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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 DISORORDER GROUP ACTION

Between:

CHARLES WAYNE McCLURG & OTHERS

Plaintiffs;

and

CHIEF CONSTABLE OF THE ROYAL ULSTER CONSTABULARY

Defendant.

SYNOPSIS

COGHLIN J

[1] This synopsis does not form part of the judgment in this litigation. It is provided as a guide to the judgment but it is no more than a guide as it cannot adequately reflect the range and complexity of the issues that the litigation involved. It should not be treated as a comprehensive summary of the contents of the judgment.

[2] The judgment is divided into two parts. Part one relates to generic issues and part two consists of ten lead cases selected by both the plaintiffs and the defendant for the purposes of illustrating the practical application of some of the generic issues.

[3] The plaintiffs consist of 5,500 former and serving members of the Royal Ulster Constabulary ("RUC") and Police Service of Northern Ireland ("PSNI"). Each of these plaintiffs claims to have sustained a

psychological/psychiatric disorder as a consequence of exposure to trauma experienced during the course of the terrorist campaign in Northern Ireland. While the litigation has tended to focus upon the disorder known as post traumatic stress disorder ("PTSD") the claims also encompass other conditions such as depression, anxiety and adjustment reactions or disorders.

[4] The claims range over a period of some 30 years from 1970 to 2000. While both sides identified a number of discrete generic issues in their opening written submissions, ultimately, both the plaintiffs and the defendants tended to focus upon:

(i) the date upon which the defendant ought reasonably to have foreseen that exposure to trauma was likely to cause police officers, who did not have any pre-existing vulnerability or predisposition, to suffer from recognisable mental disorders, and

(ii) the nature and extent of the precautions that it was reasonable for the defendant to take once such foreseeability had been established.

[5] Paragraphs 4 to 7 deal with the importance of context noting the enormous changes that have taken place not only in this society during the course of the appalling campaign of terrorist violence spanning some 30 years but also developments in health and safety legislation and occupational medicine.

[6] Paragraphs 8 to 13 outline the relevant legal principles.

[7] Consideration of the generic issue of foreseeability commences at paragraph 14 and the issue has been sub divided into –

(i) foreseeability by whom;

(ii) foreseeability of what;

(iii) foreseeability when.

[8] Within a few months of the defendant's Occupational Health Unit opening for business in 1986 officers had begun to attend displaying symptoms of mental disorder resulting from exposure to trauma and, consequently, the defendant conceded that from that point forseeability had been established. Much of the expert evidence was concentrated upon the issue as to whether forseeability on the part of the defendant should have been established at an earlier date with the focus eventually becoming the period between 1977 and 1982. Paragraphs 27 to 42 contain a discussion of the evidence submitted on behalf of both parties. Ultimately, I reached the

conclusion that the plaintiffs had not persuaded me that foreseeability had been established at any date earlier than the defendants' concession.

[9] At paragraphs 43 to 46 I discuss the relevant Northern Ireland literature and at paragraphs 47 to 58 there is a consideration of the general literature relating to the development of knowledge about the link between trauma and mental disorder prior to 1982.

[10] Paragraphs 59 to 70 deal with the development of the Occupational Health Unit covering the period between the initial discussions and exchange of ideas leading to the appointment of the Committee on Health and Management of the Force ("CHMF") in 1981/82 and the appointment of Dr Courtney as the first head of the Unit in February 1986. The membership of CHMF represented an impressive spectrum of experience and expertise and included a Consultant Cardiologist, a representative of the Public Service Training Council, an Industrial Psychologist specialising in organisational stress and survey methodology, the head of the RUC Welfare Service and several high ranking police officers. The Police Federation ("the Federation") were consulted and a representative subsequently co-opted on to the CHMF. As a consequence of the preliminary report from CHMF the Police Authority for Northern Ireland ("PANI") agreed in principle to the establishment of the OHU in December 1984, a sub committee was appointed, the Northern Ireland Office ("NIO") granted approval in principle for the establishment and funding of the OHU in July 1985 and the advertisement appeared for the post of Medical Adviser in October with the appointment of Dr Courtney confirmed in February of 1986. On 13 June 1986 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.

[11] Paragraphs 71 to 97 deal with the problems that persisted with staffing and resources for the OHU and the effect that such problems had upon the Unit's performance. Appreciating the increasing demand that was being made upon the Unit to provide psychological assessment, support and treatment services, as early as October 1987, Dr Courtney wrote to PANI recommending the employment of a full-time Clinical Psychologist. An appropriate advertisement for such a post was eventually placed in the relevant newspapers in December of 1988. There were no suitably qualified applicants and no further attempts to appoint a full-time Clinical Psychologist appears to have been made by PANI until March 1992 following a review of the OHU by the Management and Manpower Review Division of the Department of Finance and Personnel. The post was further advertised in March 1992 but it was necessary to advertise yet again and renegotiate the salary upward before Dr Poole's appointment was finally secured in May 1993. Demand for psychological services continued to grow and in December 1996 Dr Courtney and Dr Poole with the support of the Deputy Chief Constable pressed for the recruitment of a second Clinical Psychologist. The

situation became even more urgent when Dr Poole resigned in June 1999 giving as one of his reasons for doing so the pressures of an ever increasing workload including, in particular, officers displaying major post trauma symptoms. A replacement for Dr Poole was not secured until the appointment of Dr Reid in 2003. To some degree the OHU was a victim of its own success with demand increasing inexorably over time and I accept that it is virtually inherent in the provision of medical services that demand will fluctuate and, with time, generally exceed available resources. I also recognise that, at all material times, there was a national shortage of appropriately qualified clinical psychologists and that the OHU post was less attractive because of security considerations, inferior opportunities of promotion and professional isolation. The evidence indicated that Dr Courtney and Dr Poole made repeated efforts to secure the making of suitable appointments and that, in so doing, they were supported by the defendant and his senior officers. In my view the difficulties faced by the OHU in obtaining necessary resources, including clinical psychologists, were compounded by the unyielding bureaucratic procedures operated by PANI and the NIO, the relevant Civil Service authorities. Fortunately, it appears that the situation has 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. 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. 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.

[12] Paragraphs 97 to 103 provide a history of the discussions and preparation that took place about the way in which officers should be trained, educated or otherwise provided with information about stress subsequent to the coming into operation of the OHU. The CHMF report of 1987 referred to training modules designed by the Training Research Unit at Garnerville and identified a number of principles upon the basis of which these had been produced. Mr Maguire of the Public Service Training Council had advised that it was hoped to introduce three training modules for a period of one to one half days for the ranks of recruits, probationer constables, sergeant/inspectors/chief inspectors and superintendents and upwards. An additional module was to be prepared for supervisory groups involving the identification of signs of stress in others, referral systems and counselling

skills. The report accepted that this was an innovation in training and advised that the proposals would only work if they had the understanding, backing and commitment of top management. A training video was produced together with lesson notes, handouts and information sheets. The preparations were approved by the CHMF and Inspector White of RUC training branch recommended that the package should be tested and piloted for the various groups before taking a final decision as which format would be appropriate for each level. Unfortunately it appears that these modules were never implemented because of the introduction of a training programme for PACE.

[13] Shortly after he took up his post Dr Courtney arranged for the OHU to have an input into the training courses for recruits, probationers, sergeants initial and refresher courses, inspector development, chief inspector and superintendent courses. The development, implementation and content of these courses is discussed between paragraphs 101 and 103. Ultimately, 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.

[14] Paragraphs 104 to 114 deal with "outreach" and cover the development, implementation and operation of a number of procedures designed by Dr Courtney and his associates to encourage officers who had been exposed to traumatic incidents to attend the OHU. Initially, the staff relied upon gaining access to the duty officers' reports which contained details of traumatic incidents that had occurred in the previous 24 hours. The OHU would then make contact with the relevant sub divisional commander for the purpose of ascertaining details of the incident and the names of all officers directly or indirectly involved who might have sustained significant exposure to trauma. Such officers would then be invited, initially by telephone and subsequently by letter, to attend the OHU. Attendance was on a voluntary basis.

[15] The system of relying upon the duty officer's report was superseded by Force Order 14/88 the draft of which was prepared by OHU staff and submitted to B department for approval before formal publication. This Force Order was published on 5 February 1988 and the introduction informed officers that its purpose was to provide a mechanism for a confidential counselling service by the OHU for police officers involved in traumatic incidents. Force Order 14/88 was, in turn, superseded by Force Order 16/95 in March 1995. Force order 16/95 contained a more focused definition of critical incidents, introduced the concept of Critical Incident Stress Debriefing and that of the "designated officer" as the senior officer with overall

management responsibility for officers involved in critical incidents. The requirement to refer relevant officers to the OHU was made mandatory.

[16] Despite the clear and relatively unambiguous wording of the Force Orders, neither of them achieved the degree of compliance originally intended. One of the primary purposes behind both Force Order 14/88 and Force Order 16/95 in requiring the station duty officer to identify everyone who might have been affected in accordance with the former and by making referral of all such officers mandatory in accordance with the latter was the need to avoid individuals feeling that they had been specifically identified as requiring some form of psychological help. However, provisions that did not discriminate between those who were and those who were not suffering symptoms had the potential to overwhelm the resources of the OHU and bring the system into disrepute. It seems clear that with time a number of commanders decided, in practice, to rely upon their own discretion in determining whether or not an individual or individuals should be referred to the OHU subsequent to traumatic incidents. Dr Courtney himself agreed alternative procedures with one unit in West Belfast and with the photography branch. Other examples were provided by Inspector Fergus, Mr McQuillan, ACC Sheridan, Sir Ronald Flannigan and Mr McClurg.

[17] Paragraphs 115-122 set out the basis upon which a decision was taken to introduce Stress Awareness Training to all members of the police force. A working party was appointed and made both short term and long term recommendations in its report. On 10 March 1994 Force Order 15/94 relating to Stress Awareness was published confirming that command had approved a recommendation that a stress awareness package should be delivered to all serving officers within the RUC and the RUC reserve, both full and part time, and that such a package should be distributed in early 1994. The package comprised a 20 minute video together with an individual information pack of leaflets. The Force Order directed sub-divisional commanders and branch heads to select two suitably motivated officers to be trained as welfare liaison officers whose task it was to arrange for all officers to view the video and receive the information packs. Dr Courtney explained that the thinking behind the concept of welfare liaison officer was that the package should be presented in a consistent and credible way by trained officers. Unfortunately, delivery of the stress awareness package did not prove straightforward, sufficient overtime was not afforded to the welfare liaison officers, some of the packages were mis-delivered and by February 1996 some 3,500 officers still had not received the package. In such circumstances a decision was taken at that point to deliver the remaining packages by way of mail shot without the benefit of the video and an oral presentation. Dr Courtney felt that this was "certainly less than adequate" and it was also the subject of criticism by Dr Slovak.

[18] Paragraphs 123 to 130 contain a consideration of the evidence relating to the "macho culture" ascribed to the RUC by many of the witnesses. 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. The defendant also accepted that such a culture, by its very nature, was unlikely to encourage the free and open discussion of psychiatric symptoms. According to this culture such symptoms were 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 from the point of view of those who depended upon him or her in highly dangerous circumstances. No one wanted to be thought of as requiring to see "a shrink". One consequence of such a culture was to reinforce the scepticism of many officers about the confidentiality of the OHU. It is important to remember that the culture to which so 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 had been forced to operate. Ultimately, the plaintiffs did not dispute that there was a positive side to the macho culture and they did not contend that it could be changed overnight. In my view change was bound to be gradual and related to relevant organisational change including the promotion of the OHU and the services that it provided, including the training courses at different levels, the publication of Force Orders 14/88 and 16/95 and the implementation of the stress awareness programme.

[19] Paragraphs 131 to 138 examine the way in which the RUC dealt with the problem of alcohol consumption amongst its officers. One of the themes that was debated was the theory that people who had been exposed to trauma tended to use alcohol as a form of self-medication for trauma induced symptoms. This was dealt with by a number of witnesses including some of the lead cases. Alcohol consumption was recognised as a concern by Mr Roy Rattey, head of the welfare branch, in March 1980when he wrote to the ACC of B department expressing the view that they were only "skimming the surface" with regard to drinking problems. In 1983 Force Order 73/83 (Problem Drinking and Alcoholism: Force Policy) was published recognising that problem drinking and alcoholism were to be regarded primarily as medical conditions requiring expert help and that recourse to disciplinary proceedings should only be considered as a last resort. The policy incorporated in this Force Order was described by Mr Alan Wright, a former chairman of the Police Federation, as considerate, caring and progressive. Unfortunately, the attempt to further educate the force with regard to the problems of alcohol in 1991 proved fairly unsatisfactory. On 6 April 1992 Force Order 20/92 (Video on Alcohol Related Problems) was published but it was subjected to trenchant criticism from Dr Courtney for showing a complete lack of commitment to the project by senior levels in the force. Dr Courtney was not alone in his criticism. Ultimately, I was not persuaded that

the connection for which the plaintiffs contended was a 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 it not to say that it may not have been used as a coping mechanism by some officers although a number of the lead cases also confirmed that alcohol was employed as a means of encouraging relaxation and social exchange after the discharge of onerous and dangerous duties. For the most part, I consider that the steps taken by the defendant were reasonable and practical although Force Order 20/92 proved to be a clear exception. I considered that the evidence relating to that exercise had 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 senior officer in the training department recorded that the advice of the OHU was being consistently disregarded.

[20] Between paragraphs 139 and 145 I set out my conclusions with regard to the topics of education, training and dissemination of information. I regard the two to three years after the coming into existence of the OHU as forming 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. These were not individuals found to be suffering from a particular vulnerability but men and women who had suffering injury in the line of duty no less than those who had sustained more obviously physical injuries and for whom the defendant bore an equally grave responsibility. Having regard to my finding in relation 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 16 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 to their situation not only, as the defendant properly did, with 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. The defendant appreciated from an early stage that the culture of the RUC had the potential for providing a significant obstacle to the effectiveness of training and instruction. This was recognised in the report provided by the CHMF. The CHMF and the Training Research Unit produced a coherent package of practical and appropriate training to be given to all officers and various level of management. Dr Courtney, the qualified expert in occupational health engaged by the defendant, expressed himself to be all in favour of the video and training modules produced. As far as I am able to ascertain this programme was effectively abandoned in favour of training for PACE. It seems to me that this represented a systemic failure on the part of the defendant. Dr Courtney's advice that Force Order 14/88 should be supported and supplemented by training was rejected. In my view

the evidence relating to the Stress Awareness Training Programme and the video on alcohol indicated a persisting lack of commitment on the part of the defendant to ensuring that those initiatives were supported with adequate and effective training programmes. For the reasons set out, I do not consider that the defendant's "know your men" policy was an adequate substitute for training commanders and I did not consider that the reservations expressed by Professor Shalev justified a failure to ensure that all ranks were provided with the type of non-technical, informative and non academic training that was originally envisaged by the CHMF and the Training Research Unit. No evidence was called before me to indicate that the information imparted by the OHU to different levels of officers during the regular training courses in any way inhibited such officers from subsequently discharging their duty to protect the public during a relentless terrorist campaign.

[21] Paragraphs 146 to 154 deal with the development and form of the assessment, support and treatments that were afforded to police officers by Dr Courtney and his staff including the sessional clinicians. It is important to remember that, in accepting a duty to treat, the defendant was not guaranteeing that treatment would be immediately available or that it would always be successful. 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. It was common case that the average effect of the treatments that were employed was relatively modest but that was unsurprising given the complex nature of the disorders. A number of the lead cases confirmed the benefit of treatment received at the OHU but 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 in my view 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. In the case of some of the more effective treatments such as Cognitive Behavioural Therapy ("CBT") or EYE Movement Desensitisation and Reprocessing ("EMDR") the pressure on resources may well pose significant problems.

[22] Part 2 of the judgment consists of 10 lead cases selected by the plaintiffs and the defendant as a means of illustrating the practical operation of some of the generic issues. In accordance with the wishes of both parties, while I have considered those issues that appear to be relevant, , I have not reached a final view as to compensation in any of these cases and I await any further submissions that they may wish to make.

[23] In their written closing submissions in each of the lead cases the defendant included a section raising the issue of limitation and the plaintiffs

subsequently lodged their own replies. Article 50(1) of the Limitation (NI) Order 1989 provides the court with a discretion to disapply the relevant provisions of the Order, if it considers it equitable to do so, having regard to the extent to which either party may be prejudiced thereby and to all the circumstances of the case including those particular circumstances specified in Article 50 (4). The evidence in each of the lead cases was heard over several days and I do not recall any issue of prejudice to either party arising as a result of the passage of time. In addition I take into account the breadth and complexity of the litigation with the consequential need for substantial resources in terms of research and expertise. In the circumstances my inclination would be to exercise my discretion in respect of each of the lead cases. However, I would be prepared to hear any oral submissions the parties might wish to make on the topic at their convenience.

[24] 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.