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Judgment: approved by the Court for handing down | *Delivered:* **03/07/2007**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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POST TRAUMATIC STRESS DISORDER GROUP ACTION

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BETWEEN:

CHARLES WAYNE McCLURG AND OTHERS

Plaintiffs;

-and-

THE CHIEF CONSTABLE OF THE ROYAL ULSTER CONSTABULARY

Defendant.

LEAD CASE OF JAMES SPENCER BEGGS

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COGHLIN J

[1] This plaintiff is 54 years of age having been born on 15 March 1953. On 8 January 1968 he joined the Royal Navy aged 15 years and 9 months and thereafter served for some seven years. He married in 1970 and his first child was born in 1973. He then decided to leave the Navy and return to Northern Ireland obtaining his discharge in 1975. On 26 May 1975 he joined the RUC.

[2] In October 1975 he was posted to Limavady where he carried out beat and patrol duties until he was transferred to Dungiven in October 1977. From April 1978 until November 1979 he served as a Scenes of Crime Officer (SOCO) at Portadown. In November 1979 he returned to beat and patrol duties in Lurgan where he remained until April 1970 when he was posted to the District Mobile Support Unit (DMSU) for Bessbrook/Newry. He served

with that unit until he resumed beat and patrol duties in September 1983 at Annalong before returning to DMSU service in Newry in January 1984. From May 1987 until May 1992 he worked in operational training at Palace Barracks. Thereafter he went to Dungannon to perform beat and patrol duties until June 1993 when he was promoted to the rank of sergeant at Pomeroy. He was medically discharged from the force on 11 December 1997.

[3] During the course of his police service the plaintiff was exposed to a number of potentially traumatic incidents the most significant of which seem to have been:

(*i*) While working as a SOCO officer the plaintiff attended the scene of the murder of Jim Wright, a former RUC Reservist, who had been murdered as a result of an INLA booby trap bomb left under his car in Portadown. The effect of the explosion had been to remove most of Mr Wright's body from below the waist and the plaintiff had to carry out a detailed search of the vehicle and its surroundings. Subsequently he attended the post mortem.

(*ii*) In 1979 the plaintiff attended the scene of the suicide of a 12 year old boy who had taken his life by shooting himself in the head with a 12 bore shotgun. According to the plaintiff, he was told to attend the scene of an accidental shooting and, when he arrived, the inspector in charge did not tell him what had happened but simply indicated the location of the relevant room. The plaintiff had to push open the door in order to gain entrance to a room in which he found the body of a child with most of his head missing. He described the room as being covered with blood, bits of bone and brain. Despite being emotionally distressed the plaintiff said that he was instructed by the inspector to clean the room before the boy's mother would be allowed to enter. The plaintiff said that he was compelled to carry out this duty by the inspector although he was visibly distressed and shaking. Subsequently, the plaintiff had to attend the mortuary where a post mortem was carried out on the young boy's body.

(*iii*) In August 1979 the plaintiff attended the mortuary subsequent to the massacre at Warrenpoint in the course of which eighteen soldiers lost their lives. His duties included attempting to piece together body parts in order to produce full cadavers. In February of the same year the plaintiff attended the mortuary at Craigavon Area Hospital following the murder of two youths who, with their two companions, had been blown up by a roadside bomb on the Darkley Road after being mistaken by terrorists for an army patrol.

(*iv*) During the course of attending the scenes of a series of suicides the plaintiff had to deal with the body of one man whose suicide had been undetected for several weeks. As a consequence, the body had been attacked by rats and had become infected with maggots.

(*v*) On 14 October 1980, when the plaintiff was carrying out MSU duties in an armoured Hotspur land rover close to the border, a 500lb landmine was detonated causing the vehicle to be lifted into the air. The plaintiff left the vehicle in order to give cover to the other officers. Within a short time they were relieved by another patrol in an unmarked police car. The plaintiff received a commendation for his actions upon this particular occasion.

(*vi*) On 20 May 1985 the plaintiff attended the scene at which a terrorist landmine had killed four police officers on mobile patrol. The location of this incident was close to the explosion in which the plaintiff himself had been involved. The armoured car had been blown across the road and the heat of the explosion had resulted in particularly gruesome mutilation of the bodies. During the course of an evidential search of the scene the plaintiff recovered the severed hand of a young female police officers. That officer and the plaintiff had been on friendly terms and they had been discussing her engagement to one of his colleagues shortly before her death. The plaintiff claimed that, as a consequence of this incident, he went home and drank heavily for a couple of days.

(*vii*) Apart from these specific incidents the plaintiff recorded that in an eighteen month period during 1983/84 23 police officers were either murdered or committed suicide in the Newry area. The plaintiff knew some of these officers quite well.

The development of plaintiff's symptoms

[4] In the course of giving his evidence the plaintiff said that, after the suicide of the young boy, he began to suffer from sleeplessness, helplessness, loneliness and a general sense of depression and that his nightmares really started after his involvement in the landmine explosion in October 1980. He said that his nightmares had remained continuous since that time. A particular nightmare about an unending funeral commenced around the time of his appointment as sergeant in Pomeroy in April 1993. He described these nightmares as disturbing and continuous. He also claimed that he had suffered from panic attacks and tongue biting throughout the 1980s and a diminution in his sense of smell.

[5] While it was common ground between the parties that the incidents described by Mr Beggs were the type of traumatic events that would have the potential to produce PTSD symptoms and Professor Fahy did not doubt that he must have experienced intense distress and periods of pre-occupation, reliving what had happened, there was little objective evidence to corroborate the claimant's history of continuous chronic psychological symptoms from the early 1980s.

[6] Subsequent to his involvement in the landmine explosion in October 1980 the plaintiff was seen by the local police surgeon, Dr Ward, who recorded that:

> "On examination he was excited and slightly shocked. He complained of deafness in both ears the right more than the left and tinnitus. He told me that he was taking tablets called Tavegol from his own doctor."

Dr Ward then went on to record that the claimant was 'pale and close to tears' and that he was 'suffering from shock'." He prescribed sedative tablets to be taken three times a day and sleeping tablets to be taken when necessary.

[7] The plaintiff instituted a claim in accordance with the criminal injuries compensation legislation in respect of this attack and was referred to a psychiatrist by his solicitor. The claimant gave an account of his interview by the psychiatrist which, even in his own words, was "quite extraordinary and quite bizarre". According to the claimant after the introductions were completed and he had been asked about the circumstances of the incident he was asked if he could recall the name of the psychiatrist and, when he was able to do so, he was informed that his memory was very good. The plaintiff then pointed out that the psychiatrist's name appeared on a sign on his desk and, at that stage, he was told "okay that session's finished". The plaintiff described himself as being exceptionally cross as a result of being treated in this disgraceful fashion but he was unable to recall whether he had made any complaint to his solicitor. In the event, no psychiatric evidence was presented on behalf of the claimant in the course of his claim despite the fact that, according to his evidence, he was suffering continuing psychiatric symptoms as a result of the explosion which overshadowed his physical problems, including his hearing loss. I did not find the claimant's account of his interview with the psychiatrist to be credible. I think that the more likely explanation is that, once any acute symptoms had settled, he did not continue to suffer from any significant degree of psychiatric symptom as a result of this incident.

[8] The first reference to psychological symptoms in the records held by the plaintiff's GP occurred when he attended on 11 March 1994. He had previously attended earlier that month and complained of interference with his sense of smell. On 11 March the GP noted that anxiety was a definite factor, prescribed Prozac and arranged a referral to Mr Lyttle, the neurologist. Upon that occasion the plaintiff told the GP that his symptoms had started approximately two months ago. When he saw Mr Lyttle on 19 May 1994 the plaintiff complained of beginning to experience pains in his arms, excessive tiredness, unsettled sleep, an illusion of smelling burning chimneys and tongue biting while asleep some two months ago. Mr Lyttle concluded that his symptoms were stress-related and noted that he had responded well to Prozac.

[9] The plaintiff's next relevant attendance upon his GP occurred in September 1996 after he said that he had suffered some form of mild blackout

when driving in a supermarket car park. Upon that occasion the GP recorded "stress ++" and prescribed Seroxat. The GP advised the plaintiff to attend the OHU.

[8] On 31 October 1996 the plaintiff attended Dr Crowther at the OHU. Upon this occasion he gave a history of suffering depressive episodes, poor sleep and emotional lability over three years with no obvious cause. He referred to episodes of biting his tongue, losing his temper and breaking down in tears when watching events relating to the troubles on television. Dr Crowther noted a past history of "trauma++" and recorded the specific incidents of the suicide of the 12 year old boy, the landmine explosion and the explosion in which Tracey Doak was killed. He diagnosed "delayed PTSD" and agreed with the plaintiff that he would be referred to Dr Brown for advice relating to medication and EMDR. Dr Crowther was examined and cross-examined in relation to this interview with the plaintiff and I considered him to be an impressive witness. Dr Crowther had no doubt that he received a history of symptoms over a three year period. He accepted that one of the features of fluctuating PTSD symptoms was that sufferers might not consider themselves to be ill and he thought that the depressive episode sustained by the claimant as a consequence of the responsibility of being promoted to sergeant in Pomeroy had triggered past memories into taking a more intrusive form. He also made a distinction between types of symptoms, accepting that nightmares posed a difficulty in so far as not everyone would consider them significant but expressing the opinion that flashbacks and intrusive memories were associated with the emotional arousal and drama of the original event and that both their occurrence and their relationship to the original trauma would be perceived by the sufferer. He explained that his use of the word "delayed" indicated that the history he received from the claimant was of symptoms that had lasted for three years and not one of chronic symptoms over a period of twenty years or more.

[9] When the plaintiff saw Dr Higson for his own solicitors he told him that it was not until the early 1990s when he was promoted to the rank of sergeant and transferred to Pomeroy that he started to notice the presence of distressing psychological symptoms. He recorded that he had been prescribed Prozac for stress by his GP and that he had started to identify symptoms in himself after attending stress lectures by the OHU. When he saw Dr Pilkington at PRRT in September 2004 he referred to the onset of his problems as his attendance with his GP in 1992 with sleep problems and stress because of a 16 hour working day. He gave a similar history of the development of major difficulties to Mrs Mackle-Lynch the psycho-analytic psychotherapist from whom he is currently receiving treatment and he told Professor Fahy during interview on 19 April 2005 that he had begun to develop psychological symptoms in the early 1990s. At that time he said that prior to that date he did not have the opportunity to dwell on things and "stresses were taken care of in the bottom of a bottle".

[10] In their helpful joint statement Dr Turner and Professor Fahy recorded that they had obtained differing accounts of the chronology of symptoms from the plaintiff with Dr Turner obtaining symptoms of adjustment disorder from the late 1970s, a temporary exacerbation of symptoms in 1980 and a relatively mild PTSD from 1985 onwards. Professor Fahy accepted that the claimant might have suffered from some episodic symptoms subsequent to the traumatic events identified but he did not obtain an account of PTSD prior to the 1990s. Both experts recorded a significant deterioration in symptoms in the early to mid 1990s that was supported in the medical records. In the course of his evidence Dr Turner said that he recalled receiving from the plaintiff a history of nightmares and flashbacks from which he had suffered since 1985 but I found this aspect of Dr Turner's evidence rather unconvincing. Mrs Beggs described the plaintiff complaining of nightmares within a year of meeting him in January 1986 but Professor Fahy emphasised that his interview with the plaintiff took place in the presence of his wife who did not take issue with the plaintiff's specific statement as to when his symptoms began, although she did refer to him as vigilant, tense, agitated and explosive at an earlier stage.

[11] Both Dr Turner and Professor Fahy agreed that the plaintiff tended to present his history and evidence in a rather melodramatic way and was prone to exaggeration. They also accepted that such factors required to be taken into account when assessing the reliability of the plaintiff's history of symptoms especially in the absence of objective corroboration. He is clearly a highly motivated individual determined to fulfil what he perceives to be his role as representative of the other plaintiffs in this litigation to the best of his ability. There is no doubt that, apart from a relatively brief period of remission subsequent to his discharge from the police force, the plaintiff has continued to suffer from some degree of depression and PTSD since approximately 1994. At times I thought that his evidence was simply not credible, for example, his account of the interview with the psychiatrist in 1980 and his explanation as to how the note came to be made in his GP record for 4 February 1991. On the other hand I accept that his reference in his original witness statement to having been at the scenes at Warrenpoint and the "Darkley Massacre" may have been mistakes, although it may not be without significance that he seems to have used precisely the same terminology when giving a history to Dr Pilkington. His wife referred to him as a "compulsive liar" but my impression was that this observation related primarily to the difficulties in their personal relationship and his compulsive/obsessive behaviour. Overall, it seems to me unlikely that his symptoms were either as chronic or as intense as he claimed prior to 1994 although I have no difficulty in accepting that the horrors with which he was confronted may well have produced acute symptoms for a relatively transient period. I think that it is likely that any such symptoms subsided to an extent that he was able to cope albeit with the assistance of alcohol from time to time. It seems clear that a major factor in the production of his current

difficulties was the extended responsibility that he had to shoulder after his promotion to sergeant in Pomeroy in 1993. That development and the associated anxiety and depression also seemed to have either revived or significantly exacerbated PTSD symptoms relating to his exposure to the earlier traumatic incidents.

The OHU

[12] It was accepted that this plaintiff was not exposed to any traumatic incident subsequent to 1985 and I have concluded that foreseeability did not arise until after the OHU commenced its operations in 1986. While the plaintiff may have suffered from some degree of fluctuating symptoms subsequent to 1986 I am satisfied that he was able to cope and that there was nothing to indicate to the defendant that he was suffering from any mental disorder. In fact, as the plaintiff himself conceded, during this period all of his professional appraisals indicated that he was capable of performing his police duties to a very high standard. Such appraisals continued to be exemplary even after his promotion to sergeant at Pomeroy up to the date of his appointment with Dr Crowther during a period when he was undoubtedly suffering from psychological symptoms. In such circumstances the appraisals required to be considered with a certain degree of caution. On the other hand it is clear from a number of the lead cases that less than favourable appraisals were recorded. By way of example, it was noted of this plaintiff that he was "a bit immature for his age and had his own certain set ideas" and, while there may have been difficulties with his domestic relationship as a result of his anger and irritability, Dr Turner accepted that the plaintiff had no difficulty whatever in functioning effectively as a police officer. The plaintiff himself maintained that he was "pretty good at putting up a show." The plaintiff made a number of transfer applications but some of these were routine responses to Force or Weekly Order notices while others were for specific reasons e.g. to married quarters in Annalong when his first marriage was in difficulties .

[13] Dr Turner agreed that, prior to 1994 the likelihood was that the plaintiff would not have reported suffering from any degree of psychiatric disorder unless he had been subjected to systematic questioning. The plaintiff accepted that he had been aware of the existence of the OHU with the facility to self refer from its inception. He also accepted that he was aware of force orders relating to stress resulting from exposure to traumatic incidents. The plaintiff said that he only learned that stress advice could be obtained from the OHU as a result of his sergeant's course but it is difficult to reconcile this with his agreement that he was aware of the setting up of the OHU and Force Order 14/88. In evidence he said that he was not sure whether the OHU was completely confidential and he referred to leaks as a result of which he had been able to gain information through senior officers about people who were

off on the sick. Whatever reservations he may or may not have had about the confidentiality of the unit, they did not inhibit him from attending Dr Crowther when it was suggested by his GP in 1996.

Dr Brown

[14] After the referral by Dr Crowther the plaintiff was seen by Dr Brown, consultant psychiatrist, on 2 December 1996, the 20 January 1997 and 15 April 1997. In evidence, the plaintiff stated that he had attended the OHU with the impression that they were going to make him better to enable him to return to work. He said that his attendance at the OHU confirmed his belief about the unit, namely, that it was simply an arm of Personnel the function of which was to dispense with his services. It was clear from his evidence that the claimant remains extremely bitter and resentful about the way that he believes he was treated by the OHU and Dr Brown in particular, and at one point he said:

> "I felt like I was no longer the sharpest tool in the box so just throw it out. It is easier to bring someone else in, bring a new recruit in and get rid of the dead wood, as it were. I still feel like that to this day."

He expressed the view that an officer would be "bundled out" as soon as the police became aware that he or she had a mental problem. He maintained that Dr Brown had assured him that, once he had left the force, he would get better whereas in fact his mental state became worse.

[15] In keeping with much of his testimony, it seems to me that the plaintiff's evidence about his treatment by the OHU was probably subject to distortion and needed to be approached with a degree of caution. I am satisfied that the decision to medically retire this plaintiff was only reached after a significant period of consideration and discussion. The future was discussed at his first attendance with Dr Brown when it was noted that he had 22 years service in the police and 25 years service if his period in the Navy was included. During that interview he told Dr Brown that he was no longer passionate about the job. During the appointment on 20 January 1997 he told Dr Brown that he was feeling "less and less like a policeman each day" and there were further discussions about his future. On 15 April he recorded that the more he stayed off work the less he thought about it and the less he wanted to do with it. He informed Dr Brown that his GP was happy that he should take medical discharge, he himself was happy with such a prospect and he expressed a preference for it to take place as soon as possible so as to bring an end to the stress of his current situation "in limbo". Dr Brown recorded the plaintiff as saying "I know there is no way I can ever go back." Dr Brown noted that, after discussion, the plaintiff had agreed that medically discharge was the most appropriate way forward.

[16] Since the decision to proceed with medical retirement was ultimately one for the OHU the plaintiff was seen again by Dr Crowther on 8 May 1997. The issue of medical retirement was discussed and, in evidence, Dr Crowther confirmed that any indication that the plaintiff wished to remain in the force would have been duly recorded and alternative options fully discussed. At that time the OHU enjoyed very good contacts with and co-operation from management to the extent that arrangements had been made for approximately 1,000 officers subject to some form of disability-related duty restriction to continue in the employment of the force providing useful service. Four days after this interview Dr Crowther wrote to the plaintiff's GP to confirm the history and the plaintiff's agreement with medical discharge. Dr Adams replied on 17 July 1997 advising that he was of the opinion that "… continuing to work in his chosen profession, would undoubtedly cause recurrence of his stress symptoms almost immediately and that it would be very much against his better interests, both mentally and physically". Dr Crowther confirmed that the impression he received from interviewing the plaintiff was that he was enthusiastic about medical retirement seeing it as a positive step at the time in this life. He made it clear that if the plaintiff had simply said that he was accepting retirement because he had been told that he would "get better" he would have advised caution and proceeded to explore all the alternative options in depth. Dr Crowther firmly rejected the suggestion that the function of the OHU was to bring officers to medical retirement as quickly as possible as that it was no longer "a police problem".

[17] Dr Brown said that, on the basis of his interviews with the plaintiff he had agreed that Prozac should continue to be prescribed as the appropriate medication and that, ultimately, he had decided that medical discharge, which he termed a psychosocial intervention, was the best way forward. He thought that it was very likely that he had discussed EMDR with the plaintiff but felt that he was not ready to engage in such a therapy at that time. He agreed that he might well have told the plaintiff that he hoped that his condition would improve upon discharge and he accepted that it was possible that the he might have misinterpreted what he said as providing a somewhat stronger assurance. He agreed that EMDR therapy was available at the OHU at that time and that both he and Dr Poole had been trained in its use. He said that the reason that he did not consider it appropriate at that time for the plaintiff was his history of temper and anger and that his clinical judgment was that a further period of time away from work was required for the plaintiff's condition to stabilise and for him to be suitably prepared to participate in such a demanding form of therapy.

[18] The other medical experts who gave evidence tended to be somewhat critical of the way in which the plaintiff was dealt with by Dr Brown. The notes made by Mr Best, the welfare officer, of his interview with the plaintiff on 4 March 1998 confirmed in graphic terms the degree of improvement in

the plaintiff's condition after completion of his medical retirement. He recorded in his summary:

> "All in all therefore the psychiatrist in the situation seems to have got the solution correct. Spencer was dubious when told that leaving the police would be the only way forward for him and he felt as if he was being palmed off. However it has turned out that leaving the police has been the best thing that could have happened to him and he is hopeful now that he can develop his business and that his life will go from strength to strength."

Unfortunately, this degree of improvement did not last and significant symptoms recurred in the autumn of 1998. Dr Turner pointed out that in his experience dealing with refugees suffering PTSD it was not uncommon to encounter a "honeymoon" period of remission when the individual was granted legal status but that such relief was likely to be brief. Dr Turner believed that the plaintiff should either have been referred for psychological treatment or his medication should have been reviewed and he did not consider that medical discharge in itself was an effective intervention in the circumstances. Professor Fahy did not accept that Dr Brown should have reviewed the medication and he noted that the plaintiff's symptoms were a combination of depression and PTSD. He considered that a clearer treatment plan specifically addressing post-traumatic symptoms would have been appropriate. Professor Fahy felt that while medical discharge might well have been expected to relieve the worst of the depressive symptoms, which were probably related to the additional responsibility assumed by the plaintiff after promotion to sergeant at Pomeroy, some consideration also needed to be given to trying to resolve the post-traumatic symptoms. Both Dr Turner and Professor Fahy agreed that the plaintiff would require a prolonged period of preparation before engaging in either EMDR or CBT therapy and I note that such a stage does not yet seem to have been reached even by Mrs Mackle-Lynch.

[19] It is necessary to bear in mind that, at the time of the plaintiff's medical discharge, PRRT had not yet come into being and, consequently, once the discharge had taken effect the treatment responsibility of the OHU also came to an end. On the other hand, it is clear from Mr Best's detailed and helpful notes that the plaintiff himself was, to say the least, disappointed with his attendances with Dr Brown. My impression is that there could have been a good deal more discussion with the plaintiff about the therapies that might be suitable to reduce his PTSD symptoms. In particular, some such discussion and/or preparation could have taken place during the seven months between his last appointment with Dr Brown and the completion of his medical discharge. In addition, I should have thought that it would have been helpful to furnish the GP with a suggested framework of future treatment. To do so

would have accorded with the practice described in Dr Courtney's witness statement in the following terms:

> "When officers with any health issues of significance, both physical and psychological, were being considered for early retirement on medical grounds the need for ongoing support was always considered and general practitioners contacted as appropriate."

It is difficult to reach any clear conclusion as to the extent to which, if at all, such additional steps might have resulted in the plaintiff receiving earlier treatment after his discharge. He maintains that he continually requested his GP to seek referral to a psychiatrist but that nothing ever came of such requests prior to the appointment with Dr McMahon in May 2005 apart from the appointment arranged in 1998 which was missed because the claimant alleged late delivery of the appointment letter. Whether the difficulties in obtaining a referral of the plaintiff to a psychiatrist in the supervening years is to be laid at the door of the claimant's GP or whether the plaintiff himself has been somewhat less assiduous about pressing the GP than his evidence would suggest, it is difficult to see how the failure to secure such an appointment can be attributed to the OHU. Even if Dr Brown had drawn up a framework of recommended treatment which would have suggested that the plaintiff should be kept under review by his GP so that any recurrence of symptoms subsequent to a period of remission after discharge could be effectively monitored it is unlikely that there would have been any significant change to the actual sequence of events. In addition, I note that, at all material times, Dr Brown was an independent contractor employed by the NHS providing his services to the OHU on a sessional basis.

Training/Education

[20] I have held that all members of the force should have received training in accordance with the recommendations of the CHMF by 1988 but, once again it is important to consider in what respects the failure to do so might have affected the circumstances of this particular plaintiff. I do not consider that he commenced to suffer from depression and PTSD until 1994. He was not subjected to any traumatic incidents after 1985 and he was aware of the OHU and the facility to self refer from its inception. He also agreed that he was aware of Force Order 14/88 and its application to stress resulting from exposure to trauma. As a result of his sergeant's course, at the latest, he was aware that he could obtain advice on stress from the OHU. Notwithstanding all of this he did not attend OHU until advised to do so by his GP in 1996. In the circumstance I am not persuaded that he would have done so earlier had the failures identified in the generic findings not occurred.

[21] Accordingly this plaintiff's case will be dismissed and there will be judgement for the defendant.