Neutral Citation Number: [2015] EWHC 614 (QB)

Case No: HQ12X01818

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/03/2015

Before :

THE HON. MRS JUSTICE SWIFT DBE

- -

Between :

MRS JULIE SHORTER	**Claimant**
- and -	
SURREY AND SUSSEX HEALTHCARE NHS TRUST	**Defendant**

- -
- -

Ms Charlotte Jones (instructed by **Penningtons Manches**) for the **Claimant**
Mr Julian Matthews (instructed by **Capsticks**) for the **Defendant**

Hearing dates: 18 – 20 November 20014

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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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THE HON. MRS JUSTICE SWIFT DBE

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The Honourable Mrs Justice Swift :

BACKGROUND TO THE CLAIM

1. On 13 May 2009, Mrs Lucia Sharma, who was aged 37 years and the mother of two small children, died as a result of a subarachnoid haemorrhage (SAH) from an aneurysm of the right middle cerebral artery whilst a patient at St George's Hospital, London (SGH). An earlier SAH from the aneurysm had caused her to experience a severe headache and to collapse at home on 5 May 2009. On that date, she was admitted to East Surrey Hospital (ESH), where a CT scan was performed and reported to be normal. She underwent no further investigations and no explanation for her collapse was found. It was thought she might be suffering from viral meningitis and she was discharged home without further treatment.

2. The Consultant Neurologist at ESH had had reservations about the CT scan and had arranged for it to be reviewed by a Consultant Neuroradiologist. The review did not take place until the early morning of 12 May 2009, i.e. a week later. The Consultant Neuroradiologist who undertook the review recognised that the CT scan showed evidence of a "bleed" (i.e. a SAH). Immediately after the review, arrangements were made for Mrs Sharma to be taken back to ESH, from where it was intended that she should be transferred as soon as possible to the specialist Neurosurgical Unit at SGH. In the event, it was not until about midnight on 12 May 2009 that she arrived at SGH. She immediately suffered a series of seizures, caused by a further catastrophic bleed resulting from the aneurysm. She was nursed on a life support machine and intubated, but was confirmed to be brain dead at 12.45hrs on 13 May 2009.

3. The Defendant is the NHS Trust responsible for ESH. Claims for damages were brought against the Defendant on behalf of Mrs Sharma's estate and her dependants and by her husband for nervous shock. It was alleged that those responsible for interpreting the first CT scan had been negligent in failing to detect the first SAH. The Defendant admitted liability for Mrs Sharma's death and settled those claims. The Defendant also admitted that, but for its negligence, Mrs Sharma would probably have survived. There was some dispute as to whether she would have made a full recovery; that dispute is immaterial for the purposes of this claim.

THE CLAIM

4. The claim with which I am concerned is brought by Mrs Julie Shorter, Mrs Sharma's elder sister, as a "secondary victim". She was aware of her sister's collapse on 5 May 2009 and of what happened thereafter. In particular, she was present with Mrs Sharma at ESH following Mrs Sharma's admission there on the morning of 12 May and she was also at SGH from shortly after Mrs Sharma's admission there until after she was pronounced dead on 13 May.

5. In the Claimant's Particulars of Claim, it is alleged that the Defendant, its servants or agents, were negligent in that they:

> "(a) failed to report the CT scan performed on the 5th May 2009 accurately until the 12th May 2009.

> (b) failed to diagnose the subarachnoid haemorrhage until the 12th May 2009.
>
> (c) discharged Mrs Sharma home on 7th May 2009 when the CT scan performed on the 5th May 2009 should have led to her urgent transfer to a neurosurgical centre for treatment for her subarachnoid haemorrhage."

6. In its Defence, the Defendant admits those allegations of negligence.

7. As to the causation of her death, it is contended that, had the CT scan been correctly reported at the outset and had Mrs Sharma been transferred promptly for treatment for her SHA, the probability is that she would have survived and recovered well. In the Defence, it is admitted that, but for the Defendant's negligence, Mrs Sharma would probably have survived. However, it is averred that she would probably have been left with some residual injury and would have remained at risk of delayed ischaemic deficit. For the purposes of this claim, as I have said, these averments are not relevant.

8. The Claimant's claim is based on her close relationship with Mrs Sharma. The Particulars of Claim allege at paragraph 25, that, as a result of the Defendant's negligence, the Claimant suffered a number of different insults which:

> "constituted a seamless single horrendous event starting with the news of the serious deterioration in Mrs Sharma's condition on the morning of the 12th May 2009 and that she had suffered a subarachnoid haemorrhage which had gone undiagnosed and untreated and concluding with her death which resulted in the Claimant sustaining … nervous shock …".

The nervous shock referred to was alleged to be a Major Depressive Episode.

9. In its Defence, the Defendant denied that the relationship between the Claimant and Mrs Sharma was sufficiently proximate to give rise to a cause of action for the alleged nervous shock. It denied also that the allegations were sufficient, even if proved, to give rise to a cause of action for nervous shock. Furthermore, it denied that, even insofar as any of the matters alleged may be found to be capable of giving rise to a cause of action for alleged nervous shock, the same caused the alleged or any injury or injuries.

10. At paragraph 19 of its Defence, the Defendant denied, *inter alia*:

> "that there was a seamless single horrendous event starting on the morning of the 12th May 2009, which the Claimant directly witnessed, and/or which the Claimant was directly and intimately involved in by direct sight or sound, as distinct from a gradual realisation over a prolonged period of the probable consequences for her sister of the events that commenced on 4th or 5th May 2009, sufficient to give rise to a cause of action for alleged nervous shock".

It is that issue with which this claim is primarily concerned.

THE TRIAL

11. The trial on liability and quantum in this case was heard on 18-20 November 2014. The Claimant was represented by Ms Charlotte Jones, and the Defendant by Mr Julian Matthews. I was grateful to both Counsel for their assistance.

12. I heard oral evidence from the Claimant, her husband, Mr Howard Shorter, and Mrs Sharma's widower, Mr Hitesh Sharma. The written evidence of Mr Ronald Stocker, father of the Claimant and Mrs Sharma, and of Ms Nathalie Pearson, a Senior Nursing Sister who had worked with the Claimant for many years, was uncontroversial and therefore they were not required to give oral evidence. The Defendant was content also for the written statement of Dr Anna Fletcher, the Claimant's general practitioner (GP) to be read, whilst making clear that, to the extent that she had given expert evidence, such evidence was not agreed.

13. The Defendant called oral evidence from Dr Jeffery Kimber, Consultant Neurologist at ESH and SGH, who was responsible for Mrs Sharma's care at ESH between 5 and 7 May 2009 and on 12 May. Dr Ferrigan, who was a Specialist Registrar at ESH and examined Mrs Sharma on 5 May and 12 May, was unable to give oral evidence by reason of the fact that she was pregnant with twins and deemed by her treating doctor to be at high risk. Her written evidence was admitted as hearsay evidence. Mrs Tunya Duggan and Ms Gillian Lees, who were Nurses on the Tilgate Ward at ESH during Mrs Sharma's time there on 12 May, provided witness statements which were based on manuscript accounts of the relevant events; those accounts had been written in August 2009. Both of them gave oral evidence.

14. Expert evidence was provided by two Consultant Neurosurgeons and two Consultant Psychiatrists. For the Claimant, Professor Paul Marks, Consultant Neurosurgeon at the General Infirmary at Leeds and Senior Lecturer in Neurosurgery at the University of Leeds, provided a Report dated 27 August 2013, in which he gave his opinion on the neurosurgical history which led to Mrs Sharma's catastrophic re-bleed and death. Mr Richard Mannion, Consultant Neurosurgeon at Spire Cambridge Lea Hospital, reported for the Defendant on 9 September 2013. On 4 August 2014, Professor Marks and Mr Mannion provided a Joint Statement setting out the results of a telephone discussion between them on 2 July 2014. They did not give oral evidence.

15. Dr Stuart Turner, a Consultant Psychiatrist, who is now in private practice and has considerable experience in the field of traumatic stress and post-traumatic stress disorder (PTSD), gave evidence for the Claimant. He interviewed her first on 12 October 2011 and provided a Report dealing with Condition and Prognosis. On 16 October 2013, he provided a further Report, dealing with the issue of Causation and based on the Statements of Case, the witness statements of the Claimant and Mr Sharma and the statements of the Defendant's witnesses, together with the Reports of the Consultant Neurosurgeons. Following a further interview with the Claimant on 29 January 2014, he provided a third Report dated 13 February 2014, again dealing with Condition and Prognosis.

16. Dr R. W. Latcham, Consultant Psychiatrist, gave evidence for the Defendant. Until March 2014, he had practised at the Hinchingbrooke Hospital, Huntingdon,

specialising in depression, grief disorder and PTSD. He provided a Report on Causation, Condition and Prognosis dated November 2013 for the Defendant. That Report was based on an interview with the Claimant on 12 December 2013. He also provided a Supplementary Report dated April 2014.

17. The Consultant Psychiatrists had a Joint Discussion by telephone, during which they addressed an Agenda of issues agreed by the parties. Their responses to those issues were recorded in the Note of the Joint Discussion. They both gave oral evidence at the trial.

THE CLAIMANT'S PERSONAL SITUATION

Her relationship with her sister

18. The Claimant was born on 3 December 1961 and is now 53 years old. Her sister, Mrs Sharma, was born on 30 December 1971 and was aged 37 years at the time of her death on 13 May 2009. There are also three brothers. It is clear from the evidence that this was a close family. The two sisters were particularly close to each other, with the Claimant, as the older, taking a protective role.

19. By 1989, when Mrs Sharma was 18 and still living at home with her family, the Claimant had already been married for several years and had two young children. She and her husband and children lived near to the family home and spent a good deal of time there. However, in 1989, the Claimant's mother, Mrs Stocker, became ill with leukaemia. There then followed a difficult period of about four years, during which Mrs Stocker had frequent admissions to hospital. Her illness culminated in her sudden death in October 1993 when, having been admitted to hospital for a blood transfusion, she suffered a multi-organ failure and died the following day.

20. Mrs Stocker's illness and death were distressing events for all members of her family, but especially for Mrs Sharma who was still relatively young (21 at the time of her mother's death) and living at home with her bereaved father. During this time, the Claimant provided considerable support for her sister, helping her to cope with the grief and depression she suffered following her mother's death.

21. Mrs Sharma had known the man who was to become her husband, Mr Hitesh Sharma, from her teenage years. In 2000, she became pregnant with his child. The Claimant took on a maternal role, supporting and advising her sister during her pregnancy and, once her baby was born, helping with his care. Subsequently, the Claimant assisted her sister with the arrangements for her wedding. In the years that followed, the two sisters remained close. In April 2008, Mrs Sharma gave birth to her second child, who was born only a short time before the Claimant's first grandchild. The Claimant helped both Mrs Sharma and her own daughter with the care of their young children. She lived near to her sister, saw her regularly and spoke frequently to her on the telephone.

22. In the circumstances, it is clear that the relationship between the Claimant and Mrs Sharma was a close and loving one, almost like mother and daughter. In recognition of this fact, by the time of the trial the Defendant had accepted that, for the purposes of this claim, the Claimant was within the class of persons who are eligible to bring a claim as a secondary victim.

Her work and health

23. At the time of her sister's death, the Claimant was working full-time as a Senior Sister in the Neuro-intensive Care Unit at the Hurstwood Park Neurosurgical Centre. She had been employed in that highly specialised field of work for more than 25 years. She was involved in the clinical care of patients suffering from neurological problems resulting from a variety of causes. Significantly for the purposes of this case, a large proportion of the patients with whom she dealt suffered from SAH. The Claimant was, therefore, very familiar with the condition and its treatment and was well aware of the possible outcome if treatment did not prove successful.

24. As a Senior Sister, the Claimant also had a managerial role, supervising and training the nurses on the ward, keeping records, ordering supplies and carrying out other administrative tasks so as to ensure that the Unit ran smoothly and efficiently. However, much of her work involved looking after individual patients and dealing with their anxious, and often distressed, families.

25. It is clear from her medical records that the Claimant has suffered from asthma for many years. She has had periodic episodes of this condition, which have been treated with oral steroids. In 2008, she had time off work due to her asthma.

26. In late 1993, following the death of her mother, the Claimant had several weeks off work and was prescribed medication to assist her sleeping. However, she was able to return to full-time work thereafter.

27. In 1997 and 1999, the Claimant had episodes of sciatica, necessitating short periods off work. In 2000, her sciatica became severe. For several months, she was unable to work or to undertake normal daily activities and was in constant pain. As a result, she became depressed with considerable difficulty sleeping. In January 2001, the cause of her sciatica was diagnosed and, in March 2001, she underwent an epidural which relieved the problem. Shortly afterwards, she returned to work part-time. By the end of July 2001, she was back at work full-time and her anti-depressant medication was gradually tailed off. Subsequently, she had several further episodes of back pain, notably in 2003, 2004 and 2006.

Her family position

28. The Claimant's husband, Mr Howard Shorter, suffers from rheumatoid arthritis, for which he takes regular medication. In 2008, he took voluntary redundancy, as a result of which he and the Claimant had some financial worries and he became depressed. A note made by her GP in November 2008 refers to the fact that she was suffering from "stress ++", presumably as a result of those factors. However, her evidence is that, nevertheless, she was in a "good place" before her sister's death.

THE EVENTS OF 5 MAY 2009

29. It is clear from the evidence that Mrs Sharma was in general a fit and healthy woman. However, on 2 or 3 May 2009, she began to complain of a mild headache, together with some neck pain. She and her husband attributed her symptoms to tiredness. Her second son was very young and she was getting a limited amount of sleep.

30. On the morning of 5 May 2009, Mrs Sharma's headache worsened. She was alone at home with her baby and became worried that she might collapse. She contacted her husband, asking him to return home. She then rang a friend who lived nearby and asked her to come round. She also called the emergency services, explaining that she had a "terrible headache" and was afraid that she might collapse. Before anyone arrived, however, Mrs Sharma recalled that she had blacked out and fallen, striking her face and causing bleeding to her nose and bruising to her face. She had also been incontinent of urine. When her husband arrived home, she had regained consciousness, but was shocked and disorientated. She was still complaining of a severe headache, together with neck pain.

31. The ambulance attended and Mrs Sharma was taken to ESH. The notes kept by the Ambulance Service recorded that she was complaining of pain at the side of both eyes and in the occipital region of the skull radiating down her neck and across her shoulders.

32. Once at ESH, Mrs Sharma was admitted to the Accident and Emergency (A & E) Department. Mr Sharma related that his wife continued to complain of a severe headache, neck pain and stiffness and was feeling nauseous, retching and vomiting bile. At 14.45hrs, Mrs Sharma was examined by Dr Levick. He recorded that she had "felt headache really bad behind eyes" and thought that she might have lost consciousness since she had hit her face (which was grazed) and urinated. He estimated the severity of her pain at the time of his examination as "8/10" (i.e. at a high level in the range 1-10). He recorded that she had no photophobia or neck stiffness, but was feeling very nauseous, although she had not vomited. Dr Levick's impression was that she might have had a seizure. He arranged for blood tests to be taken but the results were not available for several hours. Meanwhile, by 16.50hrs, Mrs Sharma was still in pain and vomiting and Dr Levick prescribed Cyclizine and ordered that, if her pain persisted, she should be given Codeine. She had been treated with Paracetamol at 14.00hrs. Both Cyclizine and Codeine were given some time later.

33. Mrs Sharma was transferred to the Tilgate Ward where, at 20.00hrs, she was seen by Dr Laura Ferrigan, Specialist Registrar. Dr Ferrigan recorded that Mrs Sharma had on occasion suffered headaches in the past, but none as severe as on that day. At the time of her examination, Mrs Sharma's analgesia was not settling her headache. Dr Ferrigan found her to be "comfortable at rest", although she still had "3/10 frontal headache". She arranged for her to have a CT scan of her brain that evening. Mrs Sharma had the CT scan which was viewed by a both a Radiographer and a Radiologist and was interpreted as normal. Some time later that evening, Mr and Mrs Sharma were informed that it had shown no evidence of a bleed in the brain and that the doctors would be investigating other reasons for her headache. They were told that she should stay in hospital where further investigations would be carried out, including a lumbar puncture.

34. The Claimant had known nothing of these events until about 20.00hrs, when she received a message from her father to say that Mrs Sharma had been admitted to ESH with a "collapse". She rang ESH and spoke to her brother who told her that Mrs Sharma had gone for a CT scan. The Claimant recounted how, later, at about 22.00hrs, she spoke to Mr Sharma on the telephone. He told her that the CT scan had been "all clear". The Claimant was relieved and reassured by this news.

THE EVENTS OF 6 MAY 2009

35. A short time before these events, Mrs Sharma had realised that she was pregnant once again. She believed that she was eight weeks pregnant. The events of 5 May 2009 obviously gave rise to some concerns about her pregnancy and Dr Ferrigan had arranged for her to undergo a foetal heart scan on 6 May and that was done. Later that day, she and Mr Sharma were told that there was no evidence of a foetal heartbeat, but that a further scan would be undertaken the following week, in case the pregnancy was less advanced than Mrs Sharma believed. If that were the case, it may be that the foetal heartbeat had not been detected on 6 May 2009. The second scan was scheduled for 15 May 2009.

36. After the foetal heart scan, Dr Zachariah examined Mrs Sharma in the course of a ward round. He noted that she had an ongoing headache and pain at the back of her neck. His plan was for her to remain on regular analgesics. He did not consider that there was any indication for a lumbar puncture at that stage, but recorded, "However, if symptoms do not settle, consider". It appears that Mrs Sharma was examined by another doctor during the same ward round. At 10.10hrs, Dr Acharya noted that Mrs Sharma had described the pain she had suffered the previous day as "felt like someone had hit her over back of head with a mallet" and had "spread all way round". His suggested diagnoses were SAH, migraine or viral headache. He considered that she would probably benefit from investigation by means of a lumbar puncture and requested that she should be reviewed by Dr Kimber, Consultant Neurologist. Meanwhile, he prescribed Codeine as well as Paracetamol.

37. Dr Kimber examined Mrs Sharma some time afterwards. He expressed the view in his note of the examination that her history of the events of the previous day was unclear. He suggested that she may have suffered a seizure, but regarded it as unlikely. He noted that the CT scan had showed no haemorrhage but raised a query about the appearance of the temporal horns, observing "but I'm not a neuroradiologist!" He recorded his impression thus:

> "- I do not think this is a case of VST (venous sinus thrombosis) or a SAH
>
> - I think bacterial meningitis is unlikely
>
> - Viral meningitis is a possibility
>
> - I would not perform LP (*lumbar puncture*) (pregnant) unless <u>worse</u>
>
> - Review CT in XRay meeting
>
> - I would observe 24hrs ?if improving home".

38. In his witness statement, Dr Kimber explained that his plan was to observe Mrs Sharma for 24 hours and to discharge her home if she improved. He also indicated that he had asked for the CT brain scan to be reviewed at the next weekly Neuroradiology Meeting, which was scheduled for 12 May 2009. The reason for that request is evident from an email sent by Dr Kimber on 15 May 2009. By that time, Mrs Sharma had died and the Defendant was in the process of carrying out a Serious Untoward Incident Investigation to examine the circumstances surrounding her death.

Dr Kimber had been asked for details of his involvement in her case. In the email, he indicated that, at the time of his examination of Mrs Sharma on 6 May 2009 (he stated that he saw her on 7 May 2009, but that was plainly an error), he had looked at the CT brain scan imaging and thought that it did not "look right". He had therefore arranged to review the scan with Dr Wai-Yung Li, a Neuroradiologist, at the Meeting on 12 May 2009. It is regrettable that the review was delayed for so long.

39. Mr Sharma was present when Dr Kimber examined his wife. According to him, Dr Kimber told them that there was no evidence of a bleed in the brain and observed that Mrs Sharma's pain and stiffness were not severe compared with other patients with serious conditions. He told them that he did not consider that a lumbar puncture was necessary. According to Mr Sharma, Dr Kimber told Mrs Sharma that the headaches were probably due to a virus and would improve over the next few days. He told her that she could be discharged home the next day. Mr Sharma said that he and his wife were surprised that no further investigations were to be undertaken. They were concerned that they had been given no real explanation of what had caused her collapse and that it might happen again. However, they accepted what they were told and were relieved that there appeared to be nothing seriously amiss. It does not appear that they were told about Dr Kimber's lack of certainty about the accuracy of the CT brain scan report or the fact that it was to be reviewed.

40. The Claimant arrived at ESH whilst Dr Kimber was with Mr and Mrs Sharma. She recalled being told by Mrs Sharma that Dr Kimber had said that he considered she probably had viral meningitis. The Claimant was relieved and reassured since, given Mrs Sharma's symptoms, the diagnosis of viral meningitis appeared to her to make sense.

THE EVENTS OF 7-9 MAY 2009

41. In the note of a ward round, timed at 12.40hrs on 7 May 2009, Dr Christopher Sloan recorded that Mrs Sharma "still has headaches" but that they were "no worse". He authorised her discharge from ESH and directed that she was "to return if it (*presumably the pain*) gets worse". Shortly afterwards, she returned home. According to her husband, she was still experiencing a headache, neck pain and neck stiffness and was unusually lethargic. She was taking Codeine and Paracetamol for the pain, but the dosage was limited because of the possibility that, despite the foetal scan results, she might still be pregnant.

42. On 7, 8 and 9 May 2009, Mrs Sharma remained at home, spending much of her time resting in bed or on the sofa. Her headache continued and became worse if she was exposed to strong lighting. She was unable to care for her children, receiving assistance from her husband and other members of the family. Throughout this period, Mrs Sharma was hoping that, with time, the virus from which she believed she was suffering would settle and her symptoms would cease. Meanwhile, the Claimant kept in touch with her sister by telephone. She saw her briefly on 8 May, when she appeared a little better, although complaining of photophobia.

THE VISIT TO THE WALK-IN CENTRE ON 10 MAY 2009

43. Mr Sharma's evidence was that, by the early morning of 10 May 2009, which was a Sunday, his wife was beginning to become agitated because her headache was not

improving, the medication was not controlling her pain and she felt nauseous. He said that she "knew something was not right". They called the out-of-hours GP. The note of that call, made by the GP, records, "pain in head severe". The GP advised Mrs Sharma to attend at the local Walk-In Centre. It appears that she was seen there at about 09.27hrs. The note of that attendance records the severity of her headache at that time as "5/10". It was further noted that she was advised to stop Codeine, continue her Paracetamol, and go to her GP for follow-up after a repeat foetal heart scan. The doctor examining her considered that she also required referral to a Neurologist for "investigation re ? seizure".

44. Mr Sharma's evidence was that the doctor at the Walk-In-Centre was very concerned about his wife's collapse and was surprised at the lack of follow-up investigations. The doctor felt that she had probably had an epileptic seizure. He advised her to investigate the possibility of bringing forward the date of the repeat foetal heart scan (then scheduled for 15 May 2009) and to make an urgent appointment with her GP in order to get stronger painkillers for her headaches. Meanwhile, he advised her to stop taking Codeine, which might be causing her nausea. She continued to take Ibuprofen and Paracetamol.

45. Following her attendance at the Walk-In-Centre, Mrs Sharma returned home. She rested and, by 11 May 2009, her nausea was less severe, although she still had the headaches, neck pain and stiffness and was very tired. The Claimant spoke to her on the telephone in the morning and evening of 11 May. Her evidence was that her sister appeared brighter and reported that she had managed to bathe her son, which was an improvement.

THE EVENTS OF 12 MAY 2009

The telephone call from Dr Kimber

46. Mr Sharma's evidence was that, by the morning of 12 May 2009, "things took a sudden turn for the worse". His wife had told him during the night that her headache was stronger and her neck pain more intense. In the morning, she attempted to get up and help the children to get washed and dressed but had to return to bed because she felt nauseous and sick. Her headache was "getting worse and worse". He described her rolling her head on the pillow, trying unsuccessfully to get comfortable. He said she was crying with the pain, whilst retching. He was worried at her condition and telephoned their GP at about 09.00hrs to tell him of the urgent need for the cause of her collapse and head pain to be properly investigated.

47. As Mr Sharma's conversation with the GP was coming to a conclusion, he received a call from Dr Kimber at ESH. The Hospital records show that call as having been made at 09.30hrs. Mr Sharma's evidence was that Dr Kimber informed him that a Neuroradiologist (Dr Li) from another hospital had visited ESH and reviewed Mrs Sharma's CT scan. She had found evidence of a "small bleed" on the CT scan. It subsequently transpired that the "small bleed" was a Grade 1 SAH and that, if promptly and properly treated, the prognosis was likely to have been good. Dr Kimber advised Mr Sharma that he should take his wife to the ESH immediately.

Subsequent events

48. Now that it was known that the CT scan had showed a bleed, it was clear to Dr Kimber that Mrs Sharma needed to be in a Neurosurgical Unit where she could receive appropriate investigation and treatment. There was no such Unit at the ESH. Accordingly, Dr Kimber telephoned the Neurosurgical Registrar at the Atkinson Morley Wing of SGH with responsibility for admissions, in order to make arrangements for Mrs Sharma to be transferred from ESH to the Neurosurgical Unit at SGH. However, he was told that no such transfer would be possible until the Registrar at SGH had reviewed the CT scan taken at ESH and had authorised Mrs Sharma's admission to SGH. The system for linking CT imaging between the two Hospitals electronically was out of order. Dr Kimber therefore arranged to deliver a hard copy of the CT images on CD when he attended SGH later that afternoon. Meanwhile, Mrs Sharma would have to be cared for in the ESH. The delay in providing the CT imaging meant that a considerable period of time elapsed before Mrs Sharma was transferred to SGH.

49. Dr Kimber noted in Mrs Sharma's Hospital records that she had probably suffered a SAH and that, on her arrival at ESH, she should be started on Nimodipine, a medication used to treat SAH. He arranged for her to be admitted to the Tilgate Ward, where she had been treated the previous week. However, as he explained in his oral evidence, the practices at ESH made it necessary for her to be admitted to the A & E Department before being transferred from there to the Tilgate Ward.

Mr Sharma's telephone call to the Claimant

50. Mr Sharma's evidence was that, following Dr Kimber's telephone call, he was concerned that there may be something seriously wrong with his wife, although he did not understand the full implications of the presence of a "bleed". He was angry that it appeared that she had not been properly looked after and was in such a poor state. His evidence was that she was "in more and more pain", holding her head, telling him how bad her pain was and retching and rolling around with her head on the pillow. He described her state as worse than during the previous week.

51. Meanwhile, the priority was to get Mrs Sharma to ESH. Mr Sharma telephoned her father, Mr Stocker, asking him and his partner to come round and look after the Sharmas' children. He also telephoned the Claimant and told her what Dr Kimber had said. In his witness statement, he was clear that he did not tell her that Mrs Sharma's condition had worsened markedly. He explained that he had not done so because he was in a rush to get to ESH and was anxious to keep the conversation brief. By the time he gave his oral evidence, however, he had changed his mind. He said that he had mentioned to the Claimant that Mrs Sharma was in a worse state that day. His explanation for his change of heart was that he had remembered what had actually happened whilst listening to the Claimant's evidence during the trial.

52. The Claimant's evidence was that she was at work when she received Mr Sharma's call. She recalled that it was at about 10.30-10.45hrs although, if the Hospital's timing of Dr Kimber's call to Mr Sharma was correct, it must have been earlier. Mr Sharma told her that the CT scan had been reviewed, and showed a small bleed. She was adamant that he had also told her that Mrs Sharma's headache had "suddenly got a lot worse that morning". Although she did not mention the fact in her witness

statement, she was also adamant in her oral evidence that he had told her that, as a result of Mrs Sharma's worsening condition, he had telephoned her GP. The Claimant described Mr Sharma as "really panicked". She said that she tried to reassure him but, in reality, she was in a state of panic herself. She knew that the "bleed" might be a SAH or, if not, a bleed from a tumour. Her own experience of nursing patients with SAH meant that she was fully aware of the possibility of a re-bleed if the original bleed was not properly and promptly treated. The delay of seven days in identifying the bleed was therefore worrying. As the Claimant put it in her witness statement, she "knew she (*Mrs Sharma*) was in the danger zone". She said that she was aware also that the fact that she knew that Mrs Sharma's condition had worsened made her worry even more acute. The Claimant described herself at this time as "really panicky" and "really frightened".

53. The Claimant related how she got authorisation to leave work in order to go to ESH to be with her sister. She was fully aware of the urgent need for Mrs Sharma to be transferred to a Neurosurgical Unit and that there was no such Unit at ESH. However, there was a Neurosurgical Unit at Hurstwood Park, the Hospital where she worked. So the Claimant went to the Neurological Department at Hurstwood Park, where she spoke to a Neuroradiologist and Nursing Sister about Mrs Sharma's condition. They suggested that she should get a copy of the CT scan from the ESH and bring it over to Hurstwood Park, where, if it did indeed show a bleed, Mrs Sharma could be accommodated and treated.

The Sharmas' arrival at the Accident and Emergency Department

54. After his conversation with the Claimant, Mr Sharma drove his wife to ESH. There is some uncertainty about the time of their arrival. Mr Sharma's recollection was that they got to the A & E Department at about 10.45hrs. Given the fact that the Hospital notes record Dr Kimber's call as having been at 09.30hrs and the drive from the Sharmas' home to the Hospital would have taken about 30 minutes, that seems realistic. It would also be reasonably consistent with the timing of the completion of the Nurse Assessment Form for Emergencies which was recorded at 10.35hrs. It seems to me that it is probable that they arrived at about 10.30hrs. That is far more likely to be correct than the stated arrival time of 11.30hrs which appears on another Hospital document entitled "Patient Information".

Mrs Sharma's condition

55. There was a significant issue between the parties as to Mrs Sharma's condition at the time of her arrival, and during her time in the A & E Department at ESH. Mr Sharma's evidence was that his wife was in considerable pain. Once in the A & E Department, she was placed on a trolley, where she was writhing around, trying unsuccessfully to get comfortable and was weeping. She was complaining of feeling nauseous and vomited. Mr Sharma said that he asked the Nurses whether she could have more painkillers but was told that, whilst there remained a possibility that she was still pregnant, she could have only a limited dosage. Thus, it would be necessary to await the results of the repeat foetal heart scan which would ascertain whether the foetus remained viable.

56. Once in the A & E Department, Mrs Sharma was assessed by a Nurse. The relevant record is timed at 10.35hrs. It refers to the fact that she was suffering from a

"recurrent headache". She was described as "awake and alert". There is no indication in that document that the Nurse was informed that her condition had become markedly worse that day or that she was suffering from very severe pain.

57. A little later, a clinical assessment of Mrs Sharma was carried out by Dr Ferrigan, who had examined her on 5 May. The record of the assessment was timed at 12.00hrs, whilst Mrs Sharma was still in the A & E Department. Dr Ferrigan recorded Mrs Sharma's condition thus:

> "- continues to feel unwell.
>
> - ongoing R (*right*) headache
>
> Nausea. 0 (*nil*) photophobia (only when headache bad)
>
> No focal weakness/speech/swallow deficits since
>
> Bowels loose nil other GI (*gastrointestinal*) or systematic upset
>
> Nil urinary symptoms …".

58. Dr Ferrigan recorded Mrs Sharma's general appearance as "comfortable" and her headache as being of "3/10 severity". In evidence, she said that Mrs Sharma had not appeared to be in severe pain at the time of the assessment; nor was she particularly distressed, upset or emotionally labile. She explained that it was her normal practice to ask patients to rate the severity of their pain on a scale of between one and ten, with one being hardly any pain at all and ten being the worst pain imaginable. Mrs Sharma had scored her pain as 3/10, which Dr Ferrigan had felt was consistent with her presentation. On examining Mrs Sharma, her findings were within normal limits. In particular, she recorded that there was no neck stiffness or photophobia at the time of her examination. She said that she would have asked whether Mrs Sharma had vomited and, if so, would have recorded the fact. No such record was noted, although she recalled that Mrs Sharma had complained of feeling nauseous. Her impression was that Mrs Sharma had suffered a SAH with ongoing right-sided headache. Dr Ferrigan took steps to expedite the repeat foetal heart scan and to arrange for blood tests to be conducted. Her plan was that, pending her transfer to SGH, Mrs Sharma's pain was to be controlled, with regular analgesia. She prescribed Co-codamol (a combination of Codeine and Paracetamol). It does not appear that Dr Ferrigan was aware of Dr Kimber's previous direction (given more than two hours previously) that Mrs Sharma should be given Nimodipine. It is not referred to in her notes. Co-codamol was given at 12.15hrs.

59. The point made by the Defendant was that the description of Mrs Sharma's condition contained in the nursing and clinical records was inconsistent with the account given by her husband and other members of the family. Reliance was placed on records which showed that Mrs Sharma's heart rate and respiratory rate were not at a level to be expected for someone who was in severe pain and distress. It was also pointed out that the records contain no reference to her condition having worsened markedly over the previous 24 hours. Mr Sharma's evidence was that, once he and his wife arrived at the ESH, they were not focussing on the extent to which her condition had worsened.

They were primarily concerned about the news that there had been a "bleed". He also observed that the severity of his wife's headache was fluctuating all the time so that, when examined by Dr Ferrigan, she may have been in less pain than at other times. Overall, however, he was adamant that she was worse than previously.

The Claimant's arrival at the Accident and Emergency Department.

60. Meanwhile, the Claimant had left Hurstwood Park Hospital. She was panicky and did not consider that she was in a fit state to drive herself, so she returned home, from where her husband drove her to ESH. Her recollection is that they may have arrived at about 11.15hrs, although she was uncertain in her oral evidence. It appears that they probably arrived shortly after (or, failing that, shortly before) Mrs Sharma was seen by Dr Ferrigan at 12.00hrs.

61. The Claimant described how, when she arrived, she saw her sister rolling around on a trolley, crying with pain, clutching her head and saying that she was in agony. She considered that the degree of pain from which her sister was suffering was wholly inconsistent with the pain score of 3/10 recorded by Dr Ferrigan at 12.00hrs. That score bore no relation to what she saw. The Claimant said that she was very frightened by what she saw - which was unexpected - and by the fact that her sister was in a worse condition than when she had last seen her. The Claimant said that, despite her concern, however, she tried to keep calm for the sake of Mr and Mrs Sharma. The Claimant's husband, Mr Shorter, described Mrs Sharma as being in a great deal of pain and crying. He realised that his wife was very worried about her sister.

62. The Claimant spoke to a doctor (presumably Dr Ferrigan) in an attempt to get some information about Mrs Sharma's condition. She was told that her sister had had a subarachnoid bleed. Given her own professional experience, she realised that the delay in treating Mrs Sharma gave rise to a risk that she might suffer a re-bleed. Her evidence was that she realised that the fact that Mrs Sharma's condition had worsened made the risk even greater. She was told that Mrs Sharma would shortly be taken up to a Ward and would be examined by a Neurologist.

Transfer to the Tilgate Ward.

63. Mrs Sharma was transferred from the A & E Department to the Tilgate Ward at approximately 14.00hrs. One of the Nurses on the ward, Mrs Tunya Duggan (then Miss MacRobert-Smith), recorded her arrival in the Ward and the plan for her management. She noted that Mrs Sharma should be started on Nimodipine. It was, by this time, at least four hours since Dr Kimber had directed its use.

64. Shortly after Mrs Sharma's arrival in the Tilgate Ward, Dr Kimber visited her. His evidence was that she was alert and speaking although complaining of a headache, with some photophobia, and was lying on the bed with her eyes closed. She did not appear to him to be in severe pain.

65. Dr Kimber spoke to Mr Sharma and the Claimant. He explained to them that the review of the CT scan had shown evidence of a SAH. Mr Sharma's recollection was that Dr Kimber referred to the haemorrhage as a "subtle bleed" which "anyone could have missed". He told them that Mrs Sharma needed to be transferred to the specialist

Neurosurgical Unit at SGH; he was awaiting confirmation that a bed was available, after which Mrs Sharma would be transferred there by ambulance. The Claimant informed him of the option of a transfer to Hurstwood Park Hospital, but Dr Kimber rejected that suggestion and informed her that the transfer would be to SGH. The Claimant said that she was frustrated at this because she well understood how urgent it was for the transfer to take place. Meanwhile, she said, her sister continued to be in severe pain and was also very frightened. The Claimant did her best to reassure her.

66. Dr Kimber then left ESH for SGH, taking a CD of the CT imaging with him. Before his departure, he made an untimed note in the clinical records, recording that Nimodipine should be started. He noted also that Mrs Sharma was to undergo a repeat foetal heart scan.

67. At some time during the afternoon, Mrs Sharma had the scan. It seems from the image of the scan in the Hospital records that it was probably done at 14.52hrs. The scan revealed no evidence of a foetal heartbeat and thus confirmed that a miscarriage had occurred. After that was known, Mrs Sharma was able to receive a stronger analgesic, namely Tramadol. There is some uncertainty as to whether, in fact, the Tramadol was given before or after the scan. The Hospital records appear to show that Tramadol was first administered at 14.40hrs, i.e. before the scan. It may be that, in fact, it was obtained for use at that time and administered immediately after the scan. According to the family, after she was given Tramadol, Mrs Sharma's pain lessened and she became calmer.

68. Mrs Duggan, assisted by Ms Gillian Lees, the Ward Sister, wheeled Mrs Sharma on her bed to the ultrasound scanner. Mrs Duggan described how Mrs Sharma chatted with them; her impression was that she was relaxed and that her head pain was under control even before the Tramadol. Ms Lees' recollection was that Mrs Sharma did not complain of severe pain whilst being wheeled to the scanner.

69. Both the Nurses recalled Mrs Sharma appearing relaxed during the afternoon. Ms Lees said that she had remained stable and had not given any cause for concern. She described Mrs Sharma and her relatives as "relaxed, chatty and making jokes". She did, however, recall that, at some point, Mrs Sharma had requested further analgesia and that Tramadol had been administered, in addition to the Co-codamol she was already having. Mrs Duggan's evidence was similar. She said that, during the afternoon, Mrs Sharma was sitting upright in bed and appeared relaxed. Members of her family (including her husband, the Claimant and Mr Shorter) were with her and, during the afternoon, Mrs Sharma was speaking on her mobile phone, discussing childcare arrangements with other members of the family.

70. The Claimant and Mr Sharma did not consider that Mrs Sharma had been "relaxed", as Mrs Duggan and Ms Lees suggested. They explained that, when Mr and Mrs Sharma were told that Mrs Sharma had suffered a miscarriage, it was, naturally, a source of regret to the couple. However, they related how Mrs Sharma had emphasised that her priority must be to get herself well for the sake of her remaining two children. Meanwhile, the Claimant and Mr Sharma were concentrating on reassuring Mrs Sharma and preventing her from becoming unduly distressed.

71. As time went on, Mrs Sharma's family – in particular the Claimant – became increasingly concerned at the fact that the transfer to SGH was not happening. They

tried to keep Mrs Sharma calm and cheerful. At some point, they were told that she would soon be given Nimodipine. Despite the fact that Dr Kimber had ordered the prescription at about 9.30am, it had still not been administered.

72. Mr and Mrs Sharma's sons were being cared for by Mrs Sharma's father and his partner. However, Mrs Sharma was concerned about the babysitting arrangements overnight. She asked the Claimant to care for her younger son and, with reluctance, the Claimant and her husband went back to their home, leaving Mrs Sharma and her husband at the ESH, together with other members of the family. At about 17.00hrs, when she left, the Claimant was told that the nursing staff were waiting for the Nimodipine to come down from the pharmacy, after which it would be administered immediately. She was also told that Mrs Sharma would be leaving for SGH very shortly.

THE EVENTS OF THE NIGHT OF 12/13 MAY 2009

The wait at ESH Hospital

73. According to the accounts given by Mrs Duggan and Ms Lees, in the early evening, there was a telephone call from SGH to say that Mrs Sharma could be transferred there. Ms Lees then asked the Senior House Officer on duty, Dr Ben Warner, whether Mrs Sharma should travel "with a blue light". Dr Warner indicated that that was not necessary. Mrs Sharma was still awaiting transfer when Mrs Duggan and Ms Lees handed over to the night staff.

74. Mr Sharma described how he and his wife waited for her transfer to SGH. He was becoming increasingly concerned and frustrated at the delay. Shortly after the Claimant left the Hospital, he managed to get hold of the telephone number of the Neurosurgical Unit at SGH. He telephoned the Unit several times to enquire what was happening, but got no satisfactory response from either the staff there or from the staff at ESH. He got the impression that there was "no sense of importance or urgency at all". Meanwhile, Mrs Sharma was in less pain but, as he described it, "beside herself with worry".

The Claimant's telephone call with Mrs Sharma

75. Once at home, the Claimant waited for news from Mr and Mrs Sharma. Mr Shorter described how the Claimant was "really restless and anxious". She heard nothing until 22.00hrs, when she spoke to Mrs Sharma, who informed her that she was still at ESH. The Claimant's evidence was that she was most alarmed at this news. She described herself as "terrified", although she remained outwardly calm in an attempt to reassure Mrs Sharma. Her worry was that Mrs Sharma was not yet under the care of the specialist staff she required. She spoke to Mr Sharma and emphasised the need for him to chase up the ESH staff to ensure that his wife was transferred as soon as possible. This he agreed to do.

76. The Claimant's evidence was that, during the same conversation, Mrs Sharma told her that she had not yet had any Nimodipine. However, Mr Sharma's recollection was that Mrs Sharma was given Nimodipine during the evening and that this had happened because of the Claimant's enquiry about it just before she left the Hospital.

Mr Sharma's recollection would be consistent with the Hospital records which state that Nimodipine was administered at 18.00hrs on 12 May.

The first telephone call from Mr Sharma

77. At about midnight, the Claimant received a call from Mr Sharma. He told her that he and Mrs Sharma had recently arrived at SGH, but that Mrs Sharma had suffered a seizure immediately on arrival. She had been given medication, had regained consciousness and been able to talk a little. The doctors wanted her to rest and she was now sleeping. The Claimant's evidence was that Mr Sharma was "in a real state of panic". She herself was very concerned to hear about the seizure, although she was relieved to hear that her sister was now in a specialist Unit where she would receive expert care. Moreover, the fact that Mrs Sharma had come round and was sleeping suggested to her that she had suffered a fit, rather than a re-bleed. Nevertheless, the possibility of a re-bleed remained. Mr Shorter described how the Claimant had "a look of fright" on her face as she took the telephone call and how she was extremely anxious, as well as angry that there had been such a delay in transferring Mrs Sharma to SGH.

Events after the first telephone call

78. In his witness statement, Mr Sharma described in detail the terrifying and distressing events which occurred after his wife's admission to SGH. He described the first seizure and how, after a short period of respite, Mrs Sharma began to have further seizures. His description of the effects of those seizures upon her, the attempts by the medical staff to treat her and his own feelings of distress, helplessness and confusion at what was happening was very moving. It was a dreadful experience for anyone to have to bear. He decided that he would telephone the Claimant to tell her what was happening and to ask for her help. He described himself as "in a total state of panic on the phone".

The second telephone call from Mr Sharma

79. The Claimant described how Mr Sharma telephoned her. As soon as the telephone rang she was, she said, "immediately struck with panic" and very frightened. He told her that Mrs Sharma had "started fitting" and that her pulse rate was "sky high". He was in what she described as "a state of confusion and panic". She described the telephone call as "a really frightening moment". The Claimant told Mr Sharma that she would telephone the nursing staff at SGH and attempt to find out exactly what was happening.

80. The Claimant then spoke to the Sister on the Surgical Ward at SGH. She explained her own clinical background and asked the Sister to tell her what was happening. The Sister told her that Mrs Sharma had suffered another fit and had just been taken to the Intensive Therapy Unit (ITU) where she would be intubated and would have a further CT scan. The Claimant asked whether the Sister believed that Mrs Sharma had suffered a re-bleed, whereupon the Sister replied, "Yes, I think so". The Claimant's evidence was that, at that moment, she knew that "this was really, really bad" and that they were now "in very dangerous territory". She had seen some patients recover after a re-bleed, but was well aware that, after a second bleed, the prognosis was very poor. She was, she said, "absolutely terrified".

81. After telephoning her father and brothers, the Claimant was driven to SGH by her husband. Mr Shorter's evidence was that, after the telephone call, he knew that "this was far worse than anything that had happened up to that point" because of the fear in his wife's eyes and in her voice. She was "shaky and struck with panic". The Claimant's evidence was that she was "terrified" on the journey to SGH. She said that she still had some hope; she still thought that her sister might be OK, that "they might be able to save her". She said that she still had "a glimmer of hope".

Events at St George's Hospital

82. The precise sequence of events immediately after the Claimant's arrival at SGH assumed considerable significance at trial. It is important therefore to examine the evidence in some detail.

The Claimant's evidence

83. In her witness statement, the Claimant did not make clear her precise movements on reaching SGH. She referred to the fact that her father had already arrived, but did not indicate whether she had actually seen him at that stage. The inference was that she had gone directly to the ITU. She described events as follows:

> "As soon as I walked into the ward and saw Lucia in the ITU room, I looked at her and I knew that she was in a critical state. It was that sight which made it real and it hit me like a sledgehammer that we'd probably lost her. In that moment, I felt sick and horrified. It was devastating. I looked at the monitors, saw her lying there on the life-support machine, being intubated and attached to all the tubes and equipment. For me, seeing someone lying there in that condition is not the same as it is for someone who does not have medical knowledge of these patients – I knew what it meant and it hit me like a blow. Hitesh (*Mr Sharma*) looked at me and the colour had completely drained from his face. He was in total shock.
>
> Although I have seen many people in that condition in ITU over the course of my career, this sight was horrific because I have seen so many like it and now it was my own sister, and it should not have been. I knew immediately what the implications were of the situation, so when I saw her lying in that bed it hit me in that moment how bad this truly was, and it was like my whole world came apart. It was not a case of the doctors breaking news to me gently about Lucia's prognosis, which happens with people who do not know the medical implications of the situation. I knew there and then that we had probably lost her."

84. In oral evidence, the Claimant was asked whether she had seen Mr Sharma in the day room before going into the ITU. It was pointed out to her in cross-examination that both her husband and Mr Sharma had said in their witness statements that she and her husband had first gone to see Mr Sharma in the day room. The Claimant denied this,

saying that she now recalled that she had gone to put some bags in the day room (she had not mentioned that in her witness statement), but that she had not seen Mr Sharma at that stage and had not been told by him that her sister had "gone". She was certain that it was only when she saw Mr Sharma's face as she walked into the ITU that the reality came to her.

85. In her witness statement the Claimant went on to say that, when she arrived, a doctor was there (presumably in the ITU) and said that he would speak to her, Mr Sharma and her husband in a separate room. He then confirmed what she had already realised, namely that her sister had suffered a "massive re-bleed" and nothing further could be done for her. From her own experience of dealing with families in similar situations, the Claimant said that it was clear to her that the doctor was implicitly saying that her sister would not survive.

86. The Claimant's evidence was that, shortly after this discussion, her brothers and their wives arrived. Mrs Sharma was unconscious throughout, being kept alive by the machines to which she was attached. Members of the family took it in turns to sit in her room so that they could have some time alone with her.

Mr Sharma's evidence

87. In his witness statement, Mr Sharma said that, after his second telephone call to the Claimant, the first member of the family to arrive at SGH was the Claimant's father, Mr Stocker. A Senior Registrar came to speak to the two of them in what he described as the "side room" (i.e. in an area designated for the use of families, referred to in the Hospital records as the "day room"). He told them that Mrs Sharma had suffered a re-bleed and was "too far gone" this time. Mr Sharma recalled that he (i.e. Mr Sharma) had said to his father-in-law, "we've lost her". He went on to describe how, shortly afterwards, the Claimant and her husband arrived and, after that, the Claimant's brothers and their wives. Mr Sharma described how he told the family members that Mrs Sharma "had gone" and that they had "lost her". All the family were, he said, in "total shock".

88. In his oral evidence, Mr Sharma was uncertain about where he had been when the Claimant arrived at SGH. He said that he remembered Mr Stocker arriving and that the two of them waited for the Claimant. He said that he did have a recollection of the Claimant "coming to the ITU" after he had gone there with the Nursing Sister. However, he explained that he could not remember events "minute by minute". He said, "Being with Lucia is what I remember and people turning up". When asked in re-examination whether he had any recollection of the Claimant arriving and where he was at that time, he said, "I was by the bedside. I clearly remember that". That was, of course, wholly inconsistent with the account given in his witness statement.

89. Mr Sharma went on to describe how a doctor came to speak to the family. He told them that Mrs Sharma was in the ITU and on a life support machine. He prepared them for what she would look like, with the tubes attached to her. He explained that she had suffered a "devastating re-bleed" in her brain and that tests would be needed to see how much brain damage she had suffered. Mr Sharma said that it was clear that the doctor did not expect Mrs Sharma to recover. He thought that, at that point, questions were asked by the family about what had gone wrong, to which the doctor had responded that "it does appear that a window of opportunity has been missed".

Mr Sharma said that members of the family then took it in turns to go and see Mrs Sharma, so that they could have some time alone with her. It may well be that Mr Sharma was mistaken about the timing of this conversation and that, as the Claimant believed, the family asked questions about what had happened when speaking to a doctor later on the morning of 13 May 2009.

Mr Shorter's evidence

90. In his witness statement, Mr Shorter described how, after he and the Claimant arrived at SGH, they went first to find Mr Sharma. He was in a state of utter shock. Mr Shorter said that he stayed with Mr Sharma whilst the Claimant went to see Mrs Sharma. Soon afterwards, Mr Shorter went into the ITU to join his wife. He said that he remembered the look of "total devastation" on the Claimant's face. She later told him that she had known, even before the brain stem tests were carried out, that her sister was brain dead.

Hospital records

91. The Hospital records include a document recording details of communications between members of the Hospital staff and members of the family. The document relates that Mrs Sharma was taken to the ITU, accompanied by the "crash team" and an anaesthetist. It records that Mr Sharma had been told of the results of the repeat CT scan and of the fact that his wife's prognosis was "not very good". It was noted that Mr Sharma had then requested to see his wife, but staff at the ITU had asked him to wait 15 minutes before doing so. Subsequently, it was recorded that Mr Sharma had told the Nurse who had remained with him in the day room that he would wait until Mrs Sharma's sister (i.e. the Claimant) arrived before visiting Mrs Sharma. However, he had subsequently changed his mind and went to visit Mrs Sharma. The Nurse accompanied him and remained with him in the ITU. Mr Sharma then went out of the building to smoke. The records indicated that, shortly afterwards, Mr Stocker arrived. The notes suggest that he and Mr Sharma remained together in the day room, waiting for the Claimant to arrive. No further information is given about the whereabouts of Mr Sharma or other members of the family.

Later on the morning of 13 May 2009

92. In her witness statement, the Claimant described how, at around 08.00hrs-09.00hrs on 13 May, the doctors, consultants and other clinicians working in the ITU did their rounds. They spoke to Mrs Sharma's family and told them that they were planning to undertake brain stem tests. They made clear that it was unlikely that the tests would disclose any hope of her survival.

93. The Hospital record of communications ends with an account of a meeting between two doctors and members of Mrs Sharma's family which is timed as having occurred at 10.00hrs on 13 May 2009. It relates that the family were told that the second haemorrhage had probably led to irreversible brain damage. The family agreed that brain stem tests should be carried out.

94. The family waited whilst the tests were carried out. The doctors then returned and confirmed that Mrs Sharma was "brain stem dead". They explained what would happen next, i.e. that they would switch off the life support machine, remove the

ventilation tube and cease all other forms of treatment. Those were procedures with which the Claimant was only too familiar in the course of her work. The family did not choose to witness those procedures, but were soon told that Mrs Sharma was dead.

95. In her witness statement, the Claimant recalled a conversation which she recollected having had with the doctors shortly after her sister had died. She had expressed anger at the fact that the original haemorrhage had been missed and at the delay in obtaining a second opinion on the CT scan. She recalled that one of the doctors had responded, "It does appear that there has been a window of opportunity that has been missed". She understood him to mean that "something had gone wrong". In her witness statement, she observed:

> "Normally, in this profession, the doctors will stick together, but there was nothing he could say to justify what had happened".

The Claimant described how, after this discussion, members of the family stayed with Mrs Sharma for a few more hours, going through the process of saying goodbye. Mr Sharma gave a similar account of events during this period. He also stated:

> "We were asked if we wanted to have a Coroner involved but we said no to that as we knew it was the subarachnoid haemorrhage which killed her."

96. The Claimant summed up her feelings about her sister's death thus:

> "I was absolutely heartbroken. I thought that losing my mum was terrible and in difficult circumstances, but that was nothing compared with this. In my mum's case, she was relatively young but not to the extent that Lucia was, and she had been fighting a protracted illness for a long period of time. As far as Lucia was concerned, she was so young, fit and healthy, and her death left me shocked, heartbroken and devastated. She had so much to live for. She had Hitesh and her two small boys and she was not given a chance. I felt that she had been failed at every step of the way. I deal with people who have family members in this situation on a daily basis at work, but you never expect it to happen to you. When I learned that Lucia was a good grade subarachnoid when she had the initial bleed, i.e. Grade 1, I had the knowledge that such patients can make good recovery with the right treatment. I have looked after so many Grade 1 subarachnoid haemorrhages throughout my career and they can do fantastically well with the right treatment, and Lucia did not get that chance. The knowledge that she should have survived has been incredibly hard to bear."

97. Nobody could fail to have the deepest sympathy for the Claimant and the other members of her family who have suffered the distress described by the Claimant in that moving passage.

THE CLAIMANT'S MEDICAL CONDITION FOLLOWING MRS SHARMA'S DEATH

98. The Claimant consulted her GP immediately after her sister's death. He certified her as unfit for work for a total of six weeks, during which time the GP notes described her as "absolutely devastated", "shattered" and "still in absolute shock". She returned to work on 30 June 2009. She had a further two weeks off work in August 2009. By September 2009, she was said to be "struggling" and was put on anti-depressant medication. She underwent counselling at work, the notes of which record, in October 2009, reference to "terrible memories and to flashbacks". She was also experiencing feelings of anger. Thereafter, she appears to have improved somewhat, although she continued to take anti-depressants and she had a flare-up of her asthma in March 2010. In October 2010, the Claimant's GP recorded that she was depressed although, at that time, her main concern related to her husband's moods.

99. In May 2011, it was the second anniversary of Mrs Sharma's death. That event, coupled with Mr Sharma's ongoing litigation in respect of his wife's death and problems with her husband, appear to have made the Claimant very low. Her dosage of anti-depressant medication was increased and, in June 2011, she was again certified as unfit for work by reason of bereavement and depression. She was tired, not sleeping and tearful. She was undergoing further treatment. By August, 2011, she was able to return to work on a graduated basis.

100. When Dr Turner examined the Claimant in October 2011, he noted that she was "extremely distressed" when speaking of the circumstances of her sister's death. She described herself as feeling miserable for most of the day about three or four days a week. She had a marked loss of enjoyment and of sleep. Her concentration had improved over the previous months although she was still finding it difficult to focus and experienced marked fatigue. She reported how she blamed herself for accepting without question the initial reassurances about the first CT scan. She said that she had found it hard to do clinical work since her sister's death; when she was at work and a patient was ventilated, it reminded her of Mrs Sharma's death. However, she said she had no problems with nightmares and does not appear to have mentioned any continuing flashbacks. The only reference to "flashbacks" was in the GP note of 30 October 2009.

101. Dr Turner considered that the Claimant was suffering from a Major Depressive Episode. He believed that, although symptom severity had fluctuated - worsening, for example, at the time of anniversaries of the death -the disorder had probably been present continuously ever since Mrs Sharma's death. He pointed out that, in September 2009, the Claimant had scored within the range of likely major depression on a Hospital Anxiety and Depressive Scale (HS-D) Questionnaire and, at other times, her symptoms had the characteristics of Major Depression.

102. Dr Turner noted that the Claimant had had anti-depressant medication and some psychological treatment, including Eye Movement Desensitisation and Reprocessing (EMDR). He took the view that the therapy had been insufficiently energetic and recommended a referral for further psychological treatment by an experienced Clinical Psychologist. He also recommended more active management of her drug treatment. As to the prognosis, Dr Turner considered that there was a long-term risk of further depressive episodes. He regarded her past periods of absence from work as

entirely reasonable. He described her employment position as at October 2011 as "precarious". She was back at work and coming to the end of a phasing process. He considered that "it would not take very much to push her to the point that she needed to take sickness absence again."

103. Dr Latcham saw the Claimant on 12 December 2012. His Report of November 2013 was based on that interview and also on the Statements of Case, the witness statements in the case and the Reports of the Consultant Neurosurgeons. The Report dealt both with Causation and with Condition and Prognosis. He noted the medical history to which I have already referred. At the time he saw the Claimant, she was working full-time, doing both management and clinical work. She still had feelings of guilt and of anger at the Defendant's negligence. She also reported "flashbacks", described in his Report as "vivid memories of her sister's final illness and death by reminders at work at least once a week now." She reported continuing disturbance of sleep and increase in weight.

104. Dr Latcham considered that, for about six months after Mrs Sharma's death, the Claimant had been suffering from a depressive illness, partly caused by what he termed "abnormal grief reaction". The depressive illness was characterised by sleep disturbance, poor concentration, lack of enjoyment of anything and an inability to work for periods of time. He considered that the psychological treatment she had undergone had been of benefit to her, but that further sessions would not be of benefit until after this claim had been concluded. The symptoms of "abnormal grief" were continuing but, after the end of the litigation and further therapy, they should, he considered, resolve.

105. Dr Turner's Report of 13 February 2014 was based on an interview with the Claimant a fortnight earlier. She described herself as "doing quite well now". She had been suffering problems with her knee on and off since May 2012 and, in December 2013, she underwent a knee replacement. She had been off work for about eight weeks due to her knee problems prior to seeing Dr Turner. She was due to return to work on a part-time basis the following day, but found the prospect "daunting". She still felt low at times and her sleep was "not great". Her dosage of anti-depressant medication had been increased, which had helped her. She had also undergone some counselling. She still had emotional problems at work if she encountered a patient in a situation similar to that of her sister. She had had various family problems and a health scare which had fortunately been unwarranted. The Claimant reported that she felt miserable for most of the day about two days in the week, more if she was working, especially if she was dealing with a lot of patients with SAH. Her sleep was poor and she became very tired. She reported ongoing anger at what had happened to her sister. She had no marked degree of anxiety.

106. It seems that the Claimant had undergone further counselling in late 2013. The sessions focussed on enabling her to work through the complex grief that she was experiencing as a result of Mrs Sharma's death. It was noted that her work constantly evoked the circumstances of the death. However, as the main breadwinner of the family, she could not afford to consider a change of role. Dr Turner referred to two references by a Psychological Therapist whom the Claimant saw in July 2013 to the Claimant telling her that she had experienced "flashbacks" and would sometimes "freeze" at work.

107. Dr Turner's conclusion was that the Claimant's Major Depressive Episode was, by February 2014, in partial remission, i.e. there were still some clinically significant symptoms, but the full criteria for the condition were no longer met. He considered that, although there had been a number of other stress factors in the recent past (e.g. her knee problems), the dominant cause of her emotional problems had remained the shock she experienced at the time of her sister's re-admission to ESH and her death at SGH. Her work on a Neuro-Intensive Care Ward only served to remind her of this experience. He considered that it would not take very much to "tip her to the point that she could not continue". However, he took the view that her prognosis was likely to be good and should improve with further psychological treatment. He acknowledged that, even prior to her sister's death, the Claimant was likely to have had at least one further episode of depression in the future. However, her risk of such an episode had, he believed, been increased by her sister's death. He regarded the risk of having further depression attributable to the death was "well below the balance of probabilities". If it were to happen, she would probably need sickness absence of up to three to six weeks.

108. In his Supplementary Report, Dr Latcham commented on Dr Turner's Second Report. He noted that the Claimant had undergone counselling which had focussed on complex grief. He noted and accepted Dr Turner's view that the Claimant was doing "quite well now" and that the future prognosis was good, but that the likelihood of her suffering a further incident of depression had been increased by Mrs Sharma's death.

THE PSYCHIATRIC EVIDENCE

The nature of the Claimant's psychiatric condition

109. Dr Turner's opinion was that the Claimant had suffered a Major Depressive Episode which began in the aftermath of her sister's death, improved in November 2013, and was in partial remission in January 2014.

110. Dr Latcham considered that the Claimant had suffered a depressive illness following Mrs Sharma's death, which had lasted for about six months, after which she had suffered from abnormal grief. He acknowledged that the condition known as "abnormal grief" is not one of the formal psychiatric diagnoses recognised in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or in the International Classification of Diseases:Mental and Behavioural Disorder:Clinical Descriptions and Diagnostic Guidelines (ICD-10). However, he pointed out that "abnormal grief" (described as "persistent complex bereavement disorder") is included in DSM-5 as a "condition for further study", together with proposed criteria for the condition. Dr Latcham considered that "abnormal grief" is a useful diagnostic formulation in a case such as this, where the Claimant's grief is caused by the death of her sister and the manner in which she died and is inextricably bound up with her psychiatric disorder. He said that, despite the fact that "abnormal grief" does not constitute a formal diagnosis, it is an expression that would be recognised by any psychiatrist. Dr Turner does not use the term "abnormal grief", because there is no universally accepted definition of it as a separate psychiatric disorder.

111. Despite the difference of opinion between him and Dr Turner, Dr Latcham accepted that it would be appropriate to describe the Claimant's condition as meeting many of

the criteria for the recognised diagnosis of a "Major Depressive Episode". Thus, the experts agreed that she had suffered from a formally recognised psychiatric condition. They agreed also that, although she had some symptoms of the type seen in PTSD, she had not met the full criteria for that diagnosis.

112. In the circumstances, I accept that the Claimant suffered from the recognised medical condition of Major Depressive Disorder.

The cause of the Claimant's psychiatric condition

113. Dr Turner and Dr Latcham agreed that the Claimant had had a prior vulnerability to depression. That was evident from the period of depression she had experienced at the time of her back problems in 2000/2001. They noted that, in addition, her husband's unemployment, his depression and the unexplained seizure he had suffered in July 2010 probably amounted to additive factors.

114. However, they agreed that the episode of psychiatric disorder following Mrs Sharma's death had been caused by the series of incidents leading up to and including the death. Where they disagreed was as to which of those incidents were especially important.

115. Dr Turner did not consider that the events of 5 May were relevant to the issue of causation; the Claimant was reassured that there had been a CT scan and that no bleed had been detected. Dr Latcham considered that the events of 5 May had some relevance to her psychiatric disorder since she had subsequently (and wholly unjustifiably) blamed herself for accepting the assurance that all was well. Neither of the experts suggested that the events between 5 and 12 May had a significant causative effect, save that Dr Latcham pointed out that the Claimant would have been anxious about the diagnosis of viral meningitis, which is not a trivial illness. There is, however, no indication that the Claimant had particular worries during this period, other than a natural concern that her sister was still unwell.

116. In the Agenda given to the Consultant Psychiatrists for consideration during their Joint Discussion was a list of the incidents to which it was alleged the Claimant was exposed in the period from the morning of 12 May up to and including Mrs Sharma's death on 13 May. The list mirrored (with some amendments) the list at paragraph 24 of the Particulars of Claim, and was as follows:

> (a) being advised of Mrs Sharma's sudden deterioration on the morning of 12th May 2009 (Mrs Shorter's and Mr Sharma's accounts) and that, contrary to the advice received previously, the CT scan performed on the 5th May 2009 showed subarachnoid haemorrhage;
>
> (b) seeing Mrs Sharma during the day at the East Surrey Hospital in the condition Mrs Shorter and Mr Sharma describe in the knowledge that she had previously suffered a subarachnoid haemorrhage which had gone undiagnosed and therefore untreated, and in the knowledge of the consequences of this for Mrs Sharma;
>
> (c) being advised by telephone of the first seizure on arrival at St George's Hospital;

(d) being advised by telephone of the further seizure at St George's Hospital and hearing Mr Sharma's panic and confusion;

(e) when she saw her sister upon arrival at St George's Hospital and hearing Mr Sharma's panic and confusion;

(f) being advised by medical staff that as a result of the final seizure, Mrs Sharma was unlikely to survive;

(g) Mrs Sharma's death.

The experts were asked to state what causal impact they considered each of those incidents had had on the Claimant's psychiatric disorder.

117. In the Note of the experts' Joint Discussion, Dr Turner expressed the view that (b) and (e) - i.e. the visual experience - were the two most important factors in causing the Claimant's psychiatric disorder. The first, and in Dr Turner's view the more important of these two, was (b), i.e. her visit to ESH on 12 May, seeing Mrs Sharma in pain, knowing (as a result of the previous telephone call from Mr Sharma) that a bleed had been detected and being aware (due to her own nursing experience) of the risk of a re-bleed and of the urgent need for Mrs Sharma to be transferred to a specialist Neurosurgical Unit. Dr Turner's identification of (b) as the most significant incident reflected the view expressed in his Causation Report, written in October 2013. That Report was of course based on the accounts of events given by the Claimant, Mr Sharma and Mr Shorter in their witness statements of July 2013. In that Causation Report, Dr Turner had emphasised the Claimant's feelings of responsibility and helplessness whilst at ESH and her additional vulnerability by reason of her own specialist knowledge.

118. Dr Turner identified the Claimant's experience at ESH as the main cause of her psychiatric disorder, although he did consider that later events, especially seeing her sister in the ITU at SGH, probably contributed. He suggested that the "flashbacks" to the scene in the A & E Department at ESH and in the ITU at SGH which the Claimant reported experiencing supported his view as to the significance of those incidents.

119. In her witness statement dated 20 July 2013, the Claimant had referred to having "flashbacks" when she could see her sister in the A & E Department at ESH on a trolley, writhing in pain and clutching at her head. In oral evidence, Dr Turner explained that the "flashbacks" to the scene in the A & E Department reported by the Claimant were caused by emotional memories. The Claimant had reported seeking to avoid visiting the A & E Department at ESH in order not to have those memories. In addition, Dr Turner, who had observed the Claimant give evidence, said that he had noticed three "hotspots" when she had become particularly distressed and nearly "lost it" whilst in the witness box. He explained how "hotspots" can be an indicator of exposure to emotional trauma which continues to cause stress. He regarded the "hotspots" as a significant indicator of the cause of her psychiatric disorder. He said that the first of these "hotspots" had occurred when the Claimant was speaking about her attendance at the A & E Department at ESH. Dr Turner attached so much importance to this incident that, in the Note of the experts' Joint Discussion, he expressed his opinion that:

> "… the experiences in A & E were sufficient to cause the psychiatric disorder, even had Mrs Sharma in the end survived."

120. In oral evidence, he maintained that opinion, indicating that the "flashbacks" of the A & E Department scene which the Claimant reported and the "hotspot" when talking about it, indicated a type of emotional memory which would of itself have been sufficient to have caused her psychiatric disorder.

121. Dr Turner said that a second "hotspot" was evident when the Claimant was speaking of her journey with her husband to SGH. By that time, of course, she had received the telephone call from Mr Sharma, informing her of her sister's seizures. She had also spoken to the Ward Sister, who had told her that Mrs Sharma had probably suffered a re-bleed. She had told Dr Turner in 2011 that, "this is what she had been dreading would happen". She told Dr Latcham, that "the reality was horrific". She was aware that Mrs Sharma was now "in very dangerous territory" and she was "absolutely terrified". She did, however, manage to retain "a glimmer of hope". It was with those feelings, coupled no doubt with anger at the delay that had taken place, that she passed the journey to SGH.

122. In the Note of the experts' Joint Discussion, Dr Turner identified as the second of the two most important events in the causation of the Claimant's psychiatric disorder the incident when she saw her sister in the ITU at SGH. He pointed out that her specialist knowledge would have given her an immediate insight into the gravity of the situation. In oral evidence, Dr Turner expressed the view that the sight of her sister in the ITU would have had a significant emotional impact on the Claimant. That was, he said, evidenced in particular by the "flashbacks" which she experienced afterwards, especially in the course of her work, and by the distress she had demonstrated in her oral evidence (the third "hotspot") when speaking about this incident. Although he accepted that the Claimant would have had an anticipatory fear about Mrs Sharma's condition, he considered that it was the vision of her sister that brought home the reality that she had "gone".

123. Dr Turner considered that the direct witnessing and experiencing of the incidents in the A & E Department at ESH and in the ITU at SGH were important in the cause of the Claimant's psychiatric disorder. His view was that, had she not witnessed and experienced those incidents, she would have been likely to have had a normal "grief response", and would not have developed a Depressive Episode of the same severity or persistence. In oral evidence, it was suggested to him that the Claimant's vulnerability to depression, coupled with grief at her sister's death and anger at the fact that it had been caused by the failure of medical professionals, would have been sufficient to cause her to develop a Major Depressive Disorder, even had she not been physically present at the two Hospitals. Dr Turner did not accept that suggestion; he considered that she would not have developed a psychiatric disorder had it not been for the emotional impact of what she saw.

124. Dr Latcham's opinion was that the whole sequence of incidents, from the time of Mr Sharma's first telephone call on the morning of 12 May until her sister's death, had been important in causing the Claimant's psychiatric disorder. He emphasised in particular the telephone call informing her of the first seizure at SGH, the telephone call informing her of the further seizures and the fact of her sister's death. He pointed

out that the Claimant had told him that, after the first telephone call on the morning of 12 May, she was alarmed, very anxious and panicky and was shaking. She knew that there was a risk of a re-bleed and that it was "bad". He accepted that seeing Mrs Sharma in the A & E Department was significant. However, he considered that it should not be viewed in isolation, but in the light of the knowledge the Claimant already had by that time. His opinion was that, had Mrs Sharma gone on to recover well following her admission to ESH, the Claimant would not have suffered any psychiatric disorder.

125. Dr Latcham did not accept that, had she not experienced the events at ESH and SGH, the Claimant would have had a normal grief response following Mrs Sharma's death. He considered that, even had the Claimant not been present at either the A & E Department at ESH or the ITU at SGH, she would still have developed a psychiatric disorder of similar duration and severity. In other words, he did not consider that the visual images which she had experienced had made any material contribution to her psychiatric disorder. The disorder would, he suggested, still have occurred as a result of grief at the death and at the cause of it, and as a result of guilt which the Claimant would have felt at not having been present when Mrs Sharma died. He pointed out that the Claimant had on several occasions expressed guilt at her own failure to do more to ensure that Mrs Sharma received proper care. He observed also that, in his experience, failure to be present at a death can add enormously to a person's grief.

126. In oral evidence, Dr Latcham was asked about the "hotspots" referred to by Dr Turner. Dr Latcham said that a "hotspot" was a technical term used in the diagnosis of PTSD to mean experiences that result in "flashbacks" and/or nightmares. He said that, during his interview with the Claimant and when observing her give oral evidence, he had focussed on those incidents which had caused her obvious distress. Dr Latcham considered that the most significant appearance of distress was when the Claimant was talking about the last telephone call from Mr Sharma and about seeing Mrs Sharma at SGH. He observed that, at that time, she had "simply showed distress". Before that, he considered that there had been a "tinge of combative anger" and a "slight edge" to her evidence. He said that her presentation at trial had been consistent with his interview in December 2012, when the only time she had cried was when speaking of seeing Mrs Sharma at SGH.

127. Dr Latcham's view was that the whole sequence of incidents on 12/13 May had caused the Claimant's psychiatric disorder. He said that it was not possible to "carve it up", i.e. to separate the events at ESH and SGH from the information received by the Claimant in the telephone calls from Mr Sharma and the SGH Ward Sister. He pointed out that the Claimant had described to him, and had said in evidence, how the telephone calls had had a considerable emotional impact on her.

Conclusions as to the cause of the Claimant's psychiatric condition

128. As I have already said, in his Causation Report and subsequently, Dr Turner identified the Claimant's visual experiences, in particular her visual experience at the A & E Department at ESH, as of the greatest significance in causing her psychiatric disorder. In doing so, he relied on the witness evidence of the Claimant, Mr Sharma and Mr Shorter, on the Claimant's descriptions of "flashbacks" of the scene there and on her distress when giving oral evidence about the relevant events.

129. I shall deal with my conclusions on the witness evidence in due course. However, it is to be noted that, in the Claimant's first account of the events of 12 May 2009, given in October 2011 for the purposes of Dr Turner's Condition and Prognosis Report, there is a reference to the fact that Mrs Sharma "was in a lot of pain" whilst at ESH, but no mention of a distressing scene such as that described in the Claimant's witness statement of July 2013. Furthermore, the only reference to "flashbacks" in that Report was in a GP note dated 30 October 2009, recording that the Claimant had "terrible memories of her sister's death" and "flashbacks". I consider it likely that the reference to "flashbacks" in the GP note was to images of Mrs Sharma in the ITU at SGH which had been experienced by the Claimant, particularly at work. I appreciate of course that the purpose of Dr Turner's first Report was to provide advice on Condition and Prognosis, rather than on Causation. However, if what the Claimant saw on her arrival at the A & E Department was such an emotionally charged incident and the most important factor in causing her psychiatric condition, one would have expected her to have described the event to Dr Turner and him to have included it in his Report.

130. Dr Turner expressed the view that the Claimant's experiences in the A & E Department were sufficient to cause her psychiatric disorder, even had Mrs Sharma in the end survived. I must say that I found that a very surprising assertion. Had Mrs Sharma survived, the Claimant would have been spared the grief of her loss, the anger of knowing it need never have happened, the feelings of guilt at not having done more to ensure Mrs Sharma's safety and the distressing experiences which she subsequently had at SGH. She would not have had to undergo the repeated reminders of the events at SGH when at work. Moreover, she had previously witnessed her mother's death, which took place suddenly and was what the Claimant described as "horrific", even for her as a nurse, without sustaining a psychiatric disorder. It seems to me highly unlikely that she would have suffered such a disorder had Mrs Sharma survived.

131. I found it surprising also that Dr Turner laid comparatively little emphasis on what the Claimant experienced in the ITU at SGH, when seeing her sister on a life support machine brought home to her the reality that she had "lost her". It was an experience which had caused the Claimant considerable distress when speaking of it during her interview with Dr Turner in October 2011 and when giving oral evidence. It caused – and continues to cause – regular "flashbacks" in the course of her work. Yet, he appeared to attach significantly less importance to that incident than to her experience in the A & E Department at ESH.

132. Dr Latcham, on the other hand, laid little emphasis on the events at ESH and SGH. He acknowledged that they had played some part in the Claimant's disorder, but considered that, even had she not been present at either the A & E Department at ESH or the ITU at SGH, she would still have developed a psychiatric disorder of similar duration and severity. That assertion was on the basis that the Claimant would have suffered significant guilt as a result of her failure to be with her sister. It gave rise to some debate in the oral evidence about the hypothetical circumstances in which the Claimant might not have attended the Hospitals, e.g. because it was not in her power to do so; by choice; or because she was not informed of her sister's illness; and whether or not, in each circumstance, she could be expected to have suffered guilt. Such debate was necessarily speculative and I did not find it helpful in determining the issue of causation.

133. It appeared to me that the stances adopted by the two Consultant Psychiatrists were significantly influenced by their knowledge that, in the case of a "secondary victim" such as the Claimant, visual experiences are key factors in the recovery of damages. Their causation evidence was focussed primarily on the part played by those experiences. Thus, Dr Turner asserted that it was the two visual experiences in the Hospitals – and in particular, the first – which were the key incidents. Dr Latcham acknowledged that it was not possible to separate the various incidents on 12/13 May, all of which had played a part in causing the Claimant's psychiatric disorder. However, he asserted that the events of least importance were the visual experiences. I did not find either of those stances compelling

134. I consider that it is clear, on a balance of probabilities, that the incidents which occurred on 12/13 May all made a contribution to the development of the Claimant's psychiatric disorder. I do not consider that it is realistic to carve up the incidents into those which did and did not play a part. In any event, as I shall explain, I do not accept that the visual experience which the Claimant had on her arrival at ESH was as dramatic as that described by her. The extent of her distress when giving evidence was much greater when she talked of the journey to, and the time spent at, SGH. That tends to support the fact that those incidents had a greater emotional impact than the time spent in the A & E Department at ESH.

THE NEUROSURGICAL EVIDENCE

135. In their Joint Statement, the Neurosurgical experts were required to address two topics in particular. The first concerned the serious deterioration in Mrs Sharma's condition on 12 May which had been described by her husband and the Claimant. The experts agreed that a deterioration in symptoms can be caused by a complication of the original bleed, caused by hydrocephalus or raised intracranial pressure. Even if no such complication occurs, however, it is typical, following a "good grade" SAH (i.e. when the patient remain conscious without any neurological deficit), to suffer headaches and related symptoms for many weeks. Within that period, there will be a natural fluctuation in symptoms, particularly in the first two weeks. The experts agreed, therefore, that the symptoms experienced by Mrs Sharma between 5 and 12 May were typical of the Grade 1 SAH which she had suffered.

136. As to the events of 12 May, the experts agreed that there was a seeming discrepancy between the accounts given by the Claimant and Mr Sharma of the severity of Mrs Sharma's symptoms and the impression created by the Hospital records and the witness statements of the ESH staff. They said that the two versions were not necessarily inconsistent because it was possible that the headaches were fluctuating in severity that day, being reasonably controlled at the times when observations were noted in the Hospital records, and more severe at other times which were more vividly recalled by the family. They pointed out that, until Mrs Sharma underwent the foetal heart scan, her headaches may have been under-treated with medication.

137. The second topic considered by the experts was the cause of the serious deterioration on the morning of 12 May, if it is right that such a serious deterioration occurred. The experts agreed that it could have been caused by a complication of the original bleed, such as hydrocephalus or raised intracranial pressure. However, it could also have been caused by a re-bleed. In that event, it would have had to be small re-bleed, which can result in a deterioration in the symptoms (e.g. headache, neck stiffness,

photophobia, nausea/vomiting) already being suffered by the patient. Even if a re-bleed is small, however, any symptoms arising from it are likely to be rapid or instantaneous in outset and to cause a rapid increase in pain. If a re-bleed is large, it can result in a rapid deterioration to coma and death.

138. In Mrs Sharma's case, Professor Marks considered that the deterioration in her headaches on 12 May reported by Mr Sharma would probably have been caused by a small re-bleed on the morning of 12 May. However, Mr Mannion's view was that, as reported, the change in Mrs Sharma's symptoms was not entirely consistent with a re-bleed and would probably have been related to the effects of the original SAH.

139. The experts agreed that the questions of whether Mrs Sharma had suffered severe or mild pain on 12 May, and whether she had suffered a small re-bleed on the morning of 12 May had no bearing on the occurrence of her SAH on 13 May.

140. The two experts agreed that the only indisputable evidence of a second bleed came from the CT scan taken at SGH in the early hours of 13 May 2009, after Mrs Sharma had suffered a series of seizures. They agreed also that the first seizure that occurred immediately after Mrs Sharma's arrival at SGH was probably the result of a small re-bleed, and that the later seizures were caused by a further, devastating re-bleed.

141. I accept Mr Mannion's opinion that Mrs Sharma did not suffer a re-bleed on the morning of 12 May. I consider it probable that her condition on that day was attributable to the ongoing effects of the bleed which had occurred on 5 May. I consider that it is probable also that the first re-bleed occurred immediately after Mrs Sharma's arrival at SGH at or around midnight on 12 May.

142. The experts also agreed that the Claimant, with her specialist knowledge of neurosurgical patients and SAH, would have understood the seriousness of the situation and would have been aware of the risks of complications including re-bleed. She would have been aware, on hearing about the seizure, that this could represent a re-bleed, and her anxiety is likely to have been compounded by the recognition that the diagnosis had been missed on 5 May 2009 and that the events on 12-13 May 2009 had been avoidable if Mrs Sharma had been managed appropriately the previous week. The experts agreed also that the Claimant would have had an understanding about the poor prognosis in some patients with SAH, and that a re-bleed could result in a much worse SAH than had been first observed.

Conclusions on the factual issues

143. It is clear that, on 5 May, the Claimant was reassured by the news that the CT scan had shown no abnormality. I am satisfied that, during the days that followed, she accepted that Mrs Sharma's symptoms were consistent with the diagnosis (albeit a somewhat tentative diagnosis) of viral meningitis that had been made. She kept regular contact with her sister and saw her on 8 May. It is clear, however, that she was not unduly concerned about her sister's condition. If she had been, I have no doubt that she would have actively encouraged her to seek further medical advice and/or return to ESH.

144. The position changed on the morning of 12 May, when the Claimant received the telephone call from Mr Sharma telling her that a bleed had been detected. This must

have come as a considerable shock to her. Furthermore, given her own experience, she was fully aware of the implications of the existence of a bleed, of the delay that had occurred and of the possibility that Mrs Sharma might have a re-bleed. At that stage, she described herself as "really panicky" and "really frightened"; she knew her sister was "in the danger zone".

145. I do not accept that Mr Sharma told the Claimant during that telephone conversation that Mrs Sharma's condition had worsened. In her first recorded account of events to Dr Turner in October 2011, the Claimant did not mention that he had given this information. Nor did she mention it to Dr Latcham in December 2012. Moreover, Mr Sharma was very clear in his witness statement that he had not told the Claimant of the deterioration and gave the reasons why he did not do so. I am satisfied that his change of mind in his oral evidence was strongly influenced by the evidence the Claimant had given, which persuaded him that he must have been mistaken. His oral evidence therefore did not reflect his own recollection of events. He may also have been influenced by a desire, conscious or unconscious, to do what he could to support the Claimant in her claim.

146. After the telephone call, the Claimant took practical steps to attempt to arrange for Mrs Sharma to be treated in the Neurosurgical Unit at Hurstwood Park Hospital. During the journey to ESH and throughout her time there, it is clear that the Claimant was highly conscious of the urgent need to get Mrs Sharma to a Hospital where she would receive the specialist care she needed.

147. Mr Sharma's evidence was that it was because of a serious deterioration in Mrs Sharma's condition overnight that he had telephoned her GP that morning. However, he may well have done so in any event, having regard to the advice given by the doctor at the Walk-in Centre on 10 May. It is noticeable that, at no point in the ESH records for that day, is there any indication that either Mr or Mrs Sharma had mentioned a significant and very recent deterioration in Mrs Sharma's condition. That is somewhat surprising if there had indeed been a recent deterioration of the extent described in the evidence. I appreciate that Mr and Mrs Sharma were focussing on the fact that a bleed had been detected, but they must have realised that a dramatic deterioration in Mrs Sharma's condition would be significant and that the Hospital staff should be informed. If there had been such a dramatic deterioration, it would also be surprising if the Claimant had not drawn attention to it. It is of course the fact that she was not present when Mrs Sharma was examined by the Nurse or doctors, but she did have private talk to a doctor (probably Dr Ferrigan) shortly after her arrival at ESH, and she also had a conversation with Dr Kimber soon after Mrs Sharma's move to the Tilgate Ward. She would have been aware that a sudden and serious deterioration in Mrs Sharma's condition might indicate that there had been a re-bleed and it is likely, therefore, if there had been such a deterioration, that she would have raised that possibility with one of the doctors.

148. I am satisfied that Mrs Sharma's condition on 12 May had deteriorated from what it had been when the Claimant saw her on 8 May. I accept that there was a time during 12 May when Mrs Sharma was in significant pain and she may well have been crying, from a combination of pain and of fear at the news of her bleed. Mr Sharma referred to the fact that her pain fluctuated during the day. That, as the Neurosurgeons have said, is typical of SAH. Her pain level was also no doubt influenced by the differing levels of analgesia she was taking at different times.

149. However, the Hospital records do not suggest that Mrs Sharma was in the state described by the Claimant, Mr Sharma and Mr Shorter. The notes made by the Nurse (timed at 10.35hrs) shortly after her admission to the A & E Department were very brief, but do not suggest that she was in such a condition. Readings of her heart rate and respiratory rate were not, as the Claimant herself conceded in evidence, at the levels which would be expected for a patient suffering severe pain and distress of the extent described.

150. Even more significantly, the record of Dr Ferrigan's examination is wholly inconsistent with a patient suffering the level of pain described by Mr Sharma and the Claimant. In particular, there is the record that Mrs Sharma had severity of head pain "3/10". According to Dr Ferrigan, that was a rating given by Mrs Sharma herself. If she had been in very severe pain, it is inconceivable that she would have rated herself at "3", or, indeed, that Dr Ferrigan would have done so. The Claimant's explanation that the doctor who examined her sister and who recorded the rating "must have been quite junior" was not plausible. First of all, Dr Ferrigan could not be described as "quite junior", since she was appointed as a Consultant Physician less than a year after these events. Second, if Mrs Sharma's condition had been as described by the Claimant, even a lay person (such as Mrs Sharma herself) would not have marked her at "3/10". Moreover, the note also records that Mrs Sharma had no photophobia at the time of the examination, "only when headache bad", and that she was "comfortable". That strongly suggests that the headache did not appear to be demonstrably "bad" to the extent described by the Claimant at that time. This examination took place at a time when the medication given to Mrs Sharma was limited by the fact that it was believed she might still be pregnant. However, Dr Ferrigan did prescribe Co-codamol, which suggests that she considered that Mrs Sharma was suffering a significant degree of pain at times, for which she required analgesic medication. The records show that the first dose was given at about 12.15hrs.

151. I have already found that the Claimant arrived in the A & E Department some time just before or just after Dr Ferrigan's examination. I have no doubt that, when she arrived, she was surprised and worried by the fact that Mrs Sharma was in a worse condition than she had been when she last saw her four days previously. That fact, coupled with her knowledge that there had been a bleed evident on the CT scan and a delay in treating the bleed, caused the Claimant to be very frightened. However, I do not accept that Mrs Sharma's condition was as visually distressing as the Claimant described in her witness statement or in her oral evidence. In October 2011, the Claimant told Dr Turner that her sister had been "in a lot of pain". Similarly, she told Dr Latcham that her sister had "a bad pain in her head" and that she herself was "terrified by the scan and because she *(Mrs Sharma)* had more pain". However, she did not describe to the Psychiatrists the dramatic scene which appears in her witness statement and those of Mr Sharma and Mr Shorter, all of which were written considerably later, in July 2013. Neither is there any mention of seeing her sister in the A & E Department in that distressing condition in the Letter of Claim submitted to the Defendant and dated 9 November 2011. The only reference in that document to this incident is to the effects on the Claimant of "being present with her sister waiting in hospital". By contrast, there <u>was</u> reference in the Letter of Claim to the effects of "seeing her sister in that condition" (i.e. a critical condition and not going to survive)

at SGH. The description of the shocking and distressing visual impression at ESH appears for the first time much later.

152. I do not suggest that the Claimant has deliberately sought to exaggerate what she saw at ESH. On the contrary, I consider that she was an honest and impressive witness, who was doing her best to give an accurate account of what had happened. As I have indicated, I accept that there were times when Mrs Sharma was in pain and fear and also that it was upsetting and frightening for the Claimant to see her in a worse state than when they had last met, especially when she knew that Mrs Sharma was at risk of a re-bleed. However, it seems to me probable that, over time and after detailed questioning about her visual experiences for the purposes of this claim, the Claimant has reflected on what happened and has come to believe that she saw what she has described. The same considerations apply to the evidence of Mr Sharma and Mr Shorter. The events of the day were unexpected and upsetting for them all and it would not be surprising if their recollections were not entirely accurate.

153. I can well imagine also that, looking back, the Claimant can visualise her sister in the A & E Department and that, as a result, she has found it difficult to re-visit ESH when obliged to do so, e.g. when her husband suffered a seizure in July 2010. It must bring back bad memories of the time spent there with her sister and of the failures of care which took place.

154. Mrs Sharma was transferred to the Tilgate Ward at approximately 14.00hrs. At about 14.52hrs, she had the foetal heart scan. The Nurses who took her to the ultrasound scanner both gave evidence that she did not appear to be in severe pain and was chatting normally to them. I accept their evidence on this point. I am confident that they would have recalled if Mrs Sharma had been in real distress. Their impression was that the analgesia that was being given to her was controlling her pain. Ms Lees did, however, recall Mrs Sharma requesting further analgesia and that Tramadol was given. Despite the timing in the Hospital records, that is likely to have been after the foetal heart scan had confirmed that she had suffered a miscarriage. It is clear that, once she was given Tramadol, Mrs Sharma's pain lessened and she became calmer.

155. The Nurses described Mrs Sharma and her family as "relaxed, chatting and making jokes" during the afternoon. It may have appeared that they were relaxed, but I am confident it was an entirely false impression. They could not possibly have been truly "relaxed". Mr and Mrs Sharma had just learned that they had definitely lost their baby and all the family members were aware of the previous bleed and of the urgent need to get Mrs Sharma to SGH. The Claimant in particular was becoming more and more worried and frustrated about the failure to transfer her sister and to give her the Nimodipine that had been prescribed hours earlier. However, she, her husband and Mr Sharma were all making a valiant effort to appear calm; to conceal their internal feelings; to reassure Mrs Sharma and to keep her entertained to the best of their abilities. Their sensible and courageous attitude was misinterpreted by others. Meanwhile, Mrs Sharma, who herself appears to have been a practical and a stoical individual, was concerned about the welfare of her two children and was anxious to make suitable childcare arrangements for that night.

156. The Claimant and her husband left in order to assist with that task. Whilst the Claimant was reassured to learn that her sister would be leaving for SGH "very shortly" and would soon be given Nimodipine, she remained very anxious throughout

that evening. Her anxiety was increased by the news given during a telephone call at about 22.00hrs, that Mrs Sharma was still at ESH. I accept that she was "terrified", as she described, when she heard that news.

157. The next telephone call at about midnight brought news of the first seizure. Whilst I accept that the Claimant was somewhat reassured by the fact that her sister had come round and was now at SGH, this news must have raised her level of anxiety. I accept her husband's evidence that she had "a look of fright" on her face and was extremely anxious.

158. The next telephone call, telling the Claimant of the renewed attack of seizures suffered by Mrs Sharma was plainly, as the Claimant said, "a really frightening moment". Even more frightening was her telephone conversation with the Ward Sister at SGH, who told her that Mrs Sharma had, in all probability, suffered a re-bleed. Given her knowledge of the likely consequences of a second bleed, it is not surprising that she was "absolutely terrified". She told Dr Turner that, "this is what I had been dreading would happen". She was well aware that the prognosis was very poor but, very naturally, still managed to maintain "a glimmer of hope". It is significant that, when speaking of the journey to SGH and of events there, the Claimant became very tearful in her evidence.

159. The events of the next few hours were distressing for the family members who were present and it is not surprising that the accounts of what happened differed as between individuals. I am satisfied that the accounts of the sequence of events given by Mr Sharma and Mr Shorter in their witness statements were correct. They are consistent with each other and with the Hospital records. It makes sense that the Claimant would have attempted to find Mr Sharma first, before going to the ITU. First, she would have wanted to ascertain the up-to-date position and, second, she would have wished to report to him the telephone conversation she had had with the Ward Sister.

160. Mr Sharma's insistence in his oral evidence that he had first seen the Claimant when he was in the ITU was, as I have already pointed out, wholly inconsistent with his witness statement. My impression was that, as with his evidence about the contents of his first telephone call to the Claimant on 12 May, he was persuaded by the Claimant's oral evidence that she must be correct and so gave oral evidence that did not reflect his own recollection of events. He may also have changed his mind by reason of a desire (whether conscious or unconscious) to support the Claimant in her claim. I am satisfied also that Mr Sharma told the Claimant and other members of the family on their arrival that Mrs Sharma "had gone" and that they "had lost her" and that it was after being told that news that the Claimant first went to see her sister. It seems probable that, as Mr Sharma and Mr Shorter stated in their witness statements, she went alone initially. Be that as it may, however, I have no doubt that, as the Claimant has said, it was only when she saw her sister unconscious on the life support machine that the fact of her imminent death became a reality. I can well understand also how that sight returns to haunt her and how she suffers "flashbacks" when, in the course of her work, she sees a patient in a similar situation.

161. It is unnecessary to refer in detail to the events of the next few hours. They involved further visits by members of the family to see Mrs Sharma before and after she was pronounced dead, distressing discussions with the doctors, decisions about difficult matters such as organ donation and the switching off of the life support machine.

There were also the feelings of uncertainty and anger about how Mrs Sharma's death could have been allowed to happen. This period was especially difficult for the Claimant who was familiar with the various processes and knew at all stages what was about to happen. Once again, it is understandable that she experiences great difficulties when having to support and comfort members of patients' families who find themselves in a similar situation in the Neurosurgical Department where she works.

THE LAW

The authorities

162. Claims in negligence for mental injury (or what came to be known as "nervous shock") have to meet a stringent test. In *McLoughlin v O'Brian et al* [1983] 1AC 40, the House of Lords held that, in any successful claim for mental injury standing alone (i.e. not consequential on physical injury), the 'shock' resulting from the defendant's negligence must cause the claimant to suffer some medically identifiable psychiatric illness or injury. Such illness or injury is to be distinguished from emotional distress or injury to feelings, for which no successful claim can be made in the absence of physical injury. The term "nervous shock" can be misleading. It does not mean that the "shock" is the psychiatric injury caused to the claimant; what it means is that the claimant is claiming damages for the psychiatric injury caused by the shocking event. A more appropriate term than "nervous shock" is "psychiatric injury".

163. A successful claim for psychiatric injury alone can be brought by a claimant who is within the class of persons whom the defendant should have foreseen would suffer personal injury, whether a physical injury or a psychiatric injury, as a result of the defendant's negligence. Such a person is generally known as a 'primary victim'. It is now well-established that, in certain very limited circumstances, a person is also entitled to recover damages for psychiatric injury occurring as a result of the death or serious physical injury to a near relative, where that death or physical injury is caused by the negligence of a third party. A person bringing such a claim is termed a "secondary victim" and recovery is subject to a number of conditions. Those conditions have been developed over recent years in decisions by the Court of Appeal and the House of Lords.

164. The House of Lords appeal in *McLoughlin* concerned a road traffic accident caused by the negligence of the respondents which resulted in the death of one of the appellant's children and injuries to her husband and two other children. The appellant was informed of the accident about an hour after it had occurred by a friend, who then drove her to the hospital where her family members were being treated. There, she heard the news of her daughter's death and saw her husband and two surviving children, who were in a distressed and dishevelled state, with varying degrees of injury. Lord Wilberforce described the circumstances witnessed by the appellant as "distressing in the extreme and … capable of producing an effect going well beyond that of grief and sorrow". The appellant claimed damages as a secondary victim for nervous shock suffered as a result of what she had seen.

165. The trial judge had given judgment for the respondents, concluding that they owed no duty of care to the appellant because the possibility of her suffering injury by nervous shock was, in the circumstances, not reasonably foreseeable. The Court of Appeal

upheld the judge's decision, but on different grounds. Stephenson LJ took the view that the possibility of injury to the appellant by nervous shock was reasonably foreseeable and that the respondents owed the appellant a duty of care. However, he held that considerations of policy prevented the appellant from recovering damages. Griffiths LJ also held that injury by nervous shock to the appellant was "readily foreseeable", but that the respondent owed no duty of care. The duty was, he said, limited to those on the road nearby.

166. The House of Lords reversed the decision of the Court of Appeal and held that the appellant was entitled to recover damages. The leading speech was given by Lord Wilberforce. He considered previous decisions in cases of nervous shock. He made clear that foreseeability could not of itself automatically give rise to a duty of care owed to a person or class of persons. Because of the fact that 'shock' by its nature was capable of affecting such a wide range of people, there was a real need for the law to place some limitation on the extent of admissible claims. He identified three elements which were inherent in any successful "secondary victim" claim:

a) The class of persons whose claims should be recognised; the closer the tie (not merely in relationship, but in care) the greater the claim for consideration;

b) The proximity of such persons to the accident, which must be close both in time and space. In relation to that element, Lord Wilberforce said (at page 422):

> "It is, after all, the fact and consequence of the defendant's negligence that must be proved to have caused the "nervous shock." Experience has shown that to insist on direct and immediate sight or hearing would be impractical and unjust and that under what may be called the "aftermath" doctrine one who, from close proximity, comes very soon upon the scene should not be excluded."

c) The means by which the shock is caused. Lord Wilberforce said (at page 422-423):

> "The shock must come through sight or hearing of the event or of its immediate aftermath. Whether some equivalent of sight or hearing, e.g. through simultaneous television, would suffice may have to be considered."

167. *Alcock v Chief Constable of South Yorkshire Police* [1982] 1AC 310, arose out of the Hillsborough Football Stadium disaster, when 95 people died and hundreds were injured as a result of the overcrowding on a terrace. The 15 claimants (then known as plaintiffs) were relatives of those on the terrace. Each of the claimants had either been present at the Stadium, but remote from the terrace, or had witnessed the event live on television or in later news broadcasts. The claimants claimed damages against the defendant who had been responsible for policing the match. One claimant had

been just outside the Stadium and, having seen the events on the television, had gone in to search for his missing son. All the claimants alleged that the impact of what they had seen and heard had caused them severe shock resulting in psychiatric illness.

168. The judge at first instance found that nine of the claimants, who were either parents, spouses or siblings of the victims and who were eye-witnesses of the disaster or who had watched it live on television, were entitled to claim damages. The claims of the remaining six claimants were dismissed because their relationship with the victims was more remote or because they had heard about the disaster by some means other than the live television broadcasts. The Court of Appeal allowed the defendant's appeal and dismissed the unsuccessful claimants' cross appeal.

169. In his speech at p411F-412A, Lord Oliver identified the five elements which had been found in the reported cases to be the essential criteria that a successful claimant in a secondary victim case must meet:

> "The common features of all the reported cases of this type decided in this country prior to the decision of Hidden J. in the instant case and in which the plaintiff succeeded in establishing liability are, first, that in each case there was a marital or parental relationship between the plaintiff and the primary victim; secondly, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system; thirdly, that the plaintiff in each case was either personally present at the scene of the accident or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards; and, fourthly, that the injury suffered arose from witnessing the death of, extreme danger to, or injury and discomfort suffered by the primary victim. Lastly, in each case there was not only an element of physical proximity to the event but a close temporal connection between the event and the plaintiff's perception of it combined with a close relationship of affection between the plaintiff and the primary victim. It must, I think, be from these elements that the essential requirement of proximity is to be deduced, to which has to be added the reasonable foreseeability on the part of the defendant that in that combination of circumstances there was a real risk of injury of the type sustained by the particular plaintiff as a result of his or her concern for the primary victim."

170. The five elements identified by Lord Oliver have since been described as the "control mechanisms" for limiting the class of persons who can recover damages for psychiatric illness as secondary victims. It has been recognised by the Courts that, in the absence of these "control mechanisms", the number of secondary victims who would be able to bring successful nervous shock claims would be virtually limitless.

171. Lord Oliver emphasised the importance of the element of proximity. He dealt with that element in this way at pp 416E – 417A:

> "The necessary element of proximity between plaintiff and defendant is furnished, at least in part, by both physical and temporal propinquity and also by the sudden and direct visual impression on the plaintiff's mind of actually witnessing the event or its immediate aftermath …
>
> … Grief, sorrow, deprivation and the necessity for caring for loved ones who have suffered injury or misfortune must, I think, be considered as ordinary and inevitable incidents of life which, regardless of individual susceptibilities, must be sustained without compensation. It would be inaccurate and hurtful to suggest that grief is made any the less real or deprivation more tolerable by a more gradual realisation, but to extend liability to cover injury in such cases would be to extend the law in a direction for which there is no pressing policy need and in which there is no logical stopping point. In my opinion, the necessary proximity cannot be said to exist where the elements of immediacy, closeness of time and space, and direct visual or aural perception are absent."

172. At p 401F of his speech, when discussing the relevant elements, Lord Ackner described the element of "shock" necessarily involved:

> "… the sudden appreciation by sight or sound of a horrifying event which violently agitates the mind. It has yet to include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system".

173. When speaking of the claims being made by some of the Hillsborough victims, Lord Oliver observed at p 417C-E:

> "As I read the evidence, the shock in each case arose not from the original impact of the transmitted image which did not, as has been pointed out, depict the suffering of recognisable individuals. These images provided no doubt the matrix for imagined consequences giving rise to grave concern and worry, followed by a dawning consciousness over an extended period that the imagined consequence had occurred, finally confirmed by news of the death and, in some cases, subsequent visual identification of the victim. The trauma is created in part by such confirmation and in part by the linking in the mind of the plaintiff of that confirmation to the previously absorbed image. To extend the notion of proximity in cases of immediately created nervous shock to this more elongated and, to some extent, retrospective process may seem a logical analogical development. But, as I shall endeavour to show, the law in this area is not wholly logical and whilst having every sympathy with the plaintiffs, whose suffering is not in doubt and is not to be underrated, I cannot for my part see any pressing reason of policy for taking this further step along a road which must ultimately lead to virtually limitless liability."

174. The cases of *McLoughlin* and *Alcock* remain the leading authorities on claims brought by secondary victims. However, I have been referred to a number of other cases decided since *Alcock*. *Taylorson v Shieldness Produce Ltd* [1994] PIQR P329 was a claim by the parents of a 14 year old boy who died almost three days after he had been crushed under a reversing vehicle. They were not present at the time of the accident but were informed of the accident soon after it had occurred. They went straight to the hospital to which their son was admitted and, thereafter, followed the ambulance which took him to another hospital. The boy's father glimpsed him in the ambulance and his mother saw him briefly as he was being rushed on a trolley to the Intensive Care Unit. For the next few hours, they were not allowed to see him. His father then saw him later that evening for a few minutes, but his mother did not visit until about 24 hours after the accident. The boy was on a life support machine and his parents stayed with him for most of the next two days. At the end of that period, it became obvious that he would not recover, the life support machine was switched off and he was pronounced dead.

175. The trial judge, Kennedy J, dismissed the parents' claim for damages in respect of psychiatric illness caused by reason of shock as part of the immediate aftermath of the accident. He observed that, having heard about the accident, the parents thereafter saw little of him. After that, they saw him with a dawning consciousness that they were going to lose him and eventually they did. He went on:

> "So it can be said of the illnesses of Mr and Mrs Taylorson that to extend the notion of proximity to this more elongated process may seem a logical development, but it is a development, in my judgment, outwith the law. Mr May boldly submits that, despite what is said in *Alcock's* case, I am entitled to find in the present case that the immediate aftermath of the accident extended from the time when the parents learnt of the accident to the time when they left hospital after the boy died. I am not prepared so to find."

176. The judge also found that the real psychiatric damage to the parents had resulted from grief at their son's death, not the shock of what they observed at the hospital. The Court of Appeal agreed with Kennedy J's interpretation of the law and dismissed the appeal.

177. *Galli-Atkinson v Seghal* [2003] Lloyds Rep. Med 285 was a claim by the mother of a 16 year old girl, Livia, who was killed when a car mounted the pavement and struck her. Her mother (the appellant) claimed damages against the driver in respect of the significant psychiatric disorder which she had suffered following her daughter's death.

178. The appellant was not present at the time of her daughter's accident, which occurred on her way to a ballet class. An ambulance was called and the ambulance team, together with a doctor who had also been called, treated her at the scene. Despite every effort, she was dead within 35 minutes of the accident. She was taken straight to the mortuary. Her injuries were described by the Recorder who heard the trial as "horrific", so extreme that the paramedic who had treated her required treatment afterwards for the effects upon him.

179. Livia's father had become concerned when she did not arrive back from her ballet class. He drove to where it was held but she was not there. He telephoned the appellant, who insisted on driving to meet him. Livia's father then learned of his daughter's death from a police officer who was in an area which had been cordoned off because of the accident. The appellant arrived and was told of her daughter's death by a police officer, whereupon she screamed hysterically and collapsed to the ground. The Recorder concluded that she had been aware of the police cars at the scene, but not of an ambulance, and that she saw nothing of the consequences of the accident.

180. The appellant, her husband and Livia's sister, who had also arrived at the scene, then went to the mortuary, arriving about two hours and ten minutes after the accident. Livia's father went in and confirmed that the deceased was his daughter. The appellant fell to her knees and crawled into the mortuary where Livia was lying on a trolley. Although the worst injuries had been covered, her face and her head were badly disfigured.

181. The Recorder concluded that "the mental shock the appellant had suffered at the scene was not caused by anything she saw, but by the shocking news she was given as soon as she reached the police cordon, which the police of course put up at the scenes of accident to keep people away from the shocking things often to be seen in the immediate aftermath of accidents". He did not consider that the fact that the appellant was told of her daughter's death at the scene, rather than somewhere else, made any material contribution to her psychiatric disorder. He therefore, dismissed her claim. So far as the visit to the mortuary was concerned, he found that the purpose of it was to identify the deceased, and that it did not form part of the "immediate aftermath".

182. The Court of Appeal did not accept the Recorder's finding in relation to the visit to the mortuary. In addressing the question of whether the appellant's psychiatric condition was caused by shock resulting from her appreciation of an event or its immediate aftermath, Latham LJ said at paragraphs 25-27:

> "In approaching that question, I do not consider that we are restricted by what Lord Ackner said in *Alcock* to a frozen moment in time. As Lord Wilberforce in *McLoughlin* recognised from the passage that he cited from *Benson v Lee*, an event itself may be made up of a number of components. This was accepted by this court in the case of *North Glamorgan NHS Trust v Walters* [2002] EWCA 1792. Likewise, in my judgment, can the aftermath, provided that the events alleged to constitute the aftermath retain sufficient proximity to the event. Indeed, the decision in *McLoughlin's* case can only be justified if the events in the hospital, when Mrs McLoughlin went to the hospital, are taken together as providing the trigger, if that is the right description, for the shock which produced the psychiatric illness.
>
> In the present case, the immediate aftermath, in my view, extended from the moment of the accident until the moment that the appellant left the mortuary. The judge artificially separated out the mortuary visit from what was an

> uninterrupted sequence of events, quite unlike the visit to the mortuary under consideration in *Alcock*. The visit with which we are concerned was not merely to identify the body. It was to complete the story so far as the appellant was concerned, who clearly at that stage did not want – and one can understand this – to believe that her child was dead.
>
> Accordingly, in my judgment the judge was wrong to have excluded what happened at the mortuary from consideration. If, therefore, it could properly be said, on the basis of the psychiatric evidence, that the whole of that sequence of events which was witnessed by the appellant played a part in producing the illness from which she undoubtedly suffered, then the appellant is entitled to succeed in her claim."

He went on to find, having considered the expert evidence, that the medical evidence supported a finding that the shock of what appellant saw in the immediate aftermath of the accident made a material contribution to her psychiatric condition. The Court of Appeal allowed the appellant's appeal.

183. All the cases I have referred to so far relate to accidents or (in the case of *Alcock*) a specific incident. However, I was also referred to three cases involving claims by secondary victims following different forms of negligent medical treatment.

184. The first case in time is *Taylor v Somerset Health Authority* [1993] PIQR P262. The claimant's (then the plaintiff's) husband suffered a heart attack whilst at work and died shortly after being taken to the defendant's hospital. The claimant went to the hospital within an hour and was told of her husband's death by a doctor about 20 minutes later. She was shocked and distressed. She then went to the mortuary and identified her husband's body. The defendant had been treating him for months and had negligently failed to diagnose or treat his serious heart disease. It was admitted that the claimant had suffered nervous shock (i.e. psychiatric illness) as a result of what she had heard and seen at the hospital. Auld J held that the death was the final consequence of negligence by the defendant many months earlier. He said that the "immediate aftermath" extension had been introduced as an exception to the general principle established in accident cases that a claimant could recover damages for psychiatric injury only where the accident and the primary injury or death caused by it occurred within the Claimant's sight or hearing. He continued at p 267:

> "There are two notions implicit in this exception cautiously introduced and cautiously continued by the House of Lords. They are of:
>
> (i) an external, traumatic, event caused by the defendant's breach of duty which immediately causes some person injury or death; and
>
> (ii) a perception by the plaintiff of the event as it happens, normally by his presence at the scene, or exposure to the scene and/or to the primary victim so shortly afterwards that the

> shock of the event as well as of its consequence is brought home to him.
>
> There was no such event here other than the final consequence of Mr. Taylor's progressively deteriorating heart condition which the health authority, by its negligence many months before, had failed to arrest. In my judgment, his death at work and the subsequent transference of his body to the hospital where Mrs. Taylor was informed of what had happened and where she saw the body do not constitute such an event."

185. In *Sion v Hampstead Health Authority* [1994] 5 Med LR 170. The circumstances giving rise to the claim started with a road traffic accident, when the appellant's son, who was 23 years old, was injured in a motor cycle accident. He was taken to a hospital administered by the respondent. The appellant went to the hospital and stayed with him throughout the time he was there. Over time, the appellant's son's condition deteriorated and, three days after the accident, he suffered a respiratory arrest and a cardiac arrest after which he fell into a coma. He died 14 days after the accident. The appellant's case was that his son's deterioration and death had been caused by the negligence of the hospital staff, who failed to diagnose substantial and continual bleeding from the left kidney. The allegations of negligence were denied by the respondent but, since the judge at first instance had been dealing with an application to strike out the claim, the allegations were assumed by him, and later by the Court of Appeal, to be correct. The claim was brought in respect of psychiatric illness said to have been caused by the traumatic events which had occurred during his son's time in hospital. In applying to strike out the claim, the respondent contended that it was doomed to fail.

186. The judge at first instance found that the facts set out by the appellant in his witness statement did not substantiate a finding that he had suffered the type of shock for which damages were recoverable. The Court of Appeal agreed. Staughton, LJ said:

> "In my opinion there is no trace in that report of "shock" as defined by Lord Ackner, no sudden appreciation by sight or sound of a horrifying event. On the contrary, the report describes a process continuing for some time, from first arrival at the hospital to the appreciation of medical negligence after the inquest. In particular, the son's death when it occurred was not surprising but expected. "

187. The case of *North Glamorgan NHS Trust v Walters* [2002] EWCA Civ 1792 concerned the negligent treatment of the respondent's young baby. When he was aged ten months, he became unwell and was admitted to hospital. He was mistakenly diagnosed as suffering from hepatitis A. In fact, he was suffering from acute hepatitis which led to liver failure. The NHS Trust responsible for the relevant hospital (the appellant) admitted that he had not been properly diagnosed or treated and that, if he had been, he would have been given a liver transplant and would probably have lived.

188. In the event, the baby was kept in hospital whilst various tests were carried out, but was allowed home at weekends. One weekend, his condition deteriorated and his parents took him back to hospital. The respondent stayed with him there, sleeping in

the same room. Two days or so after his readmission, the respondent awoke to hear the baby making choking noises in his cot. She saw a blood-like substance and his body was stiff. A nurse told the respondent that he was having a fit. He was transferred to the ICU and, shortly afterwards, the respondent was told by a doctor that it was very unlikely that the baby would have any serious damage as a result of the fit. She understood that he might at worse be slightly brain damaged; she did not consider it was life threatening. This information was, in fact, wholly wrong. The baby had suffered a major epileptic seizure leading to a coma and irreparable brain damage. A few hours later, after a CAT scan, the respondent was told that there was no damage to her baby's brain, but that he should be transferred to King's Hospital, London for a liver transplant. He was taken there by ambulance later that day and underwent a further CAT scan which showed diffuse brain injury consistent with a profound hypoxic ischaemic insult.

189. The respondent and the baby's father arrived at King's Hospital in the evening. There, she was told by doctors that the baby had suffered severe brain damage as a result of the fit and was on a life support machine. She was told that, if he had a liver transplant, the chances of success were only 50-50 and he would be severely handicapped. The respondent described herself as "numb, panic stricken and terrified" at what she was told. On the following day, she was told that the brain damage was so severe that her son would have no quality of life if he survived. The parents were asked whether or not they felt that it was in their son's interest to continue with life support. They made the decision that life support should be terminated, this was done shortly afterwards and the baby died in the respondent's arms.

190. The psychiatrists who gave expert evidence agreed that the respondent had suffered a recognised psychiatric illness, namely pathological grief reaction. They also agreed that, absent the events that were witnessed, experienced and participated in by the respondent over the period of her son's illness, her pathological grief reaction would not have occurred.

191. The trial judge directed himself that :

> "… the essence of what the claimant must show is that the psychiatric illness was brought about through the sudden appreciation by sight or sound of a horrifying event that affected her mind. Although the psychiatrists are agreed that she suffered "shock" and I am satisfied that her mind was violently agitated, the question is whether what happened was a sudden appreciation by sight or sound of a horrifying event rather than an accumulation over a period of time of more gradual assaults on the nervous system and that it was that sudden appreciation that caused the pathological grief reaction."

He identified "the essence of the [respondent's] case" as being that the 36 hour period beginning with the moment at which she was wakened by her son's fit until the moment at which the life support machine switched off could be looked on as a "horrifying event" which she suddenly appreciated, in contradiction to the accumulation over a period of time of more gradual assaults on the nervous system.

He held that an event could cover "in ordinary parlance something that occurs over several days".

192. Giving the leading judgment in the Court of Appeal, Ward LJ approved the trial judge's decision. At paragraph 34 he dealt with the meaning of the word "event":

> "In my judgment the law as presently formulated does permit a realistic view being taken from case to case of what constitutes the necessary "event". Our task is not to construe the word as if it had appeared in legislation but to gather the sense of the word in order to inform the principle to be drawn from the various authorities. As a word, it has a wide meaning as shown by its definition in the Concise Oxford Dictionary as: "An item in a sports programme, or the programme as a whole". It is a useful metaphor or at least a convenient description for the "fact and consequence of the defendant's negligence", per Lord Wilberforce, or the series of events which make up the entire event beginning with the negligent infliction of damage through to the conclusion of the immediate aftermath whenever that may be. It is a matter of judgment from case to case depending on the facts and circumstance of each case. In my judgment on the facts of this case there was an inexorable progression from the moment when the fit occurred as a result of the failure of the hospital properly to diagnose and then to treat the baby, the fit causing the brain damage which shortly thereafter made termination of this child's life inevitable and the dreadful climax when the child died in her arms. It is a seamless tale with an obvious beginning and an equally obvious end. It was played out over a period of 36 hours, which for her both at the time and as subsequently recollected was undoubtedly one drawn-out experience."

At paragraph 36, when considering whether the event was "horrifying", Ward LJ said:

> "For my part the facts only have to be stated for the test to be satisfied. This mother awakens to find her baby rigid after a convulsion. Blood is coming from his mouth. He is choking. Is that not as much an assault upon her senses as if her child had been involved in a road accident, suffered grievous head injuries as yet undetected and was found bleeding in the car seat? Her fear and anxiety was undoubtedly calmed not long afterwards when given an incorrect medical opinion that it was very unlikely and would be very unlucky if Elliot had suffered serious damage. Every mother would seize upon the good news for her comfort to reduce the impact of the horror. Consequently, all the more likely it is that she should have felt numb, panic stricken and terrified by the sudden turn of events when she arrived at King's College Hospital. That left her stunned. As the consultant observed she "responded as if half in a dream … in a state of emotional shock". Her hopes were lifted then they were dashed and finally destroyed when shortly

> thereafter she was advised to terminate treatment on the life support machine. That she should have felt that "this was a complete shock" seems to me to be inevitable. That her immediate reaction should have been one of anger is understandable. Anger is part of the grieving process. But the agreed medical evidence made it plain that the combination of events "witnessed and experienced" caused her pathological grief reaction and was different from a normal grief reaction. They must have been chilling moments, truly shocking events, as the experts agreed in answer to the seventh question put to them, and thus amply justifying the conclusion that this was a horrifying event."

193. Ward LJ then went on to deal with the element of "sudden appreciation of the horrifying event" which is an aspect of proximity necessary to establish liability. As he observed at paragraph 38:

> "Without the sudden and direct visual impression on the claimant's mind of actually witnessing the event or its immediate aftermath, there is no liability".

He considered that the judge had been fully justified in coming to the conclusion that the respondent's appreciation had been "sudden". Being awoken by her baby's convulsion and seeing his state had been "a sudden assault on her mind". In the same way, the bad news given to her at King's Hospital and the following morning could, he found, be characterised as "sudden and unexpected assaults on her mind". He summarised the effects thus:

> "The first … event in the series is her being woken by her child's convulsion. What she saw was unexpected. That amounted to a sudden assault on her mind. The next event is arriving at the hospital, hopes high. She is given news she did not expect and did not want. The reaction was to leave her stunned. That was a sudden and unexpected assault on her mind. The next day she is told she should switch off the life support machine. Perhaps she feared it might be so but does one doubt the consultant's evidence that she and her partner "found it particularly devastating because they thought they had been reassured prior to Elliot's transfer that his condition was treatable"? Each of these three events had their impact there and then. This is not a case of the gradual dawning of realisation that her child's life had been put in danger by the defendant's negligence. A consequence of that negligence was that the child was seized with convulsion. She was there witnessing the effect of that damage to her child. The necessary proximity in space and time is satisfied. The assault on her nervous system had begun and she reeled under successive blows as each was delivered. It comes as no surprise to me that when her new baby was ill she should suffer the flashbacks of 36 horrendous hours which wreaked havoc upon her mind"

The Court of Appeal dismissed the appeal against the judge's decision.

194. The most recent decision of the Court of Appeal to which I was referred was the case of *Crystal Taylor et al v A Novo (UK) Ltd* [2013] EWCA Civ 194. In that case, the claimant's mother had sustained injuries to her head and foot as a result of an accident at work caused by the negligence of the defendant. About three weeks later, in the presence of the claimant, she unexpectedly collapsed and died due to deep vein thrombosis and consequent pulmonary emboli which themselves were caused by the injuries sustained in the accident. The claimant had not witnessed her mother's accident, but claimed damages against the defendant for psychiatric illness (PTSD) caused by witnessing her mother's collapse and death.

195. The trial judge found that the operative "event" that caused the damage was the death, it being the second "event" caused by the defendant's negligence suffered by the mother three weeks earlier and that the claimant's injury was a reasonably foreseeable consequence of the defendant's negligence. He gave judgment for the claimant. The defendant appealed on the ground that the claimant had not been present at the scene of the accident which caused the death nor was she involved in its immediate aftermath. On behalf of the claimant, it was contended that the relevant "event" which should be considered for the purposes of deciding whether the claimant was a secondary victim was not the original accident, but the collapse and death that resulted from it.

196. Giving the judgment of the Court of Appeal, Lord Dyson MR reviewed the authorities, most of which I have already referred to. At paragraph 26, he observed that, in order to succeed as a secondary victim, the claimant would have to show that there was a relationship of proximity between herself and the defendant. He referred to the two distinct and different senses in which the term "proximity" is used in the relevant cases. The first describes the relationship between parties which is necessary in order to found a duty of care owed by one to the other. He referred to the point made by Lord Bridge in *Caparo Industries Plc v Dickman* [1990] 2 AC 605, 617-618:

> "What emerges is that, in addition to the foreseeability of damage, necessary ingredients in any situation giving rise to a duty of care are that there should exist between the party owing the duty and the party to whom it is owed a relationship characterised by the law as one of 'proximity' or 'neighbourhood'….".

197. As to the second sense in which the word "proximity" is used, Lord Dyson said at paragraph 27:

> "But in secondary victim cases, the word "proximity" is also used in a different sense to mean physical proximity in time and space to an event. Used in this sense, it serves the purpose of being one of the control mechanisms which, as a matter of policy, the law has introduced in order to limit the number of persons who can claim damages for psychiatric injury as secondary victims or to put it in legal terms, to denote whether there is a relationship of proximity between the parties. In a

> secondary victim case, physical proximity to the event is a necessary, but not sufficient, condition of legal proximity."

198. Lord Dyson MR went on to note that the defendant's single act of negligence had had two consequences. If the claimant had been in physical proximity to her mother at the time of the accident and had suffered shock and psychiatric illness as a result of seeing the accident and the injuries sustained by her mother, she would have qualified as a secondary victim on established principles. However, he continued at paragraph 29:

> "But in my view, to allow Ms Taylor to recover as a secondary victim on the facts of the present case would be to go too far."

199. Lord Dyson MR gave two reasons for this view. In relation to the first of these, he said at paragraph 30:

> "First, it seems to me that, if the judge is right, Ms Taylor would have been able to recover damages for psychiatric illness even if her mother's death had occurred months, and possibly years, after the accident (subject, of course, to proving causation). This suggests that the concept of proximity to a secondary victim cannot reasonably be stretched this far. Let us now consider the situation that would have arisen if Mrs Taylor died at the time of the accident and Ms Taylor did not witness the death, but she suffered shock when she came on the scene shortly after the "immediate aftermath". In that event, Ms Taylor would not have been able to recover damages for psychiatric illness because she (possibly only just) would have failed to satisfy the physical proximity control mechanism. The idea that Ms Taylor could recover in the first situation but not in the others would strike the ordinary reasonable person as unreasonable and indeed incomprehensible. In this area of the law, the perception of the ordinary reasonable person matters. That is because where the boundaries of proximity are drawn in this difficult area should, so far as possible, reflect what the ordinary reasonable person would regard as acceptable."

200. The second reason identified by Lord Dyson MR was public policy. At paragraph 31, he said:

> "In my view, the effect of the judge's approach is potentially to extend the scope of liability to secondary victims considerably further than has been done hitherto. The courts have been astute for the policy reasons articulated by Lord Steyn to confine the right of action of secondary victims by means of strict control mechanisms. In my view, these same policy reasons militate against any further substantial extension. That should only be done by Parliament."

201. Lord Dyson MR approved the observations of Auld J in *Taylor v Somerset Health Authority*: see paragraph 184 above. The defendant's appeal was allowed.

Discussion

202. The Defendant has conceded that the close relationship between the Claimant and Mrs Sharma was such as to bring her within the class of persons who are eligible to bring a claim as secondary victims, i.e. to found a duty of care owed by the Defendant to the Claimant. The Claimant has also established that she has suffered a psychiatric illness, namely a Major Depressive Disorder. I have found that her illness was caused by the incidents which occurred on 12/13 May. However, she must also show that her psychiatric illness was caused by the sight or sound causing an assault to her senses. She must establish sufficient proximity to the event, a sudden and direct visual impression on her mind of witnessing the event or its aftermath.

203. The Claimant's case is that she was exposed to a "seamless single horrendous event" starting on the morning of 12 May which she directly witnessed and/or in which she was directly and immediately involved, either by direct sight or by sound. On behalf of the Claimant, Ms Jones submitted that the facts of this case were very similar to those in *Walters.* The Claimant had been exposed to the visual impression of her sister in the A & E Department and had the added distress of being aware, because of her professional experience, of the implications of the news that she had had a bleed. Ms Jones pointed out that the Court of Appeal in *Walters* had found that, once the "event" started, a period of 36 hours could be regarded as a "single seamless event"; the time period in the present case was, of course, considerably shorter. Ms Jones pointed out that, following the start of the "event" in *Walters*, the mother had been given 'good news' about her baby's prognosis, but later had the shock of learning that the information had been wrong and that the prognosis was very bad. The Court of Appeal had accepted that those incidents had formed part of the single "horrifying event". She submitted that, in the present case, the Claimant's knowledge of the risk of a re-bleed and of the need to get Mrs Sharma moved to a specialist unit - and the effects on her of this knowledge - should similarly be considered as part of the relevant "event". She argued that, in a similar manner to *Walters*, the assault on the Claimant's nerves had begun when she entered the A & E Department at ESH and saw her sister and that, thereafter, she had "reeled under successive blows as each was delivered".

204. For the Defendant, Mr Matthews argued that *Walters* was distinguishable. In that case, the mother had woken up and witnessed her son rigid, bleeding and choking. There was therefore a "sudden appreciation of the horrifying event". In the present case, he said, there was no such sudden "horrifying event". Rather, the Claimant's realisation of the danger her sister was in came gradually, as a result of telephone calls, her own concerns and the events at ESH. He submitted that the Claimant did not have the required degree of proximity to a specific and shocking "event".

205. Mr Matthews argued that the case was "on all fours" with *Crystal Taylor*. In that case, there were two consequences of the defendant's negligence, i.e. first the accident and then the collapse and death. He submitted that, in this case, there were also two consequences of the accident. The first was that Mrs Sharma was not treated and therefore the biological process continued unchecked and she was exposed to the risk of a re-bleed. The second, which could have occurred months or years later, was the discovery that she had suffered a bleed and might be at risk of a re-bleed. He drew attention to the observations of Lord Dyson MR in *Crystal Taylor*:

> "But in my view, to allow Ms Taylor to recover as a secondary victim on the facts of the present case would be to go too far."

206. Mr Matthews suggested that precisely the same observations apply in the present case. Ms Jones disagreed. She submitted that *Crystal Taylor* was completely different in character. In that case, the first consequence of the defendant's negligence (the accident) was known. In this case, like *Walters*, the consequence of the negligence was unknown and unknowable until 12 May. The first part of the 'event' was the communication of the consequence of the negligence and the rest of the 'event' continued from there.

Conclusions

207. As the case law to which I have referred makes clear, the task of determining whether or not a claimant in a secondary victim case has satisfied the "control mechanisms" which must be surmounted in order to recover damages is not an easy one. It can also be a somewhat artificial exercise, involving as it does decisions about what constitutes an "event" or the "immediate aftermath" thereof and whether the claimant's experience of the event or its immediate aftermath can properly be described as "horrifying", "shocking" and/or "sudden and unexpected".

208. The early claims by secondary victims mainly concerned accidents, most often road traffic accidents. In those cases, it was comparatively easy to identify the relevant "event" (the accident) although, as the authorities show, it was often more difficult to determine precisely what constituted the "immediate aftermath" of an event.

209. Cases of clinical negligence present particularly difficult problems. The factual background of cases can be very different and often quite complex. The nature and timing of the "event" to which the breach of duty gives rise will vary from case to case. In *Taylor v Somerset Heath Authority*, the claimant's husband's heart attack and death occurred as a consequence of negligent treatment which had occurred many months before. The claimant did not observe the occurrence of the heart attack or death. She came onto the scene an hour later and viewed her husband's body at the mortuary. The trial judge found that there was no "qualifying event", just the final consequence of her husband's progressively deteriorating heart condition which the defendant, by its negligence many months before, had failed properly to treat. It was not the kind of external, traumatic event which, when perceived by a secondary victim, would give rise to a successful claim for damages. He further found that, even if the heart attack and death were to be treated as a qualifying "event", the claimant did not see her husband's body soon enough after his death to convey to her the shock of the heart attack as well as its consequence.

210. In the case of *Walters*, it is not clear how long prior to the baby's seizure the negligence had taken place. It is, I suppose, arguable that the negligence continued from the point when the wrong diagnosis was made right up to the time of the seizure. However, in that case, the Court of Appeal made clear (paragraph 34 of Ward LJ's judgment) that the "event" was a convenient description for "the fact and consequence of the defendant's negligence" and that it had begun "with the negligent infliction of damage", i.e. at the time of the baby's convulsion. That was the time when the consequence of the negligence first became evident. There would of course have been ongoing consequences affecting the baby's biological processes for some time

previously but it was only at the time of the convulsion that those consequences became evident and impacted on the claimant. The Court of Appeal found that the "event" began at that time and continued for the 36 hours up to the baby's death.

211. In the present case, the negligence which gave rise to the claim started on 5 May and continued until, a week afterwards, both the fact of the negligence and of the potential consequences of that negligence became known. As with the case of *Walters*, in reality, of course, certain consequences (i.e. the biological processes which eventually led to the fatal re-bleed) had been ongoing throughout that period and had caused Mrs Sharma's symptoms to worsen. Within about 15 hours of the time when the fact and potential consequences of the negligence became known, those consequences - i.e. the fatal re-bleed, followed by Mrs Sharma's death - actually occurred.

212. The fact of the Defendant's negligence and of its possible consequences became known to the Claimant when she received the telephone call from Mr Sharma on the morning of 12 May. At that stage, there was no element of "physical proximity" to any qualifying "event". The factual information she received was communicated by telephone. The potential implications of that information were informed by the Claimant's own extensive knowledge and experience. She became "panicky" and "really frightened", to the extent that she did not trust herself to drive.

213. I have already dealt at some length with the Claimant's subsequent arrival at the A & E Department at ESH. I have found that Mrs Sharma was not in the dramatic state of pain and distress described by the Claimant and other witnesses in their witness statements and oral evidence. She was plainly unwell, in pain, and fearful about the news of the bleed. But I am satisfied that she was not in such a condition that to see her could be described as a "horrifying event" or to cause "violent agitation of the mind". I consider that, reflecting afterwards on what had happened, the Claimant could imagine Mrs Sharma in the A & E Department. However, I do not consider that, at the time, the sight of Mrs Sharma had the visual effect on the Claimant which was later described. In the case of *Walters*, the trial judge and the Court of Appeal laid considerable emphasis on the start of the "event", when the mother awoke to find her baby rigid and choking after a convulsion, with blood pouring out of his mouth. Ward LJ likened that to the "assault upon her senses" the mother would have suffered if she had seen her child bleeding in a seat after a road traffic accident. That sort of "assault upon the senses" is, it seems to me, of a very different order to the scene in the A & E Department at ESH on 12 May. Indeed, even if Mrs Sharma had for a short time been in the state described by the Claimant, I do not consider that the sight would have come within the type of "event" described in *Walters* and the other relevant authorities. Mrs Sharma's condition was fluctuating; she did not have obvious injuries; she was not – or at least did not appear at that stage to be – in any obvious or immediate danger.

214. I am well aware that the Claimant's professional background gave her an unusual degree of insight into her sister's medical situation. It was suggested that, as a result, she would have been more sensitive to the events at ESH and therefore more likely to find them "horrifying". However, it seems to me that it is necessary to be cautious in finding that the Claimant's professional expertise made the sight of Mrs Sharma more "horrifying" than it would have been to a person without that knowledge. I consider that the "event" must be one which would be recognised as "horrifying" by a person of ordinary susceptibility; in other words, by objective standards. After all, certain

people would find it *more* frightening to have no medical knowledge and not to know what was going on; they may feel helpless and isolated. Others may have armed themselves in advance with medical information from the internet which leads them to feel far greater fear than is in fact justified. It would be unfortunate if secondary victims' claims were to become embroiled in debates about an individual claimant's level of medical knowledge and its effects upon whether an "event" should be classified as "horrifying".

215. During her time at ESH, the Claimant was of course aware of the potential dangers of her sister's condition and of the need for her to be transferred promptly to a specialist Unit. She did all she could to assist Mrs Sharma by talking to the doctors, enquiring when the transfer would take place and reminding staff about the medication that had previously been prescribed. Throughout this time, she was worried and frustrated at the delay.

216. After her departure from ESH, the Claimant remained anxious. All the information she gained over the next nine hours or so came from the four telephone conversations which took place. The first made her "terrified" because her sister had not yet been transferred to SGH. The second, informing her of the first seizure, frightened her, although she was somewhat reassured by the fact that Mrs Sharma had appeared to recover and was now at SGH. The third telephone call was, she said, "a really frightening moment". It informed her of the further seizures and, given her own knowledge, she was well aware of the dangers of the situation. By the time she had spoken to the Ward Sister at SGH, she knew that Mrs Sharma had probably suffered a re-bleed and was only too aware of what that meant. Understandably, however, she clung to the "glimmer of hope". That "glimmer" was, I have found, destroyed when she was informed by Mr Sharma that they had "lost" his wife. During the whole of that period of approximately nine hours, the Claimant did not see her sister and was not proximate to the events that were unfolding.

217. Even after her conversation with Mr Sharma, the Claimant could not quite believe that her sister would not recover. It was not until she saw Mrs Sharma on the life support machine that the reality became clear. That must have been a deeply upsetting experience for her and it is no wonder that she suffers "flashbacks" whenever she sees a similar sight in the course of her work. It was not, however, a sudden or unexpected shock. Her professional position makes the memory of that moment a great deal more difficult to bear. All the events that followed were also distressing for the Claimant and other members of her family. Again, she has suffered the additional pain of having to re-live those experiences in her working environment.

218. No one can fail to have the deepest sympathy for what the Claimant suffered during the period from Mr Sharma's telephone call on the morning of 12 May until – and indeed after – Mrs Sharma's death. However, in order to succeed in her claim for damages, she has to overcome the high bar of the "control mechanisms" which apply to cases such as hers. I have come to the conclusion that she cannot do so. It does not seem to me that what happened in this case can properly be described as a "seamless single horrifying event". There was a series of events over a period of time. The Claimant was proximate to some of those events, during the periods spent in ESH and SGH. However, much of her fear, panic and anxiety were caused by information communicated to her by telephone, or face-to-face by Mr Sharma, when he told her that her sister had "gone". I do not consider that any of the individual events within

the series actually witnessed by the Claimant gave rise to the sudden and direct appreciation of a "horrifying event". Even when she witnessed her sister on the life support machine, her perception was informed by the information she had been receiving over the previous 15 hours or so and by her own professional knowledge. Mrs Sharma did not have the type of injuries suffered by the deceased in *Galli-Atkinson*, was not in obvious pain and had not been pronounced dead at that time. In the circumstances, it does not appear to me that the sight of her can be regarded as a "horrifying event"; nor was it sudden or unexpected. In my view, there was a series of different events on 12/13 May that gave rise to an accumulation during that period of gradual assaults on the Claimant's mind and resulted in her psychiatric illness.

219. It follows therefore that the Claimant's claim must be dismissed.

DAMAGES

220. In view of my decision, I can deal with the issue of damages quite shortly.

Pain, suffering and loss of amenity

221. I have described at paragraphs 98-108 the Claimant's medical condition following Mrs Sharma's death. At paragraphs 109-134, I referred to the views of the Consultant Psychiatrists. There is no doubt that the Claimant's Major Depressive Disorder compromised her ability to work, to pursue her day-to-day activities and her enjoyment of her social and family life. Prior to Mrs Sharma's death, the Claimant derived great satisfaction from her work. Now, it brings back bad memories in the working environment and she experiences fear and apprehension that this might happen at any time. In her witness statement, Ms Pearson described the problems encountered by the Claimant at work. Mr Shorter observed in his witness statement how the Claimant is often sad when she returns from work and how, since her sister's death, she "has just never seemed to get back on track". Happily, there does appear to be some improvement in the Claimant's condition, although the Consultant Psychiatrists agreed that she remains vulnerable to a further Depressive Episode and may need further therapy in the future.

222. I was referred to the Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases (12th Edition) 2013. For the Claimant, Ms Jones submitted that the case fell within the "moderately severe" bracket. In cases within that bracket, the injured person can be expected to have significant problems associated with:

    i) The injured person's ability to cope with life and work;

    ii) The effect on the injured person's relationships with family, friends and those with whom he or she comes in to contact;

    iii) The extent to which treatment would be successful; and

    iv) Future vulnerability.

223. The range of damages within the "moderately severe" bracket is £14,000-£40,300, with the majority of cases falling somewhere near the middle of the bracket. For the

Claimant, Ms Jones argued that the Claimant's case had unusual features and therefore the Claimant fell within this bracket. She submitted that an appropriate figure would be £30,000, i.e. just above the middle of the bracket.

224. Mr Matthews submitted that the appropriate bracket would in ordinary circumstances be within the "moderate" bracket. Cases in that bracket will have the sort of problems associated with factors (i)-(iv) above, but, in these cases, there will have been a marked improvement by trial and the prognosis will be good. The range of damages for this bracket is £4,500-£14,000. Mr Matthews suggested that, in view of the unusual overlap between the Claimant's occupation and the circumstances of her sister's death, it would be appropriate to go a little way above the "moderate" bracket to the sum of £17,500.

225. The Claimant's psychiatric illness has caused a considerable loss of her enjoyment of life (in particular, her family life) and her work. It has had an effect upon her relationship with her family and with colleagues at work. Although her condition has improved and the prognosis is good, there remains the risk of a further Depressive Episode. In those circumstances, and in particular by reason of the effects she suffers at work, I consider it appropriate to place the case within the "moderately severe" bracket. It seems to me that an award for pain, suffering and loss of amenity (PSLA) of £25,000, i.e. just below the middle of the range, would properly reflect the Claimant's injury. To that will be added the interest payable thereon which amounts to £1,280.

Past Losses

226. Past loss of sickness pay is agreed at £14,595. Past loss of bank/overtime is agreed at £4,000 and past travel costs are agreed at £120. Interest thereon is agreed at £293.83.

Future Losses

227. As I have already noted, Dr Turner has expressed the view that the Claimant's employment status remains somewhat precarious. Whilst she is now working the same level of hours and taking the same responsibilities as she did prior to Mrs Sharma's death, Dr Turner takes the view, which I accept, that it would not take very much to "tip her" to the point that she could not continue.

228. The Claimant has refrained from seeking a move to an alternative field of nursing, largely because, as the main breadwinner at home, she feels obliged to remain where she is. In addition, she gains satisfaction and pride from working in such an important and specialist field. The Claimant claims future loss of earnings on the basis, first, that, in the event she is unable to continue in her present role, she would have to move to a less well paid role. Assuming that she moved to a job one salary band below her present band, that would result in an annual loss of earnings of £7,655 net. The Claimant has used a multiplier of 10.19 (taken from Ogden. 7, Table 10), calculated on the basis of retirement aged 65 years. In evidence, the Claimant said that she would hope to work to the normal retirement age. Applying the multiplier and on the basis of an estimated 40% chance of the Claimant having to move jobs, the figure claimed was £31,202.

229. By way of alternative, the Claimant sought a *Smith v Manchester* award of £30,000 to reflect the fact that, if she had to cease her present job, she would be at a disadvantage in the labour market.

230. In addition to either of those alternatives, the Claimant claimed £6,000 (i.e. 50% of the full value) by way of loss of congenial employment in the event that she has to move to a more junior post.

231. The total claim for loss of future earnings was therefore, £37,202 or £36,000, depending on which alternative was accepted. In addition, there was a claim for £10,000, representing the loss of pension that would be suffered by the Claimant if she were to have to move to a less well paid nursing post.

232. For the Defendant, Mr Matthews pointed out that the Claimant had managed to remain in her current employment for more than five years (apart from some absences) since her sister's death. In her evidence, she had expressed a desire to continue in her present job as long as possible. She had not investigated the possibility of moving to a job in a lower salary band. She had not yet considered whether to work until retirement age. She is job-sharing and has found a way to manage. He submitted that the risk of her changing her job and therefore losing earnings and/or her pension was small and should be reflected by a comparatively modest award of £5,000-£10,000.

233. I accept that, as a consequence of her own courage and determination, the Claimant has managed to remain in her job in the Neuro-Intensive Unit and is likely to be able to continue to do so. I do not consider that it is appropriate to approach her claim for loss of future earnings by reference to a multiplicand and multiplier. The claim is too speculative for that. Instead, I would award a single figure comprising her claims for loss of earnings, loss of pension and loss of congenial employment. In my view, an appropriate figure would be a total of £25,000.

234. The remaining claim for future loss, i.e. for future therapy costs, is agreed in the sum of £2,180.

235. The damages, if awarded, would therefore comprise:

PSLA	: £25,000
Interest thereon	: £ 1,280
Past losses	: £18,715
Interest thereon	: £ 293
Future losses	: £27,180
Total	: £72,468

FINAL OBSERVATIONS

236. Nobody could fail to have the deepest sympathy for the Claimant who suffered the distress of losing her much-loved sister in circumstances where, had she been properly treated, she would most probably have survived. I make it clear that my decision in this case is in no way intended to minimise the Claimant's distress, nor the serious and longstanding effects of the Defendant's negligence on the Claimant and other members of her family. The Claimant's courage and resilience in continuing

with her important and highly specialised work for the National Health Service, in circumstances where she is exposed to daily reminders of the events leading to the death of her sister, are worthy of considerable admiration.

237. I have serious concerns about the catalogue of medical and other failures leading up to Mrs Sharma's tragic death. There was the initial failure to detect the original subarachnoid haemorrhage which, it subsequently transpired, could be seen on the CT scan. There was then a failure to carry out a further test (a lumbar puncture) to exclude the possibility that, notwithstanding the apparent lack of abnormalities on the CT scan, there was in fact a SAH. Mrs Sharma was discharged from ESH without any firm or proven diagnosis having been made. When there was concern as to whether the scan had been correctly interpreted, there was a lengthy delay of about six days in having it reviewed by an expert. During that time, the family was not made aware of the fact that there was any doubt about the interpretation of the scan, or that it was to be reviewed and when that would be done. When the fact of the bleed came to light, a week after the original CT scan, the system for electronically transferring the CT imaging between ESH and SGH was out of order, resulting in a delay of several hours before SGH was able to authorise the transfer of Mrs Sharma there. Even then, another few hours elapsed before the transfer actually took place. And, for a period of about eight hours, Mrs Sharma did not receive the medication which had been prescribed for her.

238. Very shortly after Mrs Sharma's death, the Defendant identified the death as a Serious Untoward Incident. It initiated a full investigation by clinicians and staff from ESH. Independent opinion and scrutiny was provided by a Consultant Neurologist from another of the Defendant's Hospitals. The resulting Report identified most of the deficiencies to which I have referred and set out the steps which should be taken to correct them. Copies of the Report were subsequently sent to members of Mrs Sharma's family. I can only hope that by now, almost six years on, the lessons have been learned from these sad events and that those deficiencies will not be repeated.

239. There is another matter which causes me concern. Mr Sharma's evidence was that, after his wife's death, the doctors at SGH asked members of the family if they wanted "to have a Coroner involved". Assuming that he is right about that, it was not a question which the family should have been asked. The fact is that the doctors at SGH must have been aware that (to use the words attributed to them) "a window of opportunity had been missed" and that it was at least possible that Mrs Sharma's death had been caused by the Defendant's negligence and was "unnatural". In those circumstances, it is not the function of doctors or members of the deceased's family to make a decision as to whether the death falls within the jurisdiction of the Coroner. It is a matter to be decided by the relevant Coroner. He or she may or may not decide that the death falls within his/her jurisdiction and may or may not elect to order a post-mortem examination and/or an inquest. However, he/she will be able to consider whether, in the particular circumstances of the death, it is appropriate to take any of these steps. It is of course understandable that Mrs Sharma's family members were content not to involve the Coroner. It is natural that a bereaved family might prefer not to face the potential delay and additional stress of involving the Coroner, particularly when the medical cause of death is clear. However, it is important in the public interest for such decisions to be taken, not by members of the family or by doctors, but by a Coroner.