Neutral Citation Number: [2026] EWHC 898 (KB)

Case No: KB-2023-004625

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/04/2026

Before:

Edmund Burge K.C.
(sitting as a Deputy Judge of the High Court)

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Between:

BENJAMIN RIDGE **Claimant**

- and -

DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST **Defendant**

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Laura Begley (instructed by **Enable Law**) for the **Claimant**
Clare Hennessy (instructed by **DAC Beachcroft LLP**) for the **Defendant**

Hearing dates: Tuesday 17 March 2026 - Friday 19 March 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on Friday 17 April 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Edmund Burge KC:

1. In the early morning of the 29th April 2021 Benjamin Ridge climbed an electricity pylon in a field close to his home in Weymouth and suffered a significant electric shock. He was immediately rendered unconscious and fell approximately 20 feet to the ground. He survived but received severe electrical burns, fractures to two vertebrae, and subsequently underwent an above-knee amputation of the right leg. He continues to suffer back pain, phantom limb pain and nerve damage to three limbs, with physical disability and restricted mobility from having to use a wheel-chair.

2. In the days preceding this incident Mr Ridge had had extensive contact with the Defendant's mental health support services due to his depression and suicidal thoughts. That contact included a face-to-face assessment on 27th April 2021 with a locum Community Mental Health Team ('CMHT') Consultant Psychiatrist, Dr Trendafilov.

3. At that assessment Dr Trendafilov concluded that Mr Ridge was suffering from Depressive Disorder, Post-Traumatic Stress Disorder ('PTSD') and Generalised Anxiety Disorder, all of which he assessed as "moderate". He also assessed the current level of risk of self-harm as "moderate". Dr Trendafilov increased Mr Ridge's dosage of anti-depressant medication (Mirtazapine) from 30mg to 45mg, and prescribed Zolpidem sleeping tablets to aid his night-time sleep. Dr Trendafilov also arranged a further face-to-face appointment with Mr Ridge for the 30th April. He did not refer Mr Ridge to the Defendant's Home Treatment Team ('HTT') for an assessment as to his suitability for admission as a hospital inpatient.

4. Mr Ridge brings his claim against the Defendant on the basis that Dr Trendafilov's assessment of both his degree of depression and the risk of self-harm as 'moderate' fell below the standard reasonably to be expected of a competent psychiatrist in possession of the relevant facts. He argues that, had Dr Tendafilov exercised the appropriate degree of skill and care, he would have assessed both issues as 'severe'. Such an assessment ought to have resulted in the Claimant being referred to the HTT for assessment of his suitability to be admitted as an inpatient.

5. Mr Ridge says that had such a referral been made, whether on 27th or 28th April 2021, the HTT would have assessed him as being in need of immediate admission to a hospital and that he would in fact have been immediately admitted as such. Had that happened as it should have done, he argues, he would have been unable to climb the pylon early on 29th April with the consequent lasting effects on his physical and mental health.

6. The Defendant denies that Dr Trendafilov's assessment of the risk of self-harm was negligent; it says that assessing both the Claimant's level of depressive illness and his risk of inflicting significant self-harm as 'moderate' rather than 'severe' was within the range of reasonable and respectable psychiatric opinion.

7. The Defendant does accept that, given the information available to Dr Trendafilov on 27th April, and the assessments that he in fact made, he ought to have referred the Claimant to the HTT for an assessment of the most appropriate treatment pathway. However, the Defendant submits that even if Dr Trendafilov had referred Mr Ridge to the HTT for further assessment, his symptoms and presentation were not so acute that Mr Ridge would have been admitted as an inpatient.

8. Furthermore, the Defendant submits that even if the Claimant had been assessed as suitable for admission as an inpatient, because of the demand for such places it is highly unlikely that a suitable bed would have been found for him before the 29th April 2021. Therefore, says the Defendant, on 29th April Mr Ridge would still have been living at home and thus in a position to injure himself in the way that he did.

9. This judgment is concerned solely with whether the defendant is liable for Mr Ridge's claimed losses by virtue of its alleged breaches of the duties that it owed him.

The relevant law

10. The parties agreed that the tests to be applied by the Court to the evidence are as follows:
    (i) That to amount to medical negligence any error in treatment or investigation, or any failure to provide adequate treatment, must be shown on the balance of probabilities to derive from a failure to exercise the degree of skill reasonably to be expected of a competent practitioner. As was stated by McNair J in Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, "*The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of a competent man exercising that particular art";* and
    (ii) where, as in this case, the alleged breach of duty consists of an omission to do an act that ought to have been done (ie the failures (i) accurately to assess his level of depression and his risk of self-harm, (ii) to assess the Claimant's suitability for admission as an inpatient, and (iii) to admit him as such), the decision-making relied on has to be respectable, responsible and reasonable, and has to have a logical basis. Where that decision involved weighing comparative risks it has to be shown that the decision-maker had directed their mind to the comparative risks and benefits and had reached a defensible conclusion, per Bolitho v. Hackney HA [1998] AC 232.

11. Therefore, in order for his claim to succeed the Claimant must satisfy the Court on the balance of probabilities that:
    (i) In assessing the Claimant's level of depression, and the consequent risk of self-harm, as 'moderate' rather than 'severe' Dr Trendafilov fell below the standard reasonably to be expected of a competent psychiatrist; and
    (ii) had Dr Trendafilov assessed those matters as 'severe' and/or referred him to the HTT, that body would have assessed the Claimant as suitable for immediate admission as an inpatient; and
    (iii) a suitable bed would have been made available for the Claimant before the 29th April 2021, when he climbed the pylon and sustained his injuries.

The witnesses relied on by each party

12. The Claimant relied on his own witness statement, along with that of his mother and a full report by a Consultant Psychiatrist, Dr Trevor Turner MD FRCPsych.

13. The Defendant relied on the witness evidence of:

(i) Helen Green, an Occupational Therapist and a manager of the Defendant's Mental Health Services team;
(ii) Tracey Pegg, a duty nurse within the Defendant's Community Mental Health Team;
(iii) James Smith, a registered Mental Health Nurse and a senior manager in the Defendant's mental health team with responsibility for the allocation of inpatient beds, and
(iv) Dr James Eldred MRCPsych, a Consultant Psychiatrist.

14. There was also a joint report that had been prepared by the two expert psychiatrists in December 2025, which summarised their areas of agreement and disagreement on 36 separate matters.

15. There was no evidence from Dr Trendafilov. By the time the Claimant had started these proceedings Dr Trendafilov had stopped working for the Defendant as a locum Consultant Psychiatrist. Attempts to locate him by the Defendant's solicitors (made between April 2024 and late 2025) were unsuccessful. He was finally located, working in Northern Ireland, in late January 2026 – approximately six weeks before this trial was due to start.

16. Work started immediately on obtaining a full witness statement from Dr Trendafilov, and in early March 2026 the Claimant's solicitors were informed that the Defendant intended to file a witness statement from him. Given the proximity of the trial date, and as they were entitled to do, the Claimant objected to the late service of such evidence. In light of those objections, and the fact that any witness statement would also need to be considered by the expert witnesses for both sides with consequent risks to the trial date and for costs, the Defendant took the decision not to rely on Dr Trendafilov's evidence. That decision was taken, and communicated to the Claimant, on 5th March 2026, 11 days before the trial was due to start.

The background to Dr Trendafilov's assessments of the degree of the Claimant's depressive illness on 27th April 2021 and the risk of self-harm.

17. The Claimant gave evidence. He was born in May 1992, which made him 28 at the time of the events in question. His witness statement gave a history of his childhood, up-bringing and education, which included taking First Class Undergraduate and Masters Degrees (in Theatre Studies and Stand-Up Comedy, respectively) from the University of Kent in 2014.

18. He spent a year of his undergraduate degree studying in the USA, where he was an Honor Roll Student and on the Dean's List. During and after University he travelled widely in the USA and Europe, staging and performing in various productions and work-shops, and he regularly performed at the Edinburgh Fringe Festival up until 2017.

19. He gave details of his physical ill-health from the age of 11, and of the on-going effects of a traumatic incident that had occurred when he was aged eight. This history involved being diagnosed in late 2014 with Depressive Disorder, PTSD, and generalised anxiety disorder, for which he was prescribed various drugs including Fluoxetine which was replaced by Sertraline. He stopped taking Sertraline in the summer of 2020, whereupon

his mental health began to deteriorate. The majority of his written evidence concerned the further deterioration of his mental state between February and April 2021.

20. He described how his mental health began particularly to suffer in February 2021, when he was living at home with his parents in Weymouth, Dorset and was remotely undertaking a Master's Degree in comedy-writing through Falmouth University. By this time he had not been taking either anti-depressant or anti-anxiety medication for approximately 6-7 months.

21. It was during this period of time that he began to have suicidal thoughts. He contacted his GP and was again prescribed Sertraline. It was at about this time that he started to keep a handwritten diary of his thoughts, feelings and symptoms etc. That diary was typed-up for these proceedings and was exhibited to the Claimant's witness statement. As will be seen below, illegible entries were transcribed as "[?]".

22. By early March 2021 the Claimant was having episodes of mania and regular suicidal thoughts. On 10th March he made an on-line self-referral to 'Steps 2 Wellbeing', a local mental health help-line, and was given an appointment for 30th March. He was prescribed Citalopram in place of Setraline but his symptoms of anxiety were increasing and becoming harder to control. He was also experiencing stronger and more frequent suicidal thoughts.

23. On the morning of 29th March 2021 (ie a month before he sustained his injuries at the electricity pylon), he felt that he needed to be admitted to hospital and packed a bag in preparation. He spoke to his GP, who did not refer him to hospital but made an urgent referral to the Weymouth CMHT. Later that afternoon he received a call from the CMHT who recommended that he be prescribed Mirtazapine instead of the Citalopram, and suggested he contact his GP to arrange the prescription.

24. The following day (30th March 2021) he again contacted the CMHT and told them he was having on-going thoughts of self-harm, including wanting to stab himself with a pen and breaking a plate against his face. He asked to be admitted into a unit for monitoring. In a second call with the CMHT later that day he described how that afternoon he had had to fight the urge to walk into moving traffic. He again asked for an inpatient admission but this was refused.

25. Also on 30th March, after his second call with the CMHT, the Claimant had walked to a friend's house. He said that while there he had seen a hunting knife on the kitchen counter and had had the urge to pick it up and stab his friend, although he had not done so. After leaving his friend's house he had a telephone call with Steps 2 Wellbeing, who also suggested he switch medication to Mirtazpine and for which did he obtain a prescription from his GP.

26. Between 1st and 27th April the Claimant said that he had made a number of attempts to kill himself. These included attempting to drown himself by walking into the sea carrying heavy weights, several attempts to hang himself using a dressing-gown cord, and taking hold of a knife with the intention of cutting his throat or wrists. He was also recording in his diary his wishes to die and his various attempts at ending his life. Some attempts he carried through (eg sticking the handle of knife into an electric toaster), and some he did not (eg standing by the side of a busy road trying to persuade himself to

step in front of a lorry). He also tried to buy on-line what he described as 'Euthanasia drugs' (Nembutal powder) but was ultimately unsuccessful in obtaining them.

27. On the 21st April he described feeling both suicidal and 'furious' about the way he felt. He wrote "*I am so angry*" in capital letters in his diary, and recorded how he felt "*totally lost and stuck*". It was on this day that he first climbed the electricity pylon where he subsequently sustained his injuries on 27th April. His evidence was that on that day he climbed the pylon twice, both times getting past the barbed wire that was intended to prevent such acts, but he did not touch the high-voltage cables because "*I thought it might only injure and not kill me"*.

28. He said that he felt intensely suicidal over the next few days, and reported those feelings to Tracey Pegg, the CMHT nurse. She made a note dated 23rd April that he told her he had climbed an electricity pylon but had stopped himself from touching the conductors. He also told her about trying to by the Euthanasia drugs, and she noted that he asked about being referred as an inpatient. Her note ended with her confirming to the Claimant that he was due to start a course of therapy on 6th May, and with him stating that in the meantime he would not harm himself and would contact sources of support.

29. The intensity of his suicidal thoughts appeared to fluctuate between the 23rd and 26th April. Over those few days he had telephone conversations with various sources of support, including "Connections", NHS 111 and a family friend who was a trained mental health nurse. On 24th April he wrote in his diary "*Spoke with [?] with [?] SHOUT. 111. Connections [?] + [?]. All to try + help depression/anxiety. Jesus. It's like a horrendous noise [?]. I know it's just thoughts but Christ they are noisy. Will probably come up again tomorrow. Shall [?] observe + let go. [?] I am [?] excited and hopeful about my life. Just need to keep steady [?] grateful + calm [?] [?] [?] [?] now hopefully.*" His witness statement said he also felt less suicidal on the 25th April.

30. However, on the 26th April he had a strong urge to kill himself and said that he formed the intention to do so. He went back to the electricity pylon near to his house and again climbed it, but a member of the public had walked past and interrupted him so he climbed back down. Later that day he wrote in his diary "*I'm so excited to die tomorrow morning. If you are reading this, hello, I tried to climb this morning + got interrupted. Tomorrow I will go earlier. My thoughts over recent days have changed from "I'm suicidal" to "I'm going to kill myself" to "I want to kill myself" to "I need to kill myself". This started when I started Mirtazapine. It is no-one's fault. This is just something that I need to do. I have had my time. I've really enjoyed so many bits of it*". He then wrote some words of thanks to his family, and identified the songs that he wished to be played at his funeral.

31. At some point on the 26th April, although it is not clear whether before or after he had written his diary entry for the day, he again spoke to Tracey Pegg. He told her about climbing the pylon again that day, and she informed him that he had an appointment with Dr Trendafilov the following day.

32. The Claimant's witness statement said that on the morning of the 27th April he was still struggling with the same strong urge to climb the pylon and to electrocute himself, although it made no reference to him actually going to the pylon before his appointment with Dr Trendafilov.

33. In the course of his cross-examination he stated that he had gone to the pylon on the morning of the 27th April. He said that he had not climbed it because he was hopeful of there being an active intervention by the health authorities following his forthcoming meeting with Dr Trendafilov. He said he remembered that he had then returned home and that his mother had remarked to him that he was up unusually early that morning.

34. He was referred to his diary entries, and he agreed that they did not support his evidence of having been to the pylon that morning. He said that there must be some information missing from the diary, which related to his having gone there that day and looking at the pylon but having decided not to climb it.

35. In any event, the Claimant's parents drove him to the meeting with Dr Trendafilov and remained in the car while the Claimant attended his appointment. The Claimant had packed a bag in the expectation that Dr Trendafilov would arrange for him to be admitted as an inpatient that day, which is clearly what the Claimant wanted.

36. The meeting with Dr Trendafilov lasted about an hour. It appears that Dr Trendafilov was unaware that the Claimant's parents were waiting for him in the car, that he had packed a bag expecting to be admitted immediately into hospital, or that he had visited the pylon earlier that morning.

37. Dr Trendafilov made short contemporaneous notes of his meeting with the Claimant. Those notes included references to the Claimant's mood as "*very low*" and having "*had enough*". The Claimant said that he felt "*ashamed he is almost 30 years old and still lives with mum and dad*". He told Dr Trendafilov that his suicidal ideations started when he started the anti-depressants again (ie around February 2021). He disclosed that he had previously climbed the electricity pylon (which Tracey Pegg had already recorded in his notes), but he made no mention of having gone back to the pylon earlier that day. There was a discussion with Dr Trendafilov about the attempted purchase of Nembutal on-line, and he said that "*he realised he wants to kill himself repeatedly*".

38. Dr Trendafilov's contemporaneous notes of the meeting end with a future treatment plan, which included the prescription of sleeping tablets, an increase in the dosage of Mirtizapine to 45mg a day for at least the next 4-6 weeks, and a follow-up meeting to be held on Friday 30th April at 10.30am. It was also noted that if the risks of self-harm escalated, the Claimant was to be referred to the HTT.

39. Those notes were expanded upon in a letter to the Claimant from Dr Trendafilov dated 30th April 2021 (ie after the Claimant had sustained his injuries on 29th April). It started with the following note: "*Mr Ridge arrived on time and attended alone".* Under the heading "ICD10 Diagnosis" Dr Trendafilov recorded "*Recurrent Depressive Disorder, current episode moderate. PTSD, generalised anxiety disorder and cannabis misuse*". Dr Trendafilov assessed the current and medium-term risks of self-harm as "moderate". He summarised the position thus: "*Mr Ridge reported increased suicidal thoughts in the last three months. He tried to climb up an electric tower three times in the last two weeks. Mr Ridge thought to buy a "euthanasia drug" over the internet for £600 but realised it was a scam. The risk to self is moderate."* Under the heading 'Capacity' he wrote: "*Mr Ridge does have capacity to discuss the current treatment plan*".

40. The rest of the letter gave a more detailed account of the various matters that Dr Tendafilov had recorded in his contemporaneous notes. Dr Trendafilov recorded that he had asked the Claimant whether the decision to climb the pylon had been impulsive, and that the Claimant had said he had been "*thinking about it*". Under a heading 'Mental State Examination" he wrote: "*Benjamin was dressed appropriately. Reasonable eye contact was established. Polite and co-operative with good hygiene. Speech was with normal prosody. Thoughts were coherent, logical with some over-valued ideas that life was not worth living. Feeling hopeless and helpless, concerned about his future and his finances. No perceptual disturbances reported. Mood subjectively low, affect-fluctuating. Now and then Benjamin was crying and after that he was smiling and laughing whilst we discussed the comedy writing. Memory and concentration no concerns*".

41. Under the heading "Impression" Dr Trendafilov noted that the Claimant had a history of depression, and had attended a meeting with the CMHT on 29th March 2021 with suicidal thoughts and depression and with a bag packed ready for a hospital admission. He summarised the history of the Claimant's contact with the various mental health agencies since then, and recorded the following: "*Benjamin tried to climb 3 times up an electric tower with the intention to kill himself….He also reported increased suicidal thoughts when he was commenced on a new antidepressant medication. Benjamin had a plan to kill himself this morning, but at this very moment he denied and did not share any other plans. It looks (sic) his affect fluctuates and he had some positive reactions over the current interview.*" Dr Trendafilov then summarised the treatment plan as previously set out in the contemporaneous notes. A post-script at the bottom of the letter noted the Claimant's attempt to commit suicide on 29th April by climbing the pylon.
42. It is this assessment of the Claimant's current mental state, and his risk of inflicting self-harm, that he submits was below the standard reasonably to be expected of a competent psychiatrist.

43. The Claimant's diary entry for 27th April, which was clearly written after the meeting with Dr Tredafilov, included "*Well none of that fucking happened then did it. Nice one. We fight on son! There were so many times this morning in the quaking hours that I almost slipped on my black joggers + went back to the pylon once more. Alas. I sat. I sat and let it simmer and boil"*. He described how he had met Dr Trendafilov and told him how he felt. "*I told him everything…How even that morning I had planned to climb the barbed wire electricity pylon. 3 times in total now. It's almost as if I take it so far to see how much I can actually go through with it….That this is yet another blip and I will move forward again"*. He also wrote: "*I bought myself some running shoes + and looking to definitely be sorting my room out over the rest of this week. Italy? Volunteer abroad in Europe? Could be a fun summer. Could be"*.

44. The day after the meeting with Dr Trendafilov the Defendant's Multi-Disciplinary Team ('MDT') met and discussed the Claimant's case along with the others on its current case-load. Helen Green attended that meeting, and she gave evidence to the Court which is considered further at paras 65-69 below.

<u>A summary of the evidence relating to whether Dr Trendafilov's assessment of the degree of the Claimant's depressive illness on 27th April 2021, and the risk of self-harm, fell below the standard reasonably to be expected of a competent psychiatrist.</u>

45. The Claimant relied on the report of Dr Turner, who gave evidence and was cross-examined. Dr Turner's report was written in July 2025, following a face-to-face assessment of the Claimant on 1st April 2023. Dr Turner was also given access to the Claimant's medical records, a copy of his personal diary, the Defendant's Acute Inpatient Operational Policy, and the witness statements and pleadings relied on by the parties in the legal proceedings.

46. Dr Turner's conclusions were that the Claimant had experienced "*a substantial pattern of serious depression"* which "*generated substantial suicidal ideation and despair with limited response to medication*" (report, para 74).

47. In reaching this opinion Dr Turner placed considerable weight on the Claimant's repeated climbing of the electricity pylon, and the frequency of having done so within a relatively short period of time: "*…the risk presented on 23.4.21 was moderate to high at least, given his admission of climbing electricity poles. In this regard, such an action is extremely unique, and I have never encountered a patient with such a suicidal action before. My view is that on 27.4.21 he was suffering from at least a severe depression, with a severe level of risk"* (report, para 77). Dr Turner continued: "*…the unusual nature of climbing an electricity pylon needs to be recognised as indicating severe suicidal ideation, the number of attempts on balance reflecting an increasing intensity of his suicidal thoughts"* (report, para 80).

48. Dr Turner also concluded that the failure of Dr Trendafilov to take a corroborative history of the Claimant's symptoms from his parents was a failure of clinical best-practice "*it being accepted that a corroborative history from family members is vital in clarifying an individual patient's mental state and its severity. Mr Ridge's parents were waiting outside and could easily have been contacted for a discussion as to their thoughts about their son's condition"* (report, para 82).

49. Dr Turner wrote: "*…therefore I consider that the failure to offer admission to hospital was inappropriate practice, and I consider this fell below the Bolam standard of care, in that in my view no responsible body of psychiatrists would have failed to admit him"* (report, para 81). Also: "*I consider he should have been admitted to hospital, whether or not via the Home Treatment Team…Referring him to the Home Treatment Team as an option would seem to be inappropriate given his constant risk of suicide, and the fluctuating nature of his mental state and its severity"* (report, para 83).

50. On the issue of the Defendant's policy of applying the treatment pathway that placed the minimum necessary restrictions on the patient in all the circumstances, Dr Turner's opinion was that "*Safety needs to outweigh the notion of a "least restrictive environment" and admission is not necessarily a last resort. In this regard the Trust failed accurately to assess and record the risk of self-harm, and had he been assessed as at high risk of self-harm he would have been admitted to hospital and kept safe in hospital. Even if a bed had not been available, and it is standard practice to find a bed at another Trust, and I note that this comes into the consideration provided by the Trust* (sic)", (report, para 90).

51. Overall, Dr Turner's conclusion was that "*Appropriate treatment via hospital admission was not provided for him despite his declining mental state, and I consider this to have been a breach of duty. While there is likely to be a range of opinion on the matter, I would consider it illogical for any body of psychiatrists to have failed to admit, given*

the nature of Mr Ridge's presentation, and the factors in his depression as identified" (report, para 96).

52. In cross-examination Dr Turner repeated his view that the Claimant's recent history of climbing an electricity pylon as a means of possible self-harm was a highly significant factor in the proper assessment of the degree of risk that he posed to himself. In Dr Turner's view, "*the exceptional, unique and difficult nature*" of climbing a pylon meant that the Claimant needed to be hospitalised. He said "*I cannot emphasise enough the uniqueness of the climbing of the pylon. It is very significant. To go through all of those risks is a sign of the intensity of the suicidal thoughts"*.

53. Dr Turner accepted that the objective risk of harm from climbing a pylon is comparable to that of climbing a bridge or high building, but was of the opinion that the fact that it is, in practice, a more difficult process to achieve was important, because it indicated a greater intent to inflict serious self-harm. He said "*Getting up the pylon is extremely difficult; I was struck by it"* and "*I think there is a relationship between the chosen method of suicide and the risk of it happening"*. "*The more risky the suicidal act, the more likely it is that the depression is severe"*.

54. On the issue of consulting with the Claimant's parents, Dr Turner's opinion was that it was good practice to take a corroborative account from close family or friends etc, and noted that obtaining such an account was recommended by the Maudsley Handbook of Practical Psychiatry. He accepted that there was "a margin" of different professional opinion about the matter, but said that senior psychiatrists like him would consider it to be mandatory. In Dr Turner's words "*good practice is mandatory*".

55. Dr Turner did accept that the HTT that was the 'gate-keeper' to admission to hospital as an inpatient, and that therefore all referrals for admission had to be made to that body for its own consideration. In other words, it had not been within Dr Trendafilov's power to have the Claimant admitted immediately after his assessment on 27th April 2021. Dr Turner therefore also accepted that his evidence at para 83 of his report (that the severity of the Claimant's risk meant that further referral to the HTT was inappropriate – see para 49 above) was incorrect. Dr Turner said that it was after he had written his report that he had discovered that admission to hospital was only possible through the HTT, and agreed that he had not updated his report accordingly.

56. He therefore accepted that the HTT was in fact the sole route for admission as an inpatient. However, he said that had Dr Trendafilov referred the Claimant for assessment as he should have done, the HTT should have raised an immediate assessment of its own and recommended an immediate admission into hospital.

57. Dr Turner accepted that there was evidence in both the Claimant's medical notes and his personal diary that indicated a desire by the Claimant to improve his physical and mental health, as well as evidence of optimistic forward-planning involving foreign travel, work plans etc.

58. He also agreed that there were a number of other aspects of the Claimant's personal circumstances in late April 2021 (e.g. stable accommodation, a supportive family, a degree of insight into his own behaviour, active engagement with mental health services to deal with his suicidal thoughts, and declarations to staff at those services that he had

no current plans to harm himself) that were relevant to the overall assessment of risk of immediate self-harm.

59. He therefore accepted that there might be differing professional views about the level of risk of self-harm, but he repeated his opinion that no reasonable body of psychiatric opinion would have failed to have assessed the risk as 'high' or 'severe'. Likewise, while he accepted that there might be differing views about the need for admission as an inpatient, he disagreed with Dr Trendafilov's assessment "*and therefore I do not consider that it falls within the range of reasonable professional opinion*".

60. Dr Turner emphasised that he was not saying that if he disagreed with another psychiatrist's opinion then that opinion must always be outside the range of a competent professional; however he disagreed with Dr Trendafilov, and took that view of his assessment, in this particular case.

61. Dr Eldred gave evidence for the Defendant. His report had been prepared in October 2025, and was based on broadly the same documentation as that given to Dr Turner. It seems that Dr Eldred did not have a face-to-face meeting with the Claimant but, no doubt given the passage of time between the events in question and the writing of the report, no complaint about that was made on behalf of the Claimant and it was not suggested that it adversely affected Dr Eldred's opinion.

62. Section 13 of Dr Eldred's report contains his analysis of Dr Trendafilov's assessment of the Claimant on 27th April 2021, and of the assessment of the degree of depressive illness (by reference to the classification at ICD-10) and the risk of self-harm. At paragraph 13.1.3 Dr Eldred says: "*Rating the intensity of mood disorders (mild/moderate/severe) involves a degree of subjective interpretation by the clinician. For example, each clinician must form an opinion on whether a particular symptom is present continuously or fluctuates, or whether a particular symptom should be attributed to the disorder rather than any underlying personality features. It is my opinion that the diagnosis offered by Dr Trendafilov fell within the expected range of opinion of a responsible body of practitioners*".

63. Dr Eldred expanded on that opinion at paras 13.7.1 and 13.7.2 of his report. He disagreed with the Claimant that on 27th April 2021 he (the Claimant) had been *"at the very highest risk of imminent suicide or self-harm"* as stated in the Particulars of Claim.

64. In Dr Eldred's view, the fact that in his meeting with Dr Trendafilov the Claimant had expressly said there was no imminent suicidality, and had discussed his future employment options (including working for Dorset MIND) and other plans, was a significant factor that Dr Trendafilov was entitled to take into account: "*Based on the assessment that was documented by Dr Trendafilov on 27th April 2021 in my opinion it was reasonable for the Defendant to continue to work with the Claimant in the community. Any decision regarding inpatient admissions would have been made at a future date by the Home Treatment Team*".

65. Similar opinions were expressed by Helen Green in her witness statement. She is an Occupational Therapist who is employed by the Defendant as a senior manager in its Mental Health Services Team. She had discussed the Claimant's situation with her colleague Tracey Pegg in the 3-4 days before the appointment with Dr Trendafilov on

27th April 2021, and she chaired the MDT meeting on 28th April at which the Claimant's case and Dr Trendafilov's proposed treatment plan were discussed.

66. In her witness statement (dated 25th February 2025, so some 8 months before that report provided by Dr Eldred), she wrote: "*Risk is very subjective. Whilst climbing telegraph poles is high risk behaviour, Ben was not reporting a plan and he had agreed to another face to face appointment with Dr Trendafilov on 30th April 2021. The notes suggest he was positive forward planning and thinking about the future. Based on all of the above, the risk assessment by Dr Trendafilov was deemed appropriate by the team. Ben also had awareness that he could phone the duty CMHT team, as he had done previously, if he needed support in the meantime. He had previously reported finding talking helpful"* (para 9).

67. Ms Green accepted in cross-examination that she was not a psychiatrist, and that she would defer to a psychiatrist on the question of diagnosis etc. However, she said she had never had cause to question or doubt Dr Trendafilov's clinical judgment and that he, having seen the Claimant the day before, was best-placed to assess the risk that the Claimant represented.

68. In her opinion, having climbed the electricity pylon on a number of previous occasions, the fact that the Claimant had not touched the power cables suggested conscious decisions by him not to act on his suicidal thoughts. Those decisions, along with the evidence of forward-planning etc, would be relevant factors to take into account when assessing the degree of risk. As she put it: "*The mere fact that someone embarks on an inherently risky process, such as climbing a pylon or a high building, does not necessarily mean that they want to kill themselves. If they retreat each time, eg because they have other things to look forward to, that will be a matter that will be taken into account when assessing the risk that they will, in future, take their own life. Risk assessment is a subjective process that involves taking into account all relevant information about past behaviour and future plans etc, and using one's judgement to reach a conclusion"*.

69. She confirmed that Dr Trendafilov was the CMHT Consultant psychiatrist. She said that as such he could have referred the Claimant to the HTT for assessment, but it would have been for the HTT to decide whether the Claimant in fact needed to be admitted as an inpatient.

70. In cross-examination Dr Eldred agreed that if a patient requires hospital admission because of the degree of risk of imminent self-harm, then it is a Trust's duty to find them a bed as quickly as reasonably possible. However, in his opinion the assessment of whether a patient met that criterion was a subjective process which was, to some extent, affected by the psychiatrist's experience of assessing such patients for that purpose.

71. His evidence was that while "*psychiatrists on the Community Mental Health Teams* (like Dr Trendafilov and Dr Turner) *and those on the Home Treatment Teams* (such as himself) *have the same qualifications, they don't always have the same experience and knowledge."* Dr Eldred said that unless a psychiatrist works within an HTT they are not, on a daily basis, dealing with (i) the interventions that are delivered by the HTT, (ii) the HTT's case-load, or (iii) the risk profiles of the patients on an HTT's list and the attitude of the HTT to those risks.

72. That distinction is perhaps of greater relevance to the issue of whether Dr Trendafilov should have referred the Claimant to the HTT at all, thereby triggering that body's ability to form its own assessment of the risk of self-harm and the Claimant's suitability or otherwise for home treatment. In Dr Eldred's opinion, that should have been done, and therefore the Defendant has accepted and conceded that point in these proceedings.

73. However, in Dr Eldred's opinion, the failure to refer to the HTT did not affect the validity of Dr Trendafilov's assessment of the degree of the Claimant's depressive illness, and the risk of self-harm, as moderate. Those were assessments with which, on the facts available, he agreed.

74. He said that a respectable body of professional opinion would have considered the Claimant's level of depression as moderate, bearing in mind his presentation at the meeting, including laughing and joking at points during the assessment and his discussions about plans for the future. Those positive features were echoed in the Claimant's personal diary in which he had recorded his plans for foreign travel over the summer, along with other aspects of positive forward-planning.

75. Dr Eldred agreed that there were some 'high risk' factors present in the Claimant's case but did not accept Dr Turner's opinion that the seriousness of the proposed suicidal acts (eg climbing an electricity pylon) could be translated directly into the severity of the depression or the risk of self-harm. For example, the ability to resist suicidal impulses, as the Claimant had done on numerous occasions previously, was something that Dr Eldred said helped to inform the overall assessment of both the level of depression and any risk. That approach aligned with that of Helen Green.

76. On the question of obtaining a corroborative account from the Claimant's parents, Dr Eldred's opinion was that, while it would have been helpful for Dr Trendafilov to have done so (eg in order to ensure that both Dr Trendafilov and the MDT were fully aware of the duration and severity of the Claimant's recent behaviour and symptoms), a failure to do so at the first appointment was not outside everyday practice.

77. In considering the factors identified in the ICD-10 classification, Dr Eldred did not agree that on 27th April the Claimant had presented with a "*full house*" of the symptoms required for severe depression. Even if he had had a 'full house' of those symptoms, while that would have been a necessary condition for a diagnosis of severe depression it would not necessarily have been sufficient for such a diagnosis. The positive factors already referred to would also have to have been put into the balance. That is because people with more severe depressive illness tend to lose the range of mood-states and the ability to enjoy moments of levity, such as those which the Claimant had shared with Dr Trendafilov during the assessment. Those elevated mood states were therefore informative of the overall degree of the Claimant's depressive illness.

78. Therefore, Dr Eldred disagreed with the proposition that no responsible body of medical opinion would have diagnosed the Claimant with moderate depressive illness on 27th April 2021, or the risk of him causing himself serious harm as moderate. He accepted that other psychiatrists may have assessed those risks as higher than moderate, and that such opinions would have been equally responsible and respectable, but he disagreed

with Dr Turner that Dr Trendafilov's assessments fell below the standard reasonably to be expected of a CMHT Consultant Psychiatrist.

A summary of the evidence relating to whether the HTT would have assessed the Claimant as suitable for immediate admission as an inpatient

79. As noted at paras 55-56 above Dr Turner's report had proceeded on the misunderstanding that Dr Trendafilov had the power to have the Claimant admitted to hospital as an inpatient, without first referring him to the HTT for its own assessment of risk etc. Dr Turner accepted that that was incorrect, but his fundamental view on the question of admission to hospital was expressed in cross-examination as follows: "*If people are at risk of suicide they require admission to hospital. I have had patients that have been to the same suicide spot on more than one occasion; I would have admitted them to hospital*".

80. It was from this starting-point that Dr Turner approached the question of whether, had the Claimant been referred to the HTT, he would have been admitted to hospital. His evidence was that "*he should have been referred to the HTT, and the HTT should have raised an immediate assessment and recommended an admission to hospital*". He said that he did not know whether any such recommendation by Dr Trendafilov would have been accepted by the HTT, but he would have expected Dr Trendafilov to follow up on the recommendation and find out whether it had been accepted or not.

81. Dr Eldred did not agree. He considered that Dr Turner's analysis and conclusions were affected by the distinction between their relevant experience. In Dr Eldred's view, while Dr Turner had worked for Community Mental Health Teams and had made recommendations to HTT's about whether a patient should be admitted to hospital, he had no recent experience of working for an HTT itself.

82. Dr Eldred said "*I don't accept that the HTT will usually accept the recommendation of the CMHT's consultant. The HTT will seek to form their own judgment. The view of the referring consultant is but one factor for them to take into account*". He continued "*[The HTT] would assess the patient using the same tools (eg number of symptoms, nature of symptoms, and context of presentation), but the HTT would introduce new elements to their assessment, such as home treatability, the patient's willingness to comply and the suitability of the patient's home environment. Those are the skills that have become refined over time on an HTT, and they are of additional value when assessing a patient's suitability for home treatment*".

83. His opinion on whether the HTT would have referred the Claimant for immediate admission as an inpatient was set out at paras 13.4.5 to 13.4.6, para 13.5.3 and paras 13.9.1 to 13.9.5 of his report. At para 13.4.6 he wrote: "*In my opinion, based on the assessment of the Claimant…he did not require an inpatient hospital admission. The vast majority of acute mental health care in England is provided in community settings, by HTTs and CMHTs. At all times it is expected that the least restrictive approach is preferred*".

84. At para 13.1.3(x) of his report Dr Eldred wrote "*Many individuals require high frequency of contact with trained mental health professionals who have experience of delivering psychological interventions to reduce anxiety and arousal, to rehearse skills that improve distress tolerance, and alternative strategies including reaching out to HTT clinicians at times of heightened impulsivity. Hospital inpatient wards are often highly restrictive environments which bring patients into close contact with other people who are acutely unwell. This can be a counter-therapeutic experience. In my experience the availability of psychological therapy and related interventions is often higher in community settings with the involvement of the Home Treatment Team".*

85. At 13.5.3 Dr Eldred wrote "*If a referral to HTT had been made on 27 or 28 April 2021 then on [the] balance of probabilities there would have been initial phone contact from HTT on the same day to arrange a face to face assessment the following day (either 28 or 29 April). In the initial phone contact the Claimant would have been invited to contact HTT at times of heightened distress or if he felt suicidal and this support would have been available to him 24 hours a day. There would then be planned daily contact and the opportunity to engage in psychological therapy to address the Claimant's anxiety, arousal and impulsivity*".

86. Finally, at para 13.4.5: "*In my opinion, based on 18 years of clinical experience as a Consultant Psychiatrist with a Home Treatment Team, it is highly unlikely that an inpatient admission would have been decided upon prior to the follow-up appointment with Dr Trendafilov arranged for 30th April 2021*".

87. Those opinions were repeated in summary form at paras 13.9.1 to 13.9.5 of Dr Eldred's report. He did not resile from them in cross-examination.

<u>A summary of the evidence relating to whether a suitable bed would have been made available for the Claimant before the 29th April 2021.</u>

88. As noted at para 50 above, Dr Turner's position was that whether or not the Defendant had a suitable bed available within its own area, if a patient passes the threshold for requiring admission as an inpatient (which, in his opinion, the Claimant did) the Defendant has an obligation to find a suitable bed as soon as practicably possible. As he put it in cross-examination, that was what was required "*by hook or by crook. My view is the only safe option is to admit them to hospital".*

89. His evidence was that he did not know whether the Defendant's HTT needed time to assess the Claimant itself, but he said that the hospital at which he (Dr Turner) worked would be able to admit a suitable patient on the same day.

90. Dr Eldred agreed with the proposition regarding the Defendant's general obligations to find a suitable bed. However, his evidence was that there were practical considerations, such as the prioritisation of need between suitable patients, that had also to be taken into consideration when assessing whether a bed would have been found for the Claimant on or before 29th April (whether within or beyond the Defendant's area).

91. On this issue the Defendant also relied on the evidence of James Smith, who was not called for cross-examination. Mr Smith is a registered Mental Health Nurse with

responsibility for the Defendant's allocation of inpatient beds to patients with psychiatric illness.

92. His evidence was that beds are allocated according to the risk that a particular patient represents. "*If a patient is very high risk we will try and get a bed the same day even if that means going out of area or going over numbers. If a patient is not very high risk or is not suitable for an out of area bed, it can take some time to find a suitable available bed"* (witness statement, para 7). In other words, in order to qualify for immediate admission, whether within or beyond the Defendant's area, a patient would have to be assessed as very high risk.

93. Mr Smith's witness statement continued: "*In terms of whether admission is appropriate for a patient we consider whether it is an appropriate level of restraint or whether there are less restrictive alternatives such as increased community support. The Trust always works to least restrictive practice which means you wouldn't move to admission without working through less restrictive options first unless it was an emergency or extremely high risk situation"* (para 8).

94. Mr Smith then reviewed the availability of inpatient beds between 27th and 29th April 2021, and produced the relevant records as his exhibit JS/2. Those records showed that across the whole Trust area there were no suitable beds available on 27th April. There was one potentially suitable bed available on 28th April, and again no suitable beds available on 29th April. The records also showed that for the bed on 28th April there were two other patients awaiting admission; one had been referred for inpatient care on 15th April, the other had been referred on 19th April. One was suffering a relapse of a schizoaffective disorder; the other was suicidal with hypomanic symptoms. Mr Smith's statement confirmed that "*There were other patients waiting for beds for whom the bed on 28th April would have been suitable and therefore priority would have been decided based on risk"* (para 11). It appears neither of those two patients were in fact allocated that bed on 28th April.

95. Dr Eldred's evidence on the allocation of a bed, given that the Claimant was not and would not have been assessed as 'very high risk', was as follows: "*In any event, an admission to hospital would not have been arranged before the Claimant climbed the electricity pylon on 29th April 2021. Accessing a psychiatric hospital bed is a lengthy process which involves a referral to the HTT, a further face to face 'gatekeeping' assessment by the HTT, and then a multi-disciplinary decision on whether to admit. If admission was recommended then a bed would be identified and transport arranged. This process usually takes 24-48 hours meaning the Claimant would not have been admitted to hospital by the time he climbed the pylon on 29th April 2021*" (report, para 13.4.7).

The Court's findings on the three issues it has to decide

96. The Court is not satisfied, on the balance of probabilities, that Dr Trendafilov's assessment of the Claimant's depressive illness, and his risk of self-harm, as 'moderate' fell below the standard reasonably to be expected of a competent psychiatrist performing the function of a CMHT consultant psychiatrist.

97. In the Court's view Dr Turner placed too great an emphasis on the Claimant's recent history of climbing the electricity pylon, and effectively equated its unusual or unique nature with (i) the seriousness of the Claimant's underlying depressive illness and (ii) the risk of actual self-harm that he presented.

98. On balance, the Court preferred the evidence of Dr Eldred on this point, namely that against the inherent risk involved in climbing the pylon, and its unusual or unique nature, one had to weigh the fact that on at least three occasions the Claimant had resisted the impulse to kill himself and had retreated from the risk. That balancing process aligned with the evidence of Ms Green who, while not a psychiatrist, as Chair of the MDT has considerable experience of assessing the risks presented by the patients in her care.

99. In the Court's assessment Dr Turner also placed insufficient weight on the evidence in the Claimant's medical notes, in his personal diary, and in the meeting with Dr Trendafilov itself of the positive features of his presentation, including his attendance at meetings, his engagement with the available mental health support services, his forward planning, range of mood, and aspirations for the future.

100. Those positive factors are matters that the Court considers a competent CMHT Consultant Psychiatrist would be bound to take into account as part of their overall assessment of both the severity of a patient's depressive illness, and the extent to which they represented a risk of serious self-harm. Those factors, as identified by Dr Trendafilov in his assessment, were echoed in the Claimant's personal diary (particularly in the entries for 27th April 2021, as set out at para 43 above), in which he expressed optimism for future as well as, it might be thought, a degree of defiance about not having been immediately admitted as an inpatient by Dr Trendafilov. Those diary entries show that Dr Trendafilov's assessment of the positive aspects of the Claimant's presentation on 27th April was not mis-placed.

101. Dr Trendafilov's inclusion of those factors properly informed his overall assessments of the Claimant on 27th April 2021. Dr Eldred is an experienced and independent Consultant Psychiatrist who, having reviewed the evidence with care, agreed with those assessments. Dr Eldred was willing to accept that some psychiatrists may have reached different conclusions, and that such conclusions would equally have been within the range reasonably to be expected of a competent psychiatrist, but the Court is persuaded by Dr Eldred's evidence that Dr Trendafilov's assessments were not outside that range or fell short of the standard reasonably to be expected of a competent psychiatrist in Dr Trendafilov's position.

102. Finally, the Court is not persuaded that the failure by Dr Trendafilov to take a corroborative account from the Claimant's parents was either a breach of his professional duties, or that it had any material effect on the assessments that he made. In the Court's view Dr Turner placed too high a significance on the value of the information that could have been given, particularly bearing in mind that the Claimant had confirmed in evidence that he had not told his parents about his suicidal thoughts or his visits to the pylon. On balance, the Court prefers the approach to this issue that was taken by Dr Eldred, namely that while it may often be desirable to take such a corroborative account it cannot of itself be considered negligent not to do so.

103. The Court's findings mean that the Claimant's case cannot succeed. However, for the avoidance of doubt the Court sets out below its findings on the other two issues that the case raised; namely (i) whether the HTT would have referred the Claimant for immediate admission as an inpatient and (ii) if it had done so, whether the Claimant would have been found a bed on or before the 29th April 2021.

104. On the question of whether the HTT would have assessed the Claimant as requiring immediate admission as an inpatient, the Court again prefers the evidence of Dr Eldred to that of Dr Turner. Not only does Dr Eldred have considerable recent experience of making these assessments for the HTT in his own Trust area, his evidence reflected what the Court considered to be a more nuanced, practical and evidence-driven approach to those assessments than that offered by Dr Turner.

105. Dr Turner's approach was essentially one of 'safety first', in which any patient who was assessed to be at risk of self-harm should be immediately admitted into hospital for their own safety. In contrast, Dr Eldred's evidence recognised the need to balance the competing interests of protecting patients who were at risk of self-harm with ensuring that the least restrictive treatment pathway was identified, consistent with protecting their safety. Dr Eldred set out the range of support services in the community that were available to patients who were at less than 'very high risk' of self-harm. As he said, there was no sound basis for thinking that those support services would not have been sufficient to support the Claimant between 27th and 29th April 2021.

106. The Court is therefore satisfied that had the Claimant been referred to the HTT as he should have been (whether by Dr Trendafilov on 27th April or by Ms Green's MDT the following day), the HTT would have directed their mind to the comparative risks and benefits of immediate admission, and would not have recommended it. The Court is equally satisfied that in doing so they would have reached a defensible conclusion, in accordance with Bolitho v. Hackney HA. On that basis, the Claimant's case would have failed at this stage even if Dr Trendafilov's assessment had been negligent.

107. Finally, the Court is not persuaded on the balance of probabilities that a bed would have been found for the Claimant before 29th April, even if he had been recommended for immediate admission as an inpatient. The evidence of James Smith illustrated the scarcity of suitable beds within the Defendant's area, the delay between a recommendation for admission and a bed becoming available, and the degree of risk that needed to exist before immediate admission could be considered (i.e. 'very high risk'). The highest that Dr Turner put the Claimant's risk was 'severe or high'.

108. It was suggested by the Claimant in cross-examination of Dr Eldred that the bed-availability records produced by Mr Smith showed that on 28th April at least one bed was available, which neither of the two other patients on the waiting list had been allocated. This, it was suggested, showed that had the Claimant been assessed as requiring immediate admission, that bed would have been allocated to him.

109. In the Court's assessment that analysis attempts to draw an inference that cannot be supported by the evidence. As Dr Eldred pointed out, without full details of the symptoms, risks and histories of the other two patients, or an understanding of why that bed was not allocated to them on the 28th April (e.g. whether it was given to a 'very

high risk' patient from outside the Defendant's area), it is simply impossible to know whether it was available to the Claimant or whether he would have been assessed as being of sufficient priority to be given it.

110. The most that can be said is that it is possible that the bed would have been allocated to the Claimant. That falls a long way short of it being more likely than not that it would have been. Therefore, the Claimant's case would have failed on this issue as well.