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Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered: **03/07/2007**

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

BETWEEN:

CHARLES WAYNE McCLURG AND OTHERS

Plaintiffs;

-and-

CHIEF CONSTABLE OF THE ROYAL ULSTER CONSTABULARY

Defendant.

LEAD CASE OF MR A

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COGHLIN J

[1] After leaving school and completing an apprenticeship this plaintiff joined the RUC on 13 June 1982 and, upon completion of his basic training in November, he was posted to Greencastle where he performed beat and patrol duties for approximately 2½ years. Following a Force Order inviting applications the plaintiff applied to join a specialist unit and, after completing an extremely rigorous assessment and selection procedure, his application was successful and he joined the unit on 15 April 1985. Of the 28 or 29 original applicants, the plaintiff was the only one to be accepted into this unit the principal concern of which was specialised anti-terrorist surveillance. The plaintiff has since remained an extremely successful and well regarded member of that unit and, prior to giving evidence, he had been an acting sergeant for a number of years. By now may well have been formally

promoted. He has been commended and highly commended upon no less than 11 occasions during the course of his police career and I am satisfied that he has proved himself to be an officer of the highest quality.

[2] While serving in uniform at Greencastle Constable Lindsay McCormick, to whom the plaintiff had been seconded for approximately 2-3 weeks, was murdered whilst supervising children crossing the road in the Whitewell area. The plaintiff himself was targeted upon one occasion and, upon another occasion, a car bomb exploded after he had walked about 100 yards past the vehicle. During his service with the specialist unit the plaintiff was involved in many potentially dangerous incidents but he told Professor Fahy that he felt confident and in control and that he obtained relief after anxiety-provoking incidents by discussing his experiences with colleagues over a drink Apart from the normal grieving reaction subsequent to the murder of Constable McCormick, the plaintiff did not suffer any psychological ill-effects until March 1993.

[3] On 16 March 1993, whilst on surveillance duties, the plaintiff was caught by a number of men and subjected to a savage assault in the course of which his nose was broken and a hammer was used to fracture his skull. The assailants discovered that he had a weapon and an attempt was made to murder him but, fortunately, his gun failed to discharge because of a broken firing pin. Eventually, the plaintiff was rescued when a number of his colleagues arrived in a vehicle and his attackers fled. The plaintiff was taken directly to the City Hospital where he remained overnight, discharging himself the following day because of security concerns.

[4] The plaintiff was absent from work from 16 March to 15 August 1993. In evidence, he explained how he had begun to be subject to anxiety/panic attacks in which he suffered palpitations and shortness of breath. These attacks lasted for approximately half an hour to forty five minutes and were associated with recollections of the assault. His sleep was disturbed and he started to suffer nightmares linked to the attack. The plaintiff also found himself becoming much more emotional than he had been prior to the assault and he was prone to crying when watching sad or violent films. He also re-developed a marked stammer from which he had last suffered at age 11.

[5] The plaintiff's case was that the assault of 16 March 1993 produced a clinically significant post-traumatic reaction which fulfilled the diagnostic criteria for PTSD. While both experts agreed that this condition was not short-lived, despite early reports of improvement, they differed as to the duration, with Professor Fahy estimating that PTSD was present for 12-18 months followed by mild residual symptoms and Dr Turner considering that a longer reaction had occurred together with a major depressive disorder. They agreed that the post-traumatic reaction improved to the extent that the plaintiff was able to resume a demanding job without substantial impairment

and that its current residual symptoms are at the borderline of clinical significance possibly representing a very mild PTSD or mild Adjustment Disorder.

[6] Dr Turner and Professor Fahy referred to differences in the accounts given by the plaintiff at various times and both emphasised the fact that they were reliant upon the plaintiff's account as there was no substantial corroborating information. There is no doubt that there were many inconsistencies in the plaintiff's evidence and in his original witness statement he admitted that he suffered from poor memory to the extent that he had developed a habit of making notes in order to assist his recollection. When completing the questionnaire for his solicitors in the early stages of the litigation the plaintiff had responded to an enquiry as to whether he had ever been seen or treated by the OHU by stating that a male nurse had called at his home on only one occasion subsequent to the assault. After seeing the notes and records relating to Mr McCloskey's attendances both at his home and by telephone, the plaintiff accepted that this was not accurate. In his original statement of evidence the plaintiff described in detail how he had immediately gone to the scene of the murder of Constable McCormick in March 1983 and seen the dead body. In evidence he described how he had been close to the area taking a statement and that when he arrived at the relevant school he saw that the constable had been shot in the head. He said that he had felt extremely shocked and sad. When he was asked in cross-examination about his report to Professor Fahy that he had not witnessed the aftermath of the shooting he conceded that he might not have been at the scene although he had a vivid image in his mind of what must have happened. He accepted that with the passage of time his memory of the interventions from both his GP and the OHU was impaired and that he had understated the input of both the OHU and his own GP. He was unable to recall going to see Dr Lyons, consultant psychiatrist, in connection with his criminal injury claim.

[7] In the circumstances it seems to me that it would be unwise to rely upon the evidence of Mr A without some degree of support or corroboration. Mr A's wife was called and I felt that she gave her evidence with dignity and composure. She described how, after taking a few days off in order to be with her husband, she had resumed employment and, after some time, she had received a telephone call from him in which he said that he was not well, that he was not coping and that he needed someone to be with him. This was in sharp contrast to the independent and self-reliant outlook upon life previously held by her husband. She said that while his physical fitness recovered he did not appear to be the confident person that she had previously known, that his sleep patterns tended to become erratic and his mood morose. She explained how her husband had thrown himself enthusiastically into his work, not sparing himself and working very long hours. During the first year or two after his return to work she described his

mood as changeable with some days when it was good and other days when it was bad. She described their domestic situation as being "… like living with someone with a black cloud over their head just with his head down and not wanting to talk, not wanting to speak to you and if he did want to speak to you it was to say something that wasn't nice." At such times she said that he was nasty in a way that he had never previously been nasty during their married life. Mrs A explained how she had attempted to talk to her husband about this change of mood but he refused to enter into such discussions saying that she did not know what she was talking about. She fully accepted that her husband's performance at work was "brilliant" but, again, to use her own words she observed:

> "… Everybody thinks here's this great guy, he is doing all these brilliant things, couldn't work with a better guy, but it wasn't the same guy who came home to me."

She described the lowest point in their relationship as being subsequent to the birth of their second son when her husband was so depressed that he would regularly sit on the floor at the foot of the bed at night uncontrollably weeping. She recalled an occasion when her husband confessed to her that he was in such despair that he had gone out one night and seriously thought about killing himself to the extent of placing his gun in his mouth. At this point Mrs A recounted how she had told her husband that if he felt so bad he should leave the family for a period and do whatever he needed to do in order to deal with his problems. She said that she told him that if he came back it would be brilliant but if he didn't come back at least he wouldn't be dead and the only condition she imposed was that, from time to time, he let his family know how he was. That was a powerful piece of evidence from an impressive witness.

[8] Around about the same time as this conversation it seems that the plaintiff's sergeant telephoned the plaintiff at home but, since he was absent, spoke to Mrs A. When he asked how the plaintiff was Mrs A told him about the plaintiff's suicidal thoughts and how difficult she found it to communicate with the plaintiff. It seems that the sergeant said that he had noticed a change in the plaintiff but hadn't realised that matters were so bad. This conversation lasted for approximately half an hour and both the sergeant and Mrs A agreed that they would keep the plaintiff under observation. With some hesitation, because of his strong preference for privacy, Mrs A subsequently drew this telephone conversation to the attention of the plaintiff but he reacted in a more positive way than she had anticipated.

[9] Mrs A believes that the emotional discussion with the plaintiff in which she encouraged him to go away to sort out his problems together with the telephone conversation from the sergeant helped to bring home to the

plaintiff how serious his situation had become and that very slowly he began to be more amenable to discussing the difficulties that he faced. Mrs A was asked whether she had raised with her husband the suggestion that he should seek help from a psychiatrist. She replied that during the time when his mood had deteriorated so badly that the "rows were horrendous" she was afraid to raise such a possibility although she had discussed treatment with him over the last few years and, particularly, after he had attended the expert medical witnesses in this litigation. She agreed that she had been shocked and horrified by her husband's confession that he had contemplated suicide but in response to the suggestion that, at that time, it must have been clear that he would have benefited from some professional medical assistance she replied:

> "It was clear and it wasn't clear. I have to be honest and say I did not know what to do. I didn't know, I wanted to run away. I wanted to run away from it really and leave it and think gosh let this be somebody else's life, let this not be my life."

[10] In the course of his own evidence the plaintiff estimated that he was at his lowest point, associated with the thoughts of suicide, upwards of a year subsequent to his return to work and such an estimate would have been consistent with his account to Professor Fahy. However, I think that it is likely that his wife's timing is probably more accurate, taking into account the nature of the condition from which he was suffering, his self-confessed memory difficulties and her ability to fix events in relation to the birth of her children.

The OHU

[11] This plaintiff makes the case that he was not properly assessed or treated by the OHU following the assault in March 1993. The plaintiff's criticisms of the way he was treated may be found at a number of locations. When completing the original questionnaire for his solicitors in response to the question seeking details of any treatment that he had received the plaintiff said:

> "After the incident a male nurse called at my home on one occasion only."

In the statement prepared for the purpose of the litigation the plaintiff confirmed that he had been contacted on 18 March 1993 but, according to the plaintiff, Joe McCloskey did not have much to say apart from the fact that it was often up to him to recommend that police officers had their personal firearms taken from them. He said that Mr McCloskey advised him that they way he was feeling was very normal for what he had been through and he

reviewed him on a number of occasions. The plaintiff felt that Mr McCloskey seemed to care about how he was feeling but that he did not delve into the trauma and the reasons behind his psychological symptoms. The plaintiff told Dr Turner that the male nurse "did not help". In evidence, while he was prepared to accept that Mr McCloskey had tried his "damndest" to help him, the plaintiff maintained that there had not been much discussion regarding his emotional symptoms other than Mr McCloskey observing that what he was suffering was "normal from getting a beating" and he repeated that Mr McCloskey did not delve any deeper. According to the plaintiff, he was somewhat surprised when Mr McCloskey told him that one of his duties, from time to time, was to recommend to the authorities whether an officer should have his personal firearm removed. The plaintiff also expressed the view that, perhaps through ignorance, Mr McCloskey thought that he had merely been suffering from shock as a consequence of the beating.

[12] Having considered the detailed OHU notes compiled by Mr McCloskey and listened to his evidence, I reject the plaintiff's criticisms. After reading the Duty Officer's Report Mr McCloskey made telephone contact with the plaintiff on 18 March 1993, two days after the assault, and arranged to carry out a home visit on 22 March. The home visit, which lasted for approximately an hour, clearly covered the circumstances of the assault and the plaintiff's subsequent symptoms. The plaintiff received detailed advice including to keep in contact with his GP and report any symptoms associated with his head injury and Mr McCloskey provided him with literature relating to, amongst other things, coping mechanisms and stress. The record of Mr McCloskey's telephone conversation with the plaintiff on 6 April 1993 shows that he enquired about his symptoms and that the plaintiff confirmed that he was not experiencing flashbacks or nightmares at that time. He also told Mr McCloskey that he had not taken up his suggestion to go to the GP and enquire about night sedation. During the course of that telephone conversation Mr McCloskey suggested that the plaintiff might benefit from having a chat with a psychologist or psychiatrist but recorded that the plaintiff wanted things left as they were at that time. After two further attempts to follow up by telephone which were unsuccessful, a further home visit took place with Mr McCloskey on 14 May 1993 when he noted that the plaintiff was still experiencing "many post traumatic stress symptoms" although there was some improvement. Mr McCloskey completed a post traumatic stress questionnaire at this time. Once again Mr McCloskey advised the benefit of arranging an appointment with the OHU psychologist and the plaintiff told him that his GP had made a similar suggestion during his last visit. Mr McCloskey noted that the plaintiff had an appointment with Dr Lyons, consultant psychiatrist which would have related to the plaintiff's criminal injury claim. On 16 June 1993 Mr McCloskey telephoned the plaintiff who informed him that he was making a slow recovery and hoped to resume duty in August. On 18 June 1993 a home visit had to be cancelled because the plaintiff was not in residence and on 22 June the plaintiff rang to

apologise for his inability to keep that appointment. During that telephone conversation the plaintiff said he was feeling fairly well and that he would contact the OHU if there were any problems in the future. ON 16 August 1993 the plaintiff telephoned Mr McCloskey to confirm that he had resumed duty and to thank the OHU for their help. Mr McCluskey noted that a further review could be arranged at the plaintiff's request.

[13] The plaintiff was also critical of Dr Poole, consultant clinical psychologist, whom he saw at the OHU on 27 May 1993 as a consequence of referral by Mr McCloskey. In his original witness statement the plaintiff recorded that:

> "I suppose I knew that as a psychologist he could have been someone who gave me treatment. However my thoughts were that the main reason I was going to see Dr Poole was to make sure that I was fit to be a policeman and to carry a gun. I felt that this was a test to be passed and if I didn't I could be out of a job."

I note that the plaintiff would have had no reason whatever to think that this was the main reason for his appointment as a result of his interviews with Mr McCloskey who had made it quite clear that the referral was for the purposes of assessment/treatment of his emotional symptoms. In his statement the plaintiff recorded how Dr Poole had asked him whether he felt the need for revenge upon his assailants and looked "relieved" when he said that he had not. According to the plaintiff, Dr Poole then closed the meeting which would have been about 10 minutes in length. He recorded that he left the office with "a bad taste in my mouth" feeling that Dr Poole's attitude was essentially "that's fine, off you go". He received the impression that Dr Poole was not interested in his psychological symptoms. In his evidence to the court the plaintiff said that within seconds of Dr Poole's opening remarks suggesting that he might want revenge he had made up his mind that his function was "to make sure that I was sane". The plaintiff told Dr Turner and Professor Fahy that his appointment with Dr Poole had the appearance of "a rubber stamp exercise". He also told Professor Fahy that there had been no encouragement for him to disclose his feelings and that he might have opened up if the right approach had been adopted.

[14] Again, I reject the plaintiff's version of his interview with Dr Poole. I am satisfied that the interview lasted significantly longer than 10 minutes. That was confirmed by Dr Poole in evidence and supported by his notes. I am satisfied that Dr Poole took a history from the plaintiff and checked that it was consistent with the history taken by Mr McCloskey. I also accept that, during the interview, there was a discussion about exploring the plaintiff's responses to his symptoms of stress and methods of coping. Such methods

may well have included the possibility of relevant forms of psychotherapy. I am persuaded by the quality of the evidence of Mr McCloskey and Dr Poole, as supported by the notes, that their versions of the evidence are more likely to be correct given the plaintiff's conceded difficulties with memory. In addition, I am satisfied that the plaintiff approached his contacts with the OHU on the basis of a number of negative assumptions no doubt fuelled by the culture of the unit of which he was a member. Both Mr McCloskey and Dr Poole admitted that they were aware of such a culture and the self-perception of officers in the unit that they were "an elite – the best of the best". The plaintiff explained his approach to the OHU in the following terms:

> "I never thought for one moment that they could have offered help, but on the other hand even if they had made that apparent to me there was this other feeling in my head at the time that not for one moment would I be going near anybody to get any help, this is me, Mr A, and you know, this is my life; I built it this way and that's it."

[15 However, I do have two concerns about the plaintiff's interview with Dr Poole which are:

(*i*) Mr McCloskey had completed a post-trauma questionnaire in the course of his interviews with the plaintiff which provided a useful analysis of relevant symptoms and progress between his two home visits on 22 March and 14 May 1993. It appears that Dr Poole did not refer to that document and, in evidence, he said that he rarely did so in the early stages because he liked to approach his initial contact with an open mind and obtain his own assessment of the individual. He confirmed that, for him, the questionnaire was not an important clinical tool. While appreciating the need to form an independent clinical assessment, I had some difficulty in understanding why such a document as the questionnaire would not have been likely to prove helpful in either reaching the assessment or acting as an additional source of information against which the accuracy of such an assessment might be checked.

(*ii*) It is clear from Dr Poole's note that he felt that the plaintiff should have been reviewed in a further month. However, no arrangement was made to ensure that such a review took place. The suggestion was made that the plaintiff may not have had his diary available but no note was made to that effect and, even if that had been case, it seems to me that further steps should have been taken to ensure that an appointment was made. Dr Poole also said that, following this initial consultation, he would probably have spoken to Mr McCloskey who would have kept him informed of Mr A's progress. Again, no note was made to record such a contact between Dr Poole and Mr

McCloskey nor was Mr McCloskey asked about such a possibility in evidence. Whatever may have been the plaintiff's attitude, Dr Poole clearly felt that he warranted a further appointment and, in my view, the omission to ensure that the plaintiff was furnished with a date and time for a further appointment represented a failure in the system. In cross-examination Dr Poole fairly conceded that, with hindsight, that was the case. He was prepared to accept that more should have been done and that, perhaps, he could have been more vigorous in pursuing the plaintiff.

[16] However, it is difficult to conclude that the failure to ensure that a review appointment was made for the plaintiff had any significant effect upon any treatment that he might have received from the OHU. It seems clear that, for whatever reason, the plaintiff formed an adverse view of Dr Poole. Indeed, the plaintiff told Professor Fahy that if he had been offered a follow-up appointment with Dr Poole he would not have gone back. He certainly does not appear to have raised any possibility of a further appointment with Dr Poole during his subsequent contact with Joe McCl0skey. The plaintiff emphasised in evidence that he was keen to get back to work and equally keen not to discuss matters with Mr McCloskey. He said:

> "Whenever he (Mr McCloskey) did phone the last thought was it was paramount in my mind not to really to discuss anything with him, I didn't want him to know how I felt. I suppose, to put it bluntly, I didn't want to tell him any of my business."

In short, the plaintiff said, mentally, I really wanted Mr McCloskey "off my back". In such circumstances, however disillusioned he may have been with his interview with Dr Poole, it appears that the plaintiff became quite determined not to make any further disclosures about post traumatic symptoms to the OHU or, for that matter, to his own GP. Such an attitude would have been perfectly consistent with his assertion to his GP, when he attended in November 1998, that anxiety was not a cause for his complaint of palpitations and for his statement to Dr McFarland, consultant physician, in January 1999 that he was not aware of any undue stress or strain through his work that might explain his history of indigestion, despite the fact that both these attendances would have occurred during the period at which his wife described the plaintiff as being emotionally at his lowest point. As a consequence of seeing the various medical experts retained in relation to the litigation from at least 2001/2002 the plaintiff has had a diagnosis and recommendation that he would benefit from pharmacological and psychological treatment but has chosen not to undergo either. Indeed, when giving evidence he volunteered the information that, at the conclusion of one consultation, the expert recommended treatment but he gave the specialist "some reasons" why he was not prepared to accept treatment. To date, it

seems the furthest he has been prepared to commit himself was sometime around 1994-1996 when he carried out some research on the internet and made a self-diagnosis of PTSD. So far as his superiors and fellow officers were concerned, the plaintiff's evidence was that, after a relatively short period when he might have been over enthusiastic, he has been performing his job in a very professional manner during the past thirteen years. It is common case that, since the assault, he has been a highly valued member of a highly specialised team as confirmed by his regular appraisals. The only possible exception was the sergeant who telephoned his wife but it appears that, after further monitoring of the plaintiff, he reached the view that his performance at work did not warrant any further intervention.

Culture

[17] It seems likely that the culture of the specialised unit in which the plaintiff has spent the vast majority of his career was even more macho than that of the general force. However, such a culture did not prevent the plaintiff from giving a detailed account of post-traumatic symptoms to Joe McCloskey in the course of his OHU attendances nor did it prevent him from detailing his emotional symptoms to his GP and Dr Lyons in the course of his criminal injury claim. The plaintiff accepts that, since 2001, his authorities must have been aware of his inclusion in the group litigation and subsequently becoming a lead case involving the exchange of detailed medical reports. There was no evidence that such knowledge on the part of his authorities had any adverse impact upon the plaintiff's career to date.

Alcohol

[18] The plaintiff gave evidence of very heavy consumption of alcohol by his colleagues in his unit and described how an inspector had brought in several bottles of whiskey after the suicide of a colleague in a different section. He said that there was a considerable amount of drinking after the funeral of Constable McCormick. Joe McCloskey expressed the view that the plaintiff's unit would have coped with some of the situations in which they became involved by subsequently indulging in heavy drinking. However, it does not appear that this plaintiff was making any personal complaint about excessive drinking and while he referred to it in the course of giving his evidence as one of the ways in which the force dealt with traumatic incidents, it is perhaps not insignificant that his original statement of evidence contained no mention of excessive consumption of alcohol.

Training and education

[19] It seems to me that the most important generic issues in this case is whether the plaintiff's attitude to seeking treatment for any symptoms from which he suffered would have been different had he been afforded a greater

amount of training/education both in terms of detail and frequency. In relation to this topic the plaintiff's advisors referred in their closing submissions to the plaintiff's confusion at the feelings he was experiencing and his need to educate himself by reading and researching on the internet. They also referred to the need for officers to be trained that stress could be a problem, that there was help available, that it was not a weakness to admit to such symptoms and that the job was not at risk.

[20] Once again, it seems to me that the problem facing this plaintiff in relation to this issue is one of causation. As I have noted above there can be no real doubt but that the plaintiff was fully informed about post-traumatic stress, the problems it could cause and the availability of the OHU facilities as a consequence of his interviews with Joe McCloskey. In addition, in 1994 he received the stress awareness training which he originally estimated lasted approximately four hours but was probably shorter. He did not remember seeing the video but did recall being provided with leaflets. The relevant literature dealt in detail with the causes of stress, traumatic stress, signs of stress and coping mechanisms. While he could not specifically remember reading the leaflets that he was shown in cross-examination, the plaintiff did accept that had he seen them he would have been left in no doubt about the services provided by the OHU in relation to the symptoms of stress. The plaintiff also accepted that he must have told his solicitor to contact his GP about his symptoms of "nervous tension" and that the GP subsequently provided a report referring to anxiety symptoms, including palpitations, nightmares, poor sleeping and the plaintiff's attendance for speech therapy. He also agreed that the reason that his solicitor had sent him to see Dr Lyons was to obtain advice about the psychological consequences of the assault. Initially, the plaintiff attempted to say that the reason that he was prepared to give such information to his solicitor was that he "… wouldn't have any say on my health as such and wouldn't have any say as to whether I was capable of doing a job or not." However, since the subsequent medical reports were to be provided to the Northern Ireland Office and potentially made public it is difficult to see how this reason could have been sustained. In addition, as noted above, the plaintiff has still not been prepared to seek treatment despite being recommended to do so by a number of the expert witnesses by whom he has been examined for the purposes of this litigation. In such circumstances I am impelled to the conclusion that the plaintiff would not have sought treatment even if he had received the stress awareness training prior to the assault.

[18] It is difficult to reconcile the apparent lack of intervention on the part of the sergeant who took part in the telephone conversation with Mrs A with the defendant's reliance upon the system of "know your men." That officer seems to have noticed something himself but not to have even spoken to the plaintiff despite being advised of his difficulties and suicidal thoughts. It seems that the sergeant continued to monitor the plaintiff but saw no reason

for further intervention having regard to the satisfactory standard to which he performed his duties. Such an ability was recognised by the medical experts as not uncommon amongst sufferers from PTSD who, nevertheless, suffered impairment of function in their domestic life, a pattern present in some of the lead cases and the sergeant may have acted differently had he been given the benefit of appropriate training However, for the reasons set out above I am not presently persuaded that such an intervention would have led the plaintiff to seek treatment.

[19] Accordingly, this claim must be dismissed and there will be judgement for the defendant.