

Case No: D33YM060

IN THE COUNTY COURT sitting at LEEDS

Date: 28 January 2020

**Before** :

HER HONOUR JUDGE BELCHER

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**Between :**

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|  | **Neema Devi Ramdhean** | Claimant |
|  | **- and –** |  |
|  | **Alfredo Kwabla Agedo (1)**  **The Forum Dental Practice Limited (2)** | Defendants |
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**Mr William Poole** (instructed by **Atherton Godfrey LLP**) for the **Claimant**

**Mr Michael Hill** (instructed by **Applebys**) for the **Second Defendant**

Hearing dates: 10 and 11 October and 16 December 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HER HONOUR JUDGE BELCHER

**Her Honour Judge Belcher :**

1. In this matter the Claimant, Neema Ramdhean, claims damages for personal injuries and other losses suffered as the result of the alleged negligent dental treatment provided by the First Defendant, Dr Alfred Agedo. He has taken no part in these proceedings and his whereabouts are not known. The dental care provided by Dr Agedo was in fulfilment of obligations of the Second Defendant, The Forum Dental Practice Limited (“FDPL”), under an Intermediate Minor Oral Surgery contract (the “IMOS”) with Doncaster Primary Care Trust (the “PCT”). The nature of the relationship between the Defendants is at the heart of this matter and central to whether the Second Defendant has any liability in respect of any negligent work carried out by Dr Agedo. References in this judgment to the Trial Bundle will be by Tab number and page number, for example [6/81].
2. By Order dated 28 November 2018, [19/297] District Judge Batchelor ordered a split trial, with the following issues to be dealt with first:
   1. Whether the Second Defendant owed to the Claimant a non-delegable duty of care in relation to the advice and treatment provided to the Claimant by the First Defendant
   2. Whether the Second Defendant is to be held vicariously liable for any such negligence as the Claimant may subsequently prove in her claim against the First Defendant.

Those issues are the subject of this Judgment. I made it clear in the course of closing submissions that those were the issues ordered to be the subject of this split trial and that I would not address any other issues. I have in mind, in particular, the issue as to whether the Second Defendant might be liable for the alleged negligence of its receptionists in failing to book Miss Ramdhean in sufficiently promptly when she was referred back for further review. That forms no part of this judgment.

1. When the claim was first issued, NHS England was joined as a Third Defendant and NHS South Yorkshire and Bassetlaw (which by the time of the issue of the claims was the relevant PCT) was joined as the Fourth Defendant. The claim was subsequently discontinued against those parties.

The Facts

1. In 2013/14 Miss Ramdhean was a registered NHS patient of Warmsworth Road dental centre in Doncaster. Any dentist providing dental treatment to her at that centre was her general dental practitioner (“GDP”). She attended her GDP in September 2013 as a result of pain in the region of her left lower wisdom tooth. She was referred to Doncaster Royal infirmary for an x-ray of the tooth. In April 2014 she returned to her GDP and was advised that her wisdom tooth needed extracting. She was further advised that the GDP did not carry out extractions and was not qualified to do so, and that she would be referred to another practice for this procedure. Her GDP then referred her to FDPL [Witness Statement of Neema Ramdhean: 9/139; paragraphs 10-12].
2. An appointment was made for the extraction at The Flying Scotsman Centre in Doncaster. The IMOS provided that all procedures should be at The Flying Scotsman Centre, a property not owned or operated by FDPL. I was told it is owned by the NHS or PCT. On the first occasion Ms Ramdhean attended, she was sent away without treatment as she attended with her children. She was given a further appointment and she attended again on 2 September 2014, where she was seen by Dr Agedo who treated her, and told her that everything was fine. She assumed this meant the extraction had gone to plan. She was not told that the roots of the tooth had not been removed [Witness Statement of Neema Ramdhean: 9/140-141, paragraphs 14 – 15 and 21-22].
3. Miss Ramdhean’s case is that Dr Agedo had negligently failed to remove the roots. Her GDP referred her back to the Second Defendant and she attended a further appointment on 6 January 2015, again at The Flying Scotsman Centre, where she was again treated by Dr Agedo. She was not particularly happy about being seen by Dr Agedo [Witness Statement of Neema Ramdhean: 9/142; paragraphs 32 -33]. From the witness box she told me that following this treatment session, Dr Agedo told her that the roots had all come out, but subsequent x-rays showed that some of the roots had been left behind and required removal.
4. After referral by her GDP to Mexborough Montague hospital, the roots were finally removed in August 2015, but Miss Ramdhean is left with some loss of sensation around the left side of her lip, chin and tongue [Witness Statement of Neema Ramdhean: 9/ 144 -145; paragraphs 42 – 50]. From the witness box she told me that her current symptoms were earaches and tenderness in the gum but that the other symptoms had resolved.
5. In cross-examination it was suggested to Miss Ramdhean that if she had not been satisfied with Dr Agedo, had not liked him, or was concerned about the treatment he proposed, she could have refused the treatment. Her response was that she did not really have a choice because she was in pain. She did not think about whether she could go back to her own dentist.
6. The parties are agreed in this case that Dr Agedo had professional indemnity cover. However, Dr Agedo did not notify his professional indemnifiers of a possible claim in relation to Miss Ramdhean, and they have, therefore, declined cover, as they were entitled to under the terms of the indemnity cover provided. At the time of Miss Ramdhean’s treatment, FDPL held public liability insurance (to cover falls in the building and matters of that type), and Dr Jackson held personal medical indemnity insurance in respect of medical/dental work carried out by him personally. The public liability insurance does not cover clinical negligence. Dr Jackson told me that in the light of this case he approached his insurers, Target, and FDPL now holds an insurance policy which does cover them for negligent work undertaken by associates of the practice. He told me FDPL is the first dental practice in the country to hold this type of cover. This type of cover was not available in the marketplace in 2014, at the time when Dr Agedo treated Miss Ramdhean.
7. The Second Defendant is a limited company, set up in this way, on the advice of accountants, for tax reasons. Dr Keith Jackson is employed by FDPL. He is the managing director and the majority shareholder of FDPL. He is a fully qualified general dental practitioner as well as a specialist orthodontist. [Witness Statement of Keith Jackson: 10/146, paragraphs 1 and 2]. From the witness box he explained that the extraction of wisdom teeth is a specialist area of expertise. Dr Jackson does not have this expertise and in order to meet its obligations under the IMOS, FDPL had to appoint an associate surgeon to carry out any referral work for extraction of wisdom teeth and other minor oral surgery. He said that a GDP sends a written referral to FDPL. That referral must have an up-to-date medical history and a radiograph and must specify the treatment required. Dr Jackson said that acceptance of such a referral did not make the referred individual a patient of the practice.
8. Dr Jackson asserted that FDPL’s responsibility to the patient begins when the patient walks through the door and turns up for treatment. He said that the individual becomes a patient of the practice (meaning FDPL) for the purposes only of the referral for treatment. He asserted that for treatment purposes, Mrs Ramdhean was a patient only of Dr Agedo, as he was the only person in the practice who could carry out this specialist extraction work. He said that for wisdom tooth extraction and other minor oral surgery, the IMOS contract “…was delivered by Dr Agedo”.
9. I heard a lot evidence about Dr Agedo’s suitability for his appointment by FDPL as an associate for the carrying out of minor oral surgery. I have used the word “appointment” deliberately and neutrally. At the time of his appointment Dr Agedo was on the General Dental Council’s (“GDC”) list as a specialist in oral surgery and had been on it for some time [Witness Statement of Keith Jackson: 10/147; paragraph 12]. Dr Jackson was aware that Dr Agedo had been the subject of disciplinary action by the GDC previously. Dr Jackson told me he had looked on the GDC website and found that Dr Agedo had been suspended and erased from the list of dentists on the basis of retrospective alteration of notes. Dr Jackson said this was discussed in interview and that Dr Agedo explained that he had been foolish and had been through the GDC disciplinary process. Dr Jackson said that as Dr Agedo had been restored to the register, the GDC had determined he was fit to be practising dentistry.
10. Dr Jackson also told me he had spoken to colleagues in the PCT to ascertain if there were any issues with Dr Agedo’s clinical competence. None was identified. (Witness Statement of Keith Jackson: 10/148; paragraphs 17 and 18]. Dr Jackson was also cross examined about Dr Agedo’s issues with alcohol. At the time of Dr Agedo’s appointment in 2012, Dr Jackson was aware there had been allegations of an altercation in a dental practice involving Dr Agedo and that a receptionist had alleged she could smell alcohol. In those circumstances the PCT required FDPL to breathalyse Dr Agedo every day when he came into work and before he saw a patient. This was done, and there were never any issues with alcohol. In December 2013 Dr Agedo appeared in court in connection with allegations of refusing to give an alcohol sample when stopped in his car by police. Dr Agedo informed Dr Jackson of this arrest. Dr Jackson told me that there was never any evidence that alcohol was a factor in Dr Agedo’s working life. Dr Agedo was subsequently convicted of driving whilst over the prescribed limit, and the GDC removed him from the register at which point FDPL terminated its relationship with Dr Agedo.
11. As referred to in paragraph 9 above, Dr Agedo had professional indemnity cover. This was provided by Dental Protection, a mutual society that provides discretionary indemnification. Dental Protection has confirmed that Dr Agedo has not notified them of Ms Ramdhean’s claim and Dental Protection has declined cover, or any interest in these proceedings [Amended Defence of FDPL: 6/99; paragraph 40; and email at 22/304]. In his Witness Statement Dr Jackson describes the arrangement between FDPL and Dr Agedo as a subcontract, as specifically permitted by the IMOS. He states “Dr Agedo, like every one of his contemporaries across the country in similar roles was a fully qualified, self employed, individually indemnified, independent dental professional” [10/149; paragraph 24]. He asserts that the entire NHS dental industry operates under these arrangements and that the situation has been relatively unchanged since the introduction of the NHS [10/149; paragraph 28].
12. From the witness box, Dr Jackson stressed that the GDC is satisfied with discretionary professional indemnity cover for individual dentists and that the associate agreement has been part of NHS dentistry since 1948. Prior to this case, Dr Jackson was unaware of the difference between insurance cover (which Dr Jackson told me he has for his own dental work) and a discretionary product provided by a mutual provider. He told me that the GDC will not register a dentist unless he or she has adequate indemnity cover. He said that if the GDC accept that type of discretionary policy as sufficient, who is he to question that? Dr Jackson told me that the dental profession accepts that dentists are self-employed and provide their own indemnity cover. They have no employment rights and HMRC accept that they are not employees. Dr Jackson described FDPL as simply an administrative centre with only administrative responsibility for the IMOS, with the associate taking clinical responsibility.
13. FDPL received £115 per episode of treatment under the IMOS [12/245: 63,250 divided by 550 = 115]. FDPL paid Dr Agedo £50 per episode of treatment, and FDPL’s mark-up was, therefore, more than 100%. Challenged that he could not take the lion’s share of the income but pass all responsibility to Dr Agedo, Dr Jackson said that is the way the dental profession operates, and that the associate model has been in place for many years. He said associates are self-employed which has been a model accepted by the GDC and the British Dental Association (“BDA”) for many years. Any change in that would, he told me, have major implications for the dental profession. In cross examination Dr Jackson accepted that FDPL had ample assets from which it could meet any successful claim in this case.

The Legal Issues

1. Before turning to the two questions the subject matter of this trial, there are some general points which need to be made. Plainly I must decide this case on the law as I understand it to be. My decision cannot be affected by extraneous matters. It follows, in my judgment, that any potential impact on the dental profession is not a relevant consideration. The fact that dental practices have operated in this way since 1948 cannot determine the issues before me in this trial. The law has developed since 1948, as have the methods of delivering medical and dental provision to NHS patients. In response to questions from me, Dr Jackson agreed that the procedures typically covered by the IMOS would historically have been delivered in the secondary care setting of a hospital. IMOS and similar contracts were created to secure the provision of appropriate services outside the hospital setting with a view to saving cost and maximising the efficient delivery of services for all patients. He told me that IMOS is quicker than secondary services in hospital.
2. Mr Poole also made the further point that the world has also moved in the context of the breakdown in traditional forms of employment. He referred to zero hours contracts in the “gig economy” in which temporary positions are common and organisations often contract with independent workers on a short term basis to meet a particular need.
3. Similarly, in my judgment, the point made by Mr Poole in his skeleton that the Claimant’s only hope of obtaining an effective remedy is by bringing a claim against FDPL, is also not a relevant consideration. It forms no part of my decision making for me to try and find someone to impose liability on simply because they can afford to meet a claim, whether through insurance or from personal assets. There must be a proper basis for imposing a legal liability on a party, regardless of whether or not that party has the ability to meet any judgment sum awarded against it.
4. In his closing submissions, which I shall consider in detail below, when considering the issue of whether the Claimant had any control over how the Defendant choses to perform the obligations, Mr Hill made the point that FDPL and the PCT are in exactly the same position in terms of their control and he suggested any non-delegable duty should be fixed on the PCT, rather than on FDPL. Mr Poole told me that the proceedings were discontinued against the PCT and the NHS because this is a QOCS case, and if the Claimant was to succeed against one party and lose against another, she would have to pay the costs of the party she lost against out of any compensation. In those circumstances he told me all her damages would be swept away in costs. I understand that decision, but the reasons for selecting a particular party to proceed against plainly cannot inform my decision on the legal issues in this trial.

Did the Second Defendant owe to the Claimant a non-delegable duty of care in relation to the advice and treatment provided to the Claimant by the First Defendant?

1. Counsel are agreed that the starting point is the Supreme Court decision in *Woodland v Swimming Teachers Association & Others* [2013] UKSC 66 (“*Woodland*”). In that case the Appellant (W), then age 10, was a pupil at a school for which the local authority was responsible. The national curriculum at the time included swimming lessons as part of the physical training programme. The lessons were provided by an independent contractor, a Mrs Beryl Stopford, trading as Direct Swimming Services. She had contracted with the education authority to provide swimming lessons to its pupils. A swimming teacher and lifeguard were provided by Mrs Stopford. Neither was employed by the education authority. Tragically W got into difficulties and suffered a serious brain injury. W’s case was that her injuries were caused by the negligence of the swimming teacher and the lifeguard. The Supreme Court held that the local authority had assumed a non-delegable duty to ensure that W’s swimming lessons were carefully conducted and supervised, by whomever it might get to perform those functions.
2. In his judgment Lord Sumption identified five factors which have given rise to non-delegable duties of care. At paragraph 23 of his judgment he said that if highway and hazard cases are put to one side, the remaining cases are characterised by the following defining features:

“(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.

(2) There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.

(3) The claimant has no control over how the defendant chooses to perform those obligations, i.e. whether personally or through employees or through third parties.

(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant’s custody or care of the claimant and the element of control that goes with it.

(5) The third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.”

1. Mr Hill reminded me that the five features were not set out as a test, but were identified as defining features. He also referred me to Paragraph 25 of Lord Sumption’s judgment in which he said

“The courts should be sensitive about imposing unreasonable financial burdens on those providing critical public services. A non-delegable duty of care should be imputed to schools only so far as it would be fair, just and reasonable to do so.”

Mr Hill submitted that the question of whether it is fair, just and reasonable to impose such a duty must form part of the test as to whether such a duty exists on the facts of any given case.

1. Mr Poole submitted that it is crucial that this case is within the field of healthcare provision. He pointed out that I am not being asked to hold that an individual dentist owes a non-delegable duty in connection with treatment by another dentist. Instead, he submitted, this is a limited company (FDPL) with its own distinct legal personality, but which, unlike a hospital or NHS Trust, profits from the very service which is the subject matter of the claim. He submitted that FDPL should, therefore, like a hospital, owe a non-delegable duty for all the clinical treatment provided to its patients, that is patients referred to the practice.
2. Mr Poole placed particular reliance on the Court of Appeal decision in *Farraj v King’s Healthcare NHS Trust* [20009] EWCA Civ 1203 (“*Farraj*”). In the course of his closing submissions he told me I should read the judgment of Dyson LJ (as he then was) in full. I confirm that I have done so. In *Farraj* the respondent parents were carriers of a gene which could cause an inherited blood disorder. When pregnant, the wife was advised to undergo DNA testing and a sample was taken and sent to the hospital. From there it was sent to independent specialist cytogenetics laboratory for foetal cells to be cultured. The laboratory cultured the cells, notwithstanding that it had doubts about the viability of the sample, doubts which it did not communicate to the hospital. The court found that the trust was not liable in respect of the tissue sample sent to the external laboratory by the trust. In doing so the court applied the general rule that the duty to take care may be discharged by entrusting the performance of a task to an apparently competent independent contractor.
3. However, Mr Poole relies upon *Farraj* in relation to what he submitted was the positive approach that a hospital does owe a non-delegable duty. It is important to note that the court in *Farraj* did not hold that a hospital owed a non-delegable duty. The court assumed, without deciding, that the concept of a non-delegable duty extended to hospital cases, but found that did not justify the conclusion on the facts of the case that the hospital owed a non-delegable duty in respect of the genetic testing sent to the third party laboratory. At paragraph 93 Dyson LJ points to the general rule that the duty to take reasonable care may be discharged by entrusting the performance of a task to an apparently competent independent contractor. The concept of a personal non-delegable duty is a departure from the basic principles of liability in negligence as it substitutes for the duty to take reasonable care a more stringent duty, namely a duty to ensure reasonable care is taken. Dyson LJ points out that must be justified on policy grounds otherwise there is a danger that the general rule (permitting subcontracting to a competent independent contractor) would become the exception rather than the rule
4. Having set out details of the authorities including Australian authorities, Dyson LJ discusses them in paragraph 88 to 98 of his judgment. That discussion includes the following:

“88. I am prepared to assume (without deciding) that the editors of Clark and Lindsell are right and that English law has now reached the stage that the approach advocated by Lord Greene and Denning LJ should be adopted. It is true that the extent to which a hospital owes a non-delegable duty to ensure that its patients are treated with due skill and care will depend on the facts of the particular case. But I shall assume that a hospital generally owes a non-delegable duty to its patients to ensure that they are treated with skill and care regardless of the employment status of the person who is treating them….. The rationale for this is that the hospital undertakes the care, supervision and control of its patients who are in special need of care. Patients are a vulnerable class of persons who place themselves in the care and under the control of a hospital and, as a result, the hospital assumes a particular responsibility for their well-being and safety.

92. ……. In my judgment, there is a significant difference between treating a patient who is admitted to hospital for that purpose and carrying out tests on samples which are provided by a person who is a patient. Such tests are not necessarily carried out in a hospital. The special duty that exists between a patient and a hospital arises because the hospital undertakes the care, supervision and control of persons who, as patients, are in special need of care. I accept that, if a patient who is admitted to hospital for treatment has tests carried out in the hospital, then the non-delegable duty of care, which for present purposes I am assuming to exist, would extend to the carrying out of the tests. But that is because the conducting of the tests is part of treatment that the patient is receiving in the hospital.”

Dyson LJ then went on to find that there were no policy reasons for imposing a non-delegable duty in that case. The parents were not being treated by the hospital but by a medical centre in Amman. The hospital did not undertake any special responsibilities to the parents on the facts of that case.

1. Mr Poole also referred me to the judgment of Sedley LJ in *Farraj*, paragraph 93, where he refers to the fact that for reasons explained by Dyson LJ, there is now persuasive authority for importing a non-delegable duty of care in relation to public hospitals. He goes on to say that it does not apply on the facts of that case because the facts do not fit the paradigm of patient and healthcare provider. Mr Poole submitted that the facts of this case plainly fit the paradigm of patient and healthcare provider. He submitted that the Claimant was specifically referred to FDPL by her GDP. He submitted that FDP is plainly the healthcare provider, and has a non-delegable duty in respect of its patient, the Claimant. Mr Poole submitted that I should reject Mr Hill’s submission that the non-delegable duty should be extended back up to the PCT. The PCT did not carry out the treatment, and Mr Poole submitted that FDPL exercised a greater degree of control than did the trust.
2. Mr Poole went further. He submitted that *Farraj* must be read in the light of the developments in *Woodland* and, in particular, the judgment of Baroness Hale where she said as follows:

“34. No one in this case has seriously questioned that if a hospital patient is injured as a result of a nurse’s carelessness it matters whether the nurse is employed by the hospital or by an agency; or if a pupil at school is injured by a teacher it matters with the teacher is employed by the school or is self-employed. Yet these are not employees of the hospital or school, nor can it be said that their relationship with the school is “akin to employment”… The reason why the hospital or school is liable is that the hospital has undertaken to care for the patient and the school has undertaken to teach the pupil, and that responsibility is not discharged simply by choosing apparently competent people to do it. The hospital or school remains personally responsible to see that care is taken in doing it.”

1. Mr Poole submitted that it follows from the authorities that once a case falls into healthcare provision, whether that be patient/dentist or patient/doctor, there is a non-delegable duty and the other factors identified by Lord Sumption do not apply. He submitted that the five characteristics apply when you want some organisation other than a hospital to be fixed with a non-delegable duty. He submitted there is a clear policy objective and that a patient is in an even more vulnerable class than that of an employee. He submitted that the Supreme Court would find it easier to decide this case in the Claimant’s favour than the case which was before the Supreme Court in *Woodland*. Mr Poole submitted that in *Woodland* the Supreme Court was saying that the non-delegable duty is obvious and applies in all healthcare cases, and that the Supreme Court decided to extend that duty to a school pupil. He submitted that Lady Hale has brought the law up to date.
2. In my judgment that submission goes too far. It ignores the judgment of Lord Sumption which expressly refers to all five characteristics. That paragraph was agreed with expressly by Baroness Hale in paragraph 38 of her judgment. Furthermore, at paragraph 39, Baroness Hale states “The boundaries of what the hospital or school has undertaken to provide may not always be as clear-cut as in this case…… but will have to be worked out on a case by case basis as they arise”. That expressly acknowledges that there may be cases involving a hospital where a non-delegable duty does not arise. Whilst it may be the case that the facts of many healthcare cases may produce a non-delegable duty, in my judgment the simple fact that the case involves healthcare provision is not necessarily sufficient, without more, for the court to impose a non-delegable duty.
3. Having said that, I recognise that the five factors set out by Lord Sumption do not constitute a test, and Baroness Hale made it clear that such judicial statements are not to be treated as if they were statutes and can never be set in stone (paragraph 38 of *Woodland*).
4. I turn then to consider the five factors set out by Lord Sumption. I recognise that there is some overlap between the characteristics. The first is that “The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.” Mr Poole submitted that the Claimant plainly satisfies this criterion. He submitted that she was a patient of FDPL. Indeed, Dr Jackson eventually accepted that in his evidence. Mr Poole relied on the fact that FDP accepted the referral from her GDP, which placed her in the custody/charge of FDPL. That he submitted was sufficient to place on FDPL a positive duty to protect her from harm. He pointed to the fact that the Claimant has no control over the identity or appointment of Dr Agedo. He submitted that FDPL delegated to Dr Agedo the very treatment for which the Claimant was referred to FDPL.
5. Whilst Mr Hill accepted that the Claimant was a patient of FDPL, he denied she was dependent on the protection of FDPL against the risk of injury. That he submitted was to wholly ignore the role of Dr Agedo, who was on the oral surgery specialist register of the GDC and was independently indemnified as required by the GDC. Mr Hill submitted that the Claimant was, therefore, dependent upon the protection of Dr Agedo, and not FDPL.
6. Mr Hill referred me to the IMOS. Page 1 sets out the background and records the fact that it is the duty of the PCT to exercise its powers so as to provide or secure the provision of primary dental services within its area, and that in order to achieve this it is empowered by the National Health Service Act 1977 and Regulations made thereunder to enter into personal dental service agreements with specified categories of person. The IMOS then goes on to say that the PCT and the Contractor (FDPL) wish to enter into a personal dental services agreement under which FDPL is to provide personal dental services and other services in accordance with the agreement [12/160; Background A, B and D]. Mr Hill submitted that the Claimant was dependent upon the protection of the PCT in exactly the same way as she alleges she was dependent upon the protection of FDPL. He referred to the fact that she had discontinued her claim against the PCT. As I have already made clear, I do not regard the discontinuance of proceedings against the PCT and NHS as informing my judgment in this matter. Mr Hill’s point is that the PCT engaged FDPL, and FDPL engaged Dr Agedo, and that the PCT was, therefore, in exactly the same position as FDPL in passing on the arrangements.
7. I am not satisfied that the “passing on of arrangements” is the same for the PCT and for FDPL. Whilst the PCT has a duty to provide or secure the provision of primary dental services within its area, because it chose to secure that provision through FDPL, the PCT never accepted the Claimant as a patient. The PCT entered into a contract with FDPL under which FDPL was to provide the dental services. In doing so, the PCT was complying with its duty to secure the provision of primary dental services. I cannot see why that arrangement should not fall within the general rule that the duty to take reasonable care may be discharged by entrusting the performance of a task to an apparently competent independent contractor. The PCT did not undertake the care, supervision and control of the patient in this case.
8. FDPL did accept the Claimant as a patient. Whilst Dr Jackson tried to suggest that FDPL’s function was merely administrative, merely passing the patient onto Dr Agedo, I am entirely satisfied that the Claimant was a patient of FDPL. The services under IMOS were clearly to be provided by the Contractor, that is FDPL [12/179-187; Clauses 40 – 730]. The IMOS recognises that FDPL will have to employ or otherwise engage dental practitioners to perform the dental services. That is inevitable given that FDPL is a company. The IMOS contains terms and conditions relating to those performing the services and conditions for their employment or engagement, and expressly permits subcontracting of clinical matters [12/197-203; Clauses 178-201]. The IMOS also impose positive obligations on FDPL, such as, for example, ensuring that any dental practitioner performing services under the IMOS was maintaining and updating his skills and knowledge in relation to those services he was performing [12/201, Clause 195]. Whilst Dr Jackson plainly did not understand this to be an obligation on FDPL, that is beside the point. What it does illustrate is that, on any view, FDPL was not (or should not have been) the simple administrative referral service which Dr Jackson sought to suggest.
9. As indicated above, there was a great deal of evidence about whether Dr Jackson on behalf of FDPL had acted properly and/or in accordance with the contract in recruiting Dr Agedo. I make no findings on whether or not Dr Agedo was properly appointed by FDPL. If there is a non-delegable duty on FDPL, that duty remains with FDPL regardless of whether or not all proper care was taken in the appointment of Dr Agedo. It seems to me that if the recruitment of Dr Agedo was negligent, that may give rise to a primary liability on FDPL in any event. However, I consider it has no relevance to the question of whether there is a non-delegable duty.
10. Whilst bearing in mind Baroness Hale’s indication that the five characteristics are not be treated as if they were statutes or as if set in stone, I also note that the reference to the claimant being dependent on the protection of the defendant against the risk of injury is in the alternative. Lord Sumption first of all identifies the claimant as a patient or a child. If neither of those, then one has to consider whether for some other reason the claimant is especially vulnerable or dependent on the protection of the defendant against the risk of injury. He then gives prisoners and residents in care homes as likely examples of those categories. In my judgment, the Claimant in this case was clearly a patient and the first characteristic is, therefore, satisfied.
11. The second characteristic is as follows:

“There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.”

1. Mr Hill submitted that the only arguable antecedent relationship between the Claimant and FDPL could be that FDPL arranged for the Claimant to be examined by Dr Agedo. Under the terms of the Oral Surgery Associate Agreement (the “Associate Agreement”) between FDPL and Dr Agedo, FDPL “… may introduce to the Associate patients requiring Oral Surgery but the Associate shall be under no obligation to accept for advice or treatment any patient so introduced” [13/266, clause 18]. Mr Hill submitted the only decision as to whether to treat the Claimant or, indeed, to decline to treat her, was Dr Agedo’s. He submitted, therefore, that the Claimant was not in the actual care of FDPL, but in the actual care of Dr Agedo.
2. In my judgment, whilst at first sight an attractive submission, that submission is approaching the matter in the wrong order. In *Woodland* the claimant was in the actual charge or care of the lifeguard and swimming teacher at the time of the incident in the swimming pool. However, she was also in the actual charge or care of the school, and thus of local authority responsible for the school. The two are not mutually exclusive. The question is not whether the Claimant was in the care of the First Defendant (which she undoubtedly was), but whether she was in the actual care of FDPL. If I ask myself “Did FDPL undertake the care, supervision and control of the Claimant as its patient?”, I conclude that it clearly did. In my judgment, FDPL has undertaken to care for the Claimant, albeit the IMOS permits that to be by way of employing dentists, or otherwise engaging their services, including by way of sub-contracting.
3. Is it possible to impute to FDPL the assumption of a positive duty to protect the Claimant from harm and not just a duty to refrain from conduct which will foreseeably damage the Claimant? Lord Sumption stated that it is a characteristic of such relationships that they involve an element of control over the claimant which varies in intensity from one situation to another. Mr Hill submitted that FDPL had no control over the Claimant, and that the only control was exercised by Dr Agedo as the treating oral surgeon. It is undoubtedly right that the only dental surgeon that the Claimant saw as a result of her referral to FDPL was Dr Agedo. I accept that FDPL had no control over the treatment decisions made by Dr Agedo. However, in my judgment FDPL inevitably had control in the sense that it was entirely up to FDPL to refer Ms Ramhdean to Dr Agedo. Whilst Dr Agedo was the only oral surgeon available to FDPL, it seems to me that is beside the point. FDPL played a central role as the Contractor under the IMOS, in accepting Ms Ramdhean as a patient of FDPL, and in directing her to Dr Agedo as the treating dental surgeon. As Mr Poole pointed out, Ms Ramdhean did not then become a patient of Dr Agedo. Dr Agedo could not make her a patient of his own. Ms Ramdhean’s GDP could not refer her directly to Dr Agedo. FDPL played an instrumental role and, in my judgment, thereby exercised a sufficient degree of control over the Claimant.
4. Mr Hill submitted that there was no real control over the Claimant on the basis that it was open to her to decline treatment from Dr Agedo, and to revert to her GDP and ask for a different referral, either to another IMOS provider within the PCT, or by referral to secondary care within the hospital. In response to this, Mr Poole submitted that Ms Ramdhean’s GDP referred her to FDPL because FDPL provides extraction of wisdom teeth to NHS patients. He submitted it was entirely unrealistic for Mr Hill to say that Ms Ramdhean had the choice to walk away. I accept that submission.
5. The third characteristic is that the claimant has no control over how the defendant chooses to perform those obligations, i.e. whether personally or through employees or through third parties. Mr Hill again sought to rely on the fact that the Claimant could refuse treatment and could leave and seek a further and different referral from her GDP. In my judgment that submission misses the point. The third characteristic is whether the claimant had control over how FDPL chose to perform its obligations under the IMOS, whether personally or through employees or other third parties. The Claimant plainly had no control at all over those matters.
6. The fourth characteristic is that the defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and that the third party is exercising, for the purpose of the function thus delegated to him, the defendant’s custody or care of the claimant and the element of control that goes with it. Mr Hill submitted that FDPL did not accept a positive duty. He submitted its function was simply an administrative moving of the Claimant onto the First Defendant. Mr Hill also relied on the fact that FDLP was subcontracting the duty out to a far more qualified individual than in fact required by the IMOS. The IMOS requires a dental practitioner, whereas Dr Agedo was on the specialist list. Again, in my judgment, this is approaching the issue from the wrong end. Given that I have found that FDPL accepted the Claimant as a patient for minor oral surgery, in my judgment it follows that the function delegated to Dr Agedo was an integral part of that function. The care of the Claimant which FDLP accepted when it accepted the referral from the GDP, was delegated to Dr Agedo, together with the element of control that goes with that, namely the clinical decisions concerning treatment. In my judgment neither the fact that FDPL could not make those clinical decisions, nor the fact that Dr Agedo was more qualified that the minimum requirement in the IMOS, alters that.
7. The fifth characteristic is that the third party has been negligent, not in some collateral respect, but in the performance of the very function assumed by the defendant and delegated by the defendant to him. No findings have been made as to whether or not the treatment given by Dr Agedo was indeed negligent. That formed no part of the trial before me. However, the allegations in the case relate to treatment and that is clearly not a collateral matter, but the very function assumed by FDPL, and delegated by FDPL to Dr Agedo.
8. Mr Hill submitted that it would be an exceptional step for me to take to transfer personal liability from Dr Agedo to FDPL as a party who did not carry out the act said to be negligent. He said this has to operate in limited circumstances and he submitted it would not be fair, just or reasonable to do so in the circumstances of this case. He submitted that the duty remains a duty to take reasonable care which FDPL has satisfied by subcontracting. He emphasised that FDPL undertakes no examination or assessment of patients. He submitted that FDPL had subcontracted in good faith to a competent subcontractor and had informed the PCT that it was subcontracting to Dr Agedo. Mr Hill submitted that the PCT knew that the single director was an orthodontist and that he could not undertake or oversee oral surgery. He suggested that the evidence showed that the PCT promoted the appointment of Dr Agedo. I consider that submission overstates the evidence which was that Dr Jackson discussed the matter with colleagues at the PCT to get their personal views and check clinical competence, and that the PCT was involved specifically on the issues as to alcohol testing before Dr Agedo saw any patients. In any event, I agree with Mr Poole that none of those matters alters the contractual obligations imposed on FDPL by the IMOS.
9. Mr Hill submitted that in all the circumstances it is not fair or reasonable to fix FDPL with the higher duty of care. Mr Hill submitted that the Claimant’s case is an attempt to find someone to pick up liability because she is unable to pursue Dr Agedo. He submitted that there are two innocent parties before the court. He submitted that the fact that indemnifiers can refuse an indemnity is not unfairness of a nature which should fix FDPL with liability. He submitted that the Claimant was not alone in that position and that all patients face the risk of an indemnifier refusing an indemnity. He pointed out that the Regulator is satisfied with that form of cover. I accept Mr Hill’s submissions that FDPL should not be criticised for not ensuring adequate insurance under IMOS, and that the indemnity cover was adequate for the purposes of dental treatment nationwide as accepted by the GDC.
10. I accept that it must be fair, just and reasonable to impose the higher duty of care which results in the imposition of a non-delegable duty. I also accept that it is not simply a question of identifying someone with insurance and/or sufficient assets to meet a claim. However, the converse is also true. The fact that another party may have insurance cover does not determine the liabilities of other parties to proceedings. Lawyers are well familiar with situations where there may be a number of potential defendants but the only one which is sued is the one with insurance cover or who has sufficient assets to satisfy an judgment. It does not mean that those without insurance or without sufficient assets are also without liability. The fact that Dr Agedo had indemnity cover does not, in my judgment, assist me in considering whether it is fair just and reasonable to impose a non-delegable duty upon FDPL.
11. Dr Jackson told me FDPL was set up for tax reasons on the advice of financial advisers. Plainly there is nothing wrong with that. It is the company which is paid by the PCT to provide the dental services under the IMOS. Clearly the company could employ staff to provide the services, and it would then be liable in respect of any negligence by an employee. I have found that when it accepts a referral, FDPL accepts the referred patient as a patient of the practice, that is of the company. Whilst FDPL has chosen to set its business up in such a way that Dr Jackson regards it is exercising purely administrative functions, that does not alter the fact that it accepts patients, and in doing so, accepts an obligation to provide those patients with the relevant dental services. That being so, is it fair just and reasonable to impose a non-delegable duty on the company in respect of the care of those patients and in the light of the five characteristics which I have gone through? In my judgment, on the facts of this case, it is entirely fair, just and reasonable to impose that duty on FDPL. The PCT has secured the provision of dental services by FDPL through the IMOS. The PCT pays FDPL a fee in respect of each such service provided [12/245]. FDPL is a commercial concern operating to make a profit. FDPL accepted Ms Ramdhean as its patient. In my judgment all of those factors together with my analysis of the five characteristics in this case make it entirely fair, just and reasonable to impose the non-delegable duty on FDPL.
12. Accordingly, I find that the Second Defendant owed to the Claimant a non-delegable duty of care in relation to the advice and treatment provided to the Claimant by the First Defendant.

Is the Second Defendant to be held vicariously liable for any such negligence as the Claimant may subsequently prove in her claim against the First Defendant?

1. Having ruled that FDPL owes a non-delegable duty of care to Ms Ramdhean, it is technically unnecessary for me to consider this issue which arises in the alternative. However, I am mindful of the submissions made to me about the impact my decision will have on dental practitioners nationally and mindful that this matter may, therefore, go further. In those circumstances, I consider I should deal with the vicarious liability issue.
2. I was referred to a number of authorities on this issue including *Barclays Bank plc v Various Claimants* [2018] EWCA Civ 1670 (“*Barclays Bank*”). That case has been the subject of an appeal to the Supreme Court. The Supreme Court heard the matter in November 2019, but judgment has not yet been handed down, and it is not known when it will be handed down. Counsel agreed that I should proceed on the basis of the law as it stands at present. In *Barclays Bank* it was held that there was vicarious liability for the acts or omissions of an independent subcontractor. However, that conclusion was reached by applying the approach laid down by the Supreme Court in *Cox v Ministry of Justice* [2016] UKSC 10 (“*Cox*”), and *Mohamud v WM Morrison Supermarkets PLC* [2016] UKSC 11 (“*Mohamud*”) as approved in *Armes v Nottinghamshire County Council* [2017] UKSC 60 (“*Armes*”). The question in *Barclays Bank* was whether the approach in those cases supported a finding of vicarious liability conclusion on the facts of that particular case (see Judgment of Irwin LJ at paragraphs 41 – 45). I take the view that *Barclays Bank* was decided on its particular facts, and that it is not necessary for me to consider that decision when deciding this case. I must apply the approach laid down in *Cox* and *Mohamud*, as approved in *Armes*, to the facts of this case.
3. Both Counsel took as a starting point the judgment of Lord Phillips in *The Catholic Child Welfare Society v The Institute of the Brothers of the Christian Schools* [2012] UKSC 56 (the “*Christian Brothers*”). At paragraph 35 Lord Phillips identified five criteria which usually make it fair just and reasonable to impose vicarious liability on an employer:

“i ) The employer is more likely to have the means to compensate the victim than the employee and can be expected to have insured against that liability;

ii) The tort will have been committed as a result of activity being taken by the employee on behalf of the employer;

iii) The employee’s activity is likely to be part of the business activity of the employer;

iv) the employer, by employing the employee to carry on the activity will have created the risk of the tort committed by the employee;

v) the employee will, to a greater or lesser degree, have been under the control of the employer.”

1. In paragraph 2 of his judgment in *Cox*, Lord Reed stated that the scope of various liability depends upon the answers to two questions. The first is what sort of relationship has to exist between an individual and the defendant before the defendant can be made vicariously liable in tort for the conduct of that individual? The second is in what manner does the conduct of that individual have to be related to that relationship, in order for vicarious liability be to be imposed on the defendant? Lord Reed made it clear that the first question is the subject of the appeal in *Cox*, and the second question is the subject of the appeal in *Mohamud*, and that the two judgments are intended to be complementary. Cox approached the first question in the light of the judgment of Lord Phillips in *Christian Brothers*.
2. At paragraph 20, Lord Reed makes it clear that the five factors set out by Lord Phillips in *Christian Brothers* are not all equally significant. Dealing with the first factor, namely that the defendant is more likely than the tortfeasor to have the means to compensate the victim, and can be expected to have insured against vicarious liability, Lord Reed stated that this is unlikely to be of independent significance in most cases, and he continued as follows:

“It is, of course, true that where an individual is employed under a contract of employment, his employer is likely to have a deeper pocket, and can any event be expected to have insured against vicarious liability. The mere possession of wealth is not in itself any ground for imposing liability. As for insurance, employers insure themselves because they are liable: they are not liable because they have insured themselves. On the other hand, given the infinite variety of circumstances in which the question of vicarious liability might arise, it cannot be ruled out that there might be circumstances in which the absence or unavailability of insurance, or other means of meeting a potential liability might be a relevant consideration”

1. Mr Poole submitted that NHS dental patients should not find themselves in a legal black hole. If the most efficient way of delivering patient services is for the NHS to subcontract, and for the subcontractor to re-subcontract, he submitted the law should move with the times. He suggested that the business model employed by FDPL is not a traditional way for dentists to deliver their services, and that historically they would have worked as individuals or for a hospital. He referred me to paragraph 55 in the judgment of Lord Toulson in *Mohamud* in which Lord Toulson acknowledged that there have been developments in the law as to the type of relationship that has to exist between an individual and defendant for vicarious liability to be imposed, and that these developments have been a response to changes in the legal relationships between enterprises and members of their workforces, and the increasing complexity and sophistication of the organisation of enterprises in the modern world.
2. Mr Poole made the point that business arrangements should not leave an entirely innocent patient without an effective remedy. Whilst acknowledging that the business may be entirely innocent, he submitted that in this case it was FDPL that profited from the provision of the treatment to Ms Ramdhean. He further submitted that the case law decisions provided ample warning for the likes of FDPL as to its potential liabilities, and he also pointed to the fact that FDPL now insures against the very liability it contends does not exist. As already made clear this is not a case where FDPL cannot financially meet any award which might be made in favour of Ms Ramdhean, even though it carried no insurance at the relevant time. However, whilst the absence of means might be relevant to the imposition of vicarious liability, in the extracts set out above Lord Reed made it clear that the presence of insurance or the deeper pocket/means to pay is not, in principle, justification for imposing vicarious liability.
3. In dealing with the fifth factor, that the tortfeasor will, to a greater or lesser degree, have been under the control of the defendant, at paragraph 21 of *Cox* Lord Reed made the point that it no longer has the significance it was sometimes considered to have in the past as Lord Phillips had made clear in *Christian brother.*  Lord Reed continued as follows:

“Accordingly , … the significance of control is that the defendant can direct what the tortfeasor does, not how he does it. So understood, it is a factor which is unlikely to be of independent significant in most cases. On the other hand, the absence of even that vestigial degree of control would be liable to negative the imposition of vicarious liability”

1. Mr Hill relies on that in support of his submissions that there can be no finding of vicarious liability in this case. His case is that the Associate Agreement makes it clear that FDPL had no control over the treatment provided by Dr Agedo. It was up to Dr Agedo to decide what if any treatment should be carried out, or to refer a patient to secondary care. Whilst Mr Poole accepts that is the case under the Associate Agreement, he submitted that there is a degree of control, at the very least that vestigial degree of control, in that the only reason that Dr Agedo received a patient is because FDPL has passed its own patient (referred to and accepted by FDPL under IMOS) onto Dr Agedo. It is FDPL which selects Dr Agedo, and Dr Agedo cannot go out looking for business for FDPL to service under the IMOS. That is plainly right.
2. Mr Hill made the point that there were only two oral surgeons available within the PCT area and that, in effect, Dr Agedo was the only one available for FDPL to engage to deliver the IMOS. Counsel are agreed that all procedures covered by the IMOS could be delivered only by Dr Agedo. In my judgment, the fact that Dr Agedo was the only dental surgeon available for appointment by FDPL in order to discharge its obligations under the IMOS has no relevance. If Dr Agedo had been considered unsuitable, or had declined to accept the Associate Agreement, then FDPL would not have been able to deliver the IMOS. Equally, if there had been other dental surgeons available, somebody other than Dr Agedo might have been appointed. Can any of that make any difference to the question of what control FDPL had over the appointed dental surgeon? In my judgment it can make no difference at all. The fact remains that the PCT was paying FDPL to deliver the IMOS, and in order to do so, having accepted a patient, it was in FDPL’s control to determine that that work should be passed to Dr Agedo. I accept that FDPL could not tell Dr Agedo how to carry out any particular treatment, and I recognise that FDPL could not prevent him declining to treat a patient if he thought that was the right thing to do. However, the only reason that Dr Agedo was in a position to carry out treatment on Ms Ramdhean, was because she was referred to FDPL under the IMOS, and FDPL passed her on to Dr Agedo for treatment. In my judgment there is sufficient control in this case to meet the fifth of the factors set out by Lord Phillips.
3. At paragraphs 22 and 23 in *Cox*, Lord Reed noted that the remaining three factors are inter-related. Referring to those factors, Lord Reid stated that

“The essential idea is that the defendant should be liable for torts that may fairly be regarded as risks of his business activities, whether they are committed for the purpose of furthering those activities or not.”

1. He expanded further on this at paragraphs 29 – 31

“29. It is important, however, to understand that the general approach which Lord Phillips described is not confined to some special category of cases, such as the sexual abuse of children. It is intended to provide a basis for identifying the circumstances in which vicarious liability may in principle be imposed outside relationships of employment. By focusing upon the business activities carried on by the defendant and their attendant risks, it directs attention to the issues which are likely to be relevant in the context of modern workplaces, where workers may in reality be part of the workforce of an organisation without having a contract of employment with it, and also reflects prevailing ideas about the responsibility of businesses for the risks which are created by their activities. It results in an extension of the scope of vicarious liability beyond the responsibility of an employer for the acts and omissions of its employees in the course of their employment, but not to the extent of imposing such liability where a tortfeasor’s activities are entirely attributable to the conduct of a recognisably independent business of his own or other third party. An important consequence of that extension is to enable the law to maintain previous levels of protection for the victims of torts, notwithstanding changes in the legal relationships between enterprises and members of their workforces which may be motivated by factors which have nothing to do with the nature of the enterprises activities or the attendant risks.

30. It is also important not be misled by a narrow focus on semantics: for example, by words such as “business”, “benefit”, and “enterprise”. The defendant need not be carrying on activities of a commercial nature: that is apparent not only from the cases of E and the Christian Bros, but also from the long established application of vicarious liability to public authorities and hospitals. It need not therefore be a business or enterprise in any ordinary sense. Nor need the benefit which it derives from the tortfeasor’s activities take the form of a profit. It is sufficient that there is a defendant which is carrying on activities in the furtherance of its own interests. The individual for whose conduct it may be vicariously liable must carry on activities assigned to him by the defendant as an integral part of its operation and for its benefit. The defendant must, by assigning those activities to him, have created a risk of his committing the tort…..

31. The other lesson to be drawn from the cases….. Is that defendants cannot avoid vicarious liability on the basis of technical arguments about the employment status of the individual who committed the tort.”

1. Mr Hill submitted that the treatment carried out by Dr Agedo was not carried out on behalf of FDPL any more than it was carried out on behalf of PCT, and he suggested it formed no more a part of FDPL’s business activities than it formed the business activity of the PCT. I cannot accept that submission. As I have already said, Dr Agedo was only in a position to carry out the treatment of Ms Ramdhean because she was passed on to Dr Agedo by FDPL. It was FDPL’s business activity, amongst other things, to deliver services under the IMOS, and the PCT paid FDPL for those services.
2. Mr Hill further submitted that FDPL did not create the risk, and that it merely introduced patients to Dr Agedo who had ultimate control over whether to treat each patient or not. This ignores the fact that without the IMOS, Miss Ramdhean would never have been referred to Dr Agedo. In my judgment FDPL’s business activities did create the risk, in exactly the same way as an employer who employs an employee to conduct his business creates the risk, in the sense of creating the situation in which a negligent act might occur. I should make it clear, given the tenor of cross examination, that I am not saying that FDPL created the risk by a poor appointments process/ appointing an individual with known difficulties or anything of that sort. I have already made it clear I do not consider it necessary for me to make findings on that issue. I base my assessment simply on the fact that FDPL used Dr Agedo to deliver, and thereby perform, FDPL’s obligations under the IMOS in terms of treating oral surgery patients. In my judgment it is self-evident that in doing so, FDPL created the risk.
3. Accordingly, in relation to Lord Reed’s first question set out in *Cox*, and applying the criteria from the *Christian Brothers* case, I find the relationship which existed between FDPL and Dr Agedo in this case is such that the FDPL can be made vicariously liable in tort for the conduct of Dr Agedo.
4. I now turn to Lord Reed’s second question: in what manner does the conduct of Dr Agedo have to be related to the relationship in order for vicarious liability to be imposed on FDPL? This was the question covered by the judgment in *Mohamud.* Mr Poole referred me to paragraph 1 of Lord Toulson’s judgment in *Mohamud* where he described this issue as being whether there was sufficient connection between the wrongdoer’s employment and his conduct towards the claimant to make the defendant legally responsible.
5. Mr Hill did not address me separately on this limb of the vicarious liability test and in my judgment that is unsurprising. Dr Agedo was engaged precisely to carry out the services under the IMOS contract, and it is in the course of delivering those services that it is alleged that Dr Agedo was negligent. In my judgment the connection between Dr Agedo treating a patient, and the relationship between FDPL and Dr Agedo is sufficiently connected, indeed precisely what Dr Agedo was engaged to do. I am satisfied that treatment conducted by Dr Agedo is sufficiently connected to the relationship to support a finding of vicarious liability.
6. Mr Hill addressed me in some detail on the issue of whether the Associate Agreement was a relationship “akin to employment” such as to make it appropriate to impose vicarious liability. He did so by reference to the judgment of HHJ Richard Seymour QC sitting as a judge of the High Court in *Whetstone v MPS* [2014] 1024 QB (“*Whetstone*”). That case bears similarities to this case because the claimant was alleging negligent treatment by a dentist who was an “associate” of Welby House Dental Practice. In deciding whether to impose vicarious liability, the learned judge approached the case on the basis that the issue for his consideration was whether the agreement between the “associate” and Welby House Dental Practice was properly to be considered as an independent sub-contract, or whether the relationship was in fact more akin to employment, such that vicarious liability could be imposed.
7. I mean no disrespect to Mr Hill when I indicate that I do not propose to address his submissions on that case. *Whetstone* is a first instance decision which predates the Supreme Court authorities in *Cox* and *Mohamud.* I plainly have to apply the principles set out in the Supreme Court authorities, and they expressly point out that technicalities about employment status are irrelevant (See per Lord Reed at paragraph 31 in *Cox*, quoted at paragraph 64 above).
8. Whilst I agree with many of the points made by Mr Hill as to differences between the associate agreements in *Whetstone* and in this case, I do not consider that a finding as to whether the Associate Agreement was or was not akin to employment advances this case at all. The approach has to be that laid down by the Supreme Court in *Cox* and *Mohamud*, as approved in *Armes*.
9. Accordingly, I find that the Second Defendant is vicariously liable for any negligence which the Claimant may subsequently prove in her claim against the First Defendant.