BENIUS RAZUMAS v MINISTRY OF JUSTICE [2018] EWHC 215 (QB)

NOTE OF JUDGMENT

1. In a reserved judgment handed down on 12 February 2018 and following a five day trial, Cockerill J dismissed the Claimant's claim for damages for clinical negligence suffered while he was a prisoner. The Claimant had sued the Ministry of Justice alone rather than those directly responsible for any negligence. Cockerill J held that the Defendant had not breached its limited direct duty of care, did not owe a non-delegable duty of care and was not vicariously liable. Had the point arisen, the claim would have been dismissed for fundamental dishonesty.

2. This note sets out the basis on which the learned judge reached her conclusions.

The Legislative and regulatory framework (§7-67)

3. At trial the Claimant accepted the Defendant's analysis of the relevant prison and NHS legislation, which showed a transfer of statutory responsibility for the commissioning and provision of healthcare in prison from the Defendant to the Department of Health and the NHS. That gave effect to the policy that prisoners should receive the same level of care as in the community (the principle of equivalence).

4. As from 2003, regulations made under the NHS Act 1977 therefore mandated that primary care trusts (PCTs) would have the responsibility of providing, or securing the provision of, primary care services to prisoners; a responsibility maintained in the NHS Act 2006. Section 249 of that statute provided for the prison service and NHS, in exercising their respective functions, to cooperate with each other. The transfer of funding responsibility was to take place over a three to five year period from 2003. By 2010, the legislation that had previously imposed on the Defendant a duty to provide healthcare in prisons had been amended so as to mandate that prison governors '*must work in partnership with local health providers'*. Following the abolition of PCTs by the Health and Social Care Act 2012, their responsibilities in this area passed to NHS England.

5. The statutory transfer was reflected in partnership agreements between the Defendant and the Department of Health and in published prison service guidance. Under the partnership agreements, healthcare related litigation became the responsibility of the Department of Health as from April 2003 and PCTs had responsibility for monitoring healthcare provision against NHS standards. Prison service guidance (prison service orders and prison service instructions) envisaged a role for governors in clinical governance (ensuring the healthcare system operated appropriately in a prison setting) working in partnership with the local NHS. That guidance also identified specific responsibilities for healthcare staff and required that medical information be treated as confidential.

6. Cockerill J had a number of contracts before her relating to the provision of healthcare at the various prisons at which the Claimant had been located. These evidenced the fact that as a consequence of the transfer of responsibility to the NHS those providing healthcare at the prisons were not employed by the Defendant who was not a party to the contracts. Healthcare staff were either employed by the PCTs or by the party with whom the PCT contracted. The contracts incorporated standard terms and conditions consistent with directions issued by the Secretary of State for Health. These addressed matters such as terms of employment for GPs, sub-contracting, the need for patient confidentiality, compliance with identified prison policies, the requirement for insurance and indemnifying the PCT. The clinical training provided to staff, their performance evaluation, monitoring and quality control were the responsibility of the PCT and their employer.

7. The separation between the custodial and healthcare aspects of a prison also meant that these aspects were inspected by HM Inspectorate of Prisons and the Care Quality Commission respectively. It meant that there were separate complaints systems, prisoner complaints about the care received being a matter for the healthcare provider. To preserve patient confidentiality, custodial staff in prisons would not, and do not, have access to the healthcare records held on a computer database known as SystmOne and subject to NHS conditions of

confidentiality and data protection. By contrast healthcare staff in prisons could, and can, access prison records.

The Facts (§68-97)

8. The Claimant, a Lithuanian national, had been in the United Kingdom since 2004. Between 2010 and 2013 he served three periods of imprisonment during which he was held at different prisons.

9. In 2010 the Claimant developed a lump on his left calf. Despite receiving medical treatment while in prison, this lump was not diagnosed as a soft tissue sarcoma until August 2013 by which time an above the knee amputation was unavoidable.

10. By late 2010, the Claimant was in HMP Bullwood Hall. While there he had an orthopaedic consultation at Southend Hospital in January 2011. That resulted in a letter ('the Southend letter') explaining that a MRI scan would be booked (albeit no appointment date was given) and raising the possibility of malignancy. The Claimant had completed his sentence by the time this letter reached healthcare at the prison. The GP experts agreed that the healthcare professionals at Bullwood Hall who dealt with the letter had no obligation other than to file it on SystmOne. Further, there was no verified post-release address for the Claimant. Prior to his release, and in accordance with published policy, the Claimant was seen by healthcare. His medical records were noted '*fit for discharge*'. Cockerill J found that it was likely that the Claimant had called Southend Hospital on the day of his discharge having been told of a future appointment to follow up his hospital visit.

11. In April 2011, the Claimant received a second prison sentence. He spent that sentence at HMP Brixton, being released on 3 August 2011. Different GPs saw the Claimant in Brixton on several occasions. The GP experts agreed that a full history and review of the available clinical records (including the Southend letter) would have led to an urgent orthopaedic referral and MRI scan. It was common ground that there had been negligent failures to do so by three different GPs on four separate occasions. The expert evidence was that, had there been a referral at this time, the tumour would been excised and amputation would not have been necessary.

12. An orthopaedic referral on 17 May 2011 led to an outpatient appointment for 8 August 2011. Cockerill J found that it was likely that there had either been no pre-release assessment of the Claimant's fitness for discharge or an incomplete discharge process, with the result that the Claimant was not told of the appointment before release.

13. On his own evidence, the Claimant spent must of the period following his release from prison on the run after he had committed further offences.

14. In July 2012, the Claimant was arrested and imprisoned at HMP Bedford. His particulars of claim originally pleaded that he arrived at the prison with a scheduled appointment for surgery on the lump at Newham Hospital following a GP referral. He alleged a negligent failure to ensure he attended that appointment. In oral evidence, the Claimant conceded that he did not have an appointment for such surgery.

15. A GP at HMP Bedford, having noted the Southend letter, made an urgent referral. The Claimant was placed on medical hold (meaning he could not be transferred to another prison) pending that appointment. An orthopaedic specialist saw him on 2 August 2012. By now the tumour was still resectable but with a little more muscle loss. An MRI scan was arranged for 13 September 2012.

16. On 3 September 2012 and following a court appearance, the Claimant was transferred to HMP Thameside. A medical hold was only placed on his clinical records after he had been taken to the court hearing. Cockerill J found that the medical hold would have been visible to healthcare staff at whichever prison the Claimant was sent to. It was common ground that healthcare staff at HMP Thameside failed to pick up on both the medical hold and that the Claimant had a pending appointment and failed to make arrangements for him to attend that appointment. September 2012 represented the last opportunity for the Claimant's tumour to be excised without amputation.

17. The Claimant returned to HMP Bedford in October 2012. There followed further failures to refer him for appropriate treatment. It was not until January 2013 that a referral was made leading to a diagnosis and amputation.

The issues (§108)

18. Cockerill J considered seven issues:

(1) The extent of the Defendant's direct duty to the Claimant and whether any such duty had been breached. The Claimant alleged that there had been institutional and systemic failures, in particular the failure (a) in January 2011 and August 2011 to communicate the dates of medical appointments to him and (b) in September 2012 to ensure his attendance at an appointment. These failings were also said be a breach of the Defendant's admitted duty to ensure access to healthcare;

(2) Whether the Defendant owed a non-delegable duty of care in respect of those who provided healthcare at the various prisons where the Claimant was located;

(3) Whether the Defendant was vicariously liable for those responsible for the Claimant's healthcare needs while in prison;

(4) Whether a claim in various liability was barred by virtue of section 2(1) of the Crown Proceedings Act 1947;

(5) Whether the Claimant's failure to seek medical treatment when out of prison constituted an intervening act breaking the chain of causation;

(6) Whether the Claimant had been fundamentally dishonest under section 57 of the Criminal Justice and Courts Act 2015;

(7) Whether the Defendant had breached the Claimant's Article 3 rights under the Human Rights Act 1998 and his Article 13 rights under the European Convention on Human Rights.

The judgment

(1) Direct Duty (§109-122)

19. Cockerill J found that the Defendant did have a direct duty to the Claimant but one more limited in scope than that for which the Claimant argued (§109-112; 115).

20. A duty arose from the fact of custody - '*to take care as to a safe environment and also as to the less obvious risks such as that of suicide which has been found to be linked to the state of custody*'. The duty '*probably extends to matters relating to access to healthcare*' (as the Defendant had pleaded). Further, the clinical governance process made it likely that a duty arose under the legislative and regulatory framework but one limited to oversight of systems in place and to raising and seeking solutions to known and identified problems. The duty did not include a responsibility to actively reinforce the role of healthcare operators on day to day matters (§116-119).

21. The learned judge found that the Defendant did not breach any duty owed to the Claimant. No part of the custodial relationship had gone wrong and no part of the oversight of systems had been shown to be deficient. There was no failing in January 2011 in relation to the Southend letter; responsibility for the failings in August 2011 and September 2012 lay with healthcare.

(2) Non-delegable duty (§123-158)

22. Both parties cited the judgments of the Supreme Court in **Woodland v Swimming Teachers Association and Others** [2014] AC 537 and **Armes v Nottinghamshire County Council** [2017] 3 WLR 1000 (§123-129).

23. Emphasising the '*unique'* nature of his position as someone in the custody of, and so dependent on, the Defendant, the Claimant submitted that the five features identified by Lord Sumption in **Woodland** were satisfied, that his situation could be distinguished from **Armes** and there were sound reasons why it was fair, just and reasonable to impose a non-delegable duty (§129-135).

24. The Defendant submitted that a prison undertakes to protect against risks that arise from its custody and control of the Claimant. The duty did not extend to protecting against negligent medical treatment. That duty did not arise from control but from a patient's consent to treatment. In particular, in relation to the fourth feature identified by Lord Sumption (delegation to a third party of some function which is an integral part of the positive duty assumed), the Defendant relied on the statutory framework which showed a clear distinction between its control over the Claimant as a prisoner to which he could not consent and his treatment as a patient which required his consent. Relying on **Armes**, the Defendant submitted that it had no statutory obligation to provide or arrange for the provision of healthcare in prisons (§136-147).

25. Cockerill J accepted the Defendant's argument. Citing Lord Sumption, the learned judge emphasised the need for '*a nexus between the control of the claimant by the target and the purpose of that control/placing, and the care inherent in that relationship*'. Here there was no nexus: the claimant was not in prison for the purpose of receiving healthcare, which had not (at least since 2003) been part of the prison's '*mainstream (or essential) function'*. The position was as that which pertained in **A (A child) v Ministry of Defence** [2005] QB 183, endorsed by Lord Sumption (§148-152). The provision of healthcare formed no part of the statutory or common law duty owed by the Defendant; it is the duty of the PCT and its subcontractors (§154). Fair and reasonable principles did not provide an alternative route to a non-delegable duty (§158).

26. Interestingly, the learned judge disagreed with the analysis of Coulson J (in **GB v Home Office** [2015] EWHC 819 (QB)) that **Morgan v Ministry of Justice** [2010] EWHC 2248 (QB) had been wrongly decided. Noting that **GB** concerned an entirely different legislative backdrop, Cockerill J endorsed the reasoning of Supperstone J in **Morgan** (§155-157).

(3) Vicarious liability (§159-176)

27. Relying on **Cox v Ministry of Justice** [2016] AC 660 and **Armes**, the Claimant argued that his circumstances showed that the provision of healthcare was carried

out on behalf of the Defendant and was integral to its business activity, the healthcare and custodial functions being inextricably linked. Engaging a healthcare provider created the risk of negligence that might harm prisoners (§162-164).

28. The Defendant submitted, following **Armes**, that a first step was to ask whether there existed a relationship between the individual responsible for the negligent conduct and the defendant, the nature of which made it necessary to impose vicarious liability. That question was answered by applying the five factors identified by Lord Phillips in **Various Claimants v Catholic Child Welfare Society** [2013] 2 AC 1. These factors were absent here, including the absence of any employment relationship with those responsible for the torts complained of, that healthcare provision was not part of the Defendant's business activity, that the Defendant had not created a risk of clinical negligence and that it exercised no control over healthcare provision in prison (§165-173).

29. Cockerill J held that the Claimant had failed to meet the relevant test. Taking each of the factors identified by Lord Phillips, the learned judge concluded: that the tort complained of had been committed by healthcare providers acting on behalf of the PCT and not the Defendant; that the healthcare provider's activity was part of the business activity of the PCT, it was not substantially part of the activity of the Defendant there only being '*limited integration'* between the custodial and healthcare functions; that it was the contract with the PCT (over which the Defendant had no control) that created the risk of clinical negligence by a healthcare provider; and that the healthcare provider was only under the Defendant's control to a limited degree: *'Control in terms of training, contractual terms, and discipline channels through the contractual chain to the PCT.'* (§174)

30. Further, there was no shortfall of cover, the PCT having means and the providers being required to take out considerable insurance. Cockerill J considered that for any question of joint liability to arise, there would be a need for a much greater degree of integration and control (§175-176).

(4) Crown Proceedings Act 1947 (§177-184)

31. The Defendant argued that, if vicarious liability existed, then a claim would be barred by the 1947 Act as the Crown could only be liable for the actions of independent contractors employed by the Crown. The Claimant argued that there was no need for a direct contractual relationship (§178-181)

32. Noting that her finding on vicarious liability meant the point did not arise and made it somewhat artificial, Cockerill J observed that it was not unlikely that if the conditions for vicarious liability were met then (given the aims of the 1947 Act) a court would be likely to conclude that the claim was not statute barred. The statutory provision seems to have been designed to reflect the position at common law and it would be odd for it to be interpreted so as to be out of step with the common law as it had evolved (§182-184).

(5) Intervening acts/causation (§184-202)

33. The Claimant alleged that there had been clinical negligence between January 2011 and January 2013. During that time he spent two periods out of prison. The Defendant submitted that his failure to seek medical treatment when out of prison was unreasonable and broke the causative chain. In response the Claimant contended that any failure to seek medical attention did not '*eclipse'* the repeated failures by healthcare staff (§185-191).

34. Cockerill J found that the Claimant's failure to seek any treatment between January 2011 and April 2011 would have precluded liability for any negligence attributable to the Defendant in early 2011- of which she had found none (§192-194).

35. As to the second period (August 2011 to July 2012), the Defendant did not accept the Claimant's pleaded claim to have attended a GP or Newham Hospital or to have had an appointment for surgery on the lump in July 2012. Cockerill J found that it was '*quite clear that there was nothing done* [by the Claimant] *prior'* to the claimed appointment. In oral evidence, the Claimant admitted that his evidence about a surgery was a lie. The learned judge rejected his evidence that he had an appointment for some other intervention finding no reliance could be placed on it, not least because it was implausible that no relevant records had been

found. The Claimant had failed to seek medical treatment in this second period, likely because his reversion to criminality meant he was avoiding the authorities. His actions had been unreasonable and amounted to an intervening cause (§195-202).

Section 57 of the Criminal Justice and Courts Act 2015 (§203-215)

36. The Defendant argued that the Claimant, having lied about seeking treatment between August 2011 and July 2012 and having based an allegation of negligence on this lie, had been fundamentally dishonest. As this allegation involved a breach of both the direct duty and a non-delegable duty of care it was a central part of the case. The claim should therefore be dismissed under section 57(1)(b).

37. Referring to **Howlett v Davies and Ageas Insurance Limited** [2017] EWCA Civ 1696 and the recent decision of Julian Knowles J in **London Organising Committee of the Olympic and Paralympic Games v Haydn Sinfield** [2018] EWHC 51 (QB), Cockerill J posed three questions (§212):

    (a) Did the Claimant act dishonestly in relation to the primary claim and/or a related claim?

    (b) Has he thus substantially affected the presentation of his case, either in respect of liability or quantum, in a way which potentially adversely affected the defendant in a significant way?

    (c) Would the Claimant suffer substantial injustice if the claim were dismissed?

38. Having answered the first two questions in the affirmative, the learned judge concluded that fundamental dishonesty had been made out. The Claimant's argument if successful would have entitled him to relief on the main claim. As to the third question, Cockerill J found that the Claimant could not rely on substantial injustice, holding (§213-215): *It cannot in my judgement be right to say that substantial injustice would result in disallowing the claim where a claimant has advanced dishonestly a claim which if established would result in*

full compensation. That would be to cut across what the section is trying to achieve... Something more is required.'

The claim under the Human Rights Act 1998 (§216-246)

39. Shortly before trial, the Claimant sought to amend his claim to allege that the successive failures in treatment amounted to degrading treatment contrary to Article 3. The Defendant argued successfully that the HRA claim was time barred (§216-230)

40. For completeness, the learned judge set out her views on the substantive issue. The Defendant argued that it was not the correct defendant for a HRA claim. Cockerill J said that she was '*unconvinced'* by the Claimant's argument that the Court should not take an '*overly formalistic approach'* to identifying the correct defendant and that requiring him to pursue '*myriad alternative defendants'* would breach his right to an effective remedy under Article 13 of the ECHR. The learned judge observed: '*Nor do I see the principled basis on which I could properly hold that the wrong defendant should be permitted to be sued because of difficulties in identifying the right one(s)*' (§232-237).

41. Cockerill J also found that the Claimant's allegations did not meet the '*minimum severity'* test for an arguable breach of Article 3 given there had been medical treatment, there was no malicious intent or differential treatment, there was no gross negligence. Rather it was a case where a system that should have worked had fallen short.

Comment

42. The decision confirms that responsibility for the commissioning and provision of healthcare within the prison estate lies with the NHS and not the Ministry of Justice. The latter has a duty to ensure access to healthcare but whether that duty is breached in any case will depend on the particular facts. The case illustrates the importance of identifying the correct defendant(s) to a claim. That is not always a straightforward exercise given the complex legislative framework and

the modern-day prevalence of outsourcing and sub-contracting in the public sector. Where a claim is brought in reliance on non-delegable duty and vicarious liability, careful analysis of the features and factors identified in **Woodland**, **Armes** and **Various Claimants** is necessary.

43. As to fundamental dishonesty, the decision adds to those recent cases that show that the courts are taking a strict approach to the application of section 57. The threshold for a finding that a claimant would suffer '*substantial injustice*' is not a low one. It would not be enough to rely on the argument that dismissing a claim for one lie would result in a claimant losing compensation.

44. Finally, the learned judge's observations on what is needed for an arguable breach of Article 3 are indicative that ordinary clinical negligence would likely be insufficient to meet the minimum severity threshold.

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