Case No: D68YX349

IN THE COUNTY COURT AT MANCHESTER

Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

Date: 19th March 2020

Before :

RECORDER COX

- -

Between :

MR DAVID GREENWOOD (ON HIS OWN BEHALF AND AS ADMINISTRATOR OF THE ESTATE OF MRS SUZANNE GREENWOOD (DECEASED) — **Claimant**

- and -

MS LISA HIGSON — **First Defendant**

-and-

DR ANJANI KUMAR — **Second Defendant**

-and-

DR ANJANA KUMAR — **Third Defendant**

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Mr David Haines (instructed by **Express Solicitors**) for the **Claimant**
Mr Simon Butler (instructed by **BSG Solicitors LLP**) for the **Defendants**

Hearing dates: 27th – 31st January 2020

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APPROVED JUDGMENT

Recorder Cox:

Introduction

1. This claim arises from the tragic death of Suzanne Greenwood on 23 December 2014. The Claimant alleges that her death was the result of negligent treatment whilst a patient at the Edgworth Medical Centre, 354 Bolton Road, Edgworth, Bolton, BL7 ODU. The claim is brought against the First Defendant, Mrs Lisa Higson, an Advanced Nurse Practitioner. She was employed by the Second and Third Defendants, Dr Anjani Kumar and Dr Anjana Kumar who are father and daughter respectively, and were partners of the medical centre. They accept that they are vicariously liable for the acts and omissions of the First Defendant.

2. The claim is for damages pursuant to the Fatal Accidents Act 1976 and the Law Reform (Miscellaneous Provisions) Act 1934. The Claimant is Mr David Greenwood, the widower of Suzanne Greenwood and the administrator of her estate.

3. I have had the benefit of considering the pleadings and the evidence contained in several volumes of the trial bundle (the page numbers are sequential and therefore page references in this judgment are made without reference to specific bundles). I have heard oral evidence from Mr Greenwood, Ms Lisa Higson, Dr Anjani Kumar and Dr Anjana Kumar. Dr Anjani Kumar largely deferred to his daughter and I have not placed any weight on his evidence. In addition to their evidence I have also read witness statements from Mr Nigel Burke, Ms Katharine Tynan and Ms Lesley Frierson. I have also read and heard expert evidence on behalf of the parties. That expert evidence is in the discipline of nursing, general practice and psychiatry. I will return to that expert evidence below.

The Law

4. The claim is brought in negligence. The burden of proof is on the Claimant to establish on the balance of probabilities that the Defendants were in breach of their duty of care to Suzanne Greenwood, that the breach caused her death and that loss was suffered as a result.

5. In determining whether or not the Defendants are in breach of their duty of care to the Claimant I apply what is widely known as "The Bolam Test" (*Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 583*). McNair J directed the Jury by saying:

   'I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.'

6. I must therefore decide whether the acts or omissions of the Defendants fell below the standard of, in the case of the First Defendant, a responsible body of advanced nurse practitioners, and in the case of the Second and Third Defendants, a responsible body of General Practitioners. I must also bear in mind the refinement of the "Bolam Test" contained in *Bolitho* v *City and Hackney Health Authority* [1998] AC 232 where Lord Browne-Wilkinson said at p.241:

   "...in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. [1957] 1 W.L.R. 583 , 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a ' responsible body of medical men.' Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent reasonable body of opinion.' Again, in the passage which I have cited from Maynard's case [1984] 1 W.L.R. 634 , 639, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

   Later at p.243 he added:

   "I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

7. I must therefore be satisfied that the experts in the case provide a logical basis for me to reach conclusions on whether or not there has been a breach of duty in this case. I also consider the guidance in *'C' (By his Father and Litigation Friend 'F')* v *North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB) by Green J at paragraph 25 where he said:

> *"It seems to me that in the light of the case law the following principles and considerations apply to the assessment of such expert evidence in a case such as the present:*

i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.

ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.

iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.

iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and/or "respectable"; and whether the opinion is reasonable and logical.

v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion tendered in good faith, necessarily accords with sound medical practice.

vi) Responsible/competent/respectable: In Bolitho Lord Brown Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was "logical". It seems to me that whilst they may be relevant to whether an opinion is "logical" they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately, as "logical". Nonetheless these are material considerations. In the course of my discussions with Counsel, both of whom are hugely experienced in matters of clinical negligence, I queried the sorts of matters that might fall within these headings. The following are illustrations which arose from that discussion. "Competence" is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS. Such a person expressing an opinion about normal clinical conditions will be doing so with first-hand knowledge of the environment that medical professionals work under within the NHS and with a broad range of experience of the issue in dispute. This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experience within the NHS is a matter of significance. By the same token an expert who retired 10 years ago and whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion

divorced from current practical reality. "Respectability" is also a matter to be taken into account. Its absence might be a rare occurrence, but many judges and litigators have come across so called experts who can "talk the talk" but who veer towards the eccentric or unacceptable end of the spectrum. Regrettably there are, in many fields of law, individuals who profess expertise but who, on true analysis, must be categorised as "fringe". A "responsible" expert is one who does not adapt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR35 and the PD and Protocol).

vii) Logic/reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency. For example, a judge will consider whether the expert opinion accords with the inferences properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. There are 2 other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, a further issue arising in the present case emerges from the trenchant criticisms that Mr Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a précis then that should be expressly stated in the body of the opinion and, ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to."

8. I have not taken into account the authorities relied on by the Defendant that discussed the duty of care of other public bodies or employers. I am satisfied that it would be inappropriate to do so, and that the correct approach is the one that I have set out above.

9. If I am satisfied that there is a breach of duty of care, I must then go on to consider whether or not that breach caused Mrs Greenwood's death. The Defendant invites me to approach this case on the traditional "but for" test only. The Claimant says that I should apply that test, but if I am against him on that point I can find that the breach of duty materially contributed to the death of Mrs Greenwood. I will consider those arguments in more detail below.

10. If I am satisfied that there was a breach of duty, and that the breach of duty caused Mrs Greenwood's death, then I have to consider what damages are recoverable by the Claimant.

Mrs Greenwood

11. Mrs Greenwood was born on 14th August 1971. She was aged 43 when she died. She and the Claimant were married in Zanzibar on 18th August 2011. They had a long, but not straightforward, relationship before that. According to the Claimant they met in 1994 They had spent periods of time together as a couple, as well as periods of time apart. The Claimant has a daughter from a relationship that he was in during one of those periods apart. Mrs Greenwood was a teacher.

12. Her medical history has been set out in numerous documents within the trial bundles and I propose to focus on what I consider to be the most relevant parts of that history. I have not set out page references unless I felt it was necessary. The records have, in places, been difficult to interpret and I have had to cross-refer them from a variety of sources.

13. On 15th February 1993, aged 21, it was noted in her GP records that "*stressed re finals. Unable to sleep. Awake until 6am. Tired all day. Anxious. Rx Temazepam 10mg 1-2 nocte. Agreed no more*". She took the Temazepam for a short period of time. This was the first reference to her suffering from sleep disturbance in her medical records. In the early part of 1994 she suffered from insomnia and a reactive depression which was secondary to a relationship breakdown. I do not know if that was a relationship with the Claimant or not, but I understand from his evidence that they met at around this time. She was prescribed Amitriptyline, a sedative anti-depressant.

14. In 2002 there were two episodes in October and November respectively where she overdosed on prescription or over the counter medication. The context to these episodes is, in my view, important given the reliance placed on it by the Claimant during the course of the case. Mrs Greenwood said

that at about this time Mr Greenwood was having particular difficulties with the mother of his daughter that caused the Claimant to develop psychiatric symptoms to the extent that he decided that he wanted to be on his own. This caused Mrs Greenwood to be devastated and led to her taking an overdose [**p.1994**]. She was treated in hospital and I have read the letter dated 18th June 2003 from Diane Lane, Community Psychiatric Nurse discharging her from care having only seen Mrs Greenwood on one occasion at an assessment on 11th December 2002, where she was noted to be sleeping well, with a good appetite [**p.1756**]. Following this incident she was prescribed Venlafaxine, an anti-depressant.

15. Mrs Greenwood continued to take Venlafaxine and in May and June of 2004 she attended her GP where it was noted that she had a history of depression, that she was taking Venlafaxine, but that she wanted to come off that medication. It appears that the dose was initially reduced before she was then able to come off that medication.

16. The next significant event, in my view, was on 28th August 2005. Prior to that she had been having difficulties sleeping. According to her story at The Priory this was due to pressure caused by work, though that does not appear to be the whole story [**p.1994**]. The entries in the records are difficult to read at **p.1703**, but it is known that on 28th August 2005 Mrs Greenwood attended the accident and emergency department of Bolton Hospital following an acute onset of depression brought on by her father's diagnosis of bipolar disorder, where he had been placing her under stress, and also as her grandmother was terminally ill. It appears that at that time she had increased her alcohol consumption to 3 litres of spirits in two weeks, and it was felt that this was in order to try and help her sleep, as she was only getting 1-2 hours of sleep. According to the letter dated 31st August 2005 from David Gibbs in the Crisis Resolution Team to Mrs Greenwood's General Practitioner at the time, she was not hopeless, helpless or suicidal. Following this attendance and after discussion with the Psychiatric SHO she was prescribed 7 days of Mirtazapine at 15mgs and then a further 7 days at 30mgs. She was also prescribed with 14 days' worth of 7.5mgs of Zopiclone. She was advised to take time off work and taken onto the crisis resolution team for several weeks, and it was requested that the prescription should continue once it expires. She was discharged from the Crisis Resolution Team on 6th October 2005. According to the GP records from this period she was struggling to sleep, but also that she was not keen on being on anti-depressants.

17. Between 2006 and August 2009 the records show that Mrs Greenwood continued to take Zopiclone, though the frequency does not appear to be consistent. She did not attend her GP for any related examination until 10th August 2009 when it was noted that she had not been sleeping well for 5 weeks following a run in with a work colleague. She was lying awake until 4 or 5 in the morning. She was not working at the time due to the summer holidays. It is relevant to note that she did not feel depressed. She was prescribed Zopiclone again. Mrs Greenwood tells us in her story that once the tablets from the prescription had gone her sleep worsened. Her sister

then supplied them to her, but following a change in her job no longer did so. Mrs Greenwood says that it was at this point that she began to purchase Zopiclone over the internet [**p.1996**].

18. Mrs Greenwood explained that she was able to sleep better, but that her tolerance increased. She says that in 2009, aged 38 she had burned herself out [**p.1997**]. This would appear to tally with the difficulties that she was experiencing with work as set out in the previous paragraph. At this point she was stating that she wanted to leave teaching for the good of her health. She moved into educational consultancy, but this post was short-lived according to her due to cuts in the role by central government. She was not able to find alternative employment as she says that she lacked the relevant experience. She explained that she would dip in and out of teaching and that the pattern would develop that when she was not teaching she would be able to sleep, but that when she was she would struggle.

19. Mrs Greenwood describes that as a result of these setbacks she would sink into depression and would spend whole days in bed. Her Zopiclone consumption was increasing. It is at around this period that it would seem that she and the Claimant got back together, as they married as set out above in August 2011. Indeed at the inquest the Claimant confirmed to the Coroner that they got back together in 2010.

20. The Claimant was not aware of the Zopiclone addiction of Mrs Greenwood until the latter part of 2011. The Claimant said that he found that towards the end of 2011 Mrs Greenwood was struggling to get out of bed and to function properly. She told him that she had been given two weeks' supply in the mid 2000's as part of a prescription, and that when that prescription was not renewed she resorted to buying them on-line. The Claimant intervened and took the Claimant to see his GP, Dr Robinson. Dr Robinson was based at the Edgworth practice, but was not Mrs Greenwood's GP. She transferred to her.

<u>Mrs Greenwood now a Patient of Edgworth Medical Practice</u>

21. The Claimant saw Dr Robinson on 13th October 2011. The entry in the medical records noted the history of anxiety and her previous suicide attempts. At this point Mrs Greenwood was working part-time. The record noted that there was stress at work and at home. It was noted that she was complaining of insomnia and that she had become addicted to Zopiclone which had been bought off the internet. She was diagnosed with a moderate depressive episode and was prescribed a combination of Zopiclone and Mirtazapine. When the depression was better she would supervise a reduction in dose. Mrs Greenwood was followed up on 3rd November 2011. It was noted that her depression was better, and that as a result the medication could be reduced. There was also an entry on 15th December 2011 where it appears that Mrs Greenwood requested medication. She stated that there was no deterioration in her depression. She was advised to make a routine appointment with a GP in the New Year. It is relevant to note that on that occasion she saw the First Defendant, Lisa Higson.

22. In early 2012 the GP records show that there was some improvement in her symptoms. When she saw Dr Robinson on 20th January 2013 Mrs Greenwood had reduced her medication. Dr Robinson said he would chase up a counselling appointment [**p.1733**] and there is a referral letter at **p.2134**. A letter from the Primary Care Psychological Therapy Service of the Bolton NHS Foundation Trust is at **p.1779**. It records that Mrs Greenwood was seen on 21st February 2012 for an initial assessment by a Janet Lowther, a Mental Health Practitioner. That letter notes that Mrs Greenwood complained of sleep problems, anxiety symptoms and difficulties coping with stress. She felt more anxious than depressed. She was upset when recounting her feelings and history, but denied any current self-harm or suicidal thoughts. She wanted to stop her sleeping tablets eventually. A CBT approach was suggested.

23. On 1st March 2012 Mrs Greenwood appears to have seen Dr Robinson once again. It was noted that she was much better, starting a new job with less stress. She was taking a reduced dose of her medication and was noted to be sleeping well [**p.1733**]. On 3rd July 2012 Mrs Greenwood attended again where she was complaining of insomnia. The entry states that she felt worse now that she was back at work. She was weepy and only having two hours of sleep. It was noted that she had just started CBT and that she was thinking of leaving work to concentrate on her health. She wanted a sick note to cover the remainder of the term, which was given to her. Again, it is relevant that on this occasion she was seen by the First Defendant, Miss Higson [**p.1732**].

24. A letter dated 5th September 2012 from Janet Lowther, the Mental Health Practitioner referred to above, notes that Mrs Greenwood had attended CBT. It was noted that following the start of her job in April 2012 that she developed sleeping problems. She appears to have struggled to address the difficulties that she had within CBT. A referral to the "Mindfulness Group" was suggested and Mrs Greenwood was agreeable to this. She was referred to that group, but according to the letter dated 10th September 2012 she did not attend [**pp.1787 to 1788**].

The Priory

25. At about this time Mrs Greenwood wanted to attend The Priory. She and the Claimant had separated due to the symptoms that Mrs Greenwood was suffering prior to this, but had reconciled before she was admitted. She had also given up her job as a teacher. At the time of the screening on 17th September 2012 it was noted that she was of the view that she had developed a tolerance to Zopiclone, buying it from China and taking excessive doses to try and get herself to sleep. She had become dependent on it. Further, it was noted that at this time she had become isolated and was struggling to function during the day. She had begun to abuse alcohol. Following the screening it was recommended that she contact her General Practitioner to obtain a referral to the clinic [**p1840 to 1846**]. This came in the form of a letter from the Third Defendant on 20th September 2012

[**p.1847**] and Mrs Greenwood was admitted for a period of 28 days between 1st October 2012 and 29th October 2012.

26. There is a volume of documentation from Mrs Greenwood's time at The Priory that I was referred to by Counsel during the course of evidence and submissions. I have read through it. I accept that on the face of the documents that I have been provided with it says that she was being admitted to treat the misuse of alcohol and Zopiclone, but in reality it was the latter that was causing the greater issues for her. I note also that at the time of her admission she denied having suicidal thoughts and when asked about the previous overdose she stated that she did not want to die [**p.1888**]. The reason for her problems were described as being due to difficulties sleeping. The records indicate that whilst at The Priory she made good progress in understanding her addition and withdrawing from the use of Zopiclone, however I do note that when she did stop taking it that she struggled with sleep and that her mood deteriorated initially.

27. I have considered the Disease of Addictions worksheet and note that Mrs Greenwood states that "*whilst in the depths of despair I have had suicidal thoughts. I have put dangerous levels of Zopiclone into my body and washed it down with alcohol*" [**p.1987**]. It is not clear when this was completed. I have also read Mrs Greenwood's initial assessment of herself. I note that she had been signed off work in June 2012 before then handing her notice in. She wanted to be helped to understand her addiction in order to manage it.

28. The "My Story" document explains that the pattern was the same, when she was teaching her sleep suffered; when not it improved. In the year prior to her admission her tolerance had increased and she was struggling to sleep for more than a couple of hours even after taking 60 mgs of Zopiclone. The document concludes with her description of the impact on her relationship with her husband, her desire to improve that relationship, her desire to understand her symptoms and her view that she will not return to teaching.

29. There are other records from The Priory that set out the therapy that was provided to her. They show that she engaged in her treatment, that her fellow patients confirmed that and from her daily feelings diary showed that she derived a benefit from the time that she had in The Priory.

30. Following her discharge she continued to be followed up by Dr Mbaya. In his letter of 13th November 2012 [**p.1849**] he states that whilst treating Mrs Greenwood she was prescribed Trazodone alongside reducing the amount of Zopiclone that she was taking. Following this visit she was continued on Trazodone. In a letter dated 20th December 2012 Dr Mbaya recorded that the Claimant had contacted him that morning as Mrs Greenwood was not sleeping well. As a result Dr Mbaya wrote to her General Practitioner asking them to increase the amount of Trazodone from 250mg to 300mg and then 350mg to be taken at night [**p.1853**].

31. I note, however, that in February 2013 Mrs Greenwood wrote about her current state of mind [**p.2111**]. At that point she was still having difficulties with sleep, but was not saying that she had returned to taking Zopiclone. At that point she was not ready to return to work, but was optimistic about the future and was considering different options for a future career .

32. On 1st March 2013 Dr Mbaya wrote to Dr Robinson at the practice and updated her on progress noting that Mrs Greenwood had improved [**p.1855**]. It was still felt appropriate to increase the amount of Trazodone to 400mg at night in order to help her gain a few more hours of sleep. A further letter on 26th April 2013 following a clinic on 25th April 2013 noted that there had been a deterioration in her sleep, but otherwise there were no depressive symptoms. Mrs Greenwood said that she was not abusing any other hypnotics and the advice was that she went to bed later, but her medication remained the same [**p.1856**].

Attendance at Accident and Emergency 18th May 2013

33. On the above date Mrs Greenwood attended the emergency Department of the Royal Bolton Hospital accompanied by the Claimant. The notes show that she attended as a result of experiencing poor sleep for a period of about 4 weeks resulting in her being anxious about going to bed and not sleeping and has got herself into a vicious cycle. The Claimant was noted to have said that Mrs Greenwood had been worse than ever before. It was recorded that she had been admitted to the Priory in October 2012 and that she was taking Trazodone. When examined she was noted to be shaking, crying, tearful and agitated; but she denied thoughts of suicide and that lack of sleep was the trigger factor. The crisis team was contacted.

34. On 21st May 2013 Kevin Corcoran in the Crisis Resolution Team wrote to Dr Anjana Kumar. This confirmed the attendance at hospital. I note that within that letter there is a reference to Mrs Greenwood describing that she had reached "rock bottom", but that at the same time she denied any suicidal ideation. The letter notes that the outcome was that Mrs Greenwood was to be admitted to the Crisis Resolution Team, that there should be a medical review, that she was prescribed Promazine for two days, that crisis pathways were discussed and there was to be a discussion regarding a referral to primary care mental health services for anxiety. From the records that I have been provided with I could not see that there was any follow up with the crisis team, and Mrs Greenwood returned to consulting Dr Mbaya at the Priory and later her General Practitioner.

35. I have read the notes following this at that efforts were made to follow her up within the service and that whilst successful on one occasion she appeared to have returned to see Dr Mbaya at The Priory.

Events between 18th May 2013 and 20th November 2014

36. Following the attendance at Accident and Emergency Mrs Greenwood and the Claimant returned to see Dr Mbaya as an emergency on 20th May 2013.

Mrs Greenwood explained that her sleep had deteriorated to the extent that she was only sleeping for one to two hours per night, and felt that if she had a better night's sleep that her symptoms would improve. Dr Mbaya prescribed Quetiapine and a short course of Diazepam. It was felt that she would need an SSRI antidepressant in addition to the Trazodone, but the decision to prescribe that was deferred to see how she progressed [**p.1857**].

37. Mrs Greenwood was seen again on 30th May 2013, where it was noted that she was feeling a lot better, but that her sleep was still not good. It was felt that she would benefit from the addition of Escitalopram to her medication. It was also noted that she had completed 12 sessions of CBT [**p.1859**]. Mrs Greenwood was seen again on 1st July 2013 and Dr Mbaya wrote to Dr Robinson on 2nd July 2013. At this stage Mrs Greenwood was averaging six to seven hours of sleep. She was to remain on the same level of Trazodone and, if not done already, there was a slight increase in Escitalopram [**p.1860**].

38. Mrs Greenwood did not attend her appointment on 10th October 2013 [**p.1861**]. She did attend on 31st October 2013. On this occasion it was noted that she still had significant residual depressive symptoms. I note that she had been seeing a hypnotherapist, and had also attended an interview with the intention of carrying out some Private Tuition. Dr Mbaya wrote to Dr Robinson on 1st November 2013 setting this out and asking that her Escitalopram be increased [**p.1862**].

39. On 22nd November 2013 Dr Mbaya wrote to Dr Robinson following a clinic the day before. On this occasion Mrs Greenwood reported that her symptoms had improved and that she was averaging seven hours of sleep. She had also begun work as a private tutor. The impression given was that her mood was good. Her medication was to remain the same and the intention was that she was to be reviewed in six weeks [**p.1863**]. That was the last time that Dr Mbaya saw her.

40. From this point Mrs Greenwood was only seen in Primary Care at the Edgworth Medical Practice. She was in receipt of a repeat prescription of the Escitalopram and Trazodone. There was an entry on 10th April 2014 that asked why Mrs Greenwood was taking two antidepressants.

41. In 2014 Mrs Greenwood was reviewed by Dr Anjana Kumar on 20th May 2014 where the decision was taken to continue with her medication at her request, despite her mood being stable. There was no indication of self-harm of suicidal ideation. She was reviewed again on 28th July 2014. According to the notes of that review there was no indication of self-harm or suicidal ideation. It would seem that on that occasion she was suffering as she had a lot on her plate for the last 6-7 weeks. There appears to have been a discussion over increasing medication, but that this would be discussed with The Priory or in the NHS.

42. The records noted that there was a concern that Mrs Greenwood was requesting repeat prescriptions. The later request was not actioned by a

locum Doctor on 1st September 2014 and a review was said to have been needed. Mrs Greenwood was spoken to on the telephone on 4th September 2014 by Dr Bakht regarding test results and it was noted that there were some which were abnormal and she was advised to attend the GP to discuss them. She did so on 5th September 2014 and saw Dr Leach. It was noted that she was stressed with poor sleep and that she would drink a glass of wine most nights to help with sleep. It was noted that she had been on her medication for some time. At that time she was looking well.

43. She had further blood tests carried out for liver function and it was noted that she may need to wean down her medication in an entry dated 23rd September 2014. According to the report of Professor Morgan there was also a note of her dual medication and it was described as a Cocktail. These were an administrative notes by Dr Bakht and it does not appear that Mrs Greenwood was seen about these matters before 20th November 2014, though a letter was sent.

44. I will of course consider the entry relating to 20th November 2014 in more detail below. I include here the entries in the versions of the medical records that have been available to me. First, at **page 1731** in the bundle:

20/11/14	Depression resolved – Mood Stable – Reducing medication	Miss Lisa Higson
20/11/14	Medication decreased – Pt req redcued (sic) Trazodone to stop eventually. Agreed 1.100mg am, 200mg evening = 2 weeks. 2. 100mg am, 100 mg evening = 2 weeks 3. 100mg am = 2 weeks. Review after 6/52 to discontinue.	Miss Lisa Higson
20/11/14	Medication decreased – Pt stopped Excitalopram (sic) 2/12 ago with no side effects/remission in mood.	Miss Lisa Higson

45. The second is at **page 2249**:

20-Nov-2014		Other HIGSON Lisa (Mrs)
	Problem	**Medication decreased** (none) - P Pt stopped Excitalopram (sic) 2/12 ago with no side effects/remission in mood. PRIORITY=3
	Problem	**Medication decreased** (None) - Pt req redcued (sic) Trazodone to stop eventually. Agreed 1.100mg am, 200mg evening = 2 weeks. 2. 100mg am, 100 mg evening = 2 weeks 3. 100mg am = 2 weeks. Review after 6/52 to discontinue. PRIORITY=3
	Problem	**Depression Resolved** (None) - Mood Stable – Reducing medication. PRIORITY=3

Events between 20th November 2014 and Mrs Greenwood's Death

46. The 20th November 2014 was the last time that any medical practitioner saw Mrs Greenwood. On 10th December 2014 the Claimant claims to have telephoned the General Practitioner. The medical records do not record the telephone call, but there is an entry from Dr Leach on 12th December 2014 that noted that the complaint was anxiety with depression. He was telephoning the Claimant who was not able to talk at that time and that he was going to book an appointment the following week. That did not take place. That was the last contact with either the Claimant or Mrs Greenwood prior to her death.

Mrs Greenwood's Death

47. Suzanne Greenwood was found on the morning of 23 December 2014 in Haslam Park, Bolton. She was suspended from the tree by a rope. The post-mortem examination carried out by Dr Pearson on 31 December 2014, summarised in his report of 2 January 2015 [**page 823**] gave the cause of death as hanging. The inquest into her death recorded an open verdict [**p.820 and 822**].

48. Following her death a toxicology report was obtained on Mrs Greenwood. It is dated 2 March 2015 [**p.827**]. Erroneously on the front page of the report it states medication prescribed to Mrs Greenwood included sleeping tablets. That is not the case. The toxicology report found Escitalopram in the urine but not the blood, which suggested prior use and not use close to the time of death. In addition Zopiclone was found in the blood where the concentration of 1.2mg/l was consistent with "excessive ingestion of this drug prior to death". There was also a significant amount of alcohol found in the blood at a level of 137mg%. It was noted that the drink drive limit was 80mg%. The conclusions of that report were that, with the concentration of zopiclone in the blood, there was a significant risk of toxicity developing which would have been increased by the increased presence of a notable concentration of alcohol. It was said that this could offer a potential explanation for her death. Absent in the toxicology report is any mention of Trazodone.

The pleaded case

49. The central allegation in this case is that the First Defendant, Nurse Higson conducted a negligent examination of Mrs Greenwood on 20 November 2014. The allegations of negligence are set out at paragraph 111 of the amended Particulars of Claim dated 16th of January 2020 [**p.26**]. They can be summarised as follows:

    a) Conducting the examination negligently by failing to take a full history, in particular not directly questioning Mrs Greenwood on any potential resumption of Zopiclone. It is also said that there was a failure to review medical records, to carry out a formal mental state examination, a failure to understand the rationale behind Mrs Greenwood's medication, a failure to

understand Mrs Greenwoods condition, a failure to follow appropriate guidelines, a failure to consult other more senior practitioners, a failure to properly counsel Mrs Greenwood as to the effects of reducing her medication and causing her mental state to deteriorate.

b) Insofar as the Second and Third Defendants are concerned the allegations are that they failed to adequately train the First Defendant, failed to supervise her and allowed someone who was not appropriately trained to manage Mrs Greenwood.

50. The Claimant's case on causation is set out in paragraph 112 of the amended particulars of claim [**p.31**] and can be again summarised as follows:

a) If Mrs Greenwood had been appropriately managed in the consultation on 20th November 2014 she would have continued to take her Trazodone medication and would have sought advice from a psychiatrist.

b) If she had been advised to attend for review, she would have attended and at that review any deterioration in her mental state would have been identified, and an appropriate plan would have been put in place (the allegation being that review should have been arranged for a week after the consultation on 20 November 2014).

c) If she had received treatment then her mental state would not have deteriorated to the point that it reached on 23 December 2014. She may have displayed residual signs of clinical depression, but the severity would have been alleviated. In the long term she would have suffered continuing bouts of depression but that with appropriate management she would have continued to recover to the extent that she would have been able to work. Any reduction in her life expectancy was no more than 10 years.

d) Finally, it is claimed that, if there were numerous contributing factors to the deterioration of the mental state of Mrs Greenwood and her death, the reduction in Trazodone more than minimally and trivially contributed to the deterioration in the mental state of Mrs Greenwood.

51. In the amended defences of the Defendants, dated 31st December 2019, it is denied that the First Defendant was not appropriately trained to manage Mrs Greenwoods condition [**pages 2539-2572**]. It is accepted that the NICE clinical guidance CG 19 and the British National formulary are used as guidance on the management of depression in adults.

52. Insofar as the events of 20th November 2014 are concerned it is denied that the examination was carried out negligently. It is said at paragraph 28 of the amended defence [**p.2542**] that the First Defendant documented a clear regime to safely reduce the dose of Trazodone with a follow-up appointment planned. It is claimed that relevant questions were asked, medical records reviewed, an adequate history taken and that it was not uncommon for practitioners not to record a full mental state examination. It is claimed that the First Defendant is a highly experienced and competent advanced nurse practitioner with

extensive training and competency around managing patients in mental health. It goes on to say that she had regards to the NICE and BNF guidance.

53. The amended defence goes on to plead that the First Defendant was aware of the risks in stopping antidepressant medication, and advised Mrs Greenwood that instead of stopping it, she should reduce it. The Defence also pleads that Mrs Greenwood would have been advised of the pros and cons of taking Trazodone when she was first prescribed the medication by Dr Mbaya when she was an inpatient at The Priory.

54. The Defence also states that Mrs Greenwood was aware of the safety netting mechanisms that were in place should she find herself needing them. These included accident and emergency, crisis team pathways, home visiting teams and The Priory. The amended defence also makes the point that the First Defendant had to respect patient autonomy. It is also stated that the First Defendant was working within the boundaries of her abilities and that as she was working within the boundaries of her abilities there was no need to contact Dr Mbaya.

55. It is accepted that the NICE guidance is that a patient should stay on antidepressants for six months after remission of their symptoms, but if the patient requests to stop their medication sooner than that then as long as they have the mental capacity to make an informed decision then it is reasonable for them to stop the medication and a practitioner cannot be held responsible for the decision of that patient. It was noted that Mrs Greenwood had not seen Dr Mbaya, her treating psychiatrist, since 22 November 2013, and that since that time her condition was being managed within primary care. The defence states that the First Defendant advised Mrs Greenwood to seek advice from her General Practitioner if there was a relapse in mood, and also not to stop her medication bluntly. It was accepted that there is a risk of relapse of symptoms when stopping antidepressants, but the cause can be multifactorial.

56. Insofar as the allegations against the Second and Third defendants are concerned, the amended defence on their behalf states that they took all reasonable steps to ensure that staff are suitably trained and qualified to undertake the work, that the First Defendant was a highly experienced, qualified and competent advanced nurse practitioner. In support of that contention they claim that she had worked in mental health between September 2000 and 2008 and regularly attended mental-health training updates. At paragraph 41 of the amended defence of the Second and Third Defendants it states that the First Defendant had undertaken training as an independent extended/supplementary nurse prescriber in 2005, that she had completed an MSc in Advanced Practice between 2008 and 2010. It is also claimed that she had a leading role in mental health assessment with links to CAMHS and adult services. She was also involved in the implementation of a mental health screening tool and staff training.

57. Causation is denied. It is claimed that, even if the Claimant establishes negligence, such negligence was of little significance to Mrs Greenwood's actions on 23rd December 2014. It is claimed that there is no evidence that she

would have attended for review if one were arranged, and that in any event there is no evidence that such reviews would've prevented the events of 23rd December 2014.

58. The defences go on to say but it was not reasonably foreseeable but Mrs Greenwood would purchase 8000 Zopiclone tablets over the Internet, consumer a toxic level along with alcohol and then go to a park and carry out the actions that she did. Furthermore, is claimed that there was no warning, suggestion or indication that Mrs Greenwood was going to do what she did. The only contact that there was with the GP surgery following 20th November 2014 was on 10th December 2014 when the Claimant telephoned concerned that Mrs Greenwood's condition had deteriorated. On 12th December 2014 a Dr Leech, who worked at the GP surgery, telephoned the Claimant and was told by him that Mrs Greenwood's condition had improved, and that there was no further cause for concern. That was the last contact between the Greenwoods and the surgery before her death. It is denied that the reduction in Trazodone medication materially contributed to her death.

59. As a preliminary issue, I was required to rule on the admissibility of allegations contained in the amended defences of novus actus interveniens and contributory negligence. On 20th December 2019 HHJ Platts gave permission to the Claimant to rely on amended particulars of claim served with an urgent application made by the Claimant on 19th December 2019 to amend their particulars of claim. As part of his order he gave permission to the Defendants to file amended defences, if so advised. The amendments were to be limited to "*purely responding to the matters raised by the amendments to the particulars of claim only*". Furthermore he gave permission to the Defendants to rely on further evidence, if so advised, again limited to the matters raised by the amendments to the particulars of claim only.

60. For reasons that I gave at the time of that ruling, I did not allow the Defendants to rely on amendments that raised issues of "novus actus interveniens" nor did I permit the addition of an allegation of contributory negligence. I was satisfied that those particular amendments went beyond the scope of the permitted amendments envisaged by HHJ Platts, and that they were introducing new defences that had not been raised before. I was satisfied that they came too late in the day, would cause prejudice to the Claimant and would impact on the viability of the trial. I did permit the Defendants to rely on the amendments in respect of the issue of causation, as well as further witness statements from the first and third defendant as, in my view, they fell within the scope of the amendments envisaged by HHJ Platts and largely raised matters of fact that would form part of the case in any event.

61. In addition to the pleadings referred to above the Claimant also sent two Part 18 requests for further information. The first is dated 5 October 2017 and was directed to the Second and Third defendants only. It was responded to on 31 October 2017 and related to the extent of their knowledge of whether Mrs Greenwood was capable of recovery, and also whether or not they were vicariously liable for the First Defendant. The second request is dated 17th of August 2018, the replies dated 13th November 2018. Those requests appear a

little unusual as they are directed by and large to the First Defendant. In any event, they were answered and confirmed that Mrs Greenwood did not tell the First Defendant she was addicted to Zopiclone, or that she had been recently treated at the Priory. The replies defer to the First Defendant where matters are within her knowledge, but do accept that certain matters were not documented in the records, that staff have access to assessment tools in the form of PHQ–9 and GAD–7. It was also accepted that the First Defendant was aware of the cyclical nature of Mrs Greenwood's depression but that at the time of the examination it had resolved and she was capable of making decisions about her own management

Issues

62. Having considered the pleadings and the submissions I am of the view that the following issues are the ones I have to determine in this case:

a) Was the First Defendant appropriately qualified and competent to manage the treatment of Mrs Greenwood? Within that issue it will also be relevant to consider whether or not she was appropriately supervised by the Second and Third Defendants.

b) Was the examination carried out on 20th November 2014 done so negligently? Within that issue it will be relevant to consider how that examination was conducted, whether or not advice from a General Practitioner or a Psychiatrist should have been obtained and whether Mrs Greenwood was in a position to make an informed decision to cease medication?

c) If I find that there was a breach of duty, did that breach of duty cause the death of Mrs Greenwood? Within that issue I will have to consider whether or not material contribution applies to this case.

d) If the claimant establishes breach of duty and causation what is the appropriate level of damages in this case? Within that issue I will have to consider what the future might have been for Mrs Greenwood had she lived and how that would have impacted on her earning potential and the services provided at home.

Issue 1: Was the First Defendant appropriately qualified to manage the care of Mrs Greenwood?

63. In order to resolve this issue I have to consider the evidence of the First Defendant, the Second and Third Defendants, the nursing experts and the general practitioner experts. In addition, I also have to consider the documentary evidence that I have been provided with. I am satisfied that this issue cannot be resolved by the Psychiatric experts save for one matter. Nor is it an area where the Claimant or the other lay witnesses can assist me.

64. The one area that I am of the view that the Psychiatrists can help me with is the nature of the condition of Mrs Greenwood. Was it complex or not? On this issue Professor Morgan is of the view in his report that Mrs Greenwood had a "*severe, chronic mental illness of sufficient severity to require input of a*

consultant psychiatrist, and with many complicating comorbidities"[**p.233 para 7.3**]. He was of the opinion that the severity waxed and waned. He placed weight on the fact that Mrs Greenwood was treated as an in-patient at The Priory [**p.235 paras 7.24 and 7.25**].

65. Professor Morgan was of the view that there was a chronic relapsing depressive illness that had complex comorbidities which responded to prophylactic medication. Dr Khatan was of the opinion that her symptoms did not really fit into a simple diagnostic category, and having taken into account her medical history was of the view that she exhibited features that were consistent with a personality disorder or a depressive illness.

66. Professor Morgan said that she was suffering a severe chronic mental illness. There were previous suicide attempts that required the assistance of a consultant psychiatrist and complicating comorbidities. There was evidence of recurrent depression, addictive behaviour, sleep disturbance and anxiety. Dr Khatan agreed that Mrs Greenwood had longstanding mental health problems, having presented with numerous mental health symptoms. He noted that they tended to manifest themselves in the context of life stressors, and regarded these as the precipitating factors. At times of crisis she presented to her GP and on occasion to Accident and Emergency. He was of the view that perpetuating factors might have included unaddressed issues in her personal life. He was of the opinion that she suffered from reactive depression, which made it less likely that anti-depressants would have been critical to the severity of her depression at any given time. He relies on the fact that in the days leading up to her death that Mrs Greenwood did not seem to be depressed, but rather uplifted. Dr Khatan also relies on the fact that Mrs Greenwood was admitted to hospital just once to address her Zopiclone addiction.

67. I have also considered the NICE Guidelines, which give a definition of complex depression as including "depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and /or is associated with significant psychiatric comorbidity or psychosocial factors" [**p.605**].

68. Having considered the evidence I am satisfied that Mrs Greenwood's condition was not complex within the terms of the NICE Guidelines, but was complicated. I am of the view that based on the evidence that I have read and heard that sleeping difficulties were the trigger for the problems that Mrs Greenwood suffered. When she struggled to sleep, she struggled to function. She became anxious about not being able to sleep and this led to depressive symptoms as a result of the lack of sleep. The triggers for poor sleep came from a variety of sources, but appear to have a common theme, in that when it resulted in stress for the Claimant it caused her to suffer from poor sleep. Unfortunately for Mrs Greenwood she was prescribed Zopiclone to try and help her sleep. She developed an addiction to this medication associating its use with stability.

69. The addiction then needed treating as the use of Zopiclone became dangerous. The treatment was being provided within Primary Care and there was no suggestion that the General Practitioners were contemplating referring Mrs Greenwood to Secondary Care. It was Mrs Greenwood, in discussion with the Claimant, that took the decision to enter The Priory for treatment. I am satisfied that she was not referred for treatment, but elected to seek treatment. That is, of course, understandable, but has to be borne in mind when considering the overall condition of the Claimant. The Claimant was successfully treated in that she ceased using Zopiclone, and there is no evidence that she returned to using that until the toxicology report after her death. She was, however, prescribed Trazodone and Escitalopram by Dr Mbaya, which are antidepressants. The prescription was varied by Dr Mbaya. I am therefore satisfied that Mrs Greenwood's condition was significant enough to warrant treatment with anti-depressants. Even with this help Mrs Greenwood suffered relapses and I am satisfied that she was at risk of relapse. She continued with this medication, though I accept it appears to have been reduced in Primary Care, until the point of the events that are subject to this claim.

70. I am not satisfied that she was at risk of self-harm or suicide when she suffered relapses. I acknowledge of course that there had been two previous suicide attempts, but these need to be looked at in context. Firstly, they were in 2002, 12 years before her death. Secondly, they were at a time of significant emotional upset when the Claimant himself was suffering psychiatric problems as a result of difficulties caused by his relationship with the mother of his daughter. This led to conflict in the relationship with Mrs Greenwood and his decision to end his relationship with her. This devastated Mrs Greenwood and led to her actions. It is not clear to me if these were serious attempts, or a "cry for help". I note that the Claimant was of the view that it was the latter when he gave evidence at the Inquest, but I am satisfied that they were isolated incidents related to a specific set of circumstances and not part of her general condition.

71. The First Defendant has provided two statements in this matter. The first is dated 8 March 2019 and begins at **page 112** of the trial bundle. Paragraphs 2 to 20 deal with her qualifications. Before qualifying as an advanced nurse practitioner in September 2010 she had some experience working in mental health, though predominantly with adolescents. She states at paragraph 18 that it was well established that advanced nurse practitioners are appropriately trained and competent in dealing with patients with psychiatric conditions such as Mrs Greenwood and have the experience, knowledge, skill set and autonomy to change patients medication. In addition paragraph 20 of the statement says that she undertook mandatory training around mental-health and capacity and explains that she undergoes regular clinical teaching sessions and also her own studies to supplement her training.

72. The Third Defendant in her statement [**p.124**] at paragraph 13 says that the First Defendant was acting well within her competencies. The statement goes on to explain that they undertook in house training and meetings, but that ultimately individual practitioners are responsible for their own training.

They conducted in-house appraisals to ensure that she was keeping up with her continuing professional development. The statement says that an advanced nurse practitioner works like a GP in that they have the experience and autonomy to alter or stop medication, and the Royal College of Nursing defines the level of practice at which advanced nurse practitioners work. Her statement goes on to explain that they had an open door policy should any practitioner require assistance. On top of that there was an on-call mental-health team and on call psychiatrist available. The Third Defendant stands by the First Defendant and holds her in high regard.

73. When the First Defendant was cross examined by Mr Haines, there were not many questions relating to her competence to carry out the examination of Mrs Greenwood. There were questions relating to supervision and Nurse Higson accepted that she was always learning and that supervision was necessary. She says that she was supervised and assessed by the Second and Third Defendants.

74. I also note that in her evidence at the Inquest, the First Defendant repeated that she was qualified to deal with a case like Mrs Greenwood, that she had appraisals and was able to discuss cases with colleagues [**p.756-759**]. She also explained that she qualified as an advanced nurse practitioner in 2011, that she had a four month placement on a psychiatric ward, that she had forensic mental health training when she worked for eight and half years with young offenders, and as part of her general training for the advanced practitioner role she took an examination on mental health [**p.768**]. She also obtained a further qualification to allow her to prescribe medication.

75. The Third Defendant, when cross-examined, said she would have carried out assessments of Nurse Higson, and that she wanted to keep up with training and had an unblemished record. In cross-examination she reiterated that she was a masters qualified advanced nurse practitioner and that there were only a few limitations on her practice that are not relevant to this case. I note that in her evidence at the Inquest the Third Defendant was also satisfied that the First Defendant was able to manage patients with mental health conditions [**p.755**].

76. The nursing expert evidence comes from Sabine Lenny on the half of the Claimant in her report dated 14 May 2019 [**p.154**] and Louise Marriott for the Defendants in her report dated October 2019 [**p.353**]. In addition, I have two joint statements from them; one is based on the Claimant's agenda [**p.474**] and the other based on the Defendant's agenda [**p.496**].

77. In her report, Ms Lenny was specifically asked to comment on whether or not the First Defendant was acting within her remit as an advanced nurse practitioner; and in terms of the standard of care, whether there will be any difference between the standard owed by a GP and the standard owed by an advanced nurse practitioner. At paragraph 6.8 of her report she says that in her experience a patient with a complex mental health needs, determined to stop their antidepressants, can be seen by an advanced nurse practitioner. But, she would go on to seek advice from a GP colleague and would ask the mental health team if they could review the patient as they are high risk of relapse. At

paragraph 12.7 of the report, and in response to the specific question set out above, she explained that the Royal College of nursing defines the level of practice within which advanced nurse practitioners work as encompassing three of the following, "*making professionally autonomous decisions, for which they are accountable, management of patient care and quality assurance"*. Furthermore, the Royal College of Nursing states that *"ANP's act collaboratively with colleagues working in the same area of practice or refer to and share with, colleagues in more specialist areas of care"*. She is of the opinion that as Mrs Greenwood had a complex psychiatric history it would have been necessary to ask for help from a GP colleague. The report continues to link the lack of detail in the records to the issue of whether or not help should have been sort from a GP.

78. Louise Marriott's Report is brief on this issue. At paragraph 7.85 she was asked to give her opinion on whether the First Defendant was adequately trained, prepared and supported within the practice. She accepted that she did not have sight of all of the training certificates and internal records relating to the matter but concurred with Dr Longwill's opinion that there was no breach of duty on the part of the Second and Third Defendant. At paragraph 8.1 of her report she does say that the First Defendant was an appropriately experienced and qualified advanced nurse practitioner and as such was working within the scope of her competency when she consulted with Mrs Greenwood on the 20th of November 2014. In the following paragraph she says that she has had sight of her certificates and details of her registration and confirm that there is no breach of duty on the part of the First Defendant in autonomously managing the episode of care without reference to a supervising clinician.

79. In the joint statement based on the Claimant's agenda at question three they were asked to describe the entitlement/remit of an advanced nurse practitioner to prescribe drugs in a GP practice. Both agreed that an ANP could prescribe drugs within their level of competence. In the joint statement based on the Defendants agenda, question five asked if the First Defendant was, at all material times, appropriately trained to manage Mrs Greenwood. Ms Lenny was of the view that Mrs Greenwood's condition was outside of the First Defendant's remit. She refers to the NICE Guidance CG 90 para 1.8.1.5 which states that GPs needing to start patients onto antidepressants should only do this under the guidance of the consultant psychiatrist. That appears to form the basis of her view that Mrs Greenwood's case was within the remit of a consultant psychiatrist or GP rather than an advanced nurse practitioner, and that the failure of the First Defendant to realise this meant that she fell below the standard expected of any reasonable and responsible body of nurse practitioners. Ms Marriott disagreed and was of the view that the First Defendant was adequately trained, that Mrs Greenwood had not had any contact with the Priory for some time previously, that Mrs Greenwood was only taking one antidepressants when she saw the First Defendant and at no stage did the First Defendant start two antidepressants. Miss Lenny felt that Mrs Greenwood was lost to follow-up at the Priory and that this was an opportunity following necessary history taking and assessment to refer Mrs Greenwood back.

80. In cross-examination Miss Lenny agreed that the First Defendant was capable of prescribing medication in primary care but remained of the view that, as she was reducing medication, she should have referred to a psychiatrist. Miss Marriott, when she was cross examined, was of the view that if the record showed that the First Defendant had no understanding of any of the side-effects or withdrawal effects of reducing the medication, then she should have sought advice. She was of the view that the First Defendant did have some understanding of these matters.

81. I have also considered the reports of the General Practitioner experts in this case. The Claimant relies on Dr Deepak Desor, who has produced a report dated 19th April 2019 [**p.130**]. The Defendant relies on Dr Tobias Longwill, who has produced a report dated 20th October 2019 [**p.248**]. In his report, Dr Desor states at paragraph 4.21 that, in his opinion, the Second and Third Defendants had a responsibility to ensure that the First Defendant was aware of her responsibility to only act within her level of expertise, and to be aware of her responsibility to seek advice from a more senior or more qualified member of the healthcare team, when faced with a patient with a complex psychiatric problem that she was not trained to manage. A failure by the Second and Third Defendant to comply with that responsibility would be a breach of duty of care. I don't read his report on this issue as saying that the First Defendant should not have carried out examination on Mrs Greenwood. Dr Longwill, in his report, was of the view that the First Defendant was acting within her capability given her training, in particular her prior training in mental health. He also comments that there appears to have been adequate training for staff.

82. There are two joint statements from these experts, one based on the Claimant's agenda [**p. 519**]; the other based on the Defendants agenda [**p.530**]. In the joint statement based on the Defendants agenda at **page 533,** Dr Desor was of the opinion that the First Defendant did not seem to have adequate training. It appears that this opinion was based on his view of the contents of the records of the examination on 20 November 2014. Dr Longwill on the other hand remained of the view that the First Defendant was able to manage Mrs Greenwood in a GP setting and, provided that she was working within the boundaries agreed by her employer, any need for a further discussion with either a GP or a consultant psychiatrist would depend on those boundaries.

83. Dr Desor and Dr Longwill were not asked questions on the First Defendant's competence to carry out the examination of Mrs Greenwood in their oral evidence. Dr Desor was asked about the type of contract that was in place that allowed NHS work to be carried out at the Edgworth medical Centre. He confirmed that there are terms relating to appraisals with consequences for not complying, and that there was no evidence that the Defendants had compliance issues. He explained in re-examination that care quality commission examinations make it difficult to assess the quality of training, and that they are looking to see that things have been done, rather than how well they had been done. Dr Longwill when cross-examined explained at the

boundaries of practice were an agreement between clinicians that may not always be written down and he was not aware of it being done.

84. I have also looked at the documentary evidence contained within the bundle. I note that exhibited to the report of Dr Longwill is the Royal College of Nursing document entitled "*Advanced Nurse practitioners: AN RCN Guide to advanced nursing practice, advanced nurse practitioners and programme accreditation*" [**p.327**]. On page **333** under the subheading Area of Practice and then the further subheading "*Primary Care*" it states "*Some ANP's may also have the necessary skills to enable them to work with patients requiring specialist care" For instance, ANP's are able to provide services for patients with depression…*".

85. At **page 2294** there is a copy of a Care Quality Commission inspection report following an inspection carried out on 12 December 2013. This report showed that the medical centre was meeting the standards expected as part of the inspection. I have also been shown at **page 2314** a quality report from the care quality commission for Deane Medical Centre, which I understand to be the sister medical Centre to Edgworth medical Centre. In the report, following an inspection on 18th December 2014, I note that this practice was rated as outstanding in a number of fields. I note that on **page 2338** there were specific references to training and mentoring.

86. Between **pages 2339 and 2445** are a number of certificates for the First Defendant. I note in particular a certificate on **page 2424** that certifies that the First Defendant attended the mental health update training event on 26 March 2014.

87. The Claimant has criticised the Defendants for a lack of documentation relating to appraisals. It is correct to say that there are no such documents available to me. I am invited by the Claimant to draw adverse inferences due to the lack of documentation in reliance on the case of *Keefe* v *Isle of Man Steam Packet Co Ltd* [2010] EWCA Civ 683. I drew attention to the fact that my understanding was that *Keefe* was recently considered in the Court of Appeal. I am grateful to Mr Haine for providing me with a short summary of *MacKenzie* v *Alcoa Manufacturing (GB) Ltd* [2019] EWCA Civ 2110. This is also a noise induced hearing loss case, and the Court of Appeal indicated that whether it was appropriate to draw an inference would depend on the facts of the particular case and that *Keefe* should not be regarded as a rule of law.

88. In this case the Second and Third Defendants are former partners of the Edgworth Medical Centre. They no longer work there and have not been able to provide documentary evidence that appraisals were carried out. The First Defendant explained that she had left Edgworth Medical Centre between the date of this incident, but had since returned. She said that she had appraisals and supervision when employed by the Second and Third Defendants but when she left the notes were kept by them. The practice is now run by Dr Leech and the First Defendant has returned to work for them, and has been for about a year. The explanation given by the Third Defendant when cross-examined explained that appraisals were not kept. It is unfortunate that the

documentation relating to appraisals is not available, but the fact that they are not available does not mean that they did not occur. I am satisfied that on considering the evidence of the First and Third Defendant that appraisals did occur.

Findings on Issue 1

89. Standing back and considering all the available evidence on this issue, I am satisfied that, in general, an advanced nurse practitioner is capable of dealing with a patient such as Mrs Greenwood who is expressing a desire to reduce her medication. The Royal College of Nursing Guide referred to above confirms, in my view, that to be the case. Furthermore, the general consensus is that the First Defendant could carry out the examination of Mrs Greenwood, but the dispute is whether or not she should have then deferred to either a GP or a Psychiatrist.

90. I am also satisfied that the First Defendant was appropriately trained. I am also satisfied that the First Defendant was aware of the availability of colleagues in the form of general practitioners and the mental health team if she felt that she was at the edge of her competence.

91. I am also satisfied that the Second and Third Defendants had structures within the partnership to ensure that staff were appropriately trained and supervised. I agree with the Claimant that not all of the documentation is available but I do not draw an adverse inference from that. I have a wealth of documentation that, in my view, allows me to be satisfied on the balance of probabilities that the Edgeworth Medical Centre and its sister practices were being run in compliance with the standards expected by the Care Quality Commission. That indicates to me, and I find, that the specific allegations made against the Second and Third defendant fail.

Issue 2: Was the examination carried out on 20 November 2014 done so negligently?

92. It is this issue that really lies at the heart of this case. I have set out the entries relating to this consultation in the records above. The only two people that can really give evidence on what took place are the First Defendant and Mrs Greenwood. The entries in the records are therefore important, but ultimately, in my view, it will depend on the impression that I form of the First Defendant, tested against the evidence in the case, that will determine whether or not I am satisfied that she fell below the standard of a responsible advanced nurse practitioner.

93. I am of the view that the relevant expert evidence on this issue is primarily from the Nursing Experts and the General Practitioners. The Psychiatric Experts are most pertinent to the issue of causation. Where they have commented on the examination I will consider that evidence, of course, but must bear in mind their limitations on this issue as neither work in a General Practice on a day to day basis.

94. The Claimant is also not really able to provide me with much evidence on this issue. He was not present at the examination and was not aware that it had taken place.

95. Following Mrs Greenwood's death the First Defendant was asked to provide a statement relating to the care that Mrs Greenwood received by her whilst working at Edgworth Medical Centre. The letter is at **p.691**. The relevant part of the letter states:

"During the period of January 2014 to 23rd December 2014 Mrs Greenwood was seen by me on one occasion dated 20.11.14. The consultation entailed Mrs Greenwoods (sic) request to reduce her medication. Mrs. Greenwood said her current depression had resolved and that she had stopped her Escitalopram 15mgs daily 2 months previously, with no adverse withdrawal or relapse effects.

Following National Guidelines BNF 68 September 2014 states Trazodone withdrawal should preferably be reduced gradually over 4 weeks or longer if withdrawal symptoms emerge (page 249). Therefore a withdrawal drug regime was discussed and agreed by Mrs. Greenwood of:-

20/11/2014 Medication decreased – Patient request reduced Trazodone to stop eventually.

Agreed –

1. *100mg am, 200mg evening = 2 weeks*
2. *100mg am, 100mg evening = 2 weeks*
3. *100mg am = 2 weeks*

Review after 6/52 to discontinue."

96. Mrs Higson gave evidence at the Inquest into the death of Mrs Greenwood. The inquest concluded on 8th October 2015 and the relevant part of the transcript relating to the consultation on 20th November 2014 begins on **p.759**. She told the Coroner that she did not know whether or not Mrs Greenwood had expressed a preference to see her or a GP. She told the Coroner that Mrs Greenwood wanted to reduce her medication, "*which was just trazodone at that time*". The reason given was that she felt that "*her depressions had resolved*". Mrs Higson was asked questions by the Coroner about the checks and reviews that were carried out before considering the reduction. Mrs Higson replied by saying that there was a combination of a discussion and the use of a PHQ-9 scoring assessment. (A copy of such an assessment was added to the bundle during the course of the trial at **p.909A-D**). Mrs Higson agreed that there was no indication in the records that she had carried out the assessment, but claimed that she would have done it as part of her discussion at the start of the consultation. Mrs Higson stated that in her view, Mrs Greenwood scored 7 on the PHQ-9 assessment. When pressed on how she could remember that when there was no record of the assessment having been carried out she accepted that she could not remember the score, but agreed with the Coroner that it was in the mild area.

97. Mrs Higson accepted that it was not within her capacity to stop medication. Her discussion was in relation to reducing the remaining medication that Mrs Greenwood was taking, namely the Trazodone.

98. Mrs Higson accepted that she did not know whether or not Mrs Greenwood was still under the care of The Priory. She formed the understanding that Mrs Greenwood was not receiving care from The Priory, but accepted that they were the initiator of the medication that Mrs Greenwood wanted to reduce and acknowledged that she did not contact them to discuss the reduction. Under questioning from Mr Haines at the Inquest she later said that she did not know that Mrs Greenwood was being treated by The Priory or who prescribed the medication or the rationale that they had for prescribing the medication. She did explain that she had an understanding of the medication, but that she did not explore it with Mrs Greenwood

99. Her reasoning to the Coroner was that as Mrs Greenwood had already reduced some of her medication, that the planned reduction was acceptable and that there was an "open door" for Mrs Greenwood to come back of there was adverse reaction. When asked questions by Mr Haines at the Inquest, Mrs Higson thought that Mrs Greenwood had a diagnosis of depression rather than an addiction for Zopiclone. She maintained that she asked whether or not Mrs Greenwood was taking alternative medications. It was later accepted by Mrs Higson that following the decision to reduce the Trazodone there was no contact with The Priory.

100. Mrs Higson stated that she had referred to the BNF and that she understood that it said that the Trazodone could be reduced gradually over a period of 4 weeks. She understood Mrs Greenwood to have been taking 400mg per day split into 2 tablets of 200mg twice a day. She says that they discussed a gradual reduction as set out in the notes above. Insofar as the Escitalopram is concerned Mrs Higson presumed that Mrs Greenwood had just stopped taking it completely. She confirmed that she had asked if there had been any side effects as was noted, and formed the view that there was no need to recommence that drug. Mrs Higson accepted that it would have been better if that was in the notes.

101. When asked by Mr Haines at the inquest why she did not take advice from a GP, Mrs Higson stated that she referred to the BNF. She accepted that it was a guide for prescribing and not for diagnosing. She maintained that she discusses the side effects, risks and benefits of every medication, even though it was not written down, and she felt that she was competent to treat Mrs Greenwood.

102. In her first statement to the Court, dated 8th March 2019 [**p.112**], Mrs Higson states that in her view she documented a "clear regime to safely reduce the dose of Trazodone" (paragraph 25). She states that she documented Mrs Greenwood's mood by assessing if there were any physical signs that she was struggling with her mental health and that the reason why there is no mention of this is that there were no concerns. She then goes on to say that she would

have asked Mrs Greenwood how she was feeling and that this is evidenced by the contents of the notes where it stated that her depression had resolved and that her mood was stable. She then goes on to say that that "*during an examination such as this and taking into account the patient's previous medical records, it would be standard practice to discuss and advise to reduce medication as there was a clear improvement in her mood*". She goes on to say that she had the requisite knowledge to advise on the weaning off of medication. She did not prescribe any further Trazodone and simply advised her to reduce her own supply and to come back to see her GP before any total discontinuation of medication, or any relapses in mood. She makes the point in paragraph 30 of that statement that a patient with capacity who is able to make an informed decision should be respected.

103. In her second witness statement, dated 7 January 2020, she explains the limitations of the computer system that operated at the practice. At paragraph 7 of her statement she says that she would have discussed with Mrs Greenwood the reasons why she wanted to reduce her medication, assessed her capacity, relapse risks and support mechanisms to help her. At paragraph 12 of the statement she was of the view that the risk of Mrs Greenwood relapsing was not high as she was given a slow and safe withdrawal regime. She makes the point that at no stage did she advise Mrs Greenwood to stop taking trazodone. She also explains at paragraph 14 that a screening tool is not mandatory when a patient wishes to reduce or stop taking medication. She explains that the screening tools have their limitations, and that clinical experience and knowledge allows for decisions to be tailored to an individual's needs. To put it another way, to exercise their judgment.

104. The evidence of the Second and Third Defendants on this matter is limited. As set out above they were not present at the examination, and in any event the Second Defendant has largely deferred to the Third Defendant in respect of matters arising from this claim.

105. The First Defendant was extensively cross-examined by counsel for the Claimant. During cross-examination she reiterated that her recollection of the consultation is limited. Much of her evidence is therefore based on what she describes as her standard practice. She explained that not everything that was discussed would be written down. She accepted that she did not know the reason for the medication regime that Mrs Greenwood was on. She explained that she did not formally use the PHQ-9 document, but that it was underpinning her questioning. She accepted that the dosage of trazodone that Mrs Greenwood was receiving was high, and not a level prescribed in primary care, but one that can be reduced in primary care. She was asked a series of questions about the NICE guidelines and that the BNF. She accepted that under the NICE guidelines Mrs Greenwood should have been advised to continue with antidepressants for two years. She went on to say that they are guidelines and the patients have the autonomy to make their own decisions. She also accepted the recommendations she made did not accord with the NICE guidelines. Throughout cross-examination the First Defendant was reminded of the way in which she gave her evidence to the coroner, which I

have set out above. The First Defendant explained that was the first time she had been required to give evidence and that she was extremely flustered.

106. In re-examination she explained that she would have explored the medication that Mrs Greenwood was taking, that she would not have written down that "*depression had resolved*" if she have not been told that, that it was not her normal practice to expressly refer to NICE Guidelines or the BNF, that if there were concerns and that if she may have harmed herself that would have been recorded. She explained that she was using a patient centred approach to treating Mrs Greenwood.

107. The Third Defendant essentially deferred to the First Defendant in the conduct of the examination. When she was cross-examined she understood the need to keep notes but also explained the limitations that can be experienced in day-to-day practice. She was of the view that Mrs Greenwood was aware of assistance that she would be able to obtain if she was having difficulties. She accepted that Mrs Greenwood had a high risk of relapsing.

The Expert Evidence

Nursing

108. Ms Lenny, in her report was of the view that there should have been documented information on the level of sleep, appetite, alcohol intake, substance misuse, concentration, low confidence, suicidality, agitation, guilt and mood as well as past history and reference to treatment received. She was of the opinion that if an adequate history had been taken then she would have expected to see from the documents that Mrs Greenwood's reasons and motivation for wanting to stop the medication had been explored (**p.169**). She accepted that if the history had been taken then that would have been in keeping with the standard expected of a reasonable and responsible body of nurse practitioners.

109. Ms Lenny was also of the view that a PHQ-9 assessment should have been used. If it was used, and the score not recorded, and its significance not understood that would amount to a breach of duty. If one was used then this would not be a breach of duty, though the failure to record its use was. She relies on the fact that at the inquest the First Defendant was of the opinion that Mrs Greenwood scored 7 on the PHQ-9 and appeared to fail to realise that was a score of "mild" depression that should have been explained to Mrs Greenwood with the advice not to stop her anti-depressants (**p.170**). Ms Lenny was also of the view that the First Defendant should have explained the risks and potential consequences to Mrs Greenwood of stopping her medication.

110. Ms Marriott in her report was of the opinion that the advice given to Mrs Greenwood by the First Defendant on how to safely reduce her medication was reasonable. She is of the view that it is a matter for the Court to determine if an adequate history had been taken. She explains that it is common practice not to record negative findings, and whilst that detracts from the quality of the record it does not follow that it is negligent. Again, the

impression is given that if there was an enquiry about Mrs Greenwood's mood and examination then that would be sufficient.

111. Ms Marriott is of the opinion that there should have been more detail on the reasons why Mrs Greenwood wished to stop taking her medication, but that provided that there was informed consent from Mrs Greenwood there was no breach of duty. Ms Marriott is of the view that there should have been a discussion on whether or not Mrs Greenwood was taking other medication. If one did not take place then this would be a breach of duty. If a mental state examination took place that would not be a breach of duty. She was also of the view that if Mrs Greenwood was firmly of the view that she wanted to reduce her medication, then despite it being better if she could have seen a clinician who had extensive knowledge of her condition, it was not unreasonable for her to have seen the First Defendant and the reduction was safely planned. Her overall opinion is that whilst the documentation leaves room for improvement, the lack of detail does not in itself mean that there is a breach of duty.

112. I have read the joint statements of the nursing experts. In the joint statement prepared on the basis of the Claimant's agenda at **page 479** both agree that the First Defendant should have explained the risk of relapse and documented this and that a follow up appointment should have been arranged sooner. Ms Marriott explains that in her view, if there was inadequate safety netting that would be more of an indicator of a breach than the length of time for a review.

113. They agreed that if a detailed history was not taken that would amount to a breach, but there was a dispute as to the need to record negative findings. It was agreed that there should have been a discussion on the risks of relapse and withdrawal. It was agreed that there should have been a review of Mrs Greenwood's medical records, and in particular the entry on 28th July 2014. If there was not that would be a breach. They disagree as to whether or not a PHQ-9 should have been formally used. They agree that there should have been a discussion on the potential effects of withdrawing medication and her history. They agree that there should have been a discussion around Mrs Greenwood's reason for wanting to cease taking her medication and that she was at risk of relapse, with severe depression, anxiety, insomnia and mood change potentially occurring. If this took place, there was no breach. It was agreed that she should have been asked about her taking other medication, and if there was there was no breach. It was agreed that the First Defendant should have understood the rationale behind the Trazodone that Mrs Greenwood was taking, and that if she did not then that would be a breach of duty. It was also agreed that if Mrs Greenwood had declined an appointment with a GP or a Psychiatrist then she should have been offered a follow up appointment within a week or two weeks. The Joint Statement based on the agenda of the Defendant is not markedly different in my opinion.

114. Dr Desor, in his report at **p. 148**, was of the opinion that the management by the First Defendant was contradictory to the NICE Guidelines and the BNF. He was of the opinion that Mrs Greenwood, given her history, should

have been advised to continue with her medication with frequent reviews given that she had stopped taking Escitalopram. He was of the opinion that the First Defendant should have conducted a thorough and detailed assessment of Mrs Greenwood and that she should have been advised to continue with Trazodone with frequent reviews. He was also of the view that any changes should have been discussed with Dr Mbaya at The Priory.

115. Dr Longwill, in his report, at **p.259**, was of the view that if Mrs Greenwood's depression had resolved, and that there was an informed decision taken to stop the Trazodone, with a clear follow up plan in place then there was no breach of duty. He is of the view that if the medical records were checked by the First Defendant that would not be a breach of duty. He was of the view that the entry in the medical records at the time of the examination supported the contention that the First defendant had asked Mrs Greenwood about her mood, and that if she had asked about that it would not have been a breach of duty. If there has been a discussion as to why Mrs Greenwood wanted to stop taking Trazodone that would not amount to a breach of duty. If there had been a discussion about other medication that Mrs Greenwood may have been taking that would not amount to a breach of duty. Dr Longwill adds that there would have been no reason to think that Mrs Greenwood was overusing other medication.

116. Dr Longwill explains that if the First Defendant had ensured that there was coherent communication with Mrs Greenwood, that she had assessed her body language, eye contact and physical appearance as well as assessing her mental capacity there would be no breach. If a discussion on the pros and cons of withdrawing treatment had taken place that would not amount to a breach of duty. Insofar as the NICE Guidelines are concerned he explained that patients can request to stop medication sooner if they so choose. The reminder of the report does not, in my view, add further to the decision that I have to make.

117. In the joint statement based on the Claimant's agenda they disagree on whether or not Mrs Greenwood's condition was complex. Dr Desor is of the view that it was. Dr Longwill accepts that there was not a simple history, but that her type of case was commonly managed in primary care. Otherwise they are in agreement, but the premise of the report assumes that a GP's advice had been sought by the First Defendant. That is not the case here. In the joint statement based on the Defendant's agenda I noted that they agreed that Mrs Greenwood should have been offered the option of updating Dr Mbaya. Again the majority of the remainder of the report focussed on the interaction between the GP's and the First Defendant.

118. In his oral evidence Dr Desor said in examination in chief that whilst 10 minute slots are usually used for appointments that time is not set in stone and the duty is always to the patient. He also explained that the reason for the need for good notes is to ensure that the patient is protected. It allows the Doctor that sees the patient in the next examination to see what had taken place in the previous one. He was of the opinion that the information contained in the entries for 20th November 2014 were inadequate. He refers to

the note saying that depression had resolved which was at odds with the evidence of the First Defendant at the inquest where it was noted that the PHQ-9 score was at around 7. The entries in the records do not state why Mrs Greenwood wanted to stop her medication, what advice was given and what risks were discussed. It was accepted that the guidance on the reduction of Trazodone was in accordance with the BNF. When asked about reviewing records it depended on the person in front of them. In this case he was of the view that you needed to go back far enough to be able to determine if the patient had been stable on her medication for long enough to determine of it was safe to agree with her wishes. Insofar as reviewing Mrs Greenwood was concerned he was of the view that the review should have taken place after 1-2 weeks and then maybe again 3-4 weeks later. It depended on the patient.

119. In cross-examination Dr Desor maintained that there was a significant risk of relapse, but accepted that Mrs Greenwood would have been told of this at the time the medication was prescribed to her. He was of the view that the risks were different when Mrs Greenwood saw the First Defendant. He disagreed with the assertion that there was nothing in the record of 20th November 2014 that said that Mrs Greenwood should stop taking Trazodone. He was of the view that advice was given on how to do it and that was the plan. He did accept that it would have been for the reviewing clinician to determine if it should be stopped. There was some criticism of the term he used in the joint statement on the Defendant's agenda at **p.534** when he said that Mrs Greenwood had multiple suicide attempts. In re-examination he was of the view that there should have been an entry if Mrs Greenwood had denied any suicidal ideation, as it is standard practice.

120. Dr Longwill in his evidence in chief was of the view that the main reason for the records was to provide continuity of care and that there is a record for the next occasion. He was of the view that the entries for 20th November 2014 gave him sufficient information for the following consultation. He was of the view that a 4 week review was advised, but that 6 weeks would not be a breach as long as there was sufficient safety netting. The patient would have to be aware of how to access care if there was a relapse.

121. In cross-examination he accepted that in fact a review should have been arranged for about 2 weeks after the reduction in medication. He was not of the view that at the time of the consultation on 20th November 2014 that her condition was complex. He was of the view that her attendance was less than average at the GP. He noted that he saw patients like Mrs Greenwood every day. He accepted that his report was written without sight of the evidence from the Inquest. He accepted that a history was key to a diagnosis, safety, for following consultations and care. He accepted that the entries from 20th November 2014 did not document a history, that the examination findings were difficult to identify and that on one interpretation there was mere acceptance of what Mrs Greenwood told the First Defendant. He explained that in this case he may have asked Mrs Greenwood back after 3 or 4 weeks, but that safety netting should always be in place. He would not have expected an advanced nurse practitioner to depart from guidelines without recording that. He accepted that the patient would need to have their motives explored

and risks explained, but the guidance of two years in NICE can be less in practice.

122. In re-examination he confirmed that Doctors cannot control if patients take their medication. Patients can make informed decisions and take risks.

The British National Formulary

123. I have considered the British National Formulary contained within the bundle at pages **585-588**. Having considered them, I am of the view that the relevant parts are:

"*Suicidal behaviour and antidepressant therapy*

The use of antidepressants has been linked with suicidal thoughts and behaviour, young adults, and patients with a history of suicidal behaviour are particularly at risk. Where necessary patient should be monitored for suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment or if the doses changed.

Management

…

Following remission, antidepressant treatment should be continued at the same dose for at least 6 months (about 12 months in the elderly), or for at least 12 months in patients receiving treatment for generalised anxiety disorder (as the likelihood of relapse is high). Patients with a history of recurrent depression should receive maintenance treatment for at least 2 years.

Withdrawal *withdrawal effects may occur within five days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe. Drugs with a shorter half-life, such as paroxetine and venlafaxine, are associated with a higher risk of withdrawal symptoms. The risk of withdrawal symptoms is also increased if the antidepressant is stopped suddenly after regular administration for eight weeks or more. The dose should preferably be reduced gradually over about 4 weeks, or longer if withdrawal symptoms emerge (6 months in patients who have been on long-term maintenance treatment).*

The NICE Guidelines

124. I have also considered the National Institute for Health and Care Excellence Clinical Guideline for Depression in adults: Recognition and Management set out at various places in the bundle, but in particular at **p.589 to 641**. I note that on the first page it states:

"When exercising their judgment, professionals and practitioners are expected to take this guideline fully into account, alongside the individual

needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families, carers or guardians" [**p.590**].

125. The guideline covers those where depression is the primary diagnosis. There is a focus on the care being person centred as set out at **p.596**, emphasising that "*people with depression should have the opportunity to make informed decisions about their care and treatment in partnership with their practitioners.*".

126. Having read the guidelines, I am of the view that given that Mrs Greenwood had already been prescribed medication in the form of Trazodone and Escitalopram, and that there is no criticism of the practitioners in deciding to implement that regime, and no suggestion that any of those involved in the prescription failed to follow the guidelines, that the relevant section is 1.9: Continuation and Relapse prevention.

127. In that section it advised that a person should be supported and encouraged to continue medication for at least 6 months after remission of an episode of depression where they have benefited from taking an anti-depressant. It was said that there should be a discussion that this greatly reduced the risk of relapse, and that anti-depressants should not be associated with addiction. There should also be a review of a person with depression as to the need for continued antidepressant treatment beyond 6 months after remission. For those with a significant risk of relapse or who have a history of recurrent depression there should be a discussion of treatment to reduce the risk of recurrence that should be influenced by the patients previous history and the persons preference.

128. Patients with depression should continue with antidepressants for at least two years if they are at risk of relapse. The level of medication should be maintained at which the acute treatment was effective if they have had two or more episodes of depression in the recent past, during which they experienced significant functional impairment; if there were other risk factors for relapse and the consequence was severe which included suicide attempts and an inability to work. It goes on to say that if you are to maintain a person on anti-depressant medication for a period beyond two years then there should be a re-evaluation of that person taking into account age, comorbid conditions and other risk factors. If a person is on long-term mediation they should be regularly re-evaluated. If it was felt that there was a significant risk of relapse.

129. At paragraph 1.9.1.7 it advises those "*who have had multiple episodes of depression, and who have had a good response to treatment with an anti-depressant and an augmenting agent, should remain on this combination after remission if they find the side effects tolerable and acceptable. If one medication is stopped, it should usually be the augmenting agent…*" [**p.621**].

130. The guidelines also advise those with depression who are at significant risk of relapse should be offered individual CBT for those who have relapsed despite antidepressant medication and for individuals with a significant history of depression and residual symptoms despite treatment. If they are well, then they should be offered mindfulness based cognitive therapy if they have experienced three or more previous episodes of depression. If they are having individual based CBT the duration should be between 16-20 sessions over 3-4 months. If the duration needs to be extended to achieve remission then there should be 2 sessions a week for the first 2-3 weeks of treatment. Then there should be follow up sessions, typically consisting of 4-6 sessions over the following 6 months. The mindfulness-based cognitive therapy should be delivered in groups of 8-15 participants and consist of weekly 2 hour meetings over 8 weeks and 4 follow-up sessions in the 12 months after the end of treatment.

131. Clearly, the section relating to "stopping or reducing anti-depressants" as set out in section 1.9.2 is significant in this case [**p.622**]. For that reason I set it out in full.

"1.9.2.1 Advise people with depression who are taking antidepressants that discontinuation symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. Explain that symptoms are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.

1.9.2.2 when stopping an antidepressant, gradually reduced the dose, normally over a four-week period, although some people may require longer periods, particularly with drugs with a shorter half-life (such as paroxetine and venlafaxine). This is not required with fluoxetine because of its long half-life.

1.9.2.3 inform the person that they should seek advice from their practitioner if they experience significant discontinuation symptoms. If discontinuation symptoms occur:

- *Monitor symptoms and reassure the person if symptoms are mild*
- *Consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms."*

Findings on Issue 2

132. Having considered all of the evidence as set out above, I am satisfied that on balance of probabilities the First Defendant did not breach her duty of care to Mrs Greenwood. I am satisfied that Mrs Greenwood would have presented to the GP Practice on 20th November 2014 appearing lucid, clear in her thoughts, confident and well-presented. I find that on balance of probabilities she would have expressed a clear intention to want to stop her medication and was looking to try and regain her ability to live without the

need for medication. She had previously expressed this desire when taking anti-depressant medication in the past, and in my view it is not unreasonable to want to do so.

133. The examination was also taking place in the context of what would be regarded as a routine appointment in a busy General Practice. I have heard that the average time slots for these appointments is 10 minutes. I accept entirely that the time can be extended, and that patient safety is paramount, but one also has to be realistic. Here was a patient who was expressing a desire to reduce her medication and informing the First Defendant that she had stopped taking Escitalopram without any side effects, and that her depression had resolved. She was, in my view, not displaying overt signs of depression.

134. Having heard the First Defendant give evidence, watched the manner in which she responded to sustained, persistent and robust cross-examination by Counsel for the Claimant and having listened to the way in which she expressed herself, I am satisfied that the First Defendant would have conducted a reasonable examination of Mrs Greenwood. I am satisfied that in her mind she was thinking of the British National Formulary and had in her mind the NICE Guidelines. I accept that these were probably not discussed in any detail with Mrs Greenwood, but it should be remembered that she is not giving a Judgment when advising a patient who is expressing a desire to stop taking medication, but is trying to holistically manage her care.

135. I am satisfied that a reasonable history was taken, and a reasonable view of the records made. I am not satisfied that there was a need to check at this stage if Mrs Greenwood was still under the care of The Priory. If that check had been made, then it would have shown that she had not seen anyone at The Priory for a year. Given that passage of time and the number of visits made since then to Edgworth I am satisfied that this would not have altered the decisions made in any event. This is also the case insofar as the more recent records are concerned. The First Defendant would have only had access to records within the control of Edgworth. A reasonable review would not have required her to go too far back in history. One of the purposes of the records is to ensure that the next practitioner is aware of what took place at the previous examination. In this case a review of the records would have noted that there was a need to discuss a reduction in medication in the entries immediately before the examination on 20th November 2014.

136. I accept also that there is on the face of things an inconsistency between what is contained in the entries in the records for 20th November 2014 in that it says that Mrs Greenwood's depression had resolved and what the First Defendant says about the score on the PHQ-9. I am of the view that Mrs Greenwood was, in my view, not displaying overt signs of depression when she attended, but that the First Defendant was concerned that there were still residual issues which is why she remained of the view that there were mild symptoms. It has to be remembered that I have already found

that her depression did not meet the criteria set out in the NICE Guidelines of being complex. Mild symptoms are only said to result in minor functional impairment. I am of the view that the inconsistency, though unhelpful, does not cause me to doubt the overall evidence and the view that I have of the First Defendant. I am satisfied that she accepted that at the point when she saw Mrs Greenwood it was safe to advise her on how to reduce her medication.

137. I accept entirely, and find valid, the criticisms that have been made over the quality and extent of the records that were made in this case. I am sure that the First Defendant would have wished that her record keeping was of a greater quality. Having said that, and having looked at the medical records from a variety of practitioners in this case, I am of the view that criticisms as to the quality of record keeping can be validly made against a number of practitioners. I am not satisfied that poor record keeping of itself is enough to establish a breach of duty on the part of the First Defendant. In any event, I accept that there is sufficient information contained in the entries for the next practitioner to be able to see what had occurred and what had been planned. It has to be remembered that the First Defendant was not advising Mrs Greenwood to stop taking her medication, but to reduce it pending a review.

138. I am satisfied that having discussed Mrs Greenwood's desire to stop her medication that a reasonable plan was put in place to facilitate that desire. It has to be remembered that at the heart of this case was an individual who, at the time of the examination, had been taking anti-depressant medication for two years following her discharge from The Priory. I accept entirely that between that time and the time of the examination that there had been fluctuations in her mood, most notably in May 2013 when she required a visit to hospital. On the whole, though, I am satisfied that Mrs Greenwood was still using the techniques taught to her at The Priory and had gained sufficient confidence to want to try to come off her medication. This is supported by the fact that she had unilaterally taken the decision to stop taking the Escitalopram 8 weeks before the examination. I am satisfied that the regime was in accordance with the BNF and NICE Guidelines.

139. I bear in mind the evidence given at the inquest, which was much closer in time to the events than the evidence given in the trial. I accept that criticism can be made of the First Defendant about her evidence, but I accept that was an unfamiliar environment and that she was struggling with a court environment. I formed the view that she was not comfortable giving evidence before me either. The First Defendant accepted at the Inquest that she did not investigate the rationale for the treatment that Mrs Greenwood was taking, but understood the effect of the medication. I am satisfied that given the decision that was ultimately taken to try to safely reduce the medication that a full understanding of the rationale for introducing the medication was not required in this case. Had it been the case that the First Defendant was advising Mrs Greenwood on how to stop her medication outright then I am of the view that a full rationale was needed. This was, in my view, a trial in order to see how Mrs Greenwood

would manage with a reduction in medication. She was clear that she advised on risks, benefits and side effects. If I accept, as I do, the evidence of the First Defendant on these matters, then I am satisfied that on the balance of probabilities she advised Mrs Greenwood to follow the regime agreed, which was not to stop taking Trazodone. As I have already stated this was not a case where Mrs Greenwood was being advised to stop taking her medication, but reduce it.

140. I accept that there is an alternative scenario, which is that she may have already relapsed into taking Zopiclone. It is suggested that the First Defendant did not establish if that was the case. Having been satisfied that, in my view, she conducted a reasonable examination, I am satisfied that this was explored. It may not have been to any great extent, but the First Defendant is not required to carry out a forensic enquiry and is entitled to expect a patient to be frank with them. I am also satisfied that even if the question was not put to Mrs Greenwood she would not have volunteered it anyway. At this stage, though, I am not satisfied that she had relapsed, though I accept that this is possible given that she had purchased a number of tablets in 2014 (approximately 3200 according to the evidence of the Claimant at the inquest **p.702**). To be able to be clearer on this issue would have required better evidence such as receipts for the purchases or some evidence as to when it was purchased. I do not have that.

141. I am also satisfied that there was sufficient safety netting in place, which in my view is a crucial element of the care that was provided by the First Defendant. I accept that a review was not arranged within 1-2 weeks as the nursing experts agree should have taken place, or at most at 3-4 weeks as Dr Longwill suggested. Again, though, that has to be looked at in the overall context of the relationship that Mrs Greenwood had with the GP Practice. She had been a regular attendee since 2012 when taken there by the Claimant. She knew the Doctors and had seen the First Defendant on several occasions before 20th November 2014. She also knew that she could make contact with the practice or other services if she needed to, as she had done in the past. I am also satisfied that the Claimant was aware of how to contact help if it was needed, and I am satisfied that she was reminded of this by the First Defendant, even if it may have been simply to say that she could contact the Practice if she needed to. Accordingly, I agree with Ms Marriott that whilst an earlier review may have been helpful, the fact that safety netting was in place was more important.

142. I am satisfied that on this occasion there was no need to defer to a GP or to escalate matters up to a Psychiatrist. At the time of this consultation there was a relatively straightforward plan to reduce medication in a controlled manner proposed. Having been satisfied that the First Defendant was appropriately qualified to manage the care of Mrs Greenwood I am satisfied that this is the sort of thing that she would be expected to deal with on her own.

143. The Claimant has raised in their submissions that Mrs Greenwood was not given sufficient information on the material risks of reducing her

medication, and that as a result, in light of *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11, there was a breach of duty. I am satisfied that Mrs Greenwood was aware of the risks of reducing her medication and that she was advised on them by the First Defendant. It has to be remembered that she had reduced medication in the past, had learned to manage her Zopiclone addiction at The Priory, and by the time of the examination on 20th November 2014 stopped the Escitalopram without side effects. The expert evidence agreed that Mrs Greenwood would have been made aware of the risks of reducing medication when it was first prescribed. I am therefore satisfied that there is no breach of duty on this point.

144. It follows from these finding that I have preferred the expert evidence on this issue of the Defendants over those of the Claimant. Bearing in mind the guidance I have already referred to above in *'C' (By his Father and Litigation Friend 'F')* v *North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB). At the outset, let me say that I am satisfied that all of the experts that have given evidence in this case are appropriate and suitable experts to give evidence to the Court on their respective fields. My reason for preferring the evidence of the Defendants experts over the Claimant's experts on this issue is that I am satisfied that Dr Longwill and Ms Marriott's evidence overall was more realistic and in tune with day to day life in a GP practice. I felt that they had a more reasonable approach to the care that Mrs Greenwood required and the way in which the First Defendant tried to manage it. I remember of course that they largely deferred to me and the findings that I have made, but where there was disagreement I prefer the evidence of the Defendants.

Issue 3

145. Whilst in light of my findings on the first two issues I do not necessarily need to go on to consider the third and fourth issues I have done so out of respect to the Claimant who deserves a complete set of findings on this matter.

146. If I had found that there was a breach of duty by the First Defendant I am satisfied on the balance of probabilities that the Claimant would not have been able to establish that the breach caused the death of Mrs Greenwood.

147. In reaching that view I have had regard to the evidence of the Claimant. In his statement dated 12th February 2019 at **p.104** he described the history of their relationship and that he and Mrs Greenwood first met in 1994. I note that this was around the time she first saw her GP for mental health problems that related to a relationship. He accepted that they had an on and off relationship. His perception of her mental health condition was that she would have periods where the condition was dormant and well controlled and then there would be episodes where it would flare up and be serious.

148. In his first statement at paragraph 8 he states that *"In 2002 Suzanne tried to overdose twice and was admitted to A&E Bolton Royal Hospital. I did not stay after the second attempt as it was not healthy for either of us. I was*

ill and Suzanne was not coping with my illness and we both had personal problems to sort out". Mr Greenwood was not asked about this event in cross-examination. In the context of this case I am of the view that this event is important, as it is the only time that Mrs Greenwood attempted to take her own life before the events on 23rd December 2014. In his evidence at the inquest he was of the view that they were cries of help [**p.700**]. I must also take into account what Mrs Greenwood said about this part of her life in the comments made in The Priory (see paragraph 14 above).

149. The Claimant was not part of Mrs Greenwood's life again until 2010 when they renewed their relationship. I find that he was not aware of her addiction to zopiclone until shortly before the point at which he took her to see Dr Robinson. This tells me that Mrs Greenwood was willing to keep things from the Claimant. The Claimant was asked during cross-examination by Mr Butler what he meant by paragraph 10 of his statement where he said that *"In 2011 it emerged that Suzanne had received prescription sleeping tablets…".* The Claimant said that he found that towards the end of 2011 Mrs Greenwood was struggling to get out of bed and to function properly. She told him that she had been given two weeks' supply in the mid 2000's as part of a prescription, and that when that prescription was not renewed she resorted to buying them on-line. There appear to have been other episodes as set out in his statement that was causing him concern. In his statement the Claimant says that he understood that Mrs Greenwood had discussed this with her GP, but I cannot see any record of that until the Claimant intervened and took the Claimant to see his GP, Dr Robinson.

150. The statement of the Claimant does not consider the treatment that Mrs Greenwood received at the Edgworth Practice before they decided that she should attend The Priory. He fails to mention that things had deteriorated to the extent that he left the marital home for a while prior to her admission. He had moved back in before she actually went into The Priory. The Claimant made it clear in his evidence to the Inquest as well as under cross-examination that in his mind the reason for her admission into The Priory was to treat the zopiclone addiction.

151. The statement of the Claimant says that towards the end of 2013 Mrs Greenwood was struggling to suffer a loss of sleep again and that in 2014 she became more reclusive. The statement goes on to refer to attendances at the GP prior to the attendance on 20th November 2014, which he was not aware of. He disagreed that Mrs Greenwood condition had resolved and she was distancing herself from the Claimant at this time he says.

152. The Claimant does not say much in his statement about the period between 20th November 2014 and 10th December 2014. In cross examination he accepted that there were no concerns up to that point.

153. On 10th December 2014 the Claimant claims to have telephoned the General Practitioner. The medical records do not record the telephone call, but there is an entry from Dr Leach on 12th December 2014 that noted that

the complaint was anxiety with depression. He was telephoning the Claimant who was not able to talk at that time and that he was going to book an appointment the following week. That did not take place. According to the Claimant in his statement at paragraph 27 Mrs Greenwood was very low at this point and it reminded him of times that they had gone to hospital. He accepts that he was called back by Dr Leach, but at the time he was in a branch of Aldi's Supermarket and didn't have a discussion. His evidence was that the emergency had passed by then and as a result there was no further contact with the GP or another medical practitioner. This evidence was consistent with that which he gave at the inquest.

154. Following this incident the evidence is that Mrs Greenwood had changed. The Claimant says things were different. She had been offered a new job and was "buzzing". She and the Claimant hosted a dinner party on Saturday 20th December 2014 which went very well and according to the evidence given at the inquest the reason why she struggled to sleep following this was due to the impact of alcohol. The following day, the 21st December 2014, they went to the Claimant's sisters house in Blackpool and stayed until about 1am. The Claimant described things as being normal that day. According to the Claimant she slept on the way home.

155. On 22nd December 2014, the day after the visit to her sister the Claimant left for work without speaking to Mrs Greenwood. She had retired to the attic room, which was her usual place to go when she was either having difficulties with sleep or was fearful that she may do so. The Claimant understood that she was planning on shopping for Christmas presents that day, and that she was due to have acupuncture in the evening. The Claimant told the Coroner that he didn't speak to Mrs Greenwood during the time he was at work, which was normal for them. He also explained that he finished work early that day and was home at around lunchtime. The intention had been for them both to go separately to deliver Christmas presents.

156. The last time that the Claimant spoke to Mrs Greenwood was around that time. Unfortunately a disagreement took place regarding the Claimant's daughter. The Claimant described at the Inquest seeking to avoid a full argument and they went their separate ways to deliver presents. In his witness statement the Claimant does not address this matter, and in cross examination only described "having words". In re-examination the Claimant accepted that his relationship with his daughter had caused Mrs Greenwood to be upset before. The Inquest transcript suggests that this disagreement had actually been a bit more extensive than the Claimant has indicated. I note that Mrs Greenwood's sister added comments at the end of the Claimant's evidence about the disagreement. I have to treat that evidence with caution and I do, but it is part of the jigsaw that was present in the immediate period leading up to the death of Mrs Greenwood.

157. When the Claimant arrived home Mrs Greenwood was not there and he thought that she was annoyed with him and left her to calm down. He told the Coroner that he stayed in and was not alarmed by the fact that she had not come home, even when it got to the early hours, as it was not

uncommon. In fact he explained that it was not until 10am on the morning of 23rd December 2014 that he started to look out the window to see if she was coming home. Sadly she did not and the Police informed the Claimant that Mrs Greenwood had died.

158. When she was found Mrs Greenwood had in her possession an empty bottle of Vodka and another one that appears to have been three quarters full. There was also a box of Zopiclone tablets with 23 of them missing.

159. Following her death he had discovered that she had not taken the presents that she was due to deliver. He says in his statement that there were a number of things that he discovered that caused him concern. In April 2014 Mrs Greenwood had sent a text to a friend stating that the marriage was over and the Claimant was going into The Priory which was not the case. There was a letter sent to Mrs Greenwood from the mother of an ex-partner who had committed suicide (a matter I will return to in due course) seemingly as a result of Mrs Greenwood saying that a cousin had committed suicide. There was also a text message sent to her ex-partner who had committed suicide in May 2014. The Claimant discovered that Mrs Greenwood had created an alter ego, that she had been carrying out pornographic searches on the internet. He found that there were a number of empty bottles of vodka and gin in the bin.

160. At the inquest the Claimant was of the view that Mrs Greenwood had not intended to end her life. He referred to a positive note that was written in a Christmas Card. He told the Inquest that he found some 600 zopiclone tablets in her room after her death.

161. In cross examination he accepted that he knew where to take Mrs Greenwood if there were any significant issues. He was not able to remember if he did arrange a review after speaking with Dr Leach on 12th December 2014. It is clear from the records that no such review was arranged. He also accepted that there were no signs in her recent history that she wanted to commit suicide. He explained that 2014 was a worse year than 2013. He explained that she always struggled with sleep, and that whilst there were periods of greater stress when at work he was of the view that they centred mainly around her difficulties sleeping.

162. In re-examination the Claimant explained that in his view if Mrs Greenwood had been told to do something she would do it. I am afraid that appears to be an overoptimistic reflection on her. I can see from the records that there were times when she chose not to attend appointments, to change her medication and to cease medication (in particular the unilateral decision to stop Escitalopram). It is clear from the evidence that she was strong-willed and could make her own choices. I also accept that has to be considered in the context of an addiction, and I have taken that into account.

163. I do accept that Mrs Greenwood wanted to get better as the Claimant said in re-examination. I note that the Claimant sought to downplay the period after 20th November 2014. He claims that she was low. Clearly there was a

point in December 2014 that led to him contacting the surgery, but following that the impression that I get is that things appeared to have significantly improved.

Psychiatric Evidence

164. I have also considered the evidence of the Consultant Psychiatrists in this case. The Claimant relies on the report of Professor Morgan, dated 1st May 2019 [**p.181**]. The report contains a comprehensive review of the medical records of Mrs Greenwood, and I have already made my finding on the complexity of Mrs Greenwood's condition so do not need to consider that further. Professor Morgan is of the opinion that the First Defendant did not follow the NICE Guidelines in the way in which she advised that the medication was reduced. He states that "*The Guidance at 1.9.2 (of the NICE Guidelines) relates to the manner in which a patient's dose should be reduced once there has been a decision to stop; not to the process by which the decision to stop should be reached*"[**p.236 para 7.35**]. He goes on to say that the history and complexity of Mrs Greenwood's condition was such that she should have been considered at risk of relapse. He goes on to opine that if Mrs Greenwood had received an explanation for the rationale of her treatment regime in the first place, a cost-benefit analysis of maintaining or stopping medication which would have led to an explanation the understanding for the need for long-term management she would have continued with the medication.

165. Professor Morgan was asked "*whether such a patient, once re-engaged with an appropriate medical regime and specialist treatment, is likely to have experienced the type of severe deterioration which preceded Mrs Greenwood's death*". I have read his answer to that question [**pp.239 to 241**]. I am of the view that it is based on an inaccurate assessment of the evidence that was available on Mrs Greenwood's condition following the examination on 20th November 2014. He seems to completely disregard the evidence of Mr Greenwood that following the 10th December 2014 Mrs Greenwood's behaviour, in fact, was indicative of someone in a positive state of mental health, and also ignores the fact that at no stage did the First Defendant advise Mrs Greenwood to stop taking her medication. I am not in agreement with him that there is evidence of a rapid relapse. That is not supported by the evidence. As I understand matters, following reduction, there is usually evidence within a matter of days. Here the Claimant contacted the GP's over 3 weeks later, but then did not follow that up despite being advised to do so.

166. His report concludes by accepting that Mrs Greenwood would probably have continued to suffer from relapses, but that they would be less severe and frequent. He was of the view that she was capable of recovery. She would have required medication, potentially on a long-term basis and psychosocial interventions. He was of the view that the Claimant would have suffered an initial period of difficulty, before then reaching a mental state where she could have worked. His view was that this would have been achieved in 2 years. On the balance of probabilities he was of the view that, with a sympathetic employer, she would have been able to return to work as a teacher provide that

it was not stressful, or to other employment, again provided that it was not stressful. He was of the view that there was a lifelong increased risk of suicide, with a result that her lifespan could have been foreshortened by a period of 8-10 years [**p.242-246**].

167. I note that at paragraph 7.73 of his report [**p.243**], Professor Morgan was of the opinion that Mrs Greenwood displayed an "*openness to engage with such treatment, and a lack of obvious concealment of behaviours*". I am afraid that I disagree with this statement. Mrs Greenwood had concealed her Zopiclone addiction from Mr Greenwood. It was his evidence that he discovered this addiction after they were married and it was he that took her to see Dr Robinson in the first place. There is further evidence of concealment of her behaviour. She did not tell her husband that she had stopped taking Escitalopram and nor did she tell him that she wanted to stop taking Trazodone. She did not tell him that she was going to see anyone on 20th November 2014. He was also not aware until after her death of a number of behaviours that were in his view out of character.

168. The Defendants rely on the evidence of Dr Khatan in his report dated 27th October 2019 [**p.404**]. His opinion is that *"suicide is almost always multi-factorial in origin and usually unpredictable"*. He was of the view that she suffered from complex issues relating to her mental health. They included sleeping difficulties that were not simply related to depression, a phobia of not sleeping, an addiction to Zopiclone, alcohol abuse, marital difficulties, personality issues, with borderline or emotionally unstable traits, including unstable relationships, impulsivity, deliberate self-harm, particularly at times of crisis in the context of break-up or other difficulties in intimate relationships.

169. Dr Khatan is of the view that the lack of a suicide note makes it difficult to determine what Mrs Greenwood was thinking at the time of her death and supports his view that it was an act of impulsive behaviour. He notes that in the days leading up to her death Mrs Greenwood's mood had improved and that any depression that she may have had earlier (by which I infer at about 10th December 2014) was not sustained. Dr Khatan was of the opinion that the fact that there was an argument between the Claimant and Mrs Greenwood the day before her death, the fact that she had consumed a significant level of alcohol and thoughts of her ex-boyfriend's suicide were more significant factors in unbalancing her mind. He notes the lack of any reference to the respective professional bodies by the Coroner following the inquest or Mr Greenwood himself. Dr Khatan's view was that there was no causal link between the examination on 20th November 2014 and Mrs Greenwood's death. It was unpredictable and not in keeping with her previous medical history, other than in relation to the argument that she had with her husband and ingestion of alcohol and Zopiclone. He makes the point that Mrs Greenwood did not follow the advice of the First Defendant in any event.

170. In the joint statement based on the Claimant's agenda [**p.543**] Professor Morgan is of the opinion that Mrs Greenwood suffered a severe chronic mental illness. There were previous suicide attempts that required the

assistance of a consultant psychiatrist and complicating comorbidities. There was evidence of recurrent depression, addictive behaviour, sleep disturbance and anxiety. Dr Khatan agreed that Mrs Greenwood had longstanding mental health problems, having presented with numerous mental health symptoms. He noted that they tended to manifest themselves in the context of life stressors, and regarded these as the precipitating factors. At times of crisis she presented to her GP and on occasion to Accident and Emergency. He was of the view that perpetuating factors might have included unaddressed issues in her personal life. He was of the opinion that she suffered from reactive depression, which made it less likely that anti-depressants would have been critical to the severity of her depression at any given time. He relies on the fact that in the days leading up to her death that Mrs Greenwood did not seem to be depressed, but rather uplifted. Dr Khatan also relies on the fact that Mrs Greenwood was admitted to hospital just once to address her Zopiclone addiction.

171. Professor Morgan was of the view that Mrs Greenwood fluctuated in her mental state. He relies on entries in the medical records relating to meetings with Dr Mbaya on 21st October 2013 where she presented with her mood as euthymic and then by 31st October 2013 as being depressed. Professor Morgan formed the view that this was an example of a rapidly changing picture, though manageable through prophylactic anti-depressant medication. Dr Khatan, agreed that there was a fluctuating picture but that her mood was governed by external factors such as work related stress, relationships, sleep and how she was managing the various difficulties. It was these matters that were the main factors in her deterioration in presentation and the need to seek help.

172. Professor Morgan is of the opinion that Mrs Greenwood had a complex psychiatric history. Dr Khatan is of the view that she did not suffer from a simple disorder. It was complex in that there were different components. He was of the view that the components included personality issues that were missed for the purposes of treatment. The issues were complicated by the difficulties that included Zopiclone dependence and alcohol abuse. Dr Khatan points out that the more simple the mental health condition the easier it is to fit into a medical model and where the relapse can be more easily linked to the discontinuation of medication. Dr Khatan is of the view that as Mrs Greenwood's condition was more complex other factors ought to have been considered, such as her relationship with her husband. He highlighted the fact that he had left the house just before she entered The Priory and that they slept apart. He also points out that the impact of her Zopiclone dependence on their relationship was not explored, nor was the fact that after her death he discovered texts that upset him. He also found the fact that she chose a point where a previous boyfriend died significant. He was of the view, however, that her contact with medical services was straightforward; with it mostly being with GP's and some secondary mental health services, but with no tertiary mental health services and only a relatively brief admission.

173. Professor Morgan was of the view that Mrs Greenwood showed periods of significant and sustained improvement in mood with prophylactic medication

ameliorating the severity and frequency of depressive episodes and with periods of stability between those episodes. Dr Khatan was of the view that Mrs Greenwood's mood was not related to the use of antidepressant medication. He reviewed her history and was of the view that her mental state would have fluctuated naturally. She would have enjoyed good times and bad. He points out that it is difficult to know the true position as it was not clear how many Zopiclone tablets she was taking and so it is not possible to know how her level of dependence changed. He points out that Mrs Greenwood did not fundamentally recover from her psychiatric problems, but accepted that it was possible that with focussed treatment on the underlying psychological factors she could have recovered to a greater extent.

174. Professor Morgan accepted that episodes of deterioration were characterised by deterioration in mood, heightened anxiety, sleeping difficulties, anger and agitation and thoughts of self-harm/suicide. Dr Khatan accepted that they were features of Mrs Greenwood's condition, but the extent of those symptoms depended on the self-report of Mrs Greenwood. He points out that this is not reliable, and that she may have perceived one factor as being important on one occasion and at other times there would be others.

175. Professor Morgan was of the view that there were periods of stability between the depressive episodes. Dr Khatan agreed, but pointed out that this was probably due to Mrs Greenwood feeling calmer, less stressed and pleased with the way that life was going.

176. The experts were asked whether the two-month period before 20th November 2014 and the reported cessation of Escitalopram indicated that Mrs Greenwood's depressive illness had resolved. Professor Morgan was of the view that it did not. There was a risk of relapse, and he pointed out that the maximal point of relapse was at 20 weeks following discontinuance of Escitalopram. Dr Khatan was of the view that there is limited information about this period of time. The lack of attendance at her GP indicated that either there were not problems significant to warrant an appointment or that she was incapable of making an appointment.

177. Professor Morgan regarded the 10th December 2014 report of acute low mood as being consistent with cyclical nature of her condition and indicative of a relapse. Dr Khatan was of the view that due to her condition there were bound to be fluctuations in her mental state. He points out that this episode was not corroborated by Mrs Greenwood, she was not seen by a health professional and notes that after this there were no symptoms significant enough to report.

178. Professor Morgan was of the view that the fact that Mrs Greenwood was able to enjoy social activities during periods of milder depression. He noted that when her sleep improved and repeated the point that he made in his report regarding the entries in the medical records from The Priory on 21st October 2013 and 31st October 2013. Dr Khatan is of the view that this was more suggestive that she was not suffering from a sustained depressive illness. This was, in his view, indicative that her actions on 23rd December 2014 were

unplanned, impulsive and related to the argument with her husband and her drunken state of mind.

179. Professor Morgan considered that there was a fluctuation in mood arising from the cessation of medication, which was consistent with withdrawal, which gave rise to depression and agitation. This was noted in the medical records and in the Claimant's statement reporting a sense of Mrs Greenwood being in crisis and comparing this to earlier crises. Professor Morgan was of the view that there was no other intervening cause. Dr Khatan was of the view that taking a sedative drug might have made it less likely that Mrs Greenwood would have got drunk, acted impulsively and commit suicide. He doubted that the stress she was experiencing at that time would have been overcome by the taking of an anti-depressant.

180. Professor Morgan is of the view that suicide is preventable, that it is possible to safely manage changes in anti-depressant medication that, if Trazodone had been maintained with clear warning, or reduced with clear warning and with increased scrutiny of her mental state then, the risks of catastrophic relapse would have been effectively managed. Dr Khatan's response to this question initially was that he did not accept that suicide would have been prevented by attempting to compel or even strongly advise against discontinuing Trazodone. I am of the view that Dr Khatan goes too far at **p.559** of the Joint Statement on the Claimant's agenda where he stated that the death of Mrs Greenwood would have been prevented by the Claimant not allowing her out of the house and not allowing her to drive a car which contained a rope. That statement is based on the assumption that the Claimant was aware that at that stage Mrs Greenwood had consumed a large amount of vodka and Zopiclone. I am satisfied on the evidence that I have read that was not the case. The Claimant only became aware after she had died that Mrs Greenwood had relapsed into using Zopiclone and discovered empty bottles in the bins. The Claimant's opinion was that Mrs Greenwood was not suicidal.

181. I note that Professor Morgan is of the opinion that only one thing had changed in the period leading up to the death of Mrs Greenwood, which was the withdrawal of antidepressant medication. He notes that in November 2013 there had been a good response to treatment but that following withdrawal of medication that in December 2014 the GP reported anxiety with depression and her husband indicating a similar clinical situation to her earlier mental health emergencies. He applies Occam's razor to say that the withdrawal of the medication was the most relevant precipitating factor and made a substantial, material contribution to her death. Dr Khatan is of the view that her death cannot be simply be attributed to the stopping of Trazodone. He points out that she had just got a new job and had things to look forward to. He highlights factors that could have impacted on her mood, which have already been referred to as also being important.

182. Professor Morgan appears to be of the view that Mrs Greenwood's death was preventable as psychiatrists make risk assessments based on a history and managed through a number of means without the need for admission to hospital. Dr Khatan was of the view that it was not possible to have predicted

Mrs Greenwood's death, unless someone was there in the moments leading up to it. He points out that she had never done anything like the events of 23rd December 2014 before. He is of the view that an intervention would have prevented it. I again note that there is a misinterpretation of the factual evidence in his answer.

183. In the joint statement based on the Defendant's agenda Professor Morgan and Dr Khatan again differed in their view if the type of condition that Mrs Greenwood was suffering. Professor Morgan being more of the view that there was a chronic relapsing depressive illness that had complex comorbidities which responded to prophylactic medication. Dr Khatan was of the opinion that her symptoms did not really fit into a simple diagnostic category, and having taken into account her medical history was of the view that she exhibited features that were consistent with a personality disorder or a depressive illness.

184. Professor Morgan was of the opinion that the prescription of antidepressant medication by what is described as a variety of GP's and mental health experts served to reduce the frequency and severity of relapses, and without such a role he has no doubt that they would not have been prescribed. Dr Khatan was of the opinion that more information is needed before accepting this statement. He would wish to understand the responses to the various antidepressants that she had been prescribed in the past. He would also want to know her level of compliance with the treatment regimes. He would wish to see an adequate mental state examination performed prior to the prescription of medication and then one at a suitable interval afterwards. He points out that if Mrs Greenwood was taking Paroxetine up until October 2002 this did not prevent her taking an overdose. His view was that episode was not due to depression, but was due to the break-up of her relationship. He also points out that some anti-depressants have sedative qualities, other have anxiolytic qualities. As a result when assessing any improvement in mood you have to take into account whether the improvement is in mood or anxiety or sleep.

185. In considering whether or not Mrs Greenwood would have reached a mental state compatible with her working as a teacher or teaching assistant Professor Morgan was of the opinion that she would, but does not set out here when that would have been. Dr Khatan is of the view that he wishes to see her full employment history alongside her medication. He had the feeling that she was mostly unemployed during her career.

186. Professor Morgan was of the view that as there was no evidence of systemic review of Mrs Greenwood's mental state in primary care and as a result defers to nursing and GP opinion on the adequacy of assessments as to whether nor not Mrs Greenwood had planned to end her life. Dr Khatan is of the view that that there was no evidence that Mrs Greenwood was planning to end her life. He is of the view that if such things had been expressed to her treating GP's then they would have been recorded. He also noted that when she had previously overdosed that she sought help.

187. Professor Morgan was of the opinion that Mrs Greenwood was at an increased risk of suicide given her diagnosis, the rapid relapsing nature of her condition, the comorbidities and her past attempt. He was of the view that the risk was manageable through conventional practice. Dr Khatan was of the opinion that the risk fluctuated with time. He is of the view that at the point in time when the event occurred there were potential factors that pushed into a higher risk category. He highlights the pressure of her husband's business failing, her previous boyfriends suicide, the argument she had with the Claimant on the day before her death, the impact of her intoxication with alcohol and Zopiclone and the means she had to commit the act of hanging herself.

188. Professor Morgan was of the opinion that there was an absence of advice on the risks of relapse, recommendations of anti-depressant medication, advise on the side effects of treatment withdrawal, follow-up appointments and safety netting that eroded the protection that might have assisted Mrs Greenwood. He noted that there were broader protective factors in the past that included a willingness to seek help and advice, an ability to follow a treatment regime, engagement with therapies and strategies. Dr Khatan was of the view that there were protective factors in place. In an emergency the GP or out of hours services could have been utilised.

189. Dr Khatan is of the view that it cannot be known if Mrs Greenwood would have gone on to have a long life. He does not accept Professor Morgan's calculation that it would have been foreshortened by 10 years.

190. In their oral evidence Professor Morgan accepted that Mrs Greenwood referred herself for psychiatric treatment and had to pay for her treatment at The Priory. He accepted that when prescribed her medication at The Priory that she would have been made aware of the side effects of not taking her medication. He was of the view that the risks related to Mrs Greenwood fluctuated. She may have been low risk at times and also high risk and as a result her ability to understand the effects of her condition would have also fluctuated.

191. He was challenged on entries in his report and accepted that Mrs Greenwood had not been discharged from care by Dr Mbaya, and noted that she had stopped attending appointments made for her. He accepted that the boundaries between her care were unclear. He accepted that there was no reference to Mrs Greenwood being suicidal between 2013 and November 2014. He accepted that if Mrs Greenwood was not taking her medication that was not the fault of the GP Practice.

192. Professor Morgan also accepted that his interpretation of the events after 20th November 2014 was perhaps incorrect, but he was of the view that she was at a real risk of committing suicide. In re-examination he was of the view that when a descriptor such as rock bottom is used that this was an indicator of a risk of suicide.

193. Dr Khatan accepted that he had not read all of the evidence prior to giving his evidence. In particular he had not read the Lloyd George cards and had not read all of the evidence from The Priory. I am of the view that the former is not necessarily as important as the latter and he was given the opportunity to read the records before giving the majority of his evidence. As a result I am satisfied that he had considered all relevant documents by the time he was giving his oral evidence.

194. He explained that in his report he was trying to consider possible explanations for the actions of Mrs Greenwood and that included a number of factors. He was asked about the death of a former boyfriend of Mrs Greenwood and could not discount that as insignificant. The lack of mention of that in the medical records was not something of significance to Dr Khatan as patients do not disclose everything to their practitioners. He was not looking for evidence to undermine the relationship between the Claimant and Mrs Greenwood, but was concerned to understand the whole picture.

195. He explained that in his view the records showed that Mrs Greenwood showed signs that pointed towards a diagnosis of a personality disorder but did not diagnose this. He accepted that she was at greater risk of suicide, but clarified that this was only slightly greater than the general population. He drew a strong link between the state of her mood and how well she had slept. He accepted that Trazodone is an anti-depressant, but that it was also used to aid sleep, though he was not of the view that the splitting of the dose had an effect.

196. He accepted that a reduction in Trazodone would impact on sleep, but aside from 10th December 2014 there was no report of any sleeping problems. He accepted that if she was withdrawing to her room in the attic that may be evidence of poor sleep and related to a reduction in Trazodone. He was of the view that if there were serious concerns then the Claimant would have taken Mrs Greenwood to the Doctors or to hospital.

197. Dr Khatan did not accept that the reduction in Trazodone more than minimally or trivially contributed to the reduction in her mood. He explained that he was not able to say what was happening inside the mind of Mrs Greenwood towards the end of her life.

Opinion on Psychiatric Evidence

198. Taking into account the guidance in *'C' (By his Father and Litigation Friend 'F')* v *North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB) I have considered the evidence of Professor Morgan and Dr Khatan. Both are appropriate witnesses for this case. There was criticism by the Claimant of Dr Khatan's qualification to provide evidence in this case given that he primarily works in a prison environment. I reject that criticism. I am satisfied that in the environment that he works he would encounter a variety of individuals who are suffering from complicated psychiatric conditions with associated substance abuse. It is not the case that he dealt with people detained under the Mental Health Act as was

suggested, but rather then general prison population. I am also satisfied that he had suitable experience to be able to comment on Mrs Greenwood's condition. Professor Morgan was also clearly a competent expert witness for this case. I bear in mind completely his work on suicide prevention. I suspect, however, that Professor Morgan's work involves patients with conditions that are more complex and serious, whilst Dr Khatan's day to day work may be more relevant to the type of condition that the Claimant was suffering, albeit in a prison environment.

199. Neither expert had a complete grasp of the evidence when they prepared their reports and both had to accept that assumptions that had been made were wrong. This, of course, shows that they gave their evidence in good faith. As a result I have to therefore decide between them what appears to be the most logical evidence. On this issue, I prefer the evidence of Dr Khatan. I am satisfied that his view is just about more logical. Dr Khatan appears to have taken more of a step back and considered the whole of the picture relating to Mrs Greenwood whilst Professor Morgan has not, in my view, properly dealt with the period between the 20th November 2014 and the death of Mrs Greenwood, in particular the fact that she had stopped taking Trazodone by the time of her death, which was not the advice given.

200. I also do not understand the logic behind saying that her life would be shortened by a period of 8-10 years, but also saying that she would make a return to full time work, albeit in a less stressful environment. I accept that his evidence on this issue is couched in uncertain terminology, but do not understand why he included this. I find it to be inconsistent. If she were to make a recovery to the extent that she would be able to work on a full time basis, then it seems illogical to suggest that her life would be foreshortened. My understanding is that stressors were a major trigger of her condition. Without that stress then it is unlikely that the condition would be triggered.

201. I appreciate entirely that Professor Morgan has a wealth of experience in dealing with patients with psychiatric conditions, but do not find that he is in a position to say what Mrs Greenwood would have done. I cannot accept his evidence that she would have continued to take her medication had she been fully counselled.

The Law

202. As set out above, the Claimant argued that I can deal with this matter using the "but for test", or in the alternative I can consider that the breach made a material contribution to the death of Mrs Greenwood.

203. Under the "but for test" if the Claimant is able to establish that on balance of probabilities Mrs Greenwood would not have died were it not for the decision taken to reduce her Trazodone then she succeeds in establishing causation. In order to be able to achieve this I am of the view that the Claimant must be able to show that following the consultation Mrs Greenwood followed the advice and reduced her medication in accordance with it, and that the reduction in medication impacted on her.

204. The alternative advanced by the Claimant is that the decision to reduce the level of Trazodone materially contributed to her death (*Bonnington Castings* v *Wardlaw* [1956] 2 W.L.R 707). Reliance is placed on *Williams* v *Bermuda Hospitals Board* (NHS Litigation Authority Intervening) [2016] UKPC 4 where it was held that the material contribution approach was not confined to cases where the timing of the contributory cause was simultaneous (*Hotson* v *East Berkshire HA* [1987] A.C. 750 and *McGhee* v *National Coal Board* [1973] 1 W.L.R. 1). Depending on the evidence, the sequence of events might be highly relevant in considering whether a later event had made a material contribution to the outcome or whether an earlier event had been so overtaken by later events as not to have made a material contribution to the outcome. A claim would fail if the most that could be said was that the Claimant's injury was likely to have been caused by one or more of a number of disparate factors, one of which was attributable to a wrongful act or omission of the Defendant (*Wilsher* v *Essex AHA* [1988] A.C. 1074). I accept that if there was a more than minimal of trivial contribution that is enough to establish causation and that I should be cautious when considering whether or not a risk was doubled (*Bailey* v *Ministry of Defence* [2008] EWCA Civ 883).

205. The Defendant argues that this case can be determined by the but for test and argues that Mrs Greenwood would have probably deteriorated to the extent that she did in any event. Reliance is placed on the case of *PPX (A protected party by his brother and Litigation Friend BLF) v Dr Ravinder Aulakh* [2019] EWHC 717 (QB). In particular they rely on the passage of Whipple J where it was said:

> "In my judgment, the Claimant's causation case rests on shaky foundations. The risk that a particular person, whether or not that person is under the care of the crisis team, will try to commit suicide is difficult to quantify. Certainly, there are risk factors which might increase the likelihood, and treatment options which might reduce it. But for causation to be established in this case, I have to be satisfied that it is more likely than not that with intervention following referral on 25 April 2012, this particular Claimant would not have attempted to take his own life on 20 May 2012. I cannot be satisfied of that, on the evidence before me. I can be satisfied that this Claimant would have remained unwell and prone to impulsivity for some time after 25 April 2012, even with a referral to the crisis team, but I cannot predict his outcome beyond that. Causation is not established."

206. It strikes me that this passage really is a statement inviting me to consider all of the evidence when weighing up whether or not causation is established.

207. The Defendant also invites me view the deliberate self-infliction of harm as breaking the chain of causation (*AMP* v *RTA and another* [2001] NSWCA 186). This submission is fraught with difficulty. I would have to be satisfied that Mrs Greenwood deliberately intended to kill herself on the night of her death. I am of the view that it would be inappropriate to make

that finding based on the evidence available in this case and the open verdict entered at the Inquest. It also, in my view, is an attempt to try and introduce the argument of novus actus interveniens by the back door.

Findings on Issue 3

208. I have already indicated above that the Claimant fails to establish that any breach of duty caused the death of Mrs Greenwood. Mrs Greenwood's last attendance at the GP practice was on 20th November 2014, thereafter it is simply not known whether she followed withdrawal plan or not initially. What is known is that at the time she died she had not taken Trazodone and by the time of her death she was not following the withdrawal plan.

209. I am of the view that in order for the Claimant to succeed in establishing causation there must be a chain linking the examination on 20th November 2014 to the death of Mrs Greenwood. If I had been satisfied that there had been a breach of duty, the breach would have resulted in the decision to reduce Mrs Greenwood's medication. It has to then be shown that it was the reduction in medication that led to Mrs Greenwood subsequently choosing to stop taking it, and that as a result of stopping the medication that the events on 23rd December 2014 took place. I am not satisfied that the evidence is sufficient to be able to find that.

210. There was no report of any difficulty to any medical practitioner until 10th December 2014. This is approximately three weeks after the examination. The Claimant is not able to assist with what was really happening with Mrs Greenwood at that stage. He is not able to say if Mrs Greenwood was taking her medication, or not, or if she had recommenced using Zopiclone. He was not aware that she had started purchasing it again, and I have not been provided with any documentary evidence of the purchases to assist me as to when this might have taken place.

211. There was also no suggestion that Mrs Greenwood was going to do what she did on the evening of her death. It was a significant departure from the usual pattern of her condition. The "normal" pattern at a time of relapse was a significant increase in sleeping difficulties with anxiety leading to a more severe depressive state. Mrs Greenwood would take herself to her attic room and distance herself from the Claimant whilst she was coping. I accept that there were occasions where her symptoms increased to the extent that she attended hospital, but they were not a common part of the condition and, in any event, when she did attend she was not noted to be suicidal.

212. The Claimant has explained that in the period following 10th December 2014 Mrs Greenwood was enjoying a very good period. He explained how excited she was at her new job, how they had enjoyed socialising and how positive things were. I have to bear in mind that on the one hand the Claimant knew Mrs Greenwood and had lived with her condition, but on the other was unaware of a significant number of other matters. Those matters included the death of a former boyfriend at the point where she committed suicide, the texts on the anniversary of his death and the text to his mother,

the purchasing of the Zopiclone and the internet searches. I also have to bear in mind that there was an argument too in the immediate period before she left the house, though that is merely an additional factor to weigh up along with the others.

213. Even if there were a breach by the First Defendant in failing to advise Mrs Greenwood to continue her medication, and of the risks of stopping the medication, I cannot be satisfied that caused Mrs Greenwood's death. Mrs Greenwood was, I find, aware of the effects of her medication in any event having been informed of it when treated at The Priory and the risks of stopping her medication. She was also independent and willing to take unilateral decisions in any event. In addition, if I am wrong, and there was a failure to advise Mrs Greenwood appropriately in respect of safety netting, I am not satisfied that has any impact on causation. Mrs Greenwood was aware of the options that she had if she needed them, as was the Claimant. That was evidenced by the contact that was made on 10th December 2014 by the Claimant to the Practice.

214. Applying the matters above I am not satisfied that the Claimant established that the consultation on 20th November 2014 caused Mrs Greenwood's death applying the but for test. I am also not satisfied that it materially contributed either. I am of the view that the Claimant would have to provide more evidence to show what took place between the date of the examination and the date of Mrs Greenwood's death. Firstly, I am not satisfied that the examination and the decisions taken at it more than minimally or trivially contributed to the events that followed. I simply do not have sufficient evidence to begin to consider that and I am of the view that this is not a case on a par with *McGhee* v *National Coal Board*. In that case common sense dictated that a person caked in dust was more likely to develop dermatitis, and if the employer had been negligent in exposing a person to that risk then despite it not being known how the dermatitis developed the increased risk was enough to establish causation. Here it is not possible to say that is the case. There were a number of matters that were at play at the point Mrs Greenwood decided to leave her home on the evening she died. I cannot be satisfied that the examination on 20th November 2014 caused or materially contributed to them.

Issue 4 – Damages

215. The final matter which I consider is the amount of damages that ought to be awarded in this case. Mr Butler for the Defendant did not contest the claim for pain, suffering and loss of amenity advanced by the Claimant in the sum of £5000. Nor were the sums in respect of the bereavement award or funeral expenses contested.

216. The contested heads of loss were therefore:

a) The claim for the loss of intangible benefits in the sum of £5000.
b) Financial Dependency in the sum of £289,274.96, and
c) Loss of Dependency on services in the sum of £104,132.94.

The Evidence

217. The evidence on this issue comes from the Claimant, and in particular his second statement dated 10th October 2019 at **p.924**, the statement of Nigel Burke (**p.934**), the statement of Katharine Tynan (**p.940**) and the statement of Lesley Frearson (**p.946**). The contents of the second lever arch file of the trial bundle is exclusively for quantum.

218. The claim for dependency is put on the basis that Mrs Greenwood would have returned to full time teaching in September 2018 earnings circa £40,000 gross, having worked as a teaching assistant up until that point. The Claimant, at the time of the death of Mrs Greenwood, was a Director of Burwood Supply Services Ltd, this business closed on December 2016. Since that time the Claimant has been living on a widow's pension, income from D. Greenwood Investments and his savings. The Claimant says that he would probably have returned to paid employment earning circa £40,000 gross in December 2016 and would have continued to earn this until retirement. This is the basis of the claim.

219. The evidence of the Claimant in his statement on Mrs Greenwood's ability as a teacher is limited, and largely mirrors the pleading set out above. The majority of his statement focuses on the difficulties that his business suffered. Mr Burke's statement explains that part of the reason for the business failing was due to a tax liability and increased competition. Some of this appeared to be taking place at around the time of the death of Mrs Greenwood. He noted a deterioration in the Claimant's involvement in the business in 2014. Katharine Tynan's evidence supports that of Mr Burke.

220. Lesley Frearson's statement deals with Mrs Greenwood's work. It is vague on dates, but states that when teaching she was meticulous and well organised. It was noted that she would sometimes overreact to criticism. It was accepted that there were times when she struggled to sleep, though this was not discernible in the classroom. She did recall having to take her to A & E in Bolton, which would appear to be in the incident in 2005. Mrs Greenwood became an advanced skills teacher in 2006 and she was seconded to other schools on one day a week. According to the statement she then left this role to become the ICT consultant for Trafford Schools. She was made redundant. At paragraph 13 there is reference to Mrs Greenwood applying for part-time roles. The remainder of the statement deals with her impression of Mrs Greenwood's condition.

221. In cross-examination the Claimant was struggling to recollect the events of the latter part of 2014 and whether he was at work or not. He believes that Mrs Greenwood would have returned to work part time in any event, but that in 2013/14 and 2014/15 she would have been dependent on his income.

222. I also have to bear in mind the evidence that is available from Mrs Greenwood as set out in the medical records and, in particular, from The

Priory. I am of the view that they clearly showed what could be described as a love/hate relationship with teaching. On the one hand she was passionate about wanting to help children to learn, but hated the pressure that came with it. It was the pressure that often led to her suffering from difficulties with sleep and she would end up having to cease work to address those matters.

Findings on Issue 4

223. Having considered the evidence, I am satisfied that on balance of probabilities that if Mrs Greenwood had continued to take her medication then her life would have carried on in much the same way as it had previously. I am satisfied that on the balance of probabilities she would have had periods of stability where she would have regained the confidence to attempt a return to work, and that she would probably have continued to find work, but that within a relatively short period of time, as pressure of work began to take its toll, she would have struggled with her sleep and would have had to stop work.

224. As a result I am not satisfied that she would have returned to full time work, and that on balance of probabilities she would have remained as either a teaching assistant or as a private tutor. These roles would have allowed her to work, but without a significant level of pressure. There would still have been relapses, in my view, probably due to other stressors, and that means that any employment would not be consistent. It is not therefore possible to reach a figure which is likely to reflect an annual income for the Mrs Greenwood.

225. In light of that finding I cannot say that the Claimant would have been dependent on the income of Mrs Greenwood even if he had returned to work as claimed and this head of loss is not proven.

226. The Claimant also makes a claim for the loss of affection, special support services, care and guidance provided by a wife and relies on *Regan* v *Williamson* [1988] 1 WLR 847 in the sum of £5000. This is claimed alongside the claim for loss of dependency on services. The Defendant had agreed the past loss of dependency on services claim in the sum of £13,203.14 and has offered £17,850 for the future claim.

227. The basis of the claim is for 1 hour per day in respect of domestic jobs that Mrs Greenwood would have otherwise done that the Claimant is now required to do. His witness statement on this issue states that Mrs Greenwood did more of the housework, despite there being a cleaner who would come in and help, and they shared the cooking, which the Claimant now does.

228. Having found that the Mrs Greenwood's life would have continued in much the same way as before with periods of stability followed by relapses, and with the Defendant having agreed the past loss, but limiting the future loss on the basis that she would deteriorate I am satisfied that the Claimant

and Mrs Greenwood would have continued to share the tasks. There would have been times when the Claimant would have had to do more when Mrs Greenwood was suffering from a deterioration in her symptoms and a time when she would not. Whilst this risk is acknowledged by the Claimant and a 10% reduction applied, I am of the view that is too low a discount to reflect the risk. I am of the view that there would be periods of time where she was not able to carry out housework and these periods may well be prolonged. Whilst 10% may have been appropriate for the period to trial, doing the best that I can I am of the view that the appropriate discount to apply for the future is 33%, and I would have allowed £67,355.40 under this head of loss. Having made this award I would not make an award for the loss of affection, support, care and guidance. I am of the view that would not be appropriate in this case and having considered the competing case of *Mosson* v *Spousal (London) Ltd* [2015] EWHC 53 (QB) I am satisfied that as there is a quantifiable basis for the claim for loss of services that should stand and that the claim for loss of affection, support and guidance fails.

229. In light of my findings above, had I found in favour of the Claimant I would have awarded:

Head of Loss	**Amount**
General Damages	£ 5,000.00
Interest	£ 250.88
Funeral Expenses	£ 2,690.00
Interest	£ 69.40
Cost of Wake	£ 250.00
Interest	£ 6.45
Bereavement Award	£ 12,980.00
Interest	£ 334.88
Past Loss of Services	£ 13,203.14
Interest	£ 170.32
Future Loss of Services	£ 67,355.40
Total	**£ 102,310.47**

Concluding remarks

230. As I stated at the beginning of this Judgment, the death of Mrs Greenwood was and remains tragic. Nothing that I have said in this Judgment should be in any way construed as suggestive of any negative disposition towards her or the Claimant. I understand completely the Claimant's desire to investigate fully the potential reasons for the events of 23rd December 2014, but it does not follow that blame for those events lies at the door of the Defendants in this case. Accordingly, the claim is dismissed.