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The narrow(ing) scope of duty: clinical negligence and secondary victims after *Paul and others v Royal Wolverhampton NHS Trust*

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ABSTRACT

In *Paul and others v Royal Wolverhampton NHS Trust* the United Kingdom Supreme Court (UKSC) held that a doctor who negligently misdiagnoses a patient does not owe a duty to family members who witness their death or injury. Such claimant witnesses – or 'secondary victims' – have hitherto been able to claim for psychiatric injury under an exception to the rule that there is no compensable interest arising from the death or injury of another. The majority of the UKSC curtailed this exception which, to quote the dissenting Lord Burrows, 'will mean that recovery for negligently caused psychiatric illness by secondary victims will be closed off in medical negligence cases'.[1] This commentary explores the pragmatism adopted by the court and its application of the 'scope of duty' principle. Placing this principle in a critical context, I argue that the scope of duty in clinical settings risks becoming unduly narrow and will limit access to justice for families. The decision will further amplify debate about wide-scale reform of National Health Service litigation, including a move towards a no-fault system focused on learning and accident-prevention.

INTRODUCTION

Under the common law of torts there is no compensable interest in the death or well-being of another. However, over the last century an exception emerged: a 'secondary victim' who suffered psychiatric injury after witnessing a loved one (the 'primary victim') die, be injured, or be placed at risk of injury could recover compensation. The exception emerged in the factual context of witnessing road traffic accidents. Underpinning this exception were concerns about imposing disproportionate liability on defendants relative to the negligent conduct and the risk of a high volume of claims from a substantial

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1 *Paul v Wolverhampton NHS Trust* [2024] UKSC 1, para 250.

class of claimants.[2] In the early 1990s the rules that would limit such claims were clarified against the backdrop of the Hillsborough Stadium disaster.

Comprised of three conjoined appeals and heard before a seven-member bench of the United Kingdom Supreme Court (UKSC), the central issue in *Paul and others v Royal Wolverhampton NHS Trust* was whether this exception should include cases of clinical negligence where the claimant's injury arose not by witnessing an accident but witnessing the primary victim's death (or medical crisis) which the defendant had failed to diagnose. In the cases of *Paul* and *Polmear*, the deaths were witnessed in the presence of the primary victims and, in *Purchase*, the secondary victim came upon the primary victim shortly after death.[3]

The starting point is to examine the relationship between the defendant and the secondary victim. Applying first principles under *Donoghue v Stevenson*, mere foreseeability of harm is not enough to mount a successful claim.[4] One needs to establish legal proximity without which there would be no duty. In *Alcock v Chief Constable of the South Yorkshire Police*,[5] Lord Oliver identified five elements from which proximity was to be deduced:

> [F]irst, that in each case there was a marital or parental relationship between the plaintiff and the primary victim; secondly, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system; thirdly, that the plaintiff in each case was either personally present at the scene of the accident or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards; and, fourthly, that the injury suffered arose from witnessing the death of, extreme danger to, or injury and discomfort suffered by the primary victim. Lastly, in each case there was not only an element of physical proximity to the event but a close temporal connection between the event and the plaintiff's perception of it combined with a close relationship of affection between the plaintiff and the primary victim.[6]

These elements – often termed 'control mechanisms' – became the touchstone for secondary victim claims but were difficult to apply in non-accident cases: that is, where the event was 'silent' or 'invisible',

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2 Lord Wilberforce in *McLoughlin v O'Brian* [1980] 1 AC 410; see also Lord Oliver in *Alcock v Chief Constable of the South Yorkshire Police* [1992] 1 AC 310, para 410H, who questioned the underlying rationale of the exception but accepted that it was now firmly embedded in the common law.

3 *Paul* (n 1 above).

4 *Donoghue v Stevenson* [1932] AC 562.

5 *Alcock* (n 2 above). The claims in *Alcock* arose from the deaths of 96 people who were crushed in the Hillsborough disaster in 1989.

6 Ibid paras 411F–411H.

such as in the case of a clinical failure to diagnose. In such cases, and with no event to witness, another area of uncertainty was whether liability should be governed by the time lag between the negligent act itself and the primary victim's death or injuries which caused the psychiatric injury.[7] Perhaps to circumvent such difficulties the courts had grappled with the interpretation and/or construction of 'event' to determine whether the claimant was sufficiently proximate.[8]

The question for the Supreme Court was: what constitutes the 'event' for the purpose of establishing proximity and thus liability? Was the event exclusively an accident external to the primary victim or would the event of death or injury to the primary victim suffice?[9] The UKSC preferred the former answer and dismissed the claims. In doing so, it confirmed that such claimants were outside the scope of a doctor's duty of care.

This commentary argues that the scope of duty in clinical settings risks becoming unduly narrow, thus limiting access to justice. By narrowly ring-fencing the doctor's duty of care, the Supreme Court's approach is incongruous with the relationship between clinicians and family (eg in the provision of maternity services) and with wider developments in the National Health Service (NHS). The decision continues a recent appellate trend in defining the scope of duty by close reference to clinical expertise rather than patient (and non-patient) expectations. The decision masks a more fundamental socio-economic enquiry about the duty of an (underfunded) NHS towards injured families. Such an enquiry requires a wider civic conversation about society's relationship with the NHS amid debate about reform of clinical negligence litigation.

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7 *Paul* (n 1 above) para 94.

8 Five cases of alleged clinical negligence were considered by the UKSC and, albeit some were decided on an alternate basis, there had only been one previous case where the claimant had been successful. See *Taylor v Somerset Health Authority* [1993] PIWR P262; *Sion v Hampstead Health Authority* [1994] 5 Med LR 170; *North Glamorgan NHS Trust v Walters* [2003] PIQR PI6; *Shorter v Surrey and Sussex Healthcare NHS Trust* [2015] PIWR P20; *Liverpool Women's Hospital NHS Foundation v Ronayne* [2015] PIQR P20. The claimant succeeded in *Walters*.

9 I omit for present purposes the approach taken by counsel for *Paul*. Counsel's submission was that the relevant event was the first manifestation of the injury to the primary victim. Underhill LJ in the Court of Appeal rejected the submission as unprincipled and unworkable. The majority in the UKSC agreed (see *Paul* (n 1 above) paras 97–104) and concluded that this position was highly uncertain and illogical. This view was echoed by the dissenting Lord Burrows, see ibid para 178.

FACTS

Mr Harminder Singh Paul collapsed and died from a heart attack whilst shopping with his daughters, aged 12 and 9. It was subsequently alleged that his death had occurred as a result of a negligent failure to diagnose and treat coronary artery disease some 14-and-a-half months earlier. Both daughters brought claims having suffered psychiatric injury as a result of witnessing their father's collapse and eventual death.

Esmee Polmear, aged 7, collapsed and died after a school trip to the beach. Esmee's collapse, the unsuccessful attempts in resuscitating her and her subsequent death were witnessed by her mother and father, both of whom subsequently suffered post-traumatic stress and depression. Despite Esmee displaying symptoms, a paediatrician had failed to diagnose cardiac disease five-and-a-half months before her death. The parents brought claims as secondary victims.

Evelyn Purchase was discovered by her mother at home motionless in bed with a phone in her hand. She looked alive and her skin was still warm. Her mother attempted to resuscitate her, but it was too late. It was later determined that she had died of pneumonia complications five minutes earlier with her final breaths recorded in a voicemail on her mother's mobile phone. Evelyn's mother suffered psychiatric injuries upon discovering her daughter. She brought a claim against the general practitioner (GP) who allegedly failed to assess Evelyn three days before her death.

THE LOWER COURTS

In *Paul*, Master Cook applied *Taylor v Somerset Health Authority*.[10] In *Taylor*, a failure to diagnose and treat the claimant's husband led to his heart condition getting worse and months later resulted in a heart attack at work. The claimant attended the hospital within the hour and after 20 minutes was told of her husband's death before she visited the body in the mortuary. Auld J held that there was no external, traumatic event in the nature of accident or violent happening; the death was the culmination of the process of heart disease and there was no proximity

10 *Taylor v Somerset Health Authority* [1993] 4 Med LR 34.

to the event or its immediate aftermath.[11] Accordingly, Master Cook concluded the claim brought by both daughters in *Paul* was bound to fail; a time lag of over 14 months between the negligence and death defeated the requirement of proximity. Master Cook declared that there needed to be a proximate connection between the initial negligence and the shocking event, which was a necessary, albeit not a sufficient, condition in establishing legal proximity.[12]

The decision in *Paul* was reversed on the central question of whether the death was the relevant event.[13] Chamberlain J concluded there was no authority that suggested a time lag between the negligence and the death would prevent the latter being the relevant event (eg an event where a primary victim is killed by electrocution would be the relevant event irrespective of when the earlier negligent wiring took place). Further, Chamberlain J considered that Auld J's decision in *Taylor* was inconsistent with *NHS Glamorgan Trust v Walters*[14] in which the claimant's son died following two days of illness. The mother in *Walters* was asleep in the same room when her son suffered a seizure, which led to a coma accompanied by brain damage. The appropriate clinical intervention was delayed by a misdiagnosis. Her son died in her arms approximately 36 hours after the seizure. The Court of Appeal held that the entire 36-hour period could be regarded as one drawn-out, horrifying event as there was:

> [an] inexorable progression from the moment when the fit occurred as a result of the failure to diagnose [leading to] the dreadful climax when the child died in her arms. It [was] a seamless tale with an obvious beginning and an equally obvious end.[15]

Chamberlain J also distinguished *Taylor v A Novo*.[16] Albeit a non-clinical case, *Novo* concerned the claimant's mother who sustained injuries in an accident at work. During her recovery and as a result of her injuries she collapsed and died at home three weeks later. The

11 The immediate aftermath extension was developed in *McLoughlin* (n 2 above). Mrs McLoughlin was at home when the car in which her husband and children were travelling was involved in a negligently caused collision due to the defendant's negligence. On learning of the accident from a neighbour an hour or so after it happened, she went immediately to the hospital where she was told that her daughter was dead. She saw her husband and other children injured and in distress and grimy with dirt and oil. Noting the arbitrariness of allowing recovery if the mother had attended the accident scene, but denying recovery on her arrival at the hospital, the House of Lords permitted recovery on the basis of her coming upon the immediate aftermath of the accident.

12 *Paul v Royal Wolverhampton NHS Trust* [2019] EWHC 289.

13 *Paul v Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB).

14 *NHS Glamorgan Trust v Walters* [2002] EWCA Civ 1792; [2003] PIQR 232.

15 Ibid para 35 (Ward LJ).

16 *Taylor v A Novo* [2013] EWCA Civ 194.

claimant did not witness the workplace accident but witnessed the collapse at home and suffered psychological trauma. In *Novo* there had been one accident at work which had two consequences: the initial injuries and the death three weeks later (the latter consequence causing the psychiatric injury). The claimant was not physically proximate to the original accident and to permit recovery would be to go too far, potentially including cases where the death was months or years after the accident.[17] Chamberlain J considered *Novo* was distinguishable on the simple basis that in *Paul* there was only ever one witnessable event (the first occasion where the harm caused by the negligence was manifest).

Master Cook decided *Polmear* after the appeal in *Paul* had overturned his decision in that case. Now bound, Master Cook concluded that there was a qualifying event and the fact of earlier presenting symptoms (the first actionable damage) did not negate the ability of Esmee's parents to recover for witnessing their daughter's collapse and death.[18]

Purchase was decided by District Judge Lumb a month before the appeal decision in *Paul*. Without the benefit of Chamberlain J's judgment, the judge held that he was bound by *Novo* and thus the claim was bound to fail.[19]

COURT OF APPEAL

The Court of Appeal found for the defendants in each case.[20] Noting that *Taylor* and then *Novo* had adapted the proximity requirements for clinical settings, the court was bound to follow *Novo* which it took as authority for the proposition that no claim can be brought where psychiatric injury was caused by a separate horrific event removed in time from the original negligence, accident, or first horrific event.[21] Sir

17 If the claimant's mother had died at work and the claimant had arrived upon the immediate aftermath of the accident, she would have been denied compensation. Therefore, to permit recovery in the present case would not be comprehensible to an ordinary reasonable person. Note the Court of Appeal distinguished *Walters* on the basis that *Novo* involved two separate events rather than the single drawn-out and seamless event in *Walters*. *Novo* (n 16 above) para 35.

18 *Polmear* [2021] EWHC 196 (QB) para(s) 36–43.

19 *Purchase v Ahmed County Court* (2020) C86YX712, para(s) 32–33.

20 *Paul and others v Royal Wolverhampton NHS Trust* [2022] EWCA Civ 12.

21 Ibid para 12 (Sir Geoffrey Vos MR). Underhill LJ made similar comments stating: '[a] decisive feature was simply that there had been an interval of time between breach of duty, whether or not it occasioned any injury at the time, and the shocking event. In *Novo* itself the interval was three weeks, but the principle must be the same whatever the interval, provided it is not part of the same sequence of events as in cases of the *Walters* kind' (para 102).

Geoffrey Vos MR questioned whether *Novo* had correctly interpreted the proximity requirement, noting that original references to 'physical and temporal propinquity' in *Alcock* were not directed to the relationship between the breach of duty and the shocking event but rather the need for the claimant to be close in space and time to the shocking event. Underhill LJ highlighted that in earlier cases such as *McLoughlin* and *Alcock,* the death of the primary victim and the shocking events were generally contemporaneous with the breach of duty. He went on to state that there was no principled reason for distinguishing proximity on the basis of whether the primary victim's death was immediate or a few days or weeks later.[22] Similarly, the Master of the Rolls concluded that were he to have a 'clean sheet' he would have held the claimants sufficiently proximate and permit recovery.[23] On that basis, the Court of Appeal, on its own volition, granted permission to appeal.

THE SUPREME COURT

Majority

By a majority of 6:1 the UKSC dismissed each of the appeals.[24] The Supreme Court confirmed that those bringing a secondary victim claim must witness an *accident* or its immediate aftermath caused by the defendant's negligence. The underlying event in the trilogy of *McLoughlin*, *Alcock* and *Frost* was an accident and no analogy could be drawn between cases involving accidents and cases where the secondary victim witnesses a death or medical crisis brought about by an untreated condition.[25] Accidents were discrete events that happened at a particular time, at a particular place, in a particular way, enabling one to offer a clear answer to the question of whether someone was present at the scene and/or directly perceived the accident.[26] In the ordinary sense of the word, an accident was an 'unexpected and unintended event which caused injury (or a risk of injury) by violent external means to one or more primary victims'.[27] In adopting 'rough and ready logic', the majority made clear that those who are injured

22 Ibid para 102.

23 Ibid para 12.

24 Lord Leggatt and Lady Rose gave the leading judgment. Lord Carloway gave a short five-paragraph judgment agreeing with the leading judgment, noting its potential persuasive influence on Scots law. See *Paul* (n 1 above) paras 252–256.

25 Ibid paras 140–143; *Frost v Chief Constable of South Yorkshire* [1999] 2 AC 455.

26 *Paul* (n 1 above) para 108.

27 Ibid para 52. The occurrence or first manifestation of any injury was not constitutive of an accident but a potential result of an accident. Ibid para 105.

having witnessed an accident are not more worthy of compensation than those who do not witness an accident. However, a line had to be drawn to keep liability within reasonable bounds and adopt restrictions that were reasonably straightforward and comprehensible to the ordinary person.[28]

In the Supreme Court's view, witnessing an accident in which a family member was injured or put in peril (even if they escaped unharmed) was independently capable of being disturbing and could lead to psychological trauma, for example those who see their child hit by a car.[29] By contrast, in non-accident cases where the claimant witnesses the primary victim's injury or illness, there is insufficient certainty. A medical crisis might lead to an event such as a collapse as in *Paul*, but, in other cases, there will be considerable uncertainty about the duration of symptoms: minutes, hours, days, or weeks.[30] Similarly, the degree of psychological trauma triggered by the experience of witnessing would also be variable. In the Supreme Court's view, a defensible and intelligible line could be drawn between claimants who witness the accident in which a close relative was killed or injured and those claimants who do not.

The Supreme Court stated that it would be impossible to explain to an ordinary reasonable person why a daughter could recover compensation as a result of seeing her parent die from a heart attack, but compensation be denied to someone who identified the body at a mortuary or remained with their dying family member in hospital after the accident's aftermath. For the Court, such differential treatment would lead to unfair disparities between claimants in materially similar situations. And it had a further policy argument in mind: pending any later finding of negligence, it would be undesirable to expose hospitals to civil liability and risk interfering with decisions about the presence of close family with injured patients at the end of life.[31]

The Supreme Court took the opportunity to clarify the status of several authorities. First, it confirmed that the case of *Novo* had been correctly decided: the claimant was not present at the scene of the accident or its immediate aftermath and witnessing death was not an accident. Second, the cases of *Sion*, *Shorter* and *Ronayne* were correctly decided but on the erroneous basis that there was no sudden shock and/or the events were not 'horrifying' judged against a person

28 Ibid para 141.

29 Ibid para 109.

30 See, for instance, the cases discussed in the judgment where the duration of symptoms ranged from 24 hours, as in *Shorter* (n 8 above), to 36 hours as in *Walters* (n 14 above), and finally to 14 days as in *Sion* (n 8 above).

31 *Paul* (n 1 above) para 116.

of ordinary susceptibility.[32] Third, the Court concluded that the case of *Walters* in the Court of Appeal was wrongly decided because the claimant did not witness an accident.[33] The Court also removed and/or clarified other requirements that, it was assumed, secondary victim claims needed to satisfy. Notably these included:

1 The event did *not* need to be close in time to the negligent act or omissions. The Supreme Court concluded that there was no authority that suggested liability would depend on the interval between the negligence and the events which caused psychiatric injury.[34] Highlighting an example raised by the Master of the Rolls in the Court of Appeal – that of an architect whose negligent design caused masonry to fall on a primary victim's head years later – the Supreme Court confirmed that the gap in time between the negligence and the accident would not prevent a claim by the secondary victim. A mother who saw masonry fall on her child could not rationally be prevented from a successful claim on the basis of the length of time between the negligence and the accident.
2 No claimant would need to prove injuries were as a result of sudden and unexpected shock to the nervous system[35] or involved the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind.[36] The Supreme Court concluded it was no longer necessary to demonstrate the neurological or psychological mechanism by which the psychiatric illness was induced. The claimant need only demonstrate a causal connection, under ordinary principles, between the act of witnessing and the psychiatric illness suffered.[37]
3 The event did not need to be sufficiently 'horrifying' which, relying on the language of Lord Ackner in *Alcock*, had been mistakenly extrapolated by the courts as a separate requirement. Noting 'there is no available Richter scale of horror', the attempt to evaluate whether an event was objectively horrifying was an

32 In *Walters* (n 14 above), *Shorter* (n 8 above) and *Ronayne* (n 8 above), the issue of whether the rules developed in accident cases should even apply was not expressly raised. It was simply assumed the rules so applied.

33 *Galli-Atkinson v Seghal* [2003] EWCA Civ 697. The case of *Seghal* should also not be followed because it had transposed the analysis of *Walters* to the aftermath of an accident case and problematically accepted that the claimant's visit to the mortuary was to 'complete the story rather than the purpose of identifying the body'. See *Paul* (n 1 above) para 122.

34 *Paul* (n 1 above) paras 90–96.

35 Lord Oliver in *Alcock* (n 2 above) para 411F.

36 Lord Ackner in ibid para 401F

37 *Paul* (n 1 above) para 74.

invidious task, inherently subjective and not susceptible to proper analysis.[38]

4 There is only one event – the accident and its immediate aftermath. *Walters* had opened the door to an unhelpful and artificial assessment of whether there had been an inexorable or seamless progression of events with an obvious beginning and end. The Supreme Court stated: 'we find it hard to see why the defendant's legal liability should turn on the court's impression of whether or not the facts of the case fit the dramatic pattern of a Greek tragedy'.[39]

Revisiting fundamental principles, the Supreme Court went on to address the existence and scope of the duty owed directly to the claimant – an approach buttressed by Lord Oliver's statement in *Alcock* that nothing should obscure 'the absolute essentiality' of doing so.[40] The Court concluded that family members do not fall within a doctor–patient relationship and did not accept that the doctor's role and purposes for which care is provided would extend to assuming responsibility to protect the patient's family from the risk of illness arising from witnessing death or injury to the primary victim. In a telling passage the Court stated the following:

> To impose such a responsibility on hospitals and doctors would go beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role … Although social attitudes and expectations may be changing, we would not accept that our society has yet reached a point where the experience of witnessing the death of a close family member from disease is something from which a person can reasonably expect to be shielded by the medical profession. That is so whether the death is slow or sudden, occurs in a hospital, at home or somewhere else, and whether it be peaceful or painful for the dying person. We do not mean in any way to minimise the psychological effects which such an experience may have on the person's parent, child or partner when we express our view that, in the perception of the ordinary reasonable person, such an experience is not an insult to health from which we expect doctors to take care to protect us but a vicissitude of life which is part of the human condition.[41]

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38 Ibid para 77.

39 Ibid paras 80–81. The Court stated that *Walters* also had the effect of blurring the distinction between the event and its immediate aftermath, essentially extending the period of aftermath beyond what was contemplated in *McLoughlin* (n 2 above).

40 Lord Oliver in *Alcock* (n 2 above) paras 411A–411B.

41 *Paul* (n 1 above) paras 138–139.

Minority

Lord Burrows would have allowed the appeals. He viewed the relevant event as the death of the primary victim (and thus would have overruled *Novo*). For Lord Burrows, this was an incremental step justified in the tradition of updating the common law whereas the insistence on an accident (as an event external to the primary victim) was an 'unwarranted backward step' that would close off recovery for secondary victims in medical negligence cases.[42] He highlighted that medical negligence usually involves failure to prevent injury, and it would be rare for events capable of being termed an accident (eg the injection of an incorrect drug) to occur. Lord Burrows adopted the opposing position to that of the majority: the ordinary reasonable person would find it incomprehensible for a daughter who witnessed the initial event (accident) to the primary victim to succeed and a daughter who witnessed the final death a few weeks later to be denied.[43]

PRAGMATISM AND THE NARROW(ING) SCOPE OF DUTY IN CLINICAL NEGLIGENCE

Pragmatism in common law reasoning is nothing novel.[44] Lady Hale pithily equated pragmatism with policy which requires reasoning from a given conclusion and practical solutions that work best in the case and in others like it.[45] Pragmatism in tort law is also equated with considerations of distributive justice.[46] In *Paul*, the majority's discussion of principle thinly veiled the pragmatic question – what Plunkett describes as the normative 'notional duty' enquiry – *should* the law of negligence apply to the particular situation?[47] Before placing the scope of duty in context, I consider the pragmatism adopted by the Supreme Court which I argue replaced one type of arbitrariness with another kind.

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42 Ibid paras 207–208 and 250.

43 Ibid paras 238.

44 I interpret pragmatism as an approach to law that is practical, sensible, not necessarily anchored to precedent and rather is 'forward-looking' to maximise benefits for the future needs of society. On pragmatism, see Patrick Atiyah, *Pragmatism and Theory in English Law* (39th Hamlyn Lectures, Stevens & Sons 1987). The distinction between principle and pragmatism is complex: see James Plunkett, 'Principle and policy in private law reasoning' (2016) 75(2) Cambridge Law Journal 366.

45 Lady Hale, 'Principle and pragmatism in developing private law' (Cambridge Freshfields Lecture 7 March 2019).

46 P Cane, *Key Ideas in Tort Law* (Hart 2017).

47 J Plunkett, *The Duty of Care in Negligence* (Bloomsbury 2018) 151–152.

Arbitrary policy-based reasoning

As a preliminary observation, the majority relied on the legal fiction of 'ordinary reasonable people'.[48] The use of the term 'reasonable person' is prevalent in common law adjudication but focus on their *views* – writ large and abstracted – is often more tenuous. Most striking was the majority's conclusion that an ordinary reasonable person would view witnessing death not as 'an insult to health from which we expect doctors to take care to protect us, but a vicissitude of life which is part of the human condition'.[49] This claim, even on the face of it, might startle the member of the public: witnessing death in circumstances where death is allegedly caused by clinical negligence is not a vicissitude which individuals can, or should, expect to experience over their life-time.

Second, the majority relied on broad policy arguments, including the risk of encouraging defensive practices. The Supreme Court noted that exposing hospitals to the risk of liability would interfere with decisions about the presence of families with patients at the end of life.[50] Beever and Weinrib argue *any* recourse to policy undermines the coherence of tort because it requires balancing incommensurables and/or otherwise invites unpredictability and inconsistency: namely when and why are policy factors relied on in some cases and not in others?[51] However, more specifically, assertions about undesirable consequences for public bodies and professionals has been strongly discouraged in earlier cases.[52]

In any event, there was a considerable imprecision in the Supreme Court's analysis; it is unclear whether the concern was the risk of undesirable regulation by the NHS Trust (eg unnecessary 'paper trails') or, more narrowly, a risk of interfering with the exercise of judgment by clinicians acting in the best interests of the patient. Wilberg considers that the proper approach to arguments about defensive practices is to focus on the precise 'conflict of duties' which can trigger disproportionate and/or burdensome practices.[53] Either way, the

48 Lord Reed in *Healthcare at Home Limited v The Common Services Agency* [2014] UKSC 49, [2014] 4 All ER 210, paras 1–4.

49 *Paul* (n 1 above) para 139.

50 Ibid para 117.

51 A Beever, *Rediscovering the Law of Negligence* (Hart 2007) 29; E J Weinrib, 'The disintegration of duty' in M Stuart Madden (ed), *Exploring Tort Law* (Cambridge University Press 2005).

52 See the discussion in H Wilberg, 'Defensive practice or conflict of duties? Policy concerns in public authority negligence claims' (2010) 126 Law Quarterly Review 420. See, more generally, the criticism of unanchored policy-based reasoning in *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4.

53 Ibid.

Supreme Court's speculation about defensive practices is vulnerable to critique: for example, the absence of empirical evidence to explain why such defensive practices would materialise and/or an assessment of why more defensive care is undesirable.

Pragmatism also led the Supreme Court to mount the law of secondary victims on the occurrence of an 'accident' – a conclusion that is likely to present an insurmountable barrier to claimants in clinical negligence cases. Errors in diagnosis, treatment or administration of medication would not ordinarily involve an 'accident' in the terminological sense articulated by the Court, and families would often not be physically present when such errors did occur. However, by magnifying the focus on an accident the law remains arbitrary. The accident must be external to the primary victim, but for secondary victims the death or injury to their loved one is an accident because it is 'external' to them. Adopting everyday language, families would consider an avoidable and careless death of a loved one as self-evidently *accidental*. Lord Burrows questioned the majority's arbitrary interpretation of accident: 'what is the justification for adopting that definition of an accident and not another; or, put another way, why do some accidents count and others do not?'[54]

For the majority, an accident now requires a degree of 'violence' which is a term that is highly subjective.[55] On the one hand, the Supreme Court removed the need for sudden shock and/or a horrifying event, but 'sudden' and 'horrific' are descriptors now re-assimilated into the task of identifying a 'violent' accident. Certainly, these descriptors are still 'in-play' given the fact-patterns against which the law has developed.[56] Whilst the Court was clear that adopting a Richter scale of objective 'horror' was not appropriate, one might consider it now replaced by a *de facto* scale of violence in what will require a fact-specific assessment, rather than a binary one.[57]

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54 *Paul* (n 1 above) para 211.

55 Ibid para 24: 'using that term in its ordinary sense to refer to an unexpected and unintended event which causes injury (or a risk of injury) to a victim by violent external means'. By contrast, the dictionary definition of accident does not suggest 'violence' but an unexpected and unintentional incident, typically resulting in damage or injury.

56 Much of the law refers to 'shocking events', and it is clear that in some contexts the term has been used in two senses: a) reference to the nature of the event itself; and b) reference to the event causing or leading to 'nervous shock' on the part of the claimant.

57 It is a fact-specific question whether clinical *incidents* which put primary victims at *risk* of injury could amount to *accidents* (despite recovery being permissible on the basis of placing the primary victim in peril rather than injuring). Without drawing semantic distinctions, the notion of 'incident' is common in health and safety settings and is taken to mean either a 'near-miss' that was unintended or unexpected, and which otherwise could have caused avoidable death or injury.

Thus, there is likely to be a grey band of potential qualifying events yet to be tested in the courts. To illustrate: would the injection of a patient with the wrong drug, or leaving a surgical implement within the patient's body, or errors in the physical handling or movement of the primary victim resulting in falls and impact injuries, or repeated erroneous attempts at invasive procedures (for example intubations, use of forceps), or careless attempts at stemming extreme blood loss now qualify as accidents?[58]

Delineating the scope of duty

Paul concerned a special duty regime on pure psychiatric injury in which the determinative question was the existence of a duty to the secondary victim. Nonetheless, the majority drew upon analysis from *Khan v Meadows*,[59] a case involving the scope of an established duty between a doctor and patient arising from negligent advice (and *Khan* itself incorporated analysis from cases involving the liability of negligent professional advisors for pure economic loss).[60]

Lord Leggatt has previously warned against extrapolating general principles beyond the factual matrix of an appeal and in the absence of oral argument.[61] Universalising general principles of tort across factual categories of cases is fraught with risk given the relevance of specific facts is a matter of discretionary judgment.[62] However, the majority's articulation of the general scope of a doctor's duty is an invitation to critically situate *Paul* against the backdrop of appellate jurisprudence, including those cases that did not concern secondary victims.

In *Khan,* attention fell on the scope of duty towards a patient for a precise risk leading to a particular set of losses. In *Khan*, the purpose for which a doctor was consulted concerned a particular risk in pregnancy (that of a baby born with haemophilia) and, despite their negligent advice, the doctor was not liable for the consequence of an unrelated risk (that of a baby born with autism). *Khan* led the majority in *Paul* to focus on the purpose of the doctor's duty and the risks they are expected to predict or protect against.[63] The scope of duty question

58 For more, see Alex Stutt, 'Secondary victim claims and medical negligence: what is the future after Paul? (Part 1)' (*AnthonyGold* 19 January 2024).

59 *Khan v Meadows* [2021] UKSC 21, [2022] AC 852.

60 *South Australia Asset Management Corporation v York Montague Limited* [1997] AC 191.

61 Lord Leggatt in *Khan* (n 59 above) UKSC para [96]. Lord Leggatt considered that the majority's discussion of the conceptual structure of the tort of negligence was undesirable, unnecessary and went far beyond the issues raised in *Khan* and its twinned case of *Manchester Building Society v Grant Thornton* [2021] UKSC 20, [2021] 3 WLR 81.

62 *Paul* (n 1 above) para 58.

63 *Khan* (n 59 above) UKSC para 28.

was cast in the following way: 'whether a doctor who owes a duty of care to a patient also owes a duty to members of the patient's close family to take care to protect them against the risk of illness from the experience of witnessing the medical crisis of their relative arising from the doctor's negligence'.[64]

The flaw in this approach is that it casts the duty to family members in opposition to that owed to the patient. The Supreme Court's starting point was the narrow duty between doctor and patient and whether it 'stretched' to the patient's family. It was already accepted that any duty to family members was not simply derivative of the duty to the primary victim.[65] In approaching the question in this way there was a lack of contextual and more nuanced analysis of 'doctor–family' relationships, namely the *a priori* independent relationship between clinician and family (or non-patient).[66]

Each factual situation will differ, requiring a fact-sensitive approach. However, developing relationships with families is a daily experience for doctors (especially GPs), nurses and caregivers. Family members fulfil an important function: a therapeutic one for their loved one (particularly 'vulnerable' patients, eg elderly, children, or those with limited agency) and a clinical one for those providing care (eg monitoring symptoms and/or being advocates in articulating the patient's best interests) and even assisting clinical judgment (eg questioning the risks and benefits of interventions). Thus, the scope of a doctor's duty (which is not simply determined by the immediate request of a patient) may also encompass risks that a doctor recognises or ought to recognise, including those risks to the psychological welfare of family members who are in contemplation and proximate in a spatial-temporal sense.[67]

A useful example is maternity services. Fathers are entirely expected witnesses and partake in a non-clinical collective experience of becoming

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64 Ibid para 136.

65 Lord Burrows tentatively suggested that it could be so derived, albeit in the context of the 'no liability for a pure omissions rule': *Paul* (n 1 above) paras 217–218.

66 The majority confined their discussion to only two paragraphs, ibid paras 134–135. However, there were other useful analyses and authorities available including *ABC v St George's University Hospital NHS Trust (ABC)* [2020] EWHC 455 (QB). See also R Mulheron, *Medical Negligence: Non-Patient and Third Party Claims* (Ashgate 2010) 265–296.

67 See Lord Leggatt in *Khan* (n 59 above) UKSC para 84. This is not to argue that family members are primary victims but that such categorisation poses significant difficulties. Mulheron argues that the dichotomy between primary and secondary victim status is opaque in cases of clinical negligence. In earlier cases families did not succeed in arguing they were a primary victim. See Mulheron (n 66 above) 282.

a parent alongside the patient mother. In May 2024, a report into birth trauma recognised that clinicians ought to demonstrate increased regard towards partners, not least given the psychological impact of traumatic birth injuries on partners who are helpless witnesses unable to avert the course of negligent events.[68] Before the decision in *Paul*, there had been successful claims and/or agreed settlements in the context of neonatal deaths and/or birth injuries (eg where a father raised repeated concerns about treatment and care which were dismissed by midwives and who later suffered psychiatric injury after witnessing his new-born baby daughter die).[69] Since the decision in *Paul*, similar cases brought by parents have now been abandoned.[70]

On one view, the decision in *Paul* is incongruent with existing practice, codes of professional conduct and the momentum within the NHS to protect and elevate family members.[71] In April 2024, this momentum led to the introduction of 'Martha's Rule' which gives families the *right* to a second opinion from independent medics if they consider the patient to be deteriorating and/or feel their concerns are being dismissed by the treating team, which, in essence, is a right to invite an alternative diagnosis and treatment plan.[72] As the NHS notes, parents know their child-patients best and clinical staff will be required to note changes in their condition when reported by family members.[73] Zooming out, the decision is also uncomfortably juxtaposed to the exposure of systemic failures in NHS care, such as those in maternity services and various statutory inquiries which have

68 All-Party Parliamentary Group, 'Listen to Mums: Ending the Postcode Lottery on Perinatal Care' (Birth Trauma Inquiry 13 May 2024).

69 Cited in S Lintern, 'Doctors made errors over their daughter's death. Should they be compensated?' *The Times* (London 3 March 2024).

70 See the case of Robert Miller and Katie Fowler reported in 'Royal Sussex: grieving father unlikely to get compensation for baby's death' (*BBC News* 2 February 2024), cited in Lintern (n 69 above).

71 See, indicatively, General Medical Council, *Good Medical Practice* (2024) paras 37–38; Nursing and Midwifery Council, *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* (29 January 2015, updated 10 October 2018).

72 NHS England, 'Martha's Rule'. Martha Mills died in 2021 after developing sepsis in hospital; Martha's family's concerns about her deterioration were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. This rule is having a transformative and life-saving effect: 'Martha's Rule "already saving lives" in NHS hospitals' (17 December 2024).

73 NHS England, 'NHS to "roll-out" Martha's Rule' (*Healthwatch* 21 February 2024).

recommended enhanced recognition of the risk of harm to parents and families.[74]

It is, of course, not the function of the common law to develop in lockstep with regulatory or statutory duties, or custom and practice. These developments serve different policy aims. Tort law (and the provision of corrective justice) is not on the same trajectory. Courts do not have the institutional competence to pursue policy goals but can only proceed by analogical reasoning based on precedent.[75] However, the majority in *Paul* went beyond mere analogical reasoning and took a view on policy when it was arguably not required.[76] The difficulty, as Lord Sales has acknowledged, is the absence of 'a concrete guide' as to when recourse to policy is permissible and when it is not.[77] When judges decide to incrementally update the common law they do so by acknowledging the social and practical context in which the law operates. It is not entirely clear why the majority in *Paul* divined inspiration from their interpretation of policy when, in other significant cases, policy has been entirely relegated.

The decision in *Paul* is on the appellate course set in *Khan*, namely, narrowing the scope of duty by examining the nexus between that scope and the harm. For defendant clinicians, the determination of scope of duty is shaped by the precise purpose which will be governed by the demarcation of professional specialisms. Such an approach is, of course, at odds with patient and family expectations of an overarching duty of doctors to prevent harm and/or that multiple duties of care across specialisms are 'joined-up'. Running *contra* to any sense that family members are vulnerable subjects,[78] the majority's conclusion on the scope of duty allocates (more) risk to claimants despite their reliance on a doctor's expertise. In that respect the Supreme Court

74 See the Ockenden Report: *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Service at the Shrewsbury and Telford Hospital NHS Trust* (Department of Health and Social Care 2022). More obliquely, concerns about culture and systems of safeguarding are likely to be considered by the Thirwall Inquiry which has been established to examine events at the Countess of Chester Hospital following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. Generally, various authors in 'Inquiries in the British Health Service', Martin Powell (ed) (2019) 90(2) (Special Issue) Political Quarterly.

75 See the remarks of Lord Leggatt in *Phillips v Barclays Bank* [2023] UKSC 25, paras 23–24.

76 *Paul* (n 1 above) para 24.

77 Lord Sales, 'Exploring the interface between the common law of tort and statute law' (Annual Richard Davies Lecture for the Personal Injuries Bar Association 29 November 2023).

78 C F Stychin, 'The vulnerable subject of negligence law' (2012) International Journal of Law in Context 337–353; J Stapleton, 'The golden thread at the heart of tort law: protection of the vulnerable' (2003) 24 Australian Bar Review 135–149.

risks a deferential approach by permitting the medical profession to draw or confine the boundaries of duty, albeit that the Court retains its role in determining whether any such duty has been breached.

D v Grampian Health Board illustrates the problem; a case in which Lady Wise, *obiter*, considered that the scope of duty owed by midwives to a mother when in an antenatal ward did not extend to risks to the mother which later materialised during delivery when she was in the care of obstetricians, despite it being known that prompt induction of labour would decrease the risk of harm during labour.[79] Such an approach (where the scope of duty is divisible between specialisms as closely linked as antenatal care and obstetrics) is in conflict with tort's basic purpose of corrective justice.[80]

The scope of whose duty: doctor or NHS Trust?

Questions of scope of duty and assumption of responsibility are dependent on the precise defendant. Doctors do not 'assume responsibility' for families equivalent to their patient (primary victim).[81] That is uncontroversial. Lord Burrows in his dissent postulated that the duty owed by the doctor to the secondary victim could be derivative of the duty owed to the primary victim including the doctor's assumption of care for them.[82] However neat a work-around, that approach risks undermining the primacy of the doctor–patient relationship. There would also be difficulties in the internal coherence of a 'single' duty: that is, where a doctor's duty to act in the patient's best interests conflicted with the duty to families to avoid psychiatric harm.

An alternative approach is to focus on the defendant NHS Trust and whether it directly assumes responsibility to family members

79 *D v Grampian Health Board* [2022] CSOH 63. In this case, the claimant had a traumatic birth and her son was born with severe disabilities. It was alleged midwives in the antenatal ward negligently delayed the induction of labour and, a day later, obstetricians had negligently delayed delivery of the baby on the labour ward. The cause of the injuries was umbilical cord compression triggered by the dramatic pace of labour and it was not disputed that, prior to this point, the baby was uninjured.

80 For a specific discussion of this case (and some of the evidential limitations before Lady Wise), see LawPod, 'Scope of duty since Khan v Meadows' (1 COR 25 January 2024); Julia Dias, 'Scope of duty in 2024: whither Manchester Building Society v Grant Thornton LLP and Meadows v Khan?' (Commercial Court Seminar 2024).

81 *Paul* (n 1 above) paras 217–218.

82 For instance, the standard of care and the resulting breach of the duty of care to the primary victim is the same breach upon which the secondary victim relies. Lord Burrows discussed this in the context of circumventing the rule on pure omissions because, as between the doctor and the secondary victim, there is a pure omission, ie a failure to benefit which would ordinarily rule out any duty at all: *Paul* (n 1 above) paras 218–220.

(unmediated by the at-fault doctor). Trusts are held liable vicariously due to the acts of the individual doctor, but one might consider that the NHS's wider purpose is consistent with a tortious duty owed to secondary victims who suffer psychiatric injury. The scope of the NHS Trust's duty – now encompassing wider obligations towards family members (as discussed above) – is of a different 'width' compared to that of a doctor.

The UKSC in *Darnley v Croydon Health Services NHS Trust*[83] focused squarely on the NHS Trust and held it was an established rule that a patient was owed a duty by the Trust when he presented himself to an A&E Department.[84] In allowing the appellant's appeal, Lord Lloyd-Jones considered the Court of Appeal's concentration on a non-medical member of staff on reception (the tortfeasor who gave misleading information regarding waiting times) to be flawed. The Court of Appeal had earlier concluded there was no general duty upon civilian receptionists (and thus the Trust) to keep patients informed about waiting times.[85] The UKSC clarified that distinguishing the scope of duty based on distinctions between medical and non-medical staff was inappropriate and upheld the established duty on the defendant NHS Trust; a conclusion that did not entirely escape criticism.[86]

Fact-sensitivity is integral to the identification of a duty of care. In *Paul*, the court analysed that the precise facts did not fall under the secondary victim duty as established in the case law. However, there is no universal formula to determine whether a duty exists but only an analogical and incremental approach based on previous established categories.[87] It therefore remains unclear which set of facts determine, first, the scope of any suggested duty and, second, whether that suggested duty qualifies under an established category owed by the

83 *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50; [2018] 3 WLR 1153. This case involved an individual who had suffered a head injury. Seeking treatment, he attended his local A&E where a receptionist then gave him misleading information about the waiting time, indicating that it would take four or five hours (rather than informing him he would be seen within 30 minutes by a triage nurse). Feeling too unwell to wait for hours, the individual left and returned home. He later collapsed, and despite undergoing an emergency operation, he was left with permanent brain damage and paralysis on one side of his body. The evidence suggested that had he been seen in the normal routine way by a triage nurse, he would have been admitted for surgery earlier and would have gone on to make a complete recovery.

84 See C Purshouse, 'The impatient patient and the unreceptive receptionist: *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50' (2019) 27(2) Medical Law Review 318–332.

85 *Darnley* (n 83 above) UKSC paras 11–12.

86 O Thomas KC, in LawPod, 'Darnley v Croydon Health Services NHS Trust' (1 COR 15 October 2018.

87 *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4, para 24.

NHS/hospital. Adapting the facts of *Darnley*, consider a young child admitted to hospital who suffers further injuries arising from not being seen timeously (or at all) by a negligent doctor. Presumably, after *Paul*, the child's mother who then witnesses her child collapse and suffers psychiatric injury would be unable to recover as a secondary victim: the scope of that doctor's duty was to the child alone and, coterminously, she would not be able to recover against the NHS Trust which does not owe a duty to family members directly to avoid psychiatric injury on witnessing the child's injuries.

Clinical negligence claims focus on individual error rather than the system and policies in which such an error occurred. In *Darnley*, attention was placed on the fault of the receptionist rather than the capacity, protocols and departmental arrangements in which patients were registered and triaged. This is not to argue that a direct claim against a Trust for systemic failures is impossible, but that, as Heywood considers in detail, such claims are difficult to mount and thus underutilised.[88] The pursuit of direct claims against the NHS Trust may be the only way that tort can maximise its aims of accountability, deterrence and accident-prevention (and incidentally remove the stigmatisation of individual clinicians).[89]

At present, focus on the at-fault doctor renders the duty question one of interpersonal justice.[90] However, examining the relationship between the claimant and the defendant (ie the NHS Trust) renders the duty question one of distributive justice, namely the allocation of risk among members of a society,[91] which invites a much wider enquiry about who should bear the (economic) loss. Lord Burrows rightly considered this is 'not the type of socio-economic policy argument that the courts are well equipped to assess'.[92]

Debate about non-fault systems of compensation has long been exercising tort scholars, notably after Patrick Atiyah's *Accidents, Compensation and the Law*[93] and the establishment of New Zealand's

88 R Heywood, 'Systemic negligence and NHS hospitals: an underutilised argument' (2021) 32(3) Kings Law Journal 437–465.

89 Ibid.

90 D Campbell, 'Interpersonal justice and actual choice as ways of determining personal injury law and policy' (2015) 35(3) Legal Studies 430–422. Cf A Robertson 'Policy-based reasoning in duty of care cases' (2013) 33 Legal Studies 119–140.

91 A Tettenborn et al (eds), *Clerk and Lindsell on Torts* (Sweet & Maxwell 2023) 1–20.

92 *Paul* (n 1 above) para 249.

93 P Atiyah, *Accidents, Compensation and the Law* (Cambridge University Press 2018 [1970]).

Accident Compensation Commission in 1974.[94] In April 2022, the House of Commons Select Committee on Health revisited no-fault systems in the context of clinical negligence litigation and recommended a move away from an adversarial culture to a learning 'no-blame' culture focused on candour and risk prevention.[95] Economically, payments for clinical negligence in 2022–2023 were almost £2.7 billion with the sum predicted to reach £4.6 billion by the end of this decade.[96] Billions more are already committed in future liabilities. Drawing some inspiration from models in New Zealand and Sweden, the Select Committee suggested that compensation should be awarded where there was agreement as to the failure of procedures and the system, rather than individual negligence. Compensation would be determined by a dispute resolution body and independent investigations would focus on identifying and developing safety recommendations.

It is beyond the scope of this note to develop analysis of these proposals further. The dilemma is how to fairly balance access to justice with improving quality of care and accident prevention. Does an adversarial model complement these outcomes or is it a costly and inefficient means of doing so? Certainly, clinical negligence litigation is imperfect and not a panacea for redress or accident prevention. Expectations of litigation are often unrealistic and undeliverable. Tort has inherent limits; Lord Sumption, delivering a lecture in 2017, argued that tort:

> is an extraordinarily clumsy and inefficient way of dealing with serious cases of personal injury. It often misses the target or hits the wrong target. It makes us no safer while producing undesirable side effects … at disproportionate cost and with altogether excessive delay.[97]

For legislators and policymakers the question posed is: what is the (financial) limit of corrective justice? These are questions that require a wider civic conversation about society's relationship with the NHS

94 New Zealand's Accident Compensation Commission provides universal and compulsory insurance coverage against work and non-work-related injuries on a no-fault basis for everyone in New Zealand with no or very limited rights to sue an 'at-fault' party. See 'Prevention. Care. Recovery: Improving New Zealand's quality of life'.

95 House of Commons Health and Social Care Committee, *NHS Litigation Reform* (April 2022).

96 Ibid.

97 Lord Sumption, 'Abolishing personal injuries law: a project' (Personal Injuries Bar Association Annual Lecture 16 November 2017).

which is currently apt at a time of sweeping reforms promised by the Government.[98]

CONCLUSION

Is the scope of duty principle about the control of liability or, as it ought to be, about the principled assessment of whether care was required? The concept of 'duty' in tort has always been fungible and malleable – able to be cast in various ways – vulnerable to absorbing concerns about negligence at the expense of analysis of other components (eg causation) – or reduced entirely to policy-rooted considerations.[99] None more so was this evident than in the decision in *Paul* which reinforced the view that secondary victims' claims are built on 'a patchwork quilt of distinctions [with] no refined analytical tools which … enable the courts to draw lines by way of compromise solution in a way which is coherent and morally defensible'.[100] Lord Briggs later acknowledged that, as a line drawn by fallible human beings to bring some sense of justice and order, the decision is not too bad.[101] By contrast, Esmee Polmear's father, speaking to *The Times*, viewed the decision as an insult and went on to say, 'the way this court ruling works is that the NHS doesn't have to do anything for people like us, even where they are responsible …. we're not suing them just to get money, we're suing them to get the help we need'.[102]

Rates of trust and satisfaction in the quality of NHS care are declining.[103] Decisions such as the one in *Paul* should amplify debate about reform of clinical negligence and how best to balance redress with public resources. Whether such reform can secure access to justice for claimants *and* improve public confidence in the NHS is a different question.

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98 See, for instance, Lord Darzi, 'Independent investigation of the National Health Service in England' (September 2024) and Department for Health and Social Care, 'Zero tolerance for failure under package of tough NHS reforms' (Press Release 13 November 2024).

99 See D Nolan, 'Varying the standard of care in negligence' (2013) Cambridge Law Journal 651–688.

100 *Frost v Chief Constable of South Yorkshire* [1999] 2 AC 455, at 500.

101 A few weeks after the decision, Lord Briggs delivered a lecture addressing the judgment: see Lord Briggs, 'Liability for mental injury' (Chichester University Lecture 19 January 2024).

102 Lintern (n 69 above).

103 D Campbell, 'Public satisfaction with the NHS at its lowest ever level, poll shows' *The Guardian* (London 27 March 2024); L Buzelli, G Cameron and T Gardner, 'Public perceptions of the NHS and social care: performance, policy and expectations' (The Health Foundation 3 February 2022).