COMMENTARY

A SHOCKING REQUIREMENT IN THE LAW ON NEGLIGENCE LIABILITY FOR PSYCHIATRIC ILLNESS: *LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST V RONAYNE* [2015] EWCA CIV 588

ANDREW S. BURROWS¹* and JOHN H. BURROWS²

¹Faculty of Law, University of Oxford; All Souls College, Oxford, UK

²University of Edinburgh, College of Medicine and Veterinary Medicine, Edinburgh, UK

*andrew.burrows@law.ox.ac.uk

ABSTRACT

The *Ronayne* case concerned a husband who suffered a psychiatric illness, described as an adjustment disorder, in seeing the condition of his wife who was the primary victim of admitted medical negligence. His claim for compensation, as a 'secondary victim', failed because he could not satisfy the legal requirement that there must be a sudden shocking event. This commentary criticises that requirement which appears to make no medical sense.

KEYWORDS: Negligence, Psychiatric illness, Tort, Adjustment disorder, Shock, Compensation

INTRODUCTION

Medical negligence claims for psychiatric illness by close relatives of patients have very rarely succeeded under English law. The Court of Appeal's decision in *Liverpool Women's Hospital NHS Foundation Trust v Ronayne*¹ is the latest example of such a failed claim. Yet while medical practitioners (and health authorities) may breathe a

1 [2015] EWCA Civ 588.

sigh of relief at these outcomes, their medical expertise may make them feel somewhat uncomfortable with the reasoning of the courts which, in at least one central aspect, appears to make no medical sense.

THE FACTS AND THE JUDGMENT

In the *Ronayne* case, the claimant's wife had been admitted to the Liverpool Women's Hospital, administered by the defendant NHS Foundation Trust, for a routine hysterectomy. A few days after discharge, she became unwell with a high temperature, thirst, and shallow breathing and was admitted to the Royal Liverpool University Hospital by way of its accident and emergency department. During the course of a period of about 36 h (on 18–19 July 2008), the claimant observed a rapid deterioration in his wife's condition. This was manifested most clearly in two distinct episodes. First, shortly before she underwent emergency exploratory surgery, he observed her connected to various machines, including drips and monitors. Secondly, on the following day, he observed her in her post-operative condition. She was unconscious, connected to a ventilator and was being administered four types of antibiotic intravenously. Her arms, legs, and face were very swollen. Pressure pads were in place to keep the blood in her legs flowing. The claimant described her as looking like the 'Michelin Man'.

It was not in dispute that Mrs Ronayne's condition was a consequence of negligence by the defendant Trust in the performance of the hysterectomy. A suture had been misplaced in her colon, in consequence of which she developed septicaemia and peritonitis. Although Mrs Ronayne remained in intensive care for a further 9 weeks, developed a MRSA infection, and had to deal with other very unpleasant complications, she ultimately made a complete recovery.

The case was not concerned with her own claims in the tort of negligence against the Trust. Instead, the case dealt with her husband's negligence claims for the alleged psychiatric illness he had suffered from seeing his wife in the state she was in on 18–19 July 2008.

The husband's claim succeeded before His Honour Judge Gore QC in the county court but, on an appeal by the defendant NHS Trust, that decision was overturned by the Court of Appeal. Tomlinson LJ gave the leading judgment, with which Sullivan and Beatson LJ agreed. It was not in dispute in the Court of Appeal that Mr Ronayne had suffered a recognisable psychiatric illness, described as an adjustment disorder. However, the Court of Appeal decided, contrary to the county court judge, that the events causing the adjustment disorder were spread out over a period of time so that there was no sudden shocking (or horrifying) event; and, applying the law laid down in previous cases, there had to be a sudden shocking (or horrifying) event for a claim like this to succeed. For shorthand purposes, this will be referred to in the rest of this commentary as the 'sudden shocking event' requirement.

THE GENERAL LAW ON NEGLIGENTLY CAUSED PSYCHIATRIC ILLNESS

In order to understand the requirement of a sudden shocking event, we need to look more generally at the law on liability in the tort of negligence for psychiatric illness (sometimes referred to as psychiatric injury or, in the earlier cases, 'nervous shock').

An important distinction has been drawn in the case law between primary and secondary victims. A primary victim is a person who has been physically injured, or was

within the zone of physical injury, and has suffered a psychiatric illness consequent on that physical injury or from fear of suffering a physical injury.² A secondary victim is a person who suffers a psychiatric illness consequent on (eg by seeing) physical injury to someone else.³ The *Ronayne* case was concerned with a secondary victim, Mr Ronayne. The primary victim was Mrs Ronayne.

All victims claiming for psychiatric illness, whether primary or secondary, have to establish that they have suffered a recognised psychiatric illness, rather than mere mental distress (such as worry, upset, or anger), and that that illness was caused by, and is not too remote from, the negligence of the defendant.⁴ However, the courts have imposed additional requirements, often referred to as 'control mechanisms',⁵ on claims for psychiatric illness by secondary victims. This is because there may be a wide range of secondary victims from a single negligent act or omission so that to allow claims by all such secondary victims would 'open the floodgates of litigation'.⁶ As a matter of deeper policy the fear is that, without additional controls, liability in negligence would unacceptably impose heavy financial burdens on defendants, would increase insurance premiums, and would strain the resources of the courts in dealing with such claims.⁷ In the specific context of medical negligence claims, it may be that an added fear is that, without additional limitations, there would be unacceptable costs to the NHS.

What then are the control mechanisms on claims by secondary victims? A leading case is *Alcock v Chief Constable of South Yorkshire Police*.⁸ This concerned the Hillsborough football disaster in which 96 Liverpool fans died, most by being crushed to death. Claims for post-traumatic stress disorder (PTSD) were brought by 16 relatives of those who died or were injured. All but one of those claims failed albeit that it was admitted that the death and injuries of the fans at the stadium were caused by the negligence of the defendant police force and it was assumed that each of the claimants had proved the infliction of a non-remote recognised psychiatric illness. The House of Lords laid down that, in addition to proving a negligently caused and non-remote psychiatric illness, a claimant who is a secondary victim must show: (i) that he or she had a close tie of love and affection to the primary victim; (ii) that he or she was close in time and space to the incident or its immediate aftermath; and (iii) that he or she saw or heard the incident through his or her own unaided senses rather than, for example, being told about it by a third party. Only one of the 16 claimants satisfied all three requirements, and therefore only that one claimant succeeded in recovering damages for PTSD.⁹

2 *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455; *Clerk and Lindsell on Torts* (21st edn, 2014), para. 8-64.

3 *Ibid.*

4 *Hinz v Berry* [1970] 2 QB 40; *McLoughlin v O'Brian* [1983] 1 AC 410; *Hicks v Chief Constable of the South Yorkshire Police* [1992] 2 All ER 65.

5 See, eg, the judgments of Lords Hoffmann and Goff in *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455.

6 This phrase derives from the US case of *Ultramares v Touche* 174 NE 441 (1931).

7 Law Commission, *Liability for Psychiatric Illness*, Consultation Paper No. 137 (1995), para. 4.2.

8 [1992] 1 AC 310. See also *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455, HL, which concerned failed claims by police at Hillsborough who had been involved in rescue work and had suffered PTSD.

9 William Pemberton (whose son was killed and he was outside the ground and searched for his son and identified his son in the temporary morgue) succeeded at first instance, and there was no appeal against that decision.

The speeches in the *Alcock* case indicated that there was a further fourth requirement, namely that the psychiatric illness must be caused by a sudden shocking or horrifying event rather than a gradual process. In the words of Lord Ackner,¹⁰

‘Shock’, in the context of this cause of action, involves the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind. It has yet to include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system.

This fourth requirement has subsequently been applied to deny recovery in a number of cases. For example, in *Sion v Hampstead Health Authority*,¹¹ the claimant’s son was injured in a motorcycle accident and admitted to hospital. The claimant stayed at his son’s bedside and watched him slowly deteriorate in health, suffer from a heart attack, fall into a coma, and eventually die. The claimant alleged that the hospital had been negligent in its treatment and sought damages for the abnormal grief reaction that he suffered on his son’s death. The hospital was successful in striking out the claim on the basis that the father’s psychiatric illness was not caused by a sudden shocking event. Rather, the son’s deterioration and death had been a gradual one spread out over a period of time. Similarly, in *Taylorson v Shieldness Produce Ltd*,¹² parents failed in a claim for damages for psychiatric illness suffered after the death of their son. He had been crushed by a reversing vehicle and taken straight to hospital. The claimant parents were told of the accident soon after it occurred. They had driven to the hospital and then followed an ambulance which transferred him to a second hospital. They caught brief glimpses of their son as he was taken from the ambulance into intensive care. His father went to his bedside as soon as he was allowed after the treatment, but the mother was dissuaded from going until the next day. They stayed with him during the following 2 days until his life support machine was switched off 3 days after the accident. The Court of Appeal denied their claims in the tort of negligence (against the employer of the driver of the reversing vehicle) not only because they were not at the scene of the accident or its immediate aftermath but also because the psychiatric illness was not caused by a sudden shocking event but rather grew out of a sequence of events that extended over an appreciable period of time. More recently, in *Shorter v Surrey & Sussex HC NHS Trust*,¹³ a claimant, who saw her sister in distressing circumstances in hospital and suffered a psychiatric illness in consequence, failed in her medical negligence claim because, again, there was no sudden shocking or horrifying event.

On the other side of the line stands *North Glamorgan NHS Trust v Walters*.¹⁴ This is the very rare example of a case in which a medical negligence claim for psychiatric illness by a secondary victim succeeded. It was held that the pathological grief reaction suffered by a mother following the death of her 10-month-old baby in hospital involved, as Ward LJ put it, ‘a seamless tale with an obvious beginning and an equally

10 [1992] 1 AC 310 at 398. See also at 401 (per Lord Ackner) and at 411 (per Lord Oliver).

11 [1994] 5 Med LR 170.

12 [1994] PIQR P329.

13 [2015] EWHC 614.

14 [2002] EWCA Civ 1792, [2003] PIQR P16.

obvious end'.¹⁵ The obvious beginning was the mother being awoken by her baby having a fit with blood pouring out of his mouth. The obvious end was the death of the baby in his mother's arms. Even though the matters complained of extended over 36 h, there was held to be a sudden shocking event.

In the *Ronayne* case, the claimant had no difficulty establishing three of the above four requirements. The claimant, as husband, had a close tie of love and affection to the primary victim; he was close in time and space to the operation and its aftermath; and he had himself seen the condition of his wife so that he had suffered the experience through his own unaided senses. The whole dispute in the Court of Appeal turned on the fourth requirement. Did the claimant suffer the psychiatric illness through a sudden shocking (or horrifying) event? The Court of Appeal decided, contrary to the county court judge, that the events causing the adjustment disorder were spread out over a period of time rather than there being a sudden shocking (or horrifying) event. The claim therefore failed, and the Trust's appeal succeeded.

CRITICISM OF THE SUDDEN SHOCKING EVENT REQUIREMENT

None of the four requirements are easy to defend from a medical perspective, and the Law Commission in its 1998 Report on *Liability for Psychiatric Illness*¹⁶ recommended statutory abolition of all those requirements except the first (that the claimant must have a close tie of love and affection to the primary victim). The fourth requirement is particularly hard to justify not least because it has little connection to the factors causing psychiatric illness once one moves away from PTSD. Even if one accepts that, over and above the need to prove non-remote negligently caused psychiatric illness, there should be control mechanisms for secondary victims so as to prevent opening the floodgates of litigation, those controls should not be arbitrary. Yet the need to show a sudden and shocking event appears to be just that. If a person has suffered a psychiatric illness, why should it make any difference whether that illness was induced by a sudden shocking event or by a sequence of unpleasant events over a period of time? The effect on the claimant is ultimately the same in the sense that that person has suffered a psychiatric illness. It is true that the type of psychiatric illness in question may differ. Indeed, on the facts of this case the county court judge precisely found that the claimant was not suffering from PTSD but from an adjustment disorder. But it has never been suggested that the only type of recognised psychiatric illness falling within the tort of negligence is PTSD. To allow recovery for an adjustment disorder but then to say that the illness must be caused by a sudden shocking event is incoherent.

The Law Commission thoroughly examined the arguments for and against the retention of the sudden shocking event requirement in its 1998 Report, following its 1995 consultation paper,¹⁷ and recommended its statutory abolition. Its reasons for doing so included that, if the sole purpose of the requirement is to limit the number of potential claimants, it is a very crude method of doing so; that the requirement makes no sense from a medical point of view; and that 66% of those who responded to the Law Commission's consultation paper on this issue favoured abandoning the

15 Ibid at [35].

16 Law Com No. 249.

17 Law Commission Consultation Paper No. 137.

requirement. In the words of the Law Commission: 'We have come to the conclusion that [the shock requirement] should be abandoned. We believe that it is possible to counter all the arguments raised in favour of retaining [that] requirement.'¹⁸

Subsequently, however, the Government rejected the Law Commission's recommendations for statutory reform on the basis that negligence liability for psychiatric illness is a controversial area of the law in which 'reform' is best left to the judges through development of the common law.¹⁹

It is of particular interest to consider the responses of those with medical expertise to the Law Commission consultation paper on the question of whether to retain the sudden shocking event requirement. The Mental Health Law Group of the Royal College of Psychiatrists wrote as follows:

For psychiatrists the 'shock-induced' requirement causes serious problems. The term is vague, has no psychiatric meaning and is emotively misleading. The requirement should be abandoned. Psychiatric evidence should require demonstration, or not, of a psychiatric disorder distinct from a normal mental reaction and, if present, its relationship with the index event. This is usually possible. The requirement to fit the evidence around the concept of a whether or not the disorder is 'shock-induced' has no scientific or clinical merit. It is simply playing with words.²⁰

Similarly, Miles Mandelson, a clinical psychologist wrote: 'Psychological reactions to a traumatic episode do develop over time partly as a result of the subject's ability to reflect on past events and anticipate future events and to consider their implications (processes which themselves take place over time) and partly because the traumatic episode may be protracted before the final outcome is known.'²¹

Again, Professor (now Sir) Simon Wessely pointed out that a sudden event is not the only accepted precipitant of psychiatric disorder nor is it the most common.²²

In the light of these views, and the Law Commission's recommendation, it is hard to resist the conclusion that the need for a sudden shocking event is an unnecessary and arbitrary restriction. Put another way, on the assumption that Mr Ronayne did indeed suffer a recognised psychiatric illness, the decision of the Court of Appeal appears to be unjust. Admittedly, the Court of Appeal was bound by precedent to apply the sudden shocking event requirement so that any development of the law would appear to require a decision of the Supreme Court. But that there is flexibility in applying the sudden shocking event requirement is shown by the enlightened decision in *North Glamorgan NHS Trust v Walters* which, in *Ronayne*, was distinguished as involving extreme facts.²³ While one practical effect of the requirement's retention is that medical negligence claims for psychiatric illness by secondary victims are unlikely

18 Ibid at para. 5.31.

19 See Law Commission, *Forty-Fourth Annual Report* (2010), Law Com No. 323, at para. 3.11.

20 Ibid at para. 5.39.

21 Ibid.

22 Ibid.

23 [2015] EWCA Civ 588 at [35]–[38].

to be successful, one would expect that, if given the opportunity, the Supreme Court would act to remove this requirement. Indeed, it is an unwelcome surprise that the Court of Appeal offered no criticism of the sudden shocking event requirement and made no reference to the work of the Law Commission. If, subsequent to the Law Commission's report, the courts have been left to develop the law incrementally, it is disappointing that they are failing to consider criticisms of the present law.

TWO OTHER ASPECTS OF THE DECISION

There are two other noteworthy aspects of the decision. The first is that the Court of Appeal approved the reasoning of Swift J in the *Shorter* case that, in applying the sudden shocking event requirement, one should not take into account that the claimant was a radiographer who therefore had an unusual degree of insight into her sister's medical condition thereby rendering it more likely that she would find the events shocking and horrifying than would someone without that professional background.²⁴ In other words, one must assess whether the event is shocking or horrifying by objective standards—in the words of Tomlinson LJ, 'by reference to persons of ordinary susceptibility'²⁵—and not by the standards of someone who is abnormally sensitive.

The second concerns the psychiatric illness that was in issue in *Ronayne*. The county court judge had rejected the argument that the claimant had suffered from PTSD but accepted that he had suffered a 'frank psychiatric illness',²⁶ which he was reluctant to classify but, if necessary to do so, he would have labelled adjustment disorder. The Court of Appeal criticised this reluctance of the judge to classify the psychiatric illness. Tomlinson LJ said:

I think that the judge was . . . wrong to be dismissive of the utility of diagnosis or label. While I understand his point that he was concerned only to ascertain whether the claimant had sustained a frank psychiatric illness, close attention to diagnostic criteria is . . . likely in this field to be of assistance in resolving what are often complex questions of causation. At the very least, attribution of a label introduces what might be characterised either as a discipline or as a cross-check, according to taste. I am not sure that the judge would have come to the conclusion he did on causation had he paid close attention to the diagnostic criteria for adjustment disorder, and to the significance of the fact that he had found the elements of PTSD not to be made out.²⁷

Tomlinson LJ was therefore suggesting that, had the judge focussed on the diagnostic criteria for adjustment disorder, he may have been less likely to find that the sudden shocking event requirement was made out. Rather, the adjustment disorder might well have been caused by Mr Ronayne's concerns as to his wife's ill health in general rather than by any sudden shocking event. In the penultimate paragraph of his judgment, Tomlinson LJ returned to this point:

24 Ibid at [13].

25 Ibid.

26 The use of the word 'frank' is odd. All that appears to be meant is that there was a clear psychiatric illness.

27 [2015] EWCA Civ 588 at [9].

Had the point been live before us . . . I would have wanted to give further consideration to the question, whether, in a case of adjustment disorder as opposed to PTSD, it is logically defensible to isolate one or two events from a larger continuum in an attempt to attract that liability which attaches to the perception of a tortiously caused horrifying event.²⁸

But, with respect, this serves merely to underline the point made above that, in the context of adjustment disorder, as opposed to PTSD, it makes little sense to insist on a sudden shocking event requirement. Indeed, the Law Commission pointed out that applying one of the two main psychiatric diagnostic classificatory schemes (the International Classification of Diseases, ICD-10),²⁹ the stressor for an adjustment disorder must *not* be of an unusual or catastrophic type.

Tomlinson LJ's criticism of the county court judge also reveals a tendency that lawyers have to assume, falsely, that the dividing lines between different recognised psychiatric illnesses, and indeed between psychiatric illness and mere mental distress, are clear-cut. Although adjustment disorders have been included in the major diagnostic classifications for some 50 years, they remain poorly understood and have received little attention in research. It seems likely that, in general practice, they are often misdiagnosed as depressive illness or anxiety disorder. The county court judge's reluctance to adopt a rigid classification may therefore have properly reflected the somewhat uncertain boundary between adjustment disorders and some other types of psychiatric illness.

CONCLUSION

The sudden shocking event requirement imposed on negligence claims for psychiatric illness by a secondary victim is particularly arbitrary and, in line with the Law Commission's recommendation on this requirement two decades ago, should be abandoned. It makes no medical sense to say that the law recognises adjustment disorder as a psychiatric illness and then to insist that it must be caused by a sudden shocking event. If that requirement is to be retained, the courts should apply it as flexibly as possible. It follows that the decision of the Court of Appeal in *Ronayne*, while of comfort to medical practitioners and health authorities, is otherwise hard to defend.

28 Ibid at [47].

29 ICD-10 (1992), para. F43.2, p. 149, published by the World Health Organisation. The other main classificatory scheme is the *Diagnostic and Statistical Manual of Mental Disorders*, 2013 (DSM-V) published by the American Psychiatric Association.