Stretched Hospital Resources In The Covid World

CHRISTOPHER HOUGH
SERJEANTS' INN CHAMBERS

SERJEANTS' INN

This piece is written in glorious sunshine, but during the height of the Covid lockdown. Who knows where we will be by the time it is published and read? Some children may be back at school, we may be allowed to use public transport, courts may begin to reopen and clinical negligence claims against the NHS may be something to be discussed in polite company.

As the number of deaths rises towards 40,000, it may seem somewhat parochial or insensitive to ask what the impact of Covid might be on clinical negligence. There seem to be a number of aspects:

i. Untrained or rusty doctors returning to the NHS to help. The MDU have requested that doctors lacking appropriate qualifications or experience should be immune from suit if (or perhaps when) they make mistakes. Quite rightly, this kite seems not to have taken flight.

ii. But, possibly alarmed by the twin threats of Hospital/public transport acquired Covid and being treated by an out of date and retired orthopod, tens of thousands of people are not attending Hospital when they should be. Estimates are that 18,000 cancer patients will die through want of treatment. Patients with time sensitive conditions (a stroke, for example) will suffer avoidable harm through delay in presenting. Self-evidently, there will be no claim if the patient does not seek help.

This article looks at a third aspect – whether Trusts might use Covid to argue that their resources were stretched by Covid needs, and that systems broke down, without culpability. This argument occasionally appears in Defences and, perhaps more frequently, in expert reports – but the "30-minute Caesarean" and the "3-4.5 hour stroke management" cannot be avoided by waffling on about overstretched A&E departments.

The NHSR is a cunning fox and will probably sniff that judges might be persuaded to allow some slack in judging systemic failings. With that in mind, it is worth remembering some old Court of Appeal cases to encourage the courts not to go along with this.

In Bull v Devon Area Health Authority 198 22BMLR 79 the Court of Appeal had to consider a delay in delivering a second twin. A "resources defence" was argued. There were problems in finding a Registrar. The Court held:

Slade LJ

In the face of this evidence, any unnecessary waste of time in attempting to secure the attendance of one or other of the registrar and the consultant could have been critical, particularly as it appears that neither of them was present at the hospital, and would inevitably take a little time to get there ... It is possible to imagine hypothetical contingencies which would have accounted for a failure, without any avoidable fault in the hospital's system or any negligence in its working, to secure for Mrs. Bull attendance by any obstetrician qualified to deliver the second twin between 7.35 p.m. and 8.25 p.m. In my judgment, however, all the most likely explanations for this failure point strongly either (i) to inefficiency in the system for summoning the assistance of the registrar or consultant, in operation at the hospital in 1970, or (ii) to negligence by some individual or individuals in the working of that system. This is, in my judgment, accordingly a case where the res ipsa loquitur principle had to be applied, whatever hardship this may cause the authority at this late date. The onus fell on the authority to explain satisfactorily the hospital's failure to secure the attendance of either Dr. Golding or Mr. Jefferiss before about 8.25 p.m. and to call Dr. Golding's back-up, Mr. Jefferiss, by about 7.45 p.m. It did not discharge this onus. A breach of duty has in my judgment therefore been established and the judge was right so to decide.

Dillon LJ:

It was enough the defendants had a system under which a registrar or consultant would be in the delivery room within 10 or 15 minutes of being summoned, or, in the case of a multiple delivery, within 20 minutes of the birth of the first baby. But, as I have indicated, it was

very chancy whether the defendant's system would achieve this. The risks of failing to provide attendance for the patient's foreseeable requirements was so great that the system could only rank as an acceptable system if it was operated with supreme efficiency.

Of such efficiency there is, in my judgment, no sign in the present case .... . Plainly the system had broken down. Precisely why it had broken down or what went wrong we cannot know. But all the most likely explanations involve fault on the part of people for whom the defendants are responsible, ... the plaintiff has succeeded in proving, by the ordinary civil standards of proof, that the failure to provide for Mrs. Bull the prompt attendance she needed was attributable to the negligence of the defendants in implementing an unreliable and essentially unsatisfactory system for calling the registrar.

It is argued for the defendants that delays and difficulties of communication are implicit in any system where the same staff are required to service different departments in different buildings on a split site, or in separate hospitals ... However these arguments, which really come down to saying that the defendants should be entitled to the benefit of any delays that are inherent in their system, can only be valid if the phrase "as soon as reasonably practicable" is to be construed without regard to the urgency of the patient's requirements; in my judgment, as already indicated, it is not.

Mustill LJ

.... proper care of the mother and the second twin would demand either the presence or the immediate availability, at all times after the birth of the first twin, of someone with skill, experience and authority sufficient to bring about the delivery of the second twin, if symptoms of crisis showed that it was unsafe to wait for the delivery to take place naturally.

When one looks at the system which actually existed, it is plain that it fell short of this standard. Unless the consultant or registrar, and the anaesthetist, happened to be in the building when the first twin was delivered, there would inevitably be an interval whilst (a) the house officer and midwife completed their immediate duties regarding the first twin, (b) the switchboard located the registrar, and (c) he made his way to the hospital from wherever he happened to be, and scrubbed-up and found out what had been happening, in preparation for the delivery of the second twin. If stage (b) failed, then there would be a further interval whilst the switchboard found the consultant, and whilst the consultant came in and prepared himself. Since the house officer and midwife could tackle a natural delivery of the second twin, but could not intervene in the event of an emergency, it was implicit in the system that the mother and foetus would inevitably be left for a substantial period without the care which safety required.

This decision was followed in **Richards v Swansea NHS Trust** 2007 EWHC 407 and explained as follows:

The defendant (in Bull) contended that it had an adequate system for the provision of appropriate care and that the fact it could not now say why no registrar was present did not mean that it was at fault. The trial judge decided that the onus was on the defendant to show that the situation arose without fault on its part and that it had failed to do so. His decision was upheld by the Court of Appeal. Slade LJ applied the res ipsa loquitur principle, as the trial judge had done. The delays were so substantial as to place on the defendant the burden of justifying them. Dillon and Mustill LJJ did not apply the res ipsa loquitur principle. Dillon LJ held that the system had broken down and the second plaintiff did not have to adduce positive evidence to disprove every theoretical explanation, however unlikely, that could explain what had happened in a way which absolved the defendant of fault. The second plaintiff had succeeded in proving by the ordinary civil standard that the failure to provide the mother with prompt attendance was attributable to the negligence of the defendant. Mustill LJ said that in the absence of a proved explanation for the inordinate delay or one which proved itself because it was obvious, the judge had no choice but to decide as he did.

The systemic duty was defined in **Robertson v Nottingham Health Authority [1997] 8 Med LR 1** , 13 Brooke LJ said:

"Although it is customary to say that a health authority is vicariously liable for breach of duty if its responsible servants or agents fail to set up a safe system of operation in relation to what are essentially management as opposed to clinical matters, this formulation may tend to cloud the fact that in any event it has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and safe premises (compare Wilsher v Essex Area Health Authority [1987] QB 747 per Sir Nicolas Browne-Wilkinson, at p 778 a-d , and Glidewell LJ, agreeing on this point, at p 775 b-c . A health authority owes its patient a duty to provide her

with a reasonable regime of care at its hospital (**Gold v Essex County Council [1942] 2 KB 293** per Lord Greene, MR, at pp 302 and 304; and per Goddard LJ, at p 309; **Roe v Minister of Health [1954] 2 QB 66** per Denning LJ, at p 72, applying what he said in **Cassidy v Ministry of Health [1951] 2 KB 343** , 359–365, and per Morris LJ, at pp 88–89).

Putting these cases together, I believe that there remains a duty to maintain safe systems for all patients, including non-Covid.