MRS JULIE SHORTER
- and -
SURREY AND SUSSEX HEALTHCARE NHS TRUST

THE HONOURABLE MRS JUSTICE SWIFT DBE

Wednesday 25th March 2015

SUMMARY OF JUDGMENT

This summary is provided to assist in understanding the Courts's decision. It does not form part of the reasons for the decision. The full judgment of the Court is the only authoritative document

The 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.

The Previous Claims

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, her husband and dependants. On their behalf, it was alleged that those responsible for interpreting the first CT scan had been negligent in failing to detect the SAH. The Defendant admitted that there had been negligence and that, but for that 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 these purposes. The previous claims were settled some time ago.

The Claimant

4. The claim with which I am concerned is brought by Mrs Julie Shorter, Mrs Sharma's elder sister. At the time of her sister's death, Mrs Shorter 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. Mrs Shorter was, therefore, very familiar with the condition and its treatment and was well aware of the possible outcome if treatment did not prove successful. Much of her work as a Senior Sister involved looking after individual patients and dealing with their anxious, and often distressed, families.

The Claimant's involvement on 12/13 May 2009

5. Mrs Shorter was aware of Mrs Sharma's collapse on 5 May 2009 and was in regular contact with her over the next week. On 12 May 2009, she received a telephone call from Mrs Sharma's husband, informing her that he had been told that a review of the original CT scan had showed evidence of a "bleed". Mrs Shorter's 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 Mrs Shorter put it in her witness statement, she "knew she (*Mrs Sharma*) was in the danger zone".

6. Mrs Shorter then went to ESH, where she and other members of the family waited with Mrs Sharma for her transfer to SGH. Mrs Shorter became increasingly worried by the delay. By about 17.00 hours, when Mrs Sharma still had not been transferred, Mrs Shorter left the hospital at Mrs Sharma's request, in order to care for Mrs Sharma's children. At 22.00hrs, she spoke to Mrs Sharma, who informed her that she was still at ESH and had not yet been transferred. Mrs Shorter was most alarmed at this news.

7. Then, at about midnight, Mrs Shorter received a call from Mr Sharma, who 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. Mrs Shorter was relieved that Mrs Sharma had arrived in a specialist unit but worried about the seizure. Then, some time later, Mr Sharma telephoned again and told Mrs Shorter that Mrs Sharma had "started fitting" and that her pulse rate was "sky high". He was in what Mrs Shorter described as "a state of confusion and panic" and did not know what was happening. Using her expertise, Mrs Shorter 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. Mrs Shorter asked whether the Sister believed that Mrs Sharma had suffered a re-bleed, whereupon the Sister replied, "Yes, I think so". Mrs Shorter'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". However, she still had "a glimmer of hope".

8. Mrs Shorter then went with her husband to SGH. By the time of her arrival, Mr Sharma had been told by doctors that a second CT scan had shown that Mrs Sharma had suffered a re-bleed and was "too far gone" this time. When Mrs Shorter arrived, Mr Sharma told her and other members of the family that Mrs Sharma "had gone" and that they "had lost her". Shortly afterwards, Mrs Shorter went to see Mrs Sharma in the ITU. It was only when she saw her sister unconscious on the life support machine that the fact of her imminent death became a reality. Even now, nearly six years after the event, she suffers "flashbacks" when, in the course of her work, she sees a patient in a similar situation. Shortly afterwards, the life support machine was switched off and Mrs Sharma was pronounced dead.

Secondary Victim Claims

9. A successful claim for psychiatric injury alone (i.e. without any physical injury) 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". Mrs Shorter brings this claim as a "secondary victim" of the Defendant's admittedly negligent treatment of Mrs Sharma.

10. The psychiatric injury which founds such a claim must be a medically identifiable condition and attributable to the defendant's negligence. In this case, I had no difficulty in finding that Mrs Shorter suffered a Major Depressive Disorder as a result of the circumstances of Mrs Sharma's death.

11. Previous decisions of the senior Courts have made clear that, in order to succeed in a claim, a secondary victim must surmount a number of hurdles, which have become known as "control mechanisms". I am of course bound to apply those control mechanisms in the present case. The first hurdle is that there must be a close tie of love and affection between the claimant and the primary victim. Mrs Shorter was able to surmount that hurdle. It is clear that the relationship between her and her sister, 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 Mrs Shorter had the necessary close tie and was therefore within the class of persons eligible to bring a claim as a secondary victim.

12. In order to succeed in her claim, Mrs Shorter would also have to establish that her psychiatric injury was caused by the sight or sound of the "event" resulting from the Defendant's negligence; in other words, that the event caused what has been described as "an assault to her senses". She would have to establish that her injury was caused by a sudden and direct visual impression on her mind of witnessing the event or its immediate aftermath. The relevant case law lays great emphasis on the need for visual impressions.

13. The task of determining whether or not a claimant in a secondary victim case has satisfied the control mechanisms is a somewhat artificial exercise, involving as it does decisions about what constitutes an "event" or the "immediate aftermath" thereof and whether a claimant's experience of the event or its immediate aftermath can properly be described as "horrifying", "shocking" and/or "sudden and unexpected". It is not surprising that Lord Bingham described secondary victim claims as "one of the most vexed and tantalising topics in the modern law of tort".

Conclusions

14. No one can fail to have the deepest sympathy for what Mrs Shorter 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". Rather, there was a series of events over a period of time. Mrs Shorter 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 Mrs Shorter gave rise to the sudden and direct appreciation of a "horrifying event" of the type characterised in the relevant case law. 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 visible and shocking injuries suffered by primary victims in claims which have succeeded. She was not in obvious pain and had not been pronounced dead at the time Mrs Shorter saw her. In the circumstances, it does not appear to me that the sight of her can be regarded as a "horrifying event" sufficient to found a claim; nor was it sudden or unexpected to Mrs Shorter. In my view, there was a series of different events on 12/13 May that gave rise to an accumulation during that period of a number of gradual assaults on Mrs Shorter's mind and resulted in her psychiatric injury. It follows therefore that her claim must be dismissed.

15. I make it clear that my decision in this case is in no way intended to minimise Mrs Shorter's distress, or the serious and longstanding effects of the Defendant's negligence on her and other members of her family. As she herself put it:

> "Lucia (*Mrs Sharma*) 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 (*her husband*) 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."

Despite these wholly justified feelings, Mrs Shorter has continued with her important and highly specialised work for the National Health Service. Her courage and resilience in continuing to do so, in circumstances where she is exposed to daily reminders of the events leading to the death of her sister, are worthy of considerable admiration.

Final Observations

16. 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 SAH 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 CT 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.

17. Very shortly after Mrs Sharma's death, the Defendant identified the death as a Serious Untoward Incident. It initiated a full investigation conducted 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 sets 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 those deficiencies will not be repeated.

18. 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 (and I have no reason to suspect otherwise), 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 "a window of opportunity had been lost" 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. That 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. Of course, Mrs Sharma's family members were content not to involve the Coroner. It is natural that a shocked, distressed and 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.

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