Neutral Citation Number: [1996] EWCA Civ 938
Case No: QBENF 95/0590/C
IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
MANCHESTER DISTRICT REGISTRY
(Mr Justice French)

Royal Courts of Justice
Strand, London WC2

Date: Wednesday, 13th November 1996

B e f o r e :

LORD JUSTICE NOURSE
LORD JUSTICE KENNEDY
LORD JUSTICE BROOKE

	A B & OTHERS	Plaintiffs/Respondents
	-v-	
	(1) TAMESIDE & GLOSSOP HEALTH AUTHORITY (2) TRAFFORD HEALTH AUTHORITY	Defendants/Appellants

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Smith Bernal Reporting Limited
180 Fleet Street London EC4A 2HD
Tel: 0171 831 3183 Fax: 0171 831 8838
(Official Shorthand Writers to the Court)

MR K ARMITAGE QC and MR P HOLMES (instructed by North West Health Legal Services, Manchester) appeared on behalf of the Appellant Defendants.
MR D BRENNAN QC and MR M LAPRELL (instructed by Messrs P M Beever & Co, Ashton-under-Lyne) appeared on behalf of the Respondent Plaintiffs.

J U D G M E N T (As Approved by the Court)

LORD JUSTICE NOURSE: Lord Justice Brooke will deliver the first judgment.

LORD JUSTICE BROOKE: In March 1991 the two defendant health authorities faced the problem of deciding whether, and if so, how, to break the news to their relevant patients or former patients that a health worker who had given obstetric treatment to women patients at both Tameside General Hospital and Trafford General Hospital was HIV positive and that there was a very remote risk of infection from that source. On 31st January 1995 at the Manchester Crown Court after a two-week trial Mr Justice French held that they had both acted in breach of a duty they owed to the plaintiffs in connection with this task, and this is an appeal by the defendants from that judgment. The action was brought by 100 of the 830 patients who had had dealings with the health worker at Tameside and 14 of the 98 Trafford patients.

The judge conducted the trial as to liability only. No evidence was called which bore on the question of the nature and extent of the damage, if any, sustained by any of the individual plaintiffs, apart from the nine of them who gave evidence to the judge, and two other questions remained largely unanswered at the first hearing.

These were, first, whether any act or omission on the part of the defendants increased such shock and distress as was bound to follow the news, however appropriately that news might have been imparted and subsequently dealt with, and if so, to what extent; and secondly, which, if any, of the plaintiffs had suffered such severe shock and distress as could properly be shown to amount to or to have caused psychiatric illness or psychiatric damage. The judge said that for the purposes of the hearing before him counsel had agreed that he should assume for the purposes of his judgment that some damage properly so called had been caused to each plaintiff. This assumption was to be made without prejudice to the defendants' right to contend in due course that no damage recognised by the law had

indeed been sustained. At the hearing of the appeal Mr Armitage told us that he was not aware of any agreement in such terms, but in the result this does not appear to matter for the purposes of this appeal.

I should make it clear at the outset of this judgment that this case breaks no new ground, so far as the law is concerned. I say this although there appears to have been no previous reported English case in which liability in negligence has been imposed on someone for communicating accurate, but distressing, news in a careless manner (see N J Mullany and P R Handford, *Tort Liability for Psychiatric Damage* (1993) pp 183-4). In the present case Mr Armitage conceded both before the judge and before us that a duty to take reasonable care exists where the relevant relationship is between health authorities and their patients and former patients, so that we do not have to decide this point, or to consider whether such a duty exists, or the parameters of that duty, where there is no pre-existing relationship of care.

In the present case, however, a very real difficulty emerged at the trial because of the way the defendants had limited the scope of the witness statements they had served, extremely late, before the trial started. The nature of the allegations of negligence pleaded against them and their pleaded response can be gauged from three sets of the particulars contained in the pleadings.

Statement of Claim (b) "[The defendants] failed to invite each patient to contact a named individual at the respective hospitals who would be qualified to counsel them without initially informing them in the letter that they were at risk of having contracted the HIV virus".

Defence (b) "It is admitted that the proposed choice was not adopted, but denied that the choice made by the defendants was negligent."

Statement of Claim (k) "[The defendants] sent out a letter which was in such terms that it was reasonably foreseeable that a recipient might suffer shock and psychiatric illness as a result." In further particulars it was pleaded that the plaintiffs would contend in

particular that any form of notification where face to face counselling was not available simultaneously with the provision of the factual information was negligent.

Defence (k) "It is denied that it was negligent to send letters so phrased".

Statement of Claim (l) "[The defendants] failed in the alternative to communicate with the patients by inviting their GPs to invite their attendance at his surgery where they could be provided with the relevant information and counselling in circumstances in which the GP could deal with their respective reactions, having himself received advice as to the counselling which may be necessary, and/or by ensuring that GPs visited each of the affected patients to supply them with the relevant information and to counsel them at the time when they received it."

Defence (l) "It is denied that the defendants' chosen method was more likely to cause harm than the method proposed".

It was clear on the pleadings that the defendants were asserting that two choices were open to them, and that they were not negligent to opt for communicating with their patients by letter in the way they did. The plaintiffs, for their part, appeared to be contending that there was only one non-negligent method of handling the situation.

The defendants served their two principal witness statements late: they were not completed until 9th December 1994 and 6th January 1995 respectively, and in each case served shortly thereafter. When they were served, it was found that they did not include any references at all to the practical considerations which had led them to opt for communicating by letter, although their independent witness, Dr Gentle, touched on such issues in his expert witness statement which was served in the second week of January. When the defendants heard the way the plaintiffs put their case in Mr Brennan's opening speech, they then sought to remedy the deficiency by serving, inter alia, supplementary statements by Dr Davies and Dr Hill, their two principal witnesses, at the end of the first week of the trial. On the following Monday the judge ruled that it was now too late for them to seek to adduce this evidence, and the trial thereafter took on a rather unreal aspect, with the defendants' chief witnesses being unable to explain to the judge all the details of the very real practical difficulties which they believed that the method advocated by the plaintiffs would have created, particularly for

Tameside where the numbers were so large. I should observe that this sort of practical problem is likely to increase when the reforms presaged by Lord Woolf's recent Report on *Access to Justice* take effect. It will therefore be incumbent on the parties' lawyers to be even more diligent than they are at present in ensuring that witness statements are in fact served in accordance with the timetable directed by the court, and that they cover all the principal issues that are likely to be material.

The history of this matter starts, as the judge recognised, in the year 1988. In that year a trainee surgeon in Exeter was found to be suffering from AIDS. The names of 269 patients on whom he had operated (or assisted) in the Exeter district were identified; he had come to Exeter from Redditch, and a further 70 such patients were identified there. The judge referred to this episode under the general title `Exeter' since Redditch took the same course by way of informing the relevant patients as Exeter did.

The course adopted by Exeter was to inform the GPs of the relevant patients and to supply them with literature which they should hand on to their individual patients. By this means the patients received the news that there was a remote chance of infection from their GPs face to face. This gave the GPs the chance to offer any necessary counselling and reassurance in the light of their individual patient's reaction.

A fuller account of the Exeter incident was published in the Lancet on 30th January 1990. No formal exercise to evaluate the success or otherwise of the Exeter approach, from the patients' point of view, was ever undertaken, but the judge said that he had been told by one of the defendants' witnesses, Dr Gentle, a consultant in public health medicine in Exeter, that he had the impression that it was a success in that regard. He knew of no adverse reaction and no civil proceedings ever ensued so far as that incident was concerned.

Dr Gentle had also told the judge that there was a relatively small number of patients per GP, and that they had confidence in the quality of all the local GPs, who were all known to at least one of the members of the relevant staff of the health authority, who believed that they would co-operate very well in breaking the news to the patients. Of the 269 patients, 26 were not told at all (on the GPs' advice) and a further 25 were told only by telephone or by letter. Dr Gentle said that the decision to go by the GP route was not an easy one, or an obvious one. All other things being equal, he believed that that route was preferable if it was practical. He said that the number of patients involved can be daunting, and the 269 patients in Exeter had stretched their resources considerably. He commented that those handling the incident in Tameside and Trafford had had to deal with a very large number of patients between them, and this consideration must have a considerable bearing on the selection of the approach to be used.

On 7th March 1991 the Director of Public Health for the second defendants ("Trafford"), Dr Jennifer Hill, received a telephone call from the Government's Deputy Chief Medical Officer informing her that an HIV infected health worker had worked at Trafford in the field of obstetrics and gynaecology. On the same day this news was passed on to Dr. Alun Davies, who was then the consultant in communicable disease control for the first defendants ("Tameside"). A meeting took place at the Department of Health ("DOH") four days later, which was attended by appropriate representatives from Tameside, Trafford and West Suffolk Health Authorities, and was chaired by Sir Donald Acheson, the Chief Medical Officer at the Department. The West Suffolk authority faced the same problem as the other two, but it is not involved in these proceedings.

It was decided in principle that on the grounds of "openness" and "right to know" patients should be told about this health worker, despite the remoteness of any risk, and that they should be offered counselling and/or blood-testing. It was decided to work towards posting letters to the relevant patients by first class post by noon on Monday 8th April 1991, by which time the authorities would

have had time to identify all the patients who needed to be told, and that a meeting should be held with the press on 9th April, the day on which the letters should have reached the recipients. Easter was early that year, and this Monday and Tuesday were chosen because the patients and their GPs were unlikely to be away on holiday then. GPs were to be sent letters which were designed to reach them on Saturday 6th April 1991, telling them what was afoot and giving them copies of the letter which was to be sent to the patients. The GPs were also to be sent "action sheets" and a "question and answer briefing" to help them in dealing with anxious patients. They were asked to tell Dr Davies or Dr Hill, as the case might be, if they, the GPs, knew of any reason why they should not send the standard form of letter to any particular patient.

Although these matters were canvassed on llth March, this was an exploratory meeting, and the arrangements did not crystallise until a further meeting had been held on 14th March. Among those in attendance at this second meeting were Dr Davies and Dr Hill, members of the DOH's AIDS Unit, and Dr Gentle from Exeter. It was at this meeting that the decision to inform the patients by letter, generally speaking, rather than face to face, was finally taken. The DOH had produced first drafts of suggested letters to patients, and its approval was required for the final drafts of the documents that were to be used. At this stage Tameside thought that between 400 and 500 of its patients were involved. Both Dr Hill and Dr Davies told the judge that the DOH's team had taken the lead in steering them towards the method of passing the information to patients which was in fact selected. The need to preserve the confidentiality of the health worker was one important consideration. Another was the need to synchronise the exercise being carried out in two such widely separated parts of the country as Manchester and Suffolk.

Due to no fault on the part of the defendants there was a leak to the media on 6th April about the HIV health worker and about Trafford’s plans for dealing with the matter. This resulted in articles being published in two Sunday newspapers the following day and a news item being broadcast on the

television news bulletins that day. Dr Hill had asked the Sunday Times journalist not to publish the story he had picked up because it would cause quite unnecessary worry to local people at a time when telephone helplines would not be available, but this appeal went unheeded. As might have been expected, quite a number of the patients who were to receive letters on the Tuesday heard the broadcast. Some of the plaintiffs experienced a sense of foreboding from hearing it, and the judge found that the impact of the letters on the recipients, or some of them, may well have been intensified as a consequence.

The letters sent out to the patients were in almost identical terms. The letter sent by Trafford to the patients with whom they were concerned, which included details of the telephone numbers which patients were encouraged to contact, was in these terms:

> "Dear (Blank),
> I am writing to inform you that a health worker who was involved in caring for you in the obstetric and gynaecology department at Trafford General Hospital in 1990 has recently been found to be infected with the Human Immune Deficiency Virus, the virus that causes AIDS. I would like to stress that the possibility of a health worker infecting any patient is extremely remote. Despite this reassurance I realise that this information may be worrying and you may wish to seek further advice, counselling and possibly a test. If you wish to discuss this matter please telephone our local counselling service for information... If your call is not answered immediately or the line is engaged, please keep ringing. Alternatively you may call...
>
> I have written in confidence to your GP about this matter and you may wish to contact him/her. The Department of Health has made arrangements for a special phone line at the National AIDS Help Line. Here you will receive confidential counselling and advice from expert advisors. The service is free and will operate between 10 a.m. and 10 p.m. The number is... If you receive no reply you may call the National Help Line number which operates at all times. The number is.. ."

There was a final paragraph in the Trafford letters, which were signed by Dr Hill. This read:

> "I would like to be sure that you received this letter.
> Would you please sign the attached form and return it to me in the envelope provided.
> Yours sincerely,"

Another distinction between the two letters was that, whereas the envelopes containing the Trafford letter were marked `Private and Confidential', those containing the Tameside letters were not so marked.

The main thrust of the plaintiffs' claim was that it was reasonably foreseeable that a recipient of a letter sent out in such terms might suffer shock and psychiatric illness as a result.

This complaint referred to the entirety of the letters. In particular, as I have already said, it was the plaintiffs' case that any form of notification where face to face counselling was not available simultaneously with the provision of the factual information was negligent.

In his short judgment the judge cited brief extracts from the evidence of each of the expert witnesses who gave evidence to him. The plaintiffs called two expert witnesses, Professor Pinching, who is an immunologist, and Dr Catalan, who is a psychiatrist. The passage from Professor Pinching's evidence which the judge selected was in these terms:

> "In my opinion the health authority, through the director of public health, should have insisted that the GPs relay the information in person (preferably through a home visit) or on an alternative face to face discussion with a suitably qualified and trained health professional. The GP could have been asked to make a home visit on the weekend, selected before the general publicity. This could have been synchronised with others given the time available for preparation and the fact that GPs' whereabouts had already been determined. If home visits were not used then face to face information and initial counselling could have followed a non-specific letter inviting the patient to come forward, for example, for a check up relating to their recent surgery or some similar pretext."

The judge quoted Dr Catalan as saying:

> "Insensitive handling of information about the possible risk of HIV infection can lead to substantial adverse psychological and social consequences to vulnerable individuals ...
>
> In the short-term it is likely that most plaintiffs experienced, on receiving the letters, marked feelings of shock, distress, tearfulness, disbelief and fear leading to impairment in their everyday life, work and social relations for a substantial minority. The statements provided by the plaintiffs clearly indicate that such

> short-term problems occurred and that in some cases they were of severe magnitude."

The judge then quoted very short extracts from the evidence given by the four experienced medical witnesses who gave evidence for the defendants. Dr Davies is quoted as saying:

> "In principle patients' best interests may well have been served by being informed by her GP."

Dr Hill said:

> "As to foreseeable risk of distress, I would hope there would be minimal risk of psychiatric disturbance having regard to the measures taken. It would be a shock. Fear, confusion and irrationality, would be present in some cases. One should communicate in the best way possible. In the majority of cases GP or counsellor would be the best to impart information of bad news face to face."

Dr Catherine Quigley, who was Trafford's consultant in communicable disease control, said:

> "Fundamental to the outcome in these cases is the method in which communication, at the outset, is made. If the initial approach is not the best then it will cause additional stress in principle. The initial contact should be face to face."

Dr Gentle, for his part, said:

> "The advantages of face to face imparting of news is a major consideration. There is foreseeable risk that some patients might be distressed and undergo psychiatric disturbance from sending such letters."

After reciting these extracts from the evidence the judge said that he concluded that the defendants did not exercise due care. He said that they should have realised that the best method of informing a patient of the risk of HIV or AIDS, even though the risk might be very remote, was face to face through the agency of the patient's GP or other experienced health worker, and that to give this information by letter carried a foreseeable risk that some vulnerable individuals might suffer psychiatric injury going beyond the shock and distress which was natural and foreseeable in all or most individuals. He rejected certain ancillary complaints which the plaintiffs had made. These related to counselling, the provision of premises which were allegedly inappropriate for the purposes of

counselling, blood-testing and other related matters. I will return to the judge's treatment of those complaints when I consider the issues raised in the plaintiffs' cross-appeal.

At the end of his judgment the judge said he wanted to make it clear that the defendants supposed, albeit wrongly, as they should have realised, that they were taking the course least damaging to the plaintiffs, and that they were to some extent steered in the wrong direction by the DOH. He added that those acting on behalf of the defendants had shown exemplary dedication despite the fact that it was not applied in the direction which stood the best chance of mitigating or eliminating damage to the patients.

On the hearing of the appeal the defendants contended that there was a great deal of relevant factual evidence before the judge which he had either ignored or to which he gave insufficient weight. The evidence can be conveniently categorised as the Exeter evidence, the numbers and logistics evidence and the EAGA evidence.

So far as the Exeter evidence is concerned, the defendants challenge the importance the judge appeared to have attached to the Exeter incident. He appears to have regarded Exeter as a successful use of GPs, whereas the defendants submit that the evidence was neutral in its effect, and that the judge overlooked important parts of Dr Gentle's evidence. For instance, in addition to the evidence I have already recorded, Dr Gentle had said that GPs did not necessarily provide first instance face to face contact. Of 257 patients 10% were not told at all, 7% received only a letter, 2.7% received a telephone call, and 206 (80%) were visited. Dr Gentle had told the judge that although the success of the exercise was not evaluated, the modest feedback from GPs indicated some distress, some reassurance (after receiving the news through the media) and some potential psychiatric injury. He said that even 269 patients had caused great difficulties for Exeter.

Mr Brennan submitted that Dr Gentle's evidence was not neutral -Dr Gentle was brought in because he was the only director of public health with experience of such an exercise prior to the one in Trafford and Tameside. He had explained to the judge how the exercise was done in Exeter. There was no evidence of any adverse reaction and it was accepted by the defendants' own witnesses that in principle it was preferable to inform the patients face to face. Despite that, they did their exercise in a different way without any explanation as to why. The distinctions the defendants sought to make between this case and the incident in Exeter were not justified. Numbers, he submitted, are irrelevant: it is the proportion of counsellors to patients which is material, and there was no evidence before the judge of the Tameside GPs' competence or otherwise, and no evidence on which the judge could have properly based a finding that the GPs in the Exeter area were better than those in Tameside and Trafford.

It appears to me that there is force in Mr Armitage's criticism. The judge ought to have taken into account all the evidence he heard about the Exeter incident before adopting it as a model of what the defendants ought to have done in the very different circumstances which confronted them. The fact that there was no evidence of the Tameside GPs' competence or otherwise arose from the artificial circumstances in which the case was tried, and there was certainly sufficient evidence of a substantial numbers and logistics problem, to which I now turn, to show the judge that the situation in Tameside and Trafford in 1991 was markedly different from the situation which faced Dr Gentle and his colleagues in Exeter in 1988.

So far as numbers and logistics are concerned, Mr Armitage submitted that there were ten matters which were fairly and squarely in evidence before the judge which he should have taken into account when arriving at his judgment in this case:

> (1) The number of patients at Tameside was large, about three times the size of the 1988 Exeter group; (2) The number of relevant Tameside GPs was large; (3) The ratio of patients to GPs varied, a number of GPs having only one patient, and others having 20 or more;

(4) The state of the GPs' knowledge of HIV and AIDS counselling, and thus the scale of the possible training requirement, was unknown, whereas the defendants were able to assemble teams of specialists in the counselling of HIV/AIDS victims from within their own resources, without arousing suspicion, before the date chosen to go public; (5) The difficulty of persuading or training all the relevant GPs to act in a co-ordinated manner in so large an enterprise; (6) The need for a co-ordinated strategy by three distinct health authorities, one of them many miles away; (7) The shortness of the time available to prepare the exercise before the existence of the risk became public knowledge; (8) The problems likely to be encountered by GPs or counsellors who were required to visit former patients without appointment and/or on a pretext, associated with the disadvantages of requiring former patients to attend GPs or clinics on a pretext; (9) The evidence before the judge that interventions by GPs were not demonstrably more successful than the approach by letter in six instances, which are among the "lead" cases; (10) The fact that the provision of accurate information by letter was only the initial step in the co-ordinated provision of telephone helplines, counselling and testing, as to which the judge dismissed the plaintiffs' complaints.

Mr Armitage submitted that any method of dealing with the relevant problem would have strong critics, and that in 1991, as Professor Pinching accepted, there was minimal previous experience of such exercises.

He went on to submit that Professor Pinching's evidence about the way in which Tameside might have ensured the effective co-operation and training of 120 or more GPs was wholly unrealistic, and that this demonstrated that the professor was approaching the problem on a theoretical rather than a practical basis. The professor had assumed an even spread of patients per GP, instead of the wide variations that in fact existed. He had started by envisaging that the health authority could summon all the

relevant GPs, under conditions of complete confidentiality, to a single meeting over the weekend before the news broke. At this meeting they would be given the necessary information packs and also taught how to break the news sensitively to the patients. He later conceded that it might be necessary to have several meetings, but he confessed he had no personal experience of handling GPs in this way, and he appreciated that individual GPs would not feel comfortable with the role allotted to them. He believed, however, that the public health director could quite reasonably expect GPs, as the focus of care of these patients, to take this responsibility on and act in a synchronised manner. Mr Armitage observed that Professor Pinching's belief that so many GPs would all maintain the necessary confidentiality was belied in the event by the authority's firm belief that it was a Trafford GP who had leaked the news to the press shortly after the GPs received their briefing instructions on Saturday 6th April.

On the basis of all this evidence Mr Armitage argued that there could be reasonable disagreement about the risks of the route the defendants decided to take, and that in the circumstances it was not demonstrably so inferior to the theoretically preferred route as to be a negligent choice. He observed that the large number of plaintiffs in the present action (in contrast with West Suffolk) was probably explicable on the basis of a solicitor's advertisement in the press and the publicity given to these group proceedings by the media.

Mr Brennan's response to all this depended largely on his endeavouring to show us that some of the evidence on which Mr Armitage sought to rely was not before the judge properly, or at all, because of the ruling the judge had made on the fifth morning of the trial. I accept this submission to the extent that it was not open to the judge for this reason to consider Dr Davies's qualms about the competence of a significant number of the local GPs to carry out the sensitive duties which would have been required of them, but in my judgment it was certainly open to the judge to take into account all the evidence I have listed. He ought to have taken it into account, and he failed to do so.

I turn now to what I have called the "EAGA" evidence. This arises in this way. Before the trial took place in January 1995, a publication called "Practical Guidance on Notifying Patients" had been issued by DOH in April 1993 with the endorsement of the Department's Expert Advisory Group on AIDS ("EAGA"). Professor Pinching had been a member of this Group, although he had resigned at the end of 1992 and had been a strong dissenter on one particular issue while consultation had been taking place. Nonetheless he told the judge that he accepted that the guidance commanded the support of responsible well informed people concerned with the question of HIV infection.

The relevance of this guidance is that whereas its authors accepted that as a general principle it is preferable for patients to be personally contacted by a counsellor, health advisor or other relevant professional before a press announcement is made, other methods of information would be necessary in "large-scale look-back exercises where it is not possible to personally contact patients". Professor Pinching had no difficulty with two of the recommendations made under this rubric but he strongly dissented from the first, which was "writing to patients". Mr Brennan accepted that the suggested draft letter to patients which is published in an annex to this document was in all material respects identical to that in fact sent to Trafford and Tameside's patients, in accordance with DOH guidance, in 1991.

There was available to the judge very little evidence about the state of professional opinion on this topic in 1991. In this country there had only previously been the Exeter incident, which had been reported very briefly in the Lancet. This provided a starting point, and the defendants had obtained the advice of one of the consultants who had handled that incident. Professor Pinching himself accepted that there was at that time no published guidance available to the defendants. In these circumstances, in my judgment, the evidence relating to the EAGA documents ought to have told the judge two things. First, that even after what happened at Tameside and Trafford in 1991 this expert body remained of

the view that it was appropriate to recommend the course which was in fact adopted there as one of the options to be considered by a health authority confronted with a similar large-scale information exercise. And secondly, that Professor Pinching had apparently found himself in a dissenting minority amongst a group of expert Government advisers when he was advancing in 1992 the identical philosophy to that which he advanced to the judge two years later - viz that even in a large-scale exercise, to inform patients by letter was not only not to be recommended: it was positively negligent. The judge does not appear to have taken either of these considerations into account.

The defendants' final complaint related to the judge's treatment of the "expert" evidence. They complain that the judge ignored the facts of the case and decided the issue as a matter of principle only. He adopted opinions expressed in Professor Pinching's and Dr Catalan's reports without regard to the facts of the case, and he attached too much weight to, or allowed himself to be misled by, answers given under cross-examination by the defendants' witnesses when they were dealing with a theoretical ideal rather than with what was a practical response to the very real problems with which they had actually had to deal. His review of their evidence was therefore very restricted.

Mr Armitage showed us passages in the evidence which illustrated the point he sought to advance. Dr Davies, for example, had told the judge that on earlier occasions when he had been confronted with infectious diseases of equal magnitude, the relevant information was passed by letter, and that this was a well tried public health method of contacting patients who were possibly at risk from infection. He quoted in this context two incidents nine years apart at a secondary modern school with 800 pupils where there had been a case of infectious tuberculosis. He had then mentioned another school incident involving diphtheria, where two schools were involved and more than 20 people were admitted to hospital, and an incident involving food poisoning at a wedding reception, when all the people at risk had had to be identified and informed.

Dr Davies had said he could foresee worry on the part of the recipients whichever method was used. For this reason he had discussed the matter with the chairman of his psychiatric division shortly after the second London meeting, who had consulted his colleagues before reporting that he fully agreed with the method of imparting information which Tameside intended to use, provided that the GPs were given the opportunity to stop the sending of particular letters in the case of known psychiatric patients or patients they thought should not be informed by this method.

Dr Davies had attempted to tell the judge that if he could have guaranteed a suitable response from all the GPs involved, the suggestions made by Dr Catalan, the plaintiffs' psychiatric expert witness, might have been reasonable, but this answer fell into the category of evidence the judge had ruled inadmissible. He had earlier told the judge that there were about 140 GPs involved, scattered across Tameside and four neighbouring areas. 30 of them only had one relevant patient, while others had over 20, the largest number of patients for a single GP being 23. He said that when they took the decision to communicate to patients by letter, they knew of the possible scale of the situation that confronted them, although it was not until later that variations in the quality and dependability of the GPs in his area became evident.

Dr Hill, for her part, had qualified the statement the judge had quoted. She had said that one cannot generalise, and to say that the best way of communicating these matters would have been through a GP or trained counsellor was to make assumptions about both the giver of the information and its recipient, and that human beings vary. She had also pointed out that personal contact had not prevented patients from becoming plaintiffs: four of the 14 Trafford plaintiffs fell into this category.

So far as Dr Quigley was concerned, she had made a reference to the difference between principle and practice which the judge did not mention. And, finally, the similar exercise Dr Gentle had conducted at Exeter in 1988 had been much smaller, and the judge ignored Dr Gentle's earlier answers dealing

with the practicality of communicating through GPs if the numbers were so much greater than they had had to cope with in Exeter, and the quality of all the relevant GPs was not well known.

In my judgment these criticisms are well founded.

So much for the facts. I turn now to the law. Mr Armitage argued that the judge applied the wrong standard of care, and that the standard he applied required the defendants to use the "best method" without regard to the circumstances. This was an action in negligence against two health authorities acting by their professional (medical) employees in relation to their patients or former patients. The existence of a duty of care was admitted, and Mr Armitage submitted that the relevant standard of care was to take reasonable care in all the circumstances of the case. He argued that the legal concept of negligence requires that relevant acts or omissions should be judged in the particular circumstances of the particular case: see *A C Billings and Sons Ltd v Riden* [1958] AC 240 (HL) per Lord Reid at pp 250 and 257, and per Lord Somervell of Harrow at p 264; and see, too, McNair J's well-known charge to the jury in *Bolam v Friern HMC* [1957] 1 WLR 582, where at p 586 he defined the general duty before he went on to deal with its application to special skills:

> "In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or in the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action".

Mr Armitage then submitted that the standard which should have been applied was what he called the modified standard required of those who profess special competence (in this case public health medical practitioners), that is to say the standard of the ordinary skilled practitioner in that field, gauged by the approbation of a responsible or respectable body of (professional) opinion. See *Whitehouse v Jordan* [1981] 1 WLR 246 (HL) per Lord Edmund-Davies at p 258 B-C; and *Maynard v West Midlands RHA* [1984] 1 WLR 634 per Lord Scarman at pp 637 H to 638 B (approving *Bolam*) and at 638 H ("There is seldom any one answer exclusive of all others to problems of professional judgment").

Mr Brennan, for his part, responded that since the defendants admitted that they owed a duty of care to the plaintiffs and that the discharge of their duty involved the need to inform the plaintiffs of the fact that they had been treated by a health care worker who had proved to be HIV positive, they were obliged to convey the information to the plaintiffs in such a way as to reduce the foreseeable risk of harm to the plaintiffs to a minimum. This, he submitted, represents the standard duty of care, and this was in fact the standard of care which the judge applied. The taking of reasonable care in all the circumstances of the case required the defendants to have regard to three matters: the admitted and known foreseeable risk that some of the patients might suffer shock and/or psychiatric injury upon receipt of the information; their knowledge that if there was no one present to allay the patients' fears and to offer counselling on the receipt of the information which they had to impart, then the foreseeable risk of such shock and injury would be greater; and the fact that there were two possible methods of giving the information, namely in writing or by face to face communication, and that only one of those methods would hold out the possibility of allaying the recipients' fears and of offering counselling at the place and time when the information was conveyed.

Mr Brennan therefore argued that the defendants' duty was to convey the information to the patients by the method most likely to reduce the foreseeable risk of harm to the patients to a minimum, unless they could establish that there were other circumstances which constituted a good reason, when placed in the balance, to justify the increased foreseeable risk of causing personal injury to the patients which would be caused if they adopted the method they in fact chose.

In my judgment, once the defendants had decided to inform their patients at all, they were under a duty to take such steps to inform them as were reasonable, having regard both to the foreseeable risk that some of them might suffer psychiatric injury (or any existing psychiatric injury might be materially aggravated) upon receipt of the information and to all the other circumstances of the case. This is not

a situation in which it is particularly useful for a court to investigate the previous practices of reasonably competent practitioners when handling a similar situation. With the single exception of the Exeter incident there had been no previous experience in this country, and the evidence showed that the nature of people's irrational concerns, anxieties and ignorance about HIV and AIDS is, and certainly was in April 1991, to a great extent sui generis. On the one hand, therefore, the judge was in my judgment wrong to hold that the defendants were negligent because they did not select the best method. On the other hand, I consider that in the particular circumstances of the present case Mr Armitage is confining the freedom of the court too narrowly when he cites the *Bolam* test as providing the solution because there simply was no adequate well of professional experience on which the court could usefully draw in the present case. In such a case the judge has to perform the familiar role of considering the factual evidence carefully, listening to the expert evidence, and forming a view as to whether in all the circumstances these public health authorities fell below the standards reasonably to be expected of them when they selected their preferred method of communicating the information to the patients.

Before leaving this topic it is necessary to add two further comments. In *Page v Smith* [1996] 1 AC 155 the House of Lords has authoritatively established that a cause of action in negligence may lie when a primary victim in a traumatic accident case suffers psychiatric illness or injury with no concomitant physical injury. In the present case Mr Armitage did not seek to reply to Mr Brennan's contention that the plaintiffs should be regarded as primary victims (so that the additional ingredient of "nervous shock" is not requisite: see Lord Lloyd of Berwick at p 187E), although this point may have to be considered carefully on some future occasion when that issue is fully argued in a case involving the negligent communication of accurate but frightening information and when the evidence about the relevant psychiatric injury and its trigger mechanisms is before the court, as it was not in the present case. But whatever the aetiology of the psychiatric injury or illness - and the damage may consist of the material aggravation of a pre-existing illness - it must be properly classified as a psychiatric injury

or illness (see a clear exposition of the present state of medical thinking on this topic in Part III of the Law Commission's Consultation Paper No 137 (1995), *Liability for Psychiatric Illness*, cited by Lord Browne-Wilkinson in a different context in ***Page v Smith*** at p 182A). I mention this fact because in my judgment both plaintiffs' advisers and legal aid authorities will need to identify evidence of a psychiatric illness or injury properly so called before people who have suffered distress as a result of being told some worrying piece of news in an incompetent manner are permitted or encouraged to embark on litigation which may be doomed to failure from the start, and which may only serve to increase their distress.

The other comment I have to make is that I reject one element of Mr Armitage's submissions, which he did not strongly press before us. He submitted that the central question was how a court could decide whether nervous shock was foreseeable in the absence of a test of susceptibility, more particularly where susceptibility arguably depended upon the circumstances in which and/or method by which the shock is administered. In the present case the defendants had taken reasonable steps designed to exclude vulnerable patients from the main system selected for breaking the news (whereby the first contact was by letter), by requesting GPs to vet and exclude particular patients before the letters were posted. In those circumstances he submitted that their duty thereafter was to people of ordinary fortitude, and for this limited purpose the majority opinions in ***Page*** could be distinguished. While considerations of this nature may have to be borne in mind on some future occasion, when a judge has the opportunity of considering all the circumstances of the case before him, including the likely trigger mechanisms of the psychiatric injury complained of, the system of vetting in this case was so hurried and unsophisticated that the defendants would not, in my judgment, have succeeded in any event on an argument like this. As it was, there simply was not the material before us on which we could properly have embarked on any useful examination of the distinction between primary victims and secondary victims in a "negligent communication" case.

When the appropriate legal test is applied to the totality of the factual evidence the judge should have taken into account, the only possible conclusion, in my judgment, is that the defendants were not negligent in deciding to break the news in the way they did. I would therefore allow this appeal.

I turn now to the issues which arise on the plaintiffs' cross-appeal. A large number of the plaintiffs had been very upset by the way they had been treated either by those who were manning the telephone helplines or by different features of the way the counselling and blood-testing had been conducted. Their solicitors had prepared brief witness statements, which were signed by each of the plaintiffs. These set out the complaints which each plaintiff made about the way she had been treated: a large number of the complaints recurred in more than one statement. On 5th December 1994 the district judge directed the plaintiffs to select up to 20 specimen cases to be tried on the issue of liability. Their witness statements were to be served before Christmas with the defendants being afforded the opportunity to serve statements of evidence in reply by 6th January.

In the event the judge heard evidence from nine of the plaintiffs. He did not always hear the defendants' evidence in reply to an actual complaint, because some of the relevant evidence was among the very late statements which he refused to admit on the fifth day of the trial. He did, however, hear from the defendants' principal witnesses, Mrs Munroe from Tameside and Dr Hill and Dr Quigley from Trafford, about the arrangements they had made and about their general answers to the criticisms advanced by the individual plaintiffs.

Although the evidence given by the nine plaintiffs alone lasted for more than two and a half days, the judge did not describe any of it in his judgment in which he dismissed their "ancillary complaints" in a single sentence, saying that these complaints were not made out on the balance of probabilities.

In their cross-appeal the plaintiffs have, not surprisingly, complained about the fact that the judge gave no reasons for his decision that there was no breach of any duty owed in respect of counselling. They then go on to complain in detail about the deficiencies in the defendants' counselling arrangements which the judge ought to have found. In particular, Mr Brennan argued that the judge ought to have found that the defendants should have (i) established a "helpline" which gave help in the sense of counselling rather than information and/or a referral for counselling and/or a HIV test; (ii) thereafter arranged face to face counselling by trained and competent staff forthwith; (iii) offered to carry out an HIV test and counselled the patients with regard to it; (iv) provided to the patients who chose to have an HIV test the result of the test face to face, and then offered them post-test counselling; and (v) carried out these steps in an atmosphere and, where applicable, a location which was conducive to successful counselling taking place. If the judge had analysed the defendants' duties in this way, he went on to argue that on the evidence he should have found that the defendants were in breach of all of them.

In his skeleton argument, which contained no cross-references to any passages in the transcript of the evidence to which he wished us to refer, Mr Brennan contended that his general allegations about the nature of the defendants' counselling duties were not challenged by the defendants except in relation to the method of communication of the information. As to the particular allegations, he said:

(i) the defendants did not dispute that there was a duty to take the step of establishing a "help line" but there was an issue as to whether this was in fact done and to what standard: in the absence of direct evidence from the people who counselled the nine plaintiffs who were called to give evidence, there was no evidence to contradict the plaintiffs' evidence;

(ii) the evidence from the nine plaintiffs was unanimously to the effect that there was either no counselling at all or that it did not take place forthwith;

(iii) the evidence from these plaintiffs was that there was no counselling in relation to HIV tests, and no direct evidence to the contrary from those alleged to have dealt with those plaintiffs was given;

(iv) it was accepted by Tameside, at least, that there was no post-test counselling, despite the concession made in the evidence that in other circumstances at least one of the defendants would have undertaken post-test counselling after any standard HIV test;

(v) the principle that the atmosphere and location of HIV counselling was important was accepted by the defendants.

Mr Brennan went on to contend that the evidence was overwhelmingly in favour of the contention that the defendants had acted in breach of duty in all these respects.

He said that, having regard to the weight of the evidence, there was no need for a new trial. He therefore invited the court to find for the plaintiffs on these issues from the evidence given at the trial.

In his oral submissions on these issues he was content to rely on the evidence about post-test counselling at Tameside as affording the clearest evidence of the strength of his complaints. The essence of his complaint here was that even if the patients' tests were negative, as they all proved to be, they should not have been given the results over the telephone, but in a face to face situation which would have enable them to raise any residual doubts, fears and concerns they might have had and to accept the opportunity of receiving appropriate counselling.

In advancing this contention Mr Brennan relied not only on the evidence of Professor Pinching and Dr Catalan, but also on the evidence of Trafford's responsible officers, Dr Hill and Dr Quigley. 38 of Trafford's 52 patients who had had tests received the results of their tests either face to face at hospital

or at home (the others gave good reasons for being content to receive the results over the telephone), and both Dr Hill and Dr Quigley said they believed post-test counselling was important. In contrast less than 10 of the 216 Tameside patients who were tested at the hospital received their results face to face, accompanied by an offer of counselling: Mrs Munroe did not know what the position was in relation to the 73 Tameside patients who had had their blood tested by their GPs.

In answer to this particular submission, Mr Armitage took us through the evidence adduced to the judge on behalf of Tameside. It was along the following lines. Their counselling team was led by Mrs Munroe, who is a very experienced counsellor who had undergone specialist training in HIV/AIDS counselling. Since 1986 she had been running an HIV/AIDS helpline for people in the Tameside area, and since 1988 she had been in charge of Tameside's HIV/AIDS counselling and testing services which she conducted from a designated health centre in Mossley. Her duties included the organisation of two-day training courses in this specialist field for members of the authority's professional staff.

When the present emergency arose, she was appointed to run the helpline, counselling and testing service. For this purpose she picked a team of female health care professionals, all of whom had attended at least one of her training courses, and invited them to attend a refresher course (of a type which was held regularly) in early April, when she warned them that Tameside and other authorities were about to embark on an intense information-giving exercise on HIV/AIDS. She was able to give them the documentation they needed without breaking the confidentiality of the actual exercise on which they were about to embark.

Her team was to be located in a prefabricated building which had been previously used as a psychiatric outpatients' clinic, in the grounds of Tameside General Hospital: the judge was shown photographs of the counselling rooms and members of the counselling team. There was a great anxiety that the

patients' confidentiality might be breached by the media, and for this purpose the old sign was left up while a small discreet notice "Telephone Advice Centre" was erected outside. Admission was strictly controlled by a hospital porter who kept the door locked in the interests of security. The premises were cleaned and furnished and equipped with an appropriate number of telephone lines. (The plaintiffs' more evaluative description of the premises was "a hurriedly commissioned portakabin marked `Psychiatric Out-Patients' and known internally as `Shanty Town', with a guard on the door and with patients locked in.")

Mrs Munroe told the judge how the telephone helplines were staffed during the busy period for 12 hours a day from 8am onwards, and how the counsellors saw an average of 40 patients each day. She said that half of those who attended did not want counselling but simply wanted the blood test. She observed that counselling cannot be imposed on anybody who does not want it, and she explained to the judge the techniques that HIV counsellors use to assist people with their confused irrational fears of HIV and AIDS and how they might have become involved. She explained that some of the women were deeply distressed and needed a substantial period of time with a counsellor, while others had unconnected problems which they wished to talk through. A lot of the patients were very anxious to find out who the health worker was and how he or she had got infected, and a lot of them were angry. They were angry with the health worker, angry with the counsellors as representatives of the health worker's employers, or angry with their GP if they were told by the GP it was the hospital's problem.

After they had given their blood, the patients were told to telephone after 48 hours to ascertain the result, or to leave a telephone number so that they could be contacted if the result came through more quickly. She said that most of them preferred to be told by telephone in order to avoid the inconvenience of coming back to the hospital, and less than 10 of those tested at the hospital were told of the test result face to face. She said it was implicit that counselling continued to be on offer,

because her regular unit's HIV counselling helpline was a regular feature of Tameside's arrangements for people who had concerns of this nature.

As to the remainder of the plaintiffs' complaints about the way they were treated, Mr Armitage made two points. First, he submitted that the plaintiffs' pleaded claims are for damages for nervous shock, personal injury, loss and damage. The only act capable of causing shock was the act of informing the patient that she had been exposed to a risk of incurable or fatal infection; the later acts or omissions that were alleged were not capable of causing injury or damage and thus not capable of giving rise to a cause of action in negligence. Alternatively, in so far as the judge dismissed the remaining allegations out of hand, he was right to do so because the evidence in support of them was ill-considered, sparse and unsatisfactory. In particular those plaintiffs who gave evidence about the helplines and counselling did not provide convincing evidence of what had occurred at any stage, and the expert evidence they adduced in support of their claims had been based on reading the pleadings, and not on listening to the evidence. When the plaintiffs' expert witnesses were presented with witness statements or actually heard the evidence, they said they received no realistic idea about what had actually occurred: we were shown the passages in their evidence on which Mr Armitage relied.

He concluded his submissions by saying that the essence of the plaintiffs' case was that they had been frightened and annoyed by the knowledge that they had been exposed to a risk. They had chosen not to claim damages in respect of their exposure to the risk. Apart from their complaint about the method which was in fact adopted to inform them of the risk, their claim was a catalogue of complaints about every minor feature of their treatment by the defendants, and the judge had been right to reject it.

In analysing the strength of the parties' submissions, a considerable difficulty arises out of the fact that the judge made no findings at all on the issues raised by the cross-appeal, except to say that the plaintiffs had not made out their case on the balance of probabilities. At first blush, therefore, it would

appear to be appropriate to direct a retrial on those issues. Giving reasons for a decision is an important part of the judicial function, and here no reasons were given.

However, I have come to the conclusion that nothing of value could possibly be achieved by remitting this part of the case to be retried. The plaintiffs have failed on their primary case, and we have been told that legal aid has not yet been extended to cover the cost of a psychiatric report on any of them. The events in question happened more than five and a half years ago, and Mr Brennan was constrained to accept that even if any of his clients was found to have suffered any psychiatric illness or injury at this distance in time, any psychiatrist would face a daunting task in attempting to disentangle the contents of the news itself and the defendants' method of communicating the news on the one hand from the effect of any negligent deficiencies in the counselling arrangements on the other as causative factors of whatever injury or illness he or she was able to identify.

It is also the case that this experienced judge saw and heard all nine plaintiffs give evidence, and saw and heard the responses given by the defendants' witnesses before he concluded that the plaintiffs had not made out their case on these issues on the balance of probabilities. On the question of post-test counselling, Mrs Munroe, who had considerable experience in this field, made what appears to be a valid distinction between a normal situation in which a patient has created the risk by his or her own lifestyle, and needs to be counselled even after a test has proved negative, and the present situation in which these women had done nothing at all to create the risk and needed no counselling as to how to avoid a similar risk in future.

In the end, three considerations weighed with me as valid reasons for dismissing the cross-appeal. The first is that the judge had the opportunity of seeing the witnesses, and although the complaints they made were on the face of things quite cogent ones, he held that they had not made out their case after hearing what the defendants' witnesses had had to tell him - and the passages in the defendants'

evidence which we have seen leads me to conclude that a judge would have been reasonably entitled to reach that conclusion. The second is that these complaints were essentially ancillary to, or parasitic on, the plaintiffs' main complaint, which I would dismiss, and although in theory a breach of a duty of care in this area might conceivably have afforded the trigger mechanism for a psychiatric illness a plaintiff might otherwise not have suffered, or have materially aggravated a pre-existing illness, there is no evidence of this in the papers before the court, and the possibility must more appropriately lie in the realms of the theoretical. The third is the formidable difficulty of disentangling questions of causation to which I have already referred.

For all these reasons I would dismiss the plaintiffs' cross-appeal, and dismiss their action.

LORD JUSTICE KENNEDY: This case concerns the reaction of two health authorities to the information that a health worker whom they employed and who treated patients at their hospitals had been found to be HIV positive. The worker had also treated patients at another hospital in another part of the country controlled by another health authority, which is not a party to this action. Medically, there was a remote risk that the health worker might have infected those whom he had treated, and, as Mr Armitage QC, for the appellant health authorities, stressed in his submissions before us, the first question which each health authority had to address was whether to tell the patients at all. If the answer to that question was in the affirmative, then the next question to be considered was how the information was to be imparted, and what, if any, further support should be made available.

Within about four days of the information becoming available to the health authorities a meeting was convened at the Department of Health on 11th March 1991 to discuss those questions which I have just identified. It was attended by representatives of all three health authorities involved, and it was then decided:

(1) that patients should be informed;

(2) that they should be informed by letter, the letters to be posted on Monday 8th April 1991, relevant general practitioners having been advised by letters which would reach them on Saturday 6th April 1991 together with briefing information.

The general practitioners would also be invited to advise the health authority of any patient to whom they considered that no letter should be sent;

(3) the letters to patients were to indicate that counselling and blood-testing would be available to anyone who required it.

Prior to March 1991 there had been only one occasion when a health authority in the United Kingdom had faced a similar problem, and even then it had been on a much smaller scale. That was at Exeter in 1988 and the district medical officer who handled the matter on that occasion was Doctor Gentle, so he was invited to a second meeting which was held at the Department of Health on 14th March 1991. The Exeter health worker had treated 269 patients in Exeter and seven patients in Redditch, and at Exeter the method chosen to inform patients was face to face via their general practitioners. However, even with competent general practitioners handling no more than six patients each, that exercise stretched resources to the limits, and not every patient was seen. Even by 11th March it was clear that the Tameside and Trafford figures would far exceed the Exeter figures. The first calculation suggested that there might be 450 to 500 patients to be informed - in fact there were over 900 - and over 140 general practitioners were involved. Some general practitioners were responsible for over 20 of the patients who had to be advised, one had 23, and the two health authorities had no means of knowing how competent the general practitioners would be at offering counselling if counselling should be required. They did however have available a small number of counsellors trained to deal with HIV contacts, and so, having heard from Dr Gentle on 14th March 1991, the decision was still to proceed with notification by letter along the lines envisaged at the meeting three days earlier.

In his submissions to us Mr Brennan QC, for the plaintiff respondents, submitted that the decisions were really dictated by the Department of Health, which was anxious to protect the identity of the health worker concerned. I have no doubt that was a relevant consideration, but the passages in the transcript which Mr Brennan invited us to consider do not seem to me to support his conclusion. It is to my mind noteworthy that after the meeting in London Dr Davies, the consultant in charge of communicable disease control in the Tameside & Glossop Area Health Authority, consulted his authority's principal psychiatrist, who discussed the problem with his colleagues in the psychiatric department and expressed himself as being in full agreement with the method the health authority intended to employ, provided that the general practitioners were given the opportunity to stop the sending of letters in the case of known psychiatric patients or patients whom they thought should not be informed by that method. As I have already indicated, that opportunity was given. On 6th April 1991, the day that the letters and briefing notes were sent to general practitioners, there was a leak to a newspaper reporter, so there was some publicity on Sunday 7th April 1991, the day before the letters were sent to patients. As the trial judge made clear, there was no reason to suppose that the defendants were in any way responsible for that leak.

No action was commenced until 18th March 1994, and the master statement of claim of 114 plaintiffs, as amended, raised two principal allegations:

(1) that the two defendant health authorities were negligent in choosing to inform patients by letter as opposed to face to face;

(2) that the facilities offered by the letter were not properly provided.

There were many allegations which really elaborated those two basic allegations, such as criticisms of the wording of the letter, failure to offer post-test counselling, and so forth.

The defendants denied that it was negligent to send the letters phrased as they were, and contended that the facilities which they offered were appropriate.

Unfortunately, there was then, as Mr Brennan points out, a blatant failure by the defendants to comply in time with court orders in relation to disclosure of witness statements and reports, and when the trial in relation to the issue of liability began on 17th January 1995 the defendants had still not disclosed as much evidence as they could have done in relation to the practicality of proceeding in the way contended for by the plaintiffs. After four days of trial they disclosed further evidence, but the judge refused to allow a proposed amendment to the defence which would have alleged that it was impracticable to communicate with patients other than by letter, and there is before us no challenge to that ruling. The additional evidence was therefore not admitted.

Mr Armitage contends that thereafter the trial judge seems to have proceeded on the basis that all he had to decide was "as a matter of principle" whether it would be better to inform the patients face to face rather than by letter. As Mr Brennan put it to us, the only issue was desirability, not practicability. There were two methods of informing patients canvassed before the court. The evidence showed that, all other things being equal, face to face imparting of information was to be preferred, and, Mr Brennan contended, there was no adequate evidence of impracticability, therefore the defendants were in breach of a duty of care which they admitted that they owed. The judge seems to have accepted that approach. He found that the "best method" of informing a patient is face to face, and by the patient's general practitioner or other experienced health worker, and that to inform by letter carried a foreseeable risk that some vulnerable individuals might suffer psychiatric injury; so he resolved the issue of liability in favour of the plaintiffs, even though he found that their complaints in relation to counselling and so forth were, on the balance of probabilities, not made out.

In my judgment the learned judge was misled by the dispute as to the proposed amendment and the admission of further evidence, because, even if that evidence was rejected, the question was not whether in an ideal world it would be better to inform an individual patient face to face by means of a

general practitioner or other experienced health worker, but rather whether in all the circumstances the defendant health authority, which in reality meant Dr Davies for Tameside and Dr Hill for Trafford, were negligent in deciding to proceed as they did. The relevant circumstances included:

(1) The size of the problem. Even at the outset it was realised that it was twice the size of the problem with which Exeter had contended;

(2) the lack of knowledge as to the capacity or willingness of general practitioners to assist;

(3) the distribution of patients as between general practitioners. It is one thing to ask general practitioners to see up to six patients. It is quite another to ask a general practitioner to see up to 23;

(4) the need to act quickly if there was to be any prospect of advising patients before the news leaked out.

Patently, when faced with the problem, Dr Davies and Dr Hill reacted in a responsible way. They attended meetings at the Department of Health, they had the benefit of the views of Dr Gentle (who did not object to the course proposed) and Dr Davies at least took expert psychiatric advice. There was very little experience to draw on, and no evidence to show that if the less ideal solution was adopted any serious psychiatric injury would be likely to result; but, as it seems to me, the problem was carefully considered, and, even though some experts such as Professor Pinching and Dr Catalan (the two witnesses called on behalf of the plaintiffs) would prefer the decision to have gone the other way, it is impossible to conclude that Dr Davies and Dr Hill (and thus the two defendant health authorities) were negligent in deciding as they did. In saying that, I have in mind not only the decision to communicate with patients by letter, but also the decisions as to what the contents of the letters should be.

In 1993, long after these letters were written, but well before these proceedings were commenced, the Department of Health issued written guidance as to how the problem faced by the two health

authorities in this case might be resolved. Paragraphs 8.1 to 8.3 of that guidance are worth quoting. They read :-

> "8.1 In deciding how best to contact patients a number of factors need to be borne in mind:
>
> - the numbers likely to be involved;
>
> - the profile of the patients who may require notification; and
>
> - the type of operation or procedure undertaken.
>
> 8.2 As a general principle it is preferable for patients to be personally contacted by a counsellor, health advisor or other relevant health professional before a press announcement is made and every effort should be made to do so.
>
> 8.3 In large scale look-back exercises where it is not possible to personally contact patients, they will need to be informed by other means. For example by:
>
> - writing to patients;
>
> - informing the patients' GPs and asking them to contact the patients in question with due regard to the caveats in 8.6;
>
> - appropriately briefed health visitors or community midwives in the case of women who may have been delivered by an infected worker, as they have the advantage of already knowing the family.
>
> Helplines should become operational at the same time as patients are informed as it is wise to assume that once patients have been contacted the wider local public will become aware of the exercise.
>
> Suggested draft letters to patients and GPs can be found at Annex 3."

The draft letter to be found at Annex 3 is not significantly different from that used by these appellant health authorities in 1991. In preparing the guidance the Department of Health had the benefit of expert advice from a committee of which Professor Pinching was at one time a member. He does not agree with part of the guidance, but no court would be likely to hold that a health authority which complied with guidance so formulated acted negligently. It would be surprising if this court were to hold that these health authorities were negligent because in 1991 they acted in a way which after 1993 could not be criticised.

For the reasons indicated by Lord Justice Brooke I do not believe that the cross-appeal should succeed. I too would allow the appeal and dismiss the cross-appeal.

LORD JUSTICE NOURSE: I agree with both judgments.

The judge's decision not to admit the supplementary witness statements of Dr Davies and Dr Hill half way through the trial was well within his discretion and certainly within the spirit of the times. But I think that it must have had the unfortunate, if understandable, consequence of causing him to suppose that that was practically an end of the defence. As Lords Justices Brooke and Kennedy have demonstrated, that was not the case. There was other evidence before the court from which the only conclusion that could reasonably be drawn was that the defendants were not negligent in communicating with their patients in the way that they did.

The appeal is allowed and the cross-appeal dismissed. The judge's order for damages to be assessed will be discharged and the action dismissed.

Order: appeal allowed and cross-appeal dismissed; judge's order for damages to be assessed discharged and action dismissed; parties to lodge an agreed minute as to costs.