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Head to Toe – The Mind

Psychiatric Injury

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Categories of psychiatric injury cases

- ***Mental health*** cases, e.g. suicide cases as a result of negligent mental health care provision.

- ***Primary victim*** cases: where the psychiatric injuries have occurred consequent upon actual physical injury (e.g. an amputation) or foreseeable personal injury (e.g. mother's claim for negligent delivery/birth).

- ***Nervous shock*** cases (secondary victims), e.g. relatives bringing claim for the psychiatric trauma experienced as a result of witnessing qualifying event.

Understanding Trauma

A wound in the mind.

How much of your work is informed by an understanding of trauma and how it presents in clinical and legal practice and at the interfaces in medico-legal work?

Central issues at interfaces

- What is the language and what are the concepts used at these interfaces?
- What is the balance between narrative and diagnosis
- Is there a need for translation because there is not a shared language?

Interfaces: Context

Personal Context	Legal Context	Clinical Context
Self-description Victim Survivor Patient	Client	Client Patient

Interfaces: Human Experiences of Adversity/Trauma

Personal Context	Legal Context	Clinical Context
Patient story Narrative of subjective experiences **Subjective** **Narrative**	Witness statement **Subjective** **Narrative**	Diagnosis or non-diagnosis **Objective + Subjective** **Diagnosis Narrative**

The Patient Narrative of Trauma and Themes

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Patient Narrative of Trauma

"Some people's lives seem to flow in a narrative, mine had many stops and starts. That's what trauma does. It interrupts the plot… it just happens, and then life goes on. No one prepares you for it."

Themes

- Before and after
- Sudden event or series of events
- Interruption of life pattern
- Impact
- Life post-interruption
- Resilience

The Patient Narrative of Trauma

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Example Patient Story (constructed example)

Going in for routine day surgery - home after surgery - feels unwell - returns to hospital - reassured and sent home - collapses - emergency admission - ICU - ward - discharge - dealing with non-understandable experiences of terror and fragmented memories.

→ A fragmented story.

Translation by Psychiatric Expert

Overturning of basic assumptions of predictability and trust in professionals - postoperative sepsis - toxic confusional state - delirium - psychosis - PTSD.

→ Clinical narrative and psychiatric diagnoses.

Medico-legal Report

→ Combination of narrative and diagnoses illustrating causal connections using medical model as explanatory framework of causation.

Transposing the Narrative into court documents

- **Particulars of Claim**
- **Schedules of Loss**
  - *Wright v Satellite Information Services Ltd* [2018] EWHC 812, per Yip J: "*It does need to be appreciated that schedules and counter-schedules are an essential part of the advocacy in a case. … [A schedule] should not simply be a series of calculations. It needs to be supported by sufficient narrative to explain the case being presented by the claimant.*"
- **Witness statements**
  - CPR PD 32
    - Para 18.1: The witness statement must, if practicable, be in the intended witness's own words and must in any event be drafted in their own language, the statement should be expressed in the first person…

NB, a claimant may be a vulnerable witness for the purposes of the CPR. A new Overriding Objective and CPR PD 1A came into force on 6 April 2021, addressing the participation of vulnerable witnesses in proceedings.

NB, parallel amendment to CPR r.44.3(5) in respect of proportionality – *'(f) any additional work undertaken or expense incurred due to the vulnerability of a party or any witness'*

History of Trauma Narratives (1)

- How do you translate subjective experiences of trauma into personal/medical/psychiatric/legal narratives?
- Two specific examples of translation of subjective experiences of trauma into trauma narratives and psychiatric syndromes

Holocaust survivors

- Holocaust narratives
- Wounded into narrative by historical trauma
- Trauma as a wound in the mind
- Survivor guilt

Vietnam war veterans

- States of mind and behavior
- Cultural context – ambivalence about war
- Access to care and rehabilitation

History of Trauma Narratives (2)

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Initial clinical description

- Post-Vietnam syndrome
  - "*An encapsulated, never-ending past deprives the present of meaning.*"
  - "*Apathy from a surfeit of bereavement and death.*"

Translation of an initial clinical description into a recognised clinical syndrome:

- DSM-3 introduced diagnoses of PTSD.
- Subjective experiences and changes in behaviour now incorporated into a medical model.

PTSD: the Medical Model

1. **Aetiology** — traumatic event/events
2. **Pathology** — detachment and compartmentalization of traumatic memories
3. **Symptoms**
   - Flashbacks, nightmares, intrusive memories
   - Emotional numbing
   - Fear-based avoidance
   - Hypervigilance
   - Irritability
4. **Diagnosis** — PTSD

Expansion/Development of Diagnoses and Concepts

DSM-5:

- PTSD
- PTSD with dissociation
- Delayed onset PTSD
- Acute stress disorder
- Adjustment disorder

ICD-11

- All of the above
- And complex PTSD

Non-psychiatric conditions:

- Survivor guilt
- Resilience
- Moral injury

Topics for Discussion

1. Balance between diagnosis and narrative.
2. What gets left out?
3. Fault lines (trauma and loss).
4. Is definition of a traumatic/stressful event always ultimately subjective?
5. What is resolution/recovery?
6. Co-production – future directions in mental health care.
7. The power of narrative – autobiographical competency as re-empowerment.

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Leach v North East Ambulance Service NHS Foundation Trust [2020] EWHC 2914 (QB)

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- PTSD consequent upon a delayed ambulance arrival following a subarachnoid haemorrhage.
- The final 31 minutes of the total 109 minute wait for the ambulance were admitted to be negligent.
- Were those 31 minutes causative of C's PTSD?
  - i) If C would have developed PTSD, in any event, irrespective of the negligent period of delay, the claim fails;
  - ii) If but for the period of negligent delay C would not have developed PTSD, the claim succeeds;
  - iii) If, on the other hand, the evidence is incapable of supporting either of the two propositions set out above, then if it can be shown that the negligent period of delay has made a material contribution to the PTSD, the claim succeeds.
- The judge favoured C's expert evidence supportive of (iii), rejecting D's expert evidence as having a "*lack of objectivity*"
- Further, rejecting D's invitation, PTSD was held to be an indivisible injury.

Secondary Victims: Where are We?

- *Alcock v CC of South Yorkshire Police* [1992] 1 AC 310 remains the guiding case:
  - C must have a **close tie of love and affection** with the primary victim;
  - C must have been present at the relevant event or its immediate aftermath (**proximity** in time and space)
  - The psychiatric injury must have been caused by direct perception of a **shocking event** or its immediate aftermath:
    - Was the event sufficiently "horrifying"?
    - Did the sudden appreciation of that event, i.e. shock, cause C's psychiatric illness?

Secondary Victims: Where are We?

- Birth cases:
  - Secondary victim cases in this context are particularly fact sensitive.
    - *RE (a minor) v Huddersfield and Calderdale NHS Foundation Trust* [2017] EWHC 824 (QB)
    - *Yah v Medway NHS Foundation Trust* [2018] EWHC 2964 (QB)
  - A careful analysis of the lay evidence, medical evidence, and contemporaneous documentation is required.
  - There remains a range of opinion amongst the judiciary as to what amounts to "horrifying".
  - *NB - Zeromska-Smith v United Lincolnshire Hospitals NHS Trust* [2019] EWHC 980 (QB) – in stillbirth cases mother is a primary victim and need not meet *Alcock* criteria – can recover for 'abnormal' bereavement and pathological grief disorder.

Secondary Victims: Where are We?

Paul v Royal Wolverhampton NHS Trust [2020] EWHC 1415 (QB)

- Chamberlain J allowed the Claimants' appeal from the order of Master Cook [2019] EWHC 2893 (QB) striking out their claims for damages for psychiatric injury allegedly suffered when they witnessed the collapse of their father in the street following a fatal heart attack in January 2014.
- The alleged negligence occurred two years earlier in 2012 when D failed to diagnose Mr Paul's significant coronary artery disease. Cs, aged 12 and 9 at the time of their father's death, witnessed Mr Paul's collapse and the attempts made by ambulance crew to resuscitate him.
- Held: proximity control mechanisms satisfied if Mr Paul's collapse was a qualifying 'event'. It was because:
  - Such events do not have to be synchronous with the breach of duty
  - Events arising from negligent omissions also qualify
  - It was the **first** event when damage occurred (Cs were at the scene of the tort because the court was required to assume that the cause of action accrued when the fatal collapse occurred) – *Taylor v Novo* distinguished
  - There was only **one** relevant event (even if actionable damage had been suffered earlier) – *Taylor v Novo* did not decide that an event only qualifies if it coincides with or immediately precedes actionable harm
- Appeal remains outstanding.

Polmear v Royal Cornwall Hospitals NHS Trust [2021] EWHC 196 (QB)

- Master Cook again.
- Another **proximity** case
- Dec 2014: Cs' daughter referred by GP to hospital for investigations (SOB, increased RR, high pulse rate, and cold extremities)
- Jan 2015: 24-hour ambulatory ECG monitoring (no episodes) - considered to be exertion and physiological (in fact pathological and pulmonary veno-occlusive disease)
- April 2015: GP requests second opinion – episodes more frequent and now vomiting
- 1 July 2015: before further consultation daughter collapses and dies, father tries to resuscitate
- Cs relied on *Paul*; D relied on *Taylor v Novo*

Polmear v Royal Cornwall Hospitals NHS Trust [2021] EWHC 196 (QB)

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Held:

- *Paul* was binding; Cs' claim not bound to fail.
- Daughter had suffered symptomatic actionable damage prior to relevant event BUT there was no reason to preclude recovery for secondary victims claims simply because she had suffered non-fatal episodes prior to the final fatal event (each episode could constitute damage; therefore, each episode had its own cause of action).
- That final episode was as much a consequence of D's negligence and was horrifying
- As it was possible to identify a qualifying event it was not necessary to identify a stopping point – the shocking event does not need to coincide with or immediately precede the first actionable damage to the primary victim
- **Prior actionable damage not a bar to recovery**
- PTA granted and direct to CA – CPR r.52.23

Secondary Victims: Where are We?

Practical considerations to bear in mind:

The narrative

- What was directly perceived?
- What is the relevant event?
- What made it "horrifying"?
- Contemporaneous documents?
- Does the evidence deal properly with the causal relationship between the relevant event and the shock?