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Case No: TLQ/12/1328

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/02/2014

**Before :**

**MR JUSTICE GLOBE**

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**Between :**

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| **CERI LEIGH** | **Claimant** |
| **- and -** | |
| **LONDON AMBULANCE SERVICE NHS TRUST** | **Defendant** |

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**Mr Christopher Gibson QC and Miss Kerstin Boyd** (instructed by **Russell Cooke Solicitors**) for the **Claimant**
**Mr Matthew Jackson** (instructed by **Capsticks**) for the **Defendant**

Hearing dates: 3rd, 4th, 5th and 6th February 2014

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE GLOBE

**Mr Justice Globe :**

## INTRODUCTION

1. At about 19.00 on 17 November 2008, the claimant, Ceri Leigh, boarded a bus at Wimbledon station on her way home from work. As she went to sit down on a seat towards the back of the bus, she dislocated her right kneecap, found herself trapped between the seats and was unable to move. She experienced severe pain. Several well-meaning passengers went to her aid, held her down and called an ambulance. A number of calls were made during the next 50 minutes before an ambulance arrived, whereupon paramedics were able to provide pain relief and manipulate the dislocation back into place.

2. The first emergency call was made at 19.02. The defendant has admitted that there was a negligent delay in the attendance of an ambulance, which should have attended by 19.33 at the latest. No ambulance arrived until 19.50, which was a delay of 17 minutes. Breach of duty has been admitted in respect of the 17 minutes, which is about one third of the total period between the dislocation and the arrival of the paramedics.

3. The claimant suffered pain and suffering from the dislocation and consequential psychiatric and psychological damage arising from the incident. She claims damages for the psychiatric and psychological damage. It is agreed that, arising from the incident, she has suffered Post Traumatic Stress Disorder (PTSD). It is also agreed that, from a date that is in issue, the claimant has suffered dissociative seizures.

## THE ISSUES

4. Three issues require determination.

   i) The first issue is whether there is a causative link in law, if any, between the defendant's admitted negligence and the claimant's PTSD.

   ii) The second issue is whether there is a causative link in law, if any, between the defendant's admitted negligence and the claimant's dissociative seizures?

   iii) The third issue is the assessment of damages for any such causative link or links.

## THE LEGAL FRAMEWORK

5. There is no dispute as to the legal framework of the case. The parties agree it is a "cumulative cause" type case in respect of which there should be the application of the principles summarised by Lord Justice Waller in paragraph 46 of the Court of Appeal case of ***Bailey and The Ministry of Defence [2008] EWCA Civ 883.***

> ".....I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. **Hotson** exemplifies such a situation. If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent

cause was more than negligible, the 'but for' test is modified, and the claimant will succeed."

## FIRST ISSUE – CAUSATION OF PTSD

The cases of the claimant and the defendant

6. It is agreed that the PTSD is a consequence of the incident. However, the first issue relates to whether there is a causative link in law between the defendant's admitted negligence and the PTSD. More particularly, the issue relates to whether, on the balance of probabilities, the PTSD would have occurred as a result of everything that happened prior to 19.33 in any event; or, but for the negligent delay in the arrival of the ambulance, the PTSD probably would not have occurred; or, in the further alternative, it is a case where medical science cannot establish the probability that 'but for' the 17 minute delay the PTSD would not have happened, but it can be established that the contribution of the delay was more than negligible.

7. It is the claimant's case that the events on the bus during the whole 50 minutes caused the development of the PTSD, which was an indivisible consequence of the cumulative effect of the overall trauma. It is not possible by the application of medical science to ascertain the point at which it became inevitable that the claimant would develop PTSD. The 17 minutes after 19.33 was a material part of the overall trauma and as such it made a material contribution to the development of the PTSD. Particular reliance is placed on the evidence of the claimant and that of the consultant psychiatrist instructed on behalf of the claimant, Dr David Sumners.

8. It is the defendant's case that the balance of probabilities question can be answered in the defendant's favour, namely, that the PTSD would not have been avoided if the ambulance had arrived at 19.33. It would probably have been caused within about 15 minutes. The negligent delay of 17 minutes after 19.33 therefore had no part to play in its development. Alternatively, if the balance of probabilities question cannot be answered, the negligent 17 minute delay did not make any or any material contribution to the PTSD. Particular reliance is placed on the cross-examination of the claimant in relation to what actually happened on the bus, the audio recordings and transcripts of the telephone calls to the emergency services and the evidence of the consultant psychiatrist instructed on behalf of the defendant, Dr Richard Latcham.

The claimant's evidence

9. In the claimant's statement dated 24 April 2013, she states the dislocation caused her to become trapped between seats at the back of the bus. She could not sit or stand. She was screaming in agony for the whole of the 50 minutes she was waiting for the ambulance. It was all extremely traumatic. Passengers tried to help. They held her down to stop her moving. That increased her feelings of helplessness. That memory is one of her more terrifying and distressing recurring memories. Every additional minute added to the trauma of her experience. After what she believes was about a quarter of an hour, passengers told her an ambulance was on its way from St. Georges' Hospital, which she knew was nearby. That gave her hope that the ambulance would be with her quickly. However, the continued delay in the arrival of the ambulance created increased feelings of "utter despair". She felt trapped. She was shaking violently. She became unable to hold her mind together, remembers "no longer knowing who she was", "collapsed mentally and physically" onto a woman who was sitting beside her, went "into a freeze" and became "utterly overwhelmed and traumatised".

10. In cross-examination by Mr Jackson, various issues were covered and the accuracy of the claimant's account was challenged. In relation to this issue, two specific points were raised.

11. The first point was that the claimant was not told after a quarter of an hour that the ambulance was on its way from St. Georges' Hospital. In none of the emergency calls did the operator state the ambulance was on its way from St. Georges' Hospital; nor was any fixed time given for its arrival.

12. I have listened to the audio recordings and considered the transcripts. It is correct that none of the operators said the ambulance was on its way from St. Georges' Hospital and no specific time of arrival was stated. However, at 19.21 the operator did say that the ambulance was on its way and at 19.38 the caller did ask the question of whether the ambulance was coming from St. Georges' Hospital. The hospital was therefore in somebody's mind by 19.38. It was its first reference in a call. That does not mean it was its first reference on the bus. The claimant is uncertain whether it was the controller who said the ambulance was on its way from the hospital or it was just passengers who said it to reassure her. Irrespective of whether the information was correct, I accept the claimant's evidence and am satisfied she was given periodic assurances by somebody on the bus that the ambulance was on its way and before 19.33 there probably was a reference by somebody to the ambulance coming from St. Georges' Hospital. I am also satisfied the failure of the ambulance to arrive as speedily as it should have done in accordance with those assurances was a factor in increasing the level of trauma experienced by her.

13. The second point relates to the claimant's description of the increase in her despair as time passed. The expressions cited above in her statement are not expressions referred to in the notes of the treating clinicians, who include the psychiatrist, Dr Brain, who she saw in January 2010 and the psychologists, Mr Kitson, Dr Murray, Ms Newman and Dr Billings, who she saw periodically between May 2009 and October 2011. Mr Jackson submits that, if the claimant had really experienced these feelings, she would have reported them to the treating clinicians. Mr Jackson cross-examined the claimant on the basis that their absence in the notes suggests the events did not occur.

14. I have considered the clinical notes and the medical reports. There are no references in the notes that reproduce the citations. However, I do not accept that necessarily means the claimant did not experience such feelings. The records are littered with references to her feelings of claustrophobia, being held down, trapped and restrained and having feelings of fear, helplessness and horror. On 22.02.10, Dr Billings discussed a timeline so as to discuss the claimant's cognitions and emotions at the time of the trauma. The exercise led to the discovery of emotions of which the claimant had previously been unaware. On 23.02.10, in discussions with Dr Newman, the claimant was able to identify further feelings of which she had previously been unaware. From the totality of the evidence, I am satisfied that the claimant has had understandable trauma / recollection difficulties and/or difficulties of articulating to others precisely what occurred. The generality of what occurred is manifest from a full study of the notes. They may not include the expressions about which she was cross-examined. However, I am satisfied that the description in her statement, as confirmed in her evidence, is a fair and reasonable description of what actually happened.

The evidence of Dr Sumners

15. Dr Sumners confirmed what he had said in his reports and the joint experts' statement, namely, that the claimant's experience on the bus was indivisible. The injury did not occur at any fixed time. This was not an orthopaedic situation where the relevant stresses could be calculated so as to assess when a bone would have fractured. The PTSD did not occur on the bus. It was a disorder which developed as a consequence of one indivisible event on the bus, as to which it was the whole time that was relevant. There is no scientific method of splitting up the time to reach a conclusion as to how long would be needed to induce a PTSD condition.

16. Mr Jackson cross-examined Dr Sumners on the basis that the **Diagnostic and Statistical Manual – DSM IV** states that "the severity, duration and proximity of an individual's exposure to the traumatic event are the most powerful factors affecting the likelihood of developing this disorder." Dr Sumners agreed that "proximity" is irrelevant and the "severity of….. exposure" was constant throughout. In relation to the "duration of……exposure", Dr Sumners disagreed that it was possible to subdivide the total period into separate time periods. In his opinion, it was impossible to take any defined point within the period of exposure. It was the whole experience that is relevant and there is nothing in either **DSM-IV** or **DSM-V** (its successor published in mid 2013) that states how "duration" should be quantified. Different traumas may require different periods of time. The longer the trauma is experienced the more likely it will be that PTSD will be produced, but a cross-over point cannot be scientifically calculated.

The evidence of Dr Latcham

17. Dr Latcham confirmed in cross-examination what he had said in the joint statement that the claimant would not have suffered PTSD but for the incident on the bus; that the experience on the bus was traumatic from beginning to end; that the whole experience cumulatively caused PTSD; and that the 17 minute admitted delay was a material part of the whole experience, it being about one-third of the 50 minutes that the claimant was in distress. However, it was Dr Latcham's opinion that any part of the 50 minutes was a material part of the incident. That therefore included the first 15 minutes. He stated that **DSM-IV** refers to *"severity"* and *"duration"* as being two of the most important factors affecting the likelihood of developing PTSD. **DSM-V** refers to the severity of the trauma in terms of being *"the dose"* with the greater the magnitude of the trauma, the greater the likelihood of PTSD. Here, the claimant suffered a trauma that Dr Latcham categorised as "very nasty". The audio recordings demonstrate her very great distress with her screaming being audible during the calls timed at 19.02, 19.04, 19.21 and 19.38. During the call at 19.14, the caller described her *"as going absolutely berserk screaming on the bus"*. That description was about 15 minutes after the dislocation. She had therefore experienced significant distress for half an hour before the 17 minute negligent period commenced. Dr Latcham's opinion was that the probability was that the claimant would have gone on to suffer PTSD in any event even if the ambulance had arrived at the end of the non-negligent period of 17.33. In cross examination, Dr Latcham conceded that he could not produce any statistics, papers, studies or research work to support his opinion. He denied it was based on speculation. He said it was based on logic.

18. Mr Jackson developed Dr Latcham's logic in his cross-examination of Dr Sumners and in closing submissions. At 19.00, the chance of developing PTSD was 0%. By 19.50, the chance was 100%. If a doctor had been on the bus and the kneecap had been manipulated back into place immediately, the claimant would probably not have gone on to develop PTSD. If the ambulance had arrived at 19.49, the claimant would probably still have gone on to develop PTSD. These contrasting probabilities enable the block of time to be split into pieces. For every minute after 19.00, the chance that the claimant would go on to develop PTSD will have gone up. For every minute that might have been saved before 19.50, the chance will have gone down. **DSM-IV** confirms that the longer someone is exposed to a traumatic event, the greater the risk of developing PTSD. As a matter of logic and mathematics, there must have come a time when the claimant's chance of going on to develop PTSD crossed the 50% threshold and she went from being someone who probably would not, to being someone who probably would, develop PTSD. Each minute that passed was of equal causative potency. There was no chance at 19.00 and 100% chance at 19.50. Each minute, the percentage chance of going on to develop PTSD was therefore 2%. By 19.25 50% would have been reached, which was well before the time by which the ambulance should have arrived at 19.33. Further, there are three factors that strongly suggest the threshold of 50% was reached before 19.25. First, the claimant has a history of dissociative episodes going back to her childhood that probably made her more vulnerable to the traumatic effect of the incident. Secondly, her

own perception of the incident, although irrational, was that it was *"life threatening"* and she *"nearly died"*. Its severity was therefore as severe as it could have been. Thirdly, the orthopaedic evidence is that the dislocation was not a severe dislocation, yet the audio recordings demonstrate extreme persistent screaming and, in the call at 19.14, she was described as *"going absolutely berserk"*.

Discussion

19. I have considered the competing arguments.

20. An analysis of Dr Lacham's report of August 2013 shows his conclusion on this aspect of the case was that "Her symptoms of PTSD were caused by her own screaming and fear, the pain that she experienced and the sense of being trapped, which all obtained within the first quarter of an hour after the incident **(my emphasis)**." Dr Latcham had seen the contents of the claimant's statement. He cited extracts from it. One extract was as follows. "When the last phone call was made.....someone said 'she's gone into shock'.....I had a huge fight/flight reaction.....an overwhelming feeling of wanting to get away.....feeling trapped, my whole body jumping up and down....someone held me....it felt like I was completely trapped." The last call was 19.38. In cross-examination by Mr Gibson Q.C., Dr Latcham conceded that, by 19.38, the claimant had not had all the experiences she found so terrifying. His conclusion on this aspect of the case was plainly wrong. By the time of the joint statement in December 2013, Dr Latcham's conclusion had been modified from having suffered all of the experiences by 19.33 to having suffered trauma for a long time.

21. In my judgment, Dr Latcham's acknowledgement that the conclusion in his report was plainly wrong; that his conclusion in the joint statement was different to that of his report; that neither could be supported by any statistics, papers, studies or research work; and that his eventual conclusion is a legitimate product of logic not speculation requires the closest possible scrutiny. It requires even closer scrutiny given the unsatisfactory abandonment of part of his conclusion about the claimant's dissociative seizures, the details of which is explained below.

22. Mr Jackson has sought to support Dr Latcham's conclusion by applying the logic of mathematics to the circumstances. I find there to be a superficial attraction to the exercise. However, in my judgment, upon closer analysis, it is less attractive than at first sight it may seem.

23. In both **DSM-IV** and **DSM-V**, there are sections devoted to the prevalence of **PTSD**. Both refer to variations in prevalence rates across all sampled groups. **DSM-V** goes into the topic in more depth. It is a complex topic with many variable factors including age, cultural groups, development issues and other criteria that go far beyond simple mathematics. The severity of the trauma – *"the dose"* as referred to in **DSM-V** – is of obvious relevance, but neither **DSM-IV** nor **DSM-V** seek to categorise PTSD by reference to simple mathematics. Nowhere in either ***Diagnostic and Statistical Manual*** is there any attempt to predict or quantify how much exposure to any given trauma it would take to produce the development of PTSD. These are **Manuals** that include the word ***"statistical"*** in the title and yet no statistical analysis such as that referred to by Mr Jackson appears within them. It therefore comes as no surprise to me that Dr Latcham has been unable to refer to any statistics, papers, studies or research work to support his eventual conclusion.

24. Caution needs to be exercised about the three additional factors relied upon by Mr Jackson.

25. In relation to the first factor (**the claimant's vulnerability**), **DSM-IV** states that "....personality variables and pre-existing mental disorders may influence the development of PTSD." However, "This disorder can develop in individuals without any predisposing

conditions, particularly if the stressor is especially extreme." There are obvious variables associated with numerous factors as to whether and when PTSD will develop.

26. In relation to the second factor **(irrational perception of life-threatening incident)** the differential diagnosis in **DSM-IV** is that in PTSD the stressor must be of *"an extreme (ie life-threatening) nature."* **DSM-V** refers to the criteria being *"exposure to actual or threatened death, serious injury or sexual violence."* The claimant's "irrational fear" that the event was *"life threatening"* and she *"nearly died"* is therefore not an additional factor. It was the base-line for the diagnosis.

27. In relation to the third factor (**going *"absolutely berserk at 19.14"***), the comment by the caller was a subjective assessment. There is no objective support for the screaming at 19.14 being different to the screaming at 19.02, 19.04 or 19.38. Having listened to all four calls, I have been unable to detect any significant distinction between them. The claimant may have been screaming for 12 minutes by 19.14, but how much worse the effect would have been on her if, as probably was the case, she was screaming for 36 minutes or longer, is unknown. There is no expert evidence as to the effect of such screaming. Who is to say what the effect was of 12 minutes rather than 36 minutes or longer? It is obviously an important feature of the case because the work done in therapy sessions included intense work on the consequential fear of screaming.

28. In my judgment, the opinion of Dr Sumners is to be preferred. There was no injury that was caused on the bus. There were merely circumstances that arose which later led to the onset of the disorder of PTSD. There are innumerable variables in the circumstances that will give rise to the development of such a disorder and in the people who are likely to suffer it. It is impossible to predict on any scientific or mathematical basis the moment after which someone will go on to suffer it. Adopting the ***Bailey*** test, I am unable to find on the balance of probabilities that the PTSD would have occurred in any event before 19.33. Despite the attractiveness of his submissions, I reject the logic and conclusion arrived at by Mr Jackson in his attempt to support what I find to be a flawed conclusion by Dr Latcham. To the contrary, I am satisfied that this is a case where medical science cannot establish the probability that 'but for' the negligent failure of the ambulance to arrive before 19.33, the PTSD would not have happened, but it has been established that the contribution of the negligent failure was more than negligible. It made a material contribution to the development of the claimant's PTSD. The claimant therefore succeeds on the first issue.

## SECOND ISSUE – CAUSATION OF DISSOCIATIVE SEIZURES

### The cases of the claimant and defendant

29. The claimant's case is that her **dissociative seizures** are a direct consequence of the **PTSD.**

30. The defendant's case is that the **dissociative seizures** occurred much later than the onset of **PTSD**, are unconnected to it and are consequent upon other life stressors. The claimant would have been similarly restricted irrespective of the defendant's negligence.

### The claimant's evidence

31. The claimant's evidence as to what happened after the incident can be summarised as follows.

32. In physical terms, her leg was in plaster for 10 days, in a leg brace for 6 months after which she was mobilised on crutches and then a stick. About nine months after the accident, she could still only walk about one or two paces unaided. Full function in the knee did not return for about 18 months. Mr Mitchell, an orthopaedic surgeon, would have expected her to return to work after about 6 months had there only been the physical effects of the knee and no

psychological problems. The psychological problems caused her to be unable to follow an appropriate rehabilitation programme and delayed her progress.

33. In mental terms, she was housebound for a long time. She suffered flashbacks, nightmares and a high level of anxiety and depression. She was referred to Mr.Kitson who diagnosed her with PTSD. Within a few months, she also began to suffer dissociative seizures. While housebound, she underwent treatment by telephone based cognitive behaviour therapy. Then, she had face-to-face sessions. In December 2009, she was referred to Dr Brain and then Dr Billings. Dr Billings was the one who was first to provide a diagnosis of dissociative seizures. Despite intensive treatment, symptoms persisted with all the details being a matter of medical record. She was medically retired in February 2011 from her job at the Natural History Museum, which she described as a job she loved doing. Resultant financial pressures caused her husband and her to move out of London to South Wales. The journey was debilitating. It took two days to recover after arrival in Wales. She has continuing PTSD with flashbacks, nightmares and dissociative seizures. In the flashbacks, she finds herself back on the bus experiencing the pain and anxiety she felt at the time. They are triggered by a whole variety of things. Their frequency has improved from several times a day to about once a day. The nightmares occur nightly breaking her sleep pattern and leaving her exhausted. The dissociative seizures unexpectedly cause her body to go numb and she collapses. She suffers a collapse most days. She remains conscious but feels nothing and is unable to move or speak. She is unable to travel outside on her own. She is largely housebound. When she goes out with a family member, she may suddenly collapse in the street. She finds it difficult to concentrate, plan and action ordinary activities such as housework and mentally tends to go round and round in circles. She becomes easily overwhelmed.

34. The claimant gave evidence via a video-link from South Wales so as to save her from having to travel to London. The time allotted for the video-link was limited. In order to complete his cross-examination of the claimant in time, Mr Jackson conducted his cross-examination in a fair, robust and speedy manner. I was concerned as to how the claimant might cope. I took care to monitor her progress. She appeared to cope well. She found the references to pages in the files without difficulty. She understood the questions. She gave coherent answers. Any lay observer may have been surprised that someone with her symptoms was able to give evidence in such a measured, thoughtful and intelligent manner and for such a lengthy period of time.

35. I have already dealt with aspects of the cross-examination that dealt with the first issue. There were numerous questions that related to the quantum of damages. For present purposes, I refer only to those directed towards the development of dissociative seizures.

36. Mr Jackson went through many medical notes and letters from the clinicians with the claimant. He pointed out and the claimant accepted that the first reference in any document to dissociative seizures was in two letters written by Dr Billings following a reassessment with the claimant on 28 October 2010.

37. The first letter, sent to the claimant, included the following passage:

> "You are no longer experiencing multiple distressing flashbacks every day, but tend to experience flashbacks to the trauma about three times per week now. You also described the flashbacks as not being quite so vivd and all encompassing, but rather being able to maintain awareness of your current surroundings.....You did however tell me that you continue to experience high levels of stress and anxiety and are still experiencing collapses, which we think might be some form of dissociative seizure, about three times per week. These collapses can be triggered by sudden noises or flashes of

> things in your peripheral vision and place you at significant risk of harm, for example, if crossing the road."

38. The second letter, sent to the Occupational Health Department at St. Thomas' Hospital to update previous reports in May and June 2010, included the following information:

> "Mrs Leigh's flashbacks to the trauma have reduced from experiencing multiple distressing flashbacks every day to about three times per week. She also no longer completely dissociates when flashbacks are triggered, but is able to maintain greater awareness of her present surroundings. Mrs Leigh does however still experience collapses when the flashbacks are triggered, which appear to be a form of dissociative seizure.....triggered by severe anxiety and stress."

39. Mr Jackson also referred to Dr Billings's note dated 13 December 2010 wherein she recorded;

> "Ceri reported less stress and also less severe dissociative seizures (see diary) this week, which she felt might reflect the progress we have made in therapy in terms of her understanding her earlier life experiences and their effects better. She had had one major flashback. Discussed aetiology of seizures. Ceri had thought that they were a less severe form of flashback, which we discussed as one possibility, although we also discussed an alternative theory, that dissociation is a pre-existing behavioural pattern that has been re-triggered by trauma but is something qualitatively different. (See formulation diagram). Talked about dissociation possibly being a coping strategy for sudden overwhelming emotion (much as it was in her earlier life). When discussing onset and development, it seems that the dissociative seizures started AFTER our therapy had ended (ref first incident when she came out of the dentist) and although Ceri had not experienced them in this form before, she has had similar experiences (ie escaping into imagination and writing stories, imaginary friend) earlier in life....."

40. From these documents and the fact that the claimant's therapy with Dr Billings ended in May 2010, Mr Jackson suggested to the claimant that her dissociative seizures did not occur until after May 2010, which was a long time after the incident and the onset of her PTSD. The claimant agreed the contents of the documents. She remembered discussing the particular seizure that occurred in the street after she had been to the dentist. However, she denied that that incident was her first seizure. She said it was just one memorable seizure. She maintained that she had been collapsing before then. She confirmed she had started collapsing a few months after the incident. She believed Dr Billings knew she had been collapsing, although she could not recollect having a detailed discussion with her about the topic. The claimant said she had thought that collapsing was all part and parcel of her flashbacks. The first time she was told that collapsing was a dissociative seizure was in November 2010 when Dr Billings specifically made reference to them being dissociative seizures.

41. Mr Jackson showed the claimant further documents to establish the fact that during 2010 and 2011 she had other stressful issues of concern, namely, problems with marital communications, worry about whether her husband would be made redundant, general financial problems, her son's trans-gender issues, her daughter's issues about her adoption. Mr Jackson also referred to the pressures of her litigation. The claimant agreed that the issues existed and were of concern. She denied they were what had brought on her dissociative seizures.

42. After about 2½ hours of questioning, the claimant had a seizure. It came completely without warning. One moment she was answering questions. The next, she was detached from reality. It manifested itself by her remaining seated in the video-link chair while appearing to be oblivious to what was going on around her. She was waving her hands as if to push something or someone away from her body. Her son was asked to enter the room to help her. He attempted to gain her attention. Suddenly, she collapsed in her seat and fell forwards onto the table in front of her. I had no doubt at the time from what appeared before me on the screen that what occurred was genuine. The proceedings were adjourned for further evidence the next day and with re-examination to take place two days later due to the unavailability of a video-link slot the following day.

Other evidence

43. When the case recommenced the next morning, I heard evidence from the claimant's husband, Mr Leigh, Dr Sumners and Dr Latcham. All three had been in court and had observed what had happened to the claimant. As part of their evidence, each gave evidence as to his interpretation of what had happened.

The evidence of Mr Leigh

44. Mr Leigh explained that what happened was a common experience to him. Her movements were involuntary. She was trying to push people away from her as if she was still on the bus and not wanting to be held down. Usually, she would kick her feet out at the same time. She may have been doing that but it was just not visible because she was seated at a table. Mr Leigh referred these actions as flashbacks. When she slumped forwards onto the table, he was sure she would have closed her eyes and that was what he called a seizure. He said that she would normally remain in a collapsed state for about five minutes. Occasionally, it would be for a longer period of up to about twenty minutes, but that would be rare.

45. Mr Leigh was asked when the seizures commenced. He confirmed what he had said in his statement dated 8 March 2013. The first notable incident he could remember was at the end of January 2009. The claimant had frozen when a door opened, had collapsed to the floor and became hysterical with her arms thrusting forwards as if trying to push someone off her. He described other occasions when the claimant would freeze on the spot, appear disorientated and collapse to the floor. On those occasions, she would not scream or thrash about and would lie on the floor with her eyes closed. In his statement, he did not say when the seizures had first occurred. In evidence, he said he remembered the dentist incident. That had happened suddenly while crossing the road. However, he recollected incidents before that. He could not give specific dates. He said they started occurring roughly in the first part of 2009.

The evidence of Dr Sumners

46. Dr Sumners stated that in his opinion what occurred at the end of the claimant's cross-examination was a genuine single continuous dissociative phenomenon. During the course of it, the claimant was out of touch with her surroundings, first of all trying to fend someone off and then slumping forward. Mr Leigh had referred to the event as two separate features of a flashback and a dissociative seizure. The claimant, in her description to Dr Sumners of what normally happened to her, had also described flashbacks and dissociative seizures as separate events. Dr Sumners said it had been unhelpful for the claimant's experiences to be described during clinical therapy as two separate events of "flashbacks" and "dissociative seizures". No doubt that is why Mr Leigh had described what happened to the claimant at the end of her cross-examination as being two separate things. It is also why the claimant, during the course of his examination of her, had separately described the two phenomena. Dr Sumners confirmed his opinion in his report of 7 August 2013 that the dissociative seizures were an evolution of the claimant's response to the trauma she suffered. He also confirmed his

answers in the joint statement wherein, in answer to question 18, he stated that the dissociative seizures were part of the symptomology of the PTSD and the fact that one symptom of psychological origin had arisen after some others did not mean it was unrelated to the index event or the PTSD as a whole.

47. Dr Sumners explained that **DSM-V** gives a helpful description of the diagnostic features of PTSD as follows:

> "The individual may experience dissociative states that last from a few seconds to several hours or even days, during which components of the event are relived and the individual behaves as if the event were occurring at that moment. Such events occur on a continuum from brief visual or other sensory intrusions about part of the traumatic event without loss of reality orientation, to complete loss of awareness of present surroundings. These episodes, often referred to as 'flashbacks', are typically brief but can be associated with prolonged distress and heightened arousal."

48. Dr Sumners said that he was able to apply that to the facts of this case. The events seen on the video-link were an example of it. The claimant had experienced a dissociative episode during which components of the traumatic event were re-lived. It was as if the event was occurring at that moment. That was evidenced by the claimant being seen trying to fend someone off. Such experiences occur on a continuum. At the extreme end of the continuum is a complete loss of awareness of present surroundings. That was evidenced by the claimant's ultimate collapse onto the table. The whole incident, including both the flashbacks and the seizure, were all part of the one single continuous dissociative phenomenon.

49. Dr Sumners accepted that a diagnosis of PTSD was made in December 2008 and the first reference in the documentation to the words "dissociative seizures" was not until October 2010. He accepted the evidence also suggests the claimant may not have suffered collapses as early as the onset of her other PTSD symptoms. He also agreed with the general proposition that, when PTSD symptoms manifest themselves, they should all occur together. He confirmed that he had not had a case where PTSD symptoms had manifested themselves at different times. However, Dr Sumners said that was not what had happened here. This was not a case where separate symptoms had materialised at a later stage. He was satisfied that the dissociative seizures were all part of and an extension of the flashbacks. **DSM-V** explains that that can be the case.

50. Dr Sumners also stated that there was evidence that the claimant had a vulnerability to dissociative episodes. There is evidence that in her teens or twenties she had a tendency to daydream and depersonalise things and to experience derealisation, all of which were dissociative states. Her pre-existing vulnerability is not only support for the fact that she has been suffering dissociative seizures. Her predisposition to them makes it more likely that she would have suffered them as a consequence of the incident.

51. Dr Sumners further made reference to the claimant's description in her statement, already referred to above, about her "utter despair", "collapsing mentally and physically", going "into freeze" and being "utterly overwhelmed and traumatised". Dr Sumners said that, if that account is accepted as being correct, then it is consistent with her suffering a dissociative episode on the bus. If that happened, it provides additional support for his opinion that she had a pre-existing vulnerability and the incident triggered an episode which all became part and parcel of the PTSD that later developed. I have already determined, having heard the claimant, that I am satisfied about the truthfulness and accuracy of this aspect of her account.

52. Finally, in relation to the dissociative seizures, Dr Sumners agreed that the claimant has had the other anxiety issues referred to by Mr Jackson during cross-examination of the claimant. He acknowledged their relevance. He disagreed with the proposition that they have been the cause of any dissociative seizures. He remained of the opinion that the dissociative seizures are all part and parcel of the continuous flashbacks and PTSD.

The evidence of Dr Latcham

53. Dr Latcham confirmed the contents of his report of August 2013 and his answers to the joint statement within which he had concluded with absolute certainty that the claimant's dissociative seizures were not related to her PTSD and were solely related to the other life stressors referred to by Mr Jackson in his cross-examination of the claimant. In cross-examination by Mr Gibson, Dr Latcham was unable to explain, if that was the case, why there had been no dissociative seizures before the incident on the bus.

54. In the course of Dr Latcham's evidence, it became immediately apparent that his certain conclusion was no longer sustainable after what he had seen happen to the claimant at the end of her cross-examination.

55. He was satisfied that what had happened to her was genuine. He said there had been a number of possible triggers that had brought on the event, including the use of specific words and particular issues or descriptions relevant to the incident, as well as being under intense pressure for 2½ hours of questioning. He was satisfied that her flashback was a dissociative flashback and the seizure at the end was a dissociative seizure, which was related to the dissociative flashback. Having seen it happen, he was now satisfied that, at times, the claimant's dissociative flashbacks may become so distressing for her that she may go on to suffer a dissociative seizure that would be linked to her PTSD. He had to concede that it was no longer possible for him to maintain his conclusion that all of the claimant's dissociative seizures are unrelated to her PTSD.

56. He was not prepared to go further than that. In his opinion, there were other times when the claimant's dissociative seizures were related to other emotional problems.

57. He was cross-examined about the contents of the letters of 28 October 2010. He agreed that the expression in the letters of the claimant *"still experiencing collapses"* supported the opinion of Dr Sumners that the dissociative flashbacks and dissociative seizures should all be treated as one phenomenon. However, he continued to have reservations about Dr Sumners' conclusion. In Dr Latcham's opinion, if there was no gap in time between the incidence of the collapses and the emergence of the other PTSD symptoms, the dissociative seizures were probably all related to the incident on the bus. However, if there was a gap in time, he would not be able to say that all of the dissociative seizures are so related.

Discussion

58. What happened to the claimant at the end of cross-examination was unfortunate. Undoubtedly, it was the product of the pressure of the experience. Despite best endeavours to avoid it, I very much regret that she had to suffer the distress of a dissociative episode in the context of court proceedings. However, what happened has proved to be illuminating. It has helped me to gain a better understanding of her continuing psychiatric and psychological injury. It has provided both experts with an example of what she had previously only been able to describe to them. It has fundamentally changed the certain conclusion of Dr Latcham from what it had originally been to something completely different. In the end result, it has assisted me greatly in reaching a conclusion over the second issue.

59. For the reasons already stated in paragraph 21, as now expanded upon, Dr Latcham's opinions require the closest scrutiny. In contrast, I found Dr Sumners to be a compelling expert witness. Where there are differences between them, I prefer the evidence of Dr Sumners.

60. I am impressed by Dr Sumner's explanation of the development of dissociative seizures as part of a continuous dissociative phenomenon. In addition to his own professional opinion, his citation of the passage from **DSM-V** provides a logical basis for it.

61. In support of Dr Sumner's opinion, I note that **DSM-V** also includes the following statement in its section on the development and course of PTSD:

> "Symptoms usually begin within the first three months after the trauma, although there may be a delay of months, or even years, before criteria for the diagnosis are met. There is abundant evidence for what DSM-IV called 'delayed onset' but is now called 'delayed expression', with the recognition that some symptoms typically appear immediately and that the delay is in meeting full criteria.....The symptoms of PTSD and the relative predominance of different symptoms may vary over time.....Symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stresses or newly experienced traumatic events."

62. I am unconvinced the first reference to the expression "dissociative seizures" on 28 October 2010 should be interpreted as meaning that is when the claimant commenced suffering dissociative seizures. I am mindful of the expression in both letters of the claimant *"still experiencing collapses"*. I accept the evidence of the claimant and her husband that they first occurred long before that time, soon after the onset of her PTSD symptoms. I note the contents of a letter from Dr Billings dated 17 May 2010 that included the following passage that is consistent with her having suffered dissociative episodes for some time:

> "By the end of treatment, Ms Leigh's intrusive memories of the accident had decreased from several times a day to a few times a week. When experiencing flashbacks to the incident Ms Leigh does, however, still experience a very strong physiological reaction which can cause her to either freeze or stumble and she has on occasions fallen when experiencing flashbacks."

63. I accept Dr Sumners' evidence that the claimant had a pre-existing vulnerability to dissociative episodes that pre-disposed her to such episodes after the incident. As already stated above, I am also satisfied that she suffered a dissociative episode on the bus.

64. My conclusion from the above findings is that I am satisfied that the dissociative seizures are all part of the claimant's PTSD and consequent upon it and are not related to her other life stressors.

## THIRD ISSUE – QUANTUM OF DAMAGES

65. Various heads of damage have been agreed. The determination of issues one and two resolve some other heads of damage and reduce the issues on some others. Some heads of damage require discrete findings.

### General Damages

66. Mr Gibson contends that the claimant has suffered badly from her PTSD and is seriously disabled as a result of it. He suggests that the claim falls within the "severe" Category B(a)

PTSD of Section 4 Psychiatric and Psychological Damage of the Judicial College Guidelines. The bracket is £44,000 - £74,000. The appropriate figure should be £60,00, which is just above the mid-point.

67. Mr Jackson contends that £60,000 is too high. The claimant's PTSD has varied over the period since 2008 from severe down to mild-moderate according to Dr Billings' clinical note of 5 May 2010. Further variation is likely in the future especially if she receives the therapy recommended by Dr Sumners and Dr Latcham. The award should therefore be categorised in the "moderately severe" category for which the Judicial College Guidelines suggest a bracket of £14,000 - £40,300. The award should be at or close to the mid-point of £27,500.

68. The reference by Mr Jackson to the clinical note made by Dr Billings is a snapshot of a much wider and more complex picture of the claimant's injury. It was an observation about progress and I do not read it as being a determinative of a professional evaluation of the overall severity of her PTSD. That valuation came in the formal detailed letters written by Dr Billings on 17 May 2010 to Dr Brain and to the Occupational Health Department at St. Thomas' Hospital. In both letters, Dr Billings noted that improvement had been made but only in so far as the PTSD had progressed from being categorised as "severe" to "moderate to severe".

69. For the reasons already identified, I prefer Dr Sumners' conclusions to those of Dr Latcham. In his report dated 7 August 2013, he reached the conclusion that the severity of the claimant's PTSD should be categorised as severe (ie Category A) in the Judicial College Guidelines. He reached that conclusion because there are permanent effects that will prevent the claimant from working at all or at least functioning at anything approaching her pre-trauma level. All aspects of her life are badly affected. Only a small response to additional psychological therapy is expected.

70. Having conducted the trial and having seen how debilitating the dissociative effects of the injury can be, I fully understand how debilitating the injury is. I have no hesitation in accepting the opinion of Dr Sumners and categorise the injury as "severe". I note the additional help she is to receive although the likely results are expected to be minimal. In my judgment, an appropriate award is **£60,000 with interest payable at 3.7%**.

Agreed other heads of damages

71. Consequent upon the determination of the above issues, there are some agreed heads of damages.

| | | |
|---|---|---|
| Miscellaneous losses | : | £200 |
| Past medical expenses | : | £50 |
| Past care | : | £9,070 |
| **Total** | **:** | **£9,320 + interest at 2.57%** |

| | | |
|---|---|---|
| Future travel | : | £50 |
| Future medical | : | £4,500 |
| Future incidental | : | £1,500 |
| Future care | : | £34,949 |
| **Total** | **:** | **£40,999** |

Past and future loss of earnings

72. The amount claimed is £98,887 plus interest for past loss of earnings and £185,243 for future loss of earnings.

73. The figures arise out of the claimant's inability to continue working at the Natural History Museum. Her job had been as the exhibitions (design and conservation) manager. She managed the design, installation and conservation of specimens within the Museum Exhibition Galleries. She had hopes of promotion.

74. Mr Jackson agrees that, if the claimant had been able to continue working for the Natural History Museum, then her projected earnings over the period between November 2008 and trial, after the deduction of the payments she has actually received, would have been £98,887. He also agrees the figures for future loss of earnings if the claimant remains unable to do any work in the future. He raises two points.

75. The first point is that the claimant brought about her own ill-health retirement because she feared redundancy. Mr Jackson asked the claimant many questions about the circumstances of her retirement. He referred to her line manager mentioning redundancy in correspondence in April 2009; to the general practitioner "MED3" certificates signing her off work, which certificates made no reference to PTSD until September 2009; to her agreeing to go ahead with the process of applying for ill-health retirement in February 2010 at a time before she knew how effective her PTSD treatment was going to be; to the letter written by Dr Billings on 17 May 2010 that referred to the claimant's good progress; to a more pessimistic letter written by Dr Billings on 24 June 2010 wherein she stated that the claimant would be unlikely to be able to return to her former job and recommended that she should be retired on ill-health grounds; and to the claimant's response to her retirement being one of relief. Mr Jackson suggested to the claimant that she was the one who caused Dr Billings to change her mind between May and June and that was solely because she wanted to gain the financial benefits of an ill-health retirement. The claimant rejected all such suggestions. She gave evidence that she did nothing to cause Dr Billings to write as she did in June 2010. Dr Billings must have been asked for clarification of her earlier letter and gave it. The claimant said she loved her job and wanted to return to it if she was fit enough to do the job. Mr Leigh gave evidence to the same effect. I accept that evidence. I reject the suggestions made to her in cross-examination. I am satisfied from her evidence, the evidence of Dr Sumners and the correspondence between Dr Billings and the Occupational Health Department that the reason she could not return to work was the actionable PTSD.

76. The second point is that the claimant has had and continues to have an earning capacity. Mr Jackson relies upon the claimant's desire to undertake some form of writing or freelance work from home and upon what Dr Sumners said about that in his report dated 16 February 2012. Dr Sumners mentioned the possibility of the claimant doing work at home, possibly in relation to some aspect of writing. Dr Sumners said he was no employment expert. He recognised that the claimant had no experience of freelance writing, had no contacts in that field and had concentration issues. Mr Jackson contends that writing is not the only job that can be done at home. There are other possibilities associated with using a computer or telephone, either or both of which could produce some modest earnings. The claimant was asked about what work she could have done up to now and what work she might be able to do in the future. She has no literary contacts or ideas that are likely to generate anything of significance. The prognosis is pessimistic about any productive work being possible. There has been no convincing suggestion as to how the claimant could have earned anything by now or is likely to earn anything in the future. I am satisfied the claimant has the desire to work but that the persistence of her symptoms has prevented her from achieving her objective. I am further satisfied that any realistic prospect of her obtaining any paid work in the future is a mere possibility and should be discounted.

77. For these reasons, I award the full sum for **past loss of £98,887 plus interest at 2.57%** and the full sum for **future loss of earnings of £185,243**.

Pension

78. The amount claimed is £108,831. Mr Jackson agrees the mathematics but only on the basis that the claimant would have continued to work at the Natural History Museum. The defence contention is that the claimant would have been made redundant in any event and would have found other pensionable employment after redundancy, albeit with less valuable pension benefits than those available under the Civil Service final salary scheme. A proposes figure of £15,000 is put forward by way of alternative future pension loss.

79. I confirm the findings of fact referred to above in relation to the claim for past and future loss of earnings. I am satisfied that the claimant would otherwise have continued working for the Natural History Museum until her normal retirement age and that **the claim of £108,831 for loss of pension is justified**. I make an award for the full figure under this head of damages.

Past Travel

80. The amount claimed is £300. Mr Jackson submits the figure is too high because the journeys undertaken by the claimant include some that she would have had to make in any event because of her injury to the knee and because the mileage rate used in the calculation includes standing charges which the claimant and Mr Leigh would have had to incur in any event. An alternative figure of £150 is proposed. Mr Gibson submits that the sum of £300 has already taken into account some of the defence submissions. The original claim was for £600. Further, the alternative figure of £150 is based on the proposition that, absent the PTSD, the knee injury would have kept the claimant off work for about 15 months and, following the orthopaedic evidence, that cannot be sustained. I agree with that point. In the absence of detailed calculations as to standing charges, I cannot resolve it in favour of the claimant. I reduce the claim to **£225 plus interest at 2.57%.**

Past and future Household

81. The sum of £2,320 (by way of past household losses) and £11,304 (by way of future household losses) is claimed for the cost of increased utility bills due to the claimant being at home all day. Mr Jackson agrees the figure as a matter of mathematics but contends that because of career changes which Mr Leigh would have had to make in any event in response to his threat of redundancy, he or the claimant would have been at home for most of the time in any event. Any increase in their utility bills would therefore have occurred in any event. Mr Jackson proposes alternative respective figures of £841.50 and £8,113 to reflect other items under this head. Mr Gibson contends that the only reason that Mr Leigh now works at home is to provide support for the claimant. If she had not suffered her injury, both would still be out at work. I am satisfied that that is a reasonable proposition. I award the full sum for **past household losses of £2,320 plus 2.57% interest** and the full sum for **future household losses of £11,304**.

Move to Wales

82. The sum of £2,000 is claimed. Mr Jackson submits that the move to Wales was not necessitated by the claimant's injuries but was something she and her husband wanted in any event. Having heard the evidence, I am satisfied that they had discussed the possibility of moving to Wales at normal retirement ages, but had been compelled to move much earlier because of what had happened. I reject the submission that the move was not necessary. I award the full sum for **the move to Wales of £2,000 plus interest at 2.57%.**

Sound Therapy

83. The sum of £3,250 is claimed. Mr Jackson accepts that the claimant has paid £3,250 for sound therapy but denies that it was reasonably required. None of the clinical notes suggest additional sound therapy was necessary or advisable. Dr Sumners does not positively state that it was required. It is submitted that it was the claimant's own decision to obtain it and was not obtained on advice. The claimant gave evidence that, notwithstanding there is no corroborative note to support her evidence, she remembers Mr Kitson mentioning that it might be worthwhile and she wanted to do everything she could to get better. She says it did help her. I accept her evidence. I award **sound therapy costs of £3,250 plus interest at 2.57%.**

Total Award

84. From the above, I award:

| | | | |
|---|---|---|---|
| General damages | : | £60,000 | plus interest at 3.7% |
| Past losses | : | £116,002 | plus interest at 2.57% |
| Future losses | : | £346,377 | |
| **Total** | : | **£522,379** | |

85. For the above reasons, judgment should be entered for the claimant with damages assessed at **£522,379 plus whatever is the correct interest calculation at the above rates.**