Whose duty of care?

It's time to adopt a more mature approach to liability, says Charles Foster

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IN BRIEF

- An NHS Trust *as a whole owes* a duty to claimants. This includes a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury.
- Non-clinical staff play a part in the discharge of this duty. Whether they have discharged it will depend on what it is reasonable to expect them to do.
- The notion of contributory negligence should not be conflated with the notion of the causation required to establish primary liability.

The Supreme Court's latest foray into clinical negligence, *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50, [2018] All ER (D) 41 (Oct) will be widely cited—and usually, I expect, for precisely the wrong reasons. It will be relied upon as authority for the proposition that NHS Trusts, via their administrative staff, owe a duty of care to take reasonable steps to avoid foreseeable physical injury to patients, whereas it is primarily authority for the proposition that no new authority to that effect is needed. In some ways, then, *Darnley* is a legal non-event: it merely re-states some established principles. But it is interesting nonetheless. It shows us what the law really thinks of patients and their autonomy—and is depressing to anyone who wants to believe that the law is coherent and internally consistent.

Facts

The facts are simple enough. The claimant, then aged 26, was struck on the back of the head. He went with a friend to the Accident and Emergency Department of the defendant's hospital, and told the receptionist that he felt very unwell, that his head was hurting, that he was worried that he had sustained a head injury, and that he needed urgent attention. The receptionist (the trial judge found) told him that he would have to wait four to five hours to be seen by anyone. The claimant said that he could not wait that long because he felt he was about to collapse, but was told by the receptionist that if he did collapse he would be treated as an emergency.

The claimant left after 19 minutes of waiting because he felt too unwell to stay and wanted to go home and take some paracetamol. Neither he nor his friend told the receptionist that he was leaving.

After he got home his condition deteriorated. In fact he had a large extra-dural haematoma over his left temporal and inferior parietal lobes. He was taken to hospital by ambulance, and the haematoma was immediately evacuated. He suffered a very severe left hemiplegia.

The usual and proper advice from the receptionist would have been to the effect that the claimant would be seen by a triage nurse within 30 minutes of admission. The trial judge found that if the claimant had been told this he would have stayed, would have been seenby a triage nurse and either admitted or told to wait. It was reasonably foreseeable that, having had the misleading advice about the likely waiting time, the claimant left. Had he been told to wait, he would have done so, and would have been in hospital when he deteriorated. This would have led to his haematoma being evacuated earlier. Had it been, he would have made a near total recovery.

A duty of care?

The defendant argued that receptionists in Accident and Emergency departments are under no duty to guard patients against harm caused by failure to wait to be seen. The trial judge agreed. So did a majority of the Court of Appeal. There was no assumption of responsibility for the consequences of not waiting, and it would not be fair, just or reasonable to impose such a duty.

Lord Lloyd-Jones, with whom the other members of the Supreme Court agreed, held that this was wrong. There was no legal novelty here. The case fell squarely within established principles. 'The common law in this jurisdiction has abandoned the search for a general principle capable of providing a practical test applicable in every situation in order to determine whether a duty of care is owed and, if so, what is its scope....In the absence of such a universal touchstone, it has taken as a starting point established categories of specific situations where a duty of care is recognised and it has been willing to move beyond these situations on an incremental basis, accepting or rejecting a duty of care in novel situations by analogy with established categories' (at [15]). Where an established category of duty applies, there is no need to ask afresh whether the three criteria in *Caparo Industries v Dickman* [1990] 2 AC 605, [1990] 1 All ER 568 (damage, proximity, and fairness) are satisfied. Where the existence of a duty has previously been established, justice and reasonableness have already been taken into account: one should not start from first principles each time. It will normally be necessary to ask whether the imposition of a duty would be 'fair, just, and reasonable' only where the court is being asked to go beyond the established categories.

Here there was no such need. It was well established that bodies in the position of the Trust owe a duty to persons presenting to casualty departments to take reasonable care not to cause physical injury: see *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, [1968] 1 All ER 1068. This plainly extended to a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury: see

[16]. But in fact the court could do better (although it need not do better) than to resort to *Barnett's* general articulation of the ambit of the duty of a casualty department. There was a specifically analogous case in which a relevant duty had been found to be owed. In *Kent v Griffiths* [2001] QB 36, [2000] 2 All ER 474 a call handler had given misleading assurances that an ambulance would arrive soon. If those reassurances had not been given, alternative transport could have been used, and the delay in obtaining damage-avoiding treatment would have been reduced. There was, said the Court of Appeal in *Kent,* a duty not to provide this wrong information.

The duty owed to the claimant was a duty owed by the Trust. In deciding whether or not a duty was owed (as opposed to deciding whether or not the duty had been breached) it was not appropriate to distinguish between clinical and non-clinical staff. One of the more serious of the errors into which the Court of Appeal had fallen was to confuse questions pertinent to the breach of duty with questions pertinent to the issue of whether or not a duty was owed.

Was there a breach of duty?

In considering the question of breach, it was of course important to take into account the nature of the task deployed to hospital receptionists, and the exigencies of their situation. Patients were entitled to receive care given with the degree of skill appropriate to the task for which receptionists were employed. The standard required was that of 'an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency services' (at [25]). The receptionist here had plainly failed to meet that standard. No reasonable receptionist would provide such grossly misleading information.

Causation

In the Court of Appeal, Lord Justice Jackson had concluded that, even if he was wrong about the existence of a duty of care, causation was not established because: 'The scope of that duty cannot extend to liability for the consequences of a patient walking out without telling the staff that he was about to leave. As the judge said, there comes a point when people must accept responsibility for their own actions. The claimant was told to wait. He chose not to do so. Without informing anyone of his decision, he simply walked out of the hospital' (at [56] –[57]).

This, said the Supreme Court, was wrong. It amounted to a finding that the chain of causation had been broken by the claimant's decision to leave the hospital, and this finding was inconsistent with the findings of fact (summarised above). 'Far from constituting a break in the chain of causation, the [claimant's] decision to leave was reasonably foreseeable and was made, at least in part, on the basis of the misleading information....' (at [29]).

The Supreme Court's conclusions on the existence of a duty, on the question of breach, and on the issue of a novus actus are wholly unsurprising. But its implicit conclusions on the scope of the claimant's own responsibility to himself are both surprising and disappointing

> ***"The Canadians treat their adult claimants as grown-ups. It is time that English claimants were similarly respected"***

General assumptions about patient responsibility

Over the last 50 years the courts, at least in clinical negligence cases, have rightly truncated medical paternalism and made patient autonomy central. This is best seen in the law relating to liability in tort for allegedly inadequate provision of information. The patient's own perspective and autonomy interests have incrementally been nudged to the centre of the forensic stage. *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871, [1985] 1 All ER 643 (which made the *Bolam* test the touchstone of liability in consent cases) gave way to a cautious assertion of the priority of patient autonomy in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53, and *Pearce* was followed by the distinctly incautious *Chester v Afshar* [2005] 1 AC 134, [2004] 4 All ER 587 (plainly wrong, but a useful barometer of the judicial zeitgeist), and the more reasonable *Montgomery v Lanarkshire Health Board* [2015] AC 1430, [2015] 2 All ER 1031. Patients are now seen (for most purposes) as responsible agents whose main concern is to be the architects of their own destiny.

Darnley, though, does not see patients this way. The dissonance with the main line of authorities is uncomfortable. It could and should have been different.

It is quite right that the chain of causation was held to be intact. The law rightly requires a tectonic event to break it. But that is not the end of the matter. What about contributory negligence?

Contributory negligence?

Contributory negligence was argued at first instance: '...it was submitted that in the event that the claimant succeeded on the issue of liability, I should hold that the claimant was in part responsible for the damage he suffered,' [2015] EWHC 2301 (QB) at [81]. But there was no adjudication on this point, apparently because of the judge's conclusion that the chain of causation had been broken.

Thereafter the notion of contributory negligence seems to have been elided with the question of whether a novus actus had been established. It is, of course, a wholly distinct issue, and should have been treated as such. The fact that a claimant may have acted in a reasonably foreseeable way (as in this case) does not necessarily mean that he has acted in a reasonable way.

Contributory negligence should be raised far more often in clinical negligence cases than it is. That should follow from the picture of patients' interests and objectives painted in *Montgomery* et al. There is an understandable reluctance to delegate doctors' duties to patients, but that concern is amply accommodated by the rest of the law of breach of duty and causation.

There are few English decisions in which there have been findings of contributory negligence in a clinical negligence context. *Pidgeon v Doncaster Health Authority* [2002] Lloyd's Rep Med 130 is a good but rare example in the county court, where a patient who had repeatedly ignored reminders to have a cervical smear test was found to be two-thirds contributorily negligent in her claim against the health authority.

In Canada contributory negligence has often been successfully invoked: see, for instance, *Crossman v Stewart* (1977) 82 DLR; *Zhang v Kan* [2003] BCSC 5; *Dumaris v Hamilton* (1998) 219 AR 63. It does justice there to both claimants and defendants.

Comment

The Canadians treat their adult claimants as grown-ups. It is time that English claimants were similarly respected. The law needs to have a view of human responsibility that applies in the same way to questions of the assessment of quantum as it does to questions of liability. NLJ

Charles Foster is a barrister at Serjeants' Inn Chambers, & a Fellow of Green Templeton College, University of Oxford (*cfoster@serjeantsinn.com*).