THE HIGH COURT

[2015 2 CT]

IN THE MATTER OF AN APPEAL PURSUANT TO SECTION 5 (15) OF THE HEPATITIS C COMPENSATION TRIBUNAL ACTS, 1997-2006

IN THE MATTER OF A DECISION OF THE HEPATITIS C COMPENSATION TRIBUNAL TO THE CLAIMANT, D.J. ON THE 18TH OF FEBRUARY 2015, REFERENCE 4657-13

AND IN THE MATTER OF AN APPEAL OF THE CLAIMANT D.J.

BETWEEN

D.J.

APPELLANT

AND

THE MINISTER FOR HEALTH

RESPONDENT

JUDGMENT of Mr. Justice Bernard J. Barton delivered on the 21st day of February, 2017.

1. This case comes before the Court by way of an Appeal from a decision of the Tribunal delivered on the 18th February, 2015, dismissing the Appellant's claim brought pursuant to s.5 (3A) (a) of the Hepatitis C Compensation Tribunal Act, 1997, as amended, (the Act) in respect of a post traumatic stress disorder (PTSD) which he claims was caused by the death of his mother from the complications of Hepatitis C; she died on the 15th July, 1998. It has been agreed between the parties that that question should be determined as a preliminary issue.

Background.

2. The Appellant, D.J., was born on the 18th March, 1982, and is one of ten children. He has learning difficulties and faired poorly at school; he is functionally illiterate and has an I.Q of 78. His mother contracted Hepatitis C as a result of receiving a contaminated blood transfusion in 1970 at Waterford Regional Hospital following a miscarriage. She was diagnosed virus positive in 1996. Her reaction to the diagnosis was one of devastation: she became depressed and developed a dependence on alcohol to help her cope with what by that time were the serious consequences of Hepatitis C infection which included a rare gastric tumour that caused gastrointestinal bleeding.

3. The relationship between the Appellant's parents was strained; when his mother became ill the Appellant took on much of the responsibility and role of being a carer. This involved looking after many of his mother's personal needs and hygiene requirements during the remaining two years of her life. While the deceased undoubtedly loved all of her children, she was particularly fond of the Appellant on whom she doted and whom she tended to spoil; the progressive deterioration in her health following diagnosis resulted in a reversal of roles.

4. Witnessing the effects on his mother of her final illness, which were horrific and are not in dispute, would have been a very distressing and harrowing experience for an adult never mind a teenager with intellectual and emotional difficulties; the Appellant was only 16 years old at the time of her death.

5. The evidence of the well known child and adolescent psychiatrist Dr. Paul McQuaid, which I accept, is that the Appellant was developmentally immature by several years for his stated age and was not to be viewed diagnostically from the same standpoint as one would view a normal teenager or an adult. As will be seen, this evidence is crucial to the resolution of the question in issue between the parties.

6. On the 18th June, 2009, the Tribunal awarded the Appellant €60,000 in respect of a claim for loss of society, companionship, care and affection brought pursuant to s. 5 (3B) (b) of the Acts. At that time the Tribunal was aware of a number of other claims for loss of society which were being brought by the Appellant's siblings. In making its award the Tribunal found that the Appellant was particularly close to his mother, that he felt the loss of her society keenly and that his claim was distinct from the cases of his siblings.

7. The Tribunal had also been made aware that of the five of the deceased's children then proceeding with claims for loss of society only the Appellant intended to pursue a claim in respect of PTSD; that state of affairs was to alter subsequently. During the hearing of the appeal the Court was advised that seven of the Appellant's siblings had recovered awards for PTSD caused by their mother's death, however, the Court was not made aware of the circumstances of those claims and given the subject matter of the issue between the parties it was considered appropriate and prudent not enquire into them.

8. It follows from the foregoing that the first and foremost question on which the success or otherwise of the Appellant's claim depends and which fell for determination by the Tribunal, as it does on this Appeal, is whether or not the Appellant suffered a PTSD or 'nervous shock' as a consequence of the untimely and horrific death of his mother.

9. Section 5 (3A) (a) of the Act provides:

> *"Where a dependant referred to in paragraph (e) or (j) of section 4(1) is the child, spouse, father or mother of the person who died ('the deceased') as a result of having contracted HIV or Hepatitis C, or where HIV or Hepatitis C was a significant contributory factor to the cause of death, the Tribunal may make an award to that dependant in respect of post-traumatic stress disorder or nervous shock if he or she satisfies the Tribunal that he or she has suffered or is suffering from that condition as a result of the death.*
>
> *(b) In determining whether to make an award under this subsection, the Tribunal shall have regard to any decisions of the High Court or the Supreme Court enunciating principles of law relating to the award of damages for post-traumatic stress disorder or nervous shock, as the case may be."*

It is clear from the wording of these provisions that the category of persons entitled to bring a claim is limited to the 'dependants' of

a deceased person and that whether the claim is in respect of a PTSD or 'nervous shock' the relevant condition must have been caused in circumstances where Hepatitis C was the cause or a significant contributory factor in the cause of death; that it was a significant factor in the death of the Appellant's mother is not in issue.

10. In addition to these requirements, the Tribunal, and the Court on appeal, must have regard to the principles of law relating to these conditions enunciated in the decisions of the Superior Courts.

Diagnosis
11. As long ago as the 16th July, 2002, the Appellant was interviewed and medically assessed by Dr. Saleem Osman, General Practitioner and Psychotherapist. He had the benefit of medical reports prepared by other physicians in respect of the deceased between 1997 and 1998. He made a diagnosis; in his opinion the Appellant was suffering from:

(i) a post traumatic stress disorder,

(ii) depression,

(iii) bereavement,

(iv) a generalised anxiety disorder,

(v) the effects of substance abuse,

(vi) an intellectual impairment – categorised as mild, and,

(vii) a personality disorder – described as asthenic.

12. This diagnosis is of some considerable significance in relation to the issue in question particularly having regard to the weight which the Respondent attributes to the apparent absence of any diagnosis of PTSD during the Appellant's admission to and treatment in Waterford Regional Hospital between the 24th and 25th February, 2002, an absence which was especially relevant in circumstances where, as in this case, the Appellant's psychiatrists had assessed and reported on him years after the event.

13. However, close examination of his reports and of his evidence discloses that the Appellant's hospital admission and the reasons for it were known to Dr. Osman at the time of his assessment and diagnosis the following July. He subsequently reassessed the Appellant over a number of years and provided further reports, the last of which is dated the 13th April, 2014, in which he reiterated his diagnosis and opinion. He also gave evidence of his diagnosis and opinion to the Tribunal.

14. In the run up to the hearing on the 23rd July, 2014, a substantial claim for past care, future care and future accommodation was made for the first time as a result of which the Tribunal indicated that it required the opinion of a consultant psychiatrist and retained Dr. Kenneth Sinanan. The Appellant consulted and retained Dr. Cryan; both psychiatrists gave evidence at the adjourned hearing on the 10th December, 2014, and subsequently at the hearing of the appeal.

Conflict of Medical Opinion
15. There was a complete conflict of opinion between the experts as to whether the Appellant had suffered from PTSD or from a prolonged grief reaction being either complicated grief, prolonged grief and depression or a depressive adjustment disorder as a result of his mother's death. Both psychiatrists reiterated their diverging opinions on the hearing of this appeal at which Dr. Paul McQuaid also gave evidence on behalf of the Appellant.

Findings and Decision of the Tribunal
16. The Tribunal found that the Appellant had been shocked by his mother's death and had experienced feelings of disbelief and numbness, that he had suffered greatly, had attempted self harm and that he had suffered a significant and prolonged psychiatric illness, notwithstanding, it proceeded to dismiss his claim in the following circumstances.

17. Observing that the Appellant had been examined by a psychiatric team at Waterford Regional Hospital in 2002, just four years after his mother's death, which involved a full psychiatric work up but as a result of which no finding of post traumatic stress or shock induced psychiatric disorder had been made and further having regard to the conflicting psychiatric evidence, particularly concerning the nature of the illness from which the Appellant was undoubtedly suffering, the Tribunal concluded that it had been placed in a position where it could not prefer the opinion of one expert over the other. Accordingly, the claim was dismissed on the basis that the Appellant had failed to establish that he had suffered PTSD caused by his mother's death.

18. In reaching its decision the Tribunal had had regard to the provisions of the Act and the relevant Superior Court decisions enunciating the principals applicable to 'nervous shock' claims. In considering the provisions of subsection 5 (3A) (a) regard was also had to the factual and circumstantial context which would have been known to the Oireachtas at the time of enactment and about which the Tribunal observed that "…victims were suffering horrific deaths where there were incidents of spontaneous and uncontrolled bleeding being witnessed by dependants. Relatives were witnessing body bags, masked and protected medical attendants in their homes and in hospitals and many other examples of profoundly alarming and deeply shocking circumstances in the final moments of a loved ones life which were outside what could be described as shock in the normal experience of death which is universal."

19. I have quoted this passage from the judgment of the Tribunal to illustrate the point that although he did not witness his mother's death and fully expected her to return from hospital, as she had done on previous occasions, many of the shocking circumstances referred to, including spontaneous and uncontrolled bleeding and vomiting, were experienced by the deceased and were witnessed by the Appellant up to the time when he saw his mother being taken away from the family home by ambulance on a stretcher.

20. The Tribunal also appears to have considered that the intermingling use of legal and medical terminology in the subsection, namely PTSD and 'nervous shock', had placed it in a difficult position. The Act did not define 'nervous shock' nor was an exact definition to be found in a legal authority. Accordingly, and having been unable to determine whether or not the Appellant had suffered PTSD, the approach taken was to consider whether or not the Appellant could recover compensation otherwise for 'nervous shock'. It follows, having regard to the question in issue, that the meaning of 'nervous shock' in the provision clearly deserves attention.

21. At the hearing of the Appeal it was submitted on behalf of the Respondent that the question was more limited than the approach apparently taken by the Tribunal since the case presented on behalf of the Appellant had been confined to PTSD. I note in passing that Dr. Sinanan considered that while the Appellant had suffered from depression, which is a medically recognised psychiatric illness,

he thought that more likely attributable to a combination of a prolonged or complicated grief reaction and misuse of alcohol and illicit drugs. Significantly, he observed that there was an evolving and ongoing debate between psychiatrists as to whether or not a severe and persistent grief and mourning reaction, described as a persistent complex bereavement disorder, should be considered or classified as a psychiatric disorder at all. Critics suggest that to do so results in characterising a natural response to death as pathology.

Meaning of 'nervous shock'.

22. The aetiology of the term 'nervous shock' is to be found in the jurisprudence of the 19th century where the legal penchant for categorisation survived the passing of the Judicature Acts. It was recognised in Ireland as an illness actionable in law in *Byrne v. Great Southern and Western Railway Co. of Ireland*, Court of Appeal, February, 1884, cited by Palles C.B. in *Bell v. Great Northern Railway Co.* (1890) 26 L.R. Ir. 428 (CA) at 442, where he considered 'nervous shock' to be an "injury to the nerve and brain structures of the body" caused by fright or shock. It is an imprecise legal term which has long since been surpassed by advances in medical science. Indeed, as long ago as 1983 Lord Bridge of Harwich in his judgment in *McLoughlin v. O'Brien* [1983] 1 AC 410 (HL) at p. 432 referred to 'nervous shock' as 'a quaint term' which lawyers persist in using.

23. And so it has survived in modern jurisprudence and finds its way onto the statute books through the provisions of s. 5 (3A) (a) on foot of which these proceedings arise. The contemporary meaning of 'nervous shock' was considered and explained by Denham J. in *Mullally v. Bus Eireann* [1992] 1 I.L.R.M. 722 at p 730 as "…an old term covering post traumatic stress disorder" such condition being an example of the type of psychiatric illness which may be caused by the shock of the tortfeasor's negligent act. Subsequently, in *Kelly v. Hennessy* [1996] 1 I.L.R.M. 321 Hamilton C.J. referred to the term as one which had been used to describe "…any recognisable psychiatric illness..." which to be actionable must be shock induced.

24. Section 2 of the Civil liability Act 1961 defines "personal injury" as including any disease and any impairment of a person's physical or mental condition and provides that "injured" shall be construed accordingly.

25. Recovery of damages for personal injury is governed by the law which in addition to setting out the principles to be applied and the requirements that must be satisfied before an award and judgment can be given establishes the boundaries or limits beyond which recovery is not permitted.

26. In that regard it is now well settled that psychiatric illness unaccompanied by physical injury and caused otherwise than by fright or shock is not actionable at common law even though it is reasonably foreseeable that it might likely be the consequence of a negligent act. The point was exemplified in *Jaensch v. Coffey* (1984) 155 C.L.R. 549, approved in *Kelly v. Hennessy*, and in *Fletcher v. Commissioners of Public Works* [2003] 1 I.R. 465 at 481, where Brennan J. at p. 565 observed "The spouse who has been worn down by caring for a tortiously injured husband or wife and who suffers psychiatric illness as a result goes without compensation; a parent made distraught by the wayward conduct of a brain damaged child and who suffers psychiatric illness as a result has no claim against the tortfeasor liable to the child.

27. The relationship between fright and shock resulting from a tortious event or series of events and the consequent development of a psychiatric injury is predominately, if not exclusively, dependent upon scientific and medical evidence, see the judgment of Palles C.B. in *Bell v. Great Northern Railway Co.*, ante. Over time diagnostic medical criteria have been developed for the purposes of assisting and enabling the diagnosis of psychiatric illnesses. There are two systems of classification which are widely used by the medical profession as a categorisation of and aid to the diagnosis of psychiatric disorders; the Diagnostic and Statistical Manual of Mental Disorders, now in its fifth edition (DSM-5) which was relied upon by the Appellant's physicians and the World Health Organisation's International Classification of Diseases (ICD-10) upon which Dr. Sinanan relied. Both are similar but different in some respects.

28. Dr. Sinanan explained that he preferred ICD-10 because it was shorter, more precise, more common sense and less complicated. So far as the DSM criteria were concerned he preferred DSM-4 over DSM-5 because under the former the patient had to experience a trauma that was outside the normal experience of life.

29. Reliance on one classification or the other is a matter of clinical judgment or preference, however, the purpose of each is the same; namely, to categorise and act as an aid to physicians in the diagnosis of a myriad of mental disorders.

30. Dr. Cryan explained that she had used DSM 5 and ICD-10 in clinical practice. She emphasised, however, the importance of using one classification or the other; it was not clinically appropriate to intermix the two. She had assessed the Appellant and prepared her reports using DSM 5 as it was her understanding that the DSM classification had been legally recognised in Ireland.

31. In the context of proceedings to recover damages for "nervous shock" DSM 3-R introduced the criteria for the diagnosis of PTSD which were accepted by this Court in Mullally v. Bus Eireann, ante, at p. 728. Since that time the criteria have been developed and refined on the basis of study, research and clinical experience; the most recent iteration of which are contained in DSM 5 used by Dr. Cryan and Dr. McQuaid.

32. On all the medical evidence it was accepted that which ever classification is used it is a prerequisite criterion to the diagnosis of PTSD that there is an exposure to an initiating stressor. For the purposes of DSM 5 these are comprised in criterion (A) which provides:

> *"Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:*
>
> *1. Directly experiencing the traumatic event(s).*
>
> *2. Witnessing, in person, the event(s) as it occurred to others.*
>
> *3. Learning that the traumatic event(s) occurred to a close family member or close friend. In case of actual threatened death of a family member or friend, the event(s) must have been violent or accidental.*
>
> *4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., the first responders collecting human remains; police officers repeatedly exposed to details of child abuse).*
>
> *Note: criterion 4(A) does not apply to exposure through electronic media, television, movies or pictures, unless this exposure is work related."*

33. Criterion (A) in DSM 4 was divided into two parts:

"(A1) The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.

(A2) The person's response involved intense fear, helplessness or horror."

It is clear therefore that whilst criterion A1 in DSM 5 has been altered and expanded, criterion A2 of DSM 4 has been eliminated in DSM 5.

34. The subsequent criteria are concerned with the intellectual and behavioural responses to the stressors; these are considerably expanded and modified in DSM 5. The development and refinement of the criteria since the DSM 3- R version, accepted in *Mullally v Bus Eireann*, is readily apparent when a comparison is made with DSM 4 and DSM 5. Thus the first criterion in DSM 3 was expressed as "exposure to a recognisable stressor trauma outside the range of usual human experience, which would evoke significant symptoms of distress in almost anyone." This is very similar terminology to that used in the current ICD-10 Criterion (A) and DSM 4 (A1). It was the modification and alterations contained in DSM 5 that were not favoured by Dr. Sinanan.

35. However, it appears that even under the earlier versions of the criteria the physicians who assessed the Appellant since as long ago as 2002, including Ms. Jo Campion, Clinical Psychologist, whose report dated 26th February, 2010, has been considered by the Court, have all concluded that he had suffered a PTSD.

36. For my part I adopt the views of Thorpe LJ. in *Vernon v. Bosley* (No1) [1997] C.A. 1 All ER 577 at p 610 and 611, for the reasons given there, that these classifications should not be adopted in personal injury litigation as the yardstick by which the Plaintiff's success or failure is to be measured. As the ongoing debate between psychiatrists referred to by Dr. Sinanan and evidenced in the ongoing review of DSM 5, psychiatric illness is too complex and insufficiently concrete to be subjected to rigid analysis.

37. Although they are undoubtedly useful diagnostic aids and guidelines to and accepted by the medical profession, when considering whether or not a litigant has suffered a shock induced psychiatric illness the DSM and ICD classifications should be approached by the Court with caution. It is not the classifications which are the determinant of what is or is not a psychiatric illness rather that is a question which must be determined by the Court on the basis of the medical evidence before it. For the purposes of this judgment I am not to be understood as preferring one classification over the other in order to resolve the question in issue; both are considered valid by the profession for which they are designed to be of assistance. The question in issue must be decided on the evidence and in accordance with the principals of law which are to be applied. 'Nervous shock' means any medically recognised psychiatric illness which has been induced or caused by shock recovery of damages for which is regulated by law.

The law.
38. The principles to be applied to a claim for damages for PTSD caused by negligence were set out by Hamilton C.J. in *Kelly v. Hennessy*; these may be summarised as follows:

(1) The plaintiff must establish that he or she suffered a recognised psychiatric illness;

(2) The plaintiff must establish that his or her recognisable psychiatric illness was shock induced;

(3) The plaintiff must prove that the nervous shock was caused by the defendant's act or omission;

(4) The nervous shock sustained by a plaintiff must be by reason of actual or apprehended physical injury to the plaintiff or a person other than the plaintiff, and,

(5) The plaintiff must show that the defendant owed him or her a duty of care not to cause him or her a reasonably foreseeable injury in the form of a shock induced psychiatric illness.

39. Whilst the Tribunal, and the Court on appeal, must have regard to the decisions of the Superior Courts in relation to these matters, the case law must be read in conjunction with the terms of the subsection and against the backdrop of the statutory scheme established by the Act, the effect of which is to exclude or render unnecessary the satisfaction of the third, fourth and fifth of these requirements. For the reasons, which I adopt, see the judgment of Irvine J. in *S.C. v. The Minister for Health and Children and Anor* [2012] IEHC 49.

Decision
40. I had an opportunity to observe the demeanour of the Appellant when he gave his evidence. I am satisfied that he is a reliable witness and gave truthful evidence which it is not intended to summarise but which I accept. Suffice it to say that the Appellant formed a bond with his mother during her final illness which went far beyond that of the ordinary and normal relationship between a mother and son of his age. He helped to feed her, to wash her, to give her painkilling medication, to massage her, to help her mobilise, to keep her company, to comfort her and to clean up afterwards when she vomited blood and mucus, something which occurred with ever increasing frequency as she neared the end of her life.

41. The level of devotion to and care of his mother and his two younger sisters, who were still living at home, was such that he missed out on his education, attending school infrequently. That his mother literally became the centre of his life is not an exaggeration. He did not believe and did not know how to respond to his mother when she told him in the weeks before her death that she was dying. He could not contemplate life without her and his disbelief on being told by his brother of her death was not surprising.

42. The Appellant described how, in the final weeks of her life, his mother, by then very frail, gradually began to stop eating and her skin became tanned; towards the end she took on a ghostly appearance. The deceased had been taken to hospital on a number of occasions during the last two years of her life because of tumour related vomiting and other complications of Hepatitis C infection. After stabilisation in hospital she had always returned home, something which was usual in the experience of the Appellant to the point that it was expected.

43. I accept the evidence and find that when she was taken to hospital from her home by ambulance for what transpired to be the last time, the Appellant still believed that his mother would once more return notwithstanding that to the ordinary observer she would obviously have been gravely ill. Her final days were horrific, punctuated by constant vomiting and terrible pain which worsened in intensity to the point that the poor woman would scream in agony; at least in that respect death must have come as a mercy.

44. The Appellant's life changed beyond all recognition after the death of his mother. He was in disbelief when told of her death by his

brother and did not know what to think or how to react to the news; shock, numbness, devastation, disbelief and depression followed. He developed bizarre behaviours which included sleeping on his mother's grave and burying personal articles, such as holy medals, under the stones covering the grave. To deal with the mental pain and emotional turmoil he started drinking alcohol for the first time which in turn led him to taking drugs; his life literally fell apart. He was angry with his father, whom he blamed as well as himself for his mother's death. He felt his life was over and could not believe that his mother was gone. He developed intrusive thoughts, disturbing dreams, nightmares, and flash backs which included scenes of his mother being removed from the house on a stretcher with her hand up in the air, then of seeing her laid out and being lowered into the grave.

45. The Appellant became emotionally detached; not being able to accept his mother's death he avoided talking about or otherwise confronting it. He was distressed by his disturbing dreams and became clinically depressed which ultimately led to self harm when he cut his wrists with a boning knife in 2002. I pause to observe here that it was agreed between the parties and, indeed, the psychiatrists are at one, that the Appellant suffered a severe and prolonged grief reaction which manifested itself in denial, anger, depression, lying on her grave, crying in memory of her, sadness and yearning.

46. In addition, however, there were feelings of self-blame, together with sleep disturbance, nightmares, intrusive thoughts, avoidance behaviour, emotional detachment, irritable mood and hyper arousal. It was accepted by the psychiatrists that many of the behaviours experienced and seen in grief are also shared and seen in PTSD. The essential difference between the psychiatrists and psychologists for the Appellant and Dr. Sinanan so far as the diagnostic criteria are concerned, is that as Dr. Sinanan did not consider that the Appellant satisfied criterion (A1) in DSM 4 or ICD-10, accordingly, although he had experienced responses seen in both PTSD and a severe grief reaction he did not satisfy the initiating and essential criteria for a diagnosis of PTSD whereas the evidence on behalf of the Appellant was that such a diagnosis was warranted as that criterion in DSM 4 and DSM 5 was met.

47. With regard to his opinion, Dr. Sinanan considered it particularly significant that when the Appellant was admitted to Waterford Regional Hospital in 2002 following the attempted suicide no diagnosis of PTSD had been made by the medical team who had assessed him. If there had been specific features indicative of post traumatic stress disorder he would have expected these to have been recorded, however, perusal of the notes suggested otherwise.

48. In relation to the absence of any PTSD diagnoses in the hospital notes, Dr. Cryan gave evidence of her experience of over 20 years as a consultant psychiatrist in a busy emergency department of a major hospital. While ordinarily one would expect that features of PTSB, if apparent, would have been noted, she explained that in the case of the Appellant one had to bear in mind that at the time he was abusing alcohol and drugs and that as soon as he was in a position to do so he had informed the hospital that he wished to be discharged.

49. The circumstances leading to the admission also had to be considered; the Appellant had taken a boning knife to his wrists. Although the lacerations were not deep enough to be fatal he had been found in a blood soaked bed by his brother in law at a time in his life when he was depressed and had been thrown out of his home by his father because he was seriously abusing alcohol and drugs.

50. On the basis of her experience, the main focus of the medical team would have been to concentrate on the Appellant's safety rather than on anything else. They clearly felt that there were psychological issues as evidenced by making an out patient appointment for him but which he failed to keep. In her view the fact that no diagnosis of PTSB had been made in Waterford Regional Hospital did not mean nor could it be concluded that the Appellant had not suffered or was not suffering from PTSD.

51. Although there were many features in the Appellant's intellectual response and behaviour to the death of his mother common to both grief and post traumatic stress, in the view of the Appellant's psychiatrists, the intensity duration and presence of features which were more commonly seen in PTSD and which were present warranted and were consistent with a diagnosis of PTSD.

Were the consequences shock induced?

52. Relying on the evidence of Dr. Sinanan, the Respondent's case was that the death of the Appellant's mother was part of life's experience. Many teenagers of the Appellants age have the unfortunate experience of watching a parent die at different stages of life, sometimes very unexpectedly, from a serious illness. The death of that parent would undoubtedly provoke all of the symptoms and behaviours commonly found in and associated with grief. It was submitted that this is precisely what had happened to the Appellant except that his grief was severe and had remained unresolved for a prolonged period of time; it had led to the development of anti-social and criminal behaviour and other unfortunate consequences but it was not a post traumatic stress disorder.

53. Dr. William Kinsella is an educational psychologist. He prepared a report, dated 22nd December, 2011, for the hearing before the Tribunal which the Court has read and considered. The report illustrates the educational and intellectual problems experienced by the Appellant. In her evidence Dr. Cryan emphasised the importance of viewing the Appellant from a subjective perspective. Account had to be taken of his intellectual and emotional development leading up to and at the time of his mother's death. He was not to be seen or treated as an ordinary, average, normal teenager; developmentally he was emotionally and intellectually several years behind his stated age.

54. While accepting that most teenagers would likely be able to deal with and would likely experience grief alone on the death of a parent, Dr. Cryan's view was that the Appellant had pre-morbid vulnerabilities both emotionally and intellectually which predisposed him to suffering PTSD. When those vulnerabilities were taken into account in the particular circumstances of the case, the death of his mother was not only a shock but what she described in evidence as a catastrophic shock to him; I accept that evidence.

55. The nature of the question in issue between the parties is such that I consider it appropriate to the task of resolution that the correct approach to be taken by the Court is a subjective one and that what has to be considered are the particular circumstances pertinent to the Appellant surrounding, at the time of and immediately following his mother's death.

Conclusion

56. When that exercise is undertaken it is hard to conceive of a relationship between mother and son which could have been closer. Having regard to his pre morbid vulnerabilities in emotional, intellectual and educational development I am quite satisfied in the circumstances leading up to what was for him an unexpected event, that the death of his mother and learning of that from his brother was a catastrophic shock which caused PTSD together with a sever prolonged and unresolved grief reaction.

57. For the purposes of completeness, I would add that although damages for normal grief and bereavement suffered as a result of another's negligence are not recoverable otherwise than for mental distress and suffering as provided for under Part IV of the Civil Liability Act 1961, as amended, and under the Act, a pathological grief disorder (PGD) (grief which becomes so severe as to be regarded as abnormal and giving rise to a recognised psychiatric illness) caused by the death of a person where Hepatitis C was a

significant contributory factor in the death, comes within the meaning of 'nervous shock' in s. 5(3A) (a) of the Act. For a discussion on- recoverability in respect of a Pathological Grief Disorder (PGD) See *Vernon v. Bosley*, ante.

58. Fortunately, so far as the present is concerned, the Appellant has come a long way. He has found some solace in his life and now benefits greatly from counselling. He has given up abusing alcohol and using illicit drugs; he lives with his sister Christine and her husband Andrew Hepburn for whom he works one day a week. Although he continues to grieve for his mother he has become more accepting of her loss and when he was assessed in 2014 by Dr Cryan she considered that the features of his PTSD had essentially resolved in 2010.

Ruling

59. Having regard to the findings made and the conclusion reached that the Appellant suffered a PTSD as a result of his mother's death on the 15th July, 1998, from the complications of Hepatitis C, the Court rules that he is entitled to pursue a claim for an award of compensation pursuant to s. 5(3A) (a) of the Act.

60. I will discuss with Counsel the final form of the Order to be made with respect to the reliefs sought on the Notice of Appeal.