Neutral Citation Number: [2021] EWHC 1576 (QB)

Case No: F90BS630

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
BRISTOL DISTRICT REGISTRY

Civil Justice Centre
Bristol BS1 6GR

Date: Wednesday 16 June 2021

Before :

PHILIP MOTT QC
Sitting as a Deputy High Court Judge

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Between :

JAMIE KING	**Claimant**
- and -	
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	**Defendant**

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- -

Ben Collins QC and Kara Loraine (instructed by **Augustines Injury Law**) for the **Claimant**
Jeremy Hyam QC and Gemma Witherington (instructed by **Bevan Brittan**) for the **Defendant**

Hearing dates: 24 - 27 May 2021

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Approved Judgment

Philip Mott QC :

Introduction

1. The Claimant is an actor. He is married to another actor, Tamara Podemski. They have a son, Oliver, who was born on 8 July 2014 in the Royal United Hospital, Bath ("RUH"). Their second son, Benjamin, was born there by emergency caesarean section on 5 May 2016. Tragically he died on 10 May 2016. On 4 July 2017 the Defendant admitted liability for his death "*in not providing care that would have led to the option of Benjamin being delivered before 5 May 2016*". It was accepted that "*had Benjamin been delivered before 5 May 2016, he would have avoided injury and survived*". As a result the full details of Benjamin's death have not been explored in evidence in this trial, but it is clear that his viability was severely compromised by meconium aspiration.

2. Claims on behalf of the estate, for bereavement, and for psychiatric injury to Tamara have all been dealt with. I was not provided with any details, but understand that Tamara's claim was made as a primary victim, since Benjamin was in law still a part of her when the negligence occurred.

3. By this action, the Claimant seeks damages for psychiatric injury, with consequential loss and damage. It is accepted that he does so as a secondary victim. As a result, it is common ground that in order to succeed he needs to satisfy the control mechanisms derived from *Alcock v South Yorkshire Police* [1992] 1 AC 310. These have been described as "*both arbitrary and pragmatic*" by the Court of Appeal in *Liverpool Women's NHS Foundation Trust v Ronayne* [2015] EWCA Civ 588, but they are binding and must be applied here.

4. Four control mechanisms are laid down, but it is common ground that all are satisfied save for the last. The four requirements, as summarised in *Ronayne*, are:

   i) The Claimant must have a close tie of love and affection with the person killed, injured or imperilled;

   ii) The Claimant must have been close to the incident in time and space;

   iii) The Claimant must have directly perceived the incident rather than, for example, hearing about it from a third person; and

   iv) The Claimant's illness must have been induced by a sudden shocking event.

5. Even if these control mechanisms are satisfied, recovery is limited to loss arising from frank psychiatric injury, as opposed to what Lord Oliver described in *Alcock* at page 410E as

> "grief, sorrow, deprivation and the necessity for caring for loved ones who have suffered injury or misfortune [which] must, I think, be considered as ordinary and inevitable incidents of life which, regardless of individual susceptibilities, must be sustained without compensation."

6. The fourth control mechanism, which is the only matter in dispute on liability, was defined or described in *Alcock* as follows:

i) By Lord Oliver at page 411F as "*sudden and unexpected shock*".

ii) By Lord Ackner at page 401F as "*the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind*". It does not include "*the accumulation over a period of time of more gradual assaults on the nervous system*".

7. These descriptions or definitions are not to be treated in the same way as statutory language (see *North Glamorgan NHS Trust v Walters* [2002] EWCA Civ 1792, per Clarke LJ at [48]). But the control mechanisms are now fixed and cannot be extended by analogy (see *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455, per Lord Steyn at page 500B and Lord Hoffman at pages 502D and 511B; and *Taylor v A Novo (UK) Limited* [2013] EWCA Civ 194, per Lord Dyson MR at [24] and [31]). None of this is contentious, and I do not need to extend this judgment by setting out the case law in great detail.

8. When it comes to the practical application of these principles to particular sets of facts, I have been referred to a number of previous cases to which I will return when I have considered the facts and evidence on liability in this case.

9. As now pleaded in the Amended Particulars of Claim, the Claimant founds his claim solely on what he saw and was told on his first visit to see Benjamin in the Neonatal Intensive Care Unit ("NICU") at the RUH on the morning of 5 May 2016. The stress of the next few days, which culminated in the Claimant and his wife having to make the terrible decision to move to palliative care, and therefore to allow Benjamin to die as he did on 10 May 2016, can form no part of this claim because of the requirement of a single shocking event in the control mechanisms.

10. It is agreed by the clinical psychologist instructed for the Claimant and the psychiatrist instructed for the Defendant that the Claimant suffered from post-traumatic stress disorder ("PTSD"), and that clinically the cause of this was the "*psychological impact of seeing his critically ill son on his first visit to NICU after his son's birth*".

11. I therefore turn first to the factual disputes surrounding the circumstances of that first visit.

The first visit to NICU – evidence

12. I heard evidence on this from the Claimant, and from Dr Edmonds and Dr Jones for the Defendant. Witness statements from Tamara Podemski and the Claimant's father add a little to the background. There are also extensive clinical records, some written retrospectively. It was agreed that these are admissible as evidence of the facts stated, but the weight to be attached to them may be less where the maker has not been called as a witness to be cross-examined.

13. The Claimant's evidence sets the scene. Their first child, Oliver, had spent two weeks in the NICU at RUH after his birth, which had been a frightening experience and gave the Claimant a heightened degree of anxiety in the run up to Benjamin's birth. His wife was two weeks overdue by the time of the birth. On 4 May 2016 they went to the Frome Birthing Centre, where the midwife noticed a deceleration in Benjamin's heartbeat. They decided to send Tamara to RUH by a blue light ambulance. As a result both

parents began to feel anxious. By the early evening it had been decided to put off the caesarean section until the next morning, and the Claimant and his wife went home to Frome. Early the next morning (she says about 5 am) Tamara woke and could not feel Benjamin moving. The Claimant drove her back to RUH. She felt something was terribly wrong and told him so. He says:

> "*My heart was racing and I was feeling very anxious. I knew something was wrong and we had to get to the hospital as soon as possible … I was very scared … As soon as we arrived, I shouted out in the reception area that this was an emergency and where was everybody, and a receptionist told me to calm down. I said that she didn't understand what was going on. Tamara was in pieces and I desperately wanted help to come. It was very intense … Tamara and I were both panicking.*"

14. At that stage, the Claimant says, events moved very quickly. Tamara was taken for surgery almost immediately. He was left outside the delivery suite, and paced up and down in the corridor, anxious and afraid, trying not to think of the worst. Eventually he says he stopped a random member of staff to ask what was going on, as a result of which a member of the team came out to tell him that Benjamin had been born and had been taken to NICU. He was relieved to hear this and asked to go there immediately. The nurse went with him and he went straight in. His statement continues:

> "*When I entered I saw that there were a lot of people around Benjamin's cot working on him and I kept telling myself he was alive and he would be okay. As I walked closer I saw that it was much worse than I thought. He was attached to machines and they were all bleeping loudly. There were a lot of different people working around the cot and there seemed like a lot of panic. I recognised Dr Steve Jones who had cared for Oliver and I said "He's alive?" but Dr Jones said, "Yes, he's alive, but he is very sick and we still might lose him". In that instant all my hopes were dashed and I shouted out "Don't say that, we don't know that yet". My knees were weak and I was fighting the energy in me. I felt like I wanted to punch him for taking away my hope. There was a lot of tension in the room. As I looked down at Benjamin, I felt sick to my stomach. I desperately wanted to hold him but I couldn't. He was all hooked up to machines, looking like a science experiment and I couldn't get close to him. At that point I remember my knees feeling weak."*

15. It was after this first sight of Benjamin, and the information from Dr Jones, according to the Claimant, that he first met Dr Edmonds. She asked him to sit down and gave him a glass of water. She said to Dr Jones "He's ok but I think what you just said really shocked him". She then took him to a waiting room back on the Central Delivery Suite ("CDS") near the operating theatre where Tamara underwent the caesarean section. Dr Kirk (who performed the operation) was there, in tears. Ms Qureshi, the obstetric consultant, also came in. The Claimant's recollection of the conversation there, as recorded in his statement, is as follows:

> "*They explained that Benjamin had been born with thick meconium in his lungs and that he had been without oxygen for a long time. They said there was a chance that he might have brain damage and that he would need specialist treatment.*"

16. Thereafter the Claimant spoke to Tamara, and they both saw various doctors at different times during the morning with updates on Benjamin's condition and the proposals for his transfer to the specialist children's hospital, St Michael's in Bristol. Both he and Tamara visited Benjamin in NICU before he left for Bristol. The Claimant's statement continues to describe the tragic and harrowing events of the next few days as the prognosis for Benjamin became more and more gloomy, he started to have fits, and eventually both parents agreed that he must be allowed to die quietly. They were given a room and had Benjamin with them after the machines were disconnected. Although he appeared to rally briefly, he died that night. Not surprisingly, the Claimant says "*I felt my world cracking apart … The whole experience was deeply traumatising*".

17. Dr Clare Edmonds was the consultant paediatrician on duty overnight until 08:30. She was called to the CDS at 06:59 and arrived at 07:03. She saw the Claimant in the corridor with a member of staff, looking very distressed. She did not stop to speak to him then. Benjamin had been delivered at 06:55, and was 8 minutes and 20 seconds old when she arrived. She was involved in directing the resuscitation process before Benjamin was taken to NICU. This involved wheeling him in a resuscitaire a short distance from the CDS. She does not think that they passed the Claimant on the way, and he does not now suggest that they did. Her statement continues with three important paragraphs:

> "*7. After ensuring that the baby was safely transferred to NICU I went back to the delivery suite, at around 07:30, and went to speak with Mr King in the coffee room there, which is a room we use to hold discussions with parents. I cannot recall exactly who else was involved with this discussion but Obstetric Consultant Miss Qureshi and Lisa Kirk, the Obstetric Specialist Registrar who had carried out the caesarean section were also present. We held a sensitive conversation with Mr King, saying first that we were very sorry that his son had been born in need of resuscitation and sympathising that it must have been an awful experience for him and his wife to go through. I explained to Mr King that his son had been short of oxygen for a prolonged period and had needed a very long period of resuscitation including cardiac massage for a significant amount of time. Following his birth, despite having an ETT [endo-tracheal tube] and being given oxygen it was hard for us to get oxygen into Benjamin's body because of the thick meconium in his lungs. I told Mr King that Benjamin had needed adrenaline to help his heart rate recover. I explained sensitively that Benjamin may have suffered an injury to his brain and that he would need specialist treatment by way of cooling in St Michael's Hospital in Bristol. I was honest with Mr King, explaining that the meconium in Benjamin's lungs was worrying and he would need to remain on ventilator support. I offered our sincere apologies*

for what had happened and said that a full investigation would be undertaken to look at everything that could have been done differently and that he and his wife would be fully updated as this progressed. At this point I did not know that there had been any shortcomings in the obstetric care provided. At this time Benjamin's mother was still in the recovery unit being monitored after her caesarean section.

8. I explained to Mr King that Benjamin was being looked after in the neonatal intensive care unit (NICU). I carefully prepared Mr King for what he would see when he came to see him. I said that his son would be surrounded by machines and I explained each machine one by one, the breathing machine (the ventilator), machines which measure the heart rate and blood pressure and I also explained that his son would have tubes in his nose, mouth and coming out of veins including the belly button. I explained there would also be probes attached to the baby's head to link up to CFM monitoring brain activity and that it was quite normal for babies in the intensive care department at Bath to be considered for transfer to Bristol Hospital, which was our cooling centre, for further care. I would have provided this explanation in a calm manner. I recall that Mr King asked appropriate questions and appeared to deal with the situation very well. After the discussion Mr King was taken to the neonatal intensive care unit to visit his son. I cannot recall whether I went straight to NICU with Mr King after our discussion or whether I went back to NICU to check that everything was ready before arranging for a member of staff to go back to collect Mr King. Mr King would have been accompanied on his initial visit to the NICU.

9. When Mr King first saw Benjamin in NICU he would not have seen any particularly distressing activity. Benjamin was still and calm, he was sedated and not in any pain. Benjamin was in an incubator in a reasonably large room around 12 metres long with 12 cots in it. I recall Benjamin was at the end of the room by the double doors. Benjamin's heart rate and cerebral function were being monitored and I remember Mr King was particularly interested in CFM (cerebral function monitoring) and asked hopefully whether there were any signs of activity, asking for positive confirmation of his baby's health. Mr King would not have observed any fitting, seizures or bleeding. Benjamin was a beautiful baby, he was not bruised from the delivery and he was in an incubator with a nurse by his cot side. The initial visit would have taken place for around 20 minutes."

18. Dr Edmonds goes on to say that Dr Cara Cochrane, a very experienced neonatal registrar, went to speak to Mr King with Dr Jones at about 09:45 to update him and explain what was happening. Later that day, at around lunchtime, Dr Edmonds had a

further discussion with Mr King and his wife in NICU. Quite understandably, they were stunned by the situation and asked repeatedly for reassurance.

19. Dr Stephen Jones was the consultant paediatrician on duty from 08:30 on 5 May 2016. He arrived early, in accordance with his normal practice, and went to his office next to the NICU. Around 08:00 he was asked by Dr Cochrane to assist as Dr Edmonds was speaking to Mr King in the delivery suite. The records show that he prescribed Pancuronium, a muscle relaxant, which was given at 08:05. The Claimant was not present when this was going on. At some point he came to see his son. Dr Jones recalls that he was accompanied by Dr Edmonds and, he thinks, a midwife. No one can enter NICU without being accompanied by a member of the nursing or clinical staff with an access card.

20. Dr Jones says that he updated Mr King with Dr Cochrane, as set out in her notes. This update is not timed, but must be before 09:10 when the notes were written. Dr Jones's statement describes his recollection as follows:

> "*7. … At this point we were getting oxygen into Benjamin's body and his heart rate and blood pressure were acceptable. Benjamin would have looked pale pink, as we were beginning the cooling process, and he would have been still and looked peaceful not least as his muscles were paralysed and he was ventilated. It is my experience that parents can find the sight of their baby, in this situation, looking as if they are sleeping, reassuring, potentially better than they had imagined after the clinical situation is explained to them, though it is obviously upsetting to see their baby attached to the various monitors we use. There would have been no blood, fitting or any other such distressing signs. Although we were aware that Benjamin was in a critical condition there would have been no sense of panic. All staff are trained to care for babies in Benjamin's condition and there would have been an atmosphere of calm concentration from staff attending him.*
>
> *8. Dr Cochrane and I held a conversation with Mr King at the cot side. It is my practice to sit parents down on the raised bar chairs we have so that they can be on a level with their baby next to the cot. Building on what I expected Dr Edmonds to have said to Mr King before he came on the NICU, I explained that we were very concerned about Benjamin. He had suffered oxygen deprivation but we had been able to restart his heart. He had thick meconium in his lungs but we were managing to ventilate him. The CFM showed a depression of brain activity but at this point the extent of any damage was unclear, cooling treatment is the key treatment to try and reduce damage. I explained that Benjamin would need to go to Bristol for ongoing cooling and ongoing care. I note from the Particulars of Claim that Mr King said that he asked me whether Benjamin was still alive and I said that he was alive but very ill and that he may still die. I have always considered that it is best to be honest when discussing a baby's condition with parents, although inevitably the*

> *information we have to give may be very distressing. I believe it is likely that I would have used words such as "he was critically ill and we could lose him" to explain how ill Benjamin was and that he might die, although I would temper this with telling Mr King that we would have to see how he responded to the treatment that we were able to provide and that I had seen babies just as ill as Benjamin make a good recovery. Benjamin was in a critical condition but we were doing all we could to maximise his chances of recovery and I had seen babies in a similar condition make a good recovery. After this discussion, which probably took around 10 minutes, it is likely that we guided Mr King to one of the quiet rooms on our unit to give him some time and space to take the information in. He would have been accompanied there and made comfortable by one of the doctors or nursing staff.*"

21. The hospital notes disclose the following relevant entries for 5 May 2016:

    i) The Theatre Notes [B696] show that the caesarean section started at 06:52 and ended at 07:25. Dr Kirk is shown as "Time In 06:50". Ms Qureshi is shown as "Time In 07:17". Both are shown as "Time Out 07:51", which is also recorded as "Time Patient Left Theatre".

    ii) Dr Kirk wrote a retrospective note at 08:30 [B672-3]. This records: "*After theatre, met with Jamie (baby's Dad). Long discussion – Mrs Qureshi + Dr Edwards also in attendance*".

    iii) Ms Qureshi's retrospective note is in letter format [B680-1], apparently written at 13:00 on 5 May 2016, after Benjamin had been transferred to Bristol. She says that when she arrived the baby had been delivered by Dr Kirk, and Dr Edmonds with her team were resuscitating him. Dr Kirk was physically distressed at that moment. She continues: "*We safely concluded the caesarean section and did our team brief and then came out to speak to Jamie, who is Benjamin's dad, along with Dr Kirk and then Dr Edmonds joined us as well*". She says that about two hours later she saw the Claimant again, "*with a NICU update that baby's gases had deteriorated*".

    iv) Dr Edmonds made a retrospective note at 09:30 [B748-752]. The relevant parts of that note are essentially reproduced in paragraph 7 of her witness statement, set out above. It does not include any of the detail about the machines and their purpose which appears in paragraph 8. Much was made of this in cross-examination.

    v) Dr Cochrane's retrospective note is timed at 09:10 [B744-7]. She records that Benjamin was "*Brought to NICU at ≈30 minutes of age* [i.e. around 07:25] *Dr Edmonds D/W* [discussing with] *father*". A little later (though untimed in the note) she says she "*Asked Dr Jones to attend (Dr Edmonds c* [Latin 'cum' = with] *father)*". CFM was set up. During this time the baby extubated at about 08:00. Pancuronium was given by Dr Jones, and she intubated Benjamin again. Right at the end of her note, untimed but presumably before 09:10, she records "*Dad updated by myself and Dr Jones – v. concerned about Benjamin …*".

The parties' submissions

22. Mr Collins, for the Claimant, points out that the discussion cannot have been as early as 07:30, as Dr Edmonds suggests, because Dr Kirk and Ms Qureshi were in theatre until 07:51. Therefore the credibility of Dr Edmonds' evidence that the discussion was before the Claimant's first visit to NICU is undermined. He points to Dr Edmonds' inability to recall whether she accompanied the Claimant to NICU, or whether she was present in NICU when Dr Jones told the Claimant "we might lose him". He submits that the only explanation for the Claimant's question to Dr Jones, "He's alive?", is that there had been no prior discussion, especially as Dr Edmonds said that she was unaware of any substantial or immediate risk of death at that stage. And he relies on Dr Jones' recollection that Dr Edmonds took the Claimant away after he said "we might lose him".

23. As to the content of the discussion, whenever it took place, he points to the absence of any mention in Dr Edmonds' retrospective note of any machines or their function, as described in paragraph 8 of her witness statement. And crucially, he submits, the Defendant has chosen not to call Dr Kirk or Ms Qureshi as witnesses.

24. Mr Collins further suggests that the Claimant's first visit to NICU may have coincided with the attempts to re-intubate Benjamin, which would have been particularly distressing.

25. Mr Hyam, for the Defendant, invites me to rely more on the contemporaneous records than the Claimant's recollection. The procedure on NICU was that prior approval from the nurse in charge of the unit was required for a parental visit, and a check would be made of the nurse in charge of the baby to ensure that the timing was appropriate. He submits that the involvement of Dr Jones at around 08:00 is explicable only because Dr Edmonds was not available, and the only other place she could have been was with the Claimant.

26. As to what the Claimant saw and was told on his visit to NICU, Mr Hyam accepts that it would have been undoubtedly distressing, but submits that it does not meet the high threshold of the legal test of a shocking event.

My Findings of Fact

27. I find as a fact that there was a discussion with the Claimant involving Dr Edmonds, Dr Kirk and Ms Qureshi before the Claimant first visited his son in NICU. To some extent this is because I find Dr Edmonds to be a more reliable witness in this respect than the Claimant. That may be hardly surprising in view of the fact that he was in a high state of anxiety throughout, as he describes himself. There are also two possible inconsistencies in his evidence, which I should deal with specifically.

    i) His account to his clinical psychologist, Ms MacArthur-Kline, in March 2018 was understood by her to be that he saw his wife being brought out of the operating theatre without the baby, and felt panic-stricken, shocked and angry. He went immediately to NICU and saw Benjamin there. That account was used for the Particulars of Claim, and in fact remained in the Amended Particulars of Claim although at variance with the Claimant's witness statement which had by then been disclosed. He explained that this was a mistake by Ms MacArthur-

Kline which he failed to notice. He must also have failed to notice it in the much shorter Particulars of Claim which he saw, and authorised the statement of truth to be signed on his behalf, prior to service on 11 April 2019. Ms MacArthur-Kline was not required as a witness because the joint statement showed agreement about psychiatric matters. I therefore note this discrepancy, but do not rely on it in my assessment of the reliability of the Claimant's evidence.

ii) More important as a guide to reliability is that the Claimant described in evidence seeing not only beeping machines, but also Benjamin with bubble wrap around him on his first visit to NICU. Dr Edmonds told me, without any challenge on behalf of the Claimant, that bubble wrap would not have been used in the NICU at Bath, but only in Bristol, because they only used passive cooling in Bath, not the active cooling used in Bristol.

28. There are a number of other reasons why I prefer the evidence of Dr Edmonds on this issue.

i) The placing of the discussion in the sequence of events before the Claimant's first visit to NICU is consistent with all the hospital records. I take into account that a number of the record-makers have not been called to give evidence, and that the detailed descriptions of the discussion were written retrospectively, but no suggestion was put to Dr Edmonds that her long note contained a deliberate error in this respect.

ii) The timing must have been a bit later than the 07:30 contained in Dr Edmonds' note, perhaps as late as 07:51 when Tamara left theatre and Dr Kirk and Ms Qureshi are also recorded as leaving. A discussion at about this time is consistent with Dr Edmonds being unavailable at about 08:00 when Dr Jones was asked to help although he was not yet formally on duty.

iii) It is agreed that this first discussion took place in the CDS, attended by Dr Kirk and Ms Qureshi, who were obstetric staff, not involved with NICU. It is understandable that obstetric staff should be involved again in later discussions, when Tamara was able to take part and needed to know what had happened while she was under general anaesthetic. But there is no logical reason why the Claimant should have been taken back from NICU to the CDS shortly after 08:00 to have a discussion involving two obstetricians immediately after his first visit to NICU as he alleges. There were quiet rooms available in NICU which would have been much more convenient if the sequence of events had been as the Claimant now remembers them.

iv) The Claimant recalls that Dr Kirk was in tears at that meeting. Ms Qureshi's note says that Dr Kirk was physically distressed after the caesarean section, when Dr Edmonds and her team were resuscitating Benjamin. It is unlikely that these two events were much separated in time. Much more likely is that the discussion took place soon after Benjamin was taken to NICU at about 07:30, and before the Claimant first went there.

v) The record of the discussion, both in the Claimant's statement and in that of Dr Edmonds, as well as in the hospital records, suggests that it raised only the possibility that Benjamin may have suffered brain damage as a result of lack of

oxygen. That was the extent of Dr Edmonds' knowledge prior to the Claimant's first visit to NICU. She told me, and I accept, that at that time she had no knowledge of CFM readings or more up-to-date blood gas analysis. That explanation would make no sense if she had just heard Dr Jones say that Benjamin was so ill that he might die. Dr Edmonds struck me as a careful and sensitive communicator, and I note from her CV that she is the joint author of a paper entitled "How to Break Bad News", published in 2007. I do not accept that she would have avoided dealing with the substantial risk of death if she had been aware of the deterioration in the blood gases at the time of her discussion with the Claimant. The fact that she clearly did not do so strongly suggests that the discussion took place before the Claimant first spoke to Dr Jones.

vi) A discussion before the Claimant's first visit to NICU is also consistent with his recollection that Dr Jones was in NICU when he first visited. Dr Jones was not called there until about 08:00, yet Benjamin had been moved to NICU by 07:30 and Tamara had left the CDS at 07:51. A discussion starting around this time would fill the gap between this and the Claimant's first visit to NICU.

29. What was said in that discussion? Whilst the detailed description of the various machines and their functions, as set out in Dr Edmonds' witness statement at paragraph 8, does not appear in her retrospective note, I accept that she did give this explanation. The Claimant was asked about it in his evidence, and said that he had no complaint about what he was told, or the way he was told it, only that it came after the shock of going to NICU and seeing Benjamin. As he put it "*there may have been perhaps an explanation as to what I had just seen*". The absence of full details in the notes is not surprising in my judgment. I accept that he was fully prepared for all the interventions and machinery he would see, and that this came before his visit to NICU.

30. What did he see on that first visit to NICU? I accept the descriptions in Dr Edmonds' and Dr Jones' statements. Benjamin was like a sleeping new-born baby except for the many tubes and wires. The Claimant did not suggest in his evidence that Benjamin was showing any signs of distress. Indeed, the fact that Benjamin was apparently so peaceful may explain the Claimant's question to Dr Jones asking for confirmation that he was alive. In addition, I find that there was no panic. Even the Claimant changed this in his evidence to "a sense of urgency", with a complaint that it was "difficult to see past the throng". In a neonatal intensive care unit, the presence of a high number of staff and intense concentration on the babies under their care, which the Claimant may have interpreted as a sense of urgency, is hardly surprising and would to some parents be comforting.

31. It follows that I reject Mr Collins' suggestion that the Claimant may inadvertently observed the NICU team attempting to intubate Benjamin again around 08:00. Dr Edmonds told me, elaborating on what was in Dr Jones' statement, that the decision to admit a parent to NICU is made by the nurse in charge of the unit, in consultation with the nurse caring for the baby. It would be unheard of for anyone to bring in a parent without checking first. I am satisfied that the Claimant would not have been allowed into NICU at this time, or before Benjamin had been settled. His first visit was some time after 08:05, when the Pancuronium muscle relaxant was given and Benjamin had been re-intubated. It was also after he had received a full explanation of what he was likely to see.

32. Later in the day there were further explanations, as more information became available. Dr Jones and Dr Cochrane provided an update after the Claimant had visited NICU, probably around 09:00. Later discussions and visits involved both the Claimant and Tamara, when she had recovered from her anaesthetic.

33. It must have been an exhausting and harrowing morning for the Claimant. I do not find it at all surprising that his recollection of the various discussions, and his visits to see Benjamin, has become a little confused.

Does this satisfy the legal test?

34. I return to the legal test to be applied to these factual findings. For the Claimant to recover as a secondary victim, he must have suffered a "*sudden and unexpected shock*" which amounted to "*a horrifying event, which violently agitates the mind*".

35. The most recent Court of Appeal authority is *Ronayne*. Tomlinson LJ (with whom Sullivan and Beatson LJJ agreed) at [13] expressly agreed with the observations of Mrs Justice Swift in *Shorter v Surrey and Sussex Healthcare NHS Trust* [2015] EWHC 614 (QB) that "*the "event" must be one which would be recognised as "horrifying" by a person of ordinary susceptibility*". He also at [14] cited with apparent approval the comment of His Honour Judge Hawkesworth QC in *Ward v The Leeds Teaching Hospital NHS Trust* [2004] EWHC 2106 (QB) that:

> "*An event outside the range of human experience, sadly, does not it seems to me encompass the death of a loved one in hospital unless also accompanied by circumstances which were wholly exceptional in some way so as to shock or horrify.*"

Tomlinson LJ added, at [17]:

> "*A visitor to a hospital is necessarily to a certain degree conditioned as to what to expect, and in the ordinary way it is also likely that due warning will be given by medical staff of an impending encounter likely to prove more than ordinarily distressing.*"

36. *Ronayne* was a case in which the condition of the Claimant's wife deteriorated sharply after a routine hysterectomy because of a suture misplaced in her colon, leading to septicaemia and peritonitis. When the Claimant first saw her, on the evening after her re-admission to hospital as an emergency case, she was connected to various machines, including drips, monitors, etc. Tomlinson LJ said of this sight, at [41]:

> "*The reaction of most people of ordinary robustness to that sight, given the circumstances in which she had been taken into the A&E Department, and the knowledge that abnormalities had been found, including a shadow over the lung, necessitating immediate exploratory surgery, would surely be one of relief that the matter was in the hands of the medical professionals, with perhaps a grateful nod to the ready availability of modern medical equipment.*"

37. I was referred to a large number of other cases, which it is accepted are simply illustrations of the application of the control test to other facts. Of these, I will refer only to four relatively recent decisions of High Court judges with substantial experience in this field, *Wells & Smith v University Hospital Southampton NHS Foundation Trust* [2015] EWHC 2376 (QB), *Owers v Medway NHS Foundation Trust* [2015] EWHC 2363 (QB), *RE & Ors v Calderdale & Huddersfield NHS Foundation Trust* [2017] EWHC 824 (QB), and *YAH v Medway NHS Foundation Trust* [2018] EWHC 2964 (QB). I have considered the other decisions cited, but generally find them to be of lesser assistance.

38. What is clear from the authorities is that "shock" in the *Alcock* sense requires something more than what might be described as "shocking" or "horrifying" in ordinary speech. It may be for that reason that the word "exceptional" has crept in, not as an addition to the test, but as an explanation that the shocking event must be outside ordinary human experience in the context in which it occurs.

39. In ordinary language, what happened to the Claimant was "horrifying". He had been waiting for the birth of his second child, what should have been a joyous event, and instead he was told that Benjamin was seriously unwell and might die. That would be a nightmare for any parent. But from time to time such things happen, with or without clinical negligence, and hospital staff have to prepare the parents and allow them to see their damaged child. Fortunately it is a rare occurrence. Dr Jones told me that at RUH they have about 5,000 babies born each year, and only 0.5 to 1 in 1,000 is encephalopathic.

40. The sight of Benjamin in NICU on his first visit must have brought home to the Claimant vividly the seriousness of his condition as explained previously by Dr Edmonds. I have no doubt that the Claimant is a person especially affected by visual triggers, and with a capacity to imagine and empathise with suffering which is invaluable to him as an actor. The agreed psychiatric evidence is that this sight did cause him PTSD. But in my judgment it was not an objectively shocking and horrifying event in the *Alcock* sense.

41. I have considered whether the additional words of Dr Jones take the case over the threshold. Certainly they added significantly to the level of risk to which the Claimant was alerted. Had Dr Jones realised that Dr Edmonds was not aware of the latest blood gas readings, and therefore did not fully realise the risk to life, he may have been more cautious about expressing himself as he did. But the Claimant had the right to know the truth, and Dr Jones tempered his warning with the information that other babies in Benjamin's condition had made a good recovery. In my judgment this does not take the case over the threshold. Even taking what the Claimant saw and what he was told together, this was not an objectively shocking and horrifying event in the *Alcock* sense.

42. As a result the claim must fail on liability. In case I am wrong on that, I go on to consider quantum.

The Actionable Injury

43. The psychiatric evidence is summarised in the joint statement dated 29 June 2020 from the Claimant's clinical psychologist, Ms Angelica MacArthur-Kline, and the Defendant's psychiatrist, Dr Martin Baggaley. They agree on a diagnosis of a

combination of PTSD and Pathological Grief (either a prolonged grief disorder in ICD 11 or a persistent complex bereavement disorder in DSM 5). They agree that the PTSD was caused by the Claimant witnessing his son critically ill in NICU on his first visit there, and the belief that he was going to die. They also agree that the Pathological Grief was caused by the circumstances of Benjamin's death and the knowledge that the death was avoidable.

44. The experts further agree that these conditions (plural, so apparently taken together) were of moderate severity in relation to the Judicial College Guidelines. Clinically they were "*severe for 12 months after Benjamin's death but have gradually improved with time and treatment and would now* [June 2020] *be mild/on the borderline of clinical significance*". In relation to the Claimant's ability to work, the joint statement records the following agreement:

> "*… he was too unwell to work as an actor by virtue of his psychiatric injury for 12 months. He was then fit to audition and find work as an actor. He experienced some difficulties with particular roles which triggered reminders of his son (for example exposure to blood in a vampire film/playing the role of a negligent surgeon) whilst his symptoms were moderate. However with time and treatment we agree he is now fit for almost all roles although he might struggle with roles in which the plot involved the death of children.*"

45. It is agreed by the parties that the PTSD may give rise to a secondary victim claim, but not the Pathological Grief. However, the two experts did not give evidence, and their joint statement does not divide up the consequences of each part of the diagnosis. Mr Collins' submission is that the court therefore cannot distinguish between them, and should treat all the psychiatric consequences as arising, at least in part, from the PTSD.

46. Mr Hyam relies on the underlying reports of the Claimant's own expert, Ms MacArthur-Kline. Her first report, dated 27 April 2018, concludes that the remaining unresolved psychological presentation as at that date is consistent with a diagnosis of Persistent Complex Bereavement Disorder [A127]. In more detail, she states that "*the duration of his most intrusive and full post traumatic distress lasted for approximately 12 months*" [A140, §11]. His PTSD started to recover after the second inquest [the adjourned hearing in February 2017] and improved again after he started auditioning and working again [she says this was in February 2017, but the first audition of which clear evidence was given at the trial, and in which the Claimant was successful in obtaining a part, was on 2 June 2017]. However "*his continuing psychological reactions, which no longer qualify for full PTSD, remain uncomfortable*" [A141, §14]. A reassessment report dated 20 November 2019 concludes that the Claimant's psychological symptoms no longer conform to a persistent complex bereavement disorder, and that "*he continues to suffer from mild anxious and depressive adjustment issues in the face of an as yet unresolved litigation process*" [A165, §9].

47. My task is not made easy by this limited evidence. In legal theory the Claimant is entitled to be put in the position he would have been in if the actionable damage had not been caused. That involves a comparison between his actual history and the hypothetical position he would have been in if he had not suffered PTSD but Benjamin

had still died, with all the effects on both the Claimant and his wife arising from that tragedy.

48. That comparison is not a simple one on the evidence available to me. My approach is this. Where I can properly draw a distinction between the effect of the Claimant's first visit to NICU and the effect on him and his wife of Benjamin's death, I should do so. Where the evidence does not support such a distinction, I should not speculate, but should assume that it all arises at least in part from the PTSD.

49. So far as damages for pain and suffering and loss of amenity are concerned, the problem is minor. Mr Collins puts forward a figure of £20,000. Mr Hyam suggests £15,000. It is agreed that the Judicial College Guidelines give a bracket of £7,680 to £21,730 with the 10% *Heil v Rankin* uplift. If such damages were appropriate in this case, I would value them at £17,500.

Loss of Earnings

50. The claim for loss of earnings gives rise to the major area of disagreement. Very different approaches are adopted by the two sides. The Claimant's schedule asserts that he was on the verge of a big break, so can claim lost earnings at a rate substantially higher than his earnings in the years prior to May 2016. Varying calculations are put forward, dependent on the extent of his notional increased earnings and the period of loss. The Claimant's primary case values past losses at £1,143,503 and future losses at £8,524,802, a total approaching £10 million.

51. The Defendant's counter-schedule is based on a loss of earnings only to the end of 2019, and only at the level of his average earnings in the three years before May 2016. That produces a sum of £19,760. In closing submissions, Mr Hyam amended this to the average earnings in the six years prior to May 2016, producing a sum of £34,771. The Defendant does not accept any continuing loss, nor any loss of a chance of a big break.

52. I heard evidence from the Claimant and his current manager in Los Angeles, Pearl Hanan, together with statements from the Claimant's father, Christopher King, a former film/television director and writer, and the well-known film director Mike Leigh. Expert evidence on employment prospects was given by Kathryn Arnold, for the Claimant, and Keith Carter for the Defendant. Various calculations can be found in expert accountancy reports from Vitek Frenkel for the Claimant and Ralph Chatfield for the Defendant.

Before May 2016

53. The Claimant was born on 9 July 1981, and is now approaching the age of 40. He started acting while still at school. His father says he was outstanding in a play there. He went to LAMDA on a partial scholarship for three years. Whilst there he was spotted by a top UK agent Claire Maroussas, of the Independent Talent Group, and signed up to her agency. Early on he worked for the National Theatre, playing the role of Dakin in "The History Boys". A summary of his acting history from age 20 is set out in Mr Carter's report at paragraph 8 [A450]. Highlights were a substantial part in a TV series "The Tudors", playing Thomas Wyatt; the small part of Kaspar in the acclaimed "Tinker Tailor Soldier Spy"; a substantial part playing the Scottish painter David Roberts in "Mr Turner", directed by Mike Leigh; and the part of Thomas Wintour in "Gunpowder

5/11", a TV movie/documentary. In addition there were parts in commercial TV series such as "CSI:Miami", "Mad Men" and "Air Force One is Down".

54. Mike Leigh's statement provides important but very general evidence about the Claimant's talents. He describes the Claimant as "*a talented actor who I would have expected to have a successful career ahead of him*".

55. The Claimant's son Oliver was born in July 2014. For a while around that time he was not working so much, as he wanted to be available for the birth of his first child. Thereafter both he and his wife took time off to find their way as new parents. Tamara suffered from post-natal depression and needed to be with her family in Toronto. Following this Tamara was offered a job in Toronto and the Claimant went with her to help look after Oliver. The Claimant then worked for the first half of 2015 at Stratford-on-Avon with the Royal Shakespeare Company, playing Fernando in "Love's Sacrifice", a 17th century play by John Ford (perhaps better known for his work "Tis Pity She's a Whore"). That run finished in July 2015.

56. On 22 February 2016 the Claimant was asked to a meeting with the well-known film director, Christopher Nolan, who was preparing to start work on the epic film "Dunkirk". The casting director was Toby Whale, whom the Claimant had worked with on "The History Boys". The Claimant auditioned that day, not for a particular part but generally. He thought it went very well. In April 2016 his agent, Claire Maroussas, contacted him to say that she had been told they had him in mind for a role which would be shooting in the summer. She told him he had "nailed it". Ms Maroussas was not called as a witness, but I accept this account from the Claimant. Filming on "Dunkirk" apparently started on 23 May 2016 and went on for many months. Nothing further was heard about a part for the Claimant before Benjamin was born, and after his death the Claimant pulled out of contention. I shall need to consider this further when looking at the loss of a chance that this is said to represent.

57. Prior to Benjamin's birth, the Claimant and Tamara had planned to move to Los Angeles for work reasons. They had arranged to sell their house in England and for the contents to be shipped out to Los Angeles. They had flights booked to Toronto in June 2016, following which the Claimant would go down to Los Angeles to find suitable accommodation to rent. After the summer Tamara, Oliver and the new baby would join him there. All this changed after Benjamin died.

After May 2016

58. The Claimant's first statement set out four issues which had affected his career prospects, as follows:

    i) *The fact that I could not take part in "Dunkirk" which meant that I did not have a high profile recent film on my CV;*

    ii) *The fact that I could not move to LA, as planned, to be in the middle of the industry to be available for auditions;*

    iii) *Finally* [sic]*, the fact that I cannot anyway audition for some roles because the subject matter is too difficult for me to contemplate at the moment, bearing in mind my psychological state.*

iv) *I have found it difficult to be away from my family which means I'm not available for most work.*

59. One of the important events in Los Angeles each year is what is known as the pilot season. This occurs substantially in the first half of the year, and is when all the regular TV series are cast. In order to get parts it is necessary to be living in Los Angeles, and to be there throughout the pilot season. The Claimant missed the 2017 pilot season because of his PTSD, and cut short his attendance at the 2018 pilot season. By the beginning of 2019, he says, he could not afford to be in Los Angeles for a prolonged period, and therefore did not attend the pilot season.

60. What the Claimant has actually done since the birth of Benjamin, and the onset of his PTSD, can now be fairly accurately reconstructed. At a late stage in the preparation for trial a large number of emails were disclosed in relation to auditions. These have been usefully scheduled by Mr Hyam and Ms Witherington, and annotated by Mr Collins and Ms Loraine. The Claimant's first part was offered to him without audition on 2 June 2017, a guest part as Dr Bertram Lennox in the TV series Murdoch Mysteries. He says that he was heavily triggered by the blood and death in one scene, but completed the role. Thereafter he attended 13 auditions in person from 8 August 2017 to the end of 2019 in Los Angeles and Toronto (7 in Los Angeles, 6 in Toronto), and obtained two parts. In the same period he also submitted 18 self-tape auditions, obtaining two parts, and passed on five auditions because the subject matter was too painful. The year 2020 brought the Covid-19 pandemic, which heavily affected the acting profession.

61. The importance of not being resident in Los Angeles is shown by parts of the Claimant's second statement, dated 30 April 2021. He says that in January 2018 "*it was becoming apparent that me not being based in Los Angeles was making things difficult*" [A68c §13]. This is after his PTSD had receded sufficiently for him to be fit to audition for most parts. Later still, in July 2018, the casting department for a big movie entitled "Le Mans" put a 'hold' on him, but pulled the offer when they found out that he was not a local in Los Angeles [A68c §17]. Then in October 2019 he was offered a role in "Orville" which he declined as he could not afford to travel and stay in Los Angeles when his family were still based in Toronto [A68d §26]. The importance of an actor being local to Los Angeles to get parts was confirmed in her evidence by Pearl Hanan.

62. In cross-examination, the Claimant highlighted the loss of Ms Maroussas and living in Canada as the key factors putting him in a completely different position from where he was before Benjamin was born. The fact that he was living in Canada meant that he was not available in Los Angeles.

63. It is clear that some hindrances to the Claimant re-establishing his career arose from Benjamin's death, and its effect on the whole family, not from the Claimant's PTSD. These must be discounted when assessing his loss of earnings and prospects of earnings.

i) Whenever Oliver is ill, the Claimant feels a fear for him as a result of losing Benjamin [A57 §28]. An illustration of this effect is that he left Los Angeles and the pilot season early in February 2018 because Oliver was ill in Toronto [A68c §14].

ii) The Claimant's own evidence is that he and Tamara needed to take time as a family to work through the experience of the death of Benjamin. He felt drained

of energy (and was then suffering from PTSD which meant that he could not work). Tamara was very volatile. They were fighting a lot [A59 §34].

iii) The Claimant says that both Tamara and he needed to be in Toronto together while they grieved and to support each other [A64 §44]. Of course this relates specifically to the period of the Claimant's PTSD, but it is clear from his evidence as a whole that the need to keep the family together has extended beyond that, prompted by the grief reactions they both suffered. The Claimant said in his first statement of December 2019 that he had not worked since October 2018, and Benjamin's death had a profound effect [A65-6 §52]. His second statement says, in relation to a six week period in Los Angeles in August 2017, that "*Being away from home was also far more difficult than I had expected*" [A68b §9]. He confirmed in cross-examination that they could not function as a family in Los Angeles, that Tamara needed the emotional support of her family in Toronto, that they needed the healthcare provision in Canada, and therefore he could not support his family and work at the same time.

iv) Tamara very sadly had an early miscarriage in May 2018 [A68 §60; A68c §16].

64. On 3 May 2017 Claire Maroussas sent the Claimant an email ending her connection as his agent. This was clearly a severe blow, because of the quality of the actors she represents and the high regard in which she is held in the industry. The Claimant believes that she decided to end that connection because he had become difficult to work with, and that this was because of his PTSD. However, this is not the reason she gave in her email, which reads as follows [D1746]:

> "*Dearest Jamie,*
>
> *I had a nice chat with Paul* [Hemrend of SMS in Los Angeles] *last night. It helped to consolidate my feelings that perhaps you and I should part ways. I can tell that you are in safe hands with him, so I feel that now is a good time for me to step back. I am hugely fond of you Jamie, and it feels like the most supportive thing I can do at this stage. I know that you are concerned about commission, and if I remove myself from the team, then it solves the problem for you.*
>
> *As you know, I have worked tirelessly for you for the best part of twenty years. During that time, there have been long periods when that work was fruitless, because of the pressures of your locations. I sense that we might be entering another such extended period. Paul was clear that he will cover LA until such time as you find an American rep, and meanwhile you will be working in Canada. I can tell that you trust him and have obviously known him for a long time through Tamara. Realistically, I don't see you being able to engage in European projects for the foreseeable future.*
>
> *I'm sure our paths will cross again in the future, and I look forward to hearing all about your adventures in Toronto and beyond. Please give my love to Oliver and Tamara.*

Much love,

Claire x"

65. Ms Maroussas was initially a witness in the case, but apparently declined to give evidence at the trial. Mr Hyam invited me to draw adverse inferences from her absence, but I cannot see that this is justified. All that her absence means is that there is nothing to put a gloss on her reasons as set out in her email at the time. I therefore reject the Claimant's interpretation of the reason for her ceasing to be his agent. It is another result of the family decision to stay in Toronto, which itself was prompted by the grief reactions of both the Claimant and Tamara, her need to be near her parents and family, and the desire to have Canadian healthcare cover. It therefore was not caused by the Claimant's absence from work as a result of his PTSD.

66. The Claimant's own assessment of his future prospects in his first statement was that he would have expected his earnings to increase to about £65,000 (this is a gross figure, I think) [A67 §57]. There would then have been a year on year increase as he cemented his position in Los Angeles and obtained more roles. The Claimant's first Schedule of Loss prepared on this basis in November 2018 claimed £232,992 for past loss of earnings, £116,150 for future loss of earnings, and a round sum of £500,000 for loss of opportunity relating to the potential big break.

Expert Evidence

67. Mr Hyam submitted that Ms Arnold was not really giving appropriate expert evidence at all, both because of her lack of experience in assessing labour market trends and because of inherent flaws in her objectivity. Mr Collins submitted that Mr Carter was singularly ill-suited to assisting the Court because labour market analysis does not provide answers to an actor's career prospects.

68. The reality is that these two experts were each giving useful, but wholly different, evidence. However, Ms Arnold's opinions must be used carefully, so as to limit them to the areas in which she has expertise, and to be consistent with other evidence in the case. This was her first experience of the trial process in England and Wales. She is clearly more used to US claims tried by a jury. Although she had been made aware of the provisions of CPR Part 35, her report clearly went beyond her area of expertise in some respects, and even strayed into the realms of advocacy. The most egregious example of this is her unwillingness to accept the joint statement of the psychologist and psychiatrist in relation to the effect of the Claimant's PTSD. This is apparent in the section entitled "Psychological Injury and its Effect on The Claimant's Earning Capacity" [A172], and even more clearly in the joint statement of the employment experts, paragraphs 51 to 56 [A517-2], where she purports to rely on conversations with and writings of other psychiatrists and psychologists in other cases she has worked on to substitute her own view of the length of time that the Claimant was affected by his PTSD.

69. The key features, in Ms Arnold's opinion, are that:

    i) Prior to Benjamin's death, the Claimant was on an upward swing in his career, having just come from working with Mike Leigh on "Mr Turner" and participating in a season at the RSC.

ii) He had been selected to be a part of the casting process for "Dunkirk".

iii) In the 12 months after the death of his son, his absence in the industry and his inability to work in either the UK or Los Angeles caused Ms Maroussas to let him go.

iv) The psychological trauma had longer term effects on his ability to work and audition beyond the initial 12 month period. Indeed, he had not recovered enough to be present for the 2018 pilot season.

v) The continuing legal proceedings, and press coverage of the inquest into Benjamin's death, helped to undermine the Claimant's self-confidence.

vi) As a result, he has effectively been out of circulation for 5 years.

70. As a result of these factors, according to Ms Arnold, the Claimant lost the chance to obtain a role in "Dunkirk" similar to that of Colonel Winant, ultimately played by James D'Arcy. That, and his availability in Los Angeles for the pilot seasons, would have led to substantial increases in his earnings. She provides three possible scenarios; the first (minimum range) mirrors the career of James D'Arcy; the second (high range) mirrors the career of another actor, Taylor Kinney; and the third is a mid-range scenario.

71. The reality is not quite in accordance with Ms Arnold's assertions.

i) The work on "Mr Turner" took place in 2013, and the film was released in 2014. There was no sign of an upswing in the Claimant's career as a result of this.

ii) A part in the film "Dunkirk" was a real possibility, but far from certain. All the evidence shows that it was a very fluid casting and filming process. There was no fixed script. There were no fixed parts, below the top level. A 'squad' of possible actors was assembled, but the chance of ending up with a significant part which remained in the final film was a very uncertain process.

iii) Ms Maroussas' decision to part company with the Claimant in May 2017 stemmed from his decision to base himself in Toronto with his family, not from his PTSD or his inability to work because of his illness. It was an assessment of the chances of his being available in future for the work she could provide, not a judgment on his unavailability during the preceding 12 months.

iv) The psychological effects of his PTSD on the Claimant's ability to work is a matter agreed in the joint statement of Ms MacArthur-Kline and Dr Baggaley, and cannot be undermined by Ms Arnold.

v) The continuing legal proceedings do not give rise to a cause of action here. The inquest was completed within the 12 months following the death of Benjamin.

vi) As a result, Ms Arnold's assessment of the length of time the Claimant was out of circulation by reason of his PTSD is greatly overstated.

72. During the course of her cross-examination, Ms Arnold was asked whether, if the Claimant had been able to move to Los Angeles and work normally from the middle of 2017, he could have got his career back on track fairly quickly. She replied that, if Ms

Maroussas had remained as his agent, "*he would have had a very good chance of actually getting his career back on track. It may have taken a year or two …*". That accords with what the Claimant said to me at the end of his cross-examination, that if he could have lived in Los Angeles from May 2017 it would have been easier for him to restart his career.

73. Mr Carter's two reports follow the pattern of his work over the past 40 years. Essentially he provides the Court with desk-based statistics, which can be invaluable in making an assessment of career prospects, but which cannot provide a definitive answer in any specific case. I have found his material useful in particular for the schedules of roles that the Claimant has undertaken, both before and after May 2016. The details of average earnings for waged actors in the UK and US markets are little more than a basic check on the lower end of the acting profession.

My Approach to Quantum

74. Bearing all this evidence in mind, the factual approach to quantum I would take, to some extent foreshadowed in my comments above, is as follows:

    i) The Claimant was unable to work at all for 12 months due to his PTSD.

    ii) Thereafter he was fit to audition and find work, but there were still a few roles he could not take because they would trigger reminders of Benjamin (and specifically, in relation to this claim, those would have to be triggers of the experience of his first visit to the NICU).

    iii) There was nothing arising from his PTSD which prevented his family moving to Los Angeles after 12 months. The issues related to the grief reactions of the Claimant and Tamara, her need of the support from her family in Toronto, his desire to keep the family together, and their wish to retain the healthcare support available in Canada, especially after Tamara's miscarriage. Although in the end finances became important, these would not have prevented the family moving to Los Angeles in May 2017.

    iv) If the family had moved to Los Angeles in May 2017, the Claimant could have got his career back on track within a year or two.

75. In these circumstances the right approach is to start with the solid figures of past earnings, to which the Claimant could have returned within a year or two. To these should be added a further sum for the loss of a chance of a big break, if that is made out.

76. As to the solid earnings, there is no dispute about the calculations. Mr Chatfield sets out three tables of net loss, based on whether the starting point is the Claimant's average for 2010 to 2013 (when he was based in Los Angeles), for 2013 to 2015 (the last three years), or the whole period from 2010 to 2015. In my judgment it is fairest to take the full six years prior to May 2016. Although Ms Arnold spoke of the Claimant being able to get his career back on track "within a year or two", the Defendant has always accepted that his losses should be calculated to the end of 2019, and Mr Hyam did not seek to resile from that. The total figure from Mr Chatfield's report, based on the full six years prior to May 2016, is a net loss of £58,465 [A529, §6.5].

Loss of a Chance

77. I turn next to consider the claim for loss of a chance. The legal test where the chance depends not on the Claimant's actions or decisions, but on the actions of one or more third parties, is set out in *Allied Maples Group Ltd v Simmons & Simmons* [1995] 4 All ER 907, at 915-916. The first question, and the one in respect of which Mr Hyam submits the claim fails, is whether there was a real and substantial chance of the third party acting as the Claimant alleges.

78. Here the evidence as a whole discloses various uncertainties:

    i) Would the Claimant have got a sufficiently significant part in "Dunkirk" to potentially make a difference to his career? This would require not just being cast for a part, and engaging in filming, but for that part to remain significant in the final cut of the film. In my judgment that was likely, but not certain, for the reasons set out above. If I had to assess this alone, I would say there was a 75% chance of him landing such a role.

    ii) Would he have given a sufficiently strong performance to improve his career chances? Assuming that the Claimant had a significant part in the final film, it may be further assumed that it was because the director was satisfied with his performance, and that this would therefore improve his career chances.

    iii) Would better parts have been offered on the back of "Dunkirk"? That is far from certain. It is only fair, in the forensic context, to look at past performance. After his roles in "The Tudors" and "Mr Turner" there was no sign of a big break, or a rush of better parts being offered. Of course, the big break is not a once and for all opportunity. But the lack of movement after these parts illustrates the fundamental uncertainty of the acting profession, which Ms Arnold accepted wholeheartedly in her cross-examination. I would therefore assess no more than a 50% chance of a role in "Dunkirk" leading to significantly better parts.

    iv) Would the Claimant have given sufficiently strong performances in one or more better parts to maintain his career growth thereafter? The acting profession is littered with examples of "one-hit wonders", actors who never managed to capitalise on their big break. There may be many reasons for this, from pure chance to matters unconnected with pure acting ability, such as congeniality or drive. There is no doubting the Claimant's ambition, but the chances of his maintaining any boost from a part in "Dunkirk" may be assessed at no more than 75%.

79. The existence of so many uncertainties must reduce the overall assessment of any lost chance, though not by any precise mathematical calculation. There was a prospect of significantly improved parts and pay even without a significant part in "Dunkirk", but this is even less predictable.

80. My assessment is that there was a substantial and significant chance of a big break for the Claimant if he had not suffered PTSD, but this was very far from certain. My best estimate is to allow one-third of his possible increase in pay to reflect this loss of a chance.

81. As to the level of increase, there is no evidence which in my judgment justifies going further than James D'Arcy, that is to say Ms Arnold's minimum scenario. I would therefore have allowed one-third of the difference between this and the solid earnings to compensate the Claimant for his loss of a chance. I would have calculated these to end of 2019 as for the solid earnings. Since he should have been able to get his career back on track by then in the absence of other matters than his PTSD, he would by then have also been in a position to take advantage of another big break. As Ms Arnold points out in her report, there are many top stars who achieved that status after the age of 35 and beyond.

82. Mr Frenkel's second report, in Appendix 20, gives the appropriate figures. For the years 2016 to 2019 the net loss at full rate is $357,806. To this I would apply a conversion rate of $1.40 to £1, giving a sterling figure of £255,575. Deducting the loss on solid earnings of £58,465 leaves £197,110. One third of this for the lost chance would be £65,703.

Conclusions

83. Thus I would have assessed the total loss of earnings including loss of chance at £58,465 plus £65,703, a total of £124,168 to the end of 2019.

84. Other past losses for medical and other expenses are agreed at £8,530.95. Future medical expenses are also agreed at £589.86.

85. There is a claim for 50% of future adoption costs. This additional expense arises from a combination of the death of Benjamin and Tamara's subsequent miscarriage, not from the Claimant's PTSD. Accordingly it is not recoverable in these proceedings. It was not pressed strongly by Mr Collins in closing when I raised it.

86. The total sums I would have awarded if liability had been established are as follows:

    i) PSLA £17,500

    ii) Past losses

        a) Earnings (including loss of chance) £124,168

        b) Medical and other expenses £8,530.95

    iii) Future medical expenses £589.86

    These sums would be subject to the usual interest calculations.

87. Since I have found that the Claimant has failed to establish liability, no sum is payable.

88. I shall invite the parties to agree the form of order and costs, if possible. Otherwise I will determine costs and any other consequential matters on written submissions.