Neutral Citation Number: [2008] IEHC 292

THE HIGH COURT

1988 No. 3563 P

BETWEEN

VICTOR MURTAGH

PLAINTIFF

AND
THE MINISTER FOR DEFENCE, IRELAND AND THE ATTORNEY GENERAL

DEFENDANTS

Judgment delivered by Mr. Justice Declan Budd on the 22nd day of July, 2008

Background

1. The plaintiff was a soldier in the Defence Forces. He was born on 22nd October, 1965. He was aged three when his mother died in an accident and he was brought up by his maternal grandparents in Ballymote, Co. Sligo. Dr. Mary Scully, a local GP, gave evidence about his upbringing and knowing him while he was being brought up by his grandparents for whom she had a high regard. He and his wife Veronica were only eighteen when they married on 16th February, 1984, and later that year in November 1984 at the age of nineteen he joined the Irish Defence Forces and was an employee of the army until he was discharged on 1st March, 1998, as being medically unfit. They started their married life in a local authority house in Sligo town. In May 1986 they had their second child and the plaintiff was posted to Athlone and then Mullingar in preparation for duty in the Lebanon. They wished to move and to buy their own house in Ballymote and in order to fund this purchase, the plaintiff volunteered to serve in the Lebanon. On 11th June, 1986, he was examined by army doctors, being his annual medical, and his fitness rating since his enlistment examination was confirmed as medical category A1. Soldiers going abroad on overseas service have to have further medical examination and he underwent this on 4th September, 1986. This is recorded in his personal medical record book known as an LA30. His fitness category was in the top grade, being A1 which he had previously been given on enlistment in 1984 and this was again confirmed in June 1986. On 22nd October, 1986, on his 21st birthday, he flew out with the 60th battalion to the Lebanon for a six month tour of duty, being his first and only tour abroad. Part of his training was as a mortar man in a weapons company. An element of this training involved his having been subjected to weapons fire, where troops are deployed in trenches and then weapons are fired over them to accustom them to being under gunfire and to give them some "battle inoculation".

2. Lebanon at that time had an atmosphere of hostility in that there were several different factions including the Israeli Defence Forces ("IDF"), the South Lebanese Army ("SLA"), Shia Moslems and Hezbollah (armed elements). On 21st August, 1986, almost two months before the arrival of the 60th Battalion, Lieutenant Frank Murphy had been the first Irish soldier killed during UNIFIL service in the Lebanon. This was while he was based at Camp Shamrock. Within days of their arrival at Camp Shamrock the battalion was subjected to hostile fire on a frequent and regular basis. The plaintiff became unwell on 29th November, 1986, and was admitted to the RAP (Regimental Aid Post), a slight misnomer as it was a battalion hospital, at Tibnin. Lt-Col. Collins was the senior doctor who saw the plaintiff and in the LA30 he noted "query petit mal epilepsy attack on 29/11/1986" on pp. 26 and 27 of the LA30. This notation was followed by a medical sign meaning "secondary to exhaustion". The plaintiff had complained of a problem at the back of his throat and he was given an injection of diazepam, a form of valium, to calm him down. He was kept in overnight and on 30th November he was allowed to return to duty with the proviso that he was not to be on duty with less than two colleagues. The plaintiff's case is that the significance of this was that the army doctors had or should have realised that the plaintiff was of vulnerable personality and at risk and not coping with pressures of a post traumatic stress variety. Camp Shamrock was the Irish battalion headquarters near Tibnin village, and there was also Camp Shakra and Camp Charlie. Brashit was a company headquarters for the plaintiff's weapons platoon.

3. On 6th December 1986 Private William O'Brien from Athlone was killed by gunfire. The troops were all trained in the use of radio transmitters and on 6th December, 1986, the plaintiff was at a checkpoint post 6-21 and he heard that an Irish soldier had been injured. He had heard firing and then was aware of a UNIFIL helicopter arriving. He realised that this meant a serious or fatal injury requiring an airlift to hospital. The plaintiff naturally was stressed by this event. He had trained with and knew William O'Brien.

4. On 10th January, 1987, Corporal Dermot McLoughlin was killed by a shrapnel round from an IDF tank. The Corporal was from Co. Sligo, as was the plaintiff. According to several of the other NCOs who gave evidence, Dermot McLoughlin had befriended and been supportive and caring of the plaintiff when on occasions the plaintiff had been stricken by fear. The Corporal had looked after him and restored him with a cup of tea, talk and sympathy. While the plaintiff was not physically present at the post at which either of his colleagues was killed, nevertheless he had been at an outpost which was within hearing of the fatal gunfire and of the tank shell explosion and was aware of these incidents as the outposts have radio contact with the company headquarters and, he was aware of the calls for ambulance and helicopter and then learned of these sudden and unexpected deaths of Irish soldiers well known to him. From all that Victor Murtagh said of Cpl McLoughlin, it was clear that he and his colleagues held Dermot McLoughlin in high esteem and Victor Murtagh particularly was grateful to Corporal McLoughlin for his advice, help and encouragement to him in his times of acute anxiety. I mention this because Cpl. McLoughlin's widow was called as a witness by counsel for the defendants and an issue was made as to whether Vincent Murtagh had been a friend of the late Dermot McLoughlin at all. This issue is one of several points in conflict which the court needs to resolve. There is one aspect of this which I should emphasise at this stage, which is that the evidence of Victor Murtagh and of the Corporal's fellow NCOs was all in praise of the conduct of Cpl. McLoughlin and, in particular, of his kindness and consideration and help to Victor Murtagh whom he had comforted in his distress when Victor was upset by close firing or by the ferocious electrical storms of the Lebanon in winter. I will return to the issues which arose which upset Mrs. McLoughlin in the hope that since my assessment of her late husband's role in the Victor Murtagh saga was all entirely to Dermot McLoughlin's credit, this may help to alleviate any unresolved grief syndrome in respect of her late husband who was clearly a decent and humane man, ready to help his fellow county man in distress, while serving far from home in the Lebanon beset by hostile factions.

5. It is common case that the 60th Battalion tour of duty was more than stressful and Lt.-Col. Maurice Collins, the senior medical officer, made this clear and often said that this was "a tough battalion". Clearly the plaintiff and his colleagues particularly in December, 1986 and January, 1987, came under close firing and threats from the faction fighting between the IDF, SLA (the surrogates of the IDF) and Hezbollah and "Armed Elements". It is significant that a number of the NCOs commented on how stressful this tour had been and one veteran NCO conceded that on his return that he had taken to the drink to cope with his experiences and memories in the Lebanon that winter and that it had taken him quite some time before he managed to escape from using alcohol as a palliative and regain a normal lifestyle.

6. It is noteworthy that the plaintiff was examined at the RAP at Tibnin in the episode mentioned above when he was brought in on 29th November, 1986, having become distressed and after losing consciousness. He was examined and then kept in overnight and

injected with diazepam as a sedative. On the plaintiff's Overseas Service Report AF667A the senior medical officer, Lt.-Col. Maurice Collins, wrote on 18th April, 1987, just before the plaintiff returned home, "This man is relatively emotionally immature and came under very severe pressure. He is liable to incapacitating anxiety states in such circumstances and should NOT serve o/seas for three years". The plaintiff had gone to the Lebanon after several medical examinations at the first of which on his enlistment he had been rated as a medical Cat. A1. In the course of this case it has been suggested on behalf of the defendants that the plaintiff suffered from alcoholism, having been drinking from an early age and as having a susceptibility to alcoholism before ever he volunteered to go to the Lebanon. Counsel for the plaintiff cogently made the point that it was hardly likely that the army would risk having an alcoholic mortar man in the weapons company of the battalion and that it seemed highly improbable that the army would risk having such weapons in the hands of an alcoholic on an overseas tour of duty, when such an addiction would involve danger to his fellow soldiers, and when, indeed, the Irish people take such a great pride in the expected and respected high standards of the Irish peace keeping battalions. The significance of the plaintiff's treatment and recuperation over two days at the end of November is that Lt.-Col. Collins was clearly aware of the plaintiff's acute state of anxiety and indeed, as a humane and dutiful medical man caring for his patients, he had gone out, as was his practice, in his jeep and checked out soldiers who came under his care with their platoon or company officers. He would have been aware from his discussions with Capt. McEvoy, the plaintiff's platoon commander, and with Cpl. Gaffney, and Sgt Gerry McCabe as well as CQMS Flanagan, among whom it was well known, that Victor Murtagh was suffering more stress than others and was reacting at times to gunfire and to electrical storms, with thunder and lightning, by uncontrollable shaking and tremulousness. The descriptions of the plaintiff's incapacitating states of anxiety with him shaking and "being out of it", meaning incapable and in a state of paralysis with terror, is reminiscent of the condition of a gun-shy dog after a fusillade of shots or the cacophony of noises of explosions at Halloween in Dublin. Several of the NCOs said that the condition of Victor Murtagh was common knowledge in the platoon and the company. Indeed, Capt. McEvoy confirmed that Sgt. McCabe, who was in command of a new outpost 621, for which his weapons platoon had responsibility, made it clear that he would prefer not to have Victor Murtagh among the troops under his command at outpost 621. This was a particularly stressful post as it had been set up on a hillside below an SLA compound which was subjected to attacks by Hezbollah or other factions which onslaughts involved much gunfire. Several of the NCOs mentioned that Victor Murtagh also would enquire as to the state of the weather when going on duty, and they were puzzled by this. However, one of them pointed out that electrical storms in the Lebanon have a spectacular ferocity. Anyone who has seen a dog cowering during thunderstorms at the noises of explosions or indeed who have seen people who are frightened of thunderstorms becoming upset by the electrical discharges, will readily understand why the sounds of guns or the explosions of lightning and thunder may subject some people to terror. The vulnerability of the plaintiff due to his immaturity at only just 21, and his gentle personality and strong reaction to the noise of thunderstorms or firing close to his position, and the effect which such incidents had in causing him acute anxiety states, should all have alerted the officers under whose command he was serving and the army doctors to the fact that Victor Murtagh was particularly susceptible to post traumatic stress.

7. The phrase "post traumatic stress disorder" came into wide usage in about 1980, but nervous shock, shell shock, and neurasthenia had been known to physicians for centuries. I am indebted to Commandant Gerry Kerr for his thesis on post traumatic stress disorder in combat veterans, and in particular for his noting of the many antique names by which this condition was known such as "soldier's heart" and "effort syndrome" during the American Civil War. Neurasthenia was described during that time and was attributed to the civil war experience of some veterans. In 1871, DaCosta described the symptomatology of modern day post traumatic disorder (PTSD) in his paper "On Irritable Heart". The First World War saw the addition of the diagnosis of "shell shock" and "battle fatigue" to the index of psychiatric illnesses. Apparently the term "shell shock" described those veterans of combat, who suffered from a combination of restlessness, irritability, startle reactions, mutism, tremors and other symptoms of anxiety, as well as repetitive battle dreams. Apparently at the time of the Korean War, the first edition of the diagnostic and statistical manual included the condition referred to as "gross stress reaction" in 1952. Comdt. Kerr interestingly points out that when the second edition was published in 1968, a time when there was no war, this disorder was dropped from the manual. He concludes that the recognition of PTSD as an entity in its own right resulted largely from studies carried out on returning veterans of the Vietnam War. The follow up of these veterans coupled with the long acknowledged fact that the battlefield was an area of high risk, psychologically as well as physically, led to the organisation of the many symptoms into a single diagnosis. Anyone who has read the poems of Wilfred Owen and Siegfried Sassoon can be in no doubt as to the reality of soldiers who have literally been scared out of their wits by the appallingness of carnage and inhumanity to which they have been subjected by the ghastliness of war, particularly in sodden, rat-infested trenches of the First World War. Col. Collins mentioned that the thinking on such psychological effects led to recognising the benefit of treatment near the front line. This would be in keeping with the thinking of the French Army doctors during the First World War where they developed such remedial measures for shell shocked troops near the battle zone with of course the advantage of retaining man power near the front line so that those who recover rapidly can take their place again in the firing line. I note the view that PTSD was a nomenclature which gained in use from about 1980, although the symptoms forming the constellation known as PTSD would have been well known for many years before then, such as flashbacks, intrusive recollections, startle reactions, restlessness, agitation, irritability and other symptoms such as evidence of stimuli associated with the trauma and hyper-arousal and perseveration, all belonging to the constellation of symptoms making up PTSD. It became recognised that PTSD carried risks of mobility, mortality, chronicity (being long lasting), increased risks of physical and psychiatric disturbances, and impairment of interpersonal and professional functions. With improved research as a basis for change over the years in the diagnostic criteria for PTSD these advances were reflected in the various editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM III 1980 and DSM III-R 1987 and DSM IV 1994). Diagnostic Criteria DSM III, is of interest in that in 1980 it was suggested that Criterion A consists of a stressor that would evoke significant symptoms of distress in almost everyone. Criterion B required that there be evidence of re-experiencing of the traumatic event. Criterion C necessitated demonstration of reduced responsiveness to or involvement with the outside world. Criterion D dictated the presence since the trauma of at least two of the following hyper-alertness or exaggerated startle response, sleep disturbance, guilt related to survival, memory or concentration impairment, avoidance of activities which arouse recollection of the traumatic events, intensification of symptoms by exposure to events that symbolise or resemble the traumatic event. Specifically, the stressor was not confined to war or its experience and therefore, although combat exposure provided much material for research, the diagnosis was not exclusively confined to military personnel or experiences. I will return to this aspect of the state of knowledge about nervous shock or neurasthenia or PTSD in due course, but I would be very surprised if humane, well educated Irish doctors assiduous in caring for their patients such as Lt Col. Collins and Comdt. Kerr would not have read *Shell Shock: The Psychological Impact of War* (1998 London) by Wendy Holden giving the history and chronology of knowledge about shell shock. While the book was published in 1998 well after the plaintiff's 1986/7 anguish in Lebanon it is a mine of information and makes clear that army doctors had to be well aware of PTSD and its constellation of symptoms either by 1986 under the name of PTSD, which was used widely since about 1980, or Nervous Shock, Shell Shock, Neurosis, Neurasthenia or the legion of other names by which the condition of the psyche was known. PTSD, however, has wider connotations than Shell Shock. I am sure that the Army doctors are aware of the works of Jennifer Johnson "*How many miles to Babylon?*" and of Wilfred Owen's "*Mental Cases*":

> "Who are these? Why sit they here in twilight?...
>
> These are men whose minds the Dead have ravished.
>
> Memory fingers in their hair of murders,

Multitudinous murders they once witnessed…

Always they must see these things and hear them,

Batter of guns and shatter of flying muscles,

Carnage incomparable and human squander

Rucked too thick for these men's extrication."

"*Mental Cases*" Wilfred Owen.

8. In 1917 Wilfred Owen suffered concussion on the Somme. In summer 1917 he was sent to recuperate at Craiglockart War Hospital near Edinburgh where he met Siegfried Sassoon. He later won the MC in France but was killed a week before the Armistice was signed. His work was first collected in 1920 by Sassoon. Doctors in the First World War had never encountered a war on that same scale nor had they ever seen anything like the varying degrees of mental breakdown among soldiers or experienced it in such massive numbers. The symptoms were wildly diverse, from total paralysis and blindness to loss of speech, vivid nightmares, hallucinations and memory loss. Some patients declined eventually into schizophrenia, chronic depression and even suicide. The medical consequences of severe trauma to the moral and mental state on the battlelines were, it seemed, unquantifiable. There was no telling who would be affected or why and the military and medical establishment were caught completely off guard, according to Wendy Holden in "*Shell Shock*". These considerations may be a diversion but one that is worthwhile. In the First World War the effect of terror on the minds of servicemen was first recognised as a problem that necessitated serious military-medical diagnosis, not least because the sheer numbers of men affected could not be spared from the frontlines, as the conflict throughout Europe continued to claim countless lives. The long term well-being of those who were stricken was considered very much a secondary issue to the manpower crisis. Thorough analysis of the problem was thought vital only in as much as it could distinguish genuine sufferers from malingerers – those hapless men whose debilitating mental symptoms labelled them as cowards and in some instances led to their execution for cowardice. Holden writes that largely due to the requirements of an efficient war machine to stem the flow of sick men being sent home, the science of military psychiatry was born, designed to reduce men's moral objection to war and to counteract the dramatic and often fatal effects of combat on the minds of servicemen. Progressing far beyond its early remit, military psychiatry's extraordinary findings about the workings of the mind have been widely adopted throughout modern psychiatric practice ever since. There has been much progress in military psychiatry's understanding of the deep effect on the psyche of exposure to extreme anxiety since Shakespeare wrote Lady Percy's lines in *Henry IV Part I*. Lady Percy tells Hotspur of his night terrors:-

"In thy faint slumbers I by thee have watched

and heard thee murmur tales of iron wars;…

Thy spirit within thee hath been so at war

and thus hath so bestirr'd thee in thy sleep,

That beads of sweat have stood upon thy brow…

And in thy face strange motions have appear'd,

Such as we see when men restrain their breath…"

9. In the Seventeenth Century Thirty Years War, stress related disorders were attributed to home sickness, or "Heimweh". In the American Civil War (1861-5) the Union Army had no label for the condition that could help explain or legitimise the puzzling behaviour of some of its men. No category short of lunacy could account for their symptoms and many were either sent to an asylum for the rest of their natural lives, despatched on the journey home where – left to fend for themselves – they died of hunger or exposure, or were hanged as malingerers. In 1860, William Hammond, a union surgeon who became one of the pioneers of nervous and mental diseases in his age, did his best to fathom the condition he described as "nostalgia" in which veterans continually relived horrible events. He wrote later:-

> "The cases were of amazing interest. At that time I had eighty epileptics, and every kind of nerve wound – palsies, choreas, stump disorders. Thousands of pages of notes were taken … massage was used to restore action to limbs in which healing nerve wounds left the muscles palsied or for the rigidity of splinted cases."

10. Other soldiers found to have "irritable heart" problems were said to show signs of an increased heartbeat and aroused feelings of alarm triggered by reminders of conflict. He treated all those afflicted by keeping them busy with non stressful work away from the frontline of battle. Hammond complained that many of his patients were too immature; some were just sixteen. "Youths of this age are not developed", he concluded, "and are not fit to endure the fatigues and deprivations of military life. They soon break down, become sick and are thrown upon the hospitals." With the First World War looming ever nearer, the medical profession and the military showed scant concerns at the possibility of psychological casualties. As war impended a doctor in the British Medical Journal advocated alcohol as an instant salve for any problems that might arise, while an officer of the 29th Division claimed that the cure for fear was a minute tied to the barbed wire at the front. Wendy Holden writes of Richard Trafford, a veteran who was only fifteen when he first saw service in the trenches, and his belief that it was easy to tell the genuinely afflicted from those who are feigning illness. "The ones that became shell shocked were mentally disarranged, they were not with you half the time, they were in a world of their own, it was like seeing a person in a fit", he said. "I do not believe there was any of our men cowards. It's surprising what you will do when you get shell shocked, they were not responsible for their actions. A man does not join the army to fight for his country and then run away."

11. This last quotation is apposite because it will be recalled that on 29th November, 1986, the plaintiff's condition was such that Capt. McEvoy, when the plaintiff became unconscious, decided that he required medical attention and called an ambulance in which the plaintiff was transported in to the RAP in Tibnin. There the description of his convulsive fit at the initial diagnosis was "? petit mal". However, it would appear that Col. Collins subsequently revised this view and was able to reassure Capt. McEvoy that the soldier did not suffer from epilepsy, which would have obvious repercussions for the man's qualification to serve in the army for reasons of the safety of himself or his colleagues, if he did indeed suffer from epileptic seizures. Reading these historical accounts of the effect of martial encounters and the ghastly brutality of war and its effect on the human psyche of normal people, it is borne in upon one that there are competing pressures on army doctors. While I have no doubt that the Irish doctors are solicitous in caring

with skill and humanity for their patients, nevertheless there is at times a competing impetus to ensure that troops are treated and recover quickly so that they can take up their duties as peacekeepers in outposts where they may be subjected to close fire and the peril of attacks, and at the same time have to fulfil their duties as peacekeepers between warring factions.

The Plaintiff's Other Cause of Action: Noise Induced Deafness

12. The plaintiff also sued in a separate cause of action for damages for deafness caused by negligence and breach of duty on the part of the defendants as his employer, by exposing him to excessive explosive noise levels when presumably the provision of muffs and other protection would have prevented this injury. I commend the parties for having agreed that this claim should be settled on admission of liability by the defendants for the agreed sum of €2,650.00 which was based on a 6.01% hearing loss which commutes in to a sum of €2,650.00. This is the award on foot of the claim in respect of deafness and presumably this carries appropriate costs. I have a note that a sum of €2,873.00 has been agreed in respect of doctors fees and travel expenses as special damages and this sum is referable to the second head of claim, namely the failure on the part of the plaintiffs to diagnose and treat in a timely manner the plaintiff's post traumatic stress and post traumatic stress disorder which became chronic and had devastating effects on the plaintiff's life and lifestyle and family life after his return from the Lebanon to Ireland.

13. Ms Veronica Hannin gave strong and convincing evidence that the husband who left her to go on a tour to the Lebanon in 1986, and who returned to her and their family for Christmas 1986 was the same affectionate and loving husband but that the man who returned from the Lebanon on 18th April, 1987 was not the Victor Murtagh whom she had married and who had gone to the Lebanon but this was a man with a changed personality, who was irritable and difficult, particularly with the children. She described his early morning waking and intrusive nightmares and particularly his startle response to the noise of a fire engine siren just after Victor had returned home, when he leaped from the bed and searched frantically for his gun in a thoroughly agitated state, oblivious to his being in the safety of his own home.

14. This second and separate claim to the deafness is in respect of the defendants' failure to diagnose and treat the plaintiff, who was suffering from post traumatic stress which, by reason of the symptoms of this, became chronic and afflicted the plaintiff's existence severely for a number of years and made him vulnerable and susceptible to future relapses into post traumatic stress disorder with its constellation of symptoms.

The Nature of the Plaintiff's Second Claim

15. The plaintiff seeks damages for post traumatic stress disorder, claiming that the defendants were negligent in not providing remedial treatment for him following his exposure to stressful incidents. The defendants as the employers of the plaintiff were under a duty to take reasonable care for the health and safety of their employees and to keep abreast of contemporary knowledge in the area of those afflictions to which soldiers were inevitably exposed in the course of duty; and that the defendants had negligently failed to take appropriate care for the health of the plaintiff, in that they had failed to observe the obvious manifestations of post traumatic stress disorder, or else had failed to recognise the significance of the symptoms and had negligently failed to obtain remedial therapy for the plaintiff. It should be emphasised that the plaintiff in these proceedings is not claiming damages for psychiatric injury on the basis that he should not have been exposed to trauma in the Lebanon, or that the army is in some way directly responsible for the events that occurred in the Lebanon. Rather the plaintiff claims that the defendants breached their duty to him by failing, *inter alia*, to identify and provide treatment for his psychiatric problems after they had arisen, and before they became chronic and then again, once they had become chronic, by failing repeatedly to identify and provide treatment for his psychiatric problems, even after advice and directions from the Chief Medical Officer, Col. Walsh, and after a firm and definitive diagnosis of the plaintiff having indeed contracted chronic post traumatic stress disorder when the army psychiatrist, Capt. Fionnuala Ó Loughlin conclusively diagnosed and confirmed her working opinion of post traumatic stress disorder made in her initial meeting with the plaintiff on 17th November, 1995. This working or preliminary diagnosis was confirmed on 29th February, 1996, when Capt. Ó Loughlin administered the CAPS test to the plaintiff, and by this confirmed her clinical diagnosis from his history and the symptoms which he was manifesting that he had indeed contracted post traumatic stress in the Lebanon, and it had remained undiagnosed and untreated to the affliction of the plaintiff, and the alienation of his wife and six children to the extent that his wife, the friend of his childhood, and the mother of his six children with whom he had lived from the time of their marriage in 1984 to their separation in 1995, found him to be so changed and difficult that she felt she had to leave him.

16. The plaintiff is not entitled to compensation because in his work in the army in the Lebanon he had been exposed to stress or because he has suffered post traumatic stress in the course of his work as a peacekeeper amid the hostility of the various factions involved in the conflict in the Lebanon. The plaintiff must prove, on the balance of probabilities, that his injury from the post traumatic stress disorder was caused by the fault of his employer in the failure to diagnose and treat and eliminate or reduce the levels of his PTSD. The plaintiff's strange and out of character behaviour while he was based near Bayt-Yahun and his manifest symptoms should have been noted and his obviously stressed condition brought to the attention of the medical officers as indeed it was, as Capt. McEvoy sent him in to the RAP at Tibnin for medical attention on 29th November, 1986. It is all the more surprising that he did not receive counselling and therapy since he showed clear signs of stress and incipient post traumatic stress disorder in early 1987, and his acute stress reactions were actually noted by the senior medical officer. Despite this awareness of the plaintiff's immaturity and vulnerability to psychiatric problems and his obviously stressed condition, there was a failure to recognise the obvious perils and the need to treat his symptoms, and as result of this culpable negligence on the part of his superior officers and the medical officers, their failure resulted in his contracting chronic post traumatic stress disorder. On the medical evidence, counsel for the plaintiff submits that the likelihood is that, if the plaintiff had received counselling and therapy when he showed the clear signs of stress and incipient post traumatic stress disorder in early 1987, then his condition would have been relieved, reduced or remedied and he would not have become subject to the long running and persistent post traumatic stress disorder which has so adversely affected him in his working, social, domestic and family life.

17. Counsel for the plaintiff adopted the phrases of O'Donovan J. in describing the plaintiff's claim in *Knowles v. Minister for Defence* delivered on 22nd February, 2002:-

> "However, the fact of the matter is that he (the plaintiff) does not complain that the defendants negligently inflicted psychiatric damage on him but rather that, having developed psychological and psychiatric problems which he maintains were manifest and ought to have been recognised as such by the defendants, the defendants negligently failed to initiate appropriate treatment for those problems." (p. 3 of the unreported judgment).

18. At p. 2 O'Donovan J. explained that:-

> "Accordingly, Mr. Knowles comes before the court seeking damages by way of compensation for the negligent failure of the army to identify and treat the psychological and psychiatric problems which he developed in the year 1978."

19. Mr. Knowles was a member of the 1st Irish Battalion serving as part of the United Nations Peacekeeping Force in the Lebanon in

the year 1978, when he was exposed to events which gave rise to severe psychological and psychiatric problems which progressed to a condition of chronic post traumatic stress disorder. However, Mr. Knowles failed to prove the essential factors in his case.

20. Counsel for the plaintiff has helpfully collected together the particulars of negligence and breach of duty and breach of contract alleged by the plaintiffs and I set these out seriatim, albeit they appear in several different documents from the statement of claim to several replies to notices for particulars:-

> "1. The defendants failed properly to monitor or treat the plaintiff;
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> 2. The defendants failed properly to examine the plaintiff;
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> 3. The defendants failed properly to counsel the plaintiff;
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> 4. The defendants failed properly to brief the plaintiff prior to engagement in the Lebanon;
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> 5. The defendants failed properly to assess the impact of intrusive trauma on the plaintiff as a vulnerable soldier;
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> 6. The defendants failed to warn the plaintiff of the potential risk of post traumatic stress disorder;
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> 7. The defendants failed to identify the symptoms of post traumatic stress disorder in the plaintiff;
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> 8. The defendants failed to recognise that the plaintiff was displaying symptoms of psychological problems, which required treatment;
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> 9. The defendants failed to recognise the significance of the symptoms that the plaintiff exhibited;
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> 10. The defendants failed to provide remedial therapy for the plaintiff;
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> 11. The defendants delayed in sending the plaintiff for psychiatric assessment, notwithstanding the symptoms he had displayed;
>
> 12. The defendants failed properly to provide follow up services for the plaintiff;
>
> 13. Insofar as they did participate in his treatment, failed to properly and professionally identify and diagnose his actual condition of post traumatic stress and failed to provide and maintain a proper and full medical history extending back to the incident which gave rise to treatment in the Lebanon to his treating psychiatrists so that they could properly assess and diagnose his condition leading to proper and appropriate treatment;
>
> 14. Having treated him for alcohol abuse, apparently successfully, failed to ensure his treating psychiatrists knew and were aware of the traumatic events to which he was exposed during service in the Lebanon giving rise to the necessity to treat him there and his subsequent development of post traumatic stress;
>
> 15. Caused, allowed or committed a systemic failure of transmission of information to occur as affected the plaintiff in that there was no system by which the plaintiff's operational officers and NCOs reported their observations of the plaintiff's inability to cope and deal with the pressures and trauma to which he was exposed to the medical corps or from one branch of the medical corps to another, and in turn to the treating psychiatrists;
>
> 16. Caused, allowed or committed the plaintiff to be treated simplicitor for alcohol abuse without ensuring his treating doctors were aware of the traumatic events which gave rise to his problems while serving in the Lebanon and had a full and complete picture of his medical history so as to give rise as to a suspicion of an underlying cause for his abuse of alcohol so as to enable same to be treated at the earliest opportunity."

21. The plaintiff in this case claims that the defendants failed in their duties to him in the respects set out above, particularly at 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16. I will refer to these in due course. Counsel for the plaintiff also claims that the defendants owed him continuing duties. In other words, while he remained in their service in the army, they remained under a continuing obligation to monitor and follow up on his symptoms to see how his known vulnerability to and a propensity for acute anxiety states when under pressure would continue to afflict him and, they also owed him a continuing duty to assess him and provide appropriate therapy or assistance to him in the event that the post traumatic stresses further developed which he had sustained in the various incidents in the Lebanon, which were well known to the senior medical doctors in the Lebanon with the 60th Battalion. Furthermore, they continued to owe him a duty to assess him and provide appropriate therapy or assistance to him while he was a member of the Defence Forces. In short, once they were aware that he suffered from psychological problems, whether of the nature of post traumatic stress disorder or depression or acute anxiety states, they should have specifically informed the army doctors under whose care he would be on his return from the Lebanon. The experienced civilian psychiatrist, Dr. Mary McGuire, said that once the diagnosis had been made that he suffered from acute anxiety states while in the Lebanon and in view of his being in obvious difficulties on his return to Ireland, she would have thought there would be some system of follow up for those who have been deemed to be psychologically unsuitable because of the afflictions which they have undergone in the Lebanon; there would at least be either a referral to the army psychiatrist on the man's return from the Lebanon before chronic post traumatic stress disorder should get a firm hold on him, or else they should have a system whereby when a soldier who has served in the Lebanon subsequently displays symptoms of post traumatic stress disorder or alcoholism that his LA30 and his CMF file should be copied, and this together with a report of a comprehensive nature from the doctor responsible for him in the army, should be sent to such civilian psychiatrist or other specialist who is treating the patient. It would appear that the lack of exchange of information between the treating psychiatrist in St. Columba's in Sligo and the army doctor responsible for his well being in Western Command meant that Dr. O'Flynn was given no information whatsoever about the 60th "tough Battalion" in which he had served in the Lebanon and the sort of pressures which he was recorded in his LA30 as having been under, not to mention the acute anxiety states and the knowledge of his extremely significant behaviour when he was cowering terror-stricken in his billet, or when he actually passed out probably from terror when about to go on duty during electric storms. Other incidents were when there was significant gunfire and explosions being exchanged between the hostile factions, particularly, while he was posted to the hotspot at Post 621 when the Hezbollah invaded the compound on top of the hill above manned by the SLA and drove away their vehicles and killed those in command of the compound. A useful history would contain a reference and description of any incidents of a life threatening nature or any killings which were of importance relating to the plaintiff and his symptoms. For example, it would have been imperative that Dr. O'Flynn would be told of the deaths of Pte William O'Brien who had trained with the plaintiff and was in the same company and also that of Corporal Dermot McLoughlin who

had befriended and looked after and helped to sustain the plaintiff during what was a very stressful and difficult time for him in the Lebanon.

22. The plaintiff maintains that the defendants owed a duty of care to him but failed to honour this in the respects set out above. The plaintiff also claims that the defendants owed him such duties on a continuing basis. In other words, while he remained in their service, they remained under a continuing obligation as his employer to monitor him and owed him a continuing duty to assess his needs and to provide appropriate therapy or assistance to him. The plaintiff's claim is that they failed in those duties for the duration of his service during and from his time in the Lebanon until his eventual discharge in March, 1998.

23. Accordingly, the present proceedings involve different issues from those which arise in classic cases of "nervous shock", for example, where someone comes upon the scene of an accident or attends hospital to visit a member of their family in the aftermath of an accident; accordingly, many of the legal issues which would arise in that sort of case do not feature in the present situation.

24. The factual pattern of this case is also different from cases of stress, bullying or harassment in the workplace. In those cases, the employer is generally alleged to be directly responsible for causing or permitting the harmful conduct to occur (for example through the acts of another employee).

25. The plaintiff's submission is that the general legal obligation of the defendants is as stated by O'Higgins C.J. in *Dalton v. Frendo* (Unreported, Supreme Court, 15th December, 1977). In this case O'Higgins C.J. on behalf of the Supreme Court said that the "duty of an employer towards a servant is to take reasonable care for the servant's safety in all the circumstances of the case".

26. In *McHugh v. Minister for Defence, Ireland and the Attorney General*, [2001] I.R. 424 at p. 429 it was stated that:-

> "The defendants, as employer, are under a duty to take reasonable care for the safety of their employees and must keep abreast with contemporary knowledge in the field of reduction in the effects of potential afflictions to which soldiers are inevitably exposed in the course of duty".

27. I have been told by counsel that has been accepted as a correct summary of the obligation of the defendants to a soldier in their service.

28. Counsel for the plaintiff then submitted that O'Donovan J.'s judgment in *Knowles v. Minister for Defence* delivered on 22nd February, 2002, is consistent with the McHugh decision in that O'Donovan J. stated that:-

> "In this regard, it seems to me that if, while he was a serving soldier in the Lebanon, the plaintiff, for whatever reason, manifested severe psychological or psychiatric problems which ought to have been recognised as such by his superiors and/or by the army medical corps to the extent that it was obvious that he required medical treatment, I think that the army were under an obligation to arrange for such treatment and that their failure to do so would in the event that it could be established that that failure compounded the plaintiff's problems, amount to negligence in respect of which the plaintiff would be entitled to compensation. However, to that end it would be necessary for the plaintiff to establish that the psychological problems which he manifested were readily recognisable as such." (Pages 41-42)

29. Counsel then submitted that this was a more specific statement of the broader principle which had been set out in the *McHugh* case and this specific statement would be relevant in the context of the issues that had to be determined by O'Donovan J. in *Knowles.* In fact O'Donovan J. concluded by saying that while he did not doubt the plaintiff Knowles's honesty, he considered that he was a totally unreliable witness and also was not satisfied that the plaintiff Knowles manifested any such psychiatric problems to the extent that they ought to have been recognised as such by the defendants. Furthermore he came to the conclusion that the implication from the medical records was that the plaintiff's besetting problem in June 1978 in the Lebanon was home sickness attributable to his loneliness and thus the judge did not think that the defendants could be faulted for the treatment afforded to the plaintiff at that time. Hence that plaintiff's claim was dismissed. There is a stark contrast between that and the manifestations of PTS by the plaintiff Murtagh and his acute states of anxiety, causing loss of conciousness and inability to speak, which incapacitating conditions were noted by the medical officers and NCOs of the 60th Battillion who were well aware of the plaintiff's paralysingly nervous condition at times of stress.

30. In the present case a clear issue arises as to whether or not Lt-Col Goggin did address the officers and NCOs in the 60th Battalion while they were having lectures, talks and briefings in preparation for their departure to the Lebanon in October 1986. An issue arose as to when Lt.-Col. Goggin first addressed the officers and NCOs before their departure to the Lebanon. Earlier in the case, long before Lt-Col Goggin was called, Sgt. Gerry McCabe had given evidence relevant to at least two of the issues which confront the court. The first of these issues in contention is as to when Lt-Col Goggin first addressed the officers and NCOs of the battalion in preparation for departure to the Lebanon. Sgt Gerry McCabe was giving direct evidence having been called by Mr. Smyth, counsel for the plaintiff. In the course of describing some of these briefings, Sgt. McCabe said that there was also a briefing from a Lt-Col and said "I cannot remember his name, he was something of a doctor, what was his title…?" He was asked "what did he talk about?" and he replied "he talked about mental health basically".

> Mr. Smyth: Q. Mental?
>
> A. Your mental state going over there and what you might witness in the event of witnessing a shooting or a killing or an illegal killing or whatever.
>
> Mr. Smyth: Q. Tell my Lord about that, can you remember what was said about mental health?

31. The Sgt. confirmed that a briefing had been at St. Columbs's Camp at Mullingar and he then said that he thought "the Lt-Col's name might have been Goggin, I think it is". And he said that the Colonel just gave them a lecture on what to expect. He talked graphically about bodies being blown to pieces and the likes. In the event of an explosion he said "being on a patrol sent to investigate, this will not be a nice scene you are going to see". He gave graphic talks. It was all during the one talk but there was a break or two in the talk. When he was asked about the mention of mental health, did he mention anything about that? and the Sgt replied "to be quite honest he talked at a level I did not really understand a lot about it". The Sergeant said:-

> "The only incident that stuck with me a lot of years afterwards was that he said he had treated or dealt with a guy somewhere, I do not know where, whereby the guy said every time he smelt aftershave off his hands, he remembered something that happened when recovering a body at some point. I do not even remember what country he was talking about, to be quite honest".

32. In answer to a question from Mr. Smyth the Sergeant then said:-

> "He talked that if you were sent in to recover bodies, get on with it, this person's life was over, it was part of the day's work."

33. Sgt. McCabe was clear that this talk had not been prior to his previous trip to the Lebanon but was at Mullingar during the preparation for the 60th Battalion's departure in 1986. Subsequently when Lt-Col. Goggin (retired) came to give his evidence he described to the court that he had been at a conference in Paris in the spring of 1986, involving a research group of military psychologists at which he had made many useful contacts and was able to keep up to date with current research. In particular, the Americans had been very helpful to him as they were in touch with the Israelis who had recent experience of the psychological effects of armed combat. Col. Goggin's own evidence was convincing that it was later in 1986 that he had given his talk to the officers and NCOs at Mullingar. Subsequently it was suggested to Lt-Col. Goggin that he was mistaken as to the year and Col. Goggin said that unfortunately when he retired from the army he had left his documents and papers accumulated over the years in an office and that these papers had been cleared out and destroyed. It does seem extraordinary that in an organisation which must depend on record keeping so as not to repeat earlier mistakes and particularly, in such a cutting edge and important study as the psychological effects on soldiers of the damaging mental effects of conflict, that the records of the army psychologist, a former veteran of the Congo expedition, should be simply destroyed. This probably meant the destruction of the material for an interesting book as Col. Goggin according to Niall McEvoy, a later witness and retired captain said that the Colonel was a renowned raconteur and certainly his notes on military psychological matters would have been of great interest. I should add that the former Capt. McEvoy and Lt-Col. Maurice Collins, the senior doctor with the 60th Battalion in 1986/7 both said that they did not attend Col. Goggin's talk in 1986. Capt. McEvoy agreed that Col. Goggin was a man who was not forgetful but of good memory and, it appears to me that both Capt. McEvoy and Lt-Col. Maurice Collins were part of the battalion in preparation for the tour of duty in the Lebanon, but for various good reasons as busy officers they must have missed this particular talk. I have every confidence that Lt-Col. Goggin's memory is correct in that he did address the officers and NCOs and I am sure that he would be very likely to remember the first occasion when he carried out such a briefing after his attending the conference in Paris in the spring. There he made good contacts and became friendly with many of the other delegates. I am sure that Lt-Col. Maurice Collins, as the Senior Medical Officer in Western Command had many calls on his time and would not be able to attend all the briefings. I am happy to rely on Lt-Col. Goggin's positive memory of doing this briefing in the aftermath of the Paris conference, and in this he is supported by Sgt. McCabe who had given his evidence long before Col. Goggin and was able to remember his name after a time and also some graphic snippets of the address, about bodies being blown to pieces and the need if you were sent in to recover bodies, then to get on with it as that person's life was over and it was part of the day's work.

34. Sgt. Gerry McCabe's evidence is particularly relevant on two other aspects which are contentious. He was asked about training in respect of signals in relation to communications while you are at your outpost or at a checkpoint. He explained that once you were at a post in Lebanon, each post would have communications back to the central post which would be the company headquarters, so all personnel had to be able to use a "77 set" at the time. This was a radio system of communications and all the troops had to be trained to use this radio set. They would be able to make the call from an outpost to a company headquarters. The central communication would be in the company headquarters which for the Weapons Platoon was at Post 6-16 in Brashit. The importance of this piece of information is that the plaintiff said he was at an outpost at the time of the killing of Pte. William O'Brien on 6th December, 1986. His training ensured that Victor Murtagh would have been taught how to use the radio since all the soldiers had to be able to use a "77 set", and this meant that there was communication between the various outposts and the central communication centre at company headquarters. This ties in with Victor Murtagh's evidence that on 6th December 1986 there was a commotion of messages on the radio and his awareness of the tank attack at Brashit on 10th January, 1987.

35. Sgt. McCabe was also able to describe the part of the training which involved a three mile run at 7.00 o'clock in the morning and how, when one got back one would then shower and have breakfast and be on parade by 8.30am. He explained how the weapons platoon would be the smallest. Sgt. McCabe also confirmed that the 7.00am three mile run was obligatory for everyone, unless you could not take part for a reason other than ill health. He confirmed that one man was returned to his unit in Finner over missing a run. The Sergeant confirmed that as an NCO you were there to observe the soldiers' fitness. He was asked how did he know whether somebody was up to the mark and he responded that as an NCO you were there to observe these things, mainly an NCO trained these men on whatever weapon he was involved in for that day. He explained that if you found a man not doing what he was supposed to be doing, then you would note it and remark this to the platoon Sgt or platoon officer. I mention this episode as indicating that the training period was a time during which the officers and NCOs were able to monitor the suitability of the soldiers for going overseas and also a period in which the officers could assess the soldiers and the NCOs. This was the time in which doubts about a person's suitability could be expressed and investigated. There was a suggestion that a number of the soldiers from the Sligo area, including Victor Murtagh had been out late one night and had not been ready for the run. No doubt this would have caused scrutiny of the conduct and record of each of the men involved. I had some reservations about this aspect but there was certainly a strong observation made that a Sergeant had been regarded as unsuitable and was not taken overseas on another occasion. My assessment of this aspect was that there had been no serious concerns or any anxiety expressed, if any at all, about Victor Murtagh before he went to the Lebanon in respect of any untoward conduct in respect of the excessive consumption of alcohol.

36. Sergeant McCabe was asked if he ever had cause to mention Victor Murtagh to Cpt. McEvoy in the context of the training period and in the context of whether a soldier was up of the mark from the point of view of being fit to travel overseas. Sergeant McCabe said that he never did have cause to mention Victor Murtagh to Capt. McEvoy at this training stage which was when the fitness programme included a three mile run at 7.00 am in the morning. Earlier in his evidence in answer to counsel for the plaintiff, Sgt. McCabe said that there was one man who was returned to his unit over missing a run and that that person did not take part then in the trip to the Lebanon. Counsel then asked the Sergeant about the suggestion that Pte. Murtagh had some affection for drink and asked if he knew anything about this before they went to the Lebanon. The Sergeant's answer was that "he may have been fond of a drink, no more than I was myself nor any of the rest of us, but I was not aware of a drink problem". Counsel then asked "and if a soldier had a drink problem would that be something that should have come to the attention of an NCO or even an officer while on the preparatory course in Mullingar?" Sergeant McCabe answered this by saying "that was the purpose of phase two of the training, to observe the forms of people" and on being asked if any weakness was there, would it usually be observed during that period? He replied that it might be and then again somebody might still get by, it was possible. He seemed to speak with candour and fairness.

37. The significance of this evidence given by Sgt. McCabe is that the Sergeant was one of the NCOs who would have known Victor Murtagh well and was a senior NCO in the weapons platoon in C Company. Furthermore it would seem that he had no reservations about Victor Murtagh, particularly in respect of the matter of alcohol, before they went to the Lebanon. While in the Lebanon, he was NCO under the command of Capt. McEvoy who supervised the building of the new post below the SLA compound in the latter part of the tour of duty and it was he who had voiced reservations to Capt. McEvoy about the condition of Victor Murtagh, not in respect of alcohol intake, but because he was suffering from incapacitating agitated states and the shakes. This was at a time when the plaintiff's vulnerability to stress had produced states of agitation to the extent of loss of consciousness and also seizures which

caused both Capt. McEvoy and Lt-Col Collins to have initial fears of the plaintiff having a susceptibility to epilepsy. However it seems that Col. Collins satisfied himself that the plaintiff had suffered acute anxiety stress while under severe pressure and had an immature personality. This presumably was not surprising in view of the fact that he was only just twenty one as he arrived in Lebanon. Colonel Collins said in evidence that he wrote T (the symbol for 'query') "acute anxiety state" at the bottom of the page in the LA30 but his recollection was that this was written in respect of the plaintiff having arrived in by ambulance to the RAP Tibnin on the 29th November, and he had been examined and given an intra muscular injection of Diazepam. The note on the medical records is that the patient was aware of his tongue going to the back of his throat and that he had subsequently had loss of consciousness and that this was when he was going on duty. Colonel Collins had noted in his distinctive handwriting:

> "? Petit mal epileptic attack
>
> ? 2. exhaustion" (which I was told meant secondary to exhaustion).

38. The note went on to say that on 30th November, 1986, he was discharged to his unit well but with the instructions that:

> 1. Not to be on duty with less than two others
>
> and underneath this "PLNCDR advised" meaning "platoon commander advised".
>
> 2. Advised to rest and to inform if any further problems

39. and this was signed by Lt.-Col Maurice Collins on the 30th November, 1986. Again on 2nd December, 1986, it was countersigned at the bottom of the page where medical category A1 appears with Lt-Col. Maurice Collins' signature and SMO after that written in his handwriting. On the next page of this note against the date 29th November, 1986, there is a further note by Lt-Col. Collins which includes:

> "0900 slept well, tongue sore nil else"

40. below this the Colonel wrote

> "rest. Check P (pulse) BP and temp (temperature) 6 hourly".

41. Under this the Colonel noted Rohypnol 1 nocte which means he was given the hypnotic Rohypnol at night, this being a sleeping tablet.

42. At the bottom of this second page there is under an entry for 18th December, 1986, also in the colonel's handwriting a T symbol which he said meant query "acute anxiety attack". Lieutenant Colonel Collins related this note by him back to his querying in his own mind his 29th November, 1986 entry – was it really a convulsive episode or was it because a patient had had an acute anxiety attack on 29th November, 1986.

43. For completeness in respect of this important medical note I should add that in the intervening note for 18th December, 1986, under "notes", the colonel had written

> "Reviewed last night" (meaning 17th December, 1986). Considerable emotional pressures.
>
> Domestic problems.
>
> Going home (holidays) today and hopes to be able to resolve all this Otherwise says trip is "great".

44. It would seem from these medical records made at the RAP (Regimental Aid Post) at Camp Shamrock at Tibnin on about both 30th November, 1986, and 18th December, 1986 that the plaintiff was suffering on the 29th November, 1986, from a seizure and loss of consciousness when going on duty about midnight and that this had some resemblance to an epileptic petit mal convulsive attack which episode Col. Collins suspected was secondary to exhaustion.

45. Subsequently the plaintiff was seen again on the 17th December, 1986, and Col. Collins' note was written up on 18th December, 1986. At some stage, probably he thought on 18th December 1986, he wrote "acute anxiety attacks" with a query, which is the symbol like a T. This was a very significant entry for several reasons. First, it makes very clear that the senior medical officer at the Battalion headquarters at Camp Shamrock, Tibnin, on reflection felt that the plaintiff was suffering from acute anxiety attacks. He subsequently in the AF667A, signed on the 18th April, 1987, wrote that "This man is relatively emotionally immature and came under very severe pressure. He is liable to incapacitating anxiety states in such circumstances and should NOT serve o/seas for 3 years" and marked him as suitable on physical assessment but unsuitable on psychological assessment. From this it is clear that by the end of the tour in Lebanon the senior medical officer had confirmed his view that the plaintiff was liable to incapacitating anxiety states in circumstances where he came under very severe pressure. This indicates that the medical officers were aware that the plaintiff had come under very severe pressure and also that he was liable to incapacitating anxiety states. In such circumstances it is clear from the expert psychiatric evidence given by Dr. Mary McGuire that this diagnosis of liability to incapacitating anxiety states and the awareness that he had been afflicted by a number of such manifestations of anxiety states while in the Lebanon should have entailed that the plaintiff needed to be and should have been referred for medical and probably particularly psychiatric examination on his return to Ireland. I will give a more detailed description of Dr. McGuire's evidence in due course.

46. Certainly it would seem vital that once the medical officers were aware of the plaintiff's difficulties of this serious nature under pressure in the Lebanon that he should have been referred to the army psychiatrist on his return to Ireland. I appreciate that the senior medical officer is not a psychiatrist but he is a very senior military medical doctor and, as Dr. Mary McGuire pointed out, they as doctors had been aware over centuries of post traumatic stress disorder, although it was not called that widely until about 1980; nevertheless the condition had previously been well known under a string of different names from "neurasthenia" to "shell shock". By whatever name it was known, the military were well aware that soldiers exposed to gunfire and brutality and fear of death and injury and their mortality were often affected in the mind. The mental hospitals of Europe, during the First World War, were many of them full of those suffering from "shell shock". As to the pressures on this tour of duty, having listened to Col. Collins and Capt. McEvoy I have no doubt that the troops came under extreme pressures with Hezbollah mounting attacks on the SLA compound, particularly in the vicinity of the outposts being manned by Capt. McEvoy's weapons platoon, including the plaintiff, both of which outposts were within about a 1000 metres of the SLA compound and the firing of weapons and fighting would have been particularly ferocious when the Hezbollah attacked and stole troop carriers from the SLA compound and drove them down past the Irish Battalion outposts during

the period from the end of November to the end of January during which both Pte. William O'Brien and Cpl. McLoughlin were killed, both being well known to the plaintiff. Cpl. McLoughlin had been from Sligo and was particularly supportive and kindly to the plaintiff.

The existence of post traumatic stress disorder in the present case

47. The plaintiff was diagnosed as suffering from post traumatic stress disorder by the army psychiatrist who was Dr. Capt. Fionnuala O'Loughlin, who saw him in November, 1995. On his return to Ireland in April 1987, the plaintiff's wife found him to be a man of changed personality. Shortly after his return he had the episode at night of leaping from his bed and searching frantically for his rifle, when he was disturbed by a fire siren in the night. He subsequently resorted to alcohol to try to overcome his problems which resulted in his having at least nine admissions to St. Columba's Hospital in Sligo, many of which were in respect of excessive taking of alcohol. I should add that the case being made on behalf of the plaintiff is that he should have been examined and treated both in the Lebanon, when he exhibited the acute anxiety states, and on his return to Ireland suffering from post traumatic stress disorder. Unfortunately, while the army would have had his LA30 and his central medical file, very little information, if any, was given to Dr. Fidelma Flynn, the treating Psychiatrist in the psychiatric hospital in Sligo. She was never sent a proper history or file about his experiences in the Lebanon and of course she was dealing with a patient who was repeatedly admitted as an emergency patient in respect of abuse of alcohol. However, eventually her locum Dr. McCarrick and his assistant Dr. Paddy Breslin, despite the lack of information about the stresses in his tour of duty in 1986/7 in the Lebanon, raised the question as to whether the plaintiff was suffering from PTSD, rather than from depression and the results of taking excessive alcohol. On the 2nd June, 1994, Dr. Breslin wrote to Capt. Dr. Kerr:-

> "Dear Doctor,
>
> Mr. Murtagh was admitted to our care on 3/5/94 for alcohol detoxification. He has history of previous admission to mental health services dating back to June '88 for treatment of alcohol abuse and depression. Prior to this admission he admitted to drinking heavily for the three previous weeks. Claimed he was drinking on account of depression and that he felt under stress in the army. Felt very discontented with army life and they were not treating him fairly (Dr. Breslin omitted the "not" but in evidence said this was simply a mistake on his part and his explanation accorded with sense in the context).
>
> He underwent uneventful detox regime and attended AA counselling; he was also commenced on Prozac 20mg mane, which has elicited a beneficial response. He was commenced on Melleril 25mg nocte due to restlessness and agitation in the evening. But his history reveals he is a married man with four children who has lived in Ballymote all his life. He joined the army at a young age and performed duties in the Lebanon in 1986 (approx) – two close friends of his were fatally injured while on duty and Victor claims that this affected him severely. He claims he started to drink heavily on his return from the Lebanon, felt depressed and found it difficult to work in the army. He also claims that he still suffers from insomnia and nightmares associated with service in the Lebanon when his positions were under attack.
>
> Dr. McCarrick feels that he may be suffering a form of post traumatic stress disorder and feels that treatment with his problems may help Victor's problem. We were made aware of the army having facilities which deal with this problem in Dublin and perhaps Victor might be a candidate for assessment for such treatment. Present meds: Melerill 25mg nocte, Prozac 20mg marne, Librium 5g nocte, reducing dose. We are planning to discharge Victor on 26/94 and will follow him up at the Ballymote OPD.
>
> Thanking you
>
> Yours sincerely
>
> DP Breslin SHO (Senior House Officer)

48. It is clear that Col. Collins must have seen this letter as he wrote on the foot of it:-

> "Dr. Breslin is locum for Dr. Flynn (this is incorrect; Dr. McCarrick, an experienced psychiatrist, was the locum and Dr. Breslin was the SHO).
>
> Capt. Kerr is arranging for review with Dr. Flynn and will discuss proposal to refer to Dublin.
>
> 25. this MS memo was signed by Col. Collins."

49. Unfortunately neither Dr. Flynn nor her locum Dr. McCarrick nor any of the GPs in Sligo were given a history of the plaintiff's experiences on tour of duty in the Lebanon in 1986/7. Despite the warning note sounded by Dr. Breslin on behalf of Dr. McCarrick (who was an experienced psychiatrist who had had experience in dealing with casualties of the 'Desert War'), it was not until 7th November, 1995, that a handwritten letter was sent fromDr Kerr at Finner Camp near Ballyshannon to Dr. Fionnuala O'Loughlin, the army psychiatrist. This letter is significant for its tone and content and so I quote it in full:-

> "850416 Pte Murtagh Victor
>
> C Corp 28th Inf Bn
>
> Finner Camp dob 22.10.65
>
> Finner Camp, Ballyshannon, 7th Nov. 95
>
> Dear Fionnuala,
>
> Thanks for seeing this 30 year old married (with four children) but separated soldier who has various psychological and psychiatric illnesses including alcohol abuse going back as far as 1988 at least. He is currently Med. Cat. C. He has several admissions in the past to St. Columba's Hospital under care of Dr. Fidelma Flynn, psychiatrist with both alcohol abuse and depression. The most recent one being from 17th July to 28th July '95. I gather that Victor failed to attend for follow up on at least one occasion following his discharge. Victor is currently on S.L. (sick leave) and is on Molipaxin 150mg nocte. He is determined to leave the army but before setting up a new file for the board I would value your opinion and in addition wish to out rule any possibility of Post Traumatic Stress Disorder. Victor apparently mentioned this to Dr. Flynn's locum in June '94, but both she (Dr. Flynn) and I never found supporting evidence. By its nature however it is probably better that this issue is clarified before the man is reviewed by Med Board. I intend to inform Dr. Fidelma Flynn of

my intention of referring the patient to you (so far today I have failed to contact her) in case she might like to add any further comments/information.

Kind regards

G. Kerr."

50. I have underlined the phrase "I would value your opinion and in addition wish to out rule any possibility of Post Traumatic Stress Disorder". An inference might be drawn from this that Dr. Kerr had misgivings about Dr. McCarrick's suggestion about the need for a referral and the obtaining of the views of the army psychiatrist. I should also add that Dr. Flynn under cross examination did agree with Counsel for the plaintiff that the hospital notes did include references to several symptoms of PTSD; however the patient was referred to her often as an emergenct admission suffering from too much alcohol and traumatised patients are notoriously and understandably reticent in narrating the terrifying incidents which have afflicted them. Furthermore, there appears to have been no protocol or considered system for ensuring that a copy of the contents of even the LA 30 of a soldier who had served in a tough and terrifying tour in the Lebanon would be sent to the treating doctors in a Psychiatric Hospital being attended frequently by the soldier patient, even though the plaintiff patient had an A1 med category and no psychiatric problems before the experiences in the Lebanon. Dr. F. O'Loughlin moved quickly and on 17th November, 1995, she had interviewed Victor Murtagh and wrote to Capt. Dr. Kerr from St. Bricin's Military Hospital, Infirmary Road, Dublin 7, date 17/11/95 Re: Pte. Victor Murtagh:-

"Dear Gerry,

Thank you for referring this man. He is a difficult historian and quite reluctant to discuss Leb. incidents. However, I think he may still be suffering residual effects and may in fact have PTSD.

I have asked him to come back on 29th (Wednesday, 11.30 am) to go into things in more detail.

Yours sincerely

F. O'Loughlin."

51. Dr. O'Loughlin explained in evidence, she meant by ~"difficult historian" that the plaintiff had difficulty in talking about his experiences particularly in the Lebanon. In evidence she said that in this initial interview she formed a working diagnosis that he did in fact have PTSD still. As for his being a difficult historian and being quite reluctant to discuss Lebanon incidents, there was ample psychiatric evidence given that this is quite a usual feature of patients suffering from PTSD. She interviewed the patient again and on the 29th February, 1996, she confirmed her diagnosis that he was suffering from PTSD. This she confirmed by administering a CAPS test, which was done by her administering the questions in a prepared form and noting the category into which the answers fall. The CAPS test was devised by the National Center for Post Traumatic Stress Disorder in October 1990 and is a clinician-administered PTSD scale.

"Purpose: the CAPS 1 was developed to measure cardinal and hypothesised signs and symptoms of PTSD. This clinician-administered instrument provides a method to evaluate the frequency and intensity of individual symptoms, as well as the impact of the symptoms on social and occupational functioning, the degree of improvement since an earlier rating, the validity of the ratings obtained and the overall intensity of the symptoms. Whenever possible, the CAPS 1 should be used in conjunction with self-report, behavioural, and physiological measures when assessing either baseline or post treatment status."

"If the patient makes the PTSD diagnostic criteria for the past month, he or she automatically meets the criteria for a lifetime diagnosis. If not, use the "Lifetime Symptom Query" to establish a high-symptom one month period since the trauma for which to re-assess the frequency and intensity of each symptom."

52. Section 21 deals with rating validity where the clinician estimates the overall validity of the ratings obtained. Factors that may affect validity include the patient's co-operativeness and his/her attempts to appear more or less symptomatic than is actually the case. Furthermore, the type and intensity of PTSD symptoms presented, can interfere with the patient's concentration, attention, or ability to communicate in a coherent fashion. It is significant that Dr. O'Loughlin circled 0 in this rating validity which means that the patient was co-operating and attempting to answer genuinely and not attempting to appear more or less symptomatic than is actually the case. In short, the overall validity of the ratings obtained was excellent, with no reason to suspect invalid responses. At section 22, headed "Global Severity" the interviewer's judgment is given of the overall severity of the patient's PTSD symptoms. Dr. O'Loughlin has circled 3, which denotes severe symptoms, limited functioning even with effort.

53. By letter dated 27th May, 1996, Capt. F.B. O'Loughlin, MB MRCPsych, Psychiatrist, St. Bricins Military Hospital, Dublin 7, confirmed her view in psychiatric report;

"Re: Pte. Murtagh Victor, Unit 28 Bn, Finner, date of birth 22.10.65. Army No. 850416. Pte. Murtagh was referred to the Psychiatric clinic in November 1995, by Capt. G. Kerr.

At that time he was on sick leave C/O depression since April 1995. His sleep was disturbed, and he had early morning wakening; he had become very irritable at home with his wife and children.

He had history of an alcohol problem and depression in 1987.

He was O/S in Lebanon on 1986 with the 60 BN, and described a number of incidents which caused him distress. A friend was killed in an explosion; and a number of colleagues were injured when Tibnin House was blown up; the funeral convoy for his friend came under fire and he and his colleagues had to take cover. He also related many instances of close firing.

He suffers from post traumatic stress disorder with a history of co-morbid alcohol abuse.

He has been on Mollipaxin 150mg since April '95. I discontinued this in March '96, prescribed Sertraline 50mg. mane.

I last saw Pte. Murtagh in March, 1996.

He remains depressed; his sleep is poor, and he continued to be quite irritable at home.

I feel the progress in Pte. Murtagh's case is not good as regards returning to work in the army. He has now been off sick for one year, and I feel it is very unlikely he will return to work.

He was unable to keep his last appointment, but I will arrange a further appointment in the next couple of weeks.

I remain

F. O'Loughlin Capt. MO AMC (Medical Officer, Army Medical Corps.)"

54. Accordingly, the plaintiff was diagnosed as suffering from post traumatic stress disorder by the Army psychiatrist who is experienced in diagnosing and treating patients with PTSD. I have absolutely no hesitation in accepting the diagnosis made by the Army psychiatrist. In her evidence she made it clear that she reached a working diagnosis at her first meeting with the plaintiff. Of course, with her experience and knowledge of avoidance and reluctance to discuss the traumatising incidents, she would have had the expertise to elicit the story from Victor Murtagh, particularly about the incident of close firing and the capture by Hezbollah of the SLA compound on the hill above the plaintiff's outpost. In evidence she said that she had reached a working, provisional diagnosis but she was fairly sure of her diagnosis on first meeting him and it was confirmed by the administration of the CAPS test. It is certainly a curious feature of this case that the defendants seem to disown and belittle the evidence given by the then army psychiatrist and the then army psychologist. The overwhelming weight of the evidence in this case is to the effect that the plaintiff did suffer from post traumatic stress disorder which stress came from his experience of stressors in the several episodes in which he succumbed to acute states of anxiety and stress while on duty in the Lebanon. In fact the great weight of the evidence is to the effect that the plaintiff did suffer from post traumatic stress disorder contracted while in the Lebanon.

55. While I shall set out the defendants' contentions about the alternatives to a diagnosis of PTSD, it seems to me that this case must differ from some others that involved an issue as to whether there was post traumatic stress, developing into PTSD. In view of the clinical diagnosis by Dr. O'Loughlin, together with result of the CAPS test on 29th February, 1996, when taken with or without the support of several other experienced psychiatrists, including Dr. John Cooney and Dr. Mary McGuire, all saying that the plaintiff did contract post traumatic stress disorder in the Lebanon and I am certain of the correctness of this diagnosis; and also that as time went on without this being treated, the condition became chronic post traumatic stress disorder, with the plaintiff becoming more and more difficult and anxious and tense, and irritable with his wife and children, to the extent that she regarded him as a changed man who came back to her from the Lebanon in April 1987.

The failure to recognise the plaintiff's symptoms

1. Knowledge of post traumatic stress disorder in 1986

56. Lieutenant Colonel Goggin gave evidence of talks and briefings that he had begun to give after attending a conference of military psychologists in Paris in the spring of 1986. In 1986 he said that he confined his briefings to talking to the officers and senior NCOs and did not include and would not like to have given the impression of having spoken to private soldiers at that stage in 1986.

57. Lieutenant Colonel Goggin had taken his primary degree in UCD in philosophy and then did post-graduate work in educational psychology and was awarded his Masters Degree in Educational Psychology in 1988. My understanding is that he had been the Army Psychologist since 1970. Unfortunately, when he retired in 2000, some forty-six years after he had enlisted in 1954, his papers were destroyed, due to a misunderstanding on the part of cleaners.

58. In the mid 1980s he had been attending military conferences of psychologists and was familiar with the need to raise the awareness of the perils of stress and the need to recognise this.. He started dealing with officers in lectures on courses and then spoke to the body of officers travelling on an overseas contingent, addressing them on stress and the need to develop an empathy for people who had been traumatised, who had been through a difficult period. At that time there was a belief that people who suffered from post traumatic stress disorder, for instance, were of a particular personality profile. In fact psychology, he said, was led down the garden path by that theory, because this was proven to be incorrect by research work. The conclusion of that research done by NATO countries on a worldwide basis was that anybody could develop post traumatic stress disorder provided that person had been subjected to a traumatic insult. He explained that actually firing and killing a person can cause the person who fires and kills to become deeply traumatised, despite the macho appearance and the macho sort of ethos that would be in military organisations. He said that the initial premise for these talks was that it was a consciousness-raising exercise. It was educational in other words that people would be aware of the individual obligation on a person initially to look after his own well-being. Secondly then there was peer support where people should watch and mind out for each other and then, thirdly, leadership came in where commanders should be on the alert for people who have been in traumatic incidents and should be on the look-out for symptoms arising from such incidents. He explained that he had based his talks on the premise that they were educational and his approach had been to stress that it was a leadership problem or a management problem and accordingly he had confined himself to speaking to NCOs and officers. The colonel reiterated this point that in 1986 he confined his address to NCOs and officers and he had not spoken to private soldiers at that stage. He told his audience of officers and NCOs to look out for changes in behaviour, where an outgoing individual suddenly becomes quiet and withdrawn or the opposite where a withdrawn and quiet individual suddenly becomes the camp comedian. He suggested that an introvert becoming an extrovert could be a sign that his change in behaviour would be due to stress. One of the important things was looking for sleep patterns, because people in the billets look out for their comrades and watch how they are reacting at night, whether they are sleeping or showing signs of waking up early in the morning which would be referred to as early morning waking and is a sign of depression. A person with early morning waking would be immediately advised to go and see the medical people as a consequence. At that stage the medical corps accepted that this was an educational matter and that Col. Goggin was not interfering on their "turf", but rather this was an educational effort where he was trying to raise the consciousness of people to alert them to the dangers of having signs of stress and kind of suppressing it or hiding it and by frank discussions among themselves to ventilate their problems and to validate that a person felt lonely and was entitled to feel lonely and to miss his wife and children particularly, perhaps around birthday time or Christmas when people would become very upset, but they would be trying to hide it. Sergeant McCabe recalled the Colonel addressing the 60th Battalion and was able to describe how the Colonel talked of putting aftershave lotion or Vick on the upper lip and he said that he could remember that, as it had to do with the appalling smell from bodies that had been decayed or decapitated or something of that nature and to prevent the smell upsetting them that they would put Vick on the upper lip or the nostrils to prevent them getting the smell. The Colonel explained that he had established good contacts at the conference with colleagues and so in the future he was able to ring his counterparts in the German Army, or British Army or American Army to get information from them. The Americans were very helpful and they had a strong association with the Israelis and they had up-to-date experience of battle and combat and made that information available to the Americans. Colonel Goggin agreed with Counsel for the defendants that there was nothing abnormal about a soldier feeling under stress in conditions where rockets are going off or guns being fired. It is only when with any particular individual the symptoms, abnormal symptoms, become manifest that you realise there is a problem. Under cross examination Col. Goggin agreed that some soldiers would not necessarily disclose problems they have even among their own peers because they might be prevented from serving overseas again and they would be seen as weak and

vulnerable because of this reluctance to talk about their problems. The Colonel said that this was why it was so important to get the peer group working so that they would not lose face by having to confess vulnerability to an NCO and so among themselves they are advised to have candour and to honestly confess their problems to one another. There would be a reluctance as a Private to go to an NCO and say "I have this problem". In recent times there had been a great improvement in the quality of the Chaplaincy. The Colonel said that the quality in-service provided by the Chaplains in 1986 would be very good.

59. Colonel Goggin gave one example of an officer who had been staying with a family in Yugoslavia whose home was shelled and the whole family was killed and all he saw afterwards was the young daughter's shattered doll and the table where they had their breakfast when the shell hit. There had been a coffee pot and a loaf of bread and the officer was utterly traumatised from merely seeing this, because it reminded him of the intimacy of the family having their breakfast. The officer never saw any of the bodies at all, he just saw the pot of coffee, the bottle of milk, a loaf of bread and the child's doll smashed and that was enough to completely throw him. The Colonel also agreed that a person could be brave through two armed raids where he was fired at and then some quite small incident subsequently could trigger post traumatic stress. Counsel for the defendants asked Col. Goggin was he correct in saying that this briefing was done in this lecture in 1986 and the Colonel replied in the affirmative. He also confirmed that he advised the officers to look out for changes in behaviour. The Colonel replied that immediately these changes were observed it was better to take action on them and this would be where medical professional people would come in. The Colonel said that you should not let changes go for more than a week as that could be very dangerous. He warned that early morning waking would be possibly the most dangerous of all the symptoms because lack of sleep can have a terrible effect. The Colonel said that he would personally intervene to take the ammunition from a person who had suffered a week of early morning waking. He would leave the man with his rifle, but he would take the ammunition from him. In conclusion, Counsel for the plaintiff referred to the entries in the AF667A attached to the LA30 dated 18th April 1987 and entries at p. 198 of Bk. 3, dealing with the entry of 29th November, 1986, where the plaintiff was found to have had (1) a "query petit mal attack subject to anxiety"; (2) on 18th December, 1986, he was found to be suffering from acute anxiety disorder; (3) on 10th January, 1987, Col. Collins found when Cpl. McLoughlin who was a friend of the plaintiff had been killed and this precipitated in the plaintiff a state of ICD300 which is an anxiety state. On 19th April, 1987, there was an entry "no psychiatric problem, but relatively immature and liable to ICD300 – anxiety under pressure – and recommended he should not serve overseas". On 18th April, 1987, there is an entry, "found the man to be relatively emotionally immature and came under very severe pressure; he is liable to incapacitating anxiety states in such circumstances". Having referred to those medical notes about Pte. Murtagh at that time, Counsel then asked the Colonel how that would measure up against the kind of stresses that a soldier would be subjected to in service in the Lebanon. The Colonel made clear that he was not a clinical psychologist but this was the kind of stress that he was advising them to look out for and to get professional help to cope with this. The Colonel made it clear that his efforts were directed towards raising awareness of the situation and then it was a matter for the medical doctors from there on.

60. Lt.-Col. Ollie Barber was one of the last witnesses called by the defence but his contribution is included here as it is germane to a challenge by the defence particularly as to when Col. Goggin gave his talk. Lt.-Col. Barber gave evidence that he had joined the army in 1973 and had gone as second in command of the Reconnaissance Company of the 60th Battalion to Lebanon for the Winter Tour of 1986/7. He had no recollection of the plaintiff who had been in "C" company. In September 1986 the Reconnaissance Company was part of the Battalion which formed up at the McKee Barracks in Kildare. Officers from there attended briefings at the Curragh.

61. He confirmed that Col. Goggin was correct in that there was a NATO group conference in early 1986 at Paris in the spring. This was the first of the meetings of Research Group 10 which Col. Goggin attended.

62. Lt.-Col. Barber made clear that Sergeant McCabe, who had given his evidence about his recalling the talk by Col. Goggin at Mullingar before Col. Goggin attended at this court, was a member of the "C" company which was formed up from Western Command in Mullingar, whereas his Reconnaisance Company was based in Kildare and had briefings at the Curragh. He also confirmed four salient matters. First he confirmed that Col. Goggin attended these conferences of military psychologists dealing with the need to become aware of the perils of stress and secondly that the Colonel put this information to good use in the army. Thirdly he said that in 1991 or 1992 the Colonel started the whole process of debriefing and by 1991 when he, Lt.-Col. Barber , attended a conference there were two excellent booklets available on such psychological topics. Fourthly, Lt.-Col. Barber said he had worked with Col. Goggin and never found him to be forgetful.

63. There seems to be a simple reason why Lt.-Col. Barber, as he now is, can not recall Col. Goggin giving the briefing to officers and NCOs at Mullingar in 1986 after the RSG conference in the spring in Paris. Lt.-Col. Barber was based in Kildare and their briefings were mainly at the Curragh. I accept Col. Goggin's recollection, corroborated in advance by the recalling by Sgt. McCabe of the talk about PTSD and the need to be practical and to get on with the job when having to cope with corpses.

64. Dr. Mary McGuire, an experienced Consultant Psychiatrist and the Clinical Director of Roscommon Psychiatric Services in Roscommon County Hospital, was called as a witness. She had interviewed the plaintiff on two occasions, firstly on 4th October, 2005, and then on 24th October, 2006, and had prepared her report on each occasion.

65. With regard to Dr. McGuire's evidence, Counsel for the defendant said that there was no objection to Dr. McGuire being led through her report and in fact this was done in respect of both her reports and we also had the benefit of Dr. McGuire's explanations and comments on the contents. The narrative may be easier to follow if I set out the conclusion to her first report and then the entire of the second report as it is both a useful source of the history and also sets out some of the material which has led to there being a number of contentious issues in this case.

66. In the conclusion to the first report which was based on an assessment done on 4th October, 2005, Dr. McGuire concluded that

> "Mr. Murtagh was a young married man in 1986, when he volunteered to go to the Lebanon. He was deemed to be 100% fit physically and mentally before he was allowed to go. Tragically, his two friends were killed while he was there and he was exposed to intensely frightening situations. During this time he worked long hours and it would appear that his periods of sleep were quite restricted. There is no doubt that he became extremely tense and anxious during this time and that he developed a severe anxiety state. This culminated in admission to hospital and sedation for what appears to be, in hindsight a very severe panic attack. On return to Ireland, Mr. Murtagh outlined symptoms of severe post traumatic stress disorder syndrome, including flashbacks to the incidents, sleep disturbance, searching for his rifle while asleep, increased startle response, increased tremulousness, depressed moods and inability to relax.
>
> To overcome these distressing symptoms he began to depend on alcohol and developed a serious problem with alcohol abuse. Unfortunately all of these problems culminated in the breakdown of his marriage and multiple admissions to the local psychiatric hospital. Mr. Murtagh also lost his job in the army because of these problems and was discharged on medical grounds. At present (October 2005) Mr. Murtagh is leading a very lonely existence in Holland and remains very sad at the loss of his family and his career. Since Mr. Murtagh was a fully fit young man in mind and body when he went to

the Lebanon, and because of the clarity with which he describes the symptoms of Post Traumatic Stress Disorder Syndrome so many years later, there is no doubt that his life-threatening experiences in the Lebanon triggered these symptoms and led to his dependence on alcohol. The alcohol abuse and psychological symptoms have led to the disintegration of his life and this is a source of great sadness for Mr. Murtagh."

67. Dr McGuire's second report is dated 16th November, 2006, and has a useful further history and touches on several matters which are related to issues which are in contention in this case. This second report is based on the more recent assessment carried out on 24th October, 2006. It seems to me that it would be useful to set out the entire of Dr. Mary McGuire's second report which is dated 16th November, 2006.

68. I should make several points clear at the outset. One of the reasons for setting out this report in full is that it contains the plaintiff's description of how he recalls certain incidents notably his account of an incident after the "pseudo funeral" at Naquora when he became upset at the sight of the army carrying an empty coffin for the purpose of film footage for the TV cameras. There undoubtedly was a ceremony to honour the late Cpl. McLoughlin, who had befriended and greatly supported the plaintiff according to other NCOs, and so the plaintiff's upset was understandable. However, while his account of the attack on the bus on the way back after the "funeral" is corroborated by Corporal Gaffney, his shooting back at Israelis is improbable as it is more likely that his gun had been taken from him at Naquora and that he actually stayed on the bus and others did leave the bus and take cover. However it may be that he did stay on the bus for a time and then came out and took cover as Cpl Declan Gaffney recalled him taking cover behind a wall outside the bus. His account of this incident to Dr. McGuire is illustrative of the reality that persons who are under stress, and in his case severe stress, may well unintentionally distort, exaggerate and embroider their story or account of an incident. Throughout this case I have been conscious of his involuntary inventive creativity and have been careful to ensure that his version of events is treated with a degree of scepticism. However, I should add that I am also conscious of the fact that one of the symptoms and effects of a person being under severe stress and then suffering from PTSD is that they do tend at times to exaggerate and to imagine part of their story and to believe in its reality and this is one of the effects and accepted symptoms of PTSD. For many aspects of his description of what occurred in the Lebanon there is nearly always ample corroboration from officers and NCOs, such as for example the accounts of his acute anxiety states causing him to be incapacitated to the point even of losing consciousness and being unable to recall the events afterwards.

69. Secondly, in her report and discussion of his condition, Dr. McGuire refers to a number of authorities and books which have been published since 1986, as is perfectly reasonable to support her findings. When criticism was made of her using such more recent books and articles, the experienced consultant psychiatrist and clinical director explained and made clear that she was well aware of the distinction between more recent research works and previous standards and practice and made the point that military doctors have known for years about the effects of the condition which became widely known from around 1980 as post traumatic stress disorder.

"Medical Report

Name: Victor Murtagh

Address: Carrigans Upper, Ballymote, Co. Sligo

DOB 22.10.1965

Date of initial assessment 4.10.2005

Date of recent assessment 24.10.2006

Date of incident 1986

Details of incident as per report of 10.10.2005.

Progress report since October '05: Mr. Murtagh informed me that he continues to work in the construction industry in Holland and keeps himself busy by working five or six days per week. He has overcome his severe alcohol problem and is able to have a few social drinks occasionally now. He does not abuse any drugs. He feels that his life is good now and he is very happy living in Holland. On reflection Mr. Murtagh believes that all his problems commenced in the Lebanon. He arrived there in October 1986 and entered a zone of duty where hostilities were increasing all the time. Tragically, his two close friends and colleagues were killed in combat there in December, 1986 and January 19867, respectively.

It was evident by 29.11.1986 that Mr. Murtagh was highly stressed and suffered some type of seizure where petit mal epilepsy was queried and it was recorded in his army medical notes and this may be secondary to exhaustion. With hindsight this attack may be better described as a severe Panic Attack. Unfortunately, when Mr. Murtagh became very distressed and in his own words "went mad" on the day of his friend's funeral, he stated that he was incarcerated in a military prison for a few days. He remembers this as an extremely distressing time. He feels that the trigger factor for his outburst was the sight of the army carrying an empty coffin for the purposes of film footage for the TV cameras. He consumed a few drinks at this stage to try to calm himself but "went berserk". He remembers travelling on a bus on the way back from his friend's funeral and stated that the Israeli soldiers were shooting at them. When he got off the bus he started shooting back at the Israelis. He remembers an army Chaplain Fr. Murphy crawling over to him and asking him to stop shooting. He stated that he was totally indifferent to danger at this stage and did not care about anything. Following his detention in military prison he stated that he was sent to the most dangerous checkpoints and felt extremely nervous and fearful for his life initially. Gradually indifference overcame him and he did not care about his safety. He stated that he often wished he was shot and even to his day at times wishes that he had been killed at that stage. He remains very sad and full of regret regarding the loss of his wife and family. He is proud of his children and they visit him frequently now. He has a great sense of loss regarding his life as he had always hoped to have "a nice bungalow", car and dog for his family and he always had dreams about bringing his children fishing. "That will never happen now".

Mental State Examination on the 24.10.2006: Mr. Murtagh looked much healthier and more vibrant than on his last assessment. His speech was spontaneous and articulate and he could describe his feelings much better. His mood was sad at times throughout the interview. He denied any active suicidal ideation but has intermittent death wishes still. He has no psychotic symptoms and his cognitive state was normal.

Conclusion: Mr. Murtagh was sent to the Lebanon as a 21 year old soldier in 1986. It is apparent that he became extremely anxious in this situation of hostile conflict and had a major panic attack in November 1986. His condition was

further exacerbated by the tragic deaths of his colleagues and close friends in an incident in January 1987. Following this it appears that Mr. Murtagh de-compensated and lost control of himself and placed himself in a situation of extreme danger by shooting at Israeli soldiers. He did not receive any treatment at this stage for his acute stress reaction but was imprisoned for a few days. Following this he was sent back on duty into very dangerous situations. His anxiety state reached such a level that he became indifferent and this is a well known consequence of severe anxiety and is referred to as "La belle Indifférence". Unfortunately Mr. Murtagh began to abuse alcohol because he was using it as a sedative to control his anxiety state and to get some sleep. His anxiety state and his sleep disturbance were directly related to his severe Post Traumatic Stress Disorder Syndrome which had been precipitated by the terrifying incidents in the Lebanon. It is unfortunate that Mr Murtagh was not treated at an early stage when he developed the sypmtoms of Post Traumatic Stress Disorder Syndrome. The vulnerability factors for chronic post traumatic stress disorder syndrome were not recognised. "An individual's recovery from trauma is facilitated by the availability of positive social supports and the inclination to use them to share the account of the trauma" (Forbes and Roger, 1999). It does not appear that Mr. Murtagh was offered any crisis intervention to help him overcome his feeling of intense grief and panic after his friend's funeral. Instead he was put into prison. This exacerbated his condition. It appears that no psychological debriefing was offered to Mr. Murtagh. Research now shows that "Bosnia peacekeepers in the debriefed group had lower HADS scores than those in the non-debriefed group and alcohol abuse problems were lessened over time in the debriefed group" (Litz et Al. 2002, Clinical Psychological; Science and Practice, Vol. 9). It is well known that Cognitive Behaviour Therapy for recently traumatised individuals have demonstrated good promising results in preventing the development of chronic psychopathology following trauma.

Unfortunately none of this treatment was afforded to Mr. Murtagh by his employers. He has suffered severe emotional stress, depression, substance abuse and huge personal and social losses in his life because of the severe PTSDS which was triggered by the highly stressful incidents in the Lebanon.

Signed: Dr. Mary McGuire

Consultant Psychiatrist/Clinical Director

Date 16.11.2006."

70. In evidence Dr. McGuire used her clinical notes as well as her report, and started by saying that the plaintiff had told her that he arrived in the Lebanon on the his twenty first birthday and was very excited and saw it as an adventure but that about six weeks later the situation became very hostile there and that there were numerous attacks on the Irish battalion by Israelis and others. Counsel for the defendants helpfully said that he had no objection to the witness being led through her report which was before the Court. Dr. McGuire said that the plaintiff named some of the hostile groups but she did not record them. He told her that during his time in the Lebanon he became very anxious to the extent that he suffered a fit on one night and was taken to Camp Shamrock and was given an injection which sedated him for a while. It is clear that this was the incident on 29th November, 1986, when he was brought in by ambulance to the RAP at Camp Shamrock at Tibnin and was kept in under the care of Col. Collins. She said that when he looked back on it now, he thinks that this was a severe panic attack, that various things had happened which made him think that he would lose his life and she had noted that at this stage he became very tearful and said he did not want to talk about them. He said that the worst part about the incidents were that he had to go back on duty after each incident. He said that the fear was so bad he could never relax and felt he was always having to be on alert. He also told her he was on duty for extended periods and got little sleep. He said that he slept with his gun beside him. He said that after his two friends had been killed he became convinced that he would never get home again himself. He became pre-occupied with these thoughts and fear and worry, but he got home in April 1987. He told Dr. McGuire that what his wife complained about when he returned home was that he was always jumping up in his sleep and searching for his rifle and that if there was any loud noise he would jump and shake uncontrollably. He stated that he had frequent vivid flashbacks. After his return he began to drink alcohol excessively to calm his nerves and his drinking went out of control. He said he knew that he became hooked on alcohol and this caused marriage problems. He became depressed and had suicidal ideas on many occasions. He was admitted to St. Columba's Hospital Sligo, in 1988 and had many admissions after that until 1997. He said he was unsure of the dates of admission, but he felt at this stage in October 2005 that he could control alcohol now.

71. I should make it clear at this point that from the aspect of the importance of a sensitising incident there is ample corroboration from the evidence of the NCOs, from Capt. McEvoy and from Lt. Col. Collins that the plaintiff was subjected to extremely severe pressures including the deaths of his two colleagues, Pte. William O'Brien in December 1986 and Cpl. Dermot McLoughlin on 10th January, 1987 and the medical officers were well aware that he was suffering from acute anxiety states and noted his condition so that they should have been well aware that he was vulnerable to post traumatic stress disorder and should have realised the need for rest, counselling and therapy to prevent his immaturity and vulnerability allowing his stressed condition from becoming chronic post traumatic stress disorder of a deep seated nature with all the problems of recurrence and relapse.

72. Dr. McGuire had formed the opinion that the plaintiff had developed symptoms of Post Traumatic Stress Disorder as a result of sensitising incidents. There was certainly corroboration from the NCOs and from Capt. McEvoy and Colonel Collins that this tour of duty was fraught with hostility and with incidents of soldiers coming under close fire and with three Irish soldiers being killed between July 1986, and February 1987. Dr. McGuire helpfully explained some of the symptoms which she gleaned from the plaintiff's account to her. These included flashbacks, sleep disturbance including early morning wakening, and startle response, which in Mr. Murtagh's case, meant that he would tremble in nervous agitation and be jumpy. Doctors call this trembling uncontrollably and she described this as very "exaggerated" and explained that this is not voluntary, but is an increased startle reflex, which is involuntary and definitely does not mean that the patient is putting this on voluntarily. The plaintiff had also developed depressed mood and an inability to relax, and he had described to her a continual sense of fear while he was in the Lebanon. The plaintiff told her that he had been deemed one hundred per cent fit before he was going to the Lebanon, and described to her that he had to be hospitalised and medicated there and had been given a Diazepam injection, and because his symptoms had continued on his return home, it is her opinion that his symptoms, flashbacks, sleep disturbance, startle response and anxiety states, depressed mood and inability to relax and his always having a sense of fear, were indicative that these symptoms had been triggered by incidents in the Lebanon and she said that the dependence on alcohol had progressed from there. He had told her that he was using alcohol to calm his nerves, and the alcohol abuse and his psychological symptoms had led to the disintegration of his family life, which was a source of great sadness for him. Dr. McGuire said that when she saw him on 24th October, 2006, he looked much better and was better able to express himself. He was much calmer and more articulate and spontaneous. He was volunteering information and he was better able to describe his feelings about the way he feels now about the loss of his wife and children. He and his wife had been separated for some time. Counsel was able to confirm that while he and his wife had been separated for some time and she was in a new relationship, nevertheless, there was no decree of divorce and so they were still married. Dr. McGuire explained that she regarded the medical records of the admission to the RAP Tibnin, on 29th November, 1986, when they queried petit mal epileptic attack secondary to exhaustion, as significant in that they indicated that he was in a highly stressed condition as a result of intense anxiety and being

overwrought, and exhaustion was recorded. She thought "petit mal" was an unusual query as "petit mal" is just an absence or a lapse and is very transient. For example, a transient lapse would be where a person may stop in mid-sentence and then recover a few moments later. It is a transient absence or interruption in the electrical activity of the brain. It may be observed as a pause in speech, or somebody stopping what they are doing for a moment. A definitive diagnosis of this would be by an EEG (Electrco Encephalogram). Dr. McGuire said that the entries with regard to his admission to the RAP at Tibnin, should have flagged the fact that he was becoming very anxious and stressed in his work situation. In the context of combat, if somebody gets acute stress reactions, then this is one of the main indicators for development of post traumatic stress disorder. Dr. McGuire indicated that with hindsight, this attack may be better described as a severe panic attack. This episode and subsequent incidents, as well as admissions to the RAP, because of incapacitating tremulous attacks should have been strong warnings of the likelihood of the development of PTSD.

73. The plaintiff had described his recollection of the scene at Naquora when he became greatly upset by the sight of the army carrying an empty coffin for the purposes of film footage for TV cameras at the farewell ceremony at UNIFIL headquarters, Camp Naquora, in respect of his colleague and supportive mentor, Cpl. McLoughlin. The plaintiff had given Dr. McGuire a colourful account of the bus coming under fire and how he had got off the bus and had started shooting back at the Israelis and an Army Chaplain crawling over to him and asking him to stop shooting, aspects of which would appear to be figments of his imagination as he had taken drink before getting on the bus, and had been relieved of his gun and may have remained on the bus when there was gunfire and others had dismounted and left the bus in order to take cover. I should add that Corporal Gaffney did say that the plaintiff had left the bus and taken cover. Dr. McGuire explained that research had shown that people who suffer with post traumatic stress disorder, sometimes their memories change over time regarding very stressful incidents. Research had now shown that these people are not lying, but their recall is different in that their memory changes over time, as to their recollection of the event. Research has shown that the more severe an interrogation is, then the less likely the person being interrogated is to recognise his interrogators afterwards. Dr. McGuire made it clear that, taking this inventiveness into her considerations, her conclusion was still firmly that the plaintiff was suffering from post traumatic stress disorder and that he had suffered post traumatic stress disorder since his time in the Lebanon. Dr. McGuire was taken through the entries in the LA30 form for December 1986, in particular from 29th November to 18th December, and in the completion AF667A form for 18th April, 1987, which stated:-

> "Completion AF667A, no psy. (Psychiatric problem) but relatively immature personality. Liable to ICD 300 under pressure. Rec. he should not serve OS (overseas) for three years."

74. She explained that ICD300 means an anxiety attack. Dr. McGuire was referred to the AF667A document at part 2 on medical suitability where there was medical category in the right hand box, A1, and then in handwriting:-

> "This man is relatively emotionally immature and came under very severe pressure. He is liable to incapacitating anxiety states in such circumstances and should not serve overseas for three years."

75. Dr. McGuire read all this and said that the fact that he was regarded as relatively emotionally immature and that he came under very severe pressure and that he was liable to incapacitating anxiety states in such circumstances, was significant. These features are main indicators of the probability or possibility of chronic Post Traumatic Stress Disorder, if not treated. Dr. McGuire subsequently expanded on this by saying that any person who has suffered from incapacitating anxiety under stress, should be referred for treatment.

76. Dr. McGuire was then referred to the proceedings of the Medical Board at Finner Camp on 15th December, 1988:

> Form AF332, for the purpose of examining No. 850416 Rank Pte. Surname Murtagh, Christian Name Victor, Unit 28 Inf. BT, age 23, service, four (years).
>
> The following documents are before the Board LA30.
>
> Patient's condition: complains of nil at present. History of anxiety/depression in Lebanon 1987; depression and alcohol abuse, June 1988.
>
> Indicate documents bearing on disability (if any) LA30.
>
> Examination reveals subject to incapacitating anxiety/depression, under pressure. History; secondary alcohol abuse, June 1988. Well since.
>
> Finding and recommendation. The Board finds that No. 850146, Rank Pte., Name, Murtagh Victor, above mentioned, is suffering from immature personality, subject to anxiety/depression when under pressure, and recommends that the man be reclassified Med. Cat. C. Needs to be closely observed for signs of stress. Not fit for o/seas service.
>
> Signed at Finner Camp, the 13th day of December, 1988
>
> Maurice Collins, Lieutenant Colonel President; Capt. G. Kerr Member Medical Board
>
> Disposal of proceedings DMC/OC 28 Inf. bat/file, which means send to Director, Medical Corps/Officer Commanding 28th Infantry Battalion/File on Colonel Collins' file.

77. Dr. McGuire was asked, on the basis of what was recorded there, "incapacitating anxiety/depression under pressure", was there any particular significance to be attached to that in the context of Mr. Murtagh and his history? She replied that it is apparent that he is decompensating psychologically following his trip to the Lebanon, and as advised by Colonel Collins, he should have been closely observed thereafter. She said that the reference to incapacitating anxiety/depression under pressure was very significant. It means that the man cannot tolerate pressure and that he developed a recognised severe anxiety state and depression when he was under pressure. He should have been checked out and monitored for any signs of development of post traumatic stress disorder, at that stage. This should have happened immediately after he was hospitalised in 1986, and it should have happened when he was on duty in the Lebanon after his hospitalisation and the stress was recognised. His psychological state should have been checked and the reasons and feelings around his incapacitating anxiety should have been explored.

78. Dr. McGuire was asked about the recommendation that the man be reclassified Med. Cat. C and "needs to be closely observed for signs of stress, Not fit for o/seas service". She was asked if she was in a position to express any view as to whether observation by non-medical officers would be sufficient or adequate in the circumstances, and she replied "as long as they knew what they were looking for and that they were trained in symptoms and signs of stress and that they could alert the appropriate personnel to the

signs of stress". She explained the prominent signs of stress as being the vulnerability factors which should be identified, being Mr. Murtagh's young age and the fact that he was away from home, and lacking social support; that he was always tense and could not sleep; and that he had been diagnosed with an anxiety state that was F300 or ICD300, which would be the recognised vulnerability factors. I then said that there was evidence that one of the men who was killed out there was from the same town as the plaintiff and was an older man in his thirties and something of a father figure to the plaintiff, and would that have any effect? Dr. McGuire said that that would be a very significant exit event. Counsel for the defendant pointed out that I had mistaken the evidence. Corporal McLoughlin was from Sligo town, the plaintiff was from Ballymote, and that I had prefaced my question by saying they were from the same town and that was factually incorrect. In fact, the plaintiff had been born and had lived in his early years in Sligo town, but on his mother's death, had gone to Ballymote to live with his grandparents, and indeed, after his marriage in 1984, he had been living in Sligo town with his wife until they moved to Ballymote in 1986. Counsel correctly said that I had prefaced my question by saying they were from the same town, and that that was factually incorrect. I mentioned that I had the impression at an earlier stage, that he had some connection with Ballymote and I was told that I was wrong. I think I was misled by the uncontradicted statement in para. 6 of the Statement of Claim that in the course of his service with UNIFIL in the Lebanon, a close comrade of the plaintiff, Pte. Dermot McLoughlin, also from Ballymote, County Sligo, was killed; this erroneous passage had not been contradicted and in fact Cpl. McLoughlin was from Sligo town. However, little hangs on this error because there was evidence that the part of the contingent from the Sligo area did associate together, and several witnesses expressly praised Cpl McLoughlin for his care of and support for the plaintiff when he became distressed and incapacitated by his anxieties while on duty at the two outposts manned by the weapons platoon. Certainly, from the evidence of Capt. McEvoy, Sgt Flanagan, and Sgt McCabe and Veronica Murtagh, the plaintiff's wife, the plaintiff was deeply grateful to the late Dermot McLoughlin and spoke well of him frequently to his wife during his telephone calls to her. In short, any inaccuracy was explicable and of little materiality in the context.

79. Counsel for the plaintiff asked Dr. McGuire if a referral is made for the purpose of carrying out an assessment as to whether the man was suffering PTSD or not, would a doctor find it valuable or useful to be given sight of the medical records, the LA30 and the CMF documents, and Dr. McGuire replied that they would be very useful. It would be very necessary to see how the man coped under stress in the Lebanon. He then asked her what significance she attached to early diagnosis and treatment of PTSD. She replied that, "present day thinking is that the earlier the diagnosis, the better the outcome, though it is really important to diagnose at a very early stage. It is really important to teach the sufferer about the symptoms and the reactions they are having, because that is very frightening for the person who is suffering from the symptoms". Counsel for the defendants pointed out that the witness had prefaced her answer by saying "present day thinking" and said that a view now based on present day thinking when assessing retrospectively back twenty-one years, was invalid. I remarked that I had pointed out at the start of the case that time factors and chronology in this case were important. Dr. McGuire responded to the suggestion that it was "wholly invalid and that we were going up the garden path by applying present day thinking retrospectively back twenty-one years" by commenting that present day thinking was that early treatment was helpful; and she added that this was long established by describing how during the First World War the British sent their people home from France to be treated for stress, but the French treated them on site promptly and more immediately, and it was recognised that they had better outcomes in that those treated in the war zone, got back to work much more quickly. She added that as long as soldiers are told that their reactions are normal in the context of the crisis or the tragedy, whatever has happened to them, that it is very therapeutic for people to realise that they are not abnormal. Counsel then asked her if she was in a position to offer a view as to whether there would have been any effect on the plaintiff if he had been treated at an early time in 1986 or 1987? She replied that this may have prevented his use of alcohol to calm his nerves and his subsequent development of such a severe alcohol problem. A delay in diagnosis and treatment meant that the plaintiff had become chronically anxious and was trying to settle his nerves himself by using alcohol. She said that cognitive behavioural therapy was the most popular, meaning usual and helpful treatment for it. This involves identifying the fears and the symptoms and teaching the person how to cope with these and how to relax while experiencing them. Medication, tranquillisers, or antidepressants are necessary at times too. Subsequently, she was asked if, to her professional knowledge, there was any noted difficulty in taking a history from military personnel who may be suffering from Post Traumatic Stress Disorder and she replied that it was an established phenomenon that they do not like to verbalise or vocalise fear because that is seen as a sign of failure on their part. This may be connected to a sense of military background or tradition, and because of peer pressure as well, because they would be seen to be weaker than their comrades. She then added that from the records she had looked at, there was no indication that this was expressed by the plaintiff nor had it been explored with him. Under cross-examination, when it was put to her that he made no complaint to anybody about any of the so-called problems, she replied, "that is my point. He would not express them". She went on to explain that she wanted to say as (he is) a soldier, it is well known that soldiers do not express their fears. It is better to be seen to have a physical illness than to be seen to be psychologically weak. She was asked if this was from her own personal observation from dealing with soldiers, or from literature on it, and replied that it was both, from her own dealings and experience treating soldiers and also part of the research being done by Dr. Morgan whom she had mentioned earlier on that day. She was asked in the context of the account given to her by the plaintiff about being on a bus and being attacked and shooting back, and on the premise that it was accepted that this was incorrect which is accurate about the unlikeliness of the plaintiff shooting back. She replied that this can be explained by people with post traumatic stress disorder being confused. She said that memories change all the time. She went on to say that the fact is that it is twenty years ago and memory does alter over time, and Mr. Murtagh's interpretation and recall of the events on that day are obviously at variance with what was being heard in court, but that is due to the way he has seen it and he is recalling. She said that all our memories vary over time and that it is said to be indicative of post traumatic stress disorder that recollections can vary more over time; that the recall of the event changes over time and the more stressful the event, the more it varies. Counsel told her that Sgt. Flanagan had said that one or two mortars had exploded, perhaps half a kilometre ahead of the convoy, which stopped. The plaintiff remained on the bus and other people got out of the bus. When the situation calmed down, they continued their journey. He asked if that sounded like a particularly stressful event and she replied, "it depends on the character and depends on how stressed the plaintiff was before he got on the bus and the state of mind which he was in". In fairness to the plaintiff I should remark that Corporal Gaffney, who knew the plaintiff well from pre Lebanon tours of duty on the Northern Ireland border did not regard the plaintiff as drunk after the Naquora ceremony, but very upset and he recalled closer firing and that the plaintiff did leave the bus and take cover, although he confirmed that the plaintiff did not have his rifle and could not have been firing back.

80. Counsel, cross-examining, then suggested the person with PTSD may not recollect accurately by amplifying the event as opposed to inventing detail which never existed. Dr. McGuire replied that she could not cite any research which makes any of those conclusions except that the memory is altered. Counsel suggested that in PTSD, an exaggeration of events is recognised in the literature but not an invention of fact and he cited an article in the American Journal of Psychiatry 1997, p. 170, "*Consistency of Memory for Combat - Related Traumatic Events in Veterans of Operation Desert Storm*", Steven M. Southwick, M.D., C. Andrew Morgan III, M.D., Andreas L. Nicolaou, Ph.D., and Dennis S. Charney, M.D. Dr. McGuire said that she was not aware of that piece of research. In fact, the objective of this article in the American Journal of Psychiatry in 1997 is explained in the head note:-

> "The nature of traumatic memories is currently the subject of intense scientific investigation. While some researchers have described traumatic memory as fixed and indelible, others have found it to be malleable and subject to substantial alteration. The current study is a prospective investigation of memory for serious combat-related traumatic events in veterans of Operation Desert Storm.

Method: Fifty-nine National Guard reservists from two separate units completed a nineteen-item trauma questionnaire about their combat experiences, one month and two years after their return from the Gulf War. Responses were compared for consistency between the two time points and correlated with levels of symptoms of post traumatic stress disorder (PTSD).

Results: There were many instances of inconsistent recall for events that were objective and highly traumatic in nature. Eighty-eight percent of subjects changed their responses on at least one of the nineteen items, while sixty-one percent changed two or more items. There was a significant positive correlation between score on the Mississippi Scale For Combat-Related Post Traumatic Stress Disorder at two years, and the number of responses on the trauma questionnaire changed from 'no' at one month to 'yes' at two years.

Conclusions: These findings do not support the position that traumatic memories are fixed or indelible. Further, the data suggest that as PTSD symptoms increase, so does amplification of memory for traumatic events."

This study raises questions about the accuracy of recall for traumatic events, as well as about the well established, but retrospectively determined relationship between level of exposure to trauma and degree of PTSD symptoms."

81. In the article, it was proposed that a high degree of consistency would support the notion that memory for traumatic events is indelible, while inconsistency of responses would favour the opposing position. Consistency of recall has implications for the widely accepted belief that high-level combat exposure is a powerful predictor of subsequent PTSD. If memories of combat are inconsistent over time, then the relationship between PTSD and combat exposure would be a tenuous one. In the discussion on the results, a questionnaire one month after the war, and then two years later, it became clear that fifty-two of fifty-nine National Guard reservists reported changes in memory for personally experienced traumatic events during Operation Desert Storm. One month after the war, forty-six percent of subjects reported one or more traumatic events that they did not recall two years later. Further the 70% of subjects at the two year evaluation recalled traumatic events that they had not reported at one month. These changes in memory were observed for a wide variety of traumatic experiences. Thus in this group of Desert Storm veterans, there were many instances of inconsistent recall for events that were generally objective and highly traumatic in nature. These inconsistencies raised doubts about the reliability of memory for combat. I think this would certainly raise doubts about the view that memories of trauma are fixed or indelible and remain remarkably accurate over the lifetime of the person involved in the traumatic incident.

82. I have mentioned the findings in this study as they have potential implications for treatment of patients, but also because it would seem that memory for traumatic events frequently changes over time which is a finding that suggests that the search for historical "truth" may be fraught with complexity. Memories described by trauma survivors in the present at times appear to be inconsistent with earlier memories for the same events. Thus efforts by therapists to uncover the real "truth" may be misguided. It may make more psycho-therapeutic sense to work with the patient's current version of the past since the "real version" may no longer exist. The study shows that changes in memory of such traumatic events can appear regardless of what actually happened. The article does not seem to make a distinction between amplification of the event as opposed to inventing a detail which never existed. It seems to me that Dr. McGuire was correct in refusing the invitation to agree that in PTSD an exaggeration of events is recognised in the literature but not an invention of fact. She was prudent in stating that she could not give any research which makes any of those conclusions except that the memory is altered. The lesson which I take from this is that the findings of this research do not support the position that traumatic memories are fixed or indelible, which certainly has been suggested in some of the sexual assault cases. Further the data suggests that as PTSD symptoms increase, so does amplification of memory for traumatic events. The study does raise questions about the accuracy of recall for traumatic events. Certainly it seems that this is a warning to be careful in forming the view that a person who is suffering from PTSD is trying to mislead the court with unrealistic exaggerations and fictional additions to facts of the traumatic event. In the present case, there is considerable information about various traumatic incidents forthcoming from the officers and NCOs in the plaintiff's Platoon and Company and there is ample corroboration that this was a "tough battalion", meaning a tough time was had by all, being the comment of Lt. Col. Collins. Dr McGuire was asked if she had given the plaintiff any treatment and she replied that she had discussed cognitive behaviour therapy with him but he said he was living in Holland and he felt that he was getting his life back in order trying to deal with his problems at that stage. She did not think it was peculiar that he was not going to hospital or to doctors after 1997 because he was controlling his alcoholic intake and he was working and trying to re-establish himself with his family. His focus was on remaining abstinent and working. But this did not detract from the fact that he became very tearful on the first day that she had met him and was obviously still very upset by the incidents in the Lebanon. A discussion then ensued between counsel and Dr. McGuire about the tentative suggestion coming from Dr. McCarrick via his SHO Dr. Paddy Breslin that Dr. McCarrick feels that he (Mr. Murtagh) may be suffering a form of post traumatic stress disorder which counsel pointed out had two qualifications in the use of the word "may" and in "a form of PTSD". Dr. McCarrick was not saying that he does suffer from post traumatic stress disorder but rather it was something that needed to be checked out. Dr. Breslin went on to mention in his letter to Dr. Kerr, that it was understood that the army psychiatrist had a clinic in Dublin and perhaps a referral would be considered. Neither Dr. McCarrick nor Dr. Breslin had the LA 30 or CMF file as neither these nor a history of the plaintiff's Lebanon tour was ever sent to St. Columba's Hospital in Sligo.

83. Counsel for the defendant told Dr. McGuire that he wanted to make an important point to her, that she had done her diagnosis in 2005, to the effect that the plaintiff was suffering from post traumatic stress disorder, by reference to a diagnostic technique that did not exist until the late 90s, so she was applying retrospectively a new diagnostic technique. She responded that the symptoms are the same and they correspond with the diagnosis of PTSDS. He said that there was a change between ICD9 and ICD10 and she agreed that they had changed the format in that the letter F has been inserted in front of all codes in ICD10. Counsel pointed out to her that the plaintiff's case is that there was a failure by the army to diagnose him as suffering from post traumatic stress disorder and therefore a failure to treat him. He suggested that in 2005, she diagnosed him as having PTSD by a set of criteria which only came into existence in the late 1990s. She agreed that this was correct and that the plaintiff had left the army at that stage. She pointed out that the man had been diagnosed not just with anxiety but in fact it was severe anxiety and that was flagging the fact that he was decompensating psychologically. She said that her point was that the man's symptoms started in the Lebanon and continued thereafter and that they should have identified him as being at risk of developing PTSD on the basis of the state of medical knowledge at that time. She had done her MB in 1974/75 and got her membership of the Royal College of Psychiatrists in 1981. She practised psychiatry in the Tyrone and Fermanagh Psychiatric Hospital and then came back to Castlerea in Co. Roscommon and had been based in the County Hospital Roscommon since 1992, after St. Patrick's Psychiatric Hospital closed and was turned into a prison. She had started training in psychiatry in 1977. She was asked if for the purpose of making her diagnosis in October 2005 she had a checklist to mark off and she replied that she did not but that she did have the CAPS document used by Dr. O'Loughlin and had based her assessment of the plaintiff on the plaintiff's history and his own description of what he suffered and felt, as well as reports available to her and the CAPS document. The plaintiff had outlined his symptoms to her, which were consistent with the checklist that is available in the PTSD SDS list of symptomatology and she recognised the symptoms as he told them to her. She wrote down his symptoms as he described them to her. She said that mentally she knew they are a part of PTSD SDS, from coming across it frequently and that was the basis of her decision. She said that she had relied on the answers recorded from him in the CAPS

document in respect of the overall assessment. Counsel made the point to her that the CAPS was not invented until October 1990 and she responded to this by accepting that, but pointing out that there was a general knowledge and understanding of PTSD for a very long time. When he asked her, if you apply your criteria, what is the first criterion concerning the alleged traumatic event, she replied that the person has experienced or witnessed an incident which is life threatening or very distressing. Dr. McGuire said that (the doctor has to be satisfied) that the person was in a situation of experiencing severe stress because of a life threatening event or danger to himself. She agreed that there was a second leg to this involving intense fear, helplessness or horror and said that was correct and said that Mr. Murtagh had described intense fear. Counsel then referred to appendix at p. 137 of Gillian Kelly's "Post Traumatic Stress Disorder and the Law" which was reprinted with permission from the *Diagnostic And Statistical Manual Of Mental Disorders* (4th Ed. 1994), of the American Psychiatric association and reads:-

> DSM-iv. Diagnostic criteria for 309.81 post traumatic stress disorder.
>
> A. The person has been exposed to a traumatic event in which both of the following were present:
>
> > 1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
> >
> > 2. The person's response involves intense fear, helplessness or horror. [Note: in children, this may be expressed instead by disorganised or agitated behaviour.]
>
> B. The traumatic event is persistently experienced in one or more of the following ways:
>
> > 1. recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. [Note: in young children, repetitive play may occur in which scenes or aspects of the trauma are expressed.]
> >
> > 2. recurrent distressing dreams of the event. Note: in children there may be frightening dreams without recognisable content.
> >
> > 3. acting or feeling as if the traumatic event were recurring (include a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). [Note: in young children, trauma-specific enactment may occur.]
> >
> > 4. intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

84. Counsel asked Dr. McGuire if she accepted the criterion as set out in para. A1 above about threat of death or serious injury to self or others as being required. She agreed and said that the plaintiff had told her that he was in a situation of intense hostilities and was involved in a life threatening incident where he was held at gun point and was convinced he was about to be killed. Counsel for the defendants said to her that the plaintiff in evidence had never described an incident where he was held at gunpoint and threatened with being killed. (In fact, this was a mistake as the plaintiff did describe such an incident at the Total Station Chekpoint. I deal with this evidence of the plaintiff about incidents of close firing and being pinned down below under Sensitising Stressors where I set out a number of such incidents which were clearly frightening and involving mortal peril which were clearly and credibly described by the plaintiff.) She simply replied by stating that is what he told me and that she had to base her assessment on what the man told her. She said that the deaths of his comrades had a major impact on him. When it was pointed out to her that he says "witnessed or confronted" she replied that he did not tell her he witnessed it but that he "experienced" it and that she knew that it was very traumatic for him anyway to discover that these two men were killed. She explained that he was in the same situation himself as his life was being exposed to the noise and the activities and the moving around, whatever area he was in. It was very immediate for him. She said that she did not know about the distances but psychologically it was a very immediate threat. She would not change her diagnosis because he had described the symptoms which emanated from his perception of whatever had happened in the Lebanon.

85. Counsel for the defendants objected to lack of notice of the plaintiff being under fire and particularly para. 6 of the Statement of Claim. However the plaintiff's case has clearly been that as a result of incidents in the Lebanon including episodes in which his colleagues were killed, the plaintiff was traumatised and subsequently there was a failure to treat him which is the gist in the Statement of Claims, Replies to Particulars and also in the Medical Report dated the 27th May 1996 of Dr. O'Loughlin, the army psychiatrist, which should have been well known to the defendants, as submitted by Colm Smyth S.C. for the plaintiff.

86. The plaintiff had shared a billet with Corporal McLoughlin in Post 6-21 and reacted to the news of his death by losing conciousness that night at Camp Brashit on 10th of January 1987. He came into the RAP at Camp Shamrock where he recalled being given an injection. I accept the plaintiff's evidence on this and I think the death of Corporal McLoughlin and the incidents on the 10th of January 1987 and pressures at the RAP is consistent with the recollection of various officers and NCOs and ties with the "acute anxiety states causing incapacity" referred to by Colonel Collins.

87. Counsel for the plaintiff submitted that there was a string of other incidents that resulted in the plaintiff going into a trancelike state and these were referred to in an omnibus fashion in Dr. McGuire's report when she referred to "various life threatening incidents" which he finds too distressing to talk about and became tearful when he mentioned them. After each incident he had to go back on duty and his anxiety state became so intense he could never relax and that was all consistent with the evidence heard from the plaintiff from CQMS Flanagan and Cpl Gaffney. Dr. McGuire simply again responded in cross examination that "all I can tell you is that the man told me that he was held at gunpoint." Counsel for the defendants then put to her that Dr. O'Loughlin described him as "an unreliable historian", meaning reluctant rather than inaccurate or deliberately unwilling. Counsel immediately corrected himself and said "a difficult historian". Dr. McGuire said that she found him to be a very upset, tearful and distressed historian and he did not wish to recount the incidents which had distressed him. On the second interview day he was much better able to express himself but on the first day he was very anxious. He gave her information about certain things but there were exceptional incidents in the Lebanon that so upset him that he did not wish to discuss them. She added that it was unusual to find a male patient sobbing and crying and that is the way the man was on that day. He told her that he had been shot at and about whatever is in the report but he did not go into specifics, and he was convinced he was going to be killed and that is the important part. This was the thought that preoccupied him in the Lebanon, that he was never going to see home. He also told her further on that he was convinced that he would never get home alive which is the same as being killed. It was suggested to her by Counsel that this was a reasonable feeling for any soldier sent out to combat situations. He asked was there anything unusual about that to which she replied that he was convinced and was

thinking about it all the time; he was preoccupied with it and that is the difference. She was sure other soldiers were frightened, but they may not be preoccupied all the time about it. Counsel then suggested to Dr. McGuire that the ICD classification produced by the World Health Organisation says PTSD could not generally be diagnosed unless there is evidence that it arose within six months after a traumatic event of an exceptional severity. Her response to this was that Mr. Murtagh was treated during his stint in the Lebanon following what he told her were traumatic incidents, so he was displaying symptoms of acute stress at that early stage.

88. Counsel for the plaintiff told the court he had just learned that there was a book of the incidents occurring to this Battalion which he was then informed was called "the Unit History of the 60th Battalion". This had not been sought up to this point and it occurs to me that if such a book does exist then in future cases the contents of this book may be very useful to all parties once discovered, particularly in reducing length of cases and costs and it may also obviate the need for lengthy inquiry and evidence about numerous incidents taking place in the Lebanon as presumably this Unit History book will contain a description of the incidents and those who were involved.

89. When Dr. McGuire returned to court after some days she confirmed that her diagnosis had been made on the basis of the plaintiff's information and his symptoms as described in the medical reports that were made available to her.

90. She was asked why Dr. Fidelma Flynn, another senior and experienced psychiatrist in the west, had not diagnosed PTSD. Dr. McGuire said that her experience was that one had to do a lot of "fire brigade" work where patients came in who had taken too much alcohol and that one treated the immediate problem and that there might not be an opportunity for the exploration of underlying reasons why a person was in such a state. Also in this particular case it was obvious that Dr Flymm did not have the benefit of the soldier's log book as to what had happened to him the Lebanon. The army had been aware of his admissions to hospital and indeed Dr. Flynn had written to the medical officer in Finner Camp. It would appear that there is no protocol or system whereby when a soldier goes into a civilian hospital that the LA30 and the CMS file are copied and sent to the treating doctor. Of course there would have to be a check on the contents of the file to preserve patient confidentiality, and the need for the patients' consent, but these are presumably matters which the army can deal with carefully with all due sensitivity. It would seem very important that treating doctors should have the complete medical history, or as complete as is practical. Dr. McGuire did express the view that the file from St. Columba's did indicate that there were symptoms referred to in it which did indicate that the plaintiff, who was a soldier and had served overseas in a hostile area, should have been explored further, such as some of the constellation of symptoms making up PTSD. Incidentally, counsel for the defendant referred to Dr. Flynn as being "the primary carer", whereas much of the thrust of the evidence of Dr. McGuire was that the army doctors in the Lebanon should have realised the vulnerability of the plaintiff and they should have identified the perils for a person of immature personality who was brought in to them on more than one occasion in a state of acute anxiety. Accordingly, they should have realised that he was susceptible to PTSD. Dr. McGuire said the plaintiff had expressed extreme anger with the army on a few occasions in the clinical notes in St. Columba's and since his expressions were disproportionate to the events, it was surprising that these feelings of anger had not been explored to see why he did feel so badly, but that there was no reference to any such exploration in the notes. For example in September 1990 there had been a note made of his having nightmares and dreams about people being buried alive as well as buzzing in his ears and there was another entry about "nightmares +++" meaning a lot of nightmares. As for the diagnostic criteria, Dr. McGuire said that the plaintiff may well have been diagnosed as ICD300 at the time because he had an acute anxiety state. That does not mean that he was not going to get post traumatic stress disorder thereafter. It does not exclude anything. She had already explained that these are just diagnostic categories for the sake of putting a code on a patient's illness, it does not mean you can exclude that PTSD may not follow on. Dr. McGuire also made the point that prior to his trip to the Lebanon, there was nothing significant on his sick leave record that would indicate any problems, he had been a good worker and had not been on sick leave noticeably prior to his return from the Lebanon. She felt that psychological counselling would have helped and also some medication, although she did say that the taking of Prozac is often stigmatised by soldiers because they do not wish to be branded as a psychiatric patient. She also made the important point that cognitive behaviour therapy was being used in the mid 1980s and group counselling was regarded as being very beneficial. In fact the plaintiff did attend group counselling in relation to his alcohol problem in Donegal and found this group therapy to be beneficial. It was suggested to Dr. McGuire that if he did not take advice about medication and counselling what could be done for him. To this Dr. McGuire replied that other people can look out for him and his interests such as his employers and his family. Counsel suggested to Dr. McGuire that the plaintiff had made no complaint to anybody in the army about the intrusive thoughts which he was having. She responded to this by pointing out that his sick leave record was telling its own story after he came back from Lebanon. She pointed out that he had been in hospital for detoxification and so the army knew about his problem. At that time in the late 80s it was a very pertinent time for PTSD because in 1987 the MOD in England had had a ruling against it that it no longer had crown immunity from looking after its injured soldiers, the ones who were injured both physically and psychologically. So PTS was a very popular and much discussed topic at that time … It was in every journal, every journal that was available to doctors in the 1980s and 1990s was full of information about PTSD. There were articles in the various journals. It was very topical after the Falklands war, that brought it into focus as did the troubles in Northern Ireland, so that it was something of which people were aware. She made it clear that what she was saying was that anyone would recognise that somebody had been traumatised in a traumatic situation and might have had it checked out further. Counsel for the defendants pointed out that it was said that Dr. Scully had indicated he should have counselling, so obviously she was alerted to it (referring to his psychological condition). Counsel asked why the other GPs did not diagnose PTSD. Dr. McGuire said that the plaintiff saw the other GPs in crisis situations with alcohol problems and he was sent into hospital and because he was admitted for detoxification, that is for a crisis admission. Counsel referred her to the LA30 "on the 26th and 27th where he had been admitted for other injuries". Dr. McGuire said that this just alerted her to the fact that she wondered why he was not called for an independent medical by his employers and why they were not worrying about why this man was missing so much time from work. In her view he should have been checked out to see what was going on. His sick leave pattern had changed so hugely since his tour in the Lebanon. None of the GPs had picked up on the PTS except Dr. Scully who had referred him on. The sooner PTSD is diagnosed, the easier it is to be treated but, having said that, people are treated successfully regardless of when it is diagnosed. She was asked if he had taken Dr. Scully's advice would the problem have been cleared up and she replied that it would have helped his problem certainly but she was told that this was in February 1988, and she said that her remark must be qualified by his mental state at the time and apparently he was in the throes of alcohol abuse, very over-alert, his autonomic (nervous system) being on alert because he was not sleeping, while he was having nightmares and was very traumatised. He was self medicating with alcohol at the time to try and relax himself. She pointed out that stopping taking medication was a very common phenomenon as was doubling the dose. When she was asked what could have anyone done for the plaintiff she replied that the first thing is that he should have been given some knowledge around his problems, if he had been educated, if he had been prepared for the onset of symptoms that he would have recognised them and he would not have been so distressed thinking he was abnormal and he would not have been hiding these problems. If there had been a support group in place for him, he could have availed of that and improved very considerably. Dr. McGuire also said in answer to the question about following Dr. Scully's advice that she did not know the answer as this depended on how unwell he was at that stage; and on being told that he was advised in respect of treatment with Prozac and psychiatric counselling, she said that most PTSD suffers did not find that intervention useful. More helpful were education, discussion with peer groups and employers' understanding of what was wrong with the employee. She felt that the employer should have checked him out, because why a man with a good work record would now go missing from work? The employer should have checked out what the cause was of the huge change in the plaintiff's sick leave pattern on his return from the Lebanon. He needed education in respect of his problems and an

understanding of them and once he had got the diagnosis from Dr. Fionnuala O'Loughlin then he started to improve by self help because of his understanding of his problems. She made it clear that her opinion was that if somebody is diagnosed with an incapacitating anxiety/depression under pressure and is remaining on as a soldier that it is imperative that he should be referred for assessment and treatment, for his own safety and the safety of his colleagues and the army. She would recommend psychological first aid at once and then the patient would or may need medication for anxiety or depressive symptoms and sleep disturbance and then, thirdly, cognitive behaviour therapy in which one gets the person to remember the details that upset them and have this in mind, so that then one trains them to relax around this and address the feelings they have about the feared situation. She made it clear that there had been a general knowledge of PTSD and remedial treatment for a very long time. From 1980 onwards there had been a lot of measurement tools devised to measure the severity and extent of PTSD, such as the Caps document which had been used by Dr. O'Loughlin. It was further put to Dr. McGuire that ICD300 specifically excluded combat fatigue situations and acute stress reactions and under re-examination she pointed out that, in the context of this case, ICD300 had been used to signify an anxiety state when in fact ICD300 means "neurotic disorders" when not qualified by a further number and so 300 simpliciter means neurotic disorders so it could cover a multitude and "liable to ICD300 under pressure" would be an anomalous term. She carefully made clear that in her view Col. Collins was not using ICD300 in any pedantically precise categorisation excluding acute stress reaction. In re-examination Dr. McGuire was also asked about incidents when the plaintiff gave evidence that he came under close fire while in the Lebanon and she replied that she was sure it had relevance as he became intensely fearful and frightened when he became so anxious in the Lebanon. If his situation was within range of close fire that would have been a trigger factor. Secondly she was asked about the incident in which Sgt. Flanagan gave evidence that the SLA compound on the hill above and near their outpost came under fire from Hezbollah and an order was given called "ground hog" which effectively means that most of the personnel have to get into the bunker. He gave evidence that the plaintiff was not in the bunker and when he went into the billet he found the plaintiff frozen in a crouching posture and unable to move and he had to be physically brought down into the bunker. Dr. McGuire replied that this particular type of paralysis was well documented during the First World War and was a sign of intense terror, so he was plainly terrified at that stage and could not move and the shelling would have been the obvious trigger for this. She was told that Sgt. Flanagan further gave evidence that when he went back into the bunker later when the others had come out, he found the plaintiff there and he had to be brought out because he was described as being in a trance like condition by CQMS Flanagan. She said that this certainly would be relevant to any issue of PTSD and said that it appeared that the plaintiff certainly developed the symptoms of acute stress reaction during that time in the Lebanon, so all those exposures to intense fear would have combined to make him chronically anxious and stressed, and, later she added, also unable to relax. In an incident on 10th January, 1987, when the plaintiff was near the Total petrol station he recounted how he was pinned down by gunfire and had to leave a vehicle and take cover in a civilian house. Dr. McGuire said that was exposure to an intensely frightening situation which would also be a trigger factor. That in fact was on the 10th January, 1987 the day on which Cpl. McLoughlin was killed and the plaintiff described himself as being terrified, after finding out about that. Dr. McGuire agreed that it would have reinforced his terror when he discovered his friend had been killed. She also confirmed that if Dr. Flynn had been made aware of the contents of the LA30 relating to his time in the Lebanon then warning bells would have rung a lot earlier about the diagnosis of simple alcoholism or indeed if she had been told of his excellent work record prior to his going to Lebanon at a time of known hostile faction fighting, then if she had been sent a copy of his medical record while abroad it is more than likely she would have looked for the underlying cause for his problems. Dr. Flynn as an experienced psychiatrist had to be well aware that soldiers returning from war zones frequently bear psychological scars from their experiences of death and serious injury and scenes of unspeakable savagery. I have recited the evidence of Dr. McGuire at some length as she is an experienced and expert psychiatrist having held a post of great responsibility as Consultant Psychiatrist and Clinical Director of Roscommon Psychiatric Services in the Roscommon County Hospital. She has dealt with all sorts of people over the years and among others she has treated soldiers. I accept her measured and careful evidence and she made clear that while PTSD has been made officially recognised under that name since 1980, the same constellation of symptoms which make up PTSD has long been recognised as an affliction to those embroiled in battle and in the valley of the shadow of death. The symptoms have long been recognised and indeed the same symptoms were known under the names of "soldier's heart" and "effort syndrome" during the American Civil war. Neurasthenia was also described during this period and "war neurosis" was another name during the First World War as well as "shell shock" which is the name of the book by Wendy Holden, which Dr. McGuire had with her. She was aware of how the British sent troops suffering from shell shock back to England for treatment, whereas the French set up treatment centres closer to the front line and managed by earlier treatment to rehabilitate sufferers of shell shock more quickly, thus meeting the army's requirements for more troops for the front line trenches. One would certainly expect the individually caring and clearly well educated members of the Irish Medical Corps to have read not only the poems of the First World War by Wilfred Owen and Siegfried Sassoon but also the extract from the poem on the statue in St. Stephen's Green of Tom Kettle, Irish Barrister, and Francis Ledwidge who was killed near Ypres on 31st July, 1917 and, as army doctors one would be confident that they would be well aware of the symptoms of and perils of untreated PTS.

91. I accept Col. Goggin's evidence supported by Sgt. Gerry McCabe who gave evidence of having attended the colonel's briefing about how to cope with grizzly scenes and what to look out for in respect of stress. Colonel Goggin has been in the forefront of developing a policy of raising awareness in the army in respect of the peril of any fatal incidents and stress particularly with regard to troops going overseas. He and Capt. O'Loughlin co-operated in producing leaflets in the years after 1986, but I think that the 60th Battalion was the first group of officers and NCOs whom Col. Goggin addressed and Sgt. McCabe particularly remembered his advice to the effect that when dealing with dead bodies one should get on with the job as part of one's day's work and to use Vick or after shave to counter the smell of dead bodies. Writing about 1990 some four years after the 60th Battalion did their preparatory training for their winter tour in the Lebanon, Capt. O'Loughlin wrote;-

> "These days we hear a lot of talk about post traumatic stress disorder. This is a disorder which sometimes affects people who have experienced situations which were extremely violent or upsetting. It involves re-experiencing the event persistently in their dreams or thoughts. The experience may be as victim or survivor of a trauma or as a witness to the trauma, such as being present at a tragedy or atrocity or seeing or handling mutilated bodies."

92. This was written after 1986 but I accept the evidence of Dr O'Loughlin and Dr McGuire that the symptoms and nature of what was widely known as PTSD from 1980 on had been well recognised by other names such as neurasthenia from long before 1980.

93. Dr. McGuire confirmed that PTSD was the topic exciting considerable interest because in the early 1980s there had been much discussion in the UK about legislation to remove the crown immunity from suit by members of the armed services who had suffered PTSD while serving in the British Armed Forces.

94. Both Lt-Col. Maurice Collins and Cmdt. Gerry Kerr were impressive witnesses. I have no doubt that both of them are well read and humane gentlemen. It was clear from their evidence that they both felt that the plaintiff was to blame and had caused difficulty for them by his failure to give them information about his symptoms of PTSD. I expect that both these respected members of the Medical Corps have read not only the poets of the First World War but also the book by Dr. Miriam Moore, *PTSD Among Irish Veterans of the UN Peacekeeping Forces* which was published in 1995 and *Shell Shock* by Wendy Holden as well as the article on PTSD by Margaret Banshoos Halla in a Vietnam magazine which Dr. McGuire said was available on the internet. I am grateful for the copy of *Post*

Traumatic Stress Disorder In Combat Veterans by Dr. G.M.M. Kerr MRCGP the dissertation published in February 1998, which is a most interesting overview of the literature with an excellent bibliography which should ensure that the work of Lt-Col Goggin in preparing contingents heading for peace keeping duties overseas will be enhanced in the future. Both Dr. McGuire and Dr. Capt. O'Loughlin gave convincing evidence about the reluctance of soldiers to talk about psychological matters and mental problems and the reticence of those soldiers afflicted by PTSD to recall and narrate the incidents which caused them to be traumatised and accordingly one would have expected military doctors to have taken this well known aversion and understandable reluctance into their considerations as a given factor in dealing with the vital matter of early diagnosis and treatment of the stress in areas where there are likely to be hostilities and gunfire. Anyone who has seen a gun-shy dog during the fusillades of rockets at Halloween will be aware of how animals and humans can be sensitised and can be smitten by uncontrollable shaking and glazed appearance and incapacity mounting to paralysis and trance like appearance. Dr. McGuire cogently made the point that the plaintiff's LA30 spoke for itself in that the plaintiff had a good work record with remarkably few sick leaves prior to his going to the Lebanon on his twenty first birthday. His wife's evidence was that he came back a changed man and certainly his subsequent, at least nine admissions to St. Columba's Hospital in Sligo, are testament to how his life became an ordeal due to the PTSD which was not definitively diagnosed until eventually he was referred to Capt. Dr. O'Loughlin at her clinic at S. Bricin's, where she at his very first attendance made a working diagnosis of PTSD and wrote that day to this effect to Capt. Kerr. She confirmed this diagnosis by the CAPS test on 29th February, 1996. The LA30 and the central medical file and the entries with regard to the plaintiff both before and during his time in the Lebanon should have given the key to an understanding as to why he went to pieces on his return to Ireland. Regrettably there was no protocol or system under which copies of these documents were sent by the army to civilian doctors treating soldiers. It is elementary that at least a history of the medical records of the soldier during a traumatic tour of duty abroad should clearly under some protocol on the matter have been given to each of the doctors who were treating the plaintiff, including Dr. Fidelma Flynn, the GPs in Ballymote and Dr. O'Loughlin, whom I recall saying that she made her initial working and provisional diagnosis without even having the LA30 or the central medical file documents. Certainly when the plaintiff had a good work record and minimal sick leave in the years before his experiences in Lebanon during a tour notorious for the traumatic experiences, it would seem imperative that the medical history of any such soldier, who subsequently goes on repeated sick leave or has multiple admissions to psychiatric hospitals, should be made available to the treating psychiatrists and other doctors attending the patient.

2. The plaintiff's condition while he was in the Lebanon

95. There has been evidence of a number of incidents when the plaintiff was exposed to fire and when his behaviour indicated that he was acting under stress and very unusually:-

1. On 29th November, 1986, the plaintiff was brought by ambulance to RAP Tibnin at Camp Shamrock. It was the chief medical post. A description of what occurred was given by Company Quartermaster Sergeant (CQMS) James Flanagan having thirty years in the army and twenty years as a Sergeant and comes from Co. Leitrim. He enlisted in 1976 and by 1977 he was a Corporal and became a Sergeant about 1988 and has been to Lebanon at least five times and once to Nicosia. Having been Battalion Sergeant Major he became in 2000 CQMS. He knew the plaintiff from Finner Camp and had done duties with him such as twenty-four hour guard duties and weekly patrols on the border. As Operations Sergeant he knew many of the soldiers and knew the plaintiff to see although he would not have been assessing him. In summer 1986 during the two months of a bonding process training together, he got to know the plaintiff much better and he was aware of nothing adverse about the plaintiff's conduct in that time and he never had any trouble with him during the training. They all had early rising and exercises and a daily routine of a 7.00 am three mile run. The training was based in Mullingar and the 60th Battalion was drawn from different areas of Western Command. On return from the run there would be time for a shower and breakfast before 8.30am. During the rest of the day there would be section duties with mortars or machine guns during that two months training. The plaintiff never came to any adverse attention. All had a medical check before going to Lebanon, the plaintiff's medical dossier was A1 and he passed both the annual medical and the September pre-Lebanon check. The contingent flew to Lebanon on 22nd October, 1986 on his twenty-first birthday and the CQMS commented that Lebanon was always hostile between October and Christmas. Irish members of UNIFIL had frequently come under fire. The weapons platoon was stationed at Bayt Yahun and both he and the plaintiff were at post 61 between Brashit and Bayt Yahun. In that area they had to deal with SLA ("South Lebanese Army"), Shia Muslims and Hezbollah and there were also LAUI ("Lebanese armed and uniformed by Israelis") and PLO ("Palestine Liberation Organisation"). Gunfire mostly came from the SLA. The checkpoint at Post 61 came under fire from an SLA position. It was usually machine gun fire. Post 61 was originally a one story house with two portacabins and an elevated tower. The CQMS knew Cpl. McLoughlin and he said that he and the plaintiff got on well and were on one shift on duty together. The CQMS was aware of the plaintiff's seizure on 29th November, 1986. On that night the plaintiff had been called and left his portacabin billet and came into the house. He was standing choking and there was a piece gone out of a slice of bread. The Sergeant approached him from behind and, as he had been making choking sounds, the sergeant started to lift under his ribcage in the Heimlich manoeuvre while another member fetched the medical orderly, who arrived and checked out the plaintiff. This incident went on for about ten minutes and the plaintiff was lying on the floor and he appeared as if he was having some sort of a fit and not just choking. Subsequently he was taken in to the RAP at Tibnin.

The CQMS and the plaintiff both went home for Christmas. For the two months in that post, both Cpl. McLoughlin and the plaintiff had a very good relationship.

On 6th December, 1986, Pte. William O'Brien was killed outside Camp Brashit. The plaintiff had trained with Pte. O'Brien and was upset.

The CQMS noted that the plaintiff often asked about the weather outside as he came on duty and he was happy to go on duty if the night was clear, but seemed down if there were electrical storms around. He seemed to be afraid of the electrical storms and the Platoon Commander, Capt. McEvoy would have been aware of this. The CQMS felt that before Christmas the plaintiff did not seem to be coping as well as the rest. This was never documented but there was verbal reporting and he said that he would have reported what he had observed about the plaintiff. While there was alcohol available in Lebanon, there was no alcohol in an outpost like Post 61. One could go in to the canteen for stationary and washing and one could then get a drink. All three of them, the plaintiff, Corporal McLoughlin and himself, were home for Christmas and when the CQMS arrived back after the others at Brashit, he found the plaintiff happier. Corporal McLoughlin and he had been detailed to the Company Headquarters at Camp Brashit 6/17C. Corporal McLoughlin was then sent to the CO's house in Brashit village. The plaintiff and weapons platoon was based in Camp Brashit and the plaintiff would have been "riding shotgun" on supply vehicles – which corroborates the plaintiff's account of his presence at the Total Station while doing escort duty in a jeep when he was pinned down by gunfire and took cover in the civilian house.

On 10th January, 1987 the CQMS recalled tank fire from an Israeli tank. The shrapnel round from the tank hit the COs house and killed Cpl. McLoughlin. The CQMS gave his evidence on a Friday and on the next Tuesday told the court that he had difficulty over the weekend and had only had three hours sleep as he was mulling over his recollection of his five

tours in the Lebanon. The worst of them (meaning from the aspect of hostilities and gunfire) were the 60th and 64th Battalion tours. He said the tour affected him in a big way "we were very glad to get home; I was glad to get out of Lebanon with my life, it was a very bad time and there were not many nights, some of our troops were not under fire". He became disillusioned with UNIFIL as they had not answered the questions as to why the Irish were being attacked, why the CO's house was hit by the shrapnel round and why William O'Brien was previously killed at a checkpoint. The CQMS said that he could not enjoy a night's sleep for a very long time. He found that he could not get over the death of Dermot McLoughlin. He spent a lot of time in the bunker and fear was keeping him awake for hours before he could close his eyes. Even now he could see and hear the firing into the COs house in Brashit village. There was an SLA compound about a mile east of Brashit village, and this SLA compound overlooked Brashit. This was the fourth tour in Lebanon for the CQMS and he had found that he was not getting much sleep; when he did go to sleep then he had nightmares. There was firing from heavy machine guns, mortars, and tank fire and those at the Post had to shelter in the bunker. His nightmares continued for the best part of a year afterwards, and he had problems with nightmares in which the gunfire from the compounds opened up. In his waking hours during the day, he was constantly going back in his mind as to why people were being killed when the Irish were out there to protect people. He recounted how a number of members had gone to Naquora for the commemoration ceremony for Cpl. McLoughlin. He himself had gone to make a phone call home from the UNIFIL headquarters there, and when he went back to draw his rifle, Lt. Murphy, who was in charge of the party, would not give Pte. Murtagh his rifle as he was under the influence of drink. The CQMS said that he knew that the plaintiff was having a problem with the death of Cpl. McLoughlin but a soldier bearing arms could not take a drink and he was punished for that offence.

The CQMS said that everyone had a repatriation medical examination before leaving Lebanon. This was a check for heart and blood pressure and for diseases. There was no examination for stress and no assessment by a Psychologist or Psychiatrist, although Lt.-Col.. Goggin was on one of the trips which the CQMS was on. There was no debriefing by officers or members of the medical corps. To this day, nobody had asked him how he was or how he had got on. In Lebanon, he did not drink anything at the outpost, the only time he drank alcohol there was at the barbeque before they left. He received no counselling on his return and he drank too much and caused a lot of trouble to a lot of people. He was not aware of any of his colleagues having a debriefing or counselling session, on return, and if they had, then he would have known about it. He did not know whether counselling, debriefing or any other kind of help would have helped, but none were offered to him. He said that he did not know why he could not put Lebanon behind him or forget the incidents and he had nightmares and thoughts about the Lebanon during the day. He took to the drink by way of self-medication and had never received any help to this day. He had started going out on his own, whereas before that tour he always went out for a drink with his wife; he became dependent on alcohol. His wife could not stand it any longer and a friend came and spoke to him and brought him to AA and that worked; he has managed to stay off drink for fourteen years now. On return from the Lebanon, he had gone back to the 28th Battalion at Finner as Operations Officer and he did not have much contact with the plaintiff. Under cross-examination, the CQMS said that he did volunteer again and went back with the 64th Battalion in 1988/1989. He had a purpose, which was to find the part of him that he had lost in the Lebanon with the 60th Battalion. He felt that he had left behind himself, far from his wife and children; he had left his personality and his humour behind in the Lebanon. It had been his own idea to go; nobody had given him advice, but his wife had said to go. He had wanted to find himself and he did not find himself. He said that when he came back in 1987, none of his behaviour had led to any charge. He had never voiced his feelings to a doctor or to his Superior Officer. The main reason why he did not speak of such matters was that he was eleven years in the army and had a lot going for him as a Sergeant at thirty-two years of age, and he could go up the ranks and was offered three Officers Courses. If he had disclosed that he had a drink problem, this would have come against him. He had always worked very hard and could always work in the mornings; he had never mentioned the invasive and intrusive thoughts to any doctor. As for the drink problem, he managed to get it under control in about 1993, and he did not let it interfere with his work but it did come to attention and he had been called aside over the smell of drink from him during morning briefings by his Operations Sergeant. It is very much to the CQMS's credit that, having explained the pressures at Brashit on this tour, over the weekend he thought long and hard again about this whole trip. He recalled that Captain McEvoy was on the post that night when the Hezbollah attacked the SLA compound at Brashit and there was gunfire from the Hezbollah into the compound at Brashit, Bayt Yahun, Hasalhowas, east of Bayt Yahun and Bintjubayl. When the Hezbollah attack was going in, all the SLA compounds and the Israelis opened up fire. It took about half an hour for the Hezbollah to take the Brashit compound which was the SLA position. The SLA Brashit compound received covering fire from other SLA positions. It took twenty minutes for the Hezbollah attack to be victorious and they then used captured vehicles to make their retreat from the compound. At this stage, the SLA fired from their other compound at Bayt Yahun, and moved in armoured vehicles through the Checkpoint 621, firing with their heavy machineguns so that at the Irish post there was fire from Brashit compound towards the Irish position at Bayt Yahun at the Hezbollah and also they had fire from the SLA going up to relieve the SLA in the Brashit compound. Captain McEvoy went to the elevated tower where the radio was to communicate with Company Headquarters in Brashit Camp 6-16 which was still in radio contact. The CQMS received the order "groundhog" meaning that all available people had to go to the bunker. He stated that:

> "My job was to make sure all who were meant to be in the bunker were in the bunker. I ran towards the roof of the house; this incident was in December, prior to 18th December 1986. The NCO on the roof with Ptes. Gamble and McKinley, was Cpl Dermot McLoughlin. Pte. Catterson was with Capt. McEvoy in the elevated tower. I brought people off the roof into the bunker; the Captain and Pte. Catterson remained on the elevated tower. I went to the bunker to do a check. On the radio in the bunker I told Captain McEvoy that Pte. Murtagh was missing. Corporal McLoughlin and I went to look for Pte. Murtagh and he was in his room in the pre-fab sleeping accommodation. He was not asleep as there was not much sleep that night. We found him in a crouched position. That was when we grabbed him and ran him to the bunker. We remained in groundhog all night until we got the all clear from Company HQ. Captain McEvoy and I were making breakfast for the troops when we noticed Pte. Murtagh missing again. He had not come out of the bunker. Captain McEvoy and I went in to the bunker where he was sitting in a corner on a bench in a shocked state. The Captain and I tried to communicate with him but he did not seem to know what had taken place the night before. I know that Pte. Murtagh spent time over the next few days in the RAP in Camp Shamrock."

The CQMS said that initially he had been wrong in his account that the plaintiff was in the sleeping accommodation and not on the roof, as he had first recounted. He had been mistaken; that was another person. "The plaintiff went that way because he had lost it." The CQMS said that what he meant was that the plaintiff needed to see somebody, as he was in shock on that morning in December 1986, after the attack by Hezbollah on the Brashit compound. The CQMS said that he was told by Captain McEvoy before he went on Christmas leave, that Pte. Murtagh was to go home and get things straightened out or not to bother coming back. Captain McEvoy also told him that he was in charge of the party going

home and if Victor Murtagh was not at the airport coming back, then he was not to wait for or look for him. That was Victor's first time under real fire, meaning artillery and mortar fire, though he had been under rifle and machinegun fire before. It is a frightening experience for everybody and people react differently. Not many like or enjoy it or put their heads up to see what is going on.

The CQMS said that after the commemoration ceremony, the plaintiff's rifle was taken from him and was handed to himself as Lt. Murphy decided not to let the plaintiff have it for the return trip and the plaintiff was later disciplined. The convoy did come under attack. Shells were fired to the right and ahead of the convoy. The CQMS said:

> "We had to stop and get out of the bus and take up positions. The plaintiff stayed on the bus. There had definitely been two explosions, two shells. The plaintiff remained on the bus and he had no gun so he could not have engaged the enemy."

The plaintiff was always nervous about the weather. In winter in the Lebanon, there are electrical storms with lightning and thunder. His asking the question about the weather brought him to the CQMS's notice. Several of the posts were closed, including the CO's house and 617 Charlie. A new post, 642, in Bayt Yahun, was opened below the compound at the top of the hill known as "the hill of the donkey". When Post 642 was opened, it was on a hillside and he narrated how they were put out in a tented guard room, though an APC came out at night to give them some protection. The CQMS said that he did duties out there with Pte. Murtagh at this new post, 642, and also at Post 646. There would have been a couple more attacks at this stage on the Brashit compound of the SLA. These were not as hectic onslaughts as the previous one.

Under cross-examination, the CQMS said that on the occasion of the choking attack, the plaintiff did not know where he was and he was not communicating coherently. When asked was he alright, he did not respond. After the Hezbollah attack on the SLA compound, the Hezbollah came to the gates of Checkpoint 617 and threatened to blow the house up unless the gates were opened, but the NCOs in 617 were instructed to open the gates and so the Hezbollah drove through the Irish Battalion through all the checkpoints and back to their own area. He thought this was the reason behind and the cause for the SLA firing on the CO's house at Brashit, despite the UN flag being lit up on the side of the building. Counsel for the defendants pointed out there was no medical record in the LA30 for any dates other than 29th November, 1986, and 18th December, 1986. However, I note that entries were not always entered daily, as for 29th of November and 30th November 1986, and perhaps no entry was made on that day in December 1986 when CQMS Flanagan recalled the plaintiff's spending further time at the RAP at Camp Shamrock after his being paralysed with fear during the Hezbollah onslaught on the SLA compound.

2. It was at about the time when Pte. O'Brien was killed on 6th December, 1986, that the Hezbollah attacked the SLA compound at Camp Brashit. I have outlined Sgt. Flanagan's evidence about this. There was firing towards C Company's position at 621 at Bayt Yahun at which the plaintiff was stationed. It is difficult to put a date on this. It is a pity that the Unit history is not available. Captain McEvoy had received the order "Groundhog" and personnel had to go to the bunker. The CQMS described how he and Cpl. McLoughlin found the plaintiff crouched in his billet and they had to bring him down to the bunker. The next morning, he did not emerge with the others and the CQMS described how he and Captain McEvoy found him in a shocked state in the corner of the bunker. When they tried to communicate with him, the plaintiff did not seem to know what had happened. The CQMS believed that the plaintiff was taken to the RAP Tibnin but there is no record in or about 6th December, 1986, of his being examined at the RAP Tibnin. Captain McEvoy was clearly justifiably concerned about the plaintiff and discussed his condition with Lt Col. Collins and was reassured that the seizure was unlikely to be epileptic.

3. On 10th January, 1987, the day when Cpl. McLoughlin was killed, the plaintiff's evidence was that he was riding "shotgun" to checkpoints. Near the checkpoint at the Total petrol station, he said that he had had to take cover in a civilian house. There was heavy firing and Cpl. McLoughlin, who was in an upstairs room in the CO's house, was killed by a shrapnel round from an IDF tank. The plaintiff later learned of his death at Camp Brashit. He was terrified and shaking and passed out unconscious and was brought to the RAP at Camp Shamrock.

The evidence of the CQMS can leave no doubt whatsoever that the plaintiff was subjected to close firing and a series of sensitising incidents where there was a fear and expectation of death, reinforced by the death of William O'Brien and Cpl. McLoughlin. Furthermore, the CQMS's frank account of how this, his fourth tour of duty in the Lebanon, affected him for several years afterwards is indicative of the severity of pressures which were on the weapons platoon constantly, particularly in December 1986 and January 1987. If this 60th Battalion tour had such an effect on a veteran like the CQMS, what devastation must it have caused to a twenty-one year old of immature personality? The abnormal behaviour of the plaintiff was well known to the NCOs and Captain McEvoy and Lt-Col Collins knew of the plaintiff's acute anxiety states and must have learned of the terrified behaviour from Captain McEvoy on his visit, when the Captain was reassured by the Colonel that the plaintiff was not suffering from epilepsy. Captain McEvoy was aware of the abnormal and unusual behaviour of the plaintiff in electrical storms and how stricken with terror and incapacitated he was when there was gunfire. It is surprising that on only two of the visits of the plaintiff to the RAP, that there is a written record in the LA30 but it is explicable in circumstances of much hostile fire. It is a pity that the 60th Battalion unit book was not made available as it might well have reduced the length of time taken up on contested incidents in the Lebanon, in a case in which it was the army psychiatrist who made the initial working diagnosis on 17th November, 1995, and communicated her positive diagnosis in her report dated 27th May, 1996, to Cmdt. Gerry Kerr. One would have thought that this positive diagnosis supported by the CAP test results would have galvanised the army medical corps into ensuring that the plaintiff received the best of counselling and therapy, particularly as he came from an army family in that two of his brothers also served in the Defence Forces so communication with his family should have been straightforward even allowing for confidentiality and sensitivity. I expect that consideration has been given to the wise advice of Colonel Walsh about contact with the family of vulnerable soldiers who have been affected adversely while on active service in battle conditions and appropriate protocols put in place to ensure proper and best practice.

4. Corporal Declan Gaffney had been stationed at Finner in Co. Donegal with the 28th Battalion and knew the plaintiff well and worked closely with him. They had been on a border unit together doing lengthy spells of duty and spent a long time together. Corporal Gaffney was the plaintiff's Corporal and he found the plaintiff to be an able man and a good soldier who was very well liked and a lively, decent man. He described how they went out to the Lebanon together. He was assigned to a different platoon at first, but on several occasions, their paths had crossed and he had seen the plaintiff towards the end of the six months and noted the change in him. He was on the convoy after Corporal McLoughlin's memorial service at

Naquora, and he took photographs. The convoy included a minibus, trucks, jeeps and some armoured personnel carriers. About ten minutes out from Naquora, the convoy came under fire from heavy mortar and artillery up towards the hills. He was in a soft skin jeep. When the convoy came to a halt, they took up position behind walls for some fifteen minutes. He saw the plaintiff who was out of the bus and taking cover behind a wall. He was unarmed. He had been disarmed in Naquora because he was regarded as being under the influence of alcohol. He was affected, in a bad state, nervous, jumpy and edgy. He was not the same Victor; he was frightened and he was talking quickly and rambling a bit. He was asked whether this was from drink and he said that he did not know for sure, but in his opinion, Victor Murtagh was not drunk. The convoy eventually went on and stopped at Camp Shamrock and then at Camp Brashit and he and the plaintiff both dismounted at Brashit. He was then sent to an outpost and did not see Murtagh.

About a week after Cpl. McLoughlin had been killed on 10th January, 1987, earlier in the tour, the Corporal had met Victor Murtagh and he was of nervous disposition. He was one of three Privates under the Corporal's command and they were at a Checkpoint where there was one private on the roof, and one NCO and two privates at the checkpoint and the privates took it in turns to go up on the roof. In the early hours of the morning, the Corporal got a phone call from the roof to the bunker at the Checkpoint. It was the plaintiff on the phone on the roof. The Corporal went up on to the roof and found the plaintiff distressed. He was visibly shaken and said that he had seen somebody on the roof, which was a large flat roof on top of the Officers Mess. There was nothing to obstruct the view across the flat roof from the machine gun post. At 1.30am, there were lights from the general lighting and there would be security lights on the roof. The incident and report of a sighting was surprising because the Corporal could see nobody there. Subsequently, in April 1987 the Corporal had been at Camp Brashit for the last six or seven weeks of the tour and Victor Murtagh was in the same camp. He said that he noticed the difference in him and, being in charge of him, he had to keep an eye to his welfare. The plaintiff looked pale; he had lost weight, and he was shaking. He had never seen him have shakes before and now he was shaking as if in fear. The Corporal had discussed his condition with the Sergeants and officers but not with Sgt. Flanagan. Everyone knew that Victor had some sort of problem. No steps were taken to help him and he had to do his duty. There were an awful lot of people in the same situation. Corporal McLoughlin was killed on 10th January, 1987. He had been a close and good friend and his death affected everybody in their different ways.

There had been no counselling or debriefing on arrival home, the medical examination was in the Lebanon. They went by convoy to McKee Barracks and then took their bags and went home. The Corporal went back to Finner Camp and he did not see the plaintiff for some years as the plaintiff was on long sick leave. He only recently met Victor Murtagh again, he was shocked. He had lost much weight. He still talked with a nervous twist in his voice and he still shook. His hands and whole body seemed to shake at times when you were having a conversation with him. The Corporal expressed the view that in his opinion, Victor Murtagh was a failed man. He had been a lot heavier, sturdier and stronger when serving with him in the Lebanon. He now speaks normally as he used to do. Corporal Gaffney did not know that the plaintiff had been detoxified. In cross examination he said that in the convoy coming from Naquora after the ceremony, the convoy was attacked and he was very sure of this. The plaintiff had no rifle because he was supposedly drunk. He did not agree with the way in which Victor Murtagh was charged as there was no blood test done. He said he could not understand why he was not charged in the way that people are in drink driving cases and he made the point that there can be use of breathalysers and blood tests. He was adamant that he did not think that the plaintiff was drunk and he explained that you do not volunteer for many things in the army and he had not volunteered to give evidence on his behalf. After the episode at the machine gun post on the roof, the Corporal had put Victor Murtagh on road duty. He did not report the incident as there was no need for that. After the return he did not see the plaintiff for well over a year until June 1988 hospitalisation. It was well over a year since he had seen him last. During their last few weeks in the Lebanon he had been one of the NCOs over the plaintiff and others. The Corporal said that on the occasion in the Lebanon when the plaintiff's whole body was shaking he had sat him down and given him tea and as the matter was sorted out he made no report at the time nor did he remove his rifle. He did discuss the matter with the NCOs but not with Sgt. Flanagan.

It is quite clear from Cpl. Gaffney's evidence that both Captain McEvoy and Captain Kilfeather knew about the plaintiff's difficulties and that at times he was shaking with fear. Both knew that the incapable condition of the plaintiff was being discussed by all ranks. Cpl. Gaffney had known and worked with the plaintiff during 1985/1986 as they were both in Finner Camp and he worked closely with the plaintiff together on a border unit during long stints of duty together. He had no adverse comments to make about the plaintiff and there was no hint of suggestion that the plaintiff had an alcohol problem whatsoever prior to going to the Lebanon. Secondly he was on the convoy from Naquora and confirmed that they had come under fire from heavy mortar and artillery. About ten minutes out from Naquora he saw Victor Murtagh out of the bus and taking cover behind a wall. He was unarmed as the rifle had been taken from him. He did not think the plaintiff was drunk but he was in a bad state of jumpiness or nervous agitation, and he was frightened. He does confirm that the plaintiff did leave the bus for at least part of the fifteen minutes delay and that the convoy had to stop because of heavy explosions on the road ahead.

5. Sergeant McCabe's account has already been given above as to how on or about the 1st March, 1987, the plaintiff had been transferred under his command to a new exposed position at Post 6/42 which they were setting up. On the plaintiff's first night there, he reacted to two shots from the SLA compound (probably aimed elsewhere) by shaking. Sergeant McCabe gave him a cup of tea and did not assign him any more night duties. Sergeant McCabe gave evidence that he told Sgt. Doherty that he did not want the plaintiff assigned to him and asked for him to be moved back to the main camp.

3. Knowledge of the plaintiff's condition in the Lebanon

96. Evidence was given by several NCOs who served with the plaintiff in the Lebanon to the effect that as CQMS Flanagan put it, "he had lost it, he needed to see or talk to someone, he was in shock". This was in relation to the plaintiff's stricken behaviour when the C Company position at 6-21 post was under fire and the order "ground hog" was given and the plaintiff acted as if paralysed with fear.

97. I suspect that this incident, from the evidence of Captain McEvoy as well, was probably just before several members returned home for Christmas 1986. Captain McEvoy described two episodes in December 1986. The first was on the night of a big electrical storm with thunder and lightning like a fireworks display. The plaintiff was on duty on top of an elevated tower where two soldiers would be posted to observe for unusual activity particularly around the SLA compound and checkpoint. Sgt. Flanagan requested Captain McEvoy to come and they went up and found the plaintiff in a very upset state of anxiety white as a sheet and so incapable that they had to bring him down. He was not only very pale from this big powerful display of nature but was shaking and had tremors in his hands. Captain McEvoy describes how in the kitchen the plaintiff was given tea and the colour eventually came back into his

face. Others in the Company had a normal reaction to this first ferocious thunder and lightning storm but Victor Murtagh was very affected. The Captain told Sgt. Flanagan not to put him back up on the tower post. It was the first experience the Captain had had of a person being terrified by noise of thunder. This ties in to evidence of the NCOs that the plaintiff was nervous going on duty and often asked about the weather outside and the inference is clear that the noise of explosions whether from shells, mortars or electrical thunder claps caused the plaintiff to shake uncontrollably.

98. The second episode the Captain recalled as later but still in December 1986, so it seems it was just before 18th December when the plaintiff was returning 'home for Christmas'. The plaintiff had been on duty and came into the kitchen and sat down for a cup of tea. He let his cup fall and the Captain recalled him on the floor having a fit, shaking convulsively and grey-faced with a tinge of blue. Captain McEvoy at once contacted Company HQ by radio and by phone to explain that an ambulance was needed. There was a delay for ten minutes in the coming of the ambulance because of protocols with the SLA checkpoint but the plaintiff was then taken with an NCO by ambulance to the RAP at Camp Shamrock and kept there overnight. Captain McEvoy said that he went the next day to the RAP at Tibnin and met Lt.-Col. Collins, the senior doctor, and expressed his concern about Victor Murtagh and his and other soldiers' safety, especially if it was an epileptic fit. Lt.-Col. Collins reassured him that it was an isolated incident and said one cannot diagnose epilepsy from one event. They kept Victor Murtagh in HQ at Camp Shamrock or at C Coy at Brashit for a time. He then enlarged on his description of Victor Murtagh on the floor with the "shakes"; he had tremors; his arms were shaking. There was concern he would swallow his tongue and an NCO put something in his mouth and held his tongue back. The Captain himself had observed this first episode for seven or eight seconds before he ran out of the room. The plaintiff had "been out of touch" but was becoming conscious and lucid, with colour coming back, when the Captain came back into the room after being out of the room for two or three minutes. He had tried the radio first and then spoke to Captain Andy Kilfeather on the landline to the effect that the need for an ambulance was urgent – as the plaintiff had suffered some sort of fit.

99. After this second episode Captain McEvoy said he discussed the plaintiff with Captain Kilfeather who said that the plaintiff had domestic problems and was going home for Christmas. At a later stage he said that he and Captain Kilfeather had many conversations and he was given the impression that Victor when home had attended a medical officer at Finner Camp. Captain McEvoy himself had accompanied Dr Captain Leonard to identify the remains of Corporal McLoughlin who was killed on 10th January 1987 and then he returned to Ireland with the remains of Corporal McLoughlin and attended the High Mass with full military honours and the two days of ceremonies.

100. Captain McEvoy had two and a half weeks leave and then returned to Lebanon at the end of January 1987. Lt.-Col. Collins had allayed his concerns about Victor in respect of epilepsy by saying these were single episodes followed by convalescence. He was briefed on matters by NCOs Flanagan, McCabe and Doherty, who were all exceptional NCOs, to the effect that the situation had calmed down after the very difficult periods in December and January. For the rest of the tour he had no issues with Victor Murtagh. He spoke to him a few times and chatted to him over tea. It was a small post with only 16 men so he had many conversations with him but Victor did not discuss personal or marital matters with him and he thought it was not for him to raise such a topic. From the end of January 1987 the Captain had to take extra care of three soldiers but Victor was not one of them although the Captain had concerns about him and had met him in Letterkenny during the 28 day leave after the April 1987 return. They had a good chat and Victor said he could not settle and the Captain had said they were all going throught the same readjustment. He was pleased that Victor had confided in him. As he became adjutant at Finner, he had more to do and did not see much of Victor. The Captain left the army in April 1996 and had learned from Victor's brother Sidney at some point that Victor had left the army in 1998.

101. Under cross-examination Captain McEvoy gave an account of an episode in early December 1986 which seems to have been a third episode. There had been machine-gun and rifle fire and shoulder-launched grenade attacks by Hezbollah on the SLA compound and checkpoint. There had been a 'ground hog' order. Sgt. Flanagan and the late Corporal McLoughlin had to fetch Victor Murtagh down to the bunker; he was not on the tower on duty but instead they had found him crouched in a state of anxiety in the billet and took him to the bunker. There was intense fire and Captain McEvoy had launched two red flares to indicate not to fire on the UN Post. The Captain and Private Catterson stayed up on the tower. The rest went into the bunker. This was around midnight and there was a lot of fire and it was "a bit scary" "It was a night we were all shocked including myself." "That night was very stressful. Everybody was upset and believed their lives were at risk. This was not so much from a premeditated attack but there was always the peril of a stray round or a mortar hitting our post – either Hezbollah or SLA could have hit our post – our safety was not their primary concern. There was a well worn pattern of attack – the Hezbollah would infiltrate near the UN position. Our concern was the peril that misdirected fire would hit us. The terrain was hilly and the mode of attack was through the wadis. It was a very difficult period."

102. Captain McEvoy said he was not surprised by Lt.-Col. Collins' entries in the LA30 about Acute Anxiety States. His own concern about a fit was about the underlying condition as it could be a danger. He said he could not recall if anything was said after the plaintiff's stay in Camp Brashit which seems to confirm that this was a third episode after which the plaintiff did recuperate for a time at Camp Brashit in December 1986.

103. In February 1987, Sgt. McCabe was detailed to set up a UN Post 642 on the mountainside to discourage Hezbollah attacks on the SLA compound nearby. Sgt. McCabe would have known the setting up of this post was tricky and could well have indicated to Sgt. Doherty that he would prefer not to have the plaintiff with him but he, Captain McEvoy, did not recall Sgt. McCabe reporting an incident to him involving flares and firing which would be fairly routine or anything about Pte. Murtagh shaking on that occasion.

104. At the end of his evidence in re-examination Captain McEvoy said he had got the impression that the plaintiff was liable to drink and he sprung the suggestion that some of the Sligo members, including the plaintiff, had been at a nightclub during training at Mullingar and did not appear for a 7am run. Clearly he had not mentioned this to Counsel for the defendants or this would have been elicited in direct evidence with an opportunity for cross-examination. Furthermore it would have been put to the plaintiff. If Captain McEvoy had any such information and concerns about a mortar man in a weapons platoon surely it was his duty to make inquiry in which case he would have found the plaintiff's LA 30 showed him as A1 medical category and with minimal, if any, absences on sick leave before the Lebanon tour and no mention or indication of drink problems whatsoever until after the mid-January 1987 incident at the UN HQ at Naquora when the plaintiff was upset by Cpl McLoughlin's death and annoyed and upset by the parading of the empty coffin for the sake of footage for TV cameras.

105. This remark about drink and another remark thrown in uninvited about the plaintiff being "almost manipulative at times" both came out of the blue and struck a discordant note, being unexpected and unsubstantiated criticisms of Victor Murtagh and completely out of tune with the observations made about the plaintiff by the NCOs Sgts Flanagan and McCabe and Corporal Gaffney whose assessments of him I accept, particularly on the aspect of his not taking of alcohol to excess before his acute states of stress in Lebanon. I also accept that there was the failure to treat him adequately there in Lebanon or on his return to Ireland, both of which Dr McGuire said, in the state of knowledge of PTSD by doctors, and particularly by military doctors, at the time in 1986/7, should have been imperative; it was clear he suffered from several episodes of acute stress even to the point of loss of consciousness and

incapacitation, so manifestly warning bells should have been rung about the perils for him of PTSD. In the state of knowledge of PTSD, according to Dr McGuire, whose careful and measured evidence on this aspect I accept, his symptoms were such that not only should he have been listed for observation and if necessary for treatment; but he should have been referred for check-up by the army psychiatrist Dr F O'Loughlin.

106. From the remarks of Sergeant McCabe it is clear that the plaintiff's problems were well known in the platoon and company:-

> "It was common knowledge in the platoon that the man in question was having problems"
>
> "The members of the platoon knew for quite a while he wasn't right."
>
> "He was not able to perform as he should be."
>
> (Sergeant McCabe, speaking of March 1987).

107. Lt. Colonel Collins, as he then was, gave evidence that he was informed by Captain McEvoy in the Lebanon that the plaintiff's rifle had been taken from him at some date after the 16th January 1987 (and therefore distinct from the episode following the memorial service for Corporal McLoughlin). However, since Captain McEvoy did not recall a second incident involving the plaintiff when his rifle was taken from him and since Lt. Colonel Collins said that the Captain was the source of this story, it would be sensible to discount this particular suggestion although not doubting the veracity of either officer.

108. Furthermore, when the plaintiff was being repatriated to Ireland in April 1987, Lt. Colonel Maurice Collins, the medical officer of the battalion noted on the form AF667A on the 18th April 1987:

> "This man is relatively emotionally immature and came under very severe pressure. He is liable to incapacitating anxiety states in such circumstances and should not serve o/seas for 3 years."

109. Col Collins initially was concerned at the plaintiff's fit on 29th November 1986 that it might have epileptic origins. It must have had convulsive type manifestations. This would have been serious for a soldier's career and I expect Col Collins was glad to be able to reassure Captain McEvoy that he had revised his initial thoughts to acute anxiety states of an incapacitating variety which partially reassured Captain McEvoy. Since Lt.-Col. Collins dutifully had the practice of driving out to visit his patients and to talk to the officers and NCOs, it is more than probable that he learned of the plaintiff's many manifestations of PTSD, the shakes and "being out of it" and paralysed with fear. Dr McGuire expressed the clear view that the plaintiff should have been noted as vulnerable to PTSD and should have been checked out and if need be referred to Dr O'Loughlin to be examined. Lt.-Col. Collins said he thought that the plaintiff would recover on his return home away from the "tough battalion's" experiences in Lebanon, meaning tough and traumatic experiences for all involved. When the huge change in the plaintiff's sick leave record and hospital admissions crossed the desk of the army doctors, with their knowledge of how soldiers use alcohol as medication for symptoms of PTSD, they should have realised that the plaintiff needed to be checked out in respect of those incapacitating anxiety states and they should have referred the plaintiff to the army psychiatrist. The 1988 Medical Board (Lt.-Col. Collins, Captain G. Kerr) had found the plaintiff to have had a "history of anxiety/depression in Lebanon 1987; depression and alcohol abuse June 1988; then 'Subject to incapacitating anxiety/depression under pressure, History 2o (secondary) alcohol abuse June 88: Well since. Immature personality, subject to anxiety/depression when under pressure". Further down the recommendation is "Needs to be closely observed for signs of stress". As time went on despite Col. Walsh's advice, as Director of the Medical Corps (DMC), that the plaintiff was vulnerable and contact should be made with his family, no such contact was made or supportive help given and the plaintiff became more dependent on alcohol. As Counsel for the plaintiff put it to Lt.-Col. Collins, by 19th June 1992 at the Medical Board at Custume Barracks in Athlone, the history "had been turned around" to "history of chronic alcohol abuse and depression". Now instead of "needs to be closely observed for signs of stress" and "subject to incapacitating anxiety/depression under pressure with secondary alcohol abuse" the emphasis has changed to "history of Chronic Alcohol Abuse and Chronic Depression" in what appears to be Lt.-Col. Collins' handwriting on the Proceedings of Medical Board "supplementary" Form.

110. Despite Dr O'Loughlin's firm and conclusive diagnosis of PTSD in her letter to Comdt Gerry Kerr on 27th May 1996, very little heed seems to have been given to this direction from the DMC Col. Walsh, and little treatment or advice was given to the plaintiff.

111. Given this evidence, the defendants failed in their duty to the plaintiff to exercise reasonable care for his safety and welfare. The defendants were obviously on notice that the plaintiff had reacted badly to stressful incidents and suffered from "incapacitating anxiety states." Dr O'Loughlin and Dr McGuire gave evidence that this was significant in the context of post traumatic stress disorder. There has been consensus that early remedial treatment for PTS and PTSD can prevent the condition from becoming chronic and can at least reduce longevity of symptoms and lessen their effects.

112. It is clear from the evidence given by the plaintiff's fellow soldiers and his LA30 and CMF, that from early on in the tour the plaintiff was unwell and not coping with the trauma and pressures to which he was exposed and that the defendants knew or ought to have known both at operational and medical level. This condition was known on his return home after his tour of service (See AF 667A). In the light of the facts known about the plaintiff at both operational and medical level it ought to have been apparent to the defendants and their servants or agents that he was suffering or might suffer from a psychiatric illness which merited investigation, diagnosis and treatment and which would have led to the diagnosis of post traumatic stress for which he should have been treated. There had been no prior history of alcohol abuse or other psychiatric or psychological disorder prior to his tour of the Lebanon with the 60th Battalion. Even from the contents of the plaintiff's LA30 and CMF (Central Medical File), his medical history changed dramatically during and following his tour of duty in the Lebanon and these documents evidence that he was "decomposing psychologically" and as per Lt. Colonel Collins' notes he should have been closely observed thereafter.

113. In the plaintiff's case prompt diagnosis or advice on the normality of his condition of acute states of stress would have empowered the plaintiff much sooner in all likelihood to understand and cope with the symptoms and to avoid his mystification as to his changed nature and problems and dependence on alcohol as a palliative; his ability to overcome his affliction once Dr. O'Loughlin made the diagnosis of PTSD and explained his condition to him would seem to indicate conclusively that if diagnosis and treatment had been made of the cause of his symptoms earlier then this would have enabled him to set about making his recovery without huge and lasting damage to himself, his working, social and family life.

114. I remarked above that evidence was given unexpectedly in re-examination by Captain McEvoy as to his belief now about the plaintiff to the effect that the plaintiff was manipulative and he hinted at an alcohol problem prior to their departure on the tour of duty with the 60th Battalion. He was the plaintiff's platoon Commander and the person who had daily contact with the Company, including the plaintiff, and had the power to decide whether the plaintiff was fit for service overseas with the 60th Battalion or not,

after the plaintiff had volunteered for such service. At this time in 1986, the plaintiff had been medically certified as A1 fit, and in those circumstances it is clear that Captain McEvoy made no complaint either to the Medical Corp or to his operational Commanders as to the fitness of the plaintiff. It is scarcely credible that he would permit a soldier under his command in a weapons platoon to travel for duty overseas in the Lebanon where it was known they would encounter hostilities as a matter of probability, in circumstances where he then allegedly knew that the plaintiff was either manipulative and or an alcoholic. It is more probable that if the plaintiff manifested any suspicious signs at that time that the Captain would have observed him closely and inquired from NCOs about him and if not reassured then would have either objected to his service or otherwise vetoed it and have advised that the plaintiff was not a fit person to serve in an environment where hostilities would take place and where he would be in possession for use of loaded and operational weapons. It defies logic that in those circumstances where the safety of the Captain himself and those others who served with him might well be compromised by a soldier who did actually have an alcoholic problem that such a soldier would be permitted to serve abroad with them. In those circumstances, no weight should be attached to the evidence of the very man who had the power to stop him serving in the Lebanon because of alleged alcoholism and who took no step to stop such service or advise his superior officer, and this evidence flies in the teeth of the sworn evidence of all the NCOs who knew the plaintiff well before and during the tour and is inconsistent with the contents of the remarks of Captain McEvoy's commanding officer, Commandant Smith who made the report on the plaintiff in the AF667A when he assessed him as he returned from the Lebanon in April 1997.

4. Misdiagnosis by the Army Medical Officers and Failure to Observe or Inquire into the Plaintiff's Symptoms

115. On the evidence, it appears that Lt. Colonel Collins diagnosed the plaintiff as being of an immature personality type, but believed, despite his own notes about the plaintiff's acute and incapacitating anxiety states, that when he was removed from the stressful environment of the Lebanon he would revert to normal. It is clear from the evidence this did not occur, and we know from the evidence of Mrs Veronica Murtagh that the plaintiff had 'waking nightmares' where he leaped from his bed and frantically searched his house at home for his gun; also that he had become very alert and watchful, would stay awake at night and had trouble sleeping, and had become emotionally detached and was cold and withdrawn. With respect to Lt.-Col. Collins, while he was not a psychiatrist, he was an experienced army doctor and an obviously well read military doctor and aware of the perils of PTSD and his diagnosis of the plaintiff was incorrect, he should have referred the plaintiff for further expert investigation, diagnosis and treatment, particularly as he himself had noted acute and incapacitating anxiety states in an immature and vulnerable 21 year old and he must have known about his patient's gun-shy shaking and behaviour and his several episodes of becoming paralysed by fear. It would be incredible if he was not aware of these symptoms from seeing manifestations of his incapacitating status of anxiety at the RAP as Tibnin and from talking to the plaintiff's platoon officer and NCOs on his visits to talk to his patient and to them. No attempt was made to interview Mrs Murtagh at all in pursuit of an accurate medical history to see what was going on, and all medical personnel in the Army knew or ought to have known that the plaintiff's turning to alcohol abuse was a form of self-medication favoured by soldiers as was evidenced by Dr McGuire and Dr O'Loughlin.

116. Even when the plaintiff's admissions to St Columba's arising from alcohol and depression came to the defendants' notice, it seems that Lt.-Col. Collins and Cmdt. Kerr, the medical officers for the Western Command, continued to assume that the plaintiff's problems arose either from (a) his being immature emotionally and/or (b) his being an abuser of alcohol. This assumption on their part was incorrect and it would appear from the evidence that their continuation of that assumption arose from the failure of the Army to have a system in place whereby operational officers and NCOs would be able to communicate their observations of an inability to cope under stress of any member under their command and the plaintiff in particular to the Medical Corps personnel and for the Medical Corps personnel to communicate accurate information and medical history to the patient's treating doctors. Even after Dr McCarrick's observations and suggestions of his suspicion of PTSD as affecting the plaintiff, there was no system in place to ensure speedy referral to Dr F. O'Loughlin and then no protocol to ensure an efficient handover of her information and advice for treatment on her move from work as Army psychiatrist in 1996.

117. Colonel Collins has given evidence of the policy adopted for the treatment of service personnel suffering from alcohol dependency. The policy was that they would be reclassified as Medical Category C until they had been alcohol-free for two years, at which time they might be upgraded. This may well indicate a consciousness on the part of the Army of a problem of alcohol abuse. However, it also indicates a failure to monitor or identify cases of post traumatic stress disorder, which might often be accompanied by alcohol abuse. From the time of the Medical Board of the 15th December 1988 on, the Army's policy was to treat the plaintiff as an alcoholic and to assume that his depression was secondary to this in the teeth of all the available evidence to suggest otherwise. Thus there was a serious failure in the defendants' system to provide timely diagnosis and treatment for the plaintiff.

5. The Army's Failure to Follow up the Plaintiff's Care and to Monitor him Notwithstanding Colonel Walsh's Advice in September 1992

118. Lt Col. Collins (as he then was) wrote to Colonel Walsh, the Director of the Army Medical Corps, on the 16th July 1992 as follows:

> "3. Capt Kerr and Dr Flynn of St Conal's Letterkenny, where Pte. Murtagh has attended an alcohol abuse rehabilitation course, are satisfied that Pte. Murtagh does not suffer from endogenous depression following the domestic crises caused by his drinking and indeed secondary to excessive alcohol ingestion.
>
> 4. The appropriate and only treatment deemed necessary at this time is total abstinence from alcohol."

119. Colonel Walsh replied to this letter on the 9th September 1992:

> "1. Yours of 16 July 1992 refers.
>
> 2. The Board recommends that "he be monitored at Unit Level".No ref to Medical follow up.
>
> 3. Dr Flynn's report to Dr Kerr is dated 11 December 1990. He was admitted to St Bricin's on 8 January 1991. AF 177 contains no reference to C2H5OH. Could Capt Kerr have alerted St Bricin's?
>
> 4. I would consider this patient as very vulnerable and would advise active medical follow up.
>
> Do local '28 Bn Medical Records have any indication of contact with his wife or family?"

120. This letter is of great significance. The Director of the Army Medical Corps queried why the Medical Board had not recommended medical follow-up. He indicated that he considered the patient as being "very vulnerable" and advised "active medical follow up". He queried whether there had been any contact with his wife or family. This clearly indicated his concerns about the need for contact with his wife or family.

121. With respect to Lt.-Col. Collins and Cmdt. Kerr, it appears that Col. Walsh's concerns were not addressed in any serious way which seems extraordinary when the advice is so strong and polite but imperative.

122. After six months, Lt.-Col. Collins replied by letter of the 16th March 1993: - (My comments are in brackets)

> "1. Your letter of 09 Sep 92 associated with Medical Board of 02 Jun 92 refers.
>
> 2. I delayed replying to this letter as I felt that the passage of some months and review by a further Medical Board would provide me with a more substantial grounds for my assessment of this patient.
>
> 3. Your comments on the recommendation of the Board are noted. The recommendation that Pte Murtagh "be monitored at Coy Level" adverted to the need for management interest and responsibility for a soldier with a history of alcohol abuse. The continued interest and observation by the Bn MO was assumed." (*This ignores Col. Walsh's* "No ref to Medical follow up". *Col. Walsh was forward looking; Lt.-Col. Collins gave retrospective explanations.*)
>
> "4. It is regretted that Capt Kerr did not advert to Pte Murtagh's history of alcohol abuse at the time of his referral to St Bricin's for a brain scan on Jan 91.
>
> 5. At review by Medical Board on 04 Mar 93 I found that Pte Murtagh has now abstained from alcohol for just over one year. He is well and active, feels all his problems have resolved and his domestic circumstances have become harmonious again. He is fit for and performing all regimental duties.
>
> 6. Pte Murtagh has a somewhat immature personality – I know him quite well, having served with him in 60 Inf Bn UNIFIL – but he does not suffer from a primary depressive illness. His depressive symptoms were secondary to alcohol abuse and have disappeared since he undertook sobriety." (*This seems to ignore the LA30 entries; and the lack of alcohol problems pre Lebanon and the sick leaves for alcohol since 1988*)
>
> "7. The Board felt it appropriate to leave Pte Murtagh in Med Cat 'C' notwithstanding his having no apparent illness at present. I am, in general, opposed to upgrading persons with a history of alcohol abuse until they have achieved two (2) years sobriety and I do not think Pte Murtagh has the maturity of personality to withstand the potential stresses of further UN Service. He will continue to be observed and reviewed by MO 28 Inf Bn.
>
> 8. CMF/850416 and Proceedings of Medical Boards of 02 Jun 92 and 04 Mar 93 are attached."

123. This letter indicates that Lt.-Col. Collins continued to consider the plaintiff as being essentially an alcoholic. He did not adopt and follow Colonel Walsh's recommendations. Rather than ensuring medical follow-up, as Colonel Walsh advised, it seems that Lt.-Col. Collins envisaged that he would be monitored for signs of alcohol abuse and the the Battalion Medical Officer, Cmdt (then Captain) Kerr would maintain "continued interest and observation". No attempt was made to contact the plaintiff's family members. It appears that Colonel Walsh's letter had no real effect. In fact it was ignored and not acted upon; what was clear to Col. Walsh and put on paper was not acted upon, despite knowledge of the effect of symptoms of PTSD which should have been obvious to persons aware of sensitivity to and perils of chronic PTSD.

6. The Army's Failure to Inform or Assist the Plaintiff's Civilian Doctors

124. The defendants failed to give adequate information to Dr Fidelma Flynn and other civilian doctors who were treating the plaintiff at St Columba's Psychiatric Hospital in Sligo. Dr Kerr wrongly and incorrectly assumed that the plaintiff had given a full history of events in the Lebanon to Dr Fidelma Flynn at St Columba's Hospital or that he knew or had the capacity to know and understand the significance of what had happened to him in the Lebanon. He saw no need (and indeed there seems to have been no protocol or systematic requirement) to provide her with documentation or a précis of the information contained on the LA30 or the Central Medical File (or other files) relating to the plaintiff, notwithstanding his own evidence of the importance of an accurate medical history in arriving at a diagnosis. He should have provided a referral note or letter furnishing a proper factual and medical history to Dr Flynn. The initial admission in Sligo was not via Dr Kerr, but once the seriousness of the plaintiff's condition was known then the system should have ensured that his LA30 (and AF667A information) and more background information was given to Dr Flynn.

125. The defendants were obliged to provide continuing care to the plaintiff, who remained within their service. If the Army did not directly provide psychiatric care to the plaintiff, they were bound (a) to refer the plaintiff to an appropriate expert for diagnosis and (b) to provide comprehensive relevant information to the plaintiff's civilian doctors. The army medical corps doctors were in receipt of medical reports from Dr Flynn which contained no reference at all to the condition of which they already knew of "acute anxiety disorder under stress" and this should have alerted them to the fact that Dr Flynn was in complete ignorance of what had occurred to the plaintiff in the Lebanon, particularly his incapacitating anxiety states and symptoms of PTSD and its consequences and relevance to her investigations, diagnosis and treatment of the plaintiff.

126. The Army delayed in referring the plaintiff for diagnosis until November 1995 and failed to provide complete information to Dr Flynn at any time. Dr Flynn said in evidence that the information in the LA30 and CMF relating to incapacitating anxiety under stress would have been relevant and significant to her. This was also the view of Dr O'Loughlin and Dr McGuire who gave their professional opinion as being that the information would have been relevant to Dr Flynn. If this information about the plaintiff's condition and abnormal behaviour in respect of incapacitating fear and loss of conciousness in panic attacks had been available to Dr. Flynn, it seems likely that she would have soon realised that PTSD underlay and explained the excessive intake of alcohol as a self administered palliative for undiagnosed and unresolved symptoms of PTSD

7. The Army's Delay in Acting when Post Traumatic Stress Disorder was Raised in 1994

127. Even after Dr McCarrick raised the issue of post traumatic stress in 1994, the defendants delayed in referring the plaintiff to Captain O'Loughlin until November 1995. Dr Kerr's letter of referral is peculiarly worded in that it specifies that the plaintiff was being referred to "outrule" the possibility of post traumatic stress disorder. Dr Kerr admitted that he did not believe that the plaintiff had post traumatic stress disorder. In this reluctance to accept a possible diagnosis and in the delay in referring the plaintiff to the Army's own specialist, the defendants again failed in their duty to the plaintiff.

128. There seems to have been a reluctance to admit failure to diagnose correctly PTSD and there was reluctance even after the positive preliminary diagnosis made during the plaintiff's first consultation, albeit a working diagnosis only, of Dr Fionnuala O'Loughlin in November 1995.

8. The Army's Failure to Acknowledge the Diagnosis of Post Traumatic Stress Disorder Made in May 1996

129. Captain O'Loughlin saw the plaintiff promptly upon referral and made a rapid working diagnosis of post traumatic stress disorder when she first saw him on November 17th 1995. She performed the CAPS test on 29th February 1996 which confirmed current and past post traumatic stress disorder. She notified the Army by letter of the 27th May 1996.

130. It does not appear that the Army took any steps to provide counselling or cognitive behaviour therapy to the plaintiff after this diagnosis was received. The Army were not relieved of their duty to provide appropriate treatment and therapy to him as he was still a soldier in their care as an employee.

131. It is strange that when Dr Deeny wrote to convene a Medical Board in 1996, having received Captain O'Loughlin's report of the 27th May 1996, he failed to mention the diagnosis of Post Traumatic Stress Disorder. In the proceedings of the final Medical Board which classed the plaintiff as Category E (below Defence Forces requirements), the Board made no mention of the finding of post traumatic stress disorder. Not even the conclusive report from the army psychiatrist in May 1996 seems to have brought home the realisation that the army had failed to recognise and diagnose the PTSD and the reason for the plaintiff's drastic change in sickness record and his need for correct diagnosis, support and treatment.

132. On the evidence in this case, the defendants closed their eyes to warning signs and indicators for post traumatic stress disorder and effectively washed their hands of responsibility once it had been diagnosed. In so doing, they failed in their duties to the plaintiff.

The Legal Recognition Of Liability For Psychiatric Injuries And Damage

133. As is well known, the Irish courts were alert to the possibility of psychiatric or mental injury as a result of a tort from an early time – indeed when psychiatry was in its infancy. The present case is factually distinct from most of these cases and accordingly the interesting legal principles about such distinctions as "primary" and "secondary" victims and issues of proximity to an accident do not arise for consideration, although the evolution in the law does demonstrate how the Courts have given increased recognition over time to psychiatric injuries.

The "Nervous Shock" Cases

134. In 1884, the Irish Court of Appeal upheld Palles C.B.'s charge to the jury in *Byrne v Great Southern and Western Railway* (Unreported, Court of Appeal, February 1884). In that case, the plaintiff was the Superintendent of the Telegraph Office at Limerick Junction. His office was at the end of a railway siding. Railway points were negligently left open and a train entered the siding and broke down the wall of the plaintiff's office. He suffered no physical harm but suffered, in the language of the time "a nervous shock". The Common Pleas Division and the Court of Appeal upheld the jury's award to the plaintiff.

135. The Exchequer Division of the High Court of Justice followed and applied that decision in *Bell v Great Northern Railway Company of Ireland* (1890) 26 L.R.Ir.428

136. In that case, Palles C.B. said (at 442):

> "As the relation between fright and injury to the nerve and brain structures of the body is a matter which depends entirely upon scientific and medical testimony, it is impossible for any Court to lay down, as a matter of law, that if negligence causes fright, and such fright, in its turn, so affects such structures as to cause injury to health, such injury cannot be 'a consequence which, in the ordinary course of things would flow from [negligence, unless such injury] accompany such negligence in point of time."

137. The development of the law and the growing recognition of psychiatric injury under the heading of "nervous shock" is described by Gillian Kelly in Chapter 1 of *Post Traumatic Stress and the Law. Byrne and Bell* were followed in England in *Dulieu v White & Sons* [1901] 2 K.B. 669.

138. In *McLoughlin v O'Brian* [1983] 1 A.C. 410, the House of Lords famously permitted a plaintiff to recover damages for psychiatric injury sustained where she attended hospital to see her family members following a very serious road traffic accident as a result of which she suffered depression and a change in personality. As is well known, the members of the House of Lords adopted different approaches to the criteria to be applied in deciding whether or not liability should be imposed. Lord Bridge adopted a more simple test of foreseeability, while Lord Wilberforce imposed an additional test of proximity limited in a number of respects.

139. In the Australian Federal High Court case of *Jaensch v Coffey* [1984] 155 C.L.R. 549, the plaintiff went to the hospital following a serious road traffic accident involving her husband. She witnessed the severity of his injuries, and was informed of the seriousness of his condition. She developed a post traumatic stress disorder as the result of what she saw and was told. The High Court of Australia held that she was entitled to recover, her injuries being reasonably foreseeable and sufficiently proximate to the accident.

140. In Ireland, in *Mullally v Bus Éireann* [1992] I.L.R.M. 722, the plaintiff's family were seriously injured (one son ultimately dying) following an accident arising from the defendant's negligence. The plaintiff was elsewhere at the time of the accident, but travelled to Limerick Hospital on learning of the accident, where she witnessed the very serious injuries of her family. Denham J. stated at p. 724 that the hospital "looked like a hospital out of a war film, like a field hospital". Within two days of the accident, the plaintiff's personality had changed and she had since been numb, emotionally detached from her family and had lost her zest for life. The plaintiff had suffered what Denham J. described at p. 727 as "painful recollections, flashbacks", noting that "she finds them extremely painful and she is unable to talk about them". Denham J. stated that "These recollections are in her subconscious all the time but she tries to keep them under control".

141. Denham J. found that the plaintiff had symptoms consistent with post traumatic stress disorder, and had regard to the criteria in the DSM III guide. Denham J. held that she should apply the ordinary criteria of reasonable foreseeability to the facts and found it to be reasonably foreseeable that a mother, exposed to the experience that the plaintiff had suffered, would break down and suffer illness as the plaintiff had. The old term "nervous shock" included post traumatic stress disorder. Denham J. referred with approval to the *Byrne and Bell* cases. I note that PTSD was accorded a diagnostic heading in 1980 by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders (DSM III). Thus by 1980 PTSD was a term in usage for a constellation of symptoms already well known particularly to military doctors.

142. In *Kelly v Hennessy* [1995] 3 I.R. 253, members of the plaintiff's family had been left permanently brain-damaged as a result of a collision with the defendant's vehicle. The plaintiff was not at the scene, but was informed of the accident by telephone and was driven to the hospital by neighbours. She witnessed her family in the hospital, each of whom was in "an appalling condition". The trial judge made the following further findings of fact:

1. the plaintiff had from that time led "a traumatised existence",

2. the plaintiff had suffered immediate nervous shock resulting in vomiting on receiving the telephone call concerning the accident and that this conditiion was gravely aggravated by the scenes she immediately thereafter witnessed in the hospital,

3. the post traumatic stress disorder continued up to 1992 (some five years after the accident) at the earliest and plaintiff continued to suffer a serious depression,

4. the learned High Court Judge was not satisfied, having regard to all the evidence, that the plaintiff would ever fully recover from what he perceived to be a clear psychiatric illness.

143. The High Court Judge held that the plaintiff's injuries were the reasonably foreseeable consequences of the defendant's negligence and held in the plaintiff's favour. The defendant appealed the decision, accepting on the appeal that the plaintiff was suffering from post traumatic stress disorder and depression, but disputing causation and the existence of a duty of care in favour of the plaintiff. The defendant argued that the plaintiff's disorders had been caused by the strain of caring for her family rather than through shock as a result of the accident. Finlay C.J., with whom Egan J. agreed, held that the plaintiff's psychiatric illness was caused by learning of the accident over the telephone and from what she saw in the hospital. It was also a reasonably foreseeable consequence of the defendant's negligence. Denham J. agreed in a separate judgment.

144. In *Curran v Cadbury (Ireland) Ltd*. [2000] 2 I.L.R.M. 343, the plaintiff suffered a psychiatric injury in circumstances where she had turned on a machine in a factory unaware that a fitter was working inside it. She became convinced that the fitter had been killed or seriously injured. In fact, this was not the case. The machine had been stopped without warning, and the plaintiff had turned it on according to normal practice. Judge Bryan McMahon applied the principles set down by the Supreme Court in *Kelly v Hennessy*. He declined to follow the decision of the House of Lords in *White v Chief Constable of South Yorkshire* [1998] 3 W.L.R. 1509. He cast doubt on the appropriateness in Irish law of a distinction between "primary" and "secondary" victims and also doubted whether policy was a material consideration in Irish law so as to limit the scope of persons who would be entitled to recover damages for psychiatric injury.

145. Judge McMahon said ([2000] 2I.L.R.M. 343, at 349):

> "Moreover, the plaintiff in addition to being a neighbour in the Atkinian sense, was also the defendant's employee in this case, and this legal relationship also imposes some obligations (tortious and contractual) on the defendant as employer. The duty of the employer towards his employee is not confined to protecting the employee from physical injury only; it also extends to protecting the employee from non-physical injury such as psychiatric illness or the mental illness that might result from negligence or from harassment or bullying in the workplace."

146. Judge McMahon held that the plaintiff was entitled to succeed on the general principles laid down in *Kelly v Hennessy* and on her claim of breach of statutory duty. Accordingly, he did not need to address the issue of the employer's common law duty to the plaintiff. He did make the following obiter comment:

> "I do not propose to address the question of whether there is a general duty on an employer to take reasonable care to prevent the employee suffering psychiatric illness because of the conditions of employment. As already mentioned, the House of Lords has considered the matter recently in the *White* case, where it held that there was no such general duty on the employer. The judgment is controversial and I would content myself with the remark that there must be a duty in this respect *in some circumstances at least*, even if a blanket duty in all circumstances is rejected. Were I pushed to make a decision, I would be inclined to the view that the plaintiff in the present case, and in the factual situation we are considering, was owed such a duty by her employer. *White's* case can be distinguished in so far as the policemen there were not participants or directly involved in the incident, and arguably were comparable to by-standers and spectators. In no way, however, could Mrs Curran in the present case be so described." ([2000] 2 I.L.R.M. 343 at 359)

147. Judge McMahon held that the plaintiff had suffered an injury which was reasonably foreseeable in the circumstances and that there were no policy reasons why the plaintiff should be denied recovery.

148. It will be noted that Judge McMahon queried the decision in *White v Chief Constable of South Yorkshire* [1998] 3 W.L.R. 1509, in which the House of Lords denied recovery to policemen who had suffered post traumatic stress disorder by assimilating their position as employees to that of plaintiffs who did not have the employee-employer relationship to the wrongdoer. The House of Lords therefore applied the tests it had set out in the *Alcock v Chief Constable of South Yorkshire* [1992] 1A.C. 310 case.

Cases of Psychiatric Illness Inflicted by an Employer through Breach of Duty to an Employee

149. It should also be noted that in recent years the Courts have had to consider claims by employees in relation to psychiatric injuries caused by stress or bullying in the workplace. The factual pattern of those cases again tends to be different from that of the present case, because in those cases the plaintiff complains that the defendant employer caused the stress which caused the psychiatric injury, and that the employer is responsible for that reason. Only some of those decisions will be noted here briefly. However, it may be noted that *McHugh v. Minister for Defence* [2001] I.R. 424 has been referred to by the Courts in this context as a relevant precedent.

150. In this context, in *Maher v Jabil Global Services Ltd*. [2005] 16 E.L.R. 233, Clarke J. quoted with approval (at 246) from the judgment of Lavan J. in *Quigley v Complex Tooling and Moulding* (Unreported High Court, Lavan J., 9 March 2005) to the effect that:

> "The fundamental question is whether the defendant fell below the standard to be properly expected of a reasonable and prudent employer."

151. Clarke J. continued:

> "It is thus clear that at the level of principle there is no distinction to be made in the assessment of the liability of an employer in cases where an employee claims that as a result of negligence he suffered, on the one hand, physical injury or, on the other hand, mental injury."

152. In the context of a claim for damages arising from a psychiatric injury which was the result of stress in the workplace, Clarke J., in accordance with other authorities, posed three questions:

> "(a) has the plaintiff suffered an injury to his or her health as opposed to what might be described as ordinary

occupational stress;

(b) if so is that injury attributable to the workplace; and

(c) if so was the harm suffered to the particular employee concerned reasonably foreseeable in all the circumstances." ([2005] 16 E.L.R. 233, 247).

153. In that case, Clarke J. held that the risk of psychological harm to the plaintiff was not reasonably foreseeable, and accordingly that portion of the plaintiff's claim was dismissed. By contrast it seems elementary that an employer such as the Army owes a duty of care to its employees in the circumstances that, as is likely, they are exposed to stress and trauma, danger of death, close firing, deaths of colleagues and realisation of one's own mortality which can all cause post traumatic stress with the peril of becoming subject to chronic PTSD if this syndrome is not diagnosed and not treated.

154. In *Pickering v Microsoft Ireland Operations Ltd* [2006] 17 E.L.R. 65, Esmond Smyth J. quoted from the decision in *Maher* and commented:

"Clarke J. simply stated that in both situations "the practical way in which the assessment of the duty of care which an employer owes may … differ". These authorities are indicative of the general understanding of the duty of care owed by an employer to his employee as described, for example, by O'Higgins C.J. in *Dalton v Frendo*, unreported, Supreme Court, December 15 1977. In that case the learned judge said that the "duty of an employer towards a servant is to take reasonable care for the servant's safety in all the circumstances of the case". As McGuinness J. later held in *Bradley v An Post* [1998] 2 I.L.R.M. 1 an employer discharges that duty to an employee '[i]f he does what a reasonable and prudent employer would have done in the circumstances"'.

155. Esmond Smyth J. carried out a wide-ranging review of the authorities in which an employee had recovered damages for psychiatric injury from his employer, including *McHugh v Minister for Defence* (see [2006] E.L.R. 65, 115-6) and ultimately granted the plaintiff an award of damages in respect of the psychological injuries that she had suffered as a result of her employer's breach of contract.

156. In conclusion, it is obvious that the defendants their servants or agents failed in their duty of care to the plaintiff in all the circumstances, not by his exposure to danger and traumatic incidents including close firing, explosions and the death of colleagues but in their failure to take appropriate care for the health of the plaintiff, and in failing to observe and recognise the warning signs of PTS in the panic stricken, incapacitating states of the plaintiff in Lebanon and the failure to recognise the significant symptoms of PTSD manifested by the plaintiff and negligently failed to refer the plaintiff to the army psychiatrist and failed to obtain remedial therapy and treatment for the plaintiff.

Claim of Statute Bar

157. Near the end of the Defence two paragraphs appear:-

"9. Without prejudice to the foregoing, the plaintiff's claim herein is barred by virtue of the operation of Section 11 of the Statute of Limitation 1957, as amended by Section 3(1) of the Statute of Limitations (Amendment) Act 1991.

10. In the premises and without prejudice to the foregoing, the defendants plead that they are prejudiced by the inordinate and inexcusable delay of the plaintiff in bringing these proceedings."

158. While I was conscious of the existence of these paragraphs, on "the run of the case", I felt that these were not live issues as the nature of the plaintiff's claim was that the defendants had failed in their duty to the plaintiff to identify and provide treatment for his psychiatric problems during his tour of duty as a soldier in the Lebanon where his problems with incapacitating anxiety states were manifest and well known to the NCOs, his officers and the army medical doctors who treated him with tranquillising injections of diazepam. Due to his immaturity and vulnerability, his susceptibility not just to stress but also to PTSD should have been recognised by the defendants through their NCOs, officers and medical doctors but the defendants failed to treat or monitor the plaintiff and failed to provide remedial therapy for the plaintiff. Dr Paddy Breslin, who was acting as Senior House Officer to the late Dr McCarrick, the experienced locum psychiatrist doing duty in 1994 for Dr Fidelma Flynn, consultant psychiatrist, in St Columba's Hospital in Sligo, gave evidence that on 31st May 1994, he had made a note that he had spoken with a social welfare officer who informed him that he had been talking with Captain Kerr, Finner Camp, and also Dr McCarrick regarding possible assessment for treatment of PTSD. There is a psychiatrist attached to the army hospital, St Bricin's in Dublin, who has set up a programme for treatment of these patients. This would be arranged on an outpatient basis. On 14th June 1994, Dr Breslin made another note about Victor Murtagh at the Ballymote OPD which included "to contact army doctor about army psychiatric course for PTSD". This was the background to Dr Breslin writing on behalf of Dr McCarrick to Dr Gerry Kerr on 2nd June 1994 at Finner:

"Dr McCarrick feels that he may be suffering a form of post traumatic stress disorder and feels that treatment with the problem may help Victor's problem. We were made aware of the Army having facilities which deal with this problem in Dublin and perhaps Victor might be a candidate for assessment for such treatment."

159. Lt.-Col. Collins was made aware of this letter as he wrote on it as an addendum:

"Dr Breslin is locum for Dr Flynn. Capt. Kerr is arranging for review with Dr. Flynn and will discuss proposal to refer to Dublin." (In fact Dr. Breslin was SHO to Dr. McCarrick who was locum to Dr. Flynn).

160. On 16th March 1993, Lt.-Col. Collins had written a memo to DMC (Director Medical Corps) which included at para. 6:

"Pte Murtagh has a somewhat immature personality – I know him quite well, having served with him in 60th Inf Bn UNIFIL – but he does not suffer from a primary depressive illness. His depressive symptoms were secondary to alcohol abuse and have disappeared since he undertook sobriety".

161. I have set out these passages to indicate that Dr McCarrick's view was very tentative and suggesting that the patient should perhaps be referred for assessment and certainly even if the soldier felt that his problems perhaps came from his experiences in Lebanon, there were strong contrary opinions held by the two senior army doctors who had the medical records, his LA30 and access to his CMF file.

162. At all events there had been no prior or preliminary application in respect of a time bar and that episode of cross-examination of

Dr Breslin was the one passage which drew any thought to the prospect of a suggestion of a live issue with regard to a time bar issue. I was anxious to clarify what issues counsel for the defendant envisaged were going to confront the Court eventually and accordingly I made the request that he would open the case for the defence so that there could be clarification for the parties and the Court as to what issues were likely to emerge as being in contention. Much earlier, Counsel for the defendants had indicated that "the matter of the Statute of Limitations is to be dealt with depending on how the evidence unfolds" as I was anxious to have clarification on the issues, particularly that of any time bar.

163. Counsel for the defendants at the close of the plaintiff's evidence did respond to the request to open his case but when Counsel for the plaintiff interrupted and said that he was misstating the plaintiff's case, he declined to proceed to open his case and called his first witness as he was entitled to do. This however had the unfortunate result that neither Counsel for the plaintiff nor the Court were aware that the issue of the Statute involving a time bar was a live issue and certainly I can recall no mention of this aspect or of any relevant cases being mentioned. At the end of the evidence Counsel opted to submit written submissions and I requested co-operation to ensure the submissions did knit and did not pass like "ships in the night" without engaging on some issues. When the submissions came in, it turned out that the defendants were actually relying on the Statute of Limitations and neither I, nor Counsel for the plaintiff were aware that this was still a live issue. Accordingly I invited the plaintiff's Counsel to put in a further submission in response to the claim of statute bar. This came in about mid-September after I had had to sit in August to complete the hearing of a judicial review involving the uncharted legal area of a further extension of a planning permission for a large windfarm, raising issues which required a lengthy judgment. I regret that the public law matter had to take priority and I am sorry that any time has passed in a case involving a psychiatric injury.

164. The case of the defendants in raising the Statute of Limitations is put on the basis that in May/June 1994 the plaintiff was aware that a locum psychiatrist, the late Dr McCarrick, thought the plaintiff was suffering from PTSD. Dr McCarrick died some time ago and so there is no evidence from him as to what he said to the plaintiff but the wording of Dr Breslin's letter dated 2nd June 1994 is of a tentative nature:

> "Dr McCarrick feels that he may be suffering a form of post traumatic stress disorder and feels that treatment for the problem may help Victor's problems."

165. The plaintiff was a soldier who had left school at the age of 15 and had been in constant work up to his tour to the Lebanon. Neither his treating psychiatrist Dr Flynn (in the absence of information about the plaintiff's torrid tour in the Lebanon) nor the senior Army doctors Dr Kerr and Lt.-Col. Collins agreed with this tentative diagnosis. Dr McCarrick's suggestion was that consideration be given to sending the plaintiff for assessment to the Army psychiatrist in Dublin.

166. The defendants submit that the plaintiff was informed in May/June 1994 that he may have PTSD and he should have instituted proceedings then but did not do so until 23rd March 1998. The Defence rely on *Gough v Neary* [2003] 3 I.R. 92 in particular the principles set out by Geoghegan J. quoting *Spargo v North Essex Health Authority* [1997] 8 Med. L.R. 125. Principle 3 states:

> "A plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation."

167. In view of the advices as to alcohol being the source of his problem from the Army doctors and Dr Flynn, who was never briefed with the copy LA30 or other records with regard to the plaintiff's acute incapacitating anxiety states in the Lebanon and the tentative suggestion made by Dr McCarrick through his SHO Dr Breslin, it would surely have been precipitate for the plaintiff to rush off to a solicitor before being referred to Captain Dr F. O'Loughlin, the Army psychiatrist. She reported definitively to Dr Kerr by her letter dated 27th May 1996 when she confirmed that the plaintiff had had and still had post traumatic stress disorder.

Sections 2 and 3 (1) of the Statute of Limitations (Amendment) Act 1991

168. Section 2 of the Statute of Limitations (Amendment) Act 1991 provides:

> 2.(1) For the purposes of any provision of this Act whereby the time within which an action in respect of an injury may be brought depends on a person's date of knowledge (whether he is the person injured or a personal representative or dependant of the person injured) references to that person's date of knowledge are references to the date on which he first had knowledge of the following facts:
>
> (a) that the person alleged to have been injured had been injured,
>
> (b) that the injury in question was significant,
>
> (c) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty,
>
> (d) the identity of the defendant, and
>
> (e) if it is alleged that the act or omission was that of a person other than the defendant, the identity of that person and the additional facts supporting the bringing of an action against the defendant;
>
> and knowledge that any acts or omissions did or did not, as a matter of law, involve negligence, nuisance or breach of duty is irrelevant.
>
> (2) For the purposes of this section, a person's knowledge includes knowledge which he might reasonably have been expected to acquire
>
> (a) from facts observable or ascertainable by him, or
>
> (b) from facts ascertainable by him with the help of medical or other appropriate expert advice which it is reasonable for him to seek.

(3) Notwithstanding subsection (2) of this section -

(a) a person shall not be fixed under this section with knowledge of a fact ascertainable only with the help of expert advice so long as he has taken all reasonable steps to obtain (and, where appropriate, to act on) that advice; and

(b) a person injured shall not be fixed under this section with knowledge of a fact relevant to the injury which he has failed to acquire as a result of that injury.

169. Section 3(1) of the Statute of Limitations (Amendment) Act 1991 provides:

> "An action, other than one to which section 6 of this Act applies, claiming damages in respect of personal injuries to a person caused by negligence, nuisance or breach of duty (whether the duty exists by virtue of a contract or of a provision made by or under a statute or independently of any contract or any such provision) shall not be brought after the expiration of three years from the date on which the cause of action accrued or the date of knowledge (if later) of the person injured."

The Plaintiff's Date of Knowledge in the Present Case

170. The plaintiff was only diagnosed with post traumatic stress disorder in 1996. As his claim is based on the negligent failure to *recognize and treat post traumatic stress disorder*, he could not have become aware of the inaction on the part of the defendant in recognizing and treating his PTSD until he had been diagnosed with that condition.

171. The plaintiff also claims that the defendants negligently failed to arrange for treatment following the diagnosis of PTSD by Captain O'Loughlin in 1996. His claim in relation this head of negligence is one that continued until the time of his discharge from the Army. No case can be made by the defendants that this head of the plaintiff's claim is statute-barred.

The Plaintiff's Knowledge of his Injury - Post Traumatic Stress Disorder

172. The injury that gives rise to these proceedings is post traumatic stress disorder. Accordingly, the Court is concerned to establish the plaintiff's date of knowledge (within the meaning of section 2 of the Statute of Limitations Act 1991) that he was suffering from this condition. The fact that the plaintiff may have been told at earlier times that he was suffering from depression or alcohol addiction therefore does not amount to knowledge of the injury that gives rise to these proceedings.

173. The plaintiff stated in evidence that the late Dr McCarrick raised the possibility of PTSD with him. The defendants now seek to rely on this as indicative of sufficient knowledge on the plaintiff's part that he had PTSD as to commence the running of the statutory limitation period.

174. Dr. McCarrick, now deceased, was locum for Dr Fidelma Flynn, at St Columba's Psychiatric Hospital, Sligo. The plaintiff in his evidence stated that Dr McCarrick said he would write a letter to the Army doctor, but he did not know if that had happened.

175. Dr Breslin then wrote to Dr Kerr by letter dated the 2nd June 1994 (Book 3 page 125) in relation to the possibility of post traumatic stress disorder, stating that "Dr McCarrick feels that he may be suffering a form of Post traumatic stress disorder and feels that treatment with this problem may help Victor's problem".

176. Dr. Fidelma Flynn wrote to Dr. Julian Flynn, one of the plaintiff's general practitioners, on the 10th August 1994 (Book 4 pages 44-5), stating "It is unclear whether it is a true post traumatic stress disorder," and that "Dr Kerr has agreed to refer Victor to the Army Counselling Service for further assessment".

177. Dr Kerr stated in evidence that he did not believe that the plaintiff had PTSD. His letter of referral to Dr O'Loughlin was not written until the 7th November 1995 and indicated that he wished to "outrule" PTSD (Book 3 page 117).

178. In circumstances where the defendants, through Dr Kerr – the medical officer of the 28th Battalion at Finner, and the Army Medical Corps, had the same information as the plaintiff in 1994-5, and did not accept it as indicating post traumatic stress disorder at that time, they are estopped from now maintaining that the said information did indicate the presence of post traumatic stress disorder and that the plaintiff accordingly was aware of same at the time.

179. It is also noteworthy that Dr Kerr, in the same letter of the 7th November 1995, stated:

> "By its nature, however, it is probably better that this issue be clarified before the man is reviewed by the [Medical] Board."

180. This is hardly consistent with a position where the plaintiff as a layman is supposed to have been armed with sufficient knowledge of his injury and of the defendants' responsibility for it, to have justified him in taking legal advice or instituting proceedings, as the defendants now allege. If a soldier's medical officers keep on regarding him as suffering from alcohol then it seems bizarre that the army should maintain that the private should ignore the advice of his army doctors who were ascribing his ailments to alcohol and depression and when the army psychiatrist did diagnose PTSD positively in May 1996 they seemed to have disregarded her conclusive diagnosis and clung to the unsubstantiated theory of the primary problem being the taking of alcohol.

181. Following her first meeting with the plaintiff in November 1995, Dr O'Loughlin provisionally diagnosed post traumatic stress disorder. In her medical notes of the 17th November 1995 (Book 2 p. 28), she recorded that the plaintiff was "For CAPS" and "?PTSD".

182. In her letter of the 17th November 1995 to Dr Kerr (Book 3 page 115), she stated that the plaintiff was a:

> "difficult historian, and quite reluctant to discuss the Lebanon incidents. However, I think he may still be suffering residual effects and may in fact have PTSD."

183. (I should explain that Dr O'Loughlin made clear in evidence that 'difficult historian' simply means that the plaintiff was reticent about talking about his traumatic ordeals. Avoidance of talking about such traumatic experiences is a quite usual sympton of PTSD. She in fact rated his validity, including co-operativeness, at the highest level, "excellent, no reason to suspect invalid response".)

184. The wording of Dr. O'Loughlin's note and of this letter indicates that as of the 17th November 1995, Dr. O'Loughlin was not

definitely diagnosing post traumatic stress disorder. She had, however, decided to administer the CAPS test so as to establish whether or not PTSD was indicated.

185. However, even assuming that this were said to operate as the plaintiff's date of knowledge, it dates from within three years prior to the institution of the proceedings.

186. Dr. O'Loughlin made a definite diagnosis of PTSD following the administration of the CAPS test. This test was completed by the 29th February 1996 (Book 2 p. 31, note at bottom of page). Dr. O'Loughlin reported to Dr Kerr by letter of the 27th May 1996 that the plaintiff indeed had post traumatic stress disorder (Book 3 page 110 and also Book 2 page 4).

187. The plaintiff did not have sufficient knowledge to institute proceedings in 1994, as the defendants appear to allege. He did not know that he had post traumatic stress disorder at that time. It had merely been mentioned as a possibility for checking by Dr. McCarrick. It appears that Dr. Fidelma Flynn (for whom Dr. McCarrick was locum) and Dr. Kerr did not think that PTSD was present. Dr. O'Loughlin's opinion was sought in order to clarify the position. Against that background, the defendants cannot plausibly now maintain that the plaintiff "knew" that he was suffering from PTSD as far back as 1994, when clearly Dr. Kerr and Lt Col. Collins did not regard this as correct and the findings of the 1988 Medical Board were turned around (as put pithily by Counsel for the plaintiff) and his client with his obvious vulnerability was clearly stressed out to the point of incapacity by stressors and terror in Lebanon and then, as suggested by Counsel, the plaintiff was 'left to swing in the wind'. Counsel for the plaintiff accordingly submit that he did not have knowledge of having suffered an injury, in the form of post traumatic stress disorder, until he was definitively diagnosed as suffering from it by Dr O'Loughlin in May 1996.

188. The plaintiff asserts that his medical adviser made a provisional diagnosis of post traumatic stress disorder on the 17th November 1995 of which he remained unaware until 1996 which assertion is supported by the medical notes and report of Dr. O'Loughlin.

189. The plaintiff was and remained unaware of the contents of all of his medical notes from the various institutions who treated him and in particular the notes of Dr. Fidelma Flynn and her registrars and/or locums until this case commenced.

"Constructive Knowledge" – Section (2) and 2(3) of the Statute of Limitations (Amendment) Act 1991

190. The defendants are not entitled to maintain that the plaintiff was affixed with knowledge that he might have been reasonably expected to acquire from facts observable or ascertainable by him or from facts ascertainable by him with the help of medical advice which it was reasonable for him to seek (under section 2(2) of the Statute of Limitations (Amendment) Act 1991).

191. The plaintiff did not know that he had post traumatic stress disorder in 1994. He could not have been expected to acquire such knowledge from facts observable or ascertainable by himself.

192. Section 2(2) of the 1991 Act is not applicable in this case, as the plaintiff's medical advisers did not ascertain that he had post traumatic stress disorder until Dr. O'Loughlin's diagnosis in 1996.

193. Dr. McCarrick had PTSD as a possibility and Dr. Breslin wrote on his behalf to Dr. Kerr on the 2nd June 1994 (Book 3 pages 45-6), suggesting that the plaintiff might be a candidate for assessment for treatment. Dr. Fidelma Flynn appears to have been sceptical about this suggestion, as was Dr. Kerr, and Dr. Kerr only referred the plaintiff to Dr. O'Loughlin, the Army's specialist in post traumatic stress disorder, on the 7th November 1995. Judging by Dr. Breslin's letter of the 2nd June 1994, Dr. McCarrick clearly appears to have envisaged the plaintiff being referred to this service run by Dr. O'Loughlin so as to have her ascertain whether his tentative suggestion of PTSD could be a correct diagnosis.

194. In the circumstances, the plaintiff was not in a position to obtain expert advice any earlier than he did because of the defendants' delay, through Dr. Kerr, in referring him to Dr. O'Loughlin, who was the relevant specialist psychiatrist employed by the Army.

195. In those circumstances, the defendants are not entitled to rely on section 2(2) of the Statute of Limitation (Amendment) Act 1991.

196. Furthermore, if the defendants were otherwise entitled to rely on that provision, they are not so entitled by virtue of section 2(3) of the Act. The plaintiff took all reasonable steps to obtain advice. Dr. Breslin, acting on Dr. McCarrick's behalf, suggested a referral for assessment by the Army's facilities for diagnosing and treating post traumatic stress disorder. The defendants delayed in making the referral until the 7th November 1995. This was a matter outside the plaintiff's control. Dr. Kerr, who was responsible for the plaintiff's care in the Army, does not appear to have discussed PTSD with him or acted to investigate the possibility until November 1995 despite the records in the plaintiff's LA30 about his condition in the Lebanon and because, with his incapacitating anxiety states requiring medication, he should have clearly been regarded as in peril of contracting chronic PTSD.

197. Furthermore, it seems that the defendants, through Dr. Kerr, delayed in referring the plaintiff to Dr. O'Loughlin until November 1995, a time when a Medical Board hearing was pending. Given their duty of care and fiduciary duty towards the plaintiff as a soldier whom they had exposed to trauma in the Lebanon, it would be inequitable to permit them to rely on their own delay in referring him for specialist opinion which found that he had chronic PTSD. They are accordingly estopped from relying on section 2(2)(b) to the plaintiff's detriment.

The Plaintiff's "Knowledge" of the Acts or Omissions alleged to constitute negligence and breach of duty

198. There was no evidence to the effect that the plaintiff knew in 1994 "that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty" – i.e., the Army's failure to treat him or monitor him for PTSD before, on or after his return from the Lebanon.

199. The principles referred to by Geoghegan J. in *Gough v Neary* [2003] 3I.R. 92, 128, quoting from *Spargo v North Essex Health Authority* [1997] 8 Med. L.R. 125 at p. 129, were as follows:

> "(1) The knowledge required to satisfy s. 14(1)(b) is a broad knowledge of the essence of the causally relevant act or omission to which the injury is attributable;
>
> (2) 'Attributable' in this context means 'capable of being attributed to', in the sense of being a real possibility;
>
> (3) a plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such

knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation;

(4) on the other hand, she will not have the requisite knowledge if she thinks she knows the acts or omissions she should investigate but in fact is barking up the wrong tree; or if her knowledge of what the defendant did or did not do is so vague or general that she cannot fairly be expected to know what she should investigate; or if her state of mind is such that she thinks her condition is capable of being attributed to the act or omission alleged to constitute negligence, but she is not sure about this, and would need to check with an expert before she could be properly said to know that it was."

200. It should be noted that in this passage, the Court is largely considering the issue of knowledge of the *act or omission* which caused the injury, not knowledge of the injury itself.

201. In the present case, the plaintiff only knew that he had suffered PTSD when Dr. O'Loughlin made a definite diagnosis in 1996, on 29th February 1996 after the CAPS test or on 27th May 1996 when she had reviewed her clinical notes and the results of the CAPS test and wrote her letter dated 27th May 1996 to Dr. Kerr explaining that the plaintiff does suffer from PTSD. Accordingly, as has been said above, the plaintiff only became aware that he had suffered an injury in the form of PTSD at this time. His date of knowledge of the *omissions* on the part of the defendants through their failure to diagnose, treat or mitigate this condition cannot be any earlier than his date of knowledge that he was suffering from the condition of PTSD.

202. In the absence of an actual diagnosis of PTSD, the plaintiff could not be said to have been armed with knowledge that the continued existence of PTSD was a consequence of the defendant's failure to monitor, diagnose and treat him.

203. In the *Neary* case, the Supreme Court held that, in the circumstances of that case, the relevant knowledge was the knowledge that the defendant had *unnecessarily* removed the plaintiff's womb. In the present case, the relevant knowledge is that the plaintiff not only was suffering from PTSD but also that this PTSD could have been ameliorated or cured by treatment and therapy by the defendants. The earlier the mental health intervention then the more rapid and satisfactory the recovery was likely to be.

204. In *Knowles v Minister for Defence* [2002] I.E.H.C. 39 O'Donovan J. dealt with the plea of the Statute of Limitations raised by the defendants in the following passage (pages 2-3):

> "In the circumstance that, in their defence delivered herein, the defendants claim (*inter alia*) that the plaintiff's claim herein is barred by virtue of the provisions of the Statute of Limitations 1957 to 1991, I decided to determine that issue as a preliminary issue and, having heard evidence from the plaintiff in that regard, I concluded that his claim herein is not statute barred for the reason that, while it is clear that, at all material times since the year 1978, the plaintiff believed that the psychological problems of which he complained and continues to complain were attributable to events which occurred while he was a serving soldier in the Lebanon, it was not until he was referred to Dr. Ian Daly, a consultant psychiatrist, in the year 1996 that he first appreciated that those problems could have been alleviated and, possibly, eradicated had he been prescribed appropriate treatment by the army medical corps at the time he is alleged to have manifested psychological and psychiatric symptoms in the Lebanon. In those circumstances, I was satisfied that Mr Knowles date of knowledge that he had a cause of action, within the meaning of the provisions of the Statute of Limitations (Amendment) Act, 1991, was when he saw Dr. Daly in 1996 and that, therefore, his claim herein is not statute barred. In this regard, notwithstanding that I made that determination on the 28th November last, the defendants revisited the issue as to whether or not the plaintiff's claim herein is statute barred in their submissions herein dated the 19th December, 2001. In that regard, it is clear from those submissions that the defendants' advisers do not appreciate the basis upon which the plaintiff's claim herein is founded. It is not based on an allegation that the defendants negligently inflicted psychiatric damage on the plaintiff, as is suggested by those submissions. If that were the basis for the plaintiff's claim, then there is no doubt but that it would be statute barred because, in the course of his evidence, the plaintiff acknowledged that he was aware that the problems of which he has complained since he went to Lebanon in 1978 were attributable to events which occurred at that time. However, the fact of the matter is that he does not complain that the defendants negligently inflicted psychiatric damage on him but rather that, having developed psychological and psychiatric problems which he maintains were manifest and ought to have been recognized as such by the defendants, the defendants negligently failed to initiate appropriate treatment for those problems and that it was not until the year 1996 that the plaintiff first knew that he had a claim against the defendants based on such negligent failure."

205. The claim advanced in the present case is similar in nature to that made in *Knowles* and it is respectfully submitted that the convincing reasoning of O'Donovan J. applies equally to the present case.

206. Furthermore a soldier in the care of Army doctors, particularly those aware of his medical record and condition of vulnerability with immature personality and incapacitating acute anxiety states cannot be faulted for trusting and relying on them to diagnose and treat him not least while and until a tentative suggestion of him maybe having PTSD is checked out and conclusively diagnosed.

207. For all these reasons I conclude that the plaintiff's claim is not statute-barred. Having made such a clear decision on the legal issue on coercive grounds I would add as an afterthought that the Statute of Limitations is a shield not a sword; if the plaintiff has suffered injury by reason of the defendants' failure to diagnose and treat his PTSD, when the army doctors had significant information as to his vulnerability to chronic PTSD, perhaps one might wonder at the defendants taking cover behind such a shield when they had so much relevant information and the soldier was initially affected while on UN peacekeeping duties with an Irish Battalion.

Germane disclosures

208. At the outset of the case I warned Counsel that from 1991 to 2000 I had dealt with a considerable number of PTSD cases as the nominated judge under the Garda Compensation Acts. I alerted Counsel to this as I am very conscious that "a little learning is a dangerous thing". I know that there are real perils for a judge who thinks he knows about a subject from his own experience. However over a period of about nine years I had reason to assess many applicants suffering from PTSD giving evidence about critical incidents and their effects on them. Since it became apparent that the state of knowledge about PTSD in and around 1986 was likely to become important, I also mentioned to Counsel that I was aware that Lt Colonel Goggin retired had been the Army psychologist for many years and that Dr. Fionnuala O'Loughlin had been the Army psychiatrist as it became clear during the opening of the case that the chronology was likely to be important, and perhaps consideration should be given as to whether the evidence of these army officers might be pertinent.

The fallacy of assuming a good history will come from a soldier smitten by PTSD and subject to reticence, avoidance and

reluctance
209. During the course of the evidence both Lt. Colonel Collins and Commandant Kerr made the point that if the plaintiff did not give a history and tell them about his problems, how could they assess and advise him? I can readily understand Dr. Kerr being upset by the realisation that a soldier as his patient would be reticent about telling even him as a caring doctor about the effect on the soldier of searing recollections of frightening events with factions fighting each other at a time of heightened hostilities in December 1986 and January 1997 in the Lebanon. Lt Colonel Collins also asked the question as to how the plaintiff could expect a doctor to be able to treat him if he did not reveal his symptoms? As to this. Dr. McGuire made clear that such reticence was usual in soldiers with PTSD and it was widely understood by doctors treating soldiers that it was common that those with PTSD were likely to have considerable avoidance of painful memories and reluctance and reticence in recalling intrusive and terrible events. Hence all the more need to encourage the patient to tell his story and relate and describe all symptoms.

210. The reticence among soldiers to discuss psychiatric problems is perfectly normal and unsurprising as any army has to be careful about the mental health of persons carrying lethal weapons. This makes it all the more important that there be patient and sympathetic questioning of those exhibiting symptoms of post traumatic stress and for there to be explanation of the symptoms as being normal after terrifying events. This is particularly so if the person has obvious immaturity or other vulnerability to PTSD so as to be able to take remedial steps to prevent the condition becoming chronic. As intelligent and well-educated doctors, both Colonel Collins and Cmdt Kerr must be very well aware of the reluctance of soldiers to confess to fear or panic attacks, or any form of problem of the psyche.

211. Such reticence and avoidance means that there must be a system to ensure that both army doctors and civilian doctors are kept informed of the history and sick records of all their military patients. It was more than surprising to learn that Dr. Fidelma Flynn was unaware of Dr. F. O'Loughlin's positive diagnosis in respect of the plaintiff as to past and present diagnosis of PTSD which Dr. O'Loughlin confirmed in her letter dated 27th May 1996 to Captain Gerry Kerr. In fact Dr. Fidelma Flynn, who had been treating the plaintiff, and liaising with the army doctors about their mutual patient, only saw this letter when arriving at this Court, which seems remarkable as she was involved in the decision to refer the plaintiff to the army psychiatrist and one would have expected that the Army would have had a system in place to ensure that such a diagnosis confounding the opinions being expressed by the senior Army doctors dealing with and caring for and treating the plaintiff would have been sent to Dr. Flynn as a matter of course and not just out of courtesy. Dr. Kerr was transferred to Cork at this period but one would expect steps to have been taken to ensure that his successor would liaise with the plaintiff's treating doctors and would also ensure that members involved in military Boards were made aware of Dr O'Loughlin's findings, not least to ensure that appropriate treatment, counselling and therapy would be ensured for the plaintiff especially as Dr O'Loughlin also was moving on secondment. Furthermore as a matter of basic fairness and justice, the Military Board should clearly have been informed of the erroneous diagnosis of primary alcoholism and it should have been given Dr. O'Loughlin's definitive diagnosis in May 1996 of the plaintiff's primary PTSD which was undiagnosed, despite his acute panic states, until 1996.

Sensitising stressor
212. The plaintiff described flying to Tel Aviv, on 22nd October 1986 on his 21st birthday, and going from there by lorry and bus in convoy to Camp Brashit in the hills. He did duty at Checkpoint 6-21. After six or seven weeks – one night in November 1986 - they came under heavy fire in the checkpoint from Israelis for a while early in the night. He got a blackout or fit that night and did not remember much happening. When he had the fit he was sent for treatment at Camp Shamrock. I think this was his admission to the RAP Tibnin on 29th November 1986.

213. Soon after this in December 1986, he heard a commotion on the radio – there was radio contact with HQ: one soldier was shot at Camp Brashit about two miles from Checkpoint 6-21 where the plaintiff was stationed. This was 6th December 1986 and the soldier was William O'Brien from Athlone who had trained with the plaintiff. Camp Shamrock was about two or three miles from Camp Brashit. He was afraid when he heard Willie was shot dead. Willie's wife was expecting another baby at Christmas. The plaintiff was afraid he would not get home to see his children.

214. He went home for Christmas about 19th December 1986 with Cpl. Dermot McLoughlin. He felt well over Christmas but was afraid and restless. He was asked about domestic problems and he said that his wife was upset that he was off in Lebanon when she had a small baby Jennifer of only a couple of months to mind on her own. He wanted to earn more money so that they could buy a house in Ballymote. His wife Veronica was happy he was back home but not happy about his going to Lebanon as their baby Jennifer was so young. However they discussed this and she was happy about it.

215. On 9th January 1987 he and Cpl McLoughlin flew again to Tel Aviv and then went by lorry to Naquora where they stayed as there was much gunfire on the road to Brashit. Next day on the way up from Naquora to Brashit Camp there was heavy fire and a Nepalese soldier was wounded. The Irish were in an APC Peugeot (an armoured personnel carrier) and had to get out and take cover. He saw the wounded Nepalese. They were told they were going to the "CO's house" at Tibnin. However, the plaintiff in fact was told to ride "shotgun", to do escort duty as observer in a jeep and went to the Total Station checkpoint. Cpl McLoughlin was sent to the CO's house at Tibnin. That night all these checkpoints came under heavy fire. The plaintiff came under heavy fire and was aware of what was going on elsewhere from hearing on the radio. There was heavy machine gun fire, rifle and mortar fire and tank rounds. He and his colleagues took cover in a civilian house beside the Total Station Checkpoint and "were pinned down and could not return fire". They came under heavy machine gun fire. The plaintiff became upset in the witness box and had difficulty in answering. He said that he had been very afraid. I believed him. His difficulty in recounting this incident is a feature of those affected by acute stress. His anquish was genuine; I am sure that was the night or early hours of 10th January 1987 when Cpl McLoughlin was killed by a shrapnel bomb which penetrated and exploded in the "CO's house" at 6-17 which was a checkpoint with a roof over it and the recollection of this night's events caused the plaintiff's loss of self-possession.

216. It seems to me that there were many incidents in the hostilities between the factions in late November and December 1986 which could have sensitised the plaintiff and the accumulation of stressful incidents would have been reinforced by the close firing incidents and explosion on the night when Cpl McLoughlin was killed. This deeply affected the plaintiff as he had shared a billet with Cpl McLoughlin at 6-21 and the Corporal had been very supportive of him.

217. Counsel for the defendants challenged the veracity of several of the incidents described by the plaintiff to both Dr McGuire and to Dr O'Loughlin. However I accept that there is a strong core of truth and an intention to be truthful and I have relied particularly on events on which there is unimpeachable evidence not least from Lt Col. Collins about this being a "tough battalion", meaning a very torrid and traumatic tour of duty, and several of the NCOs such as CQMS Flanagan, Sgt McCabe and Corporal Gaffney and how they too were affected by stressful dangers. Dr McGuire said pithily "Time and PTSD can change memory. He was in an area of hostility, felt his life in danger and that he was going to be killed". She also made the valid point:- "May I first say that epilepsy of any type, petit mal or grand mal, pseudo seizures are common symptoms of combat stress and severe anxiety. They are well documented in the research as well". I have every confidence that the diagnosis of PTSD made by both Dr McGuire and Dr F. O'Loughlin, the Army

psychiatrist, were correct. I also accept Dr McGuire's point that the DSM III and ICD 9 and 10 categorisations are guidelines, helpful for taxonomic reasons and helpful in diagnosis when used with the expertise of experience in conjunction with knowledge of the differing clinical signs of the constellation of symptoms which signify PTSD.

The alcohol proposition

218. There is no doubt that after his return in April 1987 the plaintiff resorted to drink as it were as self medication for the miserable and mystifying condition in which he found himself. He and his wife Veronica both maintained that he had been a moderate drinker before he went to and came back from the Lebanon but that then in April 1987 he was beset in the throes of symptoms such as broken sleep and early morning waking, startle response after a fire siren sounded, including his jumping from bed and then his searching frantically for his gun in a wardrobe. He was also irritable and upset to the point where she said that "he was not the Victor who had gone to the Lebanon" but was of changed personality and short with the children.

219. When opening the pleadings, counsel for the plaintiff referred to a reply giving particulars dated 9th November 2000 which included 'the plaintiff's marriage is broken up. His youngest child is two and a half years. He lives in a flat attached to his brother's house. He is a broken man. He is full of remorse about the fact his marriage has broken down. He is drinking excessively and has great difficulty holding down anything close to a job. He is constantly depressed. His young wife has six children to deal with on her own. They range in ages from 18 down to two and a half. His marriage was good up to the time he returned from the Lebanon.'

220. When Counsel for the defendants objected that information about incidents not mentioned in the Statement of Claim was being adduced, Colm Smyth S.C. for the plaintiff pointed out that these matters were set out in the Report dated 27th May 1996 of the Army psychiatrist Captain Dr F. O'Loughlin which described incidents involving close firing which led her to make a finding or diagnosis of PTSD and the defendants had admitted the fact and the defendants were aware of the contents of Dr F. O'Loughlin's Report (not least because she was the Army Psychiatrist) and the nub of the plaintiff's case was that his client had suffered PTSD which had not been treated or even diagnosed, despite his incapacitated condition and acute anxiety states in the Lebanon, until eventually he was referred to Dr O'Loughlin in November 1995.

221. Four further snippets from my note of the evidence are worth inclusion. When asked how he reacted to the news from Captain Kilfeather that Cpl McLoughlin was dead the plaintiff said he was terrified and shaking. That night he passed out at Camp Brashit and woke up in hospital in Camp Shamrock. He recalled that he got 'needle injections'. This would indicate that the plaintiff was taken in to the R.A.P. in an incapacitated anxiety state not just on occasions in December 1986 but also in or about 10th January 1987. There is further implication that the plaintiff's acute anxiety states had to be treated in both December 1986 and in January 1987 with injections of tranquillisers, probably diazepam.

222. Secondly, after the Naquora ceremonies in respect of the late Corporal McLoughlin, the plaintiff was on a UNIFIL bus with Israelis firing heavy machine gun rounds down from the hill above. He had no weapon. He was late for the bus and was given two days detention by Comdt Smith at 'Gallows Green' military prison for being drunk carrying a weapon. This punishment clearly upset the plaintiff and much of his account accords with the recollection of Corporal Gaffney who knew him well from border duty before 1987.

223. Thirdly, under cross-examination the plaintiff said he went to Holland in 1999; there he was busy working all the time and could take a drink at the weekend. He came back to see the children fairly often 'every twelve weeks but now they come out and see me'

224. Fourthly, Counsel for the defendant in cross-examination put to the plaintiff:

> "Your troubles that you have described are largely related to alcohol and alcohol dependence".

225. Mr Smyth objected on the basis that "none of that has been actually pleaded". He appears to be correct in this as there is no mention or suggestion of alcohol or an alcohol-related dependency, until that dependency came from and was related to service in the Army, being the aftermath of the plaintiff's experiences in the Lebanon. Counsel for the plaintiff submit that if the defendants intended to make such a case then it should be pleaded. Mr Smyth went through the Defence and there is no mention of alcohol in the defence, and at para.13 of a Reply to Notice for Particulars dated 9th November 2000 from the plaintiff's Solicitor it is stated: "13. The plaintiff did not have a drink problem before 1987". In a further reply dated 17th April 2003 at para 12 it is stated: "Since 1987 the plaintiff has suffered from alcoholism. He has suffered memory blackouts, insomnia and nightmares. He has suffered episodes of delirium tremens. He has experienced episodes of visual and auditory hallucinations, including flashbacks to the Lebanon..." At para.13 in that further reply again it is stated: "The plaintiff did not have a drink problem before 1987". However on 6th September 2006 the plaintiff's solicitor sent a further letter received by the Chief State Solicitor on 7th September 2006 which stated: "We refer to reply no. 13 of our Replies to Particulars dated 17th of April 2003. In that Reply we suggested that the plaintiff had no history of alcoholism prior to the events herein. We now understand on the basis of fresh instructions that that response was less than accurate. Mr Murtagh had difficulties with alcohol prior to 1987". No further letter was sent until the Chief State Solicitor wrote on 5th January 2007 to the plaintiff's solicitor:

> "Dear Sirs,
>
> For the avoidance of doubt please note that the allegation of negligence/contributory negligence against the Plaintiff in this matter includes the allegation that he failed to undergo treatment advised to him by the Army, its servants or agents."

226. No application surprisingly was made to amend the pleadings to include a specific defence in respect of alcohol problems of the plaintiff prior to 1987.

227. Mr Smyth pointed out that the plaintiff was Med Cat A1 and if he was alcohol dependent he would not have been sent to the Lebanon. "The difficulties with alcohol prior to 1987" was explained as referring to his wife being very annoyed with him because after their first child was born he had gone out for a drink on a Saturday or at other times without taking his wife with him. Mr Smyth said that he had "no objection to Mr Clarke asking the plaintiff about his difficulties with alcohol, but if Mr Clarke is going down the road of suggesting to this witness, or this plaintiff, rather, that he was an alcoholic, that he was a person who was completely dependent on alcohol, and that all his problems are alcohol related, I object to that, because if he wants to make that case, it should have been specifically pleaded. And I know that he can not make that case, because he knows that this man was categorised as having an A1 health status before he went to the Lebanon and he could not but be A1. He would not be let next, nigh or near the Lebanon into a battle situation if he was alcohol dependent." I understood Mr Smyth for the plaintiff was making the point that as a mortar man in a weapons platoon he would have to be fit and certainly not an alcoholic. He made clear that Mr Clarke was entitled to question him about "difficulties with alcohol" but he can go no further and say he was an alcoholic because that had not been pleaded. The case proceeded on this basis and no application was made to amend the defence then or at a later stage.

228. Dr Michael Bourke gave evidence as an experienced consultant psychiatrist on the lines that he had reservations about the plaintiff's past history prior to 1987 with regard to alcohol. However the plaintiff had been medically examined twice in 1986 and was A1 fit. There is no cogent evidence supporting the premise that the plaintiff had any alcohol dependency prior to his tour in 1986/7 in Lebanon. If he had had any such an alcoholic proclivity, or even tendency, one would expect some plausible witnesses to be called to give simple, direct admissible evidence to this effect.

229. Furthermore if the plaintiff had any sort of alcohol dependancy this would have been likely to have been picked up by the officers and NCOs during training. This is a strenuous testing time to sift out those with weaknesses or problems such as an alcohol dependency. Several of the NCOs including Cpl. Gaffney and CQMS Flanagan and Sergeant McCabe refuted the idea he was an alcoholic although they knew that "he took a drink, no more than the rest of us". I have much respect for the expertise and acumen of Dr Bourke but I am sure that his views were based on two incorrect premises. First he was led to believe there was no life-threatening sensitising incident. I have no doubt that the plaintiff was subjected to a plethora of incidents in which he felt he was in danger of death with the added shock of the actual deaths of Private William O'Brien and his own supportive and kindly mentor Corporal Dermot McLoughlin. There were several life-threatening, sensitising incidents which deeply affected the plaintiff according to the officers and NCOs of the weapons platoon. He clearly was profoundly affected and felt himself to be in mortal danger. Secondly, while there is an occasional hint or suggestion of the plaintiff taking a drink prior to the Lebanon tour he was certainly not alcohol dependent according to several NCOs notably Cpl. Gaffney, CQMS Flanagan and Sergeant McCabe all of whom had known the plaintiff well. Furthermore he had always been Med Cat AI and had a record quite unremarkable for lack of sick leave prior to the Lebanon tour. Accordingly neither of these two false premises stands up to scrutiny, particularly as the defendants were in a position to call proof positive easily if these false premises were capable of substantiation and more than supposition.

230. Dr Mary Scully, the experienced GP in Ballymote, knew the plaintiff's grandparents well and was his GP for three years before he went to Lebanon. She had treated him in 1985 after an RTA and for sore throats in 1986 and 1987. All his complaints had been 'run of the mill', such as respiratory infections, prior to his tour to the Lebanon. His complaints on return were much different. He had no anxiety complaints pre Lebanon. He was definitely different after the Lebanon tour. He had changed considerably and had anxieties and alcohol abuse after the Lebanon. She had known the family and had a high regard for his grandparents who had brought him up. He had had a happy childhood. Her understanding was that the alcohol only became a problem when he had come back from the Lebanon. In February 1988 she had referred him for anxiety, depression and alcohol abuse to the psychiatric clinic in Ballymote.

231. Both the plaintiff and his wife agreed that he took a drink often at the weekend but both refuted the suggestion that he had an alcohol dependancy prior to going to the Lebanon. I accept both are honest witnesses albeit at times he may be affected in telling a story by the effects of PTSD. However he tried to tell his story honestly and truthfully with admission candidly of matters against his interest. Time and again on contentious aspects such as the bus in convoy from Naquora being subject to hostile fire, his account has had support from other sources, as in this incident from Corporal Gaffney as to the bus coming under fire and that the Corporal noticed the plaintiff out of the bus and taking cover. His suggestion of returning fire seems the product of overwrought imagination and I accept Dr. McGuire's recognition of this as a symptom of PTSD.

232. His LA30 sick leave record indicates good work attendance prior to the Lebanon tour. He was medical category A1 and passed the tough training runs and the sifting process in the sessions in Mullingar. If the plaintiff had any alcohol dependancy prior to October 1986 then surely the defendants would have been able to call a witness to this effect? Not one witness was called to give positive direct eyewitness account of the plaintiff ever having been drunk prior to his tour in the Lebanon.

Conclusion

1. The plaintiff's claim was not statute barred. The defendants' doctors failed to diagnose PTSD in an immature and vulnerable 21 year old who was exhibiting numerous symptoms of acute anxiety states and had been exposed, like many of his NCOs and colleagues, to life-threatening experiences. The plaintiff in his evidence had given accounts of such experiences and of close firing. Neither the army doctors nor Dr Flynn (in her case in the absence of the information about acute anxiety states or panic attacks in his LA30 and CMF file) had diagnosed PTSD despite his constellation of symptoms. A conclusive diagnosis was made by Dr Fionnuala O'Loughlin on 27th May 1996 confirming her working diagnosis having regard to the CAPS test of 29th February 1996 and from her clinical findings and interviews with the plaintiff.

2. I accept Dr McGuire's opinion that Army doctors in 1986/7 should have recognised the symptoms of PTS and PTSD and that if appropriate counselling and therapy and treatment had been given the plaintiff would have been likely to have been cured and rehabilitated or at least the length and ghastliness of his suffering of the cluster of symptoms of PTSD would almost certainly have been greatly reduced.

3. There is a suggestion of contributory negligence on the part of the plaintiff in that he failed to undergo treatment advised to him by the Army. The plaintiff as a soldier was trained to obey orders. His constant cry for help, as recorded in the Hospital notes in St Columba's Hospital in Sligo, was for someone to tell him what was wrong with him. His symptoms should have been obvious to experienced Army doctors aware of the traumatic experiences of the members of this tour in the Lebanon and in particular the plaintiff who had to be brought in probably at least three, if not four, times to the RAP at Camp Shamrock suffering from incapacity and loss of consciousness in acute anxiety states which Dr McGuire said should have clearly indicated perils of future of chronic PTSD if the condition was left untreated. The plaintiff did attend St Conal's Hospital in Letterkenny for a group therapy course in respect of alcohol abuse which he found helpful. His whole personality was to try his best and to obey orders and any failure to comply can be attributed to his distressful state resulting from the defendant's failure to diagnose and treat him in Lebanon when his incapacitated condition and abnormal behaviour was common knowledge among his NCOs, officers and the medical officers. The failure to recognise the cause of the change in his sickness record from Med Cat AI soldier with nil or minimal sick leave to frequent sick leave of long duration, alcohol dependency and admissions to St Columba's for detoxification should have alerted the army doctors, since they were aware of his experiences of PTS, including incapacitating panic attacks, in the Lebanon and he should have been referred to the army psychiatrist on his return from the Lebanon or soon thereafter because of the dramatic rise in his sick leave record. On this aspect I accept the evidence of both Dr Mary McGuire and Dr/Captain Fionnuala O'Loughlin. Dr McGuire made clear that the plaintiff's condition afflicted by PTSD made life very difficult for the plaintiff and his condition would make compliance with medical advice difficult at times. If there was any contributory negligence on the part of the plaintiff this is explained by the advice of Dr McGuire about this and any miniscule contributory negligence on the part of the plaintiff pales into insignificance as compared with the failure of the defendants and their employees and agents to diagnose and treat the plaintiff and to refer him to Dr O'Loughlin for psychiatric examination. This failure was despite their knowing his condition of acute anxiety states, panic attacks and incapacitation in the Lebanon and the huge changes in his sick leave and medical record on his return. For completeness I should add that I have dealt with the suggestion of the plaintiff's alleged negligence or contributory negligence on the merits and

discounted the suggestion on the basis of the miniscule, if any, negligence of the plaintiff with the much greater and repeated faults of the defendants which make the former pale into insignificance. Counsel for the plaintiff did draw attention to paragraph 8 of the Defence and submitted convincingly that in the context of the wording of paragraph 8 and the ensuing Particulars of Negligence it was clear that the defendants' allegations of negligence and contributory negligence in the Defence were in fact confined to the hearing loss aspect of the claim. This is borne out by particulars in respect of failure to comply with Defence Force Regulations and failure to apply for or to wear ear protectors and failure to advise his officers of defects in his hearing. The claim for hearing loss has been compromised. Thus the suggestion of negligence in the part of the plaintiff on each aspect has been determined.

4. The evidence of Cpl. Gaffney, CQMS Flanagan and Sgt. Gerry McCabe made it quite obvious that the hostilities and explosions and deaths of Private O'Brien and Cpl. McLoughlin and the fighting between the armed factions provided many life-threatening experiences and pressures. I accept Cpl. Gaffney's evidence that the plaintiff did leave the bus and take cover when the road ahead came under fire, on the road from Naquora to Brashit but I do not think the plaintiff fired back – this was perhaps a figment of alcohol and more likely of PTSD, as Corporal Gaffney knew him well over the years and clearly was troubled by the incident and was sure that the plaintiff was not drunk but was affected by the death of Corporal McLoughlin.

5. The evidence of Dr Michael Bourke was postulated on the basis of the plaintiff having an alcohol dependency, not just a trivial familial problem of a husband going out without his wife who has to mind a new child. No cogent evidence was adduced to support the premise of alcoholism prior to the Lebanon tour but there was ample evidence that after the failure on the part of the Army to diagnose the PTSD and severe symptoms thereof that the plaintiff's quality of life, working, social and domestic disintegrated and that, as his PTSD was chronic and re-emerged at times of relapse, it continued to haunt him until Dr O'Loughlin made her firm diagnosis of PTSD and explained his condition to him.

6. Veronica Hannan, the plaintiff's wife, said his personality had changed between Christmas and his arrival back in April 1987. She described his startle reflex at the fire siren and his jumping from his bed in a panic, and how he was irritable, restless and went binge drinking after his return from Lebanon. She was a fair and measured, careful witness and I accepted her evidence especially that the plaintiff did enjoy a drink but was not stricken by dependence on alcohol until after his return in April 1987.

7. Dr Fionnuala O'Loughlin. The plaintiff's repatriation medical was on 18th April 1987 in Lebanon. The Army doctors in Lebanon must have known of the plaintiff's vulnerability and states of acute anxiety attacks on several occasions necessitating treatment at the RAP. With the vulnerability of the plaintiff was it not surprising that the Army doctors did not refer the plaintiff to Dr F. O'Loughlin in view of the plaintiff's incapacitating anxiety states? I accept Dr O'Loughlin's evidence including that formal debriefings for PTS were not started until 1993. However it was quite clear from the evidence of Dr McGuire that the incapacitating states of the plaintiff known to the army medical personnel in Lebanon were such that the Army doctors should have referred the plaintiff with his anxiety states, which had to be treated by them with injections of tranquillisers to Dr F. O'Loughlin as a patient clearly at risk of PTSD. Dr O'Loughlin made clear her diagnosis of the plaintiff's PTSD was on the basis of her clinical findings and interviews as well as the CAPS test and she supported the views of Dr McGuire about there being much knowledge of PTSD in the mid 1980s and a long history of medical knowledge of the constellation of symptoms involved.

8. Dr Mary McGuire made clear that the DSM III and ICD 10 and 9 were guidelines. It seems that the core symptoms of neurasthenia, shell shock, battle fatigue or PTSD have mainly remained the same and the DSM and ICD categorisations are for taxonomic purposes and probably particularly useful in classifying these ailments for research purposes. It seemed to me that Dr McGuire relied on her wealth of experience and clinical diagnostic expertise rather than formulaic categorisations. She expressed the view that any competent GP would have known about PTSD in the mid 1980s. I suspect that they, the GPs and Dr Fidelma Flynn, were stymied in diagnosis by the lack of the information which was in the LA30 and CMF file held by the Army. This information would have been helpful to Dr Fidelma Flynn and to other treating doctors dealing with problems of the psyche.

Dr McGuire also made the comment that the failure to recognise the symptoms of PTSD and provide therapy would be likely to affect the capacity of the patient to avail of therapy and treatment. Clearly an understanding of why one is suffering symptoms of PTSD is important to enable the patient to comprehend why he is being afflicted and how he should learn to cope with his ailment and rehabilitate himself. In this his return to his former constancy in the form of hard work doing carpentry in Holland has clearly been beneficial.

Medical Reports:

233. I have read the medical report received 23rd November 2006 of Dr Mary Scully, GP. He had been a patient since 7th July 1985 and she knew his grandparents who had reared him from the age of three. On 2nd February 1988 Victor attended her. He had been overseas in the Lebanon and two of his friends had been killed in action. Victor found this very stressful and was in fear for his own life. He informed her that he had not been able to relax or sleep after that and he had turned to alcohol to get his nerves under control. He told her he got into bother with the authorities over this. Since then he had been depressed with an over-reliance on alcohol. She treated him with anti-depressants, advised counselling services and gave him a medical certificate.

234. Over the next seven years Victor attended her sporadically and his problems included

Depression

Suicide tendencies

Alcohol abuse

Anxiety

Sleep problems and

Generally not coping with life

235. During this seven year period, Victor was referred to Sligo Hospital to detoxify in 1995, 1996 and 1997 and also to the psychiatric services. Victor did not like going to a local waiting room for the psychiatrist and missed many of his appointments. Compliance was a big problem and he did not do very well.

236. His wife separated from him towards the end of 1997. At this time his alcohol abuse got worse. He was discharged from the Army in 1998.

237. I have read the two reports of Dr Mary McGuire, consultant psychiatrist, dated respectively 10th October 2005 and 16th November 2005. I note the contents and accept her opinions expressed in her reports.

238. I have already referred to Dr O'Loughlin's two earlier reports dated respectively 11th November 1995 and 27th May 1996 and I have read her comprehensive report dated 12th September 2004.

239. She saw the plaintiff on four occasions between November 1995 and March 1996. During that time he described symptoms of post traumatic stress disorder, namely recurrent intrusive memories, nervousness in potentially threatening situations, disturbed sleep, irritability, anger and avoidance of engaging in conversation. In addition he described feeling depressed and felt suicidal at times. During that period of time, she completed a CAPS assessment on him and the findings indicated current PTSD at mild/moderate level.

240. She wrote that:

> "The prognosis for PTSD which is associated with a co morbid condition particularly substance abuse and/or depression is guarded. The more chronic symptoms become, the more difficult it is to have a full resolution of the symptoms."

241. She had not seen him for several years.

242. I have also read the two reports by Dr John Cooney dated respectively 15th April 1999 and 8th November 2006.

243. In the first he noted that this man's previous history was a clear one up to the onset of his difficulties in Lebanon. He had married a factory worker both aged 18. They had 6 children but because of his abnormal drinking pattern, after his return from Lebanon, she had left him and he said he was still devoted to her and misses her company considerably. He stated he was perfectly well up to the time he went to the Lebanon in 1986.

244. In the second report Dr Cooney writes:-

> "Mr Murtagh claims that he has suffered a "change of personality" since his return from the Lebanon. Alcohol has become a major problem in his life to the extent that he has been admitted to St Columba's on many occasions and now attends Alcoholics Anonymous intermittently. He is subject to depression characterised by sleep disturbance, indecision, inability to face the day and chronic fatigue. Moreover, he experiences flashbacks to his experiences in the Lebanon. Mr Murtagh functioned at a poor level in the Army up to his discharge in March, 1998. He was seen by Dr F. O'Loughlin, an Army Psychiatrist, in 1996. According to Mr Murtagh, she diagnosed him as suffering from post-traumatic stress disorder and prescribed treatment for him. He is currently on an antidepressant from his family doctor in Ballymote and has been advised to abstain completely from all forms of alcohol.
>
> The facts as outlined above were volunteered to me by Mr Murtagh. His wife was to have accompanied him when I had hoped to see her independently and obtain the corroboration of these facts, but she was unable to travel to my consulting rooms on the 12/3/99.
>
> I came to the opinion that Mr Murtagh was suffering from the post-traumatic stress disorder, brought about by the experiences in the Lebanon. In view of the chronicity of this condition, I believe that the prognosis must be somewhat guarded. However, were Mr Murtagh to become abstinent, his prospect of recovery would improve considerably. Moreover, there is a possibility that should he reach the state of contented sobriety, a rapprochement with his wife might be possible."

245. I am more than satisfied and feel sure that the plaintiff was obviously stricken with PTS in the Lebanon and certainly when he had to be sent for treatment to the RAP at Tibnin on what I believe were three occasions, warning bells should have rung about his condition as an immature 21 year old suffering Acute Anxiety States to the extent of loss of consciousness and uncontrollable shaking and fits. His vulnerability to PTSD should have been obvious. I do not accept that he was alcohol dependant prior to his tour in Lebanon and indeed I am convinced that it was the failure to diagnose and treat him which allowed the PTSD to become chronic. This failure to diagnose and treat him with medication, counselling and therapy or to refer him to Dr O'Loughlin or to have him monitored and contact made with his family as directed by Colonel Walsh the Director of the Medical Corps, resulted in the plaintiff's resorting in his despair about his condition to self medication with alcohol with grievous results for him in respect of his working, social and family life. If there had been appropriate early intervention I am sure that the plaintiff with an understanding that he was not abnormal in his reaction to traumatic stress, would have confronted his illness once identified and would have rehabilitated himself, as he has largely managed to do, since being properly diagnosed, by engaging in steady work as a carpenter in Holland. The defendants, by their employees and agents, were negligent and in breach of their duty of care to the plaintiff as their employee in their failure to diagnose and treat or to refer him to the Army psychiatrist for examination. Also there was the failure to have a proper system in place so that treating doctors such as Dr Flynn and Dr O'Loughlin would be supplied with a full history particularly in a case involving manifest damage to the psyche. The failure to inform Dr Flynn in St Columba's of Dr O'Loughlin's positive diagnosis of PTSD in November 1995 seems extraordinary since she agreed to and was aware of the referral to St Bricin's. Similarly there was the failure on the part of the defendants to have protocols and systems to ensure that if the Army psychiatrist is seconded elsewhere then another doctor will take up her patient caseload. There seems to have been a similar lacuna in monitoring, supervising and communicating information in that Dr Cmdt Kerr's successor at Finner seems to have been unaware of Dr O'Loughlin's diagnosis of PTSD or was not alerted to or did not realise that the plaintiff's problems stemmed from the failure on the part of the defendants to diagnose and treat him in the Lebanon and again subsequently when he was back in Ireland despite the dramatic rise in his sick leave after his previous clean record. Thus the plaintiff was left being racked by the symptoms of PTSD without any follow-up from the Army. Dr McGuire pointed out that any caring employer would have noted the good work record of the plaintiff in his LA30 and would have called him in to inquire and investigate, if necessary, what affliction had affected him since his 1986/7 tour of duty in Lebanon. I find that his stress was unlikely to have become a PTSD if it had not been for the negligent failure on the part of the defendants to recognise and remedy his symptoms of severe stress. There was ample evidence of the efficacy of early intervention being helpful to prevent and reduce PTSD in such circumstances.

246. The defendants as employer are under a duty to take reasonable care for the safety of their employees and must keep abreast of contemporary knowledge in the field of reduction in the effects of potential afflictions to which soldiers are likely to be exposed in the course of duty. The perils of PTSD in those subjected to stress have been well known to the defendants for many years prior to 1986. Having been at the conference of military psychologists in Paris in the spring of 1986, Lt.-Col. Goggin gave a briefing to the battalion officers and NCOs at Mullingar which was recalled by both Lt.-Col. Goggin and Sgt Gerry McCabe who had given his evidence days before Lt.-Col. Goggin. As is elementary the plaintiff is not entitled to compensation because in his work as a soldier in the Lebanon he was exposed to stress. He must prove on the balance of probabilities that his injury was caused by the fault of his employer. The plaintiff's strange and abnormal behaviour was well known in the platoon among officers and NCOs. He had to be treated in the RAP Tibnin on several occasions for incapacitation from known acute anxiety states. The failure to recognise and treat his symptoms or to refer him with his recognised vulnerability for checking out on his return by Dr O'Loughlin was due to culpable negligence on the part of his superiors and a failure of the army system at that time in 1986/7 and resulted in his contracting chronic PTSD. On the medical evidence it seems that the likelihood is that if the plaintiff had received proper diagnosis, counselling and therapy when he showed clear signs of stress and incipient or actual PTSD in 1986/7, his condition would have been relieved rapidly and he would not have become subject to the long-running and persistent chronic PTSD which has so adversely affected him in his working, social, domestic and family life.

247. The plaintiff is entitled to damages for the injury caused to him by reason of the negligence and breach of duty of care on the part of the defendants, their servants or agents.

Quantum of damage
248. I accept the evidence and prognosis of Dr McGuire and Dr O'Loughlin except insofar as the PTSD in 2004 seemed to have improved considerably from the severe earlier symptoms. I note that the more chronic symptoms become the more difficult it is to have a full resolution of the symptoms. I accept Dr McGuire's view that the plaintiff has suffered severe emotional distress, depression and social, personal and familial losses in his life because of the failure to diagnose and treat his acute stress and his ensuing chronic PTSD. Dr Cooney's initial opinion in 1999 was that prognosis had to be guarded because of the chronicity or longlasting nature of PTSD; on 8th November 2006 Dr Cooney reports that the plaintiff has been working consistently in Holland since 1999. His PTSD symptoms have abated to a considerable extent although he still suffers flashbacks. His wife now has a partner and has a child by this partner. The plaintiff provides for his wife on a regular basis. This is commendable and is what I would have expected from my estimate of the genuine and decent character of the plaintiff and his deep affection for his wife. I note Dr Cooney's expert view that this man has improved considerably from the PTSD brought about by his experiences in the Lebanon, with the addendum of 'and because of the failure to diagnose and treat the symptoms or to refer him to the Army psychiatrist in a timely manner.'

I General Damages

Pain and suffering to date €270,000

Including:-

Physical and psychological suffering,

Loss of vocation,

and loss of vocational enjoyment.

Separation from wife and family

Lack of treatment or explanation as to his underlying condition caused him to change personality from the viewpoint of his family and wife and made him difficult, irritable, insomniac and subject to self-treatment with alcohol.

Loss of employability

Future pain and suffering € 30,000

Including peril of recurrence

Special Damages agreed Doctors' fees, Travel € 2,873

€302,873

II General Damages re deafness agreed € 2,650

€305,523

Judgment for €305,513 and costs to be taxed in default of agreement to the plaintiff.