Neutral Citation No. [2009] NIQB 85 | *Ref:* **COG7647**

Judgment: approved by the Court for handing down | *Delivered:* **28/10/09**
*(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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BETWEEN:

BC

Plaintiff;

-and-

SEAN DEGNAN

First Defendant;

ROYAL MAIL GROUP PLC

Second Defendant.

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COGHLIN LJ

[1] The plaintiff in this case claims damages for personal injuries loss and damage sustained by him as a result of a road traffic accident alleged to have been caused by negligence of the defendants on 13 January 2005 at the Larne to Belfast dual carriageway. Mr McNulty QC and Mr Sean Smith appeared on behalf of the plaintiff while the defendants were represented by Mr Kevin Rooney. I am grateful to both sets of counsel for their helpful submissions and the succinct and economic way in which they conducted the proceedings.

Background facts

[2] On the date of the accident the plaintiff, who was then some 49 years of age, was driving his motor vehicle along the Larne to Belfast road in the outside lane some distance behind two much larger vehicles that were travelling in convoy on the inner lane. The second of the two larger vehicles was driven by the first defendant and was the property of the second defendant. As the plaintiff approached in the overtaking lane the vehicle driven by the first named defendant suddenly pulled out into his path causing the plaintiff to attempt an emergency stop. It seems that the

defendant driver may have realised his error at the last minute and attempted to resume the inner lane. However, the plaintiff was unable to avoid driving into and colliding with the rear of the Royal Mail vehicle.

[3] A defence was delivered denying liability but, in the event, the defendants did not defend the liability issue before me and the matter proceeded solely with regard to the quantum of damages.

[4] The plaintiff alleged that, as a consequence of the collision, he sustained soft tissue and muscular injuries to his neck, thoraco-lumbar spine and both hands. It was further alleged that the injuries to his lumbar spine had rendered symptomatic and accelerated by two years pre-existing degenerative changes. The plaintiff also claimed that he had suffered from post-traumatic stress disorder, a mild depressive illness and erectile dysfunction.

[5] While the statement of claim included as particulars of special damage an allegation that the plaintiff had been unable to continue with a business that he had been setting up and that there had been an adverse effect on his ability to obtain employment in the future, the claim for financial loss was not pursued before me apart from a sum of £100 in respect of insurance excess.

Personal injuries

[6] The plaintiff himself gave evidence as did Dr O'Neill, Consultant Psychiatrist who was called upon his behalf. A number of reports were also submitted in evidence by agreement of counsel. These included several reports from Mr C T Andrews, Consultant Orthopaedic Surgeon, the report of a MRI scan, a report from Dr Pang, Consultant Neurophysiologist, two reports from Professor Dinsmore and a report from Dr Fleming, the Consultant Psychiatrist who advised the defendants. I also had the benefit of seeing notes and records and a report furnished by the plaintiff's GP, Dr Mitchell.

[7] As a result of his initial examination Mr Andrews had some difficulty in explaining the severity of the plaintiff's symptoms and, with the assistance of the MRI scan, he was able to confirm multiple levels of early degenerative change that had been present in the plaintiff's lumbar spine prior to the collision. Mr Andrews's opinion was that the trauma of the accident would have provoked the start of lumbar symptoms but that, beyond some 18 months, any pain and suffering would be related to the pre-existing degenerative changes as opposed to the road traffic accident in January 2005.

[8] Dr O'Neill first saw the plaintiff on 24 November 2005, ten months after the accident, when she recorded a history of intrusive images, nightmares, flashbacks, avoidance of driving, loss of confidence in driving

and hyper-vigilance. Her initial diagnosis was one of post-traumatic stress disorder (PTSD), the symptoms of which had lessened, together with a persistent mild depressive illness. She also noted a positive history of depressive illness in the plaintiff's family but recorded that he gave no history of alcohol or drug misuse. In contrast, when he next attended her in June 2008 the plaintiff asserted that he had been drinking heavily since January 2005. Dr O'Neill recorded reduction in frequency of the PTSD symptoms but felt that there was a persisting moderate depressive illness. She was subsequently provided with the plaintiff's GP notes and records which did not indicate any pre-accident history of psychiatric illness or misuse of alcohol. The first reference to depressive symptoms occurred on 21 March 2006 subsequent to the receipt by the GP of Dr O'Neill's first medico-legal report. The records indicated that on 17 July 2008 the plaintiff had been referred for treatment of alcohol abuse and when he attended the Community Addiction Team he gave a three year history of problem drinking following the accident in January 2005. Dr O'Neill noted that it was common for those suffering from PTSD and depression to use substance abuse as a coping mechanism. The plaintiff attended Dr Fleming on behalf of the defendants on 2 September 2008. He gave a similar history of the circumstances of the accident to that which he had recounted to Dr O'Neill emphasising how frightened he had become when he thought he was going to be decapitated by passing under the lorry. He also gave Dr Fleming a history of drinking heavily from some two months after the accident when his injuries were not getting any better and he was unable to maintain his previous high level of physical fitness. The plaintiff seems to have given a much more limited range of PTSD symptoms to Dr Fleming and the relevant complaints appear to have been limited to nightmares which had decreased over time. Dr Fleming formed the opinion that he was a man who had become extremely angry as a consequence of the high levels of physical disability and pain to which he had been subjected.

[9] The plaintiff seems to have told Professor Dinsmore that he had been seen by Mr Andrews and diagnosed by Dr O'Neill as suffering from PTSD but I am not sure of the extent of any other evidence that he considered. In particular the Professor did not refer to actually seeing the reports supplied by Dr O'Neill, Dr Fleming Mr Andrews of the GP notes and records.

Discussion

[10] Both the plaintiff and Dr O'Neill were subjected to searching cross-examination as to why, despite regular attendances, the GP records did not contain any reference to psychological symptomatology until 21 March 2006, subsequent to receipt of Dr O'Neill's medico-legal report, or to any problem drinking until his referral by the GP to the Community Addiction Service in July 2008. The plaintiff agreed that he had initially told Dr O'Neill that he did not have an alcohol problem and stated that he saw no reason to tell his GP

about his drinking as it was "none of his business". He admitted that he had eventually told his GP but emphasised that he was not prepared to attend the counselling recommended by the Community Addiction Team. He said that he had been very embarrassed about his erectile dysfunction and would not have contemplated complaining of that condition to Dr O'Neill because she was a woman.

[11] I listened carefully and observed the demeanour of the plaintiff during the course of giving evidence both direct and in cross-examination. He walks in a stiff and somewhat awkward fashion with the assistance of a stick and appears to be apprehensive about his back movements. I am satisfied that he is a man who took considerable pride in the level and extent of his physical fitness prior to the accident and that the subsequent impairment of his physical abilities has been the source of a significant degree of persistent anger and frustration. In my view the major problem has been residual pain, suffering and stiffness in his lumbar region. I consider that this continuing level of disability has significantly contributed to his depression and excessive drinking. I note that Dr O'Neill expressed the view that his abuse of alcohol is probably secondary to his difficulties in dealing with chronic pain, physical disability and low mood. He told Dr Fleming that he has been left with chronic pain in his back radiating into both legs which has stopped him from doing everything that he did before leaving him unable to train or hold down an HGV licence or continue his business venture. He said that the worst thing that he currently experiences is the inability to train and play football. Having said that, I did not form the impression that the plaintiff was an untruthful man and I am prepared to accept that it was his natural sense of privacy that inhibited the earlier communication with Dr O'Neill and his GP about his drinking and/or psychological symptoms.

[12] Against that background I approached the various aspects of the plaintiff's claim for damages on the following basis:

(i) I accept that, apart from the fall from his bicycle in August 2004, the plaintiff's back had been relatively pain free prior to the accident but that, since January 2005, he has had major problems with low back pain. However, there is objective evidence by way of an MRI scan that, despite the absence of symptoms, his back was the site of multiple levels of early degenerative change prior to the accident and Mr Andrews FRCS has expressed the clear view that beyond 18 months from January 2005 any pain suffered will be related to the pre-existing degenerative changes rather than the accident.

(*ii*) On the basis of the evidence of Dr O'Neil and Dr Fleming I am satisfied that the plaintiff did initially sustain some relatively mild symptoms of PTSD subsequent to the accident that have diminished over time. His main problem since then has been depression and abuse of alcohol. While it is not uncommon for depression to be co-morbid with PTSD, I do not consider that

to be likely in this case given the relatively limited and mild symptoms of the latter condition. In my view the persisting depression is much more likely to be secondary to the plaintiff's physical complaints.

(*iii*) I also accept that the plaintiff has sustained a degree of erectile dysfunction which I also consider is more likely to be primarily associated with the plaintiff's back problems, depression and alcohol intake than the relatively mild PTSD symptoms. For the reasons set out above, it is also difficult to assess the extent to which this condition can be associated with the original accident

[13] Standing back and doing my best to view the plaintiff as a whole in my view the appropriate figure for general damages is one £30,000 to which I will add the sum of £100 in respect of insurance excess.