

## COURT OF APPEAL

6 December 2002

NORTH GLAMORGAN NHS TRUST  
v  
WALTERS

[2002] EWCA Civ 1792

Before Lord Justice WARD,  
Lord Justice CLARKE and  
Sir ANTHONY EVANSNegligence — Nervous shock — Horrifying event —  
Sudden appreciation.

The claimant's 10-month-old son was admitted to hospital suspected of suffering from hepatitis A. In fact he was suffering from acute hepatitis which the defendants admitted they had negligently failed to diagnose. They accepted that if he had been properly diagnosed the son could have been treated, probably by way of a liver transplant, and would have lived. The claimant stayed with her son in hospital. At about 3.00 am on 30 July 1996, she was woken by the sound of her son making choking noises. She was told by a nurse that he had suffered a fit but that it was unlikely that he had suffered any brain damage. In fact there had been a major epileptic seizure leading eventually to coma and irreparable brain damage. At 11.00 am the same day the claimant was told that a scan had shown no brain damage, but that her son should be transferred to a London hospital for a liver transplant. The son was taken to the London hospital by ambulance arriving at about 6.30 pm. On arrival a further scan was performed which showed diffuse brain damage. The claimant had followed the ambulance by car and arrived at about 9.00 pm. She was seen by doctors who told her that her son had suffered severe brain damage as a result of the fit, and was on a life-support machine, that his chances of survival were only 50–50 and he would be severely handicapped. On 31 July, a further scan showed that the son's brain was so severely damaged that he would have no quality of life. The parents were asked if they felt it was in the best interests of their son to continue life support, and they decided that it was not. The life-support machine was turned off and the son died in the claimant's arms at about 4.30 pm. After his death, she was told that if he had been transferred for a liver transplant at any time before 30 July, he would have had a far better chance of survival. There was agreed psychiatric evidence that the claimant had suffered a pathological grief reaction as a result of witnessing,

experiencing and participating in the events described.

At trial Thomas J held that the claimant was a secondary victim subject to the controls imposed by the law on claims by such victims, but that her psychiatric injury had been caused by the sudden appreciation by sight or sound of a horrifying event which had covered a period of time. The defendant appealed on the grounds that the 36-hour period could not be regarded in law as one horrifying event, that the claimant's appreciation of the 36-hour period was not sudden, and that the judge had paid insufficient regard to the recognised policy constraints in this area.

—Held, by CA (Lord Justice WARD, Lord Justice CLARKE and Sir Anthony EVANS) dismissing the appeal:

1. It is a matter of judgment in each case, depending on the facts and circumstances, whether what occurred amounted to the "event" required by general principle. In the present case there had been an inexorable progression from the moment when the fit occurred to the death of the child in the claimant's arms. *Chadwick v British Railways Board* [1967] 1 WLR 912; *Frost v Chief Constable of South Yorkshire Police* [1999] 2 AC 455 applied (see para 34).

2. Information given to the claimant orally as events unfolded was part of the circumstances to which the court was entitled to have regard (see para 35).

3. The entire event was justifiably found to have been horrifying (see para 36).

4. Accordingly, the judge was not only entitled but bound to find the facts in the claimant's favour (see para 37).

5. The judge was correct to find that the claimant's appreciation of events was sudden, as opposed to an accumulation of gradual assaults on her mind. Each event had its impact immediately; there was not a gradual dawning of realisation that her child's life had been put in danger by the defendant's negligence (see para 40).

6. No incremental step in advancing the frontiers of liability was involved and there was no relevant policy constraint against the finding of liability in this case (see paras 41 and 44).

The following cases were referred to in the judgments:

*Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310;

*Benson v Lee* [1972] VR 879;

*Bourhill v Young* [1943] AC 92;

- Chadwick v British Railways Board* [1967] 1 WLR 912;  
*Frost v Chief Constable of South Yorkshire Police* [1999] 2 AC 455;  
*Jaensch v Coffey* (1984) 155 CLR 549;  
*McLoughlin v O'Brian* [1983] 1 AC 410;  
*Sion v Hampstead Health Authority* [1994] 5 Med LR 170;  
*Taylorson v Shieldness Produce Ltd* [1994] PIQR P329;  
*Tredget & Tredget v Bexley Health Authority* [1994] 5 Med LR 178.

Stephen Miller QC and Gregory Chambers instructed by Welsh Legal Services for the appellant; Robert Weir instructed by Hugh James for the respondent.

6 December 2002

#### JUDGMENT

**Lord Justice WARD:** 1. This is a very sad case. It is also a difficult one. The issue is whether a mother can recover damages for the pathological grief reaction which it is agreed by the psychiatrists she suffered after waking at her young baby's bedside in hospital at 3.00 am when the child was having a fit and then, some 36 hours later, having the child die in her arms after life-support treatment was withdrawn. The hospital admitted that the child died as a result of its negligent treatment. On 7 March, Thomas J held that she was entitled to special damages of £1,216 and general damages of £20,000. He gave the NHS Trust permission to appeal.

2. The claimant, Ms Ceri Walters, was 31 years old when these events unfolded. She gave birth to her son, Elliot, on 15 September 1995. Ten months later he became unwell and was admitted to the Prince Charles Hospital in Merthyr Tydfil. Jaundice was noticed in his eyes and skin and, after various tests were carried out, the diagnosis was made that he was most likely suffering from hepatitis A, even though the tests were inconclusive. In fact he was suffering from acute hepatitis which led to fulminant hepatic (liver) 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 would probably have lived. In the light of that admission it was not necessary at

the trial to set out the precise course of treatment. He was kept in hospital whilst various tests were carried out and Ms Walters was able to stay with him. He was allowed home at weekends. On the weekend of 26 July, he was brought back to the hospital by his parents because of their concerns for him. He was a very ill baby. He did not recognise either his mother or his father. He was not drinking. He was irritable and crying.

3. His condition deteriorated in the early hours of the morning of Tuesday, 30 July 1996. I can do no better than set out the judge's findings over the critical period:

7. The claimant was at that time sleeping in the same room as Elliot at the Prince Charles Hospital. She awoke at about 3.00 am to hear Elliot making small choking noises in his cot; the claimant saw that there were large amounts of what she 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 4.15 am. 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.

8. At about 11 am that day, the claimant as 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 the ambulance arrived and a medical team took Elliot to London where he was admitted at 6.30 pm; 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.

9. The claimant had followed the ambulance in a car with Elliot's father and arrived at King's College Hospital at about 9.00 pm 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".

10. On the following day, Wednesday 31 July 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 interests to continue with life support. She discussed this with Elliot's father and they decided that 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 4.30 pm. She was told after his death that if Elliot had been transferred for a liver transplant at any time before 30 July 1996, he would have stood a far better chance of survival.

4. It is, I think, helpful to expand upon some of those findings in order to give more detail to the claimant's reaction to the unfolding tragedy. In her first witness statement made only some two months after Elliot's death, she was expressing no more than feeling "extremely annoyed at the way Elliot was treated." Her mental breakdown had not yet begun. In her witness statement prepared for the trial, she referred to the consultation at 4.45 am on 30 July when she was told that it would be very unlikely or very unlucky if anything serious were to happen to Elliot. She said:

This phrase has stayed in my mind ever since. At the time, his remarks were very encouraging, although he spent only a few moments with me. After speaking with him, I did not think the situation was life threatening in any way. At worst, I thought Elliot might be slightly brain damaged.

5. Told the next morning that there was no brain damage, she "felt a huge sense of relief". She and her partner were therefore "very positive" as they drove to London, but the news imparted to them on arrival that Elliot was severely brain damaged and that he was on a life-support machine left her feeling "completely numb".

It was such a complete turnaround. When we had stepped out of the car, we had been saying to each other that we would have our work cut out bringing Elliot back and forth to the hospital for treatment and so on and were planning our future. We were not for a second thinking that we

would leave without Elliot. I felt panic stricken, numb and terrified all at once. It did not make sense. We had been told at Prince Charles Hospital that Elliot could have a liver transplant and now we were being told that he couldn't. I had the impression that everything had been decided before we arrived and just felt numb.

6. The consultant paediatric hepatologist said at that interview with Ms Walters:

When it was explained to Ceri that her son was seriously ill and that he would not be suitable for a liver transplant, Ceri responded as if half in a dream . . . Ceri was in a state of emotional shock typical of many parents with children admitted urgently to PICU [the paediatric intensive care unit].

7. The next morning Ms Walters met the consultant neurologist to be told how severely damaged her son was:

This was a complete shock. I knew that there was a problem with him going for a liver transplant, but what she was saying was so final and severe. The whole episode seemed unreal, as though I was watching it on television and it was not happening to me . . . I was empty and numb. The situation was unreal. Approximately half an hour after this, Dr Baker turned off the ventilator and very soon Elliot died in my arms.

8. The neurologist said:

My recall is that they found it particularly devastating because they thought they had been reassured prior to Elliot's transfer that his condition was treatable.

9. The effect on Ms Walters was devastating. She had regarded herself as an outgoing and happy person before Elliot's death. She had worked as an auxiliary psychiatric nurse for a number of years and had always kept in employment until she became pregnant. She expected to go back to work. After Elliot's death, life passed in a void. She was being prescribed tranquillisers. She could not sleep properly. She lost her appetite. She began to drink herself into oblivion. Her relationship with her partner, which had been good, broke down. She had suicidal feelings. She suffered nightmares and hallucinatory experiences. She gave birth to a daughter in November 1999, but that exacerbated her anxiety and she became "worried sick" about her new baby, suffering "flashbacks" of Elliot in hospital on a ventilator.

10. There was substantial agreement between the psychiatrists to whom a series of questions were put as follows:

Question 1

Is it agreed that the claimant has suffered from a recognised psychiatric illness or condition?

## Answer 1

We agree that the claimant has suffered from a recognised psychiatric illness, namely pathological grief reaction.

## Question 2

Have the alleged events that were witnessed, experienced and participated in by the claimant over the two days, caused or materially contributed to any recognised psychiatric condition or illness identified by you (as opposed to the symptoms caused by the understandable grief of losing her child)?

## Answer 2

Yes, the alleged events witnessed and experienced caused a pathological grief reaction which differs from the normal grief reaction, both by reason of its severity of symptoms and the duration of those symptoms.

## Question 3

To what extent have the psychiatric symptoms been contributed to by what was allegedly witnessed, experienced and participated in by the claimant over the two days (as opposed to the symptoms caused by the understandable grief of losing her child)?

## Answer 3

We agree that without these events, the pathological grief reaction would not have occurred.

## Question 4

What adverse psychological/psychiatric symptoms does the claimant currently have and what is the prognosis for them?

## Answer 4

She continues to have symptoms of an unresolved pathological grief reaction, including intrusive thoughts about the deceased, yearning for the deceased and loneliness as the result of the death. She also experiences feelings of futility and purposelessness, subject to feelings of numbness and detachment. She has difficulty acknowledging the death and occasionally feels that life is empty and meaningless. She has an altered world view manifest by rational concerns about her daughter and has undertaken harmful behaviours following the death, mainly alcohol ingestion. These symptoms have lasted for some years now. The symptoms cause clinically significant impairment in social, occupational and other important areas of functioning. Recently, the symptoms have been exacerbated and medication has been prescribed by her general practitioner. While the prognosis for the mood symptoms is good, the prognosis for direct symptoms of grief remains poor.

## Question 5

To what extent, if at all, is the claimant's employability affected and what is the prognosis as far as her employability is concerned? Specifically, is the claimant at a disadvantage in the labour market, and if so, to what extent? If her employability is no longer affected, for how long was it affected, if at all?

## Answer 5

We acknowledge that we are not experts in employment issues. We agree that the claimant's employability is impaired to some extent but note that she is also the mother of a young child and has relatively low qualifications for employment. We agree that she is at a disadvantage in the labour market and has been significantly disadvantaged until 1998 and moderately disadvantaged thereafter. She will continue to be disadvantaged by reason of her having a psychiatric history in the years to come.

## Question 6

Is there any psychiatric significance in the fact that the claimant was exposed to distressing circumstances for two days rather than a shorter period?

## Answer 6

Yes. The psychiatric impact is more severe than if the child had died suddenly, as it was compounded by uncertainties over the diagnosis and readmission to various hospitals. Also, the couple had to make a decision about withdrawal of life support.

## Question 7

Has the claimant suffered shock due to what was witnessed, experienced and participated in by her?

## Answer 7

Yes.

There are no substantial areas of disagreement between us in this case.

11. When it became apparent during the course of the trial that emphasis was being placed on the effect on her of witnessing Elliot's seizure in the early hours of the morning, two further questions were formulated and answered as follows:

Q: When they began their consideration of the events of those two days, which was the first event in time that the psychiatric experts considered to have been relevant to the claimant's pathological grief reaction?

A: Shortly before admission on 17 June 1996 when the deceased was noted to be jaundiced, the claimant began to become emotionally disturbed.

Q: If the relevant events included the claimant witnessing the seizure suffered by Elliot at

3.20 am on 30 July 1996, did this materially contribute to the onset of the claimant's psychiatric symptoms or is it rather to be regarded as one of a series of materially contributory events that occurred over the period of two days?

A: It should be as one of a series of materially contributory events.

12. The first question the judge had to ask himself was whether the claimant was a primary victim or a secondary victim, that is to say one who was involved, either mediately or immediately as a participant, as opposed to one who was no more than a passive and unwilling witness or spectator to the injury caused to another. He had no difficulty in concluding that Ms Walters was a secondary victim and there is no challenge to that finding. He then held that as a secondary victim she was subject in law to certain "control mechanisms" which might bar her claim. He noted, however, that it was not in dispute that she had the necessary close relationship with the victim, that she had suffered a recognised psychiatric illness and that that could have been foreseen.

13. The judge therefore directed himself as follows:

33. It seems to me 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.

14. In deciding that question the judge first referred to the agreed psychiatric evidence and held:

34. It is clear therefore that although the psychiatrist remained of the opinion that what occurred on 30 and 31 July 1996 caused her pathological grief reaction, the claimant could not show that her awakening to find that Elliot had suffered a seizure was the cause of her illness. That incident could not be viewed on its own as a horrifying event which caused her illness, as it was what happened over the 36-hour period that caused that illness.

15. So he characterised her case in these terms:

35. It therefore was the essence of the claimant's case that the 36-hour period, beginning with the moment at which the claimant was awakened by her son's fit until the moment at

which the life-support machine was switched off, could be looked on as a horrifying event which she suddenly appreciated in contradistinction to the accumulation over a period of time of more gradual assaults on the nervous system.

16. He held that an event could cover "in ordinary parlance something that occurs over several days". He observed that the courts have considered that for some purposes in commercial context what has happened over several days or longer could be treated as "an event" in some of the authorities on nervous shock the relevant matters endured over many hours. He agreed with His Hon Judge White sitting at the Central London County Court in *Tredget & Tredget v Bexley Health Authority* [1994] 5 Med L.R. 178 that:

The courts should look realistically at what happened and that an event can extend over a short period of time such as the 48 hours in that case.

17. He concluded:

39. On the facts of this case, the claimant was present by her son's bedside when he suffered a fit. She clearly appreciated that something serious had happened. She was told initially at the Prince Charles Hospital that Elliot would be unlucky not to be all right; that was plainly negligent advice. She had to leave her son while he was transferred to London, but immediately on arrival she was told of the true significance of what had happened. The following day she made the decision to switch off the ventilator. It seems to me that the period of 36 hours from the moment at which the epileptic fit started, the misdiagnosis by the Prince Charles Hospital, the correct diagnosis by King's College Hospital and the decision to turn off the life-support machine because of the irreparable damage caused by the fit can be looked on in law as a horrifying event properly so called. Her appreciation of the horrifying event was sudden within the temporal context in contradistinction to more gradual assaults on her mind. It was that sudden appreciation of that event that caused the pathological grief reaction.

40. I do not consider that it makes a difference that the claimant, although present when Elliot had his fit shortly after 3.00 am on 30 July 1996, did not understand for herself the full significance of that fit. That had to be explained to her by the medical staff. Nonetheless, she experienced the happening of the fit when she was awakened; she remained with him thereafter except when he was being taken separately to London in the ambulance. Given the very young age of her son, the fact that a CAT scan was needed and had to be interpreted to her by the

consultants did not mean she did not appreciate what had happened by sight and sound. It is a case quite different from the parent who was not present at the scene of the accident and learnt of it from another; the claimant was in the same room as her son and awoke to find he had had a fit; what followed in the hours immediately thereafter were the attempts by the hospitals to evaluate his condition and explain it to her. Looked at overall and reviewing the factors referred to by Lord Ackner (pp 400-1 and 405) and Lord Oliver (p 411) in *Alcock v Chief Constable of South Yorkshire* [1992] AC 310, there was a very strong element of physical proximity to the event which the claimant witnessed, a very close temporal connection between the event and the claimant's perception of it, the event was horrifying and her appreciation of it sudden in contradistinction to an accumulation of gradual assaults on her mind.

So he concluded that on the unusual facts of this case the claimant was entitled to recover as she had suffered shock as that term has been defined in the cases.

18. He had also to deal with a further argument advanced on the claimant's behalf, namely that the denial of a cause of action would be a breach of her right to a fair trial protected by article 6(1) of the European Convention on Human Rights. He rejected the argument and there is no appeal from that part of his judgment.

*The grounds for appeal and for upholding the order*

19. The appellant's case was essentially this:

- (i) The judge erred in law in holding that the 36-hour period could properly be held in law to be one horrifying event.
- (ii) The judge further erred in holding that the claimant's appreciation of the 36-hour period was sudden within that temporal context in contradistinction to a more gradual assault of the mind over a period of time.
- (iii) The appellant contended that the judge had expanded the established control mechanisms with insufficient regard to the recognised policy constraints against innovation in this field of the law.
- (iv) By her respondent's notice, Ms Walters contended that if we do not uphold her primary case that the judge had correctly applied the law to the facts, then we should not flinch from taking "a small incremental step" in the development of the law so as to give this claimant relief. That small step would be to replace the shock requirement and substitute

a requirement that the psychiatric illness need only be caused by directly witnessing or experiencing some trauma.

*The law*

20. Neither the appellant nor the respondent challenges the judge's holding: (i) that the claimant was a secondary victim; (ii) she was accordingly subject to certain "control mechanisms"; and (iii) her recognised psychiatric illness was reasonably foreseeable and she had the necessary close relationship with the primary victim, so that the real and only issue in the case was whether her illness had been caused by shock for which (iv) the test was as he defined it, in short whether that illness arose from the sudden appreciation by sight or sound of a horrifying event or its immediate aftermath.

21. Given that common ground, it is unnecessary at this stage to examine the law in much detail and, as the law is presently in an unsatisfactory state being, per Lord Steyn in *Frost v Chief Constable of South Yorkshire Police* [1999] 2 AC 455, 500, "a patchwork quilt of distinctions which are difficult to justify", I am relieved to be absolved of that burden. As Lord Hoffmann observed in that case at p 511, the search for principle was called off in *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310. In his opinion, expressed at p 504:

It is too late to go back on the control mechanisms as stated in the *Alcock* case [1992] 1 AC 310. Until there is legislative change, the courts must live with them and any judicial developments must take them into account.

Accordingly, I find it necessary only to give a short summary of the development of the law in this uncertain area.

22. Claims for nervous shock seemed to advance a step with the decision of the House of Lords in *McLoughlin v O'Brian* [1983] 1 AC 410. It is worth recalling the facts. The plaintiff was at home two miles away from the road traffic accident in which her husband and family were involved at 4.00 pm. It was reported to her two hours later. She was told by her neighbour that her son was dying. She was taken to hospital where she was told that her younger daughter was dead. She saw her elder daughter through a window, crying with her face cut and begrimed with dirt and oil. She could hear her son shouting and screaming. She later saw him lapsing into unconsciousness. His face and side were covered with bandages. She saw her husband sobbing, covered in mud and oil. As Lord Wilberforce observed, p 417:

can be no doubt that these circumstances, witnessed by the appellant, were distinct in the extreme and capable of producing an effect going well beyond that of grief and

was described as "severe shock, organic injury and a change of personality".

Worst it is always dangerous to engage in a textual analysis of any judgment, even a judgment of Lord Wilberforce, yet it is interesting to note that he there described the "circumstances" which caused the effect. This appears again in the later part of his speech when he said at p 422, with the words added by me:

With regards proximity to the accident, it is clear that this must be close in both time and space. It is, after all, *the fact and consequence of the defendant's negligence* that must be proved to have caused the "nervous shock". Experience tells us that to insist on direct and immediate contact or hearing would be impractical and unjust. It is under what may be called the "after-shock" doctrine one who, from close proximity, is very soon upon the scene should not be held liable. In my opinion the result in *Benson v North Glamorgan NHS Trust* [1972] VR 879 was correct and indeed reasonable. It was based, soundly upon:

... direct perception of *some of the events* which caused to make up the accident *as an entire event*, this includes... the immediate aftermath." (p 880)

The passage serves to confirm that the "fact and consequence of the defendant's negligence" is not a series of "events". One looks to the totality of the circumstances which bring the claimant into proximity in both time and space to the event. It seems to me, therefore, to be implicit in the judgment read as a whole that when he said at

... the shock must come through sight or hearing of the event or of its immediate aftermath. I am not intending to confine "the event" to a moment of time.

The *Alcock* case is the next vital decision of the House of Lords. Those claims arose out of the disaster at the Hillsborough Stadium. The claimants sought to extend the parameters of liability by removing any restrictions on the category of persons who may sue; (2) extending the means by which the shock is caused, so that it includes view-simultaneous broadcast on television of the disaster which caused the shock; (3) modifying the requirement that the aftermath must be "immediate".

He stated that the application simpliciter of the reasonable foreseeability test was far from operative. Those propositions set out at pp 400-401 included these:

(1) Even though the risk of psychiatric illness is reasonably foreseeable, the law gives no damages if the psychiatric injury was not induced by shock. Psychiatric illnesses caused in other ways, such as by the experience of having to cope with the deprivation consequent upon the death of a loved one, attracts no damages...

(2) Even where the nervous shock and the subsequent psychiatric illness caused by it could both have been reasonably foreseen, it has been generally accepted that damages for merely being informed of, or reading, or hearing about the incident are not recoverable. In *Bourhill v Young* [1943] AC 92, 103, Lord Macmillan only recognised the action lying where the injury by shock was sustained "through the medium of the eye or the ear without direct contact". Certainly Brennan J in his judgment in *Jaensch v Coffey* (1984) 155 CLR 549, 567, recognised:

"A psychiatric illness induced by mere knowledge of a distressing fact is not compensable; perception by the plaintiff of the distressing phenomenon is essential..."

(5) "Shock", in the context of this cause of action, involves 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.

25. Thomas J clearly based his text upon that fifth proposition. As I have indicated, it is common ground in this appeal that the judge was entitled to do so and there is no challenge to his identifying that as the correct principle to test causation. We must proceed accordingly. Lord Ackner did not give authority for his proposition but he surely had in mind the judgment of Brennan J in *Jaensch v Coffey* at p 566/567 where he said:

The notion of psychiatric illness induced by shock is a compound, not a simple, idea. Its elements are, on the one hand, psychiatric illness and, on the other, shock which causes it... I understand "shock" in this context to mean the sudden sensory perception — that is, by seeing, hearing or touching — of a person, thing or event, which is so distressing that the perception of the phenomenon affronts or insults the plaintiff's mind and causes a recognisable psychiatric illness. A psychiatric illness induced by mere

I infer Lord Ackner had this passage in mind because he quoted the last sentence to support his second proposition. Before passing from that case it is at least interesting to note the facts. The wife of the injured motorcyclist was not at the scene of the accident which occurred in the early evening. The plaintiff was brought the news by police officers and taken to the hospital where she saw her husband in severe pain. She saw him taken into and brought back from the operating theatre and taken in again. Later that evening she was told to go home to sleep but also told that her husband was "pretty bad". The doctor telephoned at 5.30 am to tell her that her husband had been placed in intensive care. Three hours later she was told there was a change for the worse and she was asked to get to the hospital as soon as possible. She stayed with him much of that day and saw him "all these tubes coming out of him". She said she was "scared he was going to die and... resentful to the other person that caused the accident". When she left hospital that evening she thought her husband was going to die. She realised he would survive three or four weeks after the accident. She recovered damages.

26. There is ample other support for Lord Ackner's view of what constitutes shock. Lord Keith of Kinkel said at p 398 in *Alcock*:

In my opinion, the viewing of these scenes cannot be equated with the viewer being within "sight and hearing of the event or its immediate aftermath", to use the words of Lord Wilberforce [1983] 1 AC 410, 423B, nor can the scenes reasonably be regarded as giving rise to shock, in the sense of sudden assault on the nervous system.

27. Lord Oliver of Aylmerton said at p 411, in a passage relied on by Thomas J:

The common features of all the reported cases of this type... are, first, that in each case there was a marital or parental relationship between the plaintiff and the primary victim; second, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system; third, 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, fourth, that the injuries suffered arose from witnessing the death of, or 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 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.

28. For completeness I should add another passage from his speech at pp 416/417:

No case prior to the hearing before Hidden J from which these appeals arise has countenanced an award of damages for injuries suffered where there was not at the time of the event a degree of physical propinquity between the plaintiff and the event caused by the defendant's breach of duty to the primary victim nor where the shock sustained by the plaintiff was not either contemporaneous with the event or separated from it by a relatively short interval of time. 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 events or its immediate aftermath. To use Lord Wilberforce's words in *McLoughlin's* case [1983] 1 AC 410, 422-423:

"As regards proximity to the accident, it is obvious that this must be close in both time and space... The shock must come through the sight or hearing of the event or of 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 oral perception are absent... 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 great 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 an 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.

#### *The subsequent application of these principles*

29. The first case to which we were referred is *Sion v Hampstead Health Authority* [1994] 5 Med LR 170. There the plaintiff's claim was struck out as disclosing no cause of action. The claim was brought by the father of a young man injured in a motorcycle accident. For 14 days the father stayed at his son's bedside, watching him deteriorate in health and fall into a coma and then die. The appeal was dismissed, Staughton LJ finding that there was no trace in the medical report of "shock" as defined by Lord Ackner, no sudden appreciation by sight or sound of a horrifying event. On the contrary, the report described 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. Peter Gibson LJ with whom Waite LJ agreed, said:

I can see no reason in logic why a breach of duty causing an incident involving no violence or suddenness, such as where the wrong medicine is negligently given to a hospital patient, could not lead to a claim for damages for nervous shock, for example where the negligence has fatal results and a visiting close relative, wholly unprepared for what has occurred, finds the body and thereby sustains a sudden and unexpected shock to the nervous system.

Peter Gibson LJ also agreed that on the medical evidence there was no such sudden and unexpected shock to the father's nervous system. An accumulation of more gradual assaults on the nervous system

over a period of time was not sufficient. It was a very different case to this.

30. The next case to which we were referred is *Tredget & Tredget v Bexley Health Authority* [1994] Med LR 178, a judgment of His Hon Judge White in the Central London County Court. As a result of the defendant hospital's negligent management of Mrs Tredget's labour, her baby was born in a severely asphyxiated state and died two days later. The judge held that the actual birth of the child with its "chaos" or "pandemonium" was for those immediately and directly involved as each of the parents was frightening and horrifying. On the evidence, the event of the delivery was a powerful factor in contributing to the pathological grief reaction each suffered afterwards. The judge held that each of the plaintiffs established liability even though full appreciation of the gravity of the child's condition only came during his short struggle for life in intensive care during the 48 hours that following his birth. He held:

It is unrealistic to separate out and isolate the delivery as an event, from the other sequence of happenings from the onset of labour to Callum's death two days later, as a whole. . . . Although lasting for over 48 hours from the onset of labour to the death, this effectively was one event. . . . The law should be, and in my judgment is, "fluid enough" simply to recognise one type of traumatic event and shut its eyes to another such as that upon which this claim is founded whether or not it is necessary — and in my judgment it is not — to pray in aid the concept of the "aftermath".

31. Finally, there is *Taylorson v Shieldness Produce Ltd* [1994] PIQR 329. The appellants there were the parents of a 14-year-old boy who died three days after he had been crushed by a reversing vehicle. The appellants were informed of the accident soon after it occurred and went straight away to the hospital. The boy was seen in the ambulance and as he was rushed to the intensive care unit the parents stayed with their son during the two days he was on the life-support machine and saw him grievously injured. When there was no significant improvement, the father bravely took upon himself the task of switching off the life-support machine. The parents' claim failed. The Court of Appeal upheld the finding of Kennedy J, as he then was, that the mother had a dawning consciousness that they were going to lose their son and he declined to extend the notion of proximity to this "elongated process". The court rejected the argument that the post-accident treatment continued up to the time of this boy's death. Moreover, on the medical evidence the real psychiatric damage resulted from grief at their son's death, and the parents' illnesses

were not shown to have been caused by the shocking events relied upon.

*The first issue in this appeal — did the judge err in holding that the 36-hour period beginning with Elliot's epileptic fit and ending with his dying in his mother's arms was one horrifying event?*

32. Mr Stephen Miller QC, who now appears for the health authority, submits that there was no obvious horrifying event. The claimant's immediate reaction was of annoyance, awakening to find that Elliot had suffered a fit was not particularly traumatic although it had to be accepted on the agreed medical evidence that it was one of a series of materially contributing events. There was no "crescendo" event which brought home to the claimant the implications of what had occurred over the 36 hours. Thus there was no single horrifying event.

33. Mr Weir for the mother submits that it is clear from the authorities, in particular *McLoughlin* itself, that the "event can constitute more than a single moment in time". He relies upon Lord Wilberforce's approval of the passage in *Benson v Lee* that there has to be "direct perception of some of the events that go to make up the accident as an entire event", which includes the immediate aftermath. The entire event can be made up of one or more discrete events occurring over a period of time. For example, in *Chadwick v British Railways Board* [1967] 1 WLR 912, a rescue case, which was approved in *Frost v Chief Constable of South Yorkshire Police* [1999] 2 AC 455, 465 and 499, Waller J dealt with the case on the basis that it was "the horror of the whole experience" which caused the rescuer's psychiatric breakdown.

34. 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 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.

35. Mr Miller submits that the court cannot take account of what the mother was told about her son's condition from time to time. I do not agree. The distinction in the authorities is between the case where the claim is founded upon "merely being informed of, or reading, or hearing about the accident" and directly perceiving by sight or sound the relevant event. Information given as the events unfold before one's eyes is part of the circumstances of the case to which the court is entitled to have regard.

36. The question then is whether this entire event was "horrifying". 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 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. I have no difficulty in saying, as Lord Wilberforce did:

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There can be no doubt that these circumstances, witnessed by the [respondent], were distressing in the extreme and capable of producing an effect going well beyond that of grief and sorrow.

37. It follows that in my judgment the judge was not only entitled to find the facts as he did in the claimant's favour but also bound to do so. I can see no error in his finding of the material facts and his application of the principles of law to those findings.

*The second issue — was the judge wrong in holding that the claimant's appreciation of events was sudden in contradistinction to it being a more gradual assault on her mind over a period of time?*

38. It is, in my judgment, important to see how and why the element of the sudden appreciation of the horrifying event finds its place in the definition of shock. It is also an aspect of proximity which is necessary to establish liability. As Lord Oliver points out, there must be both physical and temporal propinquity between claimant and defendant and claimant and the event. 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. The elements of proximity and causation are closely linked together.

39. The issue here is whether her psychiatric condition was caused by shock. The medical evidence was clear that it was. That may be no surprise since the psychiatric profession have a clinical view and may, for good reason, not understand or accept the illogicality of the law as it has developed. Being a legal test, it was for the judge to decide.

40. In my judgment he was fully justified in coming to the conclusion that her appreciation was sudden in contradistinction to an accumulation of gradual assaults on her mind. The first event in the series is her being woken by her child's convulsion. What she saw next 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.

41. In my judgment the judge was right in this conclusion.

*The third issue — has an incremental step been taken advancing the frontiers of liability?*

42. In my judgment it has not. Lord Wilberforce said in *McLoughlin* at p 421:

We must then consider the policy argument. In doing so we must bear in mind that cases of "nervous shock", and the possibility of claiming damages for it, are not necessarily confined to those arising out of accidents on public roads. To state, therefore, a rule that recoverable damage must be confined to persons on or near the highway is to state not a principle in itself, but only an example of the more general rule that recoverable damages must be confined to those within sight and sound of an event caused by negligence or, at least, to those in close, or very close, proximity to such a situation.

43. Like Gibson LJ in *Sion*, I see no reason why liability for nervous shock in medical negligence cases involves any new application of principle. The same principle is being applied even if the facts to which it is applied are new. To act within the parameters of principle does not involve an incremental step.

*Finally, are we to be constrained by policy considerations to allow this appeal?*

If no incremental step is involved and this appeal is, as I think it is, essentially an appeal that the judge's findings of fact are against the weight of the evidence, then I see no room to invoke public policy whatsoever. I understand the concern of the health authority, and their insurers if there are any, that a drain on National Health resources having to meet claims for medical negligence is already sufficiently alarming as not to encourage claims being advanced by secondary victims of that clinical negligence. If I had to make the choice between redressing a wrong to an injured claimant and protecting the pocket of negligent defendants for economic reasons, then I would unrepentantly prefer to

do justice than to achieve fiscal expediency. Fortunately, however, I am not called upon to make that choice. Policy does not govern findings of fact. The facts are either there or they are not. The judge was right to find the facts in the claimant's favour and having found those facts he was bound to apply the principles of law to them, especially since there was no real dispute that those principles applied. Considerations of policy do not enter this case. If the law needs to be changed, Parliament must do it.

#### Conclusion

45. This was a careful judgment. As Lord Bridge observed in *McLoughlin* at p 443:

... if asked where the thing is to stop, I should answer, in an adaptation of the language of Lord Wright (in *Bourhill v Young* [1943] AC 92, 110) and Stephenson LJ [1981] QB 599, 612, "where in the particular case the good sense of the judge, enlightened by a progressive awareness of mental illness decides".

46. The judgment of Thomas J makes eminently good sense to me. I cannot fault it. I would, therefore, dismiss the appeal.

**Lord Justice CLARKE:** 47. I agree that this appeal should be dismissed for the reasons so comprehensively given by Ward LJ. I wish to add only a very few words of my own because I also agree with him that this is a sad and difficult case.

48. Although I recognise that, as Lord Hoffmann so graphically put it in *Frost v Chief Constable of South Yorkshire Police* [1999] 2 AC 455 at 551, the search for principle in this class of case was called off in *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310 and that, as he said at p 504, it is too late to go back on the control mechanisms stated in *Alcock*, I do not think that those mechanisms should be applied to rigidly or mechanistically.

49. Cases vary almost infinitely. Ward LJ has set out parts of the five propositions identified by Lord Ackner in *Alcock* at pp 401-402. This is not a case of the claimant "merely being informed of, or reading, or hearing about" an incident (see Lord Ackner's proposition (1)) or of a psychiatric illness induced by mere knowledge of a distressing fact (*per Brennan J in Jaensch v Coffey* at p 567, quoted by Ward LJ at para 25 of his judgment).

50. This is a developing area of the common law. I noted that Lord Ackner introduced his five propositions with the phrase "whatever may be the pattern of the future development of the law" and in his proposition (5) he said that "shock" has yet (*my emphasis*) to include psychiatric illness caused by

the accumulation over a period of time of more gradual assaults on the nervous system.

51. In these circumstances, although I agree with Ward LJ that the decision of the judge does not involve the taking of an incremental step advancing the frontiers of liability, if it did, I for my part would take that step on the facts of this case.

52. In my opinion the very close relationship between the claimant and her son Elliot, the sudden and unexpected shock or series of shocks over a short period and the presence of the claimant leading to the death of Elliot in her arms, which together had the devastating effect on her described by Ward LJ, lead to the conclusion that the judge was right to hold that she is entitled to recover damages for the pathological grief reaction which she suffered as a result of the appellant's negligence.

**Sir ANTHONY EVANS:** 53. I agree with both judgments and that the appeal should be dismissed.

#### COMMENTARY

The distressing facts of this case are bound to engage the sympathy of any person considering the matter for the mother who had suffered and witnessed the tragedy of her baby dying, after being assured that treatment was possible. However, the difficult question for the court was whether the tests for "nervous shock" claims could be met, and in particular whether an "event" could be identified. The Court of Appeal agreed with the trial judge that effectively an event can be made up of a series of incidents, even if they extend of a period of hours or days. While it was a matter of fact in each case, in the present case there was "a seamless tale with an obvious beginning and an equally obvious end" [para 34]. This might suggest that any extended treatment in the course of which a number of distressing incidents occur might qualify to be described as an "event". If it is a matter of fact and degree in every case, it seems inevitable that a much wider range of cases arising in the context of clinical negligence may give rise to a "nervous shock" claim, on the part of those who witnessed the suffering of the patient. Whether this is what was intended by the House of Lords in *Frost* and *Alcock* will have to await consideration by the House of such a case.

The court also held that the appreciation of events could properly be described as "sudden" because "each of these three events had their impact there and then. This was not a case of a dawning of realisation..." [para 40]. The psychiatric evidence had been clear that there was

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psychiatric significance in the fact that the exposure to distressing circumstances had occurred over two days rather than a shorter period [para 10]. Given the ruling on the nature of an "event" it might be thought that the ruling on suddenness was inevitable.

Although the court denied that this case represented any increment advancing the frontiers of liability, it may have such an effect in the context of courses of treatment which are negligent. It confirms that the path pioneered in *Tredget & Tredget*

*v Bexley Health Authority* (1994) 5 Med LR 178 is open. The difficulty for practitioners will be to judge how far down the path the courts will be prepared to go. If an "event" may extend over 36 hours, there may be no reason in principle why it cannot extend over a significantly longer period. Such facts seem a long way from the sudden and catastrophic events which were the initial subject of this area of the law.

REPORTED BY ROBERT FRANCIS QC