NHS Resolution

Case story

Learning lessons in maternity from a recent Supreme Court ruling

This case story is based on real events and NHS Resolution is sharing the experience of those involved to help prevent a similar occurrence happening to patients, families and staff.

Although the case occurred in the emergency department there is learning for maternity services.

As you read about this incident, please ask yourself:

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

Topic:

Learning lessons in maternity from Darnley v. Croydon Health Services NHS Trust

Key points:

- As soon as a patient attends hospital to seek medical attention there is a duty of care owed to them.
- Patients attending maternity should be provided with reasonably accurate information regarding waiting times for assessment.
- Maternity receptionists should have the appropriate training and local induction to ensure that accurate information is provided.
- Clinical and non-clinical staff should be aware of the standard for triage waiting times, ensure that accurate information is communicated and also be aware that the information they provide may influence the way patients access clinical care.

Case story

On 10 October 2018, the Supreme Court gave a judgment in the case of Darnley v. Croydon Health Services NHS Trust.

Following a head injury, Mr Darnley (the claimant) attended the emergency department at Mayday Hospital, Croydon with a friend. The receptionist advised he would have to wait between four and five hours to be seen.

Mr Darnley waited 19 minutes before leaving without telling anyone. He was not told he would have been triaged in approximately 30 minutes. Had he been told this, the trial judge found he would not have left the emergency department.

Deteriorating shortly after arriving home, Mr Darnley tragically suffered permanent and serious injury, which would have been avoided if he had not left the emergency department and had his treatment delayed as a result.

In finding for the hospital, the original trial judge and then the Court of Appeal made a number of findings including:

- the trust was not under a duty to provide accurate information about waiting times;
- there was no assumption of legal responsibility for the claimant;
- the information was provided as a courtesy by non-medical staff; and
- the claimant was responsible for his injury because he chose to leave the emergency department, when he had in fact been advised to wait.

In **overturning** the original ruling of the Court of Appeal, the Supreme Court found for the claimant that:

- as soon as the claimant attended seeking medical attention there was a patient-hospital relationship (an established category of duty of care);
- there was a duty not to provide misleading information which may foreseeably cause physical injury;
- 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; and
- **the hospital had been in breach of its duty of care.**

The full judgment can be read here: https://www.supremecourt.uk/cases/uksc-2017-0070.html

What should happen as a result of this case?

This is a very sad case because the claimant suffered significant lasting injury. Therefore the decision is an important reminder that hospital staff must take reasonable steps to ensure patients are not provided with “misinformation” including information about the availability and timing of medical assistance.

Both clinical and non-clinical staff must be made aware that emergency department waiting time information provided to patients should be reasonably accurate and may have legal consequences if it is misleading.

In October 2018 NHS Resolution sent communication to Trusts to advise that they needed to review their practices straight away, to ensure that visitors to the emergency department are provided with accurate and not misleading information about waiting times. That might entail, as the court suggested, the use of leaflets or notices.

Considerations for your maternity service

While this case story is related to the emergency department, there is valuable learning that can be shared with other disciplines within a hospital setting. Maternity services have a similar approach to the emergency department for assessing and triaging mothers.

Guidance published by the National Institute for Institute for Health and Care Excellence (NICE) in 2015 entitled 'Safe midwifery staffing for maternity settings' outlines examples of maternity red flags, and that a red flag should be considered when there is a 'delay of 30 minutes or more between presentation and triage'.

Therefore the following should be considered by maternity services:

- Do you have a standard for maternity triage waiting times? If yes, is this clearly displayed for maternity patients and their birth partners to see on arrival to the maternity unit?
- Are clinical and non-clinical maternity staff aware of the standard for maternity triage?
- Are maternity receptionists trained and informed of their roles and responsibilities in relation to providing information about waiting times?
- In relation to good practice, how are red flags escalated and monitored within your maternity service?

References:

National Institute for Institute for Health and Care Excellence (2015) guidance published 'Safe midwifery staffing for maternity settings'

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