THE HIGH COURT

IN THE MATTER OF AN GARDA SÍOCHÁNA (COMPENSATION) ACTS, 1941

AND 1945

[2013 No. 392 SP]

BETWEEN

DAVID FOLEY

APPLICANT

AND

THE MINISTER FOR PUBLIC EXPENDITURE AND REFORM

RESPONDENT

Judgment of Ms. Justice Mary Rose Gearty delivered on the 31st day of March 2021.

1. Introduction

1.1 The Applicant suffered multiple physical injuries and a psychiatric injury as a direct result of a serious and sustained assault on his person in January of 2006. He has brought a claim under the Garda Síochána (Compensation) Acts, 1941 and 1945 ("the Acts") seeking compensation for these injuries. The injuries include physical and psychiatric injuries but the psychiatric injuries went untreated until they resolved, with the support of the Applicant's wife and family, at some point before 2014.

1.2 The only issue in the case is the extent of the psychiatric damage involved. The Applicant's medical advisor has diagnosed Post Traumatic Stress Disorder [PTSD]

while the Respondent's advisor initially took the view that there were insufficient clinical symptoms to make a diagnosis of any psychiatric injury but, having considered the reports anew, agreed that there were clinical symptoms sufficient to diagnose anxiety disorder, but no more.

1.3 In one way, this is a distinction without a difference in its effect on the assessment of damages. It is necessary for the Court to award damages to compensate the Applicant on the basis of the symptoms actually suffered as opposed to the formal diagnosis. In this case, physical injuries were inflicted on the Applicant and he is entitled to an award which compensates him, fairly and reasonably, in respect of those injuries and in respect of any psychological or psychiatric sequelae. The award in this case will, and must as a matter of law, encompass such sequelae as being part and parcel of the consequences of the assault on the Applicant.

1.3 The medical experts have both listed the symptoms suffered by the Applicant, there is no issue as to his credibility or as to the accuracy of the notes taken by either medic or by the first treating psychiatrist, save to say that the notes of the latter were insufficient to make a diagnosis on his notes alone. The effect of the oral evidence is that the Applicant's psychiatrist stands over his diagnosis of PTSD and the Respondent's psychiatrist, looking at very similar symptoms, has diagnosed an anxiety disorder.

2. <u>Agreed Facts and Physical Injuries</u>

2.1 It is not disputed that the Applicant was assaulted at a time when he was off duty. The facts provide a good example of a situation which comes within s. 2(1)(c)(iii) of the Acts, as the injuries were maliciously inflicted and appear to have been deliberately inflicted "*merely because of his being a member of the Garda Síochána*." It is accepted that he suffered injuries to his nose and tooth, with extensive bruising generally.

2.2 The Applicant was 20 years old in January of 2006 and was off duty in Sligo town, with friends, when a group of three men set upon one of his friends in an unprovoked assault. The Applicant produced his identification and made it clear that he was a member of An Garda Síochána. The man was either drunk, or high, or both and he was heard shouting that "*he always wanted to kick the shit out of a guard*." The Applicant received a flurry of punches into the face, was knocked off balance and fell to the road. His assailant knelt over him and struck a final blow into his mouth connecting with his front tooth, which went back into his throat. The Applicant then blacked out momentarily. He was told afterwards that his assailant's own associates had to pull the man away. The Applicant feared that he would be killed during this sustained assault.

2.3 The Applicant was taken to A&E, in considerable pain. He had suffered a fracture to his first incisor tooth, an un-displaced fracture of the nasal bridge and soft tissue injuries to his lip and eye. In a report from his general practitioner, 6 months later, the issue of psychological injures was first mentioned and the Applicant went to a psychiatrist in December of 2006. That psychiatrist has since died and the two psychiatrists who gave evidence saw the Applicant on various dates between 2012 and 2017.

3. Psychological and Psychiatric Injuries: The Law

3.1 The issue of psychological injuries in the context of Garda Compensation cases was discussed in the comprehensive judgement of Irvine J., as she then was, in *Carey and others v the Minister for Finance* [2010] IEHC 247. That judgment also confirms various propositions of law which are now widely accepted. The case was one in which multiple claims arose after various applicants had been exposed to potentially contaminated blood and feared that they might contract transmissible diseases.

3.2 The following principles, identified in *Carey*, are directly relevant to this case: Applications under the Garda Compensation Acts should be treated in the same way

as personal injury cases generally, both in the assessment of appropriate damages and in terms of the law of torts generally. Thus, of the list outlined in *Carey* as being relevant to the assessment of psychiatric injuries, almost identical factors apply in this case, namely:

> *(i) the severity of the assault;*
>
> *(ii) whether any general or specialised medical treatment was warranted and if so the nature and extent of same;*
>
> *(iii) the injured members' ability to cope with life and work following their assault, including any time they may have spent out of work;*
>
> *iv) the effects, if any, of the injury on the members' personal relationship with his/her family and friends;*
>
> *(v) any restrictions imposed upon the member as a result of their injury;*
>
> *(vi) the prognosis for the member and any future vulnerability that they may have a result of their assault; and*
>
> *(vii) the extent to which the injured party has mitigated their loss.*

Bearing in mind that this is the legal context in which the evidence should be considered, I turn to consider that evidence next.

4. Psychological and Psychiatric Injuries: The Evidence

4.1 The assault occurred in January of 2006. This was a serious and sustained assault, capable of constituting the basis for a psychiatric injury; the Applicant was punched repeatedly in the face, was beaten until he was unconscious and feared for his life. The reasonable plaintiff, even a robust plaintiff such as a member of An Garda Síochána or the defence forces, for instance, would be expected to find such an event more difficult than one in which injuries were accidentally inflicted. The first factor identified in *Carey*, therefore, is easily assessed in this case: this was a severe and

violent assault, with an element of personal vindictiveness directed at the Applicant due to the very fact that he was a member of An Garda Síochána.

4.2 The court in *Carey* commented on the difficulty in assessing psychiatric damage with no objective, or observable signs. In that context, Irvine J. quoted, with approval, the following statement by H.G. Kennedy, in his article *"Limits of Psychiatric Evidence in Civil Courts and Tribunals: Science and Sensibility*" (2004) 10(1) MLJI 16, at p. 17:-

> "*…any clinician, and therefore any psychiatrist in the role of expert witness, can be wrong and can be deceived. In clinical practice, the psychiatrist's normal means of ensuring against being misled is never to rely only on the account of one person. Multiple primary sources of information, independent of the individual assessed, are essential*."

4.3 Irvine J. confirmed that (as is the case here) there was no question of those plaintiffs deliberately misleading their treating doctors, merely that "*the existence of a right to compensation has occasionally been shown to have corrupted the narrative or the telling of the evidence by a claimant to the court or to their medical advisors*." One might add to these observations that a treating doctor is also subject to the very human desire to support a patient whom she is treating, particularly if there is a doctor-patient relationship lasting over a period of years. In the same vein, the doctor who reports on a patient at the request of a defendant, particularly if she is a regular witness for the same defendant, may have or develop a natural inclination to assess the evidence more sceptically. Finally, in this regard, the Applicant here is acknowledged as someone who tends to understate his symptoms. In any case the patient's, or his family's, contemporaneous record of symptoms is like to be the most accurate account.

4.4 These comments are made without criticism of the witnesses in this case. Every expert has a duty to the court to which she gives evidence and it is to assist the Court as to matters within her expertise, which duty overrides any obligation to any party paying the fee of the expert (see Order 39, Rule 57 of the Rules of the Superior Courts).

By commenting on the natural human inclination towards a particular view, most notable when there is a longstanding personal relationship between a witness and a party to the litigation, the Court merely notes what is normal and may be extremely difficult for most people, even expert witnesses, to avoid. There was nothing in the evidence in this case to warrant a conclusion that either expert was doing anything other than his conscientious best to assist the Court. It is not surprising and is not a matter of concern to this Court, that each supports the position of his client. It might be of concern if an expert refused to accept a clear proposition with which no sensible person could disagree but that does not arise on the facts of this case. A genuine difference of opinion has arisen on the extent of the symptoms suffered by this Applicant and the diagnosis which should follow. Irvine J., in commenting on the approach to be taken to expert evidence in psychiatric cases, had the following advice by way of conclusion to this section of her judgment in *Carey*:

> "*174. Consequently, medical practitioners advising the court should, wherever possible, try to avoid relying solely on the account of the claimant and should have regard to any other primary sources of information available to them when coming to their conclusions. For example, a medical report prepared by a consultant psychiatrist who did not treat a claimant in respect of their injuries and who did not have any contact with their general practitioner prior to its preparation, is evidence to which the court can attach little weight, particularly if… that report relies on the existence of a number of medical conditions not previously mentioned in the course of earlier medical review by their general practitioner*."

4.5 Having set out that legal context, I turn to the facts of this case insofar as they affect the diagnosis of PTSD. It is important to note that in this case there has been no question of the *bona fides* of the Applicant himself. On the contrary, it appears to have been accepted by all witnesses and by the Respondent that the Applicant is a genuine and candid witness and that, as already noted above, he tends to understate his injuries. The Court shares that impression and reiterates at the outset of this

discussion of the issue that it may be that the label one puts on the list of symptoms suffered by the Applicant is less material than the accurate and reliable evidence that he did suffer in the way he outlined to the Court. If the sole causative element of all the symptoms described is the assault of 2006, then he is entitled to damages in respect of his symptoms, in accordance with the general principles of tort law and regardless of the label one uses. That said, the issue was raised and argued, and the Court will rule on the issue in accordance with the applicable law and with the assistance of the judgment in the *Carey* case.

5. Evidence of Psychiatric Injury

Dr. Corry

5.1 6 months after the assault, in June of 2006, the Applicant's G.P. noted for the first time that the Applicant had also suffered *a psychological injury*. The Applicant was sent to see Dr. Corry, who made notes having seen him, in total, 3 times: in 2006, 2008 and 2009. The notes are helpfully summarised in the report of Dr. Devitt, psychiatrist for the Respondent. In the first visit to Dr. Corry, in December of 2006, the notes recorded the words "*worried about wellbeing*", *embarrassed* and *careful*. Over ten months later, Dr. Corry wrote to the Applicant's solicitors asking for "a review consultation" as he had insufficient data to prepare a comprehensive psychiatric report. In January of 2008 Dr. Corry saw the Applicant again and the most relevant notes were: "*vivid intrusive thoughts, anxious, (decreased) confidence, embarrassed* and *phobic of Sligo town still*." In January of 2009, Dr. Corry noted: "*has not gone to Sligo since, more cautious, social withdrawal, mood swings, angry and case struck out*" (referring to the case against his assailant). These notes are from the first treating doctor and are the nearest in time to the period during which one might expect to see signs of the most severe symptoms. Dr. Corry died before he was able to complete a report on the Applicant and did not express any view on whether the symptoms he described were capable of supporting a diagnosis of PTSD. It is important to note, given the emphasis that was laid on the duration of his symptoms, that the Applicant had been

advised, twice, by Dr. Corry to seek counselling support in order to address his symptoms but the Applicant did not obtain any treatment in this regard.

Dr. McCormack

5.2 The next doctor to see the Applicant in respect of psychiatric symptoms was Dr. McCormack. He saw the Applicant on the 6th of May, 2010 and his report was dated 25th June. This was well over 4 years after the assault, obviously. He had access to Dr. Corry's notes at the time of this first report.

5.3 Dr. McCormack noted that the Applicant continued to feel threatened in Galway, where he then worked, as local criminals knew the history of the case. As a result, he moved to another county. He reported being embarrassed about this and felt that it had affected his work and made him cautious about potentially violent situations. The Applicant confirmed this in his evidence.

5.4 Dr. McCormack also described the Applicant as continuing to experience "*frequent flashbacks or vivid memories"* of the assault. These occurred, according to the report, on a daily basis and were prompted by looking in the mirror, feeling pain in his injured tooth or being involved in confrontation at work. At that time, he also had nightmares related to the assault about once every month. This frequency was referred to as "*frequent nightmares*", which I note to put the other symptoms into context. The Applicant told Dr. McCormack that he also experienced anxiety and occasional panic attacks, often feeling that he lacked energy and motivation. He had not returned to Sligo town since the assault. On one occasion he reached the outskirts but turned back due to severe anxiety symptoms. He was also avoiding crowded pubs and was easily startled. Dr. McCormack also noted that he suffered from low mood, lasting weeks at a time but that he was not depressed.

5.5 In terms of effects on the Applicant, the report lists a severe effect on his social life, relationship difficulties with his then girlfriend but notes also the support she and his parents had provided to the Applicant.

5.6 This psychiatrist based his diagnosis of PTSD on what he described as findings of significant and severe ongoing symptoms, including flashbacks, nightmares, anxiety, panic, avoidance, poor self-esteem and episodic depression. He concluded that no such problems would have arisen if the assault had not taken place. He recommended psychotherapy on a weekly basis for a period of 9 months to a year which would, he predicted, alleviate his symptoms.

5.7 This doctor completed a second report in 2012, at which time the Applicant had still not received any treatment for his psychological injury. He reported at that time that the harassment in the local criminal community had diminished as most of those who seemed to know about the incident were now in prison. He was also managing a soccer team which had helped alleviate his symptoms. He had been drinking more than usual but this too had stopped. His mood was now good for 90% of the time. Dr. McCormack noted his description of flashbacks being intrusive thoughts of the incident which were as "*clear as yesterday*" and which were still occurring but there is no indication as to how often. He continued to be more cautious, to avoid Sligo town and also avoided crowded bars or clubs which situations tended to trigger a hypervigilant reaction. In 2012 he was no longer experiencing panic attacks.

5.8 Dr. McCormack concludes that the Applicant was, in 2012, continuing to suffer significant symptoms of PTSD. He lists these as avoidance, intrusive thoughts, hypervigilance, startle reflex, disturbed sleep and nightmares. He also noted the effect on his social life and on his relationship. In December 2014, Dr. McCormack reviewed the Applicant who was then feeling well and had no further symptoms of anxiety with the exception that he continued to avoid Sligo town. He noted that the prognosis was good and concluded that he did not expect him to suffer further adverse consequences. It should be noted that the Applicant had not sought treatment at any stage for these symptoms and they had, by 2014, resolved without any such treatment.

5.9 In evidence Dr. McCormack expressed the view that, given that Dr. Devitt had noted all of the symptoms (such as avoidance, hypervigilance and intrusive thoughts)

required for a diagnosis of PTSD he did not know why he did not reach the same conclusion as the witness. In this respect, Dr. McCormack noted that depression was also associated with the condition of PTSD and concluded: "*I suppose one can see that ... he lost interest in things, had low self-esteem, he lost motivation for a period I suppose that low mood as being sufficient for the associated condition*."

Dr. Devitt

5.10 Dr. Devitt first saw this Applicant on the 6th of December 2012, nearly 7 years after the assault and some months after the second of Dr. McCormack's reports, in which the Applicant had described being significantly better than in 2010 but with continuing avoidance, caution and hypervigilance. Dr. Devitt noted in his evidence to the Court that he adopts a policy of asking open questions when he is reviewing a patient. He would not, for instance, have asked him whether or not he had flashbacks.

5.11 Dr. Devitt noted that he had carefully probed the applicant's "*intrusive recollections*." These were described as nightmares in which he was fighting people and reminders of the attack. He also says that he can still visualise the assault, to a 'T'. At the time of this report, the Applicant said that the memories were upsetting but were less so as time had passed and Dr. Devitt concluded that they did not have the character of sudden intrusive recollections. He was still avoiding Sligo at that time and Dr. Devitt noted that he probably was hypervigilant for a period after the assault. The diagnosis was initially one of a psychological adverse reaction to a traumatic assault, lasting for about 2 and a half years, thereafter gradually improving. The Applicant was described as a resilient, stoic individual who managed the symptoms on his own with minimal professional intervention.

5.12 In 2017, Dr. Devitt reviewed his own report and that of Dr. McCormack. Dr. McCormack had listed more severe symptoms than those noted by Dr. Devitt. The witness addressed this issue in evidence and his approach can be summarised by saying that Dr. Devitt not only reviewed the earlier reports, but in 2017, he also revised

his diagnosis as a result of Dr. McCormack's 2012 report. The witness explained that he accepted that the Applicant may have been more forthcoming with Dr. McCormack and was prepared to take this into account and, on the basis of those more severe symptoms, to diagnose a recognised psychiatric illness, namely, anxiety disorder. He went on in his 2017 report to explain why he was not satisfied, even taking the more serious symptoms into account, to revise his view that the Applicant had not suffered from PTSD. The criteria necessary for such a diagnosis are, he explained: "*a sufficiently traumatic event, intrusive symptoms, avoidance symptoms and hypervigilance.*" Finally, clinically significant distress or impairment in social, occupational or other important areas of functioning are also required. He concluded that the required level of clinically significant symptoms were not present here.

5.13 My impression of his evidence as a whole was that Dr. Devitt accepted that the Applicant had been reluctant to open up fully in respect of his symptoms and this was why, on reviewing the case, he had decided in a later report that he would change his diagnosis to one of anxiety disorder. This appeared to reflect his being persuaded that the Applicant was not exaggerating his injuries and, if anything, was inclined to minimise the emotional impact that this assault had on him.

5.14 There does not appear to be any dispute about the criteria required to establish PTSD. Instead, Dr. Devitt insists that the symptoms have to be intense and frequent and concludes, on the reports he has seen and after his attendance with the Applicant, that the symptoms here were not sufficiently severe or frequent. He also notes that the Applicant did not seek treatment for any symptoms but was sent for a medico-legal report in that regard. He concludes that he may have been understating his symptoms and revises his diagnosis to an adjustment disorder for up to a year in duration. Dr. McCormack, on the other hand, concludes that the symptoms were sufficiently severe to constitute PTSD and placed particular stress, in his evidence, on the duration of the various symptoms noted and in particular his continued avoidance of Sligo town, intrusive recollections and hypervigilance.

5.15 Both agree that the Applicant has suffered a medically verifiable psychiatric injury, therefore, but differ in terms of the medical diagnosis. Both psychiatrists agree, however, that he did not receive treatment, despite having been advised to seek counselling by Dr. Corry and by Dr. McCormack.

6. Mitigation of Loss – the Evidence

6.1 In his evidence, with great candour, the Applicant addressed these issues directly. Asked about the advice to seek help from a psychologist, which he was given by his GP in 2006, he replied:

> *"I was 20 – it's different now, I would do it now – but if you told me to go left I would go right, I should have but didn't take the advice. I was buying a house, the economy – it went wallop. You could get peer support at the job but it could be another guard and you speak to them and I didn't feel comfortable with that and not confident that this was secure or confidential enough. The support is better now."*

6.2 Under cross-examination, the Applicant agreed that he had not attended for treatment as advised by Dr. Corry and again, in 2010, when Dr. McCormack had advised the same thing but again, at 27 years old, he did not seek further treatment. While cost may have been one factor, he never enquired about the cost of the proposed treatment but decided not to undertake any counselling. Finally, in respect of this reluctance to accept treatment, the Applicant agreed that Dr. Devitt recommended psychotherapy, and he said in response: *"I don't like talking about it I felt I wanted to sort things out for myself."* Dr. McCormack's evidence contained this conclusion, which is consistent with the other evidence in the case: "*what Garda Foley described was typical of what one finds in professions with great bravado, following an assault, there is embarrassment and a reluctance to discuss, they feel peers will view it in a bad light. It is typical in that regard, a young Irish male and a garda would go for a pint rather than talk about it."*

7. Application of the *Carey* case

7.1 Noting the suggested factors set out in *Carey* and dealing with each in turn, it has already been confirmed that:

(i) this was a serious and sustained assault.

(ii) whether any general or specialised medical treatment was warranted and if so the nature and extent of same: it is agreed that counselling was warranted and, had it been availed of, it would probably have alleviated the Applicant's symptoms in a year or so, insofar as one can tell at this remove. No other treatment or medication was prescribed and there was no associated diagnosis of depression.

(iii) the injured members' ability to cope with life and work following their assault, including any time they may have spent out of work: The Applicant spent a very short time out of work but his social life was affected by these events and he moved home and began to work in another town. Happily, he met and married his wife so, to that extent, he remained able to cope with work and with life generally. His sleep was affected and he had occasional panic attacks, frequent intrusive thoughts and avoided the town of Sligo. He was hypervigilant in certain situations but avoided certain social events and situations in order to cope with this.

iv) the effects, if any, of the injury on the members' personal relationship with his/her family and friends; this Applicant had excellent support from his family but did suffer some difficulties in his relationship with his then girlfriend as a result of the assault.

(v) any restrictions imposed upon the member as a result of their injury; the most obvious and long-lasting restriction was his avoidance of Sligo town and of busy or crowded pubs.

(vi) the prognosis and any future vulnerability as a result of their assault; the prognosis is excellent, despite the long duration of the symptoms. Even without the recommended medical treatment, the Applicant had recovered from the most significant symptoms by 2012.

(vii) the extent to which the injured party has mitigated their loss. This Applicant did not mitigate his loss - he was repeatedly advised to obtain counselling therapy but did not do so.

7.2 Both psychiatrists had seen the contemporaneous notes of Dr. Corry. None of the treating doctors appears to have interviewed the Applicant's wife, who has been with him since he moved to Galway, nor were members of his family asked about his symptoms in the months or years following the assault. Without in any way ascribing blame for this omission and taking into account the views (stated above) of Professor Kennedy that there ought to be more than one source of information for a diagnosis of such a serious psychiatric illness, it is my view that the Applicant has not produced sufficient information for the Court to conclude, safely, that he probably suffered from PTSD. While I note that this was Dr. McCormack's view, it was also clear from his evidence that a key finding which supported his diagnosis was that the various symptoms described above had been of such a duration that they went beyond an anxiety reaction. He also disagreed with Dr. Devitt on the meaning of what were called "*flashbacks*". Both conclusions are discussed below.

8. Evaluation of the Evidence of the Three Psychiatrists

8.1 My conclusion is that it has not been shown with sufficiently reliable, contemporaneous evidence that the Applicant suffered from PTSD. One of the reasons for this finding, aside from any disagreement between the doctors as to what the state of the evidence was in 2012, is the fact that the original treating doctor has, sadly, died and is no longer available to describe the symptoms he noted in 2006 and 2008. His notes were quite sparse and would not have supported a diagnosis of PTSD.

Neither witness suggested that the words used, alone, would justify that clinical finding and from what I read of the notes, they would not have been sufficient to fulfil the agreed criteria.

8.2 No treating doctor sought to ask his family about the symptoms so as to get a more objective picture of the Applicant's state of health at the crucial time, namely, contemporaneous with the first symptoms. This may have been due to the Applicant's own tendency to downplay the effect of this assault on him but nonetheless, it affects the weight of the medical evidence for the reasons outlined by Dr. Kennedy. This is not to criticise the Applicant or Dr. McCormack but to make the point that no evidence is as reliable as a contemporaneous account, particularly if it is supported by independent evidence. This phenomenon has been seen time and again in the courts, particularly in so-called historic abuse cases. Even those witnesses whose credibility is beyond question may be wholly unreliable when they are asked to describe events which took place many years ago. This is due to the frailty of human memory, not due to any attempt to distort the facts or to exaggerate. As must be perfectly clear, this Applicant has not sought to exaggerate his injuries. However, it is difficult to extrapolate, after the passage of so many years, what exact symptoms were manifest in 2006 and for the two or three years thereafter. This is why doctors ask patients to describe their symptoms and take a contemporaneous note.

8.3 The case of *O'Hara* v *the Minister for Finance, Public Expenditure* [2018] IEHC 493 was referred to as being potentially relevant to this case. The evidence in that case was quite different although the case also turned on the distinction between PTSD and anxiety disorder, with the same two witnesses giving evidence to similar effect. There, the diagnosis of PTSD was made by Dr. McCormack and others with access to contemporaneous notes which supported the diagnosis. That applicant was prescribed various treatments, all of which advice he followed. Further, the only reference in the judgment of Barton J. to the reason for the distinction between Dr. McCormack and Dr. Devitt was that the latter did not consider the evidence of threats

to be sufficient basis to justify a diagnosis of PTSD. There was no comparable discussion of symptoms and severity of symptoms. The following is a crucial paragraph in distinguishing that case from this one and confirms this Court's conclusions as to the difficulty for this Applicant in establishing his case:

> *"51. In my judgement it is significant that by the time Dr. Devitt first came to assess [Garda O'Hara] for the purpose of advising in these proceedings in 2015 he had already benefitted substantially from pharmacological and psychotherapeutic treatment whereas the physicians who diagnosed the Applicant with PTSD had had the benefit of assessing him in varying degrees of relative proximity to the incidents very much closer than when he was assessed by Dr. Devitt. As mentioned at the outset of this judgement the very detailed record of symptoms consistent with a diagnosis of PTSD made by Ms Tangney in such close temporal proximity to the first threats are particularly significant*."

8.4 In this case, we have one diagnosis of PTSD made many years after the event in question but with minimal contemporaneous evidence as to the effect on the Applicant at the time. There is the evidence of an Applicant who accepts that he is not inclined to talk about the effect of the incident on him and no contemporaneous account from any other person. The Court cannot assume, because the Applicant does not want to describe them, that the symptoms were therefore worse than appeared in Dr. Corry's note. What was later described to Dr. McCormack was a series of symptoms that had remained untreated since first described to a psychiatrist, years before.

8.5 Turning then to one of the other distinctions which may explain the different diagnoses of the two psychiatrists: While Dr. McCormack described more serious symptoms, the only symptom described as being one occurring daily was identified as that of "*flashbacks or vivid memories"*, which were described as being prompted by, amongst other things, looking in the mirror or experiencing pain in the injured tooth. This is not my understanding of the medical term in the context of a PTSD injury and

I accept Dr. Devitt's evidence in that regard insofar as Dr. McCormack describes both flashbacks and vivid memories as potentially fulfilling the criteria for PTSD. Dr. Devitt took issue with the description of vivid memories as being the kind of intrusive reliving of the event that is required for a diagnosis of PTSD. Insofar as Dr. McCormack appears to use the terms interchangeably, I prefer the evidence of Dr. Devitt. His evidence fits more readily into the accepted clinical definition insofar as I understood it from both witnesses. Merely having a vivid memory of an event can be said of almost any significant life event and should not be elevated to the status of a flashback, which term must mean an intrusive and distressing memory akin to reliving the event.

8.6 This is not to suggest that the Applicant did not ever suffer from flashbacks, even in the sense of intrusive reliving of these events. The evidence is that he did, but there is insufficient evidence as to how often this occurred or as to what intensity was involved. What he mentioned to Dr. Corry in 2008 was then described as intrusive memories. Nor is there sufficient evidence that such events, of significant duration or intensity, occurred every day. At most, the Applicant recalled to a psychiatrist in 2010 that he had vivid memories every day, but there is no contemporaneous evidence of this description nor is there sufficient description of the duration and intensity of the experience. This appears to me to fall short of the evidence required to prove one of the clinical symptoms expected in a case of PTSD. Dr. Devitt concluded that the word "*flashback*" had become a devalued term and I conclude that insofar as it is a required symptom for a diagnosis of clinical PTSD, it must mean something more than a vivid memory and it must be a recurring symptom of significant intensity.

8.7 The second point of dissension in the evidence concerned the issue of duration, Dr. McCormack pointed out that these symptoms lasted for a considerable period. In my view, it is more likely that the psychiatric symptoms suffered by the Applicant were significantly protracted because they remained untreated rather than because they were signs of a very serious underlying condition such as PTSD. The condition

from which this Applicant suffered was certainly debilitating and he had many of the symptoms of PTSD but Dr. McCormack emphasised that the duration of the symptoms was one of the reasons for his diagnosis. Dr. McCormack went on to say that he was "*concerned that the symptoms had persisted*" and might become chronic. Given what we know of the initial severity of the symptoms, this longevity appears to me to be more likely because the condition remained untreated. It must be recalled that no symptoms were noted by the Applicant's G.P. for over 6 months and, even then, were noted only as psychological symptoms. He was seen by Dr. Corry, a consultant psychiatrist, at the request of the solicitor who had carriage of this case rather than by his G.P. That is not to criticise the referral in the circumstances of this case, particularly as it has now become clear that the Applicant was persistently understating the psychological effects on him, but to emphasise that the expert in mental health who first assessed him noted that he was worried about his wellbeing, was embarrassed and, only when the Applicant had written a further account of his symptoms, did Dr. Corry add that he was anxious and had vivid intrusive thoughts. In all of those circumstances, it seems to this Court that the more likely diagnosis is one of anxiety disorder, falling short of the clinical condition of PTSD. As the disorder was untreated it probably persisted for longer than it should have done otherwise.

8.8 Dr. McCormack also expressed the view in evidence that one of the differences between an adjustment disorder and PTSD, is that the first is an adjustment to a social or personal situation or change, like a bereavement or a relationship breakdown, but is not usually associated with an assault. There can be an overlap, he said, like anxiety and sleep problems, but here he saw a very clear association of symptoms with this assault and this too led him to diagnose PTSD. In this regard, Dr. Devitt agreed that the cause of the symptoms in this case was the assault and he did agree that it was sufficiently traumatic to be the basis for a diagnosis of PTSD but that was not his diagnosis here. He stressed that such a serious clinical condition was more like to follow ongoing exposure to trauma such as war or protracted violence. He did not

rule out PTSD as a result of a single event but considered that, in this case, the subsequent symptoms were not severe enough to warrant the diagnosis and had not alerted any member of his family to seek help for him, even if he was unable or unwilling to seek it himself.

8.9 This Court accepts that the cause of the Applicant's condition was the assault but does not accept the suggestion that an assault could not be the basis for an anxiety disorder diagnosis. The severity of the symptoms is the more solid basis for distinguishing between the two conditions rather than the causal factor, as Dr. Devitt stated in his evidence, which I accept in this regard. Both types of causal factor are external and while one may be more likely to lead to anxiety than PTSD, and the other more likely to lead to PTSD, this does not lead, necessarily, to the conclusion that an assault cannot lead to anxiety and must, if it leads to psychiatric damage at all, be classified as PTSD.

8.10 The lack of supporting evidence from any contemporaneous source leads me to the conclusion that there is insufficient basis for a finding of PTSD. The evidence of Dr. Devitt, as to the nature of the clinical condition and the severity of the symptoms required to support such a diagnosis, was clear and cogent. In this context, I prefer his evidence as to the more likely diagnosis. While this Applicant undoubtedly suffered from very distressing symptoms, they fall short of the requirements to support the more serious conditions of PTSD. In particular, Dr. McCormack treated the Applicant as a supportive treating expert whereas Dr. Devitt approached the evidence of trauma more sceptically. The burden of proof remains on the Applicant throughout and it has not been displaced owing to the difficulties in obtaining contemporaneous evidence and the clear evidence of Dr. Devitt on the requirement for various symptoms, each of an intense and persistent nature, before PTSD can be diagnosed. There is no doubt that the Applicant endured symptoms for a lengthy period; nearly 7 years later there were residual symptoms and he continues to avoid Sligo town. However, this appears to the Court to be due, in all likelihood, to the fact

that his condition remained untreated. Further, the treatment advised for him was counselling only rather than medication or more invasive therapy recommendations. This advice is also a factor in considering the severity of the clinical condition.

8.11 Social and family support is vital but medical treatment, once advised, must be undertaken if the applicant in such a case is to be compensated for his symptoms and for the full extent of time during which his symptoms persisted. This is not to blame him, it is an entirely normal response to want to avoid talking of these events, as Dr. McCormack makes clear, but it is also problematic; if this was a broken leg and had he ignored medical advice, the court could not compensate him for anything beyond the time it would take to heal, had it been treated.

9. Appropriate Award

9.1 Finally, in terms of assessing damages, the Court must award a sum which reflects all of the injuries but does not compensate individually for each as though it were a separate item. The time spent recovering from each individual medical problem was duplicated to the extent that he was also recovering from the other sequelae. The sum awarded must be proportionate to the injuries and, while reflecting them all, this is not a question of appraising each individually and adding the separate sums together.

9.2 For the reasons set out above, the Court is satisfied that the Applicant suffered a verifiable psychiatric illness of adjustment disorder with anxiety and that this would have been expected to last, had it been treated appropriately, for a period of approximately one year. The prognosis as to duration is supported by the expectation of Dr. McCormack that when he first saw him in 2010, with counselling, the Applicant would have been expected to recover well in 9 months to a year. Again, as a matter of probability, this is in line with a clinical diagnosis of moderate anxiety which would have resolved had he taken the treatment he was advised for these symptoms rather

than the diagnosis of PTSD, a more serious condition which would be expected to be of a longer duration.

9.3 The Applicant's symptoms were that he felt very low and did not want to face his colleagues. His mood was variable and he had intrusive thoughts. These symptoms were very pronounced in the first months after the assault. The Applicant was embarrassed, particularly as local criminals used the information against him and to taunt him. He put on a brave face on it and deflected the comments, "*but it really bothered me*", to use his words. I take into account that he inclines to understate his problems. He drank too much, for a time, to get over his reaction to these events. From June of 2006 he avoided the town and all his friends there because of intrusive memories which any visit engendered and due to his fear that he would be assaulted again. I note in particular the severity of the avoidance reaction in this respect and the fact that he moved his home and workplace to avoid the town. I note further his specific and severe reaction on an occasion when he tried to re-enter the town but suffered a panic attack. I note also the "*100% change*" he described in his social life, avoiding crowded pubs or a Saturday night event. Finally, I note his disturbed sleep since these events. In his 2015 report, Dr. McCormack notes that he was now sleeping well and this is an important sign of recovery for the Applicant.

9.4 The Applicant suffered from occasional panic attacks and a lack of energy and motivation in the aftermath of these events and he had difficulties in his relationship with his girlfriend. He states that he drank more than usual for a year after the assault, but this has stopped. I am also delighted to hear his own evidence about his 4 children and happy marriage. These factors, along with his supportive parents, have undoubtedly helped him to deal with a very distressing few years and a lengthy period of recovery from a particularly nasty assault. He also started managing a local soccer team which helped him significantly in coping with his symptoms and to that extent I note some efforts to mitigate his loss.

9.5 In that respect, while I cannot award damages to compensate for the entire duration of the psychiatric symptoms due to the failure to obtain the recommended treatment, it should be clear from the comments made in respect of the Applicant that this is not a situation in which blame attaches to him. There is every reason to be sympathetic to such a plaintiff and Dr. McCormack expressed this well in describing the typical response of the Irish male to such symptoms as being to ignore them in the hope that they will eventually dissipate. They usually do, but this case is a good example of how long it can take and how important friends and family are to those who have suffered in this way. While I am constrained in the amount I can award to this Applicant, this is in no way a reflection on his evidence or his character. It is simply apply the law to the facts of the case as the Court is obliged to do.

9.6 As a comparator, I have considered the award made in the case of *Sheehan v Bus Éireann/Irish Bus and Or* [2020] IEHC 160, where Keane J. gave a written judgment in respect of a claim of PTSD. That plaintiff suffered panic attacks at work, which led to her taking 5 weeks off initially, followed by other breaks intermittently. This was a significantly debilitating condition and this case has no comparable symptoms. The plaintiff there was continuously irritable, suffered from hyperarousal and hypervigilance, angry outbursts and intrusive thoughts, she was ruminating constantly about the event (which was an RTA in that case). Intimate relations with her husband had ceased. Years later, she was still on medication and was undergoing therapy. She received €65,000 to compensate her for her injuries to the date of the judgment and €20,000 damages into the future.

9.7 In the application of Garda Carroll, a compensation claim I considered earlier this year, the applicant had a permanent reminder of bites received in a struggle with her assailant, a numbness within that area and increased wariness, though short of a PTSD injury. The long term consequences were very mild and I took into account that cognitive behavioural therapy was advised and not undertaken. I noted that an ongoing psychological injury might attract up to 50,000 if of long duration,

particularly if clinically significant symptoms, that was not so if the condition was one short of PTSD and there had been a failure to mitigate the damage. That claimant received €18,000 given the initially horrific circumstances which quickly resolved and the scarring which acts as a permanent reminder of the traumatic event. The award was expressed to be more than would otherwise be given for a short-lived psychological injury due to the shocking circumstances and the scarring on her arms.

10. <u>Physical Injuries</u>

10.1 The Applicant significant bruising to both eyes, his jaw and a fracture of the nasal bones which led to resulting minor but initially distressing deformity in shape. He had tenderness of the left side of scalp and at the back of his head with pain and tenderness of the left spinal region, especially on the rotation and flexion. Most of these symptoms persisted for about two weeks.

10.2 The Applicant he had urgent root canal treatment and a crown was fitted to the fractured tooth. He had a small scar on his lip, which was treated with bio oil. Dr. Kilroy, his dentist, has advised that the crown will need to be replaced in the future, probably twice, for aesthetic reasons if nothing else. This will cost in the region of €1,500.

10.3 The Applicant was admitted to hospital for manipulation of the nasal bone fracture under general anaesthetic on the 30th of January 2006, following which he wore an external nasal splint for approximately 10 days. He was on sick leave from the 16th of January 2006 to the 13th of February 2006, one month in total, after which he returned to full duties.

10.4 Mr. Considine, ENT Consultant noted that after the manipulation of the fracture nasal passage was carried out the Applicant was happy with the shape of his nose. Upon review in December 2014 Garda Foley had no nasal complaints apart from some postnasal mucous in the mornings. Examination revealed that his nasal bridge was slightly to the right and that internally he had a slight deviation of his nasal

septum to the left side. The airway was normal on the right and slightly reduced on the left. He recommended a sinus rinse.

10.5 The back and head injuries resolved quickly without complication and no sequalae have arisen. There is a slight deviation of his nose but does not bother this Applicant now. For a few years he saw his nose as out of line and it was a reminder of how it happened.

10.6 The Applicant had made a substantial recovery from most of his physical injuries by mid-2006 and did not appear, at that stage, to have suffered any lasting effects from the assault.

10.7 Had this alone been the effect of the assault, an award in the order of less than €20,000 would have been sufficient to fairly compensate the Applicant for up to a year of physical impediments, none of which impaired his functioning significantly after the first few months. His nose is now permanently slightly out of line but this is not an issue for the Applicant. He has a small scar on his lower lip which, again, has not been a source of major concern.

10.8 Given the multiplicity of physical injuries (nose, dental and facial) and considering also the clinical diagnosis of anxiety disorder of at least one year's duration (insofar as it would have been of much shorter duration had it been treated appropriately), I must award a sum that is reasonable and proportionate to the various injuries and that reflects the severity of the initial assault. Bearing in mind the two comparators referred to above and considering the additional physical injuries and the specific clinical diagnosis in this case, it seems to me that this case falls somewhere between the two awards already described, being less serious and of shorter duration than the first and more serious than the second both in terms of physical injuries and psychiatric injuries. This Court considers that a fair and reasonable sum, taking all these matters into account, is one of €45,000 and will award that sum in general damages to date.

10.9 I will also award €3122.40 in respect of special damages and €1,500 for future dental treatment.