Neutral Citation no. [2007] NIQB 53 | *Ref:* **COGF5638**

Judgment: approved by the Court for handing down | *Delivered:* **29/6/07**

*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

_____

POST TRAUMATIC STRESS DISORDER GROUP ACTION

BETWEEN:

CHARLES WAYNE McCLURG AND OTHERS

Plaintiffs;

-and-

CHIEF CONSTABLE OF THE ROYAL ULSTER CONSTABULARY

Defendant.

_____

COGHLIN J

[1] The Plaintiffs in this group litigation comprise some 5,500 former and serving members of the RUC and Police Service of Northern Ireland (PSNI). They range in rank from that of Constable to that of Chief Superintendent and some 2,000 of these officers are still in service. Each of these Plaintiffs claims to have sustained a psychological/psychiatric disorder following exposure to trauma experienced during the course of the terrorist campaign in Northern Ireland. Much of the debate has focused upon Post Traumatic Stress Disorder ("PTSD") but the claims also encompass other conditions such as depression, anxiety and adjustment reactions or disorders whether occurring as free standing conditions, co-morbidly with PTSD or in some other combination.

[2] Apart from the very large number of Plaintiffs, the focus of the litigation has ranged over a period of more than 30 years and the evidence has taken some 102 days to complete. Both sides have identified, researched and marshalled a vast range of documentary materials for the assistance of the

Court. The logistics involved in securing, organising and recording the evidence far outweighed those involved in any other civil litigation in my experience and the successful completion of those tasks is a tribute to the Court Service in Northern Ireland and the Stenographers Unit. Quite simply, without the unstinting labour of the latter in providing a daily transcript my task in compiling this judgment would have proved impossible.

[3] The Plaintiffs were represented by Mr Stephen Irwin QC, as he then was, Mr Potter and Mr McMillen while Mr Nicholas Hanna QC, Mr Montague QC and Mr Donal Lunny appeared on behalf of the Defendant. I freely and gratefully acknowledge the great debt that I owe to both sets of Counsel together with their supporting solicitors for the meticulous way in which this case has been prepared, the efficiency with which they have complied with the timetable and the clarity, economy and impressive command of detail with which the evidence has been presented in Court.

The Importance of Context

[4] In common with other actions based on the tort of negligence the Plaintiffs must establish, on a balance of probabilities, that the Defendant, as their employer, failed to take reasonable care to prevent them from suffering foreseeable harm, in this case a recognisable psychiatric disorder. However, in this case, there is a fundamental issue between the parties as to when such a duty of care arose with the period under consideration running from the early 1970s to 1986. The latter date is fixed by the Defendant's concession that, in 1986, shortly after it began to operate the Occupational Health Unit ("OHU") began to receive cases of officers clearly suffering from a recognised psychiatric disorder as a result of exposure to a traumatic event/events. Thus, the relevant period to be considered in relation to the issue of foreseeability of harm occurred some 20 to 30 years ago in a context that was in many respects very different from today.

[5] After the widespread severe civil disturbances of 1968 and 1969 paragraph 82 of the Hunt Report recommended that the RUC should be relieved of all duties of a military nature as soon as possible and that its contribution to the security of the State from subversion should be limited to the gathering of intelligence, the protection of important persons and the enforcement of relevant laws. The same report also recommended that, in general, the Force should be unarmed. As the 1970s progressed the optimism underpinning the Hunt Report was to prove unfounded. When Mr Burrows, who went on to become Acting ACC Operations in charge of firearms training, entered the Training Centre in September 1971 there was no indication that he would ever receive firearms training other than as a specialist officer. By the time he finished in December he was told that his first additional training course would be in firearms although the Force had neither the weapons that he was to be trained to use nor suitable ammunition available at that time.

When considering context, it is important to ensure, as far as possible, that the perspective is not clouded by hindsight. During those early years, few if any individuals could have contemplated the depths of brutality and sectarian savagery to which the terrorists would be prepared to descend The use of high explosive to murder, maim and mutilate young people enjoying themselves at a nightclub, refuse collectors going about their daily duties or those attending an Armistice commemoration, gangs organised for the purpose of torturing and cutting the throats of victims simply on the basis of their religion or the horrific refinement of the "human proxy bomb" must have been quite outside the imagination of any ordinary citizen. At this point in time it is known that the onslaught of terrorism was to continue for almost 30 years but no one had the benefit of such knowledge in the 1970s and early 1980s. It became necessary to re-arm the RUC but in 1975 political talks took place against the background of a ceasefire. Reserve officers continued to be recruited on 3 year contracts, undoubtedly based on an expectation that the violence would reduce over time. The Chief Constable's reports during the 1970s recorded a steadily escalating role of deaths and injuries both civilian and security forces. However, these documents also reported a fluctuating picture in terms of terrorist activity. The Foreword to the Chief Constable's Report of 1979 included the statement that:

> "the horrific and widespread violence which characterised the early years of the 70s has declined to a very considerable extent."

And the equivalent document for 1980 contained the following remarks:

> "… 1980 was in fact the least violent year in Northern Ireland for a decade and there was an improvement in regard to serious crimes of all types."

[6] Quite apart from the history of terrorist violence, many developments have subsequently taken place in the relevant fields of medicine, occupational medicine and safety at work which significantly affected the ambit and content of those disciplines. In 1970 the Factories Act (Northern Ireland) 1964, the Construction (Working Places) Regulations (Northern Ireland) 1967, the Construction (General Provisions) Regulations (Northern Ireland) 1963 and the Office and Shop Premises Act (Northern Ireland) 1966, together with industry specific legislation with provisions relating to shipbuilding, docks, agriculture etc was the relevant legislation in respect of the safety of most employees. In 1972 the Robens Report (1972, Cmmd 5034) recommended that a comprehensive and orderly set of revised provisions under a new enabling act containing a clear statement of the basic principles of safety responsibility was required to replace what it described as the: "haphazard mass of ill assorted and intricate detail" of the existing legislation. This led to the passage of the Health & Safety at Work Act 1974 which unified the various inspectorates into

the Health & Safety Executive under the supervision of the Health & Safety Commission and enhanced their powers. However, it was not until 1989, following the passage of the single European Act in 1987, that the Framework Directive 89/391 came into force to be followed in due course by the "six pack" of new regulations in the UK on the 1st January 1993. These provisions articulated a wide range of detailed duties to be imposed on employers including the avoidance of risks to safety and health, the evaluation of risks which cannot be avoided, combating risks at source, developing a coherent overall prevention policy, giving collective protective measures priority over individual measures and giving appropriate instructions to workers.

[7] In the field of occupational medicine Dr Slovak, the consultant occupational physician called on behalf of the Defendant , confirmed that, as far as British occupational medicine was concerned, no mention of PTSD or stress brought about by exposure to traumatic events appeared in the available textbooks until the 8th edition of Hunter on Diseases of Occupations in 1994. That edition of the textbook contained a reference to PTSD, taking up approximately less than half a paragraph that confirmed its existence but suggested that it was quite rare. By the date of the next edition in 2000 the topic had expanded to approximately one and one third chapters. Dr Slovak's search of the relevant professional journals revealed no mention of PTSD prior to 1990 but between 1990 and 1995 there were some 7 papers which dealt with relevant topics, for example, the effects upon police officers of exposure to the Pyper Alpha disaster. Training material relating to the subject seems to have been introduced to occupational medicine courses around 1994. In the late 1990s, after public consultation in which considered and informed reservations were expressed, the Health and Safety Executive (HSE) decided to produce Management Standards on the subject of stress in the workplace rather than an Agreed Code of Practice. Dr Slovak confirmed that the Metropolitan Police did not introduce an occupational health unit until 1992 and, apart from the RUC, he did not know of any other emergency service employer in the U.K. that provided treatment for the consequences of exposure to traumatic events. In cross examination Dr Slovak agreed that earlier papers existed dealing with the reaction of police officers to shooting incidents in the U.S. but he was careful to point out that most, if not all, of these related to groups of scientific researchers talking to each other about particular themes and that it always took some time for any agreed conclusions to percolate down through the system.

The Relevant Law

[8] Despite the fact that officers in the RUC/PSNI were not employed under any contract of employment, the Defendant accepts that he owed each of the Plaintiffs during such time as they were police officers the same duty of care as was owed by an employer to his employees. That is the well-established duty of an employer to take reasonable care to provide his employees with a safe place of work, safe tools and equipment, a safe system of

work and supervision so far as is reasonable and practicable in the circumstances as re-emphasised by Lord Wright in *Wilsons and Clyde Coal Company v English* [1938] AC 57. In more recent times perhaps the best statement of general principle remains that of Swanwick J in *Stokes v Guest, King and Nettlefold (Bolts and Nuts) Limited* [1968] 1 W.L.R. 1776 at 1783 when, after referring to a number of well known authorities, the learned judge said:

> "From these authorities I deduce the principles, that the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of commonsense or newer knowledge it is clearly bad; but, where there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it; and where he has in fact greater than average knowledge of the risks, he may be thereby obliged to take more than the average or standard precautions. He must weigh up the risk in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probability of effectiveness of the precautions that can be taken to meet it and the expense and inconvenience they involve. If he is found to have fallen below the standard to be properly expected of a reasonable and prudent employer in these respects, he is negligent".

The need for the employer to familiarise himself with relevant developing knowledge was emphasised by Geoffrey Lane LJ in *McCafferty v Metropolitan Police Receiver* [1977] 2 All E.R. 756 when he said, at 773:

> "The duty of the Defendant in this case was to take reasonable care to protect the Plaintiff from dangers to safety or health of which he, the Defendant, knew or ought to have known. That involved a number of subsidiary obligations: the provision of adequate and safe equipment, the provision of adequate and safe premises and the provision of a system of working so designed as to reduce to as low a degree as was reasonably possible the risk of any harm. These obligations cannot be properly discharged unless the employer takes steps to keep himself informed of developments and increased knowledge in the sphere

> in which he operates and unless he uses any such information to keep his own system and equipment reasonably up-to-date and abreast of the times."

[9] Swanick J's summary of the employers duty to take reasonable care was quoted with approval by Hale LJ in *Hatton v Sutherland* [2002] 2 All E. R. 1. Hatton was one of four conjoined appeals in which employers had appealed to the Court of Appeal against findings of liability for psychiatric illness sustained by their employees and caused by stress at work. In the course of giving the judgment of the Court of Appeal Hale LJ summarised the relevant law by setting out, at paragraph [43], the following practical propositions:

> "(1) there are no special control mechanisms applying to claims for psychiatric (or physical) illness or injury arising from the stress of doing the work the employee is required to do (see [22], above). The ordinary principles of employer's liability apply (see [20], above).
>
> (2) the threshold question is whether this kind of harm to this particular employee was reasonably foreseeable (see [23], above): this has two components (*a*) an injury to health (as distinct from occupational stress) which (*b*) is attributable to stress at work (as distinct from other factors) (see [25], above).
>
> (3) foreseeability depends upon what the employer knows (or ought reasonably to know) about the individual employee. Because of the nature of mental disorder it is harder to foresee than physical injury, but may be easier to foresee in a known individual than in the population at large (see [23], above). An employer is usually entitled to assume that the employee can withstand the normal pressures of the job unless he knows of some particular problem or vulnerability (see [29], above).
>
> (4) the test is the same whatever the employment: there are no occupations which should be regarded as intrinsically dangerous to mental health (see [24], above).
>
> (5) factors likely to be relevant in answering the threshold question include: (*a*) the nature and extent of the work done by the employee (see [26], above). Is the workload much more than is normal for the particular

job? Is the work particularly intellectually or emotionally demanding for this employee? Are demands being made of this employee unreasonable when compared with the demands made of others in the same or comparable jobs? Or are there signs that others doing this job are suffering harmful levels of stress? Is there a normal level of sickness or absenteeism in the same job or in the same department? (*b*) signs from the employee of impending harm to health (see [27], [28], above). Has he a particular problem or vulnerability? Has he already suffered from illness attributable to stress at work? Have there recently been frequent or prolonged absences which are uncharacteristic of him? Is there reason to think that these are attributable to stress at work, for example because of complaints or warnings from him or others?

(6) the employer is generally entitled to take what he is told by his employee at face value, unless he has good reason to think to the contrary. He does not generally have to make searching enquiries of the employee or seek permission to make further enquiries of his medical advisers (see [29], above).

(7) to trigger a duty to take steps, the indications of impending harm to health arising from stress at work must be plain enough for any reasonable employer to realise that he should do something about it (see [31], above).

(8) the employer is only in breach of duty if he has failed to take the steps which are reasonable in the circumstances, bearing in mind the magnitude of the risk of harm occurring, the gravity of the harm which may occur, the costs and practicability of preventing it, and the justifications for running the risk (see [32], above).

(9) the size and scope of the employer's operation, its resources and the demands it faces are relevant in deciding what is reasonable; these include the interests of other employees and the need to treat them fairly, for example, in any redistribution of duties (see [33], above).

(10) an employer can only reasonably be expected to take steps which are likely to do some good: the court is likely to need expert evidence on this (see [34], above).

(11) an employer who offers a confidential advice service, with referral to appropriate counselling or treatment services is unlikely to be found in breach of duty (see [17], [33] above).

(12) if the only reasonable and effective steps would have been to dismiss or demote the employee, the employer will not be in breach of duty in allowing a willing employee to continue in the job (see [34], above).

(13) in all cases, therefore, it is necessary to identify the steps which the employer both could and should have taken before finding him in breach of his duty of care (see [33], above).

(14) the claimant must show that that breach of duty has caused or materially contributed to the harm suffered. It is not enough to show that occupational stress has caused the harm (see [35], above).

(15) where the harm suffered has more than one cause, the employer should only pay for that proportion of the harm suffered which is attributable to his wrong doing, unless the harm is truly indivisible. It is for the Defendant to raise the question of apportionment (see [36], [39], above).

(16) the assessment of damages will take account of any pre-existing disorder or vulnerability and of the chance that the claimant would have succumbed to a stress-related disorder in any event (see [42], above)."

[10] In *Barbour v Somerset County Council* [2004] 1 W.L.R. 1089, the House of Lords considered another of the 4 appeals originally conjoined in Hatton. In the course of his judgment, with which the majority of the members of the House agreed, Lord Walker referred to Hale LJ's exposition and commentary on the law, including the practical propositions, as; "… a valuable contribution to the development of the law" although he reserved his views on apportionment and quantification of damage in the absence of any evidence. However, I think that it is also important to record that Lord Walker, having

referred to the decision of the Court of Appeal went on to emphasise that every case will depend on its own facts and to once more approve the dictum of Swanwick J in Stokes as "the best statement of general principle".

[11] In closing the case on behalf of the Plaintiffs Mr Potter distinguished the propositions enunciated by Hale LJ in Hatton as being relevant only to cases in which individuals are claiming to have suffered occupational stress. He maintained that such propositions are not relevant at all to a class or group action of this type in which the Plaintiffs have succeeded in establishing the foreseeability of psychological harm of one sort or another from the 1970s at the latest. In such circumstances, Mr Potter submitted that the Hatton propositions were of no assistance at all and he relied upon the decision of the Court of Appeal in *Melville v The Home Office* [2005] IRLR 293.

[12] In Melville's case the Plaintiff had been employed by the Home Office as a health care officer at Her Majesty's Prison Exeter. His duties included the recovery of the bodies of prisoners who had committed suicide and, since the start of his employment in 1981, he had attended 8 such suicides. In the days that followed the last of these cases he suffered from nightmares and flashbacks and developed what was subsequently diagnosed as a stress related illness. It was common ground that, before he stopped work, the Plaintiff had given no indication that he was developing a stress related illness. Documents disclosed by the Defendant confirmed that the Home Office had recognised that persons, who were called upon to deal with certain traumatic incidents in prisons, including suicides, might sustain injury to their health and that such persons should therefore receive support from the prison care team following such an incident. The Plaintiff accepted that the Home Office had devised adequate procedures for dealing with the risk of injury to health which it had foreseen and his case was that the implementation of those procedures at HMP Exeter was lamentable. In a somewhat surprising submission the representatives of the Home Office argued that it was not enough to establish foresight of a risk of psychiatric harm to employees exposed to traumatic incidents but that, in accordance with the Hatton guidelines, it was also necessary to establish that the employer had foreseen a risk of harm to the individual employee concerned. It was argued on behalf of the Home Office that unless the employer knew of some particular problem of vulnerability he was entitled to assume that the employee was up to the normal pressures of the job. These submissions did not find favour with the Court of Appeal and Lord Justice Scott Baker said, at paragraph 133:

> "We do not accept these submissions. As is apparent from the way is which the judgment in Hatton is expressed and as Lord Walker pointed out in Barbour the guidance must be read as such and not as anything like statute. Each case will depend on its own facts. Those parts of the Hatton judgment relied on by Mrs

> Outhwaite were primarily intended to help judges resolve the issue as to whether an employer ought to have foreseen the risk of psychiatric injury attributable to stress at work. The guidance recognises that such injury is more difficult to foresee than physical injury. The question of whether the particular employee has shown indications of impending harm to health is a very relevant question when considering a situation where the employer has not in fact foreseen the risk of psychiatric injury and the employee's workload would not ordinarily carry a foreseeable risk of such injury."

That was clearly not the case in Melville in which the only evidence before the court was that the employer plainly had foreseen that employees who were exposed to particular traumatic incidents might suffer psychiatric injury.

[13] It seems to me that the decision in *Melville v The Home Office* should be regarded with a degree of caution. The submission advanced by the Defendant in that case and so firmly rejected by the Court of Appeal appears to have been ill fated from the start and I do not think that its rejection has any significant impact upon the relevance of the Hatton guidelines. Since they were first articulated in Hatton those guidelines have been repeatedly described in subsequent decisions by both the Court of Appeal and the House of Lords as affording "useful practical guidance" but not to be regarded as having the force of statute or being set in stone. In this case foreseeability has remained very much a live issue at least until 1986 and, in such circumstances, it seems to me that the appropriate approach to liability is to apply Swanwick J's general statement of principle in the light of those propositions identified by Hale LJ as may be relevant to the specific factual matrix with which this litigation is concerned bearing in mind, in particular, that this is a generic rather than an individual issue concerning cases that essentially involve exposure to trauma rather than to occupational stress.

Foreseeability

[14] In dealing with the concept of breach of duty Hale LJ said at paragraph [32] of her judgment in Hatton:

> "What then is it reasonable to expect the employer to do? His duty is to take reasonable care. What is reasonable depends, as we all know, upon the foreseeability of harm, the magnitude of the risk of that harm occurring, the gravity of the harm which may take place, the cost and practicability of preventing it and the justification for running the risk (see the off-quoted summary of Swanwick J in *Stokes v Guest, Keen*

and Nettlefold (Bolts and Nuts) Limited [1968] 1 W.L.R. 1976 at 1983)."

In closing, both sides drew my attention to the passage in the 19th edition of Clerk & Lindsell on torts at paragraph 8-16 at which the learned authors observed:

> "The criterion of reasonable foreseeability focuses on the knowledge that someone in the Defendant's position would be expected to possess. The greater the awareness of the potential for harm, the more likely it is that this criterion will be satisfied."

[15] Foreseeability has proved to be one of the fundamental issues in this litigation and to put it in context I think it is helpful if it is considered from 3 different aspects.

Foreseeability by Whom?

[16] In the title to this litigation the Defendant is the Chief Constable of the Royal Ulster Constabulary but the Defendant's representatives accept that, for the purposes of the litigation, that office includes successive Chief Constables of both the RUC and the PSNI during the relevant period and/or such senior officers of either organisation who may have been in a position to influence relevant police policy. However, it is important to remember that, at whatever level of command, it is police officers serving in Northern Ireland to whom foreseeability must be attributed by the Plaintiffs on the balance of probabilities and that what may or may not have been foreseeable to them might differ significantly from what may have been foreseeable to academics, consultants or clinicians in psychology, psychiatry or occupational health practising outside or inside Northern Ireland.

Foreseeability of What?

[17] The Defendant expressly concedes: (*a*) that during the relevant period it was foreseeable that, in the course of their duties, police officers were on occasions liable to experience, witness or be confronted with events that would involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and (*b*) that it was foreseeable that the response of such officers to their exposure to such events was liable to involve intense fear, helplessness or horror. However, the Defendants do not concede that there was a reasonably foreseeable risk of psychiatric injury to police officers, who were not subject to any relevant vulnerability or predisposition, as a consequence of exposure to such events until, at the earliest, after the Occupational Health Unit ("OHU") had been established in 1986. The effect of these concessions is to focus upon the distinction, accepted by both sides,

between a recognised psychiatric injury or condition, whether it is termed acute or chronic, and the transient emotions experienced by the majority of human beings as a result of exposure to such events. The Defendant further submits that, in addition to the risk of sustaining a recognised psychiatric condition, the Plaintiffs must also establish that it was reasonably foreseeable that the Defendant's failure to act would result in the loss of an opportunity to prevent or alleviate all or part of the original injury caused in the first instance by exposure to the traumatic event. The need for such a refinement arises from the fact that the alleged relevant act or omission in this case is not the act of exposing the individual to a traumatic event but the failure to take some step or steps to prevent or alleviate the consequences of such exposure.

[18] While it is accepted by both sides that it is not the only recognised psychiatric illness or disorder that may be caused by exposure to a traumatic event/events, the disorder that has featured most strongly in the evidence and with which the litigation has come to be generally associated in the public mind is Post Traumatic Stress Disorder ("PTSD"). This condition made its first appearance in the 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association in 1980 ("DSM-III").

[19] DSM-III described the essential features of chronic or delayed PTSD as the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. Such symptoms involve re-experiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphonic, or cognitive symptoms. Diagnostic criteria for PTSD were detailed as follows:

(a) existence of a recognisable stressor that would evoke significant symptoms of distress in almost everyone;

(b) re-experiencing of the trauma as evidenced by at least one of the following:

(i) recurrent and intrusive recollections of the event;
(ii) recurrent dreams of the event;
(iii) sudden acting or feeling as if the traumatic event was reoccurring, because of an association with an environmental or ideational stimulus.

(c) numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma as shown by at least one of the following:

(i) markedly diminished interest in one or more significant activities;

(ii) feeling of detachment or estrangement from others;
(iii) constricted affect.

(d) at least 2 of the following symptoms that were not present before the trauma:

(i) hyper alertness or exaggerated startle response;
(ii) sleep disturbance;
(iii) guilt about surviving when others have not or about behaviour required for survival;
(iv) memory impairment or trouble concentrating;
(v) avoidance of activities that arouse recollection of the traumatic event;
(vi) intensification of symptoms by exposure to events that symbolise or resemble the traumatic event.

In order for the condition to be diagnosed as chronic the symptoms must last for 6 months or more and in cases where the onset of symptoms is at least 6 months after the trauma the delayed condition is the appropriate diagnosis. An acute form of the condition is diagnosed where the onset of the symptoms takes place within 6 months of the trauma and the duration of the symptoms is less than 6 months.

[20] The concept of PTSD was further refined in DSM-III-R published in 1987 and DSM-IV in 1994. From a European standpoint the condition was first formally recognised in International Classification of Diseases 10 published by the World Health Organisation in 1994 ("ICD-10"). In that publication PTSD was classified under "reaction to severe stress, and adjustment disorders". The publication described such disorders as being thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful event or the continuing unpleasant circumstances was seen as the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders were depicted as maladaptive responses to severe or continued stress insofar as they interfered with successful coping mechanisms and lead to problems of social functioning. PTSD was described as arising as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which was likely to cause pervasive distress in almost anyone. As in DSM-III the classification recognised that predisposing factors such as personality traits or a previous history of neurotic illness might lower the threshold for the development of the syndrome or aggravate its course but they were neither necessary nor sufficient to explain its occurrence. Typical features were described as including episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surrounding, anaerobia,

and avoidance of activities and situations reminiscent of the trauma. The publication noted that there was usually a state of autonomic hyper arousal with hyper vigilance, and enhanced startle reaction, and insomnia. Anxiety and depression were said to be commonly associated with such symptoms and signs and suicidal ideation was said to be not infrequent. The onset of the condition was said to follow the trauma with a latency period that might range from a few weeks to months. The course was said to be fluctuating but recovery could be expected in the majority of cases. In a small proportion of cases the condition might follow a chronic course over many years with eventual transition to an enduring personality change. As well as PTSD, ICD-10 also included acute stress reactions and adjustment disorders within this classification.

Foreseeability When?

[21] The relevant period within which the Plaintiffs have sought to establish that it was reasonably foreseeable that police officers, without any relevant predisposition or vulnerability would suffer recognised psychiatric disorders as a consequence of being exposed to traumatic events commences with the onset of the terrorist campaign in Northern Ireland in 1969/70 and terminates within a few months of April 1986. The reason that the period terminates at the latter time is the concession made by the Defendants that, within a few months of the OHU coming into operation a number of officers had attended who appeared to be suffering from such disorders related to such exposure although many of these cases seemed to be fairly complex, involving multi-factorial problems.

[22] The Plaintiffs have not always been consistent as to the date upon which they allege that it should first have been reasonably foreseeable to the Defendant that there was a risk of police officers suffering from such psychiatric disorders. At paragraph A4 of part 5 of the amended generic statement of claim served on the 8th March 2004 the Plaintiffs alleged:

> "A4. By 1972 in view of the escalating level of violence in Northern Ireland generally and towards the police in particular and in view of the increasing involvement in and exposure to traumatic incidents of police officers the Defendant ought to have ensured that management of the RUC at the appropriate level [namely a level at which suitable policy decisions could be made and the necessary instructions/orders issued and enforced] was provided with and made aware of the contents of (*a*) all literature in relation to the psychiatric/psychological aspect of occupational health (*b*) all literature in relation to psychological services available within other police forces particularly Law

> Enforcement Agencies in the United States of America (*c*) all literature in relation to the known and potential effect on personnel of stress (*d*) all literature in relation to the known and potential effect on personnel [both in general and in relation to personnel already exposed to stressful working conditions] of exposure to or involvement in one or more than one traumatic incidents."

The Plaintiffs pleadings went on to allege that from about the same time the Defendants should have carried out studies into the effects on RUC officers of exposure to or involvement in traumatic incidents, that such studies and relevant literature should have been repeated on a continuing basis and that, had the literature been obtained and the studies carried out, the Defendants would have known or ought to have known that a large number of officers were suffering or were likely to suffer from one or other of the relevant psychiatric disorders. At paragraph B6 of the same document the Plaintiffs alleged:

> "B6. The Plaintiffs say that the Defendants were in breach of their continuing duty of care to the Plaintiffs in not making adequate mental health provision for the Plaintiffs from in or about 1972. Adequate mental health provision (assuming detection) would have included the referral of all officers involved in the traumatic incident or incidents for assessment and where necessary intervention/treatment."

[23] By the date of drafting their written opening submissions the Plaintiffs had somewhat modified this view. While noting, at paragraph 1.13 that the exceptional situation and experience of the RUC from the early 1970s coupled with the pre-existing knowledge that traumatic experiences could lead to psychiatric damage would have entitled the Plaintiffs to allege that the Defendants should have been thinking about and planning how to deal with the problem by the early 1970s or at the latest 1974/75 they conceded at paragraph 1.14 that it might have been reasonable for those commanding the RUC to think that the troubles would be resolved reasonably quickly particularly in the context of the IRA ceasefire in 1975. In the same paragraph they acknowledged that the operational challenge of coping with the IRA would have been the major pre-occupation together with a degree of indecision as to whether the RUC or the Army was to take the operational lead. At paragraph 1.15 the Plaintiffs asserted that by the summer of 1977 none of these factors applied, that the police had moved into "pole position" as a result of the "Ulsterisation" policy and that the Ulster Workers Council strike provided evidence that the RUC was liable to attract increasing hostility from the Loyalist Community. The Plaintiffs specifically cited the Bodenstown speech by Jimmy Drumm in June 1977 confirming that the conflict would be a "long

haul" and the private assessment of the security situation given by Brigadier General Glover and subsequently leaked by the IRA in which he also advised that the struggle was likely to be prolonged. In such circumstances the Plaintiffs described the summer of 1977 as a "clear landmark" in the story.

[24] It is clear from the Plaintiffs' opening written submissions that, once the problem had been appreciated, they did not seriously criticise the length of time which the Defendants took in practice to open the OHU for business i.e. a period of some 5 to 6 years – see paragraphs 1.19 to 1.22 of the Plaintiffs' opening submissions. In terms, the Plaintiffs said that if the clock started, at the latest, in 1978 the OHU and relevant Force Order organising referrals should have been in place by 1983. In his opening oral submissions Mr Irwin QC specifically abandoned the position originally taken by the Plaintiffs in the amended generic statement of claim and confirmed that it was no longer suggested in terms of breach or causation that the Defendant should have been focusing on stress or its consequence by 1972 or 1973. Consistently with his opening written submissions Mr Irwin QC again specifically referred to the Bodenstown Commemorations speech and the assessment by Brigadier General Glover as confirming that the terrorist campaign was likely to continue unabated and that, therefore, 1977/1978 was the last sensible point at which the RUC should have come to grips with the problem. In essence, therefore, as the evidence commenced, the plaintiffs case was that the risk of one of the relevant disorders being sustained by police officers as a consequence of exposure to traumatic events was or ought to have been reasonably known to the defendants by 1977/1978 and that, as a consequence, arrangements of the type that the defendants did adopt in practice in 1986 should have been in operation by approximately 1983.

[25] In their written closing submissions the plaintiff asserted that the evidence had borne out all that had been said in their written opening and they adopted and repeated that opening in toto. They maintained that the defendants ought to have recognised the risk and initiated a chain of enquiry in the "late 70s". In this document no mention was made of the Bodenstown speech or the military assessment by Brigadier General Glover in what was earlier described as the landmark summer of 1977. Instead, the plaintiff asserted that by the 1970s there was "widespread popular understanding that traumatic events or war could lead to significant physiological injury" and that "by the late 1970s the history and circumstances of the RUC and the Troubles, would, without more, impose a duty on the Chief Constable to enquire about the psychological effects of the terrorists campaign on the force". These submissions also referred to the "building blocks" identified by Dr Turner which were noted at paragraph 2.24 to have included common sense, recognition by other police forces of the pressures on the RUC, the knowledge of bereavement reactions and other "life events", rising criminal injury claims by police officers in relation to psychological injury, greater demand on the welfare services throughout the decade of the 1970s and increased incidents of

marital problems and alcohol problems together with increased and sustained higher levels of sickness.

[26] In my view, the plaintiffs should not necessarily become the subject of any criticism for any real or perceived inconsistencies between the original pleadings and the case as ultimately summarised in their submissions. The plaintiffs have sought to adopt a reasonable approach in presenting their case and, in so doing, is hardly surprising that they may have come to reappraise their views to some degree as the case developed. However, since it is accepted that, in practice, it would have taken 5/6 years for the defendant to institute an OHU, it does seem that their focus for foreseeability is restricted to the period 1977/1978 to 1981/1982. It appears to me that the evidence that was relevant to foreseeability during this period may be usefully broken down under a number of headings.

The Case for Earlier Foreseeability

[27] During the course of his report for 1972 the Chief Constable noted that the number of days lost to the force through sickness and injury revealed an alarming increase in the previous year's figures. As gross figures these were 70,158 compared with 45,756 in 1971. The main causes of "ordinary illness" were noted as influenza, common cold, stomach upsets, nervous debility and tonsillitis. Separate figures were not available in respect of each of these conditions. Tables prepared by Professor Edgar Jones using a "days lost per officer" index confirmed an increase of approximately 42% from 11.2 in 1971 to 15.9 in 1972. Thereafter the rate appears to have stabilised at an average of approximately 15 days per officer until raising again to 18.9 in 1978 before falling back again to the previous average levels. A sustained increase was also recorded during the period 1988 to 1990. A further table provided by Professor Jones indicated that the RUC was ranked between 3rd and 18th in terms of days absent through sickness and injury between 1980 and 1994 although caution is required when using figures provided by other UK forces for comparison with the RUC figures.

[28] Professor McFarlane, who was called on behalf of the plaintiffs, was asked to comment upon this increase in sickness absences by RUC officers and he expressed the view that as a consequence of the increase, coupled with one of the causes of absence being described as "nervous debility" the defendant ought to have sought expert opinion from a relevant group of experts.

[29] Prior to the creation of the Police Code in 1974 sickness absence was monitored by the Force Medical Officer. Officers who were absent from work for more than 3 days were required to provide a certificate from their GP and those who were absent from work for more than a month were required to attend for assessment by the Force Medical Officer ('FMO'). Paragraph 28 of Section 16 of the Police Code provided as follows;

> "28 in any case where – *(a)* having regard to the nature of the illness, resumption of duty is apparently being unduly delayed, or *(b)* a member is incapacitated for a period of 1 month, *(c)* for any reason it is considered that the Medical Officer's advice should be sought; a report will be forwarded to the Chief Constable in order that the case may be placed before the Medical Officer".

In due course this provision was replaced by Force Order 22/83 which was entitled "Statutory Sick Pay Scheme Self-Certification (sick leave)". Paragraph 7.4 of this scheme provided as follows;

> "7.4 Referring of illness to the Force Medical Officer.
>
> In any case where; - *(a)* Having regard to the nature of the illness, resumption of duty is apparently being unduly delayed; or *(b)* a member is incapacitated for a period of one month; *(c)* for any reason it is considered that the Medical Officers advice should be sought; a report will be forwarded to the Chief Constable (Personnel) in order that the case may be placed before the Medical Officer".

Paragraph 7.6 of the same document provided:

> "7.6 Frequent incapacity for duty.
>
> If a member is frequently incapacitated for duty, even for short periods, the person in charge of the station or branch will report the circumstances to the Sub-Divisional Commander/Head of Branch who will, in the first instance, on receipt of the file arrange to interview the member concerned to discuss his/her sickness report and ascertain if there are any underlying reasons other than ill health, which have a bearing on his/her frequent absences".

Annual reports provided by the Chief Constable for the period 1970 – 1980 demonstrated the way in which this system was used to monitor sickness absences. During this decade the FMO to the RUC was also the Principal Medical Officer for the Medical Referee Service and both services were provided by the Department of Health and Social Services. Members of the RUC who appeared to be suffering relevant symptoms would be referred by the FMO to Dr William Norris, a Consultant Psychiatrist, who carried out sessional work at Tyrone House, Ormeau Avenue, Belfast. In addition, during that decade, Dr Norris was extensively involved in medico-legal work involving patients with psychiatric systems alleged to have been caused by terrorist incidents.

[30] Professor McFarlane expressed the view that by November 1971 or, possibly, 1972 the defendant should have recognised that it was probable that his officers would suffer adverse psychological outcomes as a result of the terrorist campaign. He continued to maintain this opinion despite being cross-examined by Mr Hanna QC on the basis that during that decade the sickness absence monitoring system, including referrals to Dr Norris, had not produced any indication of any long-term psychological problems resulting from exposure to trauma. Professor McFarlane suggested that the level of exposure of officers to trauma together with the increase in rates of sickness absence was such that the defendant should have consulted an appropriate group of experts, notwithstanding the absence of any relevant reports or information from Dr Norris.

[31] Dr Stewart Turner, Consultant Psychiatrist, also gave evidence on behalf of the plaintiff in relation to this issue. Dr Turner did not agree with Dr McFarlane's opinion that the risk of psychiatric disorder should have been foreseen by the defendant as early as 1971/1972. In his formal report, at page 196, he expressed the view that; "…. By 1980 or soon there afterwards the RUC should have been offering in-house treatment for emotional and drinking problems, or ensuring appropriate services were in place elsewhere for the treatment of RUC members". In the course of his evidence he said that it would have been important for the defendant to have taken advice from a clinician with experience of trauma associated psychological disorder during the period 1978 – 1980. Ultimately Dr Turner identified a number of what he described as "building blocks" which included "common sense", the defendant's alarm at the increase in sickness rates in 1972, an increasing demand upon the RUC Welfare Services referred to by Mr Rattey, Chief Welfare Officer, in his 1980 report and the offer of respite holidays by forces in England and Wales against the background of a persisting high level of traumatic incidents. At one point he also referred to criminal injury claims brought by police officers as a "pointer" although he conceded that he was unable to give the court a firm view about this factor. Ultimately he expressed the opinion that the defendant should have been alerted by the building blocks to the risk of traumatic stress and should have then carried out relevant investigations. However, in both his report and evidence Dr Turner readily accepted that the defendant would have been subject to pressures relating to "operational survival" which would have inhibited him from focusing on the problem until the "late 70s". When pressed, Dr Turner, understandably was not prepared to provide a more accurate estimate than the "late 1970s" or "1978 or thereabouts" as the time at which he believed that the defendant ought reasonably to have appreciated the problem.

[32] There is no doubt, as both sides recognised, that police officers employed by the defendant, from the early 1970s, regularly experienced events that would subsequently come to be classified as "traumatic" in both the DSM

and ICD systems of classification. The annual reports published by the defendant provide a contemporary record of the savagery of the terrorist attacks upon the civilian population and police officers together with the stresses and pressures that were thereby imposed upon the latter. A number of witnesses described how the threat from terrorism affected officers not only in the course of their professional duties but extended into their social lives to include activities such as going to church, mowing the lawn, attending places of entertainment, impressing upon children that they should not reveal their occupation and, of course, the safety and personal security of their families in their own homes. Mr Burrows described how the RUC became known as "the third community." In the early years of that decade various constabularies in England and Wales expressed concern for the "constant stresses" to which police officers in Northern Ireland and their families were subject and a number offered holiday accommodation in the homes of police officers for children of RUC personnel. In 1973 the Chief Constable's report recorded the number of police officers killed and injured as a result of a terrorist campaign describing the figures as "…a terrible toll which indicates the extent to which they (the officers) had bravely endured appalling conditions". In the same year the IRA issued a statement confirming that the married quarters, private homes and families of police personnel were to be classified as "legitimate targets". This was also the decade that saw Mr Rattey appointed as the first civilian welfare officer for the RUC and the Chief Constable's reports record the expansion of a demand for welfare services justifying the acquisition of additional staff, the appointment of divisional welfare committees and a transfer to new accommodation. In 1980 Mr Rattey, responding to a minute from an Assistant Chief Constable, accepted that the Welfare Branch were only "skimming the surface" with regard to matrimonial and drinking problems amongst police officers. As a result of his travels around the various divisions Mr Rattey thought it was possible that there might be several hundred policemen involved in extra marital relationships or with heavy drinking. He believed that much could be done if Divisional Commanders would take a more active and personal interest in the living conditions at police stations and expressed his considered opinion that a lot of the problems such as stress, alcoholism etc were the result of such poor conditions together with a lack of social and recreational amenities. Mr Rattey did not specify exposure to trauma as one of the problems about which he was concerned.

[33] During the course of their closing submissions the plaintiffs emphasised that, in the context of the increasing tide of severe violence, it was really a matter of common sense that Dr Turner's "building blocks" should have established foreseeability at this time. However, it is important that this issue should be determined without the benefit of hindsight in respect of senior officers, including the defendant, who had no psychiatric/psychological qualification and who were engaged in defending the public and their officers against terrorist attacks on a day to day basis. While it would be difficult, if not impossible, to deny that common sense would lead an observer to anticipate

that discharging such duties might well cause anger, outrage, disgust, distress, despair, grief or sorrow, it seems to me that something more would have been required to raise the reasonable possibility that officers would develop psychiatric disorders. This was a decade when Sally Meekin and Dr Turner agreed that the lay understanding of "trauma" would have been in terms of physical rather than psychiatric/psychological damage and Professor Wessley when preparing the index for his paper dealing with the relevant text books before 1980 noted that the words "trauma" and "stress" were almost entirely absent. Patricia Donnelly, who had a particular interest in the field, agreed that there was little interest and a lot of scepticism among practitioners in Northern Ireland about PTSD in the late 1970s/early 1980s and she had no recollection of a connection being made between trauma and chronic mental disorder in the 1970s.

[34] Furthermore, it is important to remember that the Chief Constable and his senior officers were not left to reach judgments simply on the basis of lay impressions or opinions but had the benefit of access to information produced by the welfare and sickness monitoring systems. It does not appear that either of these systems produced any information during the 1970s that should have alerted the defendant to a need to consult expert psychiatric opinion about the risk of his officers sustaining chronic mental disorders as a consequence of being exposed to traumatic events. As noted above the welfare service was established and expanded during this decade yet Mr Rattey's report in response to the ACC memo did not refer to any such risk but expressed the view that the main cause of the problems such as stress and alcoholism were the bad living conditions and lack of social and recreational amenities. The defendant's annual reports recorded throughout the decade the monitoring of sickness absences by the FMO and his assistants who made large numbers of personal visits to officers and maintained close contact with Personnel Branch. Again, neither the GP certificates submitted by sick officers nor the monitoring by the FMO and his assistants appear to have produced any reference to the risk of officers suffering mental disorders as a result of exposure to traumatic events. The rise in general sickness absences referred to by the Chief Constable in 1972 as "alarming" stabilised thereafter at a level comparable to forces in England and Wales and it is to be noted that the reference to "nervous debility" as one of the main causes disappeared after 1974. In 1975 the Chief Constable noted the improvement in working days lost through sickness and recorded that the incidents of illnesses showed no particular trend.

[35] During this decade Dr Norris was the Consultant to whom the FMO was able to refer police officers in respect of whom it was felt that psychiatric advice or an opinion should be obtained. Dr Norris, who retired some 15 years prior to the hearing, was an eminent Consultant Psychiatrist in Northern Ireland who enjoyed an extensive NHS and medico-legal practice. He had served as the Vice Chairman of the Irish Division of the Royal College of Psychiatrist and had been nominated by that body as a medical examiner for

the General Medical Council's health procedures. He had also taught at both Queens University and the New University of Ulster. Dr Norris was not at any stage employed or directly retained by the defendant but he accepted in evidence that from the early 1970s up to his meeting with the Chief Constable in July 1982 he would certainly have seen "more than dozens" of policemen in the course of his referral sessions. In both his witness statement and his evidence on behalf of the plaintiff Dr Norris expressed the view that during the 1970s and early 1980s specialised knowledge would not have been required in order to consider whether there might have been psychiatric problems among police officers and that he felt that GPs in Northern Ireland during that period would have been able to make the connection between terrorist incidents and the onset of psychiatric symptoms in patients. He expressed the view that by then "…. there was considerable information from previous wars, people exposed to conflict and trauma might have an adverse reaction". However, despite such knowledge, Dr Norris agreed that he could not recall that any of the dozens of police officers referred to him during this period had appeared to be suffering from adverse psychiatric reactions as a result of exposure to trauma.

[36] By early 1982 concerns had been expressed by, inter alia, the Association of Police Surgeons, the FMO and the chairman of the Police Federation about levels of stress within the RUC giving rise to suicide, alcoholism, debt, family conflict, marital separation and divorce. A decision was taken in 1982 to establish the Committee on the Health and Management of the Force ("CHMF"). Subsequently Dr Norris received an invitation from the then FMO, Dr Brendan Wright, to attend a working lunch at police headquarters with Dr Wright, Dr Sloane then Deputy Chief Medical Officer for Northern Ireland, the Chief Constable and a number of senior police officers. Dr Wright's invitation seems to have been informal and no pre-meeting agenda was issued. However, it seems reasonably clear that one of the purposes of the meeting was to consider the service provided by the Force Medical Officer and, accordingly, in keeping with his usual practice, Dr Norris prepared a fairly detailed note or briefing paper. It is clear that this document was the product of some thought on the part of Dr Norris as it contained a number of reasoned suggestions as to how the service might be improved. It seems likely that Dr Norris anticipated that the issue of stress amongst police officers might arise and he included at paragraph 6 a list of what he considered to be likely causes and problems. These were:

> "(i) affluence;
> (ii) alcoholism;
> (iii) marital instability;
> (iv) domestic/marital family stresses as a result of long and irregular hours on duty."

[37] On the 6th July 1982, the day following the working lunch, Dr Norris prepared a memo dealing with the course of the discussions. He recorded the purposes of the meeting as including the need to identify particular problems which might give rise to medical referrals and to identify officers who might be at risk health wise. Consistently with his briefing note this memo indicated that the members of the Force referred to him by the FMO had fallen into fairly identifiable groups including alcoholism, martial/domestic instability or disharmony, disciplinary problems and psychiatric illnesses which could arise in any member of the general population and were probably unrelated to service experiences. The role that affluence, alcoholism and marital/domestic problems played in the presentation of these groups was discussed in some detail. Dr Norris specifically recorded that "psychiatric problems are minimal in those districts or areas in which officers are most vulnerable" and that in those areas there was a

> "… tendency for members of the Force to form closely integrated groups in that there is an inter-dependency necessary for operational duties, and a strong sense of camaraderie. Sickness records and problems are often low in this group but it is important to monitor individuals who may come under stress in the process of their duties, and who may not wish to express views on this subject either to their colleagues or senior officers through a sense of loyalty but at the same time may be developing stress symptoms."

Memos produced by other persons attending this working lunch were generally consistent with that produced by Dr Norris. The secretary, Mr G M Barr, staff officer recorded that "all present agreed that only in exceptional cases did danger or unpleasant duties appear to be a direct cause of stress" but the reference there was to general stress rather than psychiatric problems which Dr Norris had advised were "minimal" in those districts or areas in which officers were most vulnerable.

[38] Despite the involvement of police officers in the violent history of this province during the 12 years from 1970 to 1982 Dr Norris did not recall seeing any cases of psychiatric disorder resulting from exposure to traumatic events among his many police referrals. The absence of any such cases would have been consistent with the likely causes of stress that he identified in his briefing note and that were discussed at the working lunch. It seems quite clear that the specialist psychiatric advice that the Chief Constable and the other senior officers who attended that working lunch received was that, while the monitoring system could be undoubtedly improved and that there was a need for greater investigation, communication and co-operation, exposure to traumatic events had not and did not represent a significant factor in the causation of psychiatric problems among police officers. Dr Norris accepted

that, at the date of the working lunch, he had probably not been aware that the concept of PTSD had been introduced by DSM-III and agreed that it was probable that even into the late 1980s many psychiatrists in the UK and Northern Ireland would not have used the term. Despite his evidence in court that there was recognition much earlier of a connection between trauma and subsequent psychiatric conditions even in individuals who did not show evidence of previous psychiatric disorder, he was unable to explain why he had not raised the need to consider the consequences of exposure to traumatic incidents upon the mental health of police officers at the meeting with the Chief Constable and his fellow senior officers. It was not difficult to have some sympathy for Dr Norris who was being asked to recall a meeting that took place some 23 years ago and about his recollection of referrals some 10 years earlier. At all times he has enjoyed a high reputation as a skilled and conscientious consultant and I have no doubt that he would have advised the meeting of the risk of significant psychiatric disorder had he perceived that to have been a reasonably foreseeable consequence of exposure to traumatic events at that time. In the circumstances I am driven to the conclusion, that quite understandably, his evidence was to some extent affected by hindsight and that the true position is more accurately represented by the contemporary records, including his notes.

[39] It is perhaps not too difficult to understand why Dr Norris may not have referred to the risk of PTSD when attending the working lunch with the Chief Constable on the 5th July 1982. Dr Goss, a consultant clinical psychologist who performed sessional work for the OHU between October 1990 and July 1993, described how it would have been very rare to encounter any reference to PTSD during her clinical work in the mid to late 1980's in psychiatric hospitals in Northern Ireland. Dr Bell, a consultant psychiatrist called on behalf of the Plaintiffs, confirmed that he encountered scepticism about the concept of PTSD as running counter to deep-seated conventional wisdom that had been present for many years in the psychiatric community in Northern Ireland when he presented papers on the topic between 1986 and 1989. He said that, at that time, very few of the general adult psychiatrists in Northern Ireland were up-to-date with the diagnostic criteria for PTSD contained in DSM-III and expressed the view that it was really the presentation of those papers that sparked off the debate. It seems that the resistance that he encountered stemmed from a combination of a certain amount of scepticism about American diagnosis in general and a belief that victims of violence in Northern Ireland, whether they were civilians, police officers or soldiers, tended to present with anxiety and depression rather than PTSD. When asked by Mr Hanna QC whether the observations contained in paragraph 2.4 of the NICE Guidelines on PTSD reflected the attitude of the psychiatric community in Northern Ireland between 1986 and 1989 Dr Bell said that he thought the general belief was that the vast majority of people developed a transient reaction after a traumatic event while a smaller number developed anxiety and depression and that it was assumed that such people had some underlying vulnerability or

were towards that end of the spectrum. The approach would have been to look for some underlying previous disposition of some kind if chronicity developed. In a paper entitled "Northern Ireland, Studies of Stress In" published in the encyclopaedia of stress in 2000 Dr Bell referred to his earlier paper in 1988 as having forced psychiatrists in Northern Ireland to reappraise their views on the psychological effects of violence with PTSD coming to be seen as a true psychological injury for the first time. He noted that from then on it was becoming clear that PTSD was an injury analogous to a grief reaction in that it was a psychological reaction that happened to normal people when placed under extreme stress.

[40] The Plaintiffs also relied upon the evidence of Mr Beamish in relation to foreseeability. Mr Beamish was employed by the Public Services Training Council ("PSTC") between 1975 and 1985 serving as Deputy Director from 1977. The PTSC developed a cross service programme called "Stress, Strain and Management Performance" and ran courses relating to stress from 1977/1978 until approx 1990. In his original witness statement Mr Beamish expressed the belief that for at least a year before the setting up of the CHMF the PSTC had been talking to the Defendant about the need to tackle the problem of stress in the Force. The course was devised with the assistance of Dr Andrew Stewart; an occupational psychologist who also conducted questionnaire based psychological profiles in the early days. Some of the courses were attended by senior officers from the police including a Chief Constable. During cross examination Mr Beamish accepted that the courses had never included trauma related stress as a separate topic although it was often mentioned during questions and discussion about episodic/chronic stress. Mr Beamish accepted that the main thrust of the course was organisational and management stress rather than post-traumatic stress. He was unable to recall whether the council had ever discussed having a separate section for trauma induced stress in the programme and expressed the view that, in retrospect, that might have been helpful. He said that the council was certainly aware of traumatic stress and dealt with it as he described. Mr Jim Maguire, the head of PSTC, Dr Stewart and Dr Scott, the adviser in relation to physical health, all subsequently served on the CHMF set up by the Defendant but it is to be noted that traumatic stress was not dealt with as a specific topic in either the pilot studies or the body of the reports produced by that committee the main emphasis of whose work was on organisational stress. Mr Beamish confirmed that he had met the then Chief Constable, Sir John Hermon, upon approximately 10 different occasions and that despite what he had been led to believe about his reputation, he was surprised to encounter little resistance to the need to consider the issue of stress amongst police officers.

[41] When dealing with the issue of foreseeability in their closing submissions the Plaintiffs, quite properly in my view, despite the evidence of Professor McFarlane, did not seek to argue that foreseeability arose in the early 1970s. The Plaintiffs must establish, on a balance of probabilities, that the

Defendant, as a reasonable Chief Constable in the circumstances which he found himself and his Force during the period from 1970 to 1981/2 ought to have foreseen as a reasonable possibility that a significant number of members of his Force, who did not suffer from any predisposition, would have sustained recognised mental disorders as a result of exposure to traumatic events. In applying that test the Plaintiffs have accepted, again in my view quite properly, that the primary duty and focus of the Defendant at that time would have been protection of the members of the public, together with his officers and their families, from being killed or seriously injured as a consequence of the murderous terrorist onslaught. They also accepted that the Defendant could not be judged in the context of a large industrial company in Great Britain with the benefit of a specific "risk assessment" department. However, in the context of such appropriate concessions, it seems to me that it is necessary for the Plaintiffs to point to some circumstance or combination of circumstances that would have rendered the risk such that it could not reasonably have escaped the attention of the Defendant despite the unremitting level and intensity of terrorism from 1977 to 1981. The Plaintiffs placed considerable emphasis upon "commonsense" perceptions but such perceptions alone would have been unlikely to discern that there was an important distinction to be drawn between cases of the normal human emotions likely to be generated during the course of an intense campaign of terrorism, which will cover a significant range of severity, and mental disorders produced by exposure to traumatic events. It is indisputable that the system of monitoring sickness absence amongst police officers did not produce any evidence of mental disorders produced by exposure to trauma despite dozens of cases being referred to Dr Norris during the relevant period. When asked to give his views about the problems of stress among police officers in 1982 Dr Norris gave the matter careful consideration but, having done so, did not identify exposure to trauma as a significant factor. Ultimately I am not persuaded by the "building blocks" identified by the Plaintiffs, either individually or in combination, that the risk should have been sufficiently foreseeable to the Defendant to warrant him seeking specialist advice prior to the decision to establish the CHMF. Given his consultancy status, experience and referral duties, Dr Norris would have been the obvious person from whom the Defendant would have sought advice had he thought it necessary to do so during this period. Despite the evidence that he gave, the content of Dr Norris' contemporary records persuade me that, had he been consulted by the Defendant at some earlier date, he would have expressed precisely the same views as he did in 1982.

[42] In view of my findings set out above in relation to foreseeability it is not strictly necessary for me to consider the further matters advanced on behalf of the Plaintiffs relating to that issue. However, in view of the rigour and quality of the research completed and the impressive academic and professional qualifications of the experts called to give evidence by both sides it seems to me that it would be appropriate to do so at least to some extent. In their formal closing submissions the Plaintiffs argued that, had he considered it appropriate

to do so prior to 1981/2, the Defendant should have received or obtained assistance from a number of sources.

The Northern Ireland Literature

[43] Prior to 1981 this consisted of a paper by RM Fraser in 1971 entitled "The Cost of Commotion: An Analysis of the Psychiatric Sequelae of the 1969 Belfast Riots" together with some 6 papers published between 1971 and 1979 by Dr H A Lyons a well known local consultant psychiatrist who conducted a substantial NHS and medico-legal practice. In a paper entitled "Violence in Belfast: A Review of the Psychological Affects," published by Dr Lyons in Community Health in 1973, he referred, inter alia, to the extensive literature on military psychiatry and noted that the various name changes used to describe combat reactions ranging from "nostalgia" through "shell shock", "war neurosis", combat fatigue and combat exhaustion reflected the changing attitude towards the concept of the condition. He reported that studies carried out in Northern Ireland in 1969 and 1970 established that under conditions of severe civil disturbance there was no increase in acute psychotic illness and that some important psychiatric illnesses, such as depression, showed a significant decrease especially in male residents of the most troubled areas of the city. He did however identify a group who had been "actively involved" in violent incidents and noted that many members of the general population who had been involved in terrorist bomb explosions and assassination attempts had developed psychological sequelae and were currently the subject of study. In 1974 Dr Lyons produced his paper "Terrorist Bombing and the Psychological Sequelae" which dealt with 100 patients referred for psychiatric opinion as a consequence of exposure to explosions. In 65 of these patients a diagnosis of post-traumatic anxiety state was made and 16 of them were found to be suffering from a depressive illness. The reason for psychiatric referral of these patients to Dr Lyons was usually continuing symptoms and in the "discussion" section of his paper he observed:

> "It is impossible to ascertain what proportion of people involved in bomb explosions develop psychological symptoms, but it would seem probable that the majority have some subsequent emotional disturbance. Those in the present study are self-selected to the extent that they are those who sought medical advice, but nevertheless are probably a fairly representative sample of the psychological casualties."

In a final paper entitled "Civil Violence – The Psychological Aspects" published in 1979 Dr Lyons carried out a review of the previous publications and relevant literature and expressed views as to the affects of terrorist violence upon a number of different groups. He considered that those involved in bomb explosions, that is those whom he had studied as a result of referral from

GPs, solicitors etc, probably represented a fairly random sample of the population since bombs were liable to explode in a wide variety of places but he added the specific caveat that it was impossible to ascertain what proportion of people who had been involved in explosions did not develop psychological reactions. In the "discussion" section of this paper he said:

> "It is impossible to ascertain what proportion of people involved in bomb explosions develop psychological symptoms, but it would seem probable that the majority have some subsequent emotional disturbance."

In view of his earlier remarks, it is difficult to see how he reached that conclusion unless the reference to "emotional disturbance" is taken to include normal transient reactions such as the anxiety reaction to which he referred earlier as being "appropriate to the dangerous situation". In an earlier paper entitled "Psychiatric Sequelae of the Belfast Riots" relating to patients seen by 3 general practices in West Belfast who had been involved in riot situations between August 15th and the end of September 1969 Dr Lyons had concluded that the commonest presentation was what could be termed "normal anxiety" reporting that:

> "In the community those who develop symptoms tended either to develop a short lived 'normal' anxiety reaction or in those with a previous psychiatric history the illness pattern usually repeated itself."

[44] A number of the experts on both sides were questioned in considerable detail about the views expressed by Dr Lyons in these papers. In my opinion the most useful evidence came from Dr Paul Bell who had trained with Dr Lyons for a short period of approximately 2 months in 1978 mostly at Purdysburn and Albert Road Day Hospitals.

[45] In the course of giving his evidence Dr Bell candidly conceded the difficulty he faced in disentangling the affect of hindsight and his own subsequently developed strongly held views when attempting to report factually in relation to events and opinions almost 30 years ago. In the course of direct examination Mr Irwin QC drew Dr Bell's attention to the symptomatology and diagnostic descriptions contained in Dr Lyon's 1979 paper "Civil Violence – The Psychological Aspects" and Dr Bell expressed his understanding of the contemporary approach in the following terms:

> "The spectrum of people who had been subjected to what we now call a traumatic event, the vast majority of them would have been seen as suffering from a so-called normal stress reaction or normal anxiety

> reaction, a brief stress or anxiety reaction lasting a few days to a few weeks. Large numbers of people would have fallen into this so-called normal reaction category. A smaller number would have fallen into the 2 diagnostic categories that Dr Lyons mentions in this paper, namely anxiety and reactive depression and for me that would have been the practice generally amongst psychiatrists that I worked with in the late 70s/early 80s. People who were subjected to trauma, a large number of them would have normal reactions, a smaller number developed anxiety and reactive depression."

When asked by Mr Hanna QC, in cross-examination, to comment upon paragraph 2.4 of the NICE Guidelines on PTSD 2005 recording the aetiology of PTSD prior to DSM-III in 1980 Dr Bell agreed that it reflected the attitudes which he had encountered when delivering papers between 1986 and 1989 although it was not particularly well expressed. He went on to say:

> "I think the real situation was much less black and white than that and, as I have said earlier, as this statement says, the vast majority of people after a traumatic event developed a transient reaction, a smaller number developed anxiety and depression and it was assumed that those people who developed anxiety and depression had some underlying vulnerability or were towards that end of the spectrum."

He went on to agree with the suggestion put by Mr Hanna QC that some kind of underlying previous condition would have been presumed to be required for trauma to produce a chronic mental condition. Dr Bell repeated this view to Mr Irwin QC in re-examination referring to the interaction between psychiatric vulnerability and adverse environmental stressors and saying:

> "So I think there's a continuum of psychological strength and a continuum of severity of life events so that when psychiatrists interviewed people who had had traumatic events and saw that they had symptoms of anxiety and depression they diagnosed them as anxiety or reactive depression and then went on to assume that they must have some underlying constitutional vulnerability."

When asked by Mr Irwin QC if, therefore, it was his view that people thought only people with unstable personalities, pre-existing neurotic conflicts or mental illnesses would develop chronic symptoms he said:

> "I think that's what we're stating. I think that what most psychiatrists believed in those days was that people with personality disorders, with vulnerabilities as described here, would develop psychiatric illness with relatively minor stressors."

However, he also said that most psychiatrists would have realised that with very severe or repeated traumatic events even the strongest psychological constituted individuals would have developed symptoms of anxiety or depression. Doing the best that I can from a contemporary standpoint, aware of the dangers of hindsight, it seems to me that, had the Chief Constable consulted Dr Lyons between 1978 and 1981 he would have been advised that the vast majority of people exposed to a traumatic event, if they suffered any symptoms, would have suffered from a normal stress reaction or normal anxiety reaction lasting at most a few days to a few weeks. A small number of people would have been diagnosed as suffering from reactive depression or anxiety and most psychiatrists would have assumed in such cases the existence of some form of underlying constitutional vulnerability or pre-disposition although there was a possibility that extremely severe or repeated traumas could produce symptoms of anxiety and depression in individuals with even the most strong psychological constitutions.

[46] Free of hindsight, it is very difficult to know what the Chief Constable's reaction might have been to such advice. From a lay point of view perhaps the most immediate steps would have been to consult his senior officers and those responsible for monitoring the sickness absences including Dr Wright, Dr Sloane and Dr Norris who would presumably have given him the same advice as they did in July 1982. He would have known that recruits and their GP's would have been asked to declare any previous history of mental disturbance and that no cases of officers suffering from psychiatric disorders had been referred to Dr Norris for some eight to ten years. While there might have been discussion about the relevance of alcohol, marital problems and repeated exposure to stressors, he would also have been told that psychiatric problems were minimal in those districts or areas in which officers were most vulnerable and that it was only in exceptional cases that danger or unpleasant duties appear to be a direct cause of stress. In view of the evidence of Dr Bell I think that it is highly unlikely that the diagnosis of PTSD with its radical emphasis upon the significance of the traumatic event as a case of mental disorder would have been mentioned at all or if it was, it would have been in sceptical and/or dismissive terms. In such circumstances, I am not persuaded that a reference to the Northern Ireland literature would have significantly advanced the initiation of the process leading to the establishment of the OHU.

The General Literature

[47] A great deal of time and many weeks of expert evidence was taken up by a detailed examination and analysis of historical and contemporary psychological /psychiatric publications and literature in the course of the debate between the parties as to whether the introduction of the diagnosis of PTSD in DSM-III in 1980 represented a radical development in that field of knowledge or whether it should be more legitimately perceived as the attribution of a new label to a condition that was already widely recognised and accepted.

[48] On behalf of the plaintiffs both Dr Turner and Professor Davidson looked at material relating to stress and police officers emanating from North America, Scotland, the Netherlands, Australia, Britain and Northern Ireland. This documentation was, in turn, considered on behalf of the defendant by Professor Shalev who arranged the material into tabular form. Much of this material prior to 1981 dealt with job/organisational stress in the police rather than trauma linked stress and the first references to PTSD occurred in 1986. When asked specifically in cross-examination by Mr Irwin QC whether it had been foreseeable for a long time that trauma could lead to psychological injury Professor Shalev said:

> "It has and it hasn't. It was an argument, it was an opinion, it was a prevalent trend at some point. It was then forgotten, and then people believed that trauma could not do more than reactivate peoples' previous trauma or vulnerabilities so it has been around forever, but it has not been the only interpretation of what people might experience in the aftermath of a traumatic event."

Professor Shalev agreed that in a paper entitled "Combat Stress Reaction" published in 1989 he and his co-author had written:

> "Extreme behavioural and emotional reactions to combat have been known for centuries. They can be divided into two groups: one is an immediate reaction to combat events (CSR) and the other is a prolonged condition that continues for a long time after the battle (PTSD) or stress response syndrome."

[49] In a similar type of exercise Professor McFarlane, on behalf of the plaintiff, and Professor Wessely, on behalf of the defendant, each submitted written papers analysing the leading textbooks on psychiatry in both the US

and the United Kingdom. In the "conclusion" section of his paper Professor McFarlane said:

> "In my opinion, there was much to inform a medical practitioner of the potential risks that the officers of the RUC were facing. There was a substantial knowledge about the nature of traumatic reactions to stress and that these could not simply be dismissed as due to constitutional factors. As would currently be the view, there are some individuals where the traumatic event leads to the onset of the disorder in the absence of any substantial pre-disposition. Particularly with lower levels of traumatic exposure, personality and other risk factors are more likely to play a contributing role."

For his part, Professor Wessely summarised the text books to 1984 as follows:

> "*(a)* Overwhelming psychic trauma (although the word is never used in this context) can cause psychological symptoms. These will be short lived
>
> *(b)* Prolonged reactions are not really related to the trauma, but their causes lie in childhood, genes, early upbringing, unresolved developmental conflicts and so on. What is of interest is why the person has reacted in the way that they have, and the nature of the trigger is of little or no interest. In all the text books I have studied there is hardly anything about the nature of the trauma, as we find in modern accounts of PTSD.
>
> *(c)* Where they are not short lived, the most common explanation is compensation and/or secondary gain.
>
> *(d)* By the end of the 1970s and the middle of the 1980s, the influence of the British school of social psychiatry around Browne/Harris and the MRC Social Psychiatry Unit at the Maudsley is starting to be felt, mainly in the UK. The general theme is how life events, especially those involving loss, can trigger or bring forward psychiatric disorders, but in those whose early life experiences had pre-disposed them to react in this way. This literature is almost entirely UK.
>
> *(e)* In contrast, the Vietnam experience is starting to be seen in the US. The combat psychiatry literature is

being re-discovered (it remains almost absent from all the UK text books), but the framework remains that overwhelming stressors do lead to breakdown, but this will be transient. Treatment is always following the standard military psychiatry principles, and has little to no relevance to the civilian situation.

(f) The arrival of PTSD as a result of the coup by the US psychiatrists opposed to the Vietnam War came as a surprise to the UK. For some time little attention was paid, at least by the psychiatrists. However, in the mid to late 1980s the literature started to expand, albeit largely with Vietnam papers. The real trigger for the explosion of interest in the UK was the series of high profile disasters such as the Bradford fire, Herald of Free Enterprise and Kings Cross fire. It is however possible that the steady stream of medico-legal cases arising out of the Troubles played a similar and slightly earlier role in NI."

[50] It seems clear from a consideration of the evidence and the relevant materials that the relationship between exposure to trauma and mental disorder has been the subject of a longstanding academic and clinical debate particularly in the context of military operations. In my view, in order to understand the fluctuating history of that debate it is necessary to appreciate that it has also had a political and social context. Writing in the American Handbook of Psychiatry Volume I First Edition 1959 chapter 12 the psycho-analyst Abram Kardiner observed that:

> "The neuroses incidental to war alternate between being the most urgent topic of the times and being completely and utterly neglected. Although there is no such thing as a specific neurosis of war those of a similar character that occur in peacetime are swallowed up in oblivion."

He went on to note that it was hard to find a province of psychiatry in which there was less discipline and that the relevant literature could only be characterised as anarchic. He then continued:

> "There is a widespread theory that war neuroses can only be a continuation of a pre-existing neurosis and that the war situation acts only as a precipitating agent. Although it is true that a war situation can revive pre-existing syndromes heretofore dormant, it can also create new ones."

Writing in the American Handbook of Psychiatry Volume III First Edition 1966 chapter 54 Albert J Glass expressed the view that one of the major contributions of military psychiatry in World War I was repeated demonstrations showing that situational stress and strain could produce mental disorder in so-called normal personnel as well as those of neurotic predisposition but he also confirmed that, with the end of hostilities, the contribution of military psychiatry was largely disregarded. He also recorded that following the cessation of hostilities in World War II military psychiatry, like civil psychiatry, ignored the lessons of war time experience with attention instead being focused on the then prevalent psycho-analytic concepts and practices. The linkage between warfare and interest in the relationship between trauma and mental disorder was also supported by Professor MacFarlane who referred to "lost knowledge" and the chapter headed "History of Trauma in Psychiatry" in the textbook that he edited in 1996, together with Bessel Van Der Kolk and Professor Weisaeth, referred to psychiatry suffering from periods of "marked amnesia" when well established knowledge was abruptly forgotten and the psychological impact of overwhelming experience ascribed to constitutional or intra-psychic factors alone.

[51] The practical effect of the loss of interest in this area of knowledge was reflected in the evidence of Dr Pitman who had no recollection that during his training as a Resident in Psychiatry at Boston VA Hospital – Tufts New England Medical Centre from 1970 to 1973 his attention had been drawn to the work of Kardiner and others. In cross- examination he accepted that such an omission was an embarrassment to his profession, especially in the context of a military teaching institution, but it does seem to confirm the reality of the situation.

[52] It appears that interest in the debate was stimulated by the conclusion of the Vietnam War and it seems likely that the lingering political debate relating to that conflict may have influenced the emergence of PTSD as a diagnosis in DSM-III in the US. Professor Wessely described how the diagnostic concept of PTSD was written by Lifton and Shatan, psychiatrists who were both opposed to the Vietnam War, under the direction of Professors Andreasen and Spitzer, who were responsible for chairing the PTSD Committee of DSM-III. In the course of her contribution to the section dealing with post traumatic stress disorder in Volume II of the third edition 1980 of the Comprehensive Textbook of Psychiatry edited by Freedman, Kaplan and Sadock, Professor Andreasen confirmed the close association between such disorders and warfare commencing with World War I and recorded how the interest of Grinker and Spiegel, among others, at the conclusion of the second World War culminated in the inclusion of a category called "gross stress reaction" in DSM-I in 1952. In common with the subsequent concept of PTSD DSM-I emphasised that this disorder was a

reaction to a great or unusual stress that invoked overwhelming fear in a normal person but, unlike PTSD, gross stress reaction was defined as a transient and reversible reaction. If the symptoms persisted, another diagnosis was to be given. The concept of gross stress reaction was omitted entirely from DSM-II in 1968 and, in the course of the same chapter, Professor Andreasen suggested that this may also have been linked to relatively peaceful conditions stating, at page 1518:

> "The fate of the category seems to have been tied to the history of warfare. DSM-II was compiled during the relatively tranquil interlude between World War II and the Vietnam conflict. Perhaps in the absence of military conflict and in the presence of a rather foolish optimism that did not contemplate its recurrence, the category no longer seemed necessary. The Vietnam War, together with the dissatisfaction of psychiatrists interested in psychosomatic medicine and forensic psychiatry, soon provided convincing evidence for such a need. The description of post-traumatic stress disorder in DSM-III was written to fulfil this need and to draw on the wide range of research which had been completed concerning this condition."

Professor Andreasen went on to acknowledge that at that time, 1980, the international nomenclature, as defined by ICD-9, referred only to acute reaction to stress which it defined as follows:

> "Very transient disorders of any severity in nature which occur in individuals without any apparent mental disorder, in response to exceptional, physical or mental stress such as natural catastrophe or battle and which usually subside within hours or days."

She noted that this concept was nearly identical to gross stress reaction but conceptually quite different from PTSD and that the ICD-9 classification did not appear to provide for chronic reactions to severe stress in normal individuals such as had been recognised in European research, particularly in relation to investigation of concentration camp survivors.

[53] On behalf of the plaintiffs Professor MacFarlane was a proponent of the view that DSM-III simply represented a name change for a condition which had been fully recognised before 1980 although he subsequently conceded in cross-examination that it was more than a name change but less than a philosophical shift. However, even if it is accepted that the role of exposure to trauma in relation to mental disorder was once again receiving more attention with the conclusion of the Vietnam war during the late 1970s, it does seem to

me that the elevation of that role to the position that it enjoyed in the definition of PTSD contained in DSM-III in 1980 was an event of greater significance than Professor MacFarlane was prepared to allow. In an article published in Volume 152(12) of the American Journal of Psychiatry in 1995 Professor MacFarlane together with Dr Rachel Yehuda set out to explore the historical, political and social forces that had played a major role in the acceptance of the idea of trauma as a cause of the specific symptoms of PTSD. Under the heading "conceptual origins" the authors of that paper set out their thoughts as follows:

> "The diagnosis of PTSD was established to fill a gap in the prevailing mental health field by acknowledging that extremely traumatic events could produce chronic clinical disorder in normal individuals. Although the idea that stress could contribute to psychiatric symptoms had been accounted for in previous diagnostic systems, those models primarily viewed enduring symptoms as being caused by pre-morbid vulnerability. In DSM-I and DSM-II, for example, the categories of gross stress reaction and transient situational disturbance, respectively, were used to describe acute symptomatic distress following adversity, whereas more prolonged disorders were conceptualised as being anxiety or depressive neurosis. Regardless of whether these conditions were considered as resulting from developmental fixation or genetic predisposition, the role of environmental stress was at best considered a non specific trigger that might serve to release, exacerbate, or prolong a predictable diathesis to psychiatric symptoms. Thus, the primary philosophical shift involved in including PTSD in DSM-III was to create a diagnostic category that resolved a previous quandary of how to classify a chronic condition in normal people who develop long-term symptoms following an extremely traumatic event. This formulation postulated a general concept of a `post traumatic stress disorder' and implied that PTSD involved a natural process of adaptation to extraordinarily adverse situations and that the pattern of symptoms did not depend on a constitutional vulnerability."

In a further article published in the Australian and New Zealand Journal of Psychiatry 2000 the same authors reviewed recent findings in the field of post traumatic stress disorder and examined their impact on conceptions of trauma-

focussed clinical treatment. In the course of that article Professors MacFarlane and Yehuda wrote:

> "A major dilemma was posed for clinicians by the definition of PTSD in 1980 with the accompanying recognition that trauma survivors presented a unique range of reactions that could not be addressed using the prevailing models of treatments or explained by existing knowledge. The lack of information at the time presented a major quandary for clinicians as to how to best manage patients and still remains an important issue in clinical practice."

In the course of his cross-examination Professor MacFarlane expressed himself as feeling a little ashamed and embarrassed about this reference to the lack of information. He accepted that, with hindsight he should not have made such a reference. He also accepted that the "primary philosophical shift" noted in his paper with Professor Yehuda in 1995 had not been reflected in either his first or second report for the trial and explained that, as a consequence of his further research, he felt that the 1995 and 2000 papers had overstated the degree of shift. Nevertheless, there can be little doubt that those papers were intended to reflect the authoritative views of these two well known experts at the time of publication.

[54] Professor McFarlane also went on to say that DSM-III represented "modern American psychiatry throwing off the shackles of psychoanalysis". He explained that DSM-III had achieved this result by omitting the term "neurosis" which was a term that implied the importance of early development conflict based on Freudian notions being the prime cause of most psychiatric disorders. He accepted that this consequence was a "broad shift" but noted that a close examination of the earlier literature revealed a number of people who had thrown off the shackles at an earlier stage.

[55] Professor Wessley fundamentally disagreed with the proposition that the introduction of the concept of PTSD in 1980 was simply a new name for a condition that had previously been widely recognised. He accepted that the previous literature had contained some papers supporting the thesis that exposure to trauma could cause mental disorder in normal people but felt that these had become lost in the wealth of other material supporting the necessity for a predisposition. In Professor Wessley's view "psychiatry in this area was stood on its head" by the introduction of PTSD. Professor Ariel Shalev, who was also called on behalf of the defendant, made a detailed comparison between DSM-II and DSM-III in terms of dealing with mental disorders linked to trauma. In DSM-11 such disorders, which included "fear associated with military combat and manifested by trembling, running and hiding" appeared

under the heading of "Transient Situational Disturbances" and that, according to Professor Shalev, expressed the prevalent belief at the time that a prolonged reaction in the aftermath of a traumatic event could not be classified as related to that event and required an alternative diagnosis. In such circumstances Professor Shalev considered that the advent of PTSD and DSM-III made "a huge difference" and was the "single substantial step in the history of recognising the pathogenic effect of stress in the second half of the Twentieth Century."

[56] Professor Shalev also emphasised the general difference between DSM-II and DSM- III in that the former was mainly an administrative tool which helped clinicians to make their own diagnosis on the basis of the knowledge and skills that they possessed whereas the latter actively set about defining disorders. This change in general approach was taken up by Professor Paul McHugh, Professor of Psychiatry at John Hopkins University, in an article entitled "How Psychiatry Lost its Way" published in December 1999. Professor McHugh wrote that when it came to diagnosing mental disorders psychiatry had undergone a sea change over the previous two decades the stages of which could be traced to successive editions of DSM. He referred to the significance of DSM-III in seeking to classify mental disorders by their appearance a change which he said could not be underestimated and had "baleful consequences". He noted that committees of experts had been appointed to define the mental disorders set out in DSM-III and that such experts drew upon not only their clinical experience and presuppositions but also the professional literature which he considered to be far from dependable or even stable. He noted that since DSM-III proposals for new psychiatric disorders had multiplied so feverishly that the DSM itself had grown from a mere 119 pages in 1968 to 886 pages in the new and enlarged edition and that within these hundreds of pages some categories of disorder were real, some were dubious in the sense that they were more like the normal response of sensitive people than psychiatric "entities" and that there some that were purely the invention of their proponents. In dealing specifically with PTSD Professor McHugh had this to say:

> "The first clear example of the new approach at work occurred in the late 1970s, when a coalition of psychiatrists in the Veterans Administration (VA) and Advocates for Vietnam-War Veterans propelled a condition called Chronic Post-Traumatic Stress Disorder (PTSD) into DSM-III. It was, indeed, a perfect choice – itself a traumatic product, one might say of the Vietnam war and all the conflicts and guilts that experience engendered – and it opened the door of the DSM to other and later disorders.

> Emotional distress during and after combat (and other traumatic events) has been recognised since the mid-19th century. The symptoms of `shellshock' as it came to be known in World War I, consist of a lingering anxiety, a tendency toward nightmares `flashback memories' of battle, and the avoidance of activities that might provoke a sensation of danger. What was added after Vietnam was the belief that – perhaps because of a physical brain change due to the stress of combat – veterans who were not properly treated could become chronically disabled. This lifelong disablement would explain in turn, such other problems as family disruption, unemployment, or alcohol and drug abuse."

Professor McHugh referred to the apparently intractable problems manifested by the Vietnam Veterans in Westhaven Connecticut and the war veterans in Israel and went on to express the following view:

> "After any traumatic event – whether we are speaking of a minor automobile accident, of combat in war, or of a civilian disaster like the Coconut Grove fire in Boston in 1942 – exposed individuals will undergo a disquieted, disturbed state of mind that takes time to dissipate, depending (among other things) on the severity of the event and the temperament of the victim. As with grief, these mental states are natural – indeed, `built-in' species-specific – emotional responses. Customarily, they wane over time, leaving behind scars in the form of occasional dreams and nightmares, but little more.
>
> When a patient's reaction does not follow this standard course, one need hardly leap to conclude he is suffering from an `abnormal' or `chronic' or `delayed' form of PTSD. More likely, the culprit will be a separate and complicating condition like (most commonly) major depression, with its cardinal symptoms of misery, despair, and self-recrimination. In this condition, memories of past losses, defeats, or traumas are reawakened, giving content and justification to diminished attitudes about oneself. But such memories should hardly be confused with the cause of the depression itself, which can and should be treated for what it is. America's war veterans, who are entitled to our

> respect and support, surely deserve better than to be maintained in a state of chronic invalidism."

Professor McHugh went on to observe that while the new descriptive approach adopted by DSM 111 seemed, at first, significant progress, enhancing communications among psychiatrists, stimulating research and holding out the promise of a new era of creative growth in psychiatry, some 20 years later, the weaknesses inherent in a system of classification based on appearances – and contaminated by self-interested advocacy, had become glaringly evident. He concluded his interesting article by observing:

> "In its recent infatuation with symptomatic, push-button remedies, psychiatry has lost its way not only intellectually but spiritually and morally. Even when it is not actually doing damage to the people it is supposed to help, as in the case of veterans with chronic PTSD, it is encouraging among doctors and patients alike the fraudulent and dangerous fantasy that life's every passing `symptom' can be clinically diagnosed and once diagnosed, alleviated if not eliminated by pharmacological intervention. This idea is as false to reality, and ultimately to human hopes, as it is destructive of everything the subtle and beneficial art of psychiatry has meant to accomplish."

It is of course important to record that, while not doing so in perhaps quite such colourful terms, Professor MacFarlane himself has expressed considerable scepticism about the primary role attributed to trauma in the diagnosis of PTSD introduced by DSM-III which he considers to have been "exaggerated".

[57] Institutional views also seem to support the proposition that the emergence of PTSD in DSM-III represented a significant change and in a passage which will probably remain imprinted in the memories of those conducting this litigation for many years, the National Institute for Clinical Excellence ("NICE") published Practice Guideline No 26 dealing with Post-Traumatic Stress Disorder in 2005 which contained the following at paragraph 2.4 dealing with the aetiology of PTSD:

> "It is now recognised that the traumatic event is a major cause of the symptoms of PTSD. Historically, this has been the subject of considerable debate. Charcot, Janet, Freud and Breuer suggested that hysterical symptoms were caused by psychological trauma, but their views were not widely accepted (see reviews by Gersons and Carlier, 1992; Kinzie

> and Goetz, 1996; Van der Kolk et al 1996). The dominant view was that a traumatic event in itself was not a sufficient cause of these symptoms, and experts searched for other explanations. Many suspected an organic cause. For example, damage to the spinal cord was suggested as the cause of the `railway spine syndrome', micro-sections of exploded bombs entering the brain as the cause of `shellshock' and starvation and brain damage as causes of the chronic psychological difficulties of concentration camp survivors. Others doubted the validity of the symptom reports and suggested that malingering and compensation-seeking in `compensation neurosis' were the major cause in most cases. Finally, the psychological symptoms were attributed to pre-existing psychological dysfunction. The predominant view was that reactions to traumatic events were transient, and that therefore only people with unstable personalities, pre-existing neurotic conflicts or mental illness would develop chronic symptoms (Gersons and Carlier, 1992; Kinzie and Goetz, 1996; Van der Kolk and others 1996)."

The guideline went on to record the introduction of PTSD in DSM-III and subsequently in ICD-10 which emphasised the causal role of traumatic stress disorders in producing psychological dysfunction even more clearly in that a specific group of disorders, `reaction to severe stress, and adjustment disorders', was created.

[58] It is not at all easy to reach a confident conclusion as to the likely content of any response that the defendant would have received had he decided to retain an appropriately qualified psychiatric expert/experts to advise him in relation to trauma induced mental disorder during the period 1978 to 1981. It seems likely that in the context of the post Vietnam atmosphere the view which had predominated since the end of the Second World War and which was reflected in DSM-II was being challenged primarily in America during the discussions and consultations leading up to DSM-III. On the other hand the natural course for the defendant to have taken would have been to consult local opinion and the evidence of Dr Bell suggests that this would have been sceptical about such developments while Dr Norris would have confirmed that he had not encountered any relevant cases in the course of his referral work. It seems to me that the most likely response from a local committee of psychiatrists would have been to inform the defendant that the prevailing view with regard to trauma induced mental disorder, as reflected in DSM-II, was likely to change with the inclusion of PTSD in DSM-III but that the

material factor in securing that development was felt to be a group of clinicians influenced by the consequences of the Vietnam war and that, at least for the present, there was no indication of an equivalent alteration in ICD-9. The proposition that normal individuals might suffer chronic mental disorder as a consequence of exposure to trauma/traumas was supported by certain pieces of research and some textbooks, having been particularly visible at the conclusion of major conflicts, but, for the present, it would probably be prudent to regard such cases as being limited in number and await the outcome of further research.

The Development of the Occupational Health Unit

[59] In May 1981, as a result of having attended a course at Bramshill, Superintendent McIvor delivered a paper entitled "Job Stress and the Serving Policeman. He referred to stress as being identified by researchers as a major factor in the job of the police officer which was especially true in Northern Ireland with the constant threat of violence. The Superintendent observed that:

> "The recognition of stress as a major factor in job-related disorders for policeman is only beginning to be considered as an area for concern by police forces throughout the world. It is one reason so few studies have been initiated and funded on the subject to date. As more emphasis is placed upon the nature of stress-related disorders in policemen, more work will undoubtedly be done which will make it an unavoidable matter for chief officers everywhere. The American experience in this field would seem to have a relevance to the Royal Ulster Constabulary, the latter force being the only British police service which operates in somewhat similar conditions to American Law Enforcement Agencies …"

[60] The June 1981 edition of Police Beat, the magazine of the Police Federation (the "Federation"), carried a profile of Chief Inspector Daryl Beany which included an account of his attendance at the F.B.I. Academy in Quantico Virginia – the institution that was subsequently also attended by Superintendent White in 1983 and Sir Ronald Flanagan in 1987. In the course of the article the Chief Inspector referred to a course dealing with Contemporary Police Problems in which he learned that many forces in the U.S. employed their own psychologist and that a study was taking place in Los Angeles into the effect of stress upon officers who had been involved in fatal shooting incidents. The issue was taken up by the Federation and Mr McClurg confirmed that it was from that time on that he began to become aware of the

problem of stress. Chief Inspector Beany was subsequently co-opted onto the CHMF.

[61] On 3 March 1982 the Chief Constable of the Northumbria Police, Stanley Bailey wrote to Sir John Hermon, then Chief Constable of the RUC, informing him of the decision the Association of Chief Police Officers (ACPO) to set up two committees to consider both mental stress and physical stress in the police and to invite him to nominate a representative from the RUC to participate. On 10 March 1982 the Chief Constable referred that letter to the Command Secretariat suggesting that stress was already a matter of consideration and asking for further views. On 25 March 1982 Dr John Stewart the Vice Chairman of the Association of Police Surgeons of Great Britain wrote to the Chief Constable on a purely confidential and personal basis referring to a recent radio interview with the Chairman of the Federation relating to the effect of stress on members of the force. Dr Stewart suggested that the current arrangement under which the FMO saw officers who had been off duty for more than a month could be improved by making greater use of the police surgeon's services. He raised the possibility of police surgeons making themselves available in an "industrial medical officer type" way seeing members of the force who were showing signs and symptoms of stress either on referral by the relevant Divisional Commander or by way of confidential self referral.

[62] Dr Michael Scott, Consultant Cardiologist, gave evidence that in early 1982 he was contacted by Mr Jim Maguire, with whom he had been involved in the delivery of a series of residential courses for executives on behalf of the Public Service Training Council, who inquired as to whether he would be willing to become involved in the work of a committee set up by the Chief Constable to look at stress in the RUC. On 6 April 1982 Mr Maguire furnished background information on both Michael Scott and Andrew Stewart to the Chief Constable confirming that they were both willing to take part in initial discussions. Andrew Stewart was a senior fellow of the Institute of Manpower Studies and an industrial psychologist specialising in, amongst other matters, organisational stress and survey methodology. The FMO and the Federation were notified of the decision to set up a committee to look at "stress within the force" and that the first meeting would take place on 27 April 1982 at Garnerville. The group comprised Mr Jim Maguire, Chairman, Dr Scott, Dr Stewart, ACC Steenson, Chief Superintendent Henry, Chief Superintendent Liggett, Mr Roy Rattey, RUC Welfare Services, and Mr Barr from the Command Secretariat who served as Secretary. The minutes of the first meeting show that the group recognised, from the outset, that there were difficulties in assessing stress in a disciplined organisation which worked long, unsocial hours and where any "weakness" was immediately brought to public attention. On the basis of the limited factual and statistical information available the group did not consider that an overall force stress problem was apparent although it was obvious that individuals had and were experiencing a

variety of personal problems. The group identified a number of indicators of excessive stress and agreed that a pilot study to gather information was required. It was also agreed that the Federation should be consulted before any members of the force were asked to contribute input. A further meeting of the committee took place on 21 May 1982 when Dr Stewart presented a draft programme comprising a series of stages including a pre-pilot study, a pilot scheme, a main study, a report stage and follow-up action. At that meeting it was agreed that the word "stress" was somewhat emotive and that, consequently, it would be helpful to re-title the group the Committee on Health and Management of the Force.

[63] The draft programme prepared by Dr Stewart was discussed by Dr Stewart, Mr Maguire and the Chief Constable on 23 July 1982 prior to the next meeting of the CHMF and the Chief Constable accepted the draft with some minor amendments and suggestions. The minute of the meeting of that day recorded the chairman's report that the Chief Constable had been extremely helpful and positive in his attitude towards a study and had confirmed that he wanted as thorough, scientific and open an investigation as possible consistent with the overall constraints and confidentiality. The same minute recorded a meeting between the chairman and Dr Stewart and representatives of the Federation which had been arranged by the Chief Constable and which had proved very successful with the Federation expressing support for the study. On 27 July 1982 Mr Maguire furnished Mr Barr with a draft set of terms of reference for approval and a formal set of revised proposals were furnished to the Chief Constable to be forwarded to the Police Authority for official authorisation.

[64] A series of pre-pilot interviews with members of the force serving in different circumstances were carried out for the purpose of generating material to be used in questionnaires. Dr Scott and Dr Stewart then compiled a two-part questionnaire designed to explore aspects of physical and psychological health. The questionnaires were then sent out to approximately 250 officers. Dr Scott confirmed in evidence that the Committee was left free to devise its own procedure and methodology. He also accepted that, during the course of their work, the Committee never received the impression that they were being in any way inhibited or discouraged from including the subject of trauma induced stress from their investigations.

[65] On 16 March 1983 Force Order 48 of 1983 was published announcing the survey and emphasising that participation was both voluntary and confidential. After issuing a preliminary report in December 1983 both Dr Scott and Dr Stewart presented papers to the CHMF on 3 February 1984 analysing the response to the questionnaires. The minutes of this meeting recorded that Assistant Chief Constable Steenson argued that neither of the papers had indicated there was a widespread or severe stress problem within the force but rather that the vast majority of members tested in the pilot study appeared to

be in good health and coping with the pressures extremely well. He suggested that none of the main stressors such as coronaries, heart disease, strokes, ulcers, marital break-ups, suicides, heavy drinking or smoking had manifested themselves in any degree in the research to date. He also maintained that there was a need to differentiate between "normal" stress and pressures associated with working in any large organisation and a stress "problem". Dr Stewart responded by stating that further research was needed which could only be achieved through a main study and that the fact remained that there were indicators that individuals within the force had problems, some of which could be alleviated with the aid of further research. At paragraph 6 of the report presented to the Committee under the heading "Personal Security" the following matters were recorded:

> "On the surface, the obvious risks of becoming a policeman are known and accepted. Underlying this is an awareness that the reality of continual stress is harder to cope with than they had imagined. Various coping strategies are mentioned, many of which are not in fact coping strategies at all, but repression. This is unhealthy and will lead to problems for the individuals concerned."

When the draft preliminary report was considered by the CHMF at their meeting on 2 May 1984 ACC Steenson renewed his argument that the draft had not provided enough information or statistical data to support the view that there was a major stress problem and suggested that if the Chief Constable considered that any such further investigation was merited such study could be undertaken internally by the force. The Chairman pointed out that the primary purpose of the pilot survey was to test the validity and method of gathering information and since the sample had consisted of a small number of volunteers the pilot itself would be much too small to use as a policy guide. The main study would permit more detailed investigation of selected areas and would lay a proper foundation for future strategy. The minute recorded that a discussion then took place with a diversity of views being expressed but the majority of those present were in favour of proceeding with the main study.

[66] The preliminary report of the CHMF was finalised in June 1984 and recorded that its terms of reference included:

> "*(a)* To identify any key symptoms of occupational stress and to indicate the likely causes and potential impact of exceptional stress within the force."

The terms also included the aim of establishing the incidence in the force of illness which might be stress related. In the "Background" section of the report

the CHMF also recognised that the organisational culture or value system, particularly of a police force, might be an impediment in dealing with stress related illnesses, usually because of the "macho" image of policemen and the associated reluctance to admit strain/stress as a sign of weakness. It was noted that the rank and file perceived evidence of such conditions as likely to be damaging to promotion and possibly a reason for scorn. At paragraph 2.2 the report acknowledged that to have served as a policeman in Northern Ireland at any time over the previous 15 years was to have experienced exceptional pressures and to have carried an enormous burden. It recorded that it was generally accepted that police officers had an emotionally and physically demanding job which was at times dangerous and harrowing. The authors noted of the police officer that:

> "Too often in Ulster he is the target of murder and violence – the knock at the door and covert bomb are ever present threats. The police pay heavily for the ills of our society often with scant appreciation."

In such circumstances, the report accepted that it was obvious that some officers would suffer directly or indirectly from the stressors of their job and that, contrary to general public perception, they were not immune to the stressful effects of the job, of crime and the obscenities of violence. At paragraph 6.4 under the heading "Security" the report proceeded in the following terms:

> "Contrary to what appears to be general expectation, the possibility of an attack leading to serious injury or death was not a major preoccupation with the average RUC officer. The security risks were accepted as part and parcel of the policeman's life in Northern Ireland. That is not to say he is not conscious of it, but has rationalised it, or developed coping strategies, which for the most part allow him to cope with it. Within that broad generalisation obviously there will be some individuals who because of their particular personality, perhaps the branch or location they serve in, may suffer unduly from strain and there have been instances of this over the years. But there was nothing in the sample to suggest any evidence of widespread breakdown or impending breakdown which would seriously affect the force's operational performance."

There was a reference to specific coping strategies such as "I just put it out of my mind" or "if your name is on the bullet you'll not stop it". These were not

seen as good coping strategies but as pointing to some form of avoidance or repression, unhealthy mechanisms which could lead to later problems. However, the report also noted that if there was a rational approach there was little doubt that an officer could develop his own coping skills although some such skills could be taught and should be part of a preventative programme. Section 6.5 concluded as follows:

> "Given the moderately low incidence of strain symptoms revealed in the Health and Fitness Survey, the `security' threat is not a serious debilitating influence for the majority of the Force nor is it affecting efficiency unduly, but since it is an unusual phenomenon, and there are some underlying tensions, it calls for closer analysis in the Main Study and the establishment of a monitoring device to ensure that appropriate counteraction is taken if needed."

[67] Overall, the report recorded that the view reflected back to the Committee was certainly not one of an organisation strained to the point of breakdown but rather one where individuals in management were coping remarkably well under sustained pressure often of an unusual kind. It was accepted that there were instances in which pressures had become too severe and prolonged for some people resulting in illness or breakdown related to work and these required special attention but that this was not unexpected in an organisation employing in excess of 8,000 people.

[68] In concluding their report the CHMF made the following relevant recommendations to the Chief Constable:

> "10.1.1 To establish a small occupational health unit which will include both medical and psychiatric services so that a central professional resource is created which specialises in police-related illnesses. This is a core component in a preventative strategy. Implicit in this recommendation is the introduction of regular medical check-ups and the provision of a professional post-trauma counselling service.
>
> 10.1.2 To organise a relevant and expanded data-base within the personnel function so that information about stress illnesses, various stress-related symptoms such as absenteeism etc is easily accessible. This will allow regular monitoring of trends in a number of linked symptoms. …

> 10.1.5 To introduce short training modules for all ranks on the value and importance of health, fitness and lifestyle in coping with the pressures of police life. Allied with this is a firm backing for the Welfare Officers Awareness Programme on Alcoholism.
>
> It must be stressed that the recommendations are linked and inter-dependent. Action is needed in a number of different areas and it should be sensibly and carefully planned in light of resources, operational constraints and the need for rank and file support."

The report also recommended that training in basic stress management should be provided as a normal fully integrated part of training for all levels and that special modules should be incorporated on the identification of stress symptoms and basic counselling techniques.

[69] The preliminary report from the CHMF was forwarded to the Chief Constable and to the Police Authority for Northern Ireland ("PANI"). At a meeting of the General Purposes Committee of PANI on 5 December 1984 the Chairman, Dr Conlan, recorded that an occupational health service had been recommended separately by the DHSS, the Association of Forensic Medical Officers and the CHMF. Dr Conlan referred to the role of an occupational health unit in some detail, noting that such a facility could not be established overnight, and recorded that the function of a proposed sub-committee would be to make recommendations as to the need for an occupational health service and to draw up guidelines in relation to objectives, size, staffing quotas, activities and priorities. There was provisional agreement that an occupational health service should be recommended and that Mr Maguire, who had attended the meeting together with the Chief Constable, would report after consultation with Dr Scott and the Society of Occupational Health. There was no dissent on the principle of conducting a larger study following on from the pilot study and, after some discussion as to whether the same team should immediately proceed to carry out this task or whether it should be conducted by the occupational health unit a decision was taken that the balance of advantage lay with the latter suggestion. Mr Maguire duly prepared a detailed paper dealing with the institution of an occupational health unit which was considered by the PANI sub-committee on 15 February 1985. This meeting agreed, without the dissent, that an occupational health unit was required. On 8 March 1985 the sub-committee appointed a working party under the chairmanship of Mr Maguire to make recommendations and these were furnished for consideration by the sub-committee in May. On 5 June 1985 the Assistant Secretary of PANI applied to the Northern Ireland Office ("NIO") for

funding for the OHU and approval of the first part of the main study. On 26 July the NIO granted approval in principle for the establishment of the OHU and accepted that the head of the new unit should be closely involved in the detailed consideration of the structure and staffing of the unit during the main study. The job description for the post of Medical Advisor produced in November 1985 set out the duties of the new post and included, at paragraph 13, the duty to advise on and promote the rehabilitation of officers who had suffered serious illness or injury or been involved in psychologically traumatic incidents. The advertisement appeared in three Belfast newspapers, the Lancet and the British Medical Journal between 17 and 19 October.

[70] Dr David Courtney was appointed as head of the OHU with effect from 3 February 1986 and he assumed responsibility for the duties previously carried out by the FMO from 1 April. Dr Courtney and his personal secretary moved to purpose built facilities at RUC Lisnasharragh in early June and on 13 June Force Order 32/86 announced the coming into operation of the OHU and confirmed that it was the first of its kind to be established by any police force in Western Europe. The Force Order explained that the OHU would monitor and advise the Chief Constable about the general health of the Force and individual officers within the accepted principles of confidentiality and informed consent. The job of the OHU was specified as being promotion and protection of the physical and mental health of serving officers of the force and, in particular, the unit was to be responsible for:

(a) The health assessment of prospective recruits;

(b) The health assessment of officers' suitability to undertake particular work, or work in particular environments;

(c) The health assessment of officers who have had serious illness injury or appear to have other health problems;

(d) Monitoring the general health of the Force and advising on protection against health hazards in the job;

(e) Providing health guidance and education generally in the Force;

(f) Coordinating the use of other external health functions in the Health and Social Services in support of the unit's work;

(g) Liaison with personnel and welfare services on general health and welfare matters.

Paragraph 3.4 referred to the appointment of Dr Courtney and recorded that from 1 April 1986 he would assume full responsibility for the provision of the

existing medical services to the force previously supplied by the FMO and his deputy.

The OHU – Staffing, Resources and Performance

[71] The paper "Framework for the Occupational Health Unit" that had been under consideration by the working party appointed by the PANI sub-committee suggested an initial staffing requirement for the OHU of five comprising a Chief Occupational Physician, a Senior Physician, 2 qualified Occupational Health Nurses and Clerk/Secretary. However, at the meeting of the sub-committee in April 1985 a recommendation was accepted from the working party that rather than attempt to settle the staffing requirement at the outset it would be preferable to appoint the head of the unit at an early date and to allow him to participate in identifying the support staff needed and to be involved in their selection. Dr Courtney came from a background of Occupational Health, a field in which he had worked since 1975 with Standard Telephones and Cables, and he explained that the role of occupational medicine was seen normally as a preventative rather than a therapeutic speciality in so far as it was unrealistic to try to emulate the National Health Service which had the primary responsibility for treatment. Dr Courtney's job description specified that he would not be subject to direct managerial control by either the Chief Constable or PANI but that he would be accountable to the Chief Constable for the day to day provision of a service to the police and to PANI for the efficiency and effectiveness of the service overall.

[72] From February to April 1986, between his appointment and becoming operational, Dr Courtney, with the assistance of Mr Rattey the Welfare Officer and Sally Meekin, made familiarisation visits to every police division for the purpose of introducing himself and the concept of the OHU. During the first five or six months of his appointment Dr Courtney found himself dealing with two main categories of absence referral cases, namely, those concerned with musculo-skeletal problems and those involving some form of psychological difficulty. The latter were extremely varied with mixed anxiety and depressive symptoms. Many of these conditions were relatively minor and it was possible to significantly assist the officers concerned without recourse to any specific treatment regime. Dr Courtney considered that the causes were really multi-factorial including work-related pressures, the systems within work, the quantity of work, the hours worked and family problems. However, he did note that in a number of cases the fact that an officer had been involved in a traumatic incident/s also appeared to be a factor.

[73] Recognising the limitations of his own experience, Dr Courtney carried out background reading in relation to trauma and stress in general and he believed that, having done so, it was from this source that he learned about the concept of Post-Traumatic Stress Disorder. Dr Courtney said that, at a fairly early stage, he began to feel that it would be helpful to have the assistance of a

psychologist and a psychiatrist. He reached this conclusion in the context of occupational medicine being essentially a team concept with the requirement that the team should be able to deal with the hazards specific to the relevant occupation. He considered that such assistance would be appropriate in the context of policing where some of the hazards were psychological or related to pressure of work situations. His initial intention was that the role of such specialists should be largely advisory but he accepted that it inevitably became more therapeutic as the need emerged. Dr Courtney explained that he quickly became aware of the dearth of clinical psychology provision within the National Health Service in which it was very difficult for GPs to gain access to such specialists and, when they did so, waiting lists were liable to stretch to months and sometimes over a year. Indeed it is interesting to note a recent media report that the current NHS waiting lists for Cognitive Behavioural Therapy ("CBT") are in some cases as much as four years despite the strong support for such treatment expressed in the CREST and NICE guidelines of 2003 and 2005. In addition, it soon became clear that, while they were not reluctant to attend their GPs in normal circumstances, police officers were reticent about discussing specific internal policing issues outside the force. Towards the latter part of 1986 Dr Courtney secured the services of Dr Lumsden, Clinical Psychologist, and Dr Browne, Clinical Psychiatrist on a sessional basis. A session was normally 3-4 hours at least once and sometimes twice per week. In October 1986 Mrs Sally Meekin was appointed as Occupational Nurse and in 1987 the post of Deputy Medical Advisor was filled by Dr Crowther.

[74] There can be no doubt about the experience, industry and ability of the staff of the OHU. During her service of approximately six years Sally Meekin gained a Diploma in Occupational Health Nursing and an Honours Degree in Advanced Nursing Studies. She then left to take up a Senior Officer post with the Royal College of Nursing. As part of her Diploma course Mrs Meekin prepared a dissertation on 'The Effectiveness of Counselling by an Occupational Nurse in the Post–Trauma Situation' and was later involved in the planning and implementation of a course on occupational nursing at the University of Ulster. She was succeeded by Margaret Bennett in 1992 who held a similar Diploma with distinction and who went on to gain a BA Degree, again with distinction, in Community Nursing in 1998. Joseph McCloskey, who joined the OHU at the same time as Mrs Bennett, held qualifications as both a Registered General Nurse and Registered Mental Nurse and went on to complete an Honours Degree in Occupational Health. It was a close and stimulating environment in which there was a free and productive exchange of advice, opinions and information amongst all the practitioners. As Mrs Meekin said in evidence they had regular weekly contact with specialists in psychology and psychiatry, whereas in the NHS "we would never have seen one."

[75] On 26 October 1987 Dr Courtney wrote to PANI recommending the employment of a full-time Clinical Psychologist. He pointed out that, as the

OHU service extended, it was becoming clear that the time available was insufficient for the workload and that they were unable to provide appointments as often as was required and that follow-up had become difficult. His letter then contained the following passage:

> "Workload: we have analysed the workload within the Occupational Health Unit for the first six months of 1987. During that period 427 `new' cases were dealt with which involved in broad terms psychological/psychiatric problems. Clearly only a relatively small proportion of these require professional psychological assessment and treatment but there is a major requirement to provide such support and treatment. As very often the problems are specific to the police force it is inappropriate and, indeed impossible to get psychological assistance through the normal NHS channels therefore we need to provide such service ourselves."

As seen by Dr Courtney, the alternative strategies were:

1. Extend the current service to provide more time which was impracticable since the current sessional psychologist was unable to provide additional time;

2. Refer to outside agencies which Dr Courtney considered to be unrealistic because of a lack of suitable expertise and the nature of the problems within the RUC not being suitable for outside referral; or

3 The course that he recommended, which was to employ a Clinical Psychologist.

His letter went on to point out that:

> "The potential result of this strategy not being adopted is that the current service will shortly be unable to cope with the workload. Not providing the proposed service would result in a grossly inadequate counselling and psychological service leading to an ineffective provision of psychological assessment and treatment."

[76] In order to secure an appointment of the type being sought by Dr Courtney it was necessary to obtain approval from PANI, the Northern Ireland Office ("NIO") and, ultimately, funding from the Treasury. Mr Raymond

Laverty, the appropriate official in PANI, sought to provide a rationale for this procedure by pointing out PANI operated under a grant of aid from the NIO and the NIO, in turn, had to account to the Treasury for the expenditure of that grant. The Permanent Under-Secretary to the NIO was the Accounting Officer for the Police Authority and as such required to appear before the Public Accounts Committee to answer questions about police expenditure. The initial reaction of Mr Laverty, to whom the request was relayed, was one of caution and the note that he appended to the recommendation was that "Dr Courtney is attempting to make quite a quantum leap here and we must be careful before we go too far." Mr Laverty's concern was more with the underlying philosophy of the OHU than with the specific request itself. He recalled that the advice that had been tendered by the Society for Occupational Medicine had been to the effect that the OHU should not be responsible for treatment which should be essentially a matter for the officer's GP and the NHS. Accordingly, PANI sought further advice from the Senior Medical Advisor to the Employment Medical Advisory Service, who was himself a member of the Society of Occupational Medicine, and from an Assistant Chief Constable. On 26 April 1988 PANI sought authority for the appointment from the NIO which responded on 20 May seeking a great deal of further information. Ultimately, approval was obtained from the NIO on 19 August 1988, some ten months after the request made by Dr Courtney. Further debate then took place between the departments with regard to the nature and content of the appropriate advertisement which was placed with three Belfast papers and the British Psychological Society in December.

[77] No suitably qualified applicants applied for the post of Clinical Psychologist. On 2 November 1988 Dr Courtney had furnished Mr Laverty with a report relating to staffing at the OHU which included the following passage with regard to professional staff:

> "Approval has been given to increase the psychological support to a full-time position. Even with this the `bread and butter' work will still be carried out by the basic professional staff. At present it is becoming increasingly difficult with the workload. Patients are having to wait longer to be seen than is often desirable and follow-ups less frequent than is ideal. This is particularly true of Post Traumatic Counselling. This is an area of service which was established in early 1988. This is vital preventative work in seeking to alleviate health problems resulting from traumatic incidents. This is now widely accepted as a vital area of prevention as witnessed by arrangements made for those involved in various disasters, e.g. Kings Cross, Zeebrugge etc. In the Royal Ulster Constabulary major

> traumatic incidents are a daily occurrence with far-reaching consequences. It was originally intended to see individuals within 2 to 5 days of an incident. In practice this has proved impossible and it is often several weeks before they are seen. The self-referral has also increased. I believe this is to some degree at least a reflection of some confidence in the unit by the Force and many of the problems presenting in this way are very real and treatable."

[78] There is no doubt that there was severe difficulty in recruiting clinical psychologists both in the UK generally and in Northern Ireland in particular. The training course at Queen's University was producing six trainees every two years in the late 1970s/early 1980s and the course itself was suspended for some three years during a change of management. It was virtually impossible to attract applicants for posts from outside Northern Ireland. During the 1990s Patricia Donnelly, one of the Clinical Psychologists who provided sessional services to the OHU, was involved in a Department of Health and Personal Social Services ("DHPSS") workforce planning exercise which undertook a mapping exercise of posts and vacancies for clinical psychologists. This showed that during the 1990s around 20-40% of Clinical Psychology posts in Northern Ireland were unfilled. As a manager at the Royal Victoria Hospital, Miss Donnelly had huge difficulties recruiting appropriately skilled psychologists and her experience indicated that the situation was even worse in the 1980s. Dr Poole agreed that, at this time there was a chronic shortage of Clinical Psychologists and that, even in the NHS, he had been unsuccessful in trying to get posts re-graded in order to offer enhanced remuneration. Dr Slovak described the difficulties that he had encountered in trying to recruit a clinical psychologist for his department at British Nuclear Fuels despite receiving authorisation to increase the financial rewards. He said that he had continued to experience serious problems in this area until approximately five years ago. Further disincentives would have been the enhanced security risk associated with working for the RUC and the more attractive promotional ladder offered by employment within the NHS.

[79] The minutes of the meeting of the General Purposes Committee of PANI held on 16 May 1989 recorded a conversation with Dr Courtney in the course of which he confirmed that no suitably qualified professionals had applied for either of the posts that had been advertised of full-time psychologist or part-time physiotherapist. Dr Courtney explained that it was likely that at least part of the reason for the failure to attract suitable applicants related to the remuneration package. While she was not in post at the time, Anne Burnett, who joined the Personnel Department of PANI in 1997, confirmed that her investigation of the relevant files and records had not produced evidence of any further attempt to appoint a full-time Clinical Psychologist between March 1989 and March 1992.

[80] On 10 May 1991 Dr Courtney was notified of a review of the OHU by the Management and Manpower Review Division of the Department of Finance and Personnel. The review document acknowledged requests from Dr Courtney for additional resources and that, in particular there should be appropriate grading of the Clinical Psychologist post taking account of problems experienced to date in attracting any suitable candidates at the proposed Civil Service grade of Occupational Psychologist. Accordingly, PANI sought an upgrading of the post and the MMRD report in 1991 indicated that taking account of problems experienced in attracting suitable candidates at the proposed Civil Service grade of Occupational Psychologist the post should be re-advertised at unified grade 7 level. In December 1991 Dr Courtney expressed the view that it might still prove difficult to appoint an appropriate person at this grade but accepted that he could not provide any stronger argument. The accuracy of his judgment was shortly to be validated. On 27 March 1992 a further advertisement was placed in the relevant newspapers and application packs were returned by 7 of the 11 individuals by whom they had been requested. Interviews took place in June 1992 and the post was offered to Dr Poole although no appointment was made because he felt the remuneration offered to be inadequate. In the course of his evidence he expressed the view that the salary advertised was equivalent to that of a relatively junior grade and considerably lower than the post of equivalent responsibility within the NHS. In October 1992 the job was again re-advertised and information packs were returned by 5 individuals. Dr Poole eventually accepted appointment after the NIO were persuaded to upgrade the post to grade 6, which involved an approximately 10% increase in remuneration, and some further negotiation. Dr Poole was appointed in May 1993.

[82] Demand upon the service continued to grow and in December 1996 Dr Courtney and Dr Poole secured the support of the Deputy Chief Constable, Support Services, for additional staffing. Not long after Miss Burnett joined PANI in September 1997 she had a meeting with her line manager Graham White, then Director of Personnel in PANI. Mr White wished to discuss the recruitment of a second Clinical Psychologist for the OHU, an appointment that had been requested by Dr Courtney. He explained to Miss Burnett that the organisation had previously encountered difficulty in recruiting a clinical psychologist and asked her to take responsibility for the appointment. Miss Burnett believed that the post was advertised soon after this meeting towards the end of October 1997. However, it was not possible to identify any documentation in support of the placing of this advertisement at that time and in November 1998 Dr Courtney wrote to Miss Burnett in the following terms:

> "Dear Miss Burnett
>
> I understand from Dr Poole that when he met with you on 19 October 1997 you informed him that the

> Clinical Psychologist post with Occupational Health Unit would be advertised in the Belfast Telegraph on the Tuesday of the following week i.e. 27 October. This did not happen, and the advertisement has still not appeared.
>
> I am aware that the demands on Dr Poole, have for some time been considerable, and indeed it was in recognition of this that a request was made for the establishment of an additional post. This was accepted and approval was granted approximately a year ago.
>
> Since then not only has the work pressure continued to increase but, in addition, there has been a marked further increase arising as a consequence of the Omagh bomb. I am aware that this is adding to the stress which Dr Poole has been experiencing. Indeed, he himself made this point at a meeting with the General Services Committee of the Authority on 21 September 1998 and was reinforced by myself on 16 November 1998 when presenting the annual report for `H' department. The Chairman of Committee indicated that the matter should, and would, be addressed as a matter of urgency. "

Dr Courtney went on to express his concern about the affect that continuing excessive work pressures might have upon the health of Dr Poole. Despite this letter, Miss Burnett remained firm in her recollection that the job had been advertised in October 1997 because she recalled having to seek an additional budget to meet the cost of advertising in the British Journal of Psychology. In any event it appears that no suitable applicants came forward and the appointment was readvertised towards the end of 1998 with a closing date on 8 January 1999. An interview/interviews took place in August of 1999 but no appointment was made.

[83] In the meantime Dr Poole had resigned in June 1999 giving as one of his reasons for doing so the pressure of an ever-increasing workload particularly of persons with major post trauma symptoms. He referred to the significant increase in the volume of referrals following the Omagh bomb on 15 August 1998 and continued in the following terms:

> "As a consequence of the demand for psychological treatment, and despite my colleague's assistance to limit referrals, a point has been reached where I feel

> I am unable to provide an adequate quality of service because of the quantity of demand. For me this is professionally unsatisfactory …
>
> The situation is particularly frustrating since, as far back as 1996, it was accepted by the Police Authority that the demand for psychological treatment justified the appointment of additional Clinical Psychologists. It is my understanding that funding to appoint another psychologist was made available in 1997. Certainly at the beginning of 1998 I was asked to provide a job description etc for a Clinical Psychology post. Despite repeated requests, by Dr Courtney and myself, for information from PANI about progress on the appointment, answers were not forthcoming.
>
> The matter was raised by Dr Courtney and myself with the members of the Police Authority at a meeting of the General Purposes Committee on 21 September 1998. We were assured that the appointment would be pursued as a matter of urgency. Despite this an advertisement did not appear until December 1998 with a closing date of 8 January 1999. It was only last month that short-listing took place when, I believe, the recommendation made by the external Professional Advisor was rejected by the Personnel Department. As a result arrangements have yet to be made to secure an appointment. Consequently, more than 3 years after the need for additional psychology personnel was formally recognised, there is, as yet, little prospect of an appointment in the immediate future."

Despite the fact that it was marked as copied to her, Mrs Burnett was unable to recall receiving a copy of this letter. However she did recall an earlier conversation with Dr Poole, at a time when he was thinking about resigning, during which he talked about his difficulties being increased by the Omagh bomb and expressed the view that by moving to PRRT he could provide better supported services than through the OHU. Mrs Burnett emphasised in the course of giving evidence that, had she received the letter from Dr Poole on 7 June 1999, she would have specifically discussed it with him and dealt with it in writing and that she would not have written the short note that she addressed to Dr Poole on 8 June 1999 expressing regret at his resignation and wishing him well in his new chosen career. There was a further attempt to

recruit a Clinical Psychologist in 2001 with the appointment being advertised as attracting a Grade 6 salary. The competition closed on 23 November but there were no replies. No further attempt to recruit was made until Dr Reid was appointed in 2003.

[84] It seems clear, to some degree that the OHU was a victim of its own success and that demand upon its services inexorably increased with the passage of time. Increasing demand led to increased pressure upon resources in general as recorded in the annual OHU reports and the correspondence from Dr Courtney, Dr Poole and others. In cross-examination Sally Meekin agreed that they were getting busier and busier all the time which led to too much pressure on staff. Sometimes they would stay until 8 or 9 o'clock at night to ensure that the work was completed. When asked whether with greater capacity they could have achieved more Mrs Meekin replied:

> "Oh yes. I think nurses and doctors always want to do their very best and we always want to do more. There is no doubt about that. I have never worked in a job whether hospital or anywhere else where I would have felt that I had enough people to do my utmost."

[85] As illustrated by table A annexed to this judgement by 1988 the staff comprised 2 doctors and 2 nurses and therefore complied with the recommendation that was to be made by the Association of Chief Police Officers (ACPO) in 1991, on the advice of the Faculty of Occupational Medicine, that there should be one full-time occupational health physician for 5000 staff and one health nurse for 2000 staff. The 1990 Headquarters Review concluded that the OHU was under staffed for the scale of the problems with which it had to deal. As a consequence of the MMRD report in November 1991 one additional doctor and 4 additional nurses were appointed during 1992 and 1993. From 1994 to 2001 documentation, including correspondence and memos from Dr Courtney, minutes of the Advisory Group on Health and Welfare of the Force and OHU annual reports recorded the increasing OHU workload resulting increasing general demand together with the effects of the ceasefires and the Omagh atrocity. The section of the OHU report 2000/2001 headed "Discussion" referred to the facility as "unacceptably busy" and the final paragraph commenced "The OHU has not been able to provide the service that staff would wish to on the basis of sheer workload." From 1993 until 2001 the non specialist staff comprised some 3 doctors and 6 nurses and by 2004 these figures had risen, respectively, to 4 and 10. Dr Reid's recent reports confirm persistent shortcomings resulting from staff shortages.

[86] So far as the appointment of a full-time clinical psychologist is concerned, it was accepted by both sides that there was a national shortage of appropriately qualified individuals and that the OHU post was less attractive

because of security considerations, the isolation from other clinical psychologists, the inferior opportunity of promotion and, initially the proposed level of remuneration. During this period Dr Patricia Donnelly, who had been providing specialist psychology services on the basis of two sessions a week, was able to secure the assistance of Dr Marie Goss, a clinical psychologist, which enabled the sessional assistance to increase to 4 sessions per week from 1990 onwards. When Dr Poole and Dr Courtney recommended the appointment of an additional clinical psychologist and the recommendation was accepted, both by the defendant and PANI, as noted above, once again difficulties were encountered in recruiting a suitable candidate and, in the meantime, arrangements were made for the Department of Clinical Psychology at the Royal Hospitals to provide the services of Melanie Wolfenden, clinical psychologist, for 2 sessions a week from 1998 onwards. When Dr Poole resigned his appointment in 1999 two additional clinical psychologists, Dr Pollock and Dr Rauch, were engaged to assist Dr Wolfenden. Each of these additional sessional psychologists provided 2 sessions per week. In 2003 a full-time clinical psychologist, Dr Tracy Reid was appointed to replace Dr Poole and she was assisted by the 3 sessional clinical psychologists until 2005 when a Psychotherapist, Karen Lansing, was appointed to assist her on a full-time basis.

[87] The MMRD report of 1991 recorded that there was a delay of some 4-6 weeks before patients received appointments with the sessional clinical psychologist and noted the comparable position of PANI Civil Servants who were then experiencing delays of several months in obtaining appointments with the Northern Ireland Civil Service Occupational Health Unit. The report considered that the latter delay was unacceptable and could only extend the distress of the individual together with the length of absence from work. Dr Poole confirmed that when he commenced employment with the OHU in 1993 waiting lists would not have been more than 3 or 4 weeks, that some degree of waiting list was a regular feature of virtually every type of public or private health service provision and, in the case of the NHS, might develop to be as long as a year. He said that he had never turned away any person who had been referred to him for appointment. Dr Poole also accepted that it was a small minority of those who attended the OHU with mental health problems, whether related to trauma or otherwise, who were seen by the clinical psychologist/psychiatrist and that the vast majority received appropriate therapy from his nursing and medical colleagues. A similar view was expressed by Dr Courtney when writing his report on psychological services for Deputy Chief Constable Cramphorn on 26 October 1999 when he noted, in relation to the trauma services, that:

> "However it must be emphasised that the psychological services both in the area of trauma management and indeed in the area of general psychological support have not been supplied only

> by the Clinical Psychologist. Indeed the work that the Psychologist has been undertaking is only the `tip of the iceberg'. The vast majority of psychological support work has been, and continues to be, provided by the Occupational Health physicians and nurses within the unit."

[88] Dr Courtney explained that referrals to the clinical psychologist did not occur upon a regular or steady basis and that, from 1993 to 1996, referrals to Dr Poole would have demonstrated a `peaks and trough' profile depending upon external events. He estimated that the waiting list on the worst occasions might have been between 2 or 3 months but that if someone needed to be seen urgently an appointment would very often have been managed within days. An alternative was to refer really urgent cases to the clinical psychiatrist, Dr Brown or to the officer's GP. Dr Courtney also explained that, in cases where it was necessary to wait for an appointment with Dr Poole or another clinical psychologist, the officer would be kept under review and monitored by the nursing and medical staff. Similar services were provided to deal with the bomb explosion in Omagh in 1998. Dr Courtney confirmed that many officers involved in that terrorist atrocity were seen by the nursing/medical staff within days and while he agreed that, despite the presence of Dr Poole and Dr Wolfenden and the sessional psychologist, the waiting list for specialist psychological/psychiatric therapy may have run into months, a delay compounded by the absence through illness of Dr Poole in 1999, those waiting continued to be the subject of regular review.

[89] The plaintiffs have concentrated their allegations of negligence in relation to the provision of resources for the OHU upon the two periods during which they allege that no real attempt appeared to have been made to actively recruit a clinical psychologist or an additional clinical psychologist. The first of such periods ran from the unsuccessful advertisement of January 1989 to early 1992 when Dr Courtney noted in his letter to PANI dated 13 March 1992 that "… the post for Clinical Psychologist will be re-advertised within the next 3-4 weeks." The actual appointment was further substantially delayed by the deliberations about grading and remuneration. The second period commenced with the approval by PANI for the post of an additional clinical psychologist in September 1997 until the advertisement that secured the appointment of Dr Tracy Reid in 2003. During this period two, possibly three, advertisements were placed each of which proved fruitless, namely, December 1998, 2001 and, possibly, according to the recollection of Miss Burnett October/November 1997. There is no doubt that, upon various occasions, both Dr Courtney and Dr Poole sought to encourage and secure the making of these appointments.

[90] The evidence also indicated that, in so doing, Dr Courtney and Dr Poole were supported by the defendant and his senior officers. For example, on 18 April 1988, Assistant Chief Constable Ramsay wrote to PANI referring to

conversations that he had held with Dr Courtney in relation to the appointment of a full-time clinical psychologist in which he referred to the present arrangement as being expensive with follow-up sessions becoming difficult in the context of a steadily increasing workload. On 20 April 1988 ACC Ramsay again wrote to PANI emphasising his support in the following terms:

> "Recent discussions with the Doctor and my own inquiries point to the fact that the appointments suggested are necessary and, indeed, essential to the efficient working of the Occupational Health Unit."

In the course of his evidence Sir Ronnie Flannigan, a former Chief Constable of the RUC, confirmed that no obstructions were placed in the way of obtaining a further clinical psychologist by senior command and, in his own words:

> "Certainly my attitude was as I described earlier in my evidence, that whatever those in the unit headed by Dr Courtney felt they needed should be provided. It is as simple as that My Lord."

[91] It is not difficult to sympathise with Dr Courtney when reading the prolonged debate by correspondence between PANI and the NIO the two bodies responsible for resources. In my view, the first period is accounted for by a combination of the scarcity in the market of appropriately qualified individuals and the debates about the appropriate job title, grade and level of remuneration which ultimately included the report from MMRD. The latter difficulties were resolved with the appointment of Dr Poole in 1993 and, therefore, should not have given rise to difficulties during the second period. The lack of response by suitably qualified candidates to either one or two advertisements in 1997/98 or for the further advertisement placed in 2001 suggests that the lack of suitably qualified and available candidates continued to be a significant problem.

[92] I am satisfied that the difficulties faced by the OHU in obtaining necessary resources, including clinical psychologists, were significantly compounded by the unyielding bureaucratic procedures operated by PANI and the NIO, the relevant civil service authorities. As Dr Crowther said in evidence, even with the support of the defendant and, in particular, B Department, these structures produced a slow, inflexible and bureaucratic process of recruitment. Dr Courtney's concerns about the need to increase staff had to be set out in a paper relating the increase to the original concept which was then forwarded to the Establishment Officer who in turn forwarded it to MMRD to draw up terms of reference for an inspection. At a meeting with Dr Courtney in November 1989 Mr Morrison, the Establishment Officer, explained that even if an inspection and report from MMRD recommended additional staff he could not guarantee that such staff would be forthcoming. The bid

would have to "take its place along with others" and be subjected to a decision on priority within PANI. During the course of giving evidence Dr Crowther described this system as "not fit for purpose" an assessment with which it is difficult to disagree. On the 19th March 1991 Senior Assistant Chief Constable (Support Services) McAllister wrote to the Assistant Secretary of PANI referring to serious staff shortages at the OHU which were inhibiting its ability to deliver its services and observing that:

> "It bears repeating that OHU staff needs to be increased incrementally i.e. (a) to cope with the present workload, (b) to cope with the desired extension of workload, and (c)to cope with civil service element; and in that order."

In the same letter Mr McAllister pointed out that among other OHU services that were suffering from staff shortages were the assessment and treatment of officers with stress and other psychological problems and post trauma counselling. Mr McAllister left PANI in no doubt as to the seriousness of the situation as he wrote:

> "Post-trauma counselling is an important service, however many incidents have to be 'selectively ignored' and it is not possible to provide counselling to all our members. The assessment and treatment of officers with stress and other psychological problems is time-consuming and stressful to the OHU staff. At present it is proving impossible to provide follow-up and adequate care and demand on the OHU is resulting in steady and remorselessly increasing demands on staff."

[93] It is clear that Mr McAllister had consulted Dr Courtney before writing this letter. It is also clear that Senior Assistant Chief Constable McAllister and Dr Courtney had to exert extreme pressure on PANI in order to make any progress. On the 30 May 1991 Dr Courtney informed Mr McAllister by letter that the service provided by OHU would have to be reduced unless the staffing problem was rapidly resolved. He referred to the burden upon staff as "unacceptable" and close to becoming a risk to their health. This information was relayed to PANI who replied to Mr McAllister in the following terms on 18 July 1991:

> "It is of course highly unusual for any action to be taken in advance of a staff inspection report being received or its recommendations discussed. However, your letter stressed the severe pressure being experienced by staff in the Unit because of the heavy and concentrated workload and in these circumstances I am prepared, exceptionally, to authorise the

> recruitment of two additional Occupational Nurses, bringing their strength up to four."

It should be borne in mind that this letter was written some 18 months after Dr Courtney was told of the inspection process.

[94] The delay and difficulty in obtaining resources for the OHU may be contrasted with the way in which they made available as a consequence of government activity subsequent to the Patten report for the Police Rehabilitation and Retraining Trust ("PRRT"). PRRT is a non-government charitable body, originally set up to support retired and retiring officers, for which, in the immediate aftermath of the Patten Report, the Prime Minister announced funding of £4.5 million for the first 3 years. Subsequently recourse was had to European funds. Mr McClurg, who was a central figure in the setting up of PRRT, confirmed that body was not shackled by PANI and was able to offer different terms and conditions of employment including, in particular, higher rates of earnings. PRRT was able to engage Dr Poole, who had recently resigned from OHU. The relevant CC minute of 19th August 1999 confirmed that Dr Poole had expressed disappointment at the lack of support that he had received from PANI in performing his job. Sir Ronald Flanagan, then Chief Constable, arranged to see Dr Poole personally after receiving his letter of resignation and asked him to reconsider but his recollection was that Dr Poole had already arranged to move to PRRT. In the circumstances Sir Ronald encouraged such a move insofar as Dr Poole's services would still be available to police officers. By 2002, at a time when OHU had still not found a replacement for Dr Poole, PRRT also had the assistance of some 18 psychology clinicians including both clinical psychologists and cognitive behavioural psychotherapists. The contemporary documentation confirms the sensitivity of those concerned to the potential for an invidious comparison and/or competition with the OHU.

[95] Dr Crowther explained how the situation had substantially improved with the advent of PSNI and the growth of non civil servant direct employees. The Human Resources Department of PSNI no longer has to follow strict civil service procedures, an external recruitment agency has been retained and the OHU has much more control over the process of recruitment with the ability to target individuals and compete on salary.

[96] Apart from difficulties relating to supply and demand, which played a significant role in relation to the recruitment of clinical psychologists, the main problem faced by the OHU seems to have been the unresponsive bureaucratic structures of PANI and the NIO. I am satisfied that the defendant and relevant senior command did all that was reasonably practicable in the circumstances to make those structures respond. In my view a situation in which men and women are regularly called upon to put their mental and physical health, and, indeed, their very lives at risk in the service of the State places that State under

a formidable duty to ensure that such risks are reduced as far as practicable by the timely provision of appropriate and adequate support, equipment and services. I heard evidence from a number of employees of PANI but since neither PANI nor the NIO are parties to the present proceedings and have not had an opportunity to make detailed submissions about matters that may well turn on complex budgetary considerations I do not consider that it would be either fair or appropriate to make any further observations.

Training, Education and the Dissemination of Information

[97] Shortly after his arrival, Dr Courtney attended a meeting of the CHMF on 5 February 1986. Amongst other matters, this meeting discussed the introduction of four modules as an integrated feature of force training on stress. These were to be introduced at the level of recruits, probationer constables, constables, sergeants and inspectors and senior ranks. The paper discussed suggested a purpose designed video or videos together with a handbook for general issue and that the training modules should be developed and introduced over the next year with a view to the police becoming largely self-sufficient within two years. At a further meeting of the Committee in November 1986 Inspector White of the RUC Training Branch referred to the training modules on stress recognition and stress management explaining that the initial effort would be directed towards recruits/constables and sergeants/supervisors. The emphasis was to be on a practical, rather than academic, educational process. A short video was said to be well on the way to production and currently at the story board stage. On 20 January 1987 Dr Courtney attended a meeting of the General Purposes Committee of PANI at which Mr Maguire advised that it was hoped to introduce three training modules, which would be for a period of one to one and a half days, for the ranks of recruits, probationer constables, sergeant/inspector/chief inspectors and superintendents and upwards. A pilot scheme was planned for 1987 and the training was to be initially carried out by the Public Service Training Council with a view to replacement over time by RUC staff. In late 1987 the CHMF provided the report on its main study which referred to training modules designed by the Training Research Unit at Garnerville as not yet having been tested in pilot schemes.

[98] The principles behind the training modules were set out at paragraph 6 of the report and at paragraph 6.1.4 it was recorded that there should be an additional module for the supervisory groups on stress management involving the identification of signs of stress in others, discipline and welfare issues, referral systems and counselling skills. The report noted that the senior management module had already been tested and that it had become an integral part of the management course for chief superintendents. At paragraph 6.1.5 the report continued:

> "It should be emphasised that these modules are only the foundation for other more advanced training. Counselling skills for sergeants upwards need to be developed for a selective group of individuals as an essential preventative element."

Paragraph 6.1.6 recorded that:

> "As with any innovation in training, the proposals will only work if they have the understanding, backing and commitment of top management. The evidence indicates that officers at this level are generally more 'stress hardy' than lower rank and to some extent 'less-stressed' for a variety of reasons. The culture is one of a 'tough image' and signs of being stressed are signs of weakness. It will need strong support by senior management to encourage and modify the attitude at every level to back new training initiatives in the way they deserve."

[99] By the date of the meeting of the CHMF on 30 April 1987 the Training Research Unit (TRU) under the supervision of Inspector White had produced a video, pre-read lesson notes for the recruits and constables, group and individual tasks and exercises together with handouts and information sheets for use in various courses. One section of the video was being altered and work was being initiated on the instructor's briefing notes. The latter was felt to be a particularly vital piece of work on which the success of the training package was dependent. The meeting, chaired by Mr Maguire, agreed that the ongoing work and future plans met with their total approval and Inspector White recommended that the training package should be tested and piloted for recruits, probationers, constables, sergeants and inspectors before taking a final decision as to which format would be appropriate for each level.

[100] Unfortunately, the various training modules do not appear to have progressed further and the initial report of the Stress Action Team in 1991 recorded that:

> "A Pilot Scheme using these modules was never fully implemented due to the introduction of the PACE training programme."

[101] Shortly after he took up his post Dr Courtney arranged for the OHU to have an input into the initial recruits' training course, probationer training, sergeants' initial and refresher courses, inspector development and chief

inspector and superintendent courses. The initial courses for recruits involved a talk about the function of the OHU, advice as to the confidentiality of the unit and the opportunity for self referral. This talk would also have included references to general stress and the use of alcohol. Dr Courtney accepted that, while they would have been mentioned, topics such as stress and traumatic stress would not have been dealt with in any detail and coverage at this stage would have been minimal.

[102] After his arrival, Dr Crowther became involved with recruit training for reserve constables and in the delivery of probationer training for regular officers. The lecture to reserve officers was also concerned with the introduction of the OHU, self-referral, confidentiality and the services that it provided together with a short presentation on stress and post traumatic stress. In total length, this presentation appears to have been approximately 45 minutes. In addition to Dr Crowther, Sally Meekin and Margaret Patterson also at times delivered the training session for probationer constables until that function was taken over by Dr Poole in approximately 1994. The lecture to probationers would also have dealt with general aspects of the OHU and would have incorporated a fairly prolonged session on stress and post-trauma stress, including aetiology, symptomatology and coping mechanisms, followed by an interactive session during which the subjects were encouraged to discuss any of the issues raised. At the start of the presentation, as an "ice breaker," the participants would be asked if they had experienced any critical incidents and, if so, these would be used to illustrate the talk. At the conclusion of the presentation the probationers were provided with an evaluation sheet that included a stress management input. This document reminded probationers about a number of references to the problem of stress during the talk as well as the availability of a new type of treatment for PTSD. After attending a conference in October 1987 Dr Crowther incorporated overhead projector slides dealing with PTSD and he later used similar material for his talks to sergeants, inspectors and chief inspectors. Subsequent to publication these talks also included a discussion of Force Order 14/88 and its significance. Dr Poole later arranged for a video of a bus crash to be shown which illustrated post traumatic symptoms. Dr Crowther also delivered presentations relating to the OHU and traumatic stress to sergeants participating in both initial and development courses, CID, inspectors and chief inspectors and, upon at least one occasion, superintendents. The presentation included explanations of trauma, acute stress reactions, the recognition of physical, behavioural and psychological signs and symptoms of stress and stress coping. These presentations sought in lay terms to encourage management ranks to be alert to identify, in themselves and their men, the signs of stress and the link between physical and psychological symptoms, reminding those concerned that the OHU was available as a source of guidance and assistance.

[103] Dr Crowther confirmed that, from the outset, the OHU had very good access to training courses with the full approval of the training officer and,

perhaps more significantly, of the Assistant Chief Constable in charge of B Department who was responsible for personnel and training. He also expressed the opinion that peer recommendation by word of mouth was more effective at individual level than admonitions from senior management. Sally Meekin designed leaflets for distribution dealing with post traumatic stress, counselling and other issues. As Dr Courtney had done, Ms Meekin, upon her arrival, made a point of visiting all of the police divisions and she also emphasised the importance of word of mouth communication during such familiarisation visits, visits to carry out routine blood and hearing tests in connection with firearm training and contact with other trainers at training courses. She also participated in the formal training courses afforded to probationers, sergeants and inspectors and at schools of instruction. ACC Sheridan confirmed that OHU had an input into most of the supervisors' training courses and he recalled meeting Dr Courtney when attending his initial sergeant's training course. He met Sally Meekin upon a number of occasions and was impressed by the real understanding that she displayed of the difficulties involved in policing. Specialist courses were arranged for specific groups within the force such as CID, and CARE. The routine input of OHU into training courses for the ranks of sergeant upwards seems to have come to an end in 1997 when a major review of training took place. Thereafter OHU contribution to those courses became more variable although it remained a regular part of probationer training. It was accepted by Dr Courtney and the others involved that, taking account of all the courses, formal training with regard to the OHU and trauma associated stress would have reached approximately 3% to 4% of the force per year. Dr Courtney also accepted that schools of instruction were not very effective or active and tended to be mostly geared to operational issues. The evidence suggested that operational demands upon officers engaged in protecting the public from terrorist attacks were likely to affect both the frequency with which these schools could be arranged and the numbers available to attend.

Outreach

[104] Dr Courtney and Sally Meekin appreciated the need to be pro-active in keeping with the essentially preventative philosophy of occupational health and within a few weeks of the OHU opening its doors for business and the appearance of a number of officers apparently suffering from the effects of exposure to trauma a decision was taken to gain access to the duty officer's reports ("DOR") which contained details of traumatic incidents. These were daily reports distributed by the Force Control and Information Centre listing the significant incidents in the previous 24 hours. Upon receipt of the DOR Sally Meekin would scan the document highlighting any incidents involving the exposure of officers to trauma and she would then contact the relevant Superintendent or Sub-Divisional Commander (SDC) for the purpose of ascertaining details of the incident and the names of all officers, whether directly or indirectly involved, who might have sustained significant exposure. Initially, contact was by telephone and frequently it was the operations

planning sergeant who was able to provide the most useful information. Any officers named would then be invited, initially by telephone, to attend the OHU. Both Dr Courtney and Sally Meekin agreed that there was a reasonable response to these inquiries although they also accepted that there was a certain amount of scepticism. Those who attended were put at their ease and their feelings, reactions and symptoms discussed. Explanations and reassurances were provided and in the case of those for whom it was appropriate a further appointment made or referral arranged for more specialised treatment. Attendance was voluntary and when officers responded by saying that they were not suffering from any symptoms and did not wish to attend the telephone contact was used by the relevant member of OHU staff as a educational opportunity and for the purpose of reassurance in case symptoms did develop. In time, Sally Meekin produced a standard form letter which was sent to those said to have been involved in traumatic incidents inviting them to attend the OHU for a discussion of their experience. She also produced a pro-forma document upon which was recorded the information from the DOR and some information from the officer attending together with a self report questionnaire with which the officer was supplied to complete in his or her own time. This document was created in collaboration with other members of the OHU staff including the psychiatrist and psychologist and became known as the post-trauma pack.

[105] As the business of the OHU increased it became apparent that the system of working from the DORs needed to become more formal with responsibility for contacting officers who might have been involved in traumatic incidents moving away from the hard pressed OHU staff to senior officers on the ground. It had become fairly clear that it was the officers with local knowledge, familiar with the specific events and the men and women concerned, who were best placed to advise as to the particular circumstances. The draft that was to become Force Order 14/88 was prepared by the OHU staff after consulting in detail with each other, including the sessional specialists, and drawing on the experience that had been gained and the contacts that had been made in many local sub-divisions through reference to the DOR. The draft was then submitted to B Department (Personnel Branch) to pass through a consultation period before being published as a Force Order. Dr Courtney considered that this was a new and quite different development for the Force and, having regard to the nature and content of the draft, he felt that, in addition to publication, specific advice and training ought to be provided to relevant managers. He was aware of the way in which Force Orders were read out at parades and then filed and considered that, in such circumstances, their primary function was as a mechanism to encourage referrals to the OHU with no pretensions to serve as a means of providing training in stress awareness. After some discussion, it seems that B Department concluded that this was not necessary and that managers were sufficiently aware of the manner in which Force Orders operated.

[106] Force Order 14/88 was published on 5 February 1988 and included an introduction in the following terms:

> "It is now more clearly recognised that involvement in 'Traumatic Incidents', which are an integral part of a police officer's duties, can have a detrimental effect on the health of the officer. This Force Order will provide the mechanism for a confidential Counselling Service by the Occupational Health Unit for police officers involved in traumatic incidents."

Traumatic incidents were then defined by reference to three broad categories including shooting incidents, horrific incidents and life threatening incidents. The Force Order provided that when such an incident occurred the SDC (or equivalent) should identify all police officers involved, including specialists such as CID, Mapping, Photography etc. No attempt was to be made to single out only those officers who appeared to be in some way affected by the incident and such officers were to be identified whether or not they reported non-effective. The OHU was to be directly advised, in writing, not later than 48 hours after the incident and provided with details of the incident, details of the members directly involved and details of any members indirectly involved. Provision was made for urgent contact to be made by way of telephone. SDCs were specifically warned that health problems could develop even in individuals with close associations with the incident, such as a close friendship with those involved, and advised that they should refer anyone about whom they had concern even though that individual might not have been directly involved. Home circumstances were also to be borne in mind and particular attention was to be directed to officers involved in a number of incidents.

[107] Force Orders were issued by the Force Publications Branch and constituted the means by which policy and instructions were communicated to the Force with regard to how the Force should be managed by SDCs on a day to day basis. Policy contained in Force Orders was generated from within departments and sub-departments headed by Chief Superintendents and, for a time, was reviewed by the Force Policy Board. Mr McNeill, who served as an Inspector in the Force Publications Branch, explained that Force Orders went out under the authority of the Chief Constable, carried the weight of the Chief Constable and in appropriate circumstances, might be used as the basis of a disciplinary proceeding. Paragraph 116 of Section 21 of the RUC Code recorded that Force Orders were sub-divided into three parts and, as from 1979, these were Part 1 information relating to policy, Force procedure and legislation, Part II temporary Force Orders, appointments, promotions etc and Part III secret, classified and confidential. Paragraph 116(A) applied to the distribution and storage of Force Orders and provided that:

> "They are to be filed neatly in accordance with paragraph 118 and to be kept up to date and accessible to all members. The Orders are to be read regularly by all ranks and the instructions strictly obeyed."

Mr McNeill confirmed that, in practice, it was the supervisory officers in the various stations who were tasked with the job of informing all ranks of the thrust of a particular Force Order. As he said himself, realistically, people going out on duty simply did not have time to read through a 16 page Force Order which would get filed in the ordinary way. Other witnesses confirmed that this was the practice at many stations. Mr McNeill pointed out that while a couple of sets of Force Orders were available at every station they might not be available to everyone although they should have been read by the supervisory ranks who then had the responsibility for deciding how relevant they were to the officers' day to day activities. However, he accepted that the wording of paragraph 116(A) was clear in placing an obligation upon every member of the force to read and familiarise him or her self with the contents of Force Orders and that they knew that Force Orders were the Chief Constable's instructions to the Force.

[108] Mr McNeill recalled the coming into operation of Force Orders 14/88 and 16/95 as well as referring officers to the OHU himself in accordance with those directives. He stated that officers moved into a routine of following these Force Orders fairly quickly and while there was some interpretation of what constituted a traumatic incident, he had no difficulty in reaching a judgment that terrorist incidents were serious enough to warrant the referral of the officers concerned to the OHU. He also pointed out that, despite the wording of 14/88, it was not always a straightforward matter deciding which officers should be included and he gave the example of officers carrying out traffic points duty at some distance away from a relevant incident. On the other hand, he confirmed that he was pleased about the extent to which Force Order 14/88 clarified the matter for the referring officer in so far as he was no longer required to make a judgment as to who was affected and who was not, although he accepted that some of the officers whose names were referred simply were not prepared to attend the OHU. He agreed that there was a deep rooted residual attitude in the police in the 70s and early 80s of not wanting to be seen as consulting a "shrink" which reflected the contemporary attitude in society in general but which was perhaps even a little more conservative.

[109] Dr Courtney accepted that compliance with Force Order 14/88 tended to be variable although he felt it improved with the passage of time and as a result of an increase in contact between the OHU and referring officers. The OHU continued to use the DOR as a means of cross-checking the effectiveness of Force Order 14/88 and, when necessary, this led to additional contact and further exchanges of information between the OHU and referring officers. Dr

Courtney conceded that the definitions of traumatic incident contained in Force Order 14/88 were broad and that this may have led some commanders, faced with almost daily occurrence of potentially qualifying incidents to be less than rigorous in complying with the Order. He himself gave an example of a particular unit in West Belfast involved in many incidents from which the OHU was receiving referrals and contacts upon an almost weekly basis. The OHU started to get a reaction from the unit that this was a pointless exercise since there was nothing wrong with any of the officers. After a visit to the unit by members of staff it was decided that the officers were coping and capable of reaching their own judgments as to whether to contact the OHU. In those circumstances Dr Courtney felt that the procedure was becoming counter-productive from the OHU's stand point. On the other hand, he emphasised the novelty of the procedure introduced by Force Order 14/88 and confirmed that broad categories were deliberately chosen in an effect to ascertain more accurately the nature and extent of the potential problem.

[110] Following the introduction nationally of new Association of Chief Police Officers ("ACPO") instructions on post-incident procedures to be followed subsequent to discharge of firearms by the police a new Force Order was drafted and referred to the OHU for its comments in March 1994. By way of response, Dr Poole asked for the draft to be delayed until the OHU had been afforded an opportunity to review the operation of Force Order 14/88. Divisional commanders and heads of department were notified of this review by Dr Courtney in a letter dated 1 June 1994, which also referred to problems that were being experienced with regard to the identification of traumatic incidents. The OHU review conducted by Dr Poole culminated in the promulgation of Force Order 16/95: 'Critical Incidents – Management of Psychological Aspects' in March 1995. Amongst other changes introduced by this Order was a more focused definition of "critical incidents", the introduction of the concept of Critical Incident Stress Debriefing ("CISD"), the concept of a "Designated Officer" as the senior officer with overall management responsibility for those officers involved in a critical incident and the requirement to refer relevant officers to the OHU for CISD was made mandatory. Reasons for making the requirement to refer mandatory included the need to reduce the amount of work carried out by the OHU in the process of cross-checking through the DOR and the initiation of telephone contacts together with a belief on the part of Dr Poole that making the procedure mandatory would help to ease the inhibitions of officers concerned about the stigma of attending the OHU. In his decision to include such a provision Dr Poole was influenced by a paper by James T. Reese PhD entitled "Justification for Mandating Critical Incident Aftercare". Dr Poole emphasised that, in his view, there was no assumption that officers referred to the OHU subsequent to critical incidents were necessarily suffering psychological problems and the purpose of making the reference mandatory was the provision of education, information and advice. He agreed with Mr Hanna QC in cross-examination that there was a respectable body of professional opinion that did not agree

that it was a good idea to furnish all referred officers with such information but stated that, in his clinical opinion, there were more benefits to be derived from providing such information than from not doing so.

[111] The procedure established by Force Order 16/95 required all officers involved in a designated critical incident to attend a CISD session provided by the OHU. It was the responsibility of the designated officer to establish contact with all officers involved, to convey the information that the experience might give rise to an acute emotional reaction, to advise them that the event had been designated as a critical incident and that they were therefore required to attend a CISD, to inform them that they would be advised of the time and place of the session and to emphasise that while attendance was mandatory this did not imply that they would necessarily suffer emotional problems. Wherever practical, CISD sessions were to be conducted at the officer's normal place of work. Information about the incident and the details of all officers involved were to be provided by the designated officer in writing to the OHU not later than 48 hours following the incident. At about the same time as 16/95 came into existence Force Order 15/95 (Police Use of Firearms Post Incident Procedures) was published which also required relevant officers to attend a CISD.

[112] It appears that, subsequent to the publication of 16/95, referrals to the OHU after critical incidents increased but it also seems clear that Dr Courtney was not as enthusiastic as Dr Poole about the philosophy upon which the Force Order was based. To use his own words "I had my reservations about making things mandatory… to actually force people into debriefing is somewhat difficult." Apart from Dr Poole the only other voice raised in support of mandatory reference was that of Dr Higson who modified his stance somewhat during cross-examination. However another of the plaintiffs' experts, Professor McFarlane, was adamantly opposed to compulsory attendance. It is interesting to note that ex sergeant Lamont thought that there was increasing acceptance of the OHU after the publication of force Order 16/95 which he thought resulted from "word of mouth" reports and my impression from him and other witnesses was that, quite apart from their outreach function, Force Orders 14/88 and 16/95 did also play a significant educative role. However, Dr Courtney, who was aware of the way that Force Orders were generally communicated to the men and women on the ground, was not prepared to accept that they were intended to play any significant part in training.

[113] There also seems to have been a difference of view as to whether the debriefing contemplated by 16/95 was to have been according to the formal Mitchell structure or simply the variant carried out in practice by the OHU. In his witness statement Dr Poole emphasised that the 16/95 procedure was not CISD as advocated by Mitchell but rather a psycho-educational session conducted by the nursing staff providing information and advice about post-trauma reactions. In the course of giving evidence he said that he would not

deny that such a session could be therapeutic but that was not the primary purpose. Force Order 16/95 defined CISD as "...a structured session during which individuals involved in a critical incident have the opportunity to discuss their thoughts and emotions about the event in a controlled manner as well as to receive information and advice on how to respond to any emotional reactions they may experience." While it was relatively informal and unstructured, it appears that the post trauma support interview practised by the doctors and nursing advisors in the early days of the OHU had some similarities to CISD. Dr Crowther had attended a workshop with Professor Mitchell in 1993 However, as Dr Crowther pointed out, CISD was originally developed for fire-fighters in the U.S. who were a very cohesive group living together in a section house, and this contrasted with police officers who lived separately in the community, for the most part, and were less inclined to ventilate their emotions before their fellows. In such circumstances he considered that debriefing with large groups became rather impractical and Dr Crowther's practice tended to be to work with two or three men or on a one-to–one basis. The Force Order provided that the procedure might be provided either on a group or one-to-one basis. Dr Poole accepted that the staff at OHU received training in the variation advocated by Noreen Tehrani and that some elements were common between that system and formal CISD. Essentially the former was a five stage model that incorporated an introduction followed by a discussion of the facts, the thoughts of the officer, his or her feelings and/emotions and a closing. For those in respect of whom it was felt appropriate further appointments were arranged at the OHU or referrals to specialists. While it enjoyed a period of popularity during the 1990s, ultimately, the whole concept of Mitchell CISD seems to have lost professional and academic support to the extent that not only is it no longer recommended but it is felt to be damaging by some authorities. I gained the impression that Dr Poole was somewhat defensive when dealing with this topic possibly in the context of this later lack of enthusiasm for this practice.

[114] The practical operation of Force Order 16/95 was kept under review by the OHU and in the 1998 Health Services Report Dr Courtney recorded that:

> "There remains substantial difficulty in the way the OHU is informed of incidents with considerable time being spent by Nursing Advisors establishing information and following through the contact process with officers concerned. Better means of co-ordination is constantly being sought."

It seems that Dr Courtney's concerns continued since, in 2003, within a few weeks of her taking up the post of Clinical Psychologist at the OHU, Dr Courtney asked Dr Tracy Reid to review the operation of Force Order 16/95. However, due to pressure of her other duties, Dr Reid was unable to commence this work under November 2005. Dr Reid's draft report was

submitted to Dr Courtney on 24 March 2006 and was made available to the parties at the start of June 2006.

[115] In fact, it appears that two documents were submitted by Dr Reid to Dr Courtney, namely, a draft report highlighting the current resource needs of the OHU which, by then, had become the Occupational Health and Welfare Unit (OH&W) together with a draft Trauma Support Programme. In the Trauma Support Programme Dr Reid made the following observations with regard to the provision of pre and post-trauma support resulting from the operation of Force Order 16/95:

> "This Order is out dated according to recent research and guidelines for psychological care post-incident (NICE, 2005; CREST, 2005; Wessley and Deahl 2003). Additionally, the current General Order is not fully adhered to by all managers and as a result not all critical incidents that should get reported to OH&W do so. Many incidents that are reported are not deemed 'critical' to warrant the provision of support. There is a lack of education regarding the use of this Order, and there appears to be ambiguity surrounding who is responsible for notifying OH&W when an incident is deemed 'critical' enough to refer, to whom it should be referred, and the procedures that should be in place following notification. This has meant that OH&W do not always receive notification from managers of those individuals who require post-incident support. Individuals are often left to self-refer, often after protracted periods of time. As a result they are left feeling unsupported by their organisation. By the time they are seen, with lengthy waiting lists for the Clinical Psychology Service, they are likely to experience deterioration, co-morbidity and feel demoralised with PSNI in general and OH&W in particular.
>
> Following the current General Order, individuals exposed to a critical incident are sent a letter acknowledging the incident. If the individual wishes to contact OH&W they are advised to do so. Within the current culture many fail to request help and suffering often becomes protracted. Officers will often reach a point of significant dysfunction and long-term sickness absence before they present to OH&W, if they are not referred by management.

> For these cases, as evidenced above, many more therapy sessions are required for resolution than if intervention was provided at the earliest possible stage. The Trauma Support Programme aims to significantly revise this system, and proposes a seamless system of support following exposure to critical incidents."

[116] In evidence, Dr Reid confirmed that her main criticism was a lack of education and inconsistencies in the level of knowledge among PSNI managers as to what should be defined as a critical incident, what they should do about it and who should be referred to the OH&W. She based this criticism on her three years of experience during which the OH&W was receiving referrals of officers who did not really require to attend which had made her anxious about the possibility that vulnerable officers, who needed to be monitored, were not being referred. She said there had been occasions when a sergeant or other officer might have asked for a group debrief but only two out of eight officers attended. Officers would telephone referring themselves after critical incidents because they have not been referred by their managers. There was criticism of the standard letter written to officers after critical incidents on a basis that some officers might receive six to ten letters over a period of four to six weeks resulting in the letter being regarded as meaningless. Dr Reid referred to the lack of education about the symptoms that might be experienced as a consequence of exposure to a critical incident and the culture that emphasised resilience and not asking for help. She was also critical of the different levels of training among different nurses which led to inconsistencies in the type of debriefing that was being offered.

[117] Dr Reid was cross-examined in some detail about the content and practical operation of Force Order 16/95. She readily conceded that there was little or no ambiguity about the actual wording of the Order. However, Dr Reid maintained that, over time, ambiguity and inconsistency had developed amongst managers as to their understanding of what was or was not a critical incident as well as the extent of the obligations imposed upon them as a consequence of the Order. In such circumstances, Dr Reid identified training and education as important issues and emphasised the need for educational seminars and courses of instruction that should be incorporated into regular training courses as an integral part of the wider organisational training and development programme. Dr Reid expressed her belief that such education and instruction should be aimed at ensuring that all officers would be aware of the potential vulnerability to develop symptoms after exposure to such incidents, that the development of such symptoms for a period of time should not be pathologised or seen as abnormal but that, in certain cases, persistence of such symptoms should be monitored and assessed in order to determine whether an individual should be referred to the OH&W. For such programmes

to be effective, Dr Reid was firmly of the belief that they should be formally sanctioned from the Chief Constable downwards.

[118] Once again I think that it is important to keep both context and hindsight in mind when considering the implementation and development of Force Orders 14/88 and 16/95. Dr Courtney and his team had little to assist them by way of precedent. Dr Slovak outlined some of the difficulties involved in approaching a particular occupational population with a view to identifying those suffering from symptoms of mental disorder and encouraging them to seek treatment. Placing the obligation of securing attendance upon managers makes the system dependant upon the quality of the managers which will inevitably vary. There is no doubt that neither Force Order achieved full compliance and, as Mr Stephenson's analysis suggested, in practical terms compliance levels may well have been fairly unsatisfactory. Individually, that was confirmed by a number of the lead cases. Had full compliance been approached it is likely that the resources of the OHU would have been overwhelmed and/or the attendance of officers who were not suffering any symptoms would have been such as to bring the system into disrepute. Dr Courtney's experience with the unit in West Belfast was confirmed by other witnesses. Inspector Fergus, who served in the Photography Branch from 1986, accepted that photography was specifically mentioned in Force Order 14/88 but stated that, after attempting to formally comply for three or four weeks, none of his officers took the matter seriously and the OHU requested an end to his block referrals. A mutual decision was reached that formal compliance was impractical for his branch. This exercise did prompt a response from the OHU, a representative of which attended at the Photography Branch and made a presentation. Thereafter a representative attended once or twice a year upon an informal basis visiting the individual work stations and giving the officers an opportunity to raise any relevant concerns. Inspector Fergus continued to rely upon his own powers of sensitivity and personal assessment. Mr McQuillan said that a similar situation existed during periods of severe rioting in Belfast in 2000 – 2003. He said that commanders would look particularly at officers involved in "hotspots" of violence, officers who had been with colleagues who had been injured in bomb and/or shooting attacks or experienced some particularly traumatic event and officers who displayed signs of stress. However he accepted that if all officers involved in serious rioting had been referred the OHU could not have coped. ACC Sheridan, who spent much of his time in Derry, stated that to strictly comply with the wording of Force Order 14/88 would have meant referring officers on an almost daily basis, particularly if non-terrorist traumatic events were included. Sir Ronald Flannigan, currently Her Majesty's Chief Inspector of Constabulary, described how, when acting as a Chief Superintendent, his practice had been to notify the OHU by telephone of the involvement of his men in a relevant incident rather than in writing. He would then arrange for an employee of the OHU to attend his unit for both group and one-to–one consultations. He maintained that it would not have been either necessary or

practical to notify the OHU of the names of his men in respect of every traumatic incident and that he would have exercised his discretion whether to notify in any particular circumstance. Mr McClurg gave evidence about an incident in which over 100 of his officers were injured and accepted that it would have been impractical to refer everyone, although he did believe that all their names should have been communicated to the OHU. Another example of a difficulty that might arise with this system was provided by ACC Toner who described how his sensitive preparation of two young officers for the likelihood of referral after a traumatic road traffic accident was adversely affected by the automatic issue of referral notices. He also encountered officers who were not suffering any symptoms feeling aggrieved about being referred. Ultimately both he and Mr McQuillan felt that the referral system worked although it was by no means perfect.

Stress Awareness Training

[115] Interest in the concept of stress awareness training for the whole force appears to have been re-kindled in July 1990 by a letter from the Federation to the Chief Constable following the Annual Conference. On the 6 March 1991 the Force Stress Working Party met and the chairman, Chief Superintendent Gorman, explained that it had been set up with a remit to:

> "Further research and review the causes, symptoms and coping mechanisms of stress with a view to changing existing policy and training strategy."

They looked at the 1987 proposals but decided against simply re-vamping that programme in view of the amount of new work that had been carried out within the RUC and mainland forces. They reviewed stress training offered in a number of mainland forces but, having done so, concluded that the current inputs made by specialists in the OHU, Welfare and PE Department to the RUC training courses were more comprehensive and professional. A further meeting took place on 28 May when there was general agreement that adequate information was available to the force but there remained the question of "how to get it over to the men?" Subsequently, at the meeting on 17 June, Chief Inspector White stated that the training package approved by ACC B Department in 1987 was still worthy of implementation with minor changes and an action team was deliberately selected to include officers who had been involved in the compilation of the "Stress Package" in 1987. I note that during the same meeting Constable Pearson advised that problems existed not with training but for employees in the mid-service (15 year) bracket. The initial report from the action team was provided to the Working Party in October 1991. In 1992 the preliminary report from the Working Party confirmed that post traumatic stress had not been considered because of the existing force instructions involving the OHU and Firearms Branch. The same report also referred to the recommendations of the Health and Management Survey in

1987 and the fact that the pilot scheme employing the stress training modules designed at Garnerville had never been fully implemented due to the introduction of the P.A.C.E. training programme. The report recorded that, although the OHU, Welfare Branch and Department of Physical Education all had inputs to various courses relevant to their own disciplines, there was no co-ordinated approach and no formal stress management training pack was provided for initial recruits, probationers, sergeants and inspectors. Chief inspectors and above might elect to attend Command courses at Bramshill Police College but again there was no formalised stress management training.

[116] The report of the Working Party made both short-term and long-term recommendations. They were as follows:

> "Short-term
>
> 1. To raise the awareness of the Force to the signs and symptoms of stress.
>
> 2. To increase the knowledge of positive coping mechanisms.
>
> 3. To promote a healthy lifestyle.
>
> 4. To promote the in-house assistance available; - from Welfare, the Occupational Health Unit and the Physical Education Department.
>
> Long-term
>
> 1. Extend the counselling services available through OHU and Welfare Department.
>
> 2. Consider establishment of welfare liaison officers, sub-divisional police officers.
>
> 3. Provide stress management training for initial recruits and probationer constables.
>
> 4. Improve management style by training police managers in stress awareness and management and to provide them with basis counselling skills.
>
> 5. Research psychological screening for possible selection of recruits."

For the purpose of fulfilling the short-term recommendations the Working Party decided that a small specially selected project team should be briefed to re-make and update the video that had been produced in 1987 and to supply it together with an information pack (booklet, posters and leaflets) on stress to each sub-division. The package was to be delivered to officers of all ranks by welfare officers together with a specific, sub-divisional trainer. It was envisaged that all serving officers should be supplied with the package over a period of two years. These recommendations were approved by Senior Assistant Chief Constable McAllister on 29 June 1992.

[117] On 10 March 1994 Force Order 15/94 "Stress Awareness" was published. The introduction confirmed that Force Command had approved a recommendation that a stress awareness package should be delivered to all serving officers of the Royal Ulster Constabulary and the Royal Ulster Constabulary Reserve, full and part time, and that this package would be distributed in early 1994. The package comprised a 20 minute video together with an individual information pack of leaflets. It recorded that SDCs and branch heads had been asked to select two suitably motivated officers to be trained as welfare liaison officers who were to arrange for all officers to view the video and receive the information pack and to provide an information service on internal and external agencies who could offer assistance to police officers and their families. The welfare liaison officers were to receive a three day training course prior to appointment. The qualities sought for welfare liaison officers included presentation and communication skills, ability to understand their role and a reputation for both credibility and acceptability amongst their fellow officers. Dr Courtney explained in evidence that the thinking behind the concept of welfare liaison officers was that the package should be presented to all officers in a consistent and credible way by trained officers who would then make the presentation, answer any questions and, if necessary, point the way to the various agencies that could assist. He emphasised that the intention was that this should be a specific, stand alone presentation. A public figure well known in the local media together with Patricia Donnelly, one of the sessional Clinical Psychologists, agreed to take part in the video. Ms Donnelly confirmed that the video dealt not only with general stress but also post traumatic stress and she explained its purpose in the following terms:

> "This was very much to bring it to the attention of the widest number of officers possible, particularly those who were not already presenting to the Occupational Health Department or any of the other Welfare Support Departments, to make them aware about the multi-factorial nature of stress, linked to their own behaviour and feelings. To try and work in a preventative way in terms of individual coping, but I suppose as much as

> possible, to normalise the abnormal feelings that they might have over either events that they were involved in or any stressors about the job. To normalise it to the extent that allowed them to step forward for help if necessary or to at least feel that there was some action they could take as individuals to ameliorate their distress."

As well as identifying the signs of stress the video drew attention to the fact that they might be more apparent in the family/domestic setting where there was generally less pressure to maintain a coping façade than at the place of work. The information leaflet pack dealt with the warning signs of stress in officers and their colleagues, the fact that stress was a normal reaction to an abnormal situation of which an example might be a traumatic incident, coping mechanisms and support systems. The services of the OHU, Welfare Branch, Psychical Education Unit, Police Federation and other agencies were listed. These were noted to be additional to and not in any way an alternative to the officers' normal relationship with his or her GP.

[118] A memorandum from Chief Superintendent Murray of the 26 July 1995 confirmed that some 5,000 officers had still not received the stress awareness package and emphasised that it was important to make arrangements to ensure that those members who had not received a package should do so without delay and this was recorded in the minute of the Stress Working Party of 1 August 1995. Part of the explanation seems to have been that returns had gone to the wrong places and also that many members on the list were part timers and it had not been intended to provide the package to part timers until it had been received by all full timers. The minutes of the Stress Working Party of 2 February 1996 recorded that there were still some 3,500 people who had not received the package and that it was difficult to arrange for people to view the video due to the unavailability of overtime. Inspector McNair observed that welfare liaison officers were not being facilitated by sub-divisions. Both Constable Stratton and Acting Chief Inspector Johnston were trained as welfare liaison officers but neither was particularly positive about the operation and effect of that initiative. Mr Johnston delivered the package to his unit of 30/35 officers but did not receive the impression that it made any particular impact. He felt that it was received as "just another lecture." Constable Stratton described how they went out to various stations but that only half a dozen officers at most attended any briefing.

[119] In March 1996 the chairman of the Police Federation wrote to Mr McClurg, the Secretary, recording the concern of B Department that 2,978 officers had not yet received the stress awareness package. He noted that it had been agreed that the Training Branch would show the stress video to all personnel who attended divisional schools for that purpose and that Police Federation representatives would show it to all remaining headquarters

personnel. Headquarters were to furnish the stress package to the 2,978 remaining personnel by way of a mail shot. The Secretary noted that B Department had expressed disappointment with the way in which the welfare liaison officers had carried out their duties and that their position would be terminated in the near future.

[120] The appendix to Force Order 15/94 dealt with the basic job description of welfare liaison officers. Their primary function was to deal with the presentation of the video and stress awareness package having made themselves familiar with the in-house and out-house agencies. They were also to assist the sub-divisional commander/department heads in ensuring that members who were identified as having difficulties in coping were offered help in a sympathetic and constructive way. In addition, they were charged with monitoring and assessing the effectiveness of the programme and providing constructive feedback and relevant recommendations to the working party. The appendix emphasised that the welfare liaison officers were not counsellors but simply providers of information. In view of the nature and extent of these duties an attempt was to be made to ensure that volunteers were people with a particular interest in this type of work and that appropriate training took place.

[121] While he believed that there was significantly more commitment to the stress awareness package than to the alcohol video, Dr Courtney accepted that there was delay in delivering the package and that there was a problem about affording welfare liaison officers adequate overtime. He also agreed that delivery of the material by mail shot to the last 3,000 officers, without the benefit of the video and an oral presentation, was "certainly less than adequate." In a memorandum dated 21 September 1998 to the Assistant Chief Constable of B and G Departments Superintendent Pickering confirmed that the stress awareness training had been given to all serving officers and introduced to new officers through initial training and that, in such circumstances, he recommended that the Force Order should be cancelled. He also noted that those closest to the issue, namely, the Chief Medical Advisor, Welfare Services and Police Federation no longer felt that there was a role for welfare liaison officers. On 15 June 1998 Deputy ACC Livingstone wrote to the same department indicating that there was "a major question" over the role and relevance of welfare liaison officers. He said that it appeared that few if any officers related to the welfare liaison officer, tending rather to turn to management, Welfare Branch, a Federation representative or a trusted colleague. An exception was Belfast MSU who strongly supported the welfare liaison officers whom they considered provided a very valuable roll in the MSU environment.

[122] In commenting upon the Stress Awareness initiative as well as that related to alcohol, which I deal with in greater detail below, Dr Slovak had the following observations to make at paragraph 46 of his initial report:

> "Minutes and other records show that these issues were the subject of prolonged wrangling in the working groups over such issues as overtime and discipline which whilst important no doubt in their way, were tangential to the clear and agreed benefits of the proposed developments and which seem to have contributed much to these projects running very late or into the sand over a number of years."

Dr Slovak recognised the ebbing and flowing of dialogue that the relevant papers disclosed from his own experience of trying to progress contentious issues in large bureaucratic organisations while at the same time pointing out that it was necessary to "live in the real world" in which the agenda of different interest groups within the organisation have to be managed in order to make progress. On a practical level Sergeant Wallace expressed the opinion that stress awareness training compared adversely with the detailed training and information that officers had received with regard to Equal Opportunities Sexual Discrimination and Harassment legislation.

Culture

[123] For the OHU to function effectively in its initial preventative and subsequent treatment roles it was essential that those who might benefit should appreciate the existence of the facility and the relief that it might afford to officers facing a daily threat of death and disablement and under pressure, both externally and internally, to preserve a "macho" culture. It was common case that such a culture existed, to a greater or lesser extent, and, indeed, in the context of a disciplined police force its absence would have been extraordinary. For an armed police force under constant threat of violent attack courage, resilience, solidarity and a sense of duty were attributes essential to survival. ACC Sheridan referred to toughness, resilience of character or strength of mind that enabled an officer to "…deal with it and get on and go out the next day and deal with the next incident." However the Defendant also accepted that such a culture, by its very nature, was unlikely to encourage the free and open discussion of psychiatric symptoms. At paragraph 9.1 of his first report Professor Wessely wrote:

> "There were significant barriers to seeking help for mental health problems in the RUC. These are not unique to the RUC, being found in military systems everywhere. They are also found in the general population. The stigma of mental illness is a massive

challenge to society, not just the RUC. There are no simple or proven solutions to this problem."

[124] The existence and effect of this culture was the subject of evidence from a number of officers and confirmed by several of the lead cases. They described how the symptoms of stressful exposure to trauma were not to be discussed but to be firmly suppressed since, to do otherwise, would be to make concessions to the effectiveness of the terrorist campaign and render an officer less reliable for those who depended on him or her in highly dangerous circumstances. In addition, admitting the existence of a type and degree of symptom with the potential to amount to a mental disorder was perceived as a blight upon any officer's career. For some officers this resulted in resistance to attending the OHU under any circumstances and Mr McQuillan described the difficulty that he encountered in arranging contact between Mr McCloskey of the OHU and the neighbourhood team at Musgrave Street after the murderous attack upon constable Beacom. Constable Stratton maintained that, despite a reference to this very topic in Federation News in 1986, the "stiff upper lip" attitude would have inhibited any recourse to the OHU unless a representative had attended at Middletown station and conducted one to one information interviews with each officer. However even Mr Stratton conceded that attitudes to the OHU and confidentiality had begun to change by the early 1990's. Inspector Johnston described how most officers tended to keep their feelings to themselves in such a culture but he accepted that towards the latter stages of his service with SPG/MSU during the late 1980s/early 1990s he would have been more forthright about asking officers how they felt.

[125] One specific consequence of this type of "landrover" or "canteen" culture was to reinforce the scepticism of many officers about the confidentiality of the OHU. If the facility was not confidential the risk of fellow officers learning that an officer might be a liability as a person who could not "take the pressure" became enhanced. To some extent the persistence of this scepticism may have been influenced by the fact that, in addition to its diagnosis and treatment services, another of the functions of the OHU was to review the fitness of officers on long term sick leave with a view to advising personnel of their fitness to resume duty. I am satisfied that these functions were discharged quite separately in practice and that efforts was made to ensure that the OHU should have a reputation for scrupulous confidentiality. That was made clear in every formal publication relating to the OHU and reinforced by very positive endorsement by the Federation upon a number of occasions – see relevant issues of Police Beat from 1986 to 1989. The evidence of Alan Wright, who was chairman of the Federation at the material time, indicated that officers began to trust the OHU from a fairly early stage and it was his perception that it was the stigma of admitting to mental health symptoms rather than concerns about confidentiality that was the problem. I consider that such endorsement, together with "word of mouth" approval from those who had attended the facility, was likely to be of considerably greater significance, coming, as it did,

from the officers themselves and their own representatives, than any formal directive from management. I bear in mind former ACC White's reference to a sub-culture in the police that "…automatically nearly disbelieves what the management says about anything. It works out its own version of what the truth may be."

[126] I have no doubt that some managers were less than impressed by the strict confidentiality observed by the OHU and their relationship with the facility was sometimes described as frustrating and "tetchy" especially when seeking to discover more information as to why an officer had not resumed duty. During the course of the Headquarters Review of 1990 Mr McQuillan recalled a "spirited debate" with Her Majesty's Inspector of Constabulary who felt that Force personnel managers should have access to all information. Mr McQuillan and his colleagues successfully rebutted this suggestion by emphasising the primacy of protecting the health of officers which could only be achieved, especially in the case of self-referral, if they had confidence in the confidentiality of the OHU. By the date of the 1990 review Mr McQuillan's view was that the OHU had established a reputation that it could be trusted and that the policy of confidentiality was strongly welcomed and supported. This was not a view shared by other officers who gave evidence before me but I am satisfied that the confidentiality of the OHU did become accepted and respected by the vast majority of police officers with the passage of time as the facility itself became "embedded in the organisation" to use the words of ACC Sheridan. Sergeant Lamont confirmed that there was increasing acceptance of the OHU during the 1990's when it was being more effectively promoted. Mr McClurg, with 25 years of service as a Federation representative was unable to cite any breach of confidence by the OHU. A number of officers remained sceptical but I do not consider that they could ever be convinced and that their scepticism was based more upon cynical tradition or "urban myth" than rationality to quote acting Inspector Johnston. Mr McClurg described this body as a "resolute minority" who perpetuated their views in quite a forcible manner.

[127] Again it is necessary not to be influenced by hindsight. A number of the witnesses, including some of the lead cases, accepted that senior officers would ask how they were after a traumatic incident but complained that this inquiry was always limited to their physical health and that they were not asked how they felt "emotionally." In my view it is important to remember how much society in general has changed recently in terms of knowledge, vocabulary and values, especially with regard to emotional health, before assuming that concepts and attitudes that are freely debated to-day would have been so treated twenty five years ago A culture such as that to which many officers subscribed during this period was not imposed by regulation or direction from above but was the product of values, beliefs and perceptions handed down by way of a long and respected tradition and validated by the circumstances in which they were forced to operate. Therefore there was no easy way in which

to bring about change which was not also seen as potentially undermining morale. Ultimately, the Plaintiffs did not dispute that there was a positive side to the macho culture and did not demand that every aspect of it required to be changed. They also accepted that change would not come about overnight. However the Plaintiffs emphasised that such an acceptance did not, and could not, provide a justification for doing nothing, any more than the difficulty of the task would have been accepted as a reason for failing to enforce the utilisation of safety equipment and practices in the construction industry.

[128] Dr Slovak confirmed the inherent difficulty in attempting to change generational attitudes that were imprinted in youth and became customary behaviour and he cautioned against a punitive approach which would be likely to alienate those to whom it was applied. He pointed out that the stigma concerning mental disorder was very deeply ingrained in society in general.

[129] There is no doubt that the Defendant was aware of the problem. Dr Crowther said in evidence:

> "As I have mentioned in my statement, one of the biggest problems in giving this type of service is the resistance of police officers to admitting that there may be something wrong with them at all, in particular, in the context of the terrorist situation. By admitting that it was like scoring an own goal. They saw themselves that they should be invulnerable to this. The macho culture at the time. They would be resistant to the concept of 'I may need a bit of help.' A lot of the efforts in the early post trauma counselling were to try to educate people that was not a good way to do it, that positive coping is to accept that you have a problem and to know when to seek help."

In 1984 the preliminary report of the CHMF recorded that:

> "The organisational culture or value system may be an impediment in dealing with stress-related illnesses in work, particularly in police forces. This is usually because of the 'macho' image of the policeman which means that it is a sign of weakness to admit to strain. Evidence of it is perceived by the rank-and-file to be damaging to promotion and possibly even a reason for scorn. As a result much stress may go undetected since the skills in recognising it and being able to counsel on it have not been developed.

> A serious obstacle to dealing with it effectively in most police forces is lack of professional knowledge in depth of police related illnesses and disorders."

That report then included among other recommendations the suggestion that there should be short training modules for all ranks on the value and importance of health, fitness and lifestyle in coping with the pressures of police life and that training in basic stress management should be devised to be provided as a normal fully integrated part of training for all levels.

[130] I do not believe nor did the Plaintiffs seriously contend that this sort of culture could be changed overnight. Any significant change was bound to be gradual and related to relevant organisational change. I have no doubt that promotion of the OHU and the services that it provided influenced change and this was confirmed by ex-sergeant Lamont who gave evidence that, despite the culture, he would have used the OHU in the 80s if it had been promoted then as it was in the 90s. He himself had no reservations about submitting sickness certificates specifying anxiety and stress in 1995 and 1997 and he accepted that his attendance for stress awareness training in November 1994 may have been a factor in his being prepared to do so. David Patterson of the Welfare Department, who gave evidence on behalf of the plaintiffs, believed that delivery of the Stress Awareness package in 1994/5 reduced the effect of the macho culture and encouraged officers to admit to problems with stress and take advantage of the services available. By the second half of the 1990s training courses, albeit limited in reach, had been in existence for 10 years, Force Order 16/95 had succeeded Force Order 14/88 and the stress awareness programme was being completed, all of which had been taking place against a background of continuing publicity and approval from the Federation. The initial ceasefire had been negotiated and it is clear that officers were coming to the OHU in respect of their experiences of earlier traumas. In 2001 the Writ was issued in these proceedings. A number of witnesses described the subsequent change in the culture as dramatic and Dr Crowther gave evidence that, in recent years, he had seen a number of officers with regard to ill-health retirement who had been given a diagnosis of PTSD elsewhere and who referred to symptoms such as flashbacks but who did not indicate any significant degree of impairment of function to the extent of being able to run successful businesses and pursue hobbies and outside interests. He was supported in this by Dr Courtney who confirmed that after the Omagh explosion and the Patten Review it had become more common for officers attending the OHU to claim that they were suffering from PTSD as opposed to seeking advice about their symptoms.

Alcohol

[131] One of the themes that was debated during the course of this case was the theory that people who have been exposed to trauma will use alcohol as a

form of self-medication for trauma induced symptoms. A number of witnesses gave evidence about being taken to a public house or alcohol being provided in a station by senior officers after experiencing a particularly traumatic incident. There were varying accounts as to the extent to which alcohol was used or misused. ACC Sheridan agreed that he had encountered excessive drinking during his career which, in some cases, he associated with young officers being in receipt of comparatively substantial earnings. He also accepted that, to the knowledge of the authorities, excessive drinking had persisted to an extent after the introduction of the force Alcohol Policy in 1983. Former ACC White confirmed that officers socialised at bars in police stations as they were unable to do so outside. He accepted that alcohol was used to facilitate the expression of opinions and feelings. Lindsay Boal claimed that his social drinking was exacerbated and he maintained that he and senior officers frequently drank on duty. John Stratton gave evidence about a senior officer trying to prepare much more junior policemen for the repetition of traumatic events subsequent to the murder of two colleagues. He agreed that alcohol could have a bonding effect upon the men after a traumatic incident but he said that the problem arose when drinking became habitual and was used to mask or anaesthetise against stress. Charles Johnston, an acting chief inspector called on behalf of the Plaintiffs, said that alcohol would have played a part in unofficial debriefing after traumatic incidents by loosening tongues. In such circumstances he described how officers discussed their experiences, discovered that they were not alone, not the only ones who were upset or frightened and drew upon each other's collective strength. Sergeant Rosemary Wallace, who was an impressive witness, did not consider that alcohol was a problem although she agreed that during her time in Newry she and her fellow officers probably drank more than they should have and that the Force did include officers with drink problems. She described going to a safe pub with her constables and giving support to each other after traumatic events. It was suggested that a significant deterioration in the drinking patterns of an officer might well be a sign that the officer was suffering from the symptoms of PTSD.

[132] The consumption of alcohol was recognised as a concern by the RUC. On 13 March 1980 Mr Roy Rattey, Head of the Welfare Branch, wrote to the Assistant Chief Constable of B Department expressing the view that, as a Branch, "we are only skimming the surface with regards to matrimonial and drinking problems." Mr Rattey emphasised that the Welfare Branch could only help clients who voluntarily sought assistance and expressed his personal feelings that much could be done within the divisions if divisional commanders would take a more active and personal interest in the living conditions at police stations. He also thought that the lack of Force policy on alcohol left much to be desired in that divisional commanders "… are more than often turning a blind eye because they just do not know what course of action to take." The existence of a problem within the force was confirmed by the evidence of a number of witnesses and was recognised by the Federation which published a number of helpful articles in its magazine "Police Beat."

[133] In 1983 Force Order 73/83 (Problem Drinking and Alcoholism: Force Policy) was published setting out the Force Policy on alcohol. The new Force Order recognised that problem drinking and alcoholism were to be regarded primarily as medical conditions which might require expert help, guidance and treatment and that recourse to disciplinary proceedings should only be considered when such help, guidance and treatment had been rejected, the problem remained unresolved and the member's unacceptable behaviour or inefficiency warranted such proceedings. The Force Order emphasised the importance of early recognition of individuals with a problem and the need for co-operation by line managers, personnel, the Force Medical Officer, welfare and the individual concerned. In 1985 the "Wednesday Group" was established with the assistance of the Chief Constable to provide the equivalent of an "alcoholics anonymous" group within the RUC. In his 1990 paper "Two Decades of Welfare in the RUC" Mr Rattey recorded that the force was probably the first in Western Europe to introduce a policy covering alcohol-related problems although he expressed the view that both the OHU and the Welfare Department felt that they were still only dealing with the "tip of the iceberg." David Patterson described how the approach to the problem had undergone a distinct change in the early 1990s as it became apparent that the force was committed to dealing with alcoholism as an illness for which support and treatment were available.

[134] Mr Stratton who attended the aftermath of both the Warrenpoint and Darkley massacres, gave evidence that heavy drinking continued as a pattern of behaviour after 1983. ACC Sheridan accepted that was the case and that it was known to the authorities. According to Mr Stratton some officers viewed the publication of Force Order 73/83 with cynicism in that it seemed to be giving the heavy drinkers the "soft option" of sick leave. In my view little more could be done to correct such outdated cynicism which would only decline with the passage of time. The Federation certainly had no difficulty in acknowledging the importance of the new approach as a "major breakthrough" and crediting management for its adoption. Both the Wednesday Group and Force Order 73/83 received wide-scale publicity in a major article contained in the edition of Police Beat for October 1985. Mr Alan Wright, a former Chairman of the Police Federation, called as a witness on behalf of the plaintiffs accepted that the policy contained in Force Order 73/83 was considerate, caring and progressive. However, the introduction of a video relating to alcohol-related problems was to prove much less successful.

[135] On 8th May 1991 a draft Force Order designed to educate the Force on the identification of alcohol-related problems with an associated video to be viewed in conjunction with leaflets was circulated to Dr Courtney for his views. The video was to be included for all training establishments within the Force and it was intended that viewing would take place at all sub-divisional schools with the leaflets being distributed and read prior to the viewing. In

terms of presentation the draft Force Order underlined the importance of the video achieving maximum impact and required that the viewing should be preceded by an introduction given by a member of at least chief inspector rank with a representative of the Welfare Branch being present to ensure meaningful discussion. The content of the video "From Cheers to Tears" was subsequently approved by Dr Moorhead, the Senior Consultant Psychiatrist at Shaftsbury Square, Belfast, and a man who enjoyed a very high reputation for his work in this field. Within a short space of time, on 13th May, Mr Law, Head of Welfare Services, pointed out that his resources, both in manpower and overtime, were finite and it was unlikely that he could meet such a requirement in full. On 30 May 1991 Dr Courtney recorded his own criticisms. He disagreed that the leaflets should be distributed before the video was shown and expressed considerable reservation about it being presented at sub-divisional schools. His view was that one person with a commitment to the project should be appointed to co-ordinate the presentation of the video and he maintained that all who were involved in such a presentation should have training and assistance in the use of the video and the way it was to be presented. He cautioned that if it was presented in an off-hand manner the whole exercise could rapidly become a joke. Unfortunately, Superintendent Johnston of Personnel Services seems to have thought that Dr Courtney's reservations about the suggested manner of presentation were "somewhat superficial". It appears that he had not discussed his views with Dr Courtney prior to writing his memorandum to Assistance Chief Constable B Department in June 1991 nor were they later the subject of any explanation.

[136] On 27 March 1992 Dr Courtney wrote to the Chief Superintendent of Personnel Branch enquiring as to the progress that had been made in the distribution of the video and seeking further information about the second video proposed by the original working party which was to assist management in identifying and dealing with alcohol related problems in the workforce. On 6 April 1992 Force Order 20/92 (Video on Alcohol Related Problems) was published and on 16 April 1992 Dr Courtney wrote the following letter to Mr Hayes, Assistant Chief Constable B Department:

> "Having read this Force Order I feel I must make some comments which are my personal views:-
>
> In general I have considerable concern about the methods of using this video. These have been expressed on a number of occasions, without effect.
>
> I feel that to simply publish a Force Order which states that the video will be viewed at all sub-divisional schools is not helpful when it is widely accepted that these schools are not very effective or active. The whole tenor of the Order gives the

impression of complete lack of commitment to the project by Senior levels in the Force.

The video is in my view helpful but if used in an offhand manner or on the basis that 'this has to be shown', the video and its contents can easily became laughable. I believe that one or a small number of people should be identified to show the video in a controlled way. As it is, those tasked with showing the video have no background whatsoever given to them as to how to use the video and the material and indeed may see the video themselves for the first time with their men.

I found it fascinating that I was asked by a member of your Department at what stage of the presentation I felt the leaflet should be distributed. The following day I received the Force Order clearly showing that the decision had already been made. Incidentally, I felt that the leaflet would best be distributed after the video. The Force Order says before!

I do not believe that the objective is, or ever was, considered to be 'to educate the Force on the identification of alcohol related problems'. If this is the objective, this was not my understanding as a member of the working party and the video manifestly does not meet this objective.

Comments are quite correctly made about a second (and in my view more important) video. To date nothing to my knowledge has been done to even start this video or consider in any detail its production.

I cannot speak for Welfare Branch but my understanding was that it was made clear that they could not provide a representative at each viewing.

In summary I am deeply saddened and concerned by this Force Order which I feel debases and nullifies the work which was put into the production of the video. I can only repeat my views that it would be better not to release the video than

> to do it in this half-heartened and apparently ineffective way."

It is perhaps hard to imagine a more trenchant or scathing commentary.

[137] Finally, while they may have been somewhat thin on the ground with regard to this project, it seems that Dr Courtney was not entirely without his supporters. On 14 December 1992, Superintendent Boyd of the Training Department wrote the following letter:

> "My involvement in the saga of the production of the video on alcohol related problems has been negligible and therefore I believe that I have been able to scan this file OBJECTIVELY.
>
> There are several things which have an impact upon me. The Chief Medical Advisor has been consistent throughout that the context in which any such video is shown is the key to getting the message across.
>
> Equally consistent throughout the file seems to be the disregard which has been shown to the advice of the Chief Medical Advisor.
>
> If the Force has seen fit to appoint a Chief Medical Advisor, why would it not listen to his advice?
>
> I understand that it is generally accepted in the training profession that video can only be effective when used in a controlled context by a trainer or other selected person who can authoritatively 'warm up' the audience to receive the video, and can pick up and develop the issue opened by the video. In other words, I believe Dr Courtney has been right all along.
>
> I have grave doubts about how effective the showing of the video at sub-divisional schools will have been.
>
> Phase 2
> If I were to be asked how Phase 2 should be approached, I would say:-
> . do away with the Committee!

. give the Chief Medical Advisor his proper place! Let him and the Video Production Unit get on with the job, giving them such support as they ask for."

[138] The plaintiffs sought to make the case that alcohol was abused by police officers as a means of self medication for coping with the symptoms of traumatic stress, that the defendant knew or ought to have known that to be the case but failed to take reasonable precautions to prevent such a practice. Dr Poole considered that alcohol was used in this way by a number of the officers that he saw post trauma at the OHU. The main protagonist for such a connection was Professor McFarlane who based his opinion upon the views of the Repatriation Medical Authority in Australia, an independent statutory body of the Department of Veteran Affairs, whose task is to examine relevant literature in the course of recommending entitlements to pension. However, under a searching cross examination Professor McFarlane was compelled to accept that a number of pieces of research did not support such a connection. Ultimately, I was not persuaded that the connection for which the plaintiffs contended was as clear as they claimed. Traditionally alcohol and its abuse have long played a significant role in Irish society and it would be surprising if they had not done so in the macho culture of the police force. That is not to say that it may not have been used as a coping mechanism by some officers although a number of the lead cases confirmed that alcohol was also employed as a means of encouraging relaxation and social exchange after the discharge of onerous and dangerous duties. The defendant appreciated and sought to deal with the problem in the manner outlined above and, for the most part, the steps taken seem to have been reasonable and practical. The message in the Force Orders was supplemented by appropriate references in the OHU training courses. Completing the trauma-pack after attendance at the OHU included reference to the potential for alcohol to be used as a coping mechanism and the pack contained a section in which the officer could record his alcohol consumption. Colin Burrows, retired ACC Operations, referred to the efforts of Mr Rattey and the introduction of the 1983 Force Order as "sterling work" although he was careful to make a distinction between the provision of a stiff drink to encourage group solidarity and support and the facilitation by a senior officer/s of a heavy drinking session after involvement in a traumatic incident. In fairness, Mr Burrows was quick to point out that such sessions might well have taken place irrespective of the actions of senior officers. Quite properly the subject was kept under review but, unfortunately, the attempt to further educate the force by means of Force Order 20/92 proved to be the exception. I consider that the evidence relating to that exercise also to have general relevance to the relationship between the defendant and his occupational health adviser. At a time when the training policies relating both to alcohol and stress awareness were under consideration a Superintendent in the Training

Department was recording that the advice of the head of the OHU was being consistently disregarded

Conclusions

[139] In my view the initial 2/3 years after the coming into existence of the OHU form a watershed in this litigation. Within a short space of time officers who were suffering from recognisable psychiatric disorders as a consequence of being exposed to traumatic events had begun to attend – in the first six months of 1987 Dr Courtney reported 427 cases involving psychological/psychiatric problems a small proportion of which required professional assessment and treatment. The routine attendances of OHU personnel at the firearms training unit to perform blood and hearing tests led to exchanges that identified similar reactions in officers referred to that facility. These were not individuals found to be suffering from a particular vulnerability or precondition but officers who appeared to have previously enjoyed satisfactory mental health prior to the exposure to a traumatic event/s. They were men and women who had suffered injury in the line of duty no less than those who had sustained more obvious physical injuries and for whom the Defendant bore an equally grave responsibility. Furthermore, having regard to my finding with regard to foreseeability, the Defendant had not previously appreciated the nature of the risk to which these and other officers had been exposed over the previous years and, consequently, no specific steps had been taken for their protection and support. In such circumstances it seems to me that it became vital to give urgent consideration not only to the provision of a facility such as the OHU but also to appropriate ways in which its existence might be publicised with a view to ensuring that those who needed to do so might have the opportunity to benefit from the services that it provided.

[140] In practical terms it seems to me that, once it had been established, it was largely left to Dr Courtney and his team to "sell" the OHU and its services to officers and this was confirmed by Dr Crowther in evidence. The OHU was acting in an area of policing in which there was no clear guiding precedent. Dr Courtney accepted that, coming from a background of occupational health, he was expected to take responsibility for developing an Occupational Health Service "across the board" and it was his perception that that neither the Defendant nor PANI had a clear idea of how to proceed. His job description included the requirement to advise on and promote the rehabilitation of officers who had suffered illness or injury or been involved in psychologically traumatic events but, as he himself admitted, he did not receive "a lot of in-depth briefing." He was all in favour of the video and training modules under consideration by the Training Research Unit in 1986 and believed that the main emphasis of the video should be directed towards sergeant level with suitable modification for more junior and senior ranks. However, ultimately, it was the DOR followed by Force Orders 14/88 and 16/95 that were the means adopted

for establishing direct contact between OHU staff and those exposed to traumatic incidents while communication for the purpose of education was achieved by way of the inputs into various levels of training courses. Both of these approaches eventually proved to have limitations.

[141] The Defendant relied upon the Force Order system as the method by which management communicated with this disciplined force and I have set out the mechanics of the system above. In one sense that system constituted a formal written commitment by senior management to the OHU and the services that it provided. In terms of structure and wording there was little real criticism of the Force Orders. Indeed Dr Higson described the wording of Force Order 14/88 as "excellent" and very sophisticated in terms of what it said about trauma, the effect on families and the role of senior officers and he expressed himself as entirely satisfied with the post-trauma pack. However the evidence satisfied me, on the balance of probabilities that, in practice, the system was unlikely to have been sufficiently effective as a means of communication with officers without the support of an adequate training and publicity campaign. Reserve Constable Rush stated that training for the reserves consisted of three weeks none of which was taken up with any explanation of the Force Order system although he agreed that some Force Orders would have been referred to by the section sergeant when parading for duty and they would also have been dealt with at sub-divisional schools. He said that such Orders mostly related to law, practice and procedure rather than health and safety but, for understandable reasons given the passage of time, his memory was somewhat defective For example, he had forgotten that he had been referred to and attended the OHU during the 1990s. It is also important to bear in mind that Mr Rush became a reserve constable in 1984 and, therefore, would not have had the benefit of the reserve recruit training delivered by Dr Crowther after his arrival in 1987. That training consisted of a general overview of stress-related issues, including trauma and post-trauma reactions. Later this training also included reference to the draft that was to become Force Order 14/88 and, after it was formally published, a slide of the Order itself. Inspector Johnston was an officer who made a practice of reading Force Orders but he conceded that not everyone did so. ACC Toner observed that, in common with any people orientated system, Force Orders were as good as the people who made them work. Some stations were up to date with their filing systems, others were not. Ex sergeant Lamont confirmed that Force Orders did not generally enjoy any real degree of priority as compared with the need to ensure that officers were on duty to deal with the almost daily serious incidents at the busier stations. Witness after witness confirmed how Force Orders would be read out on parade by the sergeant and then consigned to a folder or box from which they would have to be retrieved by anyone interested. When Dr Poole and ex constable Murphy who was a firearms instructor for many years, made a joint presentation about Force Order 15/95 to senior officers some of them had not seen let alone read the document. Clearly many officers did become aware of the contents of the relevant Force

Orders, as the rise in officers attending the OHU post-trauma between 1987 and 1991 demonstrated, but I do not think that they are likely to have received the attention they deserved particularly in the stations in the most hostile areas, areas in which they were particularly relevant. Dr Courtney confirmed that he did not share the view of the personnel department that managers did not require specific training because of the clear wording of the Orders but his opinion seems to have been rejected. The essence of the Force Order was that of a command to a disciplined force. Dr Courtney denied that they had any educative pretensions and remained consistently in favour of the need for complementary training and/instruction not only with regard to Force Orders 14/88 and 16/95 but also those relating to stress awareness and alcohol. It seems to me that experience of the operation of the Orders over time tended to vindicate Dr Courtney insofar as a considerable amount of telephone communication appears to have been necessary before managers began to understand their function. As Dr Courtney observed that was not surprising since this was something new to which they had not been previously accustomed.

{142] I am also satisfied that, in terms of bringing officers to the OHU as opposed to a educative function, Force Orders 14/88 and 16/95 could not have worked to their full potential in practice. Within a short time of promulgation this was appreciated by Dr Courtney and most reasonable commanders. To have enforced the Orders to the letter would have brought the system into disrepute, seriously weakened some of the stations and units and completely overwhelmed the resources of the OHU. In such circumstances it seems likely that, in addition to any problem caused by patchy availability and distribution, the adoption of ad hoc solutions in some areas may have contributed to a degree of misunderstanding and ambiguity over time. Margaret Bennett, a very experienced occupational health nurse who joined the OHU in 1992, explained the difficulty that some officers experienced after the 1994 ceasefire in accepting that non-terrorist events, such as serious road traffic accidents, were intended to fall within the ambit of the Force Order referral system. However the fact that they did not operate perfectly as designed does not mean to say that the adoption of these Orders was, in itself, negligent. They represented pragmatic attempts by reasonable individuals to deal with a situation in which there was little or no available guidance. In addition, despite the views of Dr Courtney, I think that, to some extent, they performed an effective educational function as a number of witnesses confirmed. In particular, Dr Slovak considered that they produced a double benefit in that, as well as being directives to managers, they served to raise the whole profile of the issue of traumatic stress and the services available. The Orders were kept under review, consistent with the other professional and clinical demands upon their services, by appropriately qualified experts in the persons of Dr Courtney, Dr Poole and Dr Reid. At one point in the course of his closing submissions counsel on behalf of the plaintiffs seemed to suggest that the draft Clinical Psychology Trauma Support System proposed by Dr Reid in March

2006 was a system that ought to have been adopted by the OHU shortly after it opened for business. I would reject any such suggestion. The proposal which, prima facie, appears to contain a number of positive suggestions is based upon very recent research and the introduction by the Royal Marines of the Trauma Risk Management system ("TRIM") in 2003. TRIM is a system that remains at the experimental stage and Dr Reid has asked Queen's University for a researcher to investigate its suitability for use by PSNI. It is currently the subject of an RCT being carried out by Professor Wessely's unit.

[143] The Defendant submitted that the issue of education and training for commanders should be separately considered from that thought to be suitable for the men on the ground. The former involved training/education to be provided for superintendents, district commanders, inspectors, sergeants and other middle ranking officers so as to enable them to identify relevant signs/symptoms in the men and women under their command that might warrant a referral to the OHU after exposure to a traumatic incident. The Plaintiffs argued that all ranks should be provided with enough information about PTSD and trauma related disorders to be able to recognise the symptoms in themselves. With regard to the latter type of training/education the Defendant relied upon the evidence of Professor Shalev that there was a risk of removing officers' defensive shields or undermining their resilience, particularly in the context of a continuing terrorist campaign. Since, at its height, there were arguments both ways it was submitted that the Plaintiffs had failed to discharge the burden of proof. In relation to the former the Defendant argued that commanders should simply be required to use their common sense and experience of life and those commanders who "knew their men" did not require any special training. The Defendant submitted that it was quite unrealistic to expect police commanders to exercise the skills of a mental health professional. Indeed, given the "know your men" philosophy Mr Hanna QC was firm in his submission that commanders did not need to know that exposure to trauma might be a potential cause of symptoms. He relied upon a passage from the judgement of Owen J in Multiple Claimants v Ministry of Defence [2003] EWHC/1134 (QB) at paragraphs 12.61 to 12.63. However, it is important to remember the different factual background against which that case was litigated. For example, in that case it was not in issue that there was long standing knowledge that combat caused both acute and chronic mental casualties and the need for training commanders in the psychological reactions to combat was recognised throughout the relevant period. When Professor Solomon confirmed to Owen J that she remained of the view that it was not desirable to tamper with the coping mechanisms of non-help-seekers or subject them to unnecessary treatment she did so in the context of her opinion that people needed to be aware of the symptomatology and the availability of accessible services.

[144] In my view the RUC was very fortunate to secure the service of senior officers of extremely high calibre who exercised care and sensitivity in the

course of assessing the fitness for duty of the men and women for whom they were responsible. The Defendant called ACC Sheridan, ACC Toner, Sir Ronald Flanagan and former ACC Alan McQuillan, all of whom had risen through the ranks, to give evidence concerning the "know your men" approach and the signs/symptoms to which they would have been alert. Mr McQuillan described the sort of factors that would have caused him to have concern about the effect of stress on officers, especially changes in behaviour patterns, and he recounted how, as an Inspector in Crossmaglen, he would sit down and consider whether his men were encountering any problems because of the dangers of the posting. Mr Raymond White, who served in the RUC from 1965 to 2002 rising to the rank of ACC, gave evidence on behalf of the Plaintiffs. He agreed that "know your men" was a theme that prevailed within the force and he gave as examples the cases of officers who appeared superficially to be leading from the front but who began to disregard normal safety precautions or officers who made a series of unrelated job applications as a means of gaining an honourable removal from more stressful duties. In such cases he would have arranged to interview the officer to probe a little deeper into his or her circumstances. In the case of an officer who had started to drink heavily Mr White said that he would have obtained any available information on his work and domestic background and one of the factors to be considered would have been exposure to any specific traumatic incidents. Acting Inspector Johnston, who was also a generic witness on behalf of the plaintiffs, described how, as his period of service increased, he became something of a "father figure" and he would have been prepared to approach individuals and ask how they were feeling. He said that he would have been alert to signs such as an officer becoming unduly withdrawn or unduly loud after exposure to trauma but it is also significant that he agreed that officers generally kept their feelings to themselves and that some exhibited signs of what he now knows to have been stress but he did not recognise at the time.

{145] It seems to me that a number of factors fall to be considered with regard to communication, training and education:

(1) Shortly after the creation of the OHU in 1986 the Defendant began to appreciate for the first time that exposure to traumatic incidents could cause chronic psychiatric disorders in officers without any pre-existing vulnerability or predisposition. The OHU was a new and confidential facility that was capable of providing support and some degree of treatment for such disorders. Referral might be by management or the individual concerned. In such circumstances while the numbers ultimately affected might be relatively small the risk was obvious, given the almost daily exposure to trauma, and it became important to take all reasonable steps to ensure that officers were aware of the facility and the opportunity to benefit from its services.

(2) In addition, not only did this new information require to be effectively disseminated and properly understood but it is also clear that the Defendant

should have realised that attempts to do so were likely to be met with strong cultural resistance. The terms of reference and preliminary report of the CHMF in 1984 specifically identified the problem and paragraph 6.1.6 of the 1987 report foresaw that the support of senior management at all levels would be required. In practice the OHU was given a voice in training that reached about 4% of the force. After the OHU produced the draft of Force Order 14/88 Dr Courtney's concern that management training was required in view of the novelty of the procedure was rejected by B Department on the basis that the Force Order procedure itself was clear and did not need any supplementation. As the later Stress Working Party recognised while the information may have been available there was a need "to get it over to the men." The evidence established that, in practice, Force Orders alone were an unsatisfactory means of communicating with officers on the ground no doubt as a consequence of the demands made upon them by the continuing campaign of terrorism. While the procedure was designed to avoid exposure of individuals the means adopted, given that only a small minority were liable to be significantly affected, had the potential to bring the system into disrepute as an unnecessary form of interference by the "medics". The history of compliance with Force Orders 14/88 and 16/95 confirmed the existence of a significant area of discretion and that, despite the apparent clarity of the wording, management understanding of their duties remained at best ambiguous.

(3) It is difficult to see how the Defendant could completely rely upon the experience and common sense of officers as envisaged in the "know your men" concept to provide a reliably uniform response to a phenomenon the existence of which had not previously been appreciated. Dr Crowther confirmed that awareness is an important part of stress education and that recognition of the problem is not instinctive. While there can be little doubt about the quality of many senior officers and their ability and willingness to subscribe to the "know your men"principle, it would be unrealistic, bordering on the naïve, to assume that was universally the case in an organisation comprising many thousands of individuals. Mrs Margaret Bennett accepted that come SDCs were good at operating the referral system but others were not so good and, as Mr McQuillan candidly observed, some officers were very good, some were not so good and some were awful. Mr McClurg , an officer who has held several of the highest offices in the Police Federation and in whose name this litigation was commenced, referred to a perception that management ruled by threat and he gave as an example the concern among reserve officers that their contracts would not be renewed in the context of prolonged sickness. Mr McClurg conceded that, in practice, very few contracts were not renewed and that there was a sense that "bark was worse than bite" within the police management system. Nevertheless the letter in the 1989 edition of Police Beat to which the Defendant referred in relation to that topic provided support for the existence of a policy of "bark" in some quarters. Mr Alan Wright, a former chairman of the Federation, made a speech at the Federation conference in 1983 in which he referred to too many transfers taking place as a demonstration of authority

rather than to enhance the life of individual officers or the operation or efficiency of the Force. ACC Sheridan pointed out that in earlier days it simply was not done to ask officers how they felt whereas, at present, it was a matter of routine. He accepted in cross examination that goodwill and intimacy alone were not enough and that training was necessary. ACC Toner had no difficulty in accepting the principle that stress awareness training for all ranks would have been of great benefit if it had been available in 1969. Former ACC White described training and education about stress and stress related illness as "patchy and incomplete" and observed that "..it was the blind leading the blind because if supervisors themselves weren't being trained then in a sense the advice and guidance that they were giving to people could have been somewhat suspect." It was accepted by the Defendant's witnesses that within the force there was a diversity of views with different emphases and that the approach to the policy on trauma and referral to the OHU was not systematic.

(4) On behalf of the Defendant Mr Hanna QC relied on the opinion of Professor Shalev that psycho-education was bad practice and a double edged sword in that while it might help to identify subjects at risk it also had the potential to over-sensitise and weaken an officer's protective shield. However in cross examination Professor Shalev accepted that in a paper published in 1989 he had advised that preventive intervention on the group level should include primary physicians and medics counselling commanders on the psychological impact of specific combat conditions. In that paper he identified a number of signs that might indicate the development of Combat Stress Reaction, as opposed to a normal reaction, and could be used to educate commanders on the battlefield. He made the distinction between psychological and psychopathological impact accepting that commanders were aware of and concerned about the former while the latter involved diagnosis and jargon that was essentially a matter for clinicians. He expressed the view that good commanders would know some of the signs but accepted that even a good commander might not know what they indicated unless he was taught. The task of the primary physician or medic was to counsel commanders as to the need to recognise such signs and, in appropriate cases, to refer individuals to them for assessment and/or treatment. Professor Shalev emphasised that his opposition was specifically directed towards any attempt to teach that a natural fear reaction might be the beginning of mental disorder. In that context, he would not accept Mr Irwin QC's proposition that soldiers should be informed about the possibility of flashbacks or "intrusive memories or nightmares" saying:

> "I am not sure that we're not sensitising those who have those symptoms for a few days to look at them as something very special, I am not sure that we are reducing the stress rather than sensitising, I am not sure where this kind of education will lead to, either being more aware or less aware."

On the other hand Professor Pitman, who also gave evidence on behalf of the defendant, had no reservations about referring to both nightmares and unwanted intrusive daydreams when writing his letter to the Russell Landing Zone Association although I accept that was a group of veterans. In addition, as I have noted earlier, Dr Slovak, the occupational health expert referred to the clear and agreed benefits of the stress awareness package.

[5] When asked for his views with regard to educating police officers about the potential consequences of exposure to trauma Professor Wessely expressed the opinion that there were both pros and cons to be considered but that it was an area that was pretty devoid of evidence either way. He expressed the view that it was the stigma of mental disorder rather than a lack of information or education that was the biggest barrier to effective mental health care and that there was no tried and tested way to reduce such stigma. While that may well be a point of some substance, I am persuaded that one of the significant ancillary benefits of disseminating appropriate guidance and information is likely to be the reduction of such stigma over time. Professor Wessely accepted that it was really a matter of common sense to give people information that would educate them as to the nature of likely reactions that they might expect to undergo in the course of the job and help them to cope. At the same time he noted the reservations of what he referred to as "a previous generation" as to the risk of increasing apprehension and symptoms although he agreed that that he did not know of any evidence that showed that education about traumatic stress might increase fear reactions. Perhaps even more significant was the complete absence of any evidence to suggest any adverse impact upon police officers as a consequence of the training and educational programmes endorsed by the Defendant since 1987/88, programmes that were delivered, by, amongst others, Dr Crowther, using overhead slides that dealt with both the results of PTSD and the symptoms including poor sleep, nightmares and re-experiencing. It is interesting to compare the views of Professors Shalev and Wessely with the statement of another key Defendant witness, Dr Courtney, who wrote with regard to awareness:

> "In any preventative programme an awareness of the problem is fundamental. If this does not exist, it's extremely difficult to instigate preventative strategies. In the late 1980s traumatic incidents in the RUC were effectively taken for granted as an accepted part of duties. Incidents were commonplace and for many officers incidents were not thought of as being out of the ordinary. It was not well recognised that involvement in incidents could have a deleterious effect on health and therefore it was important to raise awareness in a realistic and reasonable way."

Such views were clearly shared by Dr Crowther and Dr Tracy Reid.

(6) It was never envisaged that police supervisors/managers would become sufficiently skilled to enable them to identify the subtle signs of mental disorder familiar to clinical psychologists or psychotherapists nor did the plaintiffs call any evidence to sustain such a proposition. Neither was it suggested that the force in general should be taught to expect mental disorder as a "normal" consequence of exposure to trauma. Supervisors could not be expected to conduct clinical examinations or to ask each officer exposed to trauma whether they had any "psychological problems" as one of the lead claimants seemed to expect. Provided that they otherwise gave the impression of being more than capable of fully discharging their duties, I am not persuaded that supervisors could be expected to routinely question officers who had been exposed to trauma about their domestic lives. It might well be otherwise if an officer spoke to his or her supervisor about relevant domestic difficulties, as the stress awareness pack and video recommended, or the supervisor directly received relevant information as in the case of Mr A. What was contemplated by the CHMF and the Training Research Unit under Inspector White was that practical, as opposed to academic, and appropriate training would be given to officers and various levels of management. Anticipating the concerns expressed by Professor Shalev the training modules were to be non-technical, informative, jargon free, optimistic and based upon a common sense approach with suitable adaptations for the type of officers to whom they were to be addressed. Without in any way detracting from the eminence and authority of the expert evidence, I think that it is important not to underestimate the range and depth of the expertise and practical experience, both of life in the RUC and in their own particular fields, represented by the membership of the CHMF. Given the need to pilot the modules it seems to me that implementation of the training could have commenced by late 1987/8. If so, it would have complemented the introduction of Force Order 14/88. It is not easy to understand why training should be delivered to approximately 4% of the Force but not to the remainder until approximately 6 years later, especially when it related to a significant risk to mental health the existence of which had not previously been appreciated by management. No reasoned decision could be traced for the course adopted by the Defendant in rejecting the CHMF recommendations and the only explanation for the failure to implement their proposals seems to have been that they were superseded by the PACE training programme. It is possible that relying solely upon the use of the Force Order system represented a saving in manpower and/or overtime which appears to have been a factor in the approach to the way in which the video relating to alcohol was introduced but it is not immediately apparent why, important though it may have been, training was made available to the whole force in relation to a legal practice and procedure but not in respect of a significant risk to the mental health of officers. No evidence of any reasoned consideration or decision making process was placed before the court and, in

such circumstances the only reasonable inference to be drawn is that the training/education programme carefully developed under the supervision of the CHMF and approved by ACC of B Department was simply abandoned in favour of training for P.A.C.E. It would appear that Dr Courtney's advice both as a member of the CHMF and with regard to training in relation to Force Order 14/88 was rejected. Unfortunately it seems likely that attitudes expressed later by Superintendent Johnston rather than that of Superintendent Boyd probably held sway even at this stage. In my view the failure to adopt the precautions recommended by a reasonable and competent non-specialist occupational health doctor, a standard for which the Defendant has contended, represented a systemic failure on the part of the Defendant.

[7] The comments of Dr Courtney and Dr Slovak also served to persuade me that delivery of the Stress Awareness Package represented a further systemic failure on the part of the Defendant. Once again that was a case of an agreed package carefully conceived by a selected working party, including Dr Courtney. Upon that occasion a Force Order was produced specifically providing for the training and deployment of welfare liaison officers who were considered by Dr Courtney to be a fundamental component of the package. However arrangements to provide adequate overtime appear to have broken down and the delivery of some 3000 packages by mail shot seems to have confounded the whole basis for involving the welfare liaison officers which was to ensure that the package was delivered by men who understood their role and enjoyed a reputation for credibility and acceptability amongst their fellow officers, men who, to use the words of the Working Party, would be likely to be able to "get it over to the men." In so finding I accept that many of the packages were delivered, that officers had a personal responsibility to attend properly arranged presentations and read packages that they received.

[7] Training and education would have ensured that, probably by 1988/89, there would have been a much more widespread understanding amongst both management and other ranks of the risk and the relevance of exposure to trauma, together with the availability of the OHU and the services that it provided. It would have demonstrated that this was not simply some notion of "the medics" contained in yet another Force Order. As Dr Reid observed "a clinical psychologist going to sergeants and inspectors wouldn't have much influence." Such a programme should have confirmed the commitment of the higher levels of command and, in my view, would have served to provide an additional factor in the matrix of culture change as the stress awareness training, despite its inadequate implementation, appears to have done at a later stage. Once it became apparent that Force Orders 14/88 and 16/95 were subject to practical limitations such training would have supplied a means of ensuring that the discretionary element of the "know your men" philosophy was properly informed and exercised with a greater degree of uniformity.

[8] The extent to which such failure will be relevant to any particular individual will, of course, depend upon the circumstances of the particular case and a consideration of the lead cases will illustrate some of the difficulties that may arise.

Treatment

[146] In the course of his closing submissions the defendant has argued that the duty of care that he owed to police officers, as his employees, did not include a duty to provide treatment. Mr Hanna QC emphasised the distinction between police officers and soldiers in respect of whom the Ministry of Defence assumed a responsibility to provide a full medical service in place of the medical services provided for other members of the population by the National Health Service. The defendant submitted that, in this context, his duty of care was limited to providing a competently staffed OHU to advise and assess officers on a confidential basis; disseminating information about the OHU and the ability of police officers to refer to it on a confidential basis; identification and referral to the OHU of police officers displaying obvious signs suggestive of post traumatic mental ill-health; the assessment of those police officers who presented at the OHU; and the subsequent onward referral, on a voluntary basis, of those persons presenting themselves and assessed by the OHU staff to be in need of referral to health care professionals where such assessment and treatment as might be warranted. However, notwithstanding this submission, the defendant frankly conceded that, in practice, the OHU had provided treatment and/or access to treatment by health care professionals who were either employees of the OHU or, in the case of the sessional therapist, independent contractors. Despite the initial conception of the function of the OHU as being preventative, in keeping with the usual role of occupational medicine, it seems to me that this was a realistic and sensible concession to make in the context of the evidence of Dr Courtney, Dr Crowther, Nurse Meekin and the other nurses and professionals working within the OHU. Indeed, one of the main reasons put forward by Dr Courtney for the transition from a largely advisory to a therapeutic facility was the disappointing inability of the National Health Service, which remained at all times the primary provider of health services, to offer timely and relevant treatment. Dr Reid's 2006 report indicated that the alternative options to the OHU were private consultations starting at an average cost of £75 a session or GP referral to one of a very limited number of NHS therapists with an average waiting list of 18 months. More up to date reports indicate that the current waiting lists are likely to be substantially longer. Consequently, in the circumstances of this particular case, I am satisfied that the defendant's duty of care included a duty to treat, when appropriate, consistent with available resources.

[147] While waiting lists certainly fluctuated depending upon demand, in general, from the Autumn of 1986 every police officer who attended at the OHU apparently suffering from trauma related mental disorder was assessed and treated either by the medical staff or, in appropriate cases, by specialists in psychology and/or psychiatry. They would receive initial general advice relating to physical exercise, sleep, hygiene, alcohol intake and work activities. An initial post trauma assessment would be carried out by one of the doctors or occupational nurses during which officers would be encouraged to provide a history, recount their symptoms and given an opportunity to ventilate their feelings. During the course of this assessment they would be provided with a diagnosis and prognosis in broad terms. A re-attendance for a review for counselling might or might not be necessary and, in appropriate cases, individuals would be referred to the relevant expert in psychology/psychiatry.

[148] Until 1994 the most common form of psychological intervention was the provision of a cognitive behavioural model of treatment. This was delivered initially by Dr Lumsden and, latterly, by Dr Donnelly. Dr Donnelly's primary approach would have been based on a cognitive behavioural model but, as a practising clinician who was aware of the complexity of mental disorder, she recognised, quite properly, that a range of techniques might have to be used including stress inoculation and some exposure techniques. From 1994 onwards Dr Poole introduced Eye Movement Desensitisation and Reprocessing (EMDR) which was frequently used as a treatment to deal with post-trauma cases. The Noreen Tehrani version of CISD was also introduced subsequent to the publication of force order 16/95. Dr Donnelly considered that she had quite good outcomes with the individual officers that she treated, that they responded well to the CBT type of approach and she expressed the view that they were one of the most resilient groups that she had encountered. Nurse Meekin recorded in the study that she carried out and confirmed in cross-examination that the counselling sessions produced positive results and that those who attended reported they were feeling better and an improvement in their ability to cope. The majority of those who underwent it considered that counselling should be offered to everyone.

[149] Dr Brown and, laterally, Dr McGarry provided psychiatric services at the OHU and the former confirmed that the advantages of attending the OHU, by comparison with the NHS, included being seen more quickly, being seen by a consultant rather than a junior doctor and, generally, being afforded longer consultations. Dr Brown developed an interest in EMDR that he discussed at an early stage with Dr Poole. Both Dr Brown and his senior registrar attended training courses in the technique. It appears that they may well have been the first psychiatrists in Northern Ireland to undergo training and obtain certification in the EMDR procedure. While they did not themselves prescribe, the psychiatrists at the OHU would recommend psychotropic medication to the GPs of those who attended. Dr Brown's prescribing habits were similar to those of other psychiatrists practising in Northern Ireland at that time. In cases

of PTSD he prescribed Selective Serotonin Re-uptake Inhibitors ("SSRIs") such as Sertraline, Fluoxetine, Paroxetine, Citalopram and Fluxamine as well as Tricyclic Antidepressants. Dr Brown confirmed that his experience was that people did tend to make a good recovery as a result of the interventions provided by the OHU. When a full recovery was not achieved it was still possible to produce a significant improvement in the quality of life.

[150] Ultimately, the plaintiffs did not criticise the treatments afforded to those who attended the OHU nor did they produce any evidence to establish that treatments appropriate to the relevant time period were omitted. Indeed Dr Higson accepted that the work of Dr Donnelly and Dr Goss within the CBT framework was the appropriate treatment at the time or, to use his own words, "absolutely spot on." It was common case in the closing submissions from both sides that the average effect of the treatments that were used was relatively modest. Such an approach was generally consistent with the NICE guidelines on PTSD published in 2005 and the guidelines published by the Clinical Resource Efficiency Support Team ("CREST") for Northern Ireland in 2003. At paragraph 4 of the section dealing with "Summary and Recommendations" the CREST guidelines recorded:

> "On the basis of current research it is recommended that SSRIs are the first line pharmacological treatment to be followed by MAOIS and TCAS. The psychological treatment(s) of choice are CBT and EMDR unless reasons exist for ruling them out. Other family and social interventions should be applied as appropriate in individual cases. The efficacy of treatment intervention should be monitored closely."

[151] One of the most recent and comprehensive accounts of the extent to which those suffering from PTSD or other trauma–induced mental disorders may benefit from appropriate treatment was contained in the NICE guidelines published in 2005. The Guideline Development Group, responsible for this publication comprised a multi-disciplinary team of health care professionals, PTSD suffers and guideline methodologists that included Dr Stuart Turner, who gave evidence on behalf of the plaintiffs. A systematic review of the relevant clinical literature was carried out and, where possible, meta-analysis was used to synthesise data. The group devised thresholds for determining clinical importance that differed according to whether one active treatment was being compared against another active treatment or against waiting list or non-active intervention. When comparing randomised clinical trials ("RCTs") of pharmacological and psychological treatments they set out to achieve a recommendation based not on statistical difference alone but on the sort of change in symptom score likely to be experienced as beneficial by clinicians and PTSD sufferers. In summary, the group found that drug treatments for PTSD were disappointing. For Paroxetine there was a reliable, positive but

small effect which, although statistically significant, fell short of the target effect size of 0.5 for a clinically important intervention. Once additional unpublished data was included the group was able to demonstrate neither clinically important nor statistically significant effects in the meta-analysis for Sertraline, the other drug licensed in the UK. In the circumstances the group recommended that drug treatments for PTSD should not be used as a routine first-line treatment for adults, either in general use or by specialist mental health professionals, in preference to a trauma-focused psychological therapy. The group agreed that consideration should be given to drug treatments where the sufferer expressed preference not to engage in trauma-focused psychological treatment or where such therapy could not be started because of ongoing threat of further trauma or where the suffer had gained little or no benefit from a course of trauma-focused psychological treatment. The group accepted that hypnotic medication might be appropriate for short-term use where sleep was a major problem but that, in the longer term, consideration might have to be given to the use of suitable anti-depressants. They also advised that drug treatment might be considered as adjunct to psychological treatment for co-morbid depression or severe hyper arousal that significantly impacted upon a sufferer's ability to benefit from psychological treatment. Ultimately, only three drugs currently available in the UK were considered to be capable of producing a clinically important effect. Paroxetine, one of the SSRIs that were used by Dr Brown, was recommended solely on the basis of its robust statistically significant effect even though it did not meet the threshold for a clinically significant effect and it was the only drug included in the group's recommendation with a current UK product licence for PTSD.

[152] On the other hand, the meta-analysis conducted by the group in relation to trauma-focused CBT showed clinically important benefit over waiting list on all measures of PTSD symptoms. In addition, there was limited evidence that this therapy also produced clinically important effects on depression and anxiety. The group also noted that there was limited evidence that trauma focused CBT was superior to supportive/non-directive therapies, thus indicating that it was highly unlikely that the effectiveness of this group of treatments was due to non-specific factors such as simple attention alone. The effectiveness of EMDR was also generally supported by the meta-analysis, but the evidence base was not as strong as that for trauma-focused CBT. It was not possible to determine if there was a clinically important difference between EMDR and trauma-focused CBT on reducing the severity of PTSD symptoms as the evidence was inconclusive. The group also recorded that the evidence indicated that it was unlikely that brief, single-session debriefing or education had a clinical important effect on PTSD and that one study suggested limited evidence of harmful effects of debriefing at 13 months post-injury for PTSD diagnosis. The group noted that it had not considered any trial of critical incident stress debriefing as originally conceived by Mitchell and his colleagues, i.e. as a group intervention for teams of emergency workers, military personnel or others who were used to working together, and, in a

passage that in many ways seems to reflect the pragmatic approach of the OHU, went on to record its general views as follows:

> "Notwithstanding these methodological reservations, given the evidence that there is unlikely to be a clinical important effect on subsequent PTSD, we do not recommend that systematic, brief, single-session interventions focusing on the traumatic incident or provided individually to everyone who has been exposed to such an incident. However, we do recommend the good practice of providing general, practical and social support and guidance to anyone following a traumatic incident. Acknowledgment of the psychological impact of traumatic incidents should be part of health care and social service workers' responses to incidents. Support and guidance are likely to cover reassurance about immediate distress, information about the likely course of symptoms and practical and emotional support in the first month after the incident."

[153] In some ways the evidence supports the existence of a spectrum of opinion relating to the benefits of treatment ranging from views generated by meta-analysis of clinical/academic research to those developed by clinicians in practice . I bear in mind the relevance of the NICE and CREST guidelines for NHS expenditure as well as the natural inclination of practising clinicians to view optimistically the results of their work. I have earlier referred to the quality and experience of those who staffed the OHU, whether upon a full-time or sessional basis, and there is no doubt that, generally, they believed on the basis of their observations and feedback that the officers who attended benefited from the treatment that they received. The careful records kept by the OHU and other documents, such as the dissertation prepared by Sally Meekin confirmed such an outcome. This was expressed in practical terms by Sally Meekin in evidence when she said:

> "What I looked for is what the consumer, what the patient had to say. We listen to these people a lot. We wanted to know how they felt, did they feel they were getting better and they did feel they were getting better on many occasions. …. A lot of people did feel better …….and did actually give us that information that they were feeling better, that they were able to cope better and they felt they would actually say they felt normal again ….. The majority of them thought that counselling should be offered to everyone.

A number of the lead cases confirmed the benefit of attendance at the OHU. For example, Mr Woods, a man who had even refused to admit being under stress when directly questioned about physical symptoms by his own GP was quite clear about the benefit that he obtained in terms of symptom reduction from his first few meetings with Donna Andrews. Subsequently he underwent EMDR with Dr Tracey Reid and, while the experience was undoubtedly tiring and difficult, the benefit to his quality of life was clear.

[154] The Defendant did not seek to argue that treatments for the relevant conditions did not work but they did rely upon the relatively modest effects evidenced by the meta-analyses set out in the NICE Guidelines, particularly those relating to pharmacological interventions. The Defendant accepted that the same Guidelines were more positive in relation to the psychological therapies such as CBT and EMDR. However they emphasised that the ability to effectively provide such treatments was limited by the availability of resources, namely, suitably qualified and trained therapists.

[155] I am satisfied that, at all material times, the staff of the OHU, together with the retained sessional clinicians, provided appropriate interventions for the officers that they treated. Unsurprisingly, given the complex nature and multi-factorial causes of the disorders, in some cases the effect was much more limited than in others. Some cases may well prove unresponsive to all forms of intervention in the long term. However that does not detract from the fact that the treatments available offered the potential to achieve a material improvement in the symptoms suffered. Ultimately, it will be for the individual plaintiffs to prove on the balance of probabilities that they would have gained a material improvement in their condition as a result of a particular intervention. Without pre-judging any particular case this may prove to be a formidable task should a substantial number of claimants seek to establish that they would have benefited from receiving one of the psychotherapies, given the evidence relating to resources.

[156] In drawing this judgement to a close I return to the issue of context and remind myself that the society that exists in this Province to-day is very different to that in which most citizens were compelled to live for more than 30 years. The current mood of vibrant optimism bears little or no comparison with the dark despairing days of the terrorist campaign. That such a mood now prevails is due in no small part to the quiet, dignified and dogged courage of ordinary men and women who were prepared to place themselves and often their families between anarchy and the Rule of Law. Heroism does not only happen in headlines. In so doing they found themselves experiencing a catalogue of horrors that in some cases caused emotional damage as real as that produced by bomb or bullet. For some, troubled by persistent flashbacks and intrusive thoughts, putting the past behind them may not be a realistic option without having to undergo prolonged and distressing treatment. In opening this case on behalf of the plaintiffs Mr Irwin QC explained that they

were seeking an acknowledgement of the damage that had been sustained and compensation for those in need of help. Whether compensation is obtained in any particular case will depend upon the individual circumstances in the light of the generic findings. However, no-one who heard the evidence in some of the lead cases could seriously doubt that individuals have been damaged whilst simply doing their duty.