



THE UNIVERSITY OF
**WESTERN
AUSTRALIA**

Psychiatric Injury Resulting from Medical Negligence

Handford, P. (2002). Psychiatric Injury Resulting from Medical Negligence. *The Tort Law Review*, 10(1), 38-70.

Published in:

The Tort Law Review

Document Version

Peer reviewed version

[Link to publication in the UWA Research Repository](#)

Rights statement

Post print of work supplied. Title of post print differs from published. Link to Publisher's website supplied in Alternative Location.

General rights

Copyright owners retain the copyright for their material stored in the UWA Research Repository. The University grants no end-user rights beyond those which are provided by the Australian Copyright Act 1968. Users may make use of the material in the Repository providing due attribution is given and the use is in accordance with the Copyright Act 1968.

Take down policy

If you believe this document infringes copyright, raise a complaint by contacting repository-lib@uwa.edu.au. The document will be immediately withdrawn from public access while the complaint is being investigated.



RECENT DEVELOPMENTS IN 'NERVOUS SHOCK' AND PSYCHIATRIC INJURY IN HEALTH LAW LITIGATION

Dr Peter Handford

INTRODUCTION

1. All lawyers are familiar with the well-known line of cases dating from the early 20th century in which liability for 'nervous shock' – nowadays generally described in more up-to-date and accurate terms as psychiatric injury or illness – was recognised and gradually extended. In these cases, the parties were generally strangers to one another, and what happened is usually described as an 'accident'.

2. Railway accidents feature in the earliest cases, such as *Victorian Railways Commissioners v Coultas*,¹ in which liability was denied by the Privy Council on appeal from the Supreme Court of Victoria, and *Bell v Great Northern Railway Co of Ireland*,² in which the Irish Exchequer Division became the first court to recognise liability in what we would now call a primary victim case, where the plaintiff was in the zone of danger and suffered shock through fear of injury to himself or herself. Indeed, there was a time when the injury suffered in such cases was referred to as "railway spine", and thought to be a condition peculiar to railway accidents.³ In a later era, road accidents took over as the chief source of nervous shock cases. Notable decisions include *Dulieu v White & Sons*,⁴ the first English primary victim case; *Hambrook v Stokes Bros*,⁵ in which the English Court of Appeal became the first court to recognise a duty to what we now call a secondary victim – one who suffers shock as a result of witnessing an accident to a close relative, caused by fear for their safety; and *Bourhill v Young*,⁶ the classic Scottish case of the 'pregnant fishwife', in which liability for nervous shock received its first consideration by the House of Lords. The line of cases extends to the leading decisions of recent times on secondary victim liability, such as *McLoughlin v O'Brian*⁷ in the House of Lords in 1982 and *Jaensch v Coffey*⁸ in the Australian High Court in 1984. Then there have been accidents of greater magnitude, often featuring prominently in the leading cases of the last decade, such as the Hillsborough soccer disaster in which 95 people were crushed to death, which has now given rise to two appeals to the House of Lords – *Alcock*

¹ (1888) 13 App Cas 222.

² (1890) 26 LR Ir 428.

³ See J E Erichsen, *On Railway and Other Injuries of the Nervous System* (1867). Charles Dickens was one who suffered from it: after a railway accident in 1865, he felt "very nervous [and] faint". Noise distressed him. For years afterwards, when travelling even short distances, he would sometimes "suddenly fall into a paroxysm of fear, tremble all over, clutch the arms of the railway carriage, large beads of perspiration standing on his face, and suffer agonies of terror. ... Sometimes the agony was so great, he had to get out at the nearest station and walk home": letters quoted in F Kaplan, *Dickens: A Biography* (1988), 460-461.

⁴ [1901] 2 KB 669.

⁵ [1925] 1 KB 141.

⁶ [1943] AC 92.

⁷ [1983] 1 AC 410.

⁸ (1984) 155 CLR 549.

*v Chief Constable of South Yorkshire Police*⁹ and *White v Chief Constable of South Yorkshire Police*.¹⁰ Other examples are the Piper Alpha disaster, in which 164 men were killed in an explosion on a North Sea oil rig,¹¹ the King's Cross underground fire,¹² and in Australia the collision between HMAS Voyager and HMAS Melbourne.¹³

3. In recent years, however, it has become clear that psychiatric injury litigation is not confined to such scenarios.¹⁴ Important cases are emerging from situations in which the parties are employer and employee, or are in a relationship involving the provision of care or services of some kind. Indeed, it may not be a wildly inaccurate prediction to suggest that in time to come employment and service provision cases may be ranked alongside 'accident' cases as the three major sources of psychiatric injury law, and that the principles applied may vary somewhat from one kind of case to another. Something not dissimilar has certainly happened in the United States in relation to the tort of intentional infliction of emotional distress.¹⁵

4. I have written about the employment cases elsewhere.¹⁶ Here it suffices to say that although the English and Scottish courts have denied that the duty of employers to provide a safe working environment for employees extends to psychiatric as well as physical injury,¹⁷ the Australian High Court recognised such a duty as long ago as 1970,¹⁸ and an Irish court has recently followed suit.¹⁹ Both Australian and English courts now recognise claims for "work stress",²⁰ and the Australian decisions in particular emphasise the connections between such cases and traditional psychiatric injury cases. However, some of the rules which apply in mainstream psychiatric injury cases, such as the

⁹ [1992] 1 AC 310.

¹⁰ [1999] 2 AC 455. The later pages of the report, but not the title page, refer to the case as *Frost v Chief Constable of South Yorkshire Police*, by which name it was known in the Court of Appeal: see [1998] QB 254.

¹¹ See *McFarlane v EE Caledonia Ltd* [1994] 2 All ER 1; *Hegarty v EE Caledonia Ltd* [1997] 2 Lloyd's Rep 259.

¹² See eg *Hale v London Underground Ltd* [1993] PIQR 30.

¹³ See eg *Clark v Commonwealth* (1993) Aust Torts Reports 81-215, one of many cases in which the victims sought an extension of the limitation period in order to sue.

¹⁴ For example, cases of psychiatric injury consequent on damage to homes and other property are now well known: see eg *Attia v British Gas Plc* [1988] QB 304; *Electricity Trust of South Australia v Renault* (unreported, SC SA, No SCGRG 89909, 1 July 1993) (BC 9300322); *Electricity Trust of South Australia v Carver* (unreported, SC SA, No SCGRG 90976, 2 July 1993) (BC 9300320).

¹⁵ See N J Mullany and P R Handford, *Tort Liability for Psychiatric Damage* (1993), 297-307.

¹⁶ See P Handford, "Psychiatric Injury in the Workplace" (1999) 7 Tort L Rev 126.

¹⁷ *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455; *Robertson v Forth Road Bridge Joint Board*, 1995 SC 364.

¹⁸ *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383.

¹⁹ *Curran v Cadbury (Ireland) Ltd* [2000] 2 ILRM 343.

²⁰ *Gillespie v Commonwealth* (1991) 104 ACTR 1 (no liability on facts); *Johnstone v Bloomsbury Health Authority* [1992] 1 QB 333; *Petch v Customs and Excise Commissioners* [1993] ICR 789 (no liability on facts); *Wodrow v Commonwealth* (1993) 45 FCR 52 (no liability on facts); *Walker v Northumberland County Council* [1995] 1 All ER 737; *Queensland Corrective Services v Gallagher* [1998] QCA 426, 18 Dec 1998 (BC 9806819) (no liability on facts); *Zammit v Queensland Corrective Services Commission* [1998] QSC 169, 1 September 1998 (BC 9804330); *Midwest Radio Ltd v Arnold* (1999) EOC 79,181 (no liability on facts); *State of New South Wales v Seedsman* [2000] NSWCA 119, 12 May 2000 (BC 200002477).

requirement of “sudden shock”, do not necessarily apply in work stress cases²¹ – which provides some evidence for the point tentatively advanced in the previous paragraph.

5. Cases involving the liability of doctors, hospitals and health authorities constitute a prominent example of the extension of psychiatric injury liability to relationships involving the provision of care or services. They are not alone. Actions for psychiatric injury have received serious consideration in cases involving lawyers,²² psychiatrists,²³ the church,²⁴ banks,²⁵ teachers,²⁶ education authorities,²⁷ child care authorities,²⁸ other government departments,²⁹ the police,³⁰ prison authorities,³¹ and the supply of defective products.³²

THE GENERAL PRINCIPLES

6. The general principles which govern negligence liability for psychiatric injury have been worked out in leading cases such as those referred to above. In cases involving doctors, hospitals and health authorities, the courts in adjudicating issues of liability for psychiatric injury must either conform with these principles, or depart from them for good and sufficient reasons.

²¹ See Law Commission, *Liability for Psychiatric Illness* Law Com No 249 (1998), para 2.62 n 177.

²² *Al-Kandari v J R Brown & Co* [1988] QB 665; *Nikolau v Papsavas, Phillips & Co* (1988) Aust Torts Reports 80-225; *Hutt v Piggott Wood & Baker (a firm)* (unreported, SC Tas, No B20 of 1993, 28 May 1993) (BC 9300052); *Dickinson v Jones Alexander & Co* [1993] 2 FLR 521; *Crump v Sharah* [1999] NSWSC 884, 2 Sept 1999 (BC 9906246); *Duvall v Godfrey Virtue & Co (A Firm)* [2001] WASCA 105, 4 April 2001 (BC 200101605).

²³ *M v Newham London Borough Council* [1995] 2 AC 633.

²⁴ *Reidy v Trustees of the Christian Brothers* (1994) Aust Torts Reports 81-288; *Archbishop of Perth v 'AA' to 'JC'* (unreported, CA NSW, Nos 40126-40132 of 1995, 12 Oct 1995) (BC 9501687), special leave refused sub nom 'AA' – 'JC' *Inclusive v Hickey* (1996) 70 ALJR 385; *Clark v Corporation of Trustees of the Roman Catholic Archdiocese of Brisbane* [1998] 1 Qd R 26.

²⁵ *Pavlovic v Commonwealth Bank of Australia* (1991) 56 SASR 587; *Stergiou v Citibank Savings Ltd* [1999] FCA 1321, 24 Sept 1999 (BC 9906255); *Paola v State Bank of New South Wales Ltd* [2000] NSWSC 822, 22 Aug 2000 (BC 200005042).

²⁶ *Fraser v Marsden* [2000] NSWSC 416, 2 June 2000 (BC 200002688).

²⁷ *P v Harrow London Borough Council* [1993] 2 FCR 341; *E v Dorset County Council* [1995] 2 AC 633; *Phelps v London Borough of Hillingdon* [2000] 4 All ER 504.

²⁸ *X v Bedfordshire County Council* [1995] 2 AC 633; *Hillman v Black* (1996) 67 SASR 490; *Palmer v Tees Health Authority* [1998] Lloyd's Rep Med 447; *Barrett v Enfield London Borough Council* [1999] 3 All ER 193; *TC v New South Wales* (1999) Aust Torts Reports 81-500; *W v Essex County Council* [2000] 2 All ER 237; *Coxon v Flintshire County Council*, *The Times*, 13 March 2001; *Sullivan v Moody* [2001] HCA 59, 11 October 2001 (BC 200106147).

²⁹ *Barnes v Commonwealth* (1937) 37 SR (NSW) 511; *Williams v Minister for Aboriginal Land Rights Act 1983* (1994) 35 NSWLR 497, further proceedings [2000] NSWCA 255, 12 Sept 2000 (BC 200005431); *Cubillo v Commonwealth* [2001] FCA 1213, 31 Aug 2001 (BC 200105126).

³⁰ *Swinney v Chief Constable of Northumbria Police Force* [1997] QB 464; *Leach v Chief Constable of Gloucestershire Constabulary* [1999] 1 All ER 215; *Morgan v Tame* (2000) 49 NSWLR 20; *McNern v Metropolitan Police Commissioner* (unreported, CA Eng, 24 May 2000).

³¹ *Quayle v State of New South Wales* (1995) Aust Torts Reports 81-367; *Sloss v New South Wales* [1999] NSWSC 995, 6 Oct 1999 (BC 9906412).

³² *S v Distillers Co (Biochemicals) Ltd* [1969] 3 All ER 1412; *Vince v Cripps Bakery Pty Ltd* (1984) Aust Torts Reports 80-668; *Young v J D Coates Pty Ltd* (unreported, CA NSW, CA No 171 of 1988, 5 Oct 1990) (BC 9001914).

Recognisable psychiatric illness

7. First, the plaintiff must be able to show that as a result of the defendant's negligence the plaintiff has suffered some recognisable psychiatric illness.³³ This is to be distinguished from mere mental or emotional distress such as grief, sorrow, anxiety, worry and the like. One case involving a health authority in which these principles were applied was *Reilly v Merseyside Regional Health Authority*,³⁴ where the plaintiffs, an elderly couple one of whom suffered from angina and the other from claustrophobia, were trapped in a hospital lift for an hour and twenty minutes due to the defendant's negligence. However, given that no physical or psychiatric injury resulted, they had no right to recover – apprehension, fear, discomfort and shortness of breath not being compensable injuries. In a recent article Nicholas Mullany and I have tried to demonstrate that the recognisable psychiatric illness limitation is under a degree of strain, and that in an increasing number of cases courts are awarding damages to plaintiffs for mental suffering which would not measure up to the orthodox criterion.³⁵ However there seems little or no evidence of this in the health litigation context.

Foreseeability of psychiatric injury

8. Secondly, as a consequence of the general principle that in negligence the damage must be of a foreseeable kind, what is required in psychiatric injury cases is foreseeability of psychiatric injury – as the Privy Council said in *The Wagon Mound (No 1)*,³⁶ the test of liability for nervous shock is foreseeability of injury by shock. This has been applied in every important decision since then – notably, by the Australian High Court in *Mount Isa Mines v Pusey*³⁷ and *Jaensch v Coffey*.³⁸ In the former case, the issue before the High Court was whether the defendant had to foresee the particular psychiatric illness suffered by the plaintiff – schizophrenia – or merely psychiatric illness of some kind. It ruled that what was required was foreseeability of the broad category of psychiatric injury.

Primary and secondary victims

9. In Australian courts, the principle just stated does not admit of any exceptions. In England, in *Page v Smith*,³⁹ the House of Lords has caused great controversy by drawing a distinction in this and other respects between cases involving primary and secondary victims. According to Lord Lloyd of Berwick, expressing the opinion of three of the five members of the court, the law imposes a less onerous test on primary victims – those who are “directly involved in the accident, and well within the range of foreseeable physical injury”.⁴⁰ In such cases, foreseeability of any form of physical injury is enough to establish a duty of care, whereas in secondary victim cases, where the plaintiff is “no

³³ *Hinz v Berry* [1970] 2 QB 40, Lord Denning MR at 42-43; *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383, Windeyer J at 394.

³⁴ [1995] 6 Med LR 246.

³⁵ N J Mullany and P R Handford, “Moving the Boundary Stone by Statute – The Law Commission on Liability for Psychiatric Illness” (1999) 22 UNSWLJ 350 at 359-373.

³⁶ [1961] AC 388, Vis Simonds at 426.

³⁷ (1970) 125 CLR 383.

³⁸ (1984) 155 CLR 549.

³⁹ [1996] AC 155.

⁴⁰ *Id* at 184.

more than the passive and unwilling witness of injury caused to others”,⁴¹ it remains necessary to show that *psychiatric injury* is foreseeable. His Lordship went on to hold that rules which limit the ambit of secondary victim liability, such as the presumption that the plaintiff was a person of ordinary fortitude, and the requirement to view the circumstances of the accident with hindsight, do not apply in primary victim cases.⁴²

10. This is not the place to show that there was no warrant in the previous authorities for the making of this distinction,⁴³ or that the primary victim category as defined by Lord Lloyd was narrower than the previous statement of the primary/secondary victim distinction by Lord Oliver of Aylmerton in *Alcock*,⁴⁴ or how Lord Lloyd’s distinction has had the effect of narrowing liability to rescuers and others, as compared with the previous law.⁴⁵ What is important is that to date Australian courts have firmly resisted the importation of the *Page v Smith* doctrine into Australian law.⁴⁶ In *Morgan v Tame*,⁴⁷ Spigelman CJ in the New South Wales Court of Appeal rejected *Page v Smith* and held that it was no part of Australian law, which should continue to follow the path of orthodoxy represented by the Court of Appeal in *Page v Smith*,⁴⁸ the minority judgments in the House of Lords in that case, and the important dissenting judgment of Lord Goff of Chieveley in *White v Chief Constable of South Yorkshire Police*,⁴⁹ which provides a detailed exposure of the flaws in Lord Lloyd’s analysis.

The other proximity requirements

11. Foreseeability of psychiatric injury alone does not give rise to a duty of care.⁵⁰ The courts have thought fit to impose additional restrictions in order to keep liability within acceptable bounds – though the need for such restrictions, and the rationale behind some of the distinctions made, are constantly debated in the academic literature.

12. Some of these restrictions are specific to secondary victim claims:

- (1) There must be close ties of relationship between the secondary victim (who suffers psychiatric injury) and the primary victim who is killed, injured or endangered as a result of the defendant’s negligence. As the leading judgment of Deane J in *Jaensch v Coffey*⁵¹ shows, Australian law emphasises the strength of the individual relationship rather than simply recognising particular categories of

⁴¹ *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310, Lord Oliver at 407.

⁴² [1996] AC 155 at 188-189.

⁴³ See eg N J Mullany, “Psychiatric Damage in the House of Lords – Fourth Time Unlucky” (1995) 3 JLM 112; P Handford, “A New Chapter in the Foresight Saga – Psychiatric Damage in the House of Lords” (1996) 4 Tort L Rev 5; Mullany and Handford, above n 35 at 399-407.

⁴⁴ *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310, Lord Oliver at 407.

⁴⁵ See *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455.

⁴⁶ Though there are isolated examples of a flirtation with the English approach: see eg *Cleary v Congregation of the Sisters of the Holy Family at Nazareth* (unreported, SC Qld, No 1066 of 1995, 23 Dec 1996) (BC 9606472).

⁴⁷ (2000) 49 NSWLR 20 at 24-25.

⁴⁸ [1994] 4 All ER 522.

⁴⁹ [1999] 2 AC 455.

⁵⁰ *Jaensch v Coffey* (1984) 155 CLR 549, Gibbs CJ at 552-554, Deane J at 578-585. See also Brennan J at 571-573.

⁵¹ (1984) 155 CLR 549 at 600.

family relationships for this purpose. English law now adopts the same attitude, though it used to take the opposite view.⁵²

- (2) The secondary victim must suffer psychiatric injury as a result of personal perception of the accident or its immediate aftermath, either at the scene or in hospital during the period of immediate post-accident treatment.⁵³ The limits of this requirement of temporal and spatial proximity to the occurrence are still being worked out,⁵⁴ but for example it seems clear that the plaintiff will not come within the aftermath if there is a significant time lapse between the original accident and the point when it impacts on the plaintiff.⁵⁵
- (3) For many years it has been accepted doctrine that the plaintiff must perceive what happened through his or her own senses, and that being told by another is insufficient. But Australian courts, at least, are beginning to break down the means of communication barrier. Several recent decisions hold that plaintiffs who suffer shock through hearing the news from another – for example, over the telephone – may yet be owed a duty, if in the circumstances the overarching requirement that psychiatric injury be foreseeable is satisfied.⁵⁶ Other courts have continued to affirm the older orthodoxy.⁵⁷

13. There are other rules which apply both to primary and secondary victim cases, for example the rule that the plaintiff is assumed to be a person of ordinary fortitude. It has been suggested on many occasions that what it is proper for the reasonable person to foresee must depend on a normal standard of susceptibility, unless the defendant knows that the plaintiff is particularly susceptible.⁵⁸ Even though a different view prevails in ordinary physical injury cases, where a negligent defendant must take the plaintiff as found, it seems clearly established that in psychiatric injury cases the rule is different. Australian courts are unlikely to follow the doctrine of *Page v Smith*⁵⁹ and treat primary and secondary victim cases differently in this respect.

14. Though there was no direct authority in older law, Brennan J in *Jaensch v Coffey*⁶⁰ maintained that psychiatric injury had to be “shock-induced” in order to found

⁵² See *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310.

⁵³ See *Jaensch v Coffey* (1984) 155 CLR 549, Deane J at 605-608.

⁵⁴ See eg *Annetts v Australian Stations Pty Ltd* (2000) 23 WAR 35.

⁵⁵ See *Spence v Percy* (1991) Aust Torts Reports 81-116.

⁵⁶ *Petrie v Dowling* [1992] 1 Qd R 284; *Reeve v Brisbane City Council* [1995] 2 Qd R 661; *Pham v Lawson* (1997) 68 SASR 124; *Hancock v Wallace* [2001] QCA 227, 8 June 2001 (BC 200102969). Note also *Coates v Government Insurance Office of New South Wales* (1995) 36 NSWLR 1, particularly Kirby P at 11; *Knight v Pedersen* [1999] NSWCA 333, 16 Sept 1999 (BC9905918) at [24]; *Morgan v Tame* (2000) 49 NSWLR 20, Spigelman CJ at 30-31. The highest South African court has accepted that psychiatric injury can result from a telephone call: *Barnard v Santam Bpk*, 1999 (1) SA 202.

⁵⁷ *Annetts v Australian Stations Pty Ltd* (2000) 23 WAR 35, Ipp J at 61; *Gifford v Strang Patrick Stevedoring Ltd* [2001] NSWCA 175, 14 June 2001 (BC 200103067), Hodgson JA at [40], Ipp AJA concurring at [76].

⁵⁸ *Bourhill v Young* [1943] AC 92, Lord Wright at 110; *Jaensch v Coffey* (1984) 155 CLR 549, Gibbs CJ at 556, Brennan CJ at 568; *Morgan v Tame* (2000) 49 NSWLR 20. But note the rather different view of Windeyer J in *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383 at 405.

⁵⁹ [1996] AC 155, above para 9.

⁶⁰ (1984) 155 CLR 549 at 564-567.

recovery – in other words, there must be some evidence of sudden impact, rather than a gradual process. This rule is now generally accepted,⁶¹ though there are some important dissenting views.⁶² It seems that Brennan J had in mind the situation where the strain of caring for a grievously injured relative subsequently to the accident and its aftermath takes its toll and results in the carer suffering psychiatric illness. However, the rule is now seen as one of general application.

15. All this is presently under review. On 4 and 5 December 2001 the High Court will hear appeals in two important nervous shock cases which together raise many of the issues just discussed – the first opportunity the court has had to consider this area of law since the decision in *Jaensch v Coffey*⁶³ in 1984. In *Tame v Morgan*,⁶⁴ the plaintiff suffered a psychiatric illness as a result of the wrong blood alcohol reading being entered on her P4 accident report form following a road accident. In *Annetts v Australian Stations Pty Ltd*,⁶⁵ a young man employed as a jackaroo on a sheep station in the far north of Western Australia left in total isolation in an outlying part of the property decided he could stand his employment conditions no more, and he and a companion drove off and got lost in the desert. His parents in New South Wales suffered psychiatric injury on receiving a telephone call informing them that he was missing, or perhaps as a result of the strain of waiting and searching for news during the next four months, at which point the bodies were finally discovered. The Sydney Law Review has asked me to speculate on the likely outcome of these cases in the “Before the High Court” section of its December 2001 issue.⁶⁶

IS THERE A CASE FOR DEPARTURE FROM THE GENERAL PRINCIPLES IN HEALTH LITIGATION?

16. In cases where it is claimed that negligence by a doctor, hospital or health care authority has resulted in psychiatric injury to the patient or third parties, rules developed for road accident cases and the like in which the parties involved were previously strangers may not always be appropriate. There is a pre-existing relationship between the parties, by which one of them promises to provide care. The nature of the care and treatment undertaken may well involve a series of procedures that occupy some time rather than an event which is all over in a matter of seconds. And, unlike accident cases, in the nature of things it is unlikely that close relatives will be in a position to witness negligence that occurs during the course of an operation or some other types of medical treatment: the case of *Ibrahim (A Minor) v Muhammad*,⁶⁷ where Tayfun, a five year old Turkish Cypriot, who was being circumcised by a local doctor in the presence of his

⁶¹ See *Campbelltown City Council v Mackay* (1989) 15 NSWLR 501; *Chiaverini v Hockey* (1993) Aust Torts Reports 81-223; *Pham v Lawson* (1997) 68 SASR 124; *Morgan v Tame* (2000) 49 NSWLR 20; *Annetts v Australian Stations Pty Ltd* (2000) 23 WAR 35.

⁶² Most notably *Campbelltown City Council v Mackay* (1989) 15 NSWLR 501, Kirby P at 503. Note also *Buljabasic v Ah Lam* (unreported, CA NSW, CA 40417/96, 3 Sept 1997) (BC 9704824). The highest South African court has also rejected the rule: *Barnard v Santam Bpk*, 1999 (1) SA 202.

⁶³ (1984) 155 CLR 549.

⁶⁴ (2000) 49 NSWLR 20.

⁶⁵ (2000) 23 WAR 35.

⁶⁶ See P R Handford, “When the Telephone Rings: Restating Negligence Liability for Psychiatric Illness” (2001) 23 Syd LR (forthcoming).

⁶⁷ Unreported, QBD England, 21 May 1984.

family, with a party going on around him and the whole event being recorded on cine-film by his uncle, is rare indeed. (The doctor went too far and cut off about half of Tayfun's penis, and both his parents recovered damages for nervous shock.) In the light of all these considerations, it can be argued that in cases of medical negligence causing psychiatric injury the law should take a slightly different approach. This section of the paper considers what evidence there is for this in the cases.

17. Many of the cases to be considered involve mishaps in the birth process, resulting in a stillbirth, or the birth of a disabled child.⁶⁸ The mother is of course present, but may not be conscious if she is undergoing a caesarian; the father may be present, or may be absent but nearby, waiting for news. If there are problems, there may have to be further treatment. A bad experience may cause psychiatric injury to one or both parents. The father is inevitably a secondary victim, but the way courts have classified the mother varies.⁶⁹ It may be questioned whether it is rational to distinguish between the parents in this regard, or even to apply the primary/secondary victim analysis at all.

Australian cases

Brown v Mount Barker Soldiers' Hospital

18. The earliest Australian case involving the liability of a hospital for psychiatric injury, *Brown v Mount Barker Soldiers' Hospital Inc*,⁷⁰ is of considerable interest. The plaintiff had been admitted to the hospital to give birth, and a few days later, while the plaintiff was in her ward and the child was being cared for in a crib in the nursery, a spark from a wood fire in the nursery caused the bedclothes of the crib to catch fire, and in consequence the child's hand was badly burnt. The plaintiff was informed of the

⁶⁸ For other cases where psychiatric injury claims were made in respect of mishaps in the birth process, see *Timmerman v Choy* (unreported, SC Vic, 6 Nov 1995) (BC 9502503); *Harriton v Macquarie Pathology Services Pty Ltd* (1998) Aust Torts Reports 81-489 (application for extension of limitation period); *Marchlewski v Hunter Area Health Service* [1998] NSWSC 772, 17 Dec 1998 (BC 9804890), discussed below paras 61-63; *Gilbert v Castagna* [2000] NSWSC 461, 31 May 2000 (BC 200002914) (application for extension of limitation period); *Gilbert (now Chalk) v Illawarra Area Health Service* [2000] NSWSC 508, 1 June 2000 (BC 200003074), appeal dismissed [2001] NSWSC 323, 30 April 2001 (BC 200100938) (application for extension of limitation period); *Simms v Western Sydney Area Health Service* [2001] NSWSC 795, 11 September 2001 (BC 200105439) (application for extension of limitation period); *Ackers v Wigan Health Authority* [1991] 2 Med LR 232 (discussed below para 59); *Grieve v Salford Health Authority* [1991] 2 Med LR 295; *Kerby v Redbridge Health Authority* [1993] 4 Med LR 178; *Pearce v United Bristol Healthcare NHS Trust* [1996] EWCA 1562, 4 Nov 1996; *Cummings v Croydon Health Authority* (unreported, QBD England, 24 March 1998); *Briody v St Helens and Knowsley Health Authority* (2000) 53 BMLR 108.

⁶⁹ Cases in which the mother appears to have been treated as the primary victim include *Timmerman v Choy* (unreported, SC Vic, 6 Nov 1995) (BC 9502503) (Batt J said "this case appears to be the first case of a claim for damages for pain and suffering for Psychiatric illness resulting from obstetrical and hospital negligence at the time of delivery where the mother sues, principally at any rate, as the primary victim"); *Strelec v Nelson* (unreported, SC NSW, Smart J, No 12401 of 1990, 13 Dec 1996) (BC 9606885) (discussed below paras 22-24); *Gilbert v Castagna* [2000] NSWSC 461, 31 May 2000 (BC 200002914); *Gilbert (now Chalk) v Illawarra Area Health Service* [2000] NSWSC 508, 1 June 2000 (BC 200003074), appeal dismissed [2001] NSWSC 323, 30 April 2001 (BC 200100938); *Grieve v Salford Health Authority* [1991] 2 Med LR 295; *Kerby v Redbridge Health Authority* [1993] 4 Med LR 178; *Briody v St Helens and Knowsley Health Authority* (2000) 53 BMLR 108.

⁷⁰ [1934] SASR 128.

occurrence and it was alleged that she “suffered, and still suffers, from shock and agony of mind”. It was argued for the defendant that the Privy Council decision in *Victorian Railways Commissioners v Coultas*⁷¹ bound the court to deny recovery, and even if this was not so, according to the principles of *Hambrook v Stokes Bros*⁷² the plaintiff could not recover because she did not see the accident, but only knew of it by report some time after it had occurred. But Piper J was not prepared to be ruled by accident cases in this rather different situation, and distinguished both cases:

“Here the defendant in taking charge of Mrs Brown as a patient assumed a care of her involving the need to avoid, so far as reasonably practicable, all things that might prejudice her health and comfort, or increase her need for exertion or care. It would be a breach of duty, actionable if followed by damage, to tell her untruly that her child had been burnt. As the truthfulness of the statement was owing to negligence, the truthfulness was no legal excuse for doing harm by telling her – it was a necessary consequence of the negligence that she had to be told.”⁷³

19. While the reasoning process may appear somewhat strange, the essence of it is that while in ordinary circumstances being told of an accident might not give rise to liability, the fact that the defendants had assumed a relationship of care put a different complexion on the matter. In cases such as *Andrews v Williams*⁷⁴ the plaintiff recovered for shock caused by being told of the death of a relative on the basis that it was a consequence of a pre-existing duty, but the source of the duty was the plaintiff’s own involvement in the accident. In *Brown* the situation is entirely different. The pre-existing relationship between the parties, by which the defendants undertook an obligation to care for Mrs Brown, caused the court to conclude that the rules applicable to accident cases between strangers should not apply with full force in this rather different situation.⁷⁵

Greco v Arvind

20. Despite this promising beginning, the proposition that rules developed for road and other accident situations may require reassessment before they are automatically applied in the medical negligence context has not really been subjected to extended consideration in the subsequent Australian case law. In some cases, this is because liability is admitted and the court’s sole task is assessing quantum. *Greco v Arvind*⁷⁶ is an example. The plaintiff’s wife had problems during her pregnancy. The first defendant diagnosed an incomplete miscarriage and said she should undergo dilation and curettage. Both the diagnosis and the advice were wrong. The operation failed to terminate the

⁷¹ (1888) 13 App Cas 222, discussed above para 2.

⁷² [1925] 1 KB 141, discussed above para 2.

⁷³ Id at 130.

⁷⁴ [1967] VR 831. See also *Schneider v Eisovich* [1960] 2 QB 430; *Kohn v State Government Insurance Commission* (1976) 15 SASR 255.

⁷⁵ Note also *Briody v St Helens and Knowsley Health Authority* (2000) 53 BMLR 108, where the 19 year old plaintiff underwent an emergency caesarian and gave birth to a stillborn child, following which the doctors decided to perform a subtotal hysterectomy. She was told of the baby’s death, and the hysterectomy, by her husband next day, and was awarded damages inter alia for post-traumatic stress disorder.

⁷⁶ Unreported, SC NSW, Badgery-Parker J, No 14595 of 1990, 24 Feb 1995 (BC 9504328).

pregnancy and the child was born disabled. The plaintiff, the child's father, was of course not present during the operation but was informed of the outcome soon afterwards. He sued the doctors, claiming that on learning of the baby's condition he suffered injury by way of nervous shock, and that this affected his marriage. (It appears that there was also a nervous shock claim by the mother, but no details are given.) The defendants did not contest the father's claim, but argued that subsequent events in the plaintiff's life were partly responsible for the chronic reactive depression from which he was suffering, and this should reduce the damages payable. Badgery-Parker J said he was satisfied on the evidence that the plaintiff had sustained significant injury by way of nervous shock.

21. The father was clearly a secondary victim, but it appears that the shock suffered was caused, initially at least, by what he was told. Though he later observed the child's condition for himself, this could well have been some time after the birth. (Because liability was admitted, some details are lacking.) The medical history could also be interpreted as showing a gradual onset of depression, rather than any sudden event. And yet it seems artificial to apply the traditional rules about means of communication, aftermath and sudden shock. The father could not have been present at the operation. He was close at hand, waiting for news. He no doubt saw the baby as soon as he was allowed to do so. It is surely foreseeable that in such circumstances negligence by the defendants may cause some sort of mental injury to the two persons most closely involved – the mother and the father.

Strelec v Nelson

22. A case in which there is rather more awareness of the special circumstances of the fact situation is *Strelec v Nelson*.⁷⁷ A child was born to the plaintiff in 1985, but the birth was a difficult one: there were severe injuries during the delivery, including a traction injury to the cervical cord, and the baby was badly disabled and had respiratory problems. Despite intensive treatment he died a month later. The plaintiff remained hopeful, and when she and her husband arrived at the intensive care unit one month later she thought that she would be allowed to take the baby home – but instead the full extent of his injuries was revealed, and they were advised to let him die. The effect was devastating, and the plaintiff was later diagnosed to be suffering from a long-lasting psychiatric illness. She sued her GP, who was attending her during the birth, a specialist obstetrician who was called in when difficulties became apparent, and the hospital. All three were held liable in damages. (Her husband was by her side throughout the delivery, but no claim was made on his behalf.)

23. The major issue for Smart J was whether the plaintiff had to satisfy the sudden shock rule. On her behalf it was submitted that it was not a case where she had to prove a sudden sensory loss, because she had suffered physical injury as a result of the defendants' negligence and the psychiatric injury was a consequence of the physical injury.⁷⁸ Smart J said that the physical injury to the plaintiff unrelated to nervous shock

⁷⁷ Unreported, SC NSW, Smart J, No 12401 of 1990, 13 Dec 1996 (BC 9606885). See also the judgment on preliminary issues on 19 Feb 1996 (BC 9606883), when Smart J ruled that there was sufficient evidence to go to the jury on the psychiatric claim.

⁷⁸ Reliance was placed on *Aboushadi v CIC Insurance Ltd* (1996) Aust Torts Reports 81-384, where Handley JA held that the distinction between ordinary physical injury and psychiatric injury was illusory,

was minor, consisting only of temporary pain during the delivery and from stitching the cervix without anaesthetising the affected areas. Her psychiatric injury was not due to any of this. His Honour therefore elected to treat the case as one of pure psychiatric injury. He considered some of the authorities on sudden shock, in particular the view of Kirby P in *Campbelltown City Council v Mackay*⁷⁹ that nervous shock is rarely if ever the result of an isolated shock, and reading between the lines it seems possible that he was uncomfortable with applying the sudden shock rule to the problem of a child born disabled, where the full extent and consequences of the disability might only gradually become apparent. However, he ruled that Mrs Strelec had suffered a sudden sensory shock when arriving at the intensive care centre and being told the bad news.

24. One issue raised by the facts of this case, but not discussed by Smart J, is the nature of the ‘accident’ or ‘event’ for the purpose of applying the rules of psychiatric injury. If it was the circumstances of the birth (at which both parents were present), is there a problem in ruling that the decisive cause of the psychiatric injury did not happen until a month later? Or is this subsequent happening, rather than the birth, the ‘event’? It may seem preferable to regard the whole process, from the delivery onwards, culminating in the full realisation one month later at the intensive care centre, as one continuous process, but case law based on road accidents and the like does not easily accommodate such situations, as revealed by the English cases hereafter to be discussed.

Woods v Lowns

25. There is one other Australian case which deserves mention in this context, although the medical negligence involved is somewhat unusual – a failure to treat. *Woods v Lowns*⁸⁰ is best known as a case extending the limits of liability for omission. Dr Lowns, a Gosford GP, refused to attend and treat Patrick Woods, a ten year old epilepsy sufferer on holiday with his mother, brother and sister, when Patrick’s sister Joanna knocked on the door of his surgery and asked for his help because Patrick was having an epileptic fit. He suffered brain damage as a result of the delay in receiving treatment. Dr Lowns, and the specialist who had been treating Patrick for some time (who, it was alleged, had failed to give Patrick’s mother proper instructions and medication to deal with an emergency) were held liable in damages to Patrick at first instance. By majority, the New South Wales Court of Appeal⁸¹ dismissed the GP’s appeal but allowed that of the specialist. Though these claims are omitted from the reported version of the case, Patrick’s parents also sued the defendants for psychiatric injury.⁸² His mother was in the holiday unit with Patrick when he suffered the fit, and when he eventually received medical treatment at Gosford Hospital, and had borne the burden of caring for him since then. Patrick’s father, who was separated from his mother, was informed of what had happened by telephone, and saw Patrick subsequently in hospital.

since mental shock is in all cases the result of or accompanied by some physical disturbance in the sufferer’s system.

⁷⁹ (1989) 15 NSWLR 501 at 503.

⁸⁰ (1995) 36 NSWLR 344.

⁸¹ Sub nom *Lowns v Woods* (1996) Aust Torts Reports 81-376.

⁸² See the full judgment of Badgery-Parker J, SC NSW, No 15676 and 15678 of 1992, 9 Feb 1995 (BC 9504451).

26. The fact that Patrick's father was not present, but was informed of the news by telephone, is of course not a problem in New South Wales, where the *Law Reform (Miscellaneous Provisions) Act 1944* s 4(1) provides that liability for an act, neglect or default by which another person is killed, injured or put in peril extends to include liability for nervous shock sustained by a parent whether or not within sight or hearing at the time of the accident. It is clear that this extends to absent parents who are informed of the accident by another.⁸³ But it seems that it was some time before the full extent of Patrick's injuries became apparent to either parent. This itself did not seem to be a problem: it appears that Badgery-Parker J was prepared to take a somewhat more elastic view of the aftermath concept than generally found in accident cases. He said:

“It is not difficult to envisage cases where the phenomenon which causes injury by nervous shock is separated by some considerable time from the event which causes it. Parents may not be seriously affected and certainly not psychiatrically injured by the perception that their child has suffered what appears to be a straightforward fracture of the leg; but might suffer injury by nervous shock when, even weeks afterwards, they are informed that by reason of some vascular complication it is necessary to amputate the limb; the parents of a person who suffers a spinal injury may be seriously distressed but live in hope of a full recovery until the time comes, perhaps many days after the injury, when it is confirmed that their child will not walk again; in either case, it was foreseeable at the time of the tortious conduct that the parent might sustain injury by way of nervous shock not merely by the occurrence of the original injury but by the perception of some later deterioration or complication of the child's state. So here, in my view, if the facts establish that either of the plaintiffs sustained injury by way of nervous shock at the time of his or her perception of the fact that Patrick had suffered permanent brain damage, it was foreseeable that such might occur, even though the time of its occurrence might be delayed even for a considerable time.”⁸⁴

27. However, the problem was that the law required a sudden shock. This common law rule was not displaced by the New South Wales statute.⁸⁵ In the case of Patrick's mother, there was no identifiable occasion on which she was made suddenly aware of the gravity of her son's plight, and so her claim had to fail. The father's case was different: there was evidence of a particular occasion, four or five weeks after Patrick had been transferred out of intensive care, when the father had a meeting with the specialist referred to above who told him Patrick had massive brain damage. Accordingly the father recovered damages. The result suggests the often arbitrary nature of distinctions imposed by the sudden shock rule, and causes one to question whether this rule should be inflexibly applied without any regard to the nature of the particular circumstances.

⁸³ See eg *State Rail Authority of New South Wales v Sharp* [1981] 1 NSWLR 240; *Coates v Government Insurance Office of New South Wales* (1995) 36 NSWLR 1.

⁸⁴ *Woods v Lowins* BC 9504451 at 95.

⁸⁵ See *Chiaverini v Hockey* (1992) Aust Torts Reports 81-223.

English cases

28. The proposition being advanced in this paper is that where psychiatric damage occurs as a result of medical negligence, the pre-existing relationship of care which is undertaken by the doctor or the hospital to the patient may cause the rules to be applied a little differently from cases involving accidents between parties who are previously strangers. The conclusion from an examination of the Australian cases has to be that there is no significant evidence for this proposition, although there are a few straws in the wind. However, there is a series of recent English cases in which these issues have received much more extended discussion. The reason for this may perhaps be that English courts have adopted much tighter limitations on liability in mainstream psychiatric damage cases than hitherto imposed by courts in Australia. This is particularly evident in the two House of Lords cases dealing with the Hillsborough soccer disaster. In the first of those cases, *Alcock v Chief Constable of South Yorkshire Police*,⁸⁶ the court did at least liberalise such claims in one respect, ruling that recovery was not restricted to particular categories of close family relationship, but that what mattered was the quality of the individual relationship and whether it displayed close ties of love and affection – which appears to be the Australian position.⁸⁷ However, the court took a rigid view of the requirement of proximity. According to Lord Wilberforce in *McLoughlin v O'Brian*,⁸⁸ the two hours which elapsed before the plaintiff in that case reached the hospital and saw her injured husband and children was “upon the margin of what the process of logical progression would allow”: in *Alcock* the House of Lords resisted attempts to extend the aftermath principle to relatives who arrived at the hospital later than that, or to other situations such as searching among dead bodies for missing family members, or enduring the agony of not knowing what had happened to their loved ones. Likewise, the decision confirmed that there can be no recovery for psychiatric injury caused by being told what happened by someone else, or hearing it on radio or seeing it on television. The Australian cases which have recognised a duty in some such situations⁸⁹ have no parallel in England.⁹⁰ Finally, *Alcock* embraced the sudden shock principle, though it had not been expressly affirmed in any previous case. The second case, *White v Chief Constable of South Yorkshire Police*,⁹¹ deals primarily with the nature of the duty owed to employees and rescuers, but confirms the generally restrictive attitude. Lords Steyn and Hoffmann were both concerned with the problem of expanding liability any further. Lord Steyn said that “the only sensible general strategy for the courts is to say thus far and no further”,⁹² leaving any expansion or development to Parliament. For Lord Hoffmann, “in this area of the law, the search for principle was called off in *Alcock*”, and their Lordships were “now engaged, not in the bold development of principle, but in a practical attempt, under adverse conditions, to preserve the general

⁸⁶ [1992] 1 AC 310.

⁸⁷ See above para 12.

⁸⁸ [1983] 1 AC 410, Lord Wilberforce at 419.

⁸⁹ See above para 12.

⁹⁰ Two first instance cases which had recognised a duty in such a situation, *Hevican v Ruane* [1991] 3 All ER 65 and *Ravenscroft v Rederiaktiebolaget Transatlantic* [1991] 3 All ER 73, were disapproved, and the latter case was later reversed by the Court of Appeal: see [1992] 2 All ER 470n.

⁹¹ [1999] 2 AC 455.

⁹² *Id* at 500.

perception of the law as a system of rules which is fair between one citizen and another”.⁹³

Kralj v McGrath

29. One of the earliest English cases in which a psychiatric injury claim was made in a medical negligence context is *Kralj v McGrath*⁹⁴ – which, like the majority of the cases being considered in this section of the paper, involves the consequences of negligence in relation to childbirth. The plaintiff was admitted to hospital to give birth to twins. The first twin was born without any difficulties, but the second twin was lying in a transverse position and the defendant obstetrician put his arm inside the plaintiff in an attempt to turn the second baby by manual manipulation of the head – a procedure which according to expert opinion was horrific and wholly unacceptable. The child was eventually delivered by caesarian section. As a result of the defendant’s negligence, he was born severely disabled and died eight weeks later. The defendant admitted liability. The plaintiff’s claims for exemplary damages (which was unsuccessful) and for the financial and other consequences of having to undergo another pregnancy to replace the dead child (which succeeded) are not material for present purposes. We are concerned with her claim for damages for grief arising out of the loss of the child.

30. Mrs Kralj did not see the second twin following the birth because he was immediately taken to another hospital. Initially she was told merely that he was a bit poorly, but next day she was told that he had died but been resuscitated after 20 minutes. She eventually saw him in an incubator two days later, and watched over him every day until he died. Wolff J referred to a dictum of Lord Wilberforce in *McLoughlin v O’Brian*⁹⁵ to the effect that while no damages can be awarded for grief and sorrow, a claim may be made for nervous shock caused by negligence without the necessity of showing direct impact or fear of immediate personal injury to oneself. He then said:

“[T]here can be no doubt that Mrs Kralj is entitled to be compensated for the shock she undoubtedly suffered as a result of being told what had happened to Daniel and of seeing him during her visits.”⁹⁶

31. This case clearly disobeys some of the rules subsequently confirmed by the House of Lords in *Alcock*. In so far as the shock was caused by what Mrs Kralj was told, it contravenes the principle that rules out liability in cases where the plaintiff was told by another rather than experiencing it through his or her own senses, though it can perhaps be rationalised as a case where the injury was caused by the combined effect of what the plaintiff was told and later saw, a principle clearly endorsed in Australia by *Jaensch v Coffey*.⁹⁷ However the case seems inconsistent with the alleged sudden shock requirement, and with the authorities which rule out a duty where psychiatric injury results from subsequent contact, away from the scene of the accident and the aftermath,

⁹³ Id at 511.

⁹⁴ [1986] 1 All ER 54. See N Grace, “Doctors, Damages and Nervous Shock” [1986] Professional Negligence 46.

⁹⁵ [1983] 1 AC 410 at 418.

⁹⁶ [1986] 1 All ER 54 at 62.

⁹⁷ (1984) 155 CLR 549.

with a person suffering from the effects of the accident – principles endorsed both in England and Australia.⁹⁸ It is tempting to see the case as providing some evidence of a recognition of a need to treat mishaps during the birth process as different from ordinary accidents; and at least in relation to the non-application of the sudden shock rule, and perhaps in relation to the relaxation of the ban on told-only recovery, this might be a possible interpretation. But liability was admitted, there is very little discussion of the issues in the judgment, and the case pre-dates the leading decisions of the House of Lords in the 1990s referred to above.

Taylor v Somerset Health Authority

32. The first of the post-*Alcock* cases in which English courts have confronted the issue of psychiatric injury in a medical context is *Taylor v Somerset Health Authority*⁹⁹ - exceptional in that it does not involve the childbirth situation. Mr Taylor had a heart attack at work and died in hospital. The defendants admitted that they had been negligent in failing to diagnose and treat his serious heart disease many months beforehand. Mrs Taylor was at work when she was informed that her husband had been taken ill and rushed to hospital. On arrival at the hospital, she was told by a doctor that he was dead. She was shocked and distressed by the news, and could not believe it, but it was confirmed a few minutes later when she identified her husband's body in the hospital mortuary. The sight of the body caused her further shock and distress. As a result of these events, she suffered a psychiatric injury.

33. According to Auld J, the question at issue was whether the plaintiff's involvement, within an hour or thereabouts of his death, brought her within the aftermath principle as formulated by Lord Wilberforce in *McLoughlin v O'Brian* and endorsed in *Alcock*. In these two cases, he said, the House of Lords clearly had in mind the standard accident scenario "in which the horrific consequences of the breach of duty consist both of an external, traumatic, event such as an accident, and the suffering in it of violent injury or death".¹⁰⁰

34. Counsel for the plaintiff submitted that that the "event" to which the proximity test applied in this case was the consequence of the health authority's negligence (namely the husband's death from a heart attack), not some incident in the sense of an external traumatic event acting on the plaintiff's mind. The nature of the event was not significant. On this basis, her discovery at the hospital that he had suffered a fatal heart attack shortly beforehand, and the viewing of the dead body in the mortuary, were sufficiently proximate to the death in time and space.

35. However, counsel for the defendant submitted that on the facts of this case there was no event to which the proximity test could be applied – Mr Taylor's death long after

⁹⁸ On the sudden shock requirement, see above para 14. For the subsequent contact situation, see eg *Pratt and Goldsmith v Pratt* [1975] VR 378; *Jaensch v Coffey* (1984) 155 CLR 549, Brennan J at 565, Deane J at 602, 606. Some jurisdictions however allow recovery in such circumstances: see *Ward v Ballaughton Estate (1975) Ltd* (1989) 1987-1989 MLR 428 (Isle of Man); *Pang Koi Fa v Lim Djoe Phing* [1993] 3 SLR 317 (Singapore), discussed below paras 52-57.

⁹⁹ (1993) 16 BMLR 63.

¹⁰⁰ Id at 66.

the negligence which was responsible for it was the culmination of the natural process of heart disease, and however shocking to Mrs Taylor when she learnt of it, was not in itself an event of the kind to which the aftermath principle could be applied. Even if this was wrong, Mrs Taylor's learning from a doctor what had happened and subsequent identification of the body did not satisfy the rules about the means of communication. Auld J accepted that, for both these reasons, the claim had to fail.

36. This case exhibits a narrow approach on a number of issues, such as means of communication and the aftermath question, but in relation to medical negligence the most important limitation is the need for an external traumatic event. According to Auld J, this is an essential requirement of the aftermath principle:

“The immediate aftermath extension is one which has been introduced as an exception to the general principle established in accident cases that a plaintiff can only recover damages for psychiatric injury when the accident and the primary injury or death caused by it occurred within his sight or hearing. There are two notions implicit in this exception cautiously introduced and cautiously continued by the House of Lords. They are of:

- (1) an external, traumatic, event caused by the defendant's breach of duty which immediately causes some person injury or death; and
- (2) a perception by the plaintiff of the event as it happens, normally by his presence at the scene, or exposure to the scene and/or to the primary victim so shortly afterwards that the shock of the event as well as of its consequences is brought home to him.”¹⁰¹

If this is correct, the scope for psychiatric injury claims by secondary victims in medical negligence cases – including both mothers and fathers in childbirth situations – becomes exceedingly narrow. As we have seen, no Australian case imposes such a limitation.

Tredget v Bexley Health Authority

37. The next case, though only a decision at County Court level, demonstrates a much greater awareness of the different circumstances surrounding medical negligence claims and the need to fine-tune the law of psychiatric injury to provide an effective remedy in appropriate cases. In *Tredget v Bexley Health Authority*,¹⁰² the plaintiffs, husband and wife, claimed damages for psychiatric illness, contributing to the breakdown of their marriage, caused as a result of the death of their son within two days of his birth. The birth was a long and painful process. A decision to advise a caesarian was delayed much longer than it should have been, and then the baby's shoulder had to be broken to allow the birth process to be completed. When finally delivered the baby was in a severely asphyxiated condition with no detectable heartbeat, though he was resuscitated in an adjacent labour room and then taken to the special care baby unit and put on an incubator. He died two days later. Mrs Tredget was only partially conscious during the latter part of her ordeal. Mr Tredget was present throughout and observed all that happened.

¹⁰¹ Id at 68.

¹⁰² [1994] 5 Med LR 178.

38. The defendants admitted that the death was caused by their negligence, but argued (inter alia) that there was no “qualifying event” of the kind found in previous nervous shock cases. Rejecting this argument, His Honour Judge White adopted a much more enlightened view than that adopted by Auld J in *Taylor*:

“There is, for example, a degree of unreality, at least in the lay mind, in analyses which seek to equate or differentiate between events such as a crowd disaster at a football stadium or a road accident and the birth of a fatally damaged child, although the traumatic consequences to those affected may be the same. The latter experience measures uneasily against the two broad categories of circumstance Lord Olive [sic] identified in his speech in *Alcock* ... as giving rise, on the authorities to date, to a duty of care in ‘nervous shock’ cases; cases in which the injured plaintiff was involved either mediately or immediately as a principal and those in which the plaintiff was no more than a passive or unwilling witness of the injury caused to others. Is the mother who does not actually witness the birth of the damaged child and from whom the child is taken until its death shortly after, a participant; is the father who is present at the birth, who is asked to help by telling his wife to push and who sees the baby taken from her, simply a passive witness; does the law draw a distinction between the role and the duties owed to each parent? Again, in an analysis of the law, can the death of the child as ‘an event’ be separated from ‘the event’ of the birth some 48 hours before or does the lawyer’s logic fed by other factual situations in attempting to do so become ... divorced from reality?”¹⁰³

39. As he said, the court had to take the law as it was, and the principal disputes were whether the parents’ psychiatric illnesses resulted from a sudden shock, rather than gradual or retrospective realisation, and whether there was sufficient proximity of time and space to allow the aftermath principle to apply. The defendant had submitted that there was no ‘qualifying event’ of the type found in previous cases, and that the death had not taken place until two days afterwards and during this time the parents would have gradually realised the child’s situation. The mother, they said, was not fully aware of the gravity of the situation until told later by the doctor of the child’s condition. Judge White rejected these arguments. He said:

- (1) On the evidence, the chaos of the actual birth, the mother’s difficulties, the sense that something was wrong and the arrival of the child in a distressed condition, was for those immediately and directly involved, as both parents were, frightening and horrifying.
- (2) There should be no distinction between the situation of the father, who saw all that was happening, and was actually participating at the request of the medical staff, and the mother who was sedated and exhausted and so was not fully conscious of what was going on around her. Both parents were directly involved in and with the event of the delivery. In terms of Lord Oliver’s categories, they were principals rather than passive witnesses.

¹⁰³ Id at 182.

- (3) On the evidence, the event of the delivery was a powerful factor in contributing to the psychiatric illness each of the parties afterwards suffered. But it was unrealistic to isolate the delivery as an “event” from all the other happenings from the onset of labour to the baby’s death two days later. Though lasting over 48 hours, this was all effectively one “event”.

“Of course, it was not in the nature of an immediate catastrophe which lasts only a few seconds – panic in a stadium or a motor accident – but one just as traumatic for those immediately involved as participants as each of the parents were.

The law should be, and in my judgment is, ‘fluid enough’ not simply to recognise one type of traumatic event and to shut its eyes to another such as that upon which this claim is founded, whether or not it is necessary – and in my judgment it is not – to pray in aid the concept of the ‘aftermath’”.¹⁰⁴

40. So, according to this analysis, both parents were participants in the event, and the requirement of sudden shock was satisfied. There was no need to apply the complicated rules of secondary victim liability and to invoke concepts such as aftermath and means of communication.

Sion v Hampstead Health Authority

41. In *Sion v Hampstead Health Authority*,¹⁰⁵ issues of nervous shock in a medical context were considered for the first time by the English Court of Appeal. A young man aged 23 was badly injured in a motor-cycle accident. His father stayed at his bedside for 14 days, watching him deteriorate, fall into a coma and finally die. The father claimed damages for psychiatric illness, caused by the alleged negligent treatment of his son by the hospital staff, in particular their failure to diagnose bleeding from his kidney. The defendants denied negligence and moved to strike out the statement of claim. Brooke J allowed the defendant’s application and the appeal against this decision was dismissed. The principal reason for the decision, apart from a number of procedural issues, was that there was no trace in the medical evidence of “shock” as a sudden appreciation by sight or sound of a horrifying event, but on the contrary the evidence described a gradual process from first arrival at the hospital to the ultimate appreciation of medical negligence after the inquest.

42. Staughton LJ took an orthodox approach, saying that “[f]or the present the frontier for one type of claim is in my judgment authoritatively and conclusively fixed by the House of Lords in *Alcock*”¹⁰⁶ and that the law gave no damages if the psychiatric injury was not induced by sudden shock. Though there might be little logic in distinguishing between psychiatric illness caused by sudden shock and any other

¹⁰⁴ Id at 184.

¹⁰⁵ [1994] 5 Med LR 170.

¹⁰⁶ Id at 173.

psychiatric injury, this was what the present law required. This was plainly a secondary victim claim:

“We are not here considering psychiatric illness caused directly to a plaintiff by negligent treatment, for example by his own psychiatrist. Although the words are not wholly appropriate, these are cases of a primary victim and a secondary victim, the latter being the plaintiff.”¹⁰⁷

43. Peter Gibson LJ showed a little more readiness to concede that medical negligence situations might be different:

“It is of course correct that in most of the decided cases there has been a sudden and violent incident resulting from a breach of duty, but it is the sudden awareness, violently agitating the mind, of what is occurring or has occurred that is the crucial ingredient of shock. ... 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.”¹⁰⁸

While this does not go nearly as far as Judge White’s opinion in *Tredget* given a few months previously, it at least rules out the need for some particular kind of incident, and supports the view that the element of suddenness relates to the experience of the plaintiff.

Tan v East London and City Health Authority

44. Some five years elapsed before the next significant case, *Tan v East London and City Health Authority*¹⁰⁹ - another decision at County Court level. Mrs Tan suffered from adrenal hyperplasia. She had elected to have her baby by caesarian section, and was admitted to hospital, but due to negligence she was allowed to become dehydrated and required hydrocortisone therapy. The caesarian was delayed, and by the time it was performed the baby was already dead. Mr Tan was at home, unaware of the crisis. He was telephoned at 1.30 pm and informed that the baby was dead, and was asked to come into the hospital. He arrived at 3.00 pm (the journey took one and a half hours), comforted his wife, was present at the caesarian which took place at 4.50 pm, held the body of his dead daughter, and watched over her all night until the body was finally placed in a metal box and taken away.

45. This caused him to suffer depression, but he did not realise that he might have an action against the hospital in his own right until 1993, during the preparation of his wife’s claim. Her Honour Judge Ludlow held that his claim was statute-barred, but said that she would have exercised her discretion to allow it to proceed under the *Limitation Act 1980* (UK) s 33. However, the circumstances of the case did not give rise to a cause of action.

¹⁰⁷ Ibid.

¹⁰⁸ Id at 176.

¹⁰⁹ [1999] Lloyd’s Rep Med 389.

On the medical evidence, the judge was not satisfied that Mr Tan's undoubtedly genuine grief amounted to clinical depression. This apart, he failed to satisfy the requirements of *Alcock*. On his behalf, it was submitted that the child's death in the womb, the stillbirth, Mr Tan's overnight vigil and the removal of the body next morning were all part of a single event. It was accepted that if this submission failed, the immediacy required by the aftermath test would not be present. Moreover, since Mr Tan was initially informed of the news by telephone, the case would fail to satisfy the direct perception rule.

46. Acceptance of the "single event" theory, therefore, was crucial, but Judge Ludlow was not convinced. She distinguished *Tredget* on the basis that there the medical negligence caused the injuries to the baby, the nature and consequence of those injuries made death inevitable, and therefore given the particular circumstances and the timing in that case there was in her view one event. Judge Ludlow then said:

"It is an inevitable consequence of the death of a baby in the womb however caused that stillbirth will follow. The two events are inextricably linked. Where the baby's death occurs whilst the pregnant mother is in hospital, the stillbirth can be expected timeously. Does it therefore follow that where the death is in utero, the death is caused by an external traumatic breach of duty and there is a stillbirth, that the death and the stillbirth will always by reason of nature be treated legally as one event/accident?

Or to be viewed as one event must the death and stillbirth be proximate in time? Would just under four hours between the two events be sufficient proximity?

If Chloe had been new-born and her death had been caused by such a breach of duty post birth then it is accepted under the *Alcock* principles that her father would have needed to establish he was present at the death *or* its immediate aftermath.

I ask myself is there any distinction to be drawn in the application of those principles between cases where the traumatic breach of duty causes death in utero and those where it occurs some time after delivery? After anxious thought I conclude there is not. On the facts of this case in my judgment it is the death that is the accident/event, the stillbirth goes to the fact of death. It does not go to the actual circumstances in which the death came about since a stillbirth will occur whatever and whenever the circumstances cause a baby to die in utero."¹¹⁰

Mr Tan therefore failed to establish that he was present at the event/accident or at its immediate aftermath.

47. Her Honour went on to hold that Mr Tan also failed to satisfy the direct perception requirement, though in this part of the judgment there seems to be some

¹¹⁰ Id at 394-395.

confusion between the two different issues of means of communication and the alleged need for a sudden shock. In spite of recent authority suggesting that the sudden shock requirement was unnecessary,¹¹¹ the judge concluded that it remained in place and was not satisfied on the facts of this case.

48. A perceptive comment on this case by George Hugh-Jones, printed as an appendix to the report of the case, deplores the fact that it is so difficult to escape the *Alcock* control mechanisms, even in cases such as this where the facts are far removed from the standard accident scenario. He says that though *Tredget* was rightly distinguished on its facts, the question could have been raised whether the control mechanisms needed to apply in this case as rigorously as in others. The special knowledge of the defendant should be a ground for widening the scope of the duty:

“In this case, a father at home during his wife’s admission to hospital for labour is in a different category from the sea of relatives in the usual scenes of human disaster and injury. ... The fact that he did not attend within one to two hours of the death in utero is hardly a sensible ground for immunity in this context – the interval of time between the event and husband’s arrival ought not to have altered the hospital’s duty to *this* particular claimant – *they knew he would be coming*. ...

Mr Tan came to comfort his dead wife ... and he became an unwilling participant in a stillbirth. In *Frost*¹¹² the House of Lords made it clear that rescuers were not to be given any special consideration as secondary parties. But in the instant case the hospital knew that *this* claimant would act in *this* way. There was only one father, and his presence at the birth would not have been in doubt. Viewed in this way, the specificity of the likely effects of the breach of duty largely remove [sic] the policy needs for the control mechanisms applied in disaster cases or even road traffic accidents. As the judge rightly said, the stillbirth and the death were ‘inextricably linked’: One could say his presence at and participation in the stillbirth were inextricably linked to his role as father. ...

In conclusion, this was a case where an analysis of the special relationship between the hospital and the father could have created a duty the scope of which was wider than in other cases involving secondary parties – wide enough in any event to permit a relaxation of some of the control mechanisms.”¹¹³

Farrell v Sutton and Wandsworth Health Authority

49. The latest case in this series, *Farrell v Sutton and Wandsworth Health Authority*,¹¹⁴ shows that the English High Court may now be prepared to recognise that medical negligence cases, and in particular those involving birth mishaps, deserve to be

¹¹¹ *Frost v Chief Constable of South Yorkshire Police* [1998] QB 254, Henry LJ at 271.

¹¹² I.e. *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455.

¹¹³ [1999] Lloyd’s Rep Med 389 at 397-398.

¹¹⁴ (2000) 57 BMLR 158.

treated differently from road accidents and the like. The claimant gave birth by caesarian, but as a result of the defendant's negligence the baby suffered serious and irreversible brain damage. She did not see him at the time of birth because she was of course unconscious, but she was shown a photograph and told only that he had had a hard time and had been taken away to another hospital and put on a ventilator. It was late the next day before she was taken to see him, and it was only when she found her family in distress, and the baby in intensive care, that she knew the extent of the impairment. Since then, she had had the full-time responsibility of caring for him. She claimed damages under various heads including psychiatric injury.

50. Steel J began his analysis by contemplating the possibility that the claimant might be either a primary victim, one personally and directly owed a duty by the defendant, or a secondary victim, one to whom injury was foreseeable if the defendant was negligent or in breach of a duty owed to a third party. In the latter instance, although the principles of recovery had been laid down in *Alcock*, His Lordship stressed the importance of the statement of Lord Slynn in *W v Essex County Council*¹¹⁵ (a case which, like the medical cases under examination, involves something other than the standard accident situation) that:

“... the categorisation of those claiming to be included as primary and secondary victims is not as I read the cases finally closed. It is a concept still to be developed in different factual situations.”

51. As in earlier cases in this series, the claimant contended that her psychiatric illness was caused by the trauma of the birth, which encompassed all the events from the crisis caesarian to her final discovery of the extent of the damage, when she saw her son and was told of his condition: this, it was said, was “a seamless event with one part leading without interruption into the next”.¹¹⁶ If this interpretation of events was not open, then the claimant contended that her visit to the hospital on the day after the birth was within the immediate aftermath. Steel J indicated that he was prepared to accept both arguments:

“I am satisfied that there is no break in the chain of causation and that the ‘trauma of the birth’ encompasses not only the events in the operating theatre but also the position up to and including the first sight of her baby and the realisation (when told by the paediatric SHO) of his disability. I therefore treat her as a primary victim.

Even if I am wrong in that approach, the unusual delay of just over a day between the birth and the mother seeing her baby is wholly attributable to the defendants. They chose not to take her to the hospital where her child was and chose not to tell her of the difficulties and injury which had occurred. I am therefore satisfied that, in these particular circumstances, her sight of the child on 25 May was in the immediate aftermath of the

¹¹⁵ [2000] 2 All ER 237 at 243.

¹¹⁶ (2000) 57 BMLR 158 at 164.

birth and she would in any event be compensated as a secondary victim.”¹¹⁷

Other cases

Pang Koi Fa v Lim Djoe Phing

52. This paper does not pretend to undertake a comprehensive analysis of cases from all common law jurisdictions. However it is useful to conclude this account of the major cases contending that medical negligence merits special treatment by referring to *Pang Koi Fa v Lim Djoe Phing*,¹¹⁸ a case from Singapore. Amarjeet JC stressed that although the Singapore courts are not bound by English decisions, in relation to common law issues such as tort, and negligence in particular, decisions of the House of Lords should be “highly persuasive if not practically binding”.¹¹⁹ Despite this acceptance of the ruling effect of cases such as *Alcock*, the court argues convincingly that medical situations require a special approach.

53. The plaintiff’s daughter, to whom she was particularly close, had had a fainting spell and the defendant, a neurosurgeon, advised that she had to undergo an operation immediately, otherwise she would die. The plaintiff urged her daughter to adopt this advice. The defendant carried out an operation for removal of a tumour of the pituitary gland, but by negligence instead removed healthy tissue and caused a tear in the membrane of the brain. The daughter began to leak brain fluid and contracted meningitis. She died three months after the operation, in much pain and suffering, witnessed throughout by her mother, who was constantly at her bedside. The mother was later diagnosed to be suffering from post-traumatic stress disorder, and brought an action against the doctor.

54. Applying the standard rules of secondary victim recovery, there was no problem about the requirement of a close relationship. The other rules might be thought to present greater problems, but Amarjeet JC was prepared to apply them in a flexible manner, in the light of the particular facts. As regards proximity in time and space to the tortious event, he said:

“Here there was no accident which could have been witnessed by the plaintiff in the sense that she could have seen the physical injuries as they were being inflicted upon her daughter. The case has therefore to be viewed in a slightly different light. The situation, though, is somewhat analogous to instances such as *McLoughlin* or *Jaensch v Coffey*, where the plaintiffs came upon the immediate aftermath of the accident and witnessed the state in which the primary victim was in as a result of the defendant’s negligence.”¹²⁰

¹¹⁷ Ibid.

¹¹⁸ [1993] 3 SLR 317.

¹¹⁹ Id at 323.

¹²⁰ Id at 329.

He described the plaintiff's involvement in all stages of her daughter's treatment and post-operative suffering and said that she was proximate in both time and space to the tortious event.

55. The need for the shock to result from sight or hearing of the event or its immediate aftermath similarly required to be tailored to the fact situation:

“[I]n all the previous cases in English common law relating to nervous shock, the negligence complained of has normally led to a particular event which occurred within a short space of time, usually a traffic or railway or other accident, or as in *Alcock*, a disaster which unfolded within the space of a few minutes. In these cases therefore, it has been possible and indeed logical, to have required the immediate sight or hearing of the horrific event in question. That, however, cannot mean that in this case, merely because some of the negligent acts complained of are acts which cannot reasonably be witnessed by a person in the plaintiff's position, she immediately fails the third requirement in establishing foreseeability and thus fails in her action. One would not expect any relative or spouse of a patient to be present during an operation. Neither would one expect that person to realise immediately whether or not a particular operation was being carried out negligently. Thus while the plaintiff was not immediately aware that the defendant had been negligent in his diagnosis and in his performance of the operation, she was witnessing throughout the effects of these and the subsequent negligent acts of the defendant.”¹²¹

56. As noted previously, this is an area where the means of communication (personal perception as opposed to being told by another) and the sudden shock rule have a tendency to merge into a single rule. It is noteworthy that Amarjeet JC, having introduced the United States approach to psychiatric injury by referring to the leading Californian decision of *Dillon v Legg*,¹²² at this point invoked one of the leading United States authorities denying the need for sudden shock, *Ochoa v Superior Court of Santa Clara County*,¹²³ pointing out that the facts involved parents watching the suffering and death through negligent medical treatment of their son, who was a detainee in an institution for juvenile offenders.

“The conclusion I have come to, as well as that in Gloria Ochoa's case, is an extension beyond the existing limits in recovery for the negligent infliction of psychiatric illness established in either *Alcock* or *Dillon*. The negligent failure in both cases, to properly diagnose the ailments and give proper medical treatment (the negligent operation being an additional factor in the present case) did not amount to a sudden accidental occurrence. That, however, to my mind ought not to preclude recovery. As I have already expressed in the case of an abnormal event or abnormal case involving medical negligence – unlike that of a car accident which may be seen or heard – a doctor's negligent act or acts such as a negligent

¹²¹ *Ibid.*

¹²² 441 P 2d 912 (Cal 1968).

¹²³ 703 P 2d 1 (Cal 1985).

diagnosis, a negligent operation or negligent prescription of medicine can hardly ever be witnessed. What can be witnessed, however, and what is required to be witnessed, is the calamitous effect of that conduct on the primary victim as has happened in both these cases. The resulting trauma and psychiatric injury arising in these cases in a plaintiff is nearly always from a close, constant and unremitting perception of the suffering, distress and pain of the primary victim where death is not immediate – the perception directly inflicting emotional and mental stress as a result of the callous and negligent attitude of the medical professional and as such ought to be recognised as a logical, analogous and necessary step forward in recovery of a plaintiff’s claim. This case is different from the usual cases of nervous shock where there was a traffic accident causing the injury to the primary victim, but it is not so different to compel the law to shut its eyes to a situation which so obviously needs redress.”¹²⁴

57. Amarjeet JC therefore held that a plaintiff could recover damages if he or she had observed the defendant’s conduct as well as the resulting injury and was aware at the time that the conduct was the cause of the injury. He refused to be deterred from reaching this conclusion by statements such as that of Lord Ackner in *Alcock* to the effect that the law has yet to include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system.

“Lord Ackner’s dicta though would in my opinion exclude situations where psychiatric illness is caused to care-givers of the primary victims of negligence in ordinary cases, where the toll taken on them over a period of time of watching their close relatives suffer causes a nervous illness. This case, while appearing to be similar to those situations, is entirely different in that the psychiatric evidence and the facts as I have found, show that the trauma and the shock suffered by the plaintiff was not equivalent to that of a care-giver, but of a mother who suffered the consequences of the defendant’s negligence, who has had to suffer the distress and trauma of watching helplessly as her daughter was negligently managed and cared for by the defendant, and who realised the true impact of the defendant’s negligence only to have to witness and suffer the vain attempts to repair the damage that he had wrought.”¹²⁵

Summing up, he said that the claim was successful as an incremental and analogous extension of existing cases.

Conclusions

58. It is submitted that there is an important conclusion to be drawn from this examination of the authorities, particularly the English cases where liability for psychiatric injury in medical situations has received more extended discussion than in Australia. It is that the limitations on liability developed by the courts in cases

¹²⁴ [1993] 3 SLR 317 at 332-333.

¹²⁵ Id at 333.

predominantly involving accident and disaster situations where there is no previous relationship between the parties should not necessarily be accepted as covering the field in all situations in which those who suffer psychiatric injury caused by negligence seek damages. In particular, the existence of a pre-existing relationship of care, such as that between doctor or hospital and patient, requires a much more flexible approach. So, if on the facts the claim must be treated as a secondary victim claim, the approach to issues such as aftermath, means of communication and sudden shock (assuming the current rules on these matters are endorsed by the High Court) needs to be adjusted to the particular situation – something courts in England and Singapore have been prepared to do in at least some instances. Furthermore, the particular case of the birth mishap, in which both mother and father are actively involved, requires reappraisal. It does not seem appropriate to continue to analyse this as a secondary victim case, and make distinctions based on whether the parties were conscious or present at particular stages, or how they learnt what happened to their child. The analysis adopted by *Tredget* and *Farrell*, which suggests that in such a case the parents are *primary* rather than secondary victims, seems preferable. It is hoped that these issues will one day receive a thorough examination by an Australian court.

SOME PRIMARY VICTIM CASES

59. The cases dealt with above are, almost without exception, secondary victim cases – because these are the cases which give rise to the most difficult problems in psychiatric damage law. However, it is not uncommon to encounter claims by primary victims for psychiatric illness in the medical negligence context. In *Wilson v Tasmania*¹²⁶ the plaintiff was in hospital for investigation of a heart problem. He was given a drug by intravenous infusion, but due to either human or mechanical failure he received a substantial overdose. The plaintiff, who had trained as a psychiatric nurse and was the Director of Nursing for Tasmania, was aware within seconds of what was happening, and his shouts caused the nursing staff to come and discover the mistake. Liability for the plaintiff's proved anxiety disorder was admitted. In *Ackers v Wigan Health Authority*¹²⁷ the plaintiff, pregnant with her first child, had to have a caesarian. The anaesthetic did not work as it should have done, and the plaintiff though paralysed was conscious throughout the operation, which lasted for over an hour. The defendants admitted liability for the psychiatric illness which resulted. These are just two examples of cases of psychiatric injury resulting from negligent treatment.¹²⁸ Other cases involve failure to warn,¹²⁹ and negligent advice¹³⁰ or negligent prescription.¹³¹

¹²⁶ [1999] TASSC 145, 15 Dec 1999 (BC 9908313), award of damages varied sub nom *Tasmania v Wilson* [2000] TASSC 152, 1 Nov 2000 (BC 200006579).

¹²⁷ [1991] 2 Med LR 232.

¹²⁸ For others see *Fleming v Toltz* [2000] NSWSC 606, 4 July 2000 (BC 200003807); *Doughty v North Staffordshire Health Authority* [1992] 3 Med LR 81; *Rahman v Arearose Ltd* [2000] 3 WLR 1184.

¹²⁹ Eg *Goorkani v Tayside Health Board* [1991] 3 Med LR 33; *Smith v Barking, Havering and Brentwood Area Health Authority* [1994] 5 Med LR 285.

¹³⁰ *Gilbert v Castagna* [2000] NSWSC 461, 31 May 2000 (BC 200002914) (application to extend limitation period); *Biles v Barking Health Authority* [1998] CLY 1103, 30 Oct 1987.

¹³¹ *Davis v Jacobs* [1999] EWCA 911 (5 Mar 1999).

60. Other cases involve acts of negligence which cannot really be classified as medical treatment. In *G v North Tees Health Authority*,¹³² a child aged 6 attended hospital for treatment of a skin complaint and her mother told the doctor that she was suffering from a vaginal discharge. A swab was taken, and the presence of male sperm was reported. As a result the police and social services were informed, and the child was detained in hospital and subjected to a painful internal examination. Then it was discovered that the slide used for the swab had also been used for the swab of an older person who had had sexual intercourse. As a result of her experience the child suffered from nightmares and fear of doctors, and was preoccupied with sexual matters and genitalia. Liability was admitted. In *Millicent and District Hospital Inc v Kelly*,¹³³ the plaintiff, a 19 year old woman 10-12 weeks pregnant, was admitted to hospital following stomach pains and bleeding and a few hours later passed a blood clot. The nurse told her, “you have gone too far”, and she presumed she had miscarried and was upset. Later, awaking from sleep, she saw by her bed a clear plastic specimen bottle containing blood matter and what she took to be part of a limb. It was suggested in evidence that nurses sometimes did this to make the patient feel that she had miscarried. Though it was never established who was responsible for putting the bottle there, the judge held that the defendants should have foreseen that the loss of her child would cause distress to the plaintiff, and that the sight of the container and its contents would make the distress worse, even if in fact she was mistaken as to the nature of the contents. The appeal against this decision was dismissed.

OTHER SECONDARY VICTIM CASES

Marchlewski v Hunter Area Health Service

61. There are a number of secondary victim cases which, even if they do not address the core issues discussed above, contain points of interest.¹³⁴ One of the most well-known cases in this group is *Marchlewski v Hunter Area Health Service*.¹³⁵ In consequence of obstructed labour due to the defendants’ negligence, baby Maria suffered asphyxia at birth and then aspirated pneumonia, and died four weeks later. The case is novel in that the plaintiffs claiming to have suffered psychiatric injury as a result of these events included not only the father and the mother but also the three year old sister Delores. The mother was of course present at the delivery. The father was summoned to the hospital and attended the delivery room where he “witnessed the bloody aftermath of the delivery”. On behalf of Delores it was claimed that she suffered emotional injury as a result of losing the sister she was looking forward to, and her parents’ emotional problems consequent on the baby’s death.

¹³² [1989] FCR 53.

¹³³ Unreported, FC SA, No SCGRG-95-2486, 10 Sept 1996 (BC 9604248), noted (1997) 4 JLM 224.

¹³⁴ For other cases in which there was a psychiatric injury claim by a secondary victim, see *McCabe v Auburn District Hospital* (unreported, SC NSW, No 11551 of 1982, 31 May 1989), discussed in *CCH Australian Professional Liability – Medical*, 9-310; *X and Y (by her tutor X) v Pal* (1991) 23 NSWLR 26; *Hayes v Southern Sydney Area Health Service* (unreported, DC NSW, Nos 7071 and 17540 of 1990, 13 Aug 1996); *Perera v Ng* (unreported, SC NSW, No 20390/97, 4 Sept 1997) (BC 9704026; *Powell v Boladz* [1998] Lloyd’s Rep Med 116; *Toth v Jarman* (unreported, CA Eng, 21 Dec 2000).

¹³⁵ [1998] NSWSC 772, 17 Dec 1998 (BC 9804890).

62. The parents' claims succeeded. In the father's case, there would not have been much difficulty in holding that he came within the aftermath principle. The chief focus of discussion was the defendant's argument that the father was predisposed to an abnormal psychological condition and was therefore not a person of ordinary fortitude. The plaintiff argued that he was entitled at least to the damages that a person of ordinary fortitude would have received, relying on statements of Murphy J in *Jaensch v Coffey*,¹³⁶ and it appears that this submission was accepted. Both the father and the mother recovered substantial sums by way of general damages, with aggravated damages in addition.

63. Delores' claim was not successful. She attended the hospital with her parents when her mother went into labour, and though not present at the birth she experienced some part of the trauma and confusion of the following 28 days. She had had a great sense of anticipation of the birth. As the defendants submitted, the problem was the lack of a sudden sensory perception, and also whether it was possible to find that a child as young as three could be said to have suffered a psychiatric injury in such circumstances. Reference was made to the *Law Reform (Miscellaneous Provisions) Act 1944* (NSW) s 4, under which the common law rights of recovery were extended in the case of certain classes of relatives. However, under the statute, in order for brothers and sisters to recover, the other family member needed to be killed, injured or put in peril within their sight or hearing. This statute, plainly drafted with the standard accident scenario in mind, was of no assistance to Delores. Accordingly her claim failed.

Marinko v Masri

64. *Marinko v Masri*¹³⁷ involves medical negligence in the course of an operation to terminate a pregnancy. The plaintiff and his wife went to the doctor's surgery for the operation. The plaintiff was told that he needed more money to pay for a contraceptive device that was to be fitted to his wife, and so he left the surgery to get some. On his return, he was told by an extremely agitated doctor's secretary that his wife had collapsed and had been admitted to hospital in a coma. He went to hospital and saw his wife. It was accepted that he suffered psychiatric illness as a combination of what he was told and what he saw when he got to the hospital, and damages were awarded. The principle that shock caused by a combination of what the shock victim learns from another and what he sees with his own eyes is firmly established.¹³⁸

Krishna v Loustos

65. In a recent case, *Krishna v Loustos*,¹³⁹ the plaintiff was present at certain times during the medical treatment which eventually resulted in her husband's death. He had had an operation for discectomy and fusion of the C5-C6 vertebrae, following which he returned to his bed in the ward, and the plaintiff was present with him. An hour or so later, he developed breathing difficulties, and the plaintiff attempted to attract the attention of the nursing staff for some while before assistance arrived. Some time

¹³⁶ (1984) 155 CLR 549 at 557.

¹³⁷ [1999] NSWCA 364, 5 Oct 1999 (BC 9906377).

¹³⁸ See *Jaensch v Coffey* (1984) 155 CLR 549, Deane J at 609, Dawson J at 613.

¹³⁹ [2000] NSWCA 272, 9 Oct 2000 (BC 200006149).

afterwards, as the breathing difficulties continued, the plaintiff was asked to wait outside. Shortly afterwards, he suffered a respiratory arrest. Attempts were made to intubate him, and then a tracheostomy was performed, but the husband never recovered consciousness. He was on life support for five days before the system was turned off. The plaintiff was with him for practically all of this period. The plaintiff sued for psychiatric injury caused by what she witnessed of these events. The ground on which the Court of Appeal ultimately rejected her claim (reversing Goldring DCJ in the District Court) was that causation was lacking. Even if the defendants had performed all the necessary steps promptly, according to the evidence the plaintiff would have moved into the third stage of respiratory arrest before an airway could have been established. The defendants admitted that they owed the plaintiff a duty of care, and presumably there would have been no difficulty in satisfying the requirement of proximity of space and time even though there were times at which the plaintiff was unavoidably not present. She was nearby and knew what was happening.

LIABILITY FOR COMMUNICATION OF BAD NEWS

66. There are some other areas of psychiatric injury law in which doctors, hospitals and health authorities may become involved. One is liability for the breaking of bad news. In 1993 Nicholas Mullany and I suggested that there are two propositions for which there is some supporting authority.¹⁴⁰ One is that in certain circumstances there may be liability for psychiatric damage arising from distressing false information negligently communicated. One of the authorities put forward in support of this proposition was a Canadian case, *Jinks v Cardwell*,¹⁴¹ where a wife who suffered physical and emotional distress caused by a doctor's negligent communication of information concerning her husband, who suffered from a severe form of mental illness, was in the main false.¹⁴² The second proposition is that there may be a duty not to communicate distressing information which is true in a particularly uncaring or callous manner. One case which suggests that there may be some liability in such a case is the New Zealand case of *Furniss v Fitchett*,¹⁴³ where the plaintiff was allowed to succeed in an action against her doctor for nervous shock caused by a certificate to the effect that she was exhibiting signs of paranoia and was in need of psychiatric treatment. The doctor had provided this certificate to her husband on request, without her knowledge, and the husband's counsel produced it when cross-examining the wife in matrimonial proceedings. On the facts it was foreseeable that if the plaintiff was confronted with such a certificate it would cause her psychological harm.¹⁴⁴

¹⁴⁰ N J Mullany and P R Handford, *Tort Liability for Psychiatric Damage* (1993), 183-191.

¹⁴¹ (1987) 39 CCLT 168.

¹⁴² For other authorities, see *Barnes v Commonwealth* (1937) 37 SR (NSW) 511. To the contrary, *Blakeney v Pegus (No 2)* (1885) 6 NSW 223, and note also the obiter dictum of Windeyer J in *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383 at 407: "[U]nless there be an intention to cause nervous shock, no action lies against either the bearer of bad news tidings or the person who caused the event of which they tell. There is no duty in law to break bad news gently or to do nothing which creates bad news." This dictum does not distinguish between true and false bad news.

¹⁴³ [1958] NZLR 396.

¹⁴⁴ See also *Brown v Mount Barker Soldiers' Hospital* [1934] SASR 128, discussed above paras 18-19.

Allin v City and Hackney Health Authority

67. Since 1993 new cases have been decided which support both these propositions, and they all involve hospitals and health authorities. Dealing first with false bad news, in *Allin v City and Hackney Health Authority*,¹⁴⁵ the plaintiff alleged that, shortly after a difficult birth by caesarian, she had been informed by hospital staff that her baby was dead. About six hours later, she learnt that the baby had survived. The defendants said that no such misstatement had been made, though the plaintiff and her mother had been told in plain terms that there seemed no chance of the baby surviving. Judge McMullan in the Mayor's and City of London County Court held that on the balance of probabilities the evidence supported the plaintiff's version, and on that basis the defendants were liable for the post-traumatic stress disorder which she had been caused to suffer as a result of these events. The defendants did not dispute that they were under a duty of care in respect of statements of this sort made to the plaintiff. As the judge said, it would have been extraordinarily negligent to inform a mother that her baby was dead if this were not true.

AB v Tameside & Glossop Health Authority

68. The English Court of Appeal considered the issue of liability for true bad news in *AB v Tameside & Glossop Health Authority*.¹⁴⁶ The defendants discovered that a health worker who had given obstetric treatment to female patients at two hospitals was HIV positive, and that there was a remote risk of infection. They decided to inform the patients concerned, and that they should be informed by letter. In this action, a number of the patients claimed that the defendants were negligent in choosing to inform them by letter rather than face to face. French J at first instance held that it was negligent to inform the plaintiffs by letter, in that the defendants should have foreseen that vulnerable individuals might suffer psychiatric injury going beyond the shock and distress which was natural in the circumstances. The Court of Appeal allowed the appeal. The defendants' duty, once they had decided to inform patients at all, was to take such steps to inform them as were reasonable, having regard to the foreseeable risk that some might suffer psychiatric injury, but it was wrong to hold that they were negligent because they did not select the best method. According to Brooke LJ, the case broke no new ground, even though there was no previous English case in which liability for negligence had been imposed for communicating accurate but distressing news in a careless manner. However, counsel for the defendants conceded that a duty to take reasonable care existed where the relevant relationship was between health authorities and their patients or former patients, so that it was unnecessary to decide the point, or to consider whether a duty existed when there was no pre-existing relationship of care.

Lew v Mount Saint Joseph Hospital Society

¹⁴⁵ [1996] 7 Med LR 167. For comment on this case and *AB v Tameside & Glossop Health Authority*, discussed below para 68, see N J Mullany, "Liability for Careless Communication of Traumatic Information" (1998) 114 LQR 380. See also N J Mullany, "Negligently Inflicted Psychiatric Injury and the Means of Communication of Trauma – Should It Matter?" in N J Mullany and A M Linden (ed), *Torts Tomorrow: A Tribute to John Fleming* (1998), 162 at 195-202.

¹⁴⁶ [1997] 8 Med LR 91.

69. The issue of true bad news received more extended discussion in the Supreme Court of British Columbia in *Lew v Mount Saint Joseph Hospital Society*.¹⁴⁷ The plaintiff claimed damages for nervous shock on witnessing the effects of a brain injury sustained by his wife during a routine haemorrhoidectomy as a result of being deprived of sufficient oxygen, due to the admitted negligence of the defendant. He went to the hospital to visit his wife, and was shocked to see her attached to numerous tubes. He claimed damages against the anaesthetist as a secondary victim, and also as a primary victim for the hospital's failure to take reasonable action to prevent him from being exposed to the frightening circumstances which they knew or ought to have known would cause him injury. The hospital moved to have the action struck out as disclosing no reasonable cause of action on the basis that an action for nervous shock can only be maintained against the tortfeasor who actually caused the injuries, in this case the doctor. Henderson J dismissed this application. After a full discussion of all the bad news authorities, he held that while there are few authorities allowing recovery for negligent communication of true bad news, the law of nervous shock was still developing. Though the plaintiff's case was a novel one and not clearly within the class of cases for which recovery had hitherto been allowed, it could not be said that there was no reasonable prospect of success. The defendant's application to the Court of Appeal for leave to appeal was dismissed by Newbury JA.¹⁴⁸

FEAR FOR THE FUTURE

70. An aspect of psychiatric damage law which has gained a much higher profile over the last few years is whether a plaintiff can recover damages for psychiatric illness caused not by something that has already happened but by the fear and worry that due to exposure to a particular risk he or she may suffer some life-threatening disease or injury in the future.¹⁴⁹ The contexts in which this issue has arisen for discussion, or could potentially have been discussed, include psychiatric illness caused by fear and worry of the possibility of contracting cancer,¹⁵⁰ AIDS¹⁵¹ and Creutzfeld-Jakob Disease.¹⁵²

¹⁴⁷ (1997) 36 CCLT (2d) 35.

¹⁴⁸ (1997) 44 BCLR (3d) 84. Subsequently, Master Barber in the Supreme Court set aside a notice for jury trial because of the complexity of the issues: see (1998) 55 BCLR (3d) 394.

¹⁴⁹ For discussion in an Australian context see N J Mullany, "Fear for the Future: Liability for Infliction of Psychiatric Disorder" in N J Mullany (ed), *Torts in the Nineties* (1997), 101; N J Mullany, "Negligently Inflicted Psychiatric Injury and the Means of Communication of Trauma – Should It Matter?" in N J Mullany and A M Linden (ed), *Torts Tomorrow: A Tribute to John Fleming* (1998), 162 at 186-195.

¹⁵⁰ *Napolitano v CSR Ltd* (unreported, SC WA, No 1450 of 1994, 30 Aug 1994) (BC 9401896); *Sandstrom v Commonwealth* (unreported, Fed Ct, No NG 564 of 1991, 4 Mar 1994) (BC 9406471); *Commonwealth v Dinnison* (1995) 56 FCR 389; *Dingwall v Commonwealth* (unreported, Fed Ct, No NG 575 of 1991, 18 May 1994) (BC 9405835); *Bryan v Philips New Zealand Ltd* [1995] 1 NZLR 632.

¹⁵¹ See *Fritz v Queensland Corrective Services Commission* (unreported, SC Qld, No 556 of 1993, 24 April 1995) (BC 9505755); *Graham v Australian Red Cross Society* (unreported, SC Tas, No 613 of 1993, B29/94, 3 June 1994) (BC 9400398).

¹⁵² See *APQ v Commonwealth Serum Laboratories Ltd* [1999] 3 VR 633, leave to appeal refused (unreported, SC Vic, App Div, No 8546 of 1993, 28 April 1995); *N v United Kingdom Medical Research Council* [1996] 7 Med LR 309; *Newman v Secretary of State for Health* (1997) 54 BMLR 85; *CJD Group B Plaintiffs v Medical Research Council* [2000] Lloyd's Rep Med 161; *Andrews v Secretary of State for Health* (unreported, QBD Eng, No 1994 N No 5806, 19 June 1998).

Stephen v Riverside Health Authority

71. One such case involves a health authority. In *Stephen v Riverside Health Authority*,¹⁵³ the plaintiff developed a prickly burning sensation in the chest and other symptoms after undergoing a mammography in 1977. She had had some radiography training, and she thought that more films had been taken than were necessary. Over the next few years the doctors she went to gave her reassurances and the solicitors she consulted did not advise action, but she was not satisfied. She consulted new solicitors and, armed with a new medical opinion that she could have received a much higher dose of radiation than stated, a writ was issued in 1988. The case concerns the preliminary issue of whether the claim was statute-barred. Auld J held that she did not have the necessary knowledge until 1985 and so the action had been brought in time. There is no real discussion about the damage for which the plaintiff might ultimately recover, but it seems likely that her claim could have included damages for present psychiatric illness caused by the worry of possibly developing cancer in the future.

¹⁵³ [1990] 1 Med LR 261.