Neutral Citation Number: **[2022] EWHC 455 (QB)**

Case No: G90CF013

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

Cardiff Civil and Family Justice Centre
2 Park Street, Cardiff, CF10 1ET

Date: 4 March 2022

Before:

His Honour Judge Harrison
Sitting as a Judge of the High Court

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Between:

MRS CERI WILLIAMS ON BEHALF OF HERSELF & AS ADMINISTRATIX FOR THE ESTATE OF MR ANTONY WILLIAMS DECEASED	**Claimant**
- and -	
BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD	**Defendant**

- -

Jim Duffy (instructed by **Slater and Gordon UK Limited**) for the **Claimant**
Andrew McLaughlin (instructed by **NWSSP Legal & Risk Services**) for the **Defendant**

Hearing dates: 22-26 November 2021 and 4 February 2022

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Judgment Approved by the court for handing down

His Honour Judge Harrison:

1. Mrs Ceri Williams brings proceedings against the Defendant local university health board in relation to the death of her husband, Antony Williams on the 9th February 2014. The proceedings arise pursuant to the provisions of the Law Reform Miscellaneous Provisions Act 1934 and the Fatal Accidents Act 1976. In addition, Mrs Williams brings proceedings for psychiatric injury as a secondary victim. Damages, subject to the issue of liability, were agreed between the parties for all of the respective claims in the global sum of £300,000.

2. The claim relates to the tragedy of Mr Williams' suicide in February 2014. Mr Williams (Antony) was 41 years old and had been a long time patient of the Defendant's mental health team. The essence of the Claimant's claim can be summarised as follows. At about 9.30am on the morning of the 9th February 2014 Mrs Williams had telephoned the Defendant's Heddfan Psychiatric Unit based at Maelor Hospital in Wrexham. She reported a relapse in her husband's condition. She was put through by the Hospital's general switchboard to a senior nurse within the unit, Nurse Freestone. The 9th February 2014 was a Sunday and out of hours provision only was available. Nurse Freestone did not take any steps for immediate action or assessment. She did advise that if Mrs Williams was concerned her husband could come to the A and E Department at the same Hospital for psychiatric assessment and/or admission or that alternatively she could contact the out of hours GP. In addition she reminded Mrs Williams that if there was an imminent danger to the safety of Mr Williams or others she should phone the emergency services. Approximately 7 hours later Mr Williams took his own life. The Claimant says that Nurse Freestone dealt with that telephone call in breach of her duty of care to Mr Williams and/or that the Defendant's out of hours provision fell below the reasonable standard. Later that day the Claimant found her husband where he had hanged himself close to the family home. She claims that as such she qualifies as a secondary psychiatric victim of the alleged negligence.

3. **Background**

Mr Williams had a long history of mental illness. His symptoms first seem to have manifested themselves in or about 1990. He was diagnosed as suffering from a schitzo-affective disorder and had been admitted to hospital on many occasions. His admissions coincided with relapses and his relapses were themselves associated with symptoms of delusion and psychosis. He described auditory hallucinations and was obsessed with the "new world order". In July 2010 the police were called to his home due to his behaviour. At that time Mr Williams was suffering from paranoid delusions and was admitted for treatment under section 4 of the Mental Health Act 1983, that admission was converted to an admission under section 2 of the 1983 Act. Ultimately he was discharged on the 6th August 2010. Later that year, December 2010, he was readmitted under section 3 of the 1983 Act and remained an inpatient at the Heddfan Unit in Wrexham until the 15th March 2011. He was discharged to the care of the community psychiatric nurses and was treated with fortnightly antipsychotic depot (Risperdal) injections.

4. In fact that admission was the last before his death. There followed a comparative period of stability characterised by compliance with treatment and regular review. He remained under the care of Dr Clifford at Wrexham. In December 2011 following a clinic attendance with Mrs Williams he wrote (TB 957):

"Antony appears to be doing extremely well. His wife thinks that he is definitely back to his normal self, in fact, better than ever. She has no concerns at all about his mental state. He is not preoccupied by the new world order or the internet. He is much more able to function at home, he is able to concentrate, interact well with others and there has been no evidence of any suicidal ideation."

Following that attendance Mr Williams' Risperdal medication was reduced to 37.5mg and there was a change in his care package from Enhanced to Standard CPA with a review in twelve months.

5. 12 months later Dr Clifford wrote:

*"Antony got married 4 weeks ago. Kerry(*sic*) says this is the best that he has ever been. She is very happy and says that everything is going very well."*

"There has been no evidence of any breakthrough of his psychotic symptoms at all and on the whole Antony is fairly happy with taking the medication. He is suffering no ill-effects from the medication although I suspect his insight remains partial."

6. The final review by Dr Clifford prior to Mr Williams' suicide was on the 23rd January 2014. Following a consultation with Mr and Mrs Williams Dr Clifford wrote (TB 966):

*"Antony seems to be doing extremely well and Kerry (*sic*) is very happy with how he is. She says that he has no preoccupation at all in some of the things he seemed to be worried about such as New World Order. He does not spend any time on the internet. He is very loving towards his family and is very involved with family life. He is no longer preoccupied or distracted."*

*"The only issue that Kerry (*sic*) has picked up is that he is anxious in social situations. He does feel rather lacking in confidence for example waiting in the waiting room today with lots of people. It was difficult for Antony and he found his heart pounding and feeling sweaty and uncomfortable. He does avoid, for example, going to ASDA with his family. He would like to be doing more but at the same time he is not keen on taking any further medication."*

7. The annual reviews broadly coincided with making Care and Treatment Plans (CTP) and Care Plan Reviews. On the 24th January 2013 Mr Williams CTP was reviewed by his then care coordinator Mr Jim Davey. The document appears at TB 2775. Noting the improvement identified by Dr Clifford the plan contains a "crisis plan" (TB 2780) as follows:

"1) If I show signs of becoming unwell I agree to myself, Ceri or other family members contacting my care coordinator or person on duty on Monday to Friday 9 AM to 5 PM .

2) If I need someone to talk to or need reassurance outside of these hours I can contact CALL on 0800132737, *or my GP if out of hours to ask for advice or support. If I become too unwell I can present at A+E.*

3) I agree to increased visits and support from my care coordinator who I understand may consider arranging an urgent, outpatient appointment with Dr Clifford.

4) I understand that should I become unwell and require additional support I may be referred to the home treatment team.

5)I also understand that if I become very unwell I may need to be admitted into hospital."

8. The front page of the plan shows its distribution to Mr Williams.

9. The 2014 Care and Treatment Plan is dated 13th January 2014 and appears at TB 2789. It contains amongst other matters the following extracts:

At TB 2793 - Crisis Plan

"If I show signs of becoming unwell I agree to myself, Ceri or other family members contacting my care coordinator or person on duty on Monday to Friday 9 AM to 5 PM on 01978 726730

If I need someone to talk to or need reassurance outside of these hours I can contact CALL on 0800132737, my GP or the out of hours emergency duty team on 08450533116.In the event of an emergency I am aware to access the A and E department of the Maelor Hospital.

I agree to increased visits and support from my care coordinator who I understand may consider arranging an urgent, outpatient appointment with Dr Clifford.

I understand that should I become unwell and require additional support I may be referred to the home treatment team.

I also understand that if I become very unwell I may need to be admitted into hospital."

TB 2795 - Risk to self

"When unwell in the past, Antony has a history of suicidal ideation. He has made several attempts to hang himself and overdose with prescribed medication. No attempts since 2011. Antony is currently not presenting with any suicidality and his mental health is stable."

The assessment form records a past risk to self but not a present risk.

TB 2797 - Imminence

"There is no current imminence of Antony engaging in self harming/suicidal ideation or violent/aggressive behaviour as his mental health has been stable for the past 2 years."

TB 2797- Key Risk Indicators

"When Antony is experiencing a relapse in his mental health he will experience suicidal ideation and engage in self harm. He also has a history, when unwell, of aggressive verbal and physical behaviour towards others."

TB 2797- Risk Reducing Factors

"Antony remains concordant with his medication regime which helps to keep his mental health stable. He will remain under the care of the CMHT where his mental health and medication regime are monitored regularly thus keeping the risk of relapse to a minimum."

"Antony has a very supportive wife and family who are aware of his mental health difficulties and are vigilant to any relapse signs."

TB 2800 - Evaluation of last Care and Treatment Plan and any changes to outcomes to be achieved;

*"Antony is doing well at the moment and his partner Kerry (*sic*) is very happy with him. There was no evidence of preoccupation with things such as the New World Order. Kerry reported Antony as loving towards his family and that he is no longer distracted or preoccupied. There was no evidence of suicidality."*

"However Kerry described Antony as being anxious particularly in social situations and that he had become quite anxious waiting in the waiting area for his appointment. Antony declined further interventions from mental health services. Kerry agreed to do some graded exposure work with Antony instead."

The section dealing with distribution of the plan at TB 2799 is not completed.

10. Much of the background factual evidence is uncontroversial. A few factual issues arose and I propose to deal with those that are relevant to determination of this case at this stage.

Provision of copies of the care and treatment plan

11. Firstly it is necessary to examine the extent to which the Claimant knew what or who to contact in the case of needing assistance. The point is relevant because it was identified by the Claimant as being a point of criticism of the Defendant. In developing the argument reliance was placed upon the absence of any written confirmation of distribution of the Care and Treatment Plan in 2014 to either Antony or Ceri Williams and in 2013 the absence of documentation of a copy of the plan being given to Ceri Williams separately. Mr McLaughlin submits, and I agree, that to understand this part of the case it is necessary to understand the wider context of the evidence given on the issue.

12. There can be and should not be any doubt that Mrs Williams was anything other than a caring and devoted partner (latterly) wife to Antony Williams. They had been in a relationship since about 1996 and she went to most if not all hospital appointments with him and had input into the same.

13. Mrs Williams had had to deal with the significant relapses of the past. She told the court that she had on those occasions phoned the hospital or indeed the police if she was sufficiently concerned about Mr

Williams being a risk to himself or others. She seemed to describe her general approach as being to ring the main switchboard of the hospital and to seek onward direction from there. She also knew that in a life threatening situation she could contact the police.

14. It was equally apparent that Mrs Williams was present at the meetings when the crisis plans of 2013 and 2014 were discussed. Indeed she was present when earlier plans were discussed. What also appeared from her evidence was Mr Williams' extreme reluctance to allow any copies of documentation to be retained by his wife. Indeed it appeared from her evidence that if documentation was handed to Mrs Williams then Antony would take it from her.

15. In addition it was clear from her evidence that when crisis plans were discussed with her husband he readily agreed to the same and never raised an objection or obstacle to, for example contacting A and E or the GP if he needed assistance out of hours. Understandably in the circumstances Mrs Williams did not herself seek to indicate to the contrary or to correct the impression given by her husband.

16. It seems from the evidence that Mrs Williams' view was that in the case of needing help at the weekend she understood she could ring the hospital. That ultimately was what occurred on the 9th February 2014. She rang the switchboard and she asked to be put through to the unit where Mr Williams had been treated as an inpatient, namely the Heddfan unit.

17. On the basis of this evidence the Defendant submits that the question of whether or not the Claimant was given a copy of the care plan and any telephone numbers contained upon it is irrelevant. Firstly and most obviously on Mrs Williams' own account she would not have been able to retain the same herself anyway. Secondly, again on her own account, she knew of the crisis plan and had discussed it. Whilst the plan talked about contacting A and E, Mrs Williams rang the hospital. Again on the evidence from Mrs Williams, she rang the hospital and asked to be put through to the Heddfan unit because that is what Mr Williams was saying he wanted her to do and where he wanted to go to be seen. In such circumstances it seems to me that there is a great deal of force in the Defendant's submission that it is irrelevant whether a copy of the plan

was actually handed to Mrs Williams. Having a copy of the plan herself would, it seems to me as a matter of fact, have made no difference to what she did that day, namely to ring the hospital first. Her primary reason for doing this was because it was where her husband wanted to go.

18. Unfortunately, as we now know, direct admission to the unit was never realistically possible in the way that Mr Williams wanted. An assessment was always going to be required and at the weekend in Wrexham in 2014 that realistically meant an assessment at A and E. On the documentary evidence such direct access to Heddfan was never put forward by the Defendant as an option and it was not discussed as being part of any crisis plan for the simple reason that it not available. In other words there was not some way that Mrs Williams could have achieved what her husband wanted if only she had been provided with particular numbers or contact details.

19. In so far as it is necessary for me to make findings on the distribution of the care plan it seems to me likely that Mr Williams would have been given copies of the plans in 2013 and 2014 notwithstanding the content of TB 2799. On balance separate copies were not given to Mrs Williams although I am satisfied on the balance of probabilities had they been so provided then Mrs Williams would not have been able to retain her own copy. Of more significance I am not persuaded on the balance of probabilities that her having a copy would have made any difference to the events of February 2014 and on the balance of probabilities whatever documentation she had Mrs Williams would have rung the switchboard and asked to be put through to Heddfan Unit.

The Telephone Call to Maelor Hospital on the 9th February 2014

20. Mrs Williams gave an account of the morning of the 9th February 2014 that was extremely moving. Anyone listening to her description of the events of that day cannot be other than wholly sympathetic to her and to her attempts to get help for her husband. It is inevitable that she will have replayed the events in her mind endlessly. Very few people have an understanding of what confronted her later that day and most of us can

only imagine. Moreover we are now looking back at the events with the luxury of the sort of hindsight that those involved at the material time simply did not have.

21. Mrs Williams described how on the morning of his death Mr Williams appeared different and she was worried. She was used to him getting up early without her and to perhaps going for an early morning walk and he seems to have done so on this day. However when she awoke she found him in bed and staring at her. More unusually he seemed to be suggesting that he needed to go in to hospital.

22. It was sufficiently concerning for Mrs Williams to ring the switchboard at Wrexham Maelor Hospital. She asked to be put through to the unit and Nurse Rebecca Freestone was bleeped to respond. She was the senior nurse in charge of the unit that weekend, her main role being as deputy ward manager within the unit. The telephone call is an important part of the Claimant's case and both Mrs Williams and Nurse Freestone gave evidence as to their recollection as to what on any version of events was not a long conversation. There was a great measure of agreement between them. There may have been differences as to the precise words used but in broad terms the nature of the reported conversation was the same.

23. Mrs Williams began the call by explaining that she was Mr Antony Williams' wife, that he was a former patient on the Heddfan unit and that she was worried about him. She said that he needed to come to hospital because he was not well. She mentioned that he was under the ongoing care of Dr Clifford (consultant psychiatrist).

24. Whatever the precise word used were, Nurse Freestone indicated that bringing Mr Williams directly to the unit was not an option. Mrs Williams seemed to recall the conversation being to the effect that there was "no one there." Nurse Freestone did however go on to ask about Mr Williams' condition. Mrs Williams thought she was specifically asked whether he was suicidal. Nurse Freestone thought that she would seek such information but would do so in a more subtle way, i.e. by asking whether he was a risk to himself or others. Whatever the precise words used, I am satisfied that Nurse Freestone was probing to get some idea

of the seriousness of the situation and was not disinterested as may have been suggested at one point. Mrs Williams recalls her reply to this request as words to the effect of "he could be".

25. Nurse Freestone did not probe further into "relapse triggers" or the like. She did not ask to speak directly to Mr Williams. She recalled, and Mrs Williams accepted in her evidence, that the conversation was calm. Certainly Nurse Freestone was not overly concerned by the tone of the conversation and she went on to explain what were the standard options available out of hours. She said that Mr Williams could be brought to A and E to be assessed. Mrs Williams said that her husband would not want to come to A and E and Nurse Freestone said that she could send members of the Psychiatric Liaison Team (PLT) over to A and E to meet them after triage and deal with him there. As an alternative Nurse Freestone suggested contacting the out of hours GP service. Mrs Williams seems to have said that her husband would not do this because he would not know the GP. Nurse Freestone reminded Mrs Williams of the option of calling the emergency services if she was concerned about the safety either of her husband or of others. This was something that Mrs Williams was well aware of, not only from the crisis plan discussions that she had been a part of but also because she had previously had to call the police on a previous occasion. It is agreed that Nurse Freestone mentioned contacting the Community Mental Health Team the next day, namely Monday morning when they had returned to work. This suggestion/option must be seen in the context of Nurse Freestone then going on to ask Mrs Williams if she thought she could cope overnight. Mrs Williams accepts that she was asked if she could cope and importantly accepts that her reply was that she could. In her evidence before the court she did say that in fact she thought looking back now that she didn't think she would be able to cope but she did not tell Nurse Freestone.

26. The matters set out above set out the essence of the conversation. In summary, Mrs Williams said her husband wanted to come directly into the unit and was reluctant to be assessed otherwise. Nurse Freestone signposted her to A and E for assessment, alternatively the out of hours GP or if she was worried about imminent harm the emergency services. Mrs Williams told Nurse Freestone she could probably cope overnight whereupon the Community Mental Health Team would be available.

27. The Claimant's case is that in the light of the information provided by Mrs Williams to Nurse Freestone failed to ensure that Mrs Williams was appropriately signposted to sources of help for an urgent psychiatric assessment. It is submitted that Nurse Freestone had a discretion to allow Mr Williams to come to the unit in extreme circumstances and this option should have been offered.

28. Specifically the submission from the Claimant is that Nurse Freestone acted in breach of duty by failing to refer or pass Mrs Williams on to the Psychiatric Liaison Team (PLT) within the Heddfan Unit. I will go on to deal with the question of causation below, but the essence of the first submission is that the content of the telephone conversation was sufficient to require Nurse Freestone to take further or different action.

29. On the evidence I characterise the conversation as one which at the time was not overly concerning to Nurse Freestone but with hindsight she can look back and identify things that could have pointed to a problem.

The availability of hospital records and treatment plans

30. Associated with the telephone call there arises an issue regarding the availability of Mr Williams' Community Mental Health Team records. He was a person within the community health care system and, on the evidence provided to the court by Dr Clifford his mental health notes would have been kept at Ty Durbin some ½ mile or so away from the main Maelor Hospital. There was at the material time no electronic digital access to these records which, of course, would have contained the care and treatment plans summarised above. However it appears that an electronic system of sorts was in operation. This was referred to as the Myrddin system or "M drive" and seems to have been confined to the limited documents such as the clinical letters such as those written by Dr Clifford. It was also the evidence that in reality it took some time to upload letters onto the system, perhaps a month, and that probably the most recent letter from Dr Clifford would not have been on the system.

31. Nurse Freestone recalled printing off perhaps the last 2 or 3 letters after the telephone conversation and giving them to the Psychiatric Liaison Team just in case Mr Williams presented later.

32. The limited nature of the notes available is important since the Claimant submits that the failure to make available the Care and Treatment Plan amounted to a breach of duty. The Claimant contends that making the plan was so important in making decisions about Mr Williams that it needed to be available. If it could not be available in paper form then it needed to be available electronically. Consequently they submit that in circumstances whereby the paper notes were not on site, and where there was an electronic system of sorts available, it is incomprehensible that the care and treatment plan was not unloaded to the electronic system.

33. The Defendant's submit that this analysis is false. They argue that the proper approach to this issue is to consider first whether it was a breach of duty in 2014 to operate a paper only system of medical records. If the answer to this question was yes, as the expert evidence suggested, then the next question became whether it was unreasonable for those records not to be available out of hours because they were stored off sits and could not be accessed. The Defendants submit again that the answer to this question again is provided within the expert evidence. The joint statement from the psychiatrists seemed to agree that access to notes within 24 to 36 hours was reasonable and whilst in evidence Dr Turner for the Claimant seemed to move away from this, he ultimately accepted that he was really referring to "good practice" rather than breach of duty. In cross examination from Mr McLaughlin he said;

"It would have been good practice to access (the notes) earlier but not a breach of duty not to do so"

"It was not a breach of duty to keep CMHT notes on paper"

"I don't suggest that that it was a breach of duty for Nurse Freestone not to access the records."

Again in cross examination the Claimant expert in Psychiatric Nursing, Professor Gournay, said;

"*In 2014 CMHT records not being electronic was very common-I'm not saying it was a breach of duty not to have them electronically"*

34. The Defendant's submit that the fact that a relatively rudimentary system was in operation should not place a higher duty upon them than if no system at all were in operation.

35. It is also necessary to consider what Nurse Freestone would have done had she had sight of the Care and Treatment plan. In that regard it is necessary to place her evidence in context. She was giving evidence about an incident where her decision making was in part being blamed for the subsequent death of Mr Williams. Notwithstanding the same she was not overly defensive in her answers but rather she was reflective and was ready to accept with hindsight what might have been done differently. In giving her evidence she made the following points. Firstly she could have asked to speak to Mr Williams himself. Secondly she could have asked the psychiatric liaison team to ring Mrs Williams back. Thirdly, if she had had sight of the care plan she could have put Mrs Williams through to the Psychiatric Liaison Team directly although in all her years as a psychiatric nurse she had never done that. She would not however have given out any alternative contact numbers (such as EDT) to the Claimant or given her the option to seek help or assistance in a different way.

36. It is therefore also necessary to consider what would have happened if Nurse Freestone had referred Mrs Williams on to the Psychiatric Liaison team. The Defendants submit that even if Nurse Freestone had so referred Mr Williams to the Psychiatric Liaison Team, then it would have made no difference to the options available. The team would have approached the options available in exactly the same way. The method of admission to Heddfan was following assessment and on the evidence before me any out of hours assessment made by the Psychiatric Liaison Team was made at A and E. Whilst it was always possible to think of extreme examples of individuals "in extremis" hammering on the door of the Heddfan Unit, this was not the position that presented itself.

37. Consequently the point that is made by the Defendants is that even if the court concludes it to be a breach of duty for Nurse Freestone not to have access to the care and treatment plan and even if she had referred Mrs Williams to the Psychiatric Liaison Team, there is no evidence to suggest that they could or would have offered anything different than an attendance at A and E for assessment. They were in no real different

position to Nurse Freestone in that they could not do what Mr Williams wanted namely admit him without assessment to the Heddfan unit.

38. Before moving on from the events of that morning. It is relevant to have some regard to what happened after the telephone call was made. I emphasise in so doing that nothing in this judgment should be read as criticising Mrs Williams' actions that day. Quite the contrary is the case. It is however right to put the telephone call in context. Mrs Williams did not in fact seek to make any further contact that day. She did not involve the emergency services and, on the evidence before me she felt able to leave her husband at home for a period of time.

The expert evidence

39. The parties relied upon respective expert evidence in Psychiatry and Psychiatric Nursing. The Claimant called Dr Turner and Professor Gournay, The Defendants Dr Scott and Mr O'Neill. I have already made reference to some of the evidence from Dr Turner and Professor Gournay and their comments about the availability of electronic notes.

40. Of course expert evidence does not always determine breach of duty in a claim for clinical negligence but obviously it is important. In this case it is part of the Claimant's claim that Nurse Freestone acted in breach of her duty to Mr Williams and should have followed an alternative course. It follows that the extent to which such a submission is supported by expert evidence is extremely relevant. For the Claimant it is Professor Gournay's evidence that was obtained to address the position of a psychiatric nurse. Within the first few questions asked of him in cross examination he agreed that he was not accusing Nurse Freestone of acting negligently. He thought she was in a difficult position and having listened to her he concluded that she did not do anything wrong. In particular he felt that if it had been conveyed to her that Mrs Williams felt that she could cope overnight then that would serve to reassure Nurse Freestone. If she was so reassured then he would not expect further action to be taken. I have already dealt with the content of the telephone

conversation. Mrs Williams agrees with Nurse Freestone that such assurance was probably given albeit that perhaps with hindsight she should not have done so.

41. In submissions Mr Duffy for the Claimant invited me to reflect on the Professor Gournay "as a whole" and by reference to the contents of his reports wherein he was critical of the Defendant's response to the telephone call. It is he submits necessary to consider the factual basis upon which he appeared to be making concessions in cross examination.

42. Aside from dealing with the issue about the availability of electronic notes, Dr Turner accepted in cross examination the principle that in general terms the recognised way to assess and admit a patient out of hours was via accident and emergency. In his view the Psychiatric Liaison Team were the gatekeepers and a system whereby they assessed at A and E where they might have rooms to carry out the same was normal.

43. For the Defendants Dr Scott emphasised the need for assessment of the patient before admission. She would not have expected such an assessment to be carried out in the community by a consultant and she had never been called out to do so unless there was the need for a detention. She too was not surprised at the non-availability in 2014 of electronic notes. As she put it, the majority of patients come to A and E without information and that is the reality of clinical practice. Obviously the more information the better, but again she did not criticise an out of hours system that depended upon a patient presenting at A and E to be assessed.

44. Mr O'Neill was a registered mental health nurse who gave evidence in response to the report of Professor Gournay. Mr O'Neill added his voice to the weight of evidence to the effect that in 2014 the absence of electronic notes was not remarkable. Again he emphasised the importance of assessment prior to admission. Care Treatment plans were, of course, a guide but it was the assessment that needed to govern admission to a unit. In his view there simply was no way around the need for Mr Williams to be assessed before deciding upon admission to the unit. As he put it "*there has to be a system*" and it was "*not appropriate to offer assessment at the in-patient units*". Furthermore, if patients were allowed to come to the unit for

assessment then it would "*break the system"*. He added that going by his experience of how people accessed services and what was available at the time (2014), that which was described by the Defendants was "*common practice*".

45. All of the experts found it difficult to predict what would have happened if Mr Williams had presented for assessment at the material time.

The Law

46. In B*olam v Friern Hospital Management Committee 1957 1 WLR 582* the principle was famously stated that a clinician *"is not guilty of negligence if he has acted I accordance with the practice accepted as proper by a responsible body of medical men (sic) skilled in that particular art*". Furthermore they would not be negligent merely because "*there is a body of opinion which would take a contrary view*."

47. In *Bolitho v Hackney Health Authority* (1998) AC 232 the "*Bolam*" test was further explained thus. In order to amount to a defence the body of medical opinion relied upon has to be "*responsible reasonable and respectable"* and has to have a basis in logic.

48. For the Claimant Mr Duffy submits that notwithstanding the various view expressed by the experts in this case regarding the standard practices described as prevailing in 2014, those practices do not withstand the scrutiny of logic as required by *Bolitho*. This he submits is of particular relevance when considering the availability of electronic records.

49. Mr Duffy for the Claimant also advances a more nuanced submission. He contends that in examining the actions of Nurse Freestone that day the court is considering a situation akin to the provision of advice about "risks" that was the subject of the Supreme Court's deliberations in *Montgomery v Lanarkshire Health Board* (2015) 2 WLR 768.

50. In *Montgomery* the Supreme Court held:

"The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would attach weight to it."

Furthermore

"the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks posed by treatment and any reasonable alternatives, so that she is then in a position to make an informed decision."

and

"The doctor's advisory role cannot be regarded as solely an exercise of medical skill without taking account of the patients entitlement to decide on the risks to her health which she is willing to run."

51. Mr Duffy's argument is that the telephone call should be seen as part of the required dialogue required by *Montgomery*. It was, he submits, incumbent upon the Nurse Freestone as the nurse with responsibility to engage further in the dialogue, to understand the problems facing Mr and Mrs Williams and consequently then to offer a further alternative of onward referral to the PLT and/or assessment at the Heddfan Unit. He submits that if such onward referral had been actioned then the PLT themselves, if they engaged in the sort of dialogue envisaged by *Montgomery*, would have offered a means of assessment and admission that was acceptable to Mr Williams.

Does the Claimant establish that Nurse Freestone acted in breach of her duty of care either in failing to refer Mr and Mrs Williams to the Psychiatric Liaison Team or in failing to offer direct access and assessment at the Heddfan unit?

52. Mr Duffy submits that Nurse Freestone was aware of the following:

i) That Mr Williams wanted to come in to hospital.

ii) That Mr Williams had previously been an inpatient at the Heddfan unit

iii) That he was currently a patient under Dr Clifford

iv) That he did not want to go to A and E.

v) That he was unlikely to see an out of hours GP

vi) The Mr Williams wanted help

vii) That Mr Williams could be suicidal.

He contends that such information demanded a different approach and/or the sort of *Montgomery* dialogue set out above.

53. Whilst I understand this submission, it seems to me that it ignores the balance of the evidence about the telephone call. The following points are in my judgment most relevant;

i) That the caller was undoubtedly calm.

ii) That the option of calling the emergency services if worried about Mr Williams safety was mentioned.

iii) That Nurse Freestone did obtain confirmation that the caller felt able to manage Mr Williams until the following day.

54. Of these three additional factors it is perhaps iii) that is most relevant. It was not controversial among the experts from both sides that this would be a reassuring factor to a psychiatric nurse in Nurse Freestone's position.

55. The evidence also has to be considered against the background of the expert evidence called by the parties specifically to deal with breach of duty on the part of Nurse Freestone. I reiterate that such expert evidence is not conclusive by itself and the court must nevertheless consider and apply its own analysis for the purposes of applying the relevant tests set out above. However, Professor Gournay's acceptance that he was not criticising Nurse Freestone was not dragged from him but rather volunteered at the outset of his cross-examination. Mr Duffy was of course correct that his witness had in his reports expressed himself rather differently and that the court must be careful in looking at the factual basis upon which he was

opining. However, Professor Gournay in giving his evidence plainly accepted the reassuring effect of Mrs Williams' acceptance that she said she could cope overnight. In my judgment, and to state the obvious, the failure of the Claimant's expert in psychiatric nursing to identify and maintain a clear area of criticism of the actions of Nurse Freestone either by way of onward referral to the PLT or by herself allowing direct assessment at the unit represents a significant forensic hurdle for the Claimant especially when that evidence is read in conjunction with the Defendant's expert Mr O'Neill.

56. In considering Nurse Freestone's actions it is also necessary to examine whether her advice to Mrs Williams accurately represented what was available at the time and/or whether, either by virtue of Mr Duffy's *Montgomery* argument or otherwise, further options should have been provided.

57. In this respect I accept Nurse Freestone's evidence that what she told Mrs Williams during the telephone call represented her understanding of what the out of hours service was and how it should be operated. Furthermore her understanding was consistent with the agreed position set out in the Care and Treatments plans (ie presentation at A and E out of hours) and consistent with the expert evidence from both sides. Mr O'Neill gave a convincing and logical explanation why assessment at the unit would not be something to be encouraged. Nurse Freestone's acceptance that she could envisage "in extremis" how someone might attend at the unit and be assessed is not the point. It would not be open to Nurse Freestone to encourage attendance at the unit "in extremis". Whilst a health professional might not in such circumstances turn someone away, that is not a reason to encourage it or to offer it as an option. The course of action available if there was an immediate threat to life was to call the emergency services and this option was signposted.

58. Furthermore in considering whether what Nurse Freestone offered or advised actually represented what was available the court must reflect the balance of the expert evidence given in relation to what was common practice at the time. In that regard the experts were not in dispute that assessment at A and E out of hours was entirely consistent with what they would expect.

59. Having regard to the matters set out above I am unable to conclude that the Claimant has established a breach of duty on Nurse Freestone's part.

Does the Claimant establish that the Defendants were in breach of duty in failing to have the Care Treatment Plan available for access out of hours by Nurse Freestone?

60. Irrespective of my conclusion regarding any direct failure on the part of Nurse Freestone, the Claimant argues that the Defendants were in breach of duty in failing to afford access to Nurse Freestone to the Care Treatment Plan. I have summarised the argument above.

61. The Claimant's argument is based upon the decision in *Bolitho.* The court is invited to conclude that irrespective of the views of the experts to which I have already referred regarding common practice in 2014, the court must stand back and reflect upon the basis in logic for the views expressed. All of the experts and practitioners agree that the Care Treatment Plan is an important document which contains important information. Against that background Mr Duffy asks why not include the same in any electronic system in operation, however rudimentary. If the answer to that question has no proper basis in logic then he contends that it points to a breach on the Defendant's part.

62. In my view it is important to place the rudimentary electronic system that was operational at the time in context. On the basis of the expert evidence the court is able to conclude that the absence of an electronic medical notes system in 2014 was both commonplace and not a breach of duty on the part of the Defendant. Furthermore and whilst there was some variance in view the court is able to conclude that in 2014 having to wait out of hours for access to the psychiatric notes was neither unusual or capable of criticism. The Defendant submits that in the light of the same it is unfair to enhance the duty upon them simply because they put some notes in an electronic format. In considering this issue it seems to me to be relevant to have regard to such evidence as the court has about the Myrddin system or "M" drive. In that regard Dr Clifford and Nurse Freestone seemed to describe a system whereby vary limited information indeed was put on the system. Consultants' letters following clinics were unloaded and that these were not put on the system in

real time sometimes taking a month or so to get there. Consequently the system was not being operated as an alternative to the paper notes and would not be relied upon as such. In my view it is appropriate to regard it as an additional resource on top of a system that would otherwise fall within the band of reasonable systems being operated in 2014. In my judgment it would not illogical in 2014 for a health board to try new systems whilst maintaining an underlying reliance on a reasonable paper system. I therefore agree with Mr McLaughlin's submission that in so doing they should not be held to place themselves under a duty to do more than would otherwise be regarded as reasonable. I am unable on the evidence to conclude that the Claimant establishes either that the Defendant's approach was illogical and/or that in failing to provide electronic access to the notes the Defendant acted in breach of duty.

63. In making his helpful oral submissions Mr Duffy identified the two questions set out above as providing the Claimant's routes to liability. For the reasons explained I am not persuaded that they are made out and as such the claim fails. Nevertheless I go on to consider those matters of causation that would have to be determined if I had concluded differently.

Causation

64. It was the Claimant's case that by reason of either or both of the routes to liability dealt with above the Claimant ought to have been placed in contact with the Psychiatric Liaison Team at the Heddfan unit. Had I decided the issues above differently it would have been necessary for me to go on to consider whether direct contact with the PLT that day would have resulted in a different outcome either with or without electronic access to the Care Treatment Plan.

65. Before reaching a conclusion in respect of this, it is necessary for me to highlight a specific issue that arose at the outset of this trial regarding the Claimant's pleaded case. The original particulars of claim served on behalf of the Claimant are dated 29th January 2018 and included specific allegations that Mr Williams should have been referred to the Home Treatment Team ("HTT"). The causative potency of such a referral was pleaded as being that it was likely to have resulted in the HTT making contact with Mr and Mrs

Williams with a subsequent assessment being arranged and likely admission to hospital. In fact on the 23rd January 2020, and by order of Master Eastman the particulars of claim were amended and the HTT allegations of breach and causation were struck through in red as being abandoned. The pleadings were subsequently re amended on the 5th October 2020 but the allegations remained struck through.

66. At the outset of this trial Mr Duffy applied to reinstate the HTT issue. Unsurprisingly that application was resisted by the Defendants who reasonably had prepared for trial on the basis that the issue was not being pursued. I ruled in favour of the Defendants. Throughout his submissions Mr Mclaughlin again resisted what he perceived to be attempts to revisit this issue.

67. Mr McLaughlin's fears were not without foundation but I make no criticism of Mr Duffy's ingenuity in this regard. It was his contention that if Mr Williams had been referred to PLT then they could have spoken to Mr Williams, made an assessment and amongst other options considered referral to HTT who could have dealt with Mr Williams away from A and E.

68. In my view, whilst it was open to the Claimant to contend that there should have been referral to the PLT, the state of the pleadings make the specific reference to a HTT referral problematic and in this respect I agree with Mr McLaughlin's submissions.

69. Next I ask myself the question; if the Claimant had been referred to PLT can the Claimant establish that it would have made any difference to the outcome? In this respect there are two hurdles. Firstly, would the PLT have offered a significantly different approach to that which was in fact offered by Nurse Freestone and secondly what would have been the result of any psychiatric assessment carried out.

70. On my findings the PLT were the out of hours gatekeepers to admission. It is not disputed that they would ordinarily undertake their assessment in the A and E department at Maelor hospital and on the basis of the evidence summarised above this was not an unusual arrangement. If Mr and Mrs Williams had spoken directly to the PLT then I am satisfied that, like Nurse Freestone, their first response would be to suggest attendance at A and E. The argument for the Claimant is that given the opportunity of speaking to Mr and

Mrs Williams directly, particularly if they had access to the CTP notes, then they would have arranged a method of assessment that avoided attendance at A and E. The problem with this suggestion is that it presumes that in the course of a telephone interview sufficient information would have been gleaned so as to cause the PLT to do something out of the ordinary.

71. Once again there is a danger of approaching this issue with the benefit of perfect hindsight. On the balance of probabilities it seems to me that Mrs Williams is likely to have given broadly the same information to the PLT as she gave to Nurse Freestone. That information would, I am satisfied, have been likely to have included a similar reassurance to that given to Nurse Freestone namely that Mrs Williams could manage Mr Williams overnight.

72. Part of the criticism made by the Claimant is that the policy of requiring assessment at A and E by whoever is not part of a written system operated by the Defendant Local Health Board. Mr Duffy asks why, if this really was the system, was it not front and centre in a clear document. The fact that it is not, he submits, points to a conclusion that there was not such a rigid requirement. Consequently he contends that the PLT had a degree of flexibility that would have allowed a different approach.

73. Whilst there is force in this submission, I have already dealt in part with this issue when considering Nurse Freestone's evidence. The relevant factors are:

i) The direct evidence from the clinical professionals was that the system was presentation and assessment at A and E or via the GP and not assessment at the unit and/or at home.

ii) The expert evidence was that such a system was usual in 2014.

iii) The Care and Treatment plan expressly provides for presentation at A and E as an agreed option.

iv) Mr O'Neill's evidence about the importance of having a system and his reasoning that assessment on a unit would be undesirable.

74. In my judgment taking these factors together it seems to me that the court can conclude that the system operated by the Defendant was as described by Nurse Freestone and that it would have required something very unusual for the PLT to depart from it. They would, I am satisfied on the balance of probabilities, have had some reassurance from the conversation and/or to put it another way I am not satisfied that information would have been imparted that would have resulted in a different approach.

75. On the evidence before me I am driven to the factual conclusion that if they became involved, then the Psychiatric Liaison Team at Maelor Hospital would have wanted to assess Mr Williams to consider admission and they would have wanted to assess him at A and E because that is where they undertook such assessments.

76. For completeness sake I should also go on reach a conclusion as to whether I am satisfied on the evidence before me that the provision of the CTP either to Nurse Freestone or to the PLT would have led to a different outcome. Having specific regard to iii) above, but by reference to all of the factors, I am not persuaded on the balance of probabilities that the provision of the CTP either to Nurse Freestone or to the PLT would have materially altered their approach.

77. Finally by way of causation I have to consider whether the Claimant can establish that if a mental health assessment was undertaken it would have led to the offer of an admission to the Heddfan unit. Perhaps surprisingly, in the light of what ultimately occurred, the answer to this question is not straightforward. It is made particularly difficult by the unwillingness on the part of the expert witnesses, including those instructed on behalf of the Claimant, to express a clear view. In evidence Dr Turner said that he was unable to say that an assessment undertaken by the PLT would have avoided the Mr Williams' death. The outcome of any assessment would depend on his state of mind at the time of that assessment and that was difficult to predict. In other words Dr Turner was unable to extrapolate from the information that was available about Mr Williams and unable to conclude that on the balance of probabilities his presentation would have led to admission or to his being in a place of safety. The best that he was able to say was that there was a possibility that suicide would have been avoided. Professor Gournay was also reticent to express a clear

view on this issue. Whilst he improved his evidence in re-examination, in cross-examination he gave a similar opinion to that of Dr Turner, namely that he could not say if a psychiatric nurse would have admitted the Claimant and it would depend on the assessment made at the time.

78. The court should not simply regard this lack of evidential support as fatal to the Claimant's case. It is open to the court to form its own conclusions as to whether the particular circumstances of this case the Claimant can discharge the burden of proof. However on this issue expert evidence is important. If, despite knowing what we know now, it proves difficult for experts in this field to predict what would have happened if an assessment had been carried out that day, then in my judgment it would be unwise of the court to speculate. On this issue, had it been relevant, the Claimant would have fallen short of establishing her claim.

79. It follows from the conclusions set out above that, notwithstanding the sympathy that the court feels, the Claimant's claims fail and are dismissed.

80. Finally I should note the dignity with which the Claimant and her family presented before me. I have already commented upon this. Nothing I have said should be taken as indicating that they did not act entirely with Mr Williams' best interests at the forefront of their minds throughout. The papers before me demonstrated just how engaged and supportive Mrs Williams was and had been to her husband over a long period of time.

81. The parties are invited to agree an order in consequence of the handing down of this judgment and to provide the same to the court by 4 pm on the 11th March 2022. In the absence of agreement the case will be listed for a short remote hearing.