10 October 2018

PRESS SUMMARY

Darnley (Appellant) v Croydon Health Services NHS Trust (Respondent) [2018] UKSC 50
On appeal from [2017] EWCA Civ 151

JUSTICES: Lady Hale (President), Lord Reed (Deputy President), Lord Kerr, Lord Hodge, Lord Lloyd-Jones

BACKGROUND TO THE APPEAL

The appellant, Michael Mark Junior Darnley, was struck on the head on 17 May 2010. A friend, Robert Tubman, drove the appellant to the Accident and Emergency ("A&E") Department at Mayday Hospital, Croydon which was managed by the respondent, NHS Trust. He attended at 20:26.

The trial judge found that at the A&E reception, the appellant informed the receptionist that he thought he had a head injury and that he was feeling very unwell. The appellant and Mr Tubman both told the receptionist that the appellant was really unwell and needed urgent attention. The receptionist told the appellant that he would have to wait up to four to five hours before he could be seen by a clinician. The appellant told the receptionist he could not wait that long as he felt he was about to collapse. The receptionist replied that if he did collapse then he would be treated as an emergency. The identity of the A&E receptionist is unknown, save that it must have been one of the two receptionists on duty, neither of which had any recollection of the conversation. However, each described her usual practice when a person with a head injury asked about waiting times. One would say that they could expect to be seen by a triage nurse within 30 minutes of arrival. The other would say that the triage nurse would be informed and that they would be seen as soon as possible.

The appellant left after 19 minutes because he felt too unwell to remain and went to his mother's home. The appellant became distressed at 21:30 and an ambulance was called. He was taken back to Mayday Hospital and a CT scan identified a large extradural haematoma with a marked midline shift. He was transferred to St George's Hospital and underwent an operation at 01:00. Unfortunately, the appellant suffered permanent brain damage in the form of a severe and very disabling left hemiplegia.

The appellant brought proceedings against the respondent alleging a breach of duty by the reception staff concerning the information he was given about the time he would have to wait and the failure to assess the appellant for priority triage. The High Court dismissed the claim. The appellant appealed to the Court of Appeal. The appeal was dismissed by a majority on the grounds that neither the receptionist nor the health trust acting by the receptionist owed any duty to advise about waiting times, the damage was outside the scope of any duty owed, and there was no causal link between any breach of duty and the injury. The appellant appealed to the Supreme Court.

JUDGMENT

The Supreme Court unanimously allows the appeal and remits the case to the Queen's Bench Division for assessment of damages. Lord Lloyd-Jones gives the sole judgment with which the other Justices agree.

REASONS FOR THE JUDGMENT

Duty of care

First, the present case falls squarely within an established category of duty of care: it has long been established that such a duty is owed by those who provide and run a casualty department to persons presenting themselves complaining of illness or injury and before they are treated or received into care in the hospital's wards. The duty is to take reasonable care not to cause physical injury to the patient. In the present case, as soon as the appellant was 'booked in' at reception he entered into a relationship with the respondent of patient and health care provider. The scope of this duty of care extends to a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury **[16]**.

Secondly, the duty of care is owed by the respondent and it is not appropriate to distinguish, in this regard, between medical and non-medical staff. The respondent had charged its non-medically qualified staff with the role of being the first point of contact for persons seeking medical assistance and, as a result, with the responsibility for providing accurate information as to its availability **[17]**.

Thirdly, the judgments of the majority in the Court of Appeal elide issues of the existence of a duty of care and negligent breach of duty. [**21**]

Fourthly, observations on the social cost of imposing such a duty of care are misplaced as this is not a new head of liability for NHS health trusts and, in any event, the undesirable consequences of imposing the duty in question were considerably overstated. The Court did, however, acknowledge that the very difficult circumstances under which A&E departments operate "may well prove highly influential in many cases when assessing whether there has been a negligent breach of duty" **[22]**.

Negligent breach of duty

A receptionist in an A&E department is expected to take reasonable care not to provide misleading advice as to the availability of medical assistance. The standard required is that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care **[25]**. Moreover, responding to requests for information as to the usual system of operation of the A&E department is well within the area of responsibility of receptionists **[26]**. The two receptionists on duty were aware of the standard procedure, but the appellant was told to sit down to wait for up to four to five hours. That information was incomplete and misleading. The trial judge made the finding that it was reasonably foreseeable that a person who believes it may be four to five hours before he will be seen may decide to leave. In light of that finding, the provision of such misleading information by a receptionist as to the time within which medical assistance might be available was negligent **[27]**.

Causation

The appellant's decision to leave was reasonably foreseeable and was made, at least in part, on the basis of the misleading information **[29]**. The trial judge made further findings of fact that, (1) had the appellant been told he would be seen within 30 minutes he would have waited, been seen by a doctor and admitted, and (2) had the appellant suffered the collapse at 21:30 whilst at the Mayday Hospital, he would have undergone surgery earlier and he would have made a nearly full recovery **[30]**. Thus, the appellant's departure did not break the chain of causation.

References in square brackets are to paragraphs in the judgment

NOTE

This summary is provided to assist in understanding the Court's decision. It does not form part of the reasons for the decision. The full judgment of the Court is the only authoritative document. Judgments are public documents and are available at:
http://supremecourt.uk/decided-cases/index.html