[2004] EWHC 644 (QB)

Case No: HQ 0101462

IN THE HIGH COURT OF JUSTICE

QUEENS BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL
26 March 2004

Before:

THE HONOURABLE MR JUSTICE GAGE

Between:

A B and Others

Claimant

- and -

Leeds Teaching Hospital NHS Trust

First Defendant

Cardiff and Vale HNS Trust

Second Defendant

Mr Richard Lissack QC and Mr Peter Skelton (instructed by Clarke Willmott) for the Claimant

Miss Sally Smith QC, Mr David Hart QC and Mr Owain Thomas (instructed by Hempsons) for the Defendants

Hearing dates: 26 January to 17 February 2004

Mr Justice Gage:

Introduction

In September 1999, when giving evidence to the Inquiry into the management of the care of children receiving complex heart surgery at Bristol Royal Infirmary, Professor Robert Anderson, a distinguished professor of paediatric cardiac morphology, disclosed that for a long period of time tissue had been taken at or after post-mortems on children without being disclosed to the parents. The tissue had been removed and retained by pathologists at various named hospitals around the country. As a result a census was conducted during the year 2000 of organs and tissues retained by pathology services. The Bristol inquiry was asked to produce an interim report dealing with this issue. There followed two further inquiries one of which was an inquiry into the practice of removal and retention of children's organs at the Royal Liverpool Children's Hospital in Liverpool. These inquiries and the public outcry following the disclosure by Professor Anderson are the genesis of the litigation which has led to the trial by me of three lead actions in group litigation entitled the Nationwide Organ Group Litigation (NOGL).

The NOGL was the second of two group litigation orders made in respect of claims and potential claims by parents in respect of the removal and retention of deceased children's organs. The first order was made in respect of claims arising out of organs removed and retained at the Royal Liverpool Children's Hospital at Alder Hey (RLCL). The group order for that group was made on 18 December 2000. The NOGL order was made on 16 May 2001 in respect of organ retentions at other hospitals.

In January 2003, following mediation, the RLCL was compromised and on 31 January 2003 I made a final order in that litigation. On the same date I gave directions for the hearing of lead actions in the NOGL. These and subsequent orders have culminated in the trial of these three lead claims. In addition to the three lead claims the parties have agreed that I should decide four preliminary issues based on an agreed factual matrix and two agreed assumptions. In this way it is hoped that the resolution of the three lead claims and the preliminary issues will dispose of the vast majority of the 2140 claims on the register in the NOGL.

Background

The three lead claims all concern organs removed from children at post-mortems and retained in the hospitals where the post-mortems were carried out until such time as the organs were disposed of. In each case the claimants or claimant are the parents of the deceased children. It is alleged in each case that the organs were removed, retained and subsequently disposed of without the knowledge and consent of the claimants. The claimants claim damages for nervous shock, or psychiatric injury as it is more commonly known, caused by these events.

Karen and David Harris

The first claimants are Mr and Mrs Harris. Karen Harris was born on 16 August 1969. Her husband, David Harris, is a little older than her. He had been married before and had two sons by his first wife. One of the sons has Downs Syndrome. In 1995 Mrs Harris became pregnant with Rosina. She said in evidence that she had always wanted a large family. Ten weeks into her pregnancy she was diagnosed as diabetic. At 20 weeks she and her husband learnt that their baby was likely to suffer from a rare condition known as arthrogryposis. They were strongly advised to terminate the pregnancy. They rejected that advice and at 28 weeks on 6 October 1995 Mrs Harris was admitted to the West Dorset General Hospital (the first defendant in this action) as an emergency and underwent a caesarean delivery of her baby daughter, Rosina. The baby weighed 686 grammes and was born with severe multiple abnormalities. Rosina lived until 9 October 1995 when she died. A post-mortem was

conducted on Rosina during which her brain, heart, lungs and spinal cord were removed. These organs were retained in the Southampton University Hospital (the second defendant in this action) where the post-mortem had been carried out. On 16 October Rosina was cremated without these organs being returned to her body. By a letter dated 31 May 2001 from the Southampton University Hospital Mr and Mrs Harris learnt for the first time that Rosina's organs had been removed at the time of the post-mortem and retained in the hospital. Subsequently they were told that the organs had been disposed of. Mr and Mrs Harris complain that not only did they not consent to those organs being removed and retained but when asked if a post-mortem could be carried out they gave specific instructions that all organs removed must be returned so that Rosina could be buried or cremated whole.

Susan Carpenter

Susan Carpenter was born on 8 August 1959. In 1980 she married Alan Carpenter. They now have three children. On 12 September 1985 Susan Carpenter gave birth to a boy, Daniel Gordon Carpenter. He was her first child. Her pregnancy was normal and Daniel was for just over a year a perfectly normal healthy child. At Christmas 1986 he started to cry a lot. Throughout January 1987 his health deteriorated and at the beginning of February he was diagnosed as having a brain tumour. On 3 February 1987 at Southampton University Hospital an operation was carried out on Daniel to remove the tumour which was found to be round the brain stem. Following the operation Daniel's health improved over the next few days but suddenly deteriorated and on 8 February 1987 he died.

Mrs Carpenter was fulsome in her praise for the doctors and staff who treated Daniel at Southampton University Hospital (the defendant in this action). She was quite satisfied that everything possible had been done for him and that she knew the cause of his death. However it was explained to her that since Daniel's death occurred following an operation it had to be reported to the coroner and a post-mortem carried out. She and her husband were unwilling for a post-mortem to be carried out. Mrs Carpenter went so far as to telephone the coroner and discussed this issue with him. During the conversation she says she was told that the post-mortem would only involve the operation site. The post-mortem was carried out at the Southampton University Hospital and on 17 February 1987 Daniel was buried in Norfolk near the home of Mr Carpenter's parents. The service was conducted by the same priest who had married Mr and Mrs Carpenter.

At the time when Mr and Mrs Carpenter were married both of them were serving in the Royal Navy and living in the Gosport area. Subsequently each retired from the Navy and they went to live in Norfolk close to Mr Carpenter's parents. By a letter dated 5 March 2001, following an inquiry by Mr and Mrs Carpenter, they learnt that at the coroner's post-mortem Daniel's brain had been removed. The brain and small tissues of it were retained at the hospital. Subsequently they learnt that the brain had been cremated on 11 August 1987 but the hospital still retained a number of wax blocks and slides containing tissue samples taken from the brain and the brain stem. These were returned to the Carpenters and re-united with Daniel's remains at a service which took place on 16 November 2001.

Mrs Carpenter alleges that until March 2001 neither she nor her husband had any knowledge that Daniel's brain had been removed during the post-mortem.

Denise Shorter

Denise Shorter was born on 24 December 1966. On 6 February 1986 she was married to Brian Shorter. They now have two children. In early 1992 Mrs Shorter became pregnant with her first baby. On 9 October 1992 she went into spontaneous labour at approximately 40 weeks gestation. The midwife who examined her at home was unable to detect a foetal heart beat so Mrs Shorter was admitted to the John Radcliffe Hospital in Oxford (the defendant in this action). On admission she was examined and underwent an ultra-sound scan. The result showed that there was no foetal heart beat and Mrs Shorter was told that her baby was dead. At approximately 12.30 pm on 10 October 1992, after a difficult labour, Laura was born dead. Mrs Shorter was kept in the bereavement ward of the hospital for 4 days. During that time Laura's body was kept overnight in the mortuary but brought to her daily so that she and her husband could see her whenever they wished to do so.

On 12 October 1992 Mrs Shorter reluctantly agreed to a request for a post-mortem to be carried out on Laura. The post-mortem took place in the hospital on 13 October and Laura was buried on 20 October 1992. During the course of the post-mortem Laura's brain was removed and retained by the hospital. By a letter dated 2 November 2001 Mrs Shorter learnt for the first time that Laura's heart had been removed and retained by the hospital. Mrs Shorter complains that she only consented to the post-mortem on condition that everything which was taken out at the post-mortem would be put back before Laura was buried. She neither consented to nor was aware that Laura's brain had been retained.

The Causes Of Action

All the claimants allege that in removing and retaining organs from their babies the defendant hospitals committed the tort of wrongful interference. Mr and Mrs Harris and Mrs Carpenter further allege that the hospitals and their staff were negligent in a number of respects surrounding the post-mortems carried out on their babies. Mr and Mrs Harris also claimed damages for the tort of deceit but that cause of action was abandoned during the course of the evidence. All the claimants rely on breaches of Articles of the Human Rights Act.

All the claimants allege that the actions of the defendants have caused them to suffer psychiatric injury and they claim general and special damages arising out of their personal injuries. In addition all the claimants claim exemplary and aggravated damages.

The defendants deny that English law recognises any tort of wrongful interference with a body. In addition, they deny that they have in any way unlawfully interfered with the bodies of any of the children concerned in the lead claims. The defendants also deny that any of the actions of their servants or agents give rise to a claim in negligence.

Post-Mortems

To understand the issues in these cases, both factual and legal, it is necessary to have some understanding of the processes of and differences between hospital and coroners' post-mortems. As is well known a post-mortem is "an examination of a body to determine the causes of death" (see Black's Medical Dictionary 39th Edition). The lead claims involve two instances of hospital post-mortems (hereafter HPMs) – Harris and Shorter; and one coroner's post-mortem (CPM) – Carpenter. I shall set out first my understanding of the procedures involved in an HPM.

Hospital Post-Mortem

When an adult or baby dies in hospital either the relatives of the patient or the clinicians or both may decide that it is desirable for a post-mortem to be carried out. There are a number of reasons why it may be desirable which I shall deal with later when discussing the purpose of the individual post-mortems in the case of Rosina Harris and Laura Shorter. For present purposes it is necessary only to state that the principal reason is so that the relatives may know the cause of death and may be advised on any points of significance arising from the cause of death. It is common ground that before a post-mortem examination can be carried out in such cases the relatives must be asked if they object. All doctors who gave evidence in this case agreed that this was so. Most referred to the requirement as consent and not all were aware of the legal basis for this requirement. In fact, the Human Tissue Act 1961, to which I shall have to return later, makes non-objection of relatives a requirement before an HPM can be carried out. I shall throughout this part of the judgment use the word "consent" in respect of such post-mortems.

When consent has been obtained the post-mortem is carried out generally within a few days either in the hospital where the deceased died or in a nearby hospital with facilities for carrying out post-mortems. In HPMs the post-mortem may be specified as a full post-mortem, in which case all parts of the body may be the subject of investigation; or a limited post-mortem, in which case only those parts to which consent for a post-mortem has been given may be investigated.

The process involves the removal of human material, weighing it, examining it internally and externally, and if necessary carrying out a histological examination on it. Where, for instance, a heart is to be examined it will first be removed and examined externally in a three-dimensional form. It will then, if a histological examination is required, be fixed. This is a process of hardening it which may take anything up to 6 weeks but can be completed in less time. It is then ready to be sliced into blocks of tissue. Once the block has been made it undergoes a process which leads to the production of very thin slices which are dyed and processed onto slides so that they can be examined microscopically.

In the case of the brain or muscles the histological examination is normally carried out by a neuro-pathologist following removal by the pathologist at post-mortem.

The pathologist and/or the neuro-pathologist will prepare a report or reports setting out the examination and the conclusions. The report is sent to the clinicians so that the relatives can be informed of the result and be given any necessary advice.

The Coroner's post-mortem

In certain circumstances when an adult or baby dies in hospital the coroner must be informed (see the Registration of Births and Deaths Regulations 1987 (Regulation 41(1))). The only circumstance relevant in the case before me was the fact that Daniel Carpenter died shortly after an operation and therefore there was reasonable cause to suspect that his death was a sudden death within the terms of s8(1)(b) Coroners Act 1988.

Once the coroner, an independent judicial officer, has been informed he must decide whether or not to hold an inquest. He has a statutory duty to hold an inquest where he has reasonable cause to suspect that the deceased has died a violent or an unnatural death or has died a sudden death of which the cause is not known (see section 8 (1) of the Coroner's Act 1988).

However where the cause of death is unknown the coroner may direct a post-mortem examination if he is of the opinion that the post-mortem may prove an inquest unnecessary (see section 19 (1) of the 1988 Act).

If the coroner decides that neither a post-mortem nor an inquest is necessary he will issue a completed Form 100A or Pink Form A setting out the cause of death as certified by the deceased's clinicians. If he directs a post-mortem examination he will appoint a pathologist to carry out the examination. The coroner's authority over the body will stem from the moment he is informed. The pathologist will act as the coroner's agent, and, since the coroner has no facilities, the post-mortem will be carried out in a hospital usually the one at which the pathologist holds an appointment. The coroner pays the pathologist a fee for his work and the hospital for the use of its facilities.

If, following a post-mortem, the coroner decides that it is unnecessary to hold an inquest, as happened in Daniel Carpenter's case, he will issue a Form B certifying the cause of death. By Rule 9 of the Coroner's Rules 1984 the coroner is given authority to preserve material which in his opinion bears on the cause of death for such period as he thinks fit. There is a dispute about how long the coroner's authority over the body or any parts of it exists and what the consequences are when the coroner's authority ends. I shall have to return to this topic later in this judgment.

The process of examination at a CPM is exactly the same as for an HPM. During the course of the hearing, at the invitation of the parties, I attended the histology laboratory of St Thomas' Hospital, London. I was shown the procedure for making slides for microscopic examination from the point when slices had been taken to the point when the finished slide was produced. This is a complex procedure involving several processes some of which are carried out by sophisticated machines and some of which are carried out by trained technicians. A copy of the agreed note of this procedure, as demonstrated to me, is Appendix A to this judgment. I was told that procedures vary from hospital to hospital but only as to methods. The steps in the process are common to all hospitals and are broadly those outlined in paragraphs 17 and 18 of this judgment.

Findings Of Fact

Mr and Mrs Harris

Two issues of fact arise in respect of this claim. They are first what was the nature of the consent given by Mr and Mrs Harris for a post-mortem to be carried out on Rosina. Secondly, what was the effect, if any, on Mrs Harris' mental health when she discovered in 2001 that Rosina's body had been buried without the various organs which had been removed during the post-mortem. I shall deal with each issue separately.

Consent

In addition to the facts set out in the short synopsis in this judgment in paragraph 5 the following additional background facts are relevant. Having rejected the advice of a distinguished consultant obstetrician whom they saw in London, Mr and Mrs Harris were referred to Dr Rollo Clifford, the consultant paediatrician at the West Dorset General Hospital. He gave them less gloomy advice explaining in evidence that a pregnancy was likely to proceed more smoothly if the mother adopted a positive attitude. He did, however, advise them to consider the question of whether or not they wished vigorous efforts to

resuscitate the baby to be made if it was born in a very poor condition. He said that he would do his best to be present at the birth. In the event, shortly after this consultation, Mrs Harris was admitted for a premature delivery of Rosina. Rosina was delivered by caesarean section. She was very fragile and had many physical abnormalities. She was sent to the Special Care Baby Unit (SCBU) because her respiratory state was serious and she required ventilation and treatment. She was christened in the SCBU and during the course of the evening of 8 October 1995 Mr and Mrs Harris were advised that she would not survive. Just after midnight on 9 October 1995 the ventilation equipment was removed and Rosina died in the arms of her parents. She was certified dead at 0035 hours. Later on the same morning Mr Harris signed a consent form agreeing to a post-mortem being carried out on Rosina.

The post-mortem took place on 10 October 1995 at Southampton General Hospital and was conducted by Dr Isabella Moore, the Consultant Paediatric Pathologist at that hospital. At that post-mortem Rosina's heart, lungs, brain and spinal cord were removed for the purpose of examination. Dr Moore conducted the examination of the heart and lungs but sent the brain and spinal cord for examination by Dr David Ellison, the consultant neuro-pathologist at Southampton General Hospital at that time. There is no dispute as to the work carried out by Dr Moore and Dr Ellison. There is also no dispute that they carried out their examinations properly and professionally. Both stated in evidence that the examinations which each of them carried out were necessary for the purpose of establishing the cause of death and advising the parents about future pregnancies. The process of removing the organs from the body were described by Dr Moore. Rosina was a very small baby and it is obvious from what Dr Moore said that this process required great care and skill. For example, the heart was very small, weighing 5 grammes and was described by Dr Moore as being the size of a hazelnut. Both doctors described the process of fixing the organs and preparing blocks and slides in the same way as set out in Appendix A to this judgment. Each stated, and I accept, that neither had any intention of using any organ for the purpose of research nor was any organ so used.

Rosina's death was registered on 9 October 1995 and a certificate of death issued on 10 October 1995. On 16 October 1995 Rosina was cremated. On 14 November 1995 Mr and Mrs Harris were seen by Dr Clifford to discuss the post-mortem findings and the immediate cause of death. In the course of that meeting Dr Clifford told Mr and Mrs Harris that the cause of death was hyaline membrane disease as a result of extreme prematurity. He also informed them that Rosina was found to have been suffering from caudal regression syndrome and that the initial diagnosis of arthrogryposis was incorrect. Importantly, he told them that the abnormalities were unlikely to occur in a future pregnancy. On 24 January 1996 Dr Ellison completed his post-mortem examination of the brain and spinal cord. His report was sent to Dr Clifford. Following Dr Ellison's examination the retained material was probably disposed of at the Queen Alexandra Hospital, Portsmouth.

Mrs Harris in her witness statement stated that she and her husband made it "extremely clear" to both Dr Michael Michaels, the paediatric SHO, and Dr Clifford that at post-mortem tissue samples could be taken but whole organs were not to be taken and if removed returned to the body. In her witness statement and in evidence she said that because of her previous work experience in the medical records department of a maternity hospital in Bristol she had some knowledge of post-mortems. She had also seen medical programmes on television which gave her some insight into the nature of investigations carried out at post-mortems. She understood that biopsies would produce samples of tissue which could be examined microscopically.

She said that before Rosina was born she and her husband had discussed a number of issues concerning the prospective birth. They agreed that if the baby was very seriously ill they should not ask for her to be resuscitated. They also agreed that they would raise the question of donating her organs for possible transplants. In this latter respect Mrs Harris said in evidence that they had raised this question with Dr Michaels when they saw him in the SCBU about 10 minutes before Rosina died. Her evidence was that Dr Michaels had said that Rosina's organs were too small to be used for such a purpose. As to this, Dr Michaels agreed that there may have been such a conversation and it was possible that his view that the organs were too small for transplant may have emerged. However, he had no recollection of such a conversation and he would, in any event, have not known the answer if the matter had been raised.

Mrs Harris said that about 5 minutes after Rosina died when she, her husband and Dr Michaels were in the SCBU before Rosina's body had been taken away Dr Michaels raised the question of a post-mortem. In her statement and in evidence she said Dr Michaels asked them if they would consider a post-mortem on Rosina. He said Rosina's condition was rare and a post-mortem could be useful. She said her answer was that they would agree to a post-mortem and that biopsies and samples could be taken; the baby's organs could be weighed and photographs taken; but that Rosina must come back whole. In her statement she said that the organs could be looked at but must be put back into the body. In evidence she said that she made that a condition of consent to a post-mortem.

It is common ground that she was not present the following morning when shortly after 9.00 am Dr Clifford asked her husband to sign the post-mortem consent form. There is no dispute that David Harris did sign such a form. He signed under the following declaration:

"I consent to a post-mortem examination being carried out on the body of

Rosina Harris (in Mr Harris' handwriting)

And I am not aware that he/she had expressed objection.

I understand that this examination is carried out:

a) to verify the cause of death and to study the effects of treatment which may involve retention of tissue for laboratory study.

b) to remove tissue for the treatment of other patients and for medical education and research, as appropriate.

Deceased for cremation/burial.

Signed D Harris (in Mr Harris' handwriting)"

The form described Mr Harris as the father and was dated 9 October 1995 and witnessed by Dr Clifford.

Mrs Harris said that if she had seen that form she would have understood the word tissue to refer to material taken for a biopsy. She did not understand tissue to be a whole organ. Accordingly she would have had no anxiety about signing the form.

Mrs Harris was cross-examined about the difficulties relating to her health before the birth. She agreed that she had on several occasions refused to be admitted to hospital when advised to do so by the medical staff. She said she had a fear of hospitals particularly a fear of staying there overnight. She agreed that she was very upset at Rosina's condition when she was born and she agreed that after the birth her health was not good. She said, however, that she had a clear recollection of the conversations which she had with Dr Michaels.

Mr Harris gave evidence of the conversation with Dr Michaels about possible organ donations from Rosina's body and the conversation which he had with Dr Clifford at the time when he signed the consent form. As to the latter in his witness statement he said:

"Dr Clifford asked me if I was happy for a full post-mortem to be carried out and I said, "OK as long as samples are taken and everything else is returned". I agreed to samples being taken and thought that because she was premature they would look at heart and lungs to see how mature they were. Rosina had to be returned to us whole. "

In evidence he said of that conversation in answer to a question by Mr Lissack QC:

"I said we were quite happy for a post-mortem to happen if you take the samples they need to do whatever, but Rosina was to return to us whole."

In cross-examination he repeated that he had used the word "samples" not "biopsies" and that he and his wife wanted Rosina returned whole. Apart from the word "samples" he said that the other words used by him might not have been the same but they would have been very similar words. He said he had no anxiety about signing the consent form because he understood the word "tissue" in b) to refer to small samples. He remembered Dr Clifford explaining to him the purpose of the post-mortem and he agreed that Dr Clifford had said that it had implications for any future children that he and his wife might have. On that basis he was comfortable with what he was told and signed the form. He agreed that if he had any anxieties he would have asked Dr Clifford about them before signing the form.

Dr Michaels in his witness statement and evidence said that he remembered Mr and Mrs Harris and the tragedy surrounding baby Rosina's birth and death. However he was unable to remember precisely any conversations with them. In evidence he agreed that he may well have had a conversation at some stage about the possibility of a post-mortem being carried out. Having read the statements of Mr and Mrs Harris he said that the conversation as outlined by Mrs Harris was very unlikely to have taken place in that form because he would have been unable to reassure her about parts removed from the body being put back. He did not know what was involved in a post-mortem and would have had to have asked a consultant the answer to such a question.

Dr Michaels was asked by Mr Lissack QC whether he would have made a written record of a conversation with Mr and Mrs Harris about a post-mortem on Rosina if such a conversation had taken place. Dr Michaels' response was a little unclear. At first he said that if anything positive had come out of the discussions he would not have noted anything on the basis that that was not out of the ordinary. He went on to say that he would have made no record unless there had been a specific request which he was unable to answer. He added that if he had the opportunity to do so the next morning he would have conveyed the outcome of his discussions to Dr Clifford. He was asked if there had been a general positive response whether or not he would have made a written record. He said he would not probably because he would have known that Dr Clifford was going to see Mr and Mrs Harris on the following morning.

Dr Clifford remembered Mr and Mrs Harris but apart from the medical notes and letters written by him he was unable to recollect any specific conversation with them. In relation to obtaining their consent for the post-mortem he relied on his normal practice to explain what he would have said to both or either of them when seeking consent.

Dr Clifford agreed in cross-examination that Rosina's condition was such that he favoured a post-mortem being carried out. He wanted to find out whether Rosina's condition was some form of inherited condition or had nothing to do with either parent. In this way he would be able to advise Mr and Mrs Harris on the likelihood of the condition arising in any future children they might have. His usual practice in such cases was to explain to parents that a post-mortem could help considerably to determine the exact cause of death. An internal examination would reveal more than an external examination. His practice was to produce a blank consent form and work his way through it reading out paragraphs a) and b) beneath which the parents sign. It was not uncommon for parents to ask for b) to be struck out. He said that he was unable to remember any families saying that they did not want organs to be retained. If such a request had been made in this case he said that he could not have filled in the form in the way in which he did. He stressed that if any stipulation or condition had been made as a condition for consent being given he would have regarded that as very important and he would have been concerned to see that the parents wishes were respected.

Dr Clifford was asked by Miss Smith QC what his attitude would have been if he had been told by Mr Harris that the family wanted Rosina's body to returned whole. He said that having read a transcript of that part of Mr Harris' evidence he had given it much thought. In a long answer he said that at that time some bodies came back from post-mortems looking as if they had been in a road accident. This did not happen with Dr Isabella Moore and he would have been careful to point out that the body would be returned looking very much like Rosina was when the parents had last seen her. He would have given either a complete answer to the question or asked some supplementary questions to find out what Mr Harris meant.

Mr Lissack QC returned to this topic in cross-examination. He asked Dr Clifford what his attitude would have been if he had been told by Mr Harris that samples could be taken but the parents wanted Rosina's body back whole. Dr Clifford's answer was:

"I do not think I would be clear enough. I think I would have to – I would either make an assumption and speak back to them and they would then come back at me and say "You have not actually answered our question" or I would ask for further clarification; probably the latter. I would want to know what they meant by "whole", really, and what they meant by "samples"."

He added that he would need to know what the parents were asking him. His attitude was that he did not want to be seen to be ramming down the throats of unwilling consenters information which was unpleasant and upsetting. But, if questions were asked, he answered them as best he could. He said in fact questions were never really asked by the parents. He was quite clear that it was never his attitude that parents should be given as little information as possible in order not to put them off agreeing to a post-mortem.

Finally, Miss Sarah Goddard, a senior staff nurse at the Dorset County Hospital, gave evidence as to her recollection of events that took place surrounding the death of Rosina. She had made an entry in the nursing notes to the effect that Mr and Mrs Harris had left the SCBU immediately after Rosina had died. She said in evidence that she had heard no conversation at that time between Dr Michaels and Mr and Mrs Harris concerning a possible post-mortem.

The issue of fact in this claim is an important one and I have not found it altogether easy to resolve. Both Mrs Harris and Dr Clifford, each in their own way, were impressive witnesses. Mr Harris and Dr Michaels were less impressive but each was obviously doing his best to give fair and accurate evidence. In final submissions both Mr Lissack QC and Miss Smith QC made telling points in favour of their respective clients' version of the events. Having given careful consideration to these submissions and re-examined the evidence of each witness I have reached the following conclusions.

In my opinion, Mrs Harris' evidence is to be preferred to the evidence of Dr Michaels and I accept her evidence wherever if conflicts with his evidence. My reasons for this conclusion are as follows. Each was recalling and giving evidence of events which occurred seven years ago. Although the birth of Rosina, her obvious abnormalities and her death very shortly after her birth must have been deeply distressing and shocking for Mrs Harris, she had been prepared for these events before the birth by Dr Clifford. As her discussions on the issue of resuscitation with her husband before the birth show, she was better prepared than might be expected to deal with the tragic aftermath. Even allowing for the fact that she was in pain from stitches following the delivery of Rosina and the fact that she was unwell, in my view, she is more likely to have had a clearer recollection of these events than Dr Michaels, a very busy SHO with only little experience of paediatrics. In addition, whilst it is probable in my opinion that these events would be indelibly etched on Mrs Harris' memory Dr Michaels was only asked to recall them last year. I also regard it as significant that on 6 June 2001 in a conversation with Paul Hill (a hospital chaplain at Southampton General Hospital) Mrs Harris is recorded by Mr Hill as asking:

"Why was it done as she specifically stated at time of consent that all organs were to be returned and that nothing be retained"

I do not regard it as significant that Nurse Goddard's nursing notes do not record a conversation between Mr and Mrs Harris and Dr Michaels immediately following the death of Rosina. She accepted in cross-examination that she had not recorded everything that had been said between Mr and Mrs Harris and Dr Michaels on that evening. Assuming, such a conversation had taken place at that stage she may very well not have heard it. Nor do I think that the fact that Mr Harris gave no evidence about the conversation which Mrs Harris had with Dr Michaels is of such significance as to persuade me that it undermines Mrs Harris' evidence. It may well be that taken up with the grief of Rosina's death either he did not hear the conversation or now has no recollection of its contents.

It follows that in respect of the conversation which Mrs Harris alleges she had with Dr Michaels on the topic of a post-mortem following Rosina's death I find that there was such a conversation. I find that it took place shortly after Rosina's death either in the SCBU or very shortly after Mr and Mrs Harris had left that unit. I further find that in response to Dr Michaels raising the question of a possible post-mortem Mrs Harris told him that biopsies and photographs could be taken but any organs removed must be put back so that Rosina's body was returned to her whole. Dr Michaels made no written record of this discussion and for reasons which I shall mention later I find that he did not speak to Dr Clifford about it before Dr Clifford saw Mr and Mrs Harris on the morning of 9 October.

As to the conversation between Dr Clifford and Mr Harris on the morning of 9 October 1995, the issue as to what was said is less clear-cut. As I have said, Dr Clifford has no recollection of the conversation and relied entirely on his normal practice together with his handwritten entries on the consent form. The evidence shows that both he and Dr Michaels were regarded as careful and caring doctors. Dr Clifford's medical notes and the West Dorset General Hospital medical records in general were described by Professor Craft, the President of the Royal College of Paediatricians, an expert called by the defendants, as exemplary. Dr Clifford knew that following a post-mortem organs were retained by pathologists. It is in the circumstances difficult to reconcile his evidence with that of Mr Harris. Nevertheless, in my judgment, there must have been a conversation between Mr Harris and Dr Clifford immediately before or at the time of Mr Harris signing the consent form. Having found that Mrs Harris told Dr Michaels that she would only consent to a post-mortem if the organs were retained it seems to me very unlikely that Mrs Harris would not have made her views plain to Mr Harris before he went with Dr Clifford to discuss the question of a post-mortem. That being so, notwithstanding my view that Dr Clifford was an impressive witness, I conclude that it is more probable than not that Mr Harris did tell Dr Clifford that the post-mortem could take place provided that only samples were taken and that the body was returned whole. In my view the explanation for Dr Clifford's lack of recollection is that he took the word "whole" to mean that the body would come back giving the appearance of being complete and unmarked. In my judgment this explains his long answer given in evidence in response to Miss Smith's question which I record in paragraph 43. That answer was preceded by the observation:

"If it was now, I think it would definitely resonate with organs, but I do not think it would have done in 1995."

I find that Mr Harris did tell Dr Clifford that he and his wife would consent provided only samples were removed and that the body was returned whole. On that basis he signed the form.

On the issue whether Dr Michaels saw Dr Clifford before seeing Mr and Mrs Harris on the morning of 9 October, I find it probable that he did not. Although Dr Clifford said it was inconceivable that he saw Mr and Mrs Harris before going into the SCBU on the morning of 9 October, I find that, if he did go into the SCBU, he did not see Dr Michaels either because Dr Michaels had gone off duty or was elsewhere in the hospital. In my opinion if he had seen Dr Michaels I think it likely that Dr Michaels would have told him of his conversation with Mrs Harris and Dr Clifford would have remembered being told about it.

It is convenient at this stage to deal with a further factual issue associated with the issue of consent but which arises specifically on the issue of causation. The defendants allege that if Mr and Mrs Harris had been told that Rosina's organs would not or could not be returned to

her body before burial they would still have consented to a post-mortem being carried out. When this suggestion was put to Mrs Harris in cross-examination, it was, understandably, a very difficult question for her to answer. She was reminded by Miss Smith QC of the importance of determining the cause of Rosina's condition so that she could be advised in respect of any future pregnancy. At first Mrs Harris appeared to express the view that if she had known that the organs were not to be returned to the body she would not have been in favour of any post-mortem taking place. Later she said she would have hoped that the funeral could be delayed until the organs were returned; or that the organs could have been buried at a later time. In re-examination she opted for delaying the funeral until the organs were returned.

The defendants submit that because of the importance to Mr and Mrs Harris of discovering whether Rosina's condition was genetic and so likely to effect their desire to have a large family, inevitably, they would have consented to a post-mortem in any event. This is a powerful argument.

Given Mr and Mrs Harris' desire for a large family, it must have been important for them to know if there was a risk of the same abnormalities occurring in any subsequent child which they might have. Sadly, Mrs Harris has not become pregnant but, in my opinion, in evidence she played down the obvious anxiety which she must have had about a future pregnancy. I have no doubt that at the time of Rosina's death the question mark over the cause of her condition was more important to Mr and Mrs Harris than it seems to them today.

On this issue I find that the probability is that if Mr and Mrs Harris had been informed that Rosina's organs would have had to be retained for some months, they would not have refused consent to a post-mortem. The nature and cause of her condition were, in my opinion, far too important for them to have refused consent. However, given the strength of Mrs Harris' feelings, in my judgment, she would have consented only on the basis either that the funeral was delayed or more probably that the organs were returned for a later and subsequent interment.

Psychiatric Injury

The second main issue of fact concerns the effect on Mrs Harris' health of the discovery by her that Rosina's organs had been removed and subsequently disposed of. In the shorthand used by the consultant psychiatrists this has been referred to as organ retention knowledge which is the expression that I shall use hereafter.

Mrs Harris' evidence was that following Rosina's death the succeeding twelve months represented a very bad time for her. In addition, for three or four years following the death she and her husband blamed each other. However, although she saw her doctor during this period she declined to take anti-depressants because she wanted to come through this difficult period without having to rely upon drugs. When she received the letter of 31 May 2001 telling her of the retention of Rosina's organs, in her witness statement she said she was absolutely astounded and immediately fell to the ground. She said that she had just begun to cope with Rosina's death and to accept that she could have no more children. After this in her words "she completely lost the plot for about three weeks". Since May 2001 she has undergone counselling. She still has nightmares. She has good days and bad days. For a time she blamed her husband all over again and even now she feels that she has to attach blame to him. She said that there has not been a single aspect of their lives which has not been affected

by the organ retention knowledge. The picture of her life now painted by her in her witness statement is a bleak one.

During cross-examination it became quite apparent that in addition to the distress of Rosina's birth and death, Mrs Harris had been affected by other problems. These consisted of her inability to conceive; behavioural problems of her stepson who came to live with her husband and herself in 1997; and the breakdown of her husband's health causing him to have been unable to work since 1999. Her general practitioner's records contain the following entry for 8 August 1999:

"Numerous problems to contend with. Step-child with ADDh. Depressed husband, no money at present, constant arguing within the household. Feels depressed and contemplating leaving home or walking under a car. Tearful, poor sleep, poor concentration and not coping. Also having back pains. Have started Karen on Prozac. "

In late April 2001 her general practitioner referred her to a counsellor, Mrs Diane Steward. A report of Mrs Steward dated 7 November 2001 was served as an exhibit to Mrs Harris' witness statement. Neither Mrs Harris' witness statement nor Mrs Steward's report made any reference to any stressful event in her life other than the organ retention knowledge. It is clear, however, that Mrs Harris was referred to Mrs Steward before she received the letter from Southampton General Hospital in May 2001. It is also fair to record that Mrs Harris had her first session with Mrs Steward after she received that letter. On 17 July 2003 Mrs Steward made a further report attached to which was a copy of her handwritten notes of counselling sessions held by her with Mrs Harris. The letter disclosed many more entries in respect of other stressful events in Mrs Harris' life than entries in respect of organ retention knowledge.

Following cross-examination of Mrs Harris on this issue Mr Lissack QC very properly offered to call Mrs Steward. She was not an impressive witness. Her explanation for the omission in her first report of any reference to Mrs Harris' other domestic problems which were causing stress was in my opinion unconvincing. Her explanation for the comparatively few references to organ retention knowledge as a problem in her counselling notes was also difficult to accept. Taking her evidence as a whole I find it impossible to attach any real weight to the conclusions and opinions expressed by her.

For the purposes of this hearing Mrs Harris was examined by two consultant psychiatrists. They were Dr Duncan Veasey, called on behalf of the claimant and Dr Adrienne Reveley, called on behalf of the defendant. When Dr Veasey made his first report he had not seen Mrs Steward's notes. Dr Reveley had. In due course the doctors met and made a joint statement setting out their areas of agreement and disagreement. Essentially they are agreed that Mrs Harris suffered some psychiatric reaction as a result of the organ retention knowledge. They differed over the extent of the reaction and the implication of other factors in her present psychiatric state.

Dr Reveley diagnosed Mrs Harris as suffering from an adjustment disorder before organ retention knowledge. That diagnosis may include a pathological bereavement disorder which it is agreed is a recognised disorder. Dr Reveley was of the opinion that this adjustment disorder had a multi-factor causation and that it was exacerbated by the organ retention knowledge and is now being maintained by Mrs Harris' physical ill-health. In her opinion Mrs Harris's present condition will improve when this litigation has ended.

Dr Veasey accepted that Mrs Harris had under-estimated her pre-existing bereavement problems before organ retention knowledge. In the joint statement he acknowledged that there were other stressors present before May 2001 but in his opinion they had not caused a diagnosable psychiatric disorder before the organ retention knowledge. However he accepted that her pre-existing pathological bereavement was a vulnerability factor for the development of the adjustment disorder following the organ retention knowledge. In his opinion this knowledge was a major causative factor for her adjustment disorder and she was markedly worse psychiatrically after the organ retention knowledge than before it.

Although there is little difference between the two psychiatrists, on the whole of the evidence I prefer Dr Reveley's opinion to that of Dr Veasey. In reaching this conclusion it seems to me that the fact that Dr Veasey had not seen Mrs Steward's counselling notes before his first report and the fact that to him Mrs Harris minimised the problems relating to her stepson are of significance. I am satisfied that Mrs Harris was suffering from a recognisable psychiatric disorder before May 2001. Whether it is properly called an adjustment disorder or a pathological bereavement disorder in my opinion is immaterial. I am further satisfied that the organ retention knowledge did exacerbate Mrs Harris' adjustment disorder and that it made and continues to make some material but small contribution to her present state. I am equally satisfied that when "the fuss" – Dr Reveley's word – of this litigation is over its effect on her will cease.

On behalf of each of the three claimants Mr Skelton, junior counsel for the claimants, submitted that any sum for general damages for pain and suffering should be enhanced to reflect the insult sustained by each claimant and the gravity of the harm caused by the wrongful conduct. In my judgment, as in all cases of personal injury, the insult and gravity of the harm is reflected in the damages awarded for the consequential injury sustained. It is not an additional factor added on over and above the seriousness of the injury. That factor either is or is not capable of being recognised by awards for exemplary or aggravated damages.

It is submitted on behalf of Mrs Harris that the injury sustained by her properly comes into the moderate category (A)(c) in JSB Guidelines to Damages for Psychiatric Damage.

Miss Smith QC submitted that Mrs Harris is not entitled to any sum by way of damages for psychiatric injury. She submitted that the "strand of Mrs Harris' adjustment disorder due to organ retention" is so small as not to be material to her overall condition. I disagree. Small it may be, but in my view it is material and quantifiable.

For reasons which will appear later in this judgment the claim of Mr and Mrs Harris fails. If it had succeeded I would have awarded Mrs Harris the sum of £4,500 general damages for personal injury, pain and suffering.

Susan Carpenter

There are two topics which give rise to issues of fact in respect of her claim. The first concerns Professor Roy Weller, the pathologist who carried out an examination on Daniel's brain following the post-mortem examination. The second issue is whether and to what extent Mrs Carpenter suffered any psychiatric injury as a result of learning in March 2001 that Daniel's brain had been removed during the post-mortem and subsequently disposed of. Before I deal with these topics, it is necessary to set out in a little more detail the circumstances surrounding the death of Daniel. The defendant to her claim is the Southampton General Hospital (the defendant). At the time of Daniel's birth and subsequent

death Mr Carpenter was serving in the Royal Navy. When Daniel became ill at Christmas 1986 he was first taken to the family's general practitioner but subsequently on 29 January 1987 admitted to the Haslar Hospital in Gosport. His health did not improve and on 2 February 1987 a surgeon commander, when conducting his ward round, correctly diagnosed a suspected brain tumour. He was immediately transferred to the Southampton General Hospital where on 3 February 1987 he underwent surgery for the removal of the tumour. He survived the operation but after several days in the intensive care unit his condition rapidly deteriorated. He died on 8 February 1987.

As already stated, his parents were more than happy with the treatment which he had received from the medical and nursing staff. Following Daniel's death it is probable that the senior registrar, Mr Peter Lees, spoke to Mr Carpenter about the necessity of reporting the death to the coroner and the probability of a post-mortem taking place. Mr Carpenter, understandably, felt his wife at that time was too distressed to discuss the question of a post-mortem. On 10 February 1987 Mr Carpenter was informed that Daniel's body could not be removed from the hospital until the coroner gave his authority for the body to be released. At that point Mr Carpenter told his wife of his previous conversation with the Senior Registrar. Mrs Carpenter, as already noted, was very unwilling for a post-mortem to take place. She telephoned the coroner's office and managed to speak to the coroner himself. Apparently, the coroner made it clear that he was going to direct a post-mortem and that the body could not be released until he had issued a certificate. Mrs Carpenter states, and I accept, that if the coroner had asked for her consent for tests to be carried out on Daniel's brain she would have refused. Her attitude throughout has been that she knew the cause of death and saw no purpose in a post-mortem examination being carried out. In evidence she said that if she had known that the brain would have to be removed and subjected to histological tests she would have asked for the funeral to be delayed so that the brain and all other tissue could be returned to Daniel's body and he could be buried with all his organs replaced. There is no dispute that neither she nor Mr Carpenter were given any information about the nature of the post-mortem investigation nor were they told that the brain was going to be retained.

Factual Issues surrounding Professor Weller's examination of Daniel's brain and his arrangements with HM Coroner

The post-mortem examination was conducted by Dr W Killpack. His report is in evidence but he did not make a written statement nor was he called as a witness. Professor Roy Weller, a professor of neuro-pathology at Southampton General Hospital, carried out an examination on the brain. Once again it is clear that the brain was fixed and subjected to a process very similar to that described in Appendix A. There is no dispute that Dr Weller carried out an examination of the brain after it had been fixed. He said that he did so on the instructions of the coroner. His report to the coroner was dated 10 February 1985. There are two pathology reports which are in evidence. The first is that of Dr Killpack which is dated 10 Debruary 1987 and which stated that the brain had been fixed for further examination. The second is dated 30 April 1987 which is that of Professor Weller. The first is a general pathology report and the second is a specialist neuropathology report. This second report contained no reference to any histopathology. Professor Weller's examination of the brain took place on 30 April 1987, the date of his report. He said in evidence that he undertook a histopathological examination of the brain at a later date. He agreed that there was no written report in respect of that examination. He said that at that time it was normal not to write any further report if the histological examination confirmed the conclusions reached in the earlier examinations. The first issue of fact on this topic is whether or not Professor Weller carried out a

histological examination at all. On behalf of Mrs Carpenter, Mr Lissack QC challenged Professor Weller's assertion that he did.

Professor Weller went on to give evidence about arrangements between him and the coroner. He said that he conducted about three post-mortem examinations each month on behalf of the coroner. He also conducted a number of examinations of brains referred to him by the coroner from post-mortems conducted by other pathologists. He was paid a fee for each examination and the fee was paid into a charitable fund. The coroner rendered him a monthly statement of fees paid. His arrangements with the coroner were made orally and not evidenced by any document or documents. In cross-examination by Mr Lissack QC he was asked about the period of time which he would retain a brain before disposal. He said that the arrangement with the coroner was that he and the coroner would agree a general period of time to allow for any further inquiries or questions by the coroner before disposal. In this case the brain was retained until August 1987 before being disposed of.

Mr Lissack QC was highly critical of Professor Weller's evidence. He pointed to the fact that there is no documentary evidence to indicate that Professor Weller had carried out a histological examination of the brain after 30 April 1987 and there is no reference in his witness statement to any conversations with the coroner as to the arrangements said to have existed in respect of the retention and disposal of organs following post-mortem examinations. Mr Lissack QC submitted that these arrangements were very material to the issue of whether Professor Weller was acting with the coroner's lawful authority when retaining and disposing of Daniel's brain. He submitted that in answer to a question of mine Professor Weller gave evidence only about the arrangements post 1999 but not pre-1999.

I do not share Mr Lissack's view of Professor Weller's evidence. I see no reason to doubt that he carried out a histological examination on the brain of Daniel Carpenter. His explanation as to why there was no written report in respect of this examination was to my mind sensible and convincing. I see no reason to doubt his evidence on this issue and I find that he did carry out such an examination after the slides had been cut and prepared for him.

So far as the criticisms of his evidence about the arrangements with the coroners are concerned again I accept Professor Weller's evidence on these arrangements. Professor Lowe, a consultant neuro-pathologist, an expert called by the defendant, confirmed that these were the sort of arrangements with which he was familiar and which he would have expected between a pathologist and coroner at about that time. For the same reasons Mr Lissack QC was critical of Professor Lowe's evidence. However, in my opinion Professor Lowe was a careful and convincing witness and I see no reason to doubt his evidence on this issue. Neither side called evidence from a coroner. In the circumstances I accept the evidence of both Professor Weller and Professor Lowe on this issue and I reject the criticisms made of them by Mr Lissack QC.

Psychiatric Injury

Mrs Carpenter in her witness statement said that following the death of Daniel, he was always in her thoughts. However her attitude was that she had to deal with those thoughts and move on. She has a strong Anglican faith and from her appearance and demeanour in the witness box I judge her to be a thoroughly sensible woman who at all times would do her best to cope with the many ups and downs of everyday life. For her, and her husband, Daniel's death must have been a deeply distressing event. However it is common ground that it did not cause Mrs Carpenter to suffer any psychiatric illness.

In the intervening years between the death of Daniel and March 2001 when Mrs Carpenter acquired the knowledge of organ retention she suffered a number of misfortunes. In 1987 she became pregnant but on the advice of doctors underwent a late termination. In 1990 she had a miscarriage and was involved in a car accident. In 1991 she had a second miscarriage. In 1992 she and her husband, through no fault of their own, suffered financial problems. In 1997 her aunt died of a brain tumour which caused the onset of a depressive episode. In March 2001 she received the letter from which she learnt of the retention of Daniel's brain. In September 2001 she was the subject of an inquiry at work and suspended for 28 days. In due course that dispute between herself and her employers was settled but she said the whole episode left her feeling betrayed by her employers.

It is clear that over the years she has seen her general practitioner on a number of occasions. In 1992 her general practitioner's records contain the entry "horrendous problems".

After acquiring the organ retention knowledge Mrs Carpenter said that she had great difficulty in coping with life. She complained of trouble sleeping, mood swings, irritability and lack of concentration. She suffered from breathlessness and panic attacks. However recently she has begun to recover.

She has been examined for the purposes of her claim by Dr Stanford Bourne, a consultant psychiatrist, and Dr Reveley. There is little dispute between these two psychiatrists. They agree that Mrs Carpenter did not develop any abnormal grief reaction after the death of Daniel but that she did suffer a depressive episode in 1997 following the death of her aunt. They agree that at some stage in 2001 after she acquired the organ retention knowledge Mrs Carpenter suffered a depressive episode which Dr Bourne classifies as an adjustment disorder. Dr Bourne is of the opinion that the onset of this disorder was triggered by the organ retention knowledge in March 2001. Dr Reveley believes it did not occur until her problems at work arose in September 2001 although she accepts that the organ retention knowledge made her more vulnerable to a psychiatric illness. Both are agreed that her work related problems in September 2001 made a substantial contribution to her depressive illness.

Both doctors agree that Mrs Carpenter has now recovered from the adjustment disorder/depressive episode but that because of it she remains more susceptible to further such episodes in the future.

Despite the doctor's differing opinions as to the date of the onset of the latest episode I do not regard that difference as material for the purposes of assessing general damages. The implication of the submissions made by Mr Skelton is that Mrs Carpenter's injury was rather more severe than that of Mrs Harris. I do not agree. In my view the span of the psychiatric injury attributable to any fault by the defendant was for a shorter period than for Mrs Harris. If Mrs Carpenter's claim had succeeded, which, for reasons appearing later in the judgment, it does not, I would have assessed general damages in respect of her claim in the sum of £3,500. In arriving at this figure I take into account the length of the depressive episode and the fact that it has increased her vulnerability to future depressive episodes.

Denise Shorter

The same issues arise in respect of Mrs Shorter's claim as in the claim of Mr and Mrs Harris: that is the nature of the consent given by Mrs Shorter for a post-mortem examination and the effect, if any, on her mental health of the discovery that Laura's brain had been removed at post-mortem and retained.

Consent

Mrs Shorter said in her witness statement and in evidence that at the age of 19 she worked as a typist in the histopathology department of the John Radcliffe Hospital. She typed post-mortem and histology reports in addition to general office duties. In the course of this work she and a colleague were invited to attend a post-mortem. At the post-mortem she witnessed the opening of the body, the removal and weighing of organs and the replacement of them in the body. She also saw organs in jars which were stored on shelves in the mortuary, as she assumed, for medical research. By attending this post-mortem and through her work as a typist she gained some insight into the process of post-mortem investigations.

Mrs Shorter's pregnancy with Laura, her first child, was uneventful. On 9 October 1992 she went into spontaneous labour and at approximately 40 weeks gestation was immediately admitted to the John Radcliffe Hospital. The midwife who attended her at home had not been able to hear a foetal heart beat although she did not pass this information on to Mrs Shorter. At the hospital the senior registrar, Dr Vicky Osgood, carried out a ultrasound scan of the baby and was unable to detect any heart beat. She broke the news to Mrs Shorter that her baby was dead. Mrs Shorter complains that the news was broken to her in an abrupt and distressing manner. Although I heard evidence from her and Dr Osgood on this issue, it is not a material issue in the claim and I make no finding on it.

Mrs Shorter's reaction on hearing this news was to ask for delivery by caesarean section. She was persuaded, rightly as she now agrees, that she should deliver the baby naturally. The baby was delivered stillborn the following day at 12.33 pm. Alison Chevassut, a registered midwife, attended her at the birth. The nursing notes record that at 1600 hours Mrs Shorter was taken from the delivery suite in the labour ward to a room at Level 7 where she spent the night. The following morning she was transferred to the Ashfield Suite, a special suite for bereaved mothers and their families. She stayed there for approximately 4 days before returning home.

The documents show that Mrs Shorter signed a Notification of Death form. The form states that the baby died on 9 October 1992 and that a post-mortem examination was authorised by Mrs Shorter. The majority of the hand writing on the document is that of Mr John Fairbank, then a senior obstetric registrar at the hospital. There is no dispute that it was he who sought and obtained Mrs Shorter's consent to a post-mortem and that she signed this form.

On 13 October 1992 a post-mortem was carried out on Laura by Dr P Maheswaran, a senior registrar in paediatric pathology at the hospital. During the post-mortem Laura's brain was removed and retained for histological examination. Following removal of the brain, it underwent the fixing process and subsequent preparation of blocks and slides. Dr Stephen Gould, the consultant paediatric pathologist, carried out a histological examination of the brain. The post-mortem revealed no abnormalities and no obvious cause of death. No criticisms are made of the pathologists or the way in which the post-mortem was conducted.

On 18 November 1992, Mrs Shorter was seen by Mr Michael Gillmer, the consultant obstetrician and gynaecologist, and reassured that investigations into the cause of death had revealed nothing which might affect any subsequent child born to Mr and Mrs Shorter. As already described on 2 November 2001 Mrs Shorter was informed by letter that, unknown to her, Laura's brain had been removed at post-mortem and subsequently disposed of.

Mrs Shorter in her statement and in evidence said that following the delivery of Laura she remembered seeing a doctor and telling him that she was reluctant to consent to a post-mortem examination. She remembered her experience of watching a post-mortem and did not want her daughter's organs put in a jar and stored. She said that she told the doctor that she did not want her daughter hurt and that the post-mortem could only be carried out as long as everything removed from her body was put back. She said that she remembered the conversation taking place in the Ashfield Suite when she was sitting on the sofa with her husband present. She said that the doctor pressured her into consenting to the post-mortem. She agreed that when she was in the delivery suite the doctor had told her that there was some evidence to suggest that listeria was the cause of death. This had upset her because throughout her pregnancy she had been very careful with what she ate.

Mrs Shorter had no recollection of signing the Notification of Death form and no recollection of the consent process taking place in the delivery suite or the labour ward. It was suggested to her that the distress of the birth of a stillborn child and the pain of the delivery had caused her to be confused in her memory of what she had said when she gave consent. She did not agree that she was confused about what was said but she did accept that, despite her memory of it taking place in the Ashfield Suite, the conversation probably took place in the delivery suite.

She agreed that in a talk which she had given in the year 2000 to midwives and medical staff on the topic of giving birth to a stillborn child she had referred to witnessing "many post-mortems". She said that this was a mistake which she corrected when making her witness statement. She agreed that in her notes for this talk she referred to speaking to three doctors concerning the post-mortem on Laura. She believed that she had spoken to three doctors although one of them may have been Mrs Ashfield whom she accepted was not a doctor.

Alison Chevassut gave evidence to the effect that she believed Mr Fairbank had attended Mrs Shorter in the delivery suite. She was not present when he spoke to Mrs Shorter but she did not remember Mrs Shorter subsequently expressing any reluctance to permit a post-mortem examination. She said that it was her handwriting on the Notification of Death form which recorded that Mrs Shorter wanted to see Laura on Monday 12 October before she was taken to the mortuary for the post-mortem examination. Miss Chevassut said that she would have made this entry in the labour ward before Mrs Shorter was taken up to Level 7. She remembered going back into the delivery suite after Mr Fairbank had obtained Mrs Shorter's consent to a post-mortem. She remembered Mrs Shorter being very distressed over the suggestion that Laura's death might have been caused by listeria infection. Mrs Shorter said that she felt very guilty that something which she had eaten might have been the cause of Laura's death.

It is common ground that Miss Chevassut and Mrs Shorter became and have remained friends over the years. It was Miss Chevassut who persuaded Mrs Shorter to give the talk in the year 2000. Miss Chevassut was a good witness who gave her evidence thoughtfully and with obvious care. I have no hesitation in accepting her evidence as truthful and accurate. However, she was not present during the all important discussion about consent between Mrs Shorter and Mr Fairbank.

Mr Fairbank is now a consultant obstetrician but in 1992 was a senior registrar at the John Radcliffe Hospital. He frankly admitted that he had no recollection of any conversation between himself and Mrs Shorter. He had not been present at the birth of Laura. However, he accepted that it was his handwriting on the Notification of Death form and for that reason it

must have been him who took her consent. He said it was one of the duties of a senior registrar to take such consents. He said that because the form referred to the labour ward it was highly probable that the conversation about consent took place in the delivery suite on 10 October. It was also probable that he would have recommended that a post-mortem be carried out in order to try and discover why an apparently fit and healthy baby had been stillborn. He said his normal practice when taking consent was to offer the parents a post-mortem and if the parents wanted one it was done; if not it was not done. As far as he was concerned it was a simple question of choice by the parents. He saw no reason why he should have put pressure on Mrs Shorter to agree to a post-mortem but it was part of his job to give guidance on whether or not a post-mortem might be of benefit to the parents. He described a request such as the one said to have been made by Mrs Shorter as unusual. No one to his recollection had ever made such a request of him. He said that such a request would have rung a whole series of alarm bells which would have caused him to go away and come back to deal with the matter on another occasion. In any event he would have made a note of the request on the medical records and on the post-mortem request form. He would also probably have informed the pathologist or his team by telephone of such a request.

In cross-examination Mr Fairbank said that at the time he was unaware that organs were not returned to the body after a post-mortem examination. He agreed that if Mrs Shorter had asked him what happened to major organs he would have told her what he believed to be the position namely that they would be put back into the body. However, as I have already stated, he believed that such an unusual request would have caused him to make a note of it in her medical records. He was asked about his entry in the medical notes which read:

"Looks normal

Consent for p.m."

The note goes on to state that Mrs Shorter's general practitioner is to be informed of the stillbirth. He agreed that the notes were not timed or dated. He believed that they must have been made following his conversation with Mrs Shorter in the delivery suite. He volunteered that the notes were inappropriately scanty and gave no detail of the conversation which he had had with Mrs Shorter when she consented to a post-mortem on Laura. He also accepted that the hospital medical records show that he saw Mrs Shorter again at 11.30 am on 11 October. That visit must have taken place in a room or ward on Level 7 since the records show that it was not until 13.00 hours on the same day that Mrs Shorter was transferred to the Ashfield Suite.

Mrs Shorter was a tense and emotional witness. It was clear that giving evidence in this trial was for her very stressful. Mr Lissack QC conceded in his final submissions that this made her a difficult witness to assess but he submitted that proper allowance should be made for the emotional stress of giving evidence and that I should accept her evidence on the core issue. Although it was not pleaded he submitted that when she consented to the post-mortem in the delivery room she was not in a fit state to understand what she was doing. He invited me to accept that whatever her memory was of signing the consent form she was truthful and

accurate when she said that on an occasion in the Ashfield Suite she had made it clear that a post-mortem on Laura was only to be carried out on condition that all her organs were returned to the body. Mr Lissack QC submitted that such a condition was entirely consistent with Mrs Shorter's undoubted knowledge of what a post-mortem involves.

Mr Lissack QC submitted that Mrs Shorter's evidence was to be preferred to Mr Fairbank's bald assertion that he would have carried out his normal practice and that no one had ever sought to impose such a condition as described by Mrs Shorter. Further, Mr Lissack QC pointed to the fact that Mr Fairbank accepted that at that time he did not know that organs were retained after a post-mortem. He agreed in evidence that if Mrs Shorter had asked him about organ retention he would have told her that major organs would be buried with the body and the conversation would then have moved on.

In assessing Mrs Shorter's evidence I make all due allowance for the strain imposed on her by the necessity of giving evidence about what was undoubtedly a very stressful event. The distress and shock of giving birth at full term to a stillborn child must for any woman be almost unbearable. Describing that event will no doubt have brought back to Mrs Shorter the full horror surrounding Laura's birth. Nevertheless, making full allowance for that factor, I must record that I did not find Mrs Shorter an impressive witness. I have no doubt that she honestly believes now that she did make it a condition of her consent to a post-mortem that Laura's organs should be returned to her body. But her evidence was muddled and at times difficult to follow. She clearly had no recollection at all of signing the consent for a post-mortem. She frankly admitted as much. In her witness statement she states that she had a clear mental picture of the room where she was when she had the discussion with the registrar about a post-mortem. In her statement she said she remembered saying to him that "they could do it as long as they did not hurt her and as long as they put everything back". In evidence she identified the room as the Ashfield Suite. However, the documents, and in particular the consent form itself, shows that the conversation with Mr Fairbank, the Registrar, must have taken place in the delivery suite. During cross-examination Mrs Shorter conceded that this must be correct, although she insisted that she thought she signed the consent form in the Ashfield Suite. Further she said in her witness statement and in evidence that her husband was present when she made this stipulation. But her husband has made no witness statement nor did he give evidence. Next, I find it surprising that if she was reluctant to agree to a post-mortem Mrs Shorter did not at any time before or after signing the consent form express her reluctance to Miss Chevassut.

Two further factors are in my opinion noteworthy. First, Mrs Shorter's notes for her talk in 2000, to which I have previously referred, contain what she accepted were exaggerations and inaccuracies in her description of the events surrounding Laura's birth and her consent to the post-mortem. Secondly, when Mrs Shorter saw her doctor after learning of the retention of Laura's brain his note records her as saying that she wished she had not consented to a post-mortem. She agreed in evidence that she made no mention to him of her imposition of the condition made before she consented.

Mr Fairbank, on the other hand, gave his evidence in a fair, measured and precise way. At times his answers were over lengthy and addressed rather too many points. But nevertheless I have no doubt that he was truthful and careful in what he said. I have also no doubt that if Mrs Shorter had imposed the condition which she says she did Mr Fairbank would have recorded it or, at the least before agreeing to it, he would have discussed the matter with the department of pathology. I accept his evidence when he said that such a condition would have

set alarm bells ringing and that he would have gone away with a view to returning at a later time.

I accept Mrs Shorter's evidence that she had observed a post-mortem examination in the course of her work. But, having considered the whole of the evidence on this issue I find as a fact that she signed the consent form without imposing any condition or stipulation. Whether, at the time she signed the form, she had forgotten that she had seen organs stored in a mortuary or, more likely, the emotion of Laura's stillbirth had pushed this fact to the back of her mind, I am satisfied that she made no mention of any such condition to Mr Fairbank. In my view the explanation for her evidence on this issue is that when she learnt of the organ retention she regretted consenting to a post-mortem examination. In my opinion she has persuaded herself that she must have imposed such a condition.

The same associated issue arises on causation as with Mrs Harris' claim. Mrs Shorter was asked similar questions by Miss Smith QC. Again, it seems to me inevitable that at the time Mrs Shorter must have been very concerned to discover whether or not Laura's death was due to any genetic factor or, as Mr Fairbank agreed he suggested might be the case, due to listeria. Mrs Shorter, like Mrs Harris, was keen to have further children. In my judgment this must have been a very big factor in her decision to agree to a post-mortem. In answer to questions asked by Miss Smith QC as to what she would have done if she had been told that organs might or would be retained following the post-mortem Mrs Shorter said she did not know. In re-examination she said she would have opted for a delayed funeral service.

As in Mrs Harris' case it is not easy for her or the court to predict what she would have done if this information was available to her. I have no doubt that she would have consented to a post-mortem. The risk of her having the same problem with any future child would, in my judgment, have been too great for her simply to have refused consent. But whether she would have given consent with no condition attached or opted for a delayed funeral is difficult to predict. On balance, I accept the answer which she gave in re-examination which was that she would have opted for a delayed funeral rather than unconditionally consenting to a post-mortem.

Psychiatric Injury

There is no doubt that Mrs Shorter was extremely distressed following Laura's stillbirth. In evidence she described how she went on grieving for Laura for a number of years. She visited her grave twice a week and still visits weekly. In July 1994 she gave birth to her daughter Emily. Although this was a joyful event for her she said she had feelings of guilt that Laura was not there to enjoy Emily as well. She described learning of the retention of Laura's brain as like losing Laura all over again. She lost her confidence; had two days off work; went to the cemetery to apologise to Laura; and had to start a course of anti-depressants.

Both Dr Bourne and Dr Reveley examined Mrs Shorter for the purpose of producing reports for this trial. They are agreed that after the stillbirth Mrs Shorter suffered a pathological grief reaction properly classified as an Adjustment Disorder. They also agreed that her condition was destabilised or intensified after the organ retention knowledge. However, she has continued to be able to function in the home and has been reluctant to undergo psychotherapy. Dr Reveley was of the opinion that Mrs Shorter's disorder was intensified for

a period of approximately one year. There is no real difference between the doctors on Mrs Shorter's condition and the extent of it.

In my opinion Mrs Shorter has suffered to a quantifiable and material extent some psychiatric injury for a period of about one year over and above the pre-existing pathological grief disorder which followed Laura's stillbirth. On the basis that liability is established, in my judgment, the proper figure for general damages is the sum of £2,750.

General observations

Before I discuss in detail the legal issues in this case I propose to make some general observations. Mr Lissack QC, on behalf of the claimants and the larger cohort of claimants on the Register in this group action, addressed me at length on the importance and significance of these lead cases. He made a number of submissions under two broad headings. First he submitted that the claimants have suffered a substantial wrong at the hands of the medical profession. This wrong has, he submitted, been brought about by the medical profession adopting over many years the paternalistic practice of keeping from relatives of deceased children the knowledge that at post-mortems organs were being removed from the bodies of their children and retained. In support of the submission that this constituted a grave wrong he relied to some extent on moral and ethical considerations set out in the expert witness statement of Dr Bobbie Farsides from the Centre of Medical Law and Ethics at King's College London and summarised by Mr Lissack QC and his junior in their written closing submissions.

The second broad submission made by Mr Lissack QC is that the court has a duty to right wrongs as exemplified in the dicta of Lord Steyn in McFarlane v Tayside Health Board 1999 3WLR 1301 @ page 1318:

"It may be objected that the House must act like a court of law and not like a court of morals. That would only be partly right. The court must apply positive law. But a judge's sense of the moral answer to a question, or the justice of the case, has been one of the great shaping forces of the common law. What may count in a situation of difficulty and uncertainty is not the subjective view of the judge but what he reasonably believes that the ordinary citizen would regard as right."

In support of this submission Mr Lissack QC invited me to use the background of Articles 8 and 9 of the Human Rights Act to shape the law, where it needs shaping, to provide a remedy for these claimants.

For my part I am acutely conscious of the fact that there have been three public inquiries which have dealt with organ retention to a greater or lesser extent. Placed before me with the papers in these claims are inquiry reports, statements from ministers and reports and guidance from the chief medical officer. All of these documents refer to the distress caused to large numbers of parents when they learnt for the first time that the bodies of their children had been buried or cremated without one or more of their major organs. There have been many sad cases arising out of organ retentions. I have no doubt that many families, although maybe not all, have been deeply distressed and angered by the revelation that a major organ or organs have been removed and retained from their child's body without their consent and knowledge. No one listening to the evidence in this trial, concerning as it does the claims by

three families, could feel anything other than compassion and sympathy for the claimants and families similarly affected.

On the other side these claims concern organs removed, retained and subsequently disposed of. They do not concern organs retained for the purposes of research. Whatever may have been said by some at or after the public inquiries, the evidence from the doctors in this case, in my judgment, establishes that the clinicians and pathologists to whom I have listened have acted at all times sensitively and in good faith. I have no hesitation in stating that whether or not any of them have made mistakes I have been impressed by their obvious desire to do what they thought was in the best interests of their patients and families and conducted themselves according to what they believed was best practice. I am conscious of the fact that they are dedicated professionals and some, particularly the pathologists, feel aggrieved at the criticism and condemnation which has been heaped upon them since the scandal of organ retention was revealed in 1999. As one consultant obstetrician said in answer to the question from Mr Lissack QC, I paraphrase, Do you not think that the view taken by the medical profession was inappropriately paternalistic?:

"I think I would have to start by asking exactly what was meant by the term "paternalism". But if we accept that it has pejorative overtones to it, I would think that was a very inappropriate use of the term. At that time, in 1987, my recollection was that the greatest cause of distress to most relatives were bureaucratic delays that occurred in terms of either issuing death certificates … or referring the case to the coroner … It was really that delay which contributed to the distress of relatives and which one was seeking to avoid."

He went on to explain that if information had been requested it would have been freely, frankly and candidly given.

Mr Lissack QC, in opening, acknowledged the importance of modern pathology. It is clear that through the medium of post-mortem examinations over the years medical science has been substantially advanced for the greater good.

I bear in mind the submissions of Mr Lissack QC to which I have just referred and where proper I give due weight to them. I also bear in mind the sense of grievance of the claimants counter-balanced as it is by the feeling of clinicians and pathologists that they have been unjustly pilloried. I remind myself that my task, regardless of conclusions reached elsewhere and comments made by others, is to find the facts on the evidence which I have heard in this trial and reach conclusions strictly on the legal issues which I have been asked to determine.

The Human Tissue Act 1961

Much of the debate in respect of the two causes of action, wrongful interference and negligence, revolves round the meaning and effect of the Human Tissue Act 1961 (hereafter the 1961 Act). I propose, therefore to deal with these arguments at the outset of this section of the judgment.

The 1961 Act is a short Act which appears to have been passed for the purposes of removing any doubt about the legitimacy of using parts of a deceased person's body for transplants and medical education or research. This doubt had arisen due to the fact that the Corneal Grafting Act 1952 dealt solely with the right to use eyes for such purposes. The 1961 Act extended the

right to all parts of a deceased person's body and repealed the Corneal Grafting Act. In addition, section 2 was designed to remove the doubt about the legitimacy of post-mortems which were not covered by existing legislation (the predecessors of the Coroners Act 1984).

Section 1 deals with use of parts of the body for "therapeutic purposes or for purposes of medical education or research". Section 2 deals with post-mortems "for the purpose of confirming the causes of death or investigating the existence or nature of abnormal conditions". In so far as material the two sections are as follows:

"1. - (1) If any person, either in writing at any time or orally in the presence of two or more witnesses during his last illness, has expressed a request for his body or any specified part of his body to be used after his death for therapeutic purposes or for purposes of medical education or research, the person lawfully in possession of his body after his death may, unless he has reason to believe that the request was subsequently withdrawn, authorise the removal from the body of any part or, as the case may be, the specified part, for use in accordance with the request.

(2) Without prejudice to the foregoing subsection, the person lawfully in possession of the body of a deceased person may authorise the removal of any part from the body for use for the said purposes if, having made such reasonable enquiry as may be practicable, he has no reason to believe –

(a) that the deceased had expressed an objection to his body being so dealt with after his death, and had not withdrawn it; or

(b) that the surviving spouse or any surviving relative of the deceased objects to the body being so dealt with.

…

(7) In the case of a body lying in a hospital, nursing home or other institution, any authority under this section may be given on behalf of the person having the control and management thereof by any officer or person designated for that purpose by the first-mentioned person.

(8) Nothing in this section shall be construed as rendering unlawful any dealing with, or with any part of, the body of a deceased person which is lawful apart from this Act.

…

2. – (1) Without prejudice to section fifteen of the Anatomy Act, 1832 (which prevents that Act from being construed as applying to post-mortem examinations directed to be made by a competent legal authority), that Act shall not be construed as applying to any post-mortem examination carried out for the purpose of establishing or confirming the causes of death or of investigating the existence or nature of abnormal conditions.

(2) No post-mortem examination shall be carried out otherwise than by or in accordance with the instructions of a fully registered medical practitioner, and no post-mortem examination which is not directed or requested by the coroner or any other competent legal authority shall be carried out without the authority of the person lawfully in possession of the body; and subsections (2), (5), (6) and (7) of section one of this Act shall, with the necessary modifications, apply with respect to the giving of that authority."

Before setting out the rival contentions the following propositions are not in dispute. First, the 1961 Act does not apply to stillborn children. The title expressly refers to "… bodies of deceased persons …". Secondly, the expression "… person lawfully in possession of his body after death …" is not defined but in the context of a death in hospital would appear to refer to the hospital (see section 1(7)). Thirdly, the expression "… any surviving relative …" in section 1(2)(b) appears to have been deliberately drawn in that wide form. Fourthly, the 1961 Act provides for no criminal sanctions nor any civil remedies.

For the claimants, Mr Lissack QC made two submissions in respect of sections 1 and 2. Firstly, he submitted that the two sections must be read together with the effect that if a part or parts of a body are removed at post-mortem, the part or parts may not be retained by the hospital unless section 1(2) has been complied with in respect of both the post-mortem and the retention of any part of the body so retained. In the absence of specific non-objection or consent any retention of a part of a body will be unlawful.

Secondly, Mr Lissack QC submitted that non-objection or consent can only be validly obtained from a surviving relative who understands precisely what is involved in a post-mortem examination. In other words, the relative must have drawn to his or her attention the fact that at post-mortem a part of a body may be removed and retained.

The defendants submitted that section 1 and section 2 provide for two different regimes. They emphasised the different purposes provided for by sections 1 and 2. They submitted that non-objection or consent to a post-mortem includes non-objection or consent to all the necessary procedures including removal and retention of organs necessarily involved in a post-mortem examination. So far as the claimants' second submission is concerned the defendants submitted that the sub-section makes no requirement for information to be given to a surviving relative such that a failure to provide such information would invalidate the non-objection or consent.

On the first issue I prefer the arguments of the defendants. I accept that sections 1 and 2 provide for different regimes for two different situations. In the circumstances, as a matter of statutory construction, in my judgment, what is required before a post-mortem is carried out

is no more nor less than that the requirements of sub-section 2(2) are complied with. Once they have been complied with a post-mortem can be carried out. If the "purpose of establishing or confirming the causes of death or of investigating the existence or nature of abnormal conditions" properly requires organs to be removed and retained for examination, in my judgment, no further consent is required. I accept that the position would be different if the post-mortem examination in addition, contemplated use of a part or parts of a body for therapeutic, educational or research purposes. I am quite satisfied that the purposes of the post-mortems in none of the three lead cases involved anything other than a diagnostic purpose.

As to Mr Lissack's second submission in my judgment this also fails as a matter of statutory interpretation. It will, however, call for consideration again when considering negligence. Although in this case all the doctors have referred to the necessity of consent being obtained before a post-mortem can be carried out, as Miss Smith QC pointed out, the statutory provision is for non-objection. There may be little conceptual difference between consent and non-objection, but the latter in my view implies a more passive approach than a requirement for consent. Whether or not there is a difference between non-objection and consent I am quite satisfied that section 2 of the 1961 Act requires no more than a consent to a post-mortem being obtained without further explanation. As I shall indicate later in this judgment that does not mean that if a relative asks questions or seeks further information those questions should not be answered nor the information supplied.

The Tort of Wrongful Interference

The Rival Contentions

Although it is accepted that in English law there is no known case involving the tort of wrongful interference with a body, the claimants submit that to recognise such a tort, as has been recognised in Scotland, Canada and the USA, involves no novel propositions of law. It is submitted that the requirements of the tort are two-fold:

i. The claimant must establish a duty/right to possess the body of his or her deceased child;

ii. It must be proved that the defendant interfered with that duty/right by retaining and/or disposing of body parts without lawful authority.

If these two requirements are established it is submitted that it gives rise to actionable rights of possession and so a claim for damages.

The claimants contend that the following factors or steps lead to the conclusion that such a cause of action exists at common law. They are:

i. There exists a duty on a parent to bury a child;

ii. That duty arises on the death of the child;

iii. The duty to bury applies to a stillborn child as it does to a deceased child;

iv. The duty to bury gives rise to a right of possession of the body for that purpose;

v. The rights of possession are not defeated or abrogated by the defendant's rights to possession of a child's body when the child dies in hospital and when a post-mortem is carried out. Specifically, removal of organs from a child's body and retention after a post-mortem will be unlawful save where consent has been properly obtained pursuant to the provisions of the 1961 Act;

vi. The unlawful removal, retention and/or disposal of an organ will give rise to an action for damages for psychiatric injury as exemplified by a Canadian case and two Scottish cases.

The defendants dispute the existence of any such cause of action as is contended for. In response to the claimants' submissions the defendants argue:

i. There is no property in a deceased person's body;

ii. Although it is not conceded that a parent has a duty to bury a child's body the defendants accept that there is dicta to that effect. In any event it is contended that any duty is not unlimited;

iii. The defendants do not contend that the duty to bury a child is any different if the child is stillborn;

iv. The right to possession of a child's body is not a free-standing right but is dependent on the duty to bury;

v. The duty/right to bury is not immediate but only arises when it is reasonably practicable for the parents to perform that duty taking into account their means to do so, the state of the body and their knowledge of the location of the body and any tissue or organs separated from it; and it only extends to the body itself and not to parts of the body lawfully removed from it;

vi. There is a common law exception to the rule that there is no property in a body which applies where work or skill has been applied to a body or part of it.

I shall have to deal with these rival contentions in greater detail when setting out my conclusions. However, before discussing them in detail I must mention some of the evidence given by the doctors which may be thought to touch on some of the issues. Mr Lissack QC cross-examined most, if not all, of the doctors who gave evidence, whether witnesses of fact or experts, about their perceptions of their duties and obligations. I shall have more to say about this evidence when dealing with the issues arising under the claims in negligence. At this stage I propose to mention briefly some of the features of that evidence particularly those features relied upon by the claimants on these issues. A number of the doctors explained how they were taught to treat human bodies with dignity and respect (see for example Professor Craft). Some found the proposition that a pathologist had a right of ownership in part of a body disturbing and distasteful (Dr Moore). Some pathologists described themselves as custodians of human material removed at post-mortem (Dr Moore and Professor Weller).

I do not find it surprising that following disclosure of what has become to be known popularly as the Alder Hey organ retention scandal doctors should answer as these doctors did to general questions about proprietary rights in organs of deceased children. It would take a peculiarly insensitive doctor to assert today that a pathologist had a possessory right to a part of a body over and above the right of a parent. Whilst I pay some attention to the reliance placed by the claimants upon such evidence I do not think that in the circumstances too much weight should be attached to it when I am considering the legal principles involved.

It is perhaps also fair to comment that discussion in the court about possessory rights and ownership rights of a body or parts of a body seem inappropriate and no doubt particularly so to the parents and relatives of deceased children. The difficulty for all parties has been in finding the correct path through what commentators have rightly characterised as the uncertainty and lack of clarity of the common law on this topic.

In my opinion the most appropriate place to start the analysis of the law is from the firm ground of a proposition which is not disputed. This is the principle that there is no property in the body of a deceased person. As recently as in May 1998 the CACD reaffirmed this principle in the case of R v Kelly [1999] QB 621. In that case Rose LJ giving the judgment of the court stated (see page 630):

"We accept that however questionable the historical origins of the principle, it has now been common law for 150 years at least that neither a corpse nor parts of corpse are in themselves and without more capable of being property protected by rights: see for example, Erle J, delivering the judgment of a powerful Court for Crown Cases Reserved in Reg. v Sharpe [1857] Dears. & B. 160, 163, where he said: "Our law recognises no property in a corpse, and the protection of the grave at common law as contradistinguished from ecclesiastic protection to consecrated ground depends on this form of indictment." He was there referring to an indictment which charged not theft of a corpse but removal of a corpse from a grave.

If that principle is now to be changed, in our view, it must be by Parliament, because it has been express or implicit in all the subsequent authorities and writings to which we have been referred that a corpse or part of it cannot be stolen."

It is convenient to point out that immediately following the passage quoted above Rose LJ affirmed the principle that parts of a corpse are capable of being property. The judgment continues immediately following the passage previously cited (see page 631):

"To address the point as it was addressed before the trial judge and to which his certificate relates, in our judgment, parts of a corpse are capable of being property within section 4 of the Theft Act 1968 if they have acquired different attributes by virtue of the application of skill, such as dissection or preservation techniques for exhibition or teaching purposes, see Doodeward v Spence 6CLR 406, 413, 414 in the judgment of Griffith C.J. to which we have already referred and Dobson v North Tyneside Health Authority [1997] 1WLR 596, 601 where this proposition is not dissented from and appears in the judgment of this court to have been accepted by Peter Gibson LJ; otherwise, his analysis of the facts of Dobson's case, which appears at that page in the judgment, would have been, as it seems to us, otiose."

This latter principle is also not disputed although its application to the facts of the lead cases is.

I return now to the duty to bury. In R v Vann [1851] 2Den 325 it was held that a parent of a child who had not the means of providing for the burial of the body of his deceased child was not liable to be indicted for the misdemeanour of not providing for its burial, even though a nuisance was occasioned by the body remaining unburied. The report of the case shows that the court accepted that a parent had a duty to bury his or her deceased child. In the course of his judgment Lord Campbell CJ said (see pages 525/6):

"It is true that a man is bound to give Christian burial to his deceased child if he has the means of doing so; but he is not liable to be indicted for a nuisance, if he has not the means of providing burial for it. He cannot sell the body, put it into a hole, or throw it into the river; but unless he has the means of giving the body Christian burial he is not liable to be indicted, even though a nuisance may be occasioned by leaving the body unburied, for which the parish officer would probably be liable."

This proposition was approved in Clarke v London General Omnibus Co Ltd [1906] 2KB 648 and recently in R v Gwynedd County Council ex parte B and Another [1992] 3AER 317.

The claimants in this case rely on this proposition to establish the right of a parent to bury his or her deceased child. From that proposition it is contended that duty involves a right to possess the child for burial from the moment the child dies.

However, as Mr David Hart QC, who made the submissions on this part of the law on behalf of the defendants, pointed out, a duty to bury is not unlimited. In my judgment that is obvious from the decision in R v Vann. Furthermore, it appears from that case that the purpose of the common law duty to bury, as I hold that there is, was to prevent a nuisance caused by unburied bodies. There is also support for the proposition that others can on death have the legal possession of a body, for example the master of workhouse (see R v Feist [1858] D&B 590); and have the duty to bury a body, for example executors and administrators (see Williams v Williams [1882] CHD 659). As I have already said, section 1(7) of the 1961 Act assumes that when a person dies in hospital the hospital has the legal right to possess the

body at least initially. If consent to carry out a post-mortem examination is given the hospital will, in my opinion, continue to have the right to possess the body whilst the post-mortem and any necessary further examinations are carried out. In the case of a coroner's post-mortem, it is conceded by Mr Lissack QC that the coroner's authority is sufficient to permit the pathologist to have the legal right to possess the body until the coroner's purpose or inquiry has ceased.

In the lead cases the body of the child was returned to the parents for burial following a certificate of disposal issued in the case of hospital post-mortems and Form B in the case of the coroner's post-mortem. What was not returned were the organs which had been removed, fixed and subjected to further examinations.

The claimants contended that at that stage, or at least after any further necessary examinations, the organs should have been returned to the parents. Any retention beyond that point was unlawful. The defendants argued that the right to possess the organs had passed to the hospital in hospital post-mortem cases and to the coroner in the coroner's post-mortem case. As I have already indicated the claimants contention is based on the argument that the duty to bury confers on the claimants a right to possess the body including all its parts for the purpose of burial. The defendants' case is that the duty to bury and right to possession consequent upon that duty does not include the right to possession of organs lawfully removed from the body. In any event, the defendants argued that there is at least a right of the hospitals and pathologists to possess organs on which work and skill have been carried out.

This latter argument depends for its genesis on the Australian case Doodeward v Spence [1908] 6CLR 40. The subject matter of the action for conversion and detinue brought by the appellant was a two-headed stillborn baby which had been preserved with spirits in a bottle. It had been seized by police from the appellant on the ground that exhibiting it publicly offended public decency. The court, Higgins J, dissenting allowing the appeal ordered the return of the body to the appellant. In his judgment Griffith CJ stated (see page 414):

"If, then, there can, under some circumstances, be a continued rightful possession of a human body unburied, I think, as I have already said, that the law will protect that rightful possession by appropriate remedies. I do not know of any definition of property which is not wide enough to include such a right of permanent possession. By whatever name the right is called, I think it exists, and that, so far as it constitutes property, a human body, or a portion of a human body, is capable by law of becoming the subject of property. It is not necessary to give an exhaustive enumeration of the circumstances under which such a right may be acquired, but I entertain no doubt that, when a person has by the lawful exercise of work or skill so dealt with a human body or part of a human body in his lawful possession that it has acquired some attributes differentiating it from a mere corpse awaiting burial, he acquires a right to retain possession of it, at least as against any person not entitled to have it delivered to him for the purpose of burial, but subject, of course, to any positive law which forbids its retention under the particular circumstances. "

Barton J agreed with the reasoning of Griffiths CJ whereas Higgins J in a powerful dissenting judgment asserted that there could be no right to recover in trover or detinue a thing which is incapable of being property.

The decision in Doodeward was considered by the Court of Appeal in Dobson v North Tyneside Health Authority and Another [1997] 1WLR 596. In that case the Court of Appeal dismissed an appeal by the plaintiff against an order striking out a claim against Newcastle Area Health Authority for damages for failing to preserve the plaintiff's deceased daughter's brain and sections of brain tumours following a post-mortem. The post-mortem was a coroner's post-mortem. Giving a judgment with which the two other members of the court agreed Peter Gibson LJ stated that he was prepared to accept that the principle in Doodeward was properly arguable. In the course of his judgment he made a number of observations on which the defendants rely. He said (see page 601):

"Does this mean that it is arguable that when Dr Perry (the pathologist) fixed the brain in paraffin, he thereby transformed it into an item the right to possession of which or the property in which belonged to the plaintiffs? For my part, I do not think so. The removal of the brain was lawfully performed in the course of the post-mortem which at coroner's request Dr Perry had undertaken to determine the cause of the deceased's death. Dr Perry was under an obligation imposed by rule 9 of the Coroners' Rules 1984 to make provision for the preservation of material which in his opinion bore upon the cause of death but only for such period as the coroner thought fit. It is not alleged that Dr Perry was in breach of that obligation, and once the cause of death had been determined by the coroner with Dr Perry's help and the time for challenge for that determination had passed, there could be no continuing obligation under the rule to preserve that material."

and

"There was no practical possibility of, nor any sensible purpose in, the brain being reunited with the body for burial purposes. Mr Hone accepted that organs would usually be preserved by the pathologist who carried out a post-mortem and that if Dr Perry had disposed of the brain without fixing it in paraffin, the plaintiffs would have no cause for complaint. I do not see how the fact that the brain was so fixed rendered it an item to possession of which the plaintiffs ever became entitled for the purpose of interment or any other purpose, still less that the plaintiffs ever acquired the property in it. "

In fact Dobson was decided on the basis that since the claim was in conversion, bailment and wrongful interference with the brain, the plaintiffs could not establish that they had the right to possession at the time the brain was disposed of. Letters of administration were not issued until just before the claim was instituted.

In Kelly, the passage to which I have previously referred, Rose LJ endorsed the principles set out in Doodeward.

Mr Lissack QC sought to distinguish Dobson and Kelly. He submits that Dobson was a strike out case. Consequently the facts were not fully explored. As a result the court did not need to define the entitlement to the Doodeward exception since the work undertaken to preserve the brain was not sufficient to qualify as an exception to the general rule.

He also sought to distinguish Kelly on the basis that the court held that the anatomical specimens were for the purpose of section 4 of the Theft Act 1968 sufficient to find the offence of theft. In my judgment this submission ignores the fact that the court was

considering the ground of appeal raised by the defendants that there was no property capable of being stolen; an argument which the court rejected.

In my judgment the principle that part of a body may acquire the character of property which can be the subject of rights of possession and ownership is now part of our law. In particular, in my opinion, Kelly's case establishes the exception to the rule that there is no property in a corpse where part of the body has been the subject of the application of skill such as dissection or preservation techniques. The evidence in the lead cases shows that to dissect and fix an organ from a child's body requires work and a great deal of skill, the more so in the case of a very small baby such as Rosina Harris. The subsequent production of blocks and slides is also a skilful operation requiring work and expertise of trained scientists.

I propose now to consider the cases which Mr Lissack QC submits support the proposition that there exists a tort of wrongful interference with a deceased person's body. They are referred to in Clerk & Lindsell on Torts 18th Edition under the general heading "Subject-matter of Conversion" at paragraph 14-45:

"Dead Bodies and Human Tissue

There is no property in a corpse. (However, personal representatives or other persons charged with the duty of burying a body have a right to its custody and possession in the interim, infringements of which are actionable, and by statute those representatives also have certain powers in relation to the use of a body for medical purposes.) On the other hand once a body has undergone a process or other application of human skill, such as stuffing or embalming, it can it seems be the subject of property in the ordinary way. And the same goes for body parts: thus in the grisly case of R v Kelly robbers who abstracted and sold preserved specimens from the Royal College of Surgeons' collection were held rightly convicted of theft. It is an open question whether there can be property in bodies and body parts which have not been subject to any such process, but are legitimately wanted for some other purpose, such as accident investigation or use as an exhibit in court. … In so far as there can be property in corpses or parts thereof, presumably it will vest initially in person carrying out the stuffing or embalming process, or taking steps for their preservation, on the basis that he is the first possessor."

Two of the cases cited in Clerk & Lindsell and relied on by the claimants are Scottish cases: Pollok v Workman [1900] 2F 354 and Hughes v Robertson [1930] SC 394. Each of these cases was brought by a widow for damages for wrongful and unauthorised post-mortems carried out by the defendants on their deceased husbands. In the case of Pollok the act complained of was alleged to have been criminal and in the nature of an action of assythment. Each claim was dismissed by the appellate court on a technicality concerning the way the claim was constituted. However, in each case the court held that such a claim was "relevant" and "competent".

The Canadian case cited in Clerk & Lindsell is Edmunds v Armstrong Funeral Home Ltd [1931] DLR 676. It was also a case involving a claim by a widower for damages for what was alleged to be the unlawful carrying out of an autopsy on the body of the claimant's deceased wife. The claim had been dismissed by the judge at first instance on the ground that it disclosed no cause of action. The Court of Appeal of the Alberta Supreme Court allowed

the claimant's appeal. In his judgment Harvey CJA referred to the two Scottish cases and a passage in the 8th Edition of Clark & Lindsell. At page 680 Harvey CJA said:

"If then, as seems clearly established, the plaintiff had the right to the custody and control of the remains of his deceased wife any unauthorised interference with that right, such as is alleged, was an invasion of his right and would give a cause of action."

He then went on to consider the question of damages and concluded that damages for injured feelings and mental suffering were recoverable.

Mr Lissack QC submitted that a similar principle applies in English law. He does not seek to express the cause of action as necessarily one in trespass or conversion. He submitted that it was probably a species of conversion.

Mr Hart QC pointed out that in Canada and Scotland academic writers have not found it easy to ascribe a category or cause of action into which these cases fall. In Canada an academic writer discussed the decision in Edmunds under the principal heading of an action for trespass to the person and following the decision of Wilkinson v Downton [1897] 2QB 97. The difficulty with a claim under the Wilkinson v Downton principle is that it requires a deliberate and wilful misstatement of fact something which does not arise in any of these cases. Furthermore, Lord Hoffman in Wainwright v Home Office [2003] 3WLR 1137 expressed the view, in agreement with Buxton LJ in the Court of Appeal, that Wilkinson v Downton had nothing to do with trespass to the person.

To determine the proper basis upon which to mount a claim for wrongful interference with a corpse is in my view a necessary exercise. Mr Lissack QC accepting that at the time when the organs in these three cases were removed from the bodies of the three children, the bodies were lawfully in the possession of pathologists conducting the post-mortems, relied on a right to possession of the organs once the post-mortem purposes have been completed. Further that right must confer upon the parents a cause of action. Therefore, in my judgment, the crucial question is: Do the parents have any possessory rights in the organs once a post-mortem and attendant examinations have been completed; and do those rights give rise to a cause of action for distress and/or psychiatric injury?

In my judgment the first thing to note is that the three decisions upon which the claimants relied are all cases where the post-mortems were unauthorised. In the lead cases all the post-mortems were in my opinion authorised either by consent pursuant to the provisions of the 1961 Act or by express consent or under the coroner's authority. It seems to me that it must follow that when the organs were removed from the bodies the action of removing them was lawful and at the time those organs were lawfully in the possession of the pathologists undertaking the post-mortem or any other pathologist properly instructed to carry out a further histological examination.

Thereafter once the post-mortem examinations have been completed the law as to what rights are vested in the parents or the pathologists is far from clear. For myself, I prefer the view expressed by the authors of Clark & Lindsell that on the assumption that the Doodeward exception applies the pathologists became entitled to possess the organs, the blocks and slides at least until a better right is asserted. Mr Lissack QC relies on that part of the final sentence of Griffiths CJ's judgment in Doodeward to which I have referred which reads "… at least as

against any person not entitled to have it delivered to him for the purpose of burial …" He submits that Griffiths CJ contemplated that someone with a right to bury the body would have a better right to the part of the body even if it came within the exception.

Whilst I see the force of this submission, it must be remembered that the body in Doodeward had never been buried. In these cases the bodies were buried shortly after the post-mortems and before the process of examination of the organs had been completed. If I am right in concluding that consent to carry out a post-mortem necessarily involves consent to all the proper procedures involved in a post-mortem the removal of the organs was lawful and the right of the parents to possess them, based on a duty to bury, does not arise. This would seem to accord with Peter Gibson LJ's judgment in Dobson.

Finally, Mr Lissack QC accepted that the claimants' right to possess the bodies of their children was a right to possess the bodies in a state as anatomically complete as was reasonably practicable in the circumstances. In oral submissions he submitted this included the right to bury the blocks and slides as well as the organs. The evidence is that after the organs had been removed from the body it takes possibly as long as eight weeks before all the examinations can be completed. In Rosina Harris' case the organs which were removed were extremely small and one can imagine that the blocks, slides and remainder of the organs would themselves be extremely small. It seems to me that these facts demonstrate the impractability of a principle which relies on a body being returned to a parent in as anatomically complete state as reasonably practicable.

Mr Hart QC also argued that a right to bury an organ can only arise if a parent calls for its delivery up and that request is refused. Strictly, this may be a necessary requirement for an action for conversion. However, on the assumption that once removed the organs are lawfully retained by a hospital, following a HPM, or a pathologist acting for a coroner, following a CPM, this submission adds nothing to the defendants' case.

For the avoidance of doubt, in my opinion, in the three lead cases the evidence of the pathologists shows that the work and skill applied to the parts of the body removed at the post-mortem is sufficient to come within the Doodeward exception. They are therefore capable of being subject to rights of possession.

Finally I return to the cause of action for which the claimants contended. Assuming that my conclusions are correct that the claimants have no right of burial and possession of organs lawfully removed at post-mortem and retained, in my judgment, there can be no action for wrongful interference with the body of the child. If, on the other hand, a parent or parents when consenting to a post-mortem specifically asked for the return of an organ I can see that in certain circumstances it might be arguable that a cause of action based on conversion exists, if conversion is what is being alleged by the claimants in this group action. But in the absence of such a cause of action in respect of the body of a deceased person being recognised by an English court I am not prepared to hold that one does exist. I arrive at this conclusion notwithstanding Mr Lissack's submissions to which I refer at the outset of this section of the judgment namely in paragraphs 111 to 113. In addition, as will appear later in this judgment, if a claimant makes a stipulation that his or her consent to an HPM is conditional on all organs removed being put back in the body, the defendants concede, rightly, in my opinion, that this gives rise to a duty of care by the doctor to pass on that condition to the pathologist. It is further conceded that failure by the doctor to do so or by a pathologist to heed such a condition would prima facie amount to a breach of that duty of care. In those circumstances, where a claim for negligence can arise, I see no reason or

justification for constructing another cause of action which is not subject to the various common law controls inherent in any claim in negligence.

I shall deal with consequence of my conclusions in this section when dealing with the agreed issues which arise in respect of each of the three claims.

Negligence

The claimants' case in negligence only arises in the context of hospital post-mortems. The claimants allege that the defendants through their doctors owed a duty of care to them when obtaining consent for a post-mortem. The duty was to:

i. Counsel properly the claimants as to the nature of the post-mortem examination by explaining to them that organs would be removed during the post-mortem and would or might be retained; and

ii. Comply with the claimants wishes in relation to their child's body and organs.

In each of the two lead cases the claimants allege that the duty of care was breached either by a failure to comply with the wishes of the parents or by a failure to explain the nature of the post-mortem examination in such a way as to elicit objections to the removal and retention of organs.

By reason of those breaches it is alleged that the claimants suffered foreseeable psychiatric injury.

The defendants deny that a duty of care was owed by the doctors to the claimants when they were obtaining consent to the post-mortem examinations pursuant to the 1961 Act. Further, it is denied that if a duty of care was owed it was breached or that any breach caused any recoverable losses.

The claimants submitted that when seeking consent for a post-mortem examination pursuant to the 1961 Act, a doctor owed a professional duty of care to the bereaved family. In the Harris claim this was a continuing duty of care owed to Mr and Mrs Harris following the death of Rosina. It is alleged that the duty of care was one which exists between a patient and doctor and was owed to Mr and Mrs Harris by both Dr Michaels and Dr Clifford. In the Shorter claim the duty of care was owed by Mr Fairbank to Mrs Shorter in the context of a patient-doctor relationship. It is submitted that the consent process necessarily involved the provision of information and assurances to the bereaved parents. The information and assurances were intended to be relied on by the parents thereby giving rise to an assumption of responsibility by the doctors in the legal sense. Further, Mr Lissack QC submitted that the duty of care "is properly influenced by the statutory framework" of the 1961 Act (see Lord Brown-Wilkinson in X v Bedfordshire County Council [1995] 2AC 633 at 736). He submitted that the test of proximity, foreseeability, and fair just and reasonable are all satisfied.

Miss Smith QC submitted that when obtaining consent for a post-mortem examination under the 1961 Act, a doctor was not acting in the context of a doctor-patient relationship. There is,

she submitted, no common law duty on a doctor to explain the nature of a post-mortem examination. Further, any doctor-patient relationship that may exist in this context does not include a duty to protect the patient from psychiatric harm. In any event, it is submitted that Mrs Harris and Mrs Shorter were "secondary victims" and therefore excluded from the scope of any duty of care and from recovering damages for psychiatric harm by the "control mechanisms" applicable to such claims.

I shall deal with these submissions in greater detail later in this judgment. But first I must refer to some of the evidence given by the doctors involved in the consent process and the experts.

Duty of Care: The Harris claim

Dr Michaels, at the time a SHO working in paediatrics under Dr Clifford, said that he did not necessarily owe a professional duty to Mr and Mrs Harris after Rosina's death but this would not stop him talking to them.

Dr Clifford subscribed to the opinion of the experts that after the death of the child there was a continuing duty of care owed to the bereaved family. He argued that this duty was duty to act as part of a team which included the parents. He added that he did not owe a contractual duty of care to the parents as he was a paediatrician. He said it was his professional duty to take the consent for a post-mortem from the parents whose deceased child had been a patient of his. Taking consent was, he agreed, an important and significant issue.

Duty of Care: The Shorter claim

Mr Fairbank, an obstetrician, agreed that part of his duty of care was to help the mother of a stillborn child come to terms with her loss and investigate appropriately why the tragedy had occurred. This included seeking consent for a post-mortem.

Mr Michael Gillmer, the consultant obstetrician and gynaecologist who saw Mrs Shorter in November 1992, agreed that he would expect a member of his team responsible for obtaining consent to a post-mortem would have to exercise the same skill and care as in any other aspect of care.

Duty of Care: The Experts

In a joint experts' report following a meeting of Professor Alan Craft, a professor of child health, Mr Leslie Hamilton, a consultant paediatric cardiac surgeon, and Mr Roger Clements, a consultant obstetrician and gynaecologist, the experts agreed that following a child's death the clinicians owed a continuing duty of care to the bereaved family. This was a continuing duty to practice family centred care which involved helping the family through the bereavement and advice concerning future children.

In evidence, Mr Clements stated that he saw counselling a mother about a post-mortem as part of the duty of care which he owed to her. He added, whether or not she consented to it

was entirely a matter for her and he would not seek to persuade her. He said "I would counsel her".

Professor Craft agreed that there was a continuum of care that started before death and continued after death. It included the process of obtaining consent for a post-mortem.

Scope of the Duty of Care

Dr Clifford agreed that in 1995 he was seeking to elicit the wishes of the parents as regards post-mortems. He said that parents needed to be provided with sufficient information to make a decision about a post-mortem. He stressed that "the whole thing turns on the word sufficient" adding "our idea of sufficient in 1995 was very different from our idea of sufficient in 2000" (emphasis added).

Mr Richard Nelson, the Senior Registrar in neurosurgery and member of the neurosurgical team caring for Daniel Carpenter, agreed that if a direct request for information about a post-mortem was made he would discuss the procedures involved in a post-mortem in the same open way that he would have discussed the risks of an operation.

Professor Craft said that he worked on the principle that he had to get informed consent for whatever he was doing whether it was an operation or a post-mortem. He added that an operation was different from a post-mortem in terms of the amount of detail which the doctor needed to give. In the case of a post-mortem it depended on the amount of information that the parents wanted and needed at a time of extreme distress.

Mr Clements agreed that in 1992 the process of obtaining consent ought to have elicited any strong objection to a post-mortem if it existed in any given individual.

I have not by any means set out all the evidence given on the above two issues by the doctors and experts. But the above gives, I hope, an accurate flavour of the whole of the evidence. Again, I do not find it surprising that in cross-examination the clinicians readily assented to the proposition that they owed a professional duty of care to parents when obtaining consent to a post-mortem examination. I doubt that any of them had in mind the concept of a legal duty of care. Nevertheless, I attach more significance to this evidence than I attach to their evidence concerning proprietary rights to organs of a deceased child. I must add that all the doctors agreed that if consent to a post-mortem was conditional the doctor was under a duty to pass on the condition to the pathologist. It is common ground that pathologists were under a duty to comply with any condition attached to a consent.

Duty of Care: The Law

There is no dispute that in resolving the issue of whether a duty of care is established the court must go to what Brooke LJ described as the "battery of tests which the House of Lords has taught us to use" (see McLoughlin v Jones [2002] 2WLR 1279). He summarised those test as follows (see page 1288):

"… the "purpose" test (Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd); the "assumption of responsibility" test (Henderson v Merrett Syndicates Ltd); the "principles of

distributive justice" test (Frost v Chief Constable of South Yorkshire Police); and the "three-pronged" test (Caparo Industries plc v Dickman). The fact that these tests are usually deployed in cases involving pure financial loss does not mean that they are inappropriate for use when the only damage in question is psychiatric illness".

It is also common ground that these tests overlap in their application.

Miss Smith QC conceded that if a parent consented to a post-mortem being carried out on his or her child on condition that any removed organs were put back in the body before burial, the doctor owed a duty of care to ensure that condition was communicated to the pathologist. The same applied to any other condition made by a parent when giving consent to a post-mortem. She made this concession on the basis that in those circumstances the assumption of responsibility test was satisfied.

However, in the absence of any condition being attached to the consent, Miss Smith QC made two further submissions which she contended militated against a finding that the doctors owed a duty of care on the basis that the relationship between the doctor and the parents was not sufficiently proximate. The first was based on two decisions of the Court of Appeal and the second was based on the "control mechanisms" relating to claims for psychiatric injury, the primary/secondary victim dichotomy (as counsel have labelled this issue).

Powell v Boldaz

In Powell and Boldaz [1997] 39BMLR 35 the issue for decision in the Court of Appeal was whether doctors owed a duty of care to the parents of their deceased son in relation to events which occurred after death when the parents were allegedly given misleading or false information by doctors. The Court of Appeal applying the Caparo tests, decided that no duty of care was owed because the element of proximity was lacking. Giving the first judgment, with which the two other members of the court agreed, Stuart-Smith LJ said (see page 44):

"I propose to consider, first, whether a sufficient relationship of proximity existed. It must be appreciated that, prior to 17 April 1990, although the plaintiffs were patients of the defendants in the sense that they were on their register, the only patient who was seeking medical advice and treatment was Robert. It was to him that the defendants owed a duty of care. The discharge of that duty in the case of a young child will often involve giving advice and instruction to the parents so that they can administer the appropriate medication, observe relevant symptoms and seek further medical assistance if need be. In giving such advice, the doctor obviously owes a duty to be careful. But the duty is owed to the child, not to the parents."

and (at page 45)

"After the death, the defendants may owe the plaintiffs a duty of care; but this depends upon whether they are called upon, or undertake, to treat them as patients. There are many

situations where a doctor will have close contact with another person, without the relationship of doctor-patient arising so as to involve the duty of care."

and (lower down on page 45)

"I do not think that a doctor who has been treating a patient who has died, who tells relatives what has happened, thereby undertakes the doctor-patient relationship towards the relatives. It is a situation that calls for sensitivity, tact and discretion. But the mere fact that the communicator is a doctor, does not without more, mean that he undertakes the doctor-patient relationship. It is of course possible that the doctor in such a situation may realise that the shock has been so great that some immediate therapy is needed, but even so, this situation is probably more akin to the doctor giving emergency treatment to an accident victim. Though no doubt it will be a question of fact and degree, in each case, where the doctor-patient relationships came into existence by the doctor undertaking to treat and heal the person as a patient."

and (at page 46)

"It is clear that if the doctor-patient relationship exists, subject to the Bolam principle, which is now well-recognised and was held in Sidaway to be applicable to all aspects of treatment and advice, a doctor must give careful, truthful and candid information to his patient for the purpose of his treatment or, if need be, to advise him that no treatment is required. Failure to do so, resulting in injury, will expose the doctor to liability in negligence. But these dicta afford no authority for the proposition that there is some kind of free-standing duty of candour, irrespective of whether the doctor-patient relationship exists in a healing or treating context, breach of which sounds in damages, such damages involving personal injury. This would involve a startling expansion of law of tort."

Miss Smith QC relied on these passages. She submitted that in the lead cases the clinicians were not undertaking any treatment of the parents. In the case of the paediatricians their patient was at all times the child. In the case of the obstetrician his duty before death was owed to both the unborn child and the mother. After death no duty was owed to parents in respect of the consent procedures.

Miss Smith QC sought to gain further assistance from JD v East Berkshire Community NHS Trust [2003] 4AER 796. However, in her closing submissions that support was limited to the approval by the court to Powell and Boldaz (see page 831). For my part I see nothing in the decision in the East Berkshire case which materially assists the defendants' submissions.

The facts in Powell are very different from those in the lead cases. In Powell it was much more obvious that no doctor-patient relationship existed. In this case, if no such relationship existed, I accept the force of the submissions that the clinicians owed no free-standing duty of care. The issue in the lead cases is whether or not such a duty of care existed. This, as Stuart-Smith LJ stated in Powell, is to be judged as a matter of fact and degree in each case. In my judgment, the decision in Powell provides no further assistance in respect of the central issue in the lead cases.

The Primary/Secondary Victim Dichotomy

These claims are for damages for psychiatric injury. There can be no question of any physical injury or the risk of any physical injury. Miss Smith QC submitted that the control mechanisms applicable to claims for psychiatric injury apply to both claims. She submitted that each claimant falls into the category of a secondary victim. Mr Lissack QC submitted that the control mechanisms have no application to the circumstances of these claims. Alternatively, he submitted that the claimants are primary victims.

This issue arises out of the decisions of the House of Lords in Alcock v Chief Constable of South Yorkshire Police [1992] 1AC 310 ; Page v Smith [1996] 1AC 155; and Frost v Chief Constable of South Yorkshire Police [1999] 1AC 455. The control mechanisms are the now familiar four requirements namely: (i) the claimant must have had a close tie of love and affection with the primary victim; (ii) the claimant must be close in time and space to the event caused by the defendants' breach; (iii) the claimant must have had a sudden appreciation by sound of the horrifying event or its immediate aftermath; (iv) the claimant must not be a person abnormally susceptible to psychiatric illness. The reasons for these control mechanisms are clearly spelt out by Lord Steyn in Frost (see pages 493 – 494) and need no repetition here. There is no dispute that the claimants cannot satisfy all of these four requirements. Accordingly, if they are secondary victims, even if a duty of care arises, these claims cannot succeed in negligence. Miss Smith QC submitted that this principle falls to be considered when the court is considering the issue of duty of care under the requirement for proximity.

Alcock and Frost involved claimants who were spectators (Alcock) and policemen (Frost) present at the Hillsborough disaster. In those cases the claims for psychiatric injury were said to have been caused by the claimants witnessing the horrors of injuries caused to spectators at the match. Page concerned a claim by the driver of a car involved in an accident who suffered no physical injuries but did suffer psychiatric injuries. In Alcock and Frost the victims were described as secondary victims. In Page Lord Lloyd of Berwick, with whom Lords Ackner and Browne-Wilkinson agreed, described the claimant as a primary victim; indeed, in that case there could be no possible other primary victim. In Page Lord Lloyd described the distinction between primary and secondary victims as "… obvious and long-standing" (see page 184). Later in his speech he made reference to the following factor involved in the consideration of a case involving a secondary victim (see page 188):

"My noble and learned friend, Lord Keith of Kinkel, has drawn attention to an observation of Lord Wright in Bourhill v Young, that in nervous shock case the circumstances of the accident or event must be viewed ex post facto … This makes sense, as Lord Keith points out, where the plaintiff is a secondary victim. For if you do not know the outcome of the accident or event, it is impossible to say whether the defendant should have foreseen injury by shock. It is necessary to take account of what happened in order to apply the test of reasonable foreseeability at all. But it makes no sense in the case of a primary victim. Liability for physical injury depends on what was reasonably foreseeable by the defendant before the event."

In Frost, Lords Steyn and Hoffman gave some further guidance on the difference between primary and secondary victims. Commenting on Lord Lloyd's speech in Page, Lord Steyn said (see pages 496-497):

"Lord Lloyd said that a plaintiff who had been within the range of foreseeable injury was a primary victim. Mr Page fulfilled this requirement and could in principle recover compensation for psychiatric loss. In my view it follows that all other victims, who suffer pure psychiatric harm are secondary victims and must satisfy the control mechanisms laid down in the Alcock case."

Lord Hoffman having referred to the argument by the claimants in Frost that they were primary victims by virtue of their contract of employment with the defendants said (see pages 505-506):

"I think, my Lords that this argument really assumes what it needs to prove. The liability of an employer to his employees for negligence, either direct or vicarious, is not a separate tort with its own rules. It is an aspect of the general law of negligence. The relationship of employer and employee establishes the employee as a person to whom the employer owes duty of care. But this tells one nothing about the circumstances in which he will be liable for a particular type of injury. For this one must look to the general law concerning the type of injury which has been suffered. It would not be suggested that the employment relationship entitles the employee to recover damages in tort (I put aside contractual liability, which obviously raises different questions) for economic loss which would not ordinarily be recoverable in negligence. The employer is not, for example, under a duty in tort to take reasonable care not to do something which would cause the employee pure financial loss, e.g. by reducing his opportunities to earn bonuses. The same must surely be true of psychiatric injuries. There must be a reason why, if the employee would otherwise have been regarded as a secondary victim, the employment relationship should require him to be treated as a primary one. The employee in Walker v Northumberland County Council was in no sense a secondary victim. His mental breakdown was caused by the strain of doing the work which his employer had required him to do."

In Hatton v Sutherland [2002] 2AER 1, Hale LJ, if I may respectfully say so, provided a very helpful summary of the four categories of claims for psychiatric injury. She said (see page 12 paragraph 21):

"In summary therefore, claims for psychiatric injury fall into four different categories. (1) Tortious claims by primary victims: usually those within the foreseeable scope of physical injury, for example, the road accident victim in Page v Smith; some primary victims may not be at risk of physical harm, but at risk of foreseeable psychiatric harm because of the circumstances are akin to those of primary victims in contract (see (3) below). (2) Tortious claims by secondary victims: those outside that zone who suffer as a result of harm to others, for example, the witnesses of the Hillsborough disaster in Alcock's case. (3) Contractual claims by primary victims: where the harm is the reasonably foreseeable product of specific breaches of contractual duty of care towards a victim whose identity is known in advance, for example, the solicitors clients in Cook v S … or the employers in cases of Petch, Walker and Garrett, and in all the cases before us. (4) Contractual claims by secondary victims: where the harm is suffered as a result of harm to others in the same way as secondary victims in tort but there is also a contractual relationship with the defendant, as the police officers in White's case."

To this summary I merely add that in W v Essex County Council [2001] 2AC 601, Lord Slynn said (see page 601):

"But the categorisation of those claiming to be included as primary or secondary victims is not as I read the cases finally closed."

Miss Smith QC submitted that in the lead cases the primary victims are the deceased children. She submitted that the claimants cannot fall into categories 1, 3 and 4 of Hale, LJ's four categories and must therefore fall into category 2. She submitted that this accords with the passage from Lord Steyn's speech in Frost to which I have referred.

Mr Lissack QC submitted that the claimants in these cases are persons who were direct participants in the event, namely the negligent failure to counsel them when obtaining their consent to a post-mortem. The children cannot be primary victims because in no sense can they be victims after death. Mr Lissack QC further submitted that the question of the primary/secondary victim dichotomy has no relevance to these claims.

In my judgment, these claims do not fit easily into any of the descriptions given to primary and secondary victims. Tempting as it is to regard the primary/secondary victim dichotomy as not relevant in these claims the House of Lords has made it clear that those claiming solely for psychiatric injury must be placed in one or other category in order to determine whether or not the necessary control mechanisms come into play.

To assist in resolving the primary/secondary victim dichotomy I have gone back to the decision in Alcock. Lord Oliver in his speech describing the issue in the appeal said (see page 406):

"In each case it is admitted for the purposes of these proceedings that the defendant was in breach of a tortious duty of care owed to the primary (emphasis added) victim and that each plaintiff has suffered psychiatric illness. It is in issue whether the illness of which each plaintiff complains is causally attributable to the circumstances in which he or she became aware of the death of the primary victim. What remains in issue is whether the defendant owed a duty in tort to the plaintiffs to avoid causing the type of injury of which each plaintiff complains. In essence this involves answering the twin questions of (a) whether injury of this sort to each particular plaintiff was a reasonably foreseeable consequence of the acts or omissions constituting the breach of duty to the primary victim and (b) whether there existed between the defendant and each plaintiff that degree of directness or proximity necessary to establish liability."

It seems to me that Lord Oliver when referring to secondary victims was contemplating a situation where, as a pre-requisite, there was a primary victim to whom the defendant owed a duty of care.

The question of whether a claimant is a primary or secondary victim is "essentially a question of fact" (per Lord Goff in Frost @ page 473). Guided by the various passages in the above decisions my conclusion is that they properly fall into the category of primary victims. In reaching this conclusion the following factors are, in my opinion, relevant and important. First, unlike the secondary victims in Alcock and Frost the foreseeability test in these claims can be applied before the event, the event being the obtaining of consent for a post-mortem by the doctors. They are not cases where that test can only be conducted ex post facto. The claimants, at all times before and after that event are readily identifiable. Secondly, in my view there is force in the argument that the children were not primary victims. Neither the

clinicians nor the pathologists could possibly have owed any duty of care to them after their death. In my opinion, it follows that if the claimants are victims at all they must be primary victims. Thirdly, if, but for this argument, there would exist a doctor-patient relationship, in my judgment, these claims fit more clearly into category 1 of Hale LJ's four categories than any of the other three. The nature of the doctor-patient relationship has frequently been described as akin to a contractual relationship. In these claims, the alleged negligence of the clinicians in obtaining consent from the claimants, is the very thing which, it is alleged, caused the psychiatric injury.

Conclusions on Duty of Care

Having considered the Powell v Boldaz and the primary/secondary dichotomy, I now return to consider the question of duty of care on the evidence and by applying the "battery of tests" referred to by Brooke LJ. In my judgment this issue depends on the question of whether or not there existed a doctor-patient relationship between the clinicians and the parents when the consent to the post-mortem was obtained. If it did, there can be no real difficulty in satisfying the tests of proximity and fair just and reasonable. Further, in my opinion, the "purpose" and the "assumption of responsibility" tests will be satisfied. In this instance I do not think that the "distributive justice" test adds anything to the other tests.

In my opinion, the evidence of the doctors and the experts show that doctors can owe a duty of care to a mother after a death of her baby on a doctor-patient basis. In the case of a child born alive but dying shortly afterwards the paediatrician would inevitably have a duty to advise the mother about future pregnancies. Dr Clifford said as much. The whole purpose of the post-mortem examination of Rosina Harris was to help Dr Clifford advise Mrs Harris on the question of whether Rosina's abnormalities were genetic or whether she could be reassured in respect of future pregnancies. It seems to me that when advising Mrs Harris on that matter Dr Clifford was advising her as a treating doctor within the doctor-patient relationship notwithstanding the fact that he was a paediatrician and that his patient in the first instance was Rosina. I can foresee that negligent advice given by a doctor in relation to future pregnancies could give rise to an action by a mother at some future time if pregnant with another abnormal baby.

So far as Mrs Shorter is concerned the same considerations apply save that Mr Fairbank, as part of the obstetric team treating Mrs Shorter, was more clearly advising her in the context of a doctor-patient relationship. Mrs Shorter, as well as Laura, was his patient up to the time of birth. Thereafter Mrs Shorter remained his patient. Mr Gillmer, the senior consultant on the team, needed to give advice to Mrs Shorter about future pregnancies. Again, part of the process of giving the most informed advice would involve obtaining results from a post-mortem examination.

In my opinion taking consent for a post-mortem was not just an administrative matter bringing a doctor into contact with a mother. It was, as Professor Craft and Mr Clements agreed, part of the continuing duty of care owed by the clinicians to the mother following the death of a child. In the circumstances, in my judgment, the necessary test of proximity between the claimants and clinicians is established; and the facts of these claims can be distinguished from the facts in Powell.

As I have already indicated, once the conclusion has been reached that a doctor-patient relationship is established, in my opinion, there can be no valid reason for rejecting a duty of care under the fair just and reasonable test.

As to the scope of the duty of care, Miss Smith QC, as I have already stated, submitted that the clinician obtaining the consent of parents did not owe a duty to protect the parents against subsequent psychiatric injury. She submitted that the clinician had no duty to explain the nature and procedures of a post-mortem examination. She drew attention to the fact that section 2 of the 1961 Act made no reference to informed consent nor to a requirement that the nature of a post-mortem examination be explained to a person from whom consent was sought.

However, I cannot accept these submissions. Once the doctor-patient relationship is established, as I hold it is, in my view, the clinician owed a duty of care when seeking consent for a post-mortem examination. Although the statutory duty is to ensure non-objection, that must, in my judgment, involve some explanation of to what the parents are being asked not to object. Again, in my opinion, that must involve some explanation of the procedures of a post-mortem of which the removal and retention of organs is a relevant part. In the circumstances, I hold that the duty of care extended to giving the parents an explanation of the purpose of the post-mortem and what it involved including alerting them to the fact that organs might be retained.

Breach of Duty

As I have already stated, it is common ground, that there can be a considerable overlap between the various tests used to determine whether a duty of care exists. There can also be, and is in this case, an overlap between the issues of duty of care, breach of duty and foreseeability. In this section of the judgment I propose to consider evidence which relates to all three of those issues.

In the section of the judgment dealing with duty of care, I have already set out evidence under the heading "Scope of Duty of Care". This is also relevant to the issue of breach of duty. I do not repeat that evidence, but bear it in mind when considering whether there was a breach of the duty of care. There is other evidence given by the doctors and experts, to which I must refer, which bears directly on the issue of breach of duty; and some which bears on the issue of foreseeability.

Dr Clifford said that in 1995 and in earlier years doctors would not give information to relatives about the procedures involved in a post-mortem examination which it was felt the relatives did not need and which they would find unpleasant and upsetting. He said that parents should be provided with a sufficiency of information. Sufficiency in 1995 was not the same as in 2000. He agreed that a non-medical person might regard tissue and organs as being different. In medical terms he said the word tissue included organs. In his view the most important thing, following the death of a baby, was to discover if the baby had some inherited condition, that might affect future pregnancies. The clear tenor of his evidence was that although he knew that organs were commonly retained following post-mortems in 1995 he did not explain to parents what was involved in a post-mortem examination unless they asked questions. In that event he would give accurate and full answers. Giving details of what was involved in a post-mortem was thought at that time as being something which would unnecessarily distress parents. He agreed that if he had thought what might be the effect on a parent of finding out that her child had one of its organs removed it would have worried him considerably and he would have anticipated that it could have caused a problem. He volunteered that now it seems extraordinary that the profession did not think about the effect organ retention might have on families. In his view the medical profession in the past appeared to have been out of step with the public.

Mr Fairbank regarded the most important aspect of the counselling process after a stillbirth as making sure that the mother made as full a physical and mental recovery as possible. The assessment of why a baby died was much more than just the post-mortem examination although that was important. He accepted that if he had thought about the consequences of Mrs Shorter discovering that Laura's brain had been retained and disposed of he would have foreseen that that might have caused her serious psychiatric injury.

Mr Gillmer described the practice of obtaining consent adopted by the clinicians in the lead cases as a practice very similar to that carried out by all clinicians. He said it was a practice dictated by common sense and with an intention to do no harm. In cross-examination he said that if he had been a clairvoyant in 1992 (the date of Laura Shorter's stillbirth) he would have wished to have avoided the distress that Mrs Shorter and others had suffered, but without clairvoyant powers doctors acted in a way that seemed appropriate based on general consensus and with the primary purpose of providing the best care. He added that it was possible to foresee that in some individuals some kind of psychiatric problem might occur in the event that they discovered that organs had been retained. He said that would be true of most of life's traumas in various forms.

Dr Osgood, who had attended Mrs Shorter just before Laura's stillbirth, said that in 1992 her practice was to explain that a post-mortem was a way of looking at a baby in detail to discover why the baby had died so that the reasons for the death could be explained and the possible impact upon a future pregnancy. She would have answered any further questions asked of her by the parents. In cross-examination she conceded that it was reasonable to assume that the knowledge of subsequent organ retention in some individuals would cause distress and further might cause psychiatric problems.

The experts in their joint report stated that the practice at the time of Rosina Harris' death, was not to be explicit with parents about the details of the post-mortem examination. They agreed that Dr Clifford's usual practice, as described in his witness statement, was in keeping with the accepted practice of the day.

The experts agreed that before 1999/2000 it would be usual for a mother in Mrs Shorter's position to be given an explanation of a post-mortem but the level of detail would depend on questions asked. It was very unusual for parents to ask for a detailed explanation.

Professor Craft said that process of obtaining consent for a post-mortem before 1999 as described by the clinicians in the lead cases was exactly what he would have expected. To the suggestion that no parent asked questions about what happened at a post-mortem because generally parents did not know that organs were being removed and retained (the circular argument), Professor Craft pointed out that if that was so he would find it surprising. He said that clinicians such as himself dealt with people from all walks of life including doctors, nurses and other professional people whom, if it had been an issue, he would have expected to have raised questions. He also pointed out that it must have been obvious to, at least some, parents when they were advised some months later by the clinician following the results of the post-mortem that organs had been removed from the body of the child. In his experience no parent ever raised any questions about the process of a post-mortem at that stage. He said that it never struck the profession that people were concerned about whether the heart or brain was actually with the rest of the body.

Mr Clements said that very often parents agreed to a post-mortem but indicated that they did not want to know about the details. He expressed the view that in 1992 if he had thought

about it he would have appreciated that the late discovery of the removal of a brain from a buried child would cause great upset in some individuals. He was unable to say whether that upset would convert into psychiatric harm.

There is no dispute that the practice described by Dr Clifford and Mr Fairbank as their usual practice when obtaining consent from parents for a post-mortem examination, was one which was adopted universally by the clinicians and experts who gave evidence in this trial. There is also no real dispute that it was an almost universal practice up to 1999/2000. I have no doubt that Dr Clifford and Mr Fairbank when obtaining consent from Mr and Mrs Harris and from Mrs Shorter respectively, genuinely believed that they were acting in the best interests of these parents.

Dr Moore, the consultant pathologist, stated that it was morally and ethically wrong to retain organs against a parent's wishes. She said that a clinician taking consent for a post-mortem ought to know what a post-mortem examination involved. She said that she assumed that clinicians had such knowledge. She agreed that taking consent was not just signing a piece of paper it was a process of explaining and obtaining an informed decision from parents who at the time were under tremendous emotional stress.

The defendants accept, as I have already indicated, that if it was a condition of consent for a post-mortem examination that all organs removed from the body of a child should be put back, the clinician would be negligent if he did not communicate that condition to the pathologist. Mr Fairbank admitted that if Mrs Shorter had made such a condition a term of giving her consent to the post-mortem on Laura he would be negligent (his word) if he did not pass it on to the pathologist.

In the absence of such an express condition, Mr Lissack QC submitted that the clinicians were negligent in failing to inform the relatives that a post-mortem examination involved the removal of organs and might involve the retention of them. In failing to do so he submitted that they negligently failed to elicit the objections of parents to the retention of organs. Mr Lissack QC contended that the Bolam test, as a matter of law, does not operate in such cases to defend a practice which was, in his submission, unreasonable even if it was universally accepted. Mr Lissack QC submitted that the practice adopted by the medical profession was the result of irresponsible conservatism. The changing attitude which has occurred since the organ retention scandal only serves to show how unreasonable the practice was and why it should have been the subject of examination, debate and change many years before the year 2000.

Miss Smith QC relied on the Bolam test. Recognising the possible contradiction between her submissions on this issue and her submissions on duty of care, she nevertheless submitted that the taking of consent involved the exercise by the clinicians of skill and judgment. It required the clinician to use his professional judgment when deciding how much information should be provided to parents. She further submitted that the doctrine of informed consent has either no application in this context or, if it does, it is for the clinicians to decide how much to tell the parents.

The Bolam Test

Each side has referred me to a number of decisions on the application of the Bolam test. I start first with Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1AC 871. The plaintiffs in that case alleged negligence solely on

the basis of a failure by a surgeon to disclose or explain to her the risks inherent in the operation which he had advised. Lord Diplock, in his speech dismissing the plaintiffs appeal, stated (see page 895):

"In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; it has to rely upon and evaluate expert evidence, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion. But when it comes to warning about risks, the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks there may be involved of which I am not already aware from my general knowledge as highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not.

No doubt if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know; but we are concerned here with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient's physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo. To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The Bolam test should be applied."

Lord Templeman also dealt with the Bolam test as it applied to informing a patient about risks. He said (page 904):

"I do not subscribe to the theory that the patient is entitled to know everything nor to the theory that the doctor is entitled to decide everything. The relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient. The doctor, obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient. No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor's training and experience and as a result of the doctor's diagnosis of the patient. An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests. Some information might confuse, other information might alarm a particular patient. Whenever the occasion arises for the doctor to tell the patient the results of the doctor's diagnosis, the possible methods of treatment and the advantages and disadvantages of the recommended treatment, the doctor must decide in the light of his training and experience and in the light of his knowledge of the patient what should be said and how it should be said. At the same time the doctor is not

entitled to make the final decision with regard to treatment which may have disadvantages or dangers. Where the patient's health and future are at stake, the patient must make the final decision. The patient is free to decide whether or not to submit to treatment recommended by the doctor and therefore the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor's own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient. When the doctor himself is considering the possibility of a major operation the doctor is able, with his medical training, with his knowledge of the patient's medical history and with his objective position to make a balanced judgment as to whether the operation should be performed or not. If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational, or irrational, or for no reason. The duty of the doctor in these circumstances, subject to his overriding duty to have regard to the best interests of the patient is to provide the patient with information which will enable the patient to make a balanced judgment if the patient chooses to make a balanced judgment. A patient may make an unbalanced judgment because he is deprived of adequate information. A patient may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality. Thus the provision of too much information may prejudice the attainment of the objective of restoring the patient's health.

…

In order to make a balanced judgment if he chooses to do so, the patient needs to be aware of the general dangers and of any special dangers in each case without exaggeration or concealment. At the end of the day, the doctor, bearing in mind the best interests of the patient and bearing in mind the patient's right of information which will enable the patient to make a balanced judgment must decide what information should be given to the patient and in what terms that information should be couched."

In the same case Lord Scarman, although dissenting, described a doctor as having a therapeutic privilege which enabled a doctor in certain circumstances to withhold information from his patient. He rejected the more strict rule of informed consent adopted by courts in the United States of America.

In Bolitho v City and Hackney Health Authority [1998] 2 AC 232 the House of Lords revisited the Bolam test when its application to causation was in issue. Lord Browne-Wilkinson giving the decision of the House in a speech with which all the other members of the court agreed, said referring to submissions made by counsel for the appellant (pages 241-242):

"My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J … stated that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men". Later … he

referred to "a standard of practice recognised as proper by a competent reasonable body of opinion". Again, in the passage which I have cited from Maynard's case … , Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

There are decisions which demonstrate that a judge is entitled to approach expert professional opinion on this basis. For example, in Hucks v Cole [1993] 4 Med.L.R. 393 (a case from 1968), a doctor failed to treat with penicillin a patient who was suffering from septic spots on her skin though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated with penicillin. The Court of Appeal found the defendant to have been negligent. Sachs LJ said, at page 397:

"When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna – particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas.""

Miss Smith QC relied on the dicta of Lords Diplock and Templeman in Sidaway and Mr Lissack QC on the passage from Lord Browne-Wilkinson's speech in Bolitho.

Counsel have also referred me to a number of other decisions where the Bolam principle has been considered. They are Gold and Haringey Health Authority [1988] 1QB 481, Edward Wong Finance Co Ltd v Johnson Stokes & Master [1984] AC 296, Hucks v Cole [1993] 4MedLR 393, AB v Tameside and Glossop Health Authority [1996] 35BMRLR 39, Pearce v United Bristol Health Care NHS Trust [1998] PIQR 53, and Shakur v Situ {2000] 57BMLR 178. It is unnecessary to refer to any of these decisions save one. The cases demonstrate, as Lord Browne-Wilkinson said in Bolitho, that the court must be satisfied that the practice adopted by the body of medical opinion is reasonable and logical in its application to the circumstances of the case under consideration. The cases also recognise that the doctors' views should not lightly be set aside when they involve advice given in a therapeutic setting.

I shall refer to AB v Tameside in more detail because Mr Lissack QC argued that it exemplifies the approach which I should adopt in these cases. The claimants in AB v

Thameside claimed damages for the negligent way in which they were informed by the defendants that they may have been put at risk of infection from contact with a former health care worker who had tested HIV positive. A duty of care was admitted and the sole issue was breach of duty. It was argued on behalf of the defendants that the Bolam principle applied. Giving the leading judgment Brooke LJ said (see page 93):

"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."

Mr Lissack QC submitted that in these cases, similarly, there is no "well of professional experience". He submitted for that reason the normal principles applicable to the assessment of fault in claims of negligence should be applied.

The facts in AB v Tameside are, in my view, different from the facts in these cases. Here, there is evidence of a practice universally adopted by clinicians over many years. Secondly, this case involves doctors acting, as I find, exercising their professional duty of care. As with the other cases cited to me it is a case decided on its own particular facts.

This is another issue in this case where the right answer is not entirely clear-cut. The argument of the defendants, based on evidence of a practice universally adopted by clinicians over many years, is a strong one. Yet having carefully considered the evidence and examined the argument I find myself unable to accept it. Looked at objectively, from a common sense point of view, in my judgment, a significant number, if not all, bereaved mothers of recently deceased children would want to know if organs from their deceased child were to be retained following a post-mortem examination.

The evidence of the clinicians and the experts suggests that there were two reasons why parents were not told that organs would be removed and might be retained following a post-mortem. These reasons were first that they thought it unnecessary to go into the details of a post-mortem examination; and secondly that they thought it would unnecessarily distress parents if they were given this information. A number expressed the view that subsequent events had shown that the medical profession lagged behind the public in its appreciation of what parents wanted to know.

A number of the doctors who gave evidence were at pains to agree that they were taught to respect a dead body. All agreed that parents' wishes in respect of the body of a deceased child were to be respected and complied with. These very proper views do not fit with a failure to explain to parents that a post-mortem might well involve the removal and retention of an organ, particularly a heart or a brain.

I accept the evidence of the clinicians that they did not want unnecessarily to distress parents at a very difficult time for them, by telling them the details of what occurred at a post-mortem. But, distress would probably have been caused, in any event, by the request for consent for a post-mortem, involving, as it does, cuts being made to the body. In my view, it is difficult to see that much distress will be saved by not telling parents of the possibility of an organ being retained.

Miss Smith QC submitted that it would have been difficult for the doctors to inform parents what is required in a post-mortem examination since it will not be known until the post-mortem is being carried out precisely what will have to be removed. However, I do not see this as a serious problem. In my judgment the consent could have been framed on the basis that the pathologist was entitled to remove and retain any organ which, on examination, he found necessary for the purpose of establishing the cause of death.

There is in my judgment a considerable difference between a parent consenting to a post-mortem and a parent consenting to an organ or organs being retained by doctors after a post-mortem examination. Since the doctors agree that parents are entitled to have their wishes in respect of their deceased child's body respected and complied with it seems to me those wishes cannot be complied with unless it is explained to the parents what is involved.

Another objection to informing parents about the possible retention of organs was that they might not want to know all the unpleasant details of a post-mortem examination. Dr Clifford asked rhetorically how the doctor was to decide how much information should be given to parents. Again, I do not see this as a difficulty. In my opinion, Dr Clifford answered his own question. He said it was a question of sufficiency of information. I agree but, in my view, the process of a dialogue between doctor and patient cannot begin until, in this instance, the parents are given the basic information that there is a possibility of the removal and retention of an organ. Once that information is provided any question asked by a parent can readily be answered by the clinicians. The parent may choose to reject the advice that a post-mortem examination take place. He or she may choose to consent. But, at least, the choice will be made in the knowledge that his or her wishes will be complied with.

Finally, the evidence shows that the practice adopted was blanket practice carried out by virtually all clinicians. In so far as it involved the exercise of a therapeutic judgment it was one which does not appear to have been exercised on a case by case basis. The general view was that such information was unnecessary and likely to be distressing to parents. But there is no evidence that clinicians considered the matter individually with each parent or family. To take an example from the lead claims, although the issue does not arise in their claim, Mr and Mrs Carpenter would, in my judgment, have been quite capable of coping with this information at the time of Daniel's death. In any event, in my opinion, there was very little risk of parents being caused greater distress by being given the additional information. It would have been very simple and easy for a clinician to have provided this information and generally they ought to have done so. If the clinician did not know what was involved in a post-mortem, in my opinion, as Dr Moore said, he ought to have known. In the circumstances, my conclusion is that the practice of not warning parents and in particular a

mother that a post-mortem might involve the removal and subsequent retention of an organ cannot be justified as a practice to be adopted in all cases.

I accept that there may be some circumstances in which a clinician might have been justified in giving no details to parents of a post-mortem examination. I also accept that in all cases the question of how much information should have been given to parents will be a matter of judgment for the clinician. But to adopt the practice without thought to the individual circumstances of each parent or family cannot, in my opinion, be justified.

I add, that most of the clinicians and experts who gave evidence said that they could have foreseen that the subsequent discovery that the organ of a deceased child had been retained after burial would have caused great distress and some that it would have led to psychiatric harm. In my view the same considerations apply whether or not the post-mortem took place in 1987, 1992 or 1995. I shall deal with the specific issues in relation to the lead cases at the end of this judgment. I repeat that the answer may not be the same in all cases. However, I have been asked to express my views on the Bolam defence and I do so on the basis that it is expressed in general terms.

Having arrived at this conclusion, it is only fair to reiterate a view expressed earlier in this judgment. The doctors who gave evidence in this case were, in my opinion, conscientious and careful practitioners who at all times sought to act in the best interests of their patients. There is evidence, which I accept, that at both West Dorset General Hospital and the John Radcliffe Hospital much of the care provided was in the vanguard of best practice in respect of bereaved parents. In my opinion, the description "irresponsible conservatism" does not apply to them. The pathologists, none of whom in the lead cases were responsible for obtaining consent for post-mortems, bear no responsibility for the failure which I have found to exist. In short, I do not doubt the good faith of any of the doctors who gave evidence before me even though it is implicit in what I have said that they were at fault.

The Agreed Issues in the Lead Claims

Counsel have helpfully agreed issues in respect of the three claims in the form of questions to which they would like answers. Accordingly, I propose to deal with the agreed issues in the order set out. For ease of reference and so as not further to lengthen this already lengthy judgment the agreed issues are those set out in Appendix B – the Harris Claim, Appendix C – the Shorter Claim, and Appendix D – the Carpenter Claim:

Mr and Mrs Harris

The Facts & Negligence

Issues 1 and 2: My findings of fact on what express stipulations were made by Mrs Harris to Dr Michaels and by Mr Harris to Dr Clifford are set out in paragraphs 51-53 of the judgment.

Issue 3(i): My finding is that Dr Michaels did not inform Dr Clifford of the stipulations made by Mrs Harris. He said that if they had been made he would have recorded them in the medical records. Dr Clifford said that if such stipulations had been communicated to Dr Michaels he would have expected Dr Michaels to pass them on to him. The experts agreed

that Dr Michaels should have told Dr Clifford what Mrs Harris said but as it was an informal discussion he need not have recorded the conversation in the medical records.

Miss Smith QC submitted that Dr Michaels owed no duty of care to Mr and Mrs Harris in respect of this conversation. She argued that a duty of care would only arise if Dr Michaels agreed to pass on the information to Dr Clifford. Mr Lissack QC submitted that Dr Michaels did owe a duty of care to pass this information on to Dr Clifford. I agree with Miss Smith QC that it is only if Dr Michaels agreed to pass the information to Dr Clifford that he would owe a duty to Mr and Mrs Harris.

In her witness statement Mrs Harris states that in response to her request that Rosina's organs be returned, Dr Michaels acknowledged what she was saying and said that it would be fine. She gave no oral evidence about Dr Michaels reaction to her request and she was not cross-examined specifically on that point. But, as I have already indicated, I prefer her evidence to the evidence of Dr Michaels. It seems to me more probable than not that Dr Michaels would have responded to such a request. Quite apart from making a written record of the request I think it probable that he would have conveyed to Mrs Harris the impression that he would consult Dr Clifford on the matter. The passage in Mrs Harris' statement to which I have referred seems to me to fit best with such a finding. In those circumstances my conclusion is that Dr Michaels did owe a duty of care to pass that information on to Dr Clifford either by personally contacting him or by making a written record.

Issue 3(ii): Dr Clifford said that if any stipulations or conditions had been made he would have informed the pathologists. I shall discuss this further under Issue 9.

Issue 4: As stated in paragraph 58 of this judgment, in my opinion Mr and Mrs Harris would probably have requested that the organs be returned for a later and subsequent interment.

Issues 5 and 6: The full answers to the questions raised by these two issues are contained in paragraph 67 of the judgment. In summary, in my judgment, the discovery of organ retention did materially contribute to an identifiable psychiatric injury. The precise nature of the injury is that it was either an adjustment disorder or a pathological bereavement disorder. As I have stated, the difference in the name given by each doctor to the classification of the psychiatric injury is immaterial.

Issue 7: So far, I have not discussed the question of foreseeability in relation to psychiatric injury other than in general terms. In view of my finding that Mrs Harris was a primary victim the test for foreseeability is the usual foreseeability test in actions in tort. In Bolton v Stone [1951] AC 580 Lord Porter said (see page 858):

"It is not enough that the event should be such as can reasonably be foreseen; the further result that injury is likely to follow must also be such as a reasonable man would contemplate, before he can be convicted of actionable negligence. Nor is the remote possibility of injury occurring enough; there must be sufficient probability to lead a reasonable man to anticipate it. The existence of some risk is an ordinary incident of life, even when all due care has been, as it must be, taken."

In McLoughlin v Jones [2002] 2WLR 1279 Brooke LJ amended and approved four factors put forward by counsel that a judge should bear in mind in the case of a primary victim. The factors, as adapted to the lead cases, are:

i. The requirement that damages can only be recovered if the illness which results is a foreseeable result of the specific act or omission upon which the claimant relies;

ii. The requirement that damages can only be recovered if there is a sufficient degree of likelihood that the type of loss in question, namely psychiatric illness, will occur;

iii. The requirement that damages can only be recovered if it is foreseeable that psychiatric illness would have been suffered by the claimant, given all those features of her personal life and disposition of which the defendants were aware;

iv. The fact that the standard by which the defendants are to be judged is the standard of the ordinary reasonable man in the circumstances of the defendant namely, in this case, a consultant paediatrician and not someone who is a consultant psychiatrist.

My impression of Mrs Harris is that she is, or was at that time, a forthright and reasonably determined woman. Dr Clifford knew that she had not been an easy patient. He did not know that she and Mr Harris had been willing to donate organs from Rosina's body if they had been suitable for transplant. Dr Michaels was aware of this. Both Dr Michaels and Dr Clifford were aware, at the very least, that Mrs Harris was willing for tissue to be removed and retained.

Dr Clifford said that it was not until 1999 when he personally had a problem concerning a patient who learnt that organs had been retained from the body of his child that it struck him forcibly that such an incident might cause difficulty. That person, to his knowledge, did not suffer any medical consequence but was emotionally very upset. When asked the direct question as to whether he could have foreseen in 1995 Mrs Harris suffering any psychiatric injury, he said that it would depend very much upon her psychological physique and that he did not know enough about her to make such a prediction. He did point out that some people who were "difficult with doctors" were not the sort of people to collapse under strain.

Applying the tests set out in Bolton v Stone and bearing in mind the four factors adumbrated by Brooke LJ in McLaughlin and Jones my view is that the possibility that Mrs Harris would suffer psychiatric injury was not foreseeable by a reasonable paediatrician with Dr Clifford's knowledge of Mrs Harris at the time when he took the consent for a post-mortem from Mr Harris. In my opinion, she was a robust person and someone who Dr Clifford would have regarded as unlikely to collapse under the strain. Granted that the reasonable man in this case would be a doctor, albeit not a psychiatrist, I am not persuaded that the risk of Mrs Harris suffering psychiatric injury was sufficiently probable to have been foreseen. For this reason her claim in negligence fails. Finally, on this issue, I reject Miss Smith QC's submission that the test of reasonable foreseeability involves the clinician foreseeing the discovery of organ retention. In my judgment, that is not a relevant consideration. The question to be answered is whether or not it is foreseeable that psychiatric injury would occur whenever it was that the claimant discovered that organs had been retained.

Issues 8, 9 and 10: For the reasons set out in the section of this judgment which deals with duty of care, in my judgment, Dr Clifford owed a duty of care to Mr and Mrs Harris. That duty of care involved explaining to Mr and Mrs Harris what was involved in a post-mortem and, at the least, alerting them to the fact that organs from Rosina's body might be removed and retained following the post-mortem examination. In one sense Mr Harris was alerted to this fact. The post-mortem consent form which he signed specifically permitted the removal of tissue for treatment of other patients and for medical education and research. The first half of this form follows precisely the form recommended at Appendix 2 to the DHSS Health Circular of August 1977 entitled:

"Health Services Development

Removal of Human Tissue at Post Mortem Examination – Human Tissues Act 1961"

In my opinion, that form ought to have alerted Mr Harris to the possibility that organs might be removed and retained. In fact, of course, he knew this to be so because that is why his wife sought to impose the condition that all organs removed should be returned. The difficulty in this case arose because he thought that tissue did not include organs and Dr Clifford misunderstood what Mr Harris meant by the word "whole". In cross-examination Dr Clifford agreed that some patients might understand the word "tissue" to mean something different from the meaning given to it by doctors. He accepted that, although to him, as a doctor, it included organs, to a patient it might not include organs. In my judgment, Dr Clifford should have done what he said he would do in such circumstances that is either give a complete answer or ask some questions so as to ensure that Mr Harris was aware that organs might be retained. I find that he did neither. In addition, had Dr Michaels recorded his conversation with Mrs Harris in the medical records or spoken to Dr Clifford about that conversation, as I find that he ought to have done, it is inconceivable that Dr Clifford would not have discussed the matter more fully with Mr Harris. In the circumstances I find that Dr Michaels and Dr Clifford were negligent.

Wrongful Interference

As a result of my holding in respect of the tort of wrongful interference with a body the issues under this heading do not strictly arise. However, in the event, of this matter going further, I set out briefly my answers to the agreed issues.

Issues 11, 12 and 13: In my judgment Mr and Mrs Harris had a duty to dispose of Rosina's body. That duty did not arise until the certificate of disposal was issued on 10 October 1995 and the body released for cremation. Once the body was cremated and the ashes buried the duty was discharged.

Issues 14, 15 and 16: In my judgment Mr and Mrs Harris did not, at any stage, obtain the right to possess the organs retained from Rosina. In my opinion, following the post-mortem, the hospital acquired proprietary and possessory rights to the organs. Once the pathologists had by their work and skill removed the organs and prepared blocks and slides for histological examination those organs and the blocks and slides came within the Doodeward exception. It follows that, in my opinion, the hospital continued to have lawful possession of

the organs after the return of Rosina's body to Mr and Mrs Harris and were entitled to dispose of them.

Issues 17 and 18: In my opinion, the hospital at no time wrongfully interfered with any right held by Mr and Mrs Harris in respect of Rosina's organs. I desire to make one further comment. Mr Harris signed the form consenting to a post-mortem examination. That form included consent to remove tissue "for the treatment of other patients and other medical and education and research, as appropriate." In my judgment this clearly renders lawful the removal of the organs and their retention. Whether the cause of action is in trespass or conversion Mr and Mrs Harris consented to the removal of organs and their retention. In those circumstances a claim can only arise if negligence is proved (see per Sir John Donaldson in Sidaway in the Court of Appeal [1984] 1QB 493 at page 511 and per Lord Scarman in Sidaway [1985] 1AC 871 at page 885). Further, it follows that there can be no claim for compensatory damage.

The Control Mechanisms for Psychiatric Injury

Issues 19 – 22: The primary/secondary victim dichotomy does apply to Mrs Harris' case in negligence. Mrs Harris is a primary victim. She is not precluded from bringing a claim against the defendants for psychiatric injuries in negligence. But because I have found that the psychiatric injury suffered by her was not foreseeable her claim does not succeed. If I had found that the psychiatric injury suffered by her was foreseeable I would have awarded her the sum of £4,500.00 in respect of general damages. There is no evidence that Mr Harris suffered any psychiatric injury caused by the defendants' negligence.

Since I have found that no cause of action arises in this case under the heading "Wrongful Interference" it is unnecessary for me to decide whether the primary/secondary victim dichotomy applies to such a cause of action. I have heard little or no argument on damages in respect of this cause of action other than having placed before me an Australian decision at first instance of facts which are dissimilar and I decline to express any view on this issue.

Exemplary Damages and Aggravated Damages

On my findings there can be no claim for either exemplary or aggravated damages. However, it may prove helpful if I express some views in relation to exemplary and aggravated damages in respect of a claim such as this.

Issue 23: The claimants' skeleton argument (see paragraphs 217 – 219) implicitly concedes that exemplary damages are not available in claims for negligence. However, it is submitted that the court should assess whether to award exemplary damages by reference, not to causes of action formally attracting such awards, but on the basis of whether the facts of the claim meet the principles set out in Rookes v Barnard [1964] AC 1129. This, it is submitted would be a proper way of recognising breaches of Articles 8(1) and 9(1) of the Convention Rights.

Assuming for these purposes, but not deciding, that such a claim can be made on facts giving rise to a cause of action in negligence, in my view the facts in this claim come nowhere near satisfying the criteria set out by Lord Devlin in Rookes v Barnard. The actions of Dr Clifford, Dr Michaels and the pathologists were in my opinion not arbitrary, unlawful or outrageous. In the circumstances, in my view the claim for exemplary damages must be rejected.

Issue 24: The claim for damages for deceit is not pursued and I have found that the facts of this case do not give rise to the tort of wrongful interference. Accordingly, no award of aggravated damages can arise.

Mrs Shorter

Issues 1, 2, and 3: My finding of fact is that Mrs Shorter did not make an express stipulation when consenting to a post-mortem examination of Laura. If she had there can be no doubt that Mr Fairbank should have passed it on to the pathologist. He said as much in evidence.

If Mrs Shorter had been told that some material would be retained for the purposes of the post-mortem, as I have already stated, I find that she would have opted for a delayed funeral.

Issues 4, 5 and 6: I find that Mrs Shorter did suffer some measurable and quantifiable psychiatric injury resulting from the discovery by her of organ retention. The nature of that injury is set out under the heading Psychiatric Injury in respect of Mrs Shorter's claim.

Applying the same tests as I have applied in respect of Mrs Harris' claim in my judgment such injury was reasonably foreseeable. When asked the direct question in cross-examination whether he could have foreseen serious psychiatric harm Mr Fairbank had no hesitation in answering the question affirmatively. In my opinion that represents a fair assessment. Mrs Shorter was obviously extremely distressed following the birth of Laura. In the witness box she appeared to be an emotionally fragile person. Of course, it would not be right to view her appearance in 2004 giving evidence in a trial such as this as a true indication of how she would have appeared in 1992. Nevertheless it gives me no reason to doubt Mr Fairbank's assessment. In the circumstances my conclusion, as I have already stated, is that in 1992 the reasonable consultant obstetrician would have reasonably foreseen that this event would result in some psychiatric injury in Mrs Shorter.

Issues 7, 8 and 9: These issues are concerned with duty of care and breach of duty. The 1961 Act, as I have already stated, does not apply to stillborn children. Miss Smith QC submitted that although the clinicians and experts made no technical distinction between a stillborn child and a deceased child there was a cultural "catching up" in the context of stillbirths. Whether this was so or not in my view there is no reason to differentiate between the obtaining of consent for a post-mortem for a stillborn child and a neonatal death. In my opinion, Mr Fairbank did owe a duty of care to Mrs Shorter when seeking her consent to a post-mortem examination of Laura.

Mrs Shorter did consent to a post-mortem examination. It is clear from his witness statement and evidence that Mr Fairbank did not mention to her the possibility of Laura's organs being removed and retained. He did not know that this was part of the post-mortem procedure. Although I have rejected Mrs Shorter's evidence that she gave her consent conditionally it is in my opinion inconceivable that if Mr Fairbank had raised with her the question of organ retention she would not have imposed the condition which she now says she did. In my judgment Mr Fairbank ought to have known what was involved in a post-mortem investigation and he ought to have raised the question of organ retention with Mrs Shorter. There is no evidence that he considered at any time whether or not it would have been too distressing for Mrs Shorter to be told that organs would be removed at post-mortem and possibly retained. In the circumstances, I find he was at fault and negligent for failing to do so. For the reasons expressed above her claim in negligence succeeds.

Wrongful Interference

On my findings this cause of action does not arise but as with the Harris claim I set out my answers to the questions raised in the agreed issues.

Issues 10, 11 and 12: In my opinion Mr and Mrs Shorter did have a legal duty to bury Laura's body. That duty did not arise until the certificate of disposal was issued on 14 October 1992 and was discharged by the burial of Laura's body.

Issues 13, 14 and 15: The answers are precisely the same as those which I have given in respect of the same issues raised in the Harris claim.

Issues 16 and 17: I find that the hospital did not wrongfully interfere with any legal right held by Mr and Mrs Shorter in respect of Laura's brain and other tissue taken from her. In any event, Mrs Shorter consented to the post-mortem examination which, as I have indicated, included consent to all the necessary procedures involved in a post-mortem. In the circumstances, there can be no actionable claim for damages for wrongful interference.

The Control Mechanisms for Psychiatric Injury

Issues 18, 19 and 20: The primary/secondary victim dichotomy does apply to Mrs Shorter's case in negligence. In my judgment, she is a primary victim and is not precluded from bringing a claim in negligence against the defendants for psychiatric injuries. On my findings she is entitled to general damages in the sum of £2750.

Since I have found that no cause of action arises in this case under the heading "Wrongful Interference" it is unnecessary for me to decide whether the primary/secondary victim dichotomy applies to such a cause of action. I have heard little or any argument on that issue other than having placed before me an Australian decision at first instance of facts which are dissimilar. I decline to express any view on this issue.

Exemplary Damages and Aggravated Damages

Issues 23 and 24: Precisely the same considerations apply to these issues as in the similar issues in the Harris claim. On my findings there can be no claim for either exemplary or aggravated damages. The actions of Mr Fairbank and the pathologist were in my opinion not arbitrary, unlawful or outrageous.

Mrs Carpenter

Issues 1and 2: In my opinion the discovery of organ retention did materially contribute to an identifiable psychiatric injury in Mrs Carpenter the nature of which is discussed in paragraphs 83 – 84.

Issue 3: If it were necessary, to decide whether or not this injury was foreseeable, in my opinion, it was not. The evidence suggests that at the time of Daniel's tragic death Mrs Carpenter was a well-adjusted, practical and sensible woman. It was foreseeable that she would be angry and distressed by the knowledge of organ retention but not that she would suffer psychiatric injury. Whether the test is foreseeability of such a psychiatric injury in her or in a woman of reasonable fortitude in my opinion neither would be satisfied. I have concluded that in the intervening years between the death of Daniel and the discovery of organ retention Mrs Carpenter was subjected to what the psychiatrists described as a number

of stressor factors. It was these factors which caused her to be more vulnerable than otherwise at the time when she learnt of the retention of Daniel's organs.

Issues 4 and 5: My conclusions are that Professor Weller did have an arrangement with HM Coroner for Southampton and New Forest concerning the retention and disposal of organs by Professor Weller after a coroner's post-mortem. I have already set out my findings in respect of those arrangements. I further find that Professor Weller did undertake a histopathological examination on Daniel's brain on or after 30 April 1987. I add, that in my judgment, Professor Weller was at all times acting as agent of the coroner and, for the avoidance of doubt, I find that at no time was he acting as agent for the Southampton General Hospital.

Wrongful Interference

In view of my decision in respect of the tort of wrongful interference with a body the agreed issues do not strictly arise and Mrs Carpenter's claim must fail. However, in the event that this matter goes further I shall summarise shortly my responses to the agreed issues.

Issues 6, 7, 8 and 9: In my opinion, Mr and Mrs Carpenter had a duty to dispose of Daniel's body following certification by the Deputy Coroner on 11 February 1987. The duty arose on that date and was discharged by the burial of Daniel's body. In my opinion Mr and Mrs Carpenter did not obtain the right to possess Daniel's brain at any time.

Issues 10, 11, 12, 13 and 14: It follows from my previous findings that at all times Dr Killpack and Professor Weller were acting with the coroner's lawful authority. In my opinion the pathologists acquired the right of possession to Daniel's brain as agents for the coroner. This right arose by reason of the Doodeward exception. The pathologists did not wrongfully interfere with Daniel's body or any part of it. As I have already stated, in my opinion, the hospital was not vicariously liable for any of the work carried out by the pathologists in respect of Daniel's body and no claim for wrongful interference arises.

Outstanding Issues of Law

Issues 15 - 17: I have heard no argument on the possible application of the primary/secondary victim dichotomy as applied to wrongful interference. I decline to express any view in the absence of full argument on this topic.

Exemplary Damages

Issue 18: In view of my findings in respect of Professor Weller's conduct in this matter, even if the tort of wrongful interference had been established, I would not have awarded exemplary damages.

Aggravated Damages

Issue 19: The claim for the tort of deceit is not pursued and I have found that the facts of this claim do not give rise to the tort of wrongful interference. Accordingly, no award of aggravated damages can arise.

The Human Rights Act

In the course of the various case management conferences it became clear that the claimants were anxious to resolve a number of issues involving the use of organs for research and involving direct application of the Human Rights Act. They invited me to resolve a number of issues on an agreed factual basis. The defendants have always been sceptical about the usefulness of this exercise but with some impetus from myself the parties agreed a factual basis on which some issues could be resolved. On 4 November 2003 by consent I made an order setting out the agreed factual basis and the issues to which answers are sought. So as the better to follow the answers I set out below the agreed factual matrix, assumptions and issues of law.

The Factual Matrix

i. A pathologist lawfully acquires in the context of a coroner's post-mortem and thereafter possesses a brain taken from a child. Neither the removal nor retention of the brain is known to the child's parents.

ii. The child is buried before the fixing of the brain is completed.

iii. The coronial purpose of which the brain was acquired and fixed then comes to an end.

iv. Thereafter, and without recourse to the child's parents, the pathologist decides to use and uses the brain for a research project.

The Assumptions

i) The decision to fix and/or the fixing of the child's brain prior to its use in the research project constitutes sufficient application of work or skill so as to render the brain capable of ownership.

ii) The research project decided upon and undertaken by the pathologist is solely in the public interest.

The Issues of Law

Question: On the basis of the agreed factual matrix:

i. Is the decision to use or the use of the child's brain in the research project unlawful?

Submissions: The claimants submit that the coroner or his agent have no authority under the Coroners Rules 1984 or the Coroners Act 1988 to use the brain for research. No authority by way of non-objection has been given by the parents pursuant to section 1(2) of the 1961 Act for use of the brain for purposes of research. The pathologist cannot acquire proprietary rights over an organ which is retained unlawfully; that is in breach of the 1961 Act and the parents' common law right to possession. The pathologist's period of agency has ceased and if contrary to the claimants' submissions rights of ownership have been acquired they accrue to the coroner and not the pathologist. In any event, it is submitted that the rights of ownership are not good as against the parents. Accordingly, the claimants submit that the decision to use the brain for a research project is unlawful.

The defendants submit that the use of the brain is lawful. It is lawful because it arises from the pathologist acquiring proprietary rights in respect of the brain as a result of work and skill exercised during the post-mortem at a time when the brain was in the lawful possession of the pathologist. The parents have not called for possession of the brain before the body was buried and have no possessory rights before or after burial. Thereafter such proprietary rights as there are will have been acquired by the coroner.

Answer: In my view the difficult question is what happens after the coroner's purpose and authority has expired. As I have already stated, there is no difficulty if the organ is disposed of on the authority of the coroner. But the powers of the coroner do not, in my opinion, include a power to authorise use of organs for research. Section 1 of the 1961 Act seems to contemplate that whenever an organ may be used for research the person lawfully in possession of the body must comply with section 1(2) of the Act. Strictly speaking, it seems to me, that the obligation to satisfy that requirement in these circumstances will be on the coroner or his agent, the pathologist. The obligation is to make "such reasonable inquiry" as may be practicable of "any surviving relative". Without such inquiries being made and/or consent obtained use of the brain for research will be unlawful in the sense that it will be contrary to section 1 of the 1961 Act.

Question: Does any such unlawfulness confer a cause of action on the child's parents for wrongful interference?

Submissions: The claimants submit that the parents have a continuing right to possession of the child's brain protected by common law and the ECHR. Since no authority will have been obtained the parents' right to possession will have been infringed. It is submitted that the infringement is actionable for damages as a wrongful interference. Further it is submitted that the common law shaped by the ECHR should provide a remedy in damages.

The defendants submit that there is no such tort as wrongful interference with a body and, even if the use was unlawful, that unlawfulness provides no cause of action to the parents.

Answer: As I have already indicated when discussing the tort of wrongful interference of a body the claimants' arguments in respect of the tort of wrongful interference initially depend upon the first step being a right to possession of the body and any part of it. On my analysis of rights accruing on the agreed facts the parents will lose any right to possession for burial once the body has been buried. At that time they also lose any rights to possess a part of the body which has been removed and retained. The 1961 Act provides no civil or criminal remedy and accordingly although I have concluded that the use of the brain for research is

unlawful there is no cause of action available to the parents. Allowing for the court's duty to provide a remedy for wrongs committed where it can and to seek the assistance of the ECHR jurisprudence to do so, my view is that it cannot construct a cause of action where none exists.

Question: In relation to the ECHR – Is the decision to use or the use of the child's brain in the research project:

i. Capable of engaging Article 8(1)?

ii. Capable of justification under Article 8(2)?

Answer:

(i) The defendants accept that on these facts the decision to use the brain for the purposes of research is capable of engaging Article 8(1) and giving rise to a breach of it. I agree. Once the Human Rights Act is in force the unlawfulness of the use of the brain is capable of amounting to a breach of this Article.

(b) The claimants submit that on these facts the use of the brain is not capable of justification under Article 8(2). Each case will turn on its own facts but in my view the claimants are more likely to succeed than the defendants. Having concluded that such use would be unlawful my view is that the circumstances in which that use can be justified on grounds of public interest will probably be rare.

Question: Are any of the above answers different, assuming that the decision to fix and/or the fixing of the child's brain does not render the brain capable of ownership (contrary to Assumption (i))?

Answer: Both the claimants and the defendants submit that the answers will be the same: although in each case their answers are different. I agree. I do not think that this difference affects the answers which I have given in any way.

The Result

It follows from all that has gone before in this judgment that the claims of Mr and Mrs Harris and Mrs Carpenter must be dismissed with judgment for the defendants. In respect of Mrs Shorter's claim there will be judgment for her for the sum of £2750 general damages and such sums as are agreed for special damages and interest.

APPENDIX A: Agreed Note of site visit 30 January 2004

INTRODUCTION

This note sets out an agreed summary of the factual matters which were presented at the site visit to the Histopathology Laboratory at St Thomas' Hospital on 30 January 2004 and attended by representatives of the parties and the Judge.

The party was given a tour of the laboratory by Professor Sebastian Lucas and the Chief Biomedical Scientific Officer, Mr Bob Cummings.

The process of making blocks and slides was demonstrated in detail. First we were shown the process by which the tissue (which has already fixed in formalin for the required period of time) was processed to enable it to be embedded into a plastic cassette when paraffin wax would be added.

PROCESSING THE TISSUE INTO BLOCKS

The tissue is processed in a computerised tissue processing machine called a Vacuum Infiltration Processing machine. There are normally 14 stages of the process which involve the tissue being passed through formalin and then grades of alcohol (in order to remove the water in the tissue) and then xylene (in order to remove the fat and to ensure that the wax can be added). Finally, the tissue is impregnated with paraffin at about 62°C.

The whole of that process normally takes 12 to 15 hours although sometimes the programme is run over a weekend.

The tissue is then taken to a workstation where there is a computerised machine with a quantity of molten paraffin wax to fill metal moulds and a hot and a cold plate. The Biomedical scientist places the tissue the right way up in a mould and dispenses the required quantity of wax into the mould. Ensuring that the correct side of the piece of tissue is facing upwards, so that it can be seen at the surface of the block, is of some importance when it come to producing sections.

The plastic cassette in which the tissue had been placed when it was in the tissue processor is then placed directly on top of the open face of the mould. The tissue is thus embedded in the wax. The whole is then placed on the cold plate to cool.

Both the tissue processor and the hot/cold plate machine are similar to machines which have been used for these purposes since the 1970s.

Once the block has cooled sufficiently the block is complete and is then taken to the laboratory for microtomy.

PRODUCING THE TISSUE SECTIONS

The block is securely placed on the microtome which is equipped with a very sharp disposable blade for 3 micron thin sections to be taken from each block and put onto a slide for viewing under a microscope.

We were told that the qualifications needed today for this job (MLSO) are an BSc followed by a period of "on the job training" and study up to MSc level. The demonstrator had joined

the service at a time when this had not been necessary but she had undergone 6 years of part-time classes followed by her own on the job training and MSc equivalent qualifications.

The process of producing sections from a block was demonstrated and sometimes sections at several different layers in the block would be taken. A solution of 20% alcohol would be placed on a slide and by a process of passing the block under the blade the operator determines the appropriate level at which the blade will produce a good section. The section is about 3 microns (i.e. 3000ths of a millimetre) and is picked up with tweezers and placed on top of the alcohol solution on the slide. The slide is then picked up and dipped in to a bath of warm water at 49°. The purpose of the alcohol solution and the floating out of the section over the water is to remove any creases in the section. The tissue is then picked up on a pre-labelled slide, air-dried, and placed on a hot plate to fix the tissue to the slide.

Sometimes problems are encountered in taking sections from tissues where there a calcium deposits and these are removed by the use of formic and/or other acids.

STAINING THE TISSUE SECTIONS

The remaining wax is removed by use of xylene. The slide is then placed in a container of other slides and inserted into a machine containing several different pots of staining agents, the most common being a combination of Haematoxylin and Eosin (H&E). The different stains are designed to show different aspects of the tissue. The blue/purple dye stains the nuclear content of the cells. The pink dye stains the other aspects of the tissue. The refractive index of the slide is then increased by passing it through water, alcohol and xylene.

The process is completed when a clear mounting medium is added to the section, and a thin glass cover is placed mechanically over the stained tissue to protect it but more importantly to ensure that the slide has the necessary optical properties to enable it to be seen through a microscope.

There is a rigorous quality control process whereby the MLSO checks that the slides have been properly produced, labelled and that they are of a satisfactory quality.

The slides are then placed in order into a folder and they are all labelled uniquely to enable easy identification. They are then presented to the pathologist for reporting after verification on the laboratory database.

APPENDIX B: The Agreed Issues in respect of the Harris Claim

The Facts and Negligence

Did Mrs Harris make express stipulations to Dr Michaels in relation to organ retention, and if so what were they?

Did Mr Harris make express stipulations to Dr Clifford in respect of organ retention, and if so what were they?

In each of the above stipulations (if they were made), should (i) Dr Michaels have told Dr Clifford and/or should (ii) Dr Clifford told the pathologist?

If Mr Harris had been told that organs would be retained for the purposes of the post-mortem, would he and/or Mrs Harris have refused to allow the post-mortem and/or would they have changed their position in any other way?

Did the discovery of organ retention cause or materially contribute to an identifiable psychiatric injury in Mrs Harris?

If so – what was the nature of that injury?

Was psychiatric injury reasonably foreseeable?

Did Dr Clifford owe Mr and/or Mrs Harris a duty of care in law in respect of the post-mortem interview?

Was Dr Clifford negligent in failing to tell Mr Harris that organs would be retained, and/or negligent in failing to discuss organ retention with Mr Harris?

If Mr Harris had an objection to organ retention, was Dr Clifford negligent in failing to elicit this?

Wrongful Interference

Did Mr and Mrs Harris have a legal duty to dispose of Rosina's body?

If so, when did such duty arise?

Was any such duty discharged by the cremation and burial of Rosina's body?

Did Mr and Mrs Harris ever obtain the right to possess organs retained from Rosina, and if so, when did the right arise?

Did the hospital acquire proprietary rights in Rosina's organs, and if so when?

Did the hospital continue to have lawful possession of Rosina's organs after return of her body to Mr and Mrs Harris?

In the circumstances – did the hospital wrongfully interfere with any right held by Mr and Mrs Harris in respect of Rosina's organs?

If such an interference did occur – is it actionable by way of a claim for damages?

The Control Mechanisms for Psychiatric Injury

Does the primary/secondary victim dichotomy apply to Mrs Harris' case in negligence and/or wrongful interference?

If so – is Mrs Harris a primary victim, a secondary victim or neither?

In the circumstances – is Mrs Harris precluded for bringing a claim against the Defendants for psychiatric injuries?

Does Mr Harris have any claim which sounds in compensatory damages?

Exemplary Damages

Are Mr and/or Mrs Harris entitled to exemplary damages?

Aggravated Damages

Are Mr and/or Mrs Harris entitled to aggravated damages?

APPENDIX C: The Agreed Issues in respect of the Shorter Claim

Facts and Negligence

Did Mrs Shorter make express stipulations to Mr Fairbank in relation to organ retention, and if so what were they?

If so, should Mr Fairbank have informed the pathologist?

If Mrs Shorter had been told that some material would be retained for the purposes of the post-mortem, would she have refused to allow the post-mortem and/or would she have changed their position in any other way?

Did the discovery of organ retention cause or materially contribute to an identifiable psychiatric injury in Mrs Shorter?

If so – what was the nature of that injury?

Was psychiatric injury reasonably foreseeable?

Did Mr Fairbank owe Mrs Shorter a duty of care in law in respect of the post-mortem interview?

Was Mr Fairbank negligent in failing to tell Mrs Shorter that organs would be retained, and/or negligent in failing to discuss the full nature of organ retention with Mrs Shorter?

If Mrs Shorter had an objection to organ retention, was Mr Fairbank negligent in failing to elicit this?

Wrongful Interference

Did Mr and Mrs Shorter have a legal duty to bury Laura's body?

If so, when did such duty arise?

Was any such duty discharged by the burial of Laura's body?

Did Mr and Mrs Shorter ever obtain the immediate right to possess Laura's brain, and if so, when did the right arise?

Did the hospital acquire proprietary rights in Laura's brain and block and slides, and if so when?

Did the hospital continue to have lawful possession of Laura's brain, and tissue used for blocks and slides, after return of her body to Mr and Mrs Shorter?

In the circumstances – did the hospital wrongfully interfere with any right held by Mr and Mrs Shorter in respect of Laura's brain and other tissue taken from Laura?

If such an interference did occur – is it actionable by way of a claim for damages?

The Control Mechanisms for Psychiatric Injury

Does the primary/secondary victim dichotomy apply to Mrs Shorter's case in negligence and/or wrongful interference?

If so – is Mrs Shorter a primary victim, a secondary victim or neither?

In the circumstances – is Mrs Shorter precluded for bringing a claim against the Defendants for psychiatric injuries?

Exemplary Damages

Is Mrs Shorter entitled to exemplary damages?

Aggravated Damages

Is Mrs Shorter entitled to aggravated damages?

APPENDIX D: The Agreed Issues in respect of the Carpenter Claim

The Facts

Mrs Carpenter

Did the discovery of organ retention cause or materially contribute to an identifiable psychiatric injury in Mrs Carpenter?

If so – what was the nature of that injury?

Was psychiatric injury reasonably foreseeable? [Note: inserted at the Defendants' request; the Claimants do not consider that the issue is "in play"]

Professor Weller

In 1987 did Professor Weller have an arrangement with HM Coroner for Southampton and New Forrest concerning the retention and disposal of organs by Professor Weller after a coroner's post-mortem, and if so, what was that arrangement?

Did Professor Weller undertake histopathological examination on Daniel's brain after 30th April 1987?

Wrongful Interference

Did Mr and Mrs Carpenter have a legal duty to dispose of Daniel's body following the certification by the Deputy Coroner on 11th February 1987?

If so, when did that duty arise?

Was any such duty discharged by the burial of Daniel's body?

Did Mr and Mrs Carpenter ever obtain the right to possess Daniel's brain, and if so, when did the right arise?

Were the pathologists acting with the Coroner's lawful authority when:

i. Dr Kilpack retained Daniel's brain for neuropathological examination at the post-mortem carried out on 10th February 1987;

ii. The retention of Daniel's brain for neuropathological examination was continued after the certification of death on 11th February 1987?

iii. Professor Weller retained Daniel's brain following the removal of blocks of tissue for histological examination on or about 30th April 1987?

iv. Professor Weller retained Daniel's brain following the completion of any histological examination between 30th April and 11th August 1987?

v. Professor Weller disposed of Daniel's brain on 11th August 1987?

Did the pathologists (in their own right or as agents for the Coroner) acquire proprietary rights in Daniel's brain, and if so when?

In the circumstances – did the pathologists wrongfully interfere with any right held by Mr and Mrs Carpenter in respect of Daniel's brain?

Is the hospital vicariously liable for any such wrongful interference?

If such an interference did occur – is it actionable by way of a claim for damages?

Outstanding Issues of Law

The Control Mechanisms for Psychiatric Injury

Does the primary/secondary victim dichotomy apply to Mrs Carpenter's case in wrongful interference?

If so – is Mrs Carpenter a primary victim, a secondary victim or neither?

In the circumstances – is Mrs Carpenter precluded for bringing a claim against the Defendants for psychiatric injuries?

Exemplary Damages

Is Mrs Carpenter entitled to exemplary damages?

Aggravated Damages

Is Mrs Carpenter entitled to aggravated damages?