

Introduction

This chapter contains guidelines for the use of automated external defibrillators (AEDs) by laypeople, first responders and healthcare professionals responding with an AED outside hospital. These guidelines are appropriate for all types of AED, including those that are fully automatic. Guidelines for in-hospital use of AEDs are provided in the electrical therapies section of the advanced life support guidelines.

In the UK approximately 30,000 people sustain cardiac arrest outside hospital and are treated by emergency medical services (EMS) each year.²² Electrical defibrillation is well established as the only effective therapy for cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). The scientific evidence to support early defibrillation is overwhelming; the delay from collapse to delivery of the first shock is the single most important determinant of survival. If defibrillation is delivered promptly, survival rates as high as 75% have been reported.^{23, 24} The chances of successful defibrillation decline at a rate of about 10% with each minute of delay;²⁵ basic life support will help to maintain a shockable rhythm but is not a definitive treatment.

The Resuscitation Council (UK) recommends strongly a policy of attempting defibrillation with the minimum of delay in victims of VF/VT cardiac arrest.

Guideline changes

There are no major changes to the sequence of actions for AED users in Guidelines 2010. The ILCOR Consensus on Science and Treatment Recommendations²⁶ makes the following recommendations which are relevant to the RC(UK) AED guidelines:

1. An AED can be used safely and effectively without previous training. Therefore, the use of an AED should not be restricted to trained rescuers. However, training should be encouraged to help improve the time to shock delivery and correct pad placement.
2. Short video/computer self-instruction courses, with minimal or no instructor coaching, combined with **hands-on practice** can be considered as an effective alternative to instructor-led BLS and AED courses. Such courses should be validated to ensure that they achieve equivalent outcomes to instructor led courses.²⁶

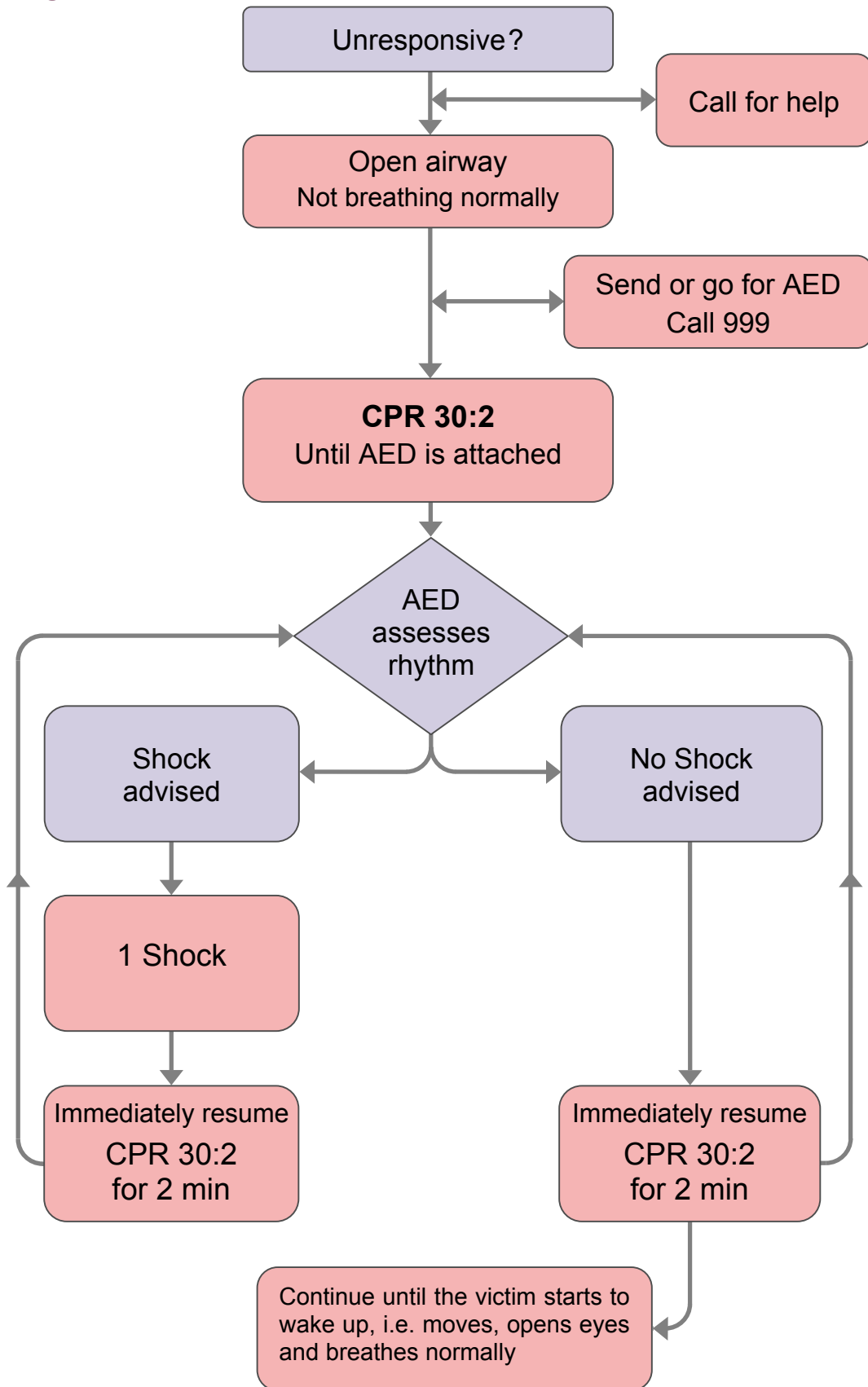
3. When using an AED minimise interruptions in chest compression. Do not stop to check the victim or discontinue cardiopulmonary resuscitation (CPR) unless the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally.

Types of automated external defibrillator

AEDs are sophisticated, reliable, safe, computerised devices that deliver electric shocks to victims of cardiac arrest when the ECG rhythm is one that is likely to respond to a shock. Simplicity of operation is a key feature: controls are kept to a minimum, voice and visual prompts guide rescuers. Modern AEDs are suitable for use by both lay rescuers and healthcare professionals.

All AEDs analyse the victim's ECG rhythm and determine the need for a shock. The semi-automatic AED indicates the need for a shock, which is delivered by the operator, while the fully automatic AED administers the shock without the need for intervention by the operator. Some semi-automatic AEDs have the facility to enable the operator (normally a healthcare professional) to override the device and deliver a shock manually, independently of prompts.

AED algorithm



Sequence of actions when using an automated external defibrillator

The following sequence applies to the use of both semi-automatic and automatic AEDs in a victim who is found to be unconscious and not breathing normally.

1. **Follow the adult BLS sequence as described in the basic life support chapter. Do not delay starting CPR unless the AED is available immediately.**
2. **As soon as the AED arrives:**
 - If more than one rescuer is present, continue CPR while the AED is switched on. If you are alone, stop CPR and switch on the AED.
 - Follow the voice / visual prompts.
 - Attach the electrode pads to the patient's bare chest.
 - Ensure that nobody touches the victim while the AED is analysing the rhythm.
- 3A. **If a shock is indicated:**
 - Ensure that nobody touches the victim.
 - Push the shock button as directed (fully-automatic AEDs will deliver the shock automatically).
 - Continue as directed by the voice / visual prompts.
 - Minimise, as far as possible, interruptions in chest compression.
- 3B. **If no shock is indicated:**
 - Resume CPR immediately using a ratio of 30 compressions to 2 rescue breaths.
 - Continue as directed by the voice / visual prompts.
4. **Continue to follow the AED prompts until:**
 - qualified help arrives and takes over OR
 - the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally OR
 - you become exhausted.

Placement of AED pads

Place one AED pad to the right of the sternum (breast bone), below the clavicle (collar bone). Place the other pad in the left mid-axillary line, approximately over the position of the V6 ECG electrode. It is important that this pad is placed sufficiently laterally and that it is clear of any breast tissue.

Although most AED pads are labelled left and right, or carry a picture of their correct placement, it does not matter if their positions are reversed. It is important to teach that if this happens 'in error', the pads should not be removed and replaced because this wastes time and they may not adhere adequately when re-attached.

The victim's chest must be sufficiently exposed to enable correct pad placement. Chest hair will prevent the pads adhering to the skin and will interfere with electrical contact. Shave the chest only if the hair is excessive, and even then spend as little time as possible on this. Do not delay defibrillation if a razor is not immediately available.

Defibrillation if the victim is wet

As long as there is no direct contact between the user and the victim when the shock is delivered, there is no direct pathway that the electricity can take that would cause the user to experience a shock. Dry the victim's chest so that the adhesive AED pads will stick and take particular care to ensure that no one is touching the victim when a shock is delivered.

Defibrillation in the presence of supplemental oxygen

There are no reports of fires caused by sparking where defibrillation was delivered using adhesive pads. If supplemental oxygen is being delivered by a face mask, remove the face mask and place it at least one metre away before delivering a shock. Do not allow this to delay shock delivery.

Minimise interruptions in CPR

The importance of early, uninterrupted chest compressions is emphasised throughout these guidelines. Interrupt CPR only when it is necessary to analyse the rhythm and deliver a shock. When two rescuers are present, the rescuer operating the AED applies the electrodes while the other continues CPR. The AED operator delivers a shock as soon as the shock is advised, ensuring that no one is in contact with the victim.

CPR before defibrillation

Provide good quality CPR while the AED is brought to the scene. Continue CPR whilst the AED is turned on, then follow the voice and visual prompts. Giving a specified period of CPR, as a routine before rhythm analysis and shock delivery, is not recommended.

Voice prompts

The sequence of actions and voice prompts provided by an AED are usually programmable and it is recommended that they be set as follows:

- deliver a single shock when a suitable rhythm is detected;
- no rhythm analysis immediately after the shock;
- a voice prompt for resumption of CPR immediately after the shock;
- a period of 2 min of CPR before further rhythm analysis.

AED use by healthcare professionals

All healthcare professionals should consider the use of an AED to be an integral component of BLS. Early defibrillation should be available throughout all hospitals, outpatient medical facilities and clinics. Sufficient staff should be trained to enable a first shock to be provided within 3 min of collapse anywhere in the hospital. Hospitals should monitor collapse-to-first-shock intervals and monitor resuscitation outcomes.

The RC(UK) advises that untrained employees working in healthcare establishments not be prevented from using an AED if they are confronted with a patient in cardiac arrest. The administration of a defibrillatory shock should not be delayed while waiting for more highly trained personnel to arrive. The same principle should apply to individuals whose certified period of qualification has expired.

Further information on AED use by healthcare professionals is provided in the in-hospital cardiac arrest chapter of these guidelines.

Storage and use of AEDs

AEDs should be stored in locations that are immediately accessible to rescuers; they should not be stored in locked cabinets as this may delay deployment. Use of the [UK standardised AED sign](#) is encouraged, to highlight the location of an AED. People with no previous training have used AEDs safely and effectively. While it is highly desirable that those who may be called upon to use an AED should be trained in their use, and keep their skills up to date, circumstances can dictate that no trained operator (or a trained operator whose certificate of training has expired) is present at the site of an emergency. Under these circumstances no inhibitions should be placed on any person willing to use an AED.

Children

Standard AED pads are suitable for use in children older than 8 years. Special paediatric pads, that attenuate the current delivered during defibrillation, should be used in children aged between 1 and 8 years if they are available; if not, standard adult-sized pads should be used. The use of an AED is not recommended in children aged less than 1 year. However, if an AED is the only defibrillator available its use should be considered (preferably with the paediatric pads described above).

Public access defibrillation (PAD)

Public access defibrillation is the term used to describe the use of AEDs by laypeople.²⁷ Two basic strategies are used. In the first, AEDs are installed in public places and used by people working nearby. Impressive results have been reported with survival rates as high as 74% with fast response times often possible when an AED is nearby.²³

In a complementary strategy, first responders are dispatched by an ambulance control centre when they might reach a patient more quickly than a conventional ambulance. The greater delay in defibrillation resulting from the need for such responders to travel to a patient has been associated with more modest success rates. However, this strategy does enable treatment of people who arrest at home, the commonest place for cardiac arrest to occur.

Further information may be found on the [RC\(UK\) web site](#).



Resuscitation Council (UK)



The legal status of those who attempt resuscitation



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Throughout this publication the masculine is used to denote the masculine or feminine.

Introduction

There is understandable concern that individuals who attempt to resuscitate someone in a state of cardiopulmonary arrest may be at risk of having a claim brought against them if that person suffers harm as a result of their intervention. The advent of the automated external defibrillator (AED) has heightened this anxiety because these devices are increasingly used by members of the lay public who have not had the benefit of formal medical training.

It is, unfortunately, extremely difficult to give any definitive advice on this subject partly due to the absence of any legal precedent and partly due to the difficulty of predicting what sort of harm might actually be suffered as a consequence of any attempted resuscitation. This document seeks to clarify, as far as possible, the potential legal liability of those individuals who choose voluntarily to intervene in emergency situations to carry out life-saving resuscitation procedures on others. Although resuscitation is attempted most commonly in adults, it may occasionally be attempted in children, and this is considered in a separate section below.

Broadly speaking, there are two kinds of legal duty to which citizens in the UK are subject; those imposed by Parliament which are known as statutory duties, and those imposed by the common law – the law that has been built up over the centuries as a result of decisions made by judges in court. There are no statutory duties relating to the field of resuscitation, but potential liability can arise at common law.

Although there have been a few cases in the United Kingdom where a claim has been brought against a ‘rescuer’, there have been no reported cases where a victim has successfully sued someone who came to his aid in an emergency. A claim might, therefore, in theory, be brought against a rescuer in the law of trespass on the grounds that his intervention constituted an assault on the victim, or in the law of negligence for a breach of his duty of care towards them. Potentially, there could also be liability for assault in criminal law, but this document will concentrate purely on principles of civil liability and claims for compensation. A claim could be brought either by the victim or, should they die, by their estate, and if the actions of the rescuer led to serious personal injury or death, a very large payment of damages by way of compensation could, in theory, be ordered by the Court.

Introduction to the 2010 revision

Since this guide was first published in 2000, two events have made revision of our original advice desirable. The first is the implementation of the Mental Capacity Act (2005), legislation (applicable in England and Wales) that has helped define the position of individuals without mental capacity (those who require resuscitation) to determine their treatment, and the responsibility of those who provide such treatment (i.e. those who attempt to help them). The second is the judgements reached in cases that have come before the Courts that have helped define the current legal position more precisely.

Our original advice was published at a time when AEDs were becoming widely available in the UK through a National Defibrillator Programme, coordinated by the Department of Health, that placed AEDs in public places. The intention was that lay members of the public who might witness a cardiac arrest would use them before the arrival of the ambulance service. At this time there was understandable anxiety that these operators, often with modest training, might subsequently be held legally responsible for the outcome in those they tried to help.

Experience since that time has been reassuring. The strategy has proved very effective and the use of AEDs in this way has been responsible for saving many lives. Adverse events have been rare and complaints very few. The use of AEDs has been so successful in some locations that the potential liability for not having one available has been questioned. In the USA, airlines have been sued for just this reason. In this revision therefore, we have attempted to provide guidance for those individuals or organisations that have responsibility for the safety of the public and are concerned about the need to make an AED (and appropriately trained staff) available.

This revision seeks to define the obligations and responsibilities of those who attempt the resuscitation of victims of sudden cardiac arrest. We hope it will prove helpful to those administering schemes that make AEDs available in public places or who are contemplating such a move.

A claim for trespass against the person – assault / battery

A claim may be brought against a rescuer for what is commonly known as assault but, more accurately, is described as battery (in England and Wales). In Scotland, the term is 'wrongful interference with the person', and where physical contact is involved, that amounts to an assault, which gives rise to a civil claim in damages. Battery is a form of trespass against the person that is actionable in itself. In other words, in order to succeed in a claim the victim does not have to show that he has suffered any actual physical harm, although it would be necessary for him to show this if he were to be awarded any more than a minimal compensatory sum. Battery is the 'infliction of unlawful personal force upon another'. Force, which can include even light touching, is unlawful if the person upon whom it is exerted has not given his consent to it. In the context of resuscitation, the contact involved in performing a procedure or in using an AED could clearly constitute battery since, if someone is in cardiopulmonary arrest and unconscious, he will clearly not be in a position to consent to being touched.

This situation is not uncommon in professional medical practice, where there are two primary defences available to a doctor or nurse who carries out medical treatment on a patient who has not expressly consented to it. The first is the defence of 'implied consent', the justification behind which is that if the person were conscious and able to make a decision, he would consent to the procedure. The second primary defence to any action for trespass against the person is that of 'necessity'. The reasoning here is that treatment without consent can be considered lawful if it is given in the best interests of the patient; in other words, if it is necessary to save his life or to improve or prevent the deterioration of his condition. There has been some controversy about whether this is a defence which does in fact exist in English law. In one famous House of Lords case, however, the judge stated 'that there exists in the common law a principle of necessity which may justify action which would otherwise be unlawful is not in doubt'.

In Scotland, it has been observed, in the context of medical treatment provided by a qualified person, that "in case of serious emergency, consent may probably be dispensed with". This appears to be a reasonable summary of the application of necessity in this situation, although the cases cited in support of that proposition are rather old.

Both defences could, it would seem, be comfortably extrapolated to the emergency situation where immediate treatment to save life is required off hospital premises. It should be added that the honest yet mistaken belief that a defence is available to a person is not sufficient grounds on which to base a defence.

There are likely, however, to be limitations on the application of these defences when procedures are carried out by non-professional rescuers, and the less well trained the rescuer the harder it may become to justify either defence. For example, it becomes more difficult to argue that an unconscious person has given implied consent to a (relatively) untrained person performing what is in effect a medical procedure, notwithstanding that the procedure may be straightforward, automated and mechanical. Similarly, it may be harder to argue that treatment by a lay person is in their best interests. The defence of necessity may be available to the non-professional rescuer, however, provided that he acts reasonably under the circumstances. It would not be reasonable for an unqualified lay person to act, for example, if a professional rescuer was present or arrived at the scene and offered to help.

In summary, given the simplicity of the AED and its reliability, a lay person would probably be justified in using one in an emergency situation when a more qualified person is not available.

The Mental Capacity Act (2005)

This legislation came into force in October 2007 and is fundamentally concerned with those who lack capacity to make decisions for themselves, a situation that obviously exists when someone has sustained a cardiac arrest and requires resuscitation.

Section 5 of the Act applies in connection with the care or treatment of another person. Whilst the legislation was primarily drafted with the doctor-patient relationship in mind, the wording of Section 5 is clearly not limited to that, as it discusses the situation where 'a person' acts in relation to 'another person'.

Where a person ('D') performs an act in connection with the care or treatment of another person ('P'), Section 5 provides that if:

- a) before performing a procedure D takes reasonable steps to establish whether P **lacks capacity** in relation to the matter in question and
- b) when performing the act reasonably believes that P **lacks capacity** in relation to the matter and
- c) that it will be in P's **best interests** for the act to be performed

then **D does not incur any liability in relation to their actions** that he would not have incurred if P

- a) Had capacity to consent and
- b) Had consented to D performing the act

Section 5 therefore suggests that if a passer-by (D) sees that someone (P) has suffered a cardiac arrest, and D reasonably believes, firstly, that P lacks capacity to determine if he wants D to use an AED in an attempt to resuscitate him, and, secondly, that it would be in P's best interests if D did so, then D would not be committing the tort of battery if he used the AED on P, though D is not excluded from liability in negligence. The act also makes it clear (in Sections 24-26) that advance decisions to refuse treatment still apply in this situation, although it is very unlikely that a rescuer acting in an emergency would be aware of the existence of such a document.

These provisions only came into force in October 2007 and as yet there appear to be no cases or articles discussing the application of Section 5 to the case of a non-professional who attempts to assist an unconscious person. However, it may act to boost the protection for those who commit battery whilst attempting rescue.

'Lack of Capacity' is defined in Section 2 of the Act. A person lacks capacity in relation to a matter if at the material time **he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain**. The impairment or disturbance may be permanent or temporary and must be decided on the balance of probabilities. This section does not apply to a person aged under 16 years.

What constitutes ‘best interests’ is defined in Section 4 of the Act. The legislation was clearly intended to apply to circumstances where time was available to make a measured decision, and requires D to consider ‘all the relevant circumstances’ including a number of specific and detailed issues.

It is very unlikely that all of the stipulated information would be available to someone who attempts the resuscitation of someone who is an unconscious and unresponsive casualty and, furthermore, there would be insufficient time to address the issues mentioned. The code of practice which accompanies the Act states ‘Sometimes people who lack capacity to consent will require emergency medical treatment to save their lives or prevent them from serious harm. In these situations, what steps are “reasonable” will differ to those in non-urgent cases. In emergencies, it will almost always be in a person’s best interests to give urgent treatment without delay.’ The Code goes on to give an example of acting in an emergency:

Mrs Prior is mugged and knocked unconscious. She is brought to hospital without any means of identification. She has head injuries and a stab wound, and has lost a lot of blood. In the emergency department, a doctor arranges an urgent blood transfusion. Because this is necessary to save her life, the doctor believes this is in her best interests. When her relatives are contacted, they say that Mrs Prior’s beliefs meant that she would have refused all blood products. But since Mrs Prior’s handbag had been stolen, the doctor had no idea who the woman was nor what her beliefs were. He needed to make an immediate decision and Mrs Prior lacked capacity to make the decision for herself. Therefore, he had reasonable grounds for believing that his action was in his patient’s best interests – and so was protected from liability.

It therefore seems unlikely that a rescuer would be expected to consider the best interests of a collapsed person in anything other than a superficial way governed by the belief that the great majority of victims of sudden cardiac death would wish to be resuscitated.

Note: Similar Scottish provisions are found in the Adults with Incapacity (Scotland) Act 2000. However, the 2000 Act defines incapacity more restrictively – “incapable” means incapable of acting, or making decisions or communicating those decisions. While those criteria might be met by an adult who has been rendered unconsciously temporarily, the Scottish legislation does not explicitly recognise such a possibility. Historically, the term incapax has carried the implication of long term inability to manage one’s affairs. The Act requires the incapacity to be due to “mental disorder” or an “inability to communicate because of physical disability”. It is arguable that a person who has lost consciousness due to a cardiopulmonary event might not fall within the definition of an adult with incapacity, as the lack of capacity may not arise from a “physical disability”. The rescuer who attempts resuscitation of an unconscious patient might therefore require to fall back on the common law defences of implied consent or necessity.

The Act does not apply in Northern Ireland, but following the Bamford Review it has been acknowledged that the law is in need of being updated, and the principles contained in the Act may well appear in Northern Ireland legislation in the future.

A claim for negligence

In order for a claim of negligence to succeed, a victim would have to show that the rescuer owed him a duty of care which he breached, thereby causing him to suffer foreseeable harm.

The duty of care

In the United Kingdom, there is generally no legal obligation on an individual to assist someone in need of resuscitation provided he was not the cause of the person requiring treatment. In other words, there is generally no legal liability for a mere omission to act. This is different from the situation in many other European countries where the law does, in certain circumstances, impose a duty to help others.

The situation may be different for those who are not mere bystanders, and who have some kind of connection with the victim. For example, ambulance personnel dispatched to attend a particular incident have been found to have a duty of care, although the Court made clear that this would not always be the case (*Kent v Griffiths [2001] Q.B.36*). Other relationships in a rescue situation which would be likely to fall within the same bracket would be that of a parent or teacher responsible for the safety of a child, whilst a doctor or nurse responsible for the health and well-being of a patient under their professional care would certainly have a duty of care, and a police officer would be under a duty to render help to the public provided it were part of his job description. There are only a limited number of relationships where courts in the United Kingdom have found that a positive duty to protect another person exists. In Canada (where similar legal principles apply), in 1978, a student ice-cream seller who failed to warn a 4-year old child of the danger of an oncoming car was found to have a duty of care to the child.

The situation may also be slightly different if the casualty is a work colleague of a workplace first-aider. Under the Health and Safety at Work Act 1974 and the subsequent Health and Safety (First Aid) Regulations 1981, an employer is under a statutory duty to provide first-aiders in the workplace for the benefit of his employees. These first-aiders must undergo training to an approved standard in a specified list of competencies. As such, an individual who takes on this role as part of his job description could be argued to owe a duty of care to his fellow employees to render first aid.

A person, whether a healthcare professional or a member of the lay public who witnesses a situation 'on the street' where resuscitation might be required is under no obligation to assist, provided the situation was not caused by him. However, if that person does choose voluntarily to intervene to render assistance he will assume a duty of care towards the individual concerned.

Whether intervening under a positive duty of care or under an assumed duty of care, a person who attempts resuscitation will only be legally liable if the intervention leaves a person in a worse position than he would have been in had no action been taken. It is difficult, in the circumstances under consideration, to see how a rescuer's intervention could leave someone worse off since, in the case of cardiopulmonary arrest, a victim would, without immediate resuscitation, certainly die. Furthermore, if an AED is being

used, it will only permit the administration of a defibrillatory shock when its sophisticated electronic algorithms determine that ventricular fibrillation is present and, since patients in this state are clinically dead, it is unlikely that any intervention with this device could make the situation worse.

If resuscitation is being carried out without an AED, however, it is slightly easier to envisage how the intervention of a rescuer might potentially leave someone worse off. For example, if a rescuer inappropriately administered chest compressions which caused damage to the chest wall or underlying organs, he would be causing damage which would not otherwise have been suffered and, given that the casualty was not in cardiopulmonary arrest, and therefore not in need of emergency resuscitation, would by his intervention be leaving him in a worse position.

It is possible that the family of someone who had been revived by resuscitation, but left in a permanent vegetative state, might attempt to pursue a rescuer for damages on the grounds that they had been left worse off as a result of his intervention, arguing that it would have been preferable if they had died rather than been left brain-damaged for life. However, in this country, legally and as a matter of public policy, this type of argument (known as a claim for 'wrongful life') should not succeed.

The standard of care

If someone is able to show that a rescuer owed him a duty of care and that, as a result of the rescuer's intervention, he has been left in a worse position than he would have been in had that rescuer not intervened, he will still have to show the Court that the standard of care employed by the rescuer in performing the resuscitation procedure was negligent, and that it was for this reason that he was left in a worse position.

The standard of care to be expected of a health professional, of a non-professional first-aider and of a member of the general public necessarily differ. When determining if the actions of a rescuer were negligent, every person will be judged by the Court according to what was reasonable for someone of their training and expertise.

Members of the healthcare professions who attempt resuscitation will be expected to employ a high professional standard of care, compatible with their position in the health service and with their level of training. Their level of competence will be judged on an objective basis and they could, therefore, be held liable if that standard of care falls below that to be expected of a reasonably competent health professional of the same qualifications and experience. Therefore, provided resuscitation procedures are performed correctly and in accordance with current guidelines, it is unlikely that a successful claim could be brought. Liability is only likely to arise if procedures are carried out incorrectly, or in inappropriate circumstances, and with disregard to accepted practice and guidelines.

A 'non-professional' first-aider, or other member of the lay public who attempts to resuscitate someone, will not be expected to employ the same standard of care as a healthcare professional. Liability will only arise if the standard of care employed falls below that to be expected of a reasonably careful person in the rescuer's position. For practical purposes, this means that if an action were brought against a non-professional the Court would be likely to take into consideration the fact that the first-aider had a skill (having been trained in resuscitation or in the use of an AED), but would also

acknowledge the fact that the individual was a volunteer first-aider and not a professional healthcare provider. If the procedure is performed correctly and in accordance with current practice and guidelines, it is unlikely that a successful claim for negligence could be brought. However, if the procedure is carried out incorrectly, with disregard for modern accepted practice and current recommendations, it is possible that liability could arise.

The unreported case of *Cattley v St John Ambulance Brigade (1988)*, which considered the standard of care owed by a first-aider, is a rare instance of someone suing a volunteer. First-aiders from St John Ambulance assisted a teenager who had been taking part in a motorcycle scrambling event and had fallen off his motorbike. The judge held that '[The volunteer rescuer in question] or any other person holding himself out as a first-aider trained in accordance with [the First Aid Manual] would be negligent if he failed to act in accordance with the standards of the ordinary skilled first-aider exercising and professing to have that special skill of first-aider' and went on to say 'the true test for establishing negligence in a first-aider is whether he has been proved to be guilty of such failure as no first-aider of ordinary skill would be guilty of, if acting with ordinary care. If in any situation the first-aider acts in accordance with the first aid manual and does so with ordinary skill, then he has met the test and he is not negligent'.

A member of the general public with no special resuscitation training will only be considered negligent if he performs an act that a reasonable and prudent man in his position would not have done in the same situation, or omits to do something which a reasonable man would have done. The standard by which he will be judged is, therefore, even lower than that of a non-professional first-aider.

The question of the standard of care required of a rescuer was considered in the case of *Day v High Performance Sports Limited (trading as Castle Climbing Centre) [2003] All ER (D) 364*. The case concerned a woman (the Claimant) who was climbing at the Defendant's climbing centre. She was climbing on the wall when she realised that she was not secured with ropes as she had thought. The duty manager was nearby and decided that the best way to rescue her was to give instructions to a nearby climber, who was close to the Claimant on the wall but was relatively inexperienced, as to how to rescue her. Before this was complete, the Claimant fell and suffered serious brain damage. The Claimant maintained that the method of rescue decided upon was inappropriate and that the duty manager had acted negligently in selecting it.

The judge reiterated the principle that 'there is no duty to attempt a rescue but that once active steps have been taken a duty of care has been assumed'. The judge also differentiated between errors of judgment and negligence. He emphasized the fact that in this case the duty manager had been acting in an emergency situation and had to make a decision very quickly, and supported the decision in the earlier case of *Marshall v Osmond [1983] 2 All ER 225* that 'the defendant's actions...were not to be judged on the same standards as those which would apply if he had time to consider all possible alternative courses of action', and that the defendant's actions must be seen in the context of the emergency. The judge found that if the duty manager made an error, it was an error of judgment in difficult circumstances, and not negligence.

It seems clear that where someone is acting in an emergency, this fact will be taken into account by a judge when determining whether or not they acted reasonably or were negligent.

In summary, a person who attempts resuscitation will only be liable for damages if negligent intervention directly causes injury which would not otherwise have occurred, or if it exacerbates an injury. In the circumstances under discussion, where without resuscitation the victim would almost certainly die, the risk of incurring such liability is extremely small. If, however, a resuscitation procedure is carried out negligently and a consequential injury can be proved to have arisen from that negligent procedure, a rescuer may be held liable for substantial damages if the standard of care he employed fell below that which could be expected of him in the given circumstances. This applies whether he is a healthcare professional, a non-professional volunteer first-aider, or simply an unskilled member of the general public.

Children

Trespass against the person

Whilst the majority of what is stated above in relation to trespass against the person applies equally to children, the defence of consent or implied consent is likely to operate differently, as, depending on the age of the child, the child may not be able to give consent and in the ordinary course of events it would be the child's parents who would give consent for a medical procedure to be carried out on the child. So if the child had suffered cardiopulmonary arrest, and its parents were present and refusing to allow a bystander to use an AED on their child, it would be difficult to argue that implied consent is applicable. Necessity could be argued in those circumstances, and the law is clear that doctors can act in an emergency to protect a child's life or health without parental consent on the basis of the defence of necessity. Whether this can be extended to unqualified bystanders is not clear.

In Scotland, the Age of Legal Capacity (Scotland) Act 1991 provides that a person under 16 has the capacity to consent to medical treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the treatment. Accordingly, the child's capacity to consent must be assessed by a medical practitioner rather than a member of the public.

The Mental Capacity Act 2005

As set out above, the Mental Capacity Act 2005 is not applicable in relation to treating those under the age of 16. Therefore, where the victim is under 16 (which of course may not always be easy to determine in an emergency) the Mental Capacity Act will not provide a defence to any rescuer.

Negligence

The section in this guide on negligence will apply equally where the victim is a child.

New Legislation

Some countries have recently established legislation to protect the users of AEDs.

In 2007, Canada enacted a law under which a non-healthcare professional who uses a defibrillator at the scene of an emergency in good faith, voluntarily and without reasonable expectation of compensation, will not be liable for damages resulting from negligence in acting or failing to act whilst using the defibrillator, unless it is established that the

damages were caused by their gross negligence (Chase McEachern Act (Heart Defibrillator Civil Liability) 2007). Similar provisions have been made by federal law in the United States of America (Section 404 Public Law 106-505, adding section 248 to the Public Health Act).

In the UK, in 2004, a private member's bill, The Promotion of Volunteering Bill, was put forward by the MP Julian Brazier. Under clause 5 of the proposed Bill:

Any person who:

- a) without payment or the expectation of payment, assists any other person, and
- b) has reasonable grounds for believing that the other person is suffering or injured or faces imminent serious injury,

shall not as a consequence of any action performed by him in good faith be liable at common law for any harm caused to that person unless he intended to cause harm.

However, the Bill was not passed by Parliament because a number of objections, largely relating to other parts of the Bill, meant that a vote could not be taken due to lack of parliamentary time. So at the present time there are no statutory laws in the UK designed to protect rescuers who attempt to help others. It can be seen, however, that there remains a good deal of protection in the common law principles that are described in this guide.

Liability of third parties

It is possible that, if a rescuer performs a procedure negligently, others may, additionally or alternatively, be pursued for damages in respect of the injuries sustained. In this context, there is a potential liability for those who train rescuers in resuscitation techniques, those who provide or maintain resuscitation equipment, and those who administer the system under which rescuers operate. In the absence of any test case, it is impossible to provide definitive guidance on this subject and it remains unclear how a court would determine the issue of liability of an organisation which had provided training in the use of an AED or was responsible for the maintenance of the devices, but it is certainly possible that liability could be found.

In the United Kingdom, the Resuscitation Council (UK) publishes or endorses guidelines to assist those attempting resuscitation. Practically all professional healthcare workers, voluntary aid societies, and other first aid groups follow these recommendations. It is possible that it might be argued that, although the rescuer performed the recommended procedure correctly, the resuscitation procedure was in itself intrinsically flawed and the Resuscitation Council (UK) should, therefore, be liable for consequential injuries. This argument will fail if the procedure recommended by the Council, and employed correctly by the rescuer, is accepted as proper by a responsible body of medical opinion, even if it is a minority body of opinion. It will not be sufficient to show that there exists another body of opinion that would take a contrary view. This being the case, it is highly improbable that the standards and guidelines employed and taught in the United Kingdom could be successfully challenged.

Hospitals that run resuscitation training courses for their staff might indirectly be held liable if resuscitation trainers in their employment teach a procedure which has not been approved by a responsible body of medical opinion, or if they teach an approved procedure incorrectly. However, provided their teaching is correct and in accordance with Resuscitation Council (UK) guidelines, it is, for the above reasons, difficult to envisage a claim being pursued.

The same principle applies to other bodies carrying out resuscitation training, whether in the voluntary sector or as commercial first aid training organisations. Training agencies, like hospitals, will owe a duty to train people properly and, if they breach this duty by training an individual incorrectly or by certifying as competent an individual who is in fact incompetent, they could be held liable for any consequential harm suffered. Similarly, an organisation responsible for maintaining AEDs and auditing the maintenance of the machines might be liable if it can be shown that harm has been suffered by an individual as a result of its failure to maintain that equipment.

The Court of Appeal case of *Watson v British Boxing Board of Control Limited and another* [2000] All ER (D) 2352 may be relevant to this issue. The Defendant had control over the provision of medical care at a boxing match at which the Claimant was injured and only given the appropriate medical treatment after a considerable delay. Lord Phillips MR held in *Watson* that previous cases 'establish that where A advises B as to action to be taken which will directly and foreseeably affect the safety or well-being of C, a situation of sufficient proximity exists to found a duty of care of A towards C. Whether in fact such a duty arises will depend upon the facts of the individual case and, in particular, upon whether such a duty of care would cut across any statutory scheme pursuant to which the advice was given'. In determining whether a duty of care in fact exists in given circumstances the Court will need to consider foreseeability, proximity, and whether it would be fair, just, and reasonable to hold that a duty exists in the particular case.

In *Watson* the Court found that a duty of care was owed. The Court did not consider it relevant that the body in question was a non-profit making organisation and did not carry insurance.

In *Wattleworth v Goodwood Road Racing Company Limited and others* [2004] All ER (D) 51, *Watson* was relied on to find that a duty of care did exist on the part of the Defendant, who had given advice in relation to safety measures at a motor racing facility at which the Claimant was injured.

The crucial issue in this context is the proximity of the individual or organisation providing advice to those who act on it. In *Sutradhar v Natural Environment Research Council* [2006] 4 All ER 490, the Defendant had published a report on wells in Bangladesh, but did not test the water for arsenic. He was sued when it was found that the water in the wells did contain arsenic, which had caused harm to the Claimant. The House of Lords held that no duty of care existed between the Defendant and the Claimant, with Lord Hoffman stating that the 'principle is not that a duty of care is owed in all cases in which it is foreseeable that, in the absence of care, someone may suffer physical injury. There must be proximity in the sense of a measure of control over and responsibility for the potentially dangerous situation'.

A new area, and one upon which it is harder again to give definitive guidance, is where an AED is purchased by a lay person or organisation outside a medically controlled system. The general principles of liability would suggest that if it is used or provided in a negligent fashion there may be liability. Therefore, it could be argued that it would be negligent if the village post office, for example, purchased an AED and encouraged villagers to use it without providing training.

Avoiding liability

The best way to avoid personal liability is good practice.

Good practice in this context means following the guidelines recommended by authoritative bodies such as the Resuscitation Council (UK), both in the teaching and in the practice of resuscitation techniques. Training should be up to date and recommendations about re-training and refresher courses should be followed. Equipment must be of a type recommended for the procedure for which it is used, and must be well maintained in accordance with the manufacturers' recommendations.

Many health care professionals will enjoy some form of protection from legal liability through NHS indemnity schemes, but often such indemnity will only cover them while they are actually carrying out their role within the NHS. It may not, for example, extend to the use of AEDs off NHS premises, and it is incumbent on the individual to be sure of the extent of their cover, particularly when volunteering for first aid duties outside their normal place of work. An analogous situation occurs with voluntary aid societies and some other first aid organisations that have indemnity cover for their members whilst they are employed on the duties of the respective organisation. This cover may not necessarily apply at other times.

Trainers in resuscitation techniques who are employed by hospitals are likely to be covered by their employers' insurance. As we have seen, a hospital may indirectly be held liable if a trainer teaches a procedure incorrectly or a procedure not recommended by a responsible body of medical opinion. It is a potential risk in respect of which NHS employing authorities should ensure that they are adequately insured. Trainers who are insured by hospitals will probably not be covered by their employers' indemnity insurance if they teach outside their employment. In this situation they may be covered by other insurance, for example that held by the voluntary aid body or other organisation for which they might be teaching. Again, it is incumbent on the trainers to ensure that they are protected, by providing a high standard of training in accordance with modern guidelines, and by having adequate indemnity cover. All organisations which teach first aid and resuscitation techniques, including the use of AEDs, should ensure they have appropriate insurance policies to cover the acts of their trainers and those trained by them.

Many countries, including a number of states in the USA, have what is known as Good Samaritan legislation which gives people who provide emergency first aid various levels of immunity from legal liability. The principles of this have been considered in more detail in preceding sections. During the ten years that has elapsed since the original publication of this guide, an attempt has been made to introduce such legislation into the UK, but this did not succeed. In any event, it remains unclear whether it is, in fact, necessary. The UK has a far less litigious culture than the USA, and there is little yet to suggest that claims of this type are being actively pursued. It is, in practice, extremely difficult to envisage (and no precedent has yet been set) how a victim could successfully sue an individual who rendered him aid in an emergency situation. If anyone were to bring a successful claim, it is likely that the rescuer would have to have acted in a grossly negligent fashion and, if this was the case, it would probably not be desirable to introduce legislation to protect him.

Responsibility to provide an AED at a public place

In the years since their introduction, the use of AEDs by lay persons has proved so successful that fears have been expressed that failing to provide an AED might lead to a claim for negligence should a member of the public suffer a cardiac arrest while on the premises. The problem was highlighted when two airline companies were successfully sued in the USA because an AED was not available to treat passengers who suffered cardiac arrests during a flight.

AEDs are being widely provided in busy public places by a government led initiative, and many other organisations have acted on their own initiative to make the equipment available. The police have equipped custody suites with AEDs and many patrol cars also carry the equipment. The first aid societies have deployed AEDs at many of the functions that they attend. There is, therefore, widespread public awareness of the purpose of such equipment, but so far there have been no cases in the UK brought against those who have not equipped themselves with AEDs.

Several US states now require AEDs to be placed in particular buildings, including schools, health clubs, day care centres, places of public assembly, and swimming pools. There is currently no such legislation in the UK.

Under English law, there can be liability in negligence for failing to take appropriate safety precautions on your premises, for example the case of *Lips v Older [2004] All ER (D) 168*, where a landlord was found to be negligent for not arranging for a handrail to be put up by a staircase with a steep drop to one side. Whether precautions are appropriate will depend on balancing the cost and benefit of the precaution. When considering the benefit, one must consider the likelihood of harm, the severity of the potential harm, and the vulnerability of potential victims that the Defendant knew or should have known about. In that and similar cases, the hazard was inherent in the premises, but it can be seen by analogy that the time might come (although it has probably not yet arrived) where certain types of premises would be considered defective if they were not equipped with AEDs.

In relation to AEDs, the likelihood of harm will depend on the type of people who use the facility, and how likely they are to have a cardiac arrest. The severity of potential harm is clearly very high. The vulnerability of potential victims will very much depend on the circumstances and the type of people attending the defendant's facility. The cost of purchasing an AED and training staff to use it may be quite high. However, when looking at the cost, lack of resources will not be a relevant factor. Failing to adopt common practice can be strong evidence that appropriate precautions were not taken. Where an AED is provided in a workplace, and used by a member of staff, it becomes work equipment to which the Provision and Use of Work Equipment Regulations 1998 apply. Failure to maintain the equipment and to train persons in its use would be a breach of the 1998 Regulations by the employer.

It may be possible to use this basis of liability to found a claim against an organisation that did not equip itself with AEDs. For any such claim to succeed, it may well have to be shown, at the least, either that the people who generally used the organisation's premises were at a particular risk of cardiac arrest (i.e. that there was a fairly high risk of potential harm), or that it was common practice amongst such organisations to have

an AED available. An example could be a gym or health club where cardiac arrests have been reported with some frequency. In addition, many such facilities (but not all) have already equipped themselves with AEDs and lives have been saved. Some states in the USA do actually require health clubs to be equipped with AEDs.

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