BRIEFING

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CONTRIBUTORS

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MEDICAL TREATMENT AND NON-DELEGABLE DUTIES OF CARE

1. A recent trio of dental treatment claims (*Ramdhean v Agedo* (2020), *Breakingbury v Croad* (2021) and *Hughes v Rattan* (2021)) have all resulted in findings that a dental practice (or its owner) owes a non-delegable duty of care to the end user. Consequent to these decisions and the related High Court decisions of *Razumas v Ministry of Justice* (2018) and *Hopkins v Akramy* (2020), there is now greater clarity around the circumstances in which a non-delegable duty of care is owed to the recipient of healthcare services, and by whom, and this clarity is to be welcomed.

2. In this article I shall summarise in brief the law regarding non-delegable duties, take a tour through some of the leading cases involving non-delegable duties in healthcare settings, and extract what I regard as the decisive factors in determining whether a non-delegable duty is owed, and by whom.

Non-delegable duties of care: the law

3. As will be familiar, a non-delegable duty is a personal duty, not just to take reasonable care in performing work, but to procure the reasonable performance of work delegated to others. It is thus an exception – along with vicarious liability – to the general rule that the law of negligence is fault-based. Importantly for our purposes it enables a litigant to bring their claim against (typically) a large corporate entity when the tortfeasor himself is un-insured or under-insured. Conversely it exposes such an entity to significant liability risks; these risks can be minimised by ensuring that any independent contractors are financially sound and covered by adequate insurance, and that any contract contains a suitable indemnity clause.

4. The landmark case of *Woodland v Swimming Teachers Association and ors* [2013] UKSC 66; [2014] A.C. 537 gives the legal test for a non-delegable duty to arise at common law. Lord Sumption, giving the leading judgment, stated that the starting point was a relationship between the two parties giving rise to a positive duty on the part of the defendant to protect a particular class of persons (including the claimant) against a particular class of risks. At paragraph 23 he identified the five defining features of a non-delegable duty. Imposition of such a duty would also need (paragraph 25) to be fair, just and reasonable, although the Supreme Court

in *Armes v Nottinghamshire County Council* [2017] UKSC 60; [2018] A.C. 355 at paragraph 36 has clarified that this threshold is met if the five defining features are satisfied.

5. Lord Sumption's five defining features are these (paragraph 23):

"(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.

(2) There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.

(3) The claimant has no control over how the defendant chooses to perform those obligations, ie whether personally or through employees or through third parties.

(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.

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

6. The duty owed by a hospital to its patients is identified in *Woodland* as a paradigmatic example of a common law non-delegable duty (along with that owed by an education authority to its pupils and by an employer to its employees): paragraph 34. This remark, although strictly obiter, reflects obiter dicta to the same effect in numerous earlier decisions by appellate courts, beginning with *Gold v Essex County Council* [1942] 2 K.B. 293, 301. For example, the House of Lords in *X (Minors) v Bedfordshire County Council*[1] [1995] 2 A.C. 633 noted, "It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital", and the Court of Appeal in *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203; [2010] 1 W.L.R. 2139 noted, "…I shall assume that a hospital generally owes a non-delegable duty to its patients to ensure that they are treated with skill and care…"

7. A non-delegable duty may alternatively arise pursuant to statute, in which case it is determined according to normal principles of statutory interpretation. In *Armes* the Supreme Court found that a local authority did not owe a non-delegable duty to children in its care whom it had placed with foster carers pursuant to section 21 of the Child Care Act 1980. The provision stated, "A local authority shall discharge its duty … by boarding him out [i.e. placing him with foster carers]". It was held that the local authority's duty was limited to arranging for, and then monitoring, the provision of care.

8. Other decisions regarding the interpretation of written duties (whether statutory or contractual) include:

- *Myton v Woods* (1980) 79 LGR 28: statute provided that the local education authority "shall make arrangements for the provision of transport". The defendant was not liable for the negligence of the taxi firm which it had contracted with.
- *Wong Mee Wan v Kwan Kin Travel Services Ltd* [1996] 1 WLR 38: a contract for a package tour of China included undertakings that the defendant would provide (and not merely arrange) particular services. The defendant was accordingly under a duty to ensure that said services were provided with reasonable skill and care.

Are detainees owed a non-delegable duty in respect of their medical care?

9. Prisoners are a category of persons identified by Lord Sumption as being vulnerable or dependent on the Defendant's protection, such as to satisfy the first of the five defining features in *Woodland*. If the statutory scheme gives the Defendant responsibility for all aspects of the Claimant's imprisonment, including medical care, then a Court is likely to find that a non-delegable duty is owed, applying the five-stage test in *Woodland*.

10. *Morgan v Ministry of Justice* [2010] EWHC 2248 (QB) is a High Court decision preceding *Woodland*. The Claimants contended that a non-delegable duty was owed by the Ministry of Justice ("MOJ") (the state department in charge of prisons) to the deceased (a prisoner) in respect of medical care provided at the prison. At the material time, the local Primary Care Trust ("PCT") was responsible for providing medical care under the statutory scheme; it had previously been the responsibility of HM Prison Service. The PCT provided medical care through Ellesmere Medical Practice. Supperstone J determined that the MOJ's duty was limited to a duty to provide access to healthcare, rather than a duty to provide healthcare[2].

11. *Razumas v Ministry of Justice* [2018] EWHC 215 (QB); [2018] P.I.Q.R. P10 is a High Court decision on similar facts, made following the case of *Woodland*. The Claimant, then a prisoner, received negligent medical care at a time after, pursuant to a statutory regime change, responsibility for healthcare at the prison had been transferred from the MOJ to the local PCT. As in the case of *Morgan*, the Judge found that the MOJ's duty was limited to providing access to healthcare provided by the PCT (or an entity contracted by the PCT). There was thus no non-delegable duty owed by the MOJ to provide reasonable medical care. The Defendant accepted (paragraph 139) that it had owed a non-delegable duty in respect of medical care prior to the statutory change, at which time medical care had been the responsibility of the prison.

12. In applying the *Woodland* judgment to the facts in *Razumas*, Cockerill J reasoned as follows:

"150. … there is a nexus between the control of the claimant by the target and the purpose of that control/placing, and the care inherent in that relationship. That facet can be easily seen in a hospital, as regards healthcare – a patient gives himself over to the hospital for the very purpose of healthcare. Or as Lord Sumption put it at [30] the claimant, as well as being in the target's care should be "receiving a service which is part of the institution's mainstream function" . To similar effect is Baroness Hale's point at [40] and also [42] that the conundrum in the Woodland case resulted from "outsourcing of essential aspects of [public authorities'] functions".
151. Here the reasoning breaks down in the current case: the reason for the prisoner being in the hands of the prison is not for, and does not comprehend, healthcare. Healthcare is not (at least since 2003) part of the prison institution's mainstream (or essential) function…
…
153. Turning to this case there is a statutory duty regarding custody and maintenance. Those are duties which the Defendant has to fulfil. Neither of those are in question in the complaints made. There is a statutorily derived common law duty as to accessing healthcare. Again that is not relevant, as I have found above. But the provision of healthcare forms no part of the statutory or common law duty. That is the duty of the PCT and its subcontractors…"

13. She commented that it was proper for consideration to be given to the existence of a common law non-delegable duty (i.e. applying the five defining features in *Woodland*) following changes to the statutory scheme: paragraph 157. Expressed differently, this means that it is appropriate to consider whether a non-delegable duty arises at common law unless such a duty either arises from the statute or is ruled out by the statute.

14. *Nyang v G4S Care and Justice Services Limited and ors* [2013] EWHC 3946 (QB) and *GB v Home Office* [2015] EWHC 819 (QB) share a similar factual matrix and were both endorsed by Cockerill J in *Razumas*.

15. In *Nyang* the Claimant received negligent medical treatment while detained in an immigration removal centre. The centre was operated entirely by the First Defendant, G4S, pursuant to a contract with the Secretary of State for the Home Department. The

relevant Detention Centre Rules required the First Defendant to have a medical practitioner and healthcare team available for the detained persons. The First Defendant conceded (paragraph 96) that it owed a non-delegable duty to detainees in respect of their medical care. Although not part of the ratio of the case, this is undoubtedly the correct outcome, based on the five *Woodland* criteria, considering that the Claimant was a detainee and that secondary legislation assigned responsibility for medical care (along with all other aspects of detention) to those operating the centre.

16. The facts in *GB* were almost identical, save that the Claimant sued the Home Office, and not Serco, the private company which the Home Office had engaged to operate the relevant immigration removal centre. Coulson J found, applying the *Woodland* criteria, that a non-delegable duty was owed by the Home Office in respect of healthcare provided to detainees at the centre. In the author's view this is a puzzling conclusion: from the facts given, it appears that the Home Office delegated all its responsibility for the immigration centre to Serco. As such, and considering the cases in the section below, it is unclear how an antecedent relationship (the second defining feature in *Woodland*) could have existed between the Claimant and the Defendant Home Office.

What if the parties' only connection is that D arranged the provision of healthcare for C?

17. I have considered the position of detainees receiving medical treatment who are reliant on the Defendant for all other aspects of their detention. I turn now to those cases in which the only connection between the Claimant and Defendant is the Defendant's duty to arrange (or provide) medical care, and any such care is in fact provided by a different legal entity. It is understandably much more difficult to establish a non-delegable duty in these circumstances. In the author's view the Courts are reluctant to find a statutory non-delegable duty except on the clearest wording; a non-delegable duty is also unlikely to arise at common law because of the difficulty in establishing an antecedent relationship.The claimants in the cases below all failed to establish a non-delegable duty.

18. The Claimant in *A (A Child) v Ministry of Defence and anr* [2004] EWCA Civ 641; [2004] 3 W.L.R. 469 was injured because of negligent care in a hospital in Germany. The First Defendant, the Ministry of Defence ("MOD"), was under a duty to arrange medical care for servicemen and their dependants (a category which included the Claimant). At the material time it had subcontracted the provision of secondary care to hospitals in Germany, having run its own military hospitals in Germany in the past. The Claimant's argument that the MOD owed a non-delegable duty to provide reasonable medical treatment to servicemen and their dependants was rejected. The MOD's sole duty was to arrange for medical care, and this duty had been discharged. The Court held (obiter) that if the MOD had been running the hospital, it would have owed a non-delegable duty (paragraph 63).

19. The case of *Farraj v King's Healthcare NHS Trust and anr* [2009] EWCA Civ 1203; [2010] 1 W.L.R. 2139 concerned Claimants who instructed the First Defendant to conduct DNA sampling of foetal tissue. The First Defendant contracted with a laboratory which cleaned and cultured the sample, returned it to the First Defendant, and negligently failed to inform it of concerns that the sample contained no foetal tissue. The Claimants on appeal contended that the First Defendant owed a non-delegable duty in performing the sampling task.The Court of Appeal rejected this submission, finding (obiter) that a Trust would owe a non-delegable duty to a patient admitted to its hospital for treatment, but (the judgment's ratio) that the provision of diagnostic services from a distance to someone not already a patient was significantly different and gave rise to no such duty.

20. *Hopkins v Akramy and ors* [2020] EWHC 3445 (QB); [2021] Q.B. 564 postdates the *Woodland* case. The Claimant was severely injured due to allegedly negligent medical treatment provided at an NHS out-of-hours clinic. The out-of-hours clinic had been run by a private company, pursuant to a contract between the company and the local PCT. The PCT's duty was to "provide" or "secure provision of" primary medical services (section 83(1) of the NHS Act 2006, as it then was); the statute allowed it to provide the services itself or make appropriate arrangements for their provision (section 83(2)). The Claimant contended that the PCT

was under a statutory (alternatively, common law) non-delegable duty to provide reasonable medical care. HHJ Melissa Clarke ruled that on the statutory wording the provision of medical care was delegable, and that the PCT had discharged its duty to "secure the provision of" primary medical care by entering a contract with the private company. The existence of a statutory delegable duty ruled out an equivalent non-delegable duty at common law.

Does a medical practice owe a non-delegable duty to its patients?

21. It is perhaps not surprising, after reflecting on the numerous judicial obiter dicta to the effect that a hospital owes a non-delegable duty to its patients, that a non-delegable duty is owed by a medical practice (or its owner) in the equivalent surgery setting. But it is notable – and brings clarity to this area of the law – that a trio of first instance decisions (two of them in the County Court) have recently been handed down with exactly this ratio.

22. In *Ramdhean v Agedo and anr* (county court, unreported) the Claimant was referred by her usual dental practice to another dental practice (The Forum Dental Practice Limited, the Second Defendant) for a particular dental procedure. The Second Defendant engaged a self-employed dental surgeon (Dr Agedo, the First Defendant), to perform the procedure, in fulfilment of its own contractual obligations to the local PCT, from which it made a profit. Its contract with the PCT required the Second Defendant to provide personal dental services and to comply with various terms and conditions relating to the employment or engagement of dental practitioners.

23. It was the Claimant's case that the First Defendant performed the procedure negligently and that the Second Defendant owed her, as its patient, a non-delegable duty to provide reasonable dental care. The Second Defendant was uninsured for clinical negligence claims, although it had sufficient assets to meet the present claim. HHJ Belcher concluded, paying close attention to the contract between the Second Defendant and the PCT, in paragraphs which merit reading in full, that the Claimant was a patient of the Second Defendant in a way that she was not a patient of the PCT (paragraphs 36-37):

"36. I am not satisfied that the "passing on of arrangements" is the same for the PCT and for FDPL [the Second Defendant]. Whilst the PCT has a duty to provide or secure the provision of primary dental services within its area, because it chose to secure that provision through FDPL, the PCT never accepted the Claimant as a patient. The PCT entered into a contract with FDPL under which FDPL was to provide the dental services. In doing so, the PCT was complying with its duty to secure the provision of primary dental services. I cannot see why that arrangement should not fall within the general rule that the duty to take reasonable care may be discharged by entrusting the performance of a task to an apparently competent independent contractor. The PCT did not undertake the care, supervision and control of the patient in this case.

37. FDPL did accept the Claimant as a patient. Whilst Dr Jackson tried to suggest that FDPL's function was merely administrative, merely passing the patient onto Dr Agedo, I am entirely satisfied that the Claimant was a patient of FDPL. The services under IMOS [the contract between D2 and the PCT] were clearly to be provided by the Contractor, that is FDPL [12/179-187; Clauses 40 – 730]. The IMOS recognises that FDPL will have to employ or otherwise engage dental practitioners to perform the dental services. That is inevitable given that FDPL is a company. The IMOS contains terms and conditions relating to those performing the services and conditions for their employment or engagement, and expressly permits subcontracting of clinical matters [12/197-203; Clauses 178-201]. The IMOS also impose positive obligations on FDPL, such as, for example, ensuring that any dental practitioner performing services under the IMOS was maintaining and updating his skills and knowledge in relation to those services he was performing [12/201, Clause 195]. Whilst Dr Jackson plainly did not understand this to be an obligation on FDPL, that is beside the point. What it does illustrate is that, on any view, FDPL was not (or should not have been) the simple administrative referral service which Dr Jackson sought to suggest."

24. HHJ Belcher proceeded to find that *Woodland's* five defining features were met: paragraphs 39-47.

25. *Breakingbury v Croad* (county court, unreported) has similar facts and is considered in more detail by Katie Ayres in her article here. In finding that a non-

delegable duty was owed by the owner of the practice, the Judge noted that it was the practice (and not the individual dentists) which contracted with the Dental Health Board, that the Claimant made payment to the practice, and that the Claimant did not choose which dentist she saw.

26. The same conclusion was again reached on very similar facts by the High Court in the decision of *Hughes v Rattan* [2021] EWHC 2032 (QB). The Claimant attended a dental practice owned by the Defendant. She contended that she had received negligent treatment from four dentists working at the practice, three of whom were self-employed. A contract between the Defendant and the local PCT required the Defendant to provide primary dental services and contained detailed terms and conditions, including regarding the employment and engagement of dental practitioners. Profits were shared between the Defendant and the dental practitioners he engaged or employed. In finding that a non-delegable duty was owed, Heather Williams QC placed weight on inter alia the following facts:

- The practice held C's dental records and arranged her appointments;
- D decided whether the dental services he had contracted with the PCT to supply would be provided by himself, his employees, associates or sub-contractors;
- Pursuant to his contract with the PCT, D agreed to a series of obligations relating to patients of the practice;
- C was treated at the practice's premises, using equipment, nursing staff and other facilities provided by D.

Conclusion

27. Whether the recent dental treatment cases in fact represent a significant extension of the law regarding non-delegable duties is arguable. They are perhaps better regarded as the inevitable consequence of the Supreme Court's *Woodland* decision, with its conclusion that the duty owed by a hospital to its patients was a paradigmatic example of a non-delegable duty. One point they do bring home is that the Courts will take the same approach to all forms of medical treatment. In the setting of a typical dental surgery – in which a patient principally engages with the practice, the practice is subject to detailed requirements by the commissioning NHS trust, and the practice provides the necessary premises and equipment – a non-delegable duty is likely to arise.

28. Of Lord Sumption's five defining features of a non-delegable duty, the one most difficult to square with the existence of a non-delegable duty in the dental treatment cases is, in the author's view, the second: the antecedent relationship, independent of the negligent act itself. The claimants received no dental care directly from the defendant, but only from the (allegedly negligent) self-employed dentists to whom they were assigned. What was the basis for the decision that there was an antecedent relationship between the claimant and the defendant, placing the claimant in the defendant's care? In answer, it is observed that the facts relied upon to demonstrate an antecedent relationship are diverse: inter alia that the claimant was regarded as belonging to the practice, a significant proportion of the payment went to the practice, the claimant had limited choice of which dentist she saw, and the practice agreed to a series of obligations in respect of its patients[3]. "Antecedent" does not equate to "pre-existing".

29. The best explanation, though, is given in *Ramdhean* at paragraph 42:

"… In Woodland the claimant was in the actual charge or care of the lifeguard and swimming teacher at the time of the incident in the swimming pool. However, she was also in the actual charge or care of the school, and thus of local authority responsible for the school. The two are not mutually exclusive. The question is not whether the Claimant was in the care of the First Defendant (which she undoubtedly was), but whether she was in the actual care of FDPL [the practice]. If I ask myself "Did FDPL undertake the care, supervision and control of the Claimant as its patient?", I conclude that it clearly did. In my judgment, FDPL has undertaken to care for the Claimant, albeit the IMOS permits that to be by way of employing dentists, or otherwise engaging their services, including by way of sub-contracting."

30. This analysis underlines the point made by Lady Hale in *Woodland*, that the five defining features are

not to be treated as set in stone. Rather than taking the features at face value, litigators should focus their attention in this setting on whether the claimant can properly be considered a "patient" of the practice.

31. Drawing together the dissimilar contexts above in which a non-delegable duty to provide healthcare may arise, it is striking that (a) there will usually be a direct relationship between the claimant and the defendant, and (b) the defendant will be bound (whether by statute or contract) to provide healthcare, whilst entitled to delegate the task.

[1] Subsequently overturned on unrelated grounds.
[2] The point was also decided under the Crown Proceedings Act, the MOJ being the Crown for the purposes of the Act. The reasoning in *Morgan* was criticised by Coulson J in *GB v Home Office* at [44]-[62] but endorsed by Cockerill J in *Razumas* v MOJ at [156].
[3] Notably these factors also point in favour of a practice being vicariously liable for negligent medical treatment by self-employed dentists it has engaged.

About the Author

Susanna Bennett was called to the Bar in 2017. She specialises in clinical negligence, while also acting in personal injury cases, inquests, and solicitor's negligence cases. Her clinical negligence work covers a broad range of cases including dental negligence, strokes cases, cancer cases, and cases concerning end of life care.

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