Post Traumatic Stress Disorder and the Law

by

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Contents

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Trevor Hicks studied Physics at Oxford University before qualifying as a doctor at Bristol University in 1985. He served for 7 years as a Royal Air Force Medical Officer both as a General Practioner and as a Military Psychiatrist during the first Gulf War. He then worked as a General Practitioner in the NHS before completing his training as a Psychiatrist with additional experience of forensic psychiatry. He has an interest in medico-legal issues relating to medicine and completed a Master of Laws in the Legal Aspects of Medical Practice at Cardiff University in 2002. He currently works as a Civilian Consultant Psychiatrist in Community Psychiatry at RAF Brize Norton in Oxfordshire and continues to treat Service Personnel suffering from Post Traumatic Stress Disorder.

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Preface

'Nervous shock' cases form an area of law, which illustrates well the operation of judicial policy. It is possible from such cases to trace the changing attitudes of lawyers, doctors and of society in general to psychiatric injury over the last century. These cases also highlight the changing judicial attitudes to the scope of duty of care and to the whole issue of policy decisions.

The recognition of nervous shock similarly illustrates the development of medical knowledge in relation to psychiatric injury. The recognition of Post traumatic Stress Syndrome (PTSD) has been a relatively new and controversial phenomenon and this disorder has now been incorporated into the various classifications of mental disorder as a recognisable psychiatric illness.

This book examines the development of the law and medical knowledge in relation to cases of nervous shock and in particular to PTSD. The expansion and subsequent contraction of liability is shown to be dynamic in nature, as both legal and medical knowledge have increased.

The intention of this book is to provide a concise review of the law comparing it to current medical knowledge in relation to PTSD. The book is intended to be of use to professionals involved in psychiatric injury cases who require an up to date understanding of PTSD.

The law is as stated at 1 September 2002.

Introduction

Canst thou not minister to a mind diseas'd

Pluck from the memory a rooted sorrow,

Raze out the written troubles of the brain,

And with some sweet oblivious antidote

Cleanse the stuff'd bosom of that perilous stuff

Which weighs upon the heart?[1]

Macbeth asked this question after witnessing a multiple murder. Today it could be argued that he was actually describing the classic symptoms of Post Traumatic Stress Disorder (PTSD). Indeed Samuel Pepys was greatly disturbed by the great fire of London and wrote of being 'much terrified in the nights nowadays with dreams of fire and falling down of houses' (September 1666).

It seems historically well known that experiencing or witnessing traumatic events can have a profound and long term effect on the mind and hence it seems surprising that there has ever been any doubt whether the courts should order compensation for those effects in the same way as physical injury to the person has been compensated. However such injury has been treated with a great deal of suspicion by the courts, particularly in the case of negligently inflicted psychiatric injury.

The law has developed in this area partly due to the increasing recognition of psychiatric injury as a genuine and non-trivial form of damage and from the spate of

[1] Shakespeare W. *Macbeth*, Act V, scene iii

disasters, which occurred in the 1980s. In 1985 the Bradford football stadium caught fire followed in 1987 by the *Herald of Free Enterprise* ferry sinking and the Kings Cross Underground fire. In 1998 the ship *Jupiter* sank carrying a number of holidaying schoolchildren near Athens and the *Piper Alpha* oilrig caught fire. In 1989 the dredger *Bowbelle* sank the riverboat *Marchioness* on the River Thames and the Hillsborough football stadium occurred. The latter resulted in the seminal House of Lords review of this area of law in *Alcock v Chief Constable of the South Yorkshire Police*.[2] As litigation ensued compensation was sought for psychiatric injury or 'nervous shock.'

Chapter 1 provides a brief history of the medical recognition of 'nervous shock' and the recognition of the condition now known as Post traumatic Stress Disorder (PTSD). The classification and diagnosis of PTSD by the *Diagnostic and Statistical Manual of Mental Disorders*[3] and the *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*[4] is contrasted and compared. The use of assessment instruments is discussed as an adjunct to diagnosing PTSD.

Chapter 2 provides a brief history of the legal recognition of 'nervous shock' and the preconditions for recovery of negligently inflicted psychiatric injury. The Judicial Studies Board guidelines are then discussed as they relate to PTSD. The chapter ends by considering the new Civil Procedure Rules as the mechanism by which civil cases are now heard in relation to psychiatric injury.

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[2] *Alcock v Chief Constable of the South Yorkshire Police* [1992] 1 AC 310

[3] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association 2000

Chapter 3 explores the expansion of liability that took place in the 1990s as reflected in cases brought claiming damages for psychiatric injury and PTSD. The seminal case of *Alcock* is then examined and the subsequent contraction of liability by the use of the *Alcock* 'control mechanisms' discussed.

Chapter 4 examines the Law Commission's Consultation Paper and subsequent Report on Liability for Psychiatric Injury. Future potential developments in the law such as the expanding areas of workplace stress, bullying and asylum seekers are discussed. The expansion in medical knowledge regarding PTSD is considered including the future potential developments in diagnosis and treatment.

Chapter 5 concludes the book by considering how medicine has integrated with the law.

[4] Sartorius N. *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (1992 WHO)

Chapter 1 History of the Development of Medical Knowledge about PTSD

This chapter will examine the history of the medical recognition of 'nervous shock' and the way in which mental disorders are now classified. The advantages and disadvantages of the different classification systems will then be compared and contrasted as well as the limitations in their use in respect to the diagnosis of PTSD. The potential differential diagnoses of PTSD are considered together with the use of assessment tools, which may be used to help distinguish between them.

1.1 Medical Recognition of Nervous Shock

The 19th century saw the development of the railway system and an increasing number of claims for injury arose out of railway accidents. Writers such as Grischsen identified a clinical pattern of symptoms following railway accidents. He described post accident symptoms such as 'severe and prolonged' nervous shock; 'weariness', 'cramps', 'twitching' and the condition he described soon became known as 'railway spine.'[5]

In 1875 Professor Erichsen described how in his view trauma could cause 'concussion of the spine'.[6] His views were however challenged by others such as Herbert Page who was a Surgeon to the London and North West Railway. Page introduced instead the concept of 'nervous shock' where he cited cases where in his view manifestations of shock were greater in cases which caused the victim greater fright.

[5] Grichen D., *Nervous Shock and Other Obscure Injuries of the Nervous System in the Clinical and Medico-Legal Aspect* 1882

[6] Erichsen J. *Concussion of the Spine: Nervous Shock and Other Obscure Injuries of the Nervous System in Their Clinical and medico-legal Aspects* cited in Napier M. & Wheat K. *Recovering Damages for Psychiatric Injury* (1st ed 1995, Blackstone) p 37

The American Civil war produced examples of psychiatric injury described as neurasthenia (physical and mental exhaustion) and other symptoms such as pains in the chest, breathlessness and weakness.

Later the horrors of the First World War produced many cases as Mott described of 'shell shock' or 'battle stress' which would now be recognised as PTSD.[7] Shell shock still maintained its links with physical medicine as it was thought to be due to minute haemorrhages in the brain caused by explosions. However when shell shock was found in those without a history of physical injury it was thought instead to be due to some weakness of character. The effects of war stress were strictly controlled by military discipline including the shooting of 346 men during the First World War who were labelled as 'cowards'.

Clinicians increasingly recognised that traumatic events can lead to psychological disturbance and began to systematically record descriptions of the symptoms associated with traumatic stress reactions. These included the spontaneous re-experiencing of aspects of the traumatic events, startle responses, irritability, impairment in concentration and memory, disturbed sleep, distressing dreams, depression, phobias, guilt, psychic numbing and multiple somatic (physical) symptoms. A variety of labels were used to describe these reactions including 'fright neurosis', 'combat/war neurosis', 'shell-shock', 'survivor syndrome', and 'nuclearism'.

[7] Mott F.W. *War Neuroses and Shell Shock* (1919 Oxford University Press)

The Second World War produced further psychiatric casualties and psychiatrists increasingly described their symptoms in terms of 'traumatic war neurosis'.[8]

Later the Vietnam War highlighted the social impact of the diagnosis of PTSD and prompted Stone to state:

> *'...no diagnosis in the history of American psychiatry has had a more dramatic and pervasive impact on law and social justice than PTSD…Vietnam veterans previously stigmatised…were transformed from social outcasts into victims viewed from the PTSD perspective…'.*[9]

Similar traumatic stress reactions have been described in civilian populations such as in the survivors of the fire at Boston's Coconut Grove nightclub.[10] Clinicians and researchers realised that even people considered to have sound personalities could develop clinically significant and long-standing psychological symptoms if they are exposed to horrific stressors such as rape, child sexual abuse or natural disasters such as floods and hurricanes.

Currently the National Center for PTSD in the United States tracks journal articles, books, technical reports and doctoral books that are written on the subject.[11] The growth in popularity of the diagnosis of PTSD is reflected in that more than 18,000 publications on the subject have been indexed to date.

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[8] Rado S. Pathodynamics and treatment of traumatic war neurosis [traumatophobia] (1942) 42 *Psychosomatic Medicine* 363-368

[9] Stone A.A. Post Traumatic Stress Disorder and the law: Critical Review of the New Frontier. *Bull American Academy Psychiatry Law* (1993) 21 at 23-36

[10] Adler A. Neuropsychiatric complications in victims of Boston's Coconut Grove disaster (1943) 123 *Journal of the American Medical Association* 1098-1101

[11] National Center for PTSD: PILOTS Database <http://www.ncptsd.org>

The diagnosis of PTSD has not been without controversy and clinicians such as Summerfield have criticised the global spread of the diagnosis of PTSD as a basis for capturing and addressing the impact of events like wars regardless of the background culture, current situation and subjective meaning brought to the experience by survivors.[12] Summerfield has stated:

> *'...the misery and horror of events such as war are reduced to a technical issue tailored to Western approaches to mental health. In Western societies the conflation of distress with "trauma" has become part of everyday descriptions of life's vicissitudes.'*[13]

Summerfield argues that the profile of PTSD has risen spectacularly, and it has become the means by which people seek victim status and its associated moral high ground in pursuit of recognition and compensation. An editorial in the *American Journal of Psychiatry* commented that it was rare to find a psychiatric diagnosis that anyone liked to have but PTSD was one.[14]

Whilst PTSD has become medically recognised there remains the problem of translating this into a form, which would be useful as a legal concept. Sparr explained the problem thus:

> *'...psychiatrists work from a framework seemingly incompatible with that used in law. Lawyers…want clear answers to clear questions so that a judge can make a clear decision…psychiatrists may seem to want to answer a different*

[12] Summerfield D., The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category (2001) 322 *British Medical Journal* 95 at 96
[13] *Ibid.*
[14] Andreasen N.C., Posttraumatic stress disorder: psychology, biology and the Manichaean warfare between false dichotomies. *Am J Psychiatry* (1995) 152 963 – 965

question. They are mostly trained to find out how to make their patient well… '[15]

Professor Eastman, Head of the Department of Medical Ethics, at Kings College London has had the benefit of a training in both the law and medicine and has said:

'...there is no direct coherence between medical and legal concepts, or between medical and legal ways of thinking. As a result, there are often substantial difficulties in translating the findings of one [medicine] *into the decision of the other* [law]. *In order to minimise inter-disciplinary confusion, it is necessary for each to have an understanding of the approach of the other.* '[16]

1.2 Classification of Mental Disorders

Historically physicians have considered that mental disorder arising from physical causes be termed 'organic' and those, which have not to be termed 'functional'. The functional group can include psychoses such as schizophrenia and manic depression whilst neurotic conditions include conditions such as anxiety, depression and PTSD. 'Nervous shock' can hence present in a number of different ways.

There are two main published classifications to mental disorders. The first is *Diagnostic and Statistical Manual of Mental Disorders*[17] published by the American Psychiatric Association, the current edition being the text revision of the 4th edition. It is used mainly by American Psychiatrists. The second is the *ICD-10 Classification of*

[15] Sparr L.F. Post Traumatic Stress Disorder Does it Exist? *Neurologic Clinics* 13 at 413-429
[16] Eastman N. Assessing for Psychiatric Injury and Nervous Shock *Advances in Psychiatric Treatment* (1995) 1 at 154-160
[17] *Op. cit.* fn 3

Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines[18], which is the 10th revision of the international classification of diseases and related health problems, published by the World Health Organisation (WHO). The majority of psychiatrists working in the United Kingdom generally use this classification system.

1.2.1 DSM-IV-TR

It was not until 1980 when the 3rd edition of the American Psychiatric Association's Diagnostic and Statistical manual (DSM III) was published that PTSD was finally recognised and given a separate diagnostic heading. DSM III was updated to DSM III R (revision) in 1987 and to DSM IV in 1994. The latest version is the DSM-IV-TR (text revision), which was published in 2000.[19]

Originally a prerequisite for developing PTSD was that the sufferer had to have experienced an event that is 'outside the range of usual experience' and that it 'would be markedly distressing to almost anyone'. This would exclude common experiences such as bereavement, business loss or marital conflict. However studies show that stressors that can lead to PTSD are actually quite common, for example road traffic accidents[20] or sexual assault.[21] Thus the DSM III definition appeared too restrictive. Scringar has described in detail the sort of trauma, which is necessary as a stressor to precipitate PTSD by reference to 'the traumatic principle'.[22]

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[18] *Op. cit.* fn 4
[19] *Op. cit.* fn 3
[20] Norris F.H. Epidemiology of trauma: frequency and impact of different potentially traumatic events on different demographic groups. (1992) 60 *Journal of Consulting and Clinical Psychology* 409-18
[21] Resnick *et al* Prevalence of civilian trauma and post-traumatic stress disorder in a representative national sample of women *Journal of Consulting and Clinical Psychology* (1993) 61 p 984-91
[22] Scrignar C.B. *Post-traumatic Stress Disorder* (2nd ed 1988 Bruno Press) p 13

The DSM III prerequisite is no longer required under the latest DSM-IV-TR classification and reflects the variety of ways that each individual can experience and be affected by stress. The current DSM-IV-TR describes needing:

> *'...exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate'.*[23]

It is not clear what constitutes 'serious' harm or injury but it would appear that it is not only the situation that is important but also the complainant's subjective experience of the threat or event that is important requiring that the 'person's response involved intense fear, helplessness, or horror'. This latter criterion takes into account that there is a large interindividual variability in the psychological response to the same situation.

In DSM-IV-TR PTSD is classified as disorder number 309.81 under anxiety disorders because of the similarity in symptom pattern and effectiveness of exposure treatment and drugs used in anxiety. However some of the symptoms would also suggest a relationship with dissociative disorders (e.g. amnesia) or depression (e.g. loss of interest). The DSM-IV-TR diagnostic criteria are reproduced at appendix 2 and the DSM-IV-TR description of PTSD at appendix 3.

[23] *Op. cit.,* fn 3 p 463

1.2.2 Issues Relating to the use of DSM - IV

There are several stated limitations to the use of the Diagnostic and Statistical Manual of Mental Disorders as follows:

Limitations of the Categorical Approach

> *'...there is no assumption that each category of mental disorder is a completely discreet entity with absolute boundaries dividing it from other mental disorders or from no mental disorder…'*[24]

Use of Clinical Judgement

> *'...DSM – IV is a classification of mental disorders that was developed for use in clinical, educational and research settings…diagnostic criteria included in DSM – IV are meant to serve as guidelines to be informed by clinical judgement and are not meant to be used in cookbook fashion…'*[25]

Use of DSM – IV in Forensic Settings

> *'... when the DSM – IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM – IV mental disorder is not sufficient to establish*

[24] *Ibid.* at xxxi

the existence for legal purposes of a 'mental disorder', 'mental disability,' 'mental disease' or 'mental defect'. In determining whether an individual meets a specified legal standard (e.g. for competence, criminal responsibility, or disability) additional information is usually required beyond that contained in the DSM – IV diagnosis...[the] *diagnosis does not carry any necessary implications regarding the causes'.*[26]

Whilst acknowledging these limitations the DSM-IV-TR is widely used as a classification system to support diagnoses in legal settings.

1.2.3 ICD-10

The Glossary of Mental Disorders in the International Classification of Diseases first recognised PTSD in 1987. In the latest ICD-10 version PTSD is classified under the category of neurotic, stress-related and somatoform disorders. This category includes those disorders characterised by reactions to severe stress and adjustment disorders. The ICD-10 description and diagnostic guidelines are reproduced at appendix 1.

The ICD-10 however provides no additional help in defining what constitutes the specific sort of trauma needed to cause PTSD other than describing it:

'...[as a] *response to a stressful event or situation (either short- or long lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made*

[25] *Ibid.* at xxxii
[26] *Ibid.*

disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime)'.[27]

Whilst 'serious' is again not defined it would appear that the important issue is the subjective experience of the victim. The ICD-10 definition is generally broader than the DSM-IV-TR criteria and implies a more common-sense understanding of which situations are likely to be extremely distressing. The ICD-10 definition implies that 'near misses' in addition to actual completed events such as road traffic accidents would also fulfil the criteria.

ICD-10 states that:

'This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A "probable" diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible'.[28]

1.2.4 ICD-10 versus DSM-IV-TR

The diagnostic systems above agree on the core symptoms of PTSD – re-experiencing, avoidance, emotional numbing, and hyperarousal – but differ in the weight assigned to them.

[27] *Op cit.* fn 4 p 147
[28] *Ibid.* p 148

DSM-IV-TR puts a stronger emphasis on the avoidance/numbing cluster of symptoms by requiring a minimum of three of these symptoms. Although emotional numbing is listed prominently in the ICD-10 diagnostic guidelines patients that meet ICD-10 criteria may not fulfil the criteria for a DSM-IV-TR diagnosis of PTSD if they have too few of these symptoms. They would be diagnosed instead as having an adjustment disorder according to the DSM-IV-TR.

The ICD-10 requires a patient to suffer from psychogenic amnesia (stress induced loss of memory) *or* hyperarousal symptoms. Thus in contrast to DSM IV-TR a patient could be diagnosed as having PTSD in the absence of hyperarousal symptoms if amnesia is present under the ICD-10 classification.

The DSM-IV-TR adopts two additional criteria that are not included in the ICD-10. The first is that there must be a symptom duration of more than one month otherwise an acute stress disorder would be diagnosed. Second it requires that the symptoms cause significant distress or impaired functioning.

Thus although the diagnostic systems largely agree on the type of symptoms that characterise PTSD the DSM-IV-TR criteria are stricter. This was confirmed in a recent large-scale study, which found a prevalence (number of cases in the community at any one time) of ICD-10 PTSD of 6.9% and a prevalence of DSM-IV-TR PTSD of 3%.[29]

[29] Andrews *et al* Classification in Psychiatry: ICD-10 versus DSM-IV (1999) 174 *British Journal of Psychiatry* 3-5

The DSM IV-TR is explicit in giving guidance on alternative diagnoses to PTSD such as the criteria for adjustment disorder where the stressor can be of any severity rather than extreme.[30] Also it makes clear that symptoms of avoidance, numbing and increased arousal that are present *before* exposure to the stressor do not meet criteria for the diagnosis of PTSD and other diagnoses such as mood or other anxiety disorder needs to be considered. Moreover if the symptom response pattern to the extreme stressor meets criteria for another mental disorder then these diagnoses should be given instead of or in addition to PTSD.

1.3 Assessment Instruments

Several semi-structured interviews assess the DSM-IV criteria for PTSD. The Structured Clinical Interview for DSM-IV (SCID) allows one to establish the diagnosis of PTSD.[31] The Clinician Administered PTSD Scale (CAPS)[32] and the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)[33] provide measures of symptom severity as well as establishing the diagnosis of PTSD.

The most widely used self-report measure of PTSD symptoms used to be the Impact of Events Scale.[34] The original two scales contained an intrusion and an avoidance scale. It has recently been expanded to include an additional hyperarousal scale (IES-R).[35] The IES-R does not cover all the symptoms of PTSD specified in DSM-IV.

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[30] *Op. cit.* fn 3 p 467
[31] First M.B. *et al., Structured Clinical Interview for DSM-IV Axis 1 Disorders-Clinician Version (SCID-CV).* Washington, DC (1st ed 1995 American Psychiatric Press)
[32] Blake D.D. *et al.,* The development of a clinician-administered PTSD scale (1995) 8 *Journal of Traumatic Stress* 75-90
[33] Brown T.A. *et al.* Anxiety disorders interview schedule for DSM-IV (1994) Graywind Albany NY
[34] Horrowitz *et al.* Impact of Event Scale: a measure of subjective stress. (1979) 41 *Psychosomatic Medicine* 209-18
[35] Weiss D.S. & Marmar C.R. The Impact of Event Scale-Revised. (1997) Cited in *Assessing psychological trauma and PTSD* (1997 Guilford Press New York) 399-411

This is why new measures that are modelled on the DSM-IV criteria are now commonly used in research studies, for example the Post traumatic Stress Diagnostic Scale (PDS).[36]

These assessment instruments are generally used as additional tools to confirm the diagnosis of PTSD following a mental state examination carried out by a psychiatrist.

[36] Foa E.B. *et al.* The validation of a self-report measure of post traumatic stress disorder: the post traumatic diagnostic scale. (1997) 9 *Psychological Assessment* 445-51

Chapter 2 History of the Development of the Law regarding PTSD

This chapter begins by examining the historical legal recognition of nervous shock and the way the law has considered and dealt with various classes of claimant within the general principles of negligence. The way in which the law has developed with particular regard to claimants with a diagnosis of PTSD is discussed and the way in which they have received special consideration from the law when awarded damages in accordance with guidelines issued by the Judicial Studies Board. This chapter concludes by considering the New Civil Procedure Rules as a development of the law intended to simplify the means of achieving compensation.

2.1 Recognised Psychiatric Illness or Ordinary Mental Distress

The courts draw a distinction between claims in respect of medically recognised psychiatric illness such as PTSD and claims for grief, sorrow or 'ordinary mental distress'. The latter symptoms are generally afforded no remedy at law. Lord Denning made it clear in *Hinz v Berry*[37] that in English law no damages are awarded for grief or sorrow caused by a person's death.

Subsequent to that decision however a sum has become payable for bereavement in limited circumstances under the Fatal Accidents Act 1976.[38] The recent case of *Yardim and others v North Middlesex Hospital NHS Trust and Barnett & Chase Farm Hospitals NHS Trust*[39] was brought under this Act by close relatives of a man who

[37] *Hinz v Berry* [1970] QB 40
[38] Fatal Accidents Act 1976
[39] *Yardim and others v North Middlesex Hospital NHS Trust and Barnett & Chase Farm Hospitals NHS Trust* QBD 20 November 2001