Neutral Citation Number: [2020] EWHC 2914 (QB)

Case No: F90NE063

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
NEWCASTLE-UPON-TYNE DISTRICT REGISTRY

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/10/2020

Before:

HIS HONOUR JUDGE FREEDMAN
(Sitting as a Deputy High Court Judge)

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Between:

MICHELLE LEACH	**Claimant**
- and -	
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	**Defendant**

- -
- -

Mr P Dean (instructed by **Armstrong Foulkes**) for the **Claimant**
Mr T Found (instructed by **Ward Hadaway**) for the **Defendant**

Hearing dates: 1-2 October 2020

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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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HIS HONOUR JUDGE FREEDMAN

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 10:30am on 30 October 2020.

HHJ Freedman:

Introduction

1. On 18 September 2016 the claimant, at the age of 41 years, (born 15.02.75) had the misfortune to suffer a subarachnoid haemorrhage ("SAH") as a result of a ruptured aneurysm. Fortunately, she has made a good recovery from the SAH. Unhappily, however, she has developed a significant Post-Traumatic Stress Disorder ("PTSD") which has manifested itself, in particular, in severe anxiety.

2. Breach of duty in this case is admitted insofar as it is accepted that there was a 31-minute negligent period of delay in the ambulance arriving at the claimant's house for the purposes of taking her to hospital. What is in dispute is whether the negligent period of delay has caused or contributed to the onset of the PTSD.

3. In advance of the trial, counsel very helpfully agreed quantum in the sum of £40,000 (or £20,000, if the court agreed to undertake an apportionment exercise), leaving only factual and legal causation to be determined.

4. The evidence as to causation is essentially a matter for expert psychiatrists and, to that end, I have received evidence from Dr Smith, instructed on behalf of the claimant and Dr Bowers, instructed on behalf of the defendant. Additionally, of course, I have heard evidence from the claimant herself, as well as from her mother.

The Narrative

5. Although breach of duty has been admitted, it is necessary to set out, in short form, the sequence of events. When the claimant suffered the SAH, she was on her own, at her home in Ingleby Barwick, Stockton-on-Tees. At the time, which was shortly after 2.00 p.m. (such is clear because the first call that she made to the ambulance service was at 14.22), she was upstairs doing some housework. She describes feeling "*a pop and gush in* [her] *head and an immense pain*". She recalls losing consciousness and vomiting. Her mobile telephone was downstairs. She managed to get downstairs and to call 999. This telephone call lasted for approximately 14 minutes during which time the claimant reported severe headache, breathlessness, vomiting and a fear of being alone. She was told that an emergency ambulance was being arranged and that somebody would be calling her back. In the event, there were a number of calls made by the Emergency Operating Centre to the claimant but, unfortunately, her mobile phone ran out of battery so that the calls went to voicemail. According to the ambulance records, at 15.10, it was noted that an ambulance was required within 30 minutes.

6. Meanwhile, the claimant was understandably anxious to attract the attention of somebody who might be able to help her. She managed to open the front door and she then lied down on the mat just inside. At this stage, she was in and out of consciousness. Eventually, she spotted a little boy on a bicycle; she asked him to go and get his mother, who happened to be a neighbour. The neighbour came straight to the house. She called the ambulance at 15.19 and again at 15.51. The neighbour also telephoned the claimant's parents.

7. At about 16.00, the claimant's mother arrived at the house. She immediately called the ambulance service. The claimant recalled her mother on the phone to the ambulance service but she thinks that she then again lost consciousness.

8. The ambulance eventually arrived at 16.11. The claimant was initially taken to University Hospital of North Tees but, thereafter, she was transferred to the James Cook University Hospital. At the JCUH, she underwent surgery to treat the SAH which proved to be successful.

9. It is accepted that it was negligent for the ambulance not to have arrived by 15.40. Such, therefore, gives rise to the admitted negligent period of delay of 31 minutes.

10. Notwithstanding this admission of breach of duty, I feel bound to observe that a total waiting time of 1 hour 49 minutes between the first call being made and the ambulance arriving is, to put it at its lowest, very surprising. I make this observation against the background of having heard the content of the first call which the claimant made to the ambulance service at 14.22. There can be no doubt whatsoever that the claimant was very poorly (whatever the diagnosis was) and in severe distress. She let it be known that she feared that she was going to die, that her condition was deteriorating, and that she urgently needed an ambulance. For my part, given the seriousness of the claimant's condition, it is difficult to comprehend how it could take such a length of time for the ambulance to arrive. Be that as it may, I am concerned with only a 31-minute period of culpable delay.

11. Before leaving this aspect of the case, I should formally record that Mr Found, on behalf of the defendant, expressly apologised to the claimant for the negligent delay in the ambulance arriving; and acknowledged that the response time fell well below the high standards which this ambulance service aims to achieve.

The Law

12. In his written skeleton argument, Mr Found contended that the proper approach in relation to causation was to apply the 'but for' test, i.e. if the claimant could not establish that her PTSD would not have developed but for the negligent period of delay, then the claim should fail. He submitted that the 'material contribution' test had no role to play in a case such as this.

13. As I understand it, however, by the end of the case, Mr Found accepted that the correct approach was that set out by Waller J in **Bailey v The Ministry of Defence & Anor [2009] 1 WLR 1052** at p.1069 at [46]. Whether or not that was finally a concession made by Mr Found, I am satisfied that the correct approach should indeed be in accordance with the guidance provided by Waller LJ. He put it this way:

> "...I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. **Hotson** exemplifies such a situation. If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the

> claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed."

14. To summarise, therefore, the position is as follows:

    i) If it can be shown that the claimant would have developed PTSD, in any event, irrespective of the negligent period of delay, then the claim fails;

    ii) If it can be shown that but for the period of negligent delay the claimant would not have developed PTSD, then the claim succeeds;

    iii) If, on the other hand, the evidence is incapable of supporting either of the two propositions set out above, then if it can be shown that the negligent period of delay has made a material contribution to the PTSD, the claim succeeds.

The Parties' Positions

15. Put simply, the defendant's case, predicated on the evidence of Dr Bowers is that the claimant would have developed PTSD, in any event, irrespective of the period of negligent delay. The claimant's case, in reliance upon the evidence of Dr Smith, was that it was not possible to say at what point the PTSD was triggered during the period between the claimant suffering the SAH and being taken to hospital in the ambulance. Further, it is submitted that given the duration of the period of negligent delay, being approximately one third of the total period of delay, it could be said, with confidence, that the latter period of delay had made a material contribution to the onset of the claimant's PTSD.

PTSD

16. It is perhaps instructive at this point to provide some understanding of the condition of PTSD. Although Dr Smith preferred to rely upon DSM-IV, in the joint statement, there was agreement that the definition set out in ICD-10 was of application. Accordingly, for present purposes, I shall refer only to ICD-10. At paragraph F43.1, it is said that PTSD:

> "...arises as a delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature which is likely to cause pervasive distress in almost anyone... Predisposing factors such as personality traits ... or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.
>
> Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks')... Commonly,

> there is fear and avoidance of cues that remind the sufferer of the original trauma...
>
> There is usually a state of autonomic hyperarousal with hypervigilance... Anxiety and depression are commonly associated...
>
> The onset follows a trauma of a latency period which may range from a few weeks to months (but rarely exceeds six months)..."

17. That the claimant developed significant PTSD within a short period of time following her admission to hospital is not in dispute. In her witness statement, she describes panic attacks and a fear of being on her own. Her sleep is adversely affected. She has a fear of the unknown. She has a specific anxiety about ambulances: the thought of an ambulance arriving at her house prompted a panic attack. Notwithstanding her ongoing symptoms, she has been able to resume her self-employment as a hairdresser, albeit with adjusted hours.

Lay Evidence

18. The claimant was closely cross-examined about the sequence of events starting with the onset of the ruptured aneurism and her eventual transfer to hospital. It should be observed that at the time when Mr Found was cross-examining the claimant, it was on the premise that, at some unknown point during the 78 minutes of 'non-negligent' delay, the claimant's experience of the trauma was such that, on the balance of probabilities, she was going to develop PTSD at a later stage. Hence, Mr Found was very anxious to demonstrate that long before the period of negligent delay, the claimant was in profound distress and fearing that she was going to die. She accepted that she felt helpless being on her own and she described her body becoming "*more paralysed*". At one stage, and again before the negligent period of delay, she agreed that she was thinking to herself that if she got any worse, she would be dead.

19. If the position had remained that the defendant's case was that there was a cut-off point at some stage prior to the period of negligent delay but after calls had been made to the ambulance service, then it would be necessary to analyse, in some detail, the claimant's evidence about how she felt and what she experienced during that 78 minute period. It would have then been necessary to come to a conclusion as to whether it could be said that there came a point when she was likely to suffer PTSD, in any event, or whether it was simply not possible to say at what point the PTSD was triggered.

20. In a somewhat dramatic way, however, the defendant's case radically changed when Dr Bowers answered my question which was directed at establishing when he thought she was going to develop PTSD, in any event. His (wholly unexpected) response was that she was destined to suffer 'full blown' PTSD as from the moment when she suffered the SAH. I shall return to Dr Bowers' opinion about this critical matter when I look at his evidence in more detail but, as it seems to me, the effect of what he said at the conclusion of his evidence does change the approach to be adopted: either the PTSD was going to occur because of the happening of the SAH or Dr Smith is right and it simply cannot be said when it was likely that the trauma would have given rise

to PTSD. Indeed, quite properly, Mr Found did not submit that the court could or should seek to pinpoint a time after calls were made to the ambulance service when it could be said that the claimant was likely to have suffered sufficient trauma to go on to develop PTSD.

21. In these circumstances, it is not necessary to look at the claimant's evidence in any further detail. I should observe, however, that I found her to be an entirely credible witness who gave her evidence in a measured and controlled way. Insofar as there were any inconsistencies, they were due entirely to tricks of memory. There was no question of any exaggeration or over-statement, far less any attempt to mislead the court.

22. Similarly, it is now not necessary to analyse in any detail the evidence of the claimant's mother. She gave her evidence in an entirely straightforward way. Suffice it to note that when she came on to the scene at about 1600 hours, she was extremely concerned (understandably) about the condition of the claimant and she immediately telephoned the ambulance service.

23. One further matter which the claimant's mother was able to assist about was when the claimant first talked about the delay in the arrival of the ambulance. Mother told me that this was first mentioned when she came out of hospital. She said that the claimant was always talking about the ambulance and thinking she was going to die because the ambulance did not come.

Expert Evidence

Dr Smith

24. Dr Smith is a consultant psychiatrist. He is responsible for a medium secure unit in York where patients are sectioned under the Mental Health Act. In the course of this work and other work which he has done in the past as a psychiatrist, he has been involved in treating patients with PTSD. It may not be a special interest for Dr Smith but, in my view, he is certainly qualified to give expert evidence about the cause, onset, and symptoms of PTSD.

25. In his written and oral evidence, Dr Smith maintained that it was simply not possible to pinpoint a moment when the PTSD was triggered during the time between the happening of the SAH and the arrival of the ambulance. He regarded the whole period as traumatic and being responsible for the onset of the PTSD. To put it another way, he was not able to say that but for the negligent period of delay, PTSD would not have occurred but, equally, he could not say that the PTSD would have evolved, even if there had not been the negligent period of delay. He did not accept the proposition advanced by Mr Found that, whether from an objective or subjective perspective, the first 78-minute period was sufficient to give rise to a diagnosis subsequently of PTSD. He was very clear, in his view, that medical science was not capable of dissecting the negligent period of delay from the rest of the time that the claimant was on her own, waiting for an ambulance. He said that he based that, at least in part, on the fact that most people who experience trauma do not go on to develop PTSD.

26. Moreover, Dr Smith noted that during the negligent period, the claimant was left with a continuing feeling that help was not going to arrive. He considered that this was a central feature of her PTSD and explains, at least in part, why she feels unable to be alone. It has made her feel very vulnerable and that can be properly attributed to the delay in the arrival of the ambulance and being on her own for much of the relevant period. He was unpersuaded that the arrival of the claimant's mother at approximately 1600 hours was material in the context of her subsequent development of PTSD. Equally, the fact that she was in and out of consciousness was not of any particular importance; she was aware that the help that she needed was not materialising. Whilst accepting that a short period of trauma can result in PTSD, it was his considered view that the longer the exposure, the more likely it was that PTSD would occur and/or that it would be more severe.

27. In his closing submissions, Mr Found made a number of criticisms about Dr Smith's evidence. He pointed out that he had been inaccurate in relation to the timing of one of the telephone calls made by the neighbour in his report. He suggested that he was not sufficiently familiar with the facts of the case to arrive at a reasoned decision. He noted that whilst Dr Smith had signed up to ICD-10 as being the methodology for diagnosing PTSD. in his oral testimony, he expressed a preference for DSM-V. He also pointed out that the records compiled by the clinical psychologist, Dr Clark, made no reference to the claimant being troubled by the delay in the ambulance arriving but this was not something which Dr Smith was prepared to place any weight upon.

28. There may be some force in Mr Found's criticism of Dr Smith insofar as there are one or two factual inaccuracies. Equally, he may not have been particularly adept at calculating times. It may also be that he should have made more detailed reference to the records of the treating psychologist. In my judgment, however, none of these criticisms is of sufficient import or significance to undermine the quality of Dr Smith's evidence or his conclusions.

29. Thus far, I have considered only the minor criticisms made by Mr Found, some of which were perhaps justified. What I do not accept, and what I reject out of hand, is that Dr Smith did not genuinely hold the views which he expressed. Mr Found suggested that he was an *"advocate of the cause"*: I saw no evidence whatsoever of that being the case. It was said that he failed to make appropriate concessions: to my mind, that was not so and I note, in particular, that he was prepared to accept that the view expressed by Dr Bowers was within a reasonable range of opinion. Generally, I consider that Dr Smith was a thoughtful, balanced, and careful expert witness who was doing his best to provide the court with his genuinely held opinion.

Dr Bowers

30. I regret to say that the observations which I have just made about Dr Smith do not apply in equal measure to Dr Bowers. Dr Bowers is a Consultant psychiatrist. He also has extensive experience of diagnosing and treating PTSD.

31. Before Dr Bowers gave evidence and before he was cross-examined by Mr Dean, there were aspects of his written report which caused me some concern. Those concerns became more significant when I heard and observed him being cross-examined. It is only necessary to give a couple of examples, by way of illustration.

At page 180, in the joint report, Dr Bowers was at pains to point out that the claimant had (apparently) significantly minimised the extent of her pre-existing mental health problems. In fact, having heard Mr Dean cross-examine Dr Bowers about this, I am unpersuaded that she had under -reported her previous mental health difficulties. Be that as it may, what to my mind was unacceptable was the suggestion that the claimant was deliberately attempting to minimise her psychiatric history for the purposes of the litigation. There was no evidential basis for such a suggestion and it should not have been made. True it is, in his oral evidence, Dr Bowers essentially accepted that there was no evidence of the Claimant attempting to be devious or deceitful but, to my mind, without more, this should not have been floated, even as a possibility, in his written evidence. It has never been in doubt that the claimant has suffered very significant PTSD in consequence of the trauma she suffered on 18 September 2016; and that it was that 'event' which was solely responsible for her PTSD.

32. Another illustration of Dr Bowers adopting a less than fair approach was at page 52 of his report where he notes that the claimant, in her witness statement, said that she "*did everything right and everything ... to get help and make sure I was safe*" but in the same paragraph, Dr Bowers observes that the claimant's telephone was not adequately charged, thereby preventing the emergency services from being able to contact her. The clear and obvious suggestion is that, in fact, the claimant did not do everything to help herself. Such a comment, in my view, is unfair: she is surely not to be criticised for not having charged up the battery on her mobile phone so that she may thereby be said to have somehow contributed to the mental illness which she went on to suffer.

33. A third matter of concern arose in the course of the cross-examination of Dr Bowers about the incidence of PTSD. He made no reference to any literature in his report but whilst being cross-examined, he said this, initially:" the literature shows that up to 60% of patients who develop SAH go on to suffer PTSD". That was a startling assertion which, if true, should have featured in his written report with reference to the supporting literature. On closer questioning, it emerged that, in fact, the range of patients who develop PTSD following SAH is somewhere between 20 percent and 60 percent. It seemed to me that the initial statistic provided by Dr Bowers was capable of being misleading. Moreover, he produced no literature to support any of this data.

34. Generally, it seems to me that Mr Dean's cross-examination of Dr Bowers to the effect that he was deliberately attempting to present a negative view of the claimant was justified. I do feel constrained to conclude that there was a lack of objectivity on the part of Dr Bowers and that there was an attempt, certainly at times, to present an assessment which was less than favourable to the Claimant. I should make it clear that I do not lightly come to this conclusion but it seems to me that it was irresistible in the face of the written and oral evidence given by Dr Bowers.

35. The other feature of his evidence which was somewhat disturbing was the answer which he gave to me at the very end of his evidence to which I have already referred. Reading his report and, in particular, the joint statement, Dr Bowers gave the very clear impression that whilst the period of negligent delay was not a causative factor, the delay in the earlier period, cumulatively was a cause of the PTSD. What Dr Bowers said in answer to question 10 of the joint statement was this:

> "Dr Bowers did not consider the negligent delay period to have caused any material contribution to the claimant's PTSD. This opinion was based on his view that the claimant would have developed PTSD in any event prior to the negligent delay, that time is not a necessary factor for the onset of PTSD, that the presence of her mother during the delay period would have attenuated any distressing experiences she had and her overall experience was not pervasively distressing as there was a period of feeling calm and peaceful during the delay period."

36. It was to be expected that Dr Bowers would express a similar opinion in his oral evidence but, as noted above, he said, unequivocally, that his view was that she would have suffered PTSD in consequence of the SAH itself. Legitimately, the question can be asked that if that was his considered view, why was it not spelt out in his written evidence? I regret to say that the approach adopted by Dr Bowers in trying to paint a negative picture of the claimant as well as the radical change in his view as to when the PTSD was triggered undermines, to a significant degree, the confidence which the court can have in his conclusions.

Discussion

37. Although Mr Found accepted that he could not go behind the answer given by Dr Bowers at the conclusion of his evidence, nevertheless, he sought to persuade me that reliance could not be placed on the opinion expressed by Dr Smith. As well as relying upon the matters set out at [27-29] above, Mr Found also contended that there were two fallacies in the view expressed by Dr Smith. In the first instance, he says that there is no diagnostic criteria which places weight on duration of trauma. I agree that that is so but it does not follow that it can be said, even on the balance of probabilities, that a short period of trauma should be taken as the trigger for PTSD, in the context of a much longer period of trauma. In other words, just because a short period of trauma can result in PTSD, it does not mean that the whole period of trauma has not made a material contribution to the PTSD. Mr Found also submitted that there was incongruity between Dr Smith being able to say that the negligent period of delay undoubtedly made a contribution to the PTSD whereas he was not able to express a view on the 'but for' test. It does not seem to me that there is any inconsistency in the stance adopted by Dr Smith. It is often very difficult, particularly in the case of an *indivisible* injury to apply the 'but for' test but much less difficulty arises where the question which is posed is whether events have made a *material contribution* to an injury. That is why the Common Law has embraced the concept of *material contribution* in looking at causation where an indivisible injury has occurred.

38. Although, in a sense, as I said at [20], the court is left with a binary decision, nevertheless, it is necessary to consider whether Dr Smith's opinion is sustainable by reference to what occurred prior to the 31-minute period of negligent delay. Undoubtedly, what occurred prior to the negligent period of delay was traumatic and, in particular, the fact that the claimant felt that she was going to die; and that she was suffering intense physical pain. Nonetheless, it does not follow that it is possible to identify a specific cut-off point when it could be said that whatever happened thereafter, PTSD was going to evolve. To the contrary, it seems to me that to look at the matter in that way is to adopt an artificial approach. It is, to my mind, in the realms of speculation to attempt to identify a fixed time when the claimant had

suffered sufficient trauma such that she was likely to go on to suffer PTSD. Accordingly, I think there is considerable force in the proposition advanced by Dr Smith to the effect that medical science is not capable of dissecting that 31-minute period from the rest of the period of delay, so as to enable the inference to be drawn that PTSD would have occurred irrespective of the 31-minute delay.

39. Notwithstanding the observations which I have made about Dr Bowers' expert evidence, consideration needs to be given as to whether the theory that the PTSD would have arisen as a direct result of the SAH alone is sustainable. As it seems to me, it is certainly possible that from the moment when the claimant suffered her SAH, she was destined to go on to develop PTSD but to come to such a conclusion, on the balance of probabilities, is a step too far. Put simply, medical science does not permit such a conclusion to be drawn.

40. In support of the above proposition, it is not unhelpful to have regard to the judgment of Globe J in the case of **Ceri Leigh v London Ambulance NHS Trust [2014] EWHC 286 (QB)**. In that case, the claimant dislocated her right kneecap whilst on a bus. An ambulance was called but it was some 50 minutes before it arrived. There was an admitted negligent delay of 17 minutes. The claimant went on to suffer PTSD. It was agreed that the PTSD was a consequence of the incident. It was the defendant's case that irrespective of the period of negligent delay, the claimant would have developed PTSD. At [28] of his judgment, Globe J said this:

> "...There was no injury that was caused on the bus. There were merely circumstances that arose which later led to the onset of the disorder of PTSD. There are innumerable variables in the circumstances that will give rise to the development of such a disorder and in the people who are likely to suffer it. It is impossible to predict on any scientific or mathematical basis the moment after which someone will go on to suffer it. Adopting the **Bailey** test, I am unable to find on the balance of probabilities that the PTSD would have occurred in any event before 19.33... I am satisfied that this is a case where medical science cannot establish the probability that 'but for' the negligent failure of the ambulance to arrive before 19.33, the PTSD would not have happened, but it has been established that the contribution of the negligent failure was more than negligible. It made a material contribution to the development of the claimant's PTSD. The claimant therefore succeeds on the first issue."

41. Despite the obvious factual differences as outlined by Mr Found, it seems to me that the reasoning of Globe J is particular apposite in the context of this case. Indeed, and with respect, I adopt what the Judge said as to the impossibility of predicting on any scientific or mathematical basis (whether prospectively or retrospectively) when a person exposed to trauma is likely to go on to suffer PTSD.

42. Having adopted that reasoning, it inexorably follows that I am wholly unpersuaded that it can be said, even on the balance of probabilities, that at the point of onset of the SAH, it was likely that the claimant would develop PTSD. Equally, it cannot be said, on a balance of probabilities, at what point during the 109 minutes when she waited

for an ambulance to arrive that the PTSD was likely to develop. To the contrary, it is, to my mind, pure speculation. In a similar vein, it cannot be said that the 31 minutes of negligent delay was of no importance. Although duration of trauma may or may not be a relevant diagnostic factor, the reality is that the period of delay was approximately one third of the overall delay. It would be verging on the absurd, in my view, to suggest that that period of delay when the claimant was in acute distress, believing that the ambulance was not going to come, did not make a material contribution to the onset of her PTSD.

43. It is submitted by Mr Found, however, that even if I were to find that the 31-minute period of negligent delay material contributed to the onset of the PTSD, nevertheless, I should undertake an apportionment exercise. I have already observed in the course of this judgment that I regard PTSD as an indivisible injury. It is far removed from, for example, industrial diseases such as noise induced deafness or asbestosis which are known to be dose related. That is simply not the case with PTSD. If I cannot say when the trigger for the PTSD occurred, it would not be logical to go on to conclude that, nevertheless, there can be an apportionment exercise. In any event, such would not be legitimate if my assessment is correct that this is an indivisible injury.

Conclusion

44. In conclusion, I find that the period of the 31-minute delay made a material contribution to the claimant's PTSD and that an apportionment exercise is not permissible in these circumstances. Accordingly, there will be judgment for the claimant in the sum of £40,000.