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Judgment: approved by the Court for handing down | *Delivered:* **25/6//09**
*(subject to editorial corrections)**

IN HER MAJESTY'S COURT OF APPEAL IN NORTHERN IRELAND

ON APPEAL FROM THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEENS BENCH DIVISION

BETWEEN:

CHARLES WAYNE McCLURG AND OTHERS

Plaintiffs/Appellants;

-and-

CHIEF CONSTABLE OF THE ROYAL ULSTER CONSTABULARY

Defendant/Respondent.

LEAD CASE OF JAMES SPENCER BEGGS

Before Kerr LCJ, Girvan LJ and Sir Anthony Campbell

KERR LCJ

Introduction

[1] This appellant joined the RUC on 26 May 1975 at the age of twenty-two. He served in various places and in a number of different capacities until his medical discharge from the force on 11 December 1997. His service record was reviewed by Coghlin J in paragraph 2 of his judgment. His exposure to traumatic incidents is discussed in paragraph 3. The appellant had attended the scene of many atrocities and was present at a number of post mortem examinations of persons killed or who died by their own hand. To witness the aftermath of some of the incidents involved must have been truly shocking and stressful.

[2] The traumatic incidents covered the period from 1978 until May 1985. During an eighteen month period in 1983/1984, when he was stationed in Newry no fewer than twenty-three police officers in the Newry area died, either as a result of terrorist murder or by suicide. The appellant knew some of these officers quite well.

Relevant medical history

[3] One of the first traumatic incidents in which the appellant had been involved was the suicide of a young boy of 12. The child had shot himself and the appellant was required by a superior officer to clean the room where the suicide had occurred. This happened in 1979. After that, the appellant claimed that he began to suffer from sleeplessness, a feeling of helplessness, loneliness and a general sense of depression. On 14 October 1980, when he was carrying out mobile support unit duties in an armoured land rover close to the border, a 500 lb landmine was detonated causing the vehicle to be lifted into the air. The appellant gave evidence that after this incident, he started to have nightmares and that these had persisted from that time onwards. He described the nightmares as disturbing and continuous. He also claimed that he had experienced panic attacks and tongue biting throughout the 1980s and suffered from a diminution in his sense of smell.

[4] Coghlin J gave little credence to these complaints and he was right to be highly sceptical of them. The appellant had made an application for criminal injury compensation in relation to the landrover incident and no claim was made that he had suffered psychiatric or psychological sequelae. When asked about this, the appellant gave an account of an interview with a psychiatrist engaged by his solicitor. The account was in the words of the appellant himself "quite extraordinary and quite bizarre". It was also patently incredible and the judge rightly rejected it. The judge was also right to conclude that once any acute symptoms had settled, he did not continue to suffer from any significant degree of psychiatric symptom as a result of the landrover incident.

[5] The first record in the appellant's general medical practitioner's notes of his having attended with psychological symptoms is on 11 March 1994. Earlier that month the appellant had attended complaining of an interference with his sense of smell. On 11 March the appellant told his GP that symptoms had begun about two months previously. The doctor recorded that anxiety was a definite factor and he referred the appellant to Dr Lyttle, a consultant neurologist. When he was seen by Dr Lyttle some two months later, the appellant complained of pains in his arms, excessive tiredness, unsettled sleep, an illusion of smelling burning chimneys and tongue biting while asleep some two months ago. Dr Lyttle concluded that his symptoms were stress-related and noted that he had responded well to Prozac.

[6] Mr Beggs next consulted his general practitioner in relation to psychological symptoms in September 1996 when he gave a history of having had a "mild blackout" while driving. The GP advised him to attend OHU and there followed a series of consultations between October 1996 and May 1997. During this time, he was seen a number of times by Dr Browne, consultant psychiatrist in the NHS, who was providing sessional assistance to OHU. The judge dealt with these consultations in a separate section of his judgment and we will return to consider them in greater detail below.

[7] For the purposes of this litigation, the appellant was interviewed by Dr Peter Higson, a consultant psychologist who had been engaged by his solicitors. He told Dr Higson 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 distressing psychological symptoms. Dr Higson recorded that the appellant had been prescribed Prozac for stress by his GP and that he had begun to identify symptoms in himself after attending stress lectures by the OHU.

[8] When he saw Dr Pilkington at PRRT in September 2004 the appellant dated the onset of his problems as his attendance with his GP in 1992. He said that he was then suffering sleep problems and stress because he was working 16 hours a day. He gave a similar history about the onset of major difficulties to Mrs Mackle-Lynch a psycho-analytic psychotherapist. He also told Professor Fahy during interview on 19 April 2005 that he had begun to develop psychological symptoms in the early 1990s.

The joint statement of the experts

[9] A joint statement was provided by Dr Turner (on behalf of the appellant) and Professor Fahy (on behalf of the respondent). The experts stated that they had obtained differing accounts of the chronology of symptoms from the appellant. The areas of disagreement and agreement can be summarised as follows:-

Difference in history

(1) Dr Turner recorded symptoms of adjustment disorder from the late 1970s, a temporary exacerbation of symptoms in 1980 and a relatively mild PTSD from 1985 onwards. (In the course of his evidence Dr Turner said that he recalled receiving from the appellant a history of nightmares and flashbacks from which he had suffered since 1985. The trial judge found this aspect of Dr Turner's evidence unconvincing);

(2) Professor Fahy accepted that the appellant might have suffered from some episodic symptoms subsequent to the traumatic events that he had described but he did not obtain an account of PTSD prior to the 1990s.

Agreement in opinion

(1) Both experts recorded a significant deterioration in symptoms in the early to mid 1990s that was supported by the medical records;

(2) They agreed that the appellant 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 appellant's history of symptoms especially in the absence of objective corroboration.

The judge's findings on the medical evidence and records

[10] The judge made the following findings on the medical evidence and records: -

- Since approximately 1994, apart from a relatively brief period of remission following his discharge from the police force, the appellant had continued to suffer from some degree of depression and PTSD;

- Although Mr Beggs may well have experienced acute symptoms for a relatively transient period in the immediate aftermath of some of the horrific incidents to which he was exposed before 1994, it was unlikely that his symptoms were either as chronic or as intense as he had claimed and he was able to cope with those symptoms, albeit with the assistance of alcohol from time to time;

- A major factor in the appellant's current difficulties was the extended responsibility that he had to shoulder after his promotion to sergeant in Pomeroy in 1993. That promotion and the anxiety and depression that it generated seemed to have either revived or significantly exacerbated PTSD symptoms which were related to his exposure to the earlier traumatic incidents.

The appellant's contact with OHU

[11] The appellant gave evidence that he went to OHU with the expectation that they were going to make him better. He claimed that it became clear to him that their aim was simply to get rid of him on medical discharge and that he felt bitter about that. He maintained that he had only agreed to medical retirement because he was assured that leaving the police force would make him better. It did not make him better. Mr Beggs also complained that OHU did not complete the appropriate follow ups with his GP following his medical retirement. He remained extremely bitter and resentful about the way that he was treated by the OHU and by Dr Browne in particular.

[12] The judge found that the appellant's evidence about his treatment by the OHU was probably distorted and needed to be approached with a degree of caution. He was satisfied that the decision to medically retire the appellant was reached after a significant period of consideration and discussion. Coghlin J also made the following specific findings:-

- It was necessary to bear in mind that, at the time of the appellant's medical discharge, PRRT had not yet come into being; consequently, once the discharge had taken effect the treatment responsibility of the OHU also came to an end;

- There could have been a good deal more discussion with the appellant 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 Browne and the completion of his medical discharge.

- 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 where he said: -

> "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 was difficult to reach any clear conclusion as to the extent to which, if at all, such additional steps would have resulted in the appellant receiving earlier treatment after his discharge. He had maintained that he continuously asked his GP to seek referral to a psychiatrist but that nothing ever came of those requests before his appointment with Dr McMahon in May 2005; it was therefore difficult to see how the failure to secure such an appointment could be attributed to the OHU. Even if Dr Browne had drawn up a framework of recommended treatment suggesting that the appellant 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.

- At all material times, Dr Browne was an independent contractor employed by the NHS providing his services to the OHU on a sessional basis.

Training/Education

[13] The judge found that the appellant would not have attended OHU earlier than he did (after he was advised to do so by his GP in 1996) even if training had been given in 1988/1989, as recommended by CHMF. He expressed the following reasons for that conclusion:-

- The appellant did not begin to suffer from depression and PTSD until 1994;

- He was not subjected to any traumatic incidents after 1985;

- He was aware of OHU and the opportunity to self refer from its inception;

- He was aware of Force Order 14/88 and its application to stress resulting from exposure to trauma.

- By the time that he had taken his sergeant's course, if not before, he was aware that he could obtain advice on stress from OHU.

The issues on appeal

[14] For the appellant it was argued that the judge was wrong to reject the opinion that he had suffered from PTSD in the 1980's and that he had failed properly to consider whether Mr Beggs was suffering from any other condition. In advancing this case, the appellant relied on what the judge had said in the following passage from paragraph 11 of his judgment: -

> "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."

[15] It was submitted that the conclusion that the appellant did not suffer from PTSD earlier than 1994 could not be reconciled with the finding that he had suffered acute symptoms which did not fully subside. Nor could it be

reconciled with the evidence of the appellant's wife to the effect that well before 1994 he suffered from symptoms highly indicative of PTSD. Moreover, the history given to Ms Mackle-Lynch was entirely consistent with the appellant having suffered from that condition long before that date.

[16] Even if the diagnosis of PTSD before the 1990's could be legitimately rejected, the judge should have considered the possibility of some other condition such as an adjustment disorder, the appellant argued. If, as he should have done, the judge had concluded that the appellant was suffering from a condition that would have responded to treatment, he ought to have found that the deficiencies in training and education provided a basis for liability in his case.

[17] Finally, the appellant claimed that the judge should have found that Dr Browne had been negligent in failing to treat the appellant with Eye Movement Desensitisation and Reprocessing (EMDR) or Cognitive Behavioural Therapy (CBT). The judge had found that there was a duty to treat and that this was not delegable. On the authority of *McDermid v Nash Dredging* [1987] AC 906 the respondent was bound to ensure that this beneficial treatment was available to the appellant. Alternatively, the respondent was liable for Dr Browne's acts and omissions because he was engaged on the respondent's business at the time (*Lister v Hesley Hall* [2001] UKHL 22 and *Majrowski v Guys and St Thomas' Hospital* [2006] UKHL 34).

The conclusion that PTSD began in 1993/4

[18] The judge was not only entitled, in our view he was correct, to find that it had not been established that the appellant suffered from PTSD before 1993/4. On a number of occasions the appellant himself had said that the onset of his chronic symptoms was after his promotion to the rank of sergeant in 1993. The judge dealt with this in paragraph [8] of his judgment: -

> "[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."

[19] Apart from this, the experts had agreed that the appellant he has a tendency to be somewhat melodramatic and to exaggerate. The judge was bound to approach his claim to have suffered from PTSD with a great deal of reservation, especially as it was plainly inconsistent with significant contemporaneous evidence. Moreover, he had been given evidence by Professor Fahy which he clearly believed to be authoritative that the diagnosis of PTSD could only be confidently be made from 1993/4 onwards. As to Mrs Beggs' evidence, the judge had to measure her claims that her husband had suffered from symptoms suggestive of PTSD before the 1990's against her failure to challenge or correct Mr Beggs' specific history to Professor Fahy (given in her presence) that his chronic problems began after his promotion to sergeant.

Alternative diagnosis

[20] In as much as the appellant's argument on this point amounts to a claim that the judge did not consider whether, if he was not suffering from PTSD before 1993/4, the appellant might have had some other mental health problems, it is plainly wrong. The judge not only acknowledged that the appellant had acute symptoms on a transient basis, he reached a view as to their intensity and duration and he concluded that they were alleviated by the appellant's consumption of alcohol.

[21] Although he did not articulate it, the judge's conclusion that the appellant did not suffer from a treatable condition is clearly implicit in his judgment. This is an unremarkable conclusion, particularly in light of the absence of any claim for psychological injury in the appellant's application for criminal injury compensation. Since the appellant did not suffer from a treatable condition before 1993/4, the question of training before that time was not relevant and it is clear that he was by then fully appraised of the treatment available at OHU.

Dr Browne's treatment

[22] It is clear that at the time of the appellant's contact with Dr Browne, both EMDR and CBT were available and that Dr Browne was able to administer these. It would be unwise to assume, however, that because he chose not to do so that he was negligent. A range of clinical options was obviously available. The selection of a particular course of treatment – or the decision not to embark on a particular course of treatment – frequently calls for fine judgment and it is often not easy to recall with complete clarity why a particular clinical choice was made.

[23] In this case Dr Browne, confronted by an absence of reference in the notes of his consultations with the appellant of any reference to a consideration of various forms of treatment, was, unsurprisingly, unable to confidently recall that these had been discussed or the reasons for deciding not to proceed with them. It must be remembered, however, that this evidence was being given at the remove of some ten years since the consultations had taken place. An inability to recall discussions of this type and a failure to record them in contemporaneous notes must not be regarded as automatically indicative of the fact that such discussions did not take place. And it is to be noted that Dr Browne said in evidence that it would be his customary practice to do so.

[24] In any event, the judge found that it had not been established that, had a treatment plan been set up for the appellant, this would in fact have been implemented. Indeed, the evidence of the appellant himself suggested that this was unlikely. Furthermore, it does not appear to us that the evidence given on this subject comes near to establishing that the mooted treatments would *in fact* have been efficacious to effect an improvement in the appellant's condition. For these reasons, we are firmly of the view that the avowed deficiencies in the treatment of the appellant by Dr Browne cannot give rise to an actionable claim.

[25] In light of that conclusion, it is strictly speaking unnecessary to express a view on the impact, if any, of Dr Browne's status on the potential liability of the respondent. But, although we have found in the generic judgment that the respondent is not entitled to a blanket immunity from a duty to treat, we have made it clear that this does not mean that in every instance a duty to treat will be activated. Moreover, the duty to treat should not be regarded as necessarily connoting a duty to ensure that treatment is effective. Without deciding the point, we consider that there is much force in Mr Hanna's argument that the duty to treat, if it existed in this case, could not have extended beyond a duty to provide access to an apparently competent, professional and suitably qualified medical practitioner.

Conclusions

[26] None of the appellant's arguments has succeeded. His appeal is dismissed.