumstances are noted as above. Post mortem examination reveals bilateral pulmonary thrombo-embolism with evidence of thrombo-emboli involving the main branches of the pulmonary artery and its tributaries. There is also deep vein thrombosis in the deep veins of the right calf representing the source of the emboli. These findings represent the cause of death, the mode of death being sudden cardio-respiratory collapse. There are a number of risk factors for the development of venous thrombo-embolism including recent immobilisation (such as long distance travel), underlying medical co-morbidity such as cardiac disease and hypercoagulable states including rare inherited thrombophilia. It is not clear from the circumstances provided if the deceased had any of these risk factors. Of note there was no evidence of malignancy in any of the organs at post mortem examination.
>
> Examination of the heart showed mild left ventricular hypertrophy and mild to moderate coronary artery atheroma. There were no other pathological findings."

Remedial action by SAS

[57] A number of changes have been implemented by SAS after the death of Mr McClenaghan which have improved the safety and accuracy of the SAS response to

999 calls in situations such as those presented by the call of Mr McClenaghan. Revisions and improvements have been implemented in the following areas of policy and practice:

The procedure to be followed where a patient cannot be located

[58] The SAS National Clinical Bulletin (017/19) was issued in November 2019 directly in response to the circumstances surrounding the death of Mr McClenaghan and the recommendations made following an internal Significant Adverse Event Review("SAER")[1] undertaken by SAS.

[59] The Bulletin contains a flowchart, which outlines the procedure that ambulance crew, emergency call handlers and call handling/dispatch supervisors should follow in order to ascertain the location of a patient in situations where a patient cannot be located. This new procedure ensures that further action is now taken by ambulance crews, supervisors and third parties to attempt to verify the location of a patient who cannot be located.

Technology to trace the location of a patient or caller

[60] In October 2018, SAS introduced Advanced Mobile Location ("AML"). AML is a system that allows SAS to pinpoint a caller's location in circumstances where the caller cannot clearly confirm it. In July 2020, SAS introduced a location search system called LS2 as part of the AML system. Within LS2, AML will trigger an automatic Gazetteer

[1] The SAER was not admitted into evidence although the court was aware that such a review had taken place.

search of locations which are nearby the coordinates from which the call is being made. Those results are then presented to the call handler for review. Where a 999 call is made from a mobile phone, a circle will appear covering the area within which the phone is located by use of signal triangulation. This circle will vary in size depending on the information supplied but is an additional tool available to assist in identifying the specific location of callers.

[61] AML coordinates will pinpoint location to an accuracy level of 50 metres for around 85% of calls made from UK locations. When a smartphone is used to make the call, AML can provide an even more accurate location of the caller, down to the nearest metre. This more accurate location is provided through use of the additional GPS and WiFi capabilities of the smartphone which are not present on older mobile phones.

[62] Separately, SAS also integrated "What3Words" into their systems as part of LS2 in October 2019. What3Words is a software tool that is available as a mobile application or by accessing the What3Words website on any internet enabled mobile device. What3Words divides the world into 3x3 square metres so that each square has a unique three-word address. It is useful because there are many areas that do not have a traditional address and can be difficult to describe, especially in an emergency, such as remote stretches of road, forestry, rivers, and hillsides, which can all be overcome using the What3Words system. Where callers to SAS can provide the three-word address for their location, the SAS call handler is able to instantly identify the location of the caller within a 3 square metre area.

[63] Locations of patients are no longer described as "unconfirmed location". Call handlers are now instructed to escalate location issues to supervisors for immediate investigation. This process might involve checking the last known number, contacting the mobile provider, liaising with police and fire services, or using GPS data or call recordings to verify the location.

Sudden Arrest Tool

[64] Further guidance on the Sudden Arrest Tool has been issued by SAS since 2018, with the most recent update in November 2024. The guidance on the use of the Sudden Arrest Tool now makes it clearer that the tool can be used at any stage during a call. It also immediately alerts the dispatch team to a change in response priority and ensures that appropriate resources, such as Community First Responders, can be tasked immediately to attend the patient and manage the scene. Use of the Sudden Arrest Tool will now prompt call handlers to ensure that any nearby AEDs (defibrillators) are identified and used as soon as possible where patients in cardiac arrest are identified.

[65] Call handlers still require to make a judgment in whether to use the Sudden Arrest Tool based on certain indications that may suggest that the patient has had an arrest. Guidance to SAS staff now specifically stipulates that:

> "when a 1st party caller stops responding and there are indications that it may be an arrest (for example, noises that can be heard, what the caller said before they stopped responding), the Sudden Arrest Icon should be used to upgrade the response."

Pre-Entry Questions

[66] In June 2021, SAS introduced a "Pre-Entry Questions Practice Guideline". This was updated in February 2022. This guideline stipulates that pre-entry questions must now be asked prior to confirming the caller's phone number and location (if not electronically obtained). This approach is consistent with the approach taken by other UK ambulance services and enables the identification of patients in cardiac arrest sooner. When a 999 call is made now, the first questions establish whether the patient is conscious and breathing before confirming the location.

Silent and Disconnected calls

[67] In April 2019, SAS commenced work on improving how MPDS operated in handling silent and disconnected calls. A number of changes were introduced in 2021 and followed up in 2024 with comprehensive MDPS Practice Guidelines that amalgamated all guidance in relation to callers who stop responding or where a call disconnects. The guidelines discuss a number of scenarios:

a) Where 1st party caller stops responding – POSSIBLE ARREST

In such a situation, the Sudden Arrest Tool is to be used. The use of the tool is a matter of judgment to be made by the call handler. All SAS call handling staff receive training to assist them in identifying signs indicative of cardiac/respiratory arrest.

b) Where 1st party caller stops responding and address is unconfirmed or unknown

In such a situation, the call handler must record any unconfirmed address information that has been provided or record that address is unknown, as appropriate. Thereafter the call handler records the call as "1ST PARTY – LINE OPEN – NO RESPONSE" within MDPS along with details of any sounds that can be heard or any other information that is known. The call must also be immediately escalated to the call handler's supervisor.

c) Where caller hangs up or call is disconnected

In such a situation, the call handler will make at least three attempts to call back the caller. If communication cannot be reestablished, the call handler should select one of two MDPS override codes within ProQA:

i) CDIS – this is to be used where the call disconnects after location has been identified

ii) NOADD – to be used when call disconnects before location information has been obtained.

Use of either of these codes will immediately escalate the call to an AMBER response code and a supervisor must be notified by the call handler.

[68] Where any call is passed to a supervisor, that supervisor is required to review all location information that is available from technology solutions and undertake further investigations including further call backs to the number and searching for any historic calls from that number. In addition, they can make enquiries with Police Scotland to identify whether they hold any historic call data from that number to assist in

identifying a location. The mobile phone provider should be contacted to ascertain details of the mobile phone account holder. Once all available information is taken into account, it is the responsibility of the Duty Manager to decide what course of action is taken for the incident.

[69] It should be borne in mind that whilst these guidelines set out steps to be taken when location information is unavailable, the automated location technology discussed above, particularly AML, make it increasingly unlikely that the call handler will not have location information available in regards to a call, even where a call is silent.

Expert Evidence

[70] The Inquiry was assisted by the expert evidence of Professor Adam Hill, Consultant Respiratory Physician and Honorary Professor, which was subject to agreement between all parties. Professor Hill provided an independent expert report in relation to the pulmonary embolism and survivability of the condition that Mr McClenaghan suffered from. His report is dated 13 December 2023. Professor Hill's conclusions were as follows:

> "In my opinion he had hypertension, hypercholesterolaemia and ischaemic heart disease prior to his death.
>
> The post mortem noted that there was adherent coiled thrombo-embolus occluding both pulmonary arteries and extending down the tributaries in keeping with pulmonary embolism and noted a right deep venous thrombosis. There was no pneumonia and no myocardial infarction or cerebral infarction.
>
> The conclusion from the post mortem was that the cause of death was 1a Pulmonary thromboembolism due to 1b Deep venous thrombosis.

> In my opinion I agree the cause of death for the late David McClenaghan was due to pulmonary embolism due to propagation from the clot in the right leg (deep venous thrombosis). In summary the blood clot went from the deep veins of the right leg to both the main arteries supplying the lungs (pulmonary arteries). There was no other cause of death identified from the post mortem- there was no pneumonia, no myocardial infarct and no cerebral infarct.
>
> The main risk factor for thrombo embolic disease was his obesity.
>
> In summary, the late David McClenaghan had symptoms of severe pulmonary embolism from around 10 am on the 26.08.2018 but did not seek medical attention. A 999 call was raised at around 17:45 hrs the same day but communication ceased, and it is likely he had a cardiopulmonary arrest at this point and life ceased at this stage. **In my opinion, it would have made no material difference even if the late David McClenaghan was found earlier by the ambulance crew. If an ambulance crew theoretically were there around, 17:52, in my opinion his life had already ceased around 17:45, it was too late for cardiopulmonary resuscitation to be successful and would therefore not have materially affected the outcome.**" (emphasis added)

[71] The Inquiry was also assisted by way of written evidence in the form of expert reports from Mr Luke Mariner, Deputy Director for Contact Centres and Consultant Paramedic, North West Ambulance Service NHS Trust and Mr James Goulding, Emergency Operations Centre Clinical Response and Governance Manager, Yorkshire Ambulance Service. Both reports were of particular assistance to the Inquiry in navigating the complexities of emergency call handling processes and practices.

[72] In his oral evidence to the Inquiry, Mr Mariner described the emergency call hander's role as one of, if not, the most difficult jobs within the ambulance service. Call handlers are required to assess calls quickly with limited information and in circumstances where callers are often in very stressful situations. Call handlers will often have only a very short window to pick up, identify and assess information from callers. Call handlers require to exercise judgment in very difficult circumstances. There

is always scope for human error and misunderstanding. All ambulance services accept that there is a level of risk in such situations and that mistakes will be made. Mr Mariner indicated that the issues that arose with Mr McClenaghan's call and the subsequent handling of the call are not unique to SAS and have been faced by ambulance services across the country.

[73] Both Mr Mariner and Mr Goulding considered the current policies and practices in place within the SAS in relation to the management of calls such as that made by Mr McClenaghan. Both agree that the current policies of the SAS are in line with MPDS standards and neither expert made any recommendation for further improvement at this time.

Discussion

[74] All parties lodged written submissions to the Inquiry at the conclusion of the evidence. Parties helpfully identified several key areas for discussion within their submissions.

Call Handling

Actions of CH1

[75] As highlighted above, CH1 was engaged in the call with Mr McClenaghan for 68 seconds before he stopped responding. During that time, the focus of the call was entirely on seeking to confirm the location of the emergency. As well as speaking to Mr McClenaghan during the call, CH1 was contemporaneously entering location search

parameters into the MDPS software. It is clear from the recording of the call that CH1 was struggling to make out what Mr McClenaghan was saying at times. CH1 believed that the call from Mr McClenaghan had disconnected when in fact we now know that he had gone silent because he was experiencing a cardio pulmonary arrest. CH1 explained that there was a very short window to pick up and identify presenting symptoms during a call where she found the caller to be unclear and required to ask him to repeat himself. CH1 explained that there was no sudden thud sound or agonal breathing that may have assisted in identifying that use of the Sudden Arrest Tool was appropriate. CH1 explained that listening to the call with the benefit of hindsight makes it more obvious that Mr McClenaghan was suffering a sudden cardiac event. CH1 indicated that they had concerns at the time regarding the coding of the call as a third party call but explained that the MPDS system would not allow them to process the call as a first party call. CH1 was of course aware that an ambulance had been dispatched quickly.

[76] CH1 considered that the call from Mr McClenaghan had disconnected. The call from Mr McClenaghan was in fact a silent call rather than a disconnected call. This issue was discussed in evidence with Mr Mariner. He explained that it is difficult for call handlers to distinguish between silent and disconnected calls. He highlighted that the telephony infrastructure used by emergency services does not produce a disconnected tone when calls disconnect. In my view, had CH1 been able to correctly identify that the call from Mr McClenaghan was in fact a silent call, it is reasonable to infer that CH1 may have considered utilising the Sudden Arrest Tool. Accordingly, I am satisfied that the failure of the telephony systems used by SAS call handlers to readily identify when a

call has been disconnected was a fact relevant to the circumstances of the death of Mr McClenaghan.

[77] The evidence from Mr Mariner was that there is currently no disconnected tone engaged when a call is disconnected. There was no other evidence before the Inquiry to indicate whether the telephony systems used by SAS have the technical capability to play a tone when a call is disconnected, or indeed to trigger some other mechanism of alert, to identify when a call has been disconnected, as opposed to when a call has gone silent. Whilst I acknowledge that the technical ability to affect change to the telephony systems used by SAS call handlers may be outwith the immediate control of SAS, I have come to the view that it is appropriate for me to make a formal recommendation that SAS seek to introduce such a capability into their telephony systems.

Malicious coding

[78] The MDPS system in 2018 required CH1 to answer "unknown" in response to questions within ProQA to enable the call from Mr McClenaghan to be progressed so that a dispatch code could be generated. The use of the term "unknown" is presumed by the ProQA software to mean that a third party caller is answering that they don't know the answer to the question. As such, the call from Mr McClenaghan generated a malicious code, namely "32B03". CH1 was not able to override this code, other than through the use of the Sudden Arrest Tool. The malicious code generated by the call from Mr McClenaghan attracted a Yellow response category.

[79] There was a clear consensus between the parties to the Inquiry and the expert witnesses that the requirements of the MDPS software for CH1 to select a malicious code was not appropriate. In particular, the use of the malicious code categorised the call from Mr McClenaghan as a third party call, which had an impact on the actions of dispatch staff (discussed below). The use of a malicious code was a failing within the MPDS system. In my view, the use of the malicious code was a fact relevant to the circumstances of the death of Mr McClenaghan

[80] In considering how the call from Mr McClenaghan would be handled now, it is clear that the availability of the CDIS or NOADD override codes would allow a call handler, assuming that the Sudden Arrest Tool was not engaged, to progress the call from Mr McClenaghan without the use of a malicious code. CH1 stated in their affidavit, that if faced with the same call today, they would use the CDIS override code, which would of course progress the call as a first party call with an amber response category.

[81] I am satisfied that SAS have made significant improvements to the MDPS system to eradicate the need for call handlers to use a malicious code in circumstances similar to that of the call from Mr McClenaghan. Accordingly, I have no recommendations to make on this issue.

Pre-entry questions

[82] In 2018, the MDPS system required that a caller's location is confirmed before pre-entry questions were asked regarding the patient's state of consciousness and

breathing. Had Mr McClenaghan been asked the pre-entry questions at the outset of the call, it is likely that would have responded with answers that would have made it abundantly clear that he was the patient. It is also very likely that Mr McClenaghan's answers may have assisted CH1 in determining whether the use of the Sudden Arrest Tool was appropriate. The timing of the pre-entry question in 2018 was a fact relevant to the circumstances of the death of Mr McClenaghan. I must caveat this with an acknowledgement that had the pre-entry questions been asked of Mr McClenaghan before any questions being asked regarding his location, it is possible that CH1 would have been unable to progress the location identification questions with Mr McClenaghan sufficiently to identify the Kia garage as the location.

[83] In 2021, SAS introduced changes to the MDPS system so that pre-entry questions are asked at the outset of a call, before any questions are asked to confirm the caller's location. This change occurred following significant improvements to location identification technology in MDPS, such as AML. Accordingly, if the call from Mr McClenaghan was to be made today, it is very likely that AML would have identified his location from his mobile phone. Mr McClenaghan would have had sufficient time to answer some, if not all, of the pre-entry questions and it is very likely that a call handler would engage the Sudden Arrest Tool. Accordingly, I have no recommendations to make on this issue.

Ambulance Control Centre/Dispatch

[84] As noted above, in 2018 there was no formal guidance available to dispatch staff on how to manage a situation where a patient could not be located. Louise Miller explained that when she was approached by David Strachan, he indicated to her that he had already attempted to call back Mr McClenaghan three times after the ambulance crew had reported to him that the patient could not be located. She logged into the call on MDPS for only 15 seconds. She did not fully review the call record on MDPS. She relied on the information provided to her and made the decision to stand down the ambulance.

[85] In her evidence, Louise Miller estimated that it would have taken her approximately 5 minutes to review all of the information relating to the call, including listening back to the original 999 call. She indicated in her evidence that she was the only supervisor on shift at the time and that her workload at the time meant that she was unable to fully review the call. There should have been two other supervisors on shift at the time. Louise Millar indicated that had she been aware of the information recorded by CH1 of "male moaning in pain", she would not have stood down the ambulance and would have taken the time to fully review all of the information available regarding the call, including listening back to the original call. Had she done so, she would have identified that this was in fact a 1st party call.

[86] In his evidence, Mr Mariner indicated that it would have been best practice for Louise Miller to have investigated matters more fully by considering all of the call information recorded on MDPS and by listening back to the call recording. However,

both Mr Mariner and Mr Goulding were clear that Lousie Miller followed all procedures and policies in place at the time and furthermore, on the basis of the information presented to her, the decision to stand down the ambulance was a reasonable and appropriate one to make at the time.

[87] The evidence from the 1st ambulance crew was that they were making their way back to the Kia garage to continue their search when they received the stand down call. Accordingly, I am satisfied that the reduced supervisor staffing levels on 26 August 2018 was a fact relevant to the circumstances of the death of Mr McClenaghan. Furthermore, the lack of clear policy or procedure in place detailing how dispatch staff should respond when a patient cannot be located by an ambulance crew was also a fact relevant to the circumstances of the death of Mr McClenaghan.

[88] There have been a number of changes introduced by SAS since 2018 that would result in the call being handled differently now by dispatch staff. The process flowchart (see appendix 1) set out in SAS National Clinical Bulletin (017/19), issued in November 2019 would be followed. A dispatch supervisor would be required to ensure that the ambulance crew have all relevant information, the supervisor would listen back to the original call and if appropriate make enquires with local hospitals, NHS 24 and police. As such, Mr McClenaghan's call would now be fully reviewed by a supervisor. This obligation would apply irrespective of staffing levels.

[89] It is worth indicating at this juncture that the family of Mr McClenaghan made submissions inviting the court to make a recommendation in relation to SAS compliance with The Heath & Care (Staffing)(Scotland) Act 2019 and the legal duty of SAS to

maintain appropriate staffing levels under this Act. I am unable to do so. The 2019 Act was not in force in 2018 but more importantly, there was no evidence led during the Inquiry regarding the provisions of the Act or how those provisions would apply to SAS. I do note however that SAS indicated in their oral submissions to the court that they now undertake a quarterly review of their compliance with their obligations under the Act. Accordingly, I have no recommendations to make on this issue.

Actions of 1st Ambulance

[90] The 1st ambulance crew, manned by Karen Kidd and David Shaw, were allocated to the call by dispatch staff at 1749 hrs and arrived at the Kia garage at 1752 hrs, taking less than three minutes to arrive. As such, the call from Mr McClenaghan resulted in a very prompt attendance by the first crew, well within the target response time for a purple or red category call. There are a number of matters arising from the attendance of the 1st ambulance crew that merit consideration:

<u>Impact of unconfirmed location</u>

[91] Both Karen Kidd and David Shaw indicated in their evidence that in 2018 call outs to unconfirmed locations were common, although the majority of calls were to confirmed locations. Whilst it is a matter of agreement that within SAS the use of the term "unconfirmed location" refers specifically to a scenario where a caller has been unable to repeat back a location address to the call handler, the evidence of Karen Kidd was that an unconfirmed location indicated "that they don't have enough details of the

location". Both Karen Kidd and David Shaw indicated in their evidence that had the address been recorded as a confirmed location, they would have acted differently. David Shaw indicated that had the address been listed as a confirmed address, they would have stopped at Parks and exited the vehicle to undertake a perimeter search of the building to identify any entry points. That the call from Mr McClenaghan was recorded as an unconfirmed location was in my view a fact relevant to the circumstances of the death of Mr McClenaghan.

[92] It was clear from the evidence that the recording of the location as unconfirmed by CH1 was appropriate and in keeping with SAS practice at the time. There have of course been changes to the processing of calls and the technology-based location search capabilities discussed above that make it less likely that a call today would be recorded as an unconfirmed location. Mr Mariner in his evidence indicated that there would always be challenges in obtaining a confirmed location in the absence of technology to assist call handlers, due to the fact that callers may often struggle to provide the necessary information for a number of reasons. Whilst the use of unconfirmed locations cannot be eradicated entirely, the technology now available to call handlers makes it far less likely than in 2018. Accordingly, I have no recommendations to make on this issue.

[93] I wish to note at this stage that I was invited on behalf of the family of Mr McClenaghan to make a recommendation that SAS use the term "not repeated" rather than "unconfirmed". I can understand the basis for such a submission, particularly given the suggestion from Karen Kidd's evidence that her understanding of the term was not in keeping with the internal SAS definition. The other evidence

available to me, including that of both Mr Mariner and Mr Goulding was that the term "unconfirmed" was clearly defined and understood within SAS. In the absence of any evidence to suggest that there may be a more widespread misunderstanding regarding the term within SAS, I take the view, on balance, that I cannot make such a recommendation.

Symptomology

[94] The Crown made written submissions under this heading which discuss how the information available to the ambulance crew did not assist them to assess the possible clinical need of the patient or the scene they would arrive at, whilst en route to the call. These submissions seem to have been prompted by the evidence of Mr Shaw and Ms Kidd regarding the information recorded by CH1 of "male moaning in pain" and the fact that "pain" is a vague symptom and very subjective. The Crown submitted that the information provided to the ambulance crew was "too non-specific to justify an immediate assumption of cardiac arrest by the ambulance crew". This is an obvious observation to make. The crew were provided with all of the available information, which was of course very limited. I do not consider that any fact relevant to the circumstances death of Mr McClenaghan fact has been identified on this issue and accordingly, I have no recommendation to make on this issue.

Search

[95] The search of the Kia garage premises undertaken by the 1st ambulance crew involved their driving around the garage forecourt area. They did not exit the vehicle and did not seek to enquire at, or gain entry to, any building on the Kia site. Whilst at first blush this may sound surprising to the average person, the crew justified their actions on the basis that there was no persons seeking to flag them down to catch their attention and the Kia garage appeared to them to be closed, with no lights on. Furthermore, and as discussed above, the location of the call was recorded as unconfirmed. The call was also coded as a third-party call with a yellow response category. As such, the crew determined that it was appropriate to make a search of the wider area around the premises, having failed to locate the patient following the drive through search of the Kia garage.

[96] Mr Mariner commented on the actions of the crew in his report as well as during his oral evidence to the Inquiry. He was of the view that the actions of the first attending crew were reasonable in the circumstances that they were faced with. In coming to that view, he relies upon the coding of the call as a third party call with an unconfirmed address. Whilst he notes that there was reference to a male in pain, there was an absence of more concerning symptoms, such as a patient struggling to breath, a patient having collapsed or a patient having been stabbed as examples. The call priority was not one of a patient at immediate threat to life. He further indicated in his evidence that it would be difficult for him to be critical of the crew in the absence of clear policy or guidance at that time.

[97] Mr Goulding in his report suggests that it would have been reasonable to expect the crew to exit the vehicle and undertake a search of the building perimeter on foot to identify if they could hear signs of anyone seeking to catch their attention. Likewise, he was of the view that it would be reasonable to expect the crew to knock on a single window or try a single door of the premises to see if they were locked. He specifically indicated that he would not expect the crew, in the circumstances that they faced, to check every door or knock at every window. He went on to highlight that in the absence of formal guidance at the time, it is difficult to be too critical of the actions of the crew. He considered that the rationale they have provided for not exiting the vehicle is not in itself unreasonable. Furthermore, he opined that there would be a reasonable number of paramedics faced with the same circumstances, coupled with the absence of a clear policy or guidance, who would support the crews' actions.

[98] I am satisfied that the lack of clear guidance and policy outlining how the crew should manage a situation where a patient cannot be located was a fact relevant to the circumstances of the death of Mr McClenaghan. Whilst I find that, on balance, the actions of the first ambulance crew were reasonable in the specific circumstances that they faced, I am satisfied that the actions of the first ambulance crew in electing not to exit their vehicle when they attended at the Kia garage was a fact relevant to the circumstances of the death of Mr McClenaghan.

[99] There has been significant change and improvement by SAS in this area. There is now a clear policy and process in place for managing incidents where a patient cannot be located. These changes impact both ambulance crews and dispatch staff. It is clear

that a call such as that made by Mr McClenaghan would be handled very differently today. An ambulance crew attending such a call today would take all reasonable steps to locate the patient and dispatch staff, including supervisory staff, would be proactive in reviewing what information was available and escalate as discussed above. Both Mr Mariner and Mr Goulding were satisfied with the improvements that have been made since 2018. Perhaps more importantly, both David Shaw and Karen Kidd indicated in their evidence that the introduction of a clear policy and guidance has been of great assistance to ambulance crews and is an improvement on the situation that they faced in 2018. Accordingly, I have no recommendations to make on this issue.

Other Submissions

[100] There were a number of written submissions made by Mr Nelson inviting the Inquiry to make particular recommendations that have not been addressed above. I will address these each in turn:

a) I was invited to consider recommending that SAS undertake a review of their investigative processes following adverse incidents. This issue was raised by Mr Nelson as a result of it only coming to light shortly before the Inquiry commenced that Karen Panton, who was CH1's control room supervisor on the day in question, had in fact assisted CH1 in identifying the correct location of the call. Accordingly, Ms Panton was not involved in the SEAR. This Inquiry did not hear any evidence regarding the SAER that was undertaken by SAS into the death of Mr McClenaghan. There was no

evidence led about how SAERs are undertaken or what policies or processes govern the SAER process. Accordingly, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances. I do note that in their submissions to the court, SAS have indicated that current practice is that all supervisory staff involved to any extent in any incident will be asked to provide a statement as part of any future SAER undertaken by SAS.

b) There was evidence before the Inquiry to suggest that the Ordinance Survey Gazetteer location search feature within MDPS can be slow to be updated. I was invited to consider recommending that SAS look to integrate other locations systems, such as Google Maps into their software systems. There was of course evidence before the Inquiry to indicate that Google Search and Google Maps are in fact employed by call handling staff routinely. CH1 made use of Google Maps when dealing with the call from Mr McClenaghan. However, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances. The correct location of Mr McClenaghan was of course identified.

c) There was some evidence led regarding the systems in place both in 2018 and currently within SAS in relation to how process developments and changes are communicated to SAS staff. This evidence came from front line

staff who spoke of their own experiences of how such communications are made within their own roles. I was invited to consider making a recommendation that SAS undertake a review of how process changes are communicated with a view to supporting feedback and auditing. Whilst this is perhaps in many ways a common sense suggestion, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances.

d) I was invited to consider making a recommendation to promoting improvements to the structure of SAS internal training and assessment programmes. Again, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances.

e) There was some evidence regarding the use of headsets by call handling staff, including the change from single to double earpiece headsets. There was evidence from CH1 and Louise Miller that they continued to use older headsets following the introduction of the newer model. I was invited to make a recommendation that SAS take steps to ensure that staff use any new equipment as soon as possible after it is issued to staff. This again on the face of it seems to be a common sense suggestion. However, CH1's evidence was that her use of the older headset was not a factor impacting the call from Mr McClenaghan and indeed went on to indicate that she has not noticed any difference in the effectiveness of the newer model headsets.

Accordingly, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances.

f) I was invited to make a recommendation that SAS introduce a mandatory requirement that ambulance crews must exit the vehicle and try all doors of any building at the location of a call. Whilst the fact that the 1st ambulance crew did not exit their vehicle when they attended at the Kia garage may seem surprising to many, a detailed consideration of the evidence led before the Inquiry supports that the actions of the crew were reasonable and appropriate given the information available to them at the time. Indeed, both Mr Mariner and Mr Goulding considered the actions of the crew to be reasonable. There was accordingly no evidence before the Inquiry to support such a recommendation. I would highlight that the remedial changes introduced by SAS since 2018 would make it very unlikely that such circumstances would face an attending crew today.

g) I was invited to consider making a recommendation that SAS introduce a properly documented process for staff to follow when a patient cannot be found, including a requirement that a supervisor reviews steps taken in the search and that they listen to the call recording. This is in fact addressed fully in the SAS National Clinical Bulletin (017/19) that was issued in November 2019. The flowchart therein specifically requires a supervisor to

screen the call recording. Accordingly, I am satisfied that such a recommendation is unnecessary.

h) Finally, I was invited to recommend that at least two Park's of Hamilton employees are on site when the premises are closed at the end of a working day. Again, whilst this may appear to be an understandable suggestion, there was no evidence before the Inquiry to suggest that such a recommendation might realistically prevent other deaths in similar circumstances.

Conclusion

[101] I wish to express my thanks to Ms Carey, Mr Hamilton KC and Ms Anderson, along with their instructing agents, for their assistance to the court in this Inquiry. A great deal of work was undertaken to agree evidence and focus matters for the Inquiry.

[102] This Inquiry heard evidence in the latter part of 2024 in relation to the death of David McClenaghan in August 2018. The toll of this process on the family of Mr McClenaghan will have been significant. Notwithstanding that, the family engaged in the process with dignity and respect for all parties. I wish to express my gratitude to Mr Nelson for the manner in which he represented the family. He did so very ably and with compassion. I hope that the conclusion of this Inquiry will enable the family to now move forward safe in knowledge that real and beneficial change has been affected as a consequence of the important lessons learned from David's passing.

[103] I end this note where the Inquiry began, with my condolences, added to those of the representatives at the Inquiry, to the family and friends of David who have and continue to be affected by his passing.

Appendix 1

Flowchart taken from SAS National Clinical Bulletin (017/19)