AN UPDATE ON THE LAW RELATING TO CLINICAL DISPUTES

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The Duty of Care

1. *ABC v St George's Healthcare NHS Trust* [2015] EWCA Civ 336. A doctor's duty of care to his patient does not extend to informing the patient of confidential information of the of another patient.

1.1. Facts. C's father was also under the care of D, having been convicted of the manslaughter of C's mother. The father was diagnosed with Huntingdon's disease, which is a hereditary disease affecting his behaviour. D counselled him to let his family be informed of his condition for their benefit, but he refused, although he voluntarily informed his brother. The family, including C engaged in "family therapy" for the father and arranged by D. The family were not informed of the father's condition. C became pregnant and went on to have a baby, but soon after one of D's staff in error informed C of her father's disease. C claimed that D breached its common law duty to her and art.8 ECHR (right to respect for private and family life) in not informing her of her father's disease and the risk that she and her baby had a 50% chance of having the disease. C claimed that had she known she would have terminated the pregnancy and now with the prospect of a child with Huntingdon's disease she had suffered psychiatric injury and expense in caring for the child.

1.2. D applied to strike out the claim and at first instance Nicol J held that it was not fair, just and reasonable to impose upon D a duty to inform C of facts, which were confidential to another patient and neither was art.8 breached because the balance favoured the father's right to confidentiality. The CA disagreed and held that it was arguable that D had a duty to a third party other than the patient demanding confidentiality. The CA decision merely keeps the argument open for full consideration at trial and it is clear that each case will depend on its own facts. It expressed the view that it may be easier to establish that duty in cases of genetic illnesses where D necessarily gained information not only about the patient, but also how it affects the third party, who would probably become a patient. It will be interesting if the case goes to full trial and we discover what the final judgment is on the facts.

1.3. The case raises important issues over the balance between confidentiality of one patient and the duty of care to another. There is the interesting potential distinction between genetic conditions and other conditions.

2. *Darnley v Croydon Health Care Services NHS Trust* [2015] EWHC 2301 HHJ Robinson. D did not have a duty to provide accurate information as to waiting times in it's A&E department.

2.1. Facts. Judgment after trial. C had been assaulted and suffered a head injury. He attended A&E and alleged he had been told that the wait would be 4-5 hours. He left after 19 minutes. Later he suffered a deterioration in his head injury resulting in left-sided hemiplegia. D's staff could not recall his attendance but said that if asked he would have been told that he would be seen by a triage nurse within 30 minutes. NICE guidelines say that a patient should have a preliminary assessment (triage) at A&E within 15 minutes. C alleged it was a breach of duty not to make a preliminary assessment before he left and in failing to give him an accurate estimate of when he might be treated and that had he been given accurate information as to when he would be seen he would have remained and been treated and not suffered left-sided hemiplegia.

2.2. The NICE guidelines were just guidelines and subject to exigencies. The experts felt that with exigent circumstances the guideline time might reasonably not be met, but the preliminary assessment must take place within 30 minutes. The unqualified receptionist, who had allegedly given the 4-5 hour wait time was not under a duty to inform patients that they would be given a preliminary assessment within 30 minutes. The receptionist's function was to complete registration forms and was only administrative. It was not fair just and reasonable to impose a duty to provide information as to likely waiting times, it had been done purely as a matter of courtesy.

2.3. The case is important as regards the duties of unqualified non-clinical staff and they are to be judged. Also the extent of D's non-delegable duty to provide information. This case is also under appeal.

Non-delegable duty of care and vicarious liability

3. *NA v Nottinghamshire CC* [2016] QB 739 CA. A case considering the limits of a body's non-delegable duty i.e. a duty to ensure that care is taken, rather than simply duty to take care for one's own acts or omissions as established in *Woodland v Swimming Teachers Association* [2014] AC 537. Under the SC ruling in *Woodlands* a non-delegable duty will generally arise in the following circumstances:

(1) The claimant is a patient or child or for some other reason especially dependent upon the defendant for protection against the risk of injury;

(2) There was an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, which placed the claimant in the actual custody, charge or care of the defendant, and from which it was possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another

(3) The claimant had no control over how the defendant chose to perform the relevant obligations (whether personally or through employees or third parties.

(4) The defendant had delegated to a third party some function which was an integral part of the positive duty which he had assumed towards the claimant.

(5) The third party had been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

In *Nottinghamshire CC* the CA declined to apply a non-delegable duty where the LA had placed children with foster carers, who abused the children on the basis that the LA's duty was only to provide accommodation and maintenance of children in its care; providing parental care was never part of its duty to delegate. The considerations in *Nottinghamshire CC* will not apply to prevent NHS institutions owing a non-delegable duty of care to patients because the NHS assumes a duty to treat and care for a patient. The considerations will be of potential importance in cases of private medical treatments including cosmetic treatments. Private healthcare providers may purport to limit their obligations e.g. to merely introducing a claimant to a competent surgeon

4. An alternative argument raised by the claimants was that the LA would be vicariously liable for the abuse by the foster carers citing *The Christian Brothers case* [2013] 2AC 1 Lord Phillips said at para.47:

"Where the defendant and the tortfeasor are not bound by a contract of employment, but their relationship has the same incidents, that relationship can properly give rise to vicarious liability on the ground that it is 'akin to that between an employer and an employee"

Vicarious liability is likely to arise even outside an employment relationship where:

(1) the tort will have been committed as a result of activity being taken by the tortfeasor on behalf of the defendant, (2) the tortfeasor's activity is likely to be part of the business activity of the defendant, and (3) the defendant, by employing the tortfeasor to carry on the activity, will have created the risk of the tort committed by the tortfeasor.[1]

Nonetheless, the principle does not mean that one business will become vicariously liable for the defaults of another genuinely independent business. As Lord Reed explained in *Cox v Ministry of Justice* [2016] AC 660:

[1] Lord Phillips in *Christian Brothers case* discussed in *Cox v Ministry of Justice* at para.22 onwards.

29 It is important, however, to understand that the general approach which Lord Phillips PSC described is not confined to some special category of cases, such as the sexual abuse of children. It is intended to provide a basis for identifying the circumstances in which vicarious liability may in principle be imposed outside relationships of employment. By focusing upon the business activities carried on by the defendant and their attendant risks, it directs attention to the issues which are likely to be relevant in the context of modern workplaces, where workers may in reality be part of the workforce of an organisation without having a contract of employment with it, and also reflects prevailing ideas about the responsibility of businesses for the risks which are created by their activities. It results in an extension of the scope of vicarious liability beyond the responsibility of an employer for the acts and omissions of its employees in the course of their employment, but not to the extent of imposing such liability where a tortfeasor's activities are entirely attributable to the conduct of a recognisably independent business of his own or of a third party. An important consequence of that extension is to enable the law to maintain previous levels of protection for the victims of torts, notwithstanding changes in the legal relationships between enterprises and members of their workforces which may be motivated by factors which have nothing to do with the nature of the enterprises' activities or the attendant risks.

5. The interplay of the non-delegable duty of care and vicarious liability could be important in cases of private medical care where the treating surgeon or clinicians may have disappeared from the picture or not been adequately insured, or even where a contract to provide treatment privately has been concluded in the UK, but the treatment takes place abroad.

Secondary victims

6. There has been a real change over the ability of secondary victims to recover damages in the clinical negligence context. The test for a duty being owed to potential secondary victims was set out in *Alcock v Chief Constable of West Yorkshire Police* [1992] AC 310 with the following basic requirements:

   (1) A particularly close relationship of love and affection;

   (2) Propinquity in time and space to the incident or its immediate aftermath;

   (3) A sufficiently horrifying event.

   Older cases had allowed cases to succeed, which would probably be decided differently today, e.g.

- *Sion v Hampstead HA* [1994] 5 Med LR 170. A father sat with his son, who had been injured in a motorcycle accident until his death 14 days later, it was then discovered that the hospital had failed to diagnose and treat internal bleeding. The case was struck out because there was no evidence of nervous shock, but there were observations from Peter Gibson LJ on the argument that a course of events over 14 days could not be regarded as a relevant event, saying:
  "I see no reason in logic why a breach of duty causing an incident involving no violence or suddenness, such as where the wrong medicine is negligently given to a

hospital patient, could not lead to a claim for damages for nervous shock, for example where the negligence has fatal results and a visiting close relative, wholly unprepared for what has occurred, finds the body and thereby sustains a sudden and unexpected shock to the nervous system."

- *North Glamorgan NHS Trust v Walters* [2003] PIQR 232. As a result of negligent misdiagnosis a baby suffered an epileptic fit, which was witnessed by his mother and led to coma and then death in his mother's arms 36 hours later. The CA said that a pragmatic view had to be taken as to what amounted to a necessary "event".

7. In *Taylor v A Novo* [2014] QB 150 CA concerned what amounted to a necessary "event" in circumstances where C did not witness the accident at work by which the primary victim suffered injury, but did witness the primary victim's later death as a result of pulmonary embolism caused by the original accident and injury. As a matter of policy the later death could not be permitted to be the relevant event or its immediate aftermath. A number of cases show how difficult it is to recover as a secondary victim in the context of clinical treatment, both because pain and suffering in the controlled environment of a hospital may not be a sufficiently horrifying event, but also because the event evolves and there may not be a coincidence between the original breach of duty and injury and what later causes psychiatric injury to the secondary victim.

- *Wild v Southend University Hospital NHS Trust* [2016] PIQR 16. A father's claim, as a secondary victim, for psychiatric illness caused by witnessing midwives determine that his baby had died in his wife's womb, could not succeed where he had experienced a growing and acute anxiety starting at a time when the baby had already died, rather than witnessing horrific events leading to a death or serious injury.
- *Shorter v Surrey & Sussex Healthcare NHS Trust* [2015] EWHC 614. A claim by a victim's sister, who learned of the primary victim's deterioration mainly by telephone over a period of 2 days, but who also attended hospital and saw the primary victim in pain and distress on a trolley and later on a life support machine could not recover. Being told of events by telephone was not sufficiently proximate and one must witness the shocking or horrifying events. Further, seeing the victim on a trolley in distress or on life support was not a sufficiently horrifying event and seeing the victim on a life support machine was not a sudden shock but part of the gradual unfolding of events.
- *Liverpool Women's Hospital v Ronayne* [2015] EWCA 588. Here the CA overturned a finding of liability in favour of a husband, who witnessed his wife's deterioration and distress after negligent surgery over a period of 36 hours and in particular on 2 occasions. The CA stated that the 36 hours could not be regarded as a seamless single event and the occurrences within that period were not sufficiently shocking or horrifying, but were informed by information received in advance from clinicians. The CA said that the circumstances fell "far short" of what was recognised as founding liability for secondary victims.
- *Owers v Medway NHS Foundation Trust* [2015] EWHC 2063. A husband was unable to recover after witnessing his wife's deterioration after a failure to diagnose stroke at the Emergency Department, from which she later died after admission to another

hospital. Whilst distressing, witnessing a failure to diagnose and treat was not a sufficiently horrifying event.

- *Wells v University Hospital Southampton* [2015] EWHC 2376. Obiter: if the mother's claim for death of her child during birth had succeeded then she would have been the primary victim, but the father would not have been able to recover as a secondary victim, although he was present at the birth, saw the baby delivered and the attempts to resuscitate the baby. Such events were not sufficiently shocking and horrifying although they were clearly distressing.
- *Morgan v Somerset Partnership NHS* 29.2.16 HHJ Denyer. C's husband attempted suicide by locking himself in his garage and cutting his wrists and was attended to by D. He was not admitted to psychiatric hospital but only medicated, which was alleged to be negligent. Six days later he did the same and was found by C in pools of blood and taken to hospital and survived. C claimed to have suffered an adjustment disorder as a result of discovering her husband in the garage at the second suicide attempt. D admitted negligence in relation the treatment of the primary victim following the first suicide attempt. The claim was struck out due to the lack of proximity between the negligence in the treatment immediately following the first suicide attempt and the horrifying events 6 days later when C discovered her husband in a pool of blood.
- *Baker v Cambridgeshire NHS* [2015] EWHC 609. Another case by a secondary victim after discovering the primary victim's body following suicide, the allegation being that D should have taken the primary victim into psychiatric care earlier. Breach of duty was not proved, but the Judge said that even if it was C would not be able to recover as a secondary victim because of the lack of proximity between the negligent acts and the later events witnessed by C.

  A recent decision which swims against the tide is *RE v Calderdale & Huddersfield NHS Foundation Trust* 12/4/17 Lawtel Goss J involving a baby who suffered hypoxic brain injury after becoming stuck in the birth canal. The mother and grandmother, who was also present at the birth claimed damages for psychiatric damage. The mother was held to be a primary victim because the injury occurred before birth was complete and mother and baby were still one person. The grandmother was a secondary victim and subject to the control mechanisms for secondary victims, but still recovered as it was considered to be a sufficiently shocking event.

Causation

8. In clinical negligence causation is established by proving on the balance of probability what the clinical outcome would probably have been had the breach of duty not occurred. This can sometimes be a speculative exercise and one in which medical science may struggle to provide an answer. This is particularly so where there are a number of causal factors affecting the outcome. In *Bailey v MoD* [2008] EWCA Civ 803 Waller LJ said:

   46 In my view one cannot draw a distinction between medical negligence cases and others. I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the

claimant will have failed to establish that the tortious cause contributed. Hotson's case exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified, and the claimant will succeed.

Those words appeared to suggest that "material contribution" was insufficient unless medical science was unable to establish what would have occurred on the balance of probability. Yet earlier cases on industrial diseases showed that material contribution was sufficient where multiple agents, innocent and wrongful, operated concurrently to cause injury. Further there was uncertainty as to whether consecutive causes of injury were sufficient.

9. The approach in ***Bailey*** was criticised in ***Williams v Bermuda Hospitals Board*** [2016] AC 888. It had always been accepted that where several factors caused or contributed simultaneously to an indivisible injury it was sufficient if one of those factors was D's breach of duty. In ***Bermuda Hospitals*** it was held that the "material contribution" did not apply only in cases where the factors operated simultaneously, but also where they operated consecutively. In that case where delay in operating upon a burst appendix led to complications, some of the delay was innocent, some the result of a breach of duty. D was liable for the whole injury. The SC said that the CA was wrong in ***Bailey*** to say that the trial judge had departed from the "but for" test, rather the case is properly understood as being an application of the but for test, albeit that there were a number of causes of the claimant's weakened state, which led to her aspirating on her own vomit and suffering ischaemic brain injury. It is not a case of exceptionally departing from the ordinary proof of causation on the balance of probability by introducing a lower test of material contribution; rather material contribution is always sufficient.

10. There may still be some debate as to whether the "but for" test and "material contribution" test are distinct alternatives or integral parts of the same test. In ***Heneghan v Manchester Dry Docks*** [2016] 1 WLR 2036 (a case decided before the SC judgment in ***Bermuda Hospitals***) the CA said:

23 There are three ways of establishing causation in disease cases. The first is by showing that but for *the defendant's negligence, the claimant would not have suffered the disease. Secondly, where the disease is caused by the cumulative effect of an agency part of which is attributable to breach of duty on the part of the defendant and part of which involves no breach of duty, the defendant will be liable on the ground that his breach of duty made a "material contribution" to the disease:* Bonnington Castings Ltd v Wardlaw [1956] AC 613 *. The disease in that case was pneumoconiosis which is a divisible disease (ie one whose severity increases with increased exposure to the agency). Thirdly, where causation cannot be proved in either of these ways, for example because the disease is indivisible, causation may be established if it is proved that the defendant materially increased the risk of the*

victim contracting the disease: the Fairchild exception. Mesothelioma is an indivisible disease.

See also *John v Central Manchester & Manchester Childrens Hospital NHS Trust* [2016] EWHC 407, decided after both *Heneghan* and *Bermuda Hospitals* in which Picken J felt that they may well be an application of the same test, saying at para.89:

… whether "material contribution" represents a departure from the "but for" test (as Waller LJ considered in the Bailey case) or application of the "but for" test (as Foskett J in the Bailey case and Lord Toulson JSC in the Williams case considered). It is this distinction, as drawn by Mr Kennedy, to which I refer in what follows when referring, on the one hand, to the "but for" test and the "material contribution" test, even though, consistent with the approach adopted by Foskett J in the Bailey case and Lord Toulson JSC in the Williams case, strictly speaking the latter may very well entail application of the former.

11. There is no doubt that since *Bermuda Hospitals* causation is easier to prove, but it still has its limitations. The following cautionary words were said by the SC:

39. The sequence of events may be highly relevant in considering as a matter of fact whether a later event has made a material contribution to the outcome (as Hotson [1987] AC 750 *illustrates), or conversely whether an earlier event has been so overtaken by later events as not to have made a material contribution to the outcome. But those are evidential considerations. As a matter of principle, successive events are capable of each making a material contribution to the subsequent outcome.*

40. A claim will fail if the most that can be said is that the claimant's injury is likely to have been caused by one or more of a number of disparate factors, one of which is attributable to a wrongful act or omission of the defendant: Wilsher v Essex Area Health Authority … In such a case the claimant will not have shown as a matter of probability that the factor attributable to the defendant caused the injury, or was one of two or more factors which operated cumulatively to cause it.

12. Further, it will not be sufficient merely to prove that the breach of duty materially increased the risk of the injury occurring. There is a distinction between material increase in risk to something occurring and an agency being proved to have actually contributed materially to an injury occurring. If there was no such distinction then the *Fairchild* exception as applied in *Heneghan* would have no need or place in the law. Further, it is notable that in *Bermuda Hospitals* the court considered the extent to which a proven increase in the risk may be evidence of actual material contribution to the cause of injury. Argument had been made of the use of a "doubling of risk" as a useful tool to prove causation in fact. The SC commented at para.48:

If it is a known fact that a particular type of act (or omission) is likely to have a particular effect, proof that the defendant was responsible for such an act (or omission) and that the claimant had what is the usual effect will be powerful evidence from which to infer causation, without necessarily requiring a detailed scientific explanation for the link. But inferring causation from proof of heightened risk is never an exercise to apply mechanistically. A doubled tiny risk will still be very small.

The recent case of *Murphy v MoD* [2016] EWHC 3 explores the way in which temporal association between an untoward event and an injury can be relied upon to prove causation even though medical science has a difficulty in explaining the causal mechanism reliably.

13. The case of *Bermuda Hospitals* not only clarifies the law on causation, but does so in a way, which in the context of clinical disputes is bound to have a significant impact. Cases where delays in treatment are alleged or are part of the factual matrix will be easier to prove. Experts will find it easier to opine that a particular breach of duty made a material contribution to the poor outcome.

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