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Medical Liability Briefing: Article 3

Duty of Care owed by particular hospital staff

Two cases from 2017 address how the duty owed by a member of staff changes with their role and expertise. They raise interesting policy questions as to the extent to which the knowledge and experience of the individual are relevant, when practically it is the Trust who bears the liability, whether the fault is systemic or the result of an individual breach of duty.

Junior Doctors

The case of *FB v Princess Alexandra Hospital NHS Trust [2017] EWCA Civ 334* concerned a one-year old girl, FB whose parents became concerned about her in the early hours of 29 September 2003. They telephoned an out of hours service and told a triage nurse that FB's eyes were rolling. This, it was found, was the reason for the call.

The nurse called an ambulance which arrived at the hospital at 4.45am. An SHO saw FB at 5:20 and recorded an impression of Upper Respiratory Tract Infection leading to FB's discharge at 5:55. The same afternoon, FB's mother took her to the GP who called an emergency ambulance. On FB's arrival at 17:53, she was referred straight to the paediatricians who commenced antibiotics. On 1 October 2003, FB was transferred to Great Ormond Street Hospital where a diagnosis of pneumococcal meningitis and multiple brain infarcts was made. FB was left with permanent brain damage. Had the SHO referred FB to the paediatricians, they would have given antibiotics by 9:00, preventing the spread of infection and any injury.

It was alleged that the SHO was negligent in failing to take an adequate history and failing to conduct an adequate examination. She did not elicit the history of eye rolling and eventually accepted that had she done so she would have referred FB to the paediatric team. The judge accepted that FB's parents would have given that information if asked, as they did to the triage nurse and paramedics. He concluded that an A&E Consultant or paediatrician would have elicited this history, but that it was not substandard practice for the SHO to fail to do so. In the Court of Appeal, Thirlwall LJ held that such a view was unsustainable on the evidence and that the standard of care for an SHO in history taking in A&E was the same as for a Consultant performing the same task. The SHO should have asked what precipitated FB's arrival at 5:00 which would have elicited the history of eye rolling.

Jackson LJ then considered the legal background to the issue of the standard to be expected of an SHO. He referred in particular to the Court of Appeal's decision in *Wilsher v Essex AHA [1987] 1 QB 730*. There it was held by the majority that a hospital doctor should be judged by the standard of skill and care appropriate to the post which they were fulfilling (whether that was their normal post or they were "acting up"). A Trust is therefore

liable if the person it puts in a particular role lacks the requisite skill to perform it. Jackson LJ held that FB's doctor was to be judged by the standard of a reasonably competent SHO in an accident and emergency department. All such SHOs are to be judged by the same standard, whether they are new in the post or whether they happen to have some paediatric experience.

The appellant accepted that if she failed on the ground relating to the history taking she was likely to fail on the examination ground. The Court of Appeal having allowed the first ground did not address the second. History taking was accepted to be a basic skill that all clinicians should possess and learn early in medical school. Thus, even judged by the standards of a reasonable SHO, Jackson LJ agreed that the history was substandard. However, picking up on subtle signs of illness does take experience. Determining the level of skill which is to be expected from different members of the hospital hierarchy is likely to be much more difficult when dealing with issues such as a failure to observe subtle symptoms. Here there was an issue as to whether FB looked well as the SHO thought or whether the SHO should have noticed the abnormal state variation which, the judge accepted, would only be noticed by a senior pair of eyes. The question, which may not yield such a straightforward answer, is how senior a pair of eyes? At what point can it be said that all doctors of a certain level of qualification should have noticed the subtle distinction? What is a Registrar permitted to miss that every competent Consultant should pick up?

"Civilians"

Darnley v Croydon Health Services NHS Trust [2017] EWCA Civ 151

Mr Darnley arrived at the Mayday Hospital following an assault in which he sustained a violent blow to the head. Some hospitals have triage nurses staffing their receptions; some, including Mayday Hospital have a 'civilian' (i.e. non-clinically trained) receptionist. Mr Darnley told the receptionist he was in considerable pain. She told him to wait in the waiting area and that it would be four or five hours until he would be seen. In fact, a triage nurse would have assessed him within 30 minutes.

After 19 minutes, Mr Darnley decided to go home and take paracetamol. Shortly after he returned home his condition deteriorated, an ambulance was called and, despite undergoing surgery to remove an extradural haematoma, Mr Darnley has been left with lasting disabilities. Had he been present when the triage nurse came for him he would have received prioritised treatment which would have led to him making a full recovery.

The judge at first instance found that it would not be fair, just and reasonable to impose a duty on civilian receptionists. The Claimant on appeal sought to liken the receptionist to telephonists in ambulance services who have been held to owe a duty to give accurate information about waiting times (*Kent v Griffiths [2001] QB 36* as interpreted by *Michael v Chief Constable of South Wales Police [2015] UKSC 2*). Jackson LJ held that the functions of an A&E receptionist were different. Their function was only to accurately record details of new arrivals and pass them to the triage nurses, not to give patient advice. He was satisfied that there is no general duty to provide information about waiting times. He also held that the receptionist had not, by giving such information, assumed responsibility for the tragic consequences which followed. Further, it would not be fair just or reasonable to

impose a duty not to provide inaccurate information about waiting times. He expressed some sympathy for floodgate arguments and considered it would be a shame if Defendants avoided risks by instructing receptionists to withhold information. Even if he was wrong, he held that the scope of any duty could not extend to liability for the Claimant's own decision to walk out of hospital.

McCombe LJ dissented, stressing that his conclusions were fact specific. He drew attention to the evidence of Mr Darnley's friend that both men had tried to impress upon the receptionist their fears that Mr Darnley had a head injury and needed to be seen urgently. He did not accept the distinction drawn by Jackson LJ between an ambulance telephonist and a receptionist. Perhaps more interestingly he rejected any distinction between clinical staff and civilians. In his judgment the hospital owed a duty not to misinform patients which could not be avoided by relying on civilian staff. On the facts, he found that in failing to give accurate information about the triage system, the hospital was in breach of duty.

McCauley v Karim & Anor [2017] EWHC 1795 (QB

Interestingly, however, the same hospital was held liable when a patient left, unaware that he still needed to undergo a blood test with again, grave consequences. Foskett J held that there was a systemic failure to identify that an important test had not been done or to attempt to contact him when it was discovered he had left. The receptionist who, it was found, had probably told the Claimant that he was not due to be seen by anyone else was not in breach of duty, nor was blame ascribed to any other specific individual. The fault lay in the systemic failings which led the Claimant to slip through the net. Further, Foskett J did not accept that the effect of *Darnley* was that the Claimant was responsible for his own decision to leave, because without being aware of the need for a blood test or the risks, that was not a properly informed decision.

Foskett J's conclusion resembles more closely the reasoning of McCombe LJ in focusing on the duty of the hospital, but avoids imposing the duty which the majority of the Court of Appeal in *Darnley* held it would not be fair, just or reasonable to impose on a civilian receptionist. Claimants seeking to limit the impact of *Darnley* may be advised to focus their analysis on the systemic rather than the personal.

By Ella Davis