THE HIGH COURT

[2009 No. 2741 P.]

BETWEEN

CATHERINE HURLEY

PLAINTIFF

AND
AN POST

DEFENDANT

JUDGMENT of Mr. Justice McDermott delivered on the 16th day of March 2018

1. The plaintiff's claim is for damages for negligence and breach of duty against her employer arising out of bullying by co-workers following an incident which occurred at her workplace on 26th July, 2006. The issue of liability has already been determined by the court in a judgment delivered on 6th October, 2017. This judgment addresses the damages to which the plaintiff is entitled as a result of the personal injuries, loss and damage caused to her by the defendants.

2. The main facts of the case are set out in the earlier judgment of the court. The plaintiff was born on 6th October, 1964. She is a married lady and has two children. She is 53 years old. The court in its judgment on liability was satisfied that the defendant employer was liable for the bullying and harassment which the plaintiff experienced from her co-workers in the course of her employment of which it was aware and failed to address in any meaningful way. The court found that the defendant was in breach of its common law duty of care to her as an employee and under s. 8 of the Safety Health and Welfare at Work Act, 2005 and exposed the plaintiff to damage and injury to her health which she suffered as a result. There are a number of issues that arose during the course of the hearing including the extent of the personal injuries suffered by the plaintiff, whether they were caused by the defendant and whether the plaintiff took steps to mitigate her losses. The court heard evidence over a number of days in relation to the personal injuries and loss of earnings allegedly suffered by the plaintiff.

Medical History

3. The plaintiff gave evidence of her medical history and the adverse effects on her health of the bullying which she experienced in the course of her employment. Expert evidence was called on both sides. The doctors who treated her were called to give evidence. Evidence was also adduced from medical experts called by the defendant.

4. The plaintiff had an extensive employment history from a very young age. From October, 1984 until October, 1998 she was employed by Apple. She was then made redundant. Subsequently she obtained employment with Buy 'N Sell as a telesales operator on a part time basis from 6th October, 1998 until 2nd May, 2000. She left after her second pregnancy.

5. She applied for a part time position with An Post in 2003 and following an interview was recommended for employment on the 10th June, 2003. She was granted a temporary employment contract from 25th August, 2003 for a minimum period of seven months for 21.25 hours per week. This contract was subsequently renewed on 25th August, 2005 and 25th February, 2006 when it was renewed for a period of six months. She was subsequently granted a further contract as auxiliary postal sorter on the 25th August, 2006 for a further period of six months.

6. In evidence Mrs. Hurley stated that following the incident with her co-worker on the 26th July, 2006 she was off work between 26th July and 15th August, 2006. She attended her general practitioner, Dr. Deirdre Burns, on 8th August, 2006 who certified her as unfit to work for that period. Dr. Burns noted that the plaintiff had anxieties about going back to work as there was a "mixed feeling at work about [the] entire incident". She was advised to return to discuss the situation with her doctor if matters did not improve. She was also encouraged to discuss the situation with her work supervisor.

7. The initial incident between the plaintiff and her co-worker on 26th July 2006 caused her great upset and she was unable to return to work for a period of two weeks. The court has already ruled that the employer is not liable for any injury loss and damage sustained by her as a result of that incident. Therefore, the assessment of damages relates to any personal injuries loss and damage caused to the plaintiff following her return to work in August 2006 and arising from the bullying and harassment which she suffered thereafter. The plaintiff must establish that she suffered personal injuries or any other loss on the balance of probabilities. The aetiology of the symptoms from which she suffered after the incident is somewhat complex and disputed by the parties.

8. Following the incident on 26th July the plaintiff went with her two daughters then aged seven and nine years to live for three weeks with her parents because she feared that her fellow worker might seek her or her family out. She was extremely nervous and fearful of him. She described how she was traumatised by the incident and by feedback which she was receiving concerning how her fellow workers viewed the incident. Even at that early stage she considered that she was becoming a focus of attention and felt under pressure because of the negative view taken by her co-workers of her involvement in the incident. The incident led to her co-worker's suspension and he was dismissed in March 2007. Her husband also worked in the sorting office. She was worried for her safety because her co-worker shortly after the incident continued for a short period to attend at his work-place. He tried on one occasion to force his way in. He had to be prevented from entering the premises and escorted from it. However, she stated and I accept that she wished to return to work as normal as soon as possible.

9. Mrs. Hurley described the treatment to which she was subjected on her return to work which is set out in the earlier judgment of the court and which I fully accept. She felt ostracised and alone. She began to question herself and whether she had done something wrong. She was completely traumatised by her work situation within a short time of her return. There was very considerable workforce anger and agitation over her fellow worker's treatment by management. Her workplace became a very unhappy place for her and she dreaded going in though she still attended. This continued until Christmas 2006. After Christmas she did not return to work because of her deep anxiety and upset.

10. In the meantime, she had made a number of complaints to members of the management staff but felt she did not have any support from them. She felt she was taking the whole burden of the situation on her own shoulders. She spoke with the company nurse, Nurse Hodgins, in January 2007 and explained matters to her. Nurse Hodgins was sympathetic to her and told her not to give in and to return to work and see how things were. She complained to Mr. Ned Keane on the 16th August, 2006 and Mr. Keane and the operations manager Mr. Harrington in September 2006. She spoke to Mr. McCarthy, a supervisor on the floor. She spoke to Ms. Karen Hassett in September 2006 a processing area manager. She complained to Mr. Keane three times in October 2006 and once in November 2006. On 28th December, 2006 she was out sick and did not return until 5th January, 2007. She attended her general practitioner Dr. Fleming during that time.

11. Dr. Fleming describes in her report of 10th September, 2008 that Ms. Hurley attended on 5th January, 2007. She described at that time how following her return to work in August 2006 she had felt isolated and ostracised by others at work. She had taken the previous ten days off work as she was unable to cope with the stress in the work environment. Dr. Fleming gave her a medical certificate to cover that ten day period and advised her to return to discuss the situation if it did not improve and to discuss the matter with her work supervisors.

12. As described above Mrs. Hurley spoke to Nurse Hodgins at this time. Mrs. Hurley was referred to Nurse Hodgins because of the certificate granted by Dr. Fleming for work related stress. Nurse Hodgins noted that the plaintiff had been absent in July 2006 for two weeks. In December 2006 she stated that she felt blamed for her colleague's suspension and some of the staff were ignoring her. She had not been invited to some Christmas functions. She had returned to work and felt she was coping well. She appeared calm and relaxed. She was sleeping well but was "being harassed and bullied" at work. She stated that friends and management were very supportive. Under the heading Plan it was stated:-

> "to contact welfare officer (contact details supplied) re her harassment and bullying allegation and discuss her options. She is fit for work at present.
>
> M. Hodgins.
>
> Management to follow normal procedure"

13. The plaintiff stated that between January and June 2007 she worked most days but took a number of days off. Her work attendance record indicates that she was absent for stress on the 5th and 10th July, 2007. However, I am satisfied that the severe pressure of the continuing bullying and harassment to which she was subjected during this period gave rise to the symptoms of stress, anxiety and depression later diagnosed by her treating psychiatrist.

14. The plaintiff took further sick leave on the 28th September, 2007 until the 7th January, 2008. Dr. Fleming notes that in October 2007 Mrs. Hurley presented with physical symptoms namely, a three week history of hip pain which was worse after prolonged standing. She diagnosed a possible bursitis at the hip joint. She was prescribed anti-inflammatories and directed to attend physiotherapy. On review on the 9th October Mrs. Hurley also complained of right shoulder and neck pain. This was consistent with soft tissue inflammation. X-ray on the 19th October revealed that her hip and shoulder were normal. On review on 5th November she stated the hip pain had settled. She continued to have right shoulder pain on abduction i.e. elevating the arm at the side of the body. She continued on anti-inflammatories and was advised to continue with physiotherapy. On 26th November there was a marked improvement and Mrs. Hurley could raise her shoulders equally on both sides. She was tender on the right anterior shoulder joint. She had pins and needles down her right upper limb suggestive of nerve root irritation. An appointment had been made to see the company doctor, Dr. O'Reilly on 27th November, 2007. Dr. Fleming expected that the plaintiff would be able to return to work by Christmas.

15. In the meantime, the plaintiff attended with Nurse Hodgins on 30th October, 2007 in relation to this absence from work. It was noted that she was now on Difene. She complained of pain radiating up and down her right arm to her right hand. She felt she had no strength in her right hand. She had three sessions with the physiotherapist of 20 minutes duration. Discomfort was eased by walking as she was more uncomfortable when seated. Pain awoke her when sleeping. She felt unable to open jars or do ironing but felt able to do light housework. She had difficulty in driving. It was accepted that she was unfit for work.

16. On 27th November, 2007 the plaintiff attended with Dr. O'Reilly, the company doctor. He noted on examination that she had a painful right shoulder. The pain was constant. She felt activity made it worse and pressure on her arm caused pain. She felt she could carry out activities but they were painful. She had been prescribed anti-inflammatories and physiotherapy once per week. Her husband was doing the heavy housework. She was still swimming. She did not feel she could return to work with the complaints which she still had with her arm. She was advised that she was fit for work and could be accommodated with breaks and light work duties. She felt the need to be pain free before returning for work.

17. Dr. Fleming reviewed Mrs. Hurley on 13th December, 2007. She was complaining of pain in her left wrist. Dr. Fleming thought that this was possibly secondary to overuse as she was not using her right hand so much. She had right shoulder pain and again reduction of abduction at the shoulder. She was referred at this stage to a consultant rheumatologist Dr. Brian Mulcahy. He referred her for a shoulder MRI which showed a tendonopathy or inflammation of the tendons.

18. Nurse Hodgins saw the plaintiff again on the 14th December. The plaintiff thought her condition had improved. She was complaining of discomfort in her shoulder radiating to the fingers of her right hand. This was intermittent. She was taking analgesics. She had discomfort in her left wrist the previous week. She noted that Mrs. Hurley had been referred to the consultant rheumatologist and was attending physiotherapy weekly and undertaking exercises at home. Her range of movements were approximately 50% and she did not feel fit to return to work at that stage. She was again reviewed on the 3rd January 2008. She reported that she was continuing to undertake light housework. She wanted to try and undertake a trial return period at work. Her certificate expired on the 7th January, 2008 and she felt fit for video coding. On review she was using a computer at home for approximately 25 minutes per day. Her difficulty with her right shoulder had cleared and there was no swelling and a good range of movement in both wrists. Her plan was to return to work at that stage avoiding heavy manual work.

19. Mrs. Hurley had a consultation with Dr. Mulcahy, a consultant rheumatologist for the first time on 28th January, 2008. He noted a history of shoulder discomfort which commenced two years previously when she was at work carrying heavy objects. It had been intermittently troublesome since. It became increasingly uncomfortable over the past number of months. In addition she was complaining of right hip discomfort which became very irritable in August 2007. She also noticed at that stage discomfort in her left wrist.

20. Dr. Mulcahy stated that clinically she had a right rotator cuff tendinopathy with impingement which he injected. She had inflammation of her combined tendon sheaths of her right hand with discomfort around her right greater trochanter. He injected her shoulder and then brought her into Shanakiel Hospital for two methylprednisolone infusions. She was then reviewed on 12th March, 2008. The shoulder hip and hand symptoms had settled down but her neck had become very stiff at the beginning of March 2008. He noted a markedly restricted range of movement of her neck with spasm of her para-cervical muscles. She had no previous history of neck injury. He placed her on steroids for a week and gave her an exercise programme for her neck. She was referred for an MRI scan of her neck. She was then reviewed by Dr. Mulcahy on 24th April, 2008. She remained symptomatic and matters were getting worse in that she was getting quite a lot of spasm in her neck. The findings on the scan were not in keeping with her clinical presentation. It was her inability to recover from the neck and shoulder symptoms having recovered from the other physical symptoms that caused Dr. Mulcahy concern and to investigate possible psychological or psychiatric causes for these continuing symptoms

21. Dr. Mulcahy questioned Mrs. Hurley further about her symptoms. She told him about the altercation at work with her fellow worker. She also informed him that since then approximately 75% of her work colleagues had been ignoring her and she was finding this very stressful. Her mood had become very low and she was very anxious about returning to work. Dr. Mulcahy concluded that it was most probable that the spasm in her neck was stress related. He recommended that she be brought into Shanakiel Hospital for intensive physical therapy and also referred her to a colleague Dr. Eugene Morgan, consultant psychiatrist to review her case.

22. Though Mrs. Hurley returned to work on 8th January, 2008, with the promise that she would be assigned light duties, she was obliged to take further sick leave on 11th February, 2008, due to stress and pain and did not return to work after that date. She was dismissed from her position on 15th July, 2011.

23. The plaintiff claimed that following her return to work in August 2006, there was a continuing resentment against her from her co-workers. It got worse until she finally left on sick leave February 2008. She tried hard to stay and continue in her job which she found very satisfying and rewarding but she felt she could not continue due to the bullying and harassment. There were some nights when nobody spoke to her for the whole night while working her shift. She would frequently cry after returning home from work and ultimately could not face returning to work. She and her family suffered a loss of income because of her absence from work. Her husband took up work as a part time taxi driver to make ends meet. They were obliged to operate one rather than two cars. This was a burden because they lived in the country. Her condition impinged very considerably on carrying out daily tasks and her family life.

24. From the time of her dismissal in July 2011 she claimed that she could not seek employment because of the pain in her neck and shoulder. She could not sustain the use of her right hand for very long. She tried to go back to work in July 2016. She took a part time position in the Mater Private Hospital in Cork. Her cousin had been working there for 30 years and she was offered temporary employment through an employment agency. She was working with her cousin who worked on the wards providing tea to the patients. She had three or four hours work, two or three days a week. Her cousin was aware of her neck and shoulder issues. However, she was then required to carry out work in another location in the hospital because of demands being made in a larger canteen. She continued to work in that job for six to seven weeks. She had a total net earning during that period of €400.00. She was very nervous about returning to any other form of employment. She continued to have pain in her neck and right arm. She tried to control the pain by taking Difene. Normally, she would lie down for half an hour to ease the pain.

25. The coding work in which she engaged at An Post involved some physical effort. She was required to continuously look at a computer screen to code illegible or partially illegible addresses on envelopes. She was required to process a set number of items per minute. Letters were processed rapidly. A break was then given for 20 minutes during which the worker was obliged to physically sort letter or postal packets as a break from coding.

26. The plaintiff described the physical limits to her working capacity in evidence. She said that she could do household tasks such as ironing but that this now took more time than heretofore. She could not do any heavy housework which was done by her husband. She had no confidence in daily interaction with others and she found it hard to converse with people or strangers. She felt that the pain in her neck and arm got worse when she was under stress. It never got better. The pain felt like something hot running up and down her arm constantly. They were both related in the sense that she suffered the neck pain at the same time as the pain in her arm. She also felt that the grip of her right hand was less than it was before 2006, when she had no problems with it. She now depended a lot on her left hand. She accepted that she had been on holidays to visit friends who were living in Dubai. Her daughter bought the flight tickets. They were there between December into January 2018. In summer 2017, they holidayed in Cancun travelling via Washington. In 2015, the family were in Orlando, Florida. She emphasised that she would have liked to have brought her daughters away on holiday during the period of her unemployment but this had not been possible. Things had improved in more recent years.

27. I accept the plaintiff's evidence in this regard. The extent to which she and her family were unable to take holidays during a period of recession and difficulty following the incident in 2006 passed and matters improved because of the general improvement in their financial situation due to improving general economic circumstances and the fact that her husband was engaged in two jobs. Some of the cost of the more recent trips were funded as a present from her daughters.

Previous Symptoms of Anxiety and Depression

28. The plaintiff's previous employment history and her alleged unwillingness to return to work following certified periods of sickness was the subject of criticism and scrutiny under cross examination. There was considerable emphasis on the course of her two pregnancies with her daughters some twenty years ago and subsequent events. Ms. Hurley's first daughter, Holly, was born on 24th November, 1997. She accepted that she had post-natal psychological difficulties. She returned to work in April/May 1998. Her maternity leave expired in March 1998. Her doctor noted her reluctance to return to work at that stage: she felt she was not ready. She suffered stress and anxiety: nevertheless, she returned to work approximately one month later. In June 1998 Mrs. Hurley became pregnant but suffered a miscarriage in October 1998. She accepted a redundancy package from Apple Computers in October 1998. Within four weeks, she had obtained a job with Buy N Sell which lasted until April 2000, when she resigned from her job. Shortly afterwards the company closed down. Her younger daughter was born on 13th December, 1999. She was confined to hospital for a period of nineteen weeks in advance of that birth because of a serious complication. The child was born by caesarean section. Mrs. Hurley remained in hospital for a number of weeks following the birth. The birth was premature and the baby had serious health difficulties. Understandably, Mrs. Hurley felt the need to be with her, was deeply concerned about her baby and did not feel well herself. She again suffered from stress related issues. It had been a very difficult pregnancy and her daughter's health issues and needs in the subsequent months dominated family life.

29. On the 7th April 2000 her then doctor, Dr. Burns indicated that she could go back to work. The plaintiff stated that she did not feel well enough to do so due to anxiety and stress issues. It was noted that she was advised to start work and had stopped taking seroxat, a medication to assist her with stress and anxiety symptoms.

30. She did not return to Buy N Sell prior to its closing. She was out of work thereafter from April 2000 until she was employed by An Post on 25th August 2003. In the meantime Mrs Hurley received social welfare payments, a form of illness benefit. She attended her doctor in September and November 2000 and last attended Dr. Burns in April 2001. In February 2003 she was found capable of work following an independent medical assessment and her payments were stopped in March 2003. An appeal against this finding was unsuccessful.

31. Mrs. Hurley did not consider that she had long term psychological problems at the time she joined An Post. She had no health issues up to the period of her pregnancies. She maintains and I accept that her history up to that time was one of continuous employment for a period of sixteen years with Apple and Buy 'N Sell. This was interrupted by the difficulties surrounding her pregnancies and the fact that her younger child was a very sick baby. This caused her a great deal of upset which resolved.

32. The defendant alleges that Mrs. Hurley "withheld" her post natal depression from various medical experts by whom she was interviewed in the course of these proceedings and from her own doctors. It was said to be particularly relevant that she deliberately withheld a "history of depressive illness". The defendants claim that any depression or anxiety related illness from which she suffered pre-existed her difficulties in An Post and were relevant to any medical review of her symptoms or conclusion that she suffered PTSD as a result thereof. It was denied that she suffered from PTSD but it was also claimed that if she suffered such psychological or psychiatric illness or symptoms this was not caused or exacerbated by her time in An Post but pre-existed her employment with An Post or the incident in July 2006.

33. It was acknowledged by the plaintiff in replies to particulars that she suffered from anxiety and psychological issues following the births of her daughters and that her treatment primarily consisted of antidepressants. The records do not indicate that she was, at any stage, referred to a consultant psychiatrist in relation to these issues nor was she diagnosed with clinical depression. However, she was prescribed seroxat. A great deal was made of the fact that she did not tell a number of doctors about this later on. She said that all of the doctors would have been aware of the difficulties from which she suffered around her pregnancies and the difficult time in life she had with the children in the early years. She said she had completely recovered and had no further problems arising from those issues. She never considered that she had been suffering from a psychiatric illness as a result. I am satisfied that the plaintiff did not consider her condition in that way and that she had as a matter of probability put it behind her when seeking work in August 2003. It is also clear that her doctor was urging her to return to work in April 2000 as she was capable for work at that time a conclusion also reached following independent medical assessment by the Department of Social Protection. There is nothing in her medical history to suggest any symptoms of that kind between 2003 and the incident with her co-worker in 2006. She was clearly considered to be an employee who was in good standing who attended as required and discharged her duties competently and willingly. Her contract was renewed on a number of occasions and there is little doubt that had the incident and the ensuing events not occurred she would have remained happily in her position. I am satisfied that she enjoyed and was happy in her work and had no intention of giving it up. There is no suggestion in her work attendance or company records that she suffered any such symptoms during this period.

Dr. Morgan

34. Mrs. Hurley was referred to Dr. Eugene Morgan, Consultant Psychiatrist, and was first seen by him in January 2008. In a report dated 16th January, 2012, he described her condition as follows:-

> "In July 2006, she was injured when a fellow worker allegedly threw a package into a trolley roughly and there was a violent confrontation where she was extremely anxious and fearful for her life.
>
> She sustained multiple injuries and was treated by her GP and in time referred to Dr. Mulcahy with neck and shoulder symptoms with ongoing symptoms. Her employer did not offer any counselling and a high profile publicity occurred about disciplinary action on assailant.
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> She returned to work in 2007 (sic) for five weeks and was shunned by her colleagues who blamed her for dismissal of alleged assailant. She was not welcome at social functions. She was not supported by her trade union.
>
> She was distressed by her physical symptoms and continuous pain which limited her lifestyle and inability to drive her children to social outings in particular riding lessons. She could with difficulty do school runs. She had anxiety constantly. She could not accept her treatment by employer and her trade union. She could see no future. Mention of Little Island caused anxiety. She had flashbacks and night terrors. Insomnia was severe. She could not rest and was fearful of future for herself and her family. She relived the event over and over again. She constantly checked all facets of her life. Her husband who was supportive relates a personality change. Married life is affected.
>
> She was treated by antidepressants and supportive psychotherapy with limited results and remains symptomatic. She found it hard to get any reassurance. Dismissal from work had effect of increase in symptomology. A car accident in July 2010 had minimal effect on her mental state.
>
> In summary, this lady has Post Traumatic Stress Disorder following an incident in 2006 at her workplace. The incident caused her to feel her life was in danger. Her progress for PTSD was affected by her physical symptoms and ongoing conflict with employers, trade union and fellow workers. Her dismissal has had a severe effect. Her prognosis is guarded and full recovery may not be expected with relapses with severe symptoms at times."

35. Dr. Morgan prepared a further report following an interview on 20th July, 2016 with the plaintiff. She reported a gradual improvement in her mental state over two and a half years. She had reduced her medication and took an anxiolytic for severe anxiety on isolated occasions. Her husband reported an improvement but not to pre-accident level. He noted that her sleep had improved but she awoke with physical skeletal pain. She suffered severe symptoms of anxiety when dealing with her legal affairs. He noted the presence of features indicative of obsession. She hoped to return to the workforce by engaging in a course for people who had psychiatric illness. He was at that time of the opinion that the PTSD was at a moderate scale. He concluded that she might suffer severe recurrences in the future. The plaintiff's prognosis was favourable but guarded in the light of her partial recovery. He had concerns about the effect of her mental symptoms over a long period on her physical health in the future.

36. In a further report for the plaintiff's solicitors dated 20th December, 2017, Dr. Morgan reported that her condition of PTSD had dramatically dis-improved over the previous few months and she found it difficult to engage in everyday life, with her lawyers and family matters. She had early and late insomnia, was irritable with anxiety and suffered panic attacks. She reported flashbacks to events that occurred in the post office and had extreme anger towards An Post. She had guilt regarding the effect of her injuries on her family and was conscious of the loss of quality of family time over the years as a result of being ill. Dr. Morgan maintained his diagnosis of PTSD. He concluded that she would be likely symptomatic for the rest of her life but at a moderate level when the present acute exacerbation was over. She had by this time been discharged by An Post. However, he was asked to comment in the report about the possibility of her returning to work with An Post. He concluded that her anxiety levels would be too high and he doubted if she could give good and sufficient service. He also concluded that her physical health would suffer in the short term due to stress. In evidence, he indicated that this could lead to possible stroke or cancer or myocardial infraction. He emphasised that this was a possibility rather than a probability.

37. Dr. Fleming stated that following the plaintiff's initial attendance with her for stress and anxiety following the incident of 26th July, 2006 she subsequently attended with similar symptoms related to her work difficulties. On 6th May, 2008 she noted that the plaintiff was very stressed because of the situation at work at that time. There had been no stress related attendance in the interim. By then she had been referred to Dr. Morgan. On 23rd June, 2008 she attended Dr. Fleming with ongoing physical symptoms of right sided neck and shoulder pain which had been treated with injections by Dr. Mulcahy. Dr. Fleming discussed the psychological impact of pain

perception with Mrs. Hurley who felt that she could differentiate work related stress from her physical symptoms. On 10th September, 2008 the plaintiff reported that she was feeling a little depressed as a result of ongoing physical symptoms of right shoulder neck pain which had resolved.

38. Dr. Fleming was questioned at length about the plaintiff's attendance with her over the years and in particular the patient's presentation with symptoms of anxiety. Dr. Mulcahy informed her in a letter in September, 2008 that he had referred her on to Dr. Morgan because of her stressed condition. Dr. Morgan contacted Dr. Fleming on 5th November, 2008. He made a recommendation that she be prescribed Cymbalta, an anti-depressant. Up to that point she had not seen the necessity to refer Mrs. Hurley to a psychiatrist or advise antidepressants or counselling. On 11th November, 2008 she discussed an antidepressant medication programme with the plaintiff. If necessary incremental increases in doses would be required. She was started on a low dose which would be reviewed within a month. On that occasion she prescribed Cymbalta and anti-inflammatory medication.

39. On 20th January, 2009 Dr. Fleming noted that the plaintiff attended and her husband indicated that she had improved on Cymbalta and was willing to restart it. This suggested that she had stopped taking the medication between November 2008 and January 2009 unknown to Dr. Fleming. She wrote a new prescription for Cymbalta and gave it to the plaintiff. Dr. Fleming accepted that during the period 2008 to 2012 the plaintiff's adherence to the anti-depressant regime was sporadic. The patient periodically ceased taking the medication without telling Dr. Fleming. She noted in January 2010 that the plaintiff was only partially in compliance with taking her antidepressant medication. The doctor was satisfied at that stage that this was not likely to have been a physical reaction to the drug because she did not change the prescribed drug when renewing prescriptions.

40. On 26th March, 2009 the plaintiff attended Dr. Fleming with a ten day history of right wrist pain, sleep disturbance and neck spasm which had been previously noted by Dr. Mulcahy in April, 2008.

41. Thereafter, there were no further attendances with Dr. Fleming between June, 2009 and January, 2010. She was at that time attending Dr. Mulcahy for ongoing pain management of her symptoms and Dr. Fleming was not surprised that there were not more frequent attendances with her during that time. She was also attending Dr. Morgan during this period.

42. Dr. Mulcahy by this stage had been involved in treating the plaintiff since 28th January, 2008. As already outlined, when examined at that time the plaintiff showed signs of right rotator cuff tendinopathy with impingement. She had discomfort around her right greater trochanter. Her shoulder was injected with steroids and she was brought into Shanakiel Hospital for steroid infusions. She was referred for an MRI scan of the right shoulder which was performed on 17th January, 2008 and this showed a small amount of subacromial fluid with evidence of tendinopathy in the supra-spinatus and sub-scapularis tendons. She had a follow-up MRI scan of her neck on 23rd March, 2008 which showed mild degenerative disease of the cervical spine. She was reviewed on 16th September, 2008. The shoulder symptoms had eased but she was complaining of quite a lot of neck pain and on several occasions he noticed "pronounced spasm of her para-cervical muscles". He noted that her mood had become very low and she was most anxious about returning to work because of being ignored by co-workers. In that context he referred her to Dr. Morgan. There had been no history of cervical injury and coupled with the onset of low mood and history of soured relations at work he was of the opinion that her persistent symptoms were stress related. He believed that if she did return to work she would remain symptomatic and her neck pain would most probably get worse: she would be at risk of developing chronic widespread pain syndrome.

43. In the letter of 10th January, 2009 to the plaintiff's solicitors Dr. Mulcahy indicated that on 28th January, 2008 he had been searching for a trigger for her symptoms which may have been caused by lifting heavy objects. He then became aware of the altercation involving a colleague and a suggestion that a trolley had been pushed or tugged while she was pushing it. He believed at the time that this incident brought on the initial physical symptoms. At that stage he considered that both her shoulder and neck injuries first arose and may have become the focal point of her chronic persistent symptoms "driven by[a] significant underlying functional component due to interpersonal difficulties at work". This is the background against which Dr. Morgan was retained and held his initial consultation which resulted in the direction of antidepressant medication and his diagnosis that she was suffering from PTSD in November, 2008. A great deal of the evidence has been directed towards the issue of whether the neck and shoulder symptoms of which Mrs Hurley complains are a result of stress, anxiety and depression occasioned by the bullying and harassment experienced by her rather than a physical deterioration which is entirely unrelated to that experience. A number of medical witnesses called on behalf of the defendant addressed the issue of whether there may be a link between the physical neck and shoulder symptoms exhibited by the plaintiff and the symptoms of stress anxiety and depression of which she also complained.

Professor Kane

44. Professor Kane, a consultant rheumatologist and clinical professor of rheumatology at Trinity College Dublin examined the plaintiff in December 2017. The only residual area of pain that was identified to him was around the neck and shoulder. She had moderate restriction of movement in those areas. There was no muscle spasm. Her movements were normal. There was no muscle wasting in particular on the right as opposed to the left side suggestive of favouring the use of her left arm over the right. She had a slight reduction in hand grip. He did not agree with an assessment made by Mr. Leonard (an occupational therapist) that her right wrist exhibited only twenty per cent grip strength. He concluded that her main problem was due to persistent symptoms from a right supraspinatus tendinopathy associated with right sided neck pain.

45. Professor Kane was satisfied that the plaintiff suffered from three problems which developed at around the same time. She suffered left hip tendonitis – an inflammation of the tendon around the hip treated by the avoidance of strain and analgesia. She suffered wrist tendonitis which also resolved. She suffered neck and shoulder pain which did not resolve. This condition was caused by the fraying of the lifting tendon in the left shoulder. This was identified on MRI scan as having low level inflammation that led to pain. The patient did not use this area. She subsequently developed muscular pain around the neck as a result. The MRI scan showed a disc degeneration in the neck which may also have disposed someone to develop this pain. It was not unusual for somebody to hold the shoulder in a protective way and engage the muscle continuously which would cause a lot of pain around the right side of the neck muscle. He considered that this condition responds to conservative therapy over time namely physiotherapy, avoidance of strain and medication. Professor Kane accepted that stress and anxiety contributed to the plaintiff's symptoms. Thus a small pain may seem much greater if one is in a stressful situation. In addition one might if under stress focus on musculoskeletal symptoms because these are easier to communicate societally than communicating stress or anxiety. Her pain response may have been accentuated by her stress but the neck and shoulder pain were not caused by the stress itself. However, Professor Kane also accepted that she continued to suffer neck and shoulder pain notwithstanding the resolution of the two other conditions. He also accepted that stress could influence the outcome of physical conditions and may overamplify the pain or symptoms exhibited and get in the way of recovery. He stated that a higher level of stress might cause an amplification of pain sensation. He was satisfied to defer to psychiatric opinion on the relevance of PTSD in the plaintiff's case. He could not discount the role of stress in her symptoms. He concluded that while the cause of the original symptoms was unlikely to be stress, the persistence of symptoms might be stress related or due to a developing chronic problem that would have arisen in any event. He accepted that if somebody was in an acutely stressful event it could cause any number of symptoms, including muscle spasm, and if a person suffered from PTSD one could relate

it to a number of well-described sequelae but he deferred to psychiatric opinion in that regard.

Treatment by Dr. Morgan
46. Mrs. Hurley had nine visits with Dr. Morgan between 2008 and 2012. She did not attend with him between 2012 until 2016 when she attended for the purpose of the preparation of a report in the course of these proceedings. She attended Ms. Moore Groarke a Consultant Psychologist over eight visits between 2012 to 2014.

47. Dr. Morgan, like Dr. Fleming, was of the view that in 2008 and into 2009 her treatment was led by Dr. Mulcahy in respect of physical symptoms. He accepted that it was somewhat unusual that stress was not a focal point of her complaints during that period. His initial diagnosis was made on the basis of her history that she was suffering from anxiety consistently since the date of the incident. The plaintiff had informed him that this was so. His report indicated that she was out of work for a period from July, 2006 to September, 2007 which he acknowledged was incorrect. When interviewed she complained of constant anxiety and flash-backs to the incident involving her co-worker. She suffered night terrors and woke up quite distressed. He indicated that people who suffered from post traumatic stress wake up quite upset; sometimes their dreams are not recalled but they have a very broken sleep known as night terrors. These were recurring all the time. He hoped that the Cymbalta would improve her condition and alleviate the severity of her symptoms thereby providing a better prognosis for her condition. He hoped she would return to work. She was treated with antidepressants and supportive psychotherapy by Dr. Morgan. She would address the issues which caused her symptoms and he would give general support and try to decrease anxiety by encouraging her not to dwell on the events that happened and general life advice. He saw her on a number of occasions in this regard. He was not aware that she had stopped taking the antidepressants.

48. Dr. Morgan did not refer Mrs Hurley to a psychotherapist which he often did in such cases. He stated that one had to reach a certain level of recovery before benefiting from more intensive psychotherapy. If a patient suffers from anxiety type symptoms they would not be able to cooperate with that treatment. The depression symptoms had to be relieved before the psychotherapy could be directed. However that stage was not reached with the plaintiff because she did not attend him after 2012. He provided elements of psychotherapy between 2008 and 2012. She was quite distressed during this period to an extent that he described as moderate to severe.

49. He diagnosed post traumatic disorder at a very early stage in his engagement with the plaintiff and therefore directed antidepressants as the appropriate orthodox treatment and medication. He saw her within six weeks of her first visit in order to adjust the dose of antidepressant to get it to the optimum level. He occasionally gave her a prescription but she was attending her own general practitioner who was aware of the medication that she was on. He became aware for the first time during the hearing and listening to the evidence that the plaintiff had only taken her antidepressant medication sporadically. However, he became aware that she had stopped taking antidepressants when he spoke to her in 2016. Had she informed him of this earlier he would have advised her to continue taking them.

50. It appears on the evidence that the first prescription for antidepressants given by Dr. Fleming on Dr. Morgan's instruction was on 5th November, 2008 for Cymbalta. In January, 2009 the plaintiff advised that she had stopped taking Cymbalta but was willing to restart. She continued to take it sporadically until January, 2010 when she attended Dr. Fleming complaining of multiple issues but informed her that she was only partially compliant with the medication.

51. In May, 2012 the plaintiff informed Dr. Fleming that she had stopped taking Cymbalta but did so without referring back to her. Dr. Fleming re-prescribed the drug. This was some four to five months after Dr. Morgan's first report.

52. Dr. Morgan noted that many patients once they think they are improving decide that they do not want to continue with the medication. This is a very frequent occurrence. However, patients are instructed that should they wish to discontinue medication they should do so gradually over a short length of time and if they have side effects to approach their general practitioner. If the patient stops taking the medication symptoms of depression will recur and they will suffer from anxiety and muscular pain. This would likely be short term. If antidepressants are to be effective they need to be taken continuously and regularly every single day and once established this should be continued for at least one or two years. Dr. Morgan stated that the vast number of cases will spontaneously remit in about one or two years. Generally speaking patients stop taking medication when they feel better. He was hoping for a good response from the plaintiff and that she would recover within two years or less. He was surprised that her symptoms had not resolved within that period because in her case he had been very hopeful for a recovery.

53. In July 2016 the plaintiff reported a gradual improvement in her condition over the previous two and a half years. She claimed to have reduced her medication. However, by 2017 symptoms were reported to be more severe.

Dr. Mohan
54. Dr. Damien Mohan, consultant forensic psychiatrist, was retained on behalf of the defendant to provide a psychiatric report on the plaintiff. The plaintiff attended another psychiatrist for the defence in advance of her attendance with Dr. Mohan. Dr. Mohan saw Mrs Hurley once shortly before the hearing. He produced a very lengthy and detailed report for the defendant. He outlined his interpretation of some of the documentation and other material in the case. He outlined her history and also his engagement with her.

55. Dr. Mohan set out some of the plaintiff's pre-employment medical history in the report of Dr. Burns dated 31st January, 2014. In particular he emphasised that following the birth of the plaintiff's first child she had post-natal difficulties "physically and psychology". She had been certified unfit for work after maternity leave in March 1998. He then noted the history of her miscarriage. He stated that following the birth of her second child she then presented with symptoms of anxiety and stress (as already referred to). She was certified unfit to return to work at that time. Though reviewed after one month and deemed fit to return, she felt she was unfit to do so. Dr. Burns at that stage considered the possibility of post-natal depression and prescribed an antidepressant medication. The doctor recorded that when further reviewed in July 2000 the plaintiff felt subjectively unable to return to work. She continued to see her and had notes for September and November 2000 and into 2001 at which stage she still suffered stress and anxiety and difficulty with life stresses.

56. Dr. Mohan considered Dr. Mulcahy's opinion in his report of 3rd November, 2008 in which he states that the plaintiff's persistent physical symptoms were stress related. It will be recalled that when taking sick leave between 28th September, 2007 and 7th January, 2008 the plaintiff complained of hip pain and right shoulder pain. Dr. Mulcahy had concluded that the plaintiff was suffering from a right rotator cuff tendinopathy with impingement and her shoulder was injected. He noted inflammation of her combined tendon sheaths of her right hand with discomfort around her greater trochanter. She was taken into Shanakiel Hospital for two steroid infusions. Dr. Mohan expressed surprise with the conclusion reached that the persistence of her symptoms was stress related in the light of the physical treatment given for her condition. In particular Dr. Mohan stated that there was no psychiatric evidence to support the conclusion reached by Dr. Mulcahy that her shoulder and neck injuries in January 2009 may have become the focal point of her chronic persistent symptoms driven by a significant underlying functional component due to interpersonal difficulties at work.

Professor Kane however appears to accept to an extent greater than Dr. Mohan that stress may have a very significant role in the plaintiff's recovery.

57. Dr. Mohan also disagreed with Dr. Morgan's conclusion that Mrs. Hurley was suffering from Post-Traumatic Stress Disorder. He noted that interpersonal conflict and emotional distress characterises most forms of harassment but do not reach the magnitude of a traumatic stressor that causes PTSD. In particular DSM-IV Criteria for Post-Traumatic Stress Disorder which provided the diagnostic tool to assist psychiatrists state:-

> "Stressor A. The person has been exposed to a traumatic event in which both of the following have been 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 involved intense fear, helplessness, or horror.
>
> Clause B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
>
> (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.
>
> (2) Recurrent distressing dreams of the event. …
>
> (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flash-back episodes, including those that occur upon awakening or intoxicated). …
>
> (5) Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event."

58. In Dr. Mohan's opinion, the plaintiff had a recurrent mixed anxiety depressive disorder, characterised by insomnia, loss of confidence, lack of self-esteem, self-doubt, low mood and a heightened sense of anxiety. She was commenced on antidepressant medication by Dr. Morgan and had made a good response to same. He was satisfied that she was not clinically depressed when he saw her and that given the absence of any attendance for treatment for a considerable period with Dr. Morgan or any other professional her symptoms had improved. However he noted that at the time of interview she continued to have symptoms of anxiety.

59. Dr. Mohan also concluded that the plaintiff had deliberately withheld details of her past psychiatric history (essentially her post-natal symptoms) from Dr. Gillian Moore Groarke ,consultant psychologist. The plaintiff indicated to her that she had no prior psychological or psychiatric history prior to the incident. He also concluded that at interview with him the plaintiff chose not to disclose details of what he termed her extensive past history of mental health problems and medically certified leave from work which predated 2003.

60. Dr. Mohan also concluded that in moving to her mother's home for three weeks after the incident with her co-worker in July 2006 she displayed elements of a pre-existing underlying psychological vulnerability. I am satisfied on the evidence of her co-worker's frightening, threatening and abusive behaviour prior to the incident and immediately subsequent to it that the plaintiff's concerns as a young mother left at home with two very young children on her own in the wake of such an experience and in the knowledge that he was still behaving in a violent and frightening manner in seeking to attend at his workplace were reasonable and entirely rational: going to her mother's house nearby for a period was quite sensible.

61. It is also clear from the evidence that she exhibited no symptoms of depression or anxiety for which she required treatment between 2003 and 2006.

62. The plaintiff's response to what were characterised by Dr. Mohan and counsel for the defendant as "deliberate" omissions of her previous medical history was that she had never thought about the anxiety and stress subsequent to the birth of her children for a "very very long time … only when you … started bringing it up in this, I have never thought about it. It was a long long time ago it is a part of my life that is gone, I have recovered from it completely. I don't think of it. … It was a baby pregnancy related incident, it was that time of my life, it is over, it is 20 years/18 years ago so it doesn't affect me." She had been working very happily in An Post for three years by the time of the incident. She rejected the proposition that she deliberately withheld that information from anybody. As accepted by the defendant and Dr. Mohan it was referenced in the replies to particulars. I am entirely satisfied that in not focusing on this history and relaying it to doctors over the years, the plaintiff was not deliberately intending to mislead them.

63. I also reject Dr. Mohan's further criticism that she was vague in addressing a possible psychological component to a claim which she brought and settled arising out of a road traffic accident on the 5th July, 2010. It was clarified to the court that the claim was settled on the basis of compensation for a physical injury arising out of the collision. There was no psychological or psychiatric component to her claim. I also reject the attempt to characterise the plaintiff as a person who has intentionally advanced false or exaggerated physical or psychological symptoms motivated by financial compensation as advanced as a possibility by Dr. Mohan.

64. It is clear that Dr. Mohan, as set out paras. 25.23 to 25.26 of his report, was satisfied that Mrs. Hurley's depression and anxiety following the verbal altercation in the work place was a reactivation of a pre-existing disorder rather than a new onset disorder. He concluded that she had a medically validated history of anxiety and depression which predated her difficulties in the workplace. This created an underlying psychological vulnerability which influenced her response to the events that may have occurred in the workplace. He considered that a failure to consider her history of pre-existing depression, what he terms the alternative source of stress caused by the road traffic accident of the 5th July, 2010 and her unreliability as a historian would result in a false attribution of her symptoms to the bullying and harassment which the court has concluded occurred in her case.

Dr. Morgan's Response

65. Dr. Morgan rejected Dr. Mohan's assessment of the plaintiff's condition. He had no doubt that she suffered and continued to suffer from anxiety and that her symptoms fitted a diagnosis of PTSD. He was satisfied she came within the DSM-IV or DSM-V classifications for that purpose. He gave evidence that PTSD was both an anxiety and depressive disorder the treatment for which were the same. The mental pain and suffering which the patient suffered was considerable. He was satisfied that whether one characterised it as PTSD or not the plaintiff certainly was depressed and anxious for a considerable amount of time which gave rise to the symptoms of which she complained. He stated that PTSD may occur for many reasons. One may have the condition and not be aware of what the stressor was. It could occur after a car accident or as a result of somebody seeing something on television or an

immediate or horrifying incident. There could be a delay between the time of the incident and when the symptoms first occur. He was not satisfied that the post-natal depression described by the witness and outlined in the medical records should be regarded as anything more than a minor consideration to be taken into account when making the diagnosis. He accepted that she was prescribed an antidepressant up to 2003 following these episodes. It would have been helpful to know this history but it was not very relevant to his conclusion. Post-natal depression was very easily treatable and he considered that most people would not accept that is was a psychiatric illness. It was a hormonal imbalance with an element of inability to cope and was a natural occurrence. It was only relevant when there was a major psychotic depression. This would involve severe symptoms of depression, possible delusions and the possible idea of self-harm. This was not such a case.

66. I do not intend to rehearse all of the evidence. I have referred to the salient points but where there is a conflict between the evidence of Dr. Morgan and Dr. Mohan I am satisfied to accept the evidence of Dr. Morgan.

Conclusion
67. The court is satisfied having considered all of the evidence adduced to accept the diagnosis of Dr. Morgan made following his engagement with the plaintiff in 2008 that she was suffering from a moderate form of PTSD as a result of the incident in July 2006 and subsequent events as a matter of probability. The court in reaching its conclusion has considered and applied the principles and guidance set out in *Kearney v. McQuillen* [2012] IESC 43 and *Shannon v. O'Sullivan* [2016] IECA 93. This is a difficult area in which numerous factors had to be considered.

68. I am satisfied that the continuing symptoms of PTSD depression and anxiety as diagnosed by Dr. Morgan were triggered initially by the incident in July 2006 and were also caused and substantially contributed to by reason of the bullying and harassment to which the plaintiff was subjected thereafter. I am satisfied that the diagnosis was delayed because other avenues and investigations were being pursued to identify an alternative cause to no avail. She was suffering from and treated for anxiety and depression with medication directed by her psychiatrist and prescribed from time to time by her general practitioner. This caused her to experience heightened symptoms of pain in her shoulder and neck. This impinged greatly on her family life and for a time caused her difficulties in executing normal daily tasks. She was treated by Dr. Morgan between 2008-2012 when she ceased to attend with him. He believed her to be on continuing medication over this period. He provided psychotherapy when she attended. The prescription of medication was a prelude to providing her with somewhat more intense psychotherapy. This could not be arranged until her immediate symptoms were relieved by the medication. In some instances further psychotherapy is not required. In her case he was hopeful that a period of two years medication would bring about a resolution of her symptoms. Therefore, he anticipated a likely recovery from what he regarded as a moderate condition within that period. This did not occur.

69. It emerged in evidence and from the medical records referred to in the course of the hearing that notwithstanding the prescription of medication directed by Dr. Morgan, the plaintiff only took it "sporadically". She did not adhere to the regime of medication prescribed for her. She defaulted on numerous occasions. Dr. Morgan was not informed of this during her attendances with him. She subsequently attended with Dr. Moore Groarke consultant psychologist from April 2012 for eight sessions of therapy about which Dr. Morgan was not informed. Dr. Moore Groarke was not informed that she was defaulting in the taking of her medication. From time to time the plaintiff re-attended with her general practitioner for further prescriptions: she was informed of noncompliance with medication from time to time. Dr. Morgan acknowledged that some patients may wish to come off medication but this should be discussed with their medical advisors. I am satisfied that the plaintiff continued to exhibit physical symptoms after that time and this was accepted by Professor Kane and Mr. Neligan whose evidence I have also considered. Mr. Neligan also declined to discount the possibility of a psychological element in the continuing symptoms.

70. I do not accept that the plaintiff resisted repeated admonitions from her employers to return to work in 2008 and 2009 on some unjustified or capricious basis which led to her dismissal in 2011. The medical/welfare department made their own assessments sometimes in the face of ongoing treatment and symptoms a matter considered in the earlier judgment. Furthermore, I do not accept the propositions advanced by the defence that her disinclination to return to work when this was demanded by her employer was contrived or linked to the issuing of legal proceedings. However, I must also consider whether the continuation of her symptoms is to be ascribed to the defendant following the diagnosis belated though it was and the treatment recommended as a result.

71. In January 2010 the plaintiff was only partially in compliance with the medication prescribed. In May 2012 she informed Dr. Fleming that she had ceased taking the medication. She does not appear to have been taking her medication in September 2012 when it was re-prescribed. She said that she then took anti-depressants in 2013 and 2014 and then stopped. There was a very limited engagement by her with those who were treating her. I consider that it is an important feature of the case that there was no contact with Dr. Morgan between 2012 and 2016.

72. I am satisfied that once the condition was diagnosed and a course of treatment commenced, a patient should follow that course of treatment as directed. A plaintiff who does not follow the regime of medication prescribed and the course of treatment ultimately directed by her consultant psychiatrist is not entitled to be compensated for pain and suffering caused by the continuation of symptoms which have not improved largely because she has failed to continue with a conservative and moderate level of treatment. I am satisfied on Dr. Morgan's evidence that it was likely that her symptoms would have resolved if she had adhered to the treatment advised.

73. I have concluded, therefore, the plaintiff is entitled to general damages for continuing symptoms of PTSD anxiety and depression from the date of her return to work in August 2006 for the period up to the end of 2011. I am satisfied that this is the period in respect of which compensation is appropriate following the diagnosis made by Dr. Morgan in 2008 and the course of treatment recommended by him because he anticipated that the plaintiff would make substantial progress in the three to four year period over which he treated her and perhaps within a period of two years. I am not satisfied to conclude that the plaintiff is entitled to damages for further pain and suffering beyond the end of 2011 nor is she entitled to succeed in a claim for loss of earnings beyond that date.

74. I am satisfied that the plaintiff is entitled to general damages in the amount of €50,000.00 for pain and suffering up to the end of 2011.

75. The plaintiff is also entitled to a sum for any loss of earnings sustained between 15th August, 2006 and the date of her dismissal and thereafter up to the end of December 2011. I am satisfied that the plaintiff by reason of her continuing symptoms could not return to work on the basis proposed by her employer in July 2008 and 2009. At that stage she was still suffering acutely from symptoms of stress, anxiety, depression and pain and was under the care of Dr. Mulcahy. She had embarked on a period of treatment under Dr. Morgan. The workplace issues and the plaintiff's workplace difficulties continued into 2008. This is reflected in the correspondence and the court has already expressed its findings in respect of liability on this matter. She is entitled to any loss of earning sustained during the period within which she might reasonably have been expected to undergo the treatment directed on the basis of Dr. Morgan's relatively positive prognosis at that time. She is entitled to net loss of earnings for the period when she was out

of work from 28th December, 2006 until 5th January, 2007, the 28th September, 2007 until 7th January, 2008 and 11th February, 2008 until 15th July, 2011. Thereafter I am satisfied that she is entitled to further loss of earnings until the end December 2011.

76. There is also an agreed figure for an award of other items of special damage in the sum of €4,643.00.

ADDENDUM

77. On the 23rd March, 2018 further submissions were made by counsel in respect of the claim for net loss of earnings in respect of the periods set out above. The calculation of that figure was agreed by the parties as €84,426.00. I am satisfied that the appropriate figure in respect of recoverable benefit under s. 13 of the Social Welfare and Pensions Act 2013 (as amended) as agreed is €39,426.00. It is agreed that the plaintiff will be credited with any pension entitlements accrued up to the 15th July, 2011, the date of her dismissal, but that sum does not form part of the calculation of the sum to be awarded in respect of loss of earnings set out above.

78. The plaintiff also claims interest on that amount pursuant to s. 22 of the Courts Act 1981. An amount of interest has been calculated at €22,064.00 and the court has been informed that the calculation is made from the date upon which the monies would have fallen due for payment in the course of her employment.

79. The court is asked to exercise its discretion in favour of the plaintiff pursuant to s. 22 of the Courts Act 1981 which provides that:-

> "(1) Where in any proceedings a court orders the payment by any person of a sum of money (which expression includes in this section damages), the judge concerned may, if he thinks fit, also order the payment by the person of interest at the rate per annum standing specified for the time being in s. 26 of the Debtors (Ireland) Act, 1840 , on the whole or any part of the sum in respect of the whole or any part of the period between the date when the cause of action accrued and the date of the judgment."

80. Section 22.5(e) precludes the awarding of interest on damages for personal injuries but not in respect of loss of earnings.

81. In.*Reaney & others v. Interlink Ireland Limited* [2018] IESC 13 the Supreme Court considered the exercise of the court's discretion under section 22. O'Donnell J. delivering the judgment of the court stated:-

> "11. It is rudimentary economic theory that money has a time value. The person who has a sum of money over a period can obtain a benefit either in interest on that sum if invested, (or other return on investment) or interest avoided because that sum does not have to be borrowed. By the same token a person who has not received money incurs a cost, in particular if they have had to borrow. By 1981 a decade of inflation had shown that in many cases an award of damages, particularly in commercial or contractual situations, could fall well short of a full remedy for a wronged party because the real value of the award at the conclusion of the proceedings could be substantially less than that monetary amount had been worth in real terms at the time of the breach of contract or the failure to pay. Accordingly s.22 gave a discretion to courts to make an award of simple interest at a rate fixed from time to time under the Debtors Ireland Act 1840. At the time of the introduction of the Act that rate was 11%. It was subsequently reduced to 8%, which was the applicable rate at the time of these proceedings, but has now been reduced to 2% by S.I. No 624/2016 Courts Act 1981 (Interest on Judgment Debts) Order 2016. … even in circumstances where damages are static, or even reducing, the logic that money has a time value should in theory be reflected in an award of interest. Interest is not simply awarded as a remedy against inflation, it reflects the fact that there is a cost in not having the money for a certain period."

82. O'Donnell J. in summarising the principles applicable stated that interest under s. 22 should be awarded when a court concludes that the amount it is awarding is clear-cut and could, and should, have been paid earlier. However where a claim is difficult and requires assessment and determination it may be appropriate not to award interest. It is appropriate for the court to consider all of the relevant features of the case in determining whether to exercise its discretion in making an award of interest in the case.

83. In this case the amount awarded in respect of loss of earnings, arose from the inability of the plaintiff to carry on her duties at work due to the negligence and breach of duty of the defendant to her as an employee. The court accepted the evidence of the effect of this loss of income upon the plaintiff and her household budget. It caused particular hardship and had a direct and continuing negative effect on the plaintiff 's standard of living and that of her family. They lived through hard times in that period without the benefit of that income. I have no doubt that this gave rise to considerable hardship for her and her family as was outlined in evidence during the course of the trial. I do not consider that there is any realistic issue in relation to an absence of diligence by the plaintiff's in pursuing these proceedings sufficient to influence the exercise of my discretion against her. Having considered all of the evidence in the case I am satisfied that it is appropriate to exercise my discretion and award interest on the loss of earnings which is calculated to be €22,064.00 on that element of the loss of earnings which is not part of the sum the subject of repayment under welfare code.

84. I am therefore satisfied to make the following award:-

> General Damages €50,000.00
>
> Loss of Earnings €84,426.00
>
> Interest €22,064.00
>
> Special Damages €4,643.00
>
> Total €161,133.00

I will therefore make an award in the amount of €161,133.00.