Neutral Citation Number: [2023] EWHC 2501 (KB)

Case No: QB-2020-003023

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/10/2023

Before :

THE HONOURABLE MR JUSTICE BOURNE

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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 JONES (A child represented by his Mother and Litigation Friend MS MISA ZGONEC-ROZEJ)**	**Claimants**
- and - **DR STEPHEN PEREIRA**	**First Defendant**
- and - **DR NEELAM BAKSHI**	**Second Defendant**
- and - **FLORENCE NIGHTINGALE HOSPITALS LIMITED Trading as 'THE NIGHTINGALE HOSPITAL'**	**Third Defendant**

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Lizanne Gumbel KC and Neil Sheldon KC (instructed by **Fieldfisher**) for the **Claimants**
Martin Porter KC and Paige Mason-Thom (instructed by **Gordons**) for the **First Defendant**

Hearing dates: 11 – 24 May 2023

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Approved Judgment

This judgment was handed down remotely at 10am on 10 October 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HONOURABLE MR JUSTICE BOURNE

Mr Justice Bourne :

Introduction

1. This claim arises from the death of John Jones KC ("Mr Jones") on 18 April 2016 at the age of 48 (d.o.b. 14.6.67). The First Claimant, then aged 40 (d.o.b. 4.3.76), was his wife. The Second and Third Claimants, then aged 8 and 6 (d.o.b. 26.12.07 and 14.12.09), are their children.

2. At the time of his death, Mr Jones was a barrister in practice at Doughty Street Chambers in London. In early 2016 he experienced mental health problems. His symptoms became acute and, on 22 March 2016, he was admitted to the Nightingale Hospital, which is owned and operated by the Third Defendant. He was admitted under the care of a consultant psychiatrist, Dr Stephen Pereira, the First Defendant ("Dr Pereira"). However, Dr Pereira was on leave from the hospital from 23 March 2016. From that date until 8 April 2016, Mr Jones was under the care of another consultant psychiatrist, Dr Neelam Bakshi, the Second Defendant. She went on leave on 8 April 2016, passing responsibility for Mr Jones' care back to Dr Pereira, who returned to work on or around 9 April 2016. Mr Jones was still an in-patient on Monday 18 April 2016. Early that morning he left the hospital and travelled to West Hampstead Thameslink railway station. There, at about 7.05 a.m., he jumped into the path of a train and died immediately.

3. 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.

4. A few days before trial, the Claimants entered a settlement agreement with the Second and Third Defendants, to which I return below. They therefore did not participate in the trial and the case against them was not tried. Only the claim against the First Defendant proceeded to trial. References to "the Defendant" in this judgment are to him.

5. The Claimants allege that there were a number of deficiencies in the care provided by Dr Pereira to Mr Jones. But for those deficiencies, they claim, Mr Jones would not have deteriorated to the point he reached on 18 April 2016 and would not have died.

6. The Claimants claim that, with appropriate treatment, Mr Jones would have recovered from his illness within a few months, would have returned to full-time practice as a barrister and would have continued and expanded a successful career specialising in international criminal law and extradition.

7. Liability and, in large part, quantum are both in dispute.

The issues

8. The headline issues are identified in the Opening Note provided by the Claimants' counsel, Lizanne Gumbel KC and Neil Sheldon KC:

1. Whether the care provided to Mr Jones by Dr Pereira was negligent in one or more of the alleged respects.

2. If so, whether Dr Pereira's negligence made a material contribution to causing Mr Jones to die on 18 April 2016.

3. Whether Mr Jones contributed to his death by his own negligence.

4. The value of the claim, having regard to the likely earnings and career progression of Mr Jones and of the First Claimant had he not died.

The allegations of negligence

9. The standard of care to be applied is that of a consultant psychiatrist holding himself out as capable of treating and managing the care of a patient suffering from the condition with which Mr Jones presented. Having regard to the well known decisions in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 852 and *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871, Dr Pereira will not be liable if he acted in accordance with a practice accepted at the time as proper by a responsible body of opinion, even if other doctors took a different approach. But as Lord Browne-Wilkinson said in *Bolitho v City & Hackney Health Authority* [1998] AC 232, it is not enough for a defendant to lead evidence from a number of medical experts who are genuinely of the opinion that his diagnosis or treatment accorded with sound medical practice. It is for the Court to decide whether any particular practice was accepted at the time as proper by a responsible body of opinion.

10. References in this judgment to acting as a reasonable psychiatrist would have acted are shorthand for conduct complying with that test. References to breaches of duty are shorthand for conduct falling short of that test.

11. In their Amended Particulars of Claim the Claimants advanced 27 particulars of negligence against Dr Pereira. These are substantially summarised by their more compressed pleading under "Particulars of Causation":

> "7.3. In particular, and without prejudice to the generality of the foregoing allegations, the Deceased's mental health would not have deteriorated to the condition in which he found himself on 18 April 2016, and he would not have taken his own life had:
>
> (a) an adequate diagnostic formulation of his condition been reached; and
>
> (b) an adequate and appropriate care and treatment plan been instituted and followed in light of that diagnostic formulation, including:
>
> (i) the provision of appropriate therapy, including 1:1 therapy of the type requested by the Deceased; and/or
>
> (ii) adequate and effective monitoring of the Deceased's condition, and the implementation of his care plan, by the Multi-Disciplinary Team ('MDT'); and/or

(iii) adequate and appropriate involvement of the Deceased's family members in his care and treatment; and/or

(iv) adequate and effective risk assessment, including formal clinical evaluation of the Deceased's risk of self-harm and monitoring of risk by the MDT; and/or

(v) adequate and effective assessment of whether the Hospital was providing the Deceased with a therapeutic environment likely to improve his condition; and/or

(vi) adequate and effective monitoring of the Deceased's condition by nursing staff, including an effective system of key nurse involvement in his case; and/or

(vii) adequate and effective monitoring of the Deceased's medication and the extent to which his medication regime was achieving therapeutic benefit to him; and/or

(viii) adequate and effective observation of the Deceased's condition, including his mood and the extent to which he was becoming increasingly isolated; and/or

(ix) adequate involvement, on the part of the First Defendant, in the Deceased's care following his admission to the Hospital."

12. In their written (and oral) closing submissions, Ms Gumbel and Mr Sheldon made the following more specific allegations of breaches of duty:

(i) failing to explain the purpose and benefits of hospital admission to Mr Jones;

(ii) failing to tell JJ 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.

13. In the course of closing submissions I was asked to focus on the latter list and I have done so. There has not been any objection based on the pleadings. I have also considered the allegation of a failure to reach an adequate diagnostic formulation of Mr Jones' condition as this is plainly still in issue, though it is not a discrete item on that list.

The evidence of fact about the care of Mr Jones

14. Mr Jones' mother, Peggy Jones, is a psychoanalyst. She remembered him experiencing some anxiety symptoms for which she recommended a colleague, Professor Pietroni, who is a psychiatrist and psychotherapist. Mr Jones was seen by Professor Pietroni in November 2014 and was referred to Dr Alexandra Richman for ten sessions of eye movement desensitisation and reprocessing therapy ("EMDR").

15. In December 2015 Mr Jones moved back to London with his wife and children from The Hague, where he had been working since September 2014. The move itself was stressful, unsurprisingly. Moreover, building works had been taking place at their house in North London and unfortunately these were not finished in time for their arrival. Mr Jones experienced severe anxiety and sleep difficulties.

16. At this time the First Claimant described him as extremely vulnerable, fearful and anxious and continually unable to sleep. She said that he "accepted, albeit with great difficulty, that he needed professional help". He did not want to discuss his condition with her, thinking that this would make it worse. He did refer to some issues or triggers but she found his explanation confused. In evidence she did not recall being made aware of Mr Jones having anxiety problems back in November 2014 and seeking advice from Professor Pietroni, but she was aware of an incident at a wedding that year where mention of a "creepy" film, *Mulholland Drive*, triggered bad memories of some traumatic events which he had experienced as a teenager in the USA, and she was aware that he then saw Dr Richman for EMDR.

17. Mr Jones saw a private GP in January 2016. I have seen a referral letter to Dr Pereira dated 4 February 2016, which refers to an appointment with Dr Pereira on 29 February 2016.

18. On 29 February 2016 Mr Jones had his first outpatient consultation with Dr Pereira. It was scheduled for 45 minutes but in fact took over an hour. Part of that consultation was also attended by his father, Hugh Jones. Dr Pereira's handwritten notes record the history which he took. This included the matters which had occurred in the USA when

Mr Jones was a teenager. He had been expelled from a boarding school ("Exeter") at the age of 15 (for "coming in late") and had then gone to a different boarding school ("Peddie") for 2 ½ years where he was very unhappy. There, he feigned mental illness and then developed some psychological symptoms, at 17 experiencing manic symptoms such as delusions of grandeur. At that age he also took illicit drugs. In due course he left Peddie and came to the UK at the age of 18, where he took A levels and went on to study at Oxford. Mr Jones also told Dr Pereira that he had had two appointments with a psychoanalyst in 2015 and that he had recently had 3 or 4 sessions of EMDR with Dr Richman. EMDR is often used as a treatment for post-traumatic stress disorder ("PTSD") and Dr Richman is a well-known expert on trauma-related illnesses.

19. At this consultation, Dr Pereira says that Mr Jones denied any thoughts or plan of self-harm but said that he had once fleetingly thought about taking an overdose but that he would not do this, bearing in mind his two young children.

20. In a reply letter to the GP on 29 February 2016, Dr Pereira described Mr Jones as having "a full house of depressive features" dating from around 2 months earlier. He referred to Mr Jones having experienced feelings of grandiosity, unstable mood and hypomanic features in the episode at the age of 17. Since then, he had not had "any clear cut episodes of hypomania or depression other than the recent episode" but had had periods of mood instability. The letter noted a strong family history of mental disorder on his paternal side. Dr Pereira considered that Mr Jones "likely suffers from a Bipolar Affective Disorder currently depressed". He set out a treatment plan with a prescription for Lamotrigine (for low mood) and Quetiapine (a mood stabiliser which would also help with insomnia), on which he would "expect him to do well", and alerted him to possible side effects including a rash caused by Lamotrigine. The dose of Lamotrigine would gradually increase over 6 weeks, and it would take that time to achieve a therapeutic level.

21. Dr Pereira also noted that Mr Jones had recently had EMDR on the hypothesis that he was suffering from Obsessive Compulsive Disorder ("OCD") but he thought that diagnosis very unlikely to be correct. He concluded:

> "6. I have suggested that he follow up with me in clinic on a once a week basis for the next 6-8 weeks so that I am able to monitor his progress.
>
> 7. If he finds it difficult to cope then there is always the option of getting admitted to the Nightingale Hospital for which he has the 24/7 number. I will keep you posted as to how we get on."

22. Following that consultation Dr Pereira provided Mr Jones with a sick note stating that he was "unwell and unfit to pursue the matters that he is dealing with" and that he would be "unfit to resume work for a period of about 6 weeks or so".

23. The First Claimant told the Court that Mr Jones was sceptical about the diagnosis and immediately questioned whether the medication he had been given was appropriate. From 5 to 7 March 2016 they went on a trip overseas which had been arranged earlier. On their return, Mr Jones heard that the Court had refused to adjourn a case in which he was instructed. This meant that, in view of his illness, he would have to return the brief. This had a very considerable adverse effect on his anxiety, self-esteem and mood.

24. Meanwhile, he booked two further outpatient appointments with Dr Pereira on 8 and 15 March 2016, a positive step which Dr Pereira considered to be encouraging. Dr Pereira planned to continue engaging with Mr Jones to achieve a fuller understanding of his condition, keeping his working diagnosis under review.

25. The second outpatient consultation took place on 8 March 2016. It is described in Dr Pereira's written and oral evidence and I have also seen his handwritten notes. On this occasion Mr Jones described his feelings about his work situation and his fear of reputational damage and his career unravelling. He referred to financial worries and to having asked a friend to lend him £50,000. He also referred to the strains of his home life, tensions with his wife and the impact of caring for their two young sons, one of whom appeared anxious. At present he was staying at his parents' house in Richmond. There was a further discussion about medication. Mr Jones said that he had taken an excessive dose of Quetiapine. Dr Pereira explained the fact that the drugs usually took 4-6 weeks to have their full effect. They discussed his obsessive thought patterns, and triggers for unease such as certain films. He said that he was not thinking of suicide because it would "devastate everyone". Dr Pereira repeated that hospital admission remained an option if Mr Jones felt unable to cope. He found it encouraging that Mr Jones was engaging and was trying to understand his symptoms, even if he was sceptical about the diagnosis.

26. A third outpatient consultation took place on 15 March 2016. Mr Jones had contacted Dr Pereira by email on 9 March, reporting a rash on his face and questioning whether he might have OCD rather than Bipolar Disorder. It also emerged that he had consciously taken excessive doses of Lamotrigine on 8 and 9 March, which could have caused the rash. On 15 March Mr Jones reported having euphoric dreams. He said he no longer needed to see Dr Richman. Dr Pereira asked if he could contact her to discuss the dreams but Mr Jones refused. He was upset about losing money from the case which he had been unable to do but said he was feeling positive. Continuing to think about the working diagnosis of Bipolar Disorder, Dr Pereira asked him about "highs" he had experienced in the past. They reviewed his medication and Dr Pereira perceived progress being made, with Mr Jones experiencing fewer unhelpful thoughts and sleeping better. Then, to Dr Pereira's surprise, Mr Jones said that a friend of his sister had recommended a therapist, Colin Campbell, whom he planned to see. Dr Pereira also thought that this was a positive step.

27. On 18 March 2016, Mr Jones sent an email to Dr Pereira about his medication. It was explained in evidence that Dr Pereira's practice was to give his patients the email address of his PA, Pat (who sadly died in 2021), rather than his own address. She would share emails from patients with him and he would direct her to send replies where appropriate. The email of 18 March said:

> "Dear Pat,
> Please pass the following message to Dr Pereira.
> 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?"

28. According to his witness statement, Dr Pereira advised that if the situation was unbearable, Mr Jones should stop the Quetiapine while he thought about alternatives. Mr Jones emailed again to say that he was worried that he would not sleep without Quetiapine and he asked about taking a sleeping pill, Stilnoct. The statement says that Dr Pereira told him that he could take Stilnoct and that his PA would find him a further outpatient slot, and that she arranged this for Tuesday 22 March 2016.

29. It emerged subsequently that Mr Jones did not just stop taking Quetiapine but also stopped taking Lamotrigine. In his witness statement Dr Pereira made repeated reference to this significant failure to follow his advice correctly.

30. However, the picture has become more complicated. In the witness box, Dr Pereira was shown his email reply which was sent to Mr Jones on 18 March. It was in fact written and sent by Pat, though it reads as if it came directly from him:

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

31. When it was put to Dr Pereira that he therefore had not advised stopping Quetiapine only, he said that he had assumed that Mr Jones was referring to Quetiapine (which was intended to help with sleep) and that his instruction to Pat to tell Mr Jones to stop that drug had been written on a sticky note.

32. A number of Dr Pereira's answers to questions prompted the Claimants' representatives to make inquiries of his representatives, during the trial, about whether there were relevant documents which had not been disclosed. Some further documents were disclosed as a result and on 17 May 2023, Dr Pereira's solicitor filed a witness statement explaining how this had come about. Among the exhibits to that statement was a newly disclosed printout of Mr Jones' email of 18 March 2016 with a handwritten annotation saying "to stop Quetiapine". That is followed by an underlining, a tick and the date "18/3" in a different handwriting which is said to be that of Pat.

33. Dr Pereira was also asked about his witness statement to the Inquest into Mr Jones' death. That statement, signed on 27 June 2016, gave the distinct impression that his advice had been to stop both medications. It said: "I advised him to stop the medication" and then "On 21 March … I was informed that he had now stopped taking the Lamotrigine and Quetiapine" without any comment that doing this was contrary to his advice.

34. Dr Pereira was also taken to the transcript of the Inquest on 6 July 2017. The Coroner appears to have understood that both medications were stopped on 18 March 2016 and she asked whether there was a risk in stopping so suddenly. He said no, and referred to the characteristics of both drugs by way of explanation.

35. So Dr Pereira's evidence at the Inquest was that both medications were stopped, but in his witness statement for this trial signed on 2 September 2022 he said that the advice was only to stop Quetiapine. He was recalled to the witness box on the last day of the

trial and, asked about this, said that this evidence had come about through his having reviewed the hand-annotated email, that it was in a file of relevant documents which had been kept for him by his administrative staff, but that he had not realized that that annotated copy was not included in the documents exhibited to his witness statement and had not been disclosed.

36. Mr Sheldon asked Dr Pereira whether the hand-annotation had been fabricated, after the event, to support his account. He denied this, pointing to Pat's dated tick mark beside the annotation.

37. It was also pointed out to Dr Pereira that, if his working practice was consistent, then there should also be an annotated printout of the next email in the series, asking about Stilnoct. Pat sent a reply to that email, again in Dr Pereira's name, confirming that Mr Jones could take the sleeping pill. But no such printout has come to light. Dr Pereira responded that Pat would have filed the printed copies of some such messages but not others. It has of course not been possible to obtain evidence from Pat.

38. I do not conclude on the balance of probabilities that the hand annotation was fabricated. Fabricating it, either with or adjacent to Pat's tick and date, would be an extremely serious and potentially career-ending act of misconduct. It would be all the more extraordinary given that the question of whether the advice was to discontinue one drug or both drugs is not central to the issue of liability in this litigation.

39. Nevertheless, this part of the evidence gives me cause for concern in several ways. First, Dr Pereira gave an incorrect account of these events to the Inquest, not so long after the event. Second, his different evidence in his witness statement in this claim, about Mr Jones' failure to follow advice, was in emphatic terms, but it turns out to have been based on the relatively weak foundation of a three word note that Dr Pereira saw several years after the event. Third, that emphatic suggestion that Mr Jones failed to follow advice turns out to be wrong, because Pat's email in Dr Pereira's name did not give the correct advice, a fact which it seems he failed to appreciate when reviewing the documents. Fourth, that fact demonstrates that Dr Pereira's system of giving important advice via brief handwritten notes to Pat could, and did, go wrong. Emails sent to patients as if from him personally not only were not typed by him, or indeed phrased directly by him, but also did not necessarily impart his advice accurately. Fifth, in such instances the original advice contained in handwritten notes was not reliably retained in any file or record. Sixth, there was a serious failure of disclosure in this litigation because some of the papers which were in a file, kept by or for Dr Pereira expressly for use in this case, were not included in his List of Documents and nobody noticed the omission until the challenge by the Claimant's team during the trial.

40. Returning to the sequence of events, on 21 March 2016 Hugh and Peggy Jones telephoned Dr Pereira, with Mr Jones in the background, and said that he had stopped the Quetiapine and the Lamotrigine and that he was in crisis. They asked if he could be admitted to the Nightingale Hospital.

41. That morning, Peggy Jones emailed Pat and said:

> "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."

42. Pat promptly confirmed that a bed was available at the Nightingale Hospital and asked whether Mr Jones would prefer to be admitted that day on a self-funding basis or to await BUPA authorisation within 24-48 hours. Mrs Jones replied that his preference was to spend another night at home and go to hospital the next day, with or without funding.

43. In a further email to Pat the next morning, Mrs Jones said:

> "We are planning on coming up to the Nightingale this morning, trying to avoid the worst of the traffic. I haven't been in touch because first, John hasn't got his BUPA information here and is very distracted and anxious and I didn't know how to contact BUPA myself, and didn't think that would help anyway …; and second, because it has been very difficult to help John see that admission is the only option. He is so convinced that nothing can or ever will help that agreeing to try something has been almost impossible.
>
> But, I think he is on board at this point …"

44. Dr Pereira has said he was surprised that Mr Jones appeared to have gone backwards. There was no time to re-assess him then but clearly he and his parents could not cope. His medication was said to be having a catastrophic effect. Dr Pereira's witness statement also refers to Mr Jones having by now made two errors in relation to the medication, though that is subject to my comments above. Although he has emphasized in his evidence that he has a "high threshold" for admitting patients to hospital, he 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 would also have access to the hospital's range of group therapies.

45. The admission necessitated an application for funding from BUPA. A form was completed and signed by Dr Pereira as the admitting consultant. It required a diagnosis to be stated by reference to the International Classification of Diseases. Dr Pereira identified ICD code F316, Bipolar Affective Disorder. There was a brief summary of the symptoms, including "self harm ideas re overdose". The form requested details of the benefits of the proposed admission. These were identified as "risk management, reduced suicidal thinking, mood stability, re-establish medication regimen". The reasons for choosing in-patient care were stated as "patient is chaotic in presentation, having severe side effects with medication plus self harm ideas". The form then required the risk of suicide and self-harm to be classified as none, mild, moderate or severe. Dr Pereira ticked the "moderate" box and identified "planning overdose" as a factor indicating intent. The proposed treatment was identified as a pharmacological regimen and "CBT groups" and the estimated length of stay was "approx 3 weeks".

46. The risk assessment part of that form was the subject of some interesting evidence.

47. In brief, there was agreement between Dr Pereira and the two psychiatric expert witnesses, Dr Meehan and Dr Maganty, that in all cases the difficulty of assessing the risk of suicide is such that it is neither helpful nor appropriate to do it by way of a tick-box exercise.

48. That is consistent with *Self-harm in over 8s: long-term management*, a clinical guideline issued by the National Institute for Health and Care Excellence ("NICE") in 2011. That was the edition in place at the relevant time, though NICE published revised guidance on self-harm in 2022. It states in particular:

> "Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.
>
> 1.3.11 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.
>
> 1.3.12 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged."

49. The Claimants' counsel pointed out that the guidance concerns the treatment of patients who have self-harmed rather than being concerned with predicting self-harm in those who have not done so. However, that does not appear to me to be a relevant distinction. If risk assessment tools and scales cannot assist with patients who already have self-harmed, it is hard to imagine how they could assist with those who have not.

50. The reason why that sort of assessment is unhelpful was addressed in evidence by Dr Maganty, the psychiatric expert witness called on behalf of Dr Pereira. In oral evidence he said:

> "Risk stratification as high, medium or low should not be done for suicide and NICE specifically says that. The reason for that is suicide is a low-frequency event, it occurs rarely even in those who are severely mentally ill. You cannot, if you start -- and the majority of people who go on to suffer a self-inflicted death are classified as low, that gives a false sense of safety. It cannot be done accurately, it cannot be done with even reasonable accuracy, therefore, as NICE says, as the Royal College of Psychiatrists says, as current psychiatric practice says, it just is not possible to decide if somebody is low risk or not and high/medium/low should not be done at all."

51. So it seems that the BUPA form invites doctors to engage in an exercise which professional guidance considers is not helpful. If they do not respond, their patients may not be admitted to hospital. So, when Mr Sheldon in cross-examination reminded Dr Pereira that he had identified a moderate risk of self-harm and suicide on the form, he responded:

> "Well, that was a form that was directed towards BUPA to ensure that there was estimation of projected risk so that the insurer would enable the admission, to enable me to give my patient what it is that they needed, or what they wanted."

52. The point was put in blunt terms by Dr Meehan, the psychiatric expert called on behalf of the Claimants, when cross-examined by Martin Porter KC (who, with Paige Mason-Thom, appears as counsel for Dr Pereira):

> "Q. The exercise is required, as we have heard, by some health insurers, and I'm sure you are aware of that with your private practice. We have seen that BUPA required a tick-box exercise as to the degree of suicide risk?
>
> A. Yes, because as I think Dr Pereira very succinctly outlined, if you want to get a patient into hospital you have to frighten BUPA and the way you frighten BUPA is by saying there is a risk.
>
> Q. But it is not a helpful predictor?
>
> A. No."

53. Dr Maganty's evidence was to similar effect:

> "When we had the experts' discussion, all of us knew that that was just -- it is accepted fact that psychiatrists can't do that. We all accepted that, you know, BUPA requires it and Dr Pereira clearly wanted his patient to be admitted, and unless he fulfilled the criteria of the form to get his patient into admission they weren't going to pay for it. It was quite obvious to us that that is what had happened from a clinical perspective. To be very fair, all of us have been in that boat. You know, that's why, with my public appointment, we have been working to stop insurance companies, others, to insist that clinicians do things which they know has no value."

54. Dr Maganty was asked whether it would therefore be reasonable for a psychiatrist, while believing the risk is low, to say on the BUPA form that it is moderate. He replied:

> "I need to consider this carefully. I think a reasonable body of psychiatrists would have done what he did, and a reasonable body of psychiatrists would not have done it. So on that basis, there would be psychiatric opinion either way, in my view. But if you are asking me personally to answer that question, considering my longstanding role on working on this issue, I would have challenged BUPA, but I don't think I would have got very far."

55. In light of that evidence I understand why Dr Pereira identified a moderate risk of self-harm and suicide on the BUPA form. It seems to me that forms of that kind are not well aligned with current thinking in the psychiatric profession and may place doctors in an ethically difficult position.

56. However, there are other difficulties with Dr Pereira's evidence about the perceived risk of suicide. In his witness statement he said 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.

57. When shown an email to him from Peggy Jones on 21 March 2016 which described Mr Jones as "a danger to himself", he said that he interpreted this as "a risk of distress". Questioned further, he said that the sentence beginning "none of the family" also needed to be corrected, and he had not realized that it contained a mistake until he was giving his oral evidence.

58. At the least, these instances along with the issue about stopping the medications (discussed above) show that Dr Pereira's witness statement was unreliable, in that it contained emphatic and self-serving statements which, when challenged, had to be withdrawn.

59. I also have concerns about the reliability of Dr Pereira's oral evidence. 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.

60. Mr Jones was admitted to the Nightingale Hospital on 22 March 2016. The timing was unfortunate because, on or around that date, Dr Pereira began 3 weeks of leave from his duties at the Nightingale. After the admission, Mr Jones would be the responsibility of another consultant, Dr Neelam Bakshi.

61. Nevertheless, it is clear from all of the documentary evidence that Dr Pereira was the admitting consultant. 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.

62. It is common ground that Dr Pereira did not tell Mr Jones that he was about to be unavailable for 3 weeks and that Mr Jones went into hospital expecting to see Dr Pereira within a day or two. In cross-examination Dr Pereira sought to make light of this, saying that this was not the focus of the conversation on 21 March 2016 which was more concerned with identifying what his patient needed and wanted.

63. Dr Meehan gave evidence that Dr Pereira's failure to tell Mr Jones that he would not be available was not consistent with good psychiatric practice.

64. Dr Maganty said that it would have been ideal to tell Mr Jones that Dr Pereira would be away, if it were possible. However, he drew a comparison with what happens in the great majority of admissions of patients to psychiatric hospitals in the NHS, where patients routinely are not told who their treating consultant will be (and sometimes do not even know in advance which hospital they will be going to). So telling Mr Jones that Dr Bakshi would be taking over from Dr Pereira would have been, in his words, "a nice thing to do", or "Rolls-Royce service" but was "not critical". He had seen no evidence to suggest that the usual NHS practice had any severe adverse impact on patients.

65. It was pointed out to Dr Maganty that a comparison with practice in the NHS was not very apt because, as he had agreed in evidence, Mr Jones' condition on 21 March 2016 was not at a level of acuteness that would have resulted in admission to an NHS hospital. So the context of this case was quite different.

66. On the question of what handover took place between Dr Pereira and Dr Bakshi, the evidence is not entirely clear.

67. For this phase of the case, lasting until Dr Pereira's return to the Nightingale on 10 April 2016, I am at a significant disadvantage. As I have said, the claims against Dr Bakshi and the hospital were settled shortly before the trial. Dr Bakshi has not given evidence. I have not been asked to read any witness statement provided by her, and of course no such statement has been tested by cross-examination. That has made it more difficult for me to determine what handover did or did not take place, as well as preventing me from assessing the merits or demerits of the care provided to Mr Jones while Dr Pereira was away.

68. In his witness statement Dr Pereira said that, because he would not be able to see Mr Jones in hospital for the next 3 weeks, he asked his experienced colleague Dr Bakshi if she would take over in his absence, and she agreed. I note in passing that, according to the BUPA form, 3 weeks was the anticipated length of the stay in hospital and therefore what was being transferred was, it would seem, responsibility for treatment during the entire in-patient phase. He went on to state that his PA sent over the clinical correspondence for Dr Bakshi's attention on 21 and 23 March and, in accordance with his usual practice, he "had a discussion with Dr Bakshi regarding Mr Jones at the time of his admission".

69. In cross-examination Dr Pereira was asked when and how he asked Dr Bakshi to take over. He replied that it would have been by telephone on either 22 or 23 March 2016 and that there was no note of the conversation.

70. He also confirmed that the "clinical correspondence" was emailed by Pat to Dr Bakshi's PA, Martel. The reference to that email triggered the investigation into disclosure failures to which I have referred above and the further disclosure, during the trial, of documents which had been in a file in Dr Pereira's possession. The newly disclosed documents included an email from Pat to Martel at 11 a.m. on 23 March 2016 saying simply "Info for Dr Bakshi on new inpatient". The subject field says "Please see attached – JJ" but the attachments have not been located. According to Dr Pereira, the clinical correspondence would have consisted of the original GP referral letter and his reply letter to the GP. Those letters of course did not address the patient's subsequent deterioration.

71. Dr Pereira said in evidence that the conversation would have covered the "catastrophic effect" of medication of which Mr Jones complained, although that detail has not been mentioned in any witness statement, and that his summary of the history and his thoughts on the case were captured in Dr Bakshi's note of her first consultation with Mr Jones on 23 March 2016.

72. In cross examination he was taken to two notes made by Dr Bakshi on that date. One of these said "Patient seen by Dr Pereira who feels it is Bipolar disorder. Patient does not think bipolar, says never had any previous depression …". The other note said "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."

73. The extent of the handover conversation is therefore not clear from contemporaneous documentation.

74. Hospital notes including a drugs chart show that Dr Pereira spoke to the admitting doctor or the nursing staff about Mr Jones' medication on 22 March 2016, the date of his admission, and that he went back onto Quetiapine and Lamotrigine with the addition of Clonazepam for stress and anxiety (and, later, Olanzapine). Dr Pereira told me that it was appropriate to resume Quetiapine and Lamotrigine, despite their alleged "catastrophic effect", now that Mr Jones could be supervised in hospital.

75. Meanwhile it was accepted by Dr Pereira in evidence that at the time of the admission, no further explanation was given to Mr Jones of the nature, purpose and benefit of his admission (i.e. the purposes recorded on the BUPA form). Dr Pereira maintained that these had been adequately explained when the contingency plan of admission was discussed back on 29 February 2016.

76. The effectiveness of this was challenged in cross-examination. Mr Sheldon put to Dr Pereira an email written by Mr Jones to the First Claimant on 24 March 2016 expressing confusion and frustration:

> "I know how I got here and fortunately or unfortunately it wasn't due to any pre-existing psychological complaint (bipolar, depression or anything) – it was, as we know, a lack of sleep (I should have checked into a hotel …) and anxiety, making it hard to work, which led to cancelling the big case, which got me more upset, got me medications which I didn't need and didn't help and so on and so forth, into a downward spiral. It's not much more than that. I'm furious at myself and at the shrink, but there it is."

77. There follows a gap in the evidence, as I have said, because I have not heard evidence about the care of Mr Jones in the hospital while Dr Pereira was away. I am not assisted in any way by the fact that the Second and Third Defendants entered into a settlement agreement with the Claimants. There has been no admission of liability and I cannot infer any acceptance of any allegation of fact.

78. That makes this a more complicated case to judge. Although I have seen hospital notes documenting the period when Dr Bakshi was the treating consultant, I am 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.

79. There is some evidence suggesting that there was a limited improvement in Mr Jones' mood during his third week in hospital. The First Claimant referred to this when she was interviewed by Dr Meehan. In oral evidence she said that his mood improved "…

in the sense that he was responsive, you could speak to him, rather than him lying in bed and barely walking" but that this did not mean that he was recovering.

80. As I have said, Dr Bakshi herself went on leave on 8 April 2016. On 10 April Dr Pereira resumed responsibility for Mr Jones' care. He says that he had a "handover telephone call" with Dr Bakshi on 8 April, read Mr Jones' hospital notes and saw him in the hospital on 11 April. In the telephone call, Dr Bakshi had said that although there was some improvement in Mr Jones' condition, he had not been engaging in the group therapy programmes which were made available in the hospital. He declined these on two occasions when assessed by the Nightingale Hospital's Therapy Team on 23 March (by Dr Meg Camm) and on 29 March (by Dr Monica Cain). Dr Bakshi had had a couple of one-to-one sessions of mindfulness-based cognitive therapy with him, aimed at dealing with obsessive ruminative phenomena. However, he had not given her access to what he found triggering, or to his "inner world".

81. There was no note of this handover conversation. In cross examination Dr Pereira said that, as in the case of his earlier handover to Dr Bakshi, this was because he was probably in transit at the moment when the two consultants managed to make contact by telephone in between other duties, and the same may have been true for her.

82. It was pointed out that Dr Bakshi kept notes headed "client daily record". Her last note on Mr Jones, dated 8 April, refers to Dr Pereira "covering from 10-17 April" but does not mention any handover conversation. However, as Dr Pereira observed, the note may have been written before the conversation happened.

83. Dr Pereira was also shown nursing notes dated 8 April 2016. These describe Mr Jones as "more relaxed" but still experiencing poor sleep and say that "his mood remains low and he is still experiencing feelings of helplessness and hopelessness". Taken to this in cross-examination, Dr Pereira observed that this was part of a generally inconsistent picture.

84. Save for a small number of mindfulness sessions, it was apparent that Mr Jones had not received any psychotherapy since his admission. Dr Pereira accepted in evidence that he had envisaged appropriate therapy being an important part of Mr Jones' effective in-patient treatment. He was reminded of his evidence at the Inquest, where he said that "a psychological intervention … could have made a huge difference".

85. In his ward round on Monday 11 April 2016 Dr Pereira saw Mr Jones as an inpatient for the first time. Dr Bakshi had prescribed Sertraline for depression and Dr Pereira slightly increased the dose. Mr Jones had not been willing to continue with Quetiapine or Lamotrigine. He had also been taking Clonazepam since the time of his admission. According to Dr Pereira's notes, Mr Jones told him that "People say I have improved" and that his wife also said that there was an improvement.

86. Dr Pereira says that he told Mr Jones that he was concerned about his lack of engagement with the group therapies in the hospital, as this was an essential part of his treatment plan. He advised that even if Mr Jones was unwilling to attend "talking" groups where patients share their thoughts and feelings, he should attend "non-talking" groups, for example practising breathing techniques, yoga or art therapy. Having discussed his feelings with him, Dr Pereira proceeded with a new working diagnosis of

obsessive ruminations. He told Mr Jones that he needed to have access to his inner feelings, and set him an exercise of setting down his thoughts in writing.

87. Later that night, Mr Jones sent an email to say that he had completed the exercise but did not wish to send it by email or post. Dr Pereira responded that they could review his note at his next ward round on 13 April.

88. In a nursing note on the evening of 11 April Mr Jones is reported as saying that a lot of people were saying that he was looking better and recovering but he did not see that.

89. On 12 April the hospital telephoned Dr Pereira to say that Mr Jones was concerned about being sedated with Clonazepam. Dr Pereira's response was to stop Clonazepam and to prescribe Pregabalin as an alternative medication for anxiety.

90. Dr Pereira saw Mr Jones again during his ward round on 13 April 2016. They had a further discussion about Mr Jones shutting himself off and not wanting to discuss his innermost thoughts. They also discussed the events which had occurred when he was a teenager in the USA. Mr Jones then showed Dr Pereira the notes that he had written on his laptop. In his witness statement, Dr Pereira said that he could not now recall these in detail, but he thought at the time that they were not what he had asked for. They contained history about what had happened at school in the USA but did not divulge details of Mr Jones' inner thoughts.

91. In cross-examination Mr Sheldon suggested to Dr Pereira that he did not read all of Mr Jones' note. Dr Pereira rejected that suggestion, describing it as "appalling". Mr Sheldon then took him to his Inquest witness statement which said "There were about three pages as I recall, and I didn't have the opportunity to read every word, but from what I read it struck me that they were still lacking in detail and I told him so." Dr Pereira explained that he "would have skimmed through the entire document looking for the information that I had wanted" but it "was just not there". The First Claimant remembers Mr Jones feeling that Dr Pereira was dismissive, saying "but everyone can write these notes".

92. On 13 April Dr Pereira and Mr Jones also discussed his medication and decided that he would continue with Sertraline and Pregabalin.

93. They also spoke about psychotherapy. As to this, Dr Pereira in his witness statement said:

> "We had a discussion that if he still was not going to be attending the groups, would he consider 1:1 individual therapy? He said that he would consider it but he was going to think further about that. Subsequent disclosures show that the patient was accessing his own one to one therapy sessions via video call whilst in hospital. He did not disclose this to me or the hospital."

94. This review on 13 April is also evidenced by a contemporary handwritten note written by Dr Pereira for the nursing staff. His note of the advice given includes the phrase "for 1:1 as not attending groups".

95. In his evidence Dr Pereira explained the applicable procedure. He would expect the nurses to note this instruction in the "ward business book" and then to ring the hospital's Therapy Department to pass on the consultant's recommendation. The therapy lead would receive that communication and would send a psychologist to the ward to carry out an assessment to determine what sort of one-to-one therapy would be suitable. There are, of course, many types of psychotherapy, such as cognitive behavioural therapy, interpersonal therapy and others.

96. Dr Pereira's observation about Mr Jones accessing his own one-to-one therapy (which was repeated in a later paragraph of his statement) was challenged in cross-examination. He was taken through emails between Mr Jones and Colin Campbell (who is already referred to above) in March and April 2016. In March, Mr Jones asked Mr Campbell if he could recommend a CBT therapist. On 24 March Mr Campbell replied that it was "difficult to know which form of therapy will be best" and that CBT might not be the right approach for the bipolar category. The emails showed that although Mr Jones and Mr Campbell discussed dates for an appointment, no meeting took place.

97. Having reviewed those emails, Dr Pereira accepted that his statement was wrong in alleging that subsequent disclosures showed that Mr Jones had been accessing therapy sessions while in hospital. This was a further instance of the witness statement being unreliable.

98. On Thursday 14 April 2016 Dr Pereira received an email from Hugh Jones, expressing deep concern about Mr Jones' lack of progress and describing a "relapse yesterday into the deepest despair and depression". The email raised questions about various options for what should happen next.

99. This prompted a meeting to be arranged between Dr Pereira and Mr Jones and his parents in the evening on Friday 15 April 2016, at the end of Dr Pereira's ward round that day. The First Claimant also attended, meeting Dr Pereira for the first time. They gave their perspectives on the history. The family expressed their view that Mr Jones was in a bad way. Dr Pereira says that Peggy Jones referred to a past history of obsessions and "melancholia", which he took to mean depression, though there is a dispute over whether that word was used. Dr Pereira says that he raised the fact that BUPA funding for in-patient treatment would not last indefinitely. One option was nevertheless to stay in hospital and access the group therapy. The other was a move to outpatient appointments combined with one-to-one CBT. It was agreed that Mr Jones would discuss matters with his family over the weekend and report back to Dr Pereira at his next ward round on the Monday.

100. Dr Pereira felt that real progress had been made at this meeting and that Mr Jones was finally about to engage with his treatment. He thought that the family were pleased too, recalling a smile and a "thumbs up" sign from Peggy Jones.

101. The family members remember the meeting differently.

102. Peggy Jones remembers Mr Jones seeming cowed and frightened and "like a broken creature sitting in his chair". She was put off by Dr Pereira's manner towards Mr Jones. When Mr Jones asked a question about his diagnosis, Dr Pereira laughed and said that Mr Jones had not given him sufficient material from which to make one. Peggy Jones

thought that Dr Pereira's comments on the note which Mr Jones had written sounded critical, saying that it "was not adequate and that he wasn't clever like John and couldn't read between the lines". She thought that perhaps Dr Pereira was using a technique of seeking to challenge the patient's resistance. Peggy Jones also did not remember giving a thumbs up, and Hugh Jones was confident that this did not happen, it not being a gesture she is in the habit of using.

103. In her oral evidence the First Claimant was asked about the meeting. Her recollections were not very detailed. However, she remembered Dr Pereira asking each person present what they thought. As to the atmosphere, she essentially remembered Dr Pereira speaking to the family while Mr Jones "was sitting there as a naughty schoolboy". Following Dr Pereira's advice, the family tried to convince Mr Jones to attend the group therapies.

104. The First Claimant told Dr Meehan that Mr Jones was more positive after the meeting, but she thought that this was a momentary sense engendered by the fact that they were all sitting there supporting him, and that this had gone by the next day.

105. Her evidence was also that Mr Jones never mentioned suicide in any conversation with her, though once on 9 April he described being in a kind of agony that was worse than physical pain and that he wished someone would give him something to end it. On another occasion when he referred to this pain, she urged him to think of the children if suicide ever occurred to him, and of what they would think. His response was that they would just think he had been sad. She was shocked to hear that.

106. Hugh Jones in evidence described the meeting in slightly more neutral terms. He did not detect any animosity. In an email to his son on 17 April, pressing him to trust Dr Pereira and participate in the hospital's therapy programme, he said that in the meeting "I felt that we had a glimmer of hope". In the witness box, however, he described this as clutching at straws.

107. I accept the evidence of Peggy and Hugh Jones that she did not give a thumbs-up sign as she left. Equally, I have no doubt that the family did express gratitude for the meeting as they left, even though Dr Pereira is wrong in his recollection of the gesture. Although they did not feel that it had been particularly successful, it is clear that the meeting was very important to them, given Mr Jones' very worrying and distressing condition.

108. That weekend, 16-17 April, Mr Jones stayed in the family home. The children returned home from a 3 week visit to Slovenia. On the Sunday evening the First Claimant put them to bed and Mr Jones went back to the hospital by public transport. Hugh Jones telephoned the First Claimant to ask her to take Mr Jones back to the hospital because he was worried about his mental state, but he had already left.

109. I also heard evidence from Julian Granville. He was an old friend of Mr Jones and is a wealthy businessman. He heard about Mr Jones' illness in February 2016. He visited him in hospital on 28 March. Mr Jones mentioned having suicidal thoughts, Mr Granville said that suicide was unthinkable because of the children and he agreed. Mr Granville advised him to take several months off work and reassured him that he, and another mutual friend who is also wealthy, would look after any financial worries. He

said that Mr Jones had never been very good at managing money though, on his return to London, he was hoping to make his practice "more commercial". Mr Granville visited again on 13 April and felt that Mr Jones had deteriorated and was now very low. That day, he made the first of two substantial payments to the Jones' builders. Mr Jones telephoned him on 15 April and expressed his feeling that hospital was not helping him. Mr Granville and he discussed plans for his leaving hospital and trying to find more effective psychological treatment. I have also seen a series of electronic messages passing between them while Mr Jones was in hospital.

110. I have already stated the bare facts of how, early in the morning on 18 April 2016, Mr Jones died at West Hampstead Station. There is no suicide note or other evidence to give any further insight into his state of mind. Dr Maganty in his first report comments:

> "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 medical expert evidence on liability

111. Expert evidence was called by both sides from experienced consultant psychiatrists.

The evidence of Dr Meehan

112. The Claimants instructed Dr John Meehan. In his first and main report he was critical of "a lack of any coherent assessment, treatment and management plan which I believe stemmed from an inadequate diagnostic formulation" which "was not addressed or rectified by appropriate and coherent therapeutic engagement", these matters representing a standard of care that would not be considered reasonable by any responsible body of consultant psychiatrists.

113. It is important to recognise that this was Dr Meehan's verdict on the care of Mr Jones by Dr Pereira, Dr Bakshi and the Nightingale Hospital considered as a whole.

114. In Dr Meehan's opinion, in this complex case it was necessary for the treating clinician(s) to embark on a "diagnostic formulation", described as follows:

> "D1. Based on my review of the documentation from the sources above, I consider that the provision of competent and effective assessment and care to Mr Jones had three separate but overlapping dimensions. These were:
>
> 1. The provision of an adequate diagnosis/diagnostic formulation
> 2. The provision of an adequate and effective care plan
> 3. The provision of an adequate and effective 'safety net' of risk management
>
> **Diagnosis/Diagnostic Formulation**

> D2. Having considered all the documents, I consider that the best explanatory framework for understanding Mr Jones' clinical presentation in 2016 was that of a post-traumatic diagnostic formulation.
>
> D3. That diagnostic formulation (combining clinical and personal narrative with a trauma informed perspective) effectively links key elements of Mr Jones' past history of trauma during adolescence with his background fears and rituals during his life, his EMDR treatment with Dr Richman and the 'here and now' stressors of his life in 2016. All of the above, (which can be divided into predisposing and precipitating factors), contributed, in my opinion, to the 'perfect storm' of the 'past and present coming together' as described by his wife, Misa.
>
> D4. It is important to understand the difference between the psychiatric diagnosis and a diagnostic formulation. The psychiatric diagnosis places individuals in particular categories and as such acts as a diagnostic label, (i.e., bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder).
>
> D5. A diagnostic formulation asks the following question: why is this person experiencing these symptoms at this moment in time? In essence, it is three questions as outlined above, rolled up into one."

115. Dr Meehan focused on the events taking place in Mr Jones' adolescence and concluded that these were the "primary source of his distress and terror" which surfaced in the last weeks of his life. Notes of his EMDR sessions with Dr Richman confirmed the levels of distress which he was experiencing. The key to understanding his clinical presentation in 2016, he felt, was the interaction of the past trauma with a "perfect storm" (a phrase used to Dr Meehan by the First Claimant) of current stressors in his life, returning from The Hague with financial strains arising from that transition combined with the unfinished building work at home and the demands of a young family.

116. As Dr Meehan put it in oral evidence, "to understand this man through the framework of a post traumatic reaction was crucial to a shared understanding between him and his treating clinicians" and "a diagnosis is based on the medical model, and this man's difficulties were not, in my opinion, understandable within the medical model. They were understandable within a psychological model, and the psychological model involves a diagnostic formulation: why is this person experiencing these symptoms at this moment in time?"

117. At this time, in Dr Meehan's view, "the nature and degree of Mr Jones' symptoms and preoccupations made self-disclosure of his inner world difficult and challenging for him" but this challenge was not insurmountable. In this situation of uncertainty about the diagnosis and diagnostic formulation, Dr Meehan considered that there was an additional duty to engage in an ongoing process of assessment and review, using all available sources of information and providing therapy in a form consistent with Mr Jones' needs and wishes. Although Mr Jones' refusal of consent for contact with Dr Richman was an obstacle, Dr Pereira should have interrogated him further about the reasons for it. As Dr Meehan put it in oral evidence, "the clues were there to bring together into a trauma narrative on what Dr Pereira knew already", and there was a

failure "to join up the dots, to incorporate it into a diagnostic formulation that made sense to the patient".

118. Dr Meehan thought that it was premature for Dr Pereira to come down firmly on the diagnosis of bipolar disorder. That set up a treatment pathway based on mood stabilising medication, involving certain side effects. Where the patient disagreed with the diagnosis, it did not create a "therapeutic alliance" of trust between patient and doctor. Dr Meehan rejected the differential diagnosis of bipolar affective disorder – a condition which may also cause episodes of depression – because that is a biologically driven disorder. He expressed the view in cross-examination that Mr Jones' depression "was reactive in nature rather than biological in nature". In answer to a question from me, he said that whilst the behaviours exhibited by Mr Jones might resemble behaviours caused by bipolar disorder, that diagnosis did not fit because the behaviours in this case were a clinical presentation of a reactive problem, not a biological problem.

119. At the end of his cross-examination of Dr Meehan, Mr Porter asked him whether Dr Pereira's differential diagnosis of bipolar disorder was one at which no reasonable psychiatrist could arrive. Dr Meehan replied that he disagreed with Dr Pereira's opinion. He added that he did not disagree with Dr Pereira or Dr Maganty on the "symptom facts", but on the interpretation of the symptoms. I asked him whether he went so far as to say that no reasonable psychiatrist could have arrived at that interpretation, and he replied:

> "I wouldn't go as far as to say that, no. I can understand why they may have arrived at that interpretation, but I disagree with that interpretation."

120. That was an important piece of evidence to which I return below.

121. Building on his criticism of the approach to diagnosis, Dr Meehan was critical of the care provided by Dr Pereira between 29 February 2016 and Mr Jones' admission to hospital on 21 March 2016 and was particularly critical of the admission itself. It occurred, he noted, at a point where Mr Jones' symptoms had become acute and where Dr Pereira said that he had no opportunity to reassess Mr Jones. Dr Meehan considered that if he did have an opportunity to re-assess him before departing on leave (and he noted a reference to an outpatient appointment having been booked for 22 March, which might have provided an opportunity), then failing to do so would be a breach of duty. Failing that, admitting him without a comprehensive handover to the hospital and to Dr Bakshi, with information about diagnostic uncertainty, the poor response to medication, the deterioration in Mr Jones' mental state and the increase in perceived risk, was a breach of duty.

122. In oral evidence Dr Meehan referred to the potential counterproductive effects of the hospital admission. It was necessary in his view for Dr Pereira to discuss with Mr Jones the aims of the admission, to maximise his treatment and to keep him safe, balanced against the risk that he would find the transition to hospital difficult, and to consider any alternatives such as intensive day care combined with individual therapy. Whilst the option of admission had been discussed at an earlier outpatient appointment, there was an unacceptable failure to discuss it at the point when the option became reality.

123. He also considered it unacceptable that Dr Pereira did not tell Mr Jones that he was about to be away for 3 weeks and therefore would not be the treating doctor.

124. Dr Meehan also criticised the lack of a properly coherent medication plan, based on a collaborative approach with the patient, explaining the role and potential benefits, and side-effects, of proposed medications. In answer to a question in cross-examination, Dr Meehan accepted that if, contrary to his view, bipolar disorder was the right diagnosis, then the medication regime implemented by Dr Pereira was appropriate for that condition. However, he considered that the lack of steps to establish this framework or to discuss it with Dr Bakshi constituted sub-standard care. He also considered that, when told of the "catastrophic" effect of medications on 18 March 2016, Dr Pereira was bound to see him on an urgent basis then rather than stopping the medication and booking an outpatient consultation for 22 March.

125. Dr Meehan also perceived a breach of duty in a failure, before Mr Jones was admitted, to discuss with him the benefits and role of therapy in his treatment, or to act on his stated wish for individual therapy. Therapy, in Dr Meehan's view, was "the cornerstone of any treatment plan" for Mr Jones. A failure by all of the Defendants including Dr Pereira to act on his rejection of group therapy and to arrange individual therapy was also negligent. In his oral evidence he agreed that this was "a complex case, with complex issues in relation to gaining access", but there was a failure to engender confidence and hope in the patient by setting out the right process to help him. In re-examination he expressed agreement with evidence given by Dr Pereira to the Inquest when asked if there was anything he would do differently in another similar case:

> "I would probably with the benefit of hindsight maybe have insisted that he engaged with therapy on day 1, giving him the opportunity."

126. A further criticism by Dr Meehan was of a failure by Dr Pereira to implement a multi-disciplinary process of risk assessment and management, in the context of a patient who was subject to an identified risk of self-harm or suicide and who was admitted to hospital to enable that risk to be properly managed. He found no evidence of a management plan for his care when in hospital and, again, no proper handover to Dr Bakshi.

127. In oral evidence Dr Meehan explained that in his view there should have been a meeting of the doctor, the nurses and a psychologist or psychotherapist "to formulate a coherent plan that took into account this man's terror and depression in a way that gave him hope that the treatment plan would enable recovery". He considered the lack of any integrated care plan or ongoing risk assessment to be a breach of the duty of care. In his view this was, instead, "a poorly conceived and poorly executed admission to hospital".

128. In answer to questions, Dr Meehan accepted that NICE guidance counsels against using tick-box exercises for assessing the risks of self-harm and suicide. He also accepted that assessment of risk as low, medium or high was not in fact a good predictor of which patients would take their own lives. It was therefore agreed that not making such assessments could not place any consultant psychiatrist in breach of duty. It was also agreed that there was never any indication by Mr Jones of suicidal intent that would have empowered the Hospital to restrict his movements.

129. Dr Meehan then turned his attention to the situation when Dr Pereira returned from leave on or around 10 April 2016, when Mr Jones had been in hospital for 3 weeks. In his opinion, Mr Jones in hospital had been in a "downward spiral", was feeling overwhelmed and terrified by his stress reaction and now urgently needed to be stabilised. Dr Pereira should have perceived his condition and his lack of improvement as an emergency and was in breach of duty by failing urgently to construct a diagnostic formulation, strive to gain access to Mr Jones' "inner world" by a more assertive therapeutic engagement and more assertive collation of relevant information from family members and elsewhere, arrange individual therapy, implement a multi-disciplinary care plan or establish a clear medication plan. As he put it in oral evidence, Mr Jones needed to have "an experience of being held and understood". In his opinion, Dr Pereira instead failed to incorporate a "trauma narrative" into his view of Mr Jones' illness.

130. Although Dr Meehan in evidence acknowledged that Dr Bakshi appears to have told Dr Pereira that Mr Jones was improving, he felt that the family's views and some of the nursing notes told a different story. His complaint was not really about the timing of what Dr Pereira did but about the content of it.

131. In oral evidence Mr Porter explored with Dr Meehan the issue of arranging or not arranging individual therapy and took him through notes indicating that Dr Pereira recommended on two occasions that individual therapy should be arranged. Dr Meehan specified that his criticism was based on the degree of urgency with which this should have been pursued.

132. The subject of multi-disciplinary working was also explored. In oral evidence Dr Meehan agreed that the two disciplines involved in treating Mr Jones in the final week were medical and nursing, psychotherapy not having started, and also that Dr Pereira on his ward rounds discussed the case with the nursing staff. His complaint was not of an absence of formal meetings labelled as being "multi-disciplinary". Rather it was of a failure to bring together the views of both consultants, the nurses and Mr Jones' family in a "coherent overview".

133. Dr Meehan was also critical of Dr Pereira's conduct of the meeting with Mr Jones and his family on 15 April 2016. He felt that Dr Pereira's response to the note which Mr Jones had typed and the "not as clever as you" remark were liable to have an alienating effect on the patient. Dr Meehan thought that it "robbed him of another level of hope in relation to being understood".

The evidence of Dr Maganty

134. Dr Dinesh Maganty was instructed on behalf of Dr Pereira. He took issue with Dr Meehan's view on nearly all of the points set out above.

135. In Dr Maganty's opinion, Dr Pereira made an adequate assessment at an early stage of a patient who was difficult to assess and treat, in particular because Mr Jones withheld information, withheld consent for contact with other practitioners and was non-compliant with the treatment provided. As to the scale of the difficulty of the case he said:

> "I have reviewed, personally, hundreds of self-inflicted deaths, and this is the first case in which I must admit I did not understand the patient."

136. In Dr Maganty's view, Dr Pereira made a reasonable working diagnosis of bipolar affective disorder which was justified by the presence of characteristic symptoms. When Dr Pereira returned from leave that diagnosis was further supported by information about a family history of an affective disorder.

137. However, Dr Maganty himself considered that if Mr Jones' condition was biological in origin, it nevertheless could have been precipitated by life stresses. Dr Maganty said that his own preferred differential diagnosis would have been a reactive depressive disorder caused by life stresses.

138. On the basis of his working diagnosis, Dr Pereira in Dr Maganty's view started the patient on appropriate medication and then made appropriate changes in response to difficulties experienced by the patient.

139. The admission to hospital in Dr Maganty's view was a reasonable response to an urgent situation. He considered that the benefits of hospital admission had been discussed between Dr Pereira and Mr Jones earlier and therefore did not need to be discussed again at the point of admission, given that Mr Jones was not requesting such a discussion or opposing the admission.

140. While Dr Maganty accepted that it would have been reasonable for Dr Pereira to tell Mr Jones that he was going on leave and therefore would not be treating him on his arrival in hospital, a discussion of that kind would not and could not happen in the vast majority of psychiatric admissions to NHS hospitals in England (though Dr Maganty agreed that Mr Jones' symptoms were not such as would have resulted in an NHS admission in any event). It would have been ideal but was not obligatory and the omission to do it, in Dr Maganty's view, did not have a severe adverse effect.

141. In hospital there were daily risk assessments. Dr Maganty emphasized that it was not open to Dr Pereira to detain Mr Jones under the Mental Health Act and therefore he could not have been prevented from leaving the hospital. In any event, he said:

> "Research shows that suicide is an extremely low frequency event even in the severely mentally ill and that self-inflicted death plans are put into action only in the hours preceding one's death in the majority. Predicting low frequency events is a difficult task."

142. Dr Maganty did not agree that there was a failure to take adequate steps to ensure that Mr Jones received psychotherapy. He emphasized that psychological therapy in a case such as this cannot be imposed on the patient, works on a long-term basis, may depend on trust being built over quite a long period and would produce benefits only over a period of several months. Moreover, deciding what problem needed to be treated and what form of treatment to provide depended on accessing the patient's inner thoughts. He said that if Dr Pereira had ultimately arrived at a confirmed diagnosis of bipolar disorder, psychotherapy would not have been indicated at all. But if the patient's innermost thoughts revealed some past experience that was traumatising him and

causing him to be overwhelmed by life stresses, then psychotherapy would be helpful. In trying to resolve this dilemma, Dr Pereira encountered a non-compliant patient and was not allowed to get any helpful input from Dr Richman.

143. In the circumstances of Mr Jones' admission and while efforts to understand his inner thoughts continued, Dr Maganty considered that it was reasonable for Dr Pereira to offer him the group therapy which was available to all in-patients at the Nightingale. He noted also that, during his admission, Mr Jones was having individual consultations with a consultant psychiatrist several times each week and also had access to individual nurse-led sessions. In addition, appropriate steps were also being taken to move towards individual psychotherapy by inviting the hospital's therapy department to assess him for that purpose.

144. Nor did Dr Maganty agree that there were shortcomings in the care provided by Dr Pereira after he resumed responsibility for Mr Jones on or around 10 April. Dr Pereira did not observe, and the patient's notes do not evidence, an obvious deterioration in his condition. In the final week Mr Jones was in and out of the hospital, seeing his family and travelling independently. In response to concerns raised by the family, Dr Pereira promptly arranged the meeting on 15 April 2016.

145. More generally, Dr Maganty considered that the amount of time made available to Mr Jones by clinicians and the multi-disciplinary provision, involving psychiatrists, nursing staff and therapists, of psychological and pharmacological treatment was in keeping with the standard practice for treatment of a depressive disorder comparable to that of Mr Jones in an in-patient setting in England.

146. Dr Maganty also did not agree with criticisms of the way in which Dr Pereira reacted to Mr Jones' note about his feelings. Although "there could be a reasonable body of psychiatrists who would say he could be more gentle", Dr Pereira had no choice but to explore Mr Jones' feelings further and tried to do so.

Negligence: discussion and conclusions

147. I begin with the question of diagnosis and diagnostic formulation. Incorrect diagnosis is not one of the 11 failures listed in the Claimants' counsel's closing submissions but it is a pleaded particular of negligence and was the subject of some focused criticism by Dr Meehan.

148. It may be helpful to bear in mind some challenges which are often posed by cases of psychiatric illness.

149. Psychiatry differs from many other medical fields in important ways. By and large, psychiatric conditions cannot be diagnosed by the use of blood-tests, scans or X-rays. The medical cause of any psychological symptom may be impossible to identify with certainty, and where "symptoms" shade into "behaviour", they may not have a medical explanation at all.

150. Instead, psychiatrists are often more dependent on the history given by the patient than other doctors would be. However, psychiatric illness itself may cause the patient to be a less reliable historian.

151. It seems to me that these are particular difficulties facing psychiatrists when attaching diagnostic labels, and there will often be psychiatric cases in which diagnostic labels are less reliable or useful.

152. Psychiatric illness may also cause a patient to be resistant to care and treatment. So psychiatrists may find themselves having to work without the co-operation which doctors might usually expect from a different kind of patient.

153. In my judgment the present case gave rise to such difficulties. With the assistance of the expert witnesses I have had to assess the way in which Dr Pereira dealt with a complex and challenging case.

154. I found Dr Meehan to be a very impressive expert witness. His observations about clinical methodology and how he would have applied it to the facts of this case were logical and persuasive. I was impressed by the close attention which he paid to what was known about Mr Jones' thoughts and feelings as clues to the possible causes of his symptoms. He had what seemed to me a realistic attitude to diagnostic labels, and a constructive openness to discarding labels if they are unhelpful. More specifically, he had regard to the published diagnostic criteria for PTSD and, observing that they did not quite fit this case, nevertheless identified similarities between this case and a case of PTSD and sought to use those in determining the type of illness and the effective treatment.

155. Dr Meehan also had a clear and forceful understanding of his role as an expert and his duty to the Court. That was particularly visible in his acceptance that, although he disagreed with Dr Pereira's diagnosis, it was one at which a reasonable psychiatrist could have arrived.

156. That acceptance has proved to be very important.

157. Having considered the views of both experts, my conclusion is that Dr Meehan's analysis of Mr Jones' illness is the more convincing. Although Dr Meehan (like any other expert witness in this case or any other similar case) had the great disadvantage of not having seen the patient, he was able to carry out a comprehensive review of all the available information and he also had the great advantage of hindsight. His approach of "joining the dots", identifying different ways in which stressful events were preying on Mr Jones' mind, was convincing. Meanwhile Dr Maganty's preferred differential diagnosis of a reactive depressive disorder caused by life stresses was, in my judgment, closer to Dr Meehan's view than it was to Dr Pereira's diagnosis of bipolar affective disorder.

158. I therefore find that on the balance of probabilities, Mr Jones was suffering from a depressive reaction to past and present stressful events and did not have bipolar affective disorder.

159. However, Dr Pereira's contrary view was a defensible one, and his arriving at a working diagnosis of bipolar affective disorder was not a breach of duty.

160. There is nevertheless more to say about diagnosis. Dr Meehan in cross-examination said:

> "Dr Pereira, in terms of good psychiatric practice, was obliged to look at his diagnosis. He set himself a working hypothesis, so you have a working hypothesis of a diagnosis, you have other evidence in front of you, and on the basis of that other evidence you may need to change your mind. If you look at the narrative of Mr Jones in hospital, Dr Bakshi, who looked after him actually changed her mind about the diagnosis. My criticism of Dr Pereira is that he stuck to a diagnosis in the face of evidence that pointed in other directions. What Dr Pereira never did, and I think it is crucial, he never brought in all the evidence that showed that this man had a severe stress response secondary to the interaction between past trauma and current difficulties."

161. That criticism was separate from, and could survive, the earlier acceptance that a reasonable psychiatrist could have arrived at the same differential diagnosis as Dr Pereira. It begs the question, however, of when it became so clear that Dr Pereira should have changed his mind that a failure to do so was a breach of duty.

162. At the point when Mr Jones was admitted to hospital, Dr Pereira had met him three times. In two of those three meetings, much attention was necessarily focused on Mr Jones' compliance with the medication regime and his reaction to it. I do not find (and I did not understand Dr Meehan to say) that the information otherwise imparted to Dr Pereira in those meetings would have led any reasonably competent consultant psychiatrist to abandon his working diagnosis and commit to treating the patient in a different way.

163. There then followed the 3 week hiatus while Dr Pereira was on leave and Mr Jones was under the care of Dr Bakshi.

164. Therefore, the only reasonable opportunity for Dr Pereira to change his mind about diagnosis was in the meetings which he had with Mr Jones as an in-patient between 11 and 15 April 2016.

165. Although I find Dr Meehan's view of Mr Jones' illness convincing, as I have said, I cannot identify a moment in that final week when the original working diagnosis, which has been conceded to have been tenable, should clearly have been abandoned.

166. It may be that Dr Pereira was too slow to understand that Mr Jones was suffering from a depressive reaction to past and present stressful events. But as will be apparent from my discussion of causation below, I do not find that any change in his approach to the illness during that final week would, on the balance of probabilities, have prevented the death of Mr Jones on 18 April.

167. Some other breach of duty issues can be taken more briefly.

168. I am not persuaded that there was a negligent failure to explain the purpose and benefits of hospital admission to Mr Jones. At the first consultation on 29 February 2016, admission was identified as an option if he could not cope. Essentially that option was then taken up. The admission was requested or suggested, quite suddenly, by his parents

on 21 March because he was not coping, was believed to pose a risk to himself and had stopped taking his medication. That led to the urgent admission on 22 March, which superseded a previous suggestion of having an out-patient consultation on that date.

169. It therefore seems to me 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 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.

170. For the same reasons I do not find that there was a negligent failure to assess Mr Jones before his admission to hospital.

171. However, I am satisfied that Dr Pereira was in breach of duty by not communicating to Mr Jones that he would not be available for the next 3 weeks. Dr Maganty's comparison with an NHS case was not illuminating. I am concerned with what was reasonable medical practice in the circumstances of this case, where the admission had been personally negotiated with Dr Pereira and the patient would have expected to see Dr Pereira – and indeed would undoubtedly have seen him had he not been on leave.

172. In those circumstances it seems to me that the omission to tell Mr Jones about the leave of absence was inexplicable. Anticipating my discussion of causation below, there is no evidence that this omission caused any measurable harm or contributed to the eventual tragic outcome. However, it does suggest a surprising lack of empathy on Dr Pereira's part.

173. The next allegation particularised in submissions is a negligent instruction to the hospital by Dr Pereira to put Mr Jones back on the medication that he had told him to stop taking on 18 March.

174. In evidence, that allegation tended to merge with the allegations of failure to have a further discussion with Mr Jones before he was admitted to hospital and to give a proper handover to Dr Bakshi. Dr Meehan did not insist that the medication regime was not a defensible one, given Dr Pereira's working diagnosis, but he was critical of a failure to review it and to do so urgently when told on 18 March that it was having a catastrophic effect.

175. I have already explained why I do not consider that Dr Pereira was bound to arrange a further consultation and assessment before the admission. I accept his evidence that it was reasonable to reinstate Quetiapine and Lamotrigine, with the addition of Clonazepam, upon Mr Jones' admission to hospital where he could be supervised. Thereafter it would have been for Dr Bakshi to monitor any side effects of those medications. In those circumstances I am not persuaded that there was a breach of duty by Dr Pereira in that respect.

176. However, on the available evidence I have concluded that there was a negligent failure to give a sufficient handover to Dr Bakshi.

177. As I have said, I was hampered in deciding this issue by the lack of an adequate record of the conversation in which Dr Pereira said that he handed the case over to Dr Bakshi. In my judgment, the fact that no adequate record of that conversation was kept was itself a departure from reasonable standards.

178. There was no dispute about the existence of duties to give a proper handover and to keep adequate records. I have had regard to *Good Psychiatric Practice*, which contains standards of practice for psychiatrists published by the Royal College of Psychiatrists. On these topics it states:

> "8 A psychiatrist must refer patients to other services or colleagues as indicated by clinical need and local protocols:
> (a) the psychiatrist should facilitate the smooth transfer of care between services, and provide a comprehensive summary of the clinical case to the receiving doctor/professional to enable them to take over the safe management and treatment of the patient
> …
> 14 A psychiatrist must maintain a high standard of record-keeping: good psychiatric practice involves keeping complete and understandable records and adhering to the following:
> i handwritten notes must be legible, dated and signed with the doctor's name and title printed
> ii electronic records must be detailed, accurate and verified
> iii a record must be kept of all assessments and significant clinical decisions
> iv the reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded
> v the record should include information shared with or received from carers, family members or other professionals
> vi notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, and signing and dating them."
>
> (emphasis added)

179. It follows from paragraph 14 that both Dr Pereira and Dr Bakshi should have made a record of the information about assessment which he "shared" and she "received".

180. The burden is on the Claimants to prove the lack of a sufficient handover. The evidence before me was Dr Pereira's assertion that there was a telephone handover, together with the emails to which the "clinical correspondence" was said to be attached. That correspondence, which had been generated right at the start of Mr Jones' engagement with Dr Pereira, would not in any event have told Dr Bakshi much if anything. The only documents obtained from Dr Bakshi which are relevant to this issue are the notes which she made when she first saw Mr Jones on 23 March 2016. As I have said, those are sparse and they do not positively evidence any information from Dr Pereira other than the stated fact that he "feels it is Bipolar disorder".

181. In oral evidence Dr Pereira said that the conversation would have covered the patient's report of the "catastrophic effect" of the medications, and he went on:

> "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."

182. That is a reasonable summary, in my judgment, of what an adequate handover should have contained.

183. However, those assertions of what was said are not supported by Dr Bakshi's notes. Nor were they contained in Dr Pereira's witness statement. I have already recorded my reservations about his oral evidence in general. And in this instance he was not speaking from direct recollection, instead saying what he "would have" done. I was also not convinced by his further assertion in oral evidence 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". First, as I have said, Dr Pereira was in fact the admitting consultant. And in any event, when the admission was being arranged, nothing was said to Mr Jones or his parents about a receiving consultant having to agree to it. The only potential hold-up was the need to obtain BUPA funding if desired.

184. In my judgment, given the duty on both consultants to keep a proper record, on the balance of probabilities a note by one or other of them would have recorded the contents of an adequate handover if one had taken place. So although I accept that there probably was a telephone conversation between them, on the balance of probabilities it was not a sufficient handover in the sense that I have described.

185. Counsel's list of alleged failures then contains four items connected with Mr Jones' care and treatment following his admission. These are items (v), (vii), (viii) and (ix) at paragraph 12 above. Ultimately these all lead to the proposition on behalf of the Claimants that there was a negligent failure to provide Mr Jones with the necessary care and treatment. If that proposition cannot be established, it will not assist the Claimants to show, for example, that Dr Pereira's engagement with Mr Jones' care and treatment plan fell below acceptable standards.

186. The evidence about the necessary treatment has focused on psychotherapy. Although there has been a debate about the choice and management of Mr Jones' medications, in the end it is not suggested that any medication error led to his death or that a different prescription could have saved him. The core allegations are that Dr Pereira himself 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.

187. Dr Meehan repeatedly described his recommended method as, metaphorically, "holding" the patient. He referred to the need to interact with the patient in an empathic manner and to create a "therapeutic alliance":

> "I think one of the core issues in psychiatric practice is to give a patient an experience that they are held and they are understood. I don't think Mr Jones as a consequence of what happened had that experience of being held or understood. I

> agree that it was a complex case, with complex issues in relation to gaining access. But the next level of confidence building and hope engendering for the patient was to actually say we have a process in action that will enable us to try and help you with your terror and your anxiety and your difficulties and will engender hope in you that you will recover from this episode. Because one of the most poignant comments, I think, in this case is what Mr Jones said on admission to hospital, 'I believe I am incurable'. 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."

188. Dr Meehan explained that he would have convened a meeting with nurses from the ward and a psychologist or psychotherapist to enable them to formulate a coherent plan which would instil hope in the patient and help them to gain access to his thoughts. Instead, he perceived a lack of the necessary "reflection and rethinking about what is going on here and what are we going to do about it". This, he said, was "basic psychiatric practice".

189. To resolve these issues, I need to consider what a consultant complying with the *Bolam* (etc) standard would have done and when he or she would have done it.

190. The first difficulty, once again, is the 3 week period when Dr Pereira was on leave immediately following Mr Jones' urgent admission to hospital.

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.

193. When he returned, as I have said Dr Pereira spoke by telephone with Dr Bakshi on 8 April, read Mr Jones' hospital notes and saw him in the hospital on 11 April. It will have been apparent to him that Mr Jones had not accessed any psychotherapy save for a couple of mindfulness sessions with Dr Bakshi.

194. The criticism of Dr Pereira's response to this situation was summarised by Dr Meehan in his oral evidence:

> "I think he came back to a situation that I think constituted an emergency. This man had been in hospital for nearly three weeks. There was no evidence that he had a consistent -- there was no evidence that people had gained access to his inner world. There was no consistent, and I think adequate, diagnostic formulation. There was no provision of one-to-one therapy. And there was no coordinated and integrated risk management risk assessment. Therefore I think the obligation for Dr Pereira at that time was to look at the state of this thing and

bring these various elements together into a coherent continuing assessment and treatment plan."

195. One obstacle to my assessment of Dr Pereira's response was a further failure by both consultants to keep a record of their handover conversation on his return. However, the evidence does not indicate that Dr Bakshi gave Dr Pereira to believe that the situation was an emergency. Her handwritten note of 8 April which refers to Dr Pereira taking over from 10 to 17 April says that the patient's "mood seems to have lifted".

196. Meanwhile I agree with Dr Pereira's observation that the nursing notes presented a mixed picture. Repeated risk assessments did not give rise to concerns. There were references to Mr Jones complying with treatment. On 9 April he was "relatively settled, calm in mood and was appropriate in his behaviour". On 10 April he said that his overnight leave with his wife had gone well. On 11 April he was "calm and relaxed in mood and behaviour".

197. I do however consider that there was reason for considerable concern that his condition had drifted. When Dr Pereira saw him on 11 April, he was reaching the end of the 3 weeks which had been the anticipated length of the admission but there was still no firm diagnosis, there were continuing issues with medication, almost no psychotherapy had taken place, there had been no particular or consistent improvement in his mood and nobody seemed to have any real insight into his state of mind.

198. Dr Pereira tried to move the case forward. As I have said, he saw Mr Jones several times that week, adjusted and discussed his medication and talked to him about his state of mind. He tried to gain access to Mr Jones' inner thoughts, encouraging him to put these down in writing. They continued to discuss psychotherapy.

199. The Claimants criticise the way in which he went about this. Here I have in mind item (vii) in the list put forward by counsel at paragraph 12 above i.e. failing to take adequate steps to establish a therapeutic relationship with Mr Jones (including being dismissive of a note which Mr Jones showed him on 13 April), advising him to attend group sessions instead of arranging individual therapy, giving him alternatives of staying in the hospital with group therapy and having individual therapy as an outpatient.

200. I have considered the incident in which Dr Pereira told Mr Jones that his notes did not sufficiently reveal the truth of his innermost thoughts. In my judgment it represents a lack, or a failure, of bedside manner. It is another point at which he seemed to lack empathy with his patient. It appears that Dr Pereira never succeeded in building a trusting relationship with Mr Jones but I cannot put that down to a breach of any legal duty on his part. As I have said, psychiatric illness may make it especially difficult for a clinician to get through to a patient. This is not about blaming the patient, but is about recognising the nature of the illness. For Doctor Pereira, a strategy of challenging Mr Jones may not have been a good choice at that time, but I cannot find that it was negligent.

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.

206. In my judgment there were no other significant breaches of duty by Dr Pereira.

207. Overall, I do not find that there was a negligent failure to assess risk. Nursing notes show that the nursing staff constantly assessed risk. All of the evidence shows that Mr Jones was known to present a risk of self-harm, including suicide. That does not mean, however, that his death on 18 April was predictable or that particular steps could and should have been taken to prevent it. I accept the evidence of Dr Maganty, a specialist in this area, that suicide is a thankfully low-frequency event which is very hard to predict and that attempts to categorise the risk as low, medium or high are generally not helpful.

208. Nor do I find that there was a departure from any mandatory form of multi-disciplinary working. Dr Pereira did liaise on a daily basis with the nursing staff and he was also in communication with Mr Jones' family. I have already criticised the failure to bring a psychologist or psychotherapist into the case but in the absence of such a clinician from the team, there was no failure to co-operate with them.

Causation

209. A fundamental question is 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.

210. Ms Gumbel and Mr Sheldon submitted that if I were unable to decide whether, but for any negligent breach of duty, Mr Jones' death would on the balance of probabilities have been avoided, I should instead consider whether any negligence made a material contribution to his death. That approach is based on *Bailey v Ministry of Defence* [2009] 1 WLR 1052 where Waller LJ (with whom Sedley and Smith LJJ agreed) said at [46]:

> "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."

211. In *Williams v Bermuda Hospitals Board (NHSLA intervening)* [2016] UKPC 4, [2016] AC 888, the Privy Council commented that that case did not involve a departure from the "but for" test of causation. The injury in that case, as in *Williams*, occurred on the balance of probabilities as a result of cumulative and indivisible causes of which the defendant's negligence was one.

212. In my judgment this is not that sort of case, and it is possible to decide on the balance of probabilities whether death would have occurred in the absence of breaches of duty that I have found or that the Claimants have alleged.

213. I begin with those breaches of duty which I have found.

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. 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.

223. In case I am wrong in any of my earlier conclusions about breach of duty, I now go on to consider whether Mr Jones' death was caused or contributed to by the most important of the alleged negligent acts and omissions which I have not found to have occurred.

224. If, contrary to my conclusions above, any reasonable consultant psychiatrist would have provided a post-traumatic diagnostic formulation as described by Dr Meehan and would have done so before Mr Jones' admission to hospital, then my view of causation would be different in the following ways:

    (i) On that hypothesis, Mr Jones would have been admitted for treatment for a condition resembling, though not the same as, PTSD.

    (ii) As to the correct treatment of such a condition, Dr Meehan in his report said:

    > "Mr Jones required the lifeline of supporting and assertive therapeutic engagement by his treating clinician because of his presenting symptoms of anxiety, depression and terror combined with the subjective sense that he was not coping. Formal psychological therapy is a deeper form of therapeutic engagement."

    (iii) I did not detect a significant disagreement between the expert witnesses about the appropriate treatment of such a case with psychotherapy.

    (iv) So, in this hypothesis, psychological therapy would have been a key part of the treatment plan from at least 22 March, nearly 4 weeks before Mr Jones died,

and if the group therapy programme in the hospital was rejected, individual therapy would have been arranged promptly.

(v) In Dr Meehan's view, if a "properly functioning therapeutic and risk management framework" had been established, it was unlikely that Mr Jones' condition would have deteriorated to the point he reached on 18 April 2016. His illness was serious but was "eminently treatable with competent care". With the correct approach he "would have expected progress to have been made quite quickly and Mr Jones to have been kept safe in the meantime".

(vi) Having regard to Dr Meehan's experience of successfully treating patients with trauma-related conditions, I accept his opinion as to the probable short-term prognosis if the consultant diagnosed and treated the case in the way described.

(vii) In this hypothesis there would also have been a full and proper handover to Dr Bakshi. I have no reason not to assume that, in this hypothesis, she would have continued the same treatment.

(viii) In this hypothesis, on the balance of probabilities Mr Jones' condition would at least have remained stable, and he would not have experienced the deterioration which was seen in his self-inflicted death on 18 April 2016.

225. Because that conclusion may cause distress to Mr Jones' family, I wish to emphasize the nature of the "balance of probabilities" test. A judge cannot gaze into a crystal ball and know what would have happened. Instead the Court makes a logical assessment of the chances of one or more events happening, on certain hypotheses or assumptions. If Dr Pereira had approached this case in the ways recommended by Dr Meehan there is a chance that Mr Jones would not have died on 18 April 2016. Measuring that chance is subject to all the uncertainties inherent in diagnosing psychiatric illness and in the success or failure of psychological treatment, and to the uncertainty arising from our knowing so little about what went through Mr Jones' mind that day. I have assessed that chance as exceeding 50 per cent. But it was, nevertheless, only a chance.

Contributory negligence

226. This issue would arise if, contrary to my decision, the Defendant were liable to the Claimants.

227. It is contended on the Defendant's behalf 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 in the responsibility for the damage". The pleaded conduct by Mr Jones includes taking his own life but also includes failing in various ways to engage with medical treatment and continuing to subject himself to work pressures and stress during the period of his admission. Oral argument, however, has focused on the act of taking his own life, and on my view of the facts that is the only relevant act or omission.

228. Under section 1, the question is therefore whether it is just and equitable to reduce the Defendant's liability, having regard to the way in which the loss and damage was caused.

229. In *Corr v IBC Vehicles Ltd* [2008] UKHL 13, the claimants were the dependants of a man who was injured in an industrial accident. The accident had severe physical consequences and also caused him to suffer from PTSD and depression, and, while suffering from an episode of severe depression, he committed suicide by jumping from a high building. He left a suicide note expressing feelings of desperation. It was agreed that at that time he had the capacity to manage his own affairs, his intellectual abilities were not affected and he acted deliberately with the intention of killing himself. However, as the Court found, his depressive capacity impaired his capacity to make reasoned and informed judgments about his future. Liability was conceded for recoverable loss caused by the original accident but the defendant argued that loss resulting from the suicide was too remote and/or that the suicide broke the chain of causation. Those contentions were rejected. A majority also rejected a suggested finding of contributory negligence, but that was partly because the point had not been considered by the Court of Appeal.

230. However, Lord Scott would have reduced the damages by 20%. He emphasized that the reduction required by section 1 is "to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage. Although the claimant's depression was caused by the employer's negligence, he "remained an autonomous individual who retained the power of choice". Lord Scott distinguished the case from *Reeves v Metropolitan Police Commissioner* [2000] 1 AC 360, where a person in police custody who was known to be a suicide risk succeeded in a suicide attempt and where a reduction of 50 per cent was made.

231. Lords Mance and Neuberger agreed with Lord Scott's reasoning, finding that in principle there could be a reduction. Lord Neuberger at paragraphs 62-69 recognised a spectrum in cases of suicide from an individual is of sound mind to one who is not. No reduction would be made "where the deceased's will and understanding were so overborne by his mental state, which had been caused by the defendant, that there could be no question of any real choice on his part at all, because he had effectively lost his personal autonomy altogether" and he "does not really appreciate what he is doing when he kills himself, and he has no real control over his action" so that there would be no real fault on his part. In the middle would be cases "where the deceased, while not of entirely sound mind, can be said to have a degree of control over his emotions and actions, and will appreciate what he is doing when he kills himself". So "the question to be addressed is the extent to which the deceased's personal autonomy has been overborne by the impairment to his mind attributable to the defendant" and "where it has not been so overborne at all, the … reduction in damages, may well be 50% (as in *Reeves*)".

232. In *PPX v Aulakh* [2019] EWHC 717 (QB), Whipple J dismissed a claim against a GP for a failure to refer a claimant for urgent specialist mental health treatment, which it was claimed would have prevented an incident in which the claimant hanged himself and suffered a severe injury. The allegedly negligent omission occurred at a consultation at which the claimant, who the GP had treated for depression for some time, expressed suicidal thoughts. The claim failed on the facts but the judge briefly

addressed the way in which she would have dealt with the issue of contributory negligence. She found that the case would have fallen in Lord Neuberger's middle category. The claimant's autonomy "was overborne to an extent by his mental health condition" but "his attempted suicide was plainly an autonomous act, by a person with capacity". Whipple J would have assessed contributory negligence at 25%.

233. The Claimants submit that the First Defendant has failed to prove that Mr Jones made an autonomous decision to take his own life, and deny that any reduction would be appropriate.

234. As I have said, there is limited evidence on which to assess Mr Jones' state of mind in the last days or hours of his life. On 16 April he left the hospital for the day, saying that he would be back after 8pm and asking for his evening meal to be left in his room. The First Claimant stated that he came home in the afternoon and they tried to deal with some of his work emails and found a colleague to cover one of his cases. She found him restless and withdrawn. On 17 April he again left for the day and later telephoned the hospital to say that he would be back at 8pm and made the same request about his meal. His sons arrived back from their holiday. Mr Jones came home and was described by the First Claimant as "very tired and in a very bad shape", complaining of being unable to sleep, and he was worried that the children would notice that he was unwell. In the evening, before returning to the hospital, he was unable to describe his feelings to her, saying "nothing is happening in my head". After he left for the hospital, Hugh Jones telephoned to say that he was worried about him so she telephoned him. He said that he was arriving at the hospital, sounding "irritable, detached, withdrawn and passive". At 00.10 on 18 April Mr Jones asked the nursing staff for Clonazepam, saying that he felt anxious and could not sleep. At 05.10 he left the hospital, saying that he wanted to take a walk. At 06.50 he telephoned the hospital and said that he would be back in an hour. There is no evidence of anyone at the hospital noticing anything untoward about these interactions with him. I have already set out Dr Maganty's description of what is seen on CCTV of his actions a few minutes later.

235. Mr Jones was obviously very unwell at the time of his death and his illness drove him to take his life, but I cannot find that he had lost his autonomy. 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 value of the claim

Introduction

237. Quantum also falls to be decided in case I am wrong to find that the Defendant is not liable to the Claimants.

238. I have calculated what the award would have been if I had found that, contrary to my conclusions above, it was negligent for Dr Pereira not to proceed on the basis of the post-traumatic diagnostic formulation as described by Dr Meehan. On that hypothesis, as I have said, the test of causation would be satisfied because, on the balance of probabilities, Mr Jones' condition would at worst have remained stable and he would not have experienced the deterioration which was manifested by his self-inflicted death on 18 April 2016.

239. The parties have helpfully agreed the appropriate amount for a number of smaller heads of loss. The principal remaining task is to quantify the claim for income dependency which is by far the largest item.

240. The parties have also agreed the formula for the calculation. I must determine what would, but for the alleged negligence, have been the net earnings of Mr Jones and the First Claimant. For the period up to their younger child's 23rd birthday, the annual dependency in relation to income would consist of 75% of their combined net earnings, less the net earnings of the First Claimant. For the period after that date, the same calculation would be carried out but substituting 66% for 75%.

241. In addition it is necessary to calculate the value of "services dependency". For the period up to their younger child's 23rd birthday, the multiplicand is put at £15,000 by the Claimants and £10,000 by the Defendant. After that date the Claimants contend for £10,000 and the Defendant contends for £5,000.

242. There are then a number of issues affecting the choice of multiplier for each category of dependency.

243. On the basis of Dr Meehan's evidence, the Claimants contend that if correctly treated Mr Jones would have returned to his "pre-injury level of functioning" within 4-8 months of 21 March 2016.

244. The Claimants further contend that Mr Jones would probably have returned to work as a self-employed barrister, building up his practice to earn annual gross fees of £600,000 by 2020-21 and continuing at that level for the rest of his career, until the age of 75 which is currently the mandatory retirement age for judges.

The lay witnesses on Mr Jones' hypothetical future career

245. In early 2016 the First Claimant was aware that Mr Jones was exploring different opportunities. In 2014, he and she had set up a company, Day Jones International Law Consultancy Ltd ("DJL"). She told the Court that this was with a view to working in a more tax-efficient manner. In 2015 or early 2016 he had applied for a post as a Circuit

Judge and for jobs at a solicitors' firm and a consultancy. She emphasized the reputation which he had already earned in the field of extradition and international law, that being her professional field too. In oral evidence the First Claimant said that the family's plan had been to remain in London.

246. I heard evidence from Edward Fitzgerald KC. He was and is the Head of Chambers at Doughty Street where Mr Jones practised and is a very successful practitioner in the field of extradition and international law. He knew Mr Jones well and led him (meaning that he was instructed as King's Counsel to work in a team with Mr Jones as junior counsel) in a number of important cases, and they also were both involved in some cases after Mr Jones had taken silk (i.e. was appointed as Queen's Counsel or, today, King's Counsel) in 2013. Mr Fitzgerald described Mr Jones as a brilliant advocate and gave examples of "stellar" career achievements on his part. He estimated that Mr Jones would have earned annual fees of £600,000 by 2018 and consistent annual fees between £600,000 and £800,000 over 10-20 years. He based this on his knowledge of fees earned by members of chambers, including his own fees which exceeded those sums, and his assessment of Mr Jones' ability, his professional contacts and the international reputation which he had gained by the work he had already done. He said that some junior members of chambers who were less experienced than Mr Jones were earning annual fees of between £400,000 and £500,000.

247. When Mr Jones became ill, Mr Fitzgerald was working overseas. On 7 February 2016, Mr Jones sent him an email, saying that he had applied for a post as a Circuit Judge and asking if Mr Fitzgerald as his head of chambers would provide a reference. He added:

> "I'm not at all sure I'll get it, and there are many pros and cons to weigh up if offered it. But for reasons which I can explain over the phone, it is something I certainly want to be considered for, as I'm not sure when the next opportunity will arise."

248. On the same date I note also that Mr Jones emailed the First Claimant, saying "I've applied to be a judge! Who knows if I'll get it, but I think it's a good idea to try."

249. Mr Fitzgerald responded, saying that he would provide the reference if asked but that he would prefer Mr Jones to stay at the Bar and work with him on big cases. He also asked him to consider setting his sights higher, on an appointment as a High Court Judge. Mr Jones' reply said:

> "It would be very good to talk things through with you, as – circuit judge or not – I need to make a change in my practice soon as the work flow is far too uncertain as things stand and I am realizing, perhaps belatedly, that I need more predictability with a family to support. My diary is empty from April onwards and that is a very worrying prospect …
> You may be contacted in the meantime for a reference, so I would be very grateful if you could provide one …
> For the High Court that would be wonderful but there are no openings at present, and I would first need to sit as a recorder."

250. On 9 February Mr Fitzgerald said "I cannot believe we cannot fix your practice" and reminded him that extradition cases tend to come in at the last minute. In evidence he

said that it is not unusual even for those with successful practices to complain that their diary is empty, only to find that a case then pops up.

251. Steven Powles KC also practises from Doughty Street. He worked with Mr Jones in setting up an office in The Hague under the name "Doughty Street International", to develop work of an international kind. He too praised Mr Jones' ability and achievements and saw him as a possible future successor to Mr Fitzgerald. Mr Powles also said that he knew of two other members of Doughty Street who had had breaks for mental health issues but had then successfully returned to work.

252. Dr Rutsel Martha, a former General Counsel of Interpol, was the founder of a legal consultancy based in London specialising in public international law ("Lindeborg"). He met Mr Jones in 2015 and took an interest in collaborating with him. In 2015 they entered into a consultancy agreement which anticipated Mr Jones being paid a monthly consultancy fee from May 2016 onwards, plus commissions. During the short time that they worked together, Mr Jones introduced two new clients to Lindeborg. Dr Martha estimates that by 2017, Mr Jones could have been earning £400,000-600,000 from Lindenborg. His view was that, while giving more time to Lindenborg, Mr Jones could also have continued working from Doughty Street and sitting as a part-time Immigration Judge.

253. In respect of commissions, Mr Porter pointed out that the Bar Standards Board rules prohibit barristers from making or receiving commission payments. Dr Martha said that he was not aware of that. He also agreed that an annual income in the £400,000-600,000 range would be in the nature of a salary and would be for a very full-time job, though "all scenarios were possible".

254. Maurice MacSweeney was Business Development Director at Doughty Street in 2016. He described Mr Jones, at the time of his death, as being in a process of transition from publicly funded work such as prosecuting extradition cases on behalf of requesting states, to privately funded work representing wealthy individuals who were facing extradition or prosecution in international courts. In his view, Mr Jones' earning figures in 2015 and 2016 reflected the fact that this transition had not yet happened, and also reflected a slow-down in earnings that can happen in the early years after a barrister takes silk. Mr MacSweeney was optimistic about Mr Jones' transition plans, noting that at the time when he became ill, he had already been instructed by a leading London solicitor in an important case, and was in a good position to attract more lucrative privately funded cases. On his return to London he was also in demand for prosecution work. Mr MacSweeney also points out that the solicitor in the new case was understanding and helpful when Mr Jones became ill, and he did not believe that Mr Jones' practice would have suffered unduly from a period of absence for illness. He estimated that Mr Jones could have earned annual fees of £500,000 without difficulty by 2018, rising to £700,000 or more by 2023.

255. Mark Dembovsky joined Doughty Street as Chief Executive in October 2015. He explained the financial arrangements between chambers and its members. Although he did not know Mr Jones well, he also testified to the bright future that he saw for Mr Jones given what he had achieved before his death. His annual fees earned via Doughty Street in the financial years to 2015 and 2016 were £230,871.92 and £269,273.42. Mr Dembovsky considered that these figures were good for a barrister who had quite

recently taken silk. He believed that within a few years Mr Jones would have easily earned fees in the range of £400,00 and that that figure would then have risen sharply.

The expert witnesses on Mr Jones' hypothetical future career

256. Dr Meehan's report states:

> "D77. … It is likely, on the balance of probabilities, that the provision of that adequate diagnostic formulation combined with an effective treatment programme would have led Mr Jones to achieve self-stabilisation, symptom reduction and an appropriate processing of his traumatic memories leading to full rehabilitation and recovery. I consider this recovery would have involved an acute phase lasting 1-2 months followed by a graduated return to work and return to pre-injury level of functioning between 3-6 months after the resolution of the acute period. Mr Jones would have had some continuing therapy for a period of six months thereafter.
>
> D78. In my clinical experience, such clinical presentations of post-traumatic memories and associated psychological distress and decompensation respond well to the provision of an adequate diagnostic formulation/explanation combined with the provision of a programme of care such as the one outlined above. Given that Mr Jones' clinical presentation was of an acute decompensation in a previously highly functioning individual, it is likely, on the balance of probability, that resolution of his clinical symptoms and post-traumatic memories would have led to a full recovery and return to his previous level of functioning."

257. In weighing that expert opinion, I attach importance to Dr Meehan's clinical experience of treating patients such as soldiers who have experienced battlefield trauma. Those cases are different to this, but they have given Dr Meehan first-hand experience of the effects of treatment on patients with post-traumatic symptoms.

258. Dr Maganty's report did not address that opinion head-on. Rather, he concentrated on the alternative view of Mr Jones suffering from bipolar affective disorder, in which case the prognosis would have been much worse. Against that, he weighed up an alternative narrative in which Mr Jones was not suffering from a serious mental illness and was feigning symptoms as a means of expressing distress due to life stresses, in which case Dr Maganty thought that he would probably have recovered sufficiently to resume less stressful employment, such as that of an employed barrister, within a year. However, I have not found that alternative narrative to be applicable.

259. More generally, in his Second Addendum Report Dr Maganty commented that Mr Jones appeared to struggle significantly with the pressures of his work as a self-employed barrister, and said:

> "… Had he survived and tried to get back to the same working life which he was struggling with from at least 2014, and probably much earlier, he would have faced more setbacks and much more distress in his work, leading to further deterioration in his affective symptomatology, further increasing his risk of self-harm and suicide.

> There is no medication or psychological therapy which could have led to a cure while the drivers of his affective disorder i.e. his life stresses, specifically his work stress, were present."

260. Dr Meehan was asked about work-related stress and the question of whether Mr Jones' future career might have been interrupted by further episodes of illness. In his view, the right treatment would have given him an understanding of how the "perfect storm" had come about, making him "an engaged expert patient who had learned techniques to deal with his difficulties". He would have remained vulnerable but in Dr Meehan's view he would have been enabled to manage his vulnerability.

261. However, asked in cross-examination whether Mr Jones would have been well advised to move to more predictable employment, Dr Meehan accepted that he "would have had to have had a serious conversation with himself and his family about what type of work, or what type of lifestyle balance he had between work and family", though he would have been capable of continuing his work as leading counsel. In a further report following a joint experts' meeting on what would have happened after a recovery, Dr Meehan added:

> "… the Deceased might have further episodes of stress but his ability to cope with any stress would be dependent on the coping skills that he had acquired – or not – and the nature and degree of stressors at any particular time, had he lived. On an individual basis this is not possible to predict."

<u>What would Mr Jones have done after recovering from his illness?</u>

262. In my judgment, it is probable that Mr Jones would have resumed his practice as a barrister in or around the timescale indicated by Dr Meehan.

263. That is not a certainty. His application to become a Circuit Judge shows the immediacy and seriousness of his doubts about his future at the Bar. Nevertheless:

i. I accept the evidence of his colleagues and his wife about his passion for the international law work that he was doing. The work of a Circuit Judge would have been quite different.

ii. His email to Mr Fitzgerald about the job application and reference show that he was ambivalent about the job and might not have accepted it if it had been offered to him.

iii. Mr Fitzgerald, and probably other Doughty Street colleagues, would have encouraged him not to move to the Circuit bench. Mr Fitzgerald would have encouraged him to take a longer-term view of a possible future as a High Court Judge.

iv. I also accept the evidence that, although he had not become a high earner in his field, he had built up a considerable reputation and a very useful network of contacts. He had the full support of colleagues and staff at Doughty Street. He was well placed to attempt the intended transition to better paid work,

based in London. He was also on the point of earning additional or alternative income from Lindeborg.

v. I accept Dr Meehan's evidence that, with the right treatment of his post-traumatic illness, Mr Jones would probably have recovered to his pre-illness state. In that state he had enjoyed plenty of success and had been appointed Queen's Counsel.

264. Given that barristers tend not to be paid until some time after they complete pieces of work, I therefore consider that Mr Jones would probably have begun to receive income as a barrister after the full period of 8 months referred to by Dr Meehan. Taking a cautious view of his progress thereafter, I think it probable that it would have taken a further 6 months for him to be receiving fees at his pre-illness level.

Mr Jones' onward career path if he had not died

265. Any prediction of the hypothetical future progress of Mr Jones' career is beset with uncertainty. There are many variables concerning the success or failure of his intended transition to more lucrative work, the choices he might have made regarding judicial or other roles and, as both medical experts recognised, the life stresses he might have faced and their impact on him.

266. I have therefore sought to select appropriate multipliers and multiplicands for the dependency calculation which balance various uncertainties against each other. As I shall explain, I have come to the conclusion that it is necessary to consider separate periods (1) up to Mr Jones' 54th birthday, (2) from then until his 60th birthday and (3) from then until his 70th birthday.

267. There was a body of evidence supporting the suggestion that, resuming his Bar career, Mr Jones was well placed to generate annual fees of £600,000 within a few years. Save by reference to his illness, there was limited if any challenge to the notion that a successful silk in his field would probably reach at least that level.

268. The strongest evidence to the contrary was the fact that, in his career as a silk so far, his earnings were well below that level, and below the fees earned by junior colleagues in chambers. For the 4 years up to April 2016, his average annual fees were £352,790. In my judgment, his lower earning level was reasonably explained by a combination of facts i.e. (1) he was a fairly recently appointed silk, (2) he had been practising overseas and (3) his extradition practice to date had been dominated by publicly funded work as well as including some pro bono cases. Nevertheless, those facts have also made me slightly more cautious about the time which it would have taken him to reach a higher level.

269. The evidence of his ability and the support he enjoyed makes it probable, in my judgment, that he would have managed a transition to a practice like that of his better paid colleagues. I therefore conclude that his earnings would have risen at a steady rate over a period of about 5 years to reach a figure for annual gross fees of £600,000 by his 54th birthday in June 2021. That of course translates into a much lower figure for net

annual profits. It also takes into account the possibilities, which in my judgment balance each other out, that (1) his fees as a barrister might have remained somewhat lower but (2) he might have supplemented his income with work from other sources such as Lindeborg.

270. For the period from then until his 60th birthday, the multiplicand should be based on annual gross fees of £570,000. That is on the basis that future ill health would have interrupted his practice, on average, for 3 months every 5 years.

271. However, in my judgment it is probable that his earnings would not have remained at that level after he turned 60 in 2027, for a number of reasons.

272. First, I have in mind Dr Meehan's comment of his need for a "serious conversation" about his type of work and lifestyle choices.

273. Second, as Dr Meehan agreed, he would have been vulnerable to future depressive episodes. Dr Maganty pointed out that the types of stress to which he appeared to have a catastrophic reaction – the school episode in the USA and the practical and financial strains arising from the return to London from The Hague – were not the most acute types of stress such as might typically cause an episode of PTSD. That being so, Dr Maganty said that whilst his prognosis would be good if his life remained stress-free, "if he is exposed to similar life stresses which are not severe, quite low-level life stresses, his prognosis would still be poor". Pointing to the lack of success of his earlier treatment by Dr Richman, Dr Maganty did not accept that Mr Jones could really be cured in the sense envisaged by Dr Meehan. Given the agreed future vulnerability, I consider it improbable that Mr Jones would have pursued the arduous and competitive career of the litigation barrister indefinitely, at least with the necessary intensity to earn that high level of fees.

274. Third, more generally I take notice of the fact that many barristers do not continue in full-time practice to the age of 75, and many who continue nevertheless reduce the size of their practice. I bear in mind that if Mr Jones had had the success that others have predicted, and if the First Claimant had also continued her successful career, he would not have had any financial need to go on working into his 70s, by which time their sons would have been well into their 30s. His enthusiasm for this work in his 40s therefore does not persuade me that he would have maintained the same level during his 60s and 70s.

275. Fourth, there is a substantial possibility that Mr Jones would eventually have moved to a judicial role. In addition to the points I have already made, he had manifested his interest in judicial work by sitting as a fee-paid Immigration Judge since 2004 and by applying to become a Circuit Judge in 2016. He was clearly ambivalent about that application and it might well not have succeeded in view of his illness at that time. But there is a substantial chance that, after some further years at the Bar, he would have become a Circuit Judge or a High Court Judge or a judge at one of the international tribunals to which Mr Powles referred.

276. Overall, I find that his probable income after the age of 60 would have corresponded to annual Bar fees of £400,000. That takes account of uncertainties about whether he would in fact have chosen a judicial post or a reduced Bar practice, of what kind of

judicial post he would have had, and when, and of what enhanced pension rights would have been part of any judicial remuneration.

277. I also find that that level of income would have continued to the age of 70. That balances the uncertainties about whether he would in fact have retired earlier or later than that in one or other of the roles discussed. If he continued at the Bar he may have had a higher income but have retired earlier. If he became a judge he may have had a lower income but have retired later.

278. That income figure and hypothetical retirement date also take account of the impact of any future psychological episodes, so the multiplier and multiplicand for that period need no further adjustment in that regard.

Overheads and expenses

279. The parties agree that Mr Jones' net earnings as a barrister are to be calculated by deducting chambers expenses and rent (at an agreed level of 16% of his fee income) and other expenses identified in his accounts including "consultancy fees". These, and the incidence of tax, are considered in reports by accountancy experts on both sides.

280. Consultancy fees are an oddity of this case. They are not a typical item of expense in a barrister's accounts and nobody has been able to tell me what "consultancy" was provided to Mr Jones, or by whom, or why. The annual amounts were substantial, averaging £84,276 in his last 4 years in practice. There was some discussion in Court about whether any consultancy was provided by DJL, i.e. whether Mr Jones was in reality paying himself and gaining a tax advantage, though these expenses were also incurred before DJL came into existence. These substantial expense figures will have significantly reduced the tax which he paid on his Bar income.

281. Be that as it may, the Claimants invite me to take Mr Jones' accounting figures at face value. The effect is, if anything, to reduce the size of the claim because the mysterious consultancy expenses substantially reduce the profits which he was earning and which the Claimants therefore say that he would have continued to earn. The Defendant does not dissent from that suggested approach. There is, however, an issue about the level of consultancy expenses which should be deducted from Mr Jones' hypothetical future income.

282. Analysis of his accounts show that this item increased sharply to £104,740 in 2015 and £98,877 in 2016. In 2013 and 2014 his turnover was slightly higher but the consultancy amounts were lower, at £67,823 and £65,664.

283. The Defendant's position is encapsulated in paragraph 4.20 of the report of his accountancy expert, Robert Parry:

> "I would not expect consultants' costs to be a simple percentage of total fees earned because, at lower levels of fees, Mr Jones may not have need [sic] support from consultants, except for specialist work. At higher levels of fees, he is more likely to have needed a greater amount of support to generate additional fees."

284. For that reason Mr Parry estimated that if Mr Jones' fee income had risen to £600,000, consultancy fees would have risen to £157,500 on the basis that they would have amounted to 25% of the first £450,000 earned and 30% of the higher tranche. He explains that (1) consultancy fees averaged 25% of turnover in 2014-15 and 2015-16 and (2) when turnover increased from £358,070 in 2013-14 to £532,073 in 2014-15, consultancy fees amounted to 36% of the increase.

285. I reject that analysis for two reasons.

286. First, the turnover figure used by Mr Parry for 2014-15 does not only represent Mr Jones' fees as a barrister. It also includes £199,509 earned by DJL. The earnings of that company (for which the First Claimant also worked) are not directly relevant to my calculation of what Mr Jones might have earned as a barrister if he had survived. Just looking at Bar fees, the consultancy amounts were much higher in the years to 2015 and 2016 despite fee income being lower than in the two preceding years.

287. Second, there has been no evidence to the effect that consultancy fees are a necessary expense of the relevant work of a barrister in Mr Jones' field, let alone any evidence that such fees are an overhead of any particular sub-type of that work. While I would not dissent from a general proposition that higher income may necessitate higher overheads, I therefore see no logical basis for concluding that the mysterious consultancy figure would have increased as a percentage of turnover.

288. The Claimants' accountancy expert, Steven Segal, instead calculated loss on the basis that consultancy costs would have continued at the rate of 10% of gross fee turnover, thereby accounting for £60,000 against a hypothetical fee income of £600,000. Ms Gumbel submits that even that adjustment is generous to the Defendant because there would in fact have been little if any reason for Mr Jones to incur such fees in, for example, extradition cases.

289. I agree that there was little apparent reason for such fees to be incurred, and therefore I do not find that they would have sharply increased, either as a percentage or as a sum. However, they were consistently incurred and so I find that they would have continued to be incurred. Mr Segal's analysis in my judgment attaches insufficient weight to the substantial amounts which were incurred in every previous year. From 2012-13 to 2015-16 they averaged 24.22% of Mr Jones' Bar fees. The annual percentage ranged from 14.9% to 31.5%. The average annual sum incurred was £84,276. I note that a sum of £85,000 would be about 14% of a fee turnover of £600,000.

290. Doing the best that I can, I find that the total of consultancy fees would have increased as Mr Jones' fee turnover increased to £600,000, and that the consultancy fees would on average have amounted to 17.5 per cent of fee turnover in each year of practice after 2016.

291. There is a further issue about the other expenses (i.e. over and above chambers expenses/rent and consultancy fees) to be set against Mr Jones' fee income to arrive at an annual profit figure.

292. Mr Parry put forward an annual figure of £81,000, that being the average figure for miscellaneous expenses claimed by Mr Jones and by DJL in his last two years in practice.

293. Mr Segal put forward an annual figure of £46,125. He listed the expenses figures claimed by Mr Jones in the last 5 years. In 2015-16 there was a figure of £62,390, but that was inflated by a one-off cost of £29,745 for fitting out an office in the new house in London. Otherwise the annual figure ranged from £20,703 to £42,406. In addition there were travel and subsistence costs ranging from £9,000 in 2011-12 to £26,752 in 2015-16.

294. In closing submissions the Claimants' counsel argued that Mr Jones would have been able to reduce his high spend on accountancy fees (around £7,500 per year depending on whether DJL's expenses were included) and on travel and subsistence. Mr Fitzgerald told me that in privately funded extradition cases, travel and hotel costs were usually covered by the client. I agree that some reduction in those sums would have been a logical development.

295. Those apart, the miscellaneous expense items were of a kind which would vary only to a limited extent according to the level of fees earned.

296. I have not heard argument about whether miscellaneous expenses incurred by DJL (averaging £5,666 in the last two years) should be taken into account. I work on the assumption that some but not all of these costs are relevant to Mr Jones' hypothetical future practice.

297. That being so, and noting that the expense of fitting out the office was unusual, I conclude that the average annual figure for miscellaneous expenses in future years would have been £60,000 to the age of 60 and £50,000 thereafter.

<u>What would the First Claimant have earned if Mr Jones had not died?</u>

298. The Claimants contend that if Mr Jones had not died, Ms Zgonec-Rozej would have had net annual earnings of £43,589. The Defendant contends that her net annual earnings would have been £92,080.

299. She was born on 4 March 1976 and was 40 when he died. As long ago as 2003 she worked as a legal assistant at the International Court of Justice in The Hague. In 2015 she started studying part-time for the post-graduate Diploma in Law so as to be able to practise in the UK, though she was already qualified in Slovenia and in the USA. She planned to obtain the Diploma in 2016, then qualify as a barrister in 2018 and practise at the Bar while also doing consultancy work via DJL. She had obtained a Queen Mother Scholarship from Middle Temple which is awarded to outstanding candidates for the Bar Vocational Course. Her expectation was that she would work part-time while the children were young. She accepted that if she had remained in London, she could have matched what later proved to be her earning potential in the International Criminal Court, with the help of childcare arrangements such as the family had already had.

300. As a result of Mr Jones' death, these plans had to change. She eventually obtained the Diploma in 2018 but did not go on to study for the Bar. She moved back to the Hague and in January 2017 became a legal officer for the International Criminal Court. Her pay and benefits are not taxable in the UK, and include a housing subsidy, medical insurance and an education grant for the children. No doubt because of those complicating features, I have seen a number of slightly different estimates of her total earnings as at 2018. The Defendant's pleaded figure is €116,050 or £103,000.

301. On the Claimants' behalf Mr Segal projected her future earnings on the basis of what she actually earned from 2012 to 2016. Her witness statement explains that, before they moved to The Hague, she worked as a self-employed consultant. She had work of various kinds from the International Bar Association, UNICEF and the Bar Human Rights Committee, Amnesty, Chatham House and SOAS. She also worked with Mr Jones on some of his cases. From 2014 she carried out consultancy work through DJL. After their move to The Hague she was also occupied with her studies as I have said.

302. Mr Segal summarised her declared earnings from 2012 to 2016, ranging from £44,536 to £79,025 (in 2013-14) and averaging £54,716 before tax. That produced a post-tax figure of £43,589.

303. Ms Gumbel submitted that the First Claimant's actual career path since Mr Jones' death is irrelevant. It is a path that has been forced on her by circumstances, having to survive as a single parent and to care for the children by her own efforts. I accept that she would probably not have followed this career path if he had not died and therefore the figures are not of direct assistance.

304. Mr Porter points out that the First Claimant has a most impressive academic and professional background and is clearly ambitious and very able. She said in evidence that it was important to her to work independently. He submitted that it was entirely reasonable to assume that she would have qualified as a barrister and obtained pupillage at a leading chambers. The family already used the services of an au pair who could have supported their childcare requirements.

305. I broadly accept those submissions too. The difficulty is in predicting, nevertheless, what she would have earned and in what timescale. She was a late starter but was much more experienced and better connected than most of those who embark on pupillage. Earnings at the start of a barrister's career can be sparse but in some areas of practice they can increase quickly. I also accept her evidence that, in the early years at least, she would have worked less than full-time.

306. The Defendants in their Counter-Schedule did not contend for her 2018 income to be taken as the right level for her future assumed income. Relying on calculations by Mr Parry, they put forward a somewhat lower estimate of take-home pay of £92,080, based on a scenario of her being employed at a gross annual salary of £150,000.

307. That was compared by Mr Parry with a scenario in which she would have practised at the Bar, earning fees rising from £100,000 in 2018-19 to £400,000 in 2022-23. The latter figure would yield annual net income of around £162,000.

308. I have not been provided with any evidence of the earnings of newly qualified barristers in the First Claimant's field. I am not greatly assisted by the references in evidence to some junior counsel in extradition earning upwards of £400,000, as "junior" counsel may of course be barristers of any level of seniority who have not taken silk. Whilst the First Claimant may have reached that level eventually, I cannot say when or if that would have happened.

309. In my judgment, the First Claimant's career would probably have progressed in the following way if Mr Jones had not died:

    i. She would have passed the GDL in 2016 and qualified as a barrister in 2018.

    ii. While studying, she would have continued to earn an average net income from activities such as consultancy of £43,589.

    iii. She would have obtained pupillage and have maintained at least that average income by combining pupillage funding with other earnings.

    iv. From 2019 onwards she would have developed her practice at the Bar, working somewhat less than full-time for some years. Her fee income would have been boosted from other activity such as consultancy. It would on average have risen steadily until 2023, though it is impossible to predict the level of a peak or plateau.

310. For the period from the trial onwards (the children now being 15 and 13), it seems to me that the Defendant's figure of £92,080 is a conservative estimate which I can safely accept. Mr Parry's calculations indicate that the same net figure would be produced by annual Bar fees of (very approximately) £210,000. That corresponds with my view of what would have been achievable by the First Claimant.

Pension lump sum

311. At paragraph 7.11 of their Schedule of Loss and Damage, the Claimants put forward a further component of the income dependency claim based on lump sum payments which would have arisen from Mr Jones's judicial service pension and a private SIPP pension fund, on the basis of Mr Jones continuing his career at the Bar.

312. That item of loss has now been agreed by the parties in the sum of £47,500.

The risk of marital breakdown

313. The Defendant contends that the future dependency multipliers should be reduced to take account of a risk that Mr Jones and the First Claimant would have divorced.

314. There is some evidence of strain in the marriage. Notes reveal that Mr Jones told Dr Bakshi that he was unhappy in the marriage and wanted a divorce. In an email to his son on 14 April 2016 Hugh Jones referred to the marriage being under "huge strain".

315. That said, in view of Mr Jones' illness, strain in the marriage was hardly surprising. It seems likely that successful treatment of the illness would have alleviated the strain.

Stresses and strains around the time of the house move similarly could have been expected to pass, and the challenges of raising young children also do not last forever.

316. I have also considered the evidence contained in e-mails and texts between Mr Jones and the First Claimant. They confirm to me that the relationship remained warm and mutually supportive and that both parties were focused on their family life, the welfare of their children and the future.

317. Given the proportion of marriages which end in divorce, some risk is already recognised in the orthodox calculation of a dependency claim. In the circumstances of this claim, I do not find that the risk of divorce was such as to demand an adjustment in the calculation.

The income dependency calculation

318. This judgment, with all of the above findings of fact, was shown to the parties in draft. They then helpfully agreed the calculation of financial dependency, and the calculation of services dependency which follows, and the resulting figure for damages overall. Their agreed calculations are annexed to this judgment. The gross agreed sum for financial dependency, based on my findings, is £1,945,098.

Services dependency

319. It is common ground that, if he had lived, Mr Jones would have continued to contribute to the care of the children and to the household generally.

320. For the period up to trial it is agreed that the multiplicand for this item of loss should be £15,000, subject only the question of whether Mr Jones would have been able to deliver that level of services to his family if he was working hard enough to earn annual fees of £600,000 as a barrister.

321. In my judgment that is the appropriate multiplicand. The rise in earnings is predicated on Mr Jones obtaining more highly paid work, rather than on his necessarily devoting more time to work.

322. For the period from the trial until the younger child reaches the age of 23, the Claimants contend for a continuing multiplicand of £15,000 while the Defendant contends for a multiplicand of £10,000.

323. In my judgment it is logical to award a lower figure for services at a point where the children are no longer very young, but the difference should not be as sharp as that for which the Defendant contends. For that period the multiplicand will be £12,000.

324. After that date the Claimants contend for a continuing multiplicand of £10,000 while the Defendant contends for a multiplicand of £5,000. At a point where the children are very likely to be more independent, there should be a further reduction though, again, it is not a cliff-edge, and I have no doubt that Mr Jones would have done much that will fall on the First Claimant or have to be paid for. In my judgment the multiplicand for that period should be £8,000.

325. The Defendant contends that the multiplier for the period up to trial should be discounted by 0.5, and that the multiplier for the final period should be reduced by 1, to take account of further periods of ill health. I have already found that Mr Jones would have been vulnerable to future depressive episodes and have adjusted the figures for future loss of earnings with that in mind. However, it does not follow that his ability to provide services to his family, averaged over time, would necessarily have been reduced during periods when he was not working. I therefore do not consider it necessary to adjust this multiplier.

326. The Defendant also contends that the multiplier for that final period should be reduced by 25% to take account of the risk of marital breakdown. I have already explained why I do not consider that adjustment to be appropriate.

327. As with financial dependency, the parties have helpfully agreed the annexed calculation based on my findings as I have said. The gross figure for services dependency is £375,086.

Miscellaneous items of loss

328. The parties have helpfully agreed other quantum items which were in issue on the pleadings.

329. General damages for pain, suffering and loss of amenity are agreed at £10,000.

330. Funeral expenses are agreed at £10,000.

331. Interest on past losses is agreed at £378.

332. The statutory figure for bereavement is agreed at £13,600 and a figure of £14,000 is agreed for the loss of a husband/parent.

333. It is agreed that there would be no other award for family care, subrogated claims or probate costs.

The settlement with the Second and Third Defendants

334. From any overall liability would fall to be deducted the sums obtained by agreement from the Second and Third Defendants. The Court, and the First Defendant, have seen the terms of those agreements, which are said to be confidential. Subject to any further submissions, I see no need to set out the terms in this judgment.

335. But if the Claimants in future are awarded the sum which I have calculated for this claim, the amount recovered from the Second Defendant and the amount recovered from the Third Defendant as damages and interest must be credited against the claim for damages against the First Defendant, and regard must be had to the amount recovered from the Third Defendant in respect of costs in any claim for costs against the First Defendant.

Conclusion

336. If the claim had succeeded, the Court would have awarded damages of £1,776,122, less the amounts recovered from the Second and Third Defendants. That is the total of the items of loss assessed above, less 25% for contributory negligence. The parties' agreed detailed calculations are annexed to this judgment as I have said.

337. Although I have identified acts and omissions which were in breach of Dr Pereira's duty of care, these did not cause the death of Mr Jones or any measurable loss. The claim must therefore be dismissed.

ANNEX TO THE JUDGMENT

Agreed quantum calculation based on findings of fact

FINANCIAL DEPENDENCY

Past Financial Dependency

1. Deceased's Income: It is assumed that the reference to 'fees at his pre-illness level' [264] is to the self-employed turnover in the last full tax year (to April 2016) of £336,274.

Period	Length of Period	Gross Income p.a.	Deductions	Tax/NI	Net Income p.a
18.4.16 – 17.12.16	0.67 years	£0	£0	£0	£0
18.12.16 – 17.6.17	0.50 years	£336,274	£172,652	£66,336	£97,286
18.6.17 – 30.09.18	1.28 years	£468,137	£216,826	£107,440	£143,871
01.10.18 – 30.09.19	1.00 years	£468,137	£216,826	£107,344	£143,967
01.10.19 – 13.06.21	1.70 years	£468,137	£216,826	£107,031	£144,280
14.6.21 – 10.05.23	1.90 years	£570,000	£250,950	£139,296	£179,754

2. First Claimant's Income: The relevant findings of fact are at [309].

Period	**Gross Income p.a.**
18.4.16 – 17.12.16	£43,589
18.12.16 – 17.6.17	£43,589
18.6.17 – 30.09.18	£43,589
01.10.18 – 30.09.19	£43,589
01.10.19 – 13.06.21	£67,834
14.6.21 – 10.05.23	£67,834

3. The calculation of past financial dependency is, therefore:

Deceased's net earnings (18.04.16 – 14.06.23):	£964,258
Claimant's net earnings (18.04.16 – 14.06.23):	£394,687
Total of Claimant's and Deceased's earnings:	£1,358,946
x 75%	£1,019,209
Less Claimant's net earnings:	(£394,687)
Subtotal	£624,521
Table E discount (Death of Deceased pre-trial)	£618,276
Interest at 2.39%[1]	£14,777
Total Past Dependency (inc. interest)	**£633,053**

Future Financial Dependency

[1] Counter-Schedule, §75.

4. Period 1 runs from 11 May 2023 to 13 June 2027, when the Deceased would have turned 60: 4.09 years. The *Coward v Comex* discount factor is 75% throughout this period.

5. Period 2 runs from 14 June 2027 to 13 December 2032, when the youngest child would have turned 23: 5.50 years. The *Coward v Comex* discount factor is 75% throughout this period.

6. Period 3 runs from 14 December 2032 to 13 June 2037, when the Deceased would have turned 70: 4.50 years. The *Coward v Comex* discount factor is 66% throughout this period.

7. Period 4 runs from 14 June 2037 to 3 March 2043, when the First Claimant would have retired aged 67: 5.72 years. The *Coward v Comex* discount factor is 66% throughout this period.

8. Period 5 runs from 4 March 2043 to 4 December 2051, the Deceased's life expectancy: 8.75 years. The *Coward v Comex* discount factor is 66% throughout this period.

9. The multiplier for a term certain of 28.56 years is 29.6 (Table 36). The multiplier is apportioned as follows: (i) Period 1: 4.24; (ii) Period 2: 5.70; (iii) Period 3: 4.66; (iv) Period 4: 5.93; (v) Period 5: 9.07.

Period 1 (11 May 2023 – 13 June 2027):

Deceased's net earnings:	£179,374
Claimant's net earnings	£67,834
Total of Claimant's and Deceased's net earnings:	£247,208
x 75%:	£185,406
Less Claimant's net earnings:	£117,572
Table E adjustment:	£116,396

Multiplier:	4.24
Sub-total for Period 1 Dependency:	**£493,520**

10. Period 2 (14 June 2027 – 13 December 2032):

Deceased's net earnings:	£124,758
Claimant's net earnings	£67,834
Total of Claimant's and Deceased's net earnings:	£192,592
x 75%:	£144,444
Less Claimant's net earnings:	£76,610
Table E adjustment	£75,844
Multiplier:	5.70
Sub-total for Period 2 Dependency:	**£432,310**

11. Period 3 (14 December 2032 – 13 June 2037):

Deceased's net earnings:	£124,758
Claimant's net earnings	£67,834
Total of Claimant's and Deceased's net earnings:	£192,592
x 66.7%:	£128,459
Less Claimant's net earnings:	£60,625
Table E adjustment:	£60,019
Multiplier:	4.66
Sub-total for Period 3 Dependency:	**£279,686**

12. Period 4 (14 June 2037 – 3 March 2043):

Deceased's net income:	£15,148
Claimant's net earnings:	£67,834
Total of Claimant's and Deceased's net income:	£82,982
x 66.7%:	£55,349
Less Claimant's net earnings:	-£12,485
Table E adjustment:	-£12,360
Sub-total for Period 4 Dependency	**£0**

13. Period 5 (4 March 2043 – 4 December 2051):

Deceased's net earnings:	£15,148
Claimant's net earnings	£10,600
Total of Claimant's and Deceased's net earnings:	£25,748
x 66.7%:	£17,173
Less Claimant's net earnings:	£6,574
Table E adjustment:	£6,508
Multiplier:	9.07
Sub-total for Period 5 Dependency:	**£59,029**

14. The total value of the claim for financial dependency is, therefore:

Claim	**Value**
Past Financial Dependency	£633,053
Future Financial Dependency, Period 1	£493,520
Future Financial Dependency, Period 2	£432,310
Future Financial Dependency, Period 3	£279,686

Future Financial Dependency, Period 4	£0
Future Financial Dependency, Period 5	£59,029
Agreed Pension Lump Sum Dependency	£47,500
Total	**£1,945,098**

SERVICES DEPENDENCY

15. Period 1 (to trial): multiplicand of £15,000, multiplier of 7.05, interest at 2.39%: £108,277.

16. Period 2 (to C3 turning 23): multiplicand £12,000, multiplier of 9.59: £115,088.

17. Period 3 (for rest of D's life): multiplicand £8,000, multiplier of 18.79: £151,721.

18. The total value of the claim for services dependency is, therefore:

Claim	**Value**
Past Services Dependency: Period 1	£108,277
Future Services Dependency: Period 2	£115,088
Future Services Dependency: Period 3	£151,721
Total	**£375,086**

OTHER CLAIMS

19. As recorded in the judgment at [329-333] the value of the other heads of loss are agreed as follows:

Claim	**Agreed Value**
General Damages	£10,000
Funeral Expenses	£10,000
Interest	£378
Statutory Bereavement	£13,600
Loss of Partner/Parent	£14,000

Family Care	£0
Probate Costs	£0
Subrogated Claim	£0
Total	**£47,978**

CONTRIBUTORY NEGLIGENCE

20. The damages that would have been awarded to the Claimant would have fallen to be reduced by 25% in light of the finding of contributory negligence made at [236], as follows:

Claim	**Award**
Financial Dependency	£1,945,098
Services Dependency	£375,086
Other Claims	£47,978
Sub-Total	£2,368,162
-25%	(£592,040)
Total	**£1,776,122**

TOTAL DAMAGES

21. In light of the calculations set out above, the Claimants would have been awarded total damages of **£1,776,122** had liability been established, from which the settlement sums received from D2 and D3 would have fallen to be deducted**.**