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**LITIGATION AGAINST ENGLISH NHS AMBULANCE SERVICES
AND THE RULE IN *KENT* v. *GRIFFITHS*.**

Kevin Williams*

I. INTRODUCTION

No public healthcare service can operate without effective ambulance provision. The figures show that in England more than three million ‘emergency patient journeys’ are undertaken each year by National Health Service (NHS) ambulances.¹ Yet it had seemed unlikely that there was any common law obligation to attend and provide pre-hospital emergency care when summoned. A series of cases in the 1990s had held that none of the other emergency services was duty bound to go to the aid of persons in peril,² albeit that in 1968 it had been decided that a sick person who managed to present at an open hospital accident and emergency unit thereby effectively created a doctor/patient relationship and so was entitled to reasonably careful treatment.³ Then in 2000 the Court of Appeal, in the case of *Kent v. Griffiths*, held that an unreasonably

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¹ See *Ambulance Services, England: 2004-05*, (NHS Health and Social Care Information Centre, 2005) at para 2.3.1.

² See *Capital and Counties plc v. Hampshire County Council* [1997] Q.B. 1004 (fire fighters), *Alexandrou v. Oxford* [1993] 4 All E.R. 328 (police), and *OLL Ltd v. Secretary of State for Transport* [1997] 3 All E.R. 897 (coastguard).

³ See *Barnett v. Chelsea and Kensington Hospital Management Committee* [1969] Q.B. 428.

delayed response by an ambulance service to an emergency call could be actionable negligence.⁴

Whilst the Court seems to have operated on an implicit assumption that few claims would result from its decision, the NHS Litigation Authority (NHSLA) complained that *Kent v. Griffiths* had created what was potentially a 'very onerous duty indeed' given the large and growing number of 999 calls.⁵ Grubb observed that the courts might be seen as yet again 'diverting precious financial resources from the treatment and care of patients to compensation claims', so setting political 'alarm bells' ringing.⁶ A more apocalyptic view was expressed by the law reporter after *Kent* was decided at first instance claiming the case had come close to creating 'liability in an indeterminate amount for an indeterminate time to an indeterminate class'.⁷ This paper assesses the nature of the liability ruling in *Kent* and, through an analysis of all claims alleging medical negligence against English ambulance services across a ten-year period, evaluates whether these sorts of fears have proved to be justified.

⁴ [2001] Q.B. 36.

⁵ See *NHSLA Journal*, Issue 2, (Summer, 2003) at 7. In 2004-05, ambulance trusts in England recorded 5.6 million 999 emergency calls, more than double the number in 1994-95, see *supra* n 1, para 2.1.1 and Table 1.

⁶ See AG, 'Commentary. Medical Negligence: Liability of Ambulance Service' [2000] *Med. L. Rev.* 349 at 350.

⁷ See Commentary [1999] *Lloyd's Rep. Med.* 424 at 457.

II. THE DUTY ON AN AMBULANCE SERVICE

As noted at the outset, English law is currently marked by a strong reluctance to hold emergency service providers liable in negligence, however egregious their failure to help those in need. Ostensibly, this reluctance is founded on the distinction between acts and omissions. The difference between harming others by active carelessness and simply failing to help them is a jurisprudential distinction which has long been regarded as both 'fundamental' and 'deeply rooted in the common law'.⁸ An additional factor, and at least as influential, has been judicial anxiety that imposing duties of affirmative action may lead to indeterminate (or at least large) numbers of claims that will drain limited budgets, provoke detrimentally defensive approaches or have other adverse effects on the provision of beneficial public services. In consequence, English courts have held that fire brigades, the police and the coastguard have no duty to go to the assistance of those who are, or whose property is, in peril.⁹ Seemingly, they have no private law obligation¹⁰ to act on any summons for help and, where

⁸ See F. H. Bohlen, 'The Moral Duty to Aid Others as a Basis of Tort Liability' (1908) *University of Pennsylvania Law Review* 217 at 219. In *Smith v. Littlewoods Organisation Ltd* [1987] 2 A.C. 241 at 247, Lord Goff said 'the common law does not impose liability for what are called pure omissions'. See too Jessup J.A. in *Horsley v. MacLaren* [1970] O. R. 487 at 499 (Ont. C.A.) 'no principle is more deeply rooted in the common law'. In *Stovin v. Wise* [1996] A.C. 923 at 930, Lord Nicholls acknowledged that whilst the distinction was not without difficulty it continued to be 'fundamentally sound'.

⁹ See cases cited *supra* n 2. In Scotland, the position appears to be otherwise. See *Duff v. Highlands and Islands Fire Board* [1995] S.L.T. 1362 (obiter, negligent fire authority not immune from liability) and *Gibson v. Chief Constable of Strathclyde* [1999] S.C. 420 (police force, having assumed responsibility to warn motorists about a partially collapsed road bridge, was liable when the task was prematurely abandoned).

¹⁰ In contrast, decisions by emergency service providers about how they discharge their (usually statutory) functions may be amenable to the public law rules of judicial

they do turn up, need pay no damages unless by active carelessness they make an already bad situation worse.¹¹

While moral absolutists and many European legal systems require even mere bystanders to offer aid to others in physical danger,¹² common law systems have generally taken the view that private citizens should not be subjected to compulsory altruism. A legal obligation to undertake easy (let alone dangerous) rescue, so the argument goes, may be burdensome, interfere with individual liberty and amount to the state appropriating the citizen's resources without compensation.¹³ Such arguments sound entirely unconvincing, however, when applied to specially equipped and trained professionals, such as fire fighters, who are paid by publicly funded rescue services to save persons and property in difficult circumstances. They are not simple altruists who stumble unwittingly

review. Challenge may also be possible under the Human Rights Act 1998, as in *Van Colle v. Chief Constable of Hertfordshire* [2006] E.W.H.C. 360 (police liable for unreasonably failing to protect the life of a witness in the face of known threats by an accused). Additionally, individual emergency workers considered guilty of neglect of duty risk disciplinary action by their employers and, in some cases, by an external regulatory body. Thus, ambulance paramedics may be sanctioned by the Health Professions Council in 'fitness to practise' proceedings and doctors by the General Medical Council, see *infra* n 22.

¹¹ See *Capital and Counties*, *supra* n 2 at 1035.

¹² In most of continental Europe, legislation imposes criminal (and, sometimes, civil law) sanctions against ordinary onlookers who fail to go to the aid of persons in nearby physical danger, at least where assistance would be 'easy'. See J. Kortman, *Altruism in Private Law* (Oxford University Press, 2005), chapter 4, and A. Cadoppi, 'Failure to Rescue and the Continental Criminal Law' in M. A. Menlowe and A. McCall Smith, *The Duty to Rescue* (Dartmouth Publishing, 1993) at 93-130. The same is true in a small number of North American jurisdictions; see J. Dressler, 'Some Brief Thoughts (Mostly Negative) About "Bad Samaritan" Laws' (2000) 40 *Santa Clara Law Review* 971.

¹³ See dicta to this effect in *Stovin v. Wise* [1996] A.C. 923 at 943 *per* Lord Hoffmann.

and unprepared upon emergencies. Nonetheless, to the extent that English courts have declined to impose a duty on selected professional rescuers to go to the aid of an imperilled stranger, they have effectively equated them to ordinary private citizens.¹⁴

Until recently this also seemed to be the position of healthcare professionals. They too could decline to act as the Good Samaritan did, despite substantial exceptions having been carved out of the ‘no duty’ rule in a variety of other contexts.¹⁵ It appeared that there was no obligation to provide emergency medical care, except to those who were already patients of the healthcare practitioner in question.¹⁶ Professor Fleming summarised the conventional common law position saying that a ‘doctor may flout his Hippocratic Oath and deny aid to a stranger’, though he risks a charge of professional misconduct.¹⁷

¹⁴ See *supra* n 2. C. Booth and D. Squires, *The Negligence Liability of Public Authorities* (Oxford University Press, 2006) at para 3.106 are critical of Lord Hoffmann's 'no duty' justifications in *Stovin*, *ibid*. They suggest that a 'stronger argument' for restricting the liability of public bodies for pure omissions is the need to protect them from 'the threat of indeterminate liability'.

¹⁵ See E. J. Weinrib, 'The Case for a Duty to Rescue' (1980) *Yale Law Journal* 247 at 248, noting that even in the USA the rule was 'in the process of being consumed...by the widening ambit of exceptions'. More recently, Mr Justice Allen Linden in (2005) 13 *Tort Law Review* 59 at 61 observed that 'with so many exceptions, the pure no duty rule actually covers very few situations of nonfeasance'. Amongst other devices used to impose duty is the notion of the 'special relationship' which has been regularly employed to deny that the parties truly were 'strangers'.

¹⁶ I have argued elsewhere that a duty of emergency medical rescue should be recognised by the common law, see K. Williams, 'Medical Samaritans: Is There a Duty to Treat?' (2001) 21 *O.J.L.S.* 393.

¹⁷ See J. G. Fleming, *The Law of Torts* (Law Book Company Ltd, 8th ed, 1992) at 147. Thus, in *Stevenson v. Clearview Riverside Resort* [2000] OJ No. 4863 (Ont. H.C.) a Canadian court held, *inter alia*, that an off-duty ambulance attendant was not obliged to participate in the rescue of a friend injured at a party after diving into a shallow lake. As to professional discipline, see *infra* n 22.

However, in 1996 an Australian appellate court, by a majority, radically departed from this individualistic tradition. It held that a General Practitioner who refused to leave his surgery to treat a nearby eleven-year-old who was in the throes of an epileptic fit was liable in negligence, even though there was no pre-existing doctor/patient relationship between them.¹⁸ There was what the court styled 'physical', 'circumstantial', and 'causal' proximity sufficient to justify imposing a duty on the doctor to attend and treat the child. Dr. Lowns was close by, had the competence and capacity to respond, and no prior commitments. There was no impediment to him acting when called on in the 'professional context' of his surgery in what he ought to have recognised was a grave emergency.¹⁹ Additionally, the court noted that statutory provisions in New South Wales oblige doctors to attend promptly to any person they reasonably believe to be in need of urgent medical attention or face a charge of professional misconduct. This was regarded as background evidence of what the legislature, the profession and the public reasonably expected would be done in a medical emergency, albeit that the statute provided no direct tortious remedy to an untreated casualty.²⁰

¹⁸ See *Lowns v. Woods* [1996] Aust. Torts Reports 81-376 (N.S.W. C.A.).

¹⁹ See too *Egedebo v. Windermere District Hospital Association* (1993) 78 B.C.L.R. (2d) 63 (B.C. C.A.). A doctor in a Canadian hospital emergency room who failed to arrange treatment when asked was negligent, despite being off-duty. Arguably the sick person who made the request was already a 'patient' in the 'professional context' of the hospital. See too *Barnett*, *supra* n 3.

²⁰ In order to avoid pre-empting the answer to the duty question, it is preferable to refer to such claimants as 'casualties' rather than 'patients' since it is well established that patients are entitled to careful treatment, see n 3 and text. In *Kent v. Griffiths*, *supra* n 4 at 39, James Munby Q.C. for the defendants relied heavily on the distinction,

In England, GPs (though not other medical practitioners) are similarly obliged by regulations to respond to a request to treat anyone (and not merely their own patients) who is in immediate need and in the GP's (geographical) practice area.²¹ Failure may attract a disciplinary sanction though, as in Australia, the regulations provide no explicit remedy to an untreated casualty.²² To date, there is no record of any tortious claim ever having been made in England against a doctor in a similar position to Australia's Dr. Lowns. The likelihood of one seems remote since, regardless of what the law may say, the evidence is that GPs and hospital doctors here overwhelmingly *do* volunteer Good Samaritan treatment when needed and that altruism is a core professional value in practice, not just in theory.²³

arguing that 'the claimant's complaint relates exclusively to the period before she was accepted by or admitted to the ambulance as a patient'.

²¹ See reg. 15(6), NHS (General Medical Services Contracts) Regulations 2004 (SI 2004 No. 291) requiring that 'immediately necessary treatment' is provided to '*any* person...owing to an accident or emergency at any place in its practice area' (emphasis added). Regulation 2 defines such needful casualties as 'patients'. GPs are entitled to be paid for these services by their local Primary Care Trust.

²² Failure to treat puts a GP in breach of their statutory terms of service exposing them to disciplinary action by their Primary Care Trust. Additionally, *all* doctors are bound by the General Medical Council's code of professional ethics, breach of which risks a misconduct charge. See *Good Medical Practice*, (4th ed, November 2006) which provides, at para. 11, under the heading 'Treatment in emergencies', 'In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care.'

²³ See K. Williams, 'Doctors as Good Samaritans: Some Empirical Evidence Concerning Emergency Medical Treatment in Britain' (2003) 30 J.L.S. 258. Notions of professional and ethical responsibility principally motivated the doctors in the survey. Unsurprisingly, they had only a hazy picture of the law and what it expects of them.

Lowns v. Woods was not cited when the Court of Appeal was invited in *Kent v. Griffiths*²⁴ to consider the analogous question of whether there is a duty on an ambulance service when called to assist a casualty in the community. A pregnant woman had a serious asthma attack at home. The visiting GP made a 999 call asking for an emergency ambulance to take her patient to hospital as soon as possible. When it failed to arrive, two further calls were made and reassurances received that an ambulance was on its way. Eventually one arrived, 40 minutes after the first call, having taken at least 14 minutes longer than the trial judge found was reasonable. He held that the respiratory attack Mrs Kent suffered, which resulted in a miscarriage and brain damage, would be likely to have been averted had there been no unreasonable delay.²⁵

The Court of Appeal confirmed that the defendants were liable to pay compensation for all the damage that would have been averted by a timely arrival. Lord Woolf M.R. was not prepared to accept that ambulance crews are like fire fighters, police officers or coastguards, much less ordinary citizens who have no statutory functions and are not paid from public funds to attempt rescues. He distinguished the earlier authorities by the simple expedient of asserting that they were not concerned with the obligations of an ambulance service, a service which he preferred to equate to hospitals and other NHS healthcare providers who do owe duties of care, at least to those who can be characterised as patients.²⁶

²⁴ *Supra* n 4.

²⁵ [1999] Lloyd's Rep. Med. 424.

²⁶ See *supra* n 20.

The defendant ambulance service having conceded that the claimant's injuries were foreseeable and that it was otherwise 'fair, just and reasonable' to impose duty, proximity became the critical issue.²⁷ His Lordship regarded this as having been established once the GP's first 999 call, which put them on clear notice of the serious nature of the emergency, was accepted. The duty to attend crystallised at that moment, as it were, thus implicitly rejecting the notion that the casualty must have some pre-existing status as a 'patient' of the particular defendant. Moreover, because an available ambulance had been earmarked, the case raised no tricky questions concerning competing demands for scarce resources.²⁸ Had there been conflicting priorities or no ambulance available, it seems probable that Lord Woolf M.R. would have rejected Mrs Kent's claim on the basis that the issue was 'not suited for resolution by the courts'.²⁹ A 'no breach' analysis would also be likely to be available in such circumstances. According to his Lordship, the facts were 'unusual in the extreme'.³⁰ It certainly was extraordinary that *no* explanation was offered for what was plainly a very

²⁷ In accordance with the criteria for recognising a novel duty in *Caparo Industries plc v. Dickman* [1990] 2 A.C. 605. Initially the London Ambulance Service had conceded duty. However, following *Capital and Counties, supra* n 2, they withdrew their admission and unsuccessfully applied to strike out the claim, see *Kent v. London Ambulance Service* [1999] P.I.Q.R. P192.

²⁸ Resource allocation questions are often (though not universally) treated as non-justiciable in both private and public law litigation. See, respectively, R. Oppenheim, 'Resource allocation and clinical negligence claims' (2004) 10 *Association for Victims of Medical Accidents Medical and Legal Journal* 69 and E. Palmer, 'Resource Allocation, Welfare Rights - Mapping the Boundaries of Judicial Control in Public Administrative Law' (2000) 20 *O.J.L.S* 63.

²⁹ See *supra* n 4 at 53.

³⁰ See *supra* n 4 at 54.

late arrival or for the fact that the times in the ambulance log book had been falsified. Floodgates anxieties are readily calmed in circumstances such as these.

Partly because of its particular facts and the narrow way in which it was argued, there are doubts about the scope of the liability rule in *Kent v. Griffiths*. In negligence actions, the facts are critical and Lord Woolf repeatedly stressed their importance - an available ambulance had been sent to provide care for the benefit of a named person, in response to a specific request, which had been accepted, thus constituting her a 'patient'.³¹ Accordingly, one view is that the duty turned simply on a voluntarily given promise of help.³² If this is the proper reading of the decision, it appears to be narrowly centred on what constitutes the *breach* of an existing duty owed to a patient and, therefore, as merely confirming that an ambulance crew may be liable for unreasonably delayed or withheld treatment, just as they are for timely but careless treatment.³³ This is well within mainstream understandings about the reach of the duty of proper medical

³¹ See *supra* n 4 at 47, 50, 53 and 54. Unlike Turner J., who emphasised the allocation of a particular ambulance, Lord Woolf said, at 54, that 'acceptance of the call...established the duty of care'.

³² Kortman, *supra* n 12 at 62, says it was sufficient that 'the ambulance service had decided to intervene' and that 'an undertaking in the sense of an "implied promise" does not seem to have been required'. In *Barnett*, *supra* n 3, Nield J. seemingly based duty partly on the hospital holding itself out as providing emergency treatment and partly on an implied promise of treatment (a nurse in A & E having passed details of the night watchmen's symptoms to the on-call doctor).

³³ An alternative justification for the result, suggested in M. A. Jones, *Medical Negligence*, 3rd edn (Sweet and Maxwell 2003) at 112, is that the defendant's negligence 'did actually worsen the claimant's position' since had it been known that the ambulance would be long delayed Mrs Kent's husband would have driven her to hospital. Lord Woolf did not treat 'specific reliance' of this sort as relevant (except as regards causation). Duty should not depend on the accidental circumstance that the particular claimant had other salvation options that were foregone.

care.³⁴ Unfortunately, an 'acceptance' explanation does little to differentiate *Kent* from the earlier 'no duty' decisions involving professional rescuers. In each of those decisions, assistance had been dispatched to aid identified or, at least, identifiable victims in response to urgent calls for help.³⁵ Hence, Lord Woolf's need to insist that ambulances must be regarded as being more akin to hospitals, doctors and nurses rather than being equated to the other emergency services, whose responsibilities were unconvincingly distinguished as being owed only to the public at large.³⁶

Traditionally, ambulances were seen merely as transport services whose job was to get casualties to hospital. Nowadays, emergency ambulances have at least one fully trained paramedic on board and have become 'an essential part of networks of emergency clinical care' with responsibility to 'ensure that effective treatment is delivered to people as soon as possible'.³⁷ A broader reading of *Kent*, namely, that it settles the legally significant principle that there can be an initial duty to go to the assistance of an imperilled stranger better reflects this expanded role. We can, perhaps, test this by supposing that an ambulance dispatcher, mistakenly believing no ambulance is available, either declines to accept a 999 call or, more likely, tells the caller that help will be late in arriving.

³⁴ See *Bolitho v. City and Hackney Health Authority* [1998] A.C. 232.

³⁵ The 'no proximity' rulings in the three cases cited in *supra* n 2 seem factually implausible, though legally speaking they were critical to the shared conclusion that no duty of professional rescue exists (or, rather, should be recognised). *Alexandrou v. Oxford*, *supra* n 2, additionally relied on policy arguments for refusing to hold the police duty bound.

³⁶ See *supra* n 4 at 52-53.

³⁷ See *What CHI has found in: ambulance trusts* (Commission for Health Improvement, 2003) at 17.

Would there be liability in this hypothetical case? It is strongly arguable that Lord Woolf M.R. would have held that there was a positive duty to respond, unless there were *in fact* good grounds to refuse the call or to delay dispatch.³⁸ After all, he rejected the primary submission of the London Ambulance Service that, like a fire brigade, it was not liable, whether it failed or refused to respond or responded incompetently, provided that no more damage results than if it had done nothing at all.³⁹

Crucially, as in *Lowns*, both the trial judge and the Court of Appeal in *Kent* saw themselves as aligning the law with public expectation and moral sentiment.⁴⁰ Perhaps for this reason, the judgment has attracted little adverse comment in the medico-legal literature.⁴¹ It hardly needs adding that the earlier cases, which reject the notion (wrongly, it is submitted) that the other emergency services owe a duty to go to the assistance of those they know to be in physical peril, sit uneasily alongside *Kent*.⁴² As one commentator observed at the time, it is those cases, rather than the *Kent* decision, that are 'ripe for reappraisal'.⁴³

³⁸ Even so, liability would not necessarily follow, of course, unless the court was also prepared to see the mistake as sufficiently culpable and causative.

³⁹ *Supra* n 4 at 43 and 53.

⁴⁰ Turner J., with whom Lord Woolf agreed, said he would have found it 'offensive to, and inconsistent with, concepts of common humanity if...the law could not provide a remedy' in these circumstances, see *supra* n 25 at 453.

⁴¹ *Cf.* T. Hickman, 'And that's Magic – Making public bodies liable for failure to confer benefits' [2000] C.L.J. 432 and the law reporter's critical 'Commentary' on the reasoning of Turner J., see *supra* n 25 at 456.

⁴² See the cases cited *supra* n 2. Booth and Squires, *supra* n 14 at paras 12.02 and 12.38, say it is unclear whether this difference in outcomes is due to 'differences in the services themselves' or simply *when* the cases were decided. Only *Kent* was heard after 'the significant expansion' of public authority liability following decisions such as *Barrett v. Enfield LBC* [2001] 2 A.C. 550. The legal differences make little

The following section traces how far *Kent's* recognition of a duty of medical rescue has been translated into actual litigation against ambulance services and, hence, provides a means of testing whether pragmatic anxieties about the potential of liability to produce adverse effects on this public service provider have proved to be well-founded.

III. EXTENT OF LITIGATION AGAINST ENGLISH AMBULANCE TRUSTS

A. Source and reliability of the data.

In an attempt to establish the number and type of claims brought against ambulance trusts a data request was submitted to the NHSLA. The Litigation Authority kindly provided an anonymised summary of all claims reported under the Clinical Negligence Scheme for Trusts (CNST) in the period 1 April 1995 (since the inception of CNST) to 1 December 2004.⁴⁴

practical sense, and seem particularly arbitrary in some contexts, such as road traffic accidents, where fire, police and ambulance services are heavily inter-dependent and must necessarily work closely together if they are to be effective saving people and property, see K. Williams, 'Road Accidents and the Emergency Services: The Law and Practice of Professional Rescue Revisited' (2003) 19 P.N. 517.

⁴³ See *supra* n 6 at 351. W.V.H. Rogers (ed.), *Winfield and Jolowicz on Tort*, 17th edn (Sweet and Maxwell, 2006) at 180 points out that while the fire service is primarily concerned with saving (usually insured) property and that any duty would likely enure for the benefit of a subrogated fire insurer that 'would hardly justify a different result where life was at risk from fire'. See too R. Lewis, 'Insurance and the Tort System' (2005) 25 L.S. 85 at 103 speculating on the influence of insurance on judicial decision-making in this context.

⁴⁴ CNST is a voluntary, risk-pooling scheme which meets the cost of medical negligence claims against the NHS. All ambulance trusts are members. NHSLA handles claims arising under the Scheme on behalf of English NHS trusts. Ironically, *Kent v. Griffiths*, *supra* n 4, was not included in the data set because legal proceedings were begun in February 1994, before NHSLA began to collect claims data. In addition to actual claims notified, the NHSLA database includes potential claims or 'incidents' (where a formal letter of claim has not been received but a patient has

Some preliminary words of caution should be entered concerning the completeness and reliability of the data supplied. It is only since April 2002 that the NHSLA has handled all claims, regardless of value. Before then, lower value claims were dealt with in-house by each trust and reporting these to the NHSLA was optional between April 1995 and April 2002. Consequently, the NHSLA does not have reliable data for 'below excess' claims, which were dealt with (and funded) locally before the 'call-in' date of April 2002.⁴⁵ Information on these claims was, accordingly, not included on the data spreadsheet. The absence of information about below excess claims in the earlier period may mean that our analysis of the data that was provided does not fully represent the claims experience of ambulance trusts across the whole ten-years.⁴⁶ A second potential problem arises from the fact the NHSLA database was originally designed primarily for financial rather than research or risk management purposes. Consequently, the way that information has been coded may not be entirely consistent. Moreover, only a limited amount of information was supplied about

indicated their intention to pursue a claim). 'Incidents' are not included in the data set provided.

⁴⁵ Different trusts elected for different levels of excess ranging from £10,000 to £500,000. Until April 2002, there were two categories of claim. First, those under a trust's excess whose outcome may or may not have been reported to NHSLA. Second, those believed to over the excess or under it but outstanding on 1 April 2002, which automatically transferred to NHSLA on that date.

⁴⁶ The extent of any distortion is not known. Analysis of the data provided by NHSLA shows that most claims are lost, while those that settle mostly do so for fairly modest sums, see *D. Outcome of claims*, below. It follows that in the earlier era, before the 'call in' date in April 2002, some of these claims might not have been reported centrally to NHSLA because below the local excess. There is no central source of 'below excess' claims.

each claim.⁴⁷ This has meant that what can be said about the claims brought is necessarily circumscribed and that categorising some of them proved to be difficult. Finally, the spreadsheet showed a total of 266 claims across the ten-year period. However, three claims had to be excluded after closer inspection revealed that they had not been brought against ambulance trusts. It follows that we cannot be completely confident that the NHSLA's database search has correctly identified and included all ambulance claims.⁴⁸

B. Nature of the data and number of claims

The spreadsheet provided only basic anonymised information⁴⁹ about the remaining 263 claims, as follows:

1. a brief synopsis of the adverse event (usually in less than 50 words), together with an indication the nature of the main injury, its principal cause, and the location;
2. the incident date;
3. the notification date (when the legal claim was intimated to the trust);
4. whether the claim is open or closed;
5. the amount of damages and (usually) costs, if any, paid up to 1 December 2004.

⁴⁷ For what were said to be 'confidentiality' reasons the NHSLA took a policy decision not to allow the author access to the detailed case files.

⁴⁸ *Factsheet 3: information on claims* (NHSLA, July 2005) reveals a further discrepancy. It records the total number of claims (excluding 'below excess' claims) against ambulance services for the period April 1995 to 31 March 2005 as 242.

⁴⁹ See *supra* n 47 and text.

Here is an example of the sort of information typically provided for an individual claim. Incident details: ‘Ambulance attended patient at home. Limited investigation of patient’s condition. Patient advised suffering panic attack/indigestion. Patient left at home. Shortly thereafter suffered fatal coronary arrest’. Incident date: 11/10/1995. Notification date: 07/02/1996. Claim closed: 01/06/2000. Damages and claimant costs paid: £65,000 and £17,500.

Given the very large number of 999 calls and 'emergency patient journeys' each year,⁵⁰ and the fact that NHS ambulances provide virtually all the pre-hospital emergency care nationally,⁵¹ a total of 263 claims across almost a ten-year period seems surprisingly modest. It is possible, as indicated earlier, that the database search did not disclose all claims alleging medical negligence. On the other hand, we know that claiming is, as Mulcahy says, ‘an atypical response to medical mishap’ and that only the most serious mishaps are likely to be transformed into formal claims.⁵² It may also be that adverse outcomes are sometimes attributed

⁵⁰ See *supra* n 1 and 5.

⁵¹ Some emergency care is provided by volunteers, such as St John’s Ambulance Brigade, as well as by fire fighters, police, and NHS trained community ‘first responders.’ In parts of the country, particularly at major incidents, NHS ambulance provision may be supplemented by specialist scene-of-accident medical teams under the organisational auspices of the British Association of Immediate Care (BASICS). Details can be found at <http://www.basics.org.uk>

⁵² See L. Mulcahy, *Disputing Doctors. The socio-legal dynamics of complaints about medical care* (Open University Press, 2003) at 64. Estimates vary as to the incidence of 'adverse events' in the NHS and the frequency rate of claims. The number of claims rose almost fifteen-fold between 1995-6 and 2002-3 according to a report by the Chief Medical Officer, *Making Amends*. (Department of Health, 2003) at para 31. Even so, P. Pleasence et al, 'The experience of clinical negligence within the general population' (2003) 9 *Clinical Risk* 211 estimate that only about one negligently damaged patient per hundred actually claims. Claims are not necessarily

by damaged patients to their subsequent care when in hospital where there are more opportunities, across a longer timescale, for rectifying matters or for getting them wrong.

The 263 claims recorded against ambulance trusts represent only a very small proportion (less than 1 per cent) of all the medical negligence claims made against the NHS as a whole.⁵³ To the extent that claiming compensation is made easier by the introduction of an NHS 'redress scheme', which is intended to provide an alternative means of resolving complaints of medical negligence against hospital trusts without the need to commence court proceedings, more (low value) claims, including claims against ambulance trusts, may be made in future.⁵⁴ In 2006, the Health Minister told the House of Commons Constitutional Affairs Committee that 'we do expect more people to come forward'.⁵⁵

representative of complaints about adverse events, just as judicial decisions are not necessarily representative of claims.

⁵³ See *Factsheet 3: information on claims* (NHSLA, July 2005) showing the total number of claims against all NHS trusts between April 1995 and 31 March 2005 as 28,818 (including 242 against ambulance trusts).

⁵⁴ See NHS Redress Act 2006. Implementation of the scheme, which may be extended beyond hospitals to include claims against ambulance trusts, see s.1(5)(b), awaits detailed regulations and is unlikely to be fully operational before the end of 2008. There will be an upper limit on the value of admissible claims, which has yet to be specified. Currently, most claims against ambulance trusts that settle do so for relatively modest sums, see *D. Outcome of claims*, below. Apart from compensation, a remedial package under the redress scheme may provide for future care and rehabilitation, explanations and apologies.

⁵⁵ See *Compensation culture: NHS Redress Bill*, Fifth Report of Session 2005-06, (HC 1009, March 2006) at para 11. The projected increase in claims of 'anything from 2,200-19,500 a year' prompted the Committee, at para 12, to renew its call for the scheme to be 'piloted before national roll out'.

C. Types of claims

For the purpose of analysis, the author allocated each of the 263 claims to one or other of six categories according to the nature of the allegation or allegations made.⁵⁶ The categories of claim types employed (with the number of claims in each category given in brackets) are:

1. non-arrival of an ambulance following a summons, usually a 999 call (nil);
2. late arrival at the scene, including delayed dispatch (23);
3. delay in any subsequent journey to or between hospital(s) (13);
4. delay, as in 1 to 3 above, combined with one or more other factors, such as inadequate treatment at the scene or monitoring during a journey to hospital (16);
5. cases not involving delay at all but alleging some other failure, such as faulty diagnosis, inappropriate medication or equipment failure (202);
6. unclassified, because of inadequate case information (9).

Occasionally, allocating claims to categories was less than straightforward. For example, one laconic summary simply stated ‘Patient requested a 999 ambulance in early hours. On arrival, paramedic did not attempt resuscitation and advised that patient was dead’. It is difficult to know whether there was any element of a *Kent*-style ‘delay’ here or how this case should be classified, hence the need for a sixth category. This particular claim was closed after two and a half years

⁵⁶ See the Appendix, Table 1, showing the numbers for each type of claim and their outcome.

without any payment being made. There were nine unclassifiable claims in the sixth category accounting for 3.4 per cent of the total.

Categories 1 to 4 involve some element of ‘delay’. In that sense they resemble the sort of allegation (of failing to ameliorate existing harm) which had seemed so legally problematical before the Court of Appeal decided *Kent v. Griffith*.⁵⁷

Together the four categories constitute 52 of the total of 263 claims; fewer than one in five of all claims (19.8 per cent). The fear that *Kent* would give rise to an unmanageably large number of ‘delay’ claims has not proved to be justified in the event, though why there are so few is unclear. It may simply be that late arrival or slow journey times are comparatively rare.⁵⁸ Alternatively, prospective claimants may be deterred by the difficulty of making out a convincing case. While *Kent* may have swept away the idea that ambulance services are immune, claimants’ lawyers continue to face the not inconsiderable practical difficulty of proving that the defendant’s culpable breach of duty foreseeably caused their client’s damage. As we shall see, most claims fail.⁵⁹

It is also important to understand that ambulance services were facing negligent ‘delay’ claims well before *Kent* was decided by Turner J. at first instance in July 1999.⁶⁰ The first claim of this type in the data set is dated August 1996 and, like

⁵⁷ Had *Kent* been included in the data set it would have been a category 2 ‘late arrival’ claim.

⁵⁸ See below, *E. Arrival times and breach of duty*.

⁵⁹ See below, *D. Outcome of claims*.

⁶⁰ See *supra* n 25. The decision of the Court of Appeal, *supra* n 4, was handed down in February 2000.

Kent, involved an emergency call on behalf of a pregnant woman in distress at home.⁶¹ Moreover, whilst the number of ‘delay’ claims went up after 1999, they did so directly in line with the increase in more conventional ‘non-delay’ claims in the second half of the ten-year period under review.⁶² Accordingly, it seems clear that *Kent* has not prompted a rash of novel ‘delay’ claims; nor has it been responsible for a step change in claiming behaviour. It is more aptly seen as the judicial culmination of a pattern of claims that was already underway.⁶³ Nor does the *Kent* decision seem to have resulted in a new pattern of settlements or a more claimant-friendly approach on the part of defendants. In total, there are 36 ‘delay’ claims with known outcomes. Eight were brought between 1995 and 1999, prior to the decision in *Kent*, two of which resulted in damages being paid. A further 28 ‘delay’ claims were brought in the post-*Kent* period between 2000 and 2004, five of which resulted in a compensation settlement (17.8 per cent).

The ‘non-delay’ claims (represented by category 5) numbered 202 or 76.8 per cent of the overall total. So, the bulk of cases appear to be making what are, legally speaking, conventional complaints about negligent conduct by ambulance

⁶¹ The claim alleged delay in arrival to treat a pregnant woman with a prolapsed cord resulting in her child suffering cerebral palsy. Though a decision to admit liability and settle had been taken earlier, at the time the data spreadsheet was compiled in December 2004 the claim was still classed as outstanding, perhaps because of uncertainties about prognosis and quantum.

⁶² Between 1995 and 1999 there were 9 ‘delay’ claims, while between 2000 and 2004 there were 43 (82.7% of the total). However, 218 of the overall total of 263 claims (the vast majority of which did not involve *Kent*-like allegations at all) similarly occurred in the second five-year period, accounting for 82.9% of the total.

⁶³ It may be that ambulance services and the NHSLA did not take the ‘no duty’ point until prompted by the decision in favour of fire brigades in 1999, see *supra* n 27, and that here (as with claims against other parts of the NHS) breach and causation have always been the dominant litigation issues.

crews (such as dropping a stretcher or misdiagnosis), rather than alleging nonfeasance or failure to rescue. Given the possibility that a highly diverse range of errors might be expected to contribute to harming patients, the types of claims made turns out to be surprisingly narrow. For example, there are virtually no allegations of organisational failure associated with such matters as understaffing, too few ambulances, communications breakdowns or inadequate expenditure, equipment or maintenance. Perhaps this is because these sorts of shortcomings are less evident to potential claimants, as well as presenting their lawyers with the difficulty of mounting a successful challenge to what look like (on one view) decisions about funding or the allocation of scarce resources. Claimant lawyers may be fearful that judges will treat such challenges as non-justiciable and hence as 'no duty' areas.⁶⁴ Furthermore, the tendency of fault based liability systems is, in any event, to individualise blame.⁶⁵ In *Kent*, the trial judge said that he had not found it 'necessary' to make findings of 'organisational fault because of the serious and obvious shortcomings of both members of this ambulance crew'.⁶⁶

If we break down the category 5 'non-delay' claims, we find that more than a third (38.1 per cent) arose out of the simple act of transporting patients. Injuries were caused when patients were getting into or out of ambulances, when they

⁶⁴ See *supra* n 28 and text.

⁶⁵ See Mulcahy, *supra* n 52, chapter 4. In contrast, the NHS nowadays claims to concentrate increasingly on identifying the systemic causes of adverse incidents rather than operating a 'blame culture' focusing on the personal fault of individual members of staff.

⁶⁶ See *supra* n 25 at 447.

were being transferred to or from an ambulance, or when in transit (as by not being properly strapped in, for example).⁶⁷ Another, even larger group of claims, amounting to almost one half of the total (46.5 per cent), appear to be associated with the quality of the medical care that patients say they were given, whether that was faulty diagnosis, inappropriate medication or treatment or not being taken to hospital for further care and assessment. In principle, these are the kind of core medical negligence allegations which present no novel or troubling features for the law as regards duty, though for claimants' lawyers no doubt some may pose evidential difficulties about whether it can be shown, on balance, that the harm complained of was in fact caused by a culpable want of professional care, as defined by the conventional *Bolam* standard.⁶⁸

D. Outcome of claims

The 263 claims in the data set were analysed according to outcome. The five categories employed (with the number in each category given at the end in brackets) are:

A. claim closed or discontinued with no compensation paid (128);

⁶⁷ A minority of these claims involved transport ambulances or community care vehicles rather than emergency ambulances staffed by paramedics. According to a report by the National Audit Office, *A Safer Place for Patients: Learning to improve patient safety* (NAO, 2005), HC 456, at 32, across the NHS generally, patient falls are more routinely reported than medication errors or adverse drug reactions. Because falls (unlike some medication errors) are obvious to patients, they might also be expected to result in more complaints and, hence, claims. As to the causes and frequency of medication errors see a report by the Chief Pharmaceutical Officer, *Building a safer NHS for patients. Improving medication safety* (Department of Health, 2004).

⁶⁸ See *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582. This pro-defendant standard is relevant only to allegations of *professional* negligence. It is not available where a simple want of ordinary care is alleged, such as careless driving or dropping a stretcher.

- B. claim settled, damages below £10,000 paid (excluding costs) (36);**
- C. claim settled, damages of £10,000 or more but less than £100,000 paid (excluding costs) (13);**
- D. claim settled, damages of £100,000 or more paid (excluding costs) (3);**
- E. claim settled, amount unknown/not recorded (4);**
- F. claim outstanding at 1 December 2004 (79).**

Overall, almost a half (128 of all the 263 claims in the sample) fell into the first category as having failed (48.7 per cent) with the NHS paying the claimant nothing. This proportion rises above two thirds if we concentrate solely on the claims with known outcomes. Subtracting the 79 cases which were outstanding from the overall total of 263 cases, we are left with 184 concluded claims. Of these, only 52 (28.3 per cent) achieved any settlement resulting in a payment of damages.⁶⁹

Of the 52 successfully settled claims in all categories, 36 or more than two thirds received less than £10,000 in damages (69.2 per cent); a further quarter (13 in all) attracted damages payments above £10,000 but less than £100,000; only three claims exceeded £100,000. The highest single payment was £900,000; the lowest £500. The damages paid across the ten-year period totalled just over £2 million

⁶⁹ Claims against ambulance trusts are less successful than claims against the NHS as a whole. Between April 1995 and March 2006, some 47% of all medical negligence claims against the NHS were settled in favour of claimants, 38% were unsuccessful, while 15% were outstanding. If we subtract the outstanding claims from that total, the percentage of winners to losers is 55% to 45%. See *Factsheet: information on claims* (NHSLA, July 2006).

with the average payment amounting to £38,621.⁷⁰ Defence costs paid by the NHS averaged £12,104 per successful claim. While purely a matter of impression, since the data provide insufficient detail concerning injuries, earnings and so forth, these levels of settlement hardly suggest that successful claims against ambulance trusts as a class represent a crippling burden on NHS resources, albeit exceptional cases involving grave injury inevitably attract large sums.⁷¹

Unfortunately, because the spreadsheet provided only limited information, it is not possible to say *why* individual claims were won or lost or to identify particular characteristics as being associated with success or failure. However, it was possible to re-categorise the winners and losers according to the type of claim they brought.⁷² This shows that those involving 'delay' (categories 1 to 4) were marginally less successful than 'non-delay' (category 5) cases. There were 36 'delay' claims with known outcomes of which 29 (80.5 per cent) failed, whereas 96 of the 142 'non-delay' claims with known outcomes failed (67.6 per cent). These apparent differences in proportion are not statistically significant.⁷³

⁷⁰ In 1999-2000, the average successful medical negligence claim cost the NHS £87,000 plus £27,000 defence costs (excluding brain damage cases, which represent 5% of claims but 60% of NHS litigation expenditure), see National Audit Office, *Handling clinical negligence claims in England* (NAO, 2001) HC 403, at para 2.20. According to *Making Amends*, *supra* n 52 at para 46, damages across *all* types of claim averaged £111,595 in the mid-1990s rising to £259,038 by 2002.

⁷¹ One of the claims (concerning a young mother who suffered serious brain damage) was listed on the spreadsheet as outstanding but appears to have been settled subsequently out-of-court for a reported £2.8 million, see *The Times*, 6 December 2005 ('Mother wins £2.8m after suicide bid').

⁷² See Table 2, Appendix.

⁷³ Chi-square statistic equals 2.3 with one degree of freedom. Probability (p) = 0.013.

This may seem surprising at first sight since ‘delay’ claims might be expected to pose greater difficulties than those involving more conventional charges of medical negligence. On the other hand, because casualties are, by definition, already ill or injured, both ‘delay’ and ‘non-delay’ claimants equally face the problem of proving that it was the defendant’s unreasonable conduct that caused the adverse outcome in question. Proof of causation is a particular difficulty facing virtually all those who complain that a medical mishap has made them worse or lost them the chance of a better outcome.⁷⁴

E. Arrival targets and breach of duty

Demonstrating that a particular journey took ‘too long’ or that earlier arrival and intervention would have been beneficial is unlikely to be easy for claimants, notwithstanding that performance targets for ambulance arrival times have been in existence since 1974. More recently, in an attempt to ensure that life-threatening cases get the quickest response, a system for prioritising emergency calls was introduced on a trial basis in 1997 and, by April 2001, had been adopted by all English ambulance trusts. Currently, they are expected to reach 75 per cent of Category A calls (immediately life-threatening emergencies) within

⁷⁴ See *Gregg v. Scott* [2004] U.K.H.L. 41 confirming that claimants, ordinarily, must prove their loss on the balance of probabilities. Consequently, a failure to diagnose a patient’s cancer reasonably promptly, so reducing his chances of a cure from 42% to 25%, was not actionable. The rule is less strict for patients who complain they were not properly advised of treatment risks before giving consent, see *Chester v. Afshar* [2004] U.K.H.L. 41 holding liable a neurosurgeon despite the fact that the patient might, if warned, have consented to the operation (and hence have run the inherent risks) at a later date. For a discussion of these decisions, see S. Green, ‘Coherence of Medical Negligence Cases. A Game of Doctors and Purses’ (2006) 14 Med. L. Rev 1.

eight minutes and 95 per cent within 14 or 19 minutes, depending on whether the service in question is classed as 'urban' or 'rural'.⁷⁵

Neither of these innovations was prompted by *Kent* and, for a variety of reasons, neither should exert much influence in claims negotiations or in litigation.

Department of Health arrival targets were designed as an 'efficiency' measure of the *overall* performance of each ambulance trust and as a means of ranking trusts nationally, rather than as indicating that the response to a particular emergency call was satisfactory. Even as regards the former function, the targets are only doubtfully fair.⁷⁶ As regards the latter, researchers in the United States, where arrival times were first used, have questioned the clinical justification for generalised arrival targets.⁷⁷ There is also the well known danger that performance targets may become an end in themselves, so distorting service priorities.⁷⁸ Furthermore, the effectiveness of call categorisation is likely

⁷⁵ The official figures suggest that the proportion of timely arrivals now exceeds the targets and is rising. See *Ambulance Services, England: 2004-05*, (NHS Health and Social Care Information Centre, 2005), n 1. However, there are doubts about both the reliability and the utility of response time data. See Commission for Health Improvement, *What CHI has found in: ambulance trusts* (CHI, 2003).

⁷⁶ The Audit Commission has pointed out that different ambulance trusts not only face very different geography, populations and economies of scale, but also different levels of revenue funding and capital investment, see *A Life in the Fast Lane* (Audit Commission, 1998) at 12.

⁷⁷ See P.T. Pons and V.J. Markovchick, 'Eight minutes or less: does the ambulance response time guideline impact trauma patient outcome?' (2002) 23 *Journal of Emergency Medicine* 43, pointing out that clinical 'justification of specific time criteria for specific medical or traumatic emergencies is lacking'.

⁷⁸ A CHI report in 2003 found that the 'eight minute' target tended to divert attention from other targets (such as dealing with GP urgent calls) and encouraged 'gaming and misrepresentation'. It concluded that 'better measures' of both response times and clinical outcomes are needed, see *supra* n 75 at 9 and 17. On the potential of performance measures to produce unintended, perverse consequences see S. van Thiel

to be undermined to the extent that the information provided about medical emergencies is unreliable⁷⁹ or the 999 system is misused.⁸⁰ In the result, a 999 call may say little about the actual medical needs of an individual casualty or about the circumstances on the ground facing the ambulance crew allocated to attend. Response and arrival times are likely to be affected by a wide range of factors including traffic and weather conditions, the adequacy and accuracy of the information provided by the 999 caller, the location of available ambulances (particularly in large rural areas), crew expertise, and whether the trust faces conflicting calls on its resources.⁸¹ Accordingly, because national performance standards indicate only what government expects generally and how it measures value-for-money, they ought to be accorded negligible probative value in individual negligence claims, which will be heavily dependent on their own discrete facts.⁸²

and F. L. Leeuw, 'The Performance Paradox in the Public Sector' (2002) 25 *Public Performance and Management Review* 267.

⁷⁹ Unreliable information caused by communication problems, for example, may delay the dispatch of an ambulance or result in a caller being given inappropriate first aid advice. See J. Higgins *et al*, 'Communication difficulties during 999 ambulance calls: observational study' (2001) 323 *British Medical Journal* 781.

⁸⁰ Maybe 40% of 999 calls do not justify an emergency response. See H. Snooks *et al*, 'Appropriateness of use of emergency ambulances' (1998) 15 *Journal of Accident and Emergency Medicine* 212.

⁸¹ Whether defendants might, additionally, be able to rely on a 'no breach' argument by citing systemic difficulties caused by under-funding is both uncertain and controversial. See C. Witting, 'National Health Service Rationing: Implications for the Standard of Care in Negligence' (2001) 210 *J.L.S* 443.

⁸² Contrast the potential of *clinical* guidelines to influence how the standard of medical care might be interpreted in the courts. See A. Samanta *et al*, 'The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the *Bolam* Standard?' (2006) 14 *Med. L. Rev.* 321 cautiously recommending their use. See too *Nicolson v. States of Jersey Health and Social Services Committee* [2004] J.C.A. 203, noted by T. Hanson (2005) 13 *Med. L. Rev.* 268, where despite a failure to meet the

When deciding whether the ambulance in *Kent* had taken an unreasonably long time to arrive, Turner J. paid little attention to the then current performance target, which had been well exceeded.⁸³ Instead his Lordship concentrated on two other matters. They were, first, the defendant's signal failure to explain *why* it had taken some 34 minutes for the ambulance to travel 6.5 miles to the claimant's home, barely equal to 12 mph, when a specially staged 'test run' had indicated that the journey ought to have taken fewer than twenty minutes, and second, the fact that the times in the ambulance log book had been deliberately falsified to show a shorter travel time of about nine minutes.⁸⁴ Turner J emphasised that the delay needed some exculpatory explanation, such as heavy traffic. None was offered.

In one of the few post-*Kent* litigated decisions, *Barry v. NHS Litigation Authority*,⁸⁵ the time taken to arrive was not the issue. Rather it was alleged that the initial treatment of the pregnant claimant at her home for a prolapsed cord, and the later 'blue light' journey to hospital, were too slow. Refusing to find culpable delay, the judge was unimpressed by the theoretical possibility that

professionally recommended 'ideal' timeframe for a decision about a caesarean delivery the defendants were declared not to have been negligent on the facts.

⁸³ The 1974 ORCON target (arrival within 14 minutes at 95% of 999 calls) was a 'minor area of dispute'.

⁸⁴ See *supra* n 25 at 445-46.

⁸⁵ [2000] E.W.H.C. 894. Application for leave to appeal refused [2002] E.W.C.A. Civ. 1250.

another crew might have performed the tasks more swiftly. Counsel for the NHSLA has since said that proving breach is ‘a real hurdle in such claims’.⁸⁶

The fact that ambulances will commonly be responding to what is believed to be an emergency must inevitably weigh heavily with a court when breach questions come to be considered.⁸⁷ Thus in *Kent*, Turner J. observed that in ‘a situation of emergency the consequent duty will not be set at an unrealistically or unattainably high level’,⁸⁸ while Lord Woolf M.R. said that he would be reluctant to impute fault where, for example, in a multiple casualty incident a quick decision about who should be taken to hospital first subsequently turned out to be wrong.⁸⁹

Proving breach may also present problems to claimants who are not patients. In *King v. Sussex Ambulance NHS Trust*,⁹⁰ the Court of Appeal held that an

⁸⁶ M. de Navarro Q.C., ‘Casenote’, *Medical Litigation*, October 2002, 14 at 15.

⁸⁷ The Compensation Act 2006, s.1 allows (without requiring) courts deciding breach questions to consider whether imposing liability might prevent or discourage a ‘desirable activity’. Whether this will help ambulance services or other healthcare providers better defend medical negligence claims may be doubted, since, arguably, it merely restates the common law position, see n 91 and text. To the extent that greater openness is now an NHS goal, defendants may be more encouraged by s. 2 which declares that an apology or offer of treatment or other redress ‘shall not of itself amount to an admission of liability.’

⁸⁸ See *supra* n 25 at 453. In *Capital and Counties*, *supra* n 2 at 105, Stuart-Smith L.J. said that in a rescue context, *Bolam* imposes a ‘very high threshold test’ of liability. See too Lord Clyde in *Phelps v. Hillingdon London Borough Council* [2001] 2 A.C. 619 at 672 placing reliance on *Bolam* as a robust bulwark against unmeritorious claims.

⁸⁹ See *supra* n 4 at 53.

⁹⁰ [2002] E.W.C.A. Civ. 953.

ambulance technician who injured his back when helping to use a 'carry chair' to lift an elderly patient down a steep flight of stairs had no claim against his employer. Exposing their employee to a foreseeable risk of harm, which might have been unreasonable in other circumstances, was justified given the absence of any feasible alternative strategy or safer equipment, as well as by the exigency of the emergency. Whilst accepting the principle that an ambulance service owes the same duty of care towards its staff as other employers, both Hale and Buxton L.JJ. noted that, unlike commercial enterprises, an ambulance service does not have the luxury of being able to refuse to tackle an emergency and may be liable under the *Kent* rule if it unreasonably fails to respond. The risk of injury must be balanced against the social utility of the activity giving rise to the risk.⁹¹

In *Kent v. Griffiths* itself, Lord Woolf's view was that the burden of showing a causative want of proper care would ordinarily provide ambulance services with what he called the 'necessary protection' against liability, except where their conduct was manifestly deficient.⁹²

IV. CONCLUSIONS

At a time when the danger of a so-called 'compensation culture' spawning a 'litigation crisis' has come to dominate much public and political discourse,⁹³ it

⁹¹ See too *Watt v. Hertfordshire County Council* [1954] 1 W.L.R. 835. Buxton L.J. in *King, ibid.*, at [48] nonetheless said that *Watt* may need 'reconsideration' in the light of *Ogwo v. Taylor* [1988] 1 A.C. 431.

⁹² See *supra* n 4 at 53.

⁹³ See K. Williams, 'State of fear: Britain's "compensation culture" reviewed' (2005) 25 L.S. 499 and R. Lewis *et al.*, 'Tort personal injury claims statistics: Is there a compensation culture in the United Kingdom?' (2006) 30 J.P.I.L. 87.

would not be surprising if potential defendants were fearful of judicial decisions that seem to stretch the liability regime. The effects of such decisions may be unpredictable and costly. Being unable easily to pass on increased costs, except to taxpayers, NHS trusts and other public sector organisations, may feel especially vulnerable. In this climate, the sorts of policy concerns which appear to lie behind the judicial reluctance to impose duties of care on some public rescuers, such as fire fighters, as well as the specific floodgates anxieties expressed by the NHSLA and others in the aftermath of *Kent v. Griffiths*, are readily understandable. However, it cannot plausibly be said that the NHS faces a litigation crisis as the result of claims against ambulance trusts or, indeed, generally.⁹⁴

What this analysis has shown is that an unduly onerous burden has not been imposed and that however radical as a matter of legal theory, in practice, *Kent* has not generated an unmanageably large or costly tranche of novel rescue claims that are difficult to defend. This is, perhaps, rather as the Court of Appeal had anticipated, albeit that when the Court decided to recognise a duty of medical rescue it was inevitably doing so in an empirical vacuum.

⁹⁴ While estimates vary as to the ratio of claims to adverse events, it may be that only one negligently damaged patient per hundred claims, see Pleasence *et al*, *supra* n 52. See too the evidence of M. Jones given to the House of Commons Constitutional Affairs Committee enquiry, *Compensation Culture*, Third Report of Session 2005-06, H.C. 754-II, Ev 187 at paras 22 to 34. *Cf.* Health Minister, Jane Kennedy, inaccurately and unhelpfully justifying the introduction of the NHS Redress Bill, see *supra* n 54 and text, as an 'important step in preventing a US-style litigation culture', Department of Health press release 2005/0349, 13 October 2005.

Claims against ambulance trusts represent 0.86 per cent by number and 0.54 per cent by value of all medical negligence claims made under the CNST against the NHS as a whole.⁹⁵ We saw earlier that fewer than three claims in ten against ambulance trusts succeed and that, insofar as the data allow us to say, compensation payments appear to be relatively modest.⁹⁶ Simple care failures when transporting patients and treatment errors are four times more likely to be brought against ambulance trusts than claims alleging delays or failures to rescue.⁹⁷

If we are interested in improving medical care and reducing the harm done to patients, the value of analysing the frequency and disposition of claims has some limitations.⁹⁸ Nonetheless, it is a worthwhile exercise. As the National Audit Office observed in 2005, information gathered from complaints and litigation has tended to be an 'under-exploited...learning resource'.⁹⁹ This paper has sought to provide an explanation of the practical impact of *Kent v. Griffiths* in terms of the types and outcomes of claims, as well as a means of evaluating whether the commonly expressed pragmatic concerns about the potential of liability to

⁹⁵ Percentages derived from *Factsheet 3: information on claims* (NHSLA, July 2006) covering the period from April 1995 to 31 March 2006. In total, medical negligence claims cost less than 1% of the overall budget of the NHS.

⁹⁶ See III above, *D. Outcome of claims*.

⁹⁷ See III above, *C. Types of claim*.

⁹⁸ See, for example, J. W. Hughes and E. A. Synder, 'Evaluating Medical Malpractice Reforms' (1989) 7 *Contemporary Policy Issues* 83 on the methodological difficulties of evaluating the deterrent or other effects of legal reform strategies.

⁹⁹ See NAO report, *supra* n 67 at 10.

produce adverse effects are well-founded.¹⁰⁰ Whether the decision has had other, broader effects on the way, for example, that ambulance trusts are organised or on the quality of pre-hospital emergency care awaits further research. It is possible that *Kent v. Griffiths* has prompted managerial or other structural changes, perhaps designed to improve service delivery or to minimise its impact on the litigation budget.¹⁰¹

¹⁰⁰ Where only anecdotal evidence is available, it is likely that the practical effects of a liability rule will be poorly understood. Yet, as Lord Steyn noted in *Eastwood v. Magnox Electric plc* [2004] U.K.H.L. 35 at [39], 'the way in which a rule or principle operates in the real world is one of the surest tests of its soundness'.

¹⁰¹ Any impact study would need to evaluate the influence of a wide range of other factors, including the gradual introduction of better risk management strategies across the NHS. See, for example, *Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service* (NHSLA, 2006). Apart from other hoped for benefits, a trust meeting these standards is entitled to a discount on the CNST contribution it pays.

