Neutral Citation Number: [2025] EWCA Civ 171

Case No: CA-2023-002076

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
MR JUSTICE BOURNE
QB-2020-003023

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/02/2025

Before :

LORD JUSTICE BAKER
LADY JUSTICE NICOLA DAVIES
and
LORD JUSTICE NUGEE

- -

Between :

(1) MS MISA ZGONEC-ROZEJ (On her own behalf and as Executor of the estate of MR JOHN RICHARD WILLIAM DAY JONES deceased) **(2) PATRICK ZGONEC JONES (A child represented by his Mother and Litigation Friend MS MISA ZGONEC-ROZEJ)** **(3) ZACHARY ZGONEC-ROZEJ (A child represented by his Mother and Litigation Friend MS MISA ZGONEC-ROZEJ)**	**Appellants/ Claimants**
- and -	
DR STEPHEN PEREIRA	**Respondent /Defendant**

- -
- -

Lizanne Gumbel KC and Neil Sheldon KC (instructed by **Fieldfisher**) for the **Appellants**
Martin Porter KC and Paige Mason-Thom (instructed by **Gordons Partnership**) for the **Respondent**

Hearing date: 5 February 2025

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 26 February 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

....

Lady Justice Nicola Davies:

1. This claim arises out of the tragic death of John Jones QC (Mr Jones) on 18 April 2016 at the age of 48. His wife and his children, then aged 8 and 6, are respectively the first, second and third claimants/appellants. The claim was brought by the claimants as dependants of Mr Jones pursuant to the Fatal Accidents Act 1976, and on behalf of his estate by the first claimant under the Law Reform (Miscellaneous Provisions) Act 1934. At the time of his death Mr Jones was a voluntary inpatient at the Nightingale Hospital (the hospital) in London under the care of the defendant/respondent, Dr Stephen Pereira, a consultant psychiatrist. Claims in negligence against the hospital and against Dr Bakshi, a second consultant psychiatrist at the hospital, were settled a few days before trial without admission of liability. Only the claim against Dr Pereira proceeded to trial.

2. In essence, the claimants allege that there were deficiencies in the care provided by Dr Pereira to Mr Jones and, but for those deficiencies, his mental health would not have deteriorated to the point where he took his life. The claimants contend that with appropriate treatment, Mr Jones would have recovered from his illness, he would have returned to full time practice as a barrister and would have continued to expand upon his successful career. At trial, liability and, in large part, quantum were in issue.

3. The trial judge, Mr Justice Bourne (the judge), made a number of criticisms of Dr Pereira, three of which amounted to findings of separate breaches of duty in respect of his clinical care of Mr Jones. The judge, however, dismissed the claim against Dr Pereira upon the basis that the breaches of duty did not cause or contribute to the death of Mr Jones.

4. I granted permission to appeal on 28 June 2024 on four grounds namely:

> "1. The Judge erred in concluding that Dr Pereira's breaches of duty, including his failure to provide an adequate handover prior to his departure on leave, did not cause Mr Jones' deterioration and death. This conclusion was illogical and inconsistent with his own findings. An adequate handover would have made clear that psychotherapy should have been an important component of the treatment plan. This would have led to Mr Jones to [sic] receiving psychotherapy as an inpatient and, had this occurred, his condition would not have deteriorated and he would not have died.
>
> 2. The Judge erred in law in that, on the basis of the Judge's own findings of breach of duty by Dr Pereira, proper application of the law to the facts found by the Judge would and should have led to a finding that causation was proved. That is it followed from the Judge's findings that causation was proved to the requisite standard of balance of probabilities and in respect of the test in *Hotson v East Berkshire Area Health Authority* [1987] AC 750.
>
> 3. Further or alternatively on the Judge's own findings in respect of breach of duty by Dr Pereira these failings made a material

> contribution to the death of Mr Jones and causation was proved on the basis set out in the cases of *Bailey v Ministry of Defence* [2009] 1 WLR 1052 and *Williams v Bermuda Hospitals Board (NHSLA intervening)* [2016] UKPC 4, [2016] AC 888.
>
> 4. The Judge erred in making a finding of contributory negligence when the coroner had found "the state of his mental health at the time [he died] meant he lacked the necessary intent to categorise his death as suicide." Further neither of the expert psychiatrists supported the case that Mr Jones himself was to blame for his death in any respect."

Factual background

5. In December 2015 Mr Jones moved back to London from the Hague with his wife and children, following which he experienced severe anxiety and sleep difficulties. In January 2016 Mr Jones saw a GP who referred him to Dr Pereira. At an appointment with the doctor on 29 February 2016 a history of Mr Jones' childhood including schooling was taken. It was noted that he had recently undergone three or four sessions of eye movement desensitisation and reprocessing therapy (EMDR), a treatment for post-traumatic stress disorder (PTSD). At the consultation Mr Jones denied any thoughts or plans of self-harm.

6. In a letter to his GP on 29 February 2016, Dr Pereira described Mr Jones as having the "full house of depressive features" dating from around two months earlier. Dr Pereira considered that Mr Jones was likely to be suffering from a bipolar affective disorder and was currently depressed. He prescribed medication for low mood and a mood stabiliser which can assist with insomnia. Dr Pereira suggested a follow up once a week over the next six to eight weeks to allow for monitoring of Mr Jones' progress. In the event that Mr Jones found it difficult to cope, Dr Pereira identified the option of admission to the hospital.

7. Professional issues in early March impacted adversely upon Mr Jones and on 8 March 2016 a second outpatient consultation with Dr Pereira took place. At that consultation Mr Jones spoke of professional and family pressures. He said that he was not thinking of suicide because it would "devastate everyone". Mr Jones was sceptical of Dr Pereira's diagnosis. Dr Pereira repeated that hospital admission remained an option if Mr Jones felt unable to cope.

8. On 15 March 2016 a third out-patient consultation took place. Prior to this, Mr Jones had been in email contact with Dr Pereira reporting a rash on his face and questioning the bipolar diagnosis. His medication was reviewed, Dr Pereira perceived progress being made with Mr Jones experiencing fewer unhelpful thoughts and sleeping better. He told Dr Pereira that he no longer needed to see the treating doctor for EMDR but refused to allow Dr Pereira to contact her.

9. On 18 March 2016 in an email to Dr Pereira Mr Jones stated that:

> "The medication you prescribed is having a catastrophic effect on my memory and concentration. I have become unable to do almost any activity. All I can do is sleep. Unbearable situation

> for me and my family. I would like to come off the medication, and also to have an MRI scan to see what is going so wrong. If possible, do you have an emergency slot today?"

In an email reply written by his secretary, Dr Pereira is recorded as stating:

> "Dear John
>
> Please stop the medication and I will look at alternatives.
>
> Best wishes,
>
> Dr Stephen Pereira"

10. On 21 March 2016 Mr Jones' parents telephoned Dr Pereira. Mr Jones was in the background. They told the doctor that he had stopped the prescribed medication and that he was in crisis. They asked if he could be admitted to the hospital. On the same day Mr Jones' mother emailed Dr Pereira's secretary and stated:

> "Our son, John Jones, is in urgent need of attention. I believe he is a danger to himself, at this point, and must be provided with a safe space. Dr Pereira is his professional care-giver and must see that we have no options open to us. John is in a terrible place. Please respond as soon as possible. It is unthinkable that Dr Pereira can turn a deaf ear to this or turn away from a patient in John's condition."

11. In his judgment, the judge recorded at [44] that Dr Pereira was surprised that Mr Jones appeared to have gone backwards, there was no time to reassess him but clearly Mr Jones and his parents could not cope. Dr Pereira felt it would be helpful for Mr Jones to be "in a safe place with proper supervision where a proper medication regime could be re-established, and where he could also have access to the hospital's range of group therapies."

12. Funding was provided by BUPA, following which Mr Jones was admitted to the hospital on 22 March 2016. As the judge noted, the timing was unfortunate because on or around that day, Dr Pereira began three weeks of leave from his duties at the hospital. Following his admission, Mr Jones would be the responsibility of another consultant, Dr Neelam Bakshi. In his evidence to the judge, Dr Pereira eventually accepted that he was Mr Jones' admitting consultant, a fact found by the judge. Dr Pereira did not tell Mr Jones that he was about to be unavailable for three weeks.

13. The evidence before the judge was that on 22 or 23 March 2016, Dr Pereira and Dr Bakshi held a handover by means of a telephone call. Neither made any written record of the conversation. It is likely that the original GP referral letter and Dr Pereira's reply to it would have been sent to Dr Bakshi's secretary but the letters did not address Mr Jones' subsequent deterioration. In evidence Dr Pereira said that the handover conversation would have covered the "catastrophic effect" of the medication of which Mr Jones complained.

14. Hospital notes show that Dr Pereira spoke to the admitting doctor or the nursing staff about Mr Jones' medication on 22 March 2016 as a result of which Mr Jones went back on to the previously prescribed medication with one addition for stress and anxiety.

15. On 23 March 2016 Dr Bakshi saw Mr Jones. She made two entries in the medical records, one of which states: "Patient seen by Dr Pereira who feels it is Bipolar disorder. Patient does not think bipolar, says never had any previous depression ...". The second note states: "Patient appears to be displaying pressure of speech. Fixated on certain imagery and thoughts which are obsessional. Does not wish to take quetiapine or similar medication. To observe mental state. Impression. ? hypomania. ? severe anxiety state. ? paranoid state."

16. Dr Pereira accepted that at the time of the admission, no further explanation was given to Mr Jones of the nature, purpose and benefit of his admission. He stated that these had been adequately explained when a contingency plan for admission was discussed on 29 February 2016.

17. As to Mr Jones' hospitalisation during the period 23 March 2016 - 10 April 2016, there is close to a complete absence of evidence as to the care which he received. This is the consequence of the settlement agreed between the claimants and Dr Bakshi and the hospital. The judge saw medical records made during that period when Dr Bakshi was the treating consultant but concluded that he was not "in a position to assess the standard of the decision making and care which took place during that time. Still less can I impute responsibility to Dr Pereira for any failings which occurred during that time." [78]

18. The medical notes record that on 23 and 29 March Mr Jones was assessed by members of the hospital's therapy team. The assessing doctors, respectively Dr Camm and Dr Cain, each record that Mr Jones declined group therapy but would accept 1-to-1 CBT therapy. Dr Bakshi said that she had had a couple of 1-to-1 sessions of mindfulness-based cognitive therapy with Mr Jones but he had not given her access to what he found triggering or to his inner world. [80]

19. On 8 April 2016 Dr Bakshi went on leave and on 10 April 2016 Dr Pereira resumed responsibility for the care of Mr Jones. Dr Pereira stated that he had a handover telephone call with Dr Bakshi on 8 April (once again not recorded by either doctor) during which she said that although there had been some improvement in Mr Jones' condition, he had not been engaging in the group therapy programmes which were available in the hospital.

20. Save for the two mindfulness sessions, Mr Jones had not received any psychotherapy since his admission to the hospital. Dr Pereira accepted that he had envisaged appropriate therapy being an important part of Mr Jones' effective inpatient treatment. Dr Pereira's evidence at the inquest into the death of Mr Jones was that "a psychological intervention… could have made a huge difference".

21. On 11 April 2016 Dr Pereira saw Mr Jones as an inpatient for the first time. He altered the prescribed level of medication and advised Mr Jones that even if he was unwilling to attend "talking groups", he should attend "non-talking" for example yoga or art therapy. In evidence, Dr Pereira said that he told Mr Jones he was concerned about his lack of engagement with group therapy in the hospital as this was an essential part of

his treatment plan. Having discussed the matter with Mr Jones, Dr Pereira proceeded with a new working diagnosis of obsessive ruminations. He was concerned to access Mr Jones' inner feelings and asked him to set down his thoughts in writing.

22. On 13 April 2016 Dr Pereira saw Mr Jones. He read or skimmed the document which Mr Jones had written but Mr Jones is reported as feeling that Dr Pereira was dismissive of it. They spoke about psychotherapy and Dr Pereira asked if he would consider 1-to-1 individual therapy. Mr Jones said he would, but he would think about it further. A nursing note of the review records Dr Pereira's advice as "for 1:1 as not attending groups".

23. On 14 April 2016 Dr Pereira received an email from Mr Jones' father expressing his deep concern about his son's lack of progress and describing a "relapse yesterday into the deepest despair and depression". As a result, a meeting was arranged between Dr Pereira, Mr Jones, his parents and his wife on the evening of 15 April 2016. It was the view of the family that Mr Jones was in a bad way. Dr Pereira raised the issue of BUPA funding, which would not last indefinitely, options included remaining in hospital and accessing group therapy or a discharge from inpatient treatment but outpatient appointments combined with 1-to-1 CBT. It was agreed that Mr Jones would discuss matters with his family over the weekend and report to Dr Pereira at his ward round on the following Monday.

24. That weekend Mr Jones stayed in the family home and returned to the hospital by public transport on Sunday evening.

25. Early in the morning of 18 April 2016 Mr Jones died at West Hampstead station following a collision with a train. There is no suicide note. Dr Maganty, the psychiatric expert instructed on behalf of the defendant, stated in his report:

> "I have reviewed the CCTV footage of the death of Mr John Jones. I have noted his demeanour, including his facial expressions and movements. I note that the movements are purposeful and he does not appear overtly to have a severe depressive affect. He is calm and appears to be in control of his emotions and there is no overt symptomatology of emotional distress or crisis that I have noted."

The judgment of Bourne J

26. At trial, evidence was before the court from Mr Jones' wife, his parents and Mr Granville, a close friend. Dr John Meehan, a consultant psychiatrist, gave expert evidence on behalf of the claimants and Dr Maganty, a consultant psychiatrist, gave evidence on behalf of the defendant. The judge preferred and relied upon the evidence of Dr Meehan.

The evidence of Dr Pereira

27. The judge expressed concerns as to the veracity of the written and oral evidence of Dr Pereira. Dr Pereira's evidence as to the instructions which he gave to Mr Jones, via his secretary, to stop some or all of his medication on 18 March 2016 gave the judge "cause for concern in several ways" [38]. Dr Pereira had given an incorrect account of these

events to the inquest. His evidence differed in his witness statement made for these proceedings. Dr Pereira's statement that Mr Jones failed to follow his advice was in emphatic terms but was based on the "relatively weak foundation of a three word note that Dr Pereira saw several years after the event." The emphatic suggestion was wrong, because his secretary's email sent out in Dr Pereira's name did not give the correct advice. The judge noted that Dr Pereira's system of giving important advice via brief handwritten notes to his secretary could and did go wrong. Emails were sent to patients as if from him personally but were not typed or phrased directly by him. There were also failures of disclosure of relevant papers kept in files by Dr Pereira.

28. In filling in the BUPA form for Mr Jones' admission to the hospital, Dr Pereira identified a moderate risk of self-harm and suicide. It was accepted by the psychiatric experts that in order to obtain admission which would be funded by BUPA, the admitting psychiatrist had to comply with the BUPA's "tick-box exercise as to the degree of suicide risk." The judge accepted the explanation but observed that there were other difficulties with Dr Pereira's evidence as to the perceived risk of suicide as follows:

> "56…. In his witness statement Dr Pereira stated that "the risk of suicide and self-harm was in fact low, though some risk was inevitable with his condition" and "none of the family told me that they were concerned about the risk of suicide". In cross-examination he resiled from both of those propositions. When challenged about the inconsistency between the "low" risk identified in the witness statement and the "moderate" risk in the BUPA form, he said that the statement should be amended to read "moderate" and that this was an error which had arisen from the volume of documents in the case."

The judge identified these instances along with the issue relating to the stopping of medication as demonstrating that Dr Pereira's witness statement was unreliable in that it contained emphatic and self-serving statements which, when challenged, had to be withdrawn [58].

29. The judge also expressed concerns as to the reliability of Dr Pereira's oral evidence. At [59] he stated:

> "… At some of the points mentioned above I suspected that Dr Pereira said what he thought the Court would wish to hear. So when he told me that the witness statement should be amended to refer to "moderate" risk, it seems to me that a more candid answer would have been that (1) he did not perceive a significant and immediate risk of suicide, (2) that in any case suicide was difficult if not impossible for a psychiatrist to predict but (3) he ticked the "moderate" box on the BUPA form in order to ensure that Mr Jones would get the hospital admission which Dr Pereira believed he needed."

30. At [61] the judge noted that it was clear from all of the documentary evidence that Dr Pereira was the admitting consultant but in oral evidence "he sought to qualify that as just being "for BUPA purposes" but it seems to me that that was a defensive view."

The absence of evidence

31. The judge noted that he was at "a significant disadvantage" because Dr Bakshi had not given evidence, he had not been asked to read any witness statement provided by her, no such statement was tested in cross-examination which made it more difficult to determine what handover took place between the two psychiatrists at the hospital and it also prevented the judge from assessing the merits or demerits of care provided to Mr Jones at the hospital while Dr Pereira was away. [67]

Negligence

32. The judge acknowledged that Dr Pereira had to deal with a complex and challenging case. The claimant's counsel made the following final allegations of breach of duty:

> "(i) failing to explain the purpose and benefits of hospital admission to Mr Jones;
>
> (ii) failing to tell Mr Jones that he would be handing over his care to someone else for the next 3 weeks;
>
> (iii) failing to assess Mr Jones before admitting him;
>
> (iv) instructing the Hospital to put Mr Jones back on the medication that he had told him to stop taking on 18 March because of the catastrophic effect on him;
>
> (v) failing to play any meaningful part in the formulation of Mr Jones' care and treatment plan;
>
> (vi) failing to provide any meaningful handover either to the Hospital or Dr Bakshi;
>
> (vii) failing to take adequate steps to establish a therapeutic relationship with Mr Jones following his return to the Hospital (e.g. by being dismissive of a note which Mr Jones showed him on 13 April, advising him to attend group sessions instead of arranging individual therapy and offering him alternatives of staying in the hospital with group therapy and having individual therapy as an outpatient);
>
> (viii) failing to arrange individual therapy for Mr Jones;
>
> (ix) failing to maintain an appropriate care plan;
>
> (x) failing to conduct meaningful assessments of risk following his return to the Hospital;
>
> (xi) failing to involve the multidisciplinary team in his care."

33. The judge also considered the allegation that there was a failure by Dr Pereira to reach an adequate diagnostic formulation of Mr Jones' condition. The judge found on the balance of probabilities that Mr Jones was suffering from a depressive reaction to past

and present stressful events and did not have bipolar affective disorder. However, given that Dr Pereira's contrary view was a defensible one, the judge concluded that his working diagnosis of bipolar affective disorder did not represent a breach of duty [158] – [159]. He was unable to identify a moment in the final week of Mr Jones' life when Dr Pereira's original working diagnosis should have been abandoned [165]. The judge did not find that any change in Dr Pereira's approach to Mr Jones' illness during the final week would have prevented his death.

34. As to the hospital admission of Mr Jones, the judge did not find there was a negligent failure to explain the purpose and benefits of such admission which had been identified in earlier consultations as the hospital admission on 22 March was urgent and there was no clear opportunity for Dr Pereira to have a further discussion with Mr Jones about the purpose and benefits of hospital admission before it took place. The judge stated [169]:

> "Instead, he acceded to the request by the parents, respecting their wishes as intelligent and engaged relatives acting in their son's best interests, for an admission for the obvious immediate purposes of being supervised in a safe place where his medication could be given to him or reviewed, as necessary. While another psychiatrist might have taken the course set out by Dr Meehan, of delaying the admission in order to discuss its advantages and disadvantages, I am not persuaded that the alternative strategy of proceeding with the admission was negligent or unreasonable."

35. At [170] and for the same reasons, the judge did not find there was a negligent failure by Dr Pereira to assess Mr Jones before his admission to hospital. However, the judge was satisfied that Dr Pereira was in breach of duty by not communicating with Mr Jones that he would not be available for the next three weeks [171]. He found that there was no evidence that this 'inexplicable' omission caused any measurable harm or contributed to the tragic outcome. However, it did suggest a "surprising lack of empathy on Dr Pereira's part." [172].

36. The second breach of duty found by the judge was a negligent failure to give a sufficient handover to Dr Bakshi [176]. He also found that the absence of an adequate record of the handover conversation represented a departure from reasonable standards. *Good Psychiatric Practice* published by the Royal College of Psychiatrists states that a psychiatrist should provide a comprehensive summary of a clinical case to the receiving doctor/professional to enable them to take over the safe management and treatment of the patient. It notes that a psychiatrist must maintain a high standard of record keeping which involves keeping complete and understandable records which would include a record of all assessments and significant clinical decisions. The judge found that both Dr Pereira and Dr Bakshi should have made a record of information about assessments which he shared and she received. [178]

37. At [181] – [184] the judge analysed Dr Pereira's evidence as to the handover. Dr Pereira said that the conversation would have covered the patient's report of the "catastrophic effect" of the medication and:

> "I would have conveyed to Dr Bakshi the history, the issues to do with this patient, my thoughts, views, ideas, the treatments

> that I've tried, which is captured in her note after she saw him on 23 March in the Nightingale Hospital notes."

38. The judge acknowledged this was a reasonable summary of what an adequate handover should have contained, however those assertions were not supported by Dr Bakshi's notes nor were they contained in Dr Pereira's witness statement. He noted that Dr Pereira was not speaking from direct recollection, he was saying what he "would have" done. The judge was not convinced by Dr Pereira's further assertion in evidence to the court that "no consultant admitting a patient to the Nightingale if referred to by another consultant would accept the patient unless and until there was a discussion". The judge found that given the duty on both consultants to keep a proper record, a note by one or other of them would have recorded the contents of an adequate handover if one had taken place. He accepted there was probably a telephone conversation but it was not a sufficient handover in accordance with good practice.

39. At [186] the judge identified as the claimants' core allegations of negligence that Dr Pereira did not interact with Mr Jones in the way that he should have and that he did not ensure that Mr Jones received individual therapy. Dr Meehan had referred to the need of the doctor to interact with the patient in an empathic manner and to create a "therapeutic alliance". He accepted that this was a complex case with complex issues in relation to gaining access. In respect of words spoken by Mr Jones on admission namely that "I believe I am incurable", Dr Meehan stated: "I think the installation of hope in this man that he will get over this crisis and recover is absolutely crucial and essential to understanding what happened and what didn't happen in this case."

40. At [191] and [192] the judge made the following findings:

> "191. At the point when it was agreed that Mr Jones would be admitted, I am not satisfied that Dr Pereira had a real opportunity to work on a care and treatment plan for him as an in-patient or to discuss with him the question of whether he would participate in the hospital's group therapy programme. Nor do I consider that he was in a position to make any assumptions or predictions about that participation. Instead, the reality was that Dr Bakshi would take over Mr Jones' care once he had been admitted.
>
> 192. I therefore cannot find Dr Pereira liable for any omissions in the treatment which Mr Jones received until his return. Whilst the lack of a handover to Dr Bakshi may have contributed to any omissions by her, I have not tried the question of whether there were any omissions by her."

41. Upon Dr Pereira's return from leave on 8 April, he spoke with Dr Bakshi on the telephone, read Mr Jones' hospital notes and saw him on 11 April. The judge noted that it would have been apparent to Dr Pereira that Mr Jones had not accessed any psychotherapy save for a couple of mindfulness sessions with Dr Bakshi [193].

42. Dr Meehan was critical of this. In his view the situation as it presented itself on Dr Pereira's return constituted an emergency, Mr Jones had been in hospital for nearly three weeks, there was no evidence that people had gained access to his inner world, there was no consistent nor adequate diagnostic formulation, there was no provision of

1-to-1 therapy nor a coordinated and integrated risk management risk assessment. Dr Meehan thought it incumbent on Dr Pereira to bring the various elements together into a coherent continuing assessment and treatment plan.

43. The evidence did not indicate that Dr Bakshi gave Dr Pereira to believe that the situation was an emergency, her note of 8 April states that the patient's mood "seems to have lifted". The nursing notes presented a mixed picture and repeated risk assessments did not give cause for concern [196]. The judge concluded that "there was reason for considerable concern that his condition had drifted". By 11 April Mr Jones was reaching the end of the three weeks which had been the anticipated length of admission, there was no firm diagnosis, there were continuing issues with medication, almost no psychotherapy had taken place and there was no particular or consistent improvement in his mood and nobody seemed to have any real insight into his state of mind [197].

44. The judge accepted that Dr Pereira tried to move the case forward, he saw Mr Jones several times that week, adjusted and discussed his medication and talked to him about his state of mind. They continued to discuss psychotherapy [198].

45. At [200] the judge observed that Dr Pereira never succeeded in building a trusting relationship with Mr Jones but did not find that amounted to a breach of any legal duty on his part, psychiatric illness may make it especially difficult for a clinician to get through to a patient.

46. In respect of the judge's third finding of a breach of duty by Dr Pereira he stated:

> "201. In my judgment the only aspect of treatment which amounted to a breach of duty was the slowness in arranging individual psychotherapy for Mr Jones.
>
> 202. While it was reasonable to see if Mr Jones would engage with the group programme when he was admitted, it seems to me that by the time Dr Pereira saw him again on 11 April 2016, it was clear that he would not. Dr Pereira knew about the assessments on 23 March by Dr Camm, who noted "wants one-to-one CBT" and "Group therapy attendance: unwilling to attend", and on 29 March by Dr Cain, who noted "patient would prefer one-to-one".
>
> 203. Dr Pereira's evidence both at the Inquest and at this trial was that psychotherapy was an important part of the treatment plan. In these circumstances it seems to me that any reasonable consultant psychiatrist would, on or very soon after 11 April, have put in train the process for deciding on an appropriate form of psychotherapy at the hospital and arranging for it to happen. Instead, attendance at the group sessions was still under discussion at the meeting on 15 April, by which time Dr Pereira was proposing the alternative of individual therapy only on an out-patient basis.
>
> 204. I have not overlooked Dr Pereira's evidence that when they discussed individual therapy on 13 April, Mr Jones said that he

> wanted to think further about it. But the documentary evidence shows that he had expressed a wish for individual therapy. My finding is that if Dr Pereira had started the process of arranging it with the hospital, Mr Jones would have agreed to it.
>
> 205. I therefore conclude that the care and treatment plan was deficient because it did not contain a clear path to Mr Jones starting individual psychotherapy. This does not mean, however, that if the appropriate steps had been taken, Mr Jones would have had many, if any, psychotherapy sessions before 18 April. I return to this in my discussion of causation.

47. No other significant breaches of duty by Dr Pereira were found by the judge.

Causation

48. The fundamental question which the judge had to address was whether, in the absence of any breach of duty by Dr Pereira, the death of Mr Jones on 18 April 2016 would have been avoided. Leading counsel for the claimants submitted that if the judge was unable to decide whether, but for any negligent breach of duty, Mr Jones' death would on the balance of probabilities have been avoided he should instead consider whether any negligence made a material contribution to his death, an approach identified in *Bailey v Ministry of Defence* [2009] 1 WLR 1052 (*Bailey*) where Waller LJ at [46] stated:

> "In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified and the claimant will succeed."

49. At [212] the judge observed that on the facts of this case it was possible to decide on the balance of probabilities whether death would have occurred in the absence of breaches of duty and thus the material contribution argument was unnecessary.

50. As to the three breaches of duty which he had found and the causative effect of the same the judge stated:

> "214. As I have said, there is no evidence that Dr Pereira's omission to tell Mr Jones about his forthcoming 3 week absence at the time of his admission to hospital caused any measurable harm or contributed to his death.
>
> 215. Nor do I find that the failure to give a sufficient handover to Dr Bakshi caused any measurable harm or contributed to Mr Jones' death. That conclusion follows inexorably from the fact that I have not heard any evidence about the merits or demerits of his care and treatment by her.
>
> 216. The final breach of duty was a failure to arrange psychotherapy expeditiously. That process should have begun

on or very soon after 11 April 2023 [*sic*]. As I have said, the evidence is that a recommendation by a consultant would be followed by a visit to the ward by a psychologist for an assessment, leading to a decision on what type of individual therapy to pursue. An available therapist would have to be identified and then, no doubt, the first session would be scheduled.

217. I therefore do not know when any psychotherapy would have taken place if the process had started early in the week of 11 April 2016. It is possible that a session might have taken place before 18 April, but that is uncertain in itself, and I certainly cannot say that there would probably have been more than one.

218. As to the time needed for psychotherapy to have an effect, Dr Maganty in his report stated that therapy "needs to occur on a long-term basis if it is to lead to beneficial effect" and in a case like this, it "takes a gradual process over months of building trust and a therapeutic relationship".

219. In cross examination Dr Meehan was asked to confirm that talking therapies typically take time to work and that one or two sessions in that final week would not have saved Mr Jones' life. His answer was: "What it might have done is given him hope." In my judgment that answer was both perceptive and precise. Dr Meehan was pointing out that even one session might indeed have engendered new hope, but did not exaggerate by claiming that it would definitely have done so or that a single session would have had some probable and identifiable impact on Mr Jones' illness.

220. In addition to the considerable uncertainty about whether an initial session would have had a positive or any effect on Mr Jones' feelings, I must also contend with the lack of evidence (which I have already mentioned) of why he took his life on 18 April. I can infer that he felt a lack of hope, but I cannot know what else he may have felt in his disordered state that day. There is consequently even more uncertainty about whether any new development, such as a note of optimism arising from starting a course of therapy, would have been sufficient to dissuade him from taking his life.

221. Combining the uncertainties of whether a session would have taken place, whether it would have given Mr Jones some hope and whether such effect would have been sufficient to change the outcome, it is far from probable that the failure to take prompt steps to arrange psychotherapy caused or contributed to his death.

> 222. The Claimants are therefore unable to succeed in their claim because they cannot prove that any breaches of duty caused the loss arising from Mr Jones' death."

Contributory negligence

51. Contributory negligence would only arise if the defendant were to be found liable to the claimants. The defendant contended that any liability would fall to be reduced under section 1(1) of the Law Reform (Contributory Negligence) Act 1945 "to such extent as the court thinks just and equitable having regard to the claimant's share and the responsibility for the damage". Oral argument before the trial judge focused on Mr Jones' act of taking his own life which the judge regarded as the only relevant act or omission.

52. The judge reviewed the authorities of *Corr v IBC Vehicles Limited* [2008] 1 AC 884, *Reeves v Metropolitan Police Commissioner* [2000] 1 ACT 360 and *PPX v Aulakh* [2019] EWHC 717 QB. At [235] he concluded that Mr Jones was obviously very unwell at the time of his death and his illness drove him to take his life however the judge could not find that he had lost autonomy. The judge stated:

> "… Although he was suffering very low mood and distressing emotions, he was also having rational interactions with hospital staff, family members and Mr Granville in the last days of his life. The First Claimant and Mr Granville both believed that he did not want to die when they last saw him, and he clearly was trying to plan for the future. His state of mind must have deteriorated on 18 April but that does not mean that he did not know what he was doing. I have not been told about his doing anything else in the throes of his illness without knowing that he was doing it.
>
> 236. In *Corr*, where the Defendant actually caused the Claimant's depression, Lord Scott would have deducted 20 per cent. Dr Pereira did not cause Mr Jones to be ill but, if found liable, would have caused or contributed to his condition declining to the point which it reached on 18 April 2016. In those circumstances I would have reduced any award of damages by 25 per cent to reflect the degree of autonomy in the suicidal act. That reflects the approach in *PPX v Aulakh*, another case where the alleged negligence was a failure to treat an illness rather than an act causing an illness."

The appellants' submissions

Grounds 1 and 2 - Causation

53. In written and oral submissions, the appellant elided grounds 1 and 2. Ms Gumbel KC, on behalf of the appellants, described ground 1 as representing an error of logic on the part of the judge. Her initial submission was that as the judge accepted that psychotherapy was the cornerstone of a treatment plan for Mr Jones, and had found that the defendant was the admitting consultant, a competently conducted handover would

have included Dr Pereira informing Dr Bakshi that he regarded the institution of psychotherapy as being a fundamentally important part of the treatment plan.

54. In oral submissions Ms Gumbel placed considerable reliance upon the judge's counterfactual findings at [224] in which he offered an opinion upon the issue of causation if, contrary to his conclusions, any reasonable consultant psychiatrist would have provided a post-traumatic diagnosis formulation and would have done so before Mr Jones' admission to hospital. On this hypothesis, the judge stated that psychological therapy would have been a key part of the treatment plan from at least 22 March and if the group therapy programme in the hospital was rejected, individual therapy would have been arranged promptly.

55. The appellant identifies what is described as the "flaw" in the judge's causation analysis as being the fact that the efficacy of the psychotherapy treatment which Mr Jones failed to receive, was not dependent upon the correctness of the working 'differential' diagnosis. The judge's analysis did not reflect the evidence of Dr Pereira who regarded psychotherapy as a fundamental part of the treatment plan based upon his working diagnosis of bipolar disorder. It confuses the issue of the reasonableness of the diagnosis with the issue of the efficacy of treatment.

56. The appellant contends that there is no logic in the judge finding that because of a different diagnosis, psychotherapy treatment was not required. A diagnosis of bipolar disorder would have resulted in a treatment plan which would have included psychotherapy, a fact accepted by Dr Pereira. The reason Mr Jones did not receive the psychotherapy treatment which he required, was because Dr Pereira did not conduct a proper handover.

57. A further flaw in the judge's reasoning, so the appellant submits, is that he found that Dr Pereira was negligent in not promptly initiating the process to achieve psychotherapy upon his return in April at a time when his diagnosis remained that of bipolar disorder which is contrary to his finding that Dr Pereira was not negligent in failing to stipulate psychotherapy at the March handover.

Ground 3 - Material contribution

58. The submissions of the appellant on the issue of material contribution at trial were recorded by the judge at [210] namely that if he was unable to decide whether, but for any negligent breach of duty, Mr Jones' death would on the balance of probabilities have been avoided, he should instead consider whether any negligence made a material contribution to his death. The judge cited the authorities of *Bailey* (para 48 above) and *Williams v Bermuda Hospitals Board (NHSLA intervening*) [2016] UKPC 4, [2016] AC 888 (*Williams*), a case which did not involve a departure from the "but for" test for causation.

59. At the hearing before this court, Ms Gumbel departed from the appellants'/claimants' submission as recorded by the judge. She stated that as the judge had found that there were a number of overlapping factors which had contributed to Mr Jones' death including his own actions, the failure to arrange psychotherapy and the failure to otherwise achieve treatment of his condition, this meant that the principle of material contribution was appropriate. The judge's interpretation of the principle was said to be incorrect. It was now submitted that the test for material contribution would apply, as

an alternative route, even when the "but for" test could be satisfied. The judge should have considered whether the failure at handover, combined with the other factors identified above, combined and contributed in an indivisible but material way to cause Mr Jones' deterioration and death.

Ground 4 - Contributory negligence

60. In written submissions, the appellant contended that as there was no evidence that Mr Jones planned to take his own life, no suicide note was left, there was no good evidence upon which the judge could find that a deduction of 25% for contributory negligence would have been made had primary liability been established. In oral submissions, Mr Sheldon KC on behalf of the appellant, relied upon an analysis of the judgments in *Corr v IBC Vehicles Limited* [2008] 1 AC 884 and *Reeves v Metropolitan Police Commissioner* [2000] 1 ACT 360 to support his submissions.

61. In essence, Mr Sheldon KC contended that if a defendant raises a plea of contributory negligence it is for the defendant to prove that allegation on the evidence. The question for the court is whether the evidence establishes that the deceased had retained sufficient personal autonomy over their actions such that they can properly be regarded as being at fault for their own death. That will require consideration not simply of whether the deceased has control of their physical actions, but whether they are mentally able to exercise the informed choice between acting in the way that led to their death or not. In a case in which the deceased's mental state has been impaired by the defendant's negligence, the defendant will need to adduce compelling evidence to prove an allegation of contributory negligence on this basis. The evidence identified by the judge was insufficient to establish what was going through Mr Jones' mind at the time of his death.

The respondent's submissions
Grounds 1 and 2 - Causation

62. Mr Porter KC, on behalf of the respondent, realistically focused his submissions upon the breach of duty found by the judge relating to the negligent handover. He relied upon the findings made by the judge at [191] as reflecting the evidence as to the urgency of Mr Jones' admission and the grave concern of his family that Mr Jones should be in a safe and secure place where medication could be controlled and therapy would be part of the package. Group therapy would be anticipated as part of the BUPA funded inpatient package at the hospital, 1-to-1 therapies are not routinely a part of such a package for inpatients. Dr Pereira and Dr Bakshi would have known that within the hospital, group therapy was offered (35 hours a week). He contended that the appellants failed to make the distinction between group therapy, which was offered, and individual therapy.

63. It was accepted by Dr Pereira that his "thoughts, views and ideas", at the point of handover, would have included the fact that psychotherapy had a role to play in Mr Jones' treatment [181] – [182]. Mr Porter submitted that it does not follow from Dr Pereira's evidence, or from any findings of fact by the judge, that a non-negligent handover would necessarily have included an instruction to the receiving clinician to provide immediate 1-to-1 therapy. Given the judge's finding at [191] any suggestion that it was for Dr Pereira to dictate to Dr Bakshi that a particular form of psychotherapy had to be arranged without delay is not supported by the findings of fact.

64. The appellant's case is predicated on the assumption that it was because of the negligent failure in handover that 1-to-1 therapy was not instituted sooner. This view was disavowed by the judge who correctly found that there was insufficient evidence before him to support such a conclusion [215].

65. No support can be derived from Dr Pereira's failure to arrange 1-to-1 therapy promptly upon resuming Mr Jones' care on 8/9 April because the situation faced by Dr Pereira on his return was materially different from that which pertained at the time of admission, as was accepted by the appellants.

Ground 3 - Material contribution

66. It was Mr Porter's submission that the judge dealt with this issue shortly and correctly. The judge determined that the "but for" test for causation was established and that is the end of the matter. His analysis of the authorities of *Bailey* and *Williams* was accurate, Ms Gumbel's legal submission on this issue is incorrect. If it is possible to determine the question of causation upon the "but for" basis, the issue of material contribution does not arise, no further consideration is necessary and that is what the judge did.

Ground 4 - Contributory negligence

67. Miss Mason-Thom on behalf of the respondent observed that the appellant's appeal on this issue is not upon the basis that the judge misdirected himself on the law. She took no issue with the four principles identified by Mr Sheldon save in respect of the burden of proof. Miss Mason-Thom identified the need for "sufficient" rather than "compelling" evidence. In reply, Mr Sheldon accepted this point. The question for the court is whether the judge's finding of contributory negligence was "plainly wrong" and there is nothing in the evidence nor the relevant authorities to support such a conclusion.

Discussion and conclusion

68. The judgment of Bourne J is detailed and sensitive to the complex issues in this tragic case. The judge reviewed the facts, he analysed the evidence given by all witnesses which included the two psychiatric experts, Dr Meehan and Dr Maganty, he considered the relevant law and made determinations of fact which led to his findings upon the issues of negligence and causation.

69. A fundamental difficulty for the judge in making findings of fact was the settlement reached without admission of liability, between the claimants and the second and third defendants, Dr Bakshi and the hospital. As a result, there was no evidence before the judge from the treating clinician, Dr Bakshi, in respect of the period 23 March 2016 to 8 April 2016. Applying principles of fairness, this meant that the judge was unable to make any findings as to the nature and level of care which Mr Jones did or should have received following his admission to the hospital until 8 April 2016. Such findings could have been relevant to the issue of causation given the judge's determination that there was an inadequate, indeed negligent, handover from Dr Pereira to Dr Bakshi on 22 or 23 March 2016 which constituted a breach of his duty of care to Mr Jones.

70. In my view, of relevance to the adequacy or otherwise of that handover, are the circumstances of Mr Jones' admission to hospital. It was Dr Pereira, at the outpatient appointments, who raised with Mr Jones and his parents the possibility of hospital admission. It was Mr Jones' parents who took up that offer, as a matter of urgency, in a phone call on 22 March 2016. The admission of Mr Jones to the hospital was swiftly arranged and took place the next day. An outpatient appointment had been scheduled for the 23rd March but was overtaken by events. The admission was made in circumstances of urgency. The judge found at [169] that there was no "clear opportunity for Dr Pereira to have a further discussion with Mr Jones about the purpose and benefits of hospital admission before it took place. Instead he acceded to the request by the parents, respecting their wishes as intelligent and engaged relatives acting in their son's best interest, for an admission for the obvious immediate purposes of being supervised in the safe place where his medication could be given to him or reviewed, as necessary." Based upon these findings of fact, the judge determined that there was no negligent failure by Dr Pereira to assess Mr Jones prior to his admission to hospital [170]. These are unchallenged findings which properly reflect the evidence.

71. As to the appellants' contention that part of the handover should have included Dr Pereira's view that psychotherapy was a fundamental part of the treatment plan, I regard the judge's unchallenged findings at [191] and [192] as critical. At the point when it was agreed that Mr Jones would be admitted, the judge was not satisfied that "Dr Pereira had a real opportunity to work on the care and treatment plan for him as an in-patient or to discuss with him the question of whether he would participate in the hospital's group therapy programme." Nor did the judge consider that Dr Pereira was in a position to make any assumptions or predictions about such participation. The judge recognised the reality of the situation namely that Dr Bakshi would take over Mr Jones' care once he had been admitted to the hospital.

72. Dr Pereira accepted in evidence that psychotherapy would have been part of his treatment plan for Mr Jones. That being so, a reasonable inference to draw is that at some point during the handover Dr Pereira would have mentioned that psychotherapy was recommended. Given his limited involvement with Mr Jones and the urgent nature of the admission, it would be difficult to see how Dr Pereira could insist on a particular course when he would know that the immediate care of Mr Jones was being supervised and undertaken by a fellow consultant psychiatrist. It was accepted on behalf of the appellant that a handover is not the same as a treatment plan. Mr Sheldon KC accepted that Dr Bakshi and Dr Camm would have worked up a treatment plan following admission, but would do so having received a handover from the admitting consultant. In my view, that psychotherapy was in the mind of Dr Pereira and Dr Bakshi, can be reasonably inferred from the fact that on the day of his admission Mr Jones was assessed for therapy by Dr Camm, six days later he was assessed on a second occasion by Dr Cain. Dr Bakshi undertook two sessions of 1-to-1 mindfulness CBT.

73. In the absence of evidence as to Dr Bakshi's clinical decision making, the judge was not in a position to determine whether any failures in the care provided by her to Mr Jones were attributable to Dr Pereira's breach rather than her own independent shortcomings, or a lack of therapies or funding, or that the care provided by Dr Bakshi was not of the required standard. In my view, the judge's finding that when Dr Pereira was on leave he could not be liable in law for any omission in the treatment of Mr Jones, was a reasonable and fair conclusion given the lack of evidence as to Dr Bakshi's

clinical decision making and practice, the developments in the clinical picture between Mr Jones' admission to hospital and Dr Pereira's return and any intervention by other healthcare professionals.

74. As to the appellants' reliance on the judge's finding of a third breach of duty, namely the failure by Dr Pereira, to promptly effect the process for 1-to-1 therapy on his return as support for their primary submission, I regard this as misconceived. By the time Dr Pereira returned from leave the clinical facts had significantly altered [197]. Mr Jones had spent three weeks as an inpatient under the care of a consultant psychiatrist and a regular regime of medication had been prescribed. He had refused to engage in group therapy, limited 1-to-1 therapy had been delivered. Allowing for all of this, no real improvement in Mr Jones' condition had been achieved. It was upon this basis that the judge found that the process to achieve 1-to-1 therapy should have been promptly instigated.

75. The appellants' reliance on the judge's counterfactual scenario set out at [224] ignores the fundamental problem that the judge's observations were expressed only to cover the eventuality that he was wrong in any of his earlier conclusions as to breach of duty. The judge's conclusions in respect of breach of duty have not been appealed. With respect to the judge, this part of the judgment is not strictly necessary and for the purpose of this appeal takes the matter no further. The judge found that Dr Pereira's diagnosis of bipolar affective disorder was not negligent. That is a finding and a fact which is unchallenged. It is his diagnosis which provided the basis for Dr Pereira's treatment of Mr Jones. Hypothetical scenarios do not override unchallenged findings of fact and breaches of duty.

76. Ground 1 is an appeal in respect of a conclusion of fact. It is for the appellants to satisfy the court that the judge's conclusion was plainly wrong: *McGraddie v McGraddie and Anor* [2013] 1 WLR 2477. In my judgment, the judge's conclusion that Dr Pereira's negligent failure to give a sufficient handover to Dr Bakshi did not cause any measurable harm cannot be described as plainly wrong or illogical. The judge was entitled to take into account that the respondent was handing over to an experienced consultant colleague on the reasonable assumption that Mr Jones would be able to access the extensive programme of group therapies offered by the hospital. He was also entitled to find that the lack of any evidence before the court regarding Dr Bakshi's care and clinical decision making precluded him from finding, on the balance of probabilities, that the shortcomings in the handover had a causative effect on Mr Jones' treatment whilst Dr Pereira was absent.

77. At the core of Grounds 1 and 2 is the issue of causation. As a matter of fact, the judge's findings were properly founded upon the evidence and led to findings in law which are legally sound. Grounds of appeal 1 and 2 are dismissed.

Ground 3 - Material contribution

78. The doctrine of material contribution is a recognised exception to the "but for" principle which is the primary mechanism used for determining factual causation in the law of tort. The scope of the doctrine of material contribution was authoritatively summarised by the Court of Appeal in *Bailey,* (Waller LJ at para 46), and followed by the Privy Council in *Williams*. Where the evidence before the court is such that factual causation can be determined on a "but for" basis in either party's favour, the doctrine of material

contribution does not arise. The proposition now relied upon by the appellant is contrary to the settled state of the law.

79. The judge directed himself as to the relevant authorities on the issue of causation and correctly concluded that, in circumstances where a "but for" finding was possible on the balance of probabilities, the doctrine of material contribution did not arise.

80. Further, the argument now raised by the appellants is defeated by reason of the factual findings made by the judge. The judge found that it was possible to decide on the balance of probabilities whether death would have occurred in the absence of breaches of duty [212]. He addressed each of the breaches of duty [214 – 221], para 50 above. The judge concluded at [222] that the claimants were unable to succeed in their claim because they could not prove that any of the breaches of duty caused the loss arising from Mr Jones' death. There is nothing in any of these findings by the judge which begins to provide a factual basis for the material contribution argument upon which the appellant is now seeking to rely and which is contrary to settled authority. Accordingly, ground of appeal 3 is dismissed.

Conclusion

81. Given the dismissal of the appeal upon grounds of appeal 1 to 3, a determination by this court in respect of ground of appeal 4 upon the issue of contributory negligence is not required.

Lord Justice Nugee:

82. I agree.

Lord Justice Baker:

83. I also agree.