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Ampersand Advocates Clinical Negligence Seminar 27th October 2025



Welcome

Isla Davie KC



Ampersand Advocates Clinical Negligence Conference 2025

'Who is [are] the patient[s]: redefining primary victims post-*Paul'*

Sarah McWhirter, Advocate

27th October 2025



'Who is [are] the patient[s]?'

Primary victim claims: limited only to the 'principal patient'?

- A. The 'primary v. secondary victim' distinction
- B. The 'participating in the injury'
- C. The 'property damage' cases
- D. The 'wrongful birth' cases
- E. The 'non-patient' cases



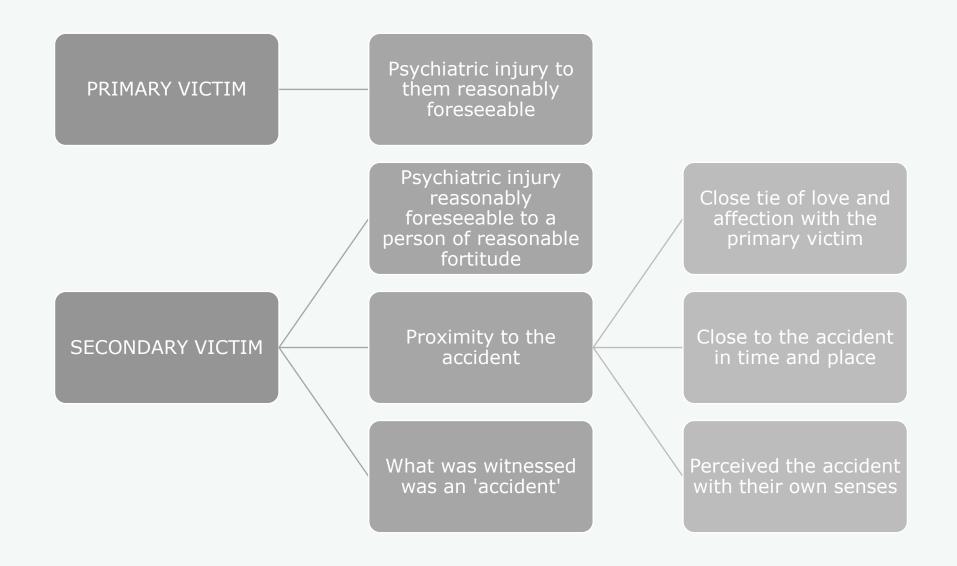
A. The 'primary v. secondary victim' distinction

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

- <u>Primary victim</u> = "involved, either mediately or immediately as a participant"
- <u>Secondary victim</u> = "no more than the passive and unwilling witness of injury caused to others"

Classification affirmed by the Supreme Court in *Paul & Anr v Royal Wolverhampton NHS Trust* [2024] UKSC 1







B. The 'participating in the injury' cases

= Where the pursuer has suffered psychiatric injury and believed themself to be a participant in the accident, but was not themself physically injured.

Salter v UB Frozen & Chilled Foods Ltd 2004 S.C. 233

- Forklift operator suffered psychiatric injuries after being involved in workplace accident, in which a colleague was fatally injured.
- The forklift operator was not at fault for the accident, but he blamed himself.
- Held: primary victim because he was an active participant in the accident, albeit blameless.



Tredget v Bexley Health Authority [1994] 2 WLUK 77

- Alleged negligence was that the mother should have been advised to have a Caesarean section. Instead, there was a prolonged labour, vacuum extraction, shoulder dystocia and the baby was born in very poor condition, requiring immediate resuscitation.
- Both parents present in the delivery room. The atmosphere was 'pandemonium.' The father was asked to help by encouraging his wife.
- Held: both parents successfully recovered damages for psychiatric injury.
- Judge White placed emphasis on the father's participation in the birth.



Tredget v Bexley Health Authority (cont.)

Mr Tredget not explicitly classified as a primary victim.

But, the language used is more akin to primary victim.

Paul – classified as secondary victim, but didn't overrule.

Academic commentary – mixed.

Watch this space...?!



C. The 'property damage' cases

= Where the pursuer has suffered psychiatric injury due to witnessing the destruction of their property.

Holdich v. Lothian Health Board 2014 S.L.T. 495

- Claim brought for damage caused to the pursuer's sperm samples, rendering them unusable.
- Pursuer had deposited the samples prior to receiving cancer treatment.
- Pursuer sought compensation for distress, depression and loss of the chance of fatherhood.
- Held at Debate: the case was allowed to proceed to probation on the basis of breach of contract and delict.



Holdich v. Lothian Health Board (Cont.)

3 requirements to claim for 'property damage':

- 1. A 'wrongful harm' committed to the interests of the pursuer;
- 2. A 'proximate relationship' between the parties; and
- 3. 'Reasonably foreseeable' harm.

Watch this space...?!



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D. The 'wrongful birth' cases

= Where the pursuer would have chosen to terminate if warned of the risks of continuing with pregnancy.

Similar analysis to 'wrongful conception' but distinguish from 'wrongful life'.

Is the father the patient?



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Anderson v Forth Valley Health Board 1998 S.L.T. 588

- Failure to provide genetic counselling
- Damages awarded to both parents.
- Married and directly affected by services relating to pregnancy, childbirth, abortion and contraception.
- Duty owed to extent reasonably expected father would be significantly involved in upbringing of child
- Duty of midwife to consider this?



McLelland v Glasgow Health Board [2001] SLT 446

- Failure to carry out amniocentesis to test for Down's Syndrome.
- Lord Prosser father not a secondary victim.
- Both parents relied on information to make decisions re pregnancy.
- Both parents would suffer severe shock and distress.
- Decision to terminate question for mother?



Goodwill v British Pregnancy Advisory Service [1996] 1 WLR 1397

- Father had an affair with the claimant.
- Claimant and father not in a relationship.
- Failed vasectomy.
- Claim failed.
- Could not be 'reasonably known' that the claimant would act in reliance of the vasectomy.
- Claimant member of an 'an indeterminately large class of females'.



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E. The 'non-patient' cases

=Duties owed to individuals who are not the patient i.e. sexual partner of a patient with HIV who the doctor fails to diagnose.

Paul – touched on but no view expressed.



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BT v Oei [1999] NSWSC 1082

- Failure to diagnose HIV in the presence of symptoms.
- HIV contracted by the patient's partner.
- Doctor did not know about the relationship.
- Causation established patient would have disclosed HIV status.
- Held: doctor did owe a duty of care.
 - Reasonable foreseeability
 - Public policy



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ABC v St. George's Healthcare NHS Trust [2020] PIQR P13

- Father detained under the Mental Health Act.
- Claimant attended family counselling sessions with her father.
- Father diagnosed with Huntingdon's disease.
- Diagnosis not disclosed to claimant.
- Claimant owed duty of care to have the genetic risk disclosed?
- Held: Balancing act needed:
 - Claimant's interest in being alerted to the genetic risk v -
 - The interest of her father in having his confidentiality preserved – v-
 - Public interest in maintaining confidentiality.



Where now... watch this space!



Any questions?

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References

- Paul & Anr v Royal Wolverhampton NHS Trust [2024] UKSC 1
- Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310
- Salter v UB Frozen & Chilled Foods Ltd 2004 S.C. 233
- Tredget v Bexley Health Authority (1994) 5 Med LR 178
- Holdich v. Lothian Health Board 2014 SLT 495
- Anderson v Forth Valley Health Board 1998 S.L.T. 588
- McLelland v Glasgow Health Board [2001] SLT 446
- Goodwill v British Pregnancy Advisory Service [1996] 1 WLR 1397
- BT v Oei [1999] NSWSC 1082



Bringing Out the Best Evidence: Recognising and Responding to Witness Vulnerability

Lisa Henderson KC



Clinical Negligence: Case Law Update

Scott Clair, Advocate Ampersand Advocates

27 October 2025



A tale of four cases

1. Limitation and Section 19A extensions in fatal cases:

Simpson v Dumfries and Galloway Health Board [2025] SAC (Civ) 12

2. Averments of direct liability at debate:

NM v Henderson [2025] CSIH 22; 2025 S.L.T. 1015

3. Scrutiny of expert opinion on breach of duty:

DS v NHS Grampian [2025] SAC (Civ) 21; 2025 S.L.T. (SAC) 87

4. Late acceptance of tenders and disapplication of QOCS:

Gasper v Tain & Fearn Area Medical Practice [2025] CSOH 96



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- Decision of the Sheriff Appeal Court, 28 April 2025.
- Most recent case dealing with section 18 and section 19A of the Prescription and Limitation (Scotland) Act 1973.
- **20 August 2019** the deceased, M, died by suicide; his mother and sister (the pursuers) become aware of his death on that date.
- 4 September 2019 the deceased's mother gives an interview to the press in which she expresses concern over the circumstances of her son's death; within the next fortnight, she seeks legal advice regarding a claim for medical negligence against the health board;
- **21 September 2019** on the advice of solicitors, the pursuers make a joint complaint to the health board, resulting in a Serious Adverse Event Review ('SAER'):
- 6 February 2020 the SAER concludes;
- 21 February 2020 the pursuers' solicitors confirm they cannot act for them as, following the SAER, they place prospects of success at less than 70%; they send several letters to the pursuers confirming medical negligence claims are subject to a three-year limitation period;
- 6 July 2020 the pursuers complain about the SAER response to the Scottish Public Services Ombudsman ('SPSO');
- 28 October 2022 the SPSO upholds the pursuers' complaint; the pursuers then pass matters to a trade union;
- 20 December 2022 a court action was raised against the health board for negligence.



- The health board submitted that the claims were timebarred as the pursuers knew all they needed to know for s.18 purposes by, at the latest, the time of the complaint to the health board i.e. 21 September 2019.
- The action, being raised on 20 December 2022, was therefore timebarred by three months.
- The pursuers claimed they did not have the necessary information until the SPSO response in October 2022 and, so, the action was not timebarred.
- In the event the court found the pursuers were timebarred, they relied on section 19A.



P argued:

- · They had followed the advice given to them by solicitors that their case had little prospects of success;
- Covid was a factor in the more than two-year delay in receiving the SPSO decision;
- There would be significant prejudice to the pursuers in refusing the s.19A application;
- Conversely, the respondent would not be prejudiced by the application being granted as a full investigation into the death had taken place; and
- The delay in the nine-week period between the SPSO decision and the raising of the action was neither unexplained nor excessive.

D argued:

- The pursuers had failed to 'fill the gap' between 28 October 2022 when the papers were passed to the trade union and 20 December 2022, when the action was raised;
- The pursuers admitted they now had the answers they sought to receive from the litigation;
- They had repeatedly ignored the advice given to them by solicitors in relation to timebar; and
- If the application were granted, the health board would be prejudiced as its staff would have to give evidence about and be expected to recall events and conversations many years after the fact.



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- At first instance, HELD The action was timebarred; and though a 'finely balanced decision', it would not be equitable to allow the action to proceed under section 19A.
- The pursuers had repeatedly been advised of the three-year limitation period, but had "paid no heed" to that advice and "closed their minds to raising any proceedings until after the SPSO issued their final decision on 28 October 2022".
- Between the issue of the SAER on 6 February 2020 and the complaint to the SPSO on 6
 July 2020, there was no action.
- Between 6 July 2020 and 10 October 2022, when the SPSO issued its draft Decision Notice, the only action taken was "the second pursuer repeatedly chasing the SPSO for a decision".
- Even after that decision was available, proceedings were not raised promptly, but only after a further delay of around six weeks on 20 December 2022.
- In balancing the prejudice to both parties, that balance lay in favour of the health board.



- The pursuers appealed both the sheriff's decisions: (i) that the action was timebarred;
 and (ii) that it would not be equitable to allow the action to be nonetheless proceeded
 with though timebarred.
- The Sheriff Appeal Court **HELD** -
 - **Timebar** The action was timebarred; the pursuers knew all they needed to by 21 September 2019, yet did not raise proceedings until 20 December 2022.
 - Equitable extension The sheriff's decision to refuse to extend the timebar fell
 within his discretion; there was a lack of cogent explanation for the pursuers
 allowing a limitation period they knew of to expire; that was sufficient reason for
 the sheriff to decline to exercise the section 19A power in their favour.



TIMEBAR - SECTION 18

- The sheriff had not erred in concluding that the appellants ought reasonably to have been aware of the statutory facts required by section 18(2)(b) by the time they sent the letter of complaint on 21 September 2019; the time period begins to run when a pursuer becomes actually or constructively aware that injuries are capable of being attributed to the acts or omissions of an identified person; what is required is not knowledge that the defender's acts or omissions caused the injuries, but rather awareness that the injuries are capable of being attributed to those acts or omissions (paras 17, 21).
- In selecting 21 September 2019 as that date, the sheriff had clearly accepted such awareness was demonstrated by the appellants lodging their complaint on that date (paras 18, 19).
- By comparing the appellants' pleadings with their original letter of complaint, they had consistently held the same position and were aware of what they needed to know in terms of section 18(2)(b) since 21 September 2019; the starting point for the triennium requires only a relatively modest level of awareness (para 20).



EQUITABLE EXTENSION - SECTION 19A

- A pursuer who seeks to rely on the discretion in section 19A bears the onus of satisfying the court that it should
 grant the remedy, and must provide an explanation for the delay that has occurred which is sufficiently cogent to
 justify depriving a defender of what would otherwise have become a complete defence to the cause; the interests
 of both parties and all the relevant circumstances must be considered; and a pursuer seeking to rely on this
 provision must provide an explanation that covers all, not merely part, of the period of delay (para 22).
- The sheriff's finding that the appellants had not discharged the onus on them to justify exercise of the section 19A power fell within his discretion; the explanation advanced by the appellants to explain the delay, in circumstances where they had been repeatedly advised by solicitors that they had three years in which to raise litigation, lacked cogency; that was sufficient reason for the sheriff to refuse to exercise the section 19A discretion in their favour; the equities were equally balanced (para 23).



Averments of direct liability at debate: NM v Henderson [2025] CSIH 22; 2025 S.L.T. 1015

- Decision of the Inner House (Second Division), 15 July 2025.
- NM, a regular ambulance service user, raised an action for damages in respect of an alleged course of abusive conduct against her by an ambulance technician.
- Sued both the technician, as an individual, and the Scottish Ambulance Service Board.
- In summary, NM averred that SASB knew or ought to have known that H posed a risk to vulnerable female ambulance service users.
- NM argued that SASB had failed to act accordingly and therefore had exposed an identifiable class of vulnerable individuals, such as herself, to a foreseeable risk of danger.
- At first instance, **HELD:** the pursuer was not in any defined class of persons under the SASB's special contemplation.
- The Lord Ordinary refused to allow the pursuer's case of direct liability to proceed to proof.
- NM reclaimed.



Averments of direct liability at debate: NM v Henderson [2025] CSIH 22; 2025 S.L.T. 1015

- The Inner House held:
- The question of whether SASB had a direct duty of care to the pursuer turned on whether
 or not it could be characterised as one raising a novel duty of care or whether it could fit
 into existing principles of negligence (para.26);
- The modern authorities had focused on what is pled in considering whether an alleged wrongdoer should have had the victim in their contemplation when considering proximity (para.27);
- NM's case, as pled, was at least capable of bringing her within that ambit; she had averred
 that she was in a particular class, namely, a young woman who had used and could be
 anticipated to continue using the ambulance service; these were clear averments that, if
 proved, may establish she was one of an identifiable class of people likely to use the service
 such that SASB should have had her in their contemplation when placing H on front line
 duties (para.28);



Averments of direct liability at debate: NM v Henderson [2025] CSIH 22; 2025 S.L.T. 1015

- Further, if NM was able to prove the key averments about the failure of SASB to properly
 investigate a complaint about H and reach a conclusion that avoided a continuing danger to
 women such as her, she may be able to demonstrate that SASB knew or ought to have
 known that continuing to deploy H on front line duties created such a risk;
- If these essential elements could be proved, then the case could be decided on the application of existing principles – i.e. without having to consider the existence of a novel duty of care (para.29);
- Accordingly, the case was not bound to fail (para.30);
- However, even had the Court been persuaded that NM's case did not fall into the
 established ambit of duties of care, it would have been 'attracted by the argument' that it
 would, in any event have been fair, just and reasonable to allow NM's claim to proceed in
 the particular circumstances averred (para.31).



Scrutiny of expert opinion on breach of duty: DS v NHS Grampian [2025] SAC (Civ) 21; 2025 S.L.T. (SAC) 87

- Decision of the Sheriff Appeal Court, 16 July 2025.
- The pursuer, DS, sued in respect of an alleged failure by her treating neuroradiologist to report a pineal cyst on an MRI brain scan.
- She claimed that the delay in diagnosis of just over two years had caused her to suffer from headaches, tinnitus and nausea for an additional two years, and to suffer from gastrointestinal problems and anxiety after it was detected.
- At first instance, the sheriff HELD: the treating neuroradiologist's review of the scan was negligent; in so doing, he accepted the evidence led by the pursuer's expert witness, and concluded that the health board's expert had conceded that what the neuroradiologist had done was a mistake; therefore, there was no opposing school of thought among the relevant group of medical practitioners between which he had to choose.
- Despite being awarded damages, DS appealed.
- The health board took the opportunity to cross-appeal against the finding of negligence.



Scrutiny of expert opinion on breach of duty: DS v NHS Grampian [2025] SAC (Civ) 21; 2025 S.L.T. (SAC) 87

- In allowing the health board's cross-appeal, the Court took the opportunity to remind litigants that the third element of the *Hunter v Hanley* test set the bar of what a pursuer had to establish to be successful high (paras.52-53).
- The sheriff had erred in concluding that the parties' respective breach experts did not belong to opposing schools of thought; but, in any event, in such a situation the court should not simply choose between the evidence of competing experts (para.56).
- The correct course when approaching the evidence of competing breach experts was to "heavily scrutinise" the evidence of the expert opining against negligence (para.65).
- The questions to be asked were: (i) Was their opinion 'respectable'?; and (ii) Did it stand up to scrutiny? If the answer to both was 'yes', then the pursuer must fail in proving negligence, as the third limb of *Hunter v Hanley* would not be satisfied.



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- Decision of the Lord Ordinary (Braid), 14 October 2025.
- Delayed diagnosis case alleged failure of defenders to properly examine and investigate the pursuer's symptoms of prostate cancer.
- Defenders denied liability, but lodged a tender for £30,000 net of CRU, on **11 December 2024**.
- The pursuer ultimately accepted the tender on 22 August 2025.
- On the pursuer seeking decree in terms of the tender and acceptance, the
 defenders sought their expenses from the date of the tender to date, in
 respect of the pursuer's late acceptance.



- A reminder unreasonable delay in the acceptance of a tender, if established, provides an exception to qualified one-way costs shifting ('QOCS'): RCS 41B.2(2)(b).
- Where QOCS is disapplied in such circumstances, a pursuer's liability should not exceed 75% of the amount of damages awarded: RCS 41B.3(2)(c).



P argued:

- Having regard to the complexities of the action and the low value of the tender in comparison to the sum sued for, the delay was not unreasonable.
- The pursuer's assessment of the medical evidence evolved and as it did so it became evident that his prognosis would not have been very different had his cancer been diagnosed earlier.
- It was only after a joint meeting of the causation experts in July 2025, when the pursuer's expert departed from his previous advice, that the pursuer was able to appreciate the weakness of his case.
- Only then was it reasonable to accept that the sum tendered was a reasonable assessment of his loss.

D argued:

- The pursuer's expert's opinion, properly read, had never supported his case on causation.
- If anything, his position in the joint meeting was more favourable to the pursuer than his report.
- The defenders had made their position on causation plain from the outset.
- The pursuer had not made out his argument that the medical evidence had evolved unfavourably to him in the manner suggested.



- The Court observed that the language of the pursuer's expert report had not changed from a draft of August 2024 to a further version in June 2025.
- Both drafts referred to the 'possibility' (rather than 'probability') of an improved prognosis on the counterfactual scenario.
- Scrutiny of the expert's position at the joint meeting showed that his view was, by that time, that earlier treatment would have extended survival but would not have been curative.
- HELD the question of whether the delay had been unreasonable was to be viewed objectively.
- Whilst the Court may retain a discretion not to make an award against a pursuer in a case of unreasonable delay, it was difficult to envisage circumstances where that would be appropriate.



- In determining whether any delay had been unreasonable, the range of factors included:
 - The information reasonably available to the pursuer at the time of the tender;
 - Whether further expert evidence or information was reasonably required before the tender could be properly considered; and
 - The stage which the action had reached in a chapter 42A case, it should be borne in mind that by the time of a case management hearing, the parties were required to obtain, and exchange, information including expert evidence.



- At the time the tender was lodged (December 2024), the pursuer had the expert's draft report of August 2024.
- At best, that report left it unclear whether the pursuer's life expectancy would have been longer.
- There was ample time for the pursuer to explore and test that view at consultation long before August 2025, when the tender was accepted.
- Further, the tender was not accepted until some five months after the exchange of draft reports and valuations.
- These factors all pointed to a delay of more than eight months as being unreasonable.
- The only explanation offered by the pursuer was the evolution in the medical evidence, but that was simply not made out.
- It was plain from the chronology that the delay, at least latterly, was caused by the forlorn hope that the defenders would increase their offer, but that did not excuse the delay in accepting the tender.
- It followed that there had been an unreasonable delay by the pursuer in accepting the tender and so the defender was entitled to the expenses from that date.



Thank You.

Scott Clair, Advocate Ampersand Advocates



Seeking successful outcomes for clients in public inquiries

Jamie Dawson KC



Questions & Closing remarks



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