SUMMER CLINICAL NEGLIGENCE CONFERENCE 2019

CASE LAW UPDATE

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Scope of Duty

George Andrews v Greater Glasgow Health Board [2019] CSOH 31

Jean Graham died at Glasgow Royal Infirmary on 8 January 2013 aged 77 years. Three days earlier she had felt unwell whilst eating her evening meal. She complained of pain in her groin and in her stomach. She had vomiting and diarrhoea over the next few hours and her partner phoned for an ambulance at around 1930 hours that evening. At the point of calling the ambulance he confirmed that that she had not vomited or passed blood or 'coffee ground material' i.e. small black granules caused by the acidity of the stomach on blood.

At A & E an ECG showed a normal sinus rhythm and nothing unusual showed in x-rays of her chest and abdomen. In particular there was no evidence of any bowel problem. Later that evening Jean Graham was noted to be walking around the ward and feeling a bit better. A working diagnosis of gastroenteritis was made and she was discharged home. The judge noted that there was an outbreak of viral gastroenteritis in the West of Scotland at that time. Up to this point there was no criticism made of the hospital.

Her condition deteriorated whilst at home. By around lunchtime the next day her partner phoned NHS 24. He described Ms Graham as being in terrible and constant pain, of having black vomit and diarrhoea. The deceased herself spoke to the call handler and asked for a doctor to attend. In response Dr Goldie arrived in the afternoon of 6 January 2013. He examined Ms Gardner and formed the impression that she might have upper gastro-intestinal bleeding. He considered that she should be referred to the Acute Assessment Unit at GRI by ambulance, by-passing A & E so that she would be promptly assessed by physicians. On the NHS form sent with Ms Gardner to the hospital he queried whether there was 'Melaena', a black watery diarrhoea caused by intestinal bleeding.

She arrived at the hospital at just before 3pm that afternoon. At the Acute Admissions Unit Ms Gardner was assessed by Dr Izzath around 3.5 hours later. Following assessment she was discharged home on the basis that she had had no episodes of diarrhoea or vomiting for over three hours.

Dr Izzath could not recollect seeing Ms Graham. From the clinical records he recorded the clinical impression of gastroenteritis. Her condition appeared to have improved over her time in AAU. He noted that she would like to go home and that she could look after herself. He did not note having carried out a rectal examination. The blood results for Ms Graham were broadly similar to those readings taken the previous day when she had been admitted to hospital.

Ms Graham returned home late in the evening of 6th January. She was not coping. She continued to have diarrhoea and lost control of her bowels. Her partner phoned for an ambulance on the evening of 7th January. A repeat abdominal x-ray in the early hours of 8th January showed dilated loops of small bowel centrally. A CT angiogram taken later that morning showed superior mesenteric artery thrombosis distal to the origin of the hepatic artery – parts of the bowel were starved of blood supply. She underwent emergency laparotomy. By the time of the operation she was suffering from

sepsis and delirium. At operation the surgeon found a significant extent of dead bowel. There was little that could be done to save her, and she passed away at around 11.30am on 8th January.

The action was brought alleging that Dr Izzath was negligent (i) in failing to advise Ms Graham that she required to be admitted to AAU on 6th January – he ought to have recognised that she might be suffering from a serious medical condition; (ii) he failed to carry out a rectal examination. Whilst it was accepted by the defenders that she ought to have been admitted to AAU on 6th January, it was not accepted to amount to negligence not to have admitted her, and further it was argued that admission at that stage would not have avoided the death. The weight of expert medical opinion suggested that Ms Graham ought to have been admitted to AAU on 6th January. The expert for the defenders, Dr Leonard, considered that, on balance, it was reasonable for Dr Izzath to have reached a diagnosis of gastroenteritis.

Interestingly, the judge rejected the approach taken by the defender's expert on the basis that it attached too much weight to the fact that Dr Izzath was a trainee doctor, and that was not the appropriate approach to the relevant standard of care. The judge found that Dr Izzath should have suspected that the deceased had a serious intra-abdominal abnormality. He also found that Dr Izzath had not offered Ms Graham the option of being admitted and had he done so she would have accepted. The defenders attempted to argue that Dr Izzath had discharged his duty of care to Ms Graham by seeking the advice of the consultant on duty that evening. But that approach was rejected by the judge. Whilst there was some authority for the suggestion that an inexperienced doctor discharged their duty of care by seeking the assistance of their superiors, the judge found that it would be going too far to say that there is any clear principle to this effect. Whilst much will depend on the particular circumstances of the case he stated that the clear principle is that a junior doctor must achieve the same standard of care as a more experienced doctor. He drew an analogy with the duty of care owed by drivers to other road users – a learner driver owes the same standard of care as any other driver. In Wilsher v Essex Area Health Authority ([1987] QB 730) the appeal court rejected the notion of a duty of care tailored to the actor rather than the duty he or she has to perform.

In relation to causation there was competing expert evidence as to when the acute embolic event occurred, and ultimately the judge preferred the evidence of the pursuer's expert to the effect that it occurred between the deceased being discharged from AAU on 6th January and her readmission on 7th January, more likely on 7th January. The question then became whether, if she had suffered an acute embolic event whilst an inpatient, could her small bowel have been saved. On balance the judge found that it was not only possible, but likely, that the condition wold have been identified and rectified if she had been admitted on 6t January.

There are some interesting comments about causation. The defenders' argument suggested that there was effectively insufficient evidence upon which the court could base any view. There was no evidence to suggest when the deterioration in the deceased's condition occurred, and so no starting point for working out what would have been likely to have happened. The judge rejected that as unrealistically narrow and theoretical. If that was correct it would mean that a pursuer had to meet

an unrealistically high standard of proof by identifying the precise moment when an occlusion occurred. In Lord Pentland's view the important factor was that the deceased would have been in hospital, but for the negligence, and there was ample evidence to show that in those circumstances her condition would have been identified and treated. Under reference to McGhee v National Coal Board (1973 SC (HL) 37) he stated that the legal concept of causation is not based upon logic or philosophy; it is based on the practical way in which the ordinary man's mind works in the everyday affairs of life – and he suggested that the approach of the defenders in this case fell into the former category.

As a 'belt and braces' approach the court also went on to consider whether, if the conventional 'but for' test did not apply in the circumstances of this case, there was scope to find that Dr Izzath's negligence had a causative impact upon the deceased's death by delaying her admission to hospital. The court had no hesitation in concluding that it did.

Hughes and ors v Turning Point Scotland [2019] CSOH 42; 2019 SLT 651; 2019 GWD 17-271

This case involved an action raised by family members of a man who died after being admitted to "Link Up" a facility operated by Turning Point Scotland which provided a service for people who were homeless or sleeping rough and experiencing crisis, including as a result of alcohol addiction.

The court held that it would not be fair, just or reasonable to impose a general duty upon the defenders to provide a safe system for admission and treatment. The relationship between the parties was akin to a contract and within the scope of the responsibility assumed by the defender, there had been no breach of duty.

Francis Hughes was 34 years old. He had a history of alcoholism and attended the facility, accompanied by his alcohol support worker, with the intention of using the service which offered accommodation and assistance in withdrawal from alcohol. He had used the service on previous occasions.

An initial assessment was carried out by a project worker, Stephen McCourtney, and Mr Hughes was admitted to a bedroom in the crisis residential unit. After the assessment, the deceased underwent a clinical institute withdrawal assessment (CIWA) for alcohol. Given the score of that assessment the project worker understood that Mr Hughes required alcohol detox, which was done by administering medication. Medication was not held on site and the defender had arrangements with two GPs who acted as on call voluntary medical officers (VMOs) to assist, one of whom was contacted regarding the deceased but was not immediately available. Mr Hughes said that he was tired and wished to 'get his head down' so he was admitted to the unit and shown to a bedroom for his use. Some three

hours later Mr Hughes was found dead in his room. The cause of death was a suspected seizure related to alcohol withdrawal.

The pursuers argued that the defender owed a common law duty of care to not assess or admit someone like Mr Hughes to use its Link Up service, failing which, there was a duty to provide a safe system for his admission and treatment. Such duties had been breached by the failure to prepare and follow an appropriate protocol or system for admitting someone like Mr Hughes. The defenders had assumed responsibility, and had breached such duty by failing to obtain medication and call an ambulance in light of the CIWA score and the lack of immediate access to medication.

The court held that it would not be fair, just or reasonable to impose the general duty to have a safe system contended for by the pursuers. The defender was a charity which sought to assist with alcohol detox. It had neither the staffing nor equipment of a medical or NHS facility. It relied on the VMOs.

The court accepted that there were certain factors which pointed to the relationship between the deceased and the defender as being akin to a contract. However the court considered that the concept of the assumption of responsibility required that the scope of the responsibility assumed was defined by the agreed, promised or represented position. It was clear that the defender had assumed responsibility to provide its services to Mr Hughes, including the provision of a bed, to request medication from a VMO and to administer it if prescribed. Mr Hughes was aware that such service was offered and had recorded his agreement by signing certain documents. It could be inferred that Mr Hughes had relied upon the defender but only to the extent of the responsibility assumed. The scope of the project worker's duty to exercise reasonable care in his dealings with the deceased was similarly delineated by the extent to which responsibility had been assumed by the defender and the context in which both operated.

So the approach of the court was to identify the limit of the assumed responsibility, and viewed in that was it held that there had been no breach of duty.

Interestingly the defenders had attempted to argue that they should be regarded as rescuers, with a restricted duty of care. The court rejected that argument.

The court was also not satisfied, on the balance of probabilities, that the administration of medication would have prevented the deceased from dying. Further, it could not be concluded that had the defender complied with its alleged duties in respect of not admitting the deceased, or phoning an ambulance and seeking to get him to hospital, that he would have been treated with appropriate medication prior to the time of his death.

Interestingly, one of the difficulties relied upon by the court in reaching its decision was that it was not dealing with something commonly experienced in ordinary life and there had been no evidence of an appropriate comparator. Whilst evidence had been led about various NHS agencies where similar detox programmes could be carried out, the court was not satisfied that such evidence could be used to inform what the ‘Link Up’ facility could or should have done.

Cf D v Victim Support (2018 SLT (Sh Ct) 91) which involved a successful claim by a pursuer wo suffered a head injury and sought the assistance of Victim Support in claiming criminal injury compensation. The agency omitted to advise that the pursuer was entitled to loss of earnings and the court was satisfied, on the evidence led about the agency, that it held itself out to be able to provide advice to someone in the pursuer's position about the extent of his claim for compensation. It emphasises the fact that a great deal might turn in these cases upon the kind of evidence which can be led before the court about the extent of assumed responsibility.

Darnley v Croydon Health Services NHS Trust [2018] UKSC 50

Mr Darnley suffered a head injury and attended the A & E department of a hospital in Croyden. He was told by the receptionist that it would be four to five hours before he would be seen. But in actual fact what would happen is that he would be examined by a triage nurse within 30 minutes, and then the triage nurse would decide how soon he needed to see a doctor. The evidence established that had Mr Darnley been told that, he would have waited for the triage nurse. However, upon being told that he would have to wait 4 – 5 hours before being seen, he decided to go home after waiting for only 19 minutes. He didn't tell anyone he was going, and he didn't see any medical staff before leaving the A & E department. At home he collapsed. He was brought back to hospital by ambulance and underwent neurosurgery, but he suffered permanent brain damage in the form of a left hemiplegia.

He raised an action for damages against the trust, alleging that it had breached its duty of care to him when he first presented at A&E by failing to assess him for emergency triage and by failing to give him accurate information about how long he would have to wait before being seen by a clinician. At first instance the trial judge found in favour of the hospital. The Court of Appeal then dismissed the appellant's appeal, holding by a majority that neither the receptionist nor the trust acting through the receptionist had any duty to advise about waiting times. Alternatively, it found that in any event Mr Darnley had broken the chain of causation by leaving A&E when he did.

Mr Darnley appealed to the Supreme Court, and it was a case of third time lucky.

The Supremes held that NHS Trusts have a duty to take reasonable care not to cause physical injury to those who present themselves at accident and emergency departments complaining of illness or injury. The scope of that duty extends to taking reasonable care not to provide misleading information, whether given by medical or non-medical staff, about how long patients might have to wait before seeing a clinician. Where the standard practice was for patients to be triaged within a

certain time of arrival, it was not unreasonable to require that they be given that information, either orally by the receptionist, in a leaflet, or by a prominent notice.

It was held that the case fell within an established category of duty of care for NHS Trusts. Those running A&E departments owed a duty to take reasonable care not to cause physical injury to those who presented themselves complaining of illness or injury, and that duty existed before the patient was treated. Once the appellant had presented at A&E seeking medical attention, had provided the information required by the receptionist and had been "booked in", he entered into a patient/health care provider relationship with the trust and was in a distinct and recognisable situation in which the law imposed a duty of care. The scope of that duty extended to a duty to take reasonable care not to provide misleading information which might foreseeably cause physical injury. The court held that there was no distinction here between medically qualified professionals and administrative staff. The non-medically qualified staff were the first point of contact for those seeking medical assistance and, consequently, those members of staff were responsible for providing accurate information about the availability of medical assistance. The trust's duty of care had to be considered in the round. It had a duty to take care not to provide misinformation and could not avoid that duty simply because the misinformation was given by receptionists rather than clinicians.

An A&E receptionist could not be expected to give each patient accurate information as to when they would be seen by a clinician, but it was not unreasonable to require them to take reasonable care not to provide misleading information as to the likely availability of medical assistance. The standard required was that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care. In the instant case, the receptionists knew that the standard procedure was to triage head injury patients. Their usual practice was to tell such patients that they would be seen by a triage nurse as soon as possible, or within 30 minutes. It was not clear why Mr Darnley had not been told that. It was not unreasonable to require that patients should be given that information, either orally, in a leaflet, or by a prominent notice. Mr Darnley was given incomplete information and was misled as to the availability of medical assistance.

The Supreme Court also disagreed with the Court of Appeal decision that Mr Darnley had broken the chain of causation. The trial judge had found that it was reasonably foreseeable that a person who believed they were facing a four or five hour wait to see a doctor might decide to leave. He found that Mr Darnley's decision to leave was based, at least in part, on the information given to him by the receptionist. He also found that, had Mr Darnley been told that he would be triaged within 30 minutes, he would not have left, his collapse would have occurred within the hospital, he would have undergone surgery sooner than he did, and he would have made an almost complete recovery. Following these findings the Supreme Court was satisfied that there was no break in the chain of causation.

Consent

Taylor v Dailly Health Centre 2018 SLT 1324; 2018 GWD 28-355

This case came to court as a proof on liability alone. The action was raised by family members of Mrs Taylor who died from coronary artery atherosclerosis aged 32 years. It was directed against the GP who was called out to attend Mrs Taylor prior to her death who took the decision not to admit her to hospital.

On 26 March 2009 Mrs Taylor felt unwell and her friend telephoned the GP surgery to report that she was suffering from pain in her chest and down her left arm. A GP, Dr Thomas Malloch, immediately made a home visit and concluded that she was suffering from musculo-skeletal pain and gastro-intestinal upset, for which he prescribed analgesics. Around one hour later Mrs Taylor died.

The pursuers claimed that Dr Malloch was negligent in failing to summon an ambulance to take the deceased to hospital to investigate whether she was suffering from an acute coronary syndrome (ACS). It was accepted that, had ACS been diagnosed and an ambulance summoned, the deceased would not have died. The defenders contended that Dr Malloch adhered to usual practice and his actions were consistent with those of a GP exercising the ordinary skill and care reasonably to be expected from him. The diagnosis had been wrong, but it was not negligent.

Lord Tyre agreed with the defender's approach. The matter turned to a large extent upon the factual findings. There were only two witnesses to what had happened when the doctor examined Mrs Taylor, Dr Malloch and her husband. The judge preferred the evidence of Dr Malloch finding the husband to be surprisingly dogmatic in some aspects of his evidence but vague on others. Basing his determination upon Dr Malloch's findings Lord Tyre held that the symptoms described by the Mrs Taylor to Dr Malloch shortly prior to her death were not typical features of cardiac arrest nor were they consistent with a cardiac cause. In the circumstances, Dr Malloch had been entitled to conclude that in describing the source of her pain Mrs Taylor had gestured to pain in the epigastrium and not to her chest. In all the circumstances, in deciding not to take her to hospital as a matter of urgency, the GP had not departed from usual and normal practice.

In this case the pursuers had argued that the GP was also in breach of the duty incumbent on him by virtue of the decision in Montgomery v Lanarkshire Health Board ([2015] UKSC 11, [2015] A.C. 1430, [2015] 3 WLUK 306), but his Lordship decided that to attempt to apply the ratio of Montgomery to the circumstances of the present case would extend it significantly beyond what the Supreme Court regarded as the scope of the duty of care that it had held to exist. This case was concerned with the consideration of investigatory or treatment options and no issue arose that required discussion of possible alternatives with a patient - the decision not to summon an ambulance was one falling within the exercise of professional skill and judgment, and not one as to which of two or more alternative forms of treatment, carrying differing risks, ought to be undertaken.

Evidence v Submission

LT (as guardian for RC) v Lothian Health Board [2019] CSIH 20

At first instance the Lord Ordinary had assoilzied a health board from the action brought by the mother of a child who sustained injuries at birth due to alleged negligence on the part of a registrar in interpreting the CTG trace during labour. This decision was the reclaiming motion by the mother.

The child's birth had required to be resuscitated upon delivery and he was ultimately diagnosed with cerebral palsy at three years old. During his birth, the CTG trace had been variable. The mother relied on three alleged grounds of fault on the part of the registrar following her assessment of the CGT trace at 2230. It was alleged that she failed (i) to properly interpret the CTG trace, (ii) failed to expedite the labour, and (iii) failed to properly obtain the mothers consent to continuing with the labour. The registrar had allowed the labour to proceed with a view to spontaneous vaginal delivery and that was said to have been negligent. The Lord Ordinary had found that the three cases had not been established. The Lord Ordinary had held that the registrar was likely to have classified the CTG trace as normal when assessing it at 2230 and had not been negligent in so doing, and that the care provided to the reclaimer thereafter had proceeded on that basis.

In the reclaiming motion it was stated that the Lord Ordinary erred in fact and law in holding that the registrar was entitled to proceed with the then current birth management plan to proceed to spontaneous vaginal delivery without obtaining the reclaimer's informed consent after approximately 2230 hours. It was suggested that certain passages of the expert evidence supported the conclusion that the CTG trace ought to have been classed as suspicious at 2230 hours.

The Inner House held, perhaps unsurprisingly, that it was for the Lord Ordinary, as primary fact finder, to assess the meaning and effect of the expert evidence. The appeal court was not satisfied on the basis of the evidence referred to that the Lord Ordinary had erred.

With reference to the consent case the court held that the *Montgomery* duty only arose when a risk arose which had not previously been discussed with the patient, and should no such risk arise, there could be no breach of duty. There had to exist a risk of which the clinician was aware, meaning that a decision had to be made as to whether a particular course of treatment ought to be followed or not followed. In the present case, the registrar, who was the relevant clinician, considered the trace to be normal, and it followed that she was not aware of the emergence of any additional risk beyond that which had been discussed. The Lord Ordinary found that interpreting the trace as normal had not been negligent. The Inner House had not been persuaded that the Lord Ordinary's assessment, or understanding of the evidence, had been wrong, so the *Montgomery* duty did not arise.

The reason that the case is referred to here is because of the discussion about the role of the appeal court in reviewing the evidence. It was said that, even had the registrar been negligent in interpreting the trace as other than suspicious, there had been no evidence led before the Lord Ordinary about the risk indicated by a suspicious trace, and certainly not about what risk the registrar should have been aware of. In the reclaiming motion use was made in submission of medical texts but it was held that was not legitimate where it was unsupported by any expert testimony. The pursuer's counsel was effectively trying to put forward submissions as evidence from

which an inference might be drawn, but the court was clear that it could not, on any view be regarded as evidence.

Causation

Leave you with a decision which is causing a bit of a stir in the world of clinical negligence on the basis that, on first blush, it appears to change the principle behind Chester v Afshar ([2004] UKHL 41).

Looking first of all at Chester, in that case a claimant suffered a neurological injury during surgery on her back. That injury wasn't caused negligently, but it was held that had she been properly advised about the risks of that back surgery she would not have undergone the surgery on that day – the court allowed recovery of compensation on the basis that the injury arose from a risk about which she should have been warned and should therefore be regarded as having been caused by the doctor's failure to warn. So there was an aspect left 'at large' in the Chester decision: the issue of whether, had the same surgery been carried out on a different day it could truly be said that a different result would have ensued. A general approach has been taken by lawyers, post-Chester, to say that, where the inherent risk of an injury from surgery is less than 50% the chance of that injury arising on a different day in another surgery would not crystallise.

Pomphrey undermines that approach…

Pomphrey v Secretary of State for Health and anor [2019] 4 WLUK 483

Mr Pomphrey suffered serious complications as a result of spinal surgery. Again, it was accepted that the surgery was not negligent, but the case was brought on the basis that there was a failure to diagnose compression of the cauda equina nerves and earlier referral to a neurosurgeon should have been made. Effectively it was argued that the operation should have been carried out earlier, and had it been Mr Pomphrey would have avoided the deterioration in his condition and permanent disability which arose from the actual operation carried out later.

In the event the judge preferred the defender's expert testimony but the important aspect of the case was that the court accepted the inherent risk of the injury which occurred in Mr Pomphrey's surgery was 7%. Following the usual post-Chester approach it was argued by the pursuer that as there was a less than 50% chance of the injury arising it would not have occurred, on balance of probabilities, had the surgery taken place earlier. The judge disagreed with that approach. He held that although there was a delay in carrying out Mr Pomphrey's surgery he felt that, on balance, the same injury was likely to have occurred on an earlier occasion – same surgery, same patient with all of his attendant physiology, and same surgeon performing the surgery. So it was held that the delay did not affect the outcome.

What is interesting is that the usual approach taken by lawyers to Chester takes too wide a reading of the case. In Ms Chester's case the reason that she could recover damages was because she had not been warned of the small risk of suffering cauda equina syndrome. There was a breach of the scope of duty of care owed to her, and all loss arising therefrom was recoverable. To focus on the level of risk arising from surgery and argue that the same surgery carried out on a different day would have had a different result was to misunderstand Chester.

The bottom line for lawyers is that great care needs to be taken in framing an action based upon warning of risk, and scope of duty of care in surgery – the courts are taking a narrow view.