

The Ten Rules of Nervous Shock

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Rule 1: The court will (almost) always be sceptical and unsympathetic.

Rule 2: Alcock remains the law. It is arbitrary and unfair.

Rule 3: It is almost impossible to win a secondary victim claim.

Rule 4: Your best hope is to make your client a primary victim.

Rule 5: ‘Shocking’ requires something truly extraordinary.

Rule 6: Walters was correctly decided but will rarely be followed.

Rule 7: Shock is required, neither ‘mere death’ nor a gradual decline will ever be enough.

Rule 8: A gap in time between breach and injury is a huge hurdle.

Rule 9: We should keep fighting these cases, but only the very strongest ones.

Rule 10: Great care is required with factual & expert evidence (including C&P reports).

Rule 1: The court will (almost) always be sceptical and unsympathetic

1. The first rule of nervous shock is, I am afraid, that you are going to struggle to succeed with your claim. The court will almost always be sceptical and unsympathetic (even if the judgment asserts otherwise).
2. Historians looking back on nervous shock claims will see a golden decade from December 2002, when we had that excellent and humane decision of the Court of Appeal in Walters v. Glamorgan. In that period, which coincided generally with a benign attitude towards the settling of cases by the NHSLA, you could happily ‘piggyback’ a claim by a secondary victim on that for the primary victim. For example the parent or spouse of a sick patient could reasonably expect to settle a claim for £10,000 plus reasonable costs. It came as a shock therefore when the Court of Appeal found in the Defendant’s favour in Taylor v Novo in March 2013. At that point, just as the NHSLA was adopting a more robust approach to fighting clinical negligence claims, it seems that a decision was made to fight all secondary victim claims.
3. If you look back over the years it is striking just how few big nervous shock decisions have been in favour of claimants. The phrase ‘nervous shock’ was first used in Victorian Railway Commissioners v. James & Mary Coultas (1888) 13 App. Cas. 222.
4. The facts sound like something out of a Victorian melodrama. At about 9pm in the evening on 8th May 1886 Mary Coultas, her husband and her brother were driving home from Melbourne, Australia. They were in a buggy which was pulled by a horse. They had to cross a railway line. When they got to the level crossing the crossing keeper opened the first gate and were part way across when they saw a train coming fast towards them. The keeper shouted to get back but James Coultas yelled at the keeper to open the opposite gate. He urged on the horse. As the train approached Mary Coultas fainted and fell forward in her brother’s arms. The buggy lurched forward, the train whistled past, missing them by a fraction.
5. The jury found that the level crossing keeper had been negligent in opening the first gate and inviting the plaintiffs on to the crossing when it was not safe.
6. The Privy Council described Mary’s injury as follows:

“The medical evidence shewed that she received a severe nervous shock from the fright, and that the illness from which she afterwards suffered was the consequence of the fright. One of the plaintiffs’ witnesses said she was suffering from a profound impression on the nervous system, nervous shock, and the shock from which she suffered would be a natural consequence of the fright. Another said he was unable to detect any physical damage; he put the symptoms down to nervous shock.”

7. They dismissed her claim in language which in my view sounds completely in keeping with the Victorian age:

“According to the evidence of the female plaintiff her fright was caused by seeing the train approaching, and thinking they were going to be killed. Damages arising from mere sudden terror unaccompanied by any actual physical injury, but occasioning a nervous or mental shock, cannot under such circumstances, their Lordships think, be considered a consequence which, in the ordinary course of things, would flow from the negligence of the gatekeeper.”

8. Their Lordships were not going to give damages for mental illness caused by ‘*mere sudden terror*’.

9. They explained that if they were to find for the plaintiff there would be just too great a risk of opening the floodgates:

“... it would be extending the liability for negligence much beyond what that liability has hitherto been held to be. Not only in such a case as the present, but in every case where an accident caused by negligence had given a person a serious nervous shock, there might be a claim for damages on account of mental injury. The difficulty which now often exists in cases of alleged physical injuries of determining whether they were caused by the negligent act would be greatly increased, and a wide field opened for imaginary claims.”

10. In other words it would lead to too many claims and to made up claims. That could not be permitted.

11. It took over a hundred years for this obvious injustice to be corrected. In Page v Smith [1996] AC 155 the House of Lords finally accepted that someone who might have suffered physical injury from the Defendant’s negligence but had not, could recover damages for psychiatric injury. In that case the claimant though not physically injured in a low speed road collision had developed chronic fatigue syndrome as a result of the shock of the accident. Lord Lloyd famously distinguished between primary and secondary victims, holding that in the case of a primary victim foreseeability of physical injury alone was sufficient to enable the claimant to recover in respect of psychiatric injury.

Rule 2: Alcock remains the law. It is arbitrary and unfair.

12. The real breakthrough in what we call ‘nervous shock’ claims came with McLoughlin v O'Brian et al [1983] 1 AC 40, Lord Wilberforce accepted that physical injury was not necessary for a successful claim for psychiatric injury. A mother who came to hospital and found her family in the immediate aftermath of a serious road accident was entitled to damages for her psychiatric injury.

13. In Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310 the House of Lords considered whether there was some fair way of identifying where the line should be drawn between those entitled to compensation for psychiatric injury and those who were not. It settled on the general concept of ‘proximity’ and then looked back at previous cases to see whether proximity could be incorporated into a test. Thus we get Lord Oliver at 510 saying:

“..in the end, it has to be accepted that the concept of ‘proximity’ is an artificial one which depends more upon the court's perception of what is the reasonable area for the imposition of liability than upon any logical process of analogical deduction.”

14. He went on to give the 5 requirements with which we are all so familiar:

“a. a marital or parental relationship between the plaintiff and the primary victim [this has been expanded to close ties of love and affection];
b. secondly, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system;
c. 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;
d. fourthly, that the injury suffered arose from witnessing the death of, extreme danger to, or injury and discomfort suffered by the primary victim.
e. 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.”

15. I have no difficulty with limiting the number of permissible claims. I agree that you could not permit a situation where all of Michael Jackson's fans could sue his anaesthetist for their own mental suffering.

16. My complaint is that the categories of claimant are just too limited. I simply do not understand why a father who witnesses a stillbirth or whose child is seriously injured at birth should not be entitled to damages for that injury.

17. In White (Frost) v. Chief Constable of South Yorkshire [1999] 2 AC 455 the House of Lords rejected a claim by police officers who had suffered psychiatric injury at Hillsborough. Lord Steyn

“My Lords, the law on the recovery of compensation for pure psychiatric harm is a patchwork quilt of distinctions which are difficult to justify. There are two theoretical solutions. The first is to wipe out recovery in tort for pure psychiatric injury. The case for such a course has been argued by Professor Stapleton. But that would be contrary to precedent and, in any event, highly controversial. Only Parliament could take such a step. The second solution is to abolish all the special limiting rules applicable to psychiatric harm. That appears to be the course advocated by Mullany & Handford, Tort Liability for Psychiatric Damage. They would allow claims for pure psychiatric damage by mere bystanders: see (1997) 113 LQR 410, 415. Precedent rules out this course and, in any event, there are cogent policy considerations against such a bold innovation. In my view the only sensible general strategy for the courts is to say thus far and no further. The only prudent course is to treat the pragmatic categories as reflected in authoritative decisions such as the Alcock case [1992] 1 AC 310 and Page v Smith [1996] AC 155 as settled for the time being but by and large to leave any expansion or development in this corner of the law to Parliament. In reality there are no refined analytical tools which will enable the courts to draw lines by way of compromise solution in a way which is coherent and morally defensible. It must be left to Parliament to undertake the task of radical law reform.”

18. So Lord Steyn was accepting that the law made no sense and it was unfair. He was saying that if you want reform in this area it would have to come from Parliament and that in the meantime the courts would have to just do the best that they could. I have two problems with this. Firstly there is no prospect at all of Parliament tackling nervous shock. Secondly, by saying 'thus far and no further' we are now stuck with an increasingly anomalous view of psychiatric injury.

19. We look back now at the First World War generals who dismissed the suffering of shell shocked soldiers as a lack of moral fibre. Attitudes towards mental illness are at long last

changing, and particularly in the last few years. The problem for us, and our clients, is that just at the time when society is beginning to understand mental illness better the courts have chosen to dig their heels in and revert 25 years to the November 1991 position taken in Alcock. Perhaps we shouldn't be surprised, greater understanding of mental illness has taught us that it is more prevalent than previously understood which might make the courts more fearful not less of extending the categories for recovery of damages.

Rule 3: It is almost impossible to win a secondary victim claim

20. Until we see a softening of approach from the courts the reality is that it is almost impossible to win a secondary victim claim. So if we look at the results in recent years, starting with a disastrous December in 2014 for Claimants, none of the following was enough:

- Lexi-Rae Speirs & Gemma Powell v. St Georges, QB, HHJ Simon Brown QC, December 2014. The 'shocking' component of a mother's psychiatric injury was caused by seeing her daughter in an incubator 14 hours after birth rather than seeing the bruising from a negligent ventouse delivery immediately after birth. Therefore the mother was a secondary rather than a primary victim and did not satisfy the Alcock criteria because the negligent event – the delivery – had not caused the mother's injury.
- Wild v. Southend, Michael Kent QC, 3.12.14, [2014] EWHC 4053 (QB) the facts of Alcock were analogous to those of the instant case in which W had experienced a growing and acute anxiety which started when the midwife failed to find a heartbeat and developed because of the staff's behaviour. W's experience did not equate to actually witnessing horrific events leading to a death or serious injury,
- Brock v. Northamptonshire, QB, December 2014. [2014] EWHC 4244 (QB), the primary victim was a teenage mum who had taken a paracetamol overdose. She was waiting for a kidney transplant when she was killed by the negligent insertion of an intracranial pressure bolt deep into her brain. Her parents went in the space of some 12 hours from believing that she would receive a lifesaving transplant to being told that she had suffered massive brain damage, would not receive a transplant, was almost dead and then switching off her life support machine. HHJ Yelton.
- Shorter v. Surrey & Sussex Healthcare NHS Trust [2015] EWHC 614 (QB) Swift J, 25/03/2015. The primary victim was negligently killed by the Defendant's failure to diagnose a sub-arachnoid haemorrhage. A claim by her sister for psychiatric injury as a secondary victim failed. The sight of her sister on a life support machine, not yet

pronounced dead and not in obvious pain was not a “‘horrifying event’, nor was it sudden or unexpected.”

- Ronayne v. Liverpool Women’s, [2015] EWCA Civ 588. June 2015. The claimant saw his wife connected to various machines and the next day he observed her in her post-operative condition, unconscious, connected to a ventilator and being given four types of antibiotic intravenously. Her arms, legs and face were very swollen. Pressure pads were in place. Later he described his wife’s then appearance as resembling the “Michelin man” (a description treated by the CA with some scepticism).
- Wells & Smith v. Southampton [2015] EWHC 2376 QB, Dingemans J. Where a baby was stillborn there was no ‘shocking event’ so the father could not recover damages as a secondary victim. “...although no one can doubt the profound distress suffered by Mr Smith there was in my judgment no shocking event. There was no assault on the senses. There was no sudden appreciation of any event, or perhaps the gradual dawning of realisation that his child’s life had been put in danger, as in other cases. There was a C section, followed by the removal of Layla for efforts at resuscitation, which failed. The control mechanisms are part of the law and I am bound to give effect to them. I would therefore have rejected Mr Smith’s claim for injury.”
- Owers v Medway NHS Trust [2015] EWHC 2363 (QB), August 2015, Stewart J. A hospital negligently failed to admit Mrs Owers following a stroke or to prescribe aspirin. Several hours later in the car Mrs Owers choked on a biscuit and her husband thought she was dying. She suffered a second stroke and arrived at another hospital later that day. The primary claim failed on causation. The husband’s claim for psychiatric injury would have failed too. He experienced an episode in the car where he thought she was going to choke to death, he took her to hospital, she was then transferred to Kings College Hospital. There he spent several hours and fully expected doctors to tell him that she had died. The following day he was driving back to hospital and received a phone call which he thought was to tell him she had died, he then saw her, very ill, but alive. All of this was summed up in a few words by Stewart J: “*After the deterioration of 0940 he not only saw a failure properly to diagnose and treat, but also the negligent discharge of his wife who was by then, on any account very seriously ill. In the aftermath, which should have been avoided, he perfectly understandably gave her a biscuit to eat and witnessed her choking upon it... to borrow the words from Ronayne ‘this was not, like Walters, ‘a seamless tale with an obvious beginning and an equally obvious end.’ There was therefore no sudden appreciation of a ‘horrifying event’.*”

- Morgan v Somerset Partnership NHSFT, Bristol CC, February 2016. Where the Trust had admitted negligence in its treatment of the primary victim who had committed suicide his wife, who suffered an adjustment disorder after finding him with cut wrists in the family garage had her claim struck out. She could not show sufficient proximity to the negligent treatment.
- Young v. Macvean [2015] CSIH 70, February 2016, a mother was on her way to the gym when she saw a badly damaged vehicle behind a police cordon. Several hours later she was told that her 26 year old son had been in the vehicle and had died. She argued unsuccessfully that being informed of what had happened when she was no longer at the scene was part of the aftermath and that she was therefore entitled to damages for her psychiatric injury as a secondary victim.

Rule 4: Your best hope is to make your client a primary victim

21. In practical terms therefore the best way forward is to bring yourself within the primary victim category if you possibly can. In many cases this will not be an option but there are three scenarios where it can work:

- a. psychological injury of a mother at the time of birth;
- b. sexual abuse cases;
- c. cases where more than one person is advised of a diagnosis.

Mothers injured at birth

22. In Farrell v. Merton (2001) 57 B.M.L.R. 158: mum claimed for the psychological consequences of the trauma of the birth, which comprised the shock of having to undergo a caesarean operation, the shock upon learning of her child's condition, long term depression and anxiety. She contended that although she had not been permitted to see her son or told about his condition until he was one day old, there had been no break in the chain of causation between his birth and her first sight of him with the result that she was liable to be compensated as a primary victim in respect of psychological complaints which were still ongoing. The Defendant submitted that the cause of F's psychiatric illness was not the events surrounding the birth, but F's gradual realisation of K's condition. It maintained that such realisation was wholly unrelated to their breach of duty to her son with the result that F was only eligible for compensation as a secondary victim.

23. The judge (HHJ Steel, sitting as High Court Judge) found for the Claimant, holding that the events of the birth and its aftermath should be viewed as a whole and that the mother's psychiatric injury was part and parcel of a single event in which both she and her baby had

suffered injury. She was therefore a primary, not a secondary, victim. Judge Steel went on to say that even if she was wrong to consider the Claimant a primary victim the Claimant could recover damages as a secondary victim:

“I am satisfied that there is no break in the chain of causation and that the “trauma of the birth” encompasses not only the events in the operating theatre but also the position up to and including the first sight of her baby and the realisation (when told by the Paediatric SHO) of his disability. I therefore treat her as a primary victim.

“Even if I am wrong in that approach, the unusual delay of just over a day between the birth and a mother seeing her baby is wholly attributable to the Defendants. They chose not to take her to the hospital where her child was and chose not to tell her of the difficulties and injury which had occurred. I am therefore satisfied that in these particular circumstances her sight of the child on 25th was in the immediate aftermath of the birth and she would in any event be compensated as a secondary victim.”

24. It is important to understand that where someone was owed a duty of care as a primary victim (because it was foreseeable that they might suffer physical injury) then if they only suffer psychiatric injury they are entitled to damages for that psychiatric injury. See Lord Hope in British Steel PLC v. Simmons [2004] UKHL 20. There a steel worker suffered minor physical injury in a workplace accident caused by his employer’s negligence but then suffered a severe depressive illness caused either by the accident itself or by his frustration and anger following the accident. See Lord Rodger:

“55 Since the pursuer in the present case actually suffered physical injuries as a result of the defenders’ fault and negligence, the starting point is that he is a primary victim in terms of Lord Lloyd’s classification. Mr Smith argued, however, that the pursuer’s psoriasis and his depressive illness sprang not from the accident itself but from his anger at the happening of the accident. Hence he could not recover damages. I see no reason to give effect to such a distinction, even supposing that it can be realistically drawn in a given case. Regret, fear for the future, frustration at the slow pace of recovery and anger are all emotions that are likely to arise, unbidden, in the minds of those who suffer injuries in an accident such as befell the pursuer. If, alone or in combination with other factors, any of these emotions results in stress so intense that the victim develops a recognised mental illness, there is no reason in principle why he should not recover damages for that illness.

56 Not only is there no hint of the distinction advocated by Mr Smith in Lord Lloyd’s speech in Page v Smith, but indeed the whole thrust of the speech is to quite the opposite effect. On Lord Lloyd’s approach, all that matters is that the defenders were in breach of their duty of care not to expose the pursuer to the risk of personal injury and that, as a result of the breach, the pursuer suffered both

physical and psychiatric injuries. The defenders are liable in damages for both types of injury and, in particular, for the exacerbation of the pursuer's psoriasis and for the depressive illness which followed—even if those developments were not reasonably foreseeable. Moreover, as the Second Division rightly held, 2003 S.L.T. 62, 67E, it does not matter whether a psychologically more robust individual would have recovered from the accident without displaying either condition: the defenders must take their victim as they find him.

25. This case seems to me very important in childbirth cases where a mother has suffered psychiatric injury. Unless the circumstances of the birth would have been identical even without the Defendant's negligence then we can argue with considerable force that where a psychiatric injury has been more than negligibly contributed to by the circumstances of the birth (as opposed only to a reaction to events subsequently) then mother is a primary victim and entitled to damages in respect of the whole of her injury.

26. For the importance of considering the whole circumstances of the birth see also Jones v Royal Devon and Exeter NHS Foundation Trust, QB, 20 March 2008, (2008) 101 B.M.L.R.154, King J. There was a claim for psychiatric injury by the mother of a child who died the day after delivery following ischaemia at birth (in utero). There was no suggestion by the Defendant that the mother was not a primary victim. In this case there was a helpful analysis from the obstetric expert, Mr Forbes, as to how the circumstances of the delivery and the anxiety faced by the Claimant during the delivery would have contributed to her overall injury.

27. See also Tredgett v. v Bexley Health Authority [1994] 5 Med. L.R. 178 where HHJ White found that both parents were primary victims and that the 'event' of birth lasted for some 48 hours from delivery. Although the classification of a father as a primary victim is in my view unlikely to be followed this case which was approved in Walters, lends support to the concept of the 'extended event of birth' which in turn helps to bring the mother and any injury she suffers firmly within the scope of the duty owed to a primary victim.

28. Secondly there is the argument advanced by Philippa Whipple QC (now Whipple J) in Wild v. Southend that conceptually there is no distinction between mother and child before birth and therefore an injury to the child is an injury to the mother (before birth). Some caution is required because the point is not analysed by the judge in any detail. The concept of mother and child as one was followed by Dingemans J in Wells, but again without any analysis, see paragraph 83:

“83. In my judgment Mrs Wells was a primary victim. This is because the negligence (if it had been established) would have occurred when Layla and Mrs Wells were still one. That meant that Layla would (albeit unknown to Mrs Wells) have aspirated the meconium, which later caused her death, when Mrs Wells and Layla were one person. This aspiration of the meconium caused Layla’s death and caused the adjustment order suffered by Mrs Wells. Although some of the distinctions in this area of law are arbitrary it does seem to me that in such circumstances Mrs Wells is a primary victim.”

29. Of course even if mum is a primary victim you need to prove that the injury she suffered was contributed to by her participation as a primary victim – for example if the evidence is that the mother’s psychiatric injury had nothing to do with having given birth but was entirely explained by the dawning realisation some months later that her child was profoundly disabled then you will be vulnerable to the defence that the psychiatric injury has in fact nothing to do with the birth and that therefore for the purposes of the injury the mother is a secondary victim.

Sexual abuse cases

30. Consider next cases of sexual abuse by doctors. Parents might have been obliged to attend hospital appointments as chaperones but have been kept on the other side of a curtain or door whilst inappropriate touching has taken place. They later discover what has happened and understandably develop a psychiatric injury. I am not aware of any decided case one way or another on this point but it seems to me strongly arguable that there exists a duty of care not to cause psychiatric injury to a parent by sexually assaulting her child secretly yet in close proximity. In W v. Essex CC [2000] 2 W.L.R. 601, the House of Lords recognised the possibility of a duty of care being owed by a local authority to foster parents who had suffered psychiatric injury after a known sexual abuser had been placed in their home. See Lord Slynn at 598:

“It seems to me that it cannot be said here that the claim that there was a duty of care owed to the parents and a breach of that duty by the defendants is unarguable, that it is clear and obvious that it cannot succeed. On the contrary whether it is right or wrong on the facts found at the end of the day, it is on the facts alleged plainly a claim which is arguable. In their case the parents made it clear that they were anxious not to put their children at risk by having a known sex abuser in their home. The council and the social worker knew this and also knew that the boy placed had already committed an act or acts of sex abuse. The risk was obvious and the abuse happened. Whether the nature of the council’s task is such that the court should not recognise an actionable duty of care, in other words that the claim is not justiciable, and whether there was a breach of the duty depend, in the first place, on an investigation of the full facts known to, and the factors influencing the decision of, the defendants.”

Diagnosis or advice given to more than one person

31. This scenario is probably the most difficult. It is where a couple attend an appointment together and are given an incorrect diagnosis, for example of cancer. I don't see why in principle, if the facts are right, you should not argue that a duty is owed to both of those attending and receiving the incorrect diagnosis.

32. There is some support for this argument in the context of private consultations, where a duty exists in contract rather than just tort. In Less v. Hussain [2012] EWHC 3513 (QB) a woman received negligent pre-conception advice from a private gynaecologist. She became pregnant and lost the baby at 26 weeks. She established breach of duty but failed on causation, the court finding that she would have chosen to become pregnant even with non-negligent pre-conception advice. HHJ Cotter QC went on to deal with the father's claim for psychiatric injury. There was a dispute as to whether he had suffered psychiatric injury rather than 'distress' at the bereavement and the judge found that in any event there was no shocking event in the Alcock sense.

33. He went on to accept Katie Gollop QC's submission for the Claimants that in principle damages for mental distress could have been awarded in contract to the father – because the consultation had been intended to seek peace of mind, by analogy with holiday and home improvement cases. On the facts he found that there was not in fact a contract between the father and the doctor, but did accept that circumstances might have been different. He relied heavily on the approach of the Court of Appeal in Yearworth v. North Bristol NHS Trust [2009] EWCA 37 – where claimants were awarded damages for mental distress after frozen sperm that they had stored prior to chemotherapy was inadvertently destroyed.

Summary

34. The key point arising from each of these three very different scenarios is that when one door closes (conventional secondary victim claims) it is important to keep pushing and probing and looking for another way to achieve a just result. It may be that extending the categories of primary victim is a better solution than flogging a dead horse with claims by secondary victims.

Rule 5: 'Shocking' requires something truly extraordinary.

35. There is a telling passage in Ronayne where Tomlinson LJ sets the bar extraordinarily high for any event in hospital to be shocking:

*“Furthermore what the Claimant saw on these two occasions was not in my judgment horrifying by objective standards. Both on the first occasion and on the second the appearance of the Claimant's wife was as would ordinarily be expected of a person in hospital **in the circumstances** in which she*

*found herself. What is required in order to found liability is something which is exceptional in nature. On the first occasion she was connected to monitors and drips. The reaction of most people of ordinary robustness to that sight, given the circumstances in which she had been taken into the A. and E. Department, and the knowledge that abnormalities had been found, including a shadow over the lung, necessitating immediate exploratory surgery, would surely be one of relief that the matter was in the hands of the medical professionals, with perhaps a grateful nod to the ready availability of modern medical equipment. The same is more or less true of her swollen appearance on the second occasion. There is I think a danger of the “Michelin Man” epithet acquiring a significance greater than it deserves. The Claimant was conditioned to see someone from whom a litre of abscess had been drained and whose life was in grave danger. The pressure pads, routine medical equipment, no doubt contributed to the swollen appearance. I can readily accept that the appearance of Mrs Ronayne on this occasion must have been both alarming and distressing to the Claimant, but it was not **in context** exceptional and it was not I think horrifying in the sense in which that word has been used in the authorities. Certainly however it did not lead to a sudden violent agitation of the mind, because the Claimant **was prepared** to witness a person in a desperate condition and was moreover already extremely angry.” (emphasis added)*

36. Once you read this you might be forgiven for packing up and going home.

37. It begs the question how bad do things have to get to qualify as horrifying in hospital. Looking back at the list of recent cases we can see that out of brain haemorrhage, stroke, unsuccessful resuscitation of newborn babies, the death of babies, none is sufficient. You might think of this as a scale from 1 to 10. Scores of 1 to 3 are events so minor we would never have brought a secondary victim claim even before the recent tightening of approach. Scores 4 to 7 were probably enough in the old days but no longer. All the unsuccessful cases in recent years have been somewhere 4 and 7. What we are looking for now is a score of 8, 9 or 10. To get to this end of the scale you need some extra ingredient which takes the case out of the ordinary.

Rule 6: Walters was correctly decided but will rarely be followed

38. I think that if Walters were being decided today by a differently constituted appeal court, that which decided Ronayne for example, then the defendant’s appeal would probably have succeeded.

39. Walters involved what Ward LJ described as a ‘seamless tale’ from beginning to end over a 36 hour period. With the different facts of recent unsuccessful cases firmly in mind it is worth revisiting the facts of Walters in the judgment of Thomas J. at first instance to consider whether the facts of this case really were all that different to cases where we are now failing:

“The final events leading to Elliot’s death started at about 3am on Tuesday July 30, 1996, when his condition deteriorated significantly. The claimant was at that time sleeping in the same room as Elliot at the Prince Charles Hospital. She awoke at about 3am to hear Elliot making small choking noises in his cot; the claimant saw that there were large amounts of what was described as “a coffee ground blood substance”; his body was stiff. She took Elliot to a nurse. The nurse told the claimant that Elliot was having a fit, though she did not appreciate that the fit had lasted an hour. The hospital notes record Elliot as being in a Grade 3 coma, responding only to deep pain. Elliot was transferred to the Intensive Care Unit of the Prince Charles Hospital at 4.15am. The claimant was told by a doctor at 4.45 am that it was very unlikely, and it would be very unlucky, if Elliot had any serious damage as a result of the fit. After speaking to the doctor she thought that Elliot might at worst be slightly brain damaged; she did not think it was life threatening. In fact Elliot had suffered a major epileptic seizure leading to a coma and irreparable brain damage.

At about 11am that day the claimant was told by a doctor at the Prince Charles Hospital after a CAT scan that there was no damage to Elliot’s brain, but that he wanted him transferred to King’s College Hospital, London, for a liver transplant. Eventually later that day an ambulance arrived and a medical team took Elliot to London where he was admitted at 6.30pm; a further CAT scan was carried out which showed universal attenuation in both cerebral hemispheres; it was interpreted as showing diffuse brain injury consistent with a profound hypoxic ischaemic insult.

The claimant had followed the ambulance in a car with Elliot’s father and arrived at King’s College Hospital at about 9pm that evening. She was seen by three doctors. They told her that Elliot had suffered severe brain damage as a result of the fit and he was on a life support machine. They told her that if a liver transplant was undertaken, the chances of survival were only 50–50 and he would be severely handicapped. The claimant described her feelings as being numb, panic stricken and terrified at the sudden turn of events; she had been told at the Prince Charles Hospital that he could have a liver transplant and she had been told then he could not. The consultant paediatric hepatologist at King’s College Hospital described her as “stunned”.

On the following day, Wednesday July 31, 1996, Elliot underwent a further CAT scan. A consultant neurologist told the claimant that Elliot’s brain was damaged so severely that he would not have any sort of life or be able to recognise his parents; he would have no quality of life. This shocked her greatly. They were asked whether or not they felt it was in Elliot’s best interest to continue with life support. She discussed this with Elliot’s father and they decided they would terminate the life support. Shortly thereafter, the life support machine was turned off and Elliot died in the claimant’s arms at approximately 4.30pm. She was told after his death that if Elliot had been transferred for a liver transplant at any time before July 30, 1996, he would have stood a far better chance of survival.”

40. The simple point is that the start of the ‘seamless tale’ was the mother waking to find her baby stiff. He was not convulsing or shaking, or frothing. There was a small amount of vomit (coffee grounds) on the cot sheet. Neither she nor the nurse thought there was much wrong at

the time. The real shock comes after transfer to London when she is described as seeming 'stunned' when she is told that his chances are 50/50. He has a further CAT scan the following day and a decision is made to switch off the life support machine. I don't underestimate any of the 'shock' involved but this was, to borrow the phrase of Tomlinson LJ in Ronayne, hardly unexpected in context.

41. I think we have to accept the reality that there has been a stiffening of resolve in the High Court and the Court of Appeal. Walters has become a mythical fairy tale which allows it to be justified as something exceptional.

Rule 7: Shock is required, neither 'mere death' nor a gradual decline will ever be enough.

42. Shortly after Walters was decided HHJ Hawkesworth QC found against a claimant in what seemed a classic Walters case. This was Ward v. Leeds Teaching Hospitals. The judgment is important because it is often misunderstood. The judge describes mum's reaction to seeing her daughter in intensive care at 9.45pm on the Wednesday evening:

"I was shocked by what I saw. Katherine looked completely different to how she had been in the recovery room. The nurse explained to me what the machines were for. I held Katherine's hand and I spoke to her. I spoke to her for a long time and I spoke to her as if she was still with me. I can remember saying to her that there were all these George Clooney lookalikes on the ward, and she was missing them. I also talked about when we were going on holiday. I can recall that the nurse heard me speaking to Katherine. She told me to keep going and to keep talking to Katherine because she said that the hearing was the last thing to go. My reaction to this was 'what do you mean? Are you telling me she's going to die?' The nurse said it was a possibility and that the doctors were going to come and talk to me. The incident was an incredible shock to me. This was the first time that there had been any intimation that the condition that Katherine was in was possibly going to be fatal."

43. Katherine died when life support was withdrawn on the Friday afternoon. This case is often trotted out by defendants to suggest that the judge found that the events were not shocking in the Walters sense. That is not correct. The judge pointed out that in Walters the experts had agreed that the events prior to death had caused the mother's injury, in this case however the experts disagreed. The Claimant's expert was rather equivocal as to the cause of the mother's psychiatric condition. For the Defendant Dr Reveley concluded that the mother's injury was a reaction to her daughter's death rather than to shock or the events that preceded her death. This is very important to understand i.e. the judge was not saying that the events described were not capable of causing 'shock' in the Alcock sense, rather he was saying that he could not conclude that they had in fact done so. See paragraph 22 of the judgment:

“I therefore cannot accept that there is here any medical basis for a finding that the events in the hospital or at the mortuary constituted events which have induced a post- traumatic stress syndrome in the Claimant. I prefer the opinion of Dr. Reveley that the proper diagnosis is a severe and prolonged bereavement reaction, which in strict diagnostic terms is an adjustment disorder with depressive and anxiety symptoms.”

44. See also the Court of Appeal’s decision in Sion v Hampstead Health Authority [1994] EWCA Civ 26 . The claimant’s son was seriously injured in a motor-cycle accident. He was taken to hospital and the staff failed to diagnose that he was bleeding from his kidney. The son went into a coma three days after the accident having suffered a heart attack. His condition deteriorated and he was placed in intensive care but unfortunately died fourteen days after the accident. The claimant remained at his son’s bedside throughout and suffered psychiatric injury as a result of witnessing his son’s deterioration over a period of about 14 days. He brought an action against the hospital alleging their negligent treatment of his son caused him to suffer psychiatric injury. The hospital applied to have the claim struck out as disclosing no cause of action. Brooke J found for the hospital and the claimant appealed. The appeal was dismissed, see Staughton LJ:

“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.”

Rule 8: A gap in time between breach and injury is a huge hurdle.

45. You will all know about Taylor v. Novo [2013] EWCA Civ 194 which in March 2013 heralded the firestorm that has all but destroyed secondary victim claims. Crystal’s mum injured her foot when some shelving fell on her at work. 21 days later she collapsed in front of Crystal at home with a PE caused by a clot from her injured ankle. She suffered PTSD and won at first instance. The Court of Appeal accepted the Defendant’s argument that there was insufficient proximity between the breach of duty and the daughter’s injury. It would have been different if the collapse had taken place at the same time as the original injury.

46. I find this decision troubling, not least for the way that Walters was rather glossed over in the judgment. The problem is this – in Walters the breach of duty may have preceded the mother’s injury by a considerable number of days. If you look back at the first instance judgment in Walters it is not clear when the breach of duty was but it may have been nearly two weeks before the child’s first fit:

“On Tuesday July 16, 1996 she noticed that the colour of Elliot’s eyes looked different. On July 17, 1996 she took him to see her general practitioner. He referred Elliot to the Prince Charles Hospital at Merthyr. Elliot was seen that day at the Prince Charles Hospital. Thereafter he was treated under the care of the Prince Charles Hospital, most of the time as an in-patient, but part of the time as an outpatient. The claimant was with him during his treatment.

Elliot was in fact suffering from acute hepatitis which led to fulminant hepatic failure. It is accepted by the defendants that he was not properly diagnosed or treated by the Prince Charles Hospital. The defendants also accept that if Elliot had been properly diagnosed and treated, he would have undergone a liver transplant and lived. It is not therefore necessary to set out the precise course of treatment and events until the period immediately preceding his death. It is, however, necessary to set out the events of the last two days as it is common ground on the psychiatric evidence that they caused her psychiatric illness.

The final events leading to Elliot’s death started at about 3am on Tuesday July 30, 1996,”

47. This ‘Walters gap’ is just not addressed in Taylor v. Novo. There are no cases of which I am aware where this point has been tackled head on within a clinical negligence context but you can see how it might arise in cases where there has been a failure to diagnose a DVT and then injury occurs to both primary and secondary victim three weeks later (i.e. unlike Taylor v. Novo there is no initial injury); or with a failure to diagnose an acute coronary disease and the primary victim drops dead after several months.

48. My view is that if you have a good enough case on ‘shock’ you should try to distinguish Taylor v. Novo on the basis that a) clinical negligence cases should be considered differently and b) there is no initial injury so whereas in Taylor there were ‘two events’ in your case there would only be one event – as in Walters. Some support for this approach can be found in the observations of Swift J in Shorter who recognised the problem (in Shorter the negligent failure to diagnose a sub-arachnoid haemorrhage occurred a week before the deceased’s collapse). Swift J found against the Claimant on the basis that there was no ‘shocking event’ rather than on the lack of proximity:

“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.

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."

Rule 9: We should keep fighting these cases, but only the very strongest ones.

49. Given the approach of the courts, the likelihood of the NHSLA fighting any nervous shock case to trial, the expense of issuing a claim and the reality that you will only be paid for winning I would not blame anyone who placed a blanket ban on their firm pursuing any secondary victim claim.

50. At the same time, if we wanted only to do easy cases we would not have become clinical negligence lawyers. In my view despite all the problems identified there remains a glimmer of hope. These cases go in cycles and we may be in a death spiral for secondary victim claims but this will not continue for ever. Our hope must be that it doesn't take as long for the recovery to start as it did after the Coultas case of the Victorian railway.

51. So where is the hope? It lies in recognising that no one has banned secondary victim cases. The bar has not been placed impossibly high. If you pick the right case, a real stomach churner, where you have supportive expert evidence then your appeal to the court can be that yours is a Walters case.

52. I think the way forward is best demonstrated in Galli Atkinson. There a mother had been told that her 16 year old daughter had been killed in a road accident, she went with her husband and other daughter to the mortuary and saw her daughter there. At first instance the claim failed because the recorder considered that her injury had been caused by being told of her daughter's death, rather than seeing it herself and because seeing her daughter at the mortuary did not constitute the aftermath.

53. The Court of Appeal disagreed and two things are particularly striking about their approach. The first is that if you read their account of the facts they really play up the drama – it is as if Latham LJ knew that he needed to make this case exceptional:

“5. ... the appellant fell to her knees, sobbing uncontrollably. She would not be helped to her feet but crawled to where Livia lay on the trolley bed. She pulled herself up and saw Livia's injured face and the upper part of her body, although the lower part, which was grotesquely distorted, had been covered by a blanket. She cradled her, saying that she was cold. Seeing and holding Livia's body must have been devastating to the appellant. Although the worst injuries were hidden, her face and head were disfigured.

6. There is no doubt that the appellant suffered an extreme reaction to Livia's death.”

54. The second is the willingness of the court, on the right facts, to wrestle with the existing law and find a way through:

“23. Whether we like it or not, we are constrained to approach the question of psychiatric injury in cases such as the present on the basis of what Lord Lloyd described in *Page v Smith* [1996] AC 155 at 189, as the “control mechanisms” identified by Lord Ackner. This is clear from the speeches of Lord Steyn and Lord Hoffmann in *Frost v Chief Constable of South Yorkshire* [1999] 2 AC 455, with both of whose speeches Lord Browne Wilkinson agreed. Both of their Lordships recognised that the law produced an unsatisfactory result. But both made it clear that the courts had to apply them, however unsatisfactory the result, unless and until Parliament intervened.

24. We have to consider therefore whether the appellant's present psychiatric condition which, as I have already said, has been accepted as being a condition which is capable of founding a claim for damages, was caused by shock resulting from her appreciation of an event or its immediate aftermath in the sense intended by Lord Wilberforce in *McLoughlin*.

25. 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 itself 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.”

Rule 10: Great care is required with factual & expert evidence (including C&P reports)

55. I think one reason why so many nervous shock claims have failed in recent years is that they have been brought, understandably, as ‘bolts-ons’ to the main event. Their value and

importance has not justified the same rigorous approach as we would normally apply to a clinical negligence claim.

56. My suggestion is that whilst 9 out of 10 potential secondary victim claims should now not be pursued for the 1 out of 10 that are you need to go full throttle.

- You need to identify the factual, legal and expert basis for your claim before you notify the defendant of the potential claim.
- You need to make sure that even your C&P evidence is consistent with your nervous shock argument – you don't want to be vulnerable to the argument that you have tightened up the argument later in response to a defendant's Alcock argument.
- You need to make sure that in every communication with the defendant, every witness statement and your expert evidence you are emphasising the horror of what happened.
- You should acknowledge that such claims will normally fail and make clear that you see your claim as different and explain why. The Defendant needs to be made to feel at risk.
- You need to emphasise 'exceptionality' – the court will only find for you if you can persuade the judge that he/ she is not in any way diluting the 'party line' or 'we don't do secondary victim claims'.
- You need to develop a 'narrative' or to use LJ Ward's phrase a 'seamless tale'. In both Walters and Galli-Atkinson it is clear that the court wanted to find for the claimant, you have to make the court want to find for you and then give the judge the necessary ingredients.
- You should make a properly costs-protective part 36 offer.

Good luck!

JOHN DE BONO QC

6th June 2016

My thanks to Sebastian Naughton and Jemma Lee for their suggestions and improvements to my draft, any remaining errors are mine alone. Please feel free to circulate this text more widely amongst colleagues. I am happy to discuss any of the matters arising or any potential claims informally by telephone or email and can be contacted by email on jdebonoqc@serjeantsinn.com