



Neutral Citation Number: [2019] EWHC 717 (QB)

Case No: HQ17C01414

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/03/2019

Before :

MRS JUSTICE WHIPPLE

Between :

**PPX (A Protected Party By His Brother and
Litigation Friend BLF)**

Claimant

- and -

Dr Ravinder Aulakh

Defendant

Jacob Levy QC and Laura Begley (instructed by Stewarts) for the Claimant
David Pittaway QC (instructed by Gordons Partnership LLP) for the Defendant

Hearing dates: 6th, 7th, 11th, 12th March 2019

Approved Judgment

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

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MRS JUSTICE WHIPPLE

Mrs Justice Whipple :

Introduction

1. This is a claim for damages for clinical negligence brought by the Claimant, PPX, a man now aged 51 years old, who acts through his brother and litigation friend, BLF. Regrettably the Claimant suffered a serious neurological injury as a consequence of an attempted suicide by hanging on 20 May 2012. The Claimant benefits from an anonymity order made at the outset of this litigation and continued by me for the trial and thereafter. I have given reasons for that order separately.
2. By this claim, it is alleged that the Claimant's General Practitioner, Dr Ravinder Aulakh (the "Defendant"), was negligent in the treatment afforded to the Claimant at a consultation on 25 April 2012. Further, it is said that if the treatment provided by her on that day had been of a proper standard, the Claimant would have been referred urgently to the local NHS mental health services, with the result that he would not have tried to commit suicide on 20 May 2012 and would have avoided his injuries.
3. This is a split trial, and I will decide issues of breach of duty and causation only. If I find against the Defendant on liability, an issue arises as to whether the Claimant contributed to the damage by his own intentional act of suicide.

Evidence

4. The case largely revolves around a single consultation between the Claimant and the Defendant on 25 April 2012.
5. The Claimant was unable to give any evidence about that consultation, written or oral, because of his incapacity consequent on his brain injury. The Claimant's case was necessarily reliant on the Defendant's note of that consultation, as the note was interpreted by experts called by the Claimant, in the context of other events at and around that time.
6. The Defendant also relied on her note. She too called expert evidence to interpret that note and to comment on the context in which it was written. The Defendant had filed a witness statement dated 5 April 2018 in preparation for this hearing (the "2018 witness statement"), and until very recently, the Defendant's intention had been to give evidence at trial and submit herself to cross-examination on the contents of that statement. However, on 22 February 2019 (just a short time before trial commenced on 6 March 2019), the defence legal team filed a hearsay notice pursuant to s 2 of the Civil Evidence Act 1995 and CPR 33.2 seeking to admit the 2018 witness statement as hearsay, on grounds that the Defendant was unfit to give evidence. The hearsay notice was in time supported by a witness statement from Alison Patricia Harden, the Defendant's solicitor, dated 26 February 2019. Ms Harden explained that there had been no doubts about the Defendant's fitness to give evidence until a consultation with leading counsel, in preparation for trial, on 15 February 2019 when it became apparent that the Defendant was having difficulty remembering the relevant events. Following that consultation, Dr Kennedy, consultant psychiatrist, assessed the Defendant and came to the view that the Defendant was not fit to give evidence at trial by reason of significant cognitive impairment; he confirmed that she retained capacity to instruct her

legal team. Based on those documents, Mr Pittaway QC for the Defendant applied to admit her statement as hearsay.

7. Mr Levy QC and Miss Begley, for the Claimant, did not dispute Dr Kennedy's evidence but they resisted the application because they said that there was reason to believe that the Defendant was already suffering cognitive deficit in April 2018 when that witness statement was signed, and thus there was reason to doubt the reliability of that statement, so that admission of the statement as hearsay should be refused under s 5(1) of the 1995 Act. In response to this line of argument, the Defendant's solicitors disclosed an earlier witness statement from the Defendant, signed by her on 23 July 2014, at a time when all agree she was cognitively unimpaired. The Defendant waived litigation privilege in the 2014 witness statement, which was in effect an earlier draft of her 2018 witness statement. Mr Pittaway invited me to admit both statements as hearsay.
8. The statements were materially similar in important ways (and contained some material differences too). I ruled that both signed statements should be admitted as hearsay evidence, on the basis that the weight to be accorded to that evidence would be a matter for submissions in due course, pursuant to s 4 of the 1995 Act. In light of the production of the 2014 statement, the Claimant's objections became groundless.
9. Accordingly, this trial proceeded in a rather unusual way, because neither of the people who were present at the key consultation on 25 April 2012 gave evidence at trial. I was, however, assisted by evidence about surrounding facts and circumstances from the following lay witnesses: for the Claimant, his two brothers and his mother (her evidence was not disputed and so was read); and for the Defendant, the Claimant's ex-wife.
10. In relation to medical issues, I was assisted by evidence from the following experts who were called "back to back":
 - i) GP experts, Dr Ingram (for Claimant) and Dr Budd (for Defendant);
 - ii) Psychiatry experts, Dr Read (for Claimant) and Dr Maganty (for Defendant); and
 - iii) Community Psychiatric Nursing experts, Prof Gournay (for Claimant) and Mr Wix (for Defendant).

Background Facts

11. The evidence given to this Court examined the Claimant's family and domestic problems in some detail. But the focus should be on the background facts as they were known to the Defendant at the time of the consultation on 25 April 2012. I therefore look to the GP notes, which would have been available to the Defendant at that consultation, as the primary source of evidence to establish the context for the consultation on that day.
12. The Claimant and his family had long been patients of the Defendant. The first note of the Defendant providing treatment as a GP to the Claimant is dated 3 December 2003. A large number of the entries in his GP notes after that date relate to consultations with the Defendant about a range of different medical issues.

13. On 4 September 2007, the Defendant noted for the first time that the Claimant had “family problems”. She prescribed medication, suggested the Claimant go to Relate, and arranged to review him in two or three weeks’ time. On 25 September 2007, the Claimant again presented saying he had had an acute reaction to stress when he had been out with his family and had left them sitting in a service station; he complained about being under pressure. The Defendant increased his medication and arranged to review him in a week’s time. On 4 October 2007, the Defendant’s recorded “marital disharmony” and she referred the Claimant to an outside agency for counselling. Thereafter in the latter part of 2007 going into 2008, there are a number of entries by the Defendant which reflect consultations with the Claimant, there is repeated reference to his marriage being in difficulty. On 8 February 2008, the Defendant noted that the Claimant is “happier now wife has made decision to divorce”.
14. The first mention of the Claimant having suicidal thoughts is in a note by the Defendant dated 2 June 2008. By this time, the Claimant reported that he had moved out of the marital home and was living with his parents. The note records “suicidal thoughts – not brave enough”. The Defendant prescribed anti-depressants and arranged to review the Claimant in a week. The next entry is 9 June 2008, when the note records that the police had confiscated the Claimant’s shotgun which he used for clay pigeon shooting but that the Claimant said he “would never have used the gun”. The Defendant increased the prescription and arranged a review in 10 days’ time. On 30 June 2008, the Claimant reported to Sister Gill Cooper at the surgery that he was feeling better although he was not back together with his wife. The Claimant saw the Defendant on 15 July 2008 and the note records that he is “feeling ok”, he had moved back to his parents’ house.
15. On 6 August 2008, he reported his mood was “ok”, he was taking his daughter on holiday. There are other unconnected entries in the following months. Then on 4 February 2009, the Defendant recorded the Claimant reporting that he had had a row again and was thinking of “ending it again” (this appears to be a reference to ending the marriage). The Defendant prescribed anti-depressants and again suggested Relate. By 30 March 2009, the Claimant was reporting that he was back with his wife and getting on better at home, things were going well; he wanted to come off anti-depressants. Further consultations in May 2009 suggest he was doing better and was back with his wife. On 23 June 2009 he attended saying he was again in low mood, although his relationship was “ok”. He was again down in mood on 9 December 2009. On 15 December 2009, the Defendant referred him to a counsellor, Mrs Roz Sweeney. (I have seen from notes prepared by Mrs Sweeney, which may or may not have been before the Defendant at the consultation on 25 April 2012, that on 27 January 2010 he had had thoughts of suicide in December - of 2009, presumably - but he had no current thoughts or plans.) He had counselling on various occasions in May to July 2010.
16. On 5 August 2010, he had a consultation with the Defendant who noted again that he had marital problems. She prescribed anti-depressants. On 31 March 2011, he again attended the Defendant who noted that there had been a difficult session of family counselling and that the Claimant’s wife had said she wanted a divorce; he was concerned about his daughter and would fight for custody.
17. On 28 June 2011, the Claimant disclosed to the Defendant that he was having suicidal thoughts “but 7yr old daughter”. This is the second clear record of suicidal ideation disclosed during the course of a consultation with the Defendant. He again attended on

19 July 2011, by then saying that he was happier with the result after mediation in the context of divorce proceedings. The Defendant continued him on anti-depressants.

18. He next attended on 7 March 2012 and saw the Defendant. The note again records marital problems and that the Claimant had said everything was great until after Christmas (presumably of 2011), that he had been sleeping with his wife but that had now stopped and he was going to move out. The Defendant continued his anti-depressants.

Consultation of 25 April 2012

19. The Claimant next attended on 25 April 2012. This is the consultation of which the Claimant complains. The note reads as follows:

“E: Divorce

S: has had suicidal thoughts ,found out wife communicating with best friends of 25yrs. living alone in flat ,sees daughter . ‘nothing to live for’ considered hanging ,stabbing with knife- increased venlafaxine -mood improved . divorce nisi coming through .would still go back to ex.

Rx: Venlafaxine Tablets 75 mg

P: rev sos .1/12 adv samaritans”

20. The next entry in the GP notes is dated 21 May 2012 and records the circumstances in which the Claimant tried to hang himself: he was in one of the outside units at the home he had shared with his ex-wife, with the door locked, he had sent his ex-wife a photograph showing him hanged, the paramedics were called and he was now in an induced coma with an uncertain outcome.

Breach of Duty

21. The Claimant’s case, set out in the Amended Particulars of Claim, is that it should have been obvious to the Defendant when she saw the Claimant on 25 April 2012 that there had been a marked deterioration in the Claimant’s mental health and that he had started to express suicidal thoughts, felt he had nothing to live for, and he was expressing the means to inflict self-harm, with no restraining or mitigating features. The Claimant argues that the Defendant should have made an urgent referral to the Community Mental Health Recovery Service, elsewhere referred to as the Crisis Mental Health Service (CMHRS or CMHS, I shall refer to it as the “crisis team”) within 24 hours; and should have provided for earlier follow up with the Claimant.
22. As the case was developed at trial, the Claimant advanced a primary case that the Defendant was expressing *current* suicidal ideation and planning at this consultation, which was in and of itself sufficient to mandate an urgent referral. The secondary case was that even if the Defendant reasonably understood the Claimant not to have *current* suicidal ideation and planning, nonetheless there were a number of psychosocial factors at play for this Claimant, in the context of suicidal ideation and planning which was at least very recent and had not been shown to have dissolved, to mandate an urgent

referral. The psychosocial factors relied on by the Claimant were: the fact that the Claimant was living in a flat, away from the former marital home, which was not very nice; that he was very upset about Facebook messages of a sexualised nature that he had seen passing between his ex-wife and his best friend; that he had recently received the decree absolute for the divorce; that he was in a poor financial state, unable to meet his tax liabilities; that he had confronted third parties about his suspicion that his ex-wife was having an affair with his best friend. Mr Levy suggested that the Court could infer that the Claimant would, on balance of probability, have been in a highly distressed state when he visited his GP on 25 April 2012 given the existence and currency of these various psychosocial factors.

23. The defence rejected any suggestion that the Claimant's presentation on 25 April 2012 was a "quantum change" from how he had presented previously. Their case was that for some years, the Claimant's mental health had waxed and waned as his relationship with his ex-wife fluctuated, and his presentation on 25 April 2012 was consistent with and a continuation of that general pattern. The defence suggested that substantial weight could and should be placed on the Defendant's witness evidence, even though it has not been possible to test her evidence by questioning, because that evidence was consistent with all the other evidence in the case and provided a logical and compelling explanation of what was written in the note of consultation; the Defendant's case was that in her professional judgment, following a thorough assessment of his mental state, the Claimant was not at any imminent risk of self-harm and the reported suicidal thoughts and planning were not ongoing; the defence argued that this was a proper account of what had occurred on 25 April 2012 and so I should find.
24. The rival cases crystallised to a single issue in the joint statement of the GP experts. Those experts agreed that if there were concerns about current suicidal ideation and planning, then this would mandate an urgent referral to the crisis team (see question 2.9.1). The necessary corollary of this agreement was that if the Claimant had given a history of suicidal ideation and planning which was in the past, then urgent referral was not required. It is helpful to have the key issue of fact identified in this way. But that factual issue must be located in its proper context, a further matter on which the GP experts agreed: GPs frequently see patients who are complaining of suicidal thoughts; the job of the GP is to assess the patient to determine whether that patient is at imminent risk of self-harm; if he or she is, then an urgent referral to the crisis team is required to protect that patient; but if the GP assesses the risk of self-harm to be low, then the patient can be managed differently, in many cases without any referral at all but continuing under the GP. Thus, it is very frequent for GPs themselves to manage patients who have presented with complaints of suicidal ideation; that complaint alone does not ordinarily lead to any form of referral. The key to determining treatment is the GP's assessment of the level of risk of self-harm. Thus, *current* ideation and planning is an indicator of high risk which, if present, mandates urgent referral. The term "current" is not limited to the expression of ideation and volition in the consulting room, because patients might well feel temporarily better while speaking to their GP. It is a broader term which relates to the patient's mental health state more generally, allowing for fluctuations in the ordinary way. It is, however, to be contrasted with *past* ideation and planning, which is an indicator of lower risk: if the ideas of suicide and planning are confined to the past, then the GP is, at least in most cases, entitled to conclude that there is no imminent risk of self-harm and no urgent referral is required.

Thus, the currency (or not) of the Claimant's suicidal ideation and planning is in effect a shorthand used by the expert GPs to describe the assessed level of risk of self-harm.

25. Based on the agreed position of the GP experts in this case, the central issue of fact which will determine breach of duty is whether the Claimant, on balance of probability, reported *current* or *past* suicidal ideation and planning at the consultation on 25 April 2012.
26. There are a number of pieces of contemporaneous evidence which cast light on this central question. The first is, of course, the Defendant's note of consultation. I accept that the note, when read in isolation, is capable of bearing both meanings contended for in this case (ie for the Claimant, that suicidal ideation and planning were current; for the Defendant, that suicidal ideation and planning were in the past). However, the use of the past tense in that note, "*has had* suicidal thoughts", "*considered* hanging...", would tend to suggest, to me at least, that these ideas and thoughts lay in the past. Further, to my eye, these parts of the note seem to be a record of the history given by the Claimant; the later entries, "increased venlafaxine – mood improved" and "would still go back to ex", are further records of what the Claimant said. These latter entries suggest that on his own account the Claimant was feeling better by the time of the consultation because he had increased his own dosage of anti-depressants, and he retained hope for the future. My reading of the note in this way is supported by Dr Budd, an experienced GP.
27. I turn next to the Defendant's own evidence. In her 2018 statement, she explains her standard practice when dealing with a patient expressing suicidal thoughts (paragraphs 28 and 30). She says she discusses these thoughts very carefully to establish if there is any chance they might be acted on; she would ask about the exact nature of the thoughts, the method of suicide visualised, when the thoughts started, how often they occurred and whether there had been any urge to act on them in the past or sense that they might be acted on in future; she would also ask about "protective factors" which are reasons to prevent a person from acting on those thoughts. She says that she routinely sees patients expressing suicidal thoughts and if concerned that a patient might act on them, she would immediately telephone the CMHT to arrange for further intervention. There are two important points to make about these passages:
 - i) First, a very similar passage appears in the Defendant's 2014 witness statement (paragraph 26-28). Therefore, this is not a late addition to the Defendant's evidence but an explanation which she has always put forward.
 - ii) Secondly, both GP experts confirmed that such a practice is sound and reflects what you would expect any competent GP to do, faced with a suicidal patient.
28. It therefore seems very likely that the Defendant is here explaining, truthfully and coherently, how she would deal with a patient who expresses suicidal thoughts. If she had been tendered for cross-examination, it is unlikely that she would have been challenged on this part of her evidence, because it reflects the agreed position.
29. The Defendant gives an account of the consultation on 25 April 2012 in her 2018 statement (paragraphs 67-71). She states that she would have questioned him carefully about the thoughts that he was expressing. As to her findings, she says that "there was no planning element to the thoughts and ... the thoughts were not current" and that he

had thoughts of the future, about his daughter and ex-wife. From their discussion, the Defendant says she “did not believe the suicidal thoughts to be ongoing” and “did not consider that there was any risk of the Claimant acting on them”. He was not anxious or distressed during the consultation and gave her no cause for concern. Her treatment plan was to increase his venlafaxine (anti-depressant) and plan to see him in a month, but she told him to return to her as necessary before then; she also suggested he sought support from the Samaritans.

30. This evidence substantially replicates similar passages in the earlier 2014 witness statement (paragraph 67). There are differences between the two statements but importantly, in that earlier statement, the Defendant states that she “would have questioned him very carefully about his thoughts to assess the likelihood of him acting on them”, and she concluded after questioning that his thoughts were “not current” and that he was not at risk of self-harm.
31. The weight to be given to these statements is in issue and my conclusion on that issue is guided by the factors at s 4 of the 1995 Act. For reasons given, the Defendant could not be called to give evidence at trial. The 2014 witness statement was made relatively close to the events in dispute (around 2 years later); I was told that that statement predated the Letter of Claim in this case and thus was composed before the Defendant knew how the Claimant would put his case. That is at least one explanation for the greater detail appearing in the later statement. Apart from defending herself against future proceedings, the Defendant had no reason to lie or conceal events in either statement. In my judgment, the evidence should certainly carry some weight with the Court: it is important evidence, and there is no obvious reason for me to conclude that it is unreliable or should be disregarded. For present purposes, I simply note that the Defendant’s explanation of the 25 April 2012 consultation, set out in both of her witness statements, is consistent with what she had stated to be her own standard practice, which practice is accepted by the relevant experts as appropriate, and that her account fits comfortably with the note she entered contemporaneously.
32. I turn next to the evidence from witnesses about how the Claimant seemed at around this time. No lay witness called to give evidence suggested that the Claimant had appeared suicidal to them at any time in April and May of 2012, or at any other time. Indeed, the tenor of the evidence overall was that the Claimant’s attempted suicide was a totally unexpected event.
33. His brother BLF admitted that he had no idea of the depths of the Claimant’s depression; BLF knew that the Claimant was under the care of his doctor for depression but it “never occurred to me that he was or could become suicidal” (statement, para 29). Although they spoke a lot in the weeks leading up to his suicide attempt, BLF was not concerned. In one phone call after 25 April 2012, BLF remembered the Claimant seeming in low mood, worse than he had been before. But BLF did not arrange to go and see him, which is what he would have done if he had been concerned.
34. The Claimant’s other brother, BDY, had not known about the Claimant’s mental health difficulties in any detail. At some point in April 2012, the Claimant had come to him in a terrible state, asking him to read some Facebook entries which the Claimant had found involving his ex-wife and a friend of the Claimant’s, but BDY refused. Although the Claimant was very worked up about this, BDY did not get the impression that there was any risk to the Claimant’s well-being.

35. The Claimant's friend FOC speaks in her witness statement of her long friendship with the Claimant. She knew that he had gone missing after an equestrian event in 2007 or so (this is referenced in his GP notes too); he later told her that he had considered shooting himself at that time. Although FOC was shocked, she did not think it was very serious (para 21 of her witness statement). After that the Claimant got better. He never came to FOC with a plan as to how he might kill himself and she never feared that this was something he might do. In mid-April 2012, the Claimant came to FOC's house early in the morning in tears because he had found messages between his ex-wife and his best friend; shortly after this the Claimant's divorce was finalised. FOC says that there was a change in the Claimant at this point: he became intense and more distressed and said things like "maybe I should go and kill myself" but FOC did not take these as serious threats of self-harm and they were not accompanied by any plans about how he would do it. They spent the afternoon together on 20 May 2012, and the Claimant "seemed happy in himself that day" (para 53 of her witness statement). He told FOC that he had been out on a date in the last couple of days. She saw him accessing his ex-wife's emails and suggested to him that he should not do that. During that period in April and May 2012, he remained well-dressed and well-kempt.
36. His mother, MOC, confirmed that the Claimant never reported suicidal thoughts to her. She and the Claimant's father went on a cruise in late April 2012. The Claimant met them at Southampton on their return in early May 2012. He told them that his anti-depressant medication had been doubled. She said that the Claimant continued to be in low mood.
37. His ex-wife, EXW, said that he had been very upset in mid-April about seeing the Facebook messages and he had confronted various people about it, including her friends. But that after this and in the first weeks of May his behaviour "was as he usually was" and she had no concerns about him (para 41 of her statement). On 20 May 2012, he had brought his daughter back at about 7.30pm and had said he needed to collect his tools from the unit. EXW had spoken to him through the locked door of the unit at about 8pm, which EXW did not think was unusual. He did not say anything then which caused her concern. A little later, he texted her a picture of himself with a rope around his neck and a message saying his was sorry. EXW ran out to the unit but could not get in because the door was locked, she shouted and then heard a bang, which it later turned out was the sound of a ladder falling against the door. She called the emergency services. She confirmed in oral evidence that this was not something she had seen coming: nothing in the preceding weeks, days and hours had caused her concern that he would self-harm. Her view was that the Claimant had not intended to die and that his actions were an attempt to get her back.
38. Thus, the Claimant did not mention to any member of his family that he was having suicidal thoughts. He did mention this to FOC, who knew him well, but FOC did not think this was a serious suggestion. EXW was not concerned about his mental health. All those who were closest to the Claimant were very shocked when he did try to hang himself. None of them had any intimation from his behaviour or words in the weeks before that he was considering doing that.
39. Finally, I turn to the expert evidence from the psychiatrists, who were asked for their views, based on all the evidence, about what the Claimant's mental health state would probably have been when he was seen by the Defendant on 25 April 2012. Dr Read's evidence, based on the note for 25 April 2012 containing references to suicidal ideation

and planning, was that the Claimant had at that stage entered a much riskier phase of his thinking and should have been referred urgently. Dr Read accepted that the Claimant had not communicated to anyone else apart from the Defendant that he was considering self-harm. Dr Read did not point to any evidence, beside the Defendant's note of 25 April 2012, to support his opinion that the Claimant was in crisis and should have been referred urgently.

40. By contrast, Dr Maganty took the view that there was nothing for the Defendant to be concerned about when she saw the Claimant on 25 April 2012. On balance of probabilities, the Claimant's mental state at that time did not involve active suicidal ideation or planning. Dr Maganty thought that the note suggested that the Claimant's presentation was not massively different from how he had presented on other occasions, which had not given cause for concern. Dr Maganty said that there was "no clear evidence" that the Claimant had been in crisis at any time; to the contrary, he thought that the evidence went the other way, noting what friends and family had said. He concluded that the Claimant was not in crisis on 25 April 2012 and that his later Claimant's suicide attempt was an impulsive act which could not have been predicted.
41. The issue for me is how to interpret the note of 25 April 2012. I look to the other evidence, beyond the note, to assist me in that exercise. There is, quite simply, nothing in any of the other evidence to suggest that the Claimant was in crisis on that date. However, there is a lot of evidence to support the Defendant's case that the Claimant was not in crisis on that date. The Defendant's witness statements, although untested, give a clear account of the Claimant's suicidal ideation and planning being in the past. The lay witness evidence does not suggest any marked deterioration in the Claimant's mental health at or around this time and instead supports the proposition that he was not in crisis.
42. The note is itself couched in the past tense, which provides some further support for the Defendant's explanation.
43. Thus, the evidence as a whole is consistent with the Defendant's case. And, combined with Mr Maganty's view, it provides me with a coherent explanation of events on 25 April 2012.
44. I have tested the Claimant's case against the evidence. The problem with the Claimant's case is that it leads to a number of problems. First, it is difficult to explain why the Defendant, an experienced GP and the Mental Health Lead in her practice, did not refer the Defendant urgently if he was in fact exhibiting *current* suicidal ideation and planning. There was simply no reason for her not to have done what any competent GP would have done, faced with such a patient. She would have been negligent almost to the point of recklessness to have left him for review in a month's time on the Claimant's case. That would be surprising, given that the Defendant was in other respects a good and careful GP who knew the Claimant and his family as patients well. Secondly, the Claimant's case must depend on the rejection of the Defendant's evidence of fact as untrue, because the Defendant says in terms that the Claimant's suicidal thoughts and plans were not ongoing when she saw him. Even though the Defendant was not called to the witness stand, I would need a compelling reason to reject her written evidence as untrue, the more so in circumstances where some parts of her evidence, where she describes her usual practice, resonate with the GP experts in the case and are very likely to be true. Third, if the Claimant was in crisis on that date or

any date around that time, it is difficult to understand how it could be that none of his friends or family, who had regular contact with him, noticed such a significant change then or at any time in the weeks following. Fourth, it is difficult to explain the gap in time between the consultation on 25 April 2012 and his suicide attempt four weeks later. At no time during this period did he communicate to any member of his family or his friends that he was having worryingly dark thoughts; nor did he return to his GP for help as she had advised him to. Dr Read did not offer any clear explanation of how a man in crisis on 25 April 2012, could have appeared consistently well immediately afterwards and for several weeks thereafter.

45. These are all hurdles in the way of the Claimant's case. I conclude that the Claimant's case just does not fit the evidence or the facts. It is inherently improbable.
46. I therefore conclude that the Claimant's case must be rejected, in both of the ways in which it is put. On balance of probability (and I would say, strongly so), the Claimant did not disclose current suicidal thoughts and planning to the Defendant on 25 April 2012. That deals with the primary case. The reason he did not disclose current suicidal thoughts and planning was because such thoughts were in the past, and the Claimant was not in fact in crisis on that date. That deals with the Claimant's secondary case. That secondary case faces the yet further difficulty that it is based on a proposition that I must reject as unsound: although the Claimant was undoubtedly under a lot of pressure at this time as a result of various psychosocial factors, I am unable to draw an inference that such pressure would probably have rendered him actively suicidal, and I do not accept that any expert called in the case invited me to go that far. It is not possible to say that a particular individual will or will not probably become suicidal as a result of particular life stressors, alone or in combination. Those stressors may have some general predictive quality when applied to the population or to a particular section of it (for example, people with mental health problems) and they may help to explain in hindsight why a person has become suicidal. But they cannot be relied on in this case to argue, without more, that the Claimant was probably suicidal when seen by the Defendant.
47. There are other smaller points which were raised in argument which do not bear on the outcome of this case. I deal with them briefly.
 - i) The Claimant argued that if the Defendant's case was right on the substance, then the Defendant was at fault, at the very least, in taking notes which were not adequate to reflect the state of the Claimant's mind (specifically, to reflect the *past* nature of his suicidal ideation and planning). I am not persuaded that I should make any finding on this matter: there is no pleaded case in relation to inadequate note-taking; and the point was a makeweight, which was not fully argued at trial.
 - ii) The Claimant suggested that the Defendant's management plan, even if the Defendant was right on the substance, was sub-standard because the Claimant was to be reviewed in a month's time which was too long. The Defendant answered that the interval of a month was adequate, especially when combined with safety-netting by telling the patient he should come back at any time on an "sos" basis, noting that the Claimant had not historically been reluctant to see his GP when he needed to. In my judgment, the Defendant provides a satisfactory answer. I am not persuaded that the Claimant's criticism of the

management plan is sound, on the facts as I have found them. The Claimant was not in crisis when seen on 25 April 2012.

- iii) The Defendant suggested that the Claimant's suicide attempt was not really a suicide attempt at all because the Claimant did not wish to die; for that further reason the Defendant invited me to conclude that he was not in crisis on 25 April 2012. I am prepared to accept that the Claimant acted impulsively on 20 May 2012 – that seems amply borne out by the evidence – but there is insufficient evidence before me to reach any conclusion on the Claimant's motivation for acting as he did, and anyway it is unnecessary for me to make any finding on this point.

Causation

48. In light of my findings on breach, it is not necessary to address causation in any detail.
49. It is agreed that if the Claimant had been referred on an urgent basis, he would have been seen by the crisis team within 24 hours. That service would have assessed him and put in place monitoring, therapies and help. It would have provided what Mr Levy referred to as a "support scaffold". The particular dimensions and duration of this scaffold are indistinct because treatment would have depended on the Claimant's precise condition and response, and to an extent also on available resources.
50. The Claimant argues that one element of support would have come from the involvement of family and friends. That proposition needs closer scrutiny: whether family and friends would have become involved depends on whether the Claimant would have been willing to seek assistance from his family and friends, or to have his medical details and treatment disclosed to them, but I cannot know whether he would have been willing to do that or not. I am satisfied that *if* his friends and family had been told that he needed support, they would have rallied around and would have provided support to him as best they could.
51. The key question on causation is whether the existence of this support scaffold, of whatever shape and duration, and with or without support from family and friends, would have averted his suicide attempt on 20 May 2012. Dr Read's view was that during the period from 25 April 2012 to 20 May 2012 the Claimant remained in "acute psycho-social crisis" with a fluctuating mental state and at high risk of and prone to impulsive behaviour. The crisis team would have offered treatment for that impulsivity (which was part and parcel of the Claimant's reactive mental health disorder) and with treatment, Dr Read thought it was unlikely that the Claimant would have attempted suicide. Under cross examination, Dr Read accepted that self-harm is difficult to predict, but he said that treatment following urgent referral to the crisis team would have had a beneficial effect and would have "reduced the Claimant's impulsivity". There was a slight difference in diagnosis between the expert psychiatrists but Dr Maganty agreed that this was a reactive (as opposed to endogenous) condition. He also agreed that the Claimant had acted impulsively on 20 May 2012 – in his view, as a means to get his ex-wife back and not because he wanted to die (I have addressed that issue above and make no finding). However, Dr Maganty's view was that impulsivity requires treatment in the longer term, certainly over more than a few weeks, to teach a patient the skills to manage impulsive thoughts of self-harm. Dr Maganty did not think that the Claimant's impulsive act would have been averted even if he had had

intervention following an urgent referral: he said that suicide is not an illness, you can only offer support but you cannot make the risk that someone will self-harm go away; and on balance of probability, in the timeframe at issue here, he did not think that the outcome would have been any different.

52. I was also assisted by evidence from the Community Psychiatric Nurses. Both had experience of treating these sorts of patients in the community, just as the Claimant suggested should have happened here. Prof Gournay pointed to the National Confidential Inquiry into Suicide and Safety in Mental Health (annual report, October 2018). In 2012, 191 patients under the crisis team committed suicide, out of a total of 2,102, which is around 16%, a minority. From this Prof Gournay suggested that it was unlikely that someone under the crisis team would commit suicide. Mr Wix agreed the numbers and accepted that in general terms it is unlikely that a person under the care of the crisis team will commit suicide. His point, as I understood it, was that the data does not assist in identifying which individuals will be in the small minority who do in fact commit suicide; in other words, suicide, even within that group, cannot be predicted. It is thus not possible to say whether the Claimant would have been one of the small minority who committed suicide even though he was under the crisis team, assuming he had been referred. Mr Wix did not think that referral would have averted the Claimant's attempted suicide: the Claimant was quite variable in his presentation, some days good, some days not good; and suicide would have been difficult to predict in such a presentation.
53. In my judgment, the Claimant's causation case rests on shaky foundations. The risk that a particular person, whether or not that person is under the care of the crisis team, will try to commit suicide is difficult to quantify. Certainly, there are risk factors which might increase the likelihood, and treatment options which might reduce it. But for causation to be established in this case, I have to be satisfied that it is more likely than not that with intervention following referral on 25 April 2012, this particular Claimant would not have attempted to take his own life on 20 May 2012. I cannot be satisfied of that, on the evidence before me. I can be satisfied that this Claimant would have remained unwell and prone to impulsivity for some time after 25 April 2012, even with a referral to the crisis team, but I cannot predict his outcome beyond that. Causation is not established.

Contributory Negligence

54. The final issue only arises if I had found for the Claimant on breach of duty and causation. The issue would then have arisen as to whether the Claimant should be held in part responsible for his damage. I was shown two cases: *Reeves v Commissioner of the Metropolis* [1999] 3 All ER 897 and *Corr (Administratrix of Corr deceased) v IBC Vehicles Ltd* [2008] UKHL; [2008] 2 All ER 943. Following guidance at [62]-[69] of *Corr*, I must make a finding about the extent to which the deceased's personal autonomy was overborne by the impairment of his mind, on the assumption that that impairment was attributable to the Defendant. I have rejected that assumption but if I had not, on the evidence I have heard, I would put this Claimant in the middle category suggested by Lord Neuberger at [69], where the answer lies between the two extremes. On the Claimant's version of events, his autonomy was overborne to an extent by his mental health condition which had gone untreated; one of its manifestations was his impulsivity and it was that impulsivity which caused him to attempt to take his own life: this is all part and parcel of his mental illness. On the other hand, his attempted

suicide was plainly an autonomous act, by a person with capacity, designed to occur at a time when his ex-wife was outside his unit aware of what was happening (that can be the only sensible explanation for the sequence of events that night). I would have assessed the Claimant's own contribution, if I had got to that point, at 25%.

Summary

55. In conclusion, I dismiss this claim which fails on breach of duty and causation.
56. I recognise that the Claimant's suicide attempt has been devastating for him and has had a profound effect on his immediate family and friends. What happened on 20 May 2012 was a tragedy. But it was not the Defendant's fault.
57. I thank all counsel for their assistance in this case, which was extremely well-prepared, and expertly presented with a clear focus on the key issues.