**Psychiatric Injury and the UN Convention on the Rights of Persons with Disabilities**

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***Abstract***

*The rules by which a claimant establishes whether a defendant owed her/him a duty of care vary depending on the type of injury she/he has suffered. In cases involving physical injuries, the rules are relatively straightforward; in psychiatric injury cases, the claimant must go to greater lengths to establish a duty. It is therefore harder for claimants with psychiatric injuries to recover damages from the careless defendants who wronged them. This discriminatory effect has long been a subject of criticism.*

*This paper employs the United Nations Convention on the Rights of Persons with Disabilities (CRPD) to add another voice to the critical chorus. The CRPD, which the UK has ratified, prohibits discrimination on the basis of psychosocial disability; that is, mental impairment. Since the special rules are engaged by, and applicable to, such disabilities, the law of negligence conflicts with the CRPD. This paper concludes that the CRPD strengthens the case for reform.*

**INTRODUCTION**

The rules governing the duty of care in psychiatric injury cases are controversial. In *Alcock v Chief Constable of South Yorkshire Police*,[[2]](#footnote-2) Lord Oliver said that they are not ‘logically defensible’;[[3]](#footnote-3) in *White v Chief Constable of South Yorkshire Police*,[[4]](#footnote-4) Lord Hoffmann lamented that they are not ‘founded upon principle’.[[5]](#footnote-5) Academic criticism has been even more scathing: the rules are ‘invidious’,[[6]](#footnote-6) ‘irrational’[[7]](#footnote-7), ‘arbitrary’,[[8]](#footnote-8) ‘illogical’,[[9]](#footnote-9) ‘ignoble’,[[10]](#footnote-10) ‘a perversion’,[[11]](#footnote-11) ‘indecorous’,[[12]](#footnote-12) ‘dreadful’,[[13]](#footnote-13) ‘inconsistent’,[[14]](#footnote-14) ‘bewildering’[[15]](#footnote-15) and ‘silly’[[16]](#footnote-16) and the law is ‘in disarray’,[[17]](#footnote-17) a ‘lottery’[[18]](#footnote-18) and even a ‘cancer’.[[19]](#footnote-19)

Much of the controversy boils down to a spurious distinction between physical and mental injuries within tort law’s conception of duty. While it is trite that a defendant ordinarily owes a duty to protect others from the reasonably foreseeable risk of *physical* injury he has created,[[20]](#footnote-20) the same straightforward obligation does not arise where there is a risk only of *psychiatric* injury. In those cases, the claimant must go to greater lengths to prove that the defendant owed him a duty. It is therefore harder for claimants who suffer only psychiatric injury to recover compensation. This differential treatment is to blame for the critical chorus which has grown louder over the last 40 years.

This article adds another voice to that chorus by refracting the rules governing duty in psychiatric injury cases through the prism of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD),[[21]](#footnote-21) which the United Kingdom (UK) has signed and ratified. The CRPD prohibits the use of disability as the justification for differential treatment; to do so is to contravene the human rights of persons with disabilities.[[22]](#footnote-22) In light of this, Bartlett says that it is difficult to see how an entire suite of laws pertaining to mental health and capacity is even ‘remotely compliant’ with the CRPD.[[23]](#footnote-23) The core claim of this paper is that the same can be said about the special rules which apply in psychiatric injury cases. Because the presence of a ‘recognisable psychiatric illness’[[24]](#footnote-24) (i.e., a mental impairment) provides the occasion for differential legal treatment, the common law rules discriminate against persons with disabilities. Since the UK has signalled its consent to be bound by the CRPD,[[25]](#footnote-25) it is under a general obligation to modify or abolish the rules in favour of a disability-neutral alternative.[[26]](#footnote-26) The CRPD therefore strengthens the case for reform in this vexed area.

This paper advances an original argument by using the CRPD to augment the existing critiques of the special rules. It also demonstrates how Article 17 of the CRPD might buttress tort law’s corrective function by expressing the same right to integrity which the duty concept arguably exists to protect. In doing so, it adds further heft to a rights-based framing of tort law. The analysis that follows is divided into three parts. Part 1 provides background to the CRPD and introduces its ‘social model’ of disability. It also discusses the Convention’s relevant contents and general implications for English law. Part 2 refracts the special rules through the CRPD’s prism. It shows that there is no reason why they should not fall within the CRPD’s remit. Consequently, the special rules constitute another ‘flashpoint’ between English law and the CRPD.[[27]](#footnote-27) Part 3 evaluates how we might address this incompatibility. Criticism of the rules is nothing new. However, few existing reform proposals would satisfy the CRPD’s requirement of disability-neutrality. The scope for reform is therefore much narrower than many previous blueprints have implied. The only plausible solution is a ‘reasonable foreseeability’ test predicated on a disability-neutral damage concept.

Before embarking on this analysis, it is worth making a few preliminary points. First, there is no settled nomenclature which describes the damage that is the subject of this paper. The traditional label, ‘nervous shock’, is inadequate: it evokes nervous Victorians reaching for the smelling salts and lacks scientificity.[[28]](#footnote-28) It is also misleading: in many cases, ‘nervous shock’ was the mode by which physical injury occurred, rather than the damage itself. The author prefers ‘psychiatric injury’ or ‘mental harm’ and uses them to refer to the adverse psychological consequences of a defendant’s negligence. I also use ‘psychosocial disability’, which may be an appropriate label for a post-CRPD era. Second, although its primary focus is English law, this is not to say that this paper lacks wider relevance. It refers to cases from several common law jurisdictions (Canada, New Zealand, Australia and South Africa), all of which have signed and ratified the CRPD and are bound by it in the same way as the UK. The CRPD is therefore likely to have implications across the common law world. Finally, limited space precludes discussion of the ‘occupational stress’ cases. The duty which a defendant-employer owes her employees requires her to provide a reasonably safe system of work.[[29]](#footnote-29) It does not turn on the presence of disability and therefore has no relevant discriminatory effect.

**PART 1: THE CRPD: BACKGROUND, CONTENT AND IMPLICATIONS**

1. *Background*
2. The provenance of the CRPD

The UN General Assembly adopted the CRPD on 13 December 2006. It was the first human rights treaty of the 21st Century and the fastest-negotiated in history.[[30]](#footnote-30) When it opened for signature on 30 March 2007, a record-breaking 82 countries became signatories.[[31]](#footnote-31) To date, the CRPD has 181 State Parties (including almost every common law jurisdiction[[32]](#footnote-32)) and 96 jurisdictions have ratified its Optional Protocol,[[33]](#footnote-33) which creates a monitoring and enforcement mechanism under the CRPD Committee. The UK was among the first 82 countries to sign the CRPD and later ratified it on 8 June 2009. It also signed and ratified the Optional Protocol in 2009.

Before the CRPD, no human rights treaty applied specifically to disabled people.[[34]](#footnote-34) Any provision that did exist appeared in non-binding UN General Assembly resolutions[[35]](#footnote-35) and took no account of ‘the irreducibility of the experience’ of persons with disabilities.[[36]](#footnote-36) The CRPD heralded a new approach by explicitly reconceiving people with disabilities as ‘rights holders’[[37]](#footnote-37) and extending human rights protections to the 15 per cent of the global population living with disability.[[38]](#footnote-38)

To counter the paternalistic tendency which had traditionally excluded disabled people, the UN invited civil society organisations to help frame the CRPD. Around 800 groups formed the ‘International Disability Caucus’ (IDC) and carried out ‘considerable campaigning and awareness-raising work’.[[39]](#footnote-39) The slogan ‘nothing about us without us’ informed the entire course of the CRPD’s negotiations. As a result, the CRPD reflects the radical participatory environment in which it was conceived. Its ‘social’ conception of disability and the principles of ‘non-discrimination’ and ‘equality’ bear the clearest imprint of the IDC’s impact.

1. The ‘social model’ of disability

The ‘social model’ locates disabilities ‘within the social organisation and discriminatory attitudes of society’.[[40]](#footnote-40) It is distinct from the ‘medical’ model, which locates disability within individuals.[[41]](#footnote-41) The social model assumes that society must adapt to the needs of individuals, not the other way round.[[42]](#footnote-42) From this perspective, disability is not something which a person suffers as a consequence of an impairment; rather, it is ‘experienced as oppression by social structures and practices’.[[43]](#footnote-43) The social model therefore represents a ‘radical modification of the social norm’.[[44]](#footnote-44)

Article 1 states that the CRPD’s purpose is to ‘promote, protect and ensure the full and equal enjoyment of all human rights by all persons with disabilities’. Its language is unequivocal. To that end, Article 5 requires States Parties to (1) recognise that ‘all persons are equal before and under the law’ and entitled without discriminationto its equal protection and benefit,[[45]](#footnote-45) and (2) prohibit ‘all discrimination on the basis of disability’.[[46]](#footnote-46) The concepts of ‘equality’ and ‘non-discrimination’ are therefore fundamental and ‘permeate the whole Convention’.[[47]](#footnote-47)

It is difficult to dispute that the CRPD ushered in a ‘new era’.[[48]](#footnote-48) Its ‘universalist approach’ *expects* that difference exists within society and actively caters for it.[[49]](#footnote-49) This rendition of equality marks a radical departure from existing human rights frameworks, whose protections may cease where disability begins. For example, the European Convention on Human Rights and Fundamental Freedoms (ECHR) permits differential treatment on grounds of disability.[[50]](#footnote-50) The CRPD makes no such exception and starts from a wholly different premise,[[51]](#footnote-51) which has implications for any laws currently animated by disability – including the special rules governing duty in negligence.

1. *Content*

What all this means for tort law is perhaps not immediately obvious. It is enough to discuss only the CRPD’s relevant provisions, concerning (i) questions of definition (Article 1), (ii) the general obligations it places on its States Parties (Article 4), (iii) access to justice (Article 13), and (iv) the right to integrity (Article 17).

1. Article 1: the definition of ‘disability’

*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which… may hinder their full and effective participation in society on an equal basis with others*.[[52]](#footnote-52)

Article 1 does not define ‘disability’. Instead, it defines ‘persons with disabilities’, albeit non-exhaustively: note the telling use of the word ‘include’. This leaves open the possibility that other impairments or combinations thereof may qualify.[[53]](#footnote-53) Article 1 also appears to conflate ‘impairment’ and ‘disability’, which poses tricky questions of interpretation. As Bartlett says, the result ‘is not entirely satisfactory’.[[54]](#footnote-54) The omission of definitions may be deliberate: exclusionary definitions would be at odds with the CRPD’s universalising spirit.[[55]](#footnote-55) But the absence of clarity jeopardises consistent application, perhaps undermining its very purpose.[[56]](#footnote-56)

There are, however, three things about which we can be fairly certain. First, ‘mental’ impairments fall within the scope of the CRPD. By extension, ‘psychiatric’ impairments must similarly engage the Convention’s protections. The reason for this is that the CRPD apparatus now prefers to describe mental, intellectual and cognitive impairments as ‘psychosocial disabilities’.[[57]](#footnote-57) The World Network of Users and Survivors of Psychiatry (WNUSP), an advocacy group involved in the CRPD negotiations, first coined this term to capture the interaction between psychological and social-cultural components of disability.[[58]](#footnote-58) It prefers the term ‘psychosocial disability’ as a substitute for ‘mental impairment’.[[59]](#footnote-59) The UN Committee on the Rights of Persons with Disabilities has since included ‘psychosocial impairment’ in its definition of ‘disability’.[[60]](#footnote-60) ‘Psychosocial disability’ includes a wider range of impairments, such as ‘mental disorders, organic brain damage, learning disabilities and intellectual disability’.[[61]](#footnote-61) This expansive interpretation is significant: it suggests that psychiatricinjuries that can sound in damages will fall within the CRPD’s scope.

Second, the use of the disjunctive in the phrase ‘physical, mental, intellectual *or* sensory impairments’ implies that these different categories are equally worthy of the CRPD’s protection. Physical impairments do not have any precedence over their mental analogues; nor are they a necessary condition of the CRPD’s protection. Therefore, there is no reason why physical impairments should enjoy a privileged status in law over their psychiatric equivalents. The CRPD assumes that people with mental impairments (or ‘psychosocial disabilities’) are equally entitled to the same protections as their physically-impaired counterparts.

Third, there is nothing to suggest that the CRPD’s ambit is limited to congenital impairments. Although Article 1 defines ‘persons with disabilities’ as those with ‘long-term’ impairments, this does not exclude the possibility that a person with an *acquired* impairment (e.g., one occasioned by a defendant’s negligence) might also qualify for the CRPD’s protection. Kayess and French thought that the temporal modifier ‘long-term’ expressly excluded impairments ‘arising from traumatic injuries and disease’.[[62]](#footnote-62) That might exclude the same psychiatric impairments with which the special rules in tort law are concerned. Yet Kayess and French were not writing with those rules in mind and their distinction appears rather spurious: a sudden, shocking traumatic injury might nevertheless give rise to ‘long-term’ psychological consequences. It would conflict with the CRPD’s universalising spirit if the *mode* by which an impairment occurs were to make such a difference. Moreover, ‘long-term’ in the text of Article 1 could just as plausibly *reinforce* the CRPD’s relevance in tort law. In 1954, Goodhart argued that a mere ‘temporary upset’ would not be sufficient to constitute nervous shock; the damage must result in a ‘serious illness’.[[63]](#footnote-63) On this view, psychiatric injuries that sound in damages are, by definition, ‘long-term’ impairments. Even if this is unconvincing, the fact that the CRPD does not specify what will amount to a ‘long-term’ impairment leaves much open to interpretation. This is surely a deliberate inclusionary tactic rather than a drafting oversight.

It follows that there is nothing in Article 1 that prevents us from concluding that psychiatric injuries for which a court might award damages can constitute impairments within the meaning of the CRPD.

1. Article 4: General obligations

The text of Article 4(1) says:

*States Parties undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.*[[64]](#footnote-64)

Article 4(1)(b) places an obligation on States Parties to modify or abolish domestic laws which ‘constitute discrimination against persons with disabilities’. That means that a State Party must amend or repeal *any* laws – presumably including the laws of tort – whose effect is to impair or nullify ‘the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field’.[[65]](#footnote-65) We will see shortly that the special rules have just that effect.

1. Article 13: Access to justice

Article 13(1) says that *‘States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others…’* Anything which might obstruct access to justice – such as a denial of a duty of care in negligence – specifically on the basis of the person’s disabilities, will therefore violate the CRPD.

1. Article 17: Right to integrity

Article 17 states:

*Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others*.[[66]](#footnote-66)

Article 17 was perhaps ‘the most contentious’ provision.[[67]](#footnote-67) Originally, it sought to protect the right to integrity of persons who might be subject to involuntary care and treatment.[[68]](#footnote-68) Following various disagreements, the Convention’s authors diluted its effect. Bartlett neatly describes the resulting problem: Article 17 either ‘accomplishes virtually nothing’ or, as a new provision in international law, it must mean *something*.[[69]](#footnote-69)

There are two things to take from Article 17. The first is that it refers specifically to ‘mental integrity’ and is therefore notionally applicable in the context of psychiatric injury. Second, if a right creates a corresponding duty to protect it,[[70]](#footnote-70) the duty of care in psychiatric injury cases may be the corollary of the right to mental integrity as described by the CRPD. If this is true, then Article 17 – and the CRPD more broadly – might provide a rights-based rationale for the realignment of the duty concept. We will return to analyse this point later.

1. *General Implications*

The UK has not incorporated the CRPD, so it does not enjoy the same status as the ECHR.[[71]](#footnote-71) At best, it expresses an emerging international consensus.[[72]](#footnote-72) Unless Parliament incorporates it, the CRPD can only ever be of interpretive interest. It is therefore tempting to conclude that the CRPD has few serious implications for English law. Yet such a hasty dismissal would be rash. First, in ratifying the CRPD, the UK signalled its consent to be bound by it.[[73]](#footnote-73) It has accepted that any of its laws which pertain to persons with disabilities should be measured against the yardstick of the CRPD. This must presumably include the law of negligence, since the UK did not exempt it from the Convention’s remit. The UK has also recognised the competence of the CRPD Committee as a monitoring and enforcement body.[[74]](#footnote-74) The CRPD therefore carries a moral heft which cannot be easily discounted. Any failure to comply with the CRPD or respect an opinion of the Committee risks significant political embarrassment. This may explain why the case for its incorporation has political currency.[[75]](#footnote-75) Furthermore, ratification is not mere lip service: the UN’s institutions assume that all States Parties have an obligation to implement the CRPD.[[76]](#footnote-76) The UN Committee has even explicitly recommended that the UK do so.[[77]](#footnote-77)

Second, there is nothing to stop English courts referring to the CRPD as a non-binding source of human rights law. They have already mentioned it in dozens of cases, sometimes merely to acknowledge its existence,[[78]](#footnote-78) or as an aid to interpretation.[[79]](#footnote-79) It is easy to see how the CRPD’s social model might become woven into the fabric of the common law. Although this would not amount to full incorporation, the CRPD’s rendering of equality and non-discrimination could nevertheless begin to alter the judicial vocabulary. This sort of ‘incorporation by the backdoor’ may also occur via the jurisprudence of the European Court of Human Rights (ECtHR). According to section 2(1)(a) of the Human Rights Act 1998, a court determining a question in connection with an ECHR right must consider any relevant ‘judgment, decision, declaration or advisory opinion of the European Court of Human Rights’. In *Glor v Switzerland*,[[80]](#footnote-80) the ECtHR recognised the CRPD as part of a ‘worldwide consensus on the need to protect people with disabilities from discriminatory treatment’.[[81]](#footnote-81) It specifically identified the CRPD as something which might influence the ‘present-day conditions’ according to which the ECHR must be interpreted.[[82]](#footnote-82) The ECtHR has since taken the CRPD into account as one of the ‘relevant international instruments’ that may be germane to the rights of persons with disabilities.[[83]](#footnote-83) It is conceivable that this will lead to closer convergence between the CRPD and the ECHR, with obvious implications for the domestic application of human rights and the common law.

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Bartlett argues that the UK signed up to a ‘paradigm shift’ upon ratifying the CRPD.[[84]](#footnote-84) He points to a number of ‘flashpoints’[[85]](#footnote-85) (e.g., civil commitment under the Mental Health Act 1983[[86]](#footnote-86)) and argues that the CRPD poses a challenge to ‘traditional mental health law’.[[87]](#footnote-87) In truth, the CRPD’s social model creates broader and hitherto-unexplored tensions. In the next part we examine the extent to which the special rules in psychiatric injury cases constitute another flashpoint between English law and the CRPD.

**PART 2: THE SPECIAL RULES AND THE CRPD**

1. *‘Recognisable psychiatric illness’*

Duty is an essential ingredient of negligence; without it, there is no liability.[[88]](#footnote-88) Where a defendant carelessly causes *physical* injury to a claimant, the duty may not even be in dispute: a duty arises automatically in certain duty-bearing relationships (e.g., doctor-patient,[[89]](#footnote-89) teacher-pupil,[[90]](#footnote-90) between road users,[[91]](#footnote-91) and so on). On other occasions, it may now be reasonable to assume that an act of carelessness which has led to physical injury will be the subject of a duty of care. In *Robinson v Chief Constable of West Yorkshire Police*,[[92]](#footnote-92) Lord Reed said that a person may owe a duty under the ‘ordinary principles of negligence’ to protect someone else from ‘a danger of injury which they have themselves created’.[[93]](#footnote-93) This is not to say that a duty is certain; there may be cogent reasons to preclude one.[[94]](#footnote-94) However, one might wonder how many such reasons continue to pertain: the courts are now far less persuaded by policy arguments against the imposition of duties in personal injury cases.[[95]](#footnote-95) Where duty *is* contested, often in novel circumstances, its existence may depend on broader considerations of foreseeability; proximity; and fairness, justice and reasonableness.[[96]](#footnote-96) There is, therefore, nothing *inevitable* about the duty of care, but its existence is highly likely in cases of physical injury.

Importantly, a claimant does not have to prove that she has suffered a *particular kind* of physical injury. All that matters is that her injury constitutes compensable actionable damage; that is, it leaves her ‘appreciably worse off’ in respect of her health.[[97]](#footnote-97) This is not a high threshold: in *Dryden v Johnson Matthey PLC*,[[98]](#footnote-98) a symptomless sensitivity to platinum salts that was not itself physically harmful was enough to qualify as actionable damage. Nor is thetype of injury the claimant has suffered likely to be a reason to preclude liability. In the related inquiry as to whether a claimant’s damage is too remote to justify recovery, the courts tend not to disaggregate physical injuries into different *kinds* of damage: personal injury constitutes a single, all-encompassing category.[[99]](#footnote-99) This stands in stark contrast to the courts’ approach in cases of property damage, in which the defendant must reasonably foresee the particular kind of damage.[[100]](#footnote-100) It is therefore unlikely that a court would conclude that a particular physical injury is not of the right kind to be made the subject of a duty of care. In cases involving physical injuries occasioned by the positive acts of a careless defendant, there is unlikely to be much dispute that the claimant was owed a duty of care.

The same is true in cases where the claimant suffers concurrent physical *and* psychiatric injuries. In *Corr v IBC Vehicles Ltd*,[[101]](#footnote-101) the claimant’s husband suffered a serious head injury during the course of his employment at the defendant’s factory. As a result of his physical injuries, he was later diagnosed with post-traumatic stress disorder, anxiety and depression and eventually committed suicide. According to Lord Bingham, the defendant-employer’s duty of care ‘embraced psychological as well as physical injury’.[[102]](#footnote-102) There was no reason to distinguish the two kinds of injury; both were the subject of the same duty. This combination of physical *and* psychiatric injury can trace its origins back to *Donoghue v Stevenson*,[[103]](#footnote-103) in which Lord Atkin made no distinction between Mrs Donoghue’s physical and mental injuries when elucidating the ‘neighbour principle’.[[104]](#footnote-104) The courts have had little difficulty in finding the same duty in other instances of concurrent injuries.[[105]](#footnote-105)

In a claim solely involving psychiatric injury, by contrast, the claimant must first prove that she has suffered a *particular kind* of mental harm. This requirement originates from *Hinz v Berry*,[[106]](#footnote-106) in which Lord Denning MR said:

*Damages are… recoverable for nervous shock, or, to put it in medical terms,* for any recognisable psychiatric illness caused by the breach of duty by the defendant.[[107]](#footnote-107)

Since *Hinz*,the courts have spun this requirement into the ‘patchwork quilt’[[108]](#footnote-108) that makes up the rules in this area. As a consequence, they have placed a premium on diagnostic labels, such as those listed in the DSM-V and the ICD-10.[[109]](#footnote-109) The same applies across the common law world too.[[110]](#footnote-110) Mere grief, distress or sorrow is not enough;[[111]](#footnote-111) a defendant will not owe a duty in respect of ‘normal human emotions’.[[112]](#footnote-112) A claimant must prove that she has suffered what has variously been described as a ‘positive psychiatric illness’,[[113]](#footnote-113) a ‘recognisable’[[114]](#footnote-114) or ‘recognised’[[115]](#footnote-115) psychiatric injury, an ‘identifiable psychiatric condition’,[[116]](#footnote-116) or a ‘frank psychiatric illness’[[117]](#footnote-117).

A wide range of conditions has been found to satisfy this requirement, including post-traumatic stress disorder;[[118]](#footnote-118) clinical depression;[[119]](#footnote-119) major depressive disorder;[[120]](#footnote-120) adjustment disorder;[[121]](#footnote-121) anorexia nervosa;[[122]](#footnote-122) chronic fatigue syndrome;[[123]](#footnote-123) pathological grief disorder;[[124]](#footnote-124) hysterical personality disorder;[[125]](#footnote-125) and schizophrenia.[[126]](#footnote-126) Applying the expansive logic of the CRPD’s apparatus, these conditions would all likely constitute mental impairments which, in conjunction with disabling social barriers, qualify as ‘psychosocial disabilities’. This means that the special rules in negligence prima facie engage the CRPD, since they apply to the same sorts of impairments with which it is concerned. This is despite the fact that the ‘nervous shock’ cases have not customarily framed the relevant injuries in terms of ‘disability’. Nevertheless, ‘disability’ is not an alien concept here: Trindade described ‘recognisable psychiatric injury’ as ‘the *disability* which the plaintiff must suffer if he is to recover damages for “nervous shock”’.[[127]](#footnote-127) In any case, the absence of the word ‘disability’ is in no way determinative: as Fennell says, ‘mental ill health *is* a disability’.[[128]](#footnote-128) The conditions which the courts have accepted are recognisable psychiatric illnesses would also constitute ‘disorders or disabilities of the mind’ for the purposes of the Mental Health Act 1983.[[129]](#footnote-129) If they notionally engage the CRPD in that context, it follows that they must also do so elsewhere.

In the absence of any reason to distinguish tort law from the rest of the domestic legal framework, we must assume that its rules deserve the same scrutiny that the CRPD invites elsewhere. If ‘recognisable psychiatric illness’ includes the same ‘psychosocial disabilities’ which the CRPD’s authors had in mind, those subject to the special rules must therefore be ‘persons with disabilities’ and, therefore, entitled to the UN Convention’s protection.

1. *The discriminatory mechanics of the special rules*

There are two reasons why the special rules are discriminatory. The first and most obvious is the higher actionability threshold they set for persons with psychosocial disabilities. Where psychiatric injuries are concerned, the law requires a *manifest pathology* to which a qualified expert can attach a diagnostic label. A symptomless and essentially-harmless sensitivity of the sort described in *Dryden* would not be enough.[[130]](#footnote-130) The law does not therefore treat claims brought by persons with psychosocial disabilities on an equal basis with others.

The second reason relates to what happens *after* a claimant’s mental harm discharges the ‘clinically-recognised’ threshold. At that point, an entirely distinct legal architecture with its own rules comes into play. As Case points out, these rules are littered with examples of unequal treatment.[[131]](#footnote-131) Since Lord Oliver devised the infamous dichotomy in *Alcock*, it has become trite that a claimant in a ‘pure’ psychiatric injury case must be classed as either a ‘primary’ or ‘secondary’ victim.[[132]](#footnote-132) These categories entail unique conceptions of foreseeability and proximity, at least some of which apply solely in psychiatric injury cases. It is worth evaluating the mechanics of primary and secondary victimhood to gauge the extent to which they contravene the CRPD’s relevant provisions.

1. Primary victims

A primary victim suffers a psychiatric injury after he ‘objectively exposed himself to danger’ or ‘reasonably believed he was doing so’.[[133]](#footnote-133) In *White*,[[134]](#footnote-134) police officers who were on duty at the Hillsborough football stadium on the day of the disaster that took place there in 1989 brought claims against the chief constable for the psychiatric injuries they had suffered as a consequence. The House of Lords held that the chief constable’s duty to them as employees did not extend to protecting them from psychiatric injury when there was no breach of the duty to protect them from physical injury. Since none of the claimant police officers had been at risk of physical injury, they were not owed a duty of care for their psychiatric injuries.

Another important case in this regard is *Page v Smith*.[[135]](#footnote-135) Here, the plaintiff was involved in a minor road traffic collision with the defendant’s car. The plaintiff suffered a relapse of myalgic encephalomyelitis (ME) – or ‘chronic fatigue syndrome’ – from which he had suffered, on and off, for 20 years. Following the collision, the plaintiff’s ME became permanent and he was unable to work again. He sued the defendant, raising the question of whether the defendant owed him a duty of care to avoid causing him psychiatric injury. By a three-two majority, the House of Lords held that he did: all that mattered was whether some kind of *personal injury* – comprising both physical *and* psychiatric injuries – was reasonably foreseeable in the circumstances. The defendant therefore owed him a duty of care; that the injuries were in fact psychiatric rather than physical was immaterial. Lord Lloyd explained that since primary victimhood depended on the claimant’s proximity to a zone of physical danger, foreseeable *personal* injury would be sufficient to establish a duty.[[136]](#footnote-136) His Lordship also pointed out that medical knowledge was ‘expanding fast’ and it was likely that artificial distinctions between physical and psychiatric injuries ‘may soon be altogether outmoded’.[[137]](#footnote-137) It would therefore be wrong to maintain a distinction in law which was without difference in practice.

The notion that a claimant might recover damages for an unforeseeable *psychiatric* injury simply because some sort of *physical* injury was foreseeable did great violence to tort doctrine in the eyes of many commentators.[[138]](#footnote-138) For example, Jones argued that *Page* does not cohere with the logic of a fault-based system of liability because a defendant can be ‘saddled with the financial consequences of the claimant’s unforeseeable psychiatric reaction’.[[139]](#footnote-139) *Page* also received robust judicial criticism: in *White*, Lord Goff described itas a ‘remarkable departure from generally accepted principles’.[[140]](#footnote-140) Implicit in these criticisms is an uncharitable assumption about psychiatric illnesses that places them in a subordinate position to physical injuries. Critics of *Page* also overstated their case: the same ‘saddling’ of defendants with the financial consequences of unforeseeable reactions has been a feature of the law of negligence since the development of the ‘eggshell skull’ rule.[[141]](#footnote-141) Ironically, that doctrine originated from *Dulieu v White & Sons*,[[142]](#footnote-142) which was the first ‘nervous shock’ case to come before an English court. Viewed in this way, *Page* is the logical corollary of the notion that a defendant must take his victim *talem qualem*. Despite this, it is no exaggeration to say that *Page’s* reinterpretation of physical and psychiatric injuries as two sides of the same coin is one of English tort law’s least-celebrated innovations.

Yet the CRPD casts *Page* in a more forgiving light. *Page’s* rendering of primary victimhood treats ‘personal injury’ as an umbrella term under which different types of injury (i.e., physical and psychiatric) can be categorised. In other words, its foreseeability test is *disability-neutral*: it applies to all claimants regardless of their disability. This led Hedley to predict that the law on nervous shock would be ‘slowly assimilated’ with the law pertaining to injuries generally.[[143]](#footnote-143) On this interpretation, *Page* is a triumph. The House of Lords’ decision may be wrong according to what some considered to be the traditional logic of negligence,[[144]](#footnote-144) but its collapsing of the boundary between different types of injury was ahead of its time. For that reason, the duty of care governing primary victimhood comports with the CRPD.

Tort law is indisputably part of a body of ‘existing laws, regulations, customs and practices’ which the UK is under a duty to ‘modify or abolish’ in cases of conflict with the CRPD.[[145]](#footnote-145) *Page* modified tort doctrine in a way which aligns with the CRPD’s non-discriminatory ethos. To argue for its reversal is to propose the restoration of an approach which discriminates on the basis of disability. Some might argue that reorganising tort doctrine according to the precepts of international human rights law overlooks the distinct functions that each serves – and it is here that the distinct logics of negligence and the CRPD pull us in different directions.[[146]](#footnote-146) Despite this obvious tension, it is possible for the duty of care to co-exist with notions of duty implied by instruments such as the ECHR.[[147]](#footnote-147) The problem is that the CRPD explicitly proscribes discrimination on the basis of disability. While it is possible for common law duties of care to exist in parallel with duties arising out of the ECHR, the same coexistence appears out of the question where the CRPD is concerned. Although primary victimhood does not amplify these tensions, the same cannot be said for the rules that apply to secondary victimhood.

1. Secondary victims

A secondary victim suffers a psychiatric injury after *witnessing* a careless defendant cause the death, injury or imperilment of another person. The courts have sought to restrict secondary victimhood by (i) employing a narrow ‘foreseeability’ requirement, and (ii) using a number of ‘control mechanisms’ to limit it to those in close relational and geographic proximity to a shocking event. The foreseeability requirement derives from *Bourhill v Young*.[[148]](#footnote-148) According to Lord Porter, a defendant is entitled to assume that the ‘ordinary frequenter of the streets has sufficient fortitude’ to cope with distressing events; he will not owe a duty to one who does not possess that ‘customary phlegm’.[[149]](#footnote-149) This represents a very different conception of reasonable foreseeability from that which applies to primary victims. Where secondary victims are concerned, *psychiatric injury* must be reasonably foreseeable to the defendant; generalised ‘personal’ injury will not suffice. Moreover, the circumstances must be likely to cause psychiatric injury in a person of ‘ordinary fortitude’. This is a far more stringent test.

Assuming she satisfies the foreseeability requirement, the claimant’s next obstacle is the ‘control mechanisms’. In *Alcock*,[[150]](#footnote-150) the House of Lords adopted the formula that Lord Wilberforce first articulated in *McLoughlin v O’Brian*,[[151]](#footnote-151) subjecting the duty concept to three additional conditions. *Alcock* involved a number of plaintiffs who were related to, or friends of, spectators who were present at the Hillsborough disaster. Some had witnessed the disaster from the relative safety of other parts of the stadium; others had seen the events on television or heard about them from radio broadcasts or by word of mouth. Each alleged that what they had seen or heard had caused psychiatric injuries. Their claims failed.

According to Lord Keith, psychiatric illness ‘is more subtle’ than cases involving ‘direct physical injury’.[[152]](#footnote-152) Satisfying the requirement of reasonable foreseeability would therefore not be enough; a claimant would also have to establish three other things.[[153]](#footnote-153) First, he must show that he has a relationship based on close ties of love and affection with the immediate victim of the defendant’s negligence. According to Lord Ackner, there is a rebuttable presumption that parent-child and spousal relationships will qualify for these purposes.[[154]](#footnote-154) In every other instance, the claimant must prove that he has the requisite close tie of love and affection. Successful claims by mere bystanders to a traumatic event are therefore vanishingly unlikely, although their Lordships refused to rule out them out as a possibility.[[155]](#footnote-155)

Second, the claimant must be proximate in time and space to the shocking event, so that she either has ‘direct visual or aural perception’ of it[[156]](#footnote-156) or comes upon the scene of the ‘immediate aftermath’.[[157]](#footnote-157) To qualify, a claimant must actually see or hear the event itself; witnessing it through any other medium will not be enough. Furthermore, the ‘immediate aftermath’ takes place in a narrow time frame. In *McLoughlin*, it was two hours and pertained because the plaintiff’s surviving family members were still ‘covered with oil and mud and distraught with pain’.[[158]](#footnote-158) In *Alcock*, by contrast, an eight-hour timeframe separating the disaster and a plaintiff’s identification of his brother-in-law’s body was deemed to stretch beyond the ‘immediate aftermath’.[[159]](#footnote-159) Anyone other than those present at the scene or its immediate aftermath is unlikely to qualify.

Third, secondary victimhood depends upon the claimant experiencing a ‘sudden assault on the nervous system’[[160]](#footnote-160) or a ‘sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind’.[[161]](#footnote-161) The claimant’s psychiatric injury therefore must occur in a certain way; events which play out over a longer period of time will not amount to a sudden shock.[[162]](#footnote-162)

All this means that the only people to whom a defendant will owe a duty are particularly close relatives of the immediate victim who are by chance at or near the scene of an accident and are so shocked by what they see and hear that they develop a psychiatric injury. Not only that, but those close relatives must be people of ‘ordinary fortitude’ for whom a psychiatric illness would be a reasonably foreseeable consequence of the defendant’s actions. This ultra-specific categorisation in no way resembles how the law establishes duties of care in cases involving physical injury. A pedestrian who suffers a physical injury after he is hit by debris when a careless motorist crashes into another car 20 yards away does not have to prove he is a person of ‘ordinary fortitude’ before he can recover damages, nor does the success of his claim turn on the nature or quality of his relationship with anyone else at the scene. As Hedley has pointed out, in ‘nervous shock’ cases a defendant is not liable ‘unless the precise victim is identifiable’.[[163]](#footnote-163) This test is ‘far stricter’ than that applied in negligence generally.[[164]](#footnote-164)

The law’s differential treatment of claimants with ‘psychosocial disabilities’ in this context is a clear instance of discrimination contrary to Article 5(1) of the CRPD. The special rules use disability as an occasion to deploy a duty concept which is a departure from the general principles of negligence. That concept puts claimants at a disadvantage by denying (or, at least, limiting) access to justice for persons with disabilities, contrary to Article 13 of the CRPD. Where the duty does arise, it imposes a more onerous burden on people suffering from psychosocial disabilities. This plainly runs counter to the tenets of equality and non-discrimination which underpin the CRPD.

Some might argue that since injury is integral to negligence, the law *necessarily* discriminates on the basis of disability.[[165]](#footnote-165) This is unconvincing: negligence is actionable generally on proof of damage, not disability. According to Lord Hoffmann, ‘damage’ in this sense ‘is an abstract concept of being worse off, physically or economically, so that compensation is an appropriate remedy’.[[166]](#footnote-166) It is not ordinarily limited to disabilities; instead, it is a general concept which applies to a multitude of injuries and losses. The only relevant occasion on which the courts have afforded ‘damage’ a narrower meaning is in cases concerning psychiatric injuries, where the requirement of a recognisable psychiatric injury plainly limits the scope of actionability to what the CRPD apparatus would term ‘psychosocial disabilities’.[[167]](#footnote-167)

The courts have long justified the special rules on the basis of public policy. In *White*, Lord Steyn gave a number of examples, such as the evidential problems inherent in proving psychiatric injuries; concerns about the ‘unconscious’ effects of compensation; and fears about the ‘floodgates’ and ‘crushing’ liability.[[168]](#footnote-168) There are many other policy reasons to which the courts have had recourse but limited space precludes a detailed rehearsal of them.[[169]](#footnote-169) However, it is worth asking whether they would excuse the special rules’ discriminatory effects.

The simple answer is that they would not. The CRPD is absolute; nowhere does it say that the domestic laws of a State Party can legitimately discriminate on the basis of disability where there is a pressing public policy reason to do so. In this way, the CRPD differs markedly from the ECHR, which contains qualified rights to which such caveats can apply.[[170]](#footnote-170) States Parties to the CRPD undertake ‘to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities *without any discrimination of any kind on the basis of disability*’.[[171]](#footnote-171) It follows that public policy justifications for the special rules are unlikely ever to be relevant.

Even if the CRPD’s rights *were* qualifiable, it is unlikely that the public policy considerations which have proved to be so influential before English courts would have any excusatory effect. According to the UN Human Rights Committee, not every differentiation will constitute discrimination ‘if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate’.[[172]](#footnote-172) Leaving aside the CRPD’s absolutist text, there is no way in which the policy reasons that justify tort law’s differential treatment in psychiatric injury cases would satisfy that ‘reasonable and objective’ threshold in any case. They have been repeatedly and consistently debunked in the literature over the years.[[173]](#footnote-173) Even the courts have begun to find traditional policy arguments against the imposition of duties of care unpersuasive.[[174]](#footnote-174) Against this backdrop, the continued influence of policy arguments in psychiatric injury cases makes them an outlier. As Teff says, the special rules owe much to a ‘flawed socio-cultural legacy’,[[175]](#footnote-175) which plainly endures in the policy reasons that justify them. It is unlikely that they would satisfy the ‘reasonable and objective’ threshold, even if differentiation were permissible under the CRPD.

**PART 3: REFORM**

Using a taxonomy first devised by Jones, this part evaluates the four main reform options:

(1) retention,

(2) abolition,

(3) amendment, and

(4) conceptual unification.[[176]](#footnote-176)

There are two points worth making at this juncture. First, Parliament is the most likely source of reform. The obvious reason for this is that the CRPD imposes duties upon its States Parties and its incorporation is solely a matter for Parliament.[[177]](#footnote-177) This is not to say that judicial innovation is out of the question: the courts have flirted with ‘theoretical equivalency’ between physical and psychiatric injuries.[[178]](#footnote-178) Prior to *Alcock*, the lower courts applied a simple test of ‘reasonable foreseeability of psychiatric damage’ in two negligence cases.[[179]](#footnote-179) There was also optimism that improvements in scientific understanding would lead the courts to change direction.[[180]](#footnote-180) However, they have since insisted on the differential treatment of psychiatric injury cases, [[181]](#footnote-181) repudiating any equivalency as a matter of law and overlooking any advances in scientific knowledge. There may also be a question of practicalities: Teff argued that ‘court-led reform’ is ‘ill-suited to producing a coherent, comprehensive framework’ in this area.[[182]](#footnote-182)

Second, there have long been calls to rectify the dissonance which the special rules bring to negligence. Some have suggested reforms which would, incidentally, achieve compliance with the CRPD.[[183]](#footnote-183) We will see that other reform proposals, which may resolve problems in the common law, would not have the same effect. The CRPD has therefore made the scope for reform in this area much narrower than it used to be.

1. *Retention*

Retention of the current rules is not a viable option and can be quickly dismissed.

1. *Abolition*

Parliament could simply abolish recovery for psychiatric injury. The best-known advocate of this is Jane Stapleton, who said that the special rules ‘bring the law into disrepute’ and ought to be abolished to restore its ‘dignity’.[[184]](#footnote-184)

It is true that abolition would, at a stroke, eliminate tricky questions about what kind of psychiatric injury is actionable and when and how a duty of care will arise. It would also be of a piece with the CRPD: abolition is one way to solve conflicts with a State Party’s domestic legal framework. The problem is that it would instantly make a bad situation worse. Most obviously, it would ‘diminish justice’, since it would ‘effectively minimise the significance of psychiatric injury’.[[185]](#footnote-185) More importantly, abolition would do nothing to tackle discrimination on the basis of disability. In fact, it would aggravate it: while the law would continue to allow physically*-*injured claimants to recover compensation, it would deny liability for psychiatricinjuries entirely*.* Whereas under the current rules at least *some* claimants can recover compensation, under Stapleton’s scheme *no* claimant could ever succeed. This is as clear an example of unequal treatment as one can expect to find. For that reason, abolition would do nothing to align the tort of negligence with the CRPD.

1. *Amendment*

The idea that the special rules might simply be amended is a long-standing feature of the literature. Towards the more conservative end of the spectrum lie the Law Commission’s proposals for ‘minimalist intervention’ in 1998.[[186]](#footnote-186) Stating that it remained persuaded by the ‘floodgates argument’, the Law Commission concluded that ‘special limitations’ should continue to apply in secondary victim cases.[[187]](#footnote-187) Its central recommendation was that a claimant who has a ‘close tie of love and affection’ with the immediate victim of the defendant’s negligence should be entitled to recover damages for psychiatric injury. This should happen ‘regardless of [his] closeness to the accident… or the means by which [he] learns of it’.[[188]](#footnote-188) The Commission said that Parliament should define what constitutes a ‘close tie of love and affection’ using a ‘fixed list’ of qualifying relationships.[[189]](#footnote-189) Beyond that, the Commission recommended that the duty rules should remain untouched, including the requirement that there be a ‘recognisable psychiatric illness’ as a prelude to recovery.[[190]](#footnote-190)

The Law Commission’s proposals enjoyed some contemporary support. Writing in the mid-1990s, Handford said that its approach accorded with medical opinion;[[191]](#footnote-191) later, he said that a sharper focus on the relationship question would lead to a ‘more satisfying jurisprudential development’ than one which makes liability depend on questions of proximity.[[192]](#footnote-192) Others were critical: Wessely said that the retention of the ‘recognisable psychiatric illness’ requirement gave ‘too high a credence to psychiatric nosology and classification’.[[193]](#footnote-193) Perhaps the biggest shortcoming was that the Commission’s recommendations predated *White*, meaning that they soon reflected an obsolete rubric. HM Government subsequently rejected the Law Commission’s recommendations, preferring to leave the matter to the courts.[[194]](#footnote-194) While they later resurfaced in the Negligence and Damages Bill, the proposals never reached the statute book.[[195]](#footnote-195)

The Law Commission’s recommendations would have made it easier for secondary victims to establish duties of care. An expanded list of qualifying relationships including, inter alia, siblings, grandparents, and aunts/uncles, coupled with the absence of the proximity and ‘sudden shock’ requirements, would have led to different outcomes in *Alcock*, for example. The problem is that they would do nothing to bring the rules into compliance with the CRPD. This is because the Commission retained the requirement of a ‘recognisable psychiatric illness’ as an animating concept. Even the Commission’s expanded pool of qualifying relationships would fall. To allow recovery by some claimants with mental impairments, but not others, because of the nature of their relationship with the immediate victim would be to assume, contrary to Article 5(1) of the CRPD, that not everyone is entitled to equal benefit of the law.[[196]](#footnote-196)

Yet if the sticking point is the retention of the ‘recognisable psychiatric injury’ requirement, then the solution might be to amend the rules so that they are no longer animated in this way. Mulheron has argued that the requirement ‘is neither legally nor medically supportable in the modern era’.[[197]](#footnote-197) She prefers a threshold of actionable damage set at the level of ‘grievous mental harm’, which would also have the advantage of allowing the courts to jettison the ‘sudden shock’ requirement.[[198]](#footnote-198) Others have proposed alternatives like ‘moderately severe mental or emotional harm’[[199]](#footnote-199) or ‘serious emotional distress’.[[200]](#footnote-200)

At the core of the case for abandoning the clinical-recognition requirement is an aversion to its highly medicalised approach.[[201]](#footnote-201) For some, the requirement sets the bar too high. Case points out that there is ‘little logical appeal’ in distinguishing recognised psychiatric disorders from ordinary emotional responses: if trivial physical injuries can sound in damages, why cannot trivial emotional injuries?[[202]](#footnote-202) Others argue that the requirement in fact sets the bar too low. Ahuja explains that a person with a snake phobia could be diagnosed with a psychiatric disorder under the ICD-10. This is despite the fact that he lives in New York City and has no occasion ever to encounter a snake in his day-to-day life.[[203]](#footnote-203) The requirement of clinical recognition therefore misses the point; what should matter is the *severity of the claimant’s distress*, not the label that might be attached to it.[[204]](#footnote-204) For a range of reasons, abandoning the need for a diagnostic label would be a welcome reform.

This is precisely the approach that the Supreme Court of Canada took in *Saadati v Moorhead*.[[205]](#footnote-205) The Court said that the requirement of a ‘recognisable psychiatric illness’ was ‘premised upon dubious perceptions of psychiatry and of mental illness in general’.[[206]](#footnote-206) To insist upon it was to treat physical and mental illnesses differently and accord unequal protection to victims of mental injury ‘for no principled reason’.[[207]](#footnote-207) Brown J held that all that is required is that the defendant foresaw an injury to the claimant – a particular label for the claimant’s psychiatric injury was unnecessary.

Scrapping the ‘recognisable psychiatric injury’ requirement in this way is essential if the law of negligence is to comply with the CRPD. Without even citing the CRPD, the Court in *Saadati* adopted what could easily be its language to condemn the discriminatory fulcrum on which the special rules turn. *Saadati* could therefore be hailed as the first psychiatric injury case in the common law world which embodies the spirit of the CRPD. The biggest obstacle to CRPD-compliance is a rule which distinguishes claimants on the basis of disability. Replacing it with a disability-neutral alternative should therefore be a priority.

However, replacing ‘recognised psychiatric injury’ with something like ‘grievous mental harm’ or ‘moderately severe mental or emotional harm’ may not be as straightforward as it seems. It raises a tricky question about *what* will qualify as actionable damage when no diagnostic label can be applied to a claimant’s disorder, whilst doing nothing to reduce the utility of such labels where they do exist. The advantage of the current scheme is that there is magic in diagnostic labels. Although this gives them an undeserved special quality,[[208]](#footnote-208) it at least makes the identification of actionable mental harm straightforward. By contrast, under a purportedly ‘disability-neutral’ scheme, this task becomes much harder.

Mulheron suggests that medical science is now ‘sufficiently developed to assist the court to decide whether the necessary threshold of “mental injury” has been met’.[[209]](#footnote-209) The problem is this still suggests that there is a residual role for psychiatric or psychological experts to attribute a particular disorder or condition to the claimant in order to evidence her damage. If so, the practice of labelling may creep into an ostensibly ‘disability-neutral’ framework, thus failing to tackle the very discrimination against persons with mental disabilities to which the CRPD takes exception. It is true that the inclusion of ‘emotional distress’ as a type of actionable damage might mitigate this problem. But this raises an obvious question about *how* a claimant might reliably prove her ‘emotional distress’. The current practice of applying a psychiatric label to a claimant’s condition lends probative force to her claim. Proving ‘emotional distress’ would presumably require something more nuanced and less amenable to objective justification. If so then the impulse to apply *some kind* of label may endure, thereby potentially rendering ‘disability-neutrality’ nothing more than a legal fiction. Perhaps not all claimants who suffer ‘grievous mental harm’ will have a psychosocial disability, but if everyone with a psychosocial disability suffers ‘grievous mental harm’, and thereupon experiences differential treatment, then the law will still indirectly discriminate on an improper basis.

1. *Conceptual unification*

The fourth option is to unify different conceptions of damage within a single duty of care. Rather than employing different rules depending on whether a claimant’s injury is physical or psychiatric, the court would simply ask whether *personal injury* was reasonably foreseeable in the given circumstances. If so, then the defendant would owe the claimant a duty of care. ‘Personal injury’ in this context would, as in *Page*, include physical and psychiatric injuries and perhaps even severe emotional distress (assuming one can evidence such a thing without requiring the attribution of an impairment), thereby decoupling conceptions of actionable damage from psychosocial disabilities. This in turn would render unnecessary the distinction between primary and secondary victims, since there would be no need to treat claimants any differently on the basis of their disability and how it was caused. The duty of care would consequently be wholly disability-neutral and comply with the CRPD.

The case for conceptual unification is not an unfamiliar one. Long before the divergence that began in *McLoughlin*, Goodhart argued that a test based on ‘reasonable foresight’ was ‘the only rational and satisfactory’ one in cases of nervous shock.[[210]](#footnote-210) From the US perspective, Bell advocated a ‘full recovery rule’ as a way of reinforcing economic incentives: it would deter careless behaviour and reduce accident costs.[[211]](#footnote-211) Later, Butler made a compelling moral case for it: if a sound mind in a damaged body can achieve much, but a damaged mind in a sound body may achieve little, then the integrity of the psyche is as worthy of protection as the integrity of the body.[[212]](#footnote-212) Similarly, Ahuja has argued that a comparatively simple ‘reasonable foreseeability’ test would achieve a more effective alignment with scientific understanding of mental harms.[[213]](#footnote-213) From a range of perspectives, and for some time, the case for conceptual unification has been made without reference to the social model disability.

The CRPD does not therefore point to a conclusion that common lawyers have not already reached by other means. Rather, it offers another reason to prefer a unified approach. Some may remain unconvinced. First, the CRPD does not explicitly refer to the sort of horizontal obligations between private parties that are the preserve of negligence; rather, it is concerned with the vertical duties between states and their citizens. Nowhere in the Committee’s various reports does it mention laws governing compensation for negligently-caused psychiatric injuries. Perhaps psychiatric injuries occasioned by negligence were not within the contemplation of the CRPD’s authors and therefore remain outside its scope. Second, even if the CRPD *is* relevant to the duty concept, the fact that its implications in more obvious contexts remain highly contested suggests that any bearing the Convention may have on negligence is unlikely to be a priority.

These objections are difficult to maintain in light of the CRPD’s radical transcendence of the vertical-horizontal divide. While it may be true that the CRPD’s authors did not specifically have in their contemplation laws pertaining to private liability for psychiatric damage, their ambitions were indisputably expansive. The CRPD is clear that States Parties must modify or abolish laws that constitute discrimination against persons with disabilities. The special rules in negligence plainly do that. The fact that they relate to obligations between private individuals is neither here nor there: the rules are part of the UK’s legal framework and therefore the state is under a duty to fix them. Furthermore, just because the CRPD raises more pressing concerns for mental health law does not mean that its wider significance can be overlooked. It has always puzzled the present author that the rules governing liability for psychiatric injuries are seldom located under the umbrella of mental health law. The rules directly pertain to persons with psychosocial disabilities and constitute a specific legal response to their circumstances. A rigid delineation of the boundaries of mental health law falsely excludes the special rules from a domain in which their relevance to the CRPD might have been much more apparent. When located within mental health law, the special rules’ conflict with the CRPD seems just as urgent as the tensions that exist elsewhere.

Another point of contention might be the expansion of the scope of liability that a straightforward test of ‘reasonable foreseeability’ would entail. Case is right that the logical corollary may be the revival of breach, causation and remoteness as renewed sites of disputation.[[214]](#footnote-214) The courts would therefore apply other brakes to prevent a more generous duty from triggering a rise in the number of successful claims. But this raises an obvious question: *why should they do that*? Restrictions on liability for psychiatric injury seem jarring in an era defined by more sympathetic attitudes towards mental health. To say that a person who has suffered a mental impairment at the hands of a careless defendant should not be allowed to recover in case it ‘opens the floodgates’ to other such claims seems profoundly out of touch. Such arguments appear to be predicated on the same assumptions that justified the special rules in the first place; namely, that psychosocial disabilities are less deserving of respect than their physical analogues. The onus should fall on those who think that psychiatric illness continues to warrant distinct legal treatment to explain why that should be.

Indeed, the CRPD might actually lend theoretical heft to tort doctrine which *strengthens* the common law. It will be recalled that Article 17 contains the contested ‘right to integrity’. It is central to rights-based theories of tort law that people have rights which impose a corresponding duty on others to protect. In Beever’s view, conceptions of rights are ‘utterly foundational’ to negligence.[[215]](#footnote-215) For example, A has a *right* to bodily integrity and therefore B has a *duty* to avoid violating it. According to this theory, the basis of negligence is a ‘primary right’ that the law must protect.[[216]](#footnote-216) From this it follows that tort law serves a corrective function, in that it identifies primary rights and corrects contraventions of them.[[217]](#footnote-217) For Beever, the problem with ‘nervous shock’ is that the law has struggled to define what the primary right is.[[218]](#footnote-218) In his view, there is no clear right to ‘psychological integrity’.[[219]](#footnote-219) As a result, the law is incoherent and confusing. The identification of a primary right is therefore essential if the duty concept is to serve the interests of justice.

Not everyone agrees about the absence of a right to psychological integrity. Stevens believes that the idea that each of us has a right which is good against others that they take care not to damage our physical *and* mental health has existed since at least *McLoughlin v O’Brian*.[[220]](#footnote-220) If tort law protects claimants’ rights in this way, and if we have a right to physical and mental health as Stevens describes, then the law should redress the consequences of any violations of that right even-handedly. It should not draw unconvincing distinctions between physical and mental harms and apply different thresholds which favour recovery in one case but not the other.

Beever and Stevens would agree that tort law is about the protection of rights inherent in all claimants, although they may disagree on whether a right to mental or psychological integrity exists. It is submitted that Article 17 gives a definitive answer to this problem. According to it, every person with disabilities has a right to respect for his/her physical *and* mental integrity *on an equal basis with others*. It follows that any law which prioritises one form of integrity over the other, or which excludes or limits the possibility of recovery for violations of that integrity on the basis of disability, fails to protect the rights inherent in every person. It does not stretch the meaning of Article 17 to suggest that we have a right to mental integrity and that the state has a corresponding duty to ensure that where, through the carelessness of a defendant, that right is violated, the injured party can recover damages for his injuries on the same basis as anyone else. Article 17 in this way is perhaps the most consequential provision of the CRPD for tort, in that it explicitly confers a right which negligence offers a mechanism to protect. Far from serving a distinct and unrelated function, it is arguable that the CRPD actually gives the law of negligence a theoretical buttress. This in turn may help to redefine the scope of liability in a way that respects the rights of persons with disabilities and lay the foundations for reform.

**CONCLUSIONS**

In the years since its ratification, the CRPD’s implications for English mental health law have been subject to considerable academic scrutiny. Its ramifications for the rules governing the duty of care in negligence cases involving claimants with psychiatric injuries have been hitherto unexplored. This paper has sought to rectify that oversight by problematising those rules against the backdrop of the CRPD. It has shown that they too are a flashpoint between the CRPD’s principles of equality and non-discrimination and English law. Consequently, it has employed the social model of disability as another avenue along which to mount a critical attack on an already-controversial area of tort law.

The CRPD requires its States Parties to treat persons with disabilities on an equal basis with others and to prohibit discrimination against them. It embodies a radically different conception of human rights which cleaves to a social model that locates the disabling effects in society rather than the individual. The CRPD therefore transcends the classic vertical-horizontal rights dichotomy and has significant implications in both the public and private spheres. For the purposes of the CRPD, ‘disability’ is the sum of a physical, mental, sensory or intellectual impairment in conjunction with disabling social structures. To comply with it, a State Party must dismantle those structures and treat persons with disabilities in the same way as anyone else. A wide range of English law fails to operate in accordance with this duty. The rules governing the duty of care in negligence are another example. First, they are animated by ‘recognisable psychiatric injuries’, a definition that includes the same sort of ‘psychosocial disabilities’ that the CRPD’s authors had in mind. Second, they apply different rules at least to some claimants with those psychosocial disabilities and do so explicitly on that basis. The cumulative effect is a duty concept which affords unequal protection to mental integrity and which treats claimants with disabilities differently from others.

The CRPD makes the case for reform even more pressing, since the special rules not only produce absurd results; they also violate the human rights of persons with disabilities. This paper has shown that in order to tackle this problem, there is only one plausible solution: the unification of physical and psychiatric injuries under the same duty concept. Anything else signally fails to protect the rights of persons with disabilities or do justice to those who have suffered psychiatric injuries at the hands of careless defendants. The CRPD therefore strengthens a critique of the special rules that is familiar to the common law and, in doing so, lends the case for reform greater conceptual coherence and urgency.

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2. [1992] 1 AC 310 (HL) [↑](#footnote-ref-2)
3. id. p. 418 [↑](#footnote-ref-3)
4. [1999] 2 AC 455 (HL) [↑](#footnote-ref-4)
5. id. p. 511 [↑](#footnote-ref-5)
6. H. Teff, ‘Liability for Negligently Inflicted Psychiatric Harm: Justifications and Boundaries’ (1998) 57(1) *Cambridge L.J.* 91, at 107 [↑](#footnote-ref-6)
7. S. Bailey and D. Nolan, ‘The *Page v Smith* Saga: A Tale of Inauspicious Origins and Unintended Consequences’ (2010) 69(3) *Cambridge L.J.* 495, at 512 [↑](#footnote-ref-7)
8. M.A. Jones, ‘Liability for Fear of Future Disease?’ (2008) 24(1) *Professional Negligence* 13, at 17 [↑](#footnote-ref-8)
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18. C. Pugh and M.R. Trimble, ‘Psychiatric Injury after Hillsborough’ (1993) 163(4) *British J. of Psychiatry* 425, at 428-9 [↑](#footnote-ref-18)
19. A. Beever, *Rediscovering the Law of Negligence* (2007) 411 [↑](#footnote-ref-19)
20. *Robinson v Chief Constable of West Yorkshire Police* [2018] AC 736 (HL), [70] (Lord Reed) [↑](#footnote-ref-20)
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22. P. Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75(5) *Modern L.Rev.* 752, at 753; CRPD, art 4(1)(b) [↑](#footnote-ref-22)
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28. H. Teff, *Causing Psychiatric and Emotional Harm* (2009) 7-8 [↑](#footnote-ref-28)
29. *Walker v Northumberland County Council* [1995] 1 All ER 737; *Hatton v Sutherland* [2002] EWCA Civ 76; *Barber v Somerset County Council* [2004] UKHL 13 [↑](#footnote-ref-29)
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65. CRPD, art 2 [↑](#footnote-ref-65)
66. CRPD, art 17 [↑](#footnote-ref-66)
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80. App no 13444/04 (ECtHR, 30 April 2009) [↑](#footnote-ref-80)
81. ibid, [53] [↑](#footnote-ref-81)
82. *Marckx v Belgium* App no 6833/77 (ECtHR, 13 June 1979), [41] [↑](#footnote-ref-82)
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87. id. p. 761 [↑](#footnote-ref-87)
88. e.g., *Hedley Byrne & Co Ltd v Heller & Partners Ltd* [1964] AC 465 (HL); *Caparo Industries PLC v Dickman* [1990] 2 AC 605 (HL) [↑](#footnote-ref-88)
89. e.g., *Cassidy v Ministry of Health* [1951] 2 KB 343 [↑](#footnote-ref-89)
90. e.g., *Barnes (An Infant) v Hampshire County Council* [1969] 1 WLR 1563 (HL) [↑](#footnote-ref-90)
91. e.g., *Haley v London Electricity Board* [1965] AC 778 (HL) [↑](#footnote-ref-91)
92. [2018] AC 736 (SC) [↑](#footnote-ref-92)
93. id. [70] (Lord Reed) [↑](#footnote-ref-93)
94. e.g., *Palmer v Tees Health Authority* [1999] Lloyd’s Rep Med 351 (CA) [↑](#footnote-ref-94)
95. e.g., *Smith v Ministry of Defence* [2013] USKC 41 [↑](#footnote-ref-95)
96. *Caparo*, op.cit., n.89,617-8 (Lord Bridge) [↑](#footnote-ref-96)
97. *Grieves v FT Everard & Sons Ltd* [2007] UKHL 39, [19] (Lord Hoffmann) [↑](#footnote-ref-97)
98. [2018] UKSC 18 [↑](#footnote-ref-98)
99. *Hughes v Lord Advocate* [1963] AC 837 (HL); c.f., *Tremain v Pike* [1969] 1 WLR 1556 [↑](#footnote-ref-99)
100. *The Wagon Mound (No 1)* [1961] AC 388 (PC) [↑](#footnote-ref-100)
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102. id. [10] (Lord Bingham) [↑](#footnote-ref-102)
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104. id. p. 580 (Lord Atkin) [↑](#footnote-ref-104)
105. e.g., *Pigney v Pointer’s Transport Services Ltd* [1957] 1 WLR 1121; *Malcolm v Broadhurst* [1970] 3 All ER 508 (QB) [↑](#footnote-ref-105)
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107. id. p. 42 (Lord Denning MR) (emphasis added) [↑](#footnote-ref-107)
108. *White*, op.cit., n.3, p.500 (Lord Steyn) [↑](#footnote-ref-108)
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110. e.g., *Tame v New South Wales* (2002) 211 CLR 317 (Australia); *van Soerst v Residual Health Management Unit* [1999] NZCA 206 (New Zealand); *Barnard v Santam Bpk* 1999 (1) SA 202 (South Africa) [↑](#footnote-ref-110)
111. *Reilly v Merseyside Regional Health Authority* [1995] 6 Med LR 246; *Vernon v Bosley* [1997] PIQR P255, 314 (Evans LJ) [↑](#footnote-ref-111)
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113. id. [↑](#footnote-ref-113)
114. *Page v Smith* [1995] 1 AC 155 (HL), 167 (Lord Keith) [↑](#footnote-ref-114)
115. id. p. 171 (Lord Jauncey) [↑](#footnote-ref-115)
116. *Reilly*, op.cit., n.125 (Mann LJ) [↑](#footnote-ref-116)
117. *Liverpool Women’s Hospital NHS Foundation Trust v Ronayne* [2015] EWCA Civ 588, [6], [7], [9]-[10], [30] (Tomlinson LJ) [↑](#footnote-ref-117)
118. *White*, op.cit., n.3 [↑](#footnote-ref-118)
119. *Tan v East London and City Health Authority* [1999] Lloyd’s Rep Med 389 [↑](#footnote-ref-119)
120. *Shorter v Surrey & Sussex Healthcare NHS Trust* [2015] EWHC 614 (QB) [↑](#footnote-ref-120)
121. *Liverpool Women’s Hospital NHS Foundation Trust v Ronayne* [2015] EWCA Civ 588 [↑](#footnote-ref-121)
122. *Froggatt v Chesterfield and North Derbyshire Royal Hospital NHS Trust* [2002] EWCA Civ 1792 [↑](#footnote-ref-122)
123. *Page*, op.cit., n.128 [↑](#footnote-ref-123)
124. *Vernon,* op.cit., *n.*125 [↑](#footnote-ref-124)
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126. *Mount Isa Mines Ltd v Pusey* 125 CLR 383 [↑](#footnote-ref-126)
127. F.A. Trindade, ‘The Principles Governing the Recovery of Damages for Negligently Caused Nervous Shock’ (1986) 45(3) *Cambridge L.J.* 476, at 477 (emphasis added) [↑](#footnote-ref-127)
128. Fennell, op.cit., n.73, p.106 (emphasis added) [↑](#footnote-ref-128)
129. Section 1(2) [↑](#footnote-ref-129)
130. e.g., *Nicholls v Rushton* [1994] WLUK 267 (CA) [↑](#footnote-ref-130)
131. P. Case, ‘Curiouser and Curiouser: Psychiatric Damage Caused by Negligent Misinformation’ (2002) 18(4) *Professional Negligence* 248, at 258 [↑](#footnote-ref-131)
132. Lord Oliver devised this taxonomy in *Alcock,* op.cit., n*.*1,at pp.407-8 [↑](#footnote-ref-132)
133. *White*, op.cit., n.3, p.499 (Lord Steyn) [↑](#footnote-ref-133)
134. *White*, op.cit., n.3 [↑](#footnote-ref-134)
135. *Page*, op.cit., n.128 [↑](#footnote-ref-135)
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137. id. p. 188 (Lord Lloyd) [↑](#footnote-ref-137)
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141. e.g., *Smith v Leech Brain & Co Ltd* [1962] 2 QB 405 [↑](#footnote-ref-141)
142. [1901] 2 KB 669 [↑](#footnote-ref-142)
143. S. Hedley, ‘Nervous Shock: Wider Still and Wider?’ (1997) 56(2) *Cambridge L.J.* 254 [↑](#footnote-ref-143)
144. [↑](#footnote-ref-144)
145. CRPD, art 4(1)(b) [↑](#footnote-ref-145)
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147. e.g., *D v East Berkshire Community Health NHS Trust* [2005] 2 AC 373; *Michael v Chief Constable of South Wales Police* [2015] AC 1732 [↑](#footnote-ref-147)
148. [1943] AC 92 (HL) [↑](#footnote-ref-148)
149. id [↑](#footnote-ref-149)
150. *Alcock*, op.cit., n.1 [↑](#footnote-ref-150)
151. *McLoughlin*, op.cit., n.126, p.422 (Lord Wilberforce) [↑](#footnote-ref-151)
152. *Alcock*, op.cit., n.1, p.396 (Lord Keith) [↑](#footnote-ref-152)
153. id. p. 402 (Lord Ackner) [↑](#footnote-ref-153)
154. id. p. 403 (Lord Ackner) [↑](#footnote-ref-154)
155. *Alcock*, op.cit., n.1, p.397 (Lord Keith); 403 (Lord Ackner); see also *McFarlane v EE Caledonia Ltd* [1997] 2 Lloyd’s Rep 259 [↑](#footnote-ref-155)
156. id. p. 417 (Lord Oliver) [↑](#footnote-ref-156)
157. *McLoughlin*, op.cit., n.126, 423 (Lord Wilberforce) [↑](#footnote-ref-157)
158. *McLoughlin*, op.cit., n.126, 419 (Lord Wilberforce); see also *Jaensch v Coffey* (1984) 33 SASR 255 [↑](#footnote-ref-158)
159. *Alcock*, op.cit., n.1, p.405 (Lord Ackner) [↑](#footnote-ref-159)
160. id. p. 398 (Lord Keith) [↑](#footnote-ref-160)
161. id. p. 401 (Lord Ackner) [↑](#footnote-ref-161)
162. *Liverpool Women’s Hospital NHS Foundation Trust v Ronayne* [2015] EWCA Civ 588 [↑](#footnote-ref-162)
163. Hedley, op.cit., n.10, p.17 [↑](#footnote-ref-163)
164. id. [↑](#footnote-ref-164)
165. *Grieves*, op.cit., n.106 [↑](#footnote-ref-165)
166. id. [7] (Lord Hoffmann) [↑](#footnote-ref-166)
167. Special duty rules also apply in economic loss cases (e.g., *Hedley Byrne* op.cit. n.89; *Playboy Club London Ltd v Banca Nazionale del Lavoro SpA* [2018] UKSC 43). However, since these rules are not animated by disability, they raise no relevant issue for the CRPD. [↑](#footnote-ref-167)
168. *White*, op.cit., n.3, p.493 (Lord Steyn) [↑](#footnote-ref-168)
169. D. Butler, ‘An Assessment of Competing Policy Considerations in Cases of Psychiatric Injury Resulting from Negligence’ (2002) 10 *Torts L.J.* 13 [↑](#footnote-ref-169)
170. e.g., ECHR, arts. 8(2), 9(2), 10(2) and 11(2) [↑](#footnote-ref-170)
171. CRPD, art 4(1) [↑](#footnote-ref-171)
172. UN Human Rights Committee, *CCPR General Comment No 18: Non-discrimination* (10 November 1989), [13] [↑](#footnote-ref-172)
173. e.g., Bell, op.cit., n.13; V.E. Nolan and E. Ursin, ‘Negligent Infliction of Emotional Distress: Coherence Emerging from Chaos’ (1982) 33 *Hastings L.J.* 583; M.A. Jones, ‘Liability for Psychiatric Illness – More Principle, Less Subtlety?’ [1995] 4 *Web JCLI* <https://www.bailii.org/uk/other/journals/WebJCLI/1995/issue4/jones4.html>; Teff, op.cit., n.27, chapter 5 [↑](#footnote-ref-173)
174. e.g., *Arthur JS Hall & Co v Simons* [2002] 1 AC 615 (HL); *Jones v Kaney* [2011] UKSC 13; *Smith v Ministry of Defence* [2014] AC 52 (HL) [↑](#footnote-ref-174)
175. H. Teff, *Causing Psychiatric and Emotional Harm* (2009) 12 [↑](#footnote-ref-175)
176. Jones, op.cit., n.187 [↑](#footnote-ref-176)
177. e.g., CRPD, art 4 [↑](#footnote-ref-177)
178. D. Nolan, ‘Psychiatric Injury at the Crossroads’ (2004) 1 *J. of Personal Injury Law* 1, at 2 [↑](#footnote-ref-178)
179. *Hevican v Ruane* [1991] 3 All ER 65 (QBD); *Ravenscroft v Rederi AB Transatlantic* [1991] 3 All ER 73 (QBD) [↑](#footnote-ref-179)
180. e.g., M. McCulloch et al, ‘Post Traumatic Stress Disorder: Turning the Tide without Opening the Floodgates’ (1995) 35 *Medicine, Science and Law* 287, at 291 [↑](#footnote-ref-180)
181. e.g., *Paul v Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB); *King v Royal United Hospitals Bath NHS Foundation Trust* [2021] EWHC 1576 (QB) [↑](#footnote-ref-181)
182. H. Teff, ‘Righting Mental Harms’ (2009) 159(7384) *New L.J.* <<https://www.newlawjournal.co.uk/content/righting-mental-harms>> [↑](#footnote-ref-182)
183. e.g., C. Hilson, ‘Liability for Psychiatric Injury: Primary and Secondary Victims Revisited’ (2002) 18(3) *Professional Negligence* 167, at 176 [↑](#footnote-ref-183)
184. Stapleton, op.cit., n.14, p.94-5 [↑](#footnote-ref-184)
185. Teff, op.cit., n.5, p.95 [↑](#footnote-ref-185)
186. Law Commission, *Liability for Psychiatric Illness* (10 March 1998, LC249), [1.6] [↑](#footnote-ref-186)
187. id. [6.8]-[6.9]; A. Burrows, ‘Liability for Psychiatric Illness: Where Should the Line be Drawn?’ (1995) 3(3) *Tort L.Rev.* 220, at 225 [↑](#footnote-ref-187)
188. id. [6.16] [↑](#footnote-ref-188)
189. id. [6.27] [↑](#footnote-ref-189)
190. id. [5.6] [↑](#footnote-ref-190)
191. P. Handford, ‘Compensation for Psychiatric Injury: The Limits of Liability’ (1995) 2(1) *Psychiatry, Psychology and Law* 37, at 42 [↑](#footnote-ref-191)
192. P. Handford, ‘Psychiatric Injury in Breach of a Relationship’ (2007) 27(1) *Legal Studies* 26, at 50 [↑](#footnote-ref-192)
193. S. Wessely, ‘Liability for Psychiatric Illness’ (1995) 39(6) *J. of Psychosomatic Research* 659, at 661 [↑](#footnote-ref-193)
194. HM Government, *The Law on Damages* (Department for Constitutional Affairs, Consultation Paper 9/07, 2007), [94] [↑](#footnote-ref-194)
195. Negligence and Damages HC Bill (2015-16) [76] [↑](#footnote-ref-195)
196. CRPD, art 5(1) [↑](#footnote-ref-196)
197. R. Mulheron, ‘Rewriting the Requirement for a “Recognised Psychiatric Injury” in Negligence Claims’ (2012) 32(1) *Oxford J. of Legal Studies* 77, at 79 [↑](#footnote-ref-197)
198. id. pp. 111-2 [↑](#footnote-ref-198)
199. Teff, op.cit., n.27, p.178 [↑](#footnote-ref-199)
200. Nolan and Ursin, op.cit., n.187, p.611 [↑](#footnote-ref-200)
201. e.g., R. Orr, ‘Speaking with Different Voices: The Problems with English Law and Psychiatric Injury’ (2016) 36(4) *Legal Studies* 547; G Ra, ‘The Law on Psychiatric Injury for Secondary Victims: In Tandem with Medicine or Still Limping Behind?’ (LL.M, University of Liverpool, 2018) [↑](#footnote-ref-201)
202. P. Case, ‘Secondary Iatrogenic Harm: Claims for Psychiatric Damage Following a Death Caused by Medical Error’ (2004) 67(4) *Modern L.Rev.* 561, at 568; *Mason v Westside Cemeteries* (1996) 135 DLR (4th) 361 [↑](#footnote-ref-202)
203. Ahuja, op.cit., n.8, p.37 [↑](#footnote-ref-203)
204. id. p. 38 [↑](#footnote-ref-204)
205. [2017] 1 RCS 543 [↑](#footnote-ref-205)
206. id. [2] (Brown J) [↑](#footnote-ref-206)
207. id. [36] (Brown J) [↑](#footnote-ref-207)
208. e.g., T. Ward, ‘Psychiatric Evidence and Judicial Fact-finding’ (1999) 3(3) *International J. of Evidence and Proof* 180, at 193 [↑](#footnote-ref-208)
209. Mulheron, op.cit., n.212, p.102 [↑](#footnote-ref-209)
210. Goodhart, op.cit., n.64, p.23-4 [↑](#footnote-ref-210)
211. Bell, op.cit., n.13, p.335 [↑](#footnote-ref-211)
212. Butler, op.cit., n.183, p.18 [↑](#footnote-ref-212)
213. Ahuja, op.cit., n.8, p.48 [↑](#footnote-ref-213)
214. Case, op.cit., n.217, p.581 [↑](#footnote-ref-214)
215. Beever, op.cit., n.18, p.410 [↑](#footnote-ref-215)
216. id. [↑](#footnote-ref-216)
217. id. p. 411 [↑](#footnote-ref-217)
218. id. [↑](#footnote-ref-218)
219. id. p. 410 [↑](#footnote-ref-219)
220. R. Stevens, *Torts and Rights* (2007) 54 [↑](#footnote-ref-220)