



Neutral Citation Number: [2021] EWHC 196 (QB)

Case No: QB-2019-003553

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/02/2021

Before :

MASTER DAVID COOK

Between :

(1) MRS LYNETTE POLMEAR

Claimant

(2) MR M POLMEAR

- and -

ROYAL CORNWALL HOSPITALS NHS TRUST

Defendant

Henry Pitchers QC (instructed by **Wolferstons**) for the **Claimants**
Charlotte Jones (instructed by **Bevan Brittan LLP**) for the **Defendant**

Hearing date: 22 January 2020

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.

.....

MASTER DAVID COOK

Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to BAILII. The date and time for hand-down is deemed to be 10:00am on Friday 5 February 2021.

MASTER COOK:

1. This is the hearing of the Defendant's application to strike out the claims by the First and Second Claimants as secondary victims for damages alleged to have been suffered as a result of witnessing the sudden and horrifying events surrounding the collapse and death of their daughter Esmee on 1 July 2015. The application was heard remotely by Teams and I am grateful to both counsel for their clear and helpful submissions.

The facts

2. The Defendant is the National Health Service Trust responsible for the management and administration of the Royal Cornwall Hospital ("the hospital") and for the provision there of medical, surgical and nursing services.
3. The events giving rise to the claim are set out in the particulars of claim and for the purpose of this application I must accept they will be proved at trial.
4. On 19 August 2014, the Esmee was seen by her GP with a history of "strange episodes where Esmee complains can't catch her breath, appears pale and after a few minutes appears blue" (taken from the clinical records). It was noted that these episodes would last around 30 minutes. They had occurred every other week, but had started to happen every other day. The First Claimant was reassured by the GP.
5. Esmee was taken back to the GP by the Claimants on 10 September 2014. The GP noted episodes of shortness of breath, with no obvious triggers. There were symptoms of rapid breathing, with cold hands and fast pulse. Esmee had almost passed out. It was noted that the episodes lasted 30 to 60 minutes.
6. The GP referred Esmee to the paediatricians at the hospital by letter, dated 17 September 2014, which provided:

"This 6 year old girl presents with a years history of episodes where she complains she can't catch her breath, her breathing becomes quite rapid, her pulse fast and her extremities very cold. These are becoming more frequent and now occur about once a week. They last for 30-60 minutes. Recently she has also looked like she's going to pass out during the episodes.

Examination is entirely unremarkable. She looks well, has good colour and well perfused. Her pulse is 92 regular, heart sounds 1+2+0 and chest clear.

Her parents are obviously concerned about this and I don't think we have managed to reassure them so I would welcome your advice as to whether this should be investigated further.

She is otherwise well and on no medications..."

7. On 1 December 2014, Esmee was seen at the hospital by Dr Buhary, Paediatric Registrar. Both Claimants were present. The following typed note of the consultation was made:

“problems: Likely vasovagal syncope...

Investigations: ECG — normal.

Lying blood pressure: 102/60ml of mercury.

Standing blood pressure: 109/73ml of mercury.

Plan: 1. Full blood count normal. Bone profile, urea and electrolytes normal, magnesium and liver function tests normal.

2. 24 hour ECG tape requested.

3. Discharge from clinic.

It was a pleasure to review Esmee Polmear in clinic with her mother today. She has been referred to us by you with complaints of shortness of breath and heart beating fast. Mainly occurring when walking for a time, such as about 10-15 minutes wherein her face turns pale, her lips are possibly turning purple. It is reported that she develops cold clammy hands and gets very anxious at this time. These are not associated with any loss of consciousness or seizures and these symptoms are typically improved by sitting down. These episodes can last for about 15-30 minutes. There are no other associated problems. Esmee's mother reports that Esmee has a good balanced diet and good fluid intake of about 2 pints of water per day. She has normal bowel and bladder habits....

On examination today her weight was 21.5kg which on the 25th-50th centile. Her height was measured at 121cm, which is on the 50th centile. Her blood pressure was 114/75. Her respiratory examination was normal. She had normal heart sounds with split second heart sounds, no murmur heard. She had normal peripheral pulses. Her abdomen was soft and non-tender. There were 170 focal neurological deficits.

Plan.

The plan is as suggested above, Esmee's blood were normal. A 24 hour ECG tape has been requested, I will write with the results of that in due course.”

8. From 21 to 22 January 2015, Esmee underwent ambulatory ECG monitoring. When the monitor was fitted at the hospital, the First Claimant requested of the clinician undertaking the fitting that the monitoring be undertaken for a full week so to ensure that it captured one of the episodes with which Esmee was suffering. At that point, the episodes were not occurring daily. The Claimants were told that this was not possible

as a different monitor would be required which would be inconvenient to obtain at the time of that appointment.

9. Esmee did not have an episode of shortness of breath whilst wearing the ECG monitor. On 5 February 2015, the results of the ECG recording were reviewed by Dr Goyal, locum Consultant Paediatrician. Dr Goyal's interpretation was recorded as follows:

“The 24 hour ambulatory ECG recording which was performed on Esmee from 21st January 2015 through to 22nd January 2015 shows that her heart rate varies normally with day to day activities and drops as expected in sleep. There were no abnormal pauses or abnormal beats. This indicates that Esmee's symptoms are more likely to be related to exertion and likely physiological with nothing to suggest an underlying abnormality of her cardiac rhythm.”

10. Dr Goyal confirmed these conclusions in correspondence with the Claimants. Due to ongoing symptoms, Esmee was taken back to her GP on 21 April 2015. The Second Claimant attended this appointment and told the GP that Esmee was vomiting nearly every morning before school and that she experienced anxiety during and after the episodes, but not prior to them. The following entry was made in the clinical records by the GP:

“...With Dadda, ongoing concerns re Esmee's episodes -still c/o episodes cant catch breath, breathing, lips blue, skin pale, feels light-headed, no further syncope — but has had prey. Recently episodes ending with vomiting. Can occur home/out at school. nb seen paed — had 24hr ecg — ok. Parents v anxious, try slow breathing/distract her but episodes occur several times a week. Would like second opinion. Otherwise well. No other concerns at school. 0/e — well, v chatty, bright, good colour, warm well perfused periph, P102, RR25, HS normal, chest clear with good ae, abdo — nad Imp — appears panic/hyperventilation. Disc re managing this, slow breathing down, can try and rebreath in paper bag/distraction. Parents would like second paed opinion”

11. Consequently, the GP made a referral back to the paediatricians at the hospital, as per the letter dated 22 April 2015:

“I would very grateful for your further view of this 7 year old girl who has previously been seen by Dr Goyal back in February. Her parents wish for a second paediatric opinion.

Over the last 12-18 months Esmee has been complaining of strange episodes where she says she cannot catch her breath and her breathing appears to be very shallow and rapid. She then goes extremely pale and after a few minutes goes quite blue around her lips. These episodes can last up to about 30 minutes and occur several times a week. They can occur at any

time in the home. She has had some episodes where she has almost passed out. Over the last couple of weeks she has also complained of an episode of vomiting before the termination of the event. Between these episodes she is not had any disturbance of her bowels or vomiting. I understand that when she was seen by Dr Goyal she had a normal ECG, normal bloods and a normal 24 hour tape.

Her parents are extremely worried and finding it very difficult to handle these episodes. We have discussed that these episodes do sound like she is getting anxious and hyperventilating and to continue to try with distraction and deep breathing exercises. They are finding that there is no obvious trigger to these episodes other than exertion and that they occur at any time, even when she seems quite happy and relaxed. They would like further reassurance on why they are happening and how to manage them.

Esmee is otherwise fit and well. She has had a tonsillectomy and adenoidectomy in 2011... She attended with her dad today but of note in the past she has attended with her mum when seen by other colleagues and her mum has been quite tearful and very anxious.

On examination today Esmee is well, very chatty and bright and had good colour. She was warm and well per fused peripherally. Pulse was 102, respiration rate 25, heart sounds normal, chest clear with good air entry and examination of her abdomen was unremarkable”

12. Before Esmee was seen again at the hospital, she collapsed and died on 1 July 2015. The cause of death was Pulmonary Veno-Occlusive Disease. It had not been diagnosed prior to her death.
13. The circumstances of Esmee’s death are as follows.
14. Esmee had an unsettled night on 30 June/1 July 2015. She was due to attend a school trip to Perranporth beach on 1 July. She did not feel well in the morning. The Second Claimant drove Esmee to school and explained to her teacher that she did not feel well. It was agreed that the Second Claimant would meet Esmee at the beach to help her back to school if this was required.
15. Later that morning, the Second Claimant went to the beach as arranged, but Esmee was not present. He walked back towards the school where he found Esmee with a teacher and another pupil. Esmee looked tired and pale and was breathless. She kept wanting to sit down but she was encouraged to try to walk. She stopped at one point and vomited. Esmee and the Second Claimant sat down on a wall for a while. The First Claimant took a break from her work and came to see Esmee and the Second Claimant.

16. Shortly thereafter, the Second Claimant, the teacher and Esmee started to walk back to school. Esmee seemed frightened at the thought of walking. She had to stop frequently. The Second Claimant finally picked up Esmee and carried her back to school. She was white and clammy, with some blueness around her lips. At the door of the school, Esmee said she felt faint. The Second Claimant knelt by her, told her everything was going to be "ok" and gave her a kiss.
17. The Second Claimant walked away from the school, but had not travelled far when he received a call on his mobile telephone asking him to return to the school. The Second Claimant ran to the school and when he arrived he saw Esmee lying on the floor in a room just off reception. A member of staff was providing some first aid, but the Second Claimant took over and attempted to give Esmee mouth-to-mouth resuscitation. He could see she was not breathing and wanted to save her.
18. The First Claimant also received a call to say that Esmee had collapsed at school. She immediately left work and ran to the school. When she arrived, she saw Esmee lying on the floor with members of staff attempting resuscitation, which the First Claimant could see was not working. Paramedics arrived at the school and began to attend to Esmee, attempting to resuscitate her. This was witnessed by the Claimants.
19. The Claimants travelled with Esmee in the ambulance to hospital. Attempts to revive Esmee continued at hospital but they were unsuccessful.
20. The particulars of claim assert that as a result of witnessing the collapse, unsuccessful attempts to resuscitate and death of Esmee, each Claimant has suffered psychiatric injury. The First Claimant has developed PTSD and Major Depression and the Second Claimant has developed PTSD and Major Depression with Addictive Behaviour (alcohol and drug abuse).
21. The Defendant admitted that Esmee's condition should have diagnosed by mid-January 2015 in a letter of response dated 12 September 2018 sent on behalf of the Hospital to a claim presented on behalf of Esmee's estate.

“It is admitted that more should have been done to pursue a diagnosis and in terms of causation had Esmee been referred for specialist paediatric cardiology or respiratory physician opinion, the severity of her condition would have been appreciated and she is likely to have been investigated and diagnosed by approximately mid-January 2015.

It is admitted that had her condition been appreciated, Esmee would subsequently have been managed in accordance with her condition so that everything possible was done to try to ensure she was more comfortable”

The law

22. CPR 3.4 (2) provides that the court may strike out a statement of case “*if it appears to the court (a) that the statement of case discloses no reasonable grounds for bringing ... the claim ...*” If the Defendant cannot establish that no reasonable grounds for bringing the claim are disclosed, there is no discretion to strike out. An application to

strike out will not be granted unless the court is certain that the claim is bound to fail, *Hughes v Colin Richards & Co* [2004] EWCA Civ 266.

23. The case law following *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310 establishes that in order to succeed as a secondary victim a claimant must satisfy the following control mechanisms;
- i) that the claimant's injury was reasonably foreseeable;
 - ii) that the claimant was a close relative of and had a close emotional relationship with the primary victim;
 - iii) that the claimant suffered a recognised psychiatric injury;
 - iv) that the injury was caused by the actions of the Defendant;
 - v) that the claimant was either present at the scene of the accident which caused the death or must have been involved in its immediate aftermath (both physical and temporal proximity being required);
 - vi) the claimant must have perceived the death, risk of injury with their own senses.
24. I do not propose to set out the case law relating to secondary victim claims at any length at this point. I gratefully adopt the summary set out at paragraphs [5] to [41] of the judgment of Chamberlain J in *Paul v The Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB). In that case I had held that the secondary victim claims of the Claimants were bound to fail because Mr Paul's tragic heart attack and death 14 ½ months after the incidence of negligence could not be said to be the relevant event for the purpose of deciding proximity. In so finding I decided that the facts could not sensibly be distinguished from those in the case of *Taylor v Somerset Health Authority* [1993] 1WLUK 683 which was a decision expressly approved by the Court of Appeal in *Crystal Taylor v A Novo (UK) Ltd* [2014] QB 150. The judge held on appeal that I was wrong to conclude that the claims could not succeed.
25. At paragraph [73] of his judgment Chamberlain J set out his understanding of the ratio of *Taylor v A. Novo*:

“where the defendant's negligence results in an event giving rise to injury in a primary victim, a secondary victim can claim for psychiatric injury only where it is caused by witnessing that event rather than any subsequent, discrete event which is the consequence of it, however sudden or shocking that subsequent event may be. It is true that, at [30] of his judgment (see [29] above), Lord Dyson reasons that it would be undesirable to allow recovery in a case where death had occurred months, and possibly years, after the accident. But this is a concern about delay between the accident (i.e. the event) and its later consequence. As I noted at [63] above, there is nothing to suggest that there would be any reason to deny recovery simply

because the accident or event occurred months or years after the negligence which caused it.”

26. In other words *Taylor* does not suggest that a secondary victim claim can only succeed if there is an accident, it simply identifies as one example, “*a paradigm example*” of a secondary victim claim. Clinical negligence claims rarely involve accidents or immediate injuries, more commonly they involve omissions and injury which becomes apparent at a later date.
27. At paragraph [74] of his judgment Chamberlain J dealt with what he called the non-paradigm case where there is no “accident”, but some other kind of event such as the seizure in the case of *North Glamorgan NHS Trust v Walters* [2002] EWCA 1792.

“... Lord Dyson was careful to say that “accident” cases were a paradigm example of those in which a claimant can recover damages as a secondary victim and that [i]n such a case the relevant event is the accident, rather than a later consequence of it. This careful formulation seems to me to allow for non-paradigm cases where there is no accident, but some other kind of event such as in *Walters*. The passage at [35] in which *Walters* is distinguished appears to recognise that an event which is external to the secondary victim, but internal to the primary victim, could in principle qualify if it is sufficiently sudden and horrifying and leads immediately or seamlessly to death or injury in the primary victim. This is consistent with the express endorsement at [33] of Auld J's reasoning in *Taylor v Somerset Health Authority* only if the requirement for an external, traumatic event is read as requiring an event external to the secondary victim. That reading is supported by Lord Dyson's implicit disapproval, in the very next sentence, of Peter Gibson LJ's observations in *Sion*. (Peter Gibson LJ had said that the crucial ingredient of shock was a sudden awareness, violently agitating the mind and it did not matter if the incident giving rise to it involved no violence or suddenness at all. So, for him, there did not even have to be an event external to the secondary victim.)”

28. Therefore at paragraph [75] of his judgment Chamberlain J concluded:

“On this analysis, I would hold that the Master was wrong to conclude that these claims are bound to fail on the facts pleaded. Here, unlike in *Taylor v A. Novo*, there was on the facts pleaded only one event: Mr P's collapse from a heart attack on 26 January 2014. On the facts pleaded, it was a sudden event, external to the secondary victims, and it led immediately or very rapidly to Mr P's death. The event would have been horrifying to any close family member who witnessed it, and especially so to children of 12 and 9. The fact that the event occurred 14 ½ months after the negligent omission which caused it does not, in and of itself, preclude liability. Nor does the fact that it was not an accident in the

ordinary sense of the word, but rather an event internal to the primary victim. In a case where such an event is the first occasion on which damage is caused, and therefore the first occasion on which it can be said that the cause of action is complete, *Taylor v A. Novo* does not preclude liability. As I have explained, for the purposes of this strike-out application, I must assume that the present is such a case”

29. The parties are agreed that for the purpose of this hearing the issue to be determined is whether the Claimants have a reasonably arguable case that the relevant “*event*” required to satisfy the control mechanism of proximity was the collapse and death of Esmee on 1 July 2015. The remaining control mechanisms are assumed to be met.

Submissions

30. On behalf of the Defendant Ms Jones maintained that the death of Esmee five or seven months after the negligent failure to diagnose could not, on the basis of the Court of Appeal’s decision in *Taylor v A Novo*, satisfy the proximity control mechanism and accordingly the Claimants’ secondary victim claims are bound to fail.
31. Ms Jones’ submitted firstly, the case of *Paul* is being appealed to the Court of Appeal, secondly, *Paul* is not a decision that is binding on this court and thirdly, that the reasoning of Chamberlain J would actually preclude liability in this case.
32. Ms Jones then referred to paragraphs [76] to [79] of the judgement in *Paul* where Chamberlain J went on to consider the position if the defendant’s negligent omission caused actionable damage prior to Mr Paul’s collapse with the consequence that the cause of action was complete at an earlier date and the collapse and death were not therefore the first manifestation of damage. At paragraph [77] of his judgment he held that:

“*Taylor v A. Novo* would preclude liability in the present case if there were a relevant event prior to Mr P’s collapse on 26 January 2014 so that the latter could be said to be separate from it. In that case, Mr P’s collapse would be, like Mrs Taylor’s, merely the consequence of the event caused by the defendant’s negligence and not the event itself”

And at paragraph [79] of the judgment:

“If it is necessary to identify a stopping point after which the consequences of a negligent act or omission can no longer qualify as an event giving rise to liability for psychiatric damage in a secondary victim, the most obvious candidate is the point when damage to the primary victim first becomes manifest or, as Swift J put it in *Shorter* (see [33] above), evident. In *Walters*, this was the point when the baby suffered a seizure, even though, as Swift J noted, [t]here would of course have been ongoing consequences affecting the baby’s biological processes for some time previously. Had the death been a discrete event, rather than the end of a single, seamless event

starting with the seizure, there could have been no liability to secondary victims for psychiatric damage caused by witnessing it. In a case where the shocking event is the point where the damage becomes evident, it is difficult to see why recovery should depend on the happenstance of whether, possibly unbeknown to the primary or secondary victims, actionable damage had previously been suffered.”

33. Ms Jones submitted the facts of this case were unlike those in *Paul* because actionable damage had occurred prior to Esmee’s collapse and death on 1 July 2015. She referred to the Claimants pleaded case set out at paragraphs [10] and [11] above. It is clear that Esme had had very concerning episodes both before and after the date on which her condition should have been diagnosed in mid-January 2015, as set out at the time of her GP consultation on 21 April 2015. These incidents involved Esme having difficulty in breathing and turning blue or vomiting, would typically last up to 30 minutes and were occurring several times a week. The GP recorded, “*Her parents are extremely worried and finding it very difficult to handle these episodes*”
34. On behalf the Claimants Mr Pitchers QC submitted that *Taylor v A Novo* can readily be distinguished for the reasons given by Mr Justice Chamberlain at paragraphs [73] and [74] of his judgment in *Paul*. His narrow submission is that the point at which the Defendant’s failure to diagnose and treat Esmee’s underlying condition became manifest and therefore the point at which damage became evident, was 1 July 2015 when Esmee collapsed, stopped breathing and died. He submits that *Paul* is binding authority that such a sequence of events is sufficient to found a successful cause of action for the secondary victims in this claim.
35. In response to Ms Jones’ submission that actionable damage had become evident at an earlier stage Mr Pitchers QC sought to describe the episodes relied on as “transient symptoms” and makes the following points;
 - i) Such transient, non-horrifying episodes do not constitute the Defendant’s negligence becoming “manifest” within the meaning of *Paul*.
 - ii) There are no policy reasons to deny a cause of action to these Claimants simply because of those episodes occurring between breach of duty and collapse/death.
 - iii) Would the Claimants in *Paul* be unable to succeed if the deceased had experienced angina a month before his heart attack? That would be an unprincipled and unjustified distinction.
 - iv) In *North Glamorgan NHS Trust v Walters* [2002] EWCA Civ 1792, the baby continued to suffer from acute hepatitis over a number of weeks (with weekends spent at home) prior to fitting and then dying on the following day. The Court of Appeal upheld judgment for the claimant.
 - v) If each episode is treated as constituting “damage” to Esmee, each would constitute its own cause of action and not be a bar to recovery based upon the events of 1 July 2015.

- vi) Alternatively, further expert evidence will be required, to be considered at trial, in order to establish a proper understanding as to the underlying disease pathology. This alone would be a basis not to strike out the claim.

Discussion and Conclusions

36. As for Ms Jones' first two points. First, neither counsel asked me to stay this application pending the Court of Appeal's decision in *Paul*. Second, the judgment of Chamberlain J was a decision made on appeal against my decision at first instance to strike out the claim. In the circumstances I consider myself bound by the appeal decision and I must therefore proceed to decide the application on the basis of the established case law including *Paul*.
37. It seems to me the issue framed by Ms Jones is whether this is a case where the primary victim, Esmee, suffered actionable damage prior to her collapse and death on 1 July 2015. If so, this would be the stopping point after which the consequences of the negligent omission can no longer qualify as an event giving rise to liability for psychiatric damage in a secondary victim, in which case the Claimants' secondary victim claims would be precluded. Such an approach would, as Chamberlain J pointed out, be consistent with the approach of Swift J in *Shorter v Surrey and Sussex Healthcare NHS Trust [2015] EWHC 614 (QB)* and the Court of Appeal in *Walters*.
38. I have to say I have not found this to be an easy task. I cannot agree with Mr Pitchers QC that the symptoms set out in the Particulars of Claim are apt to be described as *transient* or *non-horrifying*. They were regular and clearly very worrying for the Claimants as recorded in the GP's referral letter. If one poses the question, could a claim have been commenced on behalf of the primary victim Esmee on the basis of her symptoms between mid-January 2015 and 1 July 2015 the answer, in my judgement, would clearly be yes.
39. However, I agree with Mr Pitchers QC that the same could possibly be said of the primary victim Eliot in *Walters*, his parents had bought him back to the hospital on the weekend of 26th July because of their concerns for him. He referred me to the description of Eliot's condition at paragraphs [2] and [3] of the judgment.

"2. The Claimant Ms Ceri Walters, was 31 years of age when these events unfolded. She gave birth to her son Elliot on 15th 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 26th 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, 30th 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 a.m. 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 a.m. The claimant was told by a doctor at 4.45 a.m. 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..”

40. There is in my view an inherent danger in submitting the facts of such appellate decisions to detailed scrutiny in circumstances where the first instance fact finding has not been fully revealed. Each case must turn on a detailed analysis of its own facts. As Swift J said in the case of *Shorter*:

“210. In the case of *Walters*, it is not clear how long prior to the baby's seizure the negligence had taken place. It is, I suppose, arguable that the negligence continued from the point when the wrong diagnosis was made right up to the time of the seizure. However, in that case, the Court of Appeal made clear (paragraph 34 of Ward LJ's judgment) that the 'event' was a convenient description for 'the fact and consequence of the defendant's negligence' and that it had begun 'with the negligent infliction of damage', i.e. at the time of the baby's convulsion. That was the time when the consequence of the negligence first became evident. There would of course have been ongoing consequences affecting the baby's biological processes for some time previously but it was only at the time of the convulsion that those consequences became evident and impacted on the claimant. The Court of Appeal found that the 'event' began at that time and continued for the 36 hours up to the baby's death.”

41. In that case the Court of Appeal found the ongoing biological processes affecting Eliot only became evident and impacted upon Ms Walters at the time of his seizure.
42. I think it helps to stand back at this point and re-frame the argument on the basis of the unchallenged evidence. A Hospital Trust negligently fails to diagnose a life threatening condition in a child, in this case pulmonary veno-occlusive disease. The child continues to experience the consequences of that life threatening condition beyond the point at which it should have been diagnosed and treated, in this case frequent episodes of breathing difficulties and vomiting. The parents are not unnaturally concerned at the child's condition and seek further medical referral. Shortly thereafter and before referral the child has a more serious episode as a result of which she dies. In the course of that final episode the parents are present and involved in the attempts to resuscitate their child suffering psychiatric injury as a consequence.
43. On the facts pleaded, Esmee's collapse was a sudden event, external to the secondary victims, and it led very rapidly to her death. The event would have been horrifying to any close family member who witnessed it, and especially to the parents. In the circumstances the question is why should the fact that Esmee had suffered non-fatal episodes on previous occasions rule out the secondary victim claims of her parents. It seems to me that Esmee's final episode can be appropriately described as a fact and consequence of the Defendant's negligence. Mr Pitchers QC's submission that each episode should be treated as constituting "damage" to Esmee, so that each would constitute its own cause of action and not be a bar to recovery based upon the events of 1 July 2015 should be seen in this light.
44. I return to the judgment of Chamberlain J in *Paul*. At paragraph 78 he said:

“In *Taylor v A. Novo*, however, there was something that could properly be described as an event prior to that witnessed by the secondary victim the collapse of the racking boards on to Mrs Taylor (the primary victim). That event coincided with or immediately preceded the moment when actionable damage was first suffered by her, which was also the moment when that damage became manifest. The same will be true in most accident cases. But in the present case, there was nothing that could naturally be described as an event before Mr P's collapse on 26 January 2014, even on the assumption that some actionable damage was suffered before that date. The Court of Appeal in *Taylor v A. Novo* did not need to, and did not, decide whether a defendant could be liable to a secondary victim in such a case. It did not say, for example, that an event can qualify only if it coincides with or immediately precedes the first actionable damage to the primary victim.”
45. Chamberlain J prefaced paragraph 79 of his judgment by stating, “*if it is necessary to identify a stopping point after which the consequences of a negligent act or omission can no longer qualify as an event..*”, my emphasis.
46. Miss Jones' submissions are both persuasive and logical, however I would hold, on the facts of this case and on the basis of the authorities as they currently stand, it is not

necessary to identify a stopping point as it is possible to identify a qualifying shocking event and that shocking event need not coincide with or immediately precede the first actionable damage to the primary victim. I must therefore reject Ms Jones' submission that prior actionable damage is a bar to recovery in this case.

47. In the circumstances I decline to strike out the claim as I am unable say it is bound to fail, the Defendant's application must therefore be dismissed.

Events post judgment and application for permission to appeal

48. Having circulated this judgment in draft Ms Jones indicated that she wished to make an application for permission to appeal. In fairness to her I was informed at the start of the hearing that whatever my decision the losing party would probably seek permission to appeal. I have received further written submissions from her. In those submissions she requests that in the event I grant permission to appeal I make a direction under CPR 52.23 transferring the appeal directly to the Court of Appeal. Mr Pitchers QC informed me in response that while he does not oppose the application he does not consent to it.
49. By CPR 52.6 I may grant permission to appeal if I consider the appeal would have a realistic prospect of success or there is some other compelling reason for the appeal to be heard.
50. At paragraph 31 above I noted that an appeal in the case of *Paul* had been made to the Court of Appeal. There are to my knowledge a number of other similar secondary victim claims which remain stayed pending the outcome of the appeal. Since the date of the hearing before me in this application Asplin LJ has granted permission for a second appeal in *Paul*, permission being granted on 28 January 2021.
51. In my experience there have been an increasing number of secondary victim claims made in the context of clinical negligence cases. In many of those claims applications to strike out are made by the Defendant relying upon the Court of Appeal's decision in *Taylor v De Novo*. Such applications invariably involve complex legal argument, take up a considerable amount of court time and add significantly to the costs of the litigation of the primary victim.
52. In this case I found that the primary victim had clearly suffered actionable damage at a point prior to the relevant event relied upon to found the secondary victim claim. I described Ms Jones' submissions as persuasive and logical. Whilst I have taken a view on the basis of Chamberlain J's concept of a stopping point I consider that the contrary view is arguable and would satisfy the test of having reasonable prospects of success.
53. By CPR 52.23 if I were to consider the appeal would raise an important point of principle or that there is some other compelling reason for the Court of Appeal to hear the appeal I may order the appeal be transferred to the Court of Appeal.
54. I am satisfied that the appeal does raise an important point of principle, namely the circumstances in which the control mechanism of proximity can be satisfied by a Claimant bringing a claim for damages as a secondary victim, when the negligence complained of preceded the sudden shocking event giving rise to the psychiatric

injury for which compensation is sought, and what constitutes the relevant event for the purposes of establishing proximity.

55. Alternatively I am satisfied that there is a compelling reason for the Court of Appeal to hear the appeal rather than a High Court Judge namely;
- i) the lack of clarity in the law at present; and/or
 - ii) the fact that in a similar case (*Paul*) permission has now been granted to the Defendant to appeal the judgment of Chamberlain J overturning on appeal my decision to strike out the action for want of the necessary proximity: the instant case is similar on its facts to the Paul case, with a similar gap in time between the negligent treatment and the collapse and death of Mr Paul, but with the added factor of symptoms having been suffered prior to the collapse and death which were absent in Paul, and whether actionable damage having occurred prior to the sudden death would preclude the Claimants from establishing proximity; and/or
 - iii) the fact that a number of secondary victim claims have been stayed pending the outcome of the appeal in *Paul* and the general importance of the Court of Appeal now considering the issue further to its decision in *Taylor v De Novo* and particularly against the background of torts of omission.
56. Accordingly I will grant permission to appeal and order the appeal to be transferred to the Court of Appeal.