

Dunfermline

05 August 2010

Sheriff McSherry

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNFERMLINE

DETERMINATION

of

**Sheriff John Craig Cunningham
McSherry in Fatal Accident
Inquiry concerning the death of
Kirsty Campbell McQueen under
the Fatal Accidents and Sudden
Deaths Inquiry (Scotland) Act 1976.**

5th August 2010

The Sheriff, having resumed consideration of the cause, Determines:-

1. In terms of section 6(1) (a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act), that Kirsty Campbell McQueen, (Kirsty), whose date of birth was 17th February 1984, latterly residing at 11, Centre Street, Kelty, Fife KY4 0EQ, died at Queen Margaret Hospital, Dunfermline at 0745 on 4th December 2007.
2. In terms of section 6(1) (b) of the Act, that the cause of death was

1. (a) Sepsis
(b) Acute pyelonephritis
2. Epilepsy
3. In terms of section 6(1) (c) of the Act, there were reasonable precautions whereby the death might have been avoided.
4. In terms of section 6(1) (d) of the Act, there were no defects in the system of working, in the Scottish Ambulance Service (SAS) or in any of the various other medical agencies involved, which contributed to Kirsty's death.
4. In terms of section 6(1) (e) of the Act, there were no other facts relevant to the circumstances of Kirsty's death.

NOTE.

In this enquiry the Crown was represented by Mrs Catriona Dalrymple, the Procurator Fiscal, and the SAS was represented by Mr Dunlop, Counsel, NHS 24 by Mrs Sargent, Solicitor and Kirsty's mother, Mrs Fotheringham, and family by Mr Bain, Solicitor. There were fifteen witnesses who gave evidence over four days. The parties agreed certain evidence by joint minute. As there was no evidence that NHS 24 was contacted, Mrs Sargent subsequently withdrew.

The Facts and Circumstances surrounding Kirsty's Death.

On 3rd December 2007, Kirsty was out shopping with her boy friend, John Whyte. She complained of not feeling well and that she felt a fit coming on. She had

suffered from epilepsy as a child but had not had a fit for fifteen years. Around 7pm Kirsty telephoned Debra Mullen, a friend, and wanted taken by car to Asda to buy a DVD player. She called again 20 minutes later and asked Miss Mullen to take her to hospital. She complained of a sore back and not feeling well. Miss Mullen did not have available transport. Between 8pm and 9pm she telephoned a friend, Darren Fetter, complained of back pain and asked him to take her to hospital. He could not assist as he had been drinking and could not drive his vehicle. Around the same time she also telephoned her mother complaining of back pain. Her mother thought that the problem might be muscular and advised that she have a bath. While taking a bath she suffered a fit. Mr Whyte telephoned for an ambulance. The call was received by ambulance personnel, Roderick Hannah and Ralph Smith, at 8.46pm. Both of them were ambulance technicians employed by the SAS. They arrived at Kirsty's home, an upper floor flat at 8.52pm, 6 minutes after having taken the call. This was within the National Guideline of 8 minutes. On arrival they found Kirsty in the bath. The fit had ended. They assisted her out of the bath and walked her to the bedroom. She was weight bearing and able to walk with assistance. Damp towels were used to reduce her body temperature. Mr Hannah assessed Kirsty and tried to obtain measurements. Kirsty brushed the various measurement pads from her. He tried to take her blood pressure and failed at first because of her movement. The second attempt showed that her blood pressure was normal. She refused to allow an ECG check. Her blood glucose level was 8.1 and this was within the normal levels of 4 and 10. Mr Hannah tried to administer oxygen therapy, which she also refused. It was mentioned that she had a lump in her back and that she had pain

for 2 days. At first she was unaware of the day and date. Mr Hannah's was concerned that she did not know the day and date. He said that he asked Kirsty if she knew who he and Mr Smith were and she had replied that she did. He asked her other questions and she replied correctly. Her Glasgow Coma Scale (GCS) was 14 just short of 15, which is the highest level. Mr Hannah had been advised that Kirsty was not on medication. He had been told that she had had a series of fits between the ages of 7 and 15. As a result, he said that he told her that he would prefer her to go to hospital. A particular concern was that this appeared to have been her first fit in fifteen years and there could be an underlying medical cause. She could be under supervision in hospital if there was a recurrence of a fit. She was adamant that she was not going to hospital. Mr Hannah was quite clear that he had asked her on several occasions to go to hospital. She had become a lot more lucid from when the crew first arrived. She was conversing freely and Mr Hannah said that he had tried particularly hard to persuade her to go to hospital because of the question that there may be underlying reasons for the seizure. He remembered telling Kirsty that the crew was passing the hospital door and it would not have been a problem to drop her off at the hospital. Mr Hannah's attempts in this respect were confirmed by Mr Smith. Mrs Fotheringham had said that she wanted the crew to take Kirsty to hospital. Mr Hannah explained that Kirsty was over 16 and appeared to be of sound mind. Chris Brown was a paramedic who was on shift on 3rd December 2007. He was in a rapid response vehicle. At 8.55pm he received instructions from the control centre to attend at Kirsty's home. He was told that a 23 year old woman had had a fit in her bath. He arrived at 8.58pm. When he arrived Kirsty was in the bedroom sitting on the bed.

She told Mr Brown that she did not want to be examined and did not want to go to hospital. Her blood pressure was normal and he checked her pulse. Her respiratory rate was normal as was her GCS. Mr Brown confirmed that he had asked her if she did not think it better to go to hospital. She replied that she was fine. Mr Brown tried to explain to her that it was unusual to have a fit after 15 years. This required further investigation. He explained that she was running the risk of having a further seizure. She was alert and answered questions appropriately. Kirsty said that she would go to her GP in the morning. He had no concerns about Kirsty's understanding of what she was being advised. He said that it was only if the patient had an ongoing medical condition, which was being ignored, or where life was threatened that he would refer to a GP or contact the police. Mrs Fotheringham also tried to persuade Kirsty to go to hospital but she continued to refuse. Mr Brown said that she was involved in a row with her mother over her refusal to go to hospital. A patient care and advice form was left. A refusal form was completed by Mr Hannah after Mr Brown had left. Mr Brown stated that he had asked Kirsty 5-6 times to go to hospital in the 10 minutes he was present. He explained to Mrs Fotheringham that he had no power to force anyone to hospital against her wishes. Mrs Fotheringham did not appear to understand as she suggested that Kirsty be dragged to the ambulance. Mr Brown thought that Mr Whyte had also tried to persuade Kirsty without success. He confirmed that it was not unusual for a patient to refuse consent and that it would not be sensible to summon a GP every time this happened. Kirsty became more and more exasperated at the requests to go to hospital. Every one of the ambulance personnel who attended Kirsty was quite clear that, eventually, she

was aware of her surroundings and understood what she was being asked. She had been advised of the risks of not attending hospital. Around 9.15pm Messrs Hannah and Smith left as Kirsty was no longer fitting and they could do no more for her.

In the early hours of 4th December 2007, Kirsty was in bed with Mr Whyte. He said that she had gone to the toilet 3-4 times during the evening. Around 5.30am she said she felt a fit coming on again. She said she felt cold but her body was 'roasting'. She did not mention the pain in her back. At 6.05am he telephoned the emergency services. He telephoned Mrs Fotheringham. Alexander Higgins and James Graham, both ambulance technicians, received the call at 6.05am and made their way to Kirsty's house in Kelty. They were in the ambulance station in Kirkcaldy when the call was received. The journey lasted 16 minutes and they arrived at 6.23am. They found Kirsty in bed having a seizure. Mr Higgins got Mr Graham to contact control and ask for paramedic assistance. Oxygen was administered and her airways were kept clear. Mr Higgins had been asked by Mrs Fotheringham to administer diazepam but he could not. Being a technician, Mr Higgins did not carry diazepam and was not able to administer it. Only paramedics were qualified to do this. At 6.33am a paramedic crew, Paul Raynor and Chris Darlington, was despatched from Glenrothes. They arrived at 6.53am, a journey of 19 minutes. They used blue lights and treated the call as a full emergency. By this time, Kirsty had stopped her seizure and the technicians were in the course of moving her on to a chair. She was to be transferred to an ambulance. Kirsty was not moved while she was fitting as she lived in an upper floor flat and it would have been dangerous for her and the crew to do so. Kirsty

was strapped on to a chair and lifted down the stairs into the ambulance. She was unresponsive and unconscious. As she was unable to communicate, consent was not an issue this time. As she was not able to consent or refuse treatment, the SAS employees said that they acted in Kirsty's best interest at the time. Mr Raynor said he would not have administered diazepam as Kirsty's seizure had stopped. When she was placed in the ambulance Kirsty suffered cardiac arrest. She was given adrenalin and atropine to get cardiac rhythm. These drugs were administered intravenously by the paramedics. Mr Higgins applied CPR. Kirsty then went into asystolic arrest, which cannot be shocked, en route to Queen Margaret Hospital, Dunfermline. Kirsty was certified dead at 7.45am on 4th December 2007 in the mortuary at Queen Margaret Hospital.

Submissions.

The Procurator Fiscal submitted that the question to be decided by me was the cause of death. If it was Sudep, Sudden Death in Epilepsy, then the failure of the Scottish Ambulance personnel to give diazepam at 0604 on 4th December 2007 might have been a causal link in Kirsty's death. She argued that the failure of the paramedic to attend until 49 minutes after the first crew attended at 0604 on 4th December 2007 might be a defect in the system of working. Although the aim of the Scottish Ambulance Service was ultimately to have a paramedic crew on every ambulance, more effort could be taken to consider the wider picture regarding the present make up of crews to have at least one paramedic. She argued that a rapid response vehicle driven by a paramedic should be despatched automatically

where a paramedic is required. This vehicle is only deployed during daytime hours and consideration should be given to 24 hour deployment. There was not a general awareness among the ambulance personnel of how a patient might behave in a post-ictal state such as exhibiting belligerence. An understanding of such post-ictal state could be incorporated into training with regard to obtaining a patient's consent. She went on to suggest that I could recommend consideration being given to ambulance technicians as well as paramedics carrying and administering the drug medazalam.

Mr Bain for the Family submitted that what Mrs Fotheringham wished was that this inquiry might give rise to one or more recommendations which, if acted upon, would give someone placed in similar circumstances to Kirsty a better chance of surviving. He submitted that a reasonable precaution which could have been taken to avoid Kirsty's death was the taking of Kirsty to hospital on the evening of 3rd December 2007. It was disputed that Kirsty had the capacity to consent or refuse to go to hospital. Mrs Fotheringham's position was that, apart from Kirsty being asked to go to hospital and her replying in the negative, no other information such as risks and benefits were explained to her and no further attempts were made to persuade her to go to hospital. It is her position that Kirsty should have been taken to hospital as she was incapable of giving her consent. Mr Bain then went on to say that Mrs Fotheringham was aware of the legal constraints placed upon ambulance crews.

Mr Bain did not believe there had been any defect on the system of working which contributed to Kirsty's death but suggested that there had been human

error on the part of the ambulance crew. As regards other facts relevant to the case, the patient refusal form had not been signed by Kirsty. Her failure to do so might have been a clue as to her incapacity to make decisions about her treatment. He asked that the court should recommend that, where a patient refuses to sign the form, the ambulance crew should be trained to ensure that the refusing patient does sign it or if the patient refuses to sign, this should be noted clearly where the patient's signature should appear. He went on to suggest that this be witnessed by the paramedic or technician attending. Mr Robertson had suggested that, where someone has not had a seizure for 15 years, is not on medication and is not going to hospital, the ambulance crew should be instructed to contact the patient's GP. Mr Bain suggested that the court recommend that in the circumstances of a similar case as this, the patient's GP should be informed as soon as possible rather than relying on the patient who may still be confused to do so the next day. Mr Bain suggested that the court recommend that a link in calls be put into the system whereby two calls can be put together so that information is available to those at the Emergency Medical Despatch Centre,(EMDC) to make a decision regarding the category code and where or not to dispatch a paramedic. This information could remain on the system for 24 or 48 hours. This would have covered the situation here where Kirsty had seen an ambulance crew at 9pm but had not seen her GP by 6am the next day. If a patient had not seen his GP after 48 hours when the information would come off the system, responsibility would lie with the patient. Mr Bain suggested that the court recommend in a case of epilepsy or suspected epilepsy/seizure, which is deemed as a red alert by EMDC, a paramedic should be dispatched immediately as a

matter of course. Only a paramedic can provide treatment and there was no point in sending only technicians.

He also suggested that the court recommend that all ambulance crews should have one technician and one paramedic. He also suggested that the court recommend the transfer of individuals from one station to another in order to provide the correct crew balance.

He also suggested that the court recommend that SAS look into training of technicians in administering rectal diazepam to epileptics.

Mr Dunlop for the SAS submitted that I should make findings in respect of s.6.1.a and s.6.1.b only. While everyone agreed the finding of 6.1.a he allied himself with Mr Bain in respect of Sepsis being the *sine qua non* of Kirsty's death. Mr Adamson was a pathologist and was an expert in sepsis. Dr Roberts could not say either way whether it was Sudep or Sepsis. I should prefer Mr Adamson's evidence to that of Dr Roberts on balance of probabilities. As regards s.6.1.c., the evidence of the ambulance staff should be preferred as there was distress and anxiety experienced by Kirsty's mother and Mr Whyte. It was not credible that Messrs Hannah, Smith and Brown had attended and had done nothing at all. There had been a concerted effort by all of the staff and her mother and Mr Whyte to try to persuade Kirsty to go to hospital. Her refusal to do so is the reason she is no longer with us. All three ambulance staff were of the view that Kirsty was competent to take the decision not to go to hospital. There was nothing in their conduct that was unreasonable. Even if they had concerns they could not simply remove her to hospital. Even if she lacked capacity she could not

have been put in the ambulance. There was a universal protocol to send the closest resource and, accordingly, the closest crew to Kirsty consisted of 2 technicians and this crew had been sent. Mr McSporran had confirmed that the primary function of the SAS Personnel was to transport patients to first line care in hospital and not to provide first line care, which was an incidental function. The suggestion that a paramedic, who was further away from Kirsty, should have been sent would involve tinkering with an established protocol because of a perceived problem in an isolated case. To send anything other than the nearest resource might, in itself, cause a number of deaths. What was essential was the maintenance of the airway. There was insufficient evidence to justify a change in the deployment of personnel.

There was little advantage in introducing extra layers of bureaucracy where the SAS were already aware of the issue. As regards the deployment of a rapid response vehicle, trials were being carried out on an 11pm to 3am period. Training had to be developed on a macro scale and it would be detrimental to change this as a result of an isolated incident. There was no medical evidence for the court to recommend the use of medazalam. This would involve approvals from other agencies. As with possession and administration of diazepam, a change in the law would be required for technicians to use it. Where other patients have refused to go to hospital, in the vast majority of cases there have been no adverse consequences. Putting a flag on the system as suggested by Mr Bain, would involve consideration of how far would be taken. A set of questions is asked and it is not for the SAS to act as doctors might. The protocol had been developed in the USA and is applied throughout the UK. The court should make

no recommendation in this regard. Kirsty's refusal to go to hospital could not have been prevented and the court should only make findings in sections 6.1.a and 6.1.b of the Act.

Conclusions.

1. Cause of Death.

I have found that the cause or causes of Kirsty's death were

1. (a) Sepsis
(b) Acute pyelonephritis
2. Epilepsy.

Dr Brian Adamson, Consultant Pathologist, on 7th December 2007 carried out a post mortem on Kirsty and produced an autopsy report in which he gave the opinion that death was due to

1. (a) Sudden unexpected death in epilepsy.
(b) Epilepsy
2. Acute pyelonephritis.

There were 4 abnormalities namely; Pulmonary congestion and oedema; terminal gastric aspiration; hepatic congestion and acute pyelonephritis.

However, the findings of the post mortem histology and bacteriology prepared by DR Adamson on 18th December 2007 *inter alia* were that there was marked pulmonary congestion and oedema in the lungs. There were bacterial colonies noted with the alveoli reflecting post mortem proliferation of organisms. The liver was congested. Sections of kidneys showed acute pyelonephritis. The renal pelvis

showed acute inflammation and there was marked oedema of the surrounding tissues. The blood culture, tissue culture and swabs from the renal pelvis all showed a heavy growth of E-coli sensitive of Amoxicillin and other antibiotics.

Dr Adamson was of the opinion that the bacteriology and histology both indicated acute pyelonephritis as the cause of death. Accordingly, he amended the cause of death to

1. (a) Sepsis.
(b) Acute pyelonephritis.
2. Epilepsy.

He said in evidence that Kirsty was septic. There was evidence of infection in the bladder itself which would have moved up to infect the kidneys. Kirsty's history was consistent with a urinary tract infection. Seizures can carry the risk of sudden death and it was not known why the heart stops. Epilepsy may have been a secondary factor but the primary cause in his opinion was Sepsis. There was significant evidence of Sepsis that caused him to favour this as the cause of the cardiac arrest. The Sepsis could have been treated by intravenous antibiotics and the earlier the better. Sepsis in itself carried a 20% mortality rate. He was of the opinion that Kirsty's refusal to go to hospital had ultimate fatal consequences. Even if she had been admitted to hospital, Dr Adamson was aware of patients in intensive care units dying from Sepsis. The reason for this is that very serious irreversible changes had occurred. This could have applied to Kirsty. Once in the blood stream he could not give time frame for the changes to take place. He believed the lump in Kirsty's back to have been the soft tissue inflammation of the kidney. Back pain over the kidneys would have been consistent with pyelonephritis.

Her very high temperature was also consistent with the condition. Another factor which pointed away from epilepsy as a cause was that Kirsty had ceased having the seizure for around 20 minutes before the cardiac arrest. Dr Adamson did not rule out Epilepsy as a cause but was of the opinion that Sepsis was more likely. Endotoxin was liberated and the heart would go into fibrillation or would stop. In Kirsty's case it stopped. The longer the delay in treating Sepsis the more likely mortality. While intravenous antibiotics will kill the bacteria, the damage has been done. Eventually a point of no return is reached. Dr Adamson said that the administration of diazepam would have had no effect on the Sepsis. He confirmed that the ambulance crew was correct in thinking that there may be an underlying cause of the return of Kirsty's epilepsy.

Dr Richard Roberts was a Consultant Neurologist. He said that Epilepsy was one of the commonest conditions dealt with by neurologists. It was his speciality. He said that he could not be certain that Kirsty had had epileptic fits. The first seizure was 5 minutes or so, the second 30 minutes. He said that medazalam could have been administered to Kirsty. As the cause of death, he agreed that E-coli Septicaemia was very serious and could have triggered her epilepsy. He said that it seemed likely to have been a cause of death but he could not be certain. A cardiac arrest can occur even in hospital when a patient is being monitored. The fact that Kirsty had cardiac arrest 15-20 minutes after her seizure argues against Sudep. If the seizure was intense he would have expected muscle damage which was not present in Kirsty's case. He said that Sepsis was the primary cause as the epilepsy was triggered by it. When told that Kirsty had gone to the toilet

independently a number of times between fits, he then instantly changed his opinion and said that if she had overwhelming Sepsis he would have expected her to be more unwell. He thought her death to be more likely a Sudep type which was due to the prolonged seizure. He said that treatment for seizures was by drugs introduced intravenously or orally or rectally in small children. If medazalam was used there was a good chance that the seizure would have stopped but there was no guarantee of this. Rectal diazepam was not for adults, who would have it administered intravenously. Dr Roberts did seem to question whether Kirsty was having an epileptic fit on the second occasion. She was shaking, running a fever and conversing with Mr Whyte. This he said was consistent with rigors common to fever. This would take him back to Sepsis as the cause of death but he could not be certain.

I favour the evidence of the pathologist Dr Adamson over that over Dr Roberts who admitted that he was uncertain as to the cause of death. He even questioned whether Kirsty had indeed had an epileptic fit on the second occasion yet continued to indicate that Sudep could have been a cause despite the cardiac arrest occurring 15-20 minutes after the fit had ceased. While Sudep could not be ruled out, it was agreed by both doctors that either way Sepsis was a cause of death. Dr Roberts admitted that he was not an expert on Sepsis whereas Dr Adamson was. I also note that Mr Whyte when questioned as to what he told the police had said that Kirsty had been suffering from back pain for a couple of weeks rather than a couple of days and had been sitting in the house with her

coat on feeling cold when the room was warm. So it is possible that the Sepsis had been present for much more than a couple of days before her death.

2. *Reasonable Precautions whereby death might have been avoided.*

(a) *Refusal of Consent.*

Kirsty consistently refused to consent to be taken to hospital when requested by 2 technicians and a paramedic to do so. I have no doubt that they repeatedly advised her to go to hospital and that she persisted in her refusal. The ambulance personnel on the evening of 3rd December 2007 followed the procedures set out in the Guidance on Good Practice relating to Patient Consent. The SAS guidance on good practice made it clear that the consent of a patient is required to a particular examination, treatment, operation or investigation. The patient needs to have been given sufficient information in simple language what the medical treatment is, its purpose and nature and why it is being proposed. The patient should also understand its principal benefits, risks, potential complications and alternatives and, in broad terms, the consequences of not receiving the proposed treatment. Consent should be given without unfair or undue pressure. I do not accept Mrs Fotheringham's and Mr Whyte's account that no treatment was administered to Kirsty and that the ambulance personnel did not try to persuade her to go. Both of them were extremely stressed and distressed by the situation and, in the case of Mr Whyte, he did not even remember Mr Brown, the paramedic, being present. It is fair to say that a great deal was going on at the time. Both Mrs Fotheringham and Mr Whyte said that Kirsty was confused and did not know who they were. She did not know the day and date and this confusion

lasted after the ambulance personnel had left. I do not accept that she was confused when the ambulance personnel left. Mr Whyte said that Kirsty did not know who he was, yet she and he had gone to bed afterwards and they had watched television together. There was no evidence that he or Mrs Fotheringham had attempted to get Kirsty to hospital in the 8 hours between the departure of the first ambulance crew and the onset of the second fit. The evidence from the ambulance personnel was that while Kirsty was confused at first she became quite lucid and knew who they were and what they were requiring of them. In terms of the Guidelines consent is only legal when satisfied that the individual has understood everything told to them or given to them to read. It is not the case that ambulance personnel should satisfy themselves as to the legality of refusal to provide consent. The Guidelines cover the case where a patient who is not capable of understanding has given consent, and, presumably, withdraws it later. Even if Kirsty had been taken against her will to hospital, it is likely that she would have refused treatment. Hospital staff is under the same strictures as ambulance personnel as far as patient consent is concerned and would have had no power to detain or treat her.

(b) Post-ictal State.

Dr Roberts said that patients could be in a post-ictal state for up to 45 minutes following seizure. He did not know what a patient was aware of in such a state as the patient cannot remember. If she could not recognise persons close to her Kirsty would be confused and could not make informed decisions. GCS was a measure of depression of consciousness and not of cognitive ability. Dr Roberts said that if the ambulance personnel were satisfied that Kirsty was making

informed decisions about going to hospital and had recovered from the seizure, it was reasonable for them to have left her. A detailed cognitive assessment could not be expected from an ambulance technician.

Accordingly, it is, as Dr Roberts said, not for ambulance personnel to investigate the cognitive function of a patient who is refusing consent. Kirsty's GCS was normal when the technicians left. As Dr Roberts, an expert in Epilepsy, was unable to define precisely how patients might behave in a post-ictal state, I can hardly recommend any form of training in addition to that already in existence in this regard for ambulance personnel.

(c) Patient Refusal Form.

Exactly how ambulance personnel are to be trained to ensure that a refusing patient signs such a form was not made clear to me. This would probably involve forcing a patient to do something against his/her will. This would constitute an assault. It suffices in my opinion for it to be noted on the form that the patient has refused to sign it. It should be remembered that Kirsty was not only refusing to go to hospital, she was also refusing treatment. This hardly suggests that she would have been amenable to being forced to sign such a form. I see no need for any witnessing of this. Ambulance personnel attend emergency medical situations to treat and take patients to hospital and should not be subjected to requirements of writing formalities. They have better things to do.

(d) Instructing a Patient's GP.

In a similar vein, I see no need to place an obligation on emergency ambulance personnel to take the time and trouble and, moreover, assume the responsibility, to contact a refusing patient's GP. It was not made clear to me exactly what such

a GP was to do without instructions from his own patient. Mr McSporran of the SAS said that while there was no formal guidance there could be situations where a crew would contact NHS 24 or a patient's GP but it was up to the crews themselves. If the patient's health was obviously in danger a GP or, more likely, the police could be contacted.

3. *System of Working*

(a) *Linking Calls in the System.*

I see no reason, given the duties of the SAS, to recommend that a link in calls be put into the system whereby two calls can be put together so that information is available to those at the Emergency Medical Despatch Centre,(EMDC) to make a decision regarding the category code and where or not to dispatch a paramedic. It is not clear to me how anyone, apart from the patient or her GP, would know that the GP had seen the patient. Jim McSporran, the Head of Ambulance Services for Fife, said that if there was more information put on the system this may slow matters down. Again this would involve the shifting of responsibility on to the SAS who have more than enough to do already.

(b) *Makeup of Ambulance Crews.*

It is not, in my view, sensible to direct that in Epilepsy or suspected epilepsy/seizure cases, deemed as a red alert by EMDC, a paramedic and only a paramedic should be dispatched immediately as a matter of course. It is not the case that technicians could not provide treatment. They were able to keep airways clear and administer oxygen. They could not administer diazepam as only

paramedics were authorised and trained to do so. They had greater training in making assessments of medical condition. The SAS is aware of the desirability of having crews made up of one technician and one paramedic. Many technicians are training to be paramedics. Tom Robertson, a recently retired Area Services Manager for Fife, confirmed that it was the goal to have a paramedic on every vehicle and that there was a lot of people waiting to go on courses to qualify as paramedics. He agreed that it was not mandatory to send a paramedic if there was a red call and that there should not be a delay until one was available. He knew that mixing crews was done but was unable to say how often. He had criticised the makeup of crews but admitted under cross-examination that he did not know where some of the ambulances were at the material time. He said that there was nothing unreasonable in what the ambulance personnel did on the evening of 3rd December 2007. Mr McSporran said he had to maximise the use and resources he had. The SAS were working towards putting paramedics into every ambulance. The split in Fife was 72 paramedics and 73 technicians. A mix was preferred if possible but shift requirements, meal breaks, the local station of the crew members, leave and other factors had to be taken into account. It was not always the case that a paramedic in every ambulance was the best use of resources as he might not be required in every call. There was a universal protocol to send the closest resource and, accordingly, the closest crew to Kirsty consisted of 2 technicians and this crew had been sent. Mr McSporran confirmed that the primary function of the SAS Personnel was to transport patients to first line care in hospital and not to provide first line care, which was an incidental function. I agree that it would be questionable practice to send a paramedic who

was further way from the locus than a crew of technicians. Any additional delay in reaching the locus could, in itself, have fatal consequences. It is not necessary for me to make any direction or recommendation in this regard.

(c) Rapid Response Vehicle.

I was advised that, as regards the deployment of a rapid response vehicle in the evenings, trials were being carried out on an 11pm to 3am period. I see no need to make any recommendation in this regard.

(d)Technicians administering Diazepam and Medazalam.

I agree that for all crews to be issued with these, other agencies would have to be involved and consent. The decision was not for the SAS alone. There is a Drugs Protocol National Forum. Changes in the law would be required as to the possession and administration of these drugs by technicians. I see no need to make any recommendation in this regard.

The obligation to look after oneself, when one is capable of doing so, lies with the patient alone. In this case Kirsty chose not to take advice and go to hospital. Even if she had gone to hospital, the Sepsis might have caused irreversible damage. From the evidence may have been suffering for a couple of days or possibly as much as a couple of weeks during which time Sepsis is likely to have taken hold with tragic consequences for her and her family and friends. Mrs Fotheringham attended Court every day and my sincere condolences go out to her and Kirsty's family.

B728/09

Kirsty McQueen

John Craig Cunningham McSherry

Dunfermline,

5th August 2010