



# **Cardiopulmonary resuscitation, automated defibrillators and the law**

by

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*In this booklet, the term ‘bystander’ means a person who is present and able to help when someone collapses, or is found collapsed, as a result of a possible sudden cardiac arrest. Other terms such as witness, passer-by, family member, rescuer or first aider may apply equally well in certain circumstances.*



## Headline messages

- Up to 60,000 people die each year in the UK from sudden cardiac arrest (SCA).<sup>1</sup>
- Fewer than 1 person in 10 survives if SCA occurs out of hospital.<sup>2</sup>
- Cardiopulmonary resuscitation and the use of an automated external defibrillator significantly improve survival.
- Both can be delivered by untrained members of the public.
- Acting to help someone who has suffered SCA will greatly improve their chance of survival.
- The courts have always looked benevolently on those who have gone to the assistance of others.

<sup>1</sup> *European Heart Journal* (2001) 22, 1374–1450 doi:10.1053/euhj.2001.2824

<sup>2</sup> **RESUSCITATION TO RECOVERY** A National Framework to improve care of people with out-of-hospital cardiac arrest (OHCA) in England, 2017



## Executive summary

- The true annual number of deaths from sudden cardiac arrests (SCA) in the UK is currently unknown, but based on European data it is estimated to be around 60,000 per year.<sup>1</sup> However, we do know for sure that in England the ambulance service attempts resuscitation in around 30,000 cases annually.<sup>2</sup> Unfortunately, at present, fewer than 1 person in 10 survives when the SCA occurs out of hospital.<sup>2</sup> We need more bystanders to start immediate cardiopulmonary resuscitation (CPR) in cases of SCA to improve survival.
- CPR and the use of an automated external defibrillator (AED) can significantly increase survival chances in these circumstances if performed promptly. AEDs are often provided in public places and can be safely used by untrained members of the public while waiting for an ambulance.
- The likelihood of causing harm by performing CPR or using an AED is very small indeed. Nevertheless, there has been some concern that should an attempt to resuscitate someone having a suspected SCA result in harm, a legal claim could be brought against the rescuer. To date, there has been no reported successful claim to this effect.
- There are no statutory laws covering resuscitation but a potential liability could arise if a civil claim were brought by the victim, or their family, against someone on the grounds that intervention occurred without their consent and so constituted an assault and/or battery.
- In professional medical practice, there are two defences available to healthcare professionals. They include 'implied consent' (the assumption that if someone were conscious and able to make a decision, they would consent to the procedure) and 'necessity' (that the treatment is given in the best interests of the patient). While the defence of implied consent may not be as clear-cut if the rescuer isn't medically qualified, the defence of necessity may be available, provided the rescuer acts reasonably in the circumstances. For instance, it would be reasonable to carry out CPR and use an AED if no healthcare professionals were available.
- Section 5 of the Mental Capacity Act (England and Wales) 2005, which applies to people aged 16 and over, may also add weight to this defence. It suggests that if a passer-by goes to help someone believed to be having a cardiac arrest, they are not committing battery if they reasonably believe the person they are trying to help isn't mentally capable of giving consent for CPR and use of an AED, and that they believe it would be in the person's best interests to try to resuscitate them.



- A claim for negligence could be brought if it could be shown that a duty of care had been breached, leading to harm. In the UK, there is no legal obligation for others to help a person in need of resuscitation, provided they were not the cause of the person needing help. However, there are circumstances in which certain professionals, and people who have a particular relationship with the collapsed person, would be considered to have a duty of care. Also, once a bystander volunteers to help, they are then considered to have a duty of care to assist the person as far as they are able.
- Anyone who attempts resuscitation would only be legally liable if it could be shown that the intervention had left a person in a worse position than they would have been in had no action been taken. In the case of a cardiac arrest, this would be virtually impossible, since without intervention death is inevitable. Added to that, an AED will only send shocks if it detects a pattern consistent with a cardiac arrest. Someone could potentially be left worse off if CPR were carried out inappropriately, but this is highly unlikely. In this case, it would have to be shown that the standard of care were to blame and this would be judged according to the rescuer's training level.
- Third parties, such as first aid trainers, or organisations that provide training, maintain resuscitation equipment or administer the system under which rescuers operate, could also be potentially held liable. However, a claim would only be successful if the training were below standard, or equipment had not been correctly maintained, leading directly to harm.
- There is no UK legislation stipulating that AEDs must be provided in public areas, so not providing them could not result in a claim under statutory law. However, since their introduction, the use of AEDs by laypeople has been widely recommended in [international resuscitation guidelines](#). This has given rise to the concern that failing to provide an AED might lead to a claim for negligence under common law if a member of the public were to suffer a cardiac arrest on the premises. Each organisation should therefore consider assessing the pros and cons of AED provision.

<sup>1</sup> *European Heart Journal* (2001) 22, 1374–1450 doi:10.1053/euhj.2001.2824

<sup>2</sup> [RESUSCITATION TO RECOVERY](#) A National Framework to improve care of people with out-of-hospital cardiac arrest (OHCA) in England, 2017



## Introduction

Going to the aid of someone in a life-threatening situation is a perfectly natural, human response, which evidence shows improves survival chances. In recent years, however, there has been increasing concern that should an attempt to resuscitate someone undergoing a suspected cardiac arrest result in harm, a legal claim could be brought against the 'rescuer'. Understandably, this fear may make some people hesitant to intervene in an emergency.

The aim of this document is to clarify, as far as possible, the obligations and responsibilities of those who attempt the resuscitation of anyone suffering a suspected sudden cardiac arrest, and to provide guidance for organisations that are contemplating providing life-saving equipment and training for those who might use it. The advice is concerned primarily with resuscitation attempts made out of hospitals or other healthcare facilities and, while relevant to healthcare professionals, is particularly aimed at lay rescuers with modest or no first aid knowledge or training.

This document was originally published in 2000 as *The legal status of those who attempt resuscitation* and was revised in 2010. A thorough review was undertaken in 2017 by one of the original authors and a legal specialist in the field. Revisions have been incorporated to ensure that the advice remains as current and accurate as possible. We hope you find it helpful.



## Key facts about resuscitation

- Sudden cardiac arrest (SCA) is a significant cause of death in all developed western countries. In the UK, there are an estimated 60,000 cases annually, and in England, the ambulance service attempts resuscitation in around 30,000 cases per year.<sup>1,2</sup> However, at present, fewer than 1 person in 10 survives when an SCA occurs out of hospital.<sup>2</sup>
- Most cases of SCA are due to an abnormality of the heart's electrical rhythm called ventricular fibrillation. This is when the electrical impulses that normally control the heart become chaotic and uncoordinated, the heart stops beating and the circulation of blood stops. For any chance of survival, the condition must be recognised promptly and a procedure called defibrillation carried out within a critical time period.
- Defibrillation involves the use of a high-energy electric shock that stops the chaotic heart rhythm and allows the normal, organised, electrical rhythm of the heart to resume. This allows the heart to begin pumping normally again.
- The major reason so few people currently survive SCA is that defibrillation isn't provided quickly enough. For defibrillation to be successful, it needs to be carried out within a few minutes of the onset of ventricular fibrillation, although this period can be extended if a bystander provides cardiopulmonary resuscitation (CPR) without delay. Of course, this entails recognising that someone may have suffered SCA in the first place, calling the emergency services (999 or 112), and then performing CPR, which may be at the request and under instruction from a member of the ambulance control team.
- This basic first aid will maintain an oxygen supply to the brain and other organs and make it more likely that the heart can be re-started by defibrillation. The priority in the early stages is to provide chest compressions, and if a rescuer is unable or unwilling to provide rescue breaths, uninterrupted chest compressions should be continued. For further details, see the [Adult basic life support and automated external defibrillation guidelines](#).
- Nevertheless, the victim's chance of survival falls by around 10% with every minute that defibrillation is delayed. Only rarely are the emergency medical services able to attend and provide defibrillation early enough, so the best way of ensuring prompt defibrillation is for someone nearby to use an automated external defibrillator (AED) to deliver the shock that can often save a life. The strategy by which members of the public use an AED in this way has become known as public access defibrillation, or PAD.



## Key facts about automated external defibrillators

- Automated external defibrillators (AEDs) are compact, portable devices that can be easily taken to someone who has collapsed. Once it has been recognised that the collapsed person may have had a sudden cardiac arrest (SCA), the two adhesive pads (electrodes) connected to the AED must be attached to the patient's bare chest. Through these pads, the AED can both monitor the heart's electrical activity and deliver a shock. AEDs provide audible instructions and most models also provide visual prompts on a screen to help the rescuer perform the correct actions.
- The AED will analyse the heart's electrical activity and if it detects a pattern consistent with a cardiac arrest, will charge itself ready to deliver a shock. Using an AED in this way allows the provision of effective treatment during the critical first few minutes after SCA while the emergency services are on their way.
- Modern AEDs are very reliable and will not allow a shock to be given unless it's needed. They are, therefore, extremely unlikely to do any harm to a person who has collapsed with a suspected SCA. They are also safe and present minimal risk of a rescuer receiving a shock. AEDs require very little routine maintenance or servicing; most perform daily self-checks and display a warning if they need attention. Those currently offered for sale have a minimum life expectancy of 10 years. The batteries and pads have a long shelf life, allowing the AED to be left unattended for long intervals. More details about this are given in [A guide to automated external defibrillators \(AEDs\)](#).
- These features make AEDs suitable for use by members of the public who have little or no training, and for use in public access defibrillation schemes. Since 2000, AEDs have become available in many public places.
- Initially, there was some anxiety about making AEDs widely available in public places because they were to be used by people who were not medically trained. However, the strategy has proved to be very effective, saving many lives, while adverse events have been rare and complaints very few. The number of AEDs available has continued to rise, with many organisations now providing them. This in itself has led to certain legal obligations, which could result in liability if not followed. In addition, the use of AEDs has been so successful in some locations that the potential liability for not having one available has also been questioned (see *Responsibility to provide an AED in a public place*, page 21).



## Possible grounds for a claim for damages

Broadly speaking, there are two kinds of laws that must be followed in the UK: statutory laws, which are imposed by Parliament, and common laws, which have 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 could arise at common law. This document will concentrate purely on civil liability and claims for compensation.

Although there have been a few cases in the UK when a claim for damages has been brought against a member of the public or a first aider who has attempted resuscitation, there have been no reported cases in which someone has successfully sued anyone who came to help them in an emergency situation.

In theory, a civil claim might be brought by the victim or their family against someone on the grounds that their intervention constituted an assault or – perhaps in cases in which the rescuer is a healthcare professional – constituted a breach of duty of care. However, it would be necessary to show that the actions of the rescuer had led to serious personal injury or death, which in the case of an SCA is highly unlikely.

## A claim for assault and/or battery

Despite the rescuer's good intentions, if an attempt to resuscitate someone were to cause harm, it's possible that the victim or their family could make a claim for assault and/or battery. These terms are often confused but they have slightly different meanings. However, it must be stressed that the likelihood of causing harm by performing cardiopulmonary resuscitation (CPR) and using an automated external defibrillator (AED) is very small indeed.

### ■ Understanding the terms

Assault is classed as the threat of physical harm that reasonably causes fear of harm in the victim. If the victim has not actually been touched, but only threatened – or if someone has attempted to touch them – then the crime is assault.

Battery is the actual physical impact of force on another person. Force, in this instance, could include even light touching, if the person being touched hasn't given their consent to it.

### ■ How is this relevant to resuscitation?

The physical contact involved in attempting resuscitation, either during CPR or with an AED, could clearly constitute battery since, if someone is in cardiac arrest and unconscious, they are not in a position to consent to being touched. So, a claim could potentially be brought against a rescuer for what is commonly known as assault but is more accurately described as battery in England, Wales and Northern Ireland. In Scotland, the term 'wrongful interference with the person' is used when physical contact is involved. It amounts to an assault, which may give rise to a civil claim in damages.

In order to succeed in a claim in any part of the UK, the victim or claimant doesn't have to show that they have suffered any actual physical harm, although it would be necessary to show this if they were to be awarded any more than minimal compensation.

### ■ Consent to treatment: the position of healthcare professionals

In professional healthcare practice, it's not always possible for someone in urgent need of medical attention to give consent for emergency treatment, not least because they may be unconscious, confused, unable to communicate, or there simply may not be time. In this situation, healthcare professionals in the UK have two primary defences available to them.

1. **Implied consent** The justification is that if the person were conscious and able to make a decision, they would consent to the procedure.



2. **Necessity** The reasoning is that treatment without consent can be considered lawful if it is given in the best interests (or, in Scotland, for the benefit) of the patient; in other words, if it is necessary to save their life, to improve their condition or prevent deterioration.

Both of these defences could be comfortably applied in an emergency situation.

### ■ Can these defences apply to other rescuers?

Unfortunately, these defences aren't as clear-cut when it comes to rescuers who are not healthcare professionals, and the less well trained the rescuer, the harder they may be to justify.

For instance, it's harder to argue implied consent in the case of a minimally trained or even totally untrained person performing a procedure, even though it may be straightforward, automated and mechanical (an AED will only administer a shock when it detects ventricular fibrillation – a pattern consistent with a cardiac arrest). Similarly, while it may be harder to argue that treatment by a person who isn't medically qualified is in someone's best interests, we now know that bystander intervention greatly improves the chances of survival in sudden cardiac arrest (SCA).

However, the defence of necessity may be available to a non-professional rescuer, provided that they act reasonably under the circumstances. For instance, it wouldn't be reasonable for an unqualified person to act if a professional rescuer were present or arrived at the scene and offered to help. A bystander may continue to help but this would usually be under the supervision of a healthcare professional at the scene.

So, to sum up, given the importance of CPR and the simplicity, safety and effectiveness of the AED, an untrained layperson would be justified in using one in an emergency when a more qualified person is not available. This would certainly be in line with current [international](#) and [national resuscitation guidelines](#).

### ■ The Social Action Responsibility and Heroism Act (England and Wales) 2015

This [Act](#) was introduced to encourage 'volunteering and involvement in social action'. The Act requires that, when considering a claim brought for negligence or for breach of statutory duty, the court must have regard to whether the defendant was:

- acting for the benefit of society or any of its members
- demonstrating a predominantly responsible approach towards protecting the safety or interests of others
- was acting heroically.



While the intention of the Act may have been to foster social responsibility and encourage good citizenship, it has been criticised by prominent members of the legal profession who state that it adds nothing to the protection already provided by existing common law and that it may, in fact, erode the protection that already exists. Experience with the interpretation of the Act is lacking and it remains to be seen how the courts will apply it in the future.

### ■ **The Mental Capacity Act (England and Wales) 2005**

This [legislation](#), passed in England and Wales, is fundamentally concerned with people aged 16 and over who 'lack capacity' – in other words are not mentally capable – of making decisions themselves due to an 'impairment of or disturbance in the functioning of the mind or brain'. It can be a permanent or temporary situation, and it obviously applies when someone has a cardiac arrest and needs resuscitation.

#### **Care or treatment**

Section 5 of the Act is concerned with the care or treatment of another person.

It suggests that if a passer-by goes to the aid of someone believed to be having a cardiac arrest, the passer-by is not committing battery if:

- they reasonably believe the person they are trying to help isn't mentally capable of giving consent for the CPR and use of the AED, having taken steps to check this first
- they reasonably believe it would be in the person's best interests to try to resuscitate them.

However, this doesn't exclude the passer-by from being liable for negligence (see *A claim for negligence*, page 14).

To date, there have been no cases or articles discussing the application of Section 5 to the case of a medically unqualified person who attempts to resuscitate an unconscious person. However, the provisions of Section 5 may boost protection against an accusation of battery for someone attempting to help.

#### **What are 'best interests'?**

What constitutes 'best interests' is defined in Section 4 of the Act. The legislation was clearly intended to apply to circumstances in which there is plenty of time available for a measured decision to be made, as it asks the rescuer to consider 'all the relevant circumstances', including a number of specific and detailed issues.

However, in reality it's highly unlikely that all of the stipulated information would be available to someone who attempts resuscitation of an unconscious person, possibly a stranger, in an



emergency situation. And even if the information were available, there would be insufficient time to consider all the details.

Fortunately, this is acknowledged in the code of practice that accompanies the Act, which 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.

### **Example of ‘best interests’**

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 mean that she would have refused all blood products. But since Mrs Prior’s handbag had been stolen, the doctor had no idea who she was or 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.

From this example quoted in the code of practice, it seems unlikely that a rescuer would be expected to consider the best interests of a collapsed person in anything other than a very superficial way – that it’s reasonable to assume that most people who undergo SCA would wish to be resuscitated.

### **Advance decisions**

The Act also makes it clear (in Sections 24–26) that legally binding advance decisions to refuse treatment still apply in this situation, although in the real world, it’s very unlikely that a rescuer acting in an emergency would be aware of any such advance decision. However, if it became known that an advance decision to refuse treatment (ADRT) or a do not attempt cardiopulmonary resuscitation (DNACPR) recommendation were in place, then it should be respected.

## **■ Adults with Incapacity Act (Scotland) 2000**

In Scotland, the [Adults with Incapacity \(Scotland\) Act 2000](#) (paragraphs 2.40–2.42) makes provision for giving medical treatment to people who are incapable of making a treatment decision because of a mental disorder, or an inability to communicate due to physical disability. Part 5 of the Act sets out a procedure whereby a medical practitioner can certify incapacity and give medical



treatment. This procedure is unlikely to be practicable in cases where cardiac resuscitation is necessary, unless the person has already been assessed as incapable because of a condition such as dementia or a severe learning disability. However, the statutory Code of Practice makes clear that treatment can be given in emergencies under the general common-law provisions regarding implied consent and necessity.

### ■ **The Mental Capacity Act (Northern Ireland) 2016**

The Mental Capacity Act for Northern Ireland (NI) was passed in 2016, but at the time of writing it is uncertain when this will come into force. Currently in an emergency situation, the common-law defence of necessity, which provides protection for necessary treatment given in the best interests of the patient, applies. When the Mental Capacity Act is fully in force, the position will remain the same, as Section 9 provides that a lack of consent is not a basis for liability if the actions are in the patient's best interests.

## **A claim for negligence**

For a claim for negligence to succeed, a claimant would have to show that the rescuer owed them a duty of care, which was breached, leading to avoidable harm.

### **■ Who has a duty of care?**

In the UK, there is generally no legal obligation for others to help a person in need of resuscitation, provided they were not the cause of the person needing help. This applies equally to laypeople and healthcare professionals who are not on duty. In other words, you are not liable for failing to act in an emergency, and don't automatically have a duty of care to that person.

However, the situation may be different for certain professionals, as well as people who have a particular relationship with the collapsed person. This may include:

- a doctor or nurse responsible for the health and wellbeing of a patient under their professional care
- ambulance staff dispatched to attend a particular incident
- a trained responder or first aider in a workplace setting because they have willingly taken on this role as part of their employment. This will have involved training to an approved standard in a specified list of competencies.

### **■ What about volunteers?**

Although a bystander has no legal obligation to act, once someone volunteers to help, they assume a duty of care towards the person in need. This applies both to off-duty healthcare professionals and lay members of the public.

Regardless of the circumstances, anyone who attempts resuscitation would only be legally liable if the intervention leaves a person in a worse position than they would have been in had no action been taken. In the case of a sudden cardiac arrest (SCA), it is difficult to see how a volunteer rescuer's intervention could leave someone worse off, since without intervention death is inevitable.

Added to that, if an automated external defibrillator (AED) is being used, it will only deliver a shock when its sophisticated electronic algorithms detect ventricular fibrillation, a pattern consistent with cardiac arrest; since patients in this state are clinically dead, again it is difficult to see how the appropriate use of this device by a bystander could make the situation worse.



## ■ When intervention could cause harm

However, if resuscitation is carried out without an AED, it's slightly easier to envisage how an intervention could potentially leave someone in a worse state.

For example, if a rescuer inappropriately performed chest compressions, this could result in damage to the chest wall or underlying organs, although in practice, important injury is very unlikely. If the person turned out not to have been having a cardiac arrest, this intervention would have left them in a worse position than if nothing had been done.

It's 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 their intervention, arguing that it would have been preferable if they had died. Such an outcome is extremely unlikely, but legally and as a matter of public policy, this type of argument, known as a claim for 'wrongful life', is unlikely to succeed.

## ■ The standard of care

If someone could show that a rescuer owed them a duty of care and that, as a result of the rescuer's intervention, they had been left in a worse position than if there had been no intervention, the claimant would still have to show the court that the standard of care employed had been negligent. They would also have to show that this negligent care was the reason for them being in a worse state of health than they would have been otherwise.

Naturally, the standard of care expected would vary according to level of training. For instance, a member of the general public with no training wouldn't be judged by the same standards as a trained responder, and a trained responder wouldn't be judged by the same standards as a healthcare professional. Rest assured, the court would make a judgment appropriate to the level of expertise of the defendant.

### **Healthcare professionals**

The bottom line here is that, provided resuscitation procedures are performed correctly and in accordance with current guidelines, it's 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.

### **Trained responders**

A trained responder, such as a first aider, would not be expected to employ the same standard of care as a healthcare professional. Liability would only arise if the standard of care employed fell below what could reasonably be expected of a responsible person in the rescuer's position.



If an action were brought, the court would be likely to take into consideration the fact that the trained responder had a skill (having been trained in resuscitation), but would also acknowledge the fact that the rescuer was a volunteer and not a healthcare professional. If the procedure were performed correctly and in accordance with current first aid practice and guidelines, it's unlikely that a successful claim for negligence could be brought. However, if the procedure were carried out incorrectly, with disregard for modern accepted practice and current recommendations or because skills had not been kept up-to-date, it is possible that liability could arise.

**Case study example: Cattley v St John Ambulance Brigade (1988)**

This was a rare case, not officially published in a law report, of someone suing a volunteer due to the standard of care they received. First aiders from St John Ambulance came to the aid of a teenager who had been taking part in a motorcycle-scrambling event and had fallen off his motorbike. He claimed that his spinal injuries had been made worse by the fact that he was made to walk after treatment by first aiders at the trackside.

However, the judge held that if, in any situation, the first aider follows the guidance in the first aid manual with the skill normally expected of a first aider, they are not negligent. This had been the case, even though the advice on the management of spinal injuries in the Brigade's manual was criticised and has since been updated.

**An untrained layperson**

A member of the public with no special resuscitation training would only be considered negligent if they performed an act that a reasonable person in their position would not have done in the same situation, or if they omitted to do something that a reasonable person would have done. So, the standard by which a layperson would be judged is lower than that of a first aider.

**Case study example: Day v High Performance Sports Limited (trading as Castle Climbing Centre) [2003] All England Reporter (D) 364**

The claimant was climbing on the wall of the defendant's climbing centre when she realised that she was not secured with ropes as she had thought. The duty manager was nearby and decided that the best solution was to give instructions to a nearby climber, who 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.

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 emphasised the fact that in this case the duty manager had been acting in an emergency situation and had to make a decision very quickly. The judge found that if the duty manager made an error, it was an error of judgment in difficult circumstances rather than negligence.



So, it seems clear that when someone is acting in an emergency, this will be taken into account by a judge when determining whether they acted reasonably or were negligent.

### **Weighing up a rescuer's liability**

A person who attempts resuscitation would only be liable for damages if their intervention is negligent and its negligence directly leads to an injury that wouldn't otherwise have happened, or if it makes an existing injury worse. In the circumstances of cardiac arrest, when the victim would almost certainly die without resuscitation, the risk of incurring such liability is extremely small.

On the other hand, if a resuscitation procedure is carried out negligently and this is proven to result in an injury, a rescuer may be held liable for substantial damages if the standard of care they employed fell below what could be reasonably expected of them, considering the circumstances and their training level. This applies to healthcare professionals, volunteer first aiders and to unskilled members of the general public.

## **■ How the law applies to children**

### **Assault and/or battery**

Most of what has been already stated regarding a claim for assault and/or battery also applies to children. However, the defence of implied consent may operate differently, depending on the child's age, as they may be too young to give consent for a medical procedure. In this case, it would be the parents or legal guardians who would need to consent. If they were unavailable, it's likely that implied consent could be assumed.

If a child had suffered a cardiac arrest and their parents were present and were refusing to allow a bystander to use an AED on their child, it would be difficult to argue that implied consent is applicable. However, in this case, necessity could be argued as a defence. 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 (and defence) of necessity. But whether or not this can be extended to other healthcare professionals, or indeed to unqualified bystanders, is not clear.

### **The age of consent for medical treatment**

In England, Wales and Scotland, anyone aged 16 or over is entitled to consent to their own treatment unless there is significant evidence to suggest that they are not mentally capable of understanding the issues. In Northern Ireland, although the legal age of capacity is 18, those aged 16 and 17 are allowed to consent if they are considered capable of making their own decisions.

In all parts of the UK, those aged under 16 can sometimes give consent to medical treatment if they are believed to have enough intelligence, competence and understanding to appreciate fully what is involved in their treatment. However, competence must always be formally assessed.



### **The Mental Capacity Act (England and Wales) 2005**

As stated previously, the Mental Capacity Act 2005 doesn't apply to those under the age of 16 so it can't be used as a defence by a rescuer.

### **Negligence**

The section on negligence above also applies when the victim is a child.

### **■ Liability of third parties**

If a rescuer performs a procedure negligently, leading to injuries, third parties could also be sued for damages either in addition to, or instead of, the rescuer. Third parties who may potentially be liable include those who:

- train rescuers in resuscitation techniques
- provide or maintain resuscitation equipment
- administer the system under which rescuers operate.

It is currently impossible to provide definitive guidance as to how a court would determine the liability of an organisation that had provided an AED and/or training in its use.

### **The Resuscitation Council (UK)**

In the UK, the Resuscitation Council (UK) publishes or endorses guidelines for anyone attempting resuscitation. These guidelines, in turn, are based on internationally agreed evidence for the effectiveness of every procedure recommended. These recommendations are followed by virtually all professional healthcare workers, voluntary aid societies, and other first aid groups. It could be argued that, although the rescuer performed the recommended procedure correctly, the resuscitation procedure was in itself flawed and the Resuscitation Council (UK) should, therefore, be liable for consequential injuries.

However, if the recommended procedure itself is considered acceptable by a responsible body of medical opinion – even if it's a minority body – this argument would fail. This would be the case even if it could be shown that there is another body of opinion that takes a contrary view. As a result, it's extremely unlikely that the standards and guidelines employed and taught in the UK could be successfully challenged.

### **Training bodies**

Hospitals and other healthcare organisations that run resuscitation training courses for their staff – for instance, ambulance services – might indirectly be held liable if their resuscitation trainers teach a procedure that hasn't been approved by a responsible body of medical opinion, or if they teach



an approved procedure incorrectly. But, provided their teaching is correct and in accordance with Resuscitation Council (UK) guidelines, it is, for the above reasons, difficult to imagine that a claim could be pursued successfully.

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 such as hospitals have a duty to train people properly and, if they breach this duty by training someone incorrectly or by certifying an incompetent trainee as competent, they could be held liable for any harm suffered as a result.

### ■ How to avoid liability

The best way to avoid personal liability is to follow good practice. This means:

- acting in good faith for the benefit of the person with SCA to improve their chance of survival
- following instructions from 999 dispatchers, from the AED or from a volunteer professional at the scene
- following the guidelines recommended by authoritative bodies such as the Resuscitation Council (UK), both in the teaching and practice of resuscitation techniques
- keeping training up-to-date
- using the correct equipment recommended for the procedure and keeping it well maintained in accordance with the manufacturer's recommendations.

### Check your insurance

Insurance cover may vary according to circumstances such as where and when resuscitation takes place, so it's important to check.

**Bystander rescuers** No insurance would be expected or needed for lay members of the public carrying out benevolent intervention in good faith.

**Healthcare professionals** Many healthcare professionals will enjoy some form of protection from legal liability through NHS indemnity schemes, but often such indemnity only covers them while they are actually carrying out their role within the NHS. For instance, it may not extend to practice out of NHS premises, and it's down to each individual to be sure of the extent of their cover, particularly when volunteering for first aid duties outside their normal place of work.

**Trained responders** The same principle applies to trained responders or first aid organisations, which may have indemnity cover for their members while they are employed on the duties of the



respective organisation. This cover may not necessarily apply at other times. Personnel who provide trained responder or first aid services without such cover should obtain private indemnity insurance.

**Resuscitation trainers** Those who are employed by hospitals are likely to be covered by their employers' insurance or NHS indemnity schemes. As we have seen, a hospital may indirectly be held liable if a trainer teaches a procedure incorrectly or teaches a procedure not recommended by a responsible body of medical opinion. It is a potential risk for which NHS employing authorities should be adequately insured.

Trainers who are insured by hospitals would 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, such as that held by the voluntary aid body or other organisation for which they might be teaching.

Private indemnity insurance may be appropriate for bodies, such as private first aid training companies, that undertake training outside such arrangements. Again, it is the responsibility of individual trainers to ensure that they are protected by providing a high standard of training in accordance with up-to-date guidelines and by having adequate indemnity cover. All organisations that 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.



## Responsibility to provide an AED in a public place

There is no current legislation in the UK stipulating that automated external defibrillators (AEDs) must be provided in public areas, so not providing them couldn't result in a claim under statutory law. However, in the years since their introduction, the use of AEDs by the public has proved very successful and has become a strategy widely recommended in international resuscitation guidelines. This has given rise to the concern that failing to provide an AED may lead to a claim for negligence under common law if a member of the public were to have a cardiac arrest on the premises.

### ■ Where are AEDs currently provided?

Once AEDs became commercially available, they were initially used in hospitals, by the statutory ambulance services and by first aid organisations. Thanks to programmes such as the one led by the British Heart Foundation, AEDs were subsequently provided in busy public places by government-led initiatives that first concentrated on large transport centres such as airports and major railway stations. Later provision included sports arenas, large shopping centres and schools. Many other organisations have acted on their own initiative to make the equipment available. So far, there have been no cases in the UK brought against those who have not equipped themselves with AEDs.

### ■ Potential liability

In the UK, there can be liability in negligence for failing to take appropriate safety precautions on your premises. This happened in the case of *Lips v Older* (2004, All ER (D) 168), when a landlord was found to be negligent for not arranging for a handrail to be put up by a low wall running along the edge of a path with a 9ft drop into a basement area. As a result, a tenant fell and was injured.

Whether or not precautions are appropriate would depend on the cost versus the benefit of the precaution. When considering the benefit, it's important to weigh up the chance of harm, the severity of the potential harm, and the vulnerability of potential victims. In this and similar cases, the hazard was in the structure of the premises, but it could be seen how in the future certain types of premises would be considered defective if they were not equipped with AEDs in the same way as if fire extinguishers were not made available.

### ■ Assessing the risk

To assess whether you need to supply an AED, it's important to consider who uses your facility and in what circumstances. How likely are the people who use your facility to have a cardiac arrest? Obviously, the severity of potential harm is very high in the case of a cardiac arrest. To help you do this, take a look at our [risk assessment procedure](#).



## ■ Cost and training considerations

The cost of purchasing an AED and training staff to use it may be considerable. However, when looking at the cost, a lack of resources would not be considered a reasonable defence. Failing to adopt common practice can be strong evidence that appropriate precautions were not taken. When 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](#) in England, Wales and Scotland (1999 in [Northern Ireland](#)) apply. Failure to maintain the equipment or to train your staff in its use would be a breach of the regulations by the employer.

It may be possible to use this basis of liability to make a claim against an organisation that did not equip itself with AEDs. For such a 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 – so there was a fairly high risk of potential harm – or that it was common practice among such organisations to have an AED available. An example could be a gym or health club – facilities where cardiac arrests have been reported with some frequency. Many have now been equipped with AEDs and many lives have been saved as a result. Some countries and US states now require health clubs to be equipped with AEDs.



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