

**PHYSICIAN/HOSPITAL LIABILITY FOR THE  
NEGLIGENT REPORTING OR DIAGNOSIS  
OF CHILD ABUSE**

**JD v East Berkshire Community Health NHS Trust  
[2005] UKHL 23**

## **1 Introduction**

Medical practitioners, health care practitioners/providers and hospitals are increasingly called upon to make a diagnosis of children who appear to be the victims of sexual or other abuse. (For the classification of child abuse [inclusive of physical abuse, sexual abuse, non-accidental injury syndrome, chemical abuse and emotional and psychological abuse] see Carstens and Du Plessis "Medico-legal Aspects Pertaining to Children" in Davel (ed) *Introduction to Child Law in South Africa* (2000) 360; also cf Mason *Forensic Medicine* (1978) 86; Gordon and Shapiro *Forensic Medicine* (1982) 160; Schwär, Loubser and Olivier *Die ABC van Geregte Geneeskunde* (1984) 309; and Knight *Simpson's Forensic Medicine* (1997) 105.) Occasionally mistakes are made and such abuse is incorrectly diagnosed, leading to tragic consequences for the child, family and other caregivers. Children may be taken into foster care and parents may suffer psychological trauma and psychiatric illness. Parents or caregivers may even be wrongly accused of such abuse, and consequently tried and convicted on the basis of expert medical evidence. The question arises whether those wrongly accused of such abuse may institute a claim for damages and other relief. It is particularly in the common law jurisdictions that this question has recently surfaced in the context of whether a physician or hospital owes a duty of care to the wrongly accused parent (see Richardson "Liability for Negligently Reporting Child Abuse" 2002 *Journal of Legal Medicine* 131; Cobley, Sanders and Wheeler "Prosecuting Cases of Suspected 'Shaken Baby Syndrome' – A Review of Current Issues" 2003 *Criminal Law Review* 93; and Moon "Misdiagnosis of Sexual and Other Abuse: The Doctor's Duty to the Alleged Sexual Abuser" in unpublished conference proceedings of *The 16<sup>th</sup> World Conference on Medical Law*, Sydney, Australia (2004) 23).

The English courts in particular have recently been confronted with incorrect/negligent misdiagnoses of child abuse by physicians that have led to the wrongful convictions of a number of appellants who successfully challenged their convictions before the English Courts of Appeal and subsequently had their convictions set aside (see *R v Sally Clark* [2003] EWCA Crim 1020; *R v Angela Cannings* [2004] EWCA Crim 1, [2004] 1 FCR 193); and also cf *Kent County Council, Re B(A Child) v the Mother* [2004] EWHC 411 (Fam)).

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Whether physicians in England and Wales owe parents who are wrongly alleged to have abused their children a duty of care in relation to that diagnosis, has now conclusively been dealt with by the English House of Lords in the case of *JD v East Berkshire Community Health NHS Trust* ([2005] UKHL 23).

## **2 Facts**

The facts in the case relate to three separate appeals and are dealt with accordingly:

### *2.1 The first appeal*

JD, the first appellant and a registered nurse, was the mother of a child, M, who suffered from multiple allergic reactions. These allergic reactions, amongst other things, led a consultant paediatrician expert in allergic reactions to suggest that the child might be suffering as a result of Munchausen by Proxy (a syndrome whereby an infant or a child is presented to physicians, often repeatedly, with a disability or illness fabricated by an adult, for the benefit of the adult). It was thus suggested that JD was fabricating M's condition and harming him. At some stage JD had the opportunity to read the medical notes and discovered that Munchausen by Proxy was considered to be a possibility. She subsequently arranged to see a psychiatrist who found nothing wrong with her. She later claimed that she has suffered psychiatric injury as a result of the misdiagnosis of her and M's condition. She had not returned to nursing since this negligent misdiagnosis was made. She subsequently issued summons claiming damages for negligence, but her claim was dismissed on the ground that public policy considerations militated strongly against the existence of any duty on the facts of the case.

### *2.2 The second appeal*

MAK, the second appellant, instituted a claim for damages in negligence for psychiatric injury and financial loss resulting from a clinical misdiagnosis against the Dewsbury Healthcare Trust on behalf of himself and his daughter, R. At the relevant time R was nine years old. She suffered from Schamberg's disease which produces discoloured patches on the skin. She hurt herself in the genital area while riding her bicycle which resulted in bruising marks on her legs. R was taken to hospital by her father. A consultant paediatrician at the hospital thought that the marks on her legs were suggestive of sexual abuse. The consultant informed the social services. R was admitted to hospital at once and examined further. The attending doctor concluded that R had been sexually abused. Her mother was also informed. At that stage the diagnosis of Schamberg's disease was not known. MAK and his son, R's elder brother, were told that they could not sleep at home when R was released from hospital. In the hospital, in front of other patients and visitors to the ward, MAK was told he was not allowed to see R and that he could not visit her. Later the correct diagnosis of

Schamberg's disease was made. The social services took no further steps, and it was accepted that there was no question of abuse.

The trial court dismissed MAK's claim against the defendants, but the court ruled that R had an arguable claim for clinical negligence against the defendants.

### 2 3 *The third appeal*

The third appellants were RK and his wife AK. They are the parents of a young girl, M. When M was two months old and in the care of her grandmother, M started to scream when the grandmother lifted her from a settee. Her parents and grandmother took M to the hospital. On admission to the hospital the medical staff failed to take an accurate history from them and the grandmother. The attending consultant paediatrician diagnosed M as having an "inflicted injury" – a spiral fracture of the femur. The police and social services were informed. The attending physician did not investigate further the possibility of a diagnosis of *osteogenesis imperfecta* ("brittle bones"). The social services (Oldham Borough Council) applied for an interim care order to the effect that when M was discharged from hospital, she was placed in the care of her aunt with supervised access for the parents. Later the court decided that M's injuries were non-accidental and care was given to the aunt. M, however, sustained further fractures while in the care of her aunt. Further tests were carried out and the revised medical opinion was that the history and injuries were consistent with brittle bone disease and not indicative of any abuse. Nearly nine months after being admitted to hospital, M was returned to the care of her parents. It was now accepted that the initial diagnosis of non-accidental injury was wrong. The fact remained that M's mother was separated from her young baby for a period of eight months.

The parents claimed damages in negligence from the Oldham NHS Trust and from the attending paediatrician for psychiatric injury resulting from their separation from M. The trial court ruled, however, that neither defendant owed a duty of care to the parents and consequently dismissed the action.

## 3 **Judgment**

### 3 1 *The issues for decision*

The House of Lords ruled that the crucial question in this appeal was whether the parent of a minor child falsely and negligently said to have abused or harmed the child may recover common law damages for negligence against a physician or a social worker who, discharging professional functions, has made the false and negligent diagnosis/statement? In this regard the court ruled that, on conventional analysis, the answer to the posed question turns on whether a physician or social worker owed any duty of care towards the parent with reference to English precedent that dictates that "the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the party for the benefit of the other" (see *Caparo Industries v Dickman* [1990] 2 AC 605 618). For purposes of all three appeals, it was accepted that each

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child's medical condition was misdiagnosed and that such misdiagnosis was the result of a failure to exercise the standard of professional skill and care to be reasonably expected of a physician or a social worker in the same circumstances. It was also accepted that each of the appellant parents suffered a recognised form of psychiatric injury as the result of the making or maintenance of the negligent misdiagnosis in each particular case. Apart from the assessment of the applicable English law, in context of the posed question above, reference was also made to a series of decisions of the European Court of Human Rights that have shown that the application of an exclusionary rule in this sensitive area may lead to serious breaches of Convention rights for which domestic law affords no remedy and for which the law of tort (delict) should afford a remedy if facts of sufficient gravity are shown. This the court had to consider.

It should be noted that the decision of the House of Lords, in dismissing the appeals, was not unanimous. The majority judgment of Lord Nicholls of Birkenhead, Lord Steyn, Lord Rodger of Earlsferry and Lord Brown of Eaton-under-Heywood, is juxtaposed against the minority judgment of Lord Bingham of Cornhill. The minority judgment is first assessed.

### 3.2 *The minority judgment (Lord Bingham of Cornhill)*

Lord Bingham, in allowing the appeals, observed that there are, broadly speaking, three theoretical answers to be given to the question whether doctors or social workers owe any common law duty of care other than to their employer, and if so what, in a case of potential child abuse. The first is that they owe no such duty. The second is that they may on appropriate facts owe a duty to the child, but owe no duty to the parent. The third is that they may on appropriate facts owe a limited duty to the parent as well as the child (see *JD v East Berkshire Community Health Trust supra* par 20-21). After a lengthy analysis of applicable English case law, his Lordship analysed the policy considerations which militated against recognising that doctors and social workers do owe a duty of care to parents where child abuse was negligently diagnosed. These policy considerations are the following:

- (1) extending the common law duty of care to parents would cut across the whole statutory and inter-disciplinary system for protecting children at risk and raise almost impossible problems of ascertaining and allocating responsibility;
- (2) the task of a local authority and its servants in dealing with children at risk is extraordinarily delicate in the sense that there is a difficult line to tread between taking action too soon and not taking it soon enough;
- (3) local authorities might adopt a more cautious and defensive approach;
- (4) there was a risk of conflict between social worker and parent; and
- (5) there were other remedies available under legislation (see par 31-35).

Lord Bingham, however, referred to authority where it was noted that the law should develop novel categories of negligence incrementally and by analogy with established categories, rather than by massive extension of a

*prima facie* duty of care restrained only by indefinable “considerations which ought to negative or reduce or limit the scope of the duty or the class of person to whom it is owed” (see *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 481; and *X v Bedfordshire County Council* [1995] 2 AC 633).

In essence his Lordship observed that it was important to be clear on the scope of the duty which the appellants seek to be allowed to try and establish as owed by the healthcare professionals. It is a duty not to cause harm to a parent foreseeably at risk of suffering harm by failing to exercise reasonable and proper care in the making of a diagnosis of child abuse. If diagnosis of child abuse were made when the evidence did not warrant it, there would be a breach of duty to the child, with separation or disruption of the family or likely consequences. This would be a breach of the duty owed to the parents also; the consequences are not suffered by the child alone (see par 37 of the judgment). In the final instance, a long stream of Strasbourg authority (from the European Court of Human Rights) (see par 43 of the judgment; also see Article 3 and 13 of the European Convention on Human Rights; and *cf* also *Z v United Kingdom* [2110] 34 EHRR 97) and analysis of comparative jurisdictions (notably France and Germany – see par 49 of the judgment) persuaded Lord Bingham to rule that he would allow the appeals for the law of tort should evolve, analogically and incrementally, so as to fashion appropriate remedies to contemporary problems as opposed to it remaining essentially static. He stated that ultimately he was a proponent for evolution (see par 50 of the judgment).

### 3 3 *The majority judgment (Lord Nicholls of Birkenhead, Lord Steyn, Lord Rodger of Earlsferry and Lord Brown of Eaton-under-Heywood)*

Lord Nicholls, Lord Rodger and Lord Brown (with whom Lord Steyn agreed) in dismissing the appeals, observed that public confidence in the child protection system can only be maintained if a proper balance is struck, avoiding unnecessary intrusion in families while protecting children at risk of significant harm. The balance is indicative of countervailing interests. In this regard health professionals must act in good faith when assessing the possibility of child abuse. In concluding that the Court of Appeal reached the right decision, it was ruled that at common law, the interference with family life does not justify according a suspected parent a higher level of protection than other suspected perpetrators. A doctor is obliged to act in the best interests of his patient. In these cases the child is his patient. The doctor is charged with the protection of the child, not with the protection of the parent (see par 85 of the judgment). Although it was accepted that doctors often owe duties to more than one person, for instance, a doctor may owe duties to his employer as well as his patient, the seriousness of child abuse as a social problem demands that health professionals, acting in good faith in what they believe are the best interests of the child, should not be subject to potentially conflicting duties when deciding whether a child may have been abused. The duty they owe to the child in making these decisions should not be clouded by imposing a conflicting duty in favour of parents or others suspected of having abused the child (see par 86 of the judgment).

Whether a suspected parent, wrongly accused of child abuse, should rather have a claim or remedy against a negligent doctor in terms of the European Convention on Human Rights and/or the English Human Rights Act of 1998, was also dismissed, mainly for reasons of policy considerations. In particular Lord Nicholls stated that he had reservations about attempts to transplant this approach into the domestic law of negligence in cases where, as here, no claim is made for breach of a Convention right. It would lead to uncertainty and abandonment of a duty of care in English law, unless replaced by a control mechanism which recognises such limitation, and is unlikely to clarify the law (see par 94 of the judgment).

Lord Rodger, after analysing the position in comparable jurisdictions (notably Australia with reference to High Court decision in *Sullivan v Moody* (2001) 207 CLR 562), opined that contrary to his view, should a duty of care be imposed in favour of parents in these cases, he could see no proper basis for then failing to extend it to other members of the family, to friends of the family, to teachers and to child-minders; in short, to anyone who might be under suspicion of having abused the child. The potentially wide range of this supposed additional duty could only add to the risk that it would compromise the key duty of care to children (see par 117 of the judgment).

Ultimately Lord Brown observed that he readily acknowledged the legitimate grievances of these particular appellants, against whom no suspicions whatever remain, suffered from presumed want of professional skill and care on the part of the doctors treating their children. He also acknowledged that the parents are paying the price for the law's denial of a duty of care. But it is the price they pay in the interest of children generally. The wellbeing of innumerable children up and down the land depends crucially upon doctors and social workers concerned with their safety being subjected by the law to but a single duty: that of safeguarding the child's own welfare (see par 138 of the judgment).

## 4 Comments

### 4.1 *Effect of the decision*

The effect of the decision of the majority judgment of the House of Lords is that physicians do not owe a duty of care to parents where physicians diagnose sexual or other abuse by those parents of the child, even in circumstances where the diagnosis was negligent. Physicians, however, do continue to owe a duty of care to the child who is the subject of the diagnosis. In contrast, the minority judgment is indicative of the notion that the English common law should be extended or developed to allow novel categories of negligence to cope with contemporary problems. It may be observed that "policy considerations" decidedly slanted in favour of the "best interest of the child" enhanced the finding that physicians at common law do not owe the parents a duty of care. It is also clear that this almost "traditional stance" is not always in synergy with the current developments in terms of decisions relating to the English Human Rights Act of 1998 or the European Convention on Human Rights (see *Z v United Kingdom supra*; *PC and S v United Kingdom* (2002) 35 EHRR 245; and *Yousef v The Netherlands* (2002) 36 EHRR 345).

## 4.2 Comparative synopsis

A comparative investigation into the question whether physicians or hospitals owe a duty of care to the parents where child abuse is negligently reported or diagnosed reveals that the courts in Australia and New Zealand are, in principle, of the same opinion as the majority decision of the House of Lords in the *East Berkshire* decision (cf *CLT v Cannon* (2000) 77 SASR 449; *Sullivan v Moody supra*; *Attorney General v Prince* [1998] 1 NZLR 262; *B v Attorney General* [2003] 4 All ER 833; and also cf the discussion by Moon in 2004 *Conference Proceedings supra* 123).

In France and Germany, it would seem clear that such claims by the parents would not summarily be dismissed where recovery depends on proving fault. Policy considerations in Germany (based on the provisions of par 839 of the *BGB*) could very well lead to a claim by parents succeeding (cf Markesinis, Auby, Coester-Waltjen and Deakin *Tortious Liability of Statutory Bodies* (1999) 15-20; Fairgrieve "Child Welfare and State Liability in France" in Fairgrieve and Green (eds) *Child Abuse Tort Claims against Public Bodies* (2004) 179-197; and also see *JD v East Berkshire Community Health Care Trust supra* par 49).

In the United States of America, to effectuate the purpose of child abuse reporting statutes and encourage reporting, mandatory and permissible reporting are protected from potential civil or criminal liability in all states at least to some degree, on condition that all reporters should act in good faith. It can, however, generally be observed that the application of immunity to physicians who made mandatory reports of child abuse that later turned out to be false is very confusing. This is because the term "negligence" is not applied consistently by the courts. It is, however, accepted that negligence may lie in the making of a report without a proper basis/foundation on account of an incomplete medical examination conducted by the physician, alternatively, the physician may be liable when relying on a third party, such as a laboratory technician (see Richardson 2002 *Journal of Legal Medicine* 137; also cf Freiman "Unequal and Inadequate Protection Under the Law: State Child Abuse Statutes" 1982 *George Washington Law Review* 243; and Singley "Failure to Report Suspected Child Abuse: Civil Liability of Mandated Reporters" 1998 *La Verne Law Review* 236). There are cases in the United States where the courts have allowed civil damages for parents where physicians have negligently reported child abuse (see *Harding v Martini* 726 NE 2d 93 (Ill SC 2000); *Comstock v Walsh* 848 SW 2d 7 (Mo App 1992); and also cf Richardson 2002 *Journal of Legal Medicine* 140).

## 4.3 Implications for South African law

In terms of section 42 of the Child Care Act 74 of 1983, physicians (and all other health care professionals) are mandated to report child abuse to the applicable Director-General, should such a suspicion arise during the medical examination of a child. Failure to do so would, *prima facie*, amount to an unlawful omission in our law (criminal law or delict). It is thus clear that there is a statutory duty on physicians (and other health care professionals) to report alleged child abuse. This duty is, however, decidedly owed to the

child, and emanates from what the legal convictions of society (*boni mores*) would regard to be in the best interests of the child.

As far as the negligent reporting or misdiagnosis of child abuse (emanating from s 42) is concerned, and whether parents would have a subsequent civil claim against such a physician in South African law, this would first and foremost rest on the principle that a parent-plaintiff would have to prove, on a preponderance of probabilities, that the physician, when making his diagnosis or report of child abuse, acted *negligently* with reference to the yardstick of the reasonable competent physician acting with the same professional care and skill in the same circumstances. It is trite law in South Africa that criminal or delictual liability is dependent upon the element of fault (in the form of *culpa*) on the part of the physician (see *S v Kramer* 1987 1 SA 887 (A); and *Minister of Safety and Security v Hamilton* 2004 2 SA 216 (SCA)).

In the absence of comparable domestic case law in this regard, one has to observe that our courts, when confronted with similar civil claims by parents, will no doubt seek guidance from foreign jurisdictions. Such an approach would certainly be justified with reference to section 39(1) of the Constitution of the Republic of South Africa, 1996 whereby courts *may*, in the context of interpreting the Bill of Rights, consider foreign law. In the context of medical negligence our courts are inclined to lean heavily towards the English law and will in all probability, in entertaining these claims, be inclined to do so again (in context of medical negligence in reporting and the diagnosis of child abuse) (see *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 3 SA 1188 (SCA) where, in the assessment of medical negligence, the Supreme Court of Appeal relied exclusively on comparable English authority in the decision of the House of Lords in *Balitho v City and Hackney Health Authority* [1998] AC 232 (HL) [E]).

There is, however, another dimension entering into the equation when assessing the question whether aggrieved parents may institute a civil claim against a physician who negligently reported or misdiagnosed child abuse, and that is where they base their civil claim on a breach of their constitutional rights. The question arises whether the common law should then be developed to afford them an appropriate remedy? According to the decisions of the Constitutional Court, the need to develop the common law under section 39(2) of the Constitution could arise in at least two instances: the first is when a rule of the common law is inconsistent with a constitutional provision. The common law can then be adapted to resolve the inconsistency. The second possibility is that the rule is not inconsistent with the specific constitutional provision but may fall short of its spirit, purport and objects. If so, the common law must be adapted so that it grows in harmony with the objective normative value system found in the Constitution. The Constitutional Court has emphasised that the constitutional obligation to develop the common law is not discretionary but is rather a general obligation to consider whether the common law is deficient and, if so, to develop it to promote the objectives of the Bill of Rights. The obligation applies in both civil and criminal cases, irrespective of whether or not the parties have requested the court to develop the common law (see *S v Thebus* 2003 6 SA 505 (CC); *Carmichele v Minister of Safety and Security*



2001 4 SA 938 (CC) par 33 and 36; see also Currie and De Waal *The Bill of Rights Handbook* (2005) 67-69; and also *cf Van Eeden v Minister of Safety and Security* 2003 1 SA 389 (SCA) where it was ruled that the requirement of a special relationship between a plaintiff and defendant as absolute prerequisite for imposing a legal duty could no longer be supported in the light of the constitutional imperatives). It would thus seem that South African courts could entertain civil claims by aggrieved parents under these circumstances by extending the common law to fashion an appropriate remedy to contemporary problems where there may be an apparent conflict between the common law and the provisions of the Constitution. This approach would certainly accord with the minority judgment of Lord Bingham in the *East Berkshire* case and the recent decisions of the European Court of Human Rights with reference to the European Convention on Human Rights.

It is, however, submitted that whichever approach is followed by South African courts in future, the decisive consideration ought not to be dependent on the existence of a duty owed by the attending physician to the parents, but rather on due consideration to the element of fault in the form of *negligence* and more particularly *medical negligence*. The recognition of a legal duty is one thing, the assessment of a legal duty executed *negligently*, is quite another. It should be noted that the misdiagnosis of child abuse or a medical error of judgment is not *per se* indicative of medical negligence. In the case of *Mitchell v Dixon* 1914 AD 519, Innes ACJ remarked in this regard as follows:

“Now a medical man is not necessarily liable for a wrong diagnosis. No human being is infallible, and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect if his diagnosis is palpably so wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regards being had to the ordinary level of skill in his profession.”

It is clear that an error of diagnosis is not necessarily negligent and will be assessed against the yardstick of the reasonable doctor in the same circumstances, including the difficulty of making the diagnosis given the signs and symptoms and the diagnostic techniques available (also see Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 292; Claassen and Verschoor *Medical Negligence in South Africa* (1991) 31; Strauss *Doctor Patient and the Law* (1991) 252; Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid* (unpublished LLD thesis, University of Pretoria, 1996) 401; and Kennedy and Grubb *Principles of Medical Law* (1998) par 6.50).

## 5 Conclusion

The assessment of the question whether aggrieved parents will have a civil claim against a physician/hospital for the negligent reporting or misdiagnosis of child abuse, exposes the tension between the “traditionalist approach” (indicative of entrenching immunity for medical professionals on the basis of policy considerations based on a strict interpretation of the common law as applied by the majority of the courts in the common law jurisdictions), and the “evolutionist approach” which demands that the common law should

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evolve, analogically and incrementally, so as to fashion appropriate remedies to contemporary problems. It is submitted that the latter approach, which is also in keeping with the current trends and developments in comparable constitutional jurisprudence, is to be preferred.

Ultimately, it is submitted that in the assessment of the question whether aggrieved parents may institute a civil claim against physicians who negligently reported/misdiagnosed child abuse, the emphasis should not be on the question whether such physicians owe a legal duty to the parents, but rather whether such duty was executed *negligently*. The assessment should not be about a legal duty, but rather about medical negligence. In this regard there is much to be said for the persuasive arguments of Richardson, who states that

“while physicians might be discouraged from reporting suspected cases of child abuse after negligently conducting a medical examination which later result in a report of suspected child abuse, exposes physicians to no higher standard that already exists for medical malpractice. Physicians hold themselves out as qualified professionals, performing an invaluable service to society. Immunity for negligent misdiagnosis allows physicians to dodge their duty to the public, to their profession, and to their patients, to perform at a certain level of care. The consequences of immunity for negligent misdiagnosis of child abuse are injury to the child and the child’s family. By not allowing immunity, one is essentially asking physicians only to act in the manner in which the public would expect them to act in any other situation, that is, with professional skill and care” (see Richardson 2002 *Journal of Legal Medicine* 143).

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