Neutral Citation Number: [2019] EWHC 980 (QB)

Case No: HQ17C00300

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/04/2019

Before:

MR JUSTICE MARTIN SPENCER

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Between:

Justyna Zeromska-Smith	**Claimant**
- and -	
United Lincolnshire Hospitals NHS Trust	**Defendant**

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Miss Susan Rodway QC and **Mrs Sarah Fraser Butlin** (instructed by **Shoosmiths LLP**) for the **Claimant**
Mr Charles Feeny (instructed by **Browne Jacobson LLP**) for the **Defendant**

Hearing dates: 22nd, 25th, 26th, 27th and 28th February 1st, 4th, 5th and 8th March

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE MARTIN SPENCER

MR JUSTICE MARTIN SPENCER:

Introduction

1. In this matter, the Claimant seeks damages for psychiatric injury arising out of the stillbirth of her daughter on 27 May 2013. Breach of duty is admitted, as is some damage arising out of the breach of duty. In those circumstances, judgment has been entered for the Claimant and the trial has concerned the extent of the damage caused and the quantification of the claim.

2. The Claimant gave evidence over two days, on Monday 25 February and Tuesday 26 February 2019. I have no doubt that the process of reliving the events surrounding the stillbirth of her child and its consequences, including reading through her witness statement (395 paragraphs long) and then giving evidence, were traumatic for her. The case has also attracted a certain amount of publicity from the press which may have been further unsettling. After she had finished giving evidence, I said to the Claimant that if she wished not to attend the trial further, I would quite understand and she took advantage of that indication (although her husband loyally attended throughout, except for the final day when submissions were delivered). It is always to be regretted when, in a claim for psychiatric damage, the legal proceedings themselves play a part in perpetuating or exacerbating the Claimant's illness and I am aware that there may be an effect on the Claimant's psychiatric wellbeing even from reading this judgment. Whilst that cannot deflect me from adjudicating on the matters in issue fully and candidly, I wish to indicate from the outset that I am sorry if this judgment has such an effect. I am sure however that the cessation of these proceedings in terms of knowing the outcome and no longer having to ruminate about past events for the purposes of her claim will only be beneficial.

History

3. The facts are as follows. The Claimant, who is Polish, was born on 26 September 1980. She is highly educated, having attended university and obtained a Master's degree in Economics. She has what may perhaps be described as an "alpha" personality: thus, she was highly motivated, ambitious, organised, a person who always liked to be in control, a planner who believed that anything that went wrong could be fixed. She is also something of a perfectionist who expects the highest standards of herself, and therefore of others: she is intolerant of the failings of others, particularly professionals whom she expects to act professionally at all times.

4. The Claimant moved to England in July 2004 and soon thereafter met and formed a relationship with Mark Smith who was born on 30 October 1961 and was therefore some 19 years older than her. He was divorced and had 3 children by his previous marriage. They married on 28 July 2007. The Claimant had obtained a job as an Operations manager for a company called Convention Travel, based in Guildford. This involved organising conferences and incentives, and took her all over the world. She was there for about 4 years.

5. The couple always planned to have a family and they moved from London to Lincolnshire in 2009, where they were able to purchase a large, 5-bedroomed house which could accommodate their intended family. In September 2010, the Claimant obtained employment as a Data Assistant at the Federation of Academies. She was

soon promoted to the role of Data Manager at The Priory School, Lincoln, from 6 December 2010, but the job was low-paid, at £16,054 pa, and well below the Claimant's capabilities. One of her colleagues at The Priory School was Lisa Hodgson who was PA to the Head Teacher and Ms Hodgson gave evidence of the Claimant's capabilities and approach to work. She said:

> "Justyna was a key player in developing the effective use of information systems. She was also known as a very logical thinker with excellent organisation skills. Justyna was able to prioritise her work and meet the required deadlines. She was very good with dealing with queries over the phone and email and attended all team meetings. She was an independent worker as well as a good team player. Justyna was a dedicated and hardworking member of the team and had excellent communication skills with all members of the staff. … I knew Justyna was a very ambitious and driven person and it was clear that she had the ability to become even more successful. I don't know what her plans were at the time but it was obvious that Justyna would eventually secure alternative employment where she had the opportunity to progress and better her career. I got the feeling that this was not enough for her she wanted to push herself further."

6. In about October 2012, the Claimant discovered that she was pregnant and her first booking appointment at the hospital was on 24 October 2012. A 12 week scan on 2 November 2012 gave an estimated date of delivery of 15 May 2013. A further scan on 28 December 2012 revealed that the baby was a girl and the Claimant and her husband were overjoyed. They agreed a name for the baby, Megan, decorated and prepared a nursery for the baby and prepared themselves for the baby's birth. In this trial, the Claimant has emphasised the significance to her that the child was a girl. In her statement she said:

> "I had always dreamed of having a daughter and at this scan I realised that my dreams were coming true and that it was really happening- I felt the happiest person in the world at that point."

In her evidence, she expanded on this, explaining the special bond that exists between her mother and herself and her sisters, and how one of her sisters has been like a daughter to her. She said:

> "I wanted to do the same with my daughter as my mum had done to me."

7. The pregnancy proceeded uneventfully and the Claimant reached term (40 weeks' gestation). A membrane sweep was carried out at term on 15 May 2013 and a second membrane sweep was carried out a week later on 22 May 2013, neither of which precipitated labour. The Claimant was therefore admitted to the Defendant's hospital on 26 May 2013 (Term + 10) for induction of labour. At 01:00 in the early hours of 27 May 2013, a CTG trace was started which sadly revealed that there was no heartbeat and in fact the baby had died in utero. The labour had to proceed, it lasted some 18 hours, the baby was delivered by forceps and was stillborn. The Claimant was discharged the following day, 28 May 2013.

8. A number of witnesses have attested to the effect of the stillbirth on the Claimant. In addition to the Claimant herself, I heard from:

- Celina Zubel, the Claimant's older half-sister
- Halina Zeromska, the Claimant's mother
- Malgorzata Kwiatkowska, a friend;
- Mark Smith, the Claimant's husband
- Sabina Zeromska, the Claimant's younger sister
- Judyta Zubel, the Claimant's niece (Celina's daughter).

9. Celina Zubel, the Claimant's older half-sister, described Justyna as always being the leader and organiser in every situation. She described how Justyna liked to take control of a situation and had excellent organisational skills so that whenever they visited her in England, she always organised the family trips, putting together an itinerary. She said:

> "Justyna's house would be full of family and friends and there was a lot of fun in the house. If the music was on Justyna would be the first one to get up and start dancing. The house was full of smiles and laughter."

She described her sister as an aspirational and independent woman who was lively, outspoken and energetic. She was also very social enjoying being out with family and friends and colleagues. She said that the effect of the stillbirth has been devastating for the Claimant. She said:

> "Justyna has stopped smiling and laughing, she is a completely different person now. She has isolated herself and won't let anyone in. She doesn't look after herself anymore and has stopped doing all the things which she used to love and enjoy. … Nothing brings her joy, she has become very closed, wooden and vacant."

She describes the change in the Claimant's personality: she says that the Claimant now loses her temper very quickly and has a short fuse, whereas before she was always calm and collected. If the Claimant hears something she doesn't agree with, or if a particular job around the house is not completed fast enough, she loses her temper and ends up shouting. She describes the Claimant as being low in mood most of the time, lethargic and depressed. She no longer goes out of the house much but just wants to stay indoors all the time. In Celina's words:

> "She has become a paranoid prisoner in her own house."

She also describes Justyna now as being very forgetful and having poor concentration. She has also experienced Justyna expressing suicidal thoughts. She says that the relationship between Justyna and Mark has also been badly affected. I shall return to this when I consider the evidence of Mark Smith. Celina concludes her statement as follows:

> "59. Justyna is the way she is now because Megan was taken away from her. Had Megan not died, nothing would have changed in Justyna's life. Had Megan lived, there would have been no strain on the relationship with Mark, she would have developed her career and she would have gone on to have a successful family of her own.
>
> 60. All I can see at the moment for Justyna is black and darkness. Justyna has received a lot of emotional support and physical help, but it hasn't made a difference. Although Justyna is still living her life, rather than moving forwards she's going backwards. I've run out of ideas on how to help Justyna move forward with her life, I've tried everything and nothing seems to have worked."

10. Halina Zeromska confirms Celina's evidence, from her perspective as the Claimant's mother. She describes Justyna as now being very aggressive, nervous and on edge all the time. Using the Polish expression "It is as if she is sitting on hot coal". She now finds it difficult to connect with her daughter. She says:

> "Her personality has completely changed. I can't sit down and have a normal conversation with her without it leading to an argument. I can't find a way to re-connect with her. She is disinterested in everything and I am concerned she is getting worse."

She has also heard her daughter express suicidal thoughts and she confirms the negative effect of the stillbirth on the marriage of Justyna and Mark.

11. Malgorzata Kwiatkowska, the Claimant's close friend since they met in October 1999 whilst at university in Poland, describes the Claimant as "changing overnight from a very loud, bubbly and confident person to a person I didn't recognise anymore." She too describes the change in the Claimant in relation to her marriage, her family and her friends.

12. Sabina Zeromska is the younger sister whom the Claimant almost treated as a daughter when they were growing up and who was obviously very close to the Claimant. Sabina lives in West Sussex and would see Justyna as often as distance and other commitments would allow. She described Justyna as having become more temperamental, moody and irritable. She said:

> "Justyna now has a very short temper and gets herself wound up and upset over the smallest things. She can't find a happy moment to smile for."

She also described Justyna having expressed suicidal ideation.

13. Judyta Zubel, the Claimant's niece, said that she came to stay with the Claimant and Mark for six weeks in July/August 2013, although this is difficult to reconcile with a GP note that the Claimant went to Poland for 2 weeks from 24 July 2013. She describes how the Claimant was behaving "like an old person, frail, weak and lifeless." The house

was a mess and Justyna was not taking care of herself so that Judyta virtually had to take over including helping Justyna with her personal care.

Counselling in 2013/2014

14. On 2 October 2013, the Claimant commenced some counselling arranged through her employer with an organisation called Baywood Therapy and carried out by Wanita Jackson. The notes of the first session on 2 October 2013 simply state:

> "Justyna is totally devastated baby died during giving birth".

It would appear that the counsellor, Miss Jackson, was deeply moved by the Claimant's account of the stillbirth and its effect and, at one point, was herself weeping. This did not impress the Claimant. In her statement she says:

> "292 … during the first session, I told the counsellor what had happened and she started crying which I thought was unprofessional. I then lost confidence in her and found the session to be of little benefit."

The Claimant then makes no further reference to the counselling from Miss Jackson. The Claimant was equally dismissive of the counselling when she saw Dr Baggaley on 18 July 2015. In his report he simply records:

> "Mrs Smith said that she had some private counselling and that the counsellor had cried which Mrs Smith thought had been unprofessional."

Equally, when the Claimant saw Dr Jackson on 5 September 2017, he recorded:

> "She told me she was referred for counselling. She said she had indeed had some counselling early on after she lost her daughter but found it very unhelpful."

15. In my judgment, the Claimant has not accurately recounted the effects of the counselling from Miss Jackson either in her witness statement or in her evidence or in what she told the two expert psychiatrists. The records paint a different picture. What the records show is that, after that first session on 2 October 2013, there were 11 further sessions with Miss Jackson. Furthermore, the notes of those sessions show a measure of progress. On 15 November Miss Jackson recorded that Justyna and Mark were trying for another baby. On 13 December 2013 Miss Jackson recorded:

> "… Did mindful meditation with her she enjoyed it thoroughly she's had good news but is showing signs of depression, tired all the time and sleeping for hours every day."

On 24 January 2014 Miss Jackson recorded:

> "Justyna met with a work colleague (Tina), Mark and I are going away for the weekend to London. Better week than last week. Looking for another job, not being paid what I'm worth, I've

> done my homework and found evidence other like for like jobs are being paid much more."

On 30 January 2014 Miss Jackson recorded:

> "Justyna, mixed week, good weekend until I got my period, I kept thinking if it was an implantation bleed. I dreamt of my grandfather, who is dead, he told me don't worry Megan is with grandma. We spoke about head and heart conflict in a Gestalt theoretical way."

On 7 February 2014 Miss Jackson recorded:

> "Justyna got her new job, had second interview and handed in her notice today. It's going to be the start of a brand new focus start from 10 March. Mark working at the Swanholme, last session will be before 7 March 2014 then she leaves the company for new beginnings."

16. On 28 February 2014 Miss Jackson recorded that Justyna was doing much better and this was the penultimate session. In relation to the final session, undated but presumably on or about 7 March 2014, Miss Jackson recorded:

> "Justyna coping and happier with new focus."

17. Not only do the notes show some progress and improvement in the Claimant's condition with positive signs such as the fact she and her husband were trying for another baby and the Claimant's determination to find a new job which paid her what she was worth, but also it seems to me that, if the Claimant had really been as dismissive of Miss Jackson because Miss Jackson wept at the first session and had found the sessions as unhelpful as she asserts, she would not have gone back a further 11 times. The Claimant in her evidence has focused simply on the very first session and has asserted that, because of what happened then, the whole counselling was unhelpful, thereby ignoring the following 11 sessions and the apparent progress represented by the notes of those sessions.

History continued

18. So far as the GP notes are concerned, the Claimant saw Dr Tadakamalla on 8 October 2013 who recorded:

> "Stillborn baby in May 2013 very upset, devastating and traumatic experience says she has lost trust with the hospital docs. Never had problems during the pregnancy, was overdue induced and ended with stillbirth. Post-mortem done and cause was unknown so obviously very upset with what she has gone through and what she is going through. Because of all this not able to sleep and appetite decreased. Worried if she could ever conceive … very upset during the consultation."

The GP diagnosed grief reaction, there was discussion about the bereavement counselling, that the Claimant's husband was very supportive and the Claimant was denying any harmful suicidal thoughts. She was prescribed a sleeping tablet, Zopiclone.

19. The following day, 9 October 2013, the Claimant returned to the GP surgery and saw her regular GP, Dr Susie Gough, who recorded:

> "History: mood very low, sad, isn't a day or moment when doesn't think about stillbirth, worse after seeing consultant. Now feels let down by hospital, not monitored after contractions so could have been prevented. Very tearful; not been like this before, discussed counselling not keen. Saw gynaecologist in Poland, had period 1st August given progesterone to take …took progesterone to get pregnant last time."

20. The Claimant saw Dr Gough again on 11 October 2013 and was prescribed an antidepressant, Citalopram. The Claimant and her husband went on holiday to Turkey together with Mark's children from his previous marriage which the Claimant described to Dr Gough in a later appointment as "Not easy". Upon their return the Claimant went back to work on 28 October 2013 and saw Dr Gough on 30 October 2013 who recorded:

> "Didn't get on with tablets, felt nauseated, stopped last week, back at work, thinks needs counselling, gave leaflet for Lincoln Centre for Counselling as may be quicker than Archway, can use counsellor through work, City School"

I interpret this note as confirming that, as at 30 October 2013, the Claimant was looking for counselling from someone other than Miss Jackson (having only had two sessions with Miss Jackson at that stage) but recognised her need for counselling and given the difficulties/delay in alternative counselling being organised through the GP, decided to continue with the counselling arranged by her employer.

21. In relation to the Claimant's return to work, this was commented upon by Lisa Hodgson who stated:

> "When Justyna returned to work, I noticed that she had become a different person. She was very quiet and didn't want to talk to anyone at work about what had happened. She looked subdued and sad. She had her head down most of the time and left work as soon as it was time to go home. It was clear that Justyna just wanted to be left alone. She wasn't the same Justyna that I knew before she went on maternity leave. I felt like I didn't know her anymore."

Miss Hodgson was informed by the Claimant that she was leaving her job for two reasons:

> "The main reason was because she wanted a fresh start and wanted to be away from all those who knew what had happened to her daughter. Justyna felt like people were talking about her

> and she didn't want people to pity her, she wanted to have a fresh start. The other reason why Justyna left was because she wanted a different job with better career prospects so that she could progress her career."

Interestingly, Miss Hodgson does not mention the reason which the Claimant is recorded as having given to Wanita Jackson, namely that she felt that she was not being paid what she was worth and that other like for like jobs were being paid much more.

22. During November 2013, the Claimant was demonstrating symptoms of thyroiditis and on 11 November 2013 she told her GP, Dr Gough, that she had seen a specialist in respect of thyroid problems and goitre when aged 14. Although the Claimant was referred to a specialist, it would appear that she short-circuited this by seeking an appointment in Poland on a visit there in December 2013. A GP entry for 10 December 2013 reads:

> "Had a private scan in Poland on Friday, showed thyroiditis. Was given PTU [Propylthiouracil]."

The GP explained to the Claimant that in fact her TFTs (Thyroid Function Tests) were now normal so that she should stop taking the PTU.

23. As stated, the Claimant changed jobs in March 2014 starting employment as a Senior Administrator at the Lincolnshire Teaching and Learning Centre on 10 March 2014 earning £21,774 per annum. Although the Claimant saw her General Practitioner on many occasions during 2014, this was almost exclusively in relation to her attempts to become pregnant with titration of the prescription of progesterone. There was no mention of any mental health problems at all. The fact that the Claimant

- had stopped counselling (upon the recorded basis that she was doing much better, was coping and was happier with her new focus with her new job),
- had started a new job,
- was seeking to get pregnant,
- was not consulting her GP for mental health problems and
- was not taking any medication

would all point, objectively, to the Claimant making good progress in recovering from the grief she was suffering from the death of her baby.

24. It is the Claimant's case that, in fact, there was no improvement at all during 2014 and that her grief continued unabated and undiminished. In that regard, she has the supporting evidence of her family, husband and friends. How is this to be reconciled with the more objective evidence to which I have referred? The answer is, it seems to me, that firstly, there is no question but that the Claimant remained grief-stricken by the loss of her baby. Normal grief can, I am told, easily last a year, until the first anniversary of the death has passed and sometimes significantly longer. I have no doubt

that the Claimant remained a changed woman in that she did not return to the happy, outgoing, gregarious person she had been before. However, recovery from grief, although it may be slow and sometimes imperceptible on a week by week basis, nevertheless occurs in the normal course of events and the lack of treatment and the lack of need for antidepressant medication together with the signs that the Claimant was coping by getting a new job (which she was able to perform successfully) shows me that, as suggested by Dr Jackson, this was not a period of overt psychiatric illness as opposed to a period of normal, albeit deep, grief. Nevertheless, I also find that there was a strong element of avoidance in this period. As the Claimant told me, one way she used of coping with her grief was to concentrate upon getting pregnant again and, in her mind, replacing Megan with another girl. By applying her mind to things which she could control and which were within her capabilities, she was able to avoid that which she was unable to control and which was outside her "comfort zone", namely her sense of grief and loss arising from the baby's death. This was at least in part a consequence of the Claimant's personality as I have described (see paragraph 3 above) and it may well be that her avoidance behaviour prevented her from pursuing a more normal grief trajectory (if that is what it can be called).

25. When, during 2014, the Claimant failed to get pregnant again, she discussed with her GP the possibility of IVF treatment but was told that this would not be available on the NHS because Mark Smith had children in a previous relationship. However, the Claimant fell pregnant naturally over Christmas 2014 with an estimated date of delivery of 12 September 2015. Her GP, Dr Gough, recorded on 8 January 2015 that the Claimant wanted to be referred to the Queen's Medical Centre, Nottingham and wanted an elective caesarean section this time round. This was indeed agreed to: I have no doubt that, the Claimant having lost her first baby as a result (I assume) of going beyond term with consequential placental insufficiency, the hospital was amenable to a caesarean section at 38 weeks to avoid the risk of this happening again, and this is confirmed by Dr Davidson's letter to the GP: see paragraph 27 below. It seems to me unlikely that the hospital would have agreed to an elective section in the absence of the obstetric history surrounding Megan's death. It may well be though that, but for the negligence, Megan would have been delivered by caesarean section, as would any subsequent children, see paragraph 109 below.

26. Clearly, the Claimant (and her husband) were elated at the news of the pregnancy. On 1 April 2015 the Claimant attended the surgery and was seen by a nurse, Sharon Hannam who recorded that the Claimant had been seen at home on 30 March 2015 following a vaginal bleed and a request to listen to the fetal heart. Nurse Hannam recorded:

> "Justyna going on holiday today and eager to know if everything was ok prior to going … FHHR (Fetal heart heard regular) with Doppler, 150 bpm (beats per minute), maternal pulse 80 bpm. Reassurance given …"

The heart rate of 150 bpm for the foetus was wholly normal.

27. On 23 April 2015, the Claimant attended City Hospital, Nottingham, for an ultrasound scan at 19 weeks 5 days gestation and she was seen by Dr N Davidson on behalf of Dr Judith Moore, the Consultant. A detailed fetal abnormality scan was carried out which showed no obvious fetal abnormality and was normal. The Claimant and her husband

were also informed that the baby was a boy. In his evidence, Mark Smith said that this was when the Claimant "started to crumble". He said:

> "When she found out it was a boy was when she started to crumble. She was in tears when told it was a boy at the scan."

I have no doubt that the Claimant was disappointed to find out that the baby was a boy, but the contemporaneous evidence does not support the suggestion that she suffered a serious reactive depression at that stage. I do bear in mind, though, that Dr Baggaley diagnosed depression when he saw her on 18 July 2015 (see paragraph 29 below). Dr Davidson wrote to the GP as follows:

> "[Justyna] is obviously therefore very worried about experiencing labour and we have agreed that her mode of delivery this time around should be a caesarean section. We have arranged for this to take place on 1 September 2015 all being well with the pregnancy …"

28. The Claimant saw the practice nurse, Sharon Hannam, at the GP surgery in June 2015 who recorded that she was "very anxious and appears very low" and Mrs Hannam discussed counselling but the Claimant said that she had already had counselling and it didn't help.

29. On 18 July 2015, the Claimant saw Dr Martin Baggaley, the Claimant's psychiatric expert for a medico-legal report. Dr Baggaley reported that the Claimant was due to have another baby on 1st September and "She said that she feels upset because she is having a boy this time and she worries that she will never get her daughter back." Dr Baggaley stated that, upon examination of the Claimant's mental state, she was "objectively and subjectively depressed. Her thought content was preoccupied with her loss." Dr Baggaley stated the following diagnosis in his "Opinion" section:

> "Mrs Smith describes intrusive memories, avoidance of reminders and low mood since the death of her daughter. These symptoms could be related to normal grief or pathological/abnormal grief. The death of a child is known to be an especially difficult loss to come to terms with and is therefore often associated with more prolonged periods of grief. There is no specific cut-off between normal and abnormal grief but it is accepted that grief which is not resolving after 18 months would be considered pathological. Mrs Smith has made some progress in coming to terms with her loss but still has significant symptoms of grief. I would be of the opinion that given it is now over 24 months after her daughter's death, I would consider her to be suffering from 'pathological grief'. Pathological or complicated grief is a well-recognised clinical entity and is a familiar term in a legal context. Unfortunately although a well-recognised entity, pathological or complicated grief is not found as a separate entity in either the International Classification of Diseases version 10 or the Diagnostic and Statistical Manual of the American Psychiatric Association 5. In my opinion the pathological grief would be best classified as a major depressive disorder, current episode moderate, 296.2 in

> DSM-5 or a moderate depressive episode, category F32.1 in ICD–10."

Dr Baggaley considered that the pathological grief/depression was caused by the stillbirth of her daughter and the belief that it had been caused by clinical negligence. He recommended a course of cognitive behavioural therapy and was guarded about the prognosis stating a preference to re-examine the Claimant after she had had the baby and completed a course of CBT. In relation to occupational issues Dr Baggaley said:

> "Mrs Smith is fit to work subject to some reduction in effectiveness due to her symptoms of depression."

30. In the context of the Claimant's fitness to work, it is of significance that, on 31 May 2015, she had applied for the role of Business Manager at Lincolnshire Teaching and Learning Centre, stating in her application form:

> "As part of my duties I have been line managing admin. support staff across sites including their performance management. Due to the very busy nature of the post I'm constantly working to tight deadlines and at most times this means working under pressure. I need to prioritise tasks effectively, coping with conflicting demands of a diverse team. This requires me to work flexibly and meet the timescales set. To do this I need to take ownership of the tasks and ensure effective planning to complete on time. I am constantly adapting to new procedures as my role is constantly developing and changing, therefore the list of duties evolves over time. I'm a highly motivated individual who enjoys the challenge of change. I feel the range of experience that I have meets the competencies required for the post and I hope that I proved within the last 15 months that I am dedicated, hard-working professional and committed team member."

It is the Defendant's case that if what the Claimant was asserting in that job application form was true, it would be inconsistent with her suffering from significant depression as, had that been the case, she could not have functioned and performed so effectively in her job so as to be in a position to apply for this promotion. On 9 July 2015 the Claimant was appointed to the post of Business Manager (Level 2) on a salary of £32,025 per annum. In support of the job application, the Claimant obtained a reference from Mr David Thompson to whom the Claimant had been a personal assistant. He wrote in that reference dated 10 July 2015:

> "She was appointed as PA to the Head Teacher and conducted her duties with professionalism and skill. Her personal relationships are very solid at all levels and she uses her people skills to benefit the organisation. At a time of increasing pressure on the Centre Justyna remained calm and efficient and provided significant additional hours to support me. She was efficient and effective in all her dealings and had an excellent way of communicating with colleagues."

Zackary's birth

31. On 1 September 2015, the Claimant gave birth to her son, Zackary, by elective caesarean section and went on maternity leave. However, in about December 2015, she suffered a severe deterioration in her mental health. In his report, Dr Jackson, the Defendant's psychiatric expert, considered that the Claimant had suffered a substantial postnatal depression some five or six months after Zackary was born but he accepts that it could have been a bit earlier than this given that the Claimant states that she had clear suicidal thoughts in December 2015 when she had thoughts not only of ending her own life but that of Zackary too. She said:

> "I had visions of us standing on the train tracks waiting for the train."

The first time that she actively contemplated suicide seems to have been in February 2016 when she was prevented by her husband from following through with her intention. Her account is confirmed by Mark Smith who states:

> "After [Zackary] was born she went through an extremely difficult period culminating in her wanting to kill herself and Zackary. Justyna first started to feel suicidal in around December 2015. However, in February 2016, Justyna felt that there was no point in going on and decided to not only end her life but also Zackary's. This was a very dark period for her. Fortunately I was around at the time to intervene and I stopped her driving away with Zackary."

32. In his report of September 2017, Dr Jackson says:

> "Mrs Zeromska-Smith apparently developed, some five or six months after her son was born, what appears to have been a substantial postnatal depression. She developed classical depressive symptoms and in that depression found herself thinking a great deal about her daughter's death."

In that report, Dr Jackson expressed the opinion that, this being a classic postnatal depression, the Claimant's rumination about the death of her daughter did not cause or contribute to that depression. However, having heard the Claimant and other witnesses give evidence, Dr Jackson modified that view and conceded that the Claimant's pathological grief reaction arising out the stillbirth was causative of the depression suffered in 2016 in that it was at least a material contributor towards that depression.

33. Dr Baggaley saw the Claimant again on 22 April 2016. There had not, by that time, been the course of CBT which he had recommended and envisaged in his report the previous summer. He described the Claimant as being objectively and subjectively more depressed than she had been before with thought content that was pessimistic and hopeless, and she was expressing clear suicidal ideation, including taking Zackary with her. He stated:

> "She is not taking any antidepressant treatment or had any cognitive-behavioural therapy. I am of the opinion that Mrs

> Smith requires an urgent referral to the local community mental health team and I have written to her GP, Dr Smith, at the Birchwood Health Centre asking him to do this. I consider she needs to be prescribed antidepressant medication and receive considerable psychiatric support. She would benefit from a course of cognitive-behavioural therapy. I am pessimistic about the prognosis and there is a considerable risk of the marriage breaking up. There is a definite risk of suicide."

Dr Baggaley wrote to Dr Smith on 4 May 2016 and the Claimant was seen by her regular GP, Dr Susie Gough, on 6 May 2016 who recorded in the notes:

> "Has a new baby 8m old, focused on this but now realises never recovered from stillbirth, … not the person she was, feeling hopeless, suicidal thoughts, sees herself standing on level crossing in Skellingthorpe Road, affected marriage, … still breastfeeding a lot …"

Dr Gough recorded that the Claimant was going to Poland the following week. She saw the Claimant again on 25 May 2016 when she recorded:

> "Back from Poland, good trip, kept busy – walking, seeing family, still a distance, told family about mood issues, not managed to wean, as sister lived in flat and didn't want baby to cry, now 8m, thinks break has helped relationship, husband has missed them."

Dr Gough did not think that the Claimant was now suicidal but planned to refer the Claimant to an organisation called "Steps2Change Lincoln" at the Archway Centre, a provider of psychological therapies on behalf of Lincolnshire Partnership NHS Foundation Trust.

34. The Claimant was contacted by Dr Rebecca Dickinson, a perinatal consultant psychiatrist who carried out an initial telephone assessment on 1 June 2016. Dr Dickinson wrote:

> "Justyna reports that her mood has been low since her stillbirth of three years ago, which she is struggling to come to terms with and is taking legal action against the obstetric team because she believes it to be a result of human error. She has not had any input from SANDs [a stillbirth and neonatal death charity] because she did not think that anyone would be able to help her. She describes flashbacks and nightmares to the delivery. These are triggered by seeing a family of four and seeing certain toys etc. She is fearful that something will happen to Zackary, which results in her being afraid of leaving him and checking on him in the night. She is due to return to work in September as a Business Manager at a school but dreads leaving Zackary as she is unable to trust anyone to look after him."

Dr Dickinson noted that the Claimant had been prescribed an antidepressant, Sertraline (although the Claimant had not yet taken it as she was still breastfeeding Zackary) and arranged for a perinatal community mental health nurse, Ruth Hollingsworth, to make contact with the Claimant for further assessment. Dr Dickinson's initial impression from telephone triage was that the Claimant had developed post-traumatic stress disorder with a secondary depressive illness. However, it should be stated that the expert psychiatrists in this case did not agree with this diagnosis.

35. The Claimant continued to suffer from her depressive illness for the rest of 2016 and remained under the care of Dr Dickinson. She was unable to return to work because of her anxiety at being separated from Zackary and she was signed off sick by her GP. Miss Hollingsworth referred the Claimant to Steps2Change for an assessment but was unsure whether the Claimant would like to engage with bereavement support. The Claimant saw Dr Dickinson and Miss Hollingsworth together on 5 September 2016 when she was described as "tearful with regards to her situation with work" and Dr Dickinson found on-going depression albeit there had been some improvement. The Claimant was no longer suicidal, there were no psychotic symptoms and she had good insight into her situation. As the Claimant's baby was now over a year old, it was no longer appropriate for Dr Dickinson, a perinatal psychiatrist, to remain involved and on 11 October 2016 she referred the Claimant to Dr F Senthil, a consultant in general adult psychiatry. Dr Dickinson did however remain involved in the Claimant's case in the meantime, particularly in relation to the Claimant's medication.

36. On 27 October 2016, the Claimant had a telephone assessment with a psychological wellbeing practitioner at Steps2Change which lasted some 45 minutes and she was placed on a waiting list for a treatment plan involving counselling. The first appointment was on December 2016. The Claimant says:

> "Unfortunately I was unable to attend this appointment. Miss Karen Owen (counsellor) telephoned me on the same day and I explained that the reason why I couldn't attend was because I couldn't take Zackary with me to the appointment and I wasn't prepared to leave him with anyone else. I also explained that I was still unable to talk about what happened to Megan as I found it too traumatic to deal with. For this reason I was discharged from their care."

37. It appears that the Claimant's acute depressive illness abated in 2017. She remained on antidepressant medication, she continued to have low mood and anxiety but was no longer suicidal. Dr Senthil saw her on 30 January 2017 and discussed CBT and bereavement counselling. He arranged to see her again in three months' time.

38. On 11 July 2017 the Claimant was dismissed from her employment on the grounds of incapacity, namely her unfitness to work on grounds of ill health consequent upon psychiatric illness.

39. In August 2017, the Claimant was referred through her solicitor to Dr Trevor Friedman, a consultant psychiatrist at the Spire Hospital Leicester. He saw her on 29 August 2017 and decided to refer her to Dr Loumidis, a clinical psychologist, for a course of cognitive behavioural therapy concentrating on the coping strategies then adopted by

the Claimant with a view to normalising these and helping the Claimant overcome her anxieties so as to be able to function at a normal level.

40. Between 12 September 2017 and 21 November 2017 Dr Loumidis saw the Claimant on six occasions but it became obvious to him that the Claimant was not responding well to the psychological therapy. She told him that she did not feel that the therapy was helping, that she was finding it quite upsetting and that she was finding it difficult to implement the techniques that they discussed. Then, when Dr Loumidis saw the Claimant on 21 November, she revealed that she was 14 weeks pregnant. Dr Loumidis wrote:

> "This has resurfaced anxieties and worries about the possibility that a new baby may be a girl, she told me that she feels petrified about things going wrong and her pre-treatment psychometric tests for low mood … anxiety/worry … and post-traumatic stress had in fact increased. … In session we discussed the paradoxical effects of intentional hopelessness as a defence for imaginary future disaster coping in order to challenge the belief 'I always make myself low so that if I fall, I will not come down from too much height'."

Dr Loumidis reported to Dr Friedman that he suspected it was the supportive rather than the cognitive behavioural aspects of therapy which the Claimant was looking for and that she had not yet found it possible to put in practice the CBT techniques which require cognitive disputation as well as exposure with response prevention.

41. Dr Friedman saw the Claimant for the last time on 16 January 2018. By this time the Claimant had discovered the new baby was again a boy rather than a girl. The sessions with Dr Loumidis had not really changed the Claimant's behaviour and in particular her constant checking on Zackary. Dr Friedman told her straightforwardly that at some point she was going to have to separate herself from her son and suggested that he might explain to the psychiatric nurse who was to see her at home how they might go about trying to treat her. He told her that "In the end it is going to be her decision as to whether she can force herself to face some of her anxieties."

42. The baby, Tristan, was born on 8 May 2018 by which time the parties were moving towards trial with full preparation of expert reports including from occupational therapists in relation to rehabilitation.

The Claimant's evidence

43. The Claimant's evidence was principally given through an extremely long witness statement some 68 pages in length comprising 395 paragraphs. From paragraph 192 she describes the effect of the stillbirth on her life stating:

> "197. I am now a shadow of a person I used to be. I have lost all my confidence, motivation, self-worth and the joy of life I had. I can't focus on things, I don't remember simple things like dates of appointments etc I feel isolated, lonely and hopeless."

She describes her constant rumination upon Megan and the child Megan would have been, asserting "There isn't a single day that goes by when I do not think of Megan." She acknowledges the suicidal thoughts which began in December 2015 and became active in February 2016. She also describes how, before she became pregnant with Zackary, she had been drinking considerable amounts of alcohol.

44. The Claimant describes her employment history and how she had planned to get a childminder to take care of Zackary when she returned to work in September 2015 but how she had been unable to cope with her separation from Zackary. She was signed off from 4 September 2016 for an initial period of 2 months, which was extended until she was eventually dismissed from her employment in July 2017 and she has not worked since.

45. The Claimant described how her life now totally revolves around Zackary. This was, however, in a statement made in March 2018, before Tristan was born and it was somewhat surprising that, although there was a supplementary statement from the Claimant dealing with the psychiatric evidence and the question of alcohol, there was no updating statement dealing with the birth of Tristan and the change to her life which this had entailed. It seems clear that the focus of the Claimant's attention has now shifted to a certain extent to the baby, of necessity, but the Claimant retains her anxiety at being separated now from both children. When she gave evidence, the children were in a conference room opposite the court and the Claimant had a monitor in the witness box which she used to observe her children whilst giving evidence. It was only this way that she could separate from them in order to come into court and give evidence. In her statement the Claimant describes how, on some days, she is unable to get out of bed but feels exhausted, depressed and unable to face the day. An au pair, Jessica Batalla (who also gave evidence) started working for them in August 2017. The Claimant describes how, on her bad days, either her husband or the au pair look after Zackary in the house. She says:

> "I probably stay in bed for a large part of the day two or three times a week."

46. From paragraph 272, the Claimant describes her relationship with Mark Smith, her husband. Clearly, their relationship is fragile although they remain together for the time being. The Claimant says in her statement that things became much worse after Zackary was born and from then on "My husband and I became two strangers living together under one roof." She feels not merely irritable but angry towards him. She says:

> "Megan's death has taken a terrible toll on our marriage. We are on the verge of breaking up. Eventually there will come a time when it will all blow up."

When she gave evidence, the Claimant did not seek to resile from this statement. Mark Smith also confirmed that the marriage was on the brink of disintegrating and explained how Tristan was conceived in Poland only after everyone had had rather too much to drink, this being an isolated incidence of intercourse in an otherwise generally celibate marriage.

47. From paragraph 290, the Claimant describes her treatment, such as it has been. I have already described what she said about the counselling in late 2013 early 2014 (see paragraphs 14 to 17 above). The Claimant describes meeting the perinatal community psychiatric nurse, Ruth Hollingsworth, who discussed the possibility of the Claimant being admitted to a mother and baby unit, but the Claimant refused. At paragraph 322 she describes her sessions with Dr Loumidis from September 2017. What the Claimant did not say in her statement but which emerged from her oral evidence was the highly unsatisfactory circumstances of the sessions with Dr Loumidis in that they involved a round trip of three hours with Zackary in the car. The Claimant described in her evidence how, after each session, she would go home and cry all day and night and then find it difficult to get out of bed in the morning. One of the things which Dr Loumidis suggested was that the Claimant try to leave Zackary in the house with Mark and go for a 30 minute walk. She says:

> "I went outside, closed the door and walked a few steps and then panicked and ran back into the house. I just couldn't do it. Simple things like this may be easy for others but for me it was impossible. My biggest fear is to leave Zackary alone, I just can't separate him from me."

48. In her oral evidence, the Claimant said that, after Megan died, she thought she could pretend it hadn't happened and she went back to work to keep herself occupied whilst she focused on getting pregnant again. However, she found it very difficult at work because her colleagues all knew what had happened and there were constant reminders of when she had been happily pregnant with Megan and expecting a favourable outcome. She said this was why she changed jobs. She described herself as a person who liked to be in control and not only was Megan's death outside her control but what made it worse was that she had been let down by professionals not doing their job properly when she was a professional who took great pride in her work. She described herself as a bit of a "control freak": when she did so, she smiled and made good eye contact with me. She explained that she had applied for the new job in May 2015 because she had been covering for the person who did that job in any event and the Head Teacher encouraged her to apply when the post became vacant.

49. Asked about Zackary, she said:

> "Although I love Zac dearly, he is not Megan. I keep thinking he should have a sister. We go to the grave and he sings Twinkle Twinkle by her grave."

She says all her powers are now focussed on the children and trying to avoid breaking down in front of them: she says she puts a front on for their sake.

50. In cross-examination, the Claimant was asked about the counselling in 2013/2014 to which I have referred in paragraph 14 above. It was put to the Claimant that her mental condition had improved over the time of the counselling but the Claimant denied this. She said that the notes of the counselling, where they record in February 2014 she was doing much better, did not properly reflect her feelings at the time. See, however, my findings in paragraph 15 above.

51. The Claimant accepted that, during 2015, the relationship with her husband was good. She said that Zac's birth brought it home to her that she could no longer pretend that Megan's death hadn't happened. She agreed that the deterioration in her marriage coincided with her own general deterioration about three months after Zac was born, that is in about December 2015. Between Zackary's birth and December 2015 the Claimant had in fact been able to complete the first module of an on-line training course for the Business Manager role as part of her personal development plan, which had been paid for by the local authority. The Claimant said that she failed the first time, a module which, before Megan's stillbirth, she could have expected to sail through, and although she passed the second time there were five modules in all so she didn't get very far. In relation to the application for the job as Business Manager, in which she had painted a very positive picture of herself (see paragraph 30 above), the Claimant said that she was "putting a face on it" and these were the statements she needed to make in order to get the job. She said that she put on a façade at work so that no one knew what was going on and it was as if she was living a double life. She didn't seek treatment and she said she felt there was no point in going to the GP: she felt that no one understood how she was feeling and she had given up on getting help because she didn't feel it would get her anywhere.

52. The Claimant was asked about the depression with active suicidal ideation from December 2015 and she said:

> "What I'd been holding back came out overwhelmingly like a domino effect. I couldn't deal with the emotions. I felt disappointed that I had been robbed. He [Zackary] was not Megan. It was a scary feeling, because I couldn't control it. It was the realisation that I'd been fooling myself, that what I wanted was gone forever. I didn't know how to deal with it."

At this stage in her evidence the Claimant became very upset and needed a 10 minute break.

53. The Claimant was cross-examined about an assessment carried out on 16 February 2018 by a Registered Nurse in association with her claim for employment and support allowance. The assessment summary was as follows:

> "She has a mental health problem. Despite this she will care for her son, she will prepare meals and understand dangers in the kitchen, she enjoys spending time with her son during the week. She is also able to drive. If an appointment is running late she will feel anxious but is able to wait, she is able to cope with sudden changes in traffic. She reports she is able to take her son and dog to her local park alone, however she is unable to go somewhere new for an appointment due to her anxiety, this appears consistent with her mental state, and level of input. Although she is not taking any medications this is due to her being pregnant. She is able to talk to her husband and family ok but isn't able to ask for help in a waiting room or talk to others when taking her son to playgroup, this also appears consistent with her mental state and level of input at this time. She denies any violent or aggressive behaviour, she had moderate difficulty

> coping with assessment, she was tense and restless, appearing timid, she had poor eye contact and rapport, speaking very little and quietly. She is managed by specialists and has recently stopped therapy. The overall evidence suggests a significant disability is likely through a combination of going out and coping socially, however unlikely in all other mental health areas."

54. The Claimant was asked about the treatment through Dr Friedman and Dr Loumidis and she described Dr Friedman as "scary and belittling". She said she found it very offensive when Dr Friedman told her she needed to pull herself together and described her as "an intelligent girl". She said that in reality she was struggling: she didn't enjoy the journey each way, especially with a toddler in the car, and the meetings were draining and upsetting.

55. When she resumed her evidence at 2pm on 26 February 2019, the Claimant was asked about Dr Jackson's report of 5 September 2017 and in particular his description of her at section 3.1.1 and she agreed this was accurate. In this passage, Dr Jackson had stated:

> "[The Claimant] told me that she lives in Lincoln with her husband and their son (Zac who is 2 years old). She said she gets up in the morning, gets Zac up and dressed and gives him his breakfast, she takes care of him through the day. She does not work. She takes him out to the park and once a week to a toddlers group. She has help with the housework from an au pair, 30 hours a week. She goes out shopping with her husband. She cooks for her son but her husband does the cooking for her and himself. She does not have much of a social circle locally. She is in contact with one or two other mothers of toddlers. She sees her sister quite frequently Occasionally she goes to see family in Poland and family members come to visit her from Poland.

56. Returning to Dr Friedman, the Claimant agreed that he had told her she needed to modify her behaviour and that this was something she would have to do, it couldn't be done for her.

57. The Claimant was cross-examined about her claim for the cost of home schooling which has been made on the basis of her anxiety and inability to be separated from the children. It was put that Zackary would have to go to school but she denied this explaining how, at home, he would get the same education as at school but she would have the same control. Mr Feeny asked what the Claimant would do if she was advised that it was in Zackary's best interests to go to school and that it was damaging for him to remain at home and she replied:

> "I would have to explore the options".

It was put that at some stage he wouldn't want his mother around all the time and she agreed, expressing the hope that this should be as late as possible. She even suggested this could be as late as when he was 18 years old.

58. It was apparent to me when the Claimant gave evidence on day 2 that she was struggling in a way which was not apparent on day 1. This came out when she said:

> "It has been a horrible experience – I wouldn't wish it on anyone. I wish I wasn't here and I had Megan back. I will be happy when this is over, but it is only something I have had to go through. It has hit hard because it has made me realise it has happened. I'm really struggling today – I just want to go home. I have to do this – there is nothing left."

My impression was that, by this stage, the legal process had exhausted the Claimant and she was close to the end of her tether.

The evidence of Mark Smith

59. Mr Smith affirmed his statements of 23 March 2018 and 12 February 2019. He said that, for him, Justyna started to be ill on the day of Megan's death. He said that she wanted to try and control the situation and to manage it in her own way. He described her coping mechanism as being to deny what had happened and her plan was to exist until she could have another girl and thus "get Megan back". He said that the deterioration in their marriage started with there being what he described as being a rota for sexual intercourse, that it was not loving and he was under pressure to perform. When Justyna did not become pregnant she became angry with him and he became depressed. He said that when she did get pregnant, "The boxes began to open". He said that if it wasn't a girl, the solution (in her mind) would be in tatters. He knew that there would be a price to be paid and that is what happened. He said:

> "When she found out it was a boy was when she started to crumble. She was in tears when told it was boy at the scan. When she had Zac, it was anxiety and tears. Everything she did with Zac was, in her mind, what she should have done with Megan. Then the balloon burst and it was a big bang."

He described how Justyna hates to be out of control and failure is something she finds very difficult to cope with. He said that he felt as if he had lost everything.

60. Mr Smith was asked about the treatment through Dr Friedman with Dr Loumidis. He said that Dr Friedman had explained that there were two approaches: one, having cognitive behavioural therapy; the other, by getting into the detail of what Justyna was feeling and had gone through with the loss of Megan and trying to work through that. Mr Smith said that Dr Friedman recommended the first option, CBT, and therefore referred Justyna to Dr Loumidis. She built up a good rapport with him but she didn't like the process and opening up her heart to him was not something she was good at. Mr Smith described Dr Loumidis as someone she could talk to and cry to. Dr Loumidis queried whether she was making progress but she said she wanted to continue. He said that when they went back to see Dr Friedman on 9 January 2018 he had been very direct with Justyna saying "You are a clever girl" and "Look at your husband, how tired he is". Mr Smith said that he thought Dr Friedman was trying to get Justyna to think things through, but she ended up being offended. He and Justyna looked at what Dr Friedman had said in different ways.

61. Mr Smith confirmed what he had said in his statement about the state of their marriage, although it must be remembered that the statement was made before Tristan's birth. He said that they were now like strangers to each other and Justyna's behaviour has put a

huge strain on their relationship. He described living with Justyna as like "walking on eggshells" whereby she is very unpredictable and will shout at him for the smallest thing. He had had to take on the responsibility of taking care of Justyna, Zackary, their dog and the home and although Justyna would look after Zackary when she could, there were two or three days a week when she was unable even to get out of bed. He said:

> "Our personal and physical relationship no longer exists. We do not even feel like friends anymore. It feels as if we are strangers living in the same house with our son. I desperately long for the life that we used to have and the wonderful loving relationship. I can't seem to get close to Justyna, she is locked in her own world. I can't believe how much this has affected both of us. We are unrecognisable from the people we used to be. Our lives have been destroyed. I feel helpless and worthless. … I don't know if our marriage will survive this tragedy, I'm desperately holding on because we had such a wonderful life and relationship before Megan's death. I'm hoping one day that there will be a miracle and I will get Justyna back but I don't think it will ever happen."

When he gave evidence, Mr Smith confirmed what he had written but said that his responsibilities as a father would always take precedence. He expressed the intention to stay and look after his family as long as it took and he would only leave if there was no flicker of getting the old Justyna back and if everything was settled.

62. In cross-examination, Mr Smith expressed the opinion that although Justyna had gone back to work on 28 October 2013 after Megan's death, she had never in fact been fit for work. He said that she used to put a brave face on it but was struggling and was a completely different person when she came home. However, he understood why she wanted to go back to work and also confirmed that they needed the money.

63. When Mr Smith was asked about 2014, after the counselling with Wanita Jackson had finished, his evidence became a bit vague: he couldn't remember whether he had suggested further treatment and he couldn't remember whether she had had any. He explained that he too had suffered mental anguish, had been signed off work and was on medication. He was asked about her job application in May 2015 and said that Justyna had two separate lives: her work life and her outside life. It was put to Mr Smith that the really black period had started in December 2015 but Mr Smith said that it had been earlier than this, when Zac was born. He said:

> "She was having to deal with the fact that it was a boy, not Megan. Everything related to Megan – she was having to face her loss for the first time, and it destroyed her. The boxes at the back of her head cracked open – she couldn't hide from it anymore."

64. Asked about home schooling Mr Smith fairly acknowledged that, ideally, he would like his children to go to school but observed that, in view of what happened, that might not be possible. He said that he would support Justyna all the way, that she values education and he was sure that they would get a good education even if schooled at home.

65. Mr Smith was asked about Justyna's current condition and he confirmed that she's better on some days than others. Her problem is not physical but mental. Thus, she has the physical capability to do the housework but he said not the mental capacity. He expressed his concern for their relationship and its breakdown saying that they seem to have no time for themselves. He said:

> "There are constant arguments over daily routines – she is anxious and very intolerant all the time."

He said that he was sure that Justyna would get further treatment once the litigation was over. She had been very disappointed that there was no "magic wand" or "silver bullet" to cure her mental illness and the only person she had been able to talk to was Dr Loumidis.

66. In answer to questions from the court, Mr Smith confirmed that he and the Claimant no longer had sexual intercourse and slept in separate bedrooms but he said that he would never give up until he thought there was no more hope. He said that if they did get divorced, he would not take his children away from their mother. He said that he thought Justyna had given up on the idea of a baby to replace Megan in about March 2017.

67. It is appropriate for me to indicate that I was enormously impressed with Mr Smith, as a witness and as a person. His evidence epitomised all the difficulties of living with a partner who suffers from mental health issues, and it was clear to me that he was trying to give his wife all the help and support that he could, within the limitations of his own capabilities. I am sure that there is nothing that Mr Smith would want more than for his wife to make a substantial recovery and although I think it is clear that she will never be the same person as she was before Megan died, he hopes that with treatment and recovery from mental illness, concentrating on the two beautiful boys that they have and the family life they are able to enjoy together, the marriage will be repaired to the point where it resumes its loving nature and stability. Mr Smith came across to me as wholly admirable in every way: he has stood by his wife through six incredibly difficult years and it is clear that theirs was a very deep loving relationship, the foundation of which has not yet been wholly destroyed. His steadfastness and support will, in my judgment, be one of the foundation stones in relation to the Claimant's eventual recovery and he should be proud of himself for the way he has stood by his wife and children through the adversity not only of the stillbirth and its aftermath, but also the legal proceedings.

The psychiatric evidence

68. I heard evidence from two consultant psychiatrists, Dr Martin Baggaley and Dr Gary Jackson. This case has been a challenging one from the psychiatric point of view not just for the court but also for the psychiatrists who have both changed or modified their views as the case has gone on. There seems no doubt that they had come significantly closer together in their opinions by the end of the trial compared to the somewhat polarised positions they took initially and I found the evidence of both psychiatrists to be thoughtful, considered, and based on appropriate reasoning. Where I have preferred the evidence of one to the other, that is not to be taken as a reflection on the evidence of the witness not preferred but rather simply a facet of the fact that, in the end, the

court needs to make a decision and come to conclusions in order to resolve the issues in this case.

69. For the Claimant, Dr Baggaley produced five reports as part of his evidence: full reports of 23 August 2015, 29 April 2016 and 11 April 2018 together with a letter of 22 March 2018 and the joint statement with Dr Jackson of 22 August 2018. In addition, a further joint statement from the psychiatrists was produced on 28 February 2019 representing their further considered views having heard the lay witness evidence. Finally, at the end of his evidence I asked Dr Baggaley what his own treatment proposals would be if the Claimant was referred to him as a patient and this resulted in him producing a further report on 4 March 2019 setting out his treatment proposals.

70. At the start of his evidence, Dr Baggaley explained that it is a challenge to classify psychiatric injury in cases of bereavement and abnormal grief. He said that normal grief is not a psychiatric injury but is a normal response to bereavement. However, such a person can go on to develop a psychiatric disorder. He said that what we are dealing with here is a Pathological Grief Disorder, as such because the Claimant's grief issues remain unresolved. Whilst, in the current version of the International Classification of Diseases (ICD-10) prolonged grief disorder is not described, it has been included in the draft version of ICD-11. Dr Baggaley produced for the court a paper by Kristensen and others from 2017 which looks at the proposed new diagnosis of prolonged grief disorder in ICD-11 and seeks to distinguish this from depression. The authors state:

> "Prolonged grief is the most common form of complicated grief in adults. It is different from normal grief in that the immediate grief reactions persist over time with more or less undiminished strength, causing a considerable loss of everyday functioning. One may also observe little change or flexibility with regard to the way in which this grief is handled. Prolonged grief is primarily characterised by an intense longing for or persistent preoccupation with the deceased person. Other characteristics include difficulties in accepting the death, the feeling of having lost a part of oneself, difficulties in continuing with life, emotional numbness and avoidance of things/places/activities that serve as reminders of the deceased. Others also emphasised rumination over how the death could have been avoided, blaming of others and self-blame as typical of persons who struggle with prolonged grief."

The paper refers to studies which indicate that whilst some 7% of those who lose someone to death are affected by prolonged grief, higher figures have been found among parents who have lost a child and those who have been bereaved through sudden violent death. They state that the central issue in prolonged grief is its considerable impact on daily functioning. Distinguishing between prolonged grief and depression may be difficult because loss of a loved one through death is a known risk factor for development of depression. The authors suggest that a key assessment in distinguishing prolonged grief from depression involves looking at whether the thoughts and emotions continue to circle around the deceased, as in prolonged grief, or whether they are more free-floating and generalised and less associated with the loss itself, as in depression. Thus, when depressed, a patient will often express a more global feeling of guilt and a

sense of worthlessness or even self-contempt and a feeling of being a burden on others, which are not features of prolonged grief. In addition, prolonged grief and depression differ in terms of avoidance behaviour. Persons with prolonged grief will tend to avoid specific places, things and activities that remind them of the reality of the loss while depressed patients will often engage in more general avoidance behaviour and social withdrawal. Sleep disturbance is common to both but pronounced weight loss, slowness in thinking, speaking and moving and difficulty in making decisions are prominent in depression but absent in prolonged grief. Suicidal ideation is common to both. The authors also state that many people who struggle with prolonged grief tend to keep the deceased more or less constantly in their thoughts and behaviour. They state that numerous studies have shown that grief specific psychotherapy can be effective in the treatment of prolonged grief. Although there is, as yet, no psychopharmacological treatment for grief which has a documented effect, some drugs, such as Citalopram have been shown to reduce comorbid symptoms of depression.

71. Drawing on the Kristensen paper, Dr Baggaley expressed the opinion that the Claimant's symptoms are more those of prolonged grief disorder than depression and that the Claimant would benefit from psychotherapy aimed at treating grief together with antidepressant medication.

72. In his first report dated August 2015, which predated the Kristensen paper, Dr Baggaley considered that the Claimant was suffering from "pathological grief" which he described as a well-recognised clinical entity which is familiar in the legal context but is not recognised in either ICD-10 or the Diagnostic and Statistical Manual of the American Psychiatric Association ("DSM") version 5. Given the lack of recognition of pathological grief, Dr Baggaley chose to classify this as a major or moderate depressive disorder or episode. In that report he stated the view that the Claimant had "made some progress with coming to terms with her loss" but still had significant symptoms of grief. He recommended a course of CBT and antidepressant medication but was guarded about the prognosis given that, at the time of that report, Zackary's birth was imminent and he was unsure about the impact of the further child on the Claimant's condition.

73. By the time of Dr Baggaley's second report in April 2016, not only had Zackary been born (and was healthy) but the Claimant had developed her full depressive condition with suicidal ideation. He found the Claimant to be objectively and subjectively more depressed than on the previous occasion and she had pessimistic and hopeless thought content, expressing clear suicidal ideation. In his view she was now suffering from a major depressive disorder or a severe depressive episode and needed urgent referral to the local community mental health team. He took the trouble to write to the Claimant's GP suggesting such a referral.

74. Dr Baggaley's third report dated April 2018 post-dated the therapy with Dr Friedman and Dr Loumidis. His diagnosis remained that of major depressive disorder or severe depressive episode. He stated:

> "Unfortunately, the various attempts at psychiatric treatment including cognitive behavioural therapy and antidepressant medication has been ineffective. She has been unable to engage with the cognitive behavioural psychotherapy and she has failed to respond to antidepressant medication. This is compounded by the fact that she seems to have had a relatively poor relationship

> with her consultant psychiatrist and both the psychiatrist and clinical psychologist require a substantial journey to see. I am satisfied that substantial efforts have been made to ensure that Mrs Smith has received the necessary treatment to alleviate her psychiatric injury. Given the duration of illness (over five years) and the lack of response to treatment, I consider her prognosis is poor. On the balance of probability, I believe she is going to continue to be depressed with unresolved grief and sadly I cannot see this will change. There remains the high risk of the marriage breaking up and there is a definite risk of suicide. It is likely that her depression will fluctuate from moderately severe to severe. She may well suffer an exacerbation following the birth of her second son and if for example her husband were to leave."

This report followed a letter from Dr Baggaley to the Claimant's solicitor of 22 March 2018 in which he responded to a question asking his opinion on the likelihood of the Claimant sending her children to normal school when they reached the appropriate age. He stated in that letter:

> "I believe that she would not be able to tolerate the separation anxiety of allowing her children to go to school and she will therefore, on the balance of probability, decide to home school them. This is not to indicate that I support such a decision, merely what I predict will happen."

On the back of these two pessimistic opinions, a schedule of loss was served seeking damages in excess of six million pounds.

75. Dr Jackson, in his reports, took a very different view to Dr Baggaley. He was not convinced that the Claimant had suffered a psychiatric syndrome recognised in DSM-5 or ICD-10 following the stillbirth of Megan. He did acknowledge that the Claimant had developed classical symptoms of post-natal depression after Zackary's birth which, in his opinion, she would probably have developed after the birth of Zackary even if she had not lost Megan. He did not believe that the depression had been caused or materially contributed to by the stillbirth. In addition, he expressed the opinion that the Claimant had developed a pathological attachment and overprotectiveness towards Zackary but again this was not of such an order or nature as to be considered a recognised mental illness. He stated that the Claimant could now move to reverse this pathological attachment and overprotectiveness if she chose to do so but "She seems to not want to for reasons that are unclear." He further stated:

> "Mrs Zeromska-Smith is very ambivalent about psychological therapy and mostly not motivated for it. This is unfortunate. I believe if she were motivated for it she would be able to make progress overcoming her pathological attachment to her son which is not a psychiatric state over which she has no control or choice. She would also likely benefit from getting back to work of some kind to redevelop more self-esteem and a sense of achievement. All this would likely improve her mood and general adjustment and relationship with her husband."

He also advised continuance on antidepressant medication.

76. Dr Jackson produced his second report in August 2018 following a further interview with the Claimant on 4 June 2018, approximately four weeks after Tristan's birth. He described Mrs Zeromska-Smith as making good eye contact in the interview and she did not appear to be significantly depressed for most of the interview although she was briefly tearful on two or three occasions when talking about aspects of her lifestyle now, for example the poor state of her marriage. However the tears quickly dried up and she regained her composure. She had no difficulty concentrating, formulating or expressing her thoughts. Dr Jackson considered that the Claimant had not engaged in good quality CBT but had seemed simply unwilling to try and change her behaviours and in particular increase her range of activities to build confidence and step back from her pathological overprotectiveness of her son. He said:

> "In my view had she engaged constructively in therapy she would have been able to overcome her problem emotions (sic) and behaviours within six months of starting therapy."

Dr Jackson thought that the Claimant's poor adjustment to her bereavement to be a rare phenomenon in that usually an individual with a healthy robust and resilient normal personality deals much better with such a challenging or tragic event. By contrast, "This claimant claims to have suffered, for the last five years, ongoing mental illness which she imputes to losing her daughter, that substantially reduces her quality of life and range of activities and she claims to be dependant in any number of ways, day to day, on those around her."

He felt that this was not the picture one would expect in an individual with the Claimant's profile. He considered that the support system which the Claimant had gathered around her was perpetuating her pathological anxieties and helping her to avoid overcoming those anxieties and he emphasised the strong strand of avoidance in the Claimant's case. He stated:

> "I would strongly recommend (as the psychologist Dr Friedman has done on repeated occasions) that the way out of this avoidance is making the Claimant start doing more for herself and with that rebuilding confidence for a broader range of activities and independence."

Dr Jackson anticipated that once the legal process was over and so long as further care provisions were not put in place for the Claimant she will be likely to rebuild a normal range of activities and lifestyle within a year and any failure to do so would be a conscious choice on her part. On the back of this medical opinion, the Defendant served a counter-schedule valuing the claim at £7,200 being £6,000 damages for loss of bringing the pregnancy with Megan to a successful conclusion and £1,200 for the funeral costs.

77. Thus it can be seen that, as I have stated, the views of the psychiatrists after the exchange of their respective reports were polarised and were reflected in vastly different schedules of loss accordingly. Those views did not substantially change after the joint statement dated 22 October 2018: Dr Baggaley maintained the view that the Claimant was suffering from a pathological or complicated grief reaction which had

persisted since the stillbirth in May 2013, which had failed to improve and which would have been considered pathological or complicated after 18 months or so. This condition has led to significant reduction in the quality of the Claimant's family and has impaired her effectiveness in work. Dr Jackson expressed the view that the Claimant had experienced normal grief for the loss of her daughter which did not constitute a mental illness. He stated that the Claimant subsequently developed a postnatal depression after the birth of Zackary which was not attributable in causation terms to Megan's death. In time she had recovered from that postnatal depression and her ongoing unhappiness and excessive protectiveness of Zackary were in part attributable to the loss of Megan and in part were a function of the ongoing legal process as well as a now failing marriage.

78. After the psychiatrists had sat in court and heard the evidence of the witnesses of fact, they both modified their views significantly. In particular Dr Jackson now conceded that the unresolved grief had made a material contribution to the development of the onset of the post-natal depression suffered by the Claimant after the delivery of Zackary. Furthermore the psychiatrists agreed that the Claimant had unresolved grief although they still differed as to whether that constituted a psychiatric illness or not. Dr Baggaley also was now of the opinion that, having heard the evidence and in particular that of Mr Smith, there had been a gradual deterioration since Megan's stillbirth. In relation to the prognosis, Dr Jackson considered that the Claimant would recover fully within a year of the finalisation of the proceedings and return to work. However, Dr Baggaley maintained his view that the Claimant's psychiatric illness would run a chronic course. Both were concerned about the impact of the Claimant's attachment issues with Zackary.

79. Dr Jackson's concession that the depressive illness which followed Zackary's birth was caused in part by Megan's stillbirth and therefore the negligence admitted in this case was a significant development in this assessment of damages. Dr Jackson's position was further modified in the course of his evidence. He acknowledged that the Claimant has got "stuck" in recovering from her grief disorder: he said that the Claimant had hoped that a replacement child would help but it didn't and since then "She has lost her sense of control, and become very anxious in relation to Zackary, with marriage problems and inability to get back to work." He described her having retreated into a limited range of activities and lifestyle whereby she is able to control the internal environment. She has remained stuck in this situation and has been unable to regain mastery of her life. There are perpetuating factors such as anger and also an inability to move on until the legal process has finished. She has still not fully dealt with the loss of Megan and has "kept her world small". She wasn't ready to engage with the CBT offered by Dr Loumidis. Dr Jackson stated the opinion that once the legal process was over, that would allow the Claimant to start the process of recovery. He no longer suggested that her failure to do so to date was voluntary but he maintained the opinion that things would change in the future. In addition, in cross-examination Dr Jackson conceded that, although not a classified psychiatric disease, he does recognise pathological bereavement disorder as something which is abnormal and which would be treated.

80. These concessions effectively meant that there was essentially little difference between the parties in relation to the recovery of damages up to the date of trial. Although, in his final submissions, Mr Feeny for the Defendant has left open the issue whether the period for which the Claimant is entitled to compensation is restricted to one year from

December 2015, he recognised that, in the light of Dr Jackson's evidence, the court would be more likely to find that there was a compensable psychiatric illness to the date of trial, with the principal issues for decision being whether there was compensable psychiatric illness prior to December 2015 and, secondly, whose evidence as to prognosis was to be preferred.

81. So far as the prognosis is concerned, by the end of his evidence Dr Baggaley had revised his ultra-pessimistic prognosis and he produced treatment proposals for the Claimant which anticipated supportive treatment until September 2032 which would involve a period of intensive treatment between September 2021 and September 2022 and then supportive treatment for a further ten years with a 12 month period of intensive treatment at some point in 2027 to 2029, to coincide with the children reaching secondary school age. On the basis of these treatment proposals and Dr Baggaley's revised opinion, the Claimant proposes a revised schedule of loss amounting to £2,171,630 as set out and explained in paragraph 106 below.

82. So far as the Defendant is concerned, on the basis that I reject a period of only one year from December 2015 to December 2016 as representing the period for which the Claimant is entitled to recover damages, it is submitted that I should find there will be recovery within one year after the end of the trial and that the valuation should amount to £157,946.54.

83. Before considering the resolution of these issues, it is appropriate that I should refer to the evidence from the expert occupational therapists, Sharmin Campbell for the Claimant and Safi Madar for the Defendant. Their evidence was principally directed at quantification of the claim and is contingent upon the findings I make in relation to the issues of causation and prognosis governed principally by the psychiatric evidence. However, I did find the evidence of Ms Madar of some significant assistance in helping me to resolve the issue of prognosis. Ms Madar explained how an occupational therapist would take a look at the division of roles in the family in terms of occupational functions, daily living, strategies for childcare, leisure time, relaxation techniques and the need for separation. She said that the occupational therapist would work closely with the case manager and the psychotherapist to devise strategies to cope with, for example, the Claimant learning to leave the home and separate from the children. She said that a holistic approach with the children would be adopted and an adjustment period would be needed. She described how the occupational therapist needs to be able to give strategies to enable the Claimant to adapt. She acknowledged that the Claimant has good organisational skills and needs to improve her self-esteem and self-confidence. I was impressed with this evidence because of its emphasis on the important part which an occupational therapist would play in the treatment strategies, working with the consultant psychiatrist, the psychologist and the rest of the team on a holistic basis. This is not something which has been suggested before or has played any part in the strategies adopted to date. In so far as Ms Madar's suggestions involve a qualitatively different approach to that which has been tried to date, it encourages a conclusion that, with optimal treatment, the prospects of recovery are reasonably good despite the failure of the attempts at therapy to date. Ms Madar explained how the occupational therapist would assist the Claimant in taking the first steps towards separating from her children. It would be a graded approach involving initially leaving the house together and engaging in activities including relaxation techniques and anxiety management techniques, all of which requires a person such as an occupational

therapist who has the requisite skill and training. She felt that this would be a different approach to the recommendations of Dr Baggaley and Dr Jackson because an occupational therapist would look at all the areas, not just individual aspects, and would be more empathetic to the Claimant's needs.

The issues

84. Miss Rodway QC and Mr Feeny have helpfully provided me with a list of issues which arises for decision in the case. The resolution of issues 1 and 2 provides the framework for the quantification of the case which is then covered by issues 3 to 8. The issues of principle are as follows:

> "1. It is now accepted that the Claimant suffered from a psychiatric injury or illness as a result of the stillbirth of Megan on 28 May 2013 The Court is now required to make findings on the following:
>
> (a) At what point in time did the Claimant suffer from a psychiatric injury or illness?
>
> (b) What was the nature and severity of the psychiatric injury or illness?
>
> (c) Has the Claimant recovered from the psychiatric injury or illness?
>
> (d) If not what is the prognosis for her recovery?
>
> 2. In the light of the findings on issue 1:
>
> (a) What is the treatment plan which is most likely to assist the Claimant's recovery?
>
> (b) What is the cost of such a plan?
>
> (c) What will be the nature of the Claimant's recovery?
>
> (d) When will this probably be achieved?"

The Claimant's submissions

85. For the Claimant, Miss Rodway QC and Mrs Fraser Butlin submit that, on the evidence, the Claimant suffered psychiatric injury or illness effectively from the time of Megan's stillbirth. They rely on the evidence of the family and in particular Mark Smith. In particular, reliance is placed on Mr Smith's evidence that although the Claimant returned to work on 28 October 2013, in his view she was not fit to do so and would return home each day in tears, unable to do very much. Reliance is placed on the Claimant's evidence that the main driver for her change of jobs was to escape the constant memories of Megan which her old place of work was associated with. They further rely on the evidence that the Claimant was adopting avoidance strategies whereby she was able to avoid confronting the issues surrounding Megan's death until, as she thought, she could become pregnant again and replace Megan with another daughter. All this, they say, is abnormal and reflects psychiatric injury or illness. Furthermore, reliance is placed upon Dr Baggaley's assessment on 18 July 2015 when he found her to be "objectively and subjectively depressed".

86. For the period from December 2015 to December 2016, there is no dispute that the Claimant was suffering from a significant depressive illness. Thereafter, until trial, I have already indicated that, in the light of Dr Jackson's concessions, there was ongoing psychiatric illness and injury in the form of the unresolved pathological grief disorder.

87. The main issue concerns the prognosis and treatment plan covered by issues 1(d) and 2. It is submitted on behalf of the Claimant that I should prefer the evidence of Dr Baggaley to that of Dr Jackson on the basis that Dr Baggaley's answers were focussed and he was clearly seeking to assist the court in coming to conclusions in what he acknowledged was a difficult case. It is submitted that there has been undue emphasis upon the effect of the litigation process. The fact that the Claimant's difficulties have persisted for almost six years should inform the court as to the prognosis for the future. Thus Dr Baggaley's treatment programme and prognosis are commended.

88. The Claimant also submitted that the evidence of Dr Jackson lacked impartiality and objectivity, for example by reference to his late change of opinion with regard to the causation of the Claimant's psychiatric illness. It was submitted that Dr Jackson could and should have modified his opinion significantly sooner than he did and it was submitted that Dr Jackson had taken an unreasonably extreme and unfavourable approach towards the Claimant's condition in his reports. It is suggested that he has failed to grasp the nature and complexities of the Claimant's condition in suggesting that she will be effectively recovered within a year.

The Defendant's submissions

89. In relation to the period between October 2013 and December 2015, the Defendant submits that the Claimant returned to a normal life and there is objective contemporaneous evidence indicating her level of functioning. The relevant employment documents show a strong performance at work which, as Dr Baggaley accepted, would not be consistent with any significant mental impairment at the time. Nor was the Claimant seeking medical attention and there is no independent evidence of any difficulties in the relationship between the Claimant and her husband: they went on holiday together to the Far East in late 2014. This all suggests a normal lifestyle and reasonable recovery from the stillbirth albeit, with hindsight, it can now be seen that the Claimant's grief had not fully resolved.

90. The Defendant submits that I should reject the evidence that the Claimant was struggling from day one. Reliance is placed on Dr Baggaley's findings of July 2015 when he took the view that the grief was pathological or abnormal because of the period of time for which it had persisted. His description of the Claimant did not, it is submitted, accord with the retrospective evidence from the Claimant and her husband that the Claimant was, by now, deeply depressed, specifically by reference to the 20 weeks scan in May 2015 which informed the couple that the new baby was a boy, not a girl. The Defendant submits that Dr Baggaley's diagnosis was, in any event, inappropriate: he did not have available to him the objective evidence which showed that the Claimant was performing extremely well at work.

91. In relation to the period after December 2016, the Defendant submits that Dr Baggaley's assessment is contradicted by the assessment of, for example, Dr Friedman who was treating the Claimant in 2017/2018 and did not consider her to be severely depressed. It is submitted that Dr Friedman's direct and robust approach at the last meeting would

not be consistent with a consultant psychiatrist who thought he was dealing with a severely depressed patient. Although Dr Dickinson did refer to severe depression secondary to bereavement, the Defendant submits that this was a label attached to the Claimant's condition since Dr Baggaley's initial referral to the GP in April 2016 and Dr Dickinson's thinking in supporting this is not clear.

92. So far as the prognosis is concerned, the Defendant is critical of Dr Baggaley's views. It is submitted that there is no support in the literature for a lifelong bereavement reaction and the concept is counter-intuitive, with the literature supporting up to about three years as being prolonged. The Defendant is also critical of Dr Baggaley's revised prognosis and in particular why there should be progress over a period as long as five to ten years. It is submitted:

> "Dr Baggaley was unable to give any clear explanation as to this time period and at one stage appeared to be suggesting that the time period for recovery would be proportionate to the period of the symptoms to date."

Dr Baggaley did indeed suggest this and the basis for it seemed very difficult to understand.

93. It is submitted by the Defendant that Dr Baggaley's suggestion that the Claimant should undergo therapy at a cost of £20,000 per annum for a period of 13 years is extraordinary and outwith any reasonable clinical experience. Dr Baggaley conceded that he had no experience of the type of treatment programme proposed.

94. By contrast, the Defendant submits that Dr Jackson's evidence was underpinned by clear logic and careful thinking. Having considered the Claimant's evidence he made an appropriate concession in relation to causation. It is submitted that his opinion and treatment proposals are in line with "mainstream thinking" in relation to depressive disorders and his timeframe for improvement would be consistent with a reasonable expectation.

95. In addition, the Defendant relies on the evidence of Ms Madar who carried out an objective assessment of the Claimant based on her experience of mental health patients. It is submitted that Ms Madar's assessment is much more consistent with the overall impression from the evidence and her suggestions as to improvement in terms of a package for case management and occupational therapy were constructive and logical.

Discussion

96. It is appropriate first to consider the appropriate legal category into which the Claimant falls for the purposes of her claim to damages. It seems to me that the Claimant is a primary victim and not a secondary victim. In this regard, I am assisted by, and endorse, the decision of Mrs Justice Whipple in *YAH v Medway NHS Foundation Trust* [2018] EWHC 2964 (QB). In that case, the Claimant's daughter sustained brain damage with cerebral palsy as a result of the negligent care when she was born. Whipple J held that the claimant was a primary victim, following the decisions of Dingemans J in *Wells v University Hospital Southampton NHS Foundation Trust* [2015] EWHC 2376 (QB) and Goss J in *RE v Calderdale and Huddersfield NHS Foundation Trust* [2017] EWHC 824 (QB). The starting point is that the law regards the mother and the foetus as one legal

person. Although the baby, if born alive, has its own set of rights derived from the Congenital Disabilities (Civil Liability) Act 1976, those rights do not derogate from the right of the mother to sue as a primary victim. Whipple J had been counsel for the claimant in *Wild v Southend University Hospital NHS Foundation Trust* [2014] EWHC 4053 (QB) in which Michael Kent QC, sitting as a Deputy High Court Judge, had held that, in a case where, as a result of negligence, the child had died in utero, the mother is a primary victim and has a claim whether or not she has suffered psychiatric illness as a result of the events leading to the stillbirth. That case is on all fours with the present case and, in my judgment, the learned Deputy High Court Judge was correct in his analysis. The result is that it is not necessary for the Claimant to bring herself within the "*Alcock*" criteria (*Alcock v Chief Constable of South Yorkshire* [1992] 1 AC 310) whereby, for a secondary victim to be able to recover, they must suffer shock as defined in that case by Lord Ackner. A primary victim does not have to satisfy the *Alcock* criteria or control mechanisms, and specifically need not demonstrate that psychiatric illness has been caused by witnessing the sort of shocking event described by Lord Ackner in that case.

97. In consequence, if the Claimant has suffered injury, including mental injury, as a primary victim it is unnecessary for her to show that what she has suffered amounted at the relevant time to a formal classified psychiatric injury. In particular, although damages cannot be recovered for "normal" bereavement, in my judgment damages can be recovered for "abnormal" bereavement or a pathological grief disorder and it matters not whether this amounts to a formal psychiatric diagnosis within ICD-10 or DSM-5.

98. Clearly, on the psychiatric evidence, there is a significant overlap between grief and depression. Initially, the effect on function may be indistinguishable. However, with normal grief, one would expect a trajectory of recovery over a period of a year or perhaps 18 months to encompass the first anniversary. There is never <u>complete</u> recovery: no parent will ever completely recover from the death of a child. But there are three ways in which compensable injury might occur:

    i) The grief symptoms fail to ameliorate in the usually expected way, but continue in abnormal intensity and for abnormally long thereby allowing for the diagnosis of a Pathological Grief Disorder;

    ii) By avoidance, the Claimant fails to deal with her grief but functions seemingly normally, until something happens to make the full grief symptoms re-emerge, possibly in conjunction with a depressive illness; and

    iii) The stillbirth causes the mother to be vulnerable to further injury, such as post-natal depression, which she then suffers when otherwise she would not have done, or she fails to recover as quickly or as thoroughly as she would otherwise have done.

99. The first question for me to decide is therefore whether, in the period up to December 2015, the Claimant was suffering from "normal" bereavement or a pathological grief disorder with or without psychiatric illness in the form of depression.

100. In my judgment, the recollection of the Claimant and her family is obscured by the events which have occurred since Zackary's birth and in particular the very significant depressive illness which the Claimant suffered through 2016 and there has been a

failure to recall and recognise the deterioration which led to that major depressive illness. The objective evidence tends to show that the Claimant, although clearly significantly grief-stricken and bereaved by the death of her longed-for baby daughter, was nevertheless following a recovery trajectory which was not outside the parameters of normality. In particular, I am influenced by the fact that she sought no medical attention for mental health problems throughout 2014, she returned to work, she changed jobs and she achieved promotion. However strong-willed and determined a personality the Claimant is, I do not believe she could have done this if she had been suffering from significant mental illness at the time. This is, in a sense, illustrated by a consideration of what would have happened had the baby conceived at the end of 2014 turned out to be a girl. It seems to me that this would have assisted the Claimant in her continuing recovery from the stillbirth of Megan because, as she told me, she regarded the baby as a replacement for Megan and the comfort of having this replacement would have assisted her on the road to recovery from the original stillbirth. I accept Mr Smith's evidence that the Claimant was devastated to learn that the new baby was a boy and not a girl and therefore could not be a replacement for Megan and from that moment there was a downward trajectory instead of an upward trajectory which put an end to any semblance of a normal grief reaction and effectively turned the Claimant's mental state into an abnormal pathological grief disorder. I accept Mr Smith's evidence that this was the start of the process whereby, as he put it, the "boxes in the back of the Claimant's head" started to fracture and manifested itself in a florid depressive illness through 2016.

101. In my judgment, and in answer to issue 1(c) the Claimant did not and has not recovered from this psychiatric injury or illness. She has many of the characteristics of abnormal grief disorder as described in the Kristensen paper with, superimposed upon them, an anxiety disorder manifesting itself in an inability to separate from her children and a form of agoraphobia. This has been a potent and debilitating combination for the Claimant.

102. So far as the future and the prognosis is concerned, in my judgment Dr Jackson and Ms Madar are more likely to be right than Dr Baggaley. In particular, I find that Dr Baggaley has placed too much emphasis on the length of time since the stillbirth of Megan in making his assessment when, as the evidence has shown, particular circumstances have intervened to prolong the illness in the past. The treatment from Dr Friedman and Dr Loumidis, although along the right lines, was doomed to failure because of the distance which the Claimant had to travel to attend those appointments and the lack of assistance and support in implementing the cognitive behavioural techniques when she got home. I was very impressed by Ms Madar's evidence as to the likely efficacy of a holistic approach whereby an occupational therapist, on the ground, would play a key part in helping the Claimant to overcome her anxiety at being separated from the children on a step by step and gradual basis. Dr Jackson in his evidence referred to standard techniques for helping patients to overcome such anxiety disorders by seeing them through the initial half hour of panic which does eventually subside when the patient realises that the obsessive fear – in this case that harm will come to the children - has not in fact occurred. Once the "breakthrough" is made, I would expect the improvement to be relatively linear. It is true that this will require courage on the part of the Claimant but my assessment of her is that she is not merely a strong willed and principled person but also an extremely courageous person who is well motivated to engage in treatment and will particularly be motivated once this

litigation is at an end. I, like Dr Jackson, consider that the litigation has been a significantly malignant factor in preventing the Claimant from addressing her mental illness and moving down the line to recovery. So too were the births of Zackary and Tristan which, although joyous events in themselves, would have been a significant distraction for the Claimant in concentrating on her own wellbeing. The fact that they were boys brought home to the Claimant that which everyone else had already seen for themselves, namely that she would never get Megan back.

103. In all this, I again emphasise the important role which will be played by Mark Smith in helping his wife to implement the techniques which will, I assume, be devised by a multi-disciplinary team consisting of a consultant psychiatrist, a consultant psychologist, an occupational therapist and the case manager. Mark will have his important part to play in not just supporting Justyna but also helping with the children and creating as benign an environment as possible for the Claimant to succeed in overcoming her fears and conquering her anxieties. I consider that the extent of care, support and treatment presented by the Claimant's Schedule of Loss would actually be counter-productive by reinforcing the Claimant's role as a victim when what is required is a move away from people doing things for the Claimant and a move towards the Claimant doing more and more for herself.

104. In the circumstances, the appropriate approach to future loss is to assume that the regime proposed by the Defendant will be implemented but, in my judgment, for a period of two years rather than one year to give a margin of error and allow for setbacks or unexpected eventualities. Equally, the claim for the cost of home schooling is, in my judgment, misconceived as it assumes that the Claimant will continue to suffer anxiety at separation from her children unremittingly and that this will be visited upon the children by preventing them from going to school. It is inevitable, as everybody realises and accepts, that the children will grow up and eventually separate from their mother. The reference by the Claimant to this being when Zackary is 18 illustrates vividly the lack of clarity in her thinking processes. In my judgment, not only is it likely that the best interests of the children will be followed by them being sent to school but that, as it turns out, this will also be in the best interests of the Claimant.

105. In the light of these findings, my findings on the issues set out in paragraph 84 above are as follows:

(a) At what point in time did the Claimant suffer from a psychiatric injury or illness?

Answer: from about 1 June 2015 soon after she discovered that the new baby was male, which caused her recovery path to turn downwards and manifest itself as a florid, severe depressive illness from December 2015.

(b) What was the nature and severity of the psychiatric injury or illness?

Answer: a prolonged, pathological grief disorder complicated by a separation anxiety since Zackary was born and agoraphobia, and a severe depressive disorder from December 2015 until about December 2016.

(c) Has the Claimant recovered from the psychiatric injury or illness?

Answer: there has been recovery from the severe depression, but the Claimant has not yet recovered from the pathological grief disorder, the separation anxiety and agoraphobia.

(d) If not, what is the prognosis for her recovery?

Answer: with appropriately devised and implemented treatment, the Claimant will recover within about 2 years from trial.

2. In the light of the findings on issue 1:

(a) What is the treatment plan which is most likely to assist the Claimant's recovery?

Answer: the treatment plan proposed by the Defendant.

(b) What is the cost of such a plan?

Answer: see below.

(c) What will be the nature of the Claimant's recovery?

Answer: a full recovery from the pathological grief disorder, separation anxiety and agoraphobia. The Claimant will never be the same person she was before the stillbirth, but that will be normal for someone who has lost a child.

(d) When will this probably be achieved?"

Answer: within about 2 years of trial.

Quantum

106. I turn to the remaining issues agreed between the parties which are subsumed and dealt with in my findings on the quantification of this claim. Although the Defendant has made submissions on two alternative bases, I have rejected the first, namely that the period for which the Claimant is entitled to compensation is limited to 1 year. Taking the Defendant's secondary case, therefore, the parties' respective positions are reflected in the following table:

General damages	Claimant	Defendant
Damages for PSLA	£104,057.00	£30,000.00
Loss of congenial employment	£15,000.00	£0.00
Loss of the satisfaction of bringing her pregnancy to a successful conclusion		
	£6,000.00	£6,000.00
Interest	£5,180.44	£1,465.20
Total general damages and interest	£130,237.44	£37,465.20
Past losses		
Care	£144,991.65	£20,763.15
Travel	£5,366.63	£1,379.52
Therapy	£2,025.00	£2,025.00

Earnings and pension	£64,382.97	£26,980.74
Items bought for Megan	£2,368.09	£2,368.09
Funeral costs	£1,200.00	£1,200.00
Miscellaneous	£1,033.50	£179.00
Interest	£3,199.22	£458.16
	£224,567.05	£55,353.66
Future losses		
Care and domestic assistance	£513,150.78	£6,216.27
Home education	£428,359.36	£0.00
Case management	£92,558.94	£6,350.00
Earnings and pension loss	£333,863.60	£31,783.50
Holidays	£29,627.64	£0.00
Miscellaneous	£1,368.02	£208.00
Treatment costs	£420,088.86	£10,060.00
Occupational Therapy	£0.00	£10,510.00
Total future losses	£1,819,017.20	£65,127.77
OVERALL TOTAL LUMP SUM	£2,173,821.69	£157,946.63

I shall deal with these heads of loss in turn.

General Damages

Damages for PSLA

107. The Claimant's figure is derived from the Judicial College Guidelines (14th edition) giving a range of £48,080 to £101,470 for severe psychiatric and psychological harm. The factors taken into account in this category include:

i) Ability to cope with life, education and work;

ii) Effect on relationships with family, friends etc;

iii) The extent to which treatment would be successful;

iv) Future vulnerability; and

v) Prognosis.

In the severe category, the prognosis will be very poor. My findings, however, are such that the Claimant does not fall within this category, never mind at the top of this category, as I consider the prognosis to be good with appropriate treatment.

108. The range of damages for the category of moderately severe psychiatric and psychological harm where the prognosis is much more optimistic is £16,720 to £48,080 and the Defendant's figure is in the middle of this range. I generally agree with the

Defendant's approach, but given my slightly longer period for recovery, I assess general damages for PSLA in the sum of £35,000.

109. In addition to the above, I have considered whether the Claimant is entitled to a further sum to compensate her for the fact that she has had to undergo two caesarean sections which she would not otherwise have needed. Although it is clear that the deliveries of Zackary and Tristan were by caesarean section in consequence of Megan's stillbirth, what is less clear is whether, but for the negligence, fetal distress would have been detected and Megan would have been delivered by caesarean section to have avoided her stillbirth. As I think I must assume this to have been the case, it would follow that the Claimant has had two caesarean sections and would also have done had there been no negligence, so no additional damages fall to be awarded for this aspect.

Loss of Congenial Employment

110. It is suggested in the schedule and the Claimant's closing submissions that the Claimant had a successful career, was ambitious and the inability to progress her career is a considerable loss. The Defendant resists any such award on the basis that the Claimant will be able to resume her employment within one year (or, on my above findings, two years).

111. The category of loss of congenial employment was originally developed for those cases where the Claimant had a vocational job such as nursing, where the loss of that particular employment (for example where a nurse had suffered a back injury and was now only able to work as a ward clerk) merited a separate award. In more recent times, however, the category has been widened to a whole variety of employments. Nevertheless, I would have been reluctant to make a separate award for this Claimant: she had achieved her promotion only just before she left on maternity leave and she had not yet established herself in her career. Compare, for example, the case of *Evans v Virgin Atlantic Airways* [2011] EWHC 1805 (QB) where the Claimant had been employed by the Defendant as a full-time beauty therapist from July 2005 until July 2006 when she was redeployed on medical grounds. She was aged 35 when she was redeployed and 40 at the date of trial. During the course of her employment she had undertook extensive and prolonged massage treatments for passengers on the Defendant's airline. The learned judge made an award of £10,000 for loss of congenial employment because the Claimant was entitled to consider that she had achieved professional success in her field, but would no longer be able to work as a beauty therapist and was working in significantly lower paid work which was considerably less congenial. She now faced an uncertain future and a requirement for retraining. None of that applies here.

112. The decision is, in any event, made easy by my findings as to prognosis and the fact that the Claimant will, if she wishes, be able to return to her chosen career within about 2 years and therefore no award under this head of claim is appropriate.

Loss of the satisfaction of bringing her pregnancy to a successful conclusion

113. The parties agree that the award of damages under this head should be £6,000.

Interest

114. The rate of interest is agreed to be 4.07%. My assessment of general damages is £41,000 and the figure for interest is therefore £1,668.70

Past Losses

Care

115. This claim comprises gratuitous care and childcare with domestic assistance, less credit for the childcare costs which would have been incurred in any event with the Claimant's return to work. The Claimant's figure of £142,912 is made up of past gratuitous care of £74,097 (incorporating a 20% *Housecroft v Burnett* discount), paid childcare and domestic assistance of £87,658 and credit of £18,844 in respect of childcare costs which would have been incurred in any event. However, as the Defendant points out, the claim for £87,658 is based on a major miscalculation as it covers 26 August 2017 to 21 February 2019 which is said to be 544 weeks when in fact this is a period of only 78 weeks. Interrogation of the Claimant's spreadsheet shows that the relevant cell calculates the number of days between the two dates, and the formula should have been divided by 7. The Claimant's revised schedule is calculated to 6 March 2019, a period of 79.57 weeks, and I calculate that the claim should be for £13,349 instead of £87,658 and the total should be £68,603 rather than £142,912. If a 25% *Housecroft* discount is taken instead of 20%, the claim would be £63,972.

116. The Defendant's figure, based on the evidence of Ms Madar, is £20,763.15. However, how that figure is precisely made up is not clear to me. The Defendant's case is that the calculations should only start from December 2015. Ms Madar's figures include both childcare and domestic tasks, but at different hourly rates, making it difficult to compare like with like. For the childcare aspect, Ms Madar's hourly rate is in fact higher than Ms Campbell's. It is also the Defendant's case that there should be no award for the period 8 May 2018 to 8 August 2018 as the Claimant would have required care and assistance during that period in any event.

117. The solution I have adopted is as follows. First, I have allowed the claim from 1 June 2015 as that is the date from when the Claimant's grief became pathological and compensable (see paragraph 105(a) above). Secondly, I have generally accepted and adopted Ms Madar's figures which seem to me to be the more correct: I agree with and accept the criticisms made of the Claimant's figures, for example in relation to sleep-in assistance at night. Thirdly, I have excluded the period from 8 May 2018 to 8 August 2018 as the Claimant would have required care and assistance in that period anyway. Fourthly, I have applied a *Housecroft v Burnett* discount of 25% (I do not accept the arguments on behalf of the Claimant that the discount should only be 20%). The resulting figure is £23,255 (rounded up) calculated as follows:

	Period		Weeks	Hours		Rate ph	Total	Less HvB discount of 25%
	Start	End		Hours per week	Total hours in period			
	01/06/2015	02/09/2015	13.29	17.5	232.50	£7.21	£1,676.33	£1,257.24
Childcare	02/09/2015	01/12/2015	13.00	21	273.00	£9.43	£2,574.39	£1,930.79
Domestic	02/09/2015	01/12/2015	13.00	20	260.00	£7.21	£1,874.60	£1,405.95
Childcare	01/12/2015	01/04/2016	18.00	6	108.00	£9.43	£1,018.44	£763.83
Domestic	01/12/2015	01/04/2016	18.00	15.5	279.00	£7.21	£2,011.59	£1,508.69
Childcare	01/04/2016	01/11/2016	31.00	6	186.00	£10.06	£1,871.16	£1,403.37
Domestic	01/04/2016	01/11/2016	31.00	15.5	480.50	£7.66	£3,680.63	£2,760.47
Childcare	01/11/2016	01/02/2017	13.00	6	78.00	£10.06	£784.68	£588.51
Domestic	01/11/2016	01/02/2017	13.00	15.5	201.50	£7.66	£1,543.49	£1,157.62
Childcare	01/02/2017	01/04/2017	9.00	6	54.00	£10.06	£543.24	£407.43
Domestic	01/02/2017	01/04/2017	9.00	15.5	139.50	£7.66	£1,068.57	£801.43
Childcare	01/04/2017	26/08/2017	21.00	6	126.00	£10.38	£1,307.88	£980.91
Domestic	01/04/2017	26/08/2017	21.00	15.5	325.50	£7.90	£2,571.45	£1,928.59
Childcare	26/08/2017	08/05/2018					£1,730.00	£1,730.00
Domestic	26/08/2017	01/04/2018	31.00	8	248.00	£7.90	£1,959.20	£1,469.40
Domestic	01/04/2018	08/05/2018	5.00	8	40.00	£8.62	£344.80	£258.60
Domestic	08/08/2018	06/03/2019	30.00	8	240.00	£8.62	£2,068.80	£1,551.60
Childcare	08/08/2018	06/03/2019	30.00			£60.00	£1,800.00	£1,350.00
Total:							£30,429.25	£23,254.43

118. In the above table, the rate for the final period is the weekly rate, not the hourly rate. The figure for the period 26/8/17 to 8/5/18 is derived from Ms Madar's figures of £1,080 for childcare and £650 for the au pair's lodging expenses.

Travel

119. The claim for £5,367 comprises 3,449 miles to various medical appointments, claimed at 40p per mile (£1,379), the cost of the airfare to Poland in December 2013 (£217) for thyroid treatment, and £3,770 as the cost of family travel for the Claimant's mother, sister, and niece from Poland, and younger sister from West Sussex together with some expenses for the au pair. The Defendant concedes the sum of £1,379.52.

120. In my judgment, much of the travel is not recoverable. Thus, there would have been trips by the Claimant's family from Poland in any event, had Megan not been stillborn, and Sabina would have visited her sister frequently given their close relationship. I consider that the figure conceded by the Defendant is reasonable and that is the figure therefore allowed.

Therapy

121. This figure is agreed in the sum of £2,025.

Earnings and pension

122. The claim for loss of earnings commences from 5 November 2016 when the Claimant went onto half pay, and then zero pay from 5 January 2017. According to the schedule

of loss, her net pay was £25,157 and at paragraph 21 of her statement, the Claimant says that when she was promoted to the post of Business Manager, her salary increased to £32,025 (gross). The Defendant says that the net salary should be £21,188.96 based upon gross earnings of £26,556, derived from page 1225 of the bundle which gives the starting salary for the Claimant's post of Bursar as from 1 September 2016. However, this ignores page 1226 which states that the Claimant's protected salary is £29.556. In any event, the documents confirm the Claimant's appointment as Business Manager L2, not Bursar (see page 1357) and page 1359 confirms the figure of £32,025 as stated in the Claimant's witness statement. I therefore accept the net salary of £25,157 claimed in the schedule of loss.

123. In the counter-schedule, it is pleaded that credit needs to be given for absence as a result of the birth of Tristan, and loss of earnings is therefore only conceded to mid-April 2018. However, it seems to me that the Claimant would have been entitled to maternity pay before and after Tristan's birth. I therefore prefer the Claimant's calculations which are £63,433 to 21 February 2019. This includes a figure of £1,509 for lost pension contributions which appears to me to be reasonable. As I am taking my calculations to 6 March 2019, I add £968 representing 2 weeks further pay, bringing the total to £64,401.

Items bought for Megan

124. This figure is agreed at £2,368.

Funeral costs

125. This figure is agreed at £1,200.

Miscellaneous

126. The figure claimed comprises costs incurred in anticipation of IVF (£435), the cost of prescription charges (£179) and a sum of £420 paid to a teacher for advice about home education. The Defendant concedes only the prescription charges. I disallow the sum paid to the teacher but allow the other costs making a total of £614.

Interest

127. The total of special damages allowed above is £95,243. The rate of interest claimed from 26 May 2013 to 21 February 2019 is 2.87%. Allowing the extra fortnight to 6 March 2019, the rate is £2.89% and interest at half this rate is accordingly assessed at £1,376..

Future Losses

Multipliers

128. In accordance with my findings at paragraph 104 above, future loss will be limited to the period of two years from 6 March 2019. The appropriate multiplier at -0.75% is 2.02.

Care and domestic assistance

129. As I have indicated above, I consider the approach to future care, domestic assistance, case management and occupational therapy should be that advocated by Ms Madar, but for a period of 2 years rather than 1 year. This will basically follow the recommendations set out in paragraphs 13.9 to 13.24 of Ms Madar's report of August 2018. My findings are as follows:

i) **Nanny**

Ms Madar recommends 15 hours a week for 6 months and then 10 hours a week for 3 months at £8.25ph with annual insurance of £135. I will modify this to 15 hours a week for 12 months and then 10 hours a week for a further 12 months, with 2 years of insurance. The calculations are:

15 hours x £8.25 x 52 weeks = £6,435

10 hours x £8.25 x 52 weeks = £4,290 x 1.02 = £4,376

Total: £10,811

ii) **Case Management**

Again, Ms Madar takes a higher rate for the first 6 months, and a reduced rate for the following 3 months. Consistently with the above, I take the higher rate for 12 months and the reduced rate for a further 12 months. The calculations are:

First Year

2 hours x £100ph x 18 visits = £3,600

Travel: 2 hours x £50ph x 18 visits: £1,800

Mileage: 100 miles at 50p pm x 18 visits = £900

Research and Admin: 2 hours per month x £100 x 12 = £2,400

Second Year

2 hours x £100ph x 8 visits = £1,600

Travel: 2 hours x £50ph x 8 visits: £800

Mileage: 100 miles at 50p pm x 8 visits = £400

Research and Admin: 2 hours per month x £100 x 12 = £2,400

Multiplier enhancement for second year: £104

Total: £14,004.

iii) **Occupational Therapy**

Ms Madar allows 24 Sessions in the first 3 months (ie 8 sessions a month), reducing to 6 sessions in the next 3 months and then 3 sessions in the final 3 months. Given the crucial part which the occupational therapist will play, I will allow the 8 sessions a month for the first 9 months, reducing to 2 sessions a month for the next year, and finally the 3 sessions in the last 3 months. The calculations are:

Assessment

£325

First 9 months

1.5 hours x £90ph x 72 sessions = £9,720

Travel: 2 x £50ph x 72 sessions = £7,200

Mileage: 100 miles x 50p pm x 72 sessions = £3,600

Admin and research: 2 hours x £90ph x 9 months = £1,620

The Next Year

1.5 hours x £90ph x 24 sessions = £3,240

Travel: 2 x £50ph x 24 sessions = £2,400

Mileage: 100 miles x 50p pm x 24 sessions = £1,200

Admin and research: 2 hours x £90ph x 12 months = £2,160

Final 3 months

2 hours x £90ph x 3 sessions = £540

Travel: 2 x £50ph x 3 sessions = £300

Mileage: 100 miles x 50p pm x 3 sessions = £150

Admin and research: 3 hours x £90ph = £270

Multiplier enhancement for second year: £160

Total: £32,885.

iv) **Cleaning and Family Care (Emotional Support)**

Annual multiplicand: £1,959.36

Multiplier: 2.02

Total: £3,958.

Home education

130. For the reasons stated in paragraph 104 above, this claim is disallowed in its entirety.

Earnings and pension loss

131. Multiplicand: £26,666

Multiplier: 2.02

Total = £53,865.

Holidays

132. This claim is disallowed as I consider that the Claimant will be able to care for her children when she goes on holiday.

Miscellaneous

133. This relates to the cost of prescriptions, which are allowed at £104 pa for 2 years (multiplier 2.02). Total: £210.

Treatment costs

134. Dr Jackson allows for the cost of psychiatry over 12 months of £1,500, psychotherapy of £4,000 over 6-8 months, grief counselling of £2,880 over 12 months and couples counselling of £1,680.

135. I consider that the couple's counselling should be sufficient at £1,680 as Mark and Justyna's relationship will improve in any event as the therapy and recovery takes effect. I allow psychiatry for 2 years at £3,000, psychotherapy over 12 – 16 months at £8,000 and grief counselling for 18 months (£4,200) as this will become redundant, or even counter-productive, in the final 6 months of recovery.

136. The total treatment costs are therefore: £16,880.

Conclusion

137. In the light of the above findings, the award of damages is £271,901 comprised as follows:

General damages	
Damages for PSLA	£35,000.00
Loss of congenial employment	£0.00
Loss of the satisfaction of bringing her pregnancy to a successful conclusion	£6,000.00
Interest	£1,669.00
Total general damages and interest	£42,669.00
Past losses	
Care	£23,255.00
Travel	£1,380.00
Therapy	£2,025.00
Earnings and pension	£64,401.00
Items bought for Megan	£2,368.00
Funeral costs	£1,200.00
Miscellaneous	£614.00
Interest	£1,376.00
	£96,619.00
Future losses	
Care and domestic assistance including case management and occupational therapy	£61,658.00
Home education	£0.00
Earnings and pension loss	£53,865.00
Holidays	£0.00
Miscellaneous	£210.00
Treatment costs	£16,880.00
Total future losses	£132,613.00
OVERALL TOTAL LUMP SUM	£271,901.00