Case No: A83YP866

IN THE COUNTY COURT

Manchester Civil Justice Centre,
1 Bridge Street West,
Manchester,
M60 9DJ

Date: 31st March 2017

HIS HONOUR JUDGE P. R. MAIN QC

Between :

MARY TERESA MAGUIRE	**Claimant**
- and -	
CARILLION SERVICES LIMITED	**Defendants**

Marcus Grant (instructed by **Brian Barr, Solicitors)** for the **Claimant**
Shaun Ferris (instructed by **Kennedys, Solicitors)** for the **Defendants**

Hearing dates: 5th – 9th December 2016
Draft judgment handed down 27th January 2017

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JUDGMENT

In the course of this judgment, I will refer to the trial bundles presented by the parties. The 6 main trial bundles I will refer to, will be by reference to the bundle number and page reference ***(B../page..)****. I will also refer to the parties' respective closing written submissions, for which timely preparation, I am very grateful*[1].

Introduction

1. The Claimant was born on 7th August 1957 and she is now aged 59 years 4 months. At all material times and until 31st March 2014, the Claimant was employed by HMRC as

[1] I should also place on record my gratitude for the excellent indexed Chronology prepared by Mr Grant.

a Higher Auditor in Internal Audit. In November 2011, the Claimant was working on secondment at the Defendants' premises located on the 2nd floor of Ralli Quays, Stanley Street, Salford, Manchester ("the premises").

2. On 25th November 2011, at about midday[2], when in the course of returning and ascending to the 2nd floor of the premises, using the 'scenic' lift, she alleges she suffered accidental injuries, loss and damage after the lift suffered interference and damage in the course of its ascent. There is no dispute as to the happening of the event and negligence in respect of such happening, has been admitted by the Defendants, their servants or agents.

3. On 21st November 2014, proceedings were commenced. In due course, the matter was transferred to the Manchester County Court. Directions were given by district judge Thexton on 13th July 2015, allocating the claim to the multi-track with a case management conference being diarised for 24th September 2015.

4. On 24th September 2015, district judge Obodai gave extensive case management directions - directions which seem to have been successful in presenting the claim for a pre-trial review on 2nd November 2016. The matter has remained in the county court, although as the Claimant's updated schedule of damage suggests, the Claimant has continued to experience very significant ongoing symptoms and seeks damages and interest at a figure just shy of £560,000.

5. Liability for the incident has not been seriously disputed and an 'open' concession of liability was made on 11th January 2013. The presentation of the Claimant in the context of her physical and psychological injuries is a complex one - not least, as a consequence of the Claimant's underlying pre-morbid ailments - to which, I shall return in the course of this judgment. However, a further complicating feature arises, following a decision by the Defendants' insurers to undertake covert surveillance of the Claimant, which commenced on 18th July 2014 and subsequently proceeded on 11 subsequent occasions, to 17th November 2015.

6. On 18th April 2016, deputy district judge Jones gave permission for the Defendants to rely on this surveillance evidence and admit it in evidence - I will return to the relevant surveillance later. However, the fact of the surveillance and the issues raised therein has rather set the tone for this claim. Whatever may or may not have happened on 21st November 2011 (and the Claimant is put to strict proof of any injuries that may have come about), the Defendants dispute any serious effect or long term injury was caused - physically, at most, a modest soft tissue injury, the symptoms for which could be measured in weeks and a short term aggravation of a <u>pre-existing</u> condition of fibromyalgia or a somatoform disorder. A 'long stop', of at most 6 months of causative symptoms, is asserted. Additionally, paragraph 2A of the Amended Defence **(B1/55)** now asserts that the Claimant's current and ongoing presentation before the court is fabricated - <u>fraudulent</u>, being the product of deliberate and serious exaggeration of the effects of any minor injury she may prove she did suffer at the time with the sole motive of financial gain and maximising any damages recovery. I will come to the defence shortly.

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[2] In fact, a later accident report following an investigation gave the timing of the incident at 13.21 hours **(B4/2511)** but nothing will turn on this discrepancy.

7. The trial conducted before me has therefore been confined to an assessment of the Claimant's alleged injuries, loss and damage arising out of the accident. I heard no evidence on the issue of liability.

The Claimant's employment

8. The Claimant commenced employment with HM Customs & Excise under a contract dated 31st October 1989 (**B3b/2073**), at the age of 32 years. Her position was an administrative assistant. Her health declaration form signed on 2nd August 1989, disclosed that she suffered from epilepsy - a condition diagnosed in August 1986, for which she took daily medication[3]. Otherwise, the Claimant stated she was in unremarkable health, save for the removal of an ovarian cyst during a pregnancy in 1986. I have not been made aware of the Claimant's academic credentials and attainment at school or in further education. I note from the history elicited from the Claimant by Professor Green in November 2013, that she left school at 16 years having attended St James Junior and Senior schools in Bootle. I understand initially the Claimant went into nursery nursing but did not see through the training and then gravitated into office work, before joining Customs & Excise.

9. I note the Claimant's obstetric history - she has three sons[4] living and suffered 3 stillborn pregnancies in the 1980s. Her 2 younger sons appear to have been born while the Claimant was working with Customs & Excise.

10. Having joined Customs & Excise, the Claimant worked her way up the promotional and pay scales - to administrative officer in September 1994 (**B3b/2086**) and rising to higher internal auditor by the time of the accident under review. The rise in her salary scales while at (what became) HMRC suggest she achieved separate scale promotions on 31st March 2005, 31st May 2007 and 31st March 2008 (**B3b/2373**). However, as the Claimant herself acknowledges, she aspired to attain a 'Senior' officer promotion and to that end, was required to attain certain post-graduate 'advanced' auditor practitioner qualifications, as set out by the Institute of Internal Auditing (IIA) reflected in the modules[5] leading to membership of the Institute (MIIA).

11. On pursuing her full membership, the Claimant after 4 attempts over 6 years, had just come up short. She stated that she had passed 9/10 modules to October 2010. In fact, this assertion appears inaccurate - it looks as though the Claimant had failed to pass module 'M3 Risk Audit Assurance' and had yet to Pass M4. In fact, as the email from Nic Martin of the IIA confirms (**B4/2588**), by the time of the accident, the Claimant had passed M3[6] but she had still not passed M4[7].

12. It is common ground that at about this time, HMRC was re-organising and rationalising its audit resources - numbers in the Claimant's department were being reduced. On 12th October 2010, the Claimant was notified, after seemingly having failed M3 a 4th time, that she was being removed from the Internal Audit training programme with a view to be transferred to other working. The Claimant disputed

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[3] It appears that this was a misdiagnosis that was clarified some years later.
[4] Currently aged 39, 26 and 23 years.
[5] Those modules were confirmed by the IIA as M1 – "*Strategic Management*", M2 – "*Financial Management*", M3 – "*Risk Assurance and Audit Management*" and M4 – "*Advanced Internal Auditing Case Study*" (**B4/2588**).
[6] See the confirmation letter from HMRC of 7th February 2011. There is also some suggestion that she passed M3 before she passed M2, as her letter of congratulation for the latter, is dated August 2011, 7 months after her letter relating to M3 (**B4/2590**).
[7] She appears not to have passed M4 after her re-sit on 24/11/11, the day before her accident.

this decision and asked for an internal review by letter of 9th November 2010 (**B3b/2173**). The Claimant reminded her managers that she was 'disabled' - due to a constitutional bilateral sensorineural hearing loss[8], requiring the use of hearing aids and a personal loop system. Making reference to the Disability Discrimination Act 2005 and the new Equality Act 2010 (that had just come into force), she implied 'indirect' discrimination and sought adjustment.

13. On 12th November 2010, the Claimant was reinstated onto the Internal Audit Training scheme and given the opportunity of retaking the relevant module(s). She successfully was able to extricate herself from the HR re-deployment pool, at least for the time being. Due to this thinly veiled discrimination assertion, HMRC followed up the notification with an appointment for the Claimant to be assessed by Occupational Health on 19th January 2011. This assessment was undertaken by Ruth Billington and some additional hearing appliances were recommended (**B3b/2182**) - this being a personal loop system. However, what is not established was that the cause of the Claimant's failure to pass the outstanding module(s) had anything to do with her well established hearing difficulties.

14. Nevertheless, as the Claimant's line manager, Nigel Merchant seemed to make plain in answering questions posed by the Claimant's solicitors on 13th May 2015, the Claimant was required to re-sit the final module (M4) of her Advanced diploma exams and she would have had that opportunity in June 2012 - however, it was pure speculation to assume she would have passed it. In answer to the 4th question (**B4/2535**), he seemed to be clear that to progress to a 'Senior Officer' grade, the Claimant would need to have passed, all the modules of the Higher diploma.

15. As I shall return to, regardless of whether the Clamant remained in the audit department and the need to pass M4, the Claimant alleged she had the offer of a post in Liverpool, which would have raised her up the salary scale and secured her working with HMRC until her normal retirement. Whilst her contract did appear to provide for her normal retirement at the age of 60 years, the Claimant is confident she would have wished to have gone on working until at least 65 years and possibly until her State retirement age, at age 67 years. No doubt in this context, asserting possible sex and/or age discrimination, the Claimant would have sought terms of employment no less advantageous that those available to her male counterparts at HMRC.

16. The Claimant does not appear to have been able to return to working. She was still off work at the time of a later road accident on 26th May 2012 (**B4/2724**). Her employment with HMRC was terminated on 31st March 2014. The Claimant has not returned to any form of remunerative employment.

The accident

17. The Claimant described that having entered the lift, the doors closed and it appeared to ascend quite normally. Before the lift reached the 2nd floor, she was aware of a severe grinding noise, with the sound of metal moving and cracking - this caused the lift itself to jump about and judder, causing her feet to leave the floor of the lift on several occasions although the Claimant was able to remain standing at all times. She was then suddenly aware of an intense and fast vibration passing through her body which culminated in what to her felt like an 'explosion'. The lift having shuddered to a

[8] See the letter from Dr Cardwell, registrar in Otolaryngology of 22nd October 2002, for a useful summary of the hearing issues (**B3a/1186**).

halt – after having remained in suspended animation for what seemed to the Claimant to be an eternity, it slowly then continued upwards – the doors opening at the 2nd floor. The Claimant was able then to step out of the lift.

18. Stepping out of the lift, on the Claimant's account, was not easy – by this time, the Claimant was in severe shock – she had to force herself to move her feet to step out – by then, all her muscles were shaking like 'jelly'. She then very gingerly, using the handrail, negotiated the stairs to the ground floor. Her initial instinct while still in the lift was that a bomb had gone off – everything seemed very quiet immediately after – she was terrified the lift was going to fall and she felt helpless either to prevent it or help herself. Her mind was extremely agitated and so it remained.

19. On returning to the ground floor, on looking towards the lift, she could see glass everywhere. She was then able to summon assistance. HMRC staff were able to assist her up the stairs to the 2nd floor, where she was able to get back to her desk. In fact, a window that was able to open inwards into the lift shaft at first floor level, had been opened and left open. The upper part of the lift had then ascended into contact with the window and evidently had been able to push past it, breaking the window and twisting the frame. However, the lift capsule itself had remained intact and the Claimant as occupant, physically undisturbed by any debris. The photographs taken immediately after the event, exhibited to the Claimant's 1st statement[9], show the twisted frame of the external window, forced up between the outside of the lift and the external panoramic lift shaft. The glass of the lift itself appears to be quite in-tact.

The accident aftermath

20. An ambulance call was received at 14.00 hours (**B3a/1170**) and a paramedic crew was on the scene at 14.22 hours. The account recorded by the paramedic was:

    "...The pt said her feet left the ground x2 – she was shaken + felt unwell. Pt felt shaky + had to lie on the floor of the office. Pins + needles in arms + legs which did disipate once crew arrived. ° LOC. Normal colour ° sob. The Pt then began to C/O lumber pain, lot pn to ® of spine. Pn...pressed by P15188. Muscular. Brufen + paracetamol eased the pn..." (sic)

    At 15.01 hours, the ambulance left the scene and the Claimant was conveyed to the accident unit of the Manchester Royal Infirmary (MRI). On arrival at MRI, the Claimant was clerked in by a triage nurse at 15.19 hours (**B3a/1169**). The Claimant is recorded as having entered the accident unit 'self-mobile'. The paramedics recorded the Claimant's blood pressure to be 180/98 mm/Hg shortly after arrival on the scene and 175/98 mm/Hg just prior to her arrival at MRI. The Claimant also had a tachycardia at 93 bpm. The elicited pain score at the scene was 6/10 but had reduced to 0/10 by arrival at MRI at 15.13 hours. Nevertheless,15 minutes later, by the time the Claimant was clerked in by the triage nurse at 15.28 hours, she was complaining of a *"hot burning pain to back"*.

21. The casualty officer (Dr Jane Barrow) at 17.05 hours (**B3a/1172**), recorded the following history:

    "...the lift started to jerk up and down and her feet must have left the ground x 2. Lift didn't fall. No blunt trauma to back. No immed pain went back to desk, colleagues got her some tea and she then started to feel very anxious – heart rate fast, nausea, faint, pins and needle sin hands and feet. Lay on floors started to feel a but beter but then felt burning type pain in her lower back,

[9] B1/107 & B4/2536

ambulance called. Says was in some discomfort when she walked to the ambulance pain in left lumbar region and down back of left thigh. was given paracetamol and ibuprofen in the ambulance. Since arriving at the hospital 2 hours ago sdays pain a lot better in lowper back now. No leg weaknes/numbness or parathesia. Pmh nil sig no risk factors for osteoporosis. Dh nil nka..." (sic)

On examination, Dr Barrow noted:

"...BP high in route. BP 135/70 pr 78 reg walking/sitting and standing without any ev of pain., cpsine nad. tspine nad. lspine- tender over l4-5. No def or bruising, from without pain..." (sic)

Dr Barrow diagnosed a soft tissue injury. The Claimant was given a back exercise sheet and advised to continue taking regular simple analgesia. The Claimant was given a script for *naproxen*, in the event that her back became painful the next day, which could be taken in place of the *brufen*, if something stronger was required. If the symptoms did not settle in 1-2 weeks, the Claimant was advised to consult her GP.

The Claimant's diary entries

22. After the accident, the Claimant says she was advised to keep a diary and this she did until 19th January 2012 – it is now attached to her 1st statement (**B1/127-182**). The first day or so of the diary were, it appears, written with hindsight but thereafter, the Claimant asserted the diary was written contemporaneously. Her account to me was that on the Saturday, the day following the accident, she spoke to her friend Pat Yeowart. Mrs Yeowart, on hearing the Claimant's account, advised her, that if she was no better in a day, she should keep a diary of events. Presumably, in following this advice, the Claimant started keeping the diary on the Sunday. She stopped writing the diary as she found that she was saying the same things 'day by day' and thus - as she was recording nothing really new, she stopped.

23. The diary recorded quite significant symptoms the first night (**B1/127**) – a disturbed night – very uncomfortable. Pain was experienced in both lower and upper back - across the shoulders. Pain in the back of the hips and down the legs. The claimant was not able to sleep in bed – she slept in a chair, having been for a short walk. On waking, she was aware of her fast pulse – her wrists felt *'a lot of pressure'* and she felt dizzy and sick. This lasted for 45 minutes with the pain in the arms lasting an hour. She was then aware that her ankles were hurting. She referred to experiencing a *'ring of pain'* around her arm pits and across her shoulders – so too, pain in her knees. To combat this pain, she took her *paracetamol*. Hourly and several times an hour, the Claimant experienced disturbing 'flash-backs' of being back in the lift and the lift falling, as the doors were opening. The position was in essence unchanged on the Sunday – sleep significantly disturbed – not able to sleep for more than 15 minutes at a time. On getting up at 04.30 hours, she was aware of pain *'shooting up her heels'* – so too, she had back pain, pain in her hips and her ankles. She was aware of her heart racing. By the Monday, the position was not changed – if anything the pain more generalised – no break in her pain to her back, hips, neck, shoulders and knees – with shooting pains through her heels up into her lower legs (**B1/130**).

24. On Monday 28th November 2011, the Claimant saw her GP, Dr Furnival with a complaint of back pain. The GP recorded the history as follows:

"...3/7 ago was in glass lift that broke in work. Glass smashed. Very traumatic. Got out ok. Shaken up. Paramedics attended and took her to A&E with back pain. No saddle dys/numbness. Has opened bowels today btu has since normally. No urinary sx..." (sic) (**B3a/696**).

On examination:

"...No spinal tenderness. Tender paraspinal muscles from neck dowen to lumbar region. SLR 90 deg bilat. T,P,R,S normal lower limbs...".

At the time of the examination, the Claimant was still just taking *paracetamol* and *naproxen*. Dr Furnival prescribed some stronger pain relief in the form of *co- codamol* 30/500 caplets 100 tablets to be taken *qds*, as needed.

25. The Claimant records the visit to the GP in her diary – she talks of her bowels having ceased (not moved since Friday) and being prescribed medication for it. The GP noted her complaints of flashbacks. The following morning, after a very disturbed night (woke at 05.00) back, hips and ankle pain still prominent. Unable to sit for long and feeling worn out – shoulder and neck pain with accompanying headaches dominate that morning. Was able to sleep in a chair for 3 hours later in the day but woke up with everything hurting (**B1/131**).

26. On Wednesday, the 5th day after the accident, the Claimant describes having to come down the stairs on her bottom, as her ankles and knees 'give way'. The Claimant is then able to detail just what she is incapable of doing in terms of household functions – her actions being restricted to making a cup of tea and short walks around living room and kitchen.

27. Jumping forwards in the diary entries 6 weeks, the Claimant on 18th January 2012, speaks of no relief in her symptoms - - neck, shoulders and hips painful – tossing and turning all night – not sleeping and waking exhausted – needing to take extra *paracetamol* due to the pain.

28. Of interest, on 18th December 2011 (**B1/151**), the Claimant complained of quite significant ongoing pain - to her ankles, feet (shooting pains *"like nails into lower leg"*), knees throbbing, hips stiff and painful – thighs painful – mid-back between shoulder blades painful (like *"a rod sticking into the centre of her shoulder blades"*). Inability to rotate shoulders without deep pain, neck pain with terrible headaches. The following day, 19th December 2011, the Claimant noted her pain - in her neck, shoulders, hips, knees, ankles and feet – she was able to manage the stairs and managed just to walk around ASDA with her son doing the 'clever stuff' (**B1/152**). The following day, 20th December 2011, her pain was continuing – neck, shoulders, hips, knees, ankles with shooting pains across her feet. The diary makes no mention of the fact that on 19th December 2011, the Claimant had attended and joined the DW Sports Fitness Club, in Widnes as an 'off-peak' member and in relation to the pre-exercise medical screening questionnaire, she had denied any ill-health or complaint – her answers to questions 5,6,12,13,14 being the most important (**B3B/2430**). Self-evidently some of her answers in the questionnaire, were entirely inconsistent with her contemporary reporting in the diary.

The treatment regime

29. The Claimant made sure her employers were kept up to date on the extent of her difficulties. Through 'Right Corecare', an occupational EAP, the Claimant was provided with 6 sessions of counselling, provided by Ms Gloria Collins – the first of which commenced on 7th December 2011. Ms Collins's discharge letter dated 3rd February 2012, to Dr Rathbone of the Beaconsfield Practice summarised her involvement (**B3a/922**). Plainly at that time, the Claimant was still complaining of considerable

physical discomfort and mobility difficulties. The following throws some light on the position as matters developed in early 2012:

"...Mary was clearly highly anxious, panicky, and still struggling to come to terms with what had happened to her. She described having fearful and intrusive thoughts and flashbacks both day and night, and being woken in the night with churning stomach and pounding heart. I also had the impression Mary's distress was compounded by worries about her workplace and the future of her career...".

Nevertheless, the Claimant was described as engaging well in the counselling process but Ms Collins thought that further therapy would be needed, it being her understanding that the Practice would be making a clinical referral.

30. On 5th December 2011, The Claimant had seen Dr Rathbone for a review of her back pain. By the time of his consultation, the Claimant's ailments were much more extensive than just backache –

    "...severe pains still neck and whole back, hips, knees and ankles, able to walk slowly..."

    Dr Rathbone's examination findings reported:

    *"...holding self very still, upset on recounting history, neck movement reduced 70% in all directions, back movement reduced 80% in all directions, no rotation, tender over thoracic and lumbar spine. Able to get on/off couch, unable to lift legs due to pain, power/tone normal, reflexes normal, ankles not swollen but painful with movement..." **(B3a/696)**.*

    Dr Rathbone referred the Claimant to CATS[10] for assessment (**B3a/1418**) – he signed her off work for 6 weeks on the grounds of a back injury and PTSD.

31. On 13th December 2011, the Claimant was assessed in the Physiotherapy department at Halton Hospital and she appears to have attended on 3rd, 17th, 31st January, 7th and 28th February 2012. At the end of this course, the therapist recorded:

    "...Still limited functionally. Can't swim. Housewife – struggling. Walking - ↑pain. Doing exercises 3 hrs /day. Remains sore with all movements plan Pt to continue swim & exercises. Review 6/52..." (**B3a/1423**).

32. On 23rd December 2011, the Claimant was seen by Dr Tseung, complaining of multi-level spinal pain – C5/6, T7/8 and L4/5 with a report of pain radiating into the right knee and lower limb with occasional tingling. He increased the strength of the Claimant's pain relief medication (prescribing *Tramadol Hydrochloride* 50 mgs 2 *qds* prn). Dr Tseung referred the Claimant for an MRI scan[11] to exclude some kind of compression fracture, in view of what he had been led to believe were the forces involved in the lift accident.

33. On 11th January 2012, an MRI was undertaken of the whole spine and other than some minor changes at C5/6, no abnormalities were noted. Of importance, there was no neural compression. No abnormal signals were seen to emanate from the vertebral bodies themselves – the cord was normal (**B3A/921**).

34. On 3rd February 2012, the Claimant was reviewed by Dr Rathbone. He was aware that the MRI was normal and the short courses of private counselling and NHS

[10] Clinical Assessment & Treatment Service at Halton Hospital, Warrington.
[11] **B3a/920**

physiotherapy had brought about little by way of functional improvement. He assessed the Claimant using a Patient Health Questionnaire (PHQ-9) and the Claimant scored poorly at 6/27 (**B3a/927**[12]). He therefore referred the Claimant to the Open Mind mental health service for CBT (**B3a/924-926**). The Claimant was offered an appointment to be seen by Mr Corcoran on 28th March 2012. I have not been able to find any note of this appointment – nor any clinical note of any therapy that resulted from it, until the notes compiled by Ms Rebecca Baxter, the following year, the first of which is dated 4th February 2013 (**B3a/1225**), when the claimant attended for EMDR[13] in the context of her PTSD. I presume that the NHS waiting list prevented the offer of earlier treatment. The Claimant then attended for 23 hourly CBT sessions but no EMDR was offered. By the time Mr Baxter discharged the Claimant, on 10th October 2013, as she noted, the Claimant was no longer experiencing any flashbacks to the lift incident (**B3A/1248**).

35. On 4th April 2012, the Claimant was reviewed by Dr Rathbone. Whilst there was some reported improvement in the Claimant's pain (the constant pain having gone), the pain was still continuing – affecting the same areas (viz. knees and hips, back ache and pain in arms/shoulders/neck). The Claimant reported feeling constantly tired and becoming forgetful. Further review on 11th May 2012 by Dr Rathbone presented the same picture. The Claimant did not feel she was ready to consider a return to work. She still awaited her CBT. She had finished her physiotherapy but had not yet been discharged. She reported feeling '*worn down*' and wanted to try some anti-depressants[14]. *Citalopram* was prescribed and the Claimant started the medication titrating up to a therapeutic dosage over a period of 2-3 weeks.

An intervening accident

36. On 26th May 2012, the Claimant was involved in a road accident when on her account at 11.00 hours, whilst driving her own vehicle, she was hit from behind by a third party on Switch Island – the end of the M57 in Liverpool. The claim notification form dated 21st June 2012 (**B4/2677**) spoke of the Claimant having suffered whiplash and other soft tissue injuries. On her behalf her solicitors, Irwin Mitchell stated:

> *"...sides of my neck, base of my neck, left arm, elbow and wrist, back of left and right ankles, front of left ankle, lower arm muscles..."*

37. A vehicle assessor's report into the damage to the Claimant's Renault Megan vehicle estimated the costs of repair to be of the order of £2,613 (**B4/2695**) and her own vehicle was 'off the road' undergoing repairs, until she collected it on 20th June 2012. In due course, arrangements were made for the Claimant to be examined by Mr KJ Patel, consultant orthopaedic surgeon, on 9th August 2012 and that examination duly took place at 29, The Strand in Liverpool.

38. Mr Patel was aware that the Claimant had been involved in an accident at work in November 2011 and as he recorded it in his first report, at the time of the RTA, the Claimant had made him aware that she was still symptomatic with unresolved neck and back pain. He recorded that since they had happened, the neck and back symptoms had 'eased off' although ongoing but had been aggravated by the RTA

[12] It is interesting to observe that on the self-reporting of the Claimant, she did not report any features of depression – the scores being made on poor sleep and reduced mobility.
[13] (EMDR) Eye Movement Desensitisation Reprocessing.
[14] There had obviously been a discussion on whether the Claimant should start a course of anti-depressants in April – the Claimant had not been keen then.

under review. At the time of his examination of the Claimant, he recorded that her neck had 80% of normal movements - palpation of the cervical facet joints and upper dorsal spine had revealed no tenderness and there were no neurological abnormalities in the upper limbs. There was some minimal para-spinal tenderness in the lower cervical spine. As for the shoulders, they too had an active range of 80% of normal movement with a slightly increased range, 90% on passive encouragement. Save for some diffuse soft tissue tenderness over the medial joint line of the left elbow, the Claimant's physical examination was otherwise unremarkable. He opined that the injuries attributable to the RTA would settle in 6-8 months from the date of his examination.

39. Mr Patel was provided with the Claimant's GP records and refers in the body of his report to a few of the Claimant's previous GP attendances. He was aware that the Claimant had been seen by his GP as recently as 11th May 2012 with ongoing back and neck pain.

40. Mr Patel was then invited to review the Claimant on 9th January 2014 – the account of the symptoms following the RTA were very largely the same. As before, Mr Patel examined the Claimant's neck and thoracolumbar spine. In fact, he found the range of movement of the neck had improved to 90% of normal. The shoulder symptoms were unchanged but the left elbow tenderness had gone. Of importance, as I will come to later, the palpation of the soft tissues of the cervical and upper dorsal spine did not reveal any tenderness. Allowing for the underlying pre-morbid complaint, Mr Patel ascribed a period of 12 months' recovery in total to the May 2012 accident.

41. The importance of Mr Patel's two examinations relates to whether in the light of them, the Claimant is likely at those stages to have been suffering from the acute effects of fibromyalgia syndrome, given the seeming lack of muscle tenderness or pain elicited by Mr Patel's examination? I will return to this issue later.

Renewed therapies

42. All the while throughout 2012, the Claimant was awaiting her CBT. She was also waiting a review by the physiotherapist after Easter 2012. The Claimant was provided with a self-referral physio form, on 15th June 2012 by Dr Tseung, which the Claimant filled out the same day (**B3a/1340**). The pain diagram showed the areas the Claimant then maintained were causing her pain. Of note, the Claimant was asserting that she was experiencing *'pins and needles'* in her arms and hands[15].

43. The Claimant was initially seen by an assessing physiotherapist on 14th August 2012. She drew a pain diagram (**B3A/1411**), which when compared to her earlier diagram on 15th June 2012, seemed to show some deterioration – as a new feature, the Claimant had pain and tenderness over the front of her shoulders as well as over her knees. The diagram showed the same problems over her thoracic and cervical spine, her sacro-iliac crest/lumbar areas extending down over her lateral flanks. The physiotherapist summarised this complaint as *'multiple joint pains'*. She specifically complained of: "*...feeling so tight in most muscles – arms and shoulder...*". At that time, the Claimant was still awaiting her CBT and the physiotherapist thought referral to the pain clinic ("*...Pt better treated by chronic pain team...*") was the most appropriate

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[15] This set of symptoms does not appear in Mr Patel's report – seemingly, they had developed prior to the RTA of 26th May 2012. Of note, compare this pain diagram to the later diagram prepared on physio assessment by Jackie Wood, on 22nd January 2013 [**1196**] in readiness for hydrotherapy.

course rather than progressing the physiotherapy and she appears to have been discharged from that service on the same day (**B3A/1415**).

44. On 1st August 2012, the Claimant approached the Charity for Civil Servants, complaining of lack of support and financial difficulties - she initially saw Pam Holden on 9th August 2012 and gave a history of having suffered a spinal injury affecting her shoulders, neck and all joints – a history, she repeated to Tina Jones of the same Charity on 24th August 2012 (**B3B/2436**) where it was recorded;

    "...Mary has a spinal injury affecting her shoulders, neck and all joints. She can't lift her arms above her head as all her ligaments took the impact which has affected her muscles. Mary also has (PTSD) due to the incident, which she thought was a bomb blast initially...".

45. The Claimant was then seen by Ms Vicki Slade, a second physiotherapist on 15th November 2012 in the CATS clinic (**B3a/1337**) and her examination findings recorded:

    "...this lady was very tense in her upper trapezius muscles. She has major loss of range of movement of her lumbar spine, cervical spine, bilateral shoulders and hips in all directions due to pain. There was no neurological deficit...tender over the muscle belly of her upper trapezius, biceps and quadriceps bilaterally..."

    Ms Slade noted the Claimant was still awaiting CBT and unlike her colleague, did not think it appropriate to refer the Claimant to the pain clinic. Instead, she recommended hydrotherapy and made a referral to Dr Salih, a rheumatologist, with a view to prescribing some pain relief (**B3a/1188**).

46. Meanwhile, whilst the taking of *Citalopram* had been beneficial, there was a concern about possible side-effects with the *naproxen* and the latter being stopped in July 2012. The *tramadol* taken for the back pain was not effective and so was replaced by *Oxymorph* in October 2012. The *Citalopram* was then replaced by *Amitriptyline* in later October 2012.

47. Prior to seeing Dr Salih, the Claimant was referred for ongoing physiotherapy under Suzanne Watson, her first appointment being 1st December 2012 (**B3A/1211**). At that time, Miss Watson obviously thought fibromyalgia was the working diagnosis as she referred to the Claimant giving her consent to start with the "FMS group" and she appears to have attended 6 FMS physiotherapy sessions to 5th April 2013. Meanwhile, Dr Salih saw the Claimant in clinic on 21st January 2013. He noted in a letter to Dr Martin of the Beaconsfield Surgery:

    "...she has aches and pains all over, sleep problems, tiredness, memory and concentration difficulties and in addition, has 18/18 muscular attachment points of fibromyalgia..." (**B3a/1195**).

48. Dr Salih was the first medical clinician therefore to diagnose fibromyalgia (FMS). Of interest, as he later recorded in his letter to the GP on 27th November 2013, in January 2013 (**B3a/1216**), Dr Salih had requested blood tests – they had all come back normal – there were no markers to suggest:

    "...any muscle or connective tissue disorder or peripheral joint disease of inflammatory nature...".

    This only confirmed him in his diagnosis of FMS, as the most likely working diagnosis.

49. The Claimant's hydrotherapy started on 29th January 2013 – she attended 7 sessions (missed an 8th session) (**B3a/1204**). Her discharge report dated 29th May 2013 reported her therapy had been successful with the Claimant indicating she was to continue with the exercises at the gym (she had been taught at her physio sessions) as well as join an aqua-aerobics group.

50. Trauma acquired FMS appears then to have been the operative diagnosis the Claimant used explaining her position to others – by the 8th March 2013, when the Claimant was referred for Occupational Therapy at Halton Hospital for an assessment of her functional ability – the fact of the lift incident was referred to as <u>'triggering' the FMS</u> (**B3A/1214**)[16]. Ann Smedley, the Occupational Therapist, described the Claimant's self-reported condition:

   "...she described constant excruciating pain in her back, neck, hands and feet. She described constant fatigue and lacked stamina with activities of daily living. She also described clumsiness and she frequently drops things as the sensation in her hands is also impaired... Mrs Maguire was very tearful throughout our assessment. Because of her mobility she has lost confidence to going outside and as a consequence she has lost many of her previous roles and her social life. She is unable to work and as such is bereft at the loss of her career..." (**B3A/1214**)

51. The sessions with the FMS group continued from 25th April 2013 (**B3A/1380**). On 9th May 2013, the OT treatment within the FMS group led to the Claimant socialising with others to set up their own FMS group. Throughout the Summer 2013, although the Claimant missed the odd session, she was a regular weekly attender. At the end of November 2013, Ms Smedley, on discharging the Claimant, noted the following:

   "...Mary agreed that she has made very good progress since she started here - Happy to be discharged and will contact us if she needs to..." (**B3A/1383**).

52. I have already noted the CBT sessions the Claimant attended with Ms Baxter, which ended in October 2013. Seemingly, the Claimant was happy to end the sessions, she having achieved the goals she had set herself. Ms Baxter in a somewhat belated letter to Dr Tseung of 5th December 2013 talked of the Claimant 'successfully' completing her CBT therapy, with a *'significant reduction in symptoms'*, it being Ms Baxter's view that she no longer needed EMDR (**B3A/967**).

53. Accordingly, by the end of November 2013, the Claimant's treatment had in effect ended. She was then seen in a medico-legal context by Professor Green, consultant psychiatrist, on 30th November 2013 (**B2/406**). In his opinion, the Claimant was then suffering with F43.1 PTSD[17], together with an associated chronic depressive disorder of mild/moderate severity (**B2/414**). Prof Green was aware the Claimant had attended both counselling and CBT but recorded, presumably on the Claimant's account, *"has not progressed much"* and stated a course of 4-6 EMDR sessions *"may be useful"*. In short at that time, the PTSD was still ongoing, the therapy to that time had not really been effective – next step EMDR.

54. The Claimant's solicitors then engaged Tom Corcoran to undertake a course of EMDR, the Claimant attending 10 sessions between 16th July 2015 - 24th September 2015 (**B3A/1272/3**). Later, on 5th November 2015, again at the request of her solicitors,

[16] In giving her account to Ann Smedley, the Claimant is later recorded as having stated on 7/4/13, *"... physically injured as vibration she was subjected to seems to have triggered fibromyalgia – previously fit and well..."*. (**B3A/1377**)
[17] Using ICD-10 classification of the WHO.

the Claimant started attending sessions with Keith Simpson, an agoraphobia therapist and she attended some 20 sessions until around 19th May 2016 (**B3A/1275-1320**).

Important pre-morbid events

55. The Claimant as a young child aged between 3 and 7/8 years, appears to have been the subject of 2 identified incidents of physical and sexual abuse at the hands of her older sister. As recollections, they surfaced during the course of EMDR therapy on 7th January 2016. The Claimant had not spoken of them previously. The first incident involved an attempted strangulation (**para 8/B1/251**) when she was aged 3 years, and the second, a sexual incident, when the Claimant was 7/8 years, involving the Claimant's sister stroking her fingers across the Claimant's clitoris and the Claimant reciprocating on two occasions (**para 10/B1/251**).

56. The Claimant experienced 3 pregnancies that resulted in third trimester intra-uterine 'still-births' in 1980, 1981 and 1986[18]. The latter 'still-birth' resulted in an episode of post-natal depression in August 1986 - continuing into a reactive depression in March 1987 (**B3A/739**) and ongoing anxiety issues thereafter, requiring *diazepam.*

57. In January 1988, the Claimant experienced some odd sensations of dizziness, palpitations and feeling drunk – as though about to collapse. There was concern she might have a brain tumour and underwent a CT brain scan in May 1988. An EEG suggested abnormality in the temporal lobes and the symptoms were put down to a presentation of temporal lobe epilepsy (**B3A/854**). The Claimant was started on *tegratol*, titrating her dosage to 800mgs *tds.*

58. In early 1990, the Claimant fell pregnant with her 5th child with an EDC of 11th September 1990. The *tegratol* dosage was reduced. A placenta *praevia* was diagnosed and so an elective LSCS was undertaken on 27th July 1990 and a healthy boy, weighing 2.336 kgs was delivered. The Claimant made an uneventful recovery.

59. The Claimant has constitutional bilateral sensorineural deafness - this was formally diagnosed in 1990 – pure tone audiometry showed the deficit to be between 50-60dB across all the frequencies save at 0.25Khz. The Claimant also complained of mild tinnitus (**B3A/881**).

60. The Claimant fell pregnant for a 6th time in early 1993 with an EDC of 25th November 1993. Her 3rd son was delivered in a healthy state on 14th September 1993 by emergency LSCS (**B3A/868**).

61. In February 1993, the Claimant experienced back pain – initially with dysuria and accompanying tender right loin (**B3A/750**) but then more focussed as lumbar pain. The GP thought it was bladder related and prescribed *trimethroprim* for a urinary tract infection (LMP 18/2/93).

62. On 14th February 1994, the Claimant complained of left wrist pain with no history of trauma (**B3A/755**). A sprain was diagnosed and treated by *ibuprofen* and wrist bandage. In November 1994, the Claimant was admitted for anxiety symptoms presenting waking up 3-5 nights a week with night terrors, 'atypical chest pain' and a 'dead' feeling in her left arm, sweaty and hyperventilating. A heart attack was

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[18] The first 2 pregnancies resulting in 'still-birth' had occurred at the 34th week of gestation, so the plan for the 4th pregnancy was for induced delivery at 34 weeks (**B3A/837**).

considered but excluded by the cardiologists – a presumptive diagnosis of panic attacks was made (**B3A/871**) and the *tegratol* was stopped[19].

63. By February 1995, on clinical review by Dr David Smith, consultant neurologist, the Claimant was informed that she did not have temporal lobe epilepsy (**B3/874**).

64. On 22nd June 1998, the Claimant was worried over a lump in her left breast – there was little to elicit on palpation – the Claimant had only just started her period and the GP put it down to hormonal changes to be reviewed in a week. On that review, the Claimant remained concerned – there was nothing to find on examination but referral was made to the breast clinic at Halton Hospital. Examination in the rapid access breast clinic (**B3A/1174**) showed the Claimant to have moderately dense breasts with a slight stellate deformity in the left breast – otherwise, the breast was normal and the Claimant was discharged from the clinic (**B3A/1179**).

65. During August 2003, the claimant twisted her left foot playing football with her children. X-rays revealed no bony injury but a diagnosis of a subluxation injury to her tarso-metatarsal joint was made, necessitating 4 weeks in a plaster cast, with follow up in the fracture clinic (**B3A/882**).

66. On 15th September 2003, the claimant was admitted with pleuritic chest pain extending into her lower back with increasing shortness of breath[20] (**B3A/1057**) – a pulmonary embolus was feared (as the Claimant's left foot was in a cast) but excluded (normal 'Q' scan). Chest x-rays suggested some inflammatory changes in the right *costophrenic* angle. The Claimant had a temperature in arrival but that soon settled (**B3A/1024**) - a chest infection was diagnosed and treated.

67. In August 2005, whilst on holiday in Fuengirola, Spain, the Claimant was admitted for investigation of abdominal pain – x-ray examination was essentially normal but ultrasound revealed an area of endometriosis with uterine fibrosis (**B3A/889**). In November, on her return to the UK, following some heavy bleeding *PV*, the Claimant underwent further ultrasound scanning that confirmed a slightly bulky uterus, patchy endometriosis and a small uterine fibroid (**B3A/893, 1065**). She remained tender in the right iliac fossa. On 9th February 2006, Mr Agweike, a staff grade gynaecologist, listed her for a hysteroscopy and D&C (**B3A/897**). A diagnostic laparoscopy of the right iliac fossa and an hysteroscopy on 9th March 2006, did not reveal any significant cause of the pain - the uterine cavity was normal, the ovaries and fallopian tubes were normal (with no evidence of endometriosis) – the only insignificant abnormality was a band of omental adhesion just below the umbilicus, from the bowel to the anterior abdominal wall (**B3A/898, 1076**).

68. On 28th December 2006, the Claimant gave a history of sudden onset low back pain 2 weeks earlier, left side, radiating down her left leg (**B3A/702**) – the following day, she was worse with bad spasms in her lower back. The voltarol she had been taking was not helping and she was prescribed co-codamol (100 caplets 30/500) and 10 diazepam tablets.

69. In February 2007, the Claimant experienced a stress episode, requiring a week off work, relating to the safety of her son, arising out of threats made against the family which had involved the police. The Claimant was very unwilling to elaborate when

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[19] The claimant was investigated 'vigorously' and had completely normal findings – she was then discharged from further follow up on 6th December 1994. (**B3A/873**).

[20] "*...felt like a worst pain of her life...*". (sic)

seeking an extension to her earlier sick note and reacted badly to being refused an extension (**B3A/701**)[21].

70. On 6th May 2010, the Claimant was investigated for a small lump (soft fluctuant 4cm mass) above her left shoulder blade - a likely lipoma was diagnosed - with the possibility for its removal if required (**B3A/1089**).

71. In June 2010, the Claimant was investigated for 'groin pain'. I have not been able to find any clinical referral from the GP, just the x-ray report of the Claimant's pelvis, dated 23rd June 2010 (**B3A/1090**). Degenerative changes were observed around the *symphysis pubis* but the SI joints were normal, as were the joint spaces in both hips.

72. The following year on 7th March 2011, the Claimant self-referred for physiotherapy with a complaint of back/hip pain of some 2 weeks' duration (**B3A/1091**). The MCAS assessment sheet filled out on 13th May 2011, adds in some detail as to the nature of the complaint:

    "...March insid. Onset pain LBP - off work at present →GP →° tests °xrays → eased since onset. → GP suggested self-referral. Episode of LBP previously → saw chiropractor →helped..." (**B3A/1098**).

    The Claimant described as an aggravating factor, bending forwards which increased her pain and stiffness and diurnal sleep disturbance at night[22]. A body chart was then set out by Leanne Davitt, the physiotherapist, which showed a dull ache over the back of the sacroiliac crest extending bilaterally into the trochanteric areas but with no pins and needles or numbness. The notation "*PD*" probably refers to "pain description" - and it is described as an intermittent "*dull ache*". The diagram is also marked over the upper thighs, knees and ankles (front and back). On examination (**B3A/1100**), straight leg raising was reduced bilaterally (60° right, 50° left), reduced lumbar flexion (finger tips to mid -shin) and para-spinal muscle spasm. The therapist observed that there was a 70% chance of improvement after 2-3 sessions with the Claimant doing her home exercises. The Claimant did not persist with the sessions as Ms Davitt reported to Dr Martin of the Beaconsfield Surgery, on 20th June 1011, diagnosing "*...lumbar dysfunction with deferred pain...*" (**B3A/1102**)[23].

Previous Accidents

73. The Claimant, prior to November 2011, had a number of road or other accidents, which resulted in claims being intimated to insurance companies albeit not always claiming personal injury.

    a. On 27th December 2005, the Claimant was involved in a Motorway road accident and suffered soft tissue injuries (**B3A/703**). Through solicitors, she brought a claim against the third party driver's insurers, the Zurich and compensation of £2000 was accepted in settlement.

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[21] The Claimant was sent a letter by the Practice manager warning her that any repetition of her behaviour would result in her being taken off the list. The behaviour appears to have been a "one off".

[22] In evidence Dr McKenna agreed that where the physical symptoms were accompanied by sleep disturbance, this was potentially an important marker for FMS.

[23] The entry must refer to 'referred' pain not deferred pain.

b. On 4th September 2007, the Claimant tripped and fell sustaining soft tissue injuries to her right wrist and leg. Through solicitors, compensation was claimed from Westminster City Council. The claim was later abandoned.

c. In 14th November 2007, the Claimant was involved in a road accident and suffered a soft tissue neck injury. A claim was intimated to the third party driver's insurer, Ageas and compensation of £1200 was accepted in settlement.

d. On 22nd August 2009, the Claimant was involved in a road accident. No claim appears to have been made for any pain and suffering.

e. On 3rd September 2009, the Claimant was involved in a road accident when a third party reversed into her vehicle. No injury claim was made.

f. On 26th May 2012, the Claimant was involved in a rear end collision at the bottom end of the M57 and suffered injury as reported on by Mr Patel[24]. A claim was made for personal injury.

Fibromyalgia (FMS)

74. FMS is often referred to as a chronic musculo-skeletal condition characterised by diffuse pain and hyperalgesia at specific tender sites – it occurs much more commonly in women. It is a relatively common condition, now accounting for most rheumatology appointments after osteo and rheumatoid arthritis. For many years, there has remained a debate as to whether it is a distinct clinical entity as opposed to the manifestation of a psychological condition, tied up in secondary gain and/or personality and hysterical disorders.

75. The American College of Rheumatologists[25] promulgated guidance on diagnosis criteria as a person, who has widespread pain for at least 3 months and the presence of at least 11/18 specific tender points on examination[26] ('pain' elicited by digital palpation with a force of at least 4 kgs). In rheumatology circles, the fact of FMS being a distinct clinical entity, is now very well accepted. In other fields of medicine and specifically psychiatry, clinicians may refer to the effects of FMS in terms of symptoms presentation, which comes under different diagnostic criteria and are thus, labelled differently – e.g. variants of a somatic symptom disorder[27].

76. At the heart of the condition is widespread[28] muscle pain – pain which cannot be accounted for by any well recognised singular pathogenesis. So sufferers, can have a relatively normal clinical examination (save for pain being elicited), normal x-rays and scans, blood tests and other investigations, yet continue to experience real dysfunction and disability. Leaving aside the complaint of musculoskeletal pain, sufferers very frequently complain of fatigue, sleep disturbance and/or unrefreshing

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[24] See paragraph 36 above;
[25] *Wolfe, Smythe et al:* The American College of Rheumatology 1990. Report of the Multicenter Criteria Committee. See Table 8 (**B5/3104**)
[26] This yardstick over time has been criticised and many rheumatologists will not slavishly stick to at least 11 sites and can be diagnosed with as few as 5-6 tender points. See: Yunis MB "*fibromyalgia. A central sensitivity syndrome*" 2013.
[27] DSM -V para 300.82 American Psychiatric Association.
[28] "*widespread*" here refers to all areas being affected – namely left side of the body, right side of body, above the waist and below the waist with axial skeletal pain being present (e.g. neck, anterior chest, thoracic or low back).

sleep, morning stiffness, paraesthesia and psychological distress – fatigue, being the most common.

77. FMS is sometimes referred to as a 'trait' rather than a 'state', as the condition of individuals may fluctuate – sometimes fulfilling diagnostic criteria and then becoming more quiescent. In turn, the severity of the symptoms may fluctuate depending on the 'stresses' at play of the given individual – so the pain and distress may be greater at time of great physical and/or emotional stress. To recognise this, the term *"fibro"* patient in rheumatology circles, is seemingly well understood – a patient who has had or currently has a diagnosis of FMS. It is therefore necessary in each patient to go back in the individual medical records to see whether (possibly earlier misdiagnosed) a patient later diagnosed with FMS, in fact was presenting with it, at an earlier stage[29].

78. The association of FMS following on as a consequence of physical trauma has been considered and debated over many years, especially after motor vehicle collisions. Some experts (notably Yunus and Clauw) have referred to trauma as presenting as a 'trigger' to central sensitisation and to the development of FMS. Others, refer to a physical event (RTA) providing a 'stressor' which in symbiosis with the individual's biologic vulnerability, psychosocial or cultural factors, gives rise to widespread pain or other somatic symptoms which would admit of a diagnosis of FMS[30]. However hard evidence to support a clear association remains lacking.

79. Sleep disturbance as a primary trigger for FMS has been considered to a very limited extent in the literature. It is difficult here to draw conclusions from the effects of FMS in causing sleep disturbance and any FMS cause. The vast majority of FMS sufferers complain of disturbed and non-refreshing sleep patterns with morning fatigue and stiffness. Roisenblatt *et al.*.[31] considered sleep disorders and the onset of FMS, as noted by McBeth and Mulvey in their review of the literature in February 2012[32], who spoke of the relationship between sleep disturbance and FMS, as being "well established", but the discussion is on the effect of FMS as opposed to its cause. Smythe and Moldofsky[33] wrote up some studies they had performed on small numbers of *fibrositis* sufferers with a small control group of healthy students, who were exposed to sleep disturbance – which demonstrated increasing levels of pain and morning stiffness due to disturbances of non-REM sleep but they stopped short of offering any conclusion that sleep disturbance of itself, caused FMS.

80. Childhood sexual and physical abuse has been well documented as likely to be relevant in the development of FMS (as well as those suffering from Chronic Fatigue Syndrome (CFS)) and may also explain the extent of the dysfunction and disability suffered[34]. Häuser found quite a high correlation between FMS sufferers and those subject to such abuse in their early years. Only one study had suggested a contrary conclusion, when the FMS group was compared to the control group. Borsini suggested two mechanisms explaining the link - biological mechanisms through

[29] See: Wolfe,Häuser *et al.*. *"fibromyalgia and physical trauma"*: Journal of Rheumatology 12/8/14 **(B5/3123)**
[30] See: Mclean Williams Clauw *"fibromyalgia after motor vehicle collision"* 1995.
[31] Pain Headache Rep 2011.
[32] Vol 8 Nature 108 2012.
[33] Bulletin on Rheumatic Diseases, the Arthritis Foundation Vol 28 1977-8 **(B5/3391)**.
[34] *Borsini et al* Psychological Medicine (2014) 44 **(B5/3215)** - see Table 2 where the results of 24 studies are considered and the team concluded, there was a '*strong relationship between childhood experiences and later development of CFS and FMS*'.

increased (a) inflammation and (b) abnormal HPA axis activity, giving rise to high cortisol levels[35].

Video Surveillance

81. The Defendants organised video surveillance of the Claimant which commenced on 18th July 2014. In all, on 11 separate days, between July 2014 and November 2015, surveillance operatives from the 'Surveillance Group', undertook filming of the Claimant. The Defendants attached a Schedule to the amended defence setting out their assessment of the surveillance evidence. In relying on the video surveillance, the Defendants take by way of comparison what the Claimant stated to various medical attenders[36], at or about the same time, with a view to eliciting the extent of any exaggeration on her part or worse still, lies.

82. In Mr Ferris's closing submissions, he attaches a fresh Schedule of events elicited from the video surveillance, on which, all said and done, he places particular reliance. What he submits can be seen from these various episodes, is that far from being agoraphobic and very limited in what she can do 'out of doors', so to speak, the Claimant is able to drive quite reasonable distances, she can go to the shops unaccompanied – once out shopping, she displays very little difficulty – her movements are full and unrestricted – she bends at the waist, and rotates her neck freely, she engages in lifting objects, such as large bottles of 'Coke' without hesitation, she is able to carry bags of shopping as well as wheel a shopping trolley – she is able to get in and out of her vehicle, she is able to bend and stretch in the shop as needed and on her return to the vehicle. The Claimant is able to walk around large supermarkets – and shopping centres, for quite prolonged periods, without seeming ill-effect. On one occasion, she is seen to be carrying a stick (at a Charity fair) but she places no weight on it - it merely serving as a prop. Finally, when filmed with some of her friends from the FMS Society, her mobility is generally laboured, in keeping with them but once separated from them, she regains her normal ambulation ability and appears to mobilise normally.

83. Accordingly, it is alleged the Claimant's claimed disability is selective and inconsistent – her clear capacity to act repeatedly in certain ways, is not consistent with how she described her difficulties to the medical experts. This is not inadvertent behaviour – it is inorganic and deliberate. Mr Ferris submits it is a sure sign of deliberate exaggeration for financial gain.

84. In response to this filming, Mr Grant whilst he accepts what the surveillance shows, he observes it does not in fact demonstrate a functional capacity inconsistent to that stated to her medical attenders or in her statements. Moreover, the filming is misleading - at certain times, the filming is deliberately selective and without good explanation – by implication, the operatives have engaged in selective editing of the footage or have stopped filming, so as to give a misleading impression. So it is that in the park, unaccountably, the footage cuts from one shot to the next, with quite large time lapses missing. The Claimant is seen walking away from the camera leaving the supermarket returning to the covered car park, with a good vantage point, then the

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[35] A feature also found in depression.

[36] Mr Braithwaite consultant orthopaedic surgeon, examined the Claimant on 18th February 2014, 5 months before filming began and Dr McKenna, consultant rheumatologist, examined on 29th October 2014, well after it had commenced. Reliance is also placed on Mr Patel's findings a month before Mr Braithwaite examined. Later on Dr Huskisson, consultant rheumatologist examined on 15th September 2015 and Mr Fagg, consultant orthopaedic surgeon examined on 1st October 2015.

filming stops – the Claimant is filmed having crossed the road but not in the act of leaving her house or, getting into her car or walking across the road – why is this? The surveillance operatives were not able to record that at the Charity fair, the Claimant returned to her car for a sleep – the incident went unrecorded. There are lengthy periods in the supermarket, when the Claimant is plainly in the store but no filming evidently takes place – why? I am therefore invited to have a healthy degree of scepticism about the overall validity of the surveillance – it not giving a truly representative 'snap shot' of the Claimant on the days when she did venture out of her house.

The medical evidence

85. In the course of the hearing, I was provided with expert evidence from four medical specialists – cardiac, orthopaedic, rheumatological and psychiatric. So close were the opinions of the orthopaedic and cardiac experts, that only their written reports were placed before me. The differences of opinion in respect of the psychiatric and rheumatological experts were significantly greater and I heard from both sets of specialists. I will take the written evidence first, as summarised in the respective joint statements (which show the extent of the agreements reached) and then spend greater time on the evidence given from the witness box.

Orthopaedics

86. Mr Braithwaite, instructed for the Claimant, on account of the history given to him by the Claimant, stated that from her account (and allowing for it), her scope for physical injury was "*modest at best*" (**B2/380**) – there will have been some scope for soft tissue injury, such as muscle strain and ligament sprain or possibly some joint strains but he initially thought the symptoms would not be explained beyond 6 weeks to 3 months. Mr Braithwaite examined the MRI scan of 11th January 2012 and he observed what he described as:

    "*…some degenerative change at C5/6, quite marked and clearly longstanding. In the lumbar spine there are dehydrated discs at L3/4,L4/5 and L5/S1 with disc bulges at L4/5 and L5/S1…*" (**B2/375**)

    Self-evidently, he saw more on this scan than the radiologist had reported (**B3A/921**) – where there was a report of just 'minor' changes at C5/6 with no mention of any lumbar pathology at all.

87. Allowing for this presentation, Mr Brathwaite accepted that the 6 weeks to 3 months might stretch to 3-6 months, taking into account a likelihood of some constitutional sensitivity to soft tissue trauma.

88. Mr Fagg, consultant orthopaedic surgeon instructed for the Defendants, agreed a period of recovery from this '*insignificant*' spinal injury, from between 6 weeks to 3 months, even allowing for the fact, as the Claimant had volunteered in giving her history, that she had pre-existing mechanical back pain for 12 months prior to the accident (**B2/530/para 10.1**). In their joint statement dated 1st September 2016, they agreed the Claimant will have been exposed to some shaking/jarring type mechanism with scope for transmission of forces to her body with some scope for musculoskeletal injury. They both agreed there were changes on the MRI in both low back and neck - allowing for that, the period of recovery was to between 3 and 6 months.

89. On the surveillance, Mr Braithwaite felt the Claimant gave an account to him of her capabilities generally consistent with the surveillance footage. Mr Fagg, in contrast, in the light of what he recorded she stated to him and his examination findings on 1st October 2015, was surprised at the video surveillance - indeed, he stated that her abilities on the surveillance were inconsistent with what she had stated both to him[37] and as she reported to the DWP. Let me spend a moment just looking at this.

90. As part of her claim to benefits from the DWP, the Claimant filled out a questionnaire, dealing with her physical functional abilities on 2nd June 2014. Her statements were as follows:

    a. *"...I stay at home and move around as little as possible. When I do walk around a shop I often have to leave the person with me to finish it off because of fatigue and I rest in the car..."* **(B3B/1827K)**;

    b. *"...I cannot raise and hold my arms up. I can reach in isolation e.g. put a plate away in a cupboard but I cannot repeat movements as the pain in my neck shoulders and arms starts to burn. I cannot raise a straight arm up over my head..."* (B3B/1827I);

    c. *"...I have tried lots of physio activities to build up strength and endurance but the increase in pain and fatigue has prevented me from taking up a permanent solution, other than walking once a week in a park with plenty of stops and a good sleep after..."* **(B3B/1827U)**;

On 13th October 2014, when seeking employment and support allowance, Mrs Hove a registered nurse recorded, having spoken to the Claimant:

    d. *"...Has pain, stiffness and swelling affecting the left and right arm, shoulder, elbow, forearm, wrist, hand, fingers, thumb, leg, hip, knee, ankle, foot, and neck, lower and upper back with fatigue and muscle spasms on back and cramps of legs and hands all the time. Symptoms are constant. States has no good days with this condition and states warm days she feels a bit less tensed with pain in herself but states still has pain with a lot of difficulty doing things. States occasionally on these days she will manage to drive an automatic car for a few minutes just to get out. States she has difficulty reaching, gripping, lifting, walking, bending, sitting or standing for more than 10 minutes, and doing general tasks and states she has help with all tasks including washing and dressing herself, cooking, house tasks and shopping and states family does it...."* **(B3B/1827a7)**.

91. In his supplemental report, Mr Fagg observes activities he sees on the surveillance, which in his opinion was inconsistent with his examination of her and her account. He observed her twisting and pivoting on her left leg, elevating her right shoulder to 90° when collecting a pack of kitchen rolls - for 22 minutes, she is seen sitting comfortably talking on her mobile phone in her car (contrasted to the Claimant's behaviour when he examined her on 1st October 2015) - she was able to reverse her car rotating her neck without difficulty in the process - at his examination, he was able only to elicit 25% neck movement in all directions - she bends down and flexes her hips to 90° yet to his examination, her spinal movements were markedly restricted. She is able to walk back from the Chip shop normally, then stretch across the seats and provide bags of chips to her grandchildren. She is able to go to the park and be active in the park for approaching 2 hours, elevating her arms, standing in a queue without difficulty, walking with others. She is seen to carry shopping bags in both hands, unaccompanied and walking normally back to her car in the underground car park.

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[37] See his report of 16th January 2016 (**B2/547**) and his examination findings at (**B2/534**).

Cardiology

92. The issue at hand was whether the fact of the accident had in some way given rise to atrial fibrillation, a condition after the accident, in October 2013, following investigation, which she was found to be suffering from, after complaining to her GP of palpitations. Both Professor Channer and Dr Todd, cardiologists, felt there could be no real link. Acute stress plays no part in the later development of atrial fibrillation. The likely causes were the Claimant's obesity (she was pre-morbidly obese with a BMI of 28) against an underlying hypertension[38] (her obstetric history[39] predisposing the Claimant to hypertension) arising out of left ventricular hypertrophy (confirmed by scan (ECG) and echo).

Psychiatry

93. Dr Bass and Professor Green, consultant psychiatrists provided their joint statement on 2nd October 2016. They had much common ground. They agreed that the Claimant's previous history of depression, anxiety, panic issues and stress, did render her vulnerable to psychiatric disorder. The belated acknowledgement of the Claimant's sexual and physical abuse by her sister also added to her vulnerability. The fact of her earlier obstetric history was also a relevant feature.

94. Where the psychiatrists departed was whether the Claimant was exhibiting any form of a *somatoform symptom disorder* ("SSD") - i.e. whether she was displaying inorganic complaints as part of her presenting history which more likely reflected a somatoform disorder[40] and whether the Claimant's relevant history predisposed her to a 'marked vulnerability' to develop such a condition. Dr Bass plainly thought that it did – Professor Green in his written material was silent on the issue. Dr Bass found this surprising, given Professor Green had published on the issue of 'somatisation' in the past (**B2/349**). It was agreed between them that there is a substantial overlap between rheumatological diagnosis of FMS and a psychiatric diagnosis of SSD. Professor Green's position was that if there was a readily acceptable physical diagnosis – and so far as he was concerned, on the Claimant's case there were several, he did not feel it safe to attach a SSD label deferring to other experts. Dr Bass did not agree. His premise was straight forward (1) the Claimant was markedly vulnerable to SSD and (2) many of her complaints do not have an adequate physical organic explanation.

95. The psychiatric diagnostic conclusion therefore differed – Professor Green took the view the Claimant had a chronic PTSD that proved refractive to treatment, which presented alongside a reactive depressive disorder compounded by the physical diagnosis of FMS. Dr Bass observed the Claimant had recovered from her PTSD by October 2013 – he did not see any good evidence of depression but had developed a chronic and enduring constitutional SSD (**B2/351**).

Rheumatology

96. Dr McKenna and Dr Huskisson, consultant rheumatologists, provided their joint statement on 12th September 2016. As to the Claimant's current presentation, they seemingly agreed – the Claimant did suffer from FMS and given its chronicity, only limited improvement was now to be expected. They agreed the Claimant was vulnerable

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[38] See Professor Channer's letter to the GP dated 9th November 2015, where he refers to her BP at 165/109 and later 153/108 mm/Hg (**B3A/987**).
[39] Still-births and pre-eclampsia.
[40] As recognised under DSM V 300.82.

to developing FMS, given her background and the stress she experienced at work. They both appeared to agree **(B2/344)** albeit speaking as rheumatologists, that the Claimant had exhibited SSD in the past.

97. Where the rheumatologists disagreed was whether (a) the trauma experienced by the Claimant in the context of her pre-morbid psychological vulnerability and PTSD caused the development of FMS, (b) whether the Claimant had exhibited FMS prior to the index accident, which would suggest (if established) that FMS was always likely to recur, depending on the nature of life's stresses into the future (c) whether the Claimant's presenting memory problems, were sufficiently well explained by her FMS (as opposed to other factors being at play) and (d) whether her surveillance presentation suggested subjective exaggeration on the part of the Claimant.

98. Dr Huskisson felt the Claimant's clinical history showed FMS prior to the accident and had the Claimant presented to a rheumatologist in 2011, a diagnosis of FMS would have been made. Dr McKenna disagreed – the Claimant had well documented musculo-skeletal ailments and did not have 'widespread' muscle pain to engage and satisfy the diagnostic criteria for FMS. Dr Huskisson disputed the Claimant's seeming memory loss was explicable by FMS – an accepted FMS 'fog' or muddle of thinking, would not explain the serial inaccuracies in recall which had been well established in the Claimant's account – it was also inconsistent with her performance in court from the witness box. On this Dr McKenna did not greatly disagree – at least, so far as 'major' events were concerned. Dr McKenna did not see anything on video which was inconsistent with what she had stated to him. Dr Huskisson was dismissive of the Claimant as a genuine historian compared to what was seen on the DVD surveillance – her limp was inconsistent – the use of a splint and a stick was for "show" – the DVD showed the Claimant to be functioning with near normality. He was concerned as to the Claimant's inconsistency in her reporting of her symptoms to Mr Patel on 9th August 2012, to the Accident unit the same day (complaining of an insect bite) and her later report of her difficulties to Tina Jones of the Charity for Civil Servants, on 24th August 2012 **(B3B/2436)**. Dr Huskisson concluded there was deliberate exaggeration.

Intervening medical issue

99. At 03.00 hours on 25th April 2016, the Claimant awoke with some odd right sided sensations, feeling dizzy and shaky. She attended the accident unit in St Helens and was seen at 04.26 hours. She gave a history of:

"... altered sensation to her ® arm ® leg, ® shoulder blades, ® sided back, ® face. ° weakness, numbness, feels dizzy, shaky. Had pins and needles to both hands for a while. Yesterday was reading out in church approx. 09.00, lost words on page..." **(B3A/1131)**.

Due to the presence of ataxia with right sided reduced sensation, a CVA was suspected at 04.50 hours. On later examination at 05.25 hours, the Claimant was found to be alert but disorientated. The FY2 doctor recorded sensory disturbance by which time, it appears her symptoms had resolved **(B3A/1152)**. In giving her history to the clinical staff, the Claimant is recorded as stating that her 'decision making' and 'memory' were usually normal although her 'exercise tolerance' and 'mobility' were usually impaired. The Claimant underwent an ECG examination which was normal and arrangements were made for a CT brain scan. The short report of that scan reported:

"...No IC haemorrhage, SOL or established large territory infarct, Global atrophy slightly more advanced than age..." **(B3A/1157)**[41].

100. Dr Smyth, consultant physician, recorded to the Claimant's GP, taking into account her history, that she may have experienced a minor stroke in the light of her risk factors of possible hypertension and atrial fibrillation. In keeping with this diagnosis, the Claimant was then administered anticoagulation medication *(rivaroxaban)*.

101. In considering this development both Dr McKenna and Dr Huskisson did refer to these events as 2 recorded transient CVAs on 24th and 25th April 2016. Dr McKenna accepted, that although the CT scan reported 'mild' changes, they were not reported as 'trivial' and they would support some cerebral vascular disease with 2 possible mini-strokes in 24 hours. He accepted this would have possible implications for continued working with HMRC.

Dishonest exaggeration/Fraud

102. In the amended defence, the Defendants clearly assert fraud, which they purport to particularise, relying on the surveillance and apparent inconsistency between claimed disability and evident function, the Claimant's failure to recollect and acknowledge previous accidents and previous claims and alleging memory deficits and her failure to give straight and accurate Part 20 answers. They assert it is open to the court to make such a finding. The Claimant meanwhile, asserts that leaving aside the claimed features of the Claimant's inconsistency, the Defendants have not sufficiently pleaded to the facts, to be permitted to assert fraud here. She relies on the well-known authority of *Three Rivers -v- Bank of England*[42] to the effect that allegations of fraud must be sufficiently particularised so that a defendant (to the allegation of fraud) can know the case he/she has to meet. That entails not just what inferences should be drawn from primary facts but also what primary facts are to be relied on to justify any inferences. As Lord Millett stated:

"...it is not open to the court to infer dishonesty from facts which have not been pleaded, or facts which have been pleaded but are consistent with honesty...".

In *Hussain -v- Amin & Chartis Insurance*[43], Davis LJ returned to the same issue when he stated:

"...if the second defendant considered that it had sufficient material to justify a plea that the claim was based on a collision which was a sham or a fraud, it behoved it properly and in ample time before trial so to plead in clear and unequivocal terms and with proper particulars...".

103. The Claimant asserts that instead of providing specific particulars of the facts which the defendants will prove amount to evidence of fraud on the Claimant's part, they merely make broad assertions without any specificity. As part of the Defendants' submissions following cross examination of the Claimant, Mr Ferris invites my specific attention to a whole host of specific features of the evidence – for example, the diary entries (with a view to asserting they are self-serving, concocted after the event accounts – certainly not as claimed, a contemporaneous detailed accurate narrative[44]) specific times and dates in the video surveillance and specific inconsistencies in the

[41] The more detailed radiology report can be found at **(B3A/1167)**.
[42] [2003] 2 AC 1 per Lord Millett at 291 para 183.
[43] [2012] EWCC 1456 at para 18.
[44] Mr Ferris's written closing remarks on the provenance of the diary are: "*...the Claimant's diary is a fake...*".

medical presentations before (as an example) Mr Patel compared to Mr Braithwaite and the Accident unit entries on 9th August 2012, to name but three specific examples.

104. The only assertions made under the Particulars of Fraud which can be easily elicited in terms of specific primary facts, are the agreed incidents of previous accidents and claims, which are not set out in the Claimant's Part 20 responses.

105. The question arises, have the Defendants done enough to be permitted to make the assertions which they now seek to make and as to the primary facts, which they take on the obligation of proving? Has the Claimant been sufficiently forewarned as to what specific facts the Defendants are to prove and on which the Claimant may have to give consideration to calling additional rebuttal evidence?

The fraud pleading

106. The rationale for particularising with specificity the primary facts in a fraud needs little explanation - how can the defendant to the allegations know what is being alleged and in turn proved by the party making the assertion and what evidence in rebuttal might be necessary to be collated to counter such allegation(s), without detail? Plainly on the facts here – the diary (fake or otherwise), to take an example, is not referred to in the amended defence at all - no primary facts are asserted. Further, other than some broad generality of inconsistency, the primary facts relating to the specifics are left unstated without any reference to the statement of case, the statements and/or any experts' reports. At least, so far as the mis/non-reporting of previous accidents are concerned – such primary facts are easily elicited and in the end, are not open to much doubt (the Claimant did not raise any real doubts). The video surveillance is there for all to see but almost all specificity is missing.

107. I therefore am driven to the conclusion that the amended defence is seriously defective – the only areas where I will consider an assertion of deliberate and/or fraudulent behaviour or exaggeration are (a) the previously mis/non reported accidents and (b) any established inconsistencies between the Claimant's statements, her history elicited during clinical consultation (where relevant) and the video surveillance.

108. Strictly, the latter (b) does not comply with the *Three Rivers* case but I will exercise my case management discretion to admit it as: (1) the surveillance has been available to the Claimant for many months prior to the trial (2) the Claimant has had the opportunity of considering it and providing detailed responses to each film in supplemental statements (3) in recent years, in the county court, a practice has developed where in relation to surveillance evidence, defendants have not identified in schedules, with specificity, each particularised act of inconsistency (primary facts) but that has not prevented courts from fairly assessing the evidence to determine the presence or otherwise of deliberate actions and motives. Almost always, the evidence in rebuttal will be the Claimant or a relative. Here, there has been ample opportunity to assemble such evidence and the Claimant has called a number of character and supporting witnesses.

Fraud – the standard of proof

109. So how should I approach the issue of fraud in his case – who has to prove what and to what standard? It has long been established that the onus of proving the case rests on the Claimant to the civil standard of proof – that is, a fact is proved if established, more likely than not. So too, medical causation of injury arising from an accident is proved to the same standard. If a Defendant seeks to put an alternative case to explain the facts,

the Defendant whilst faced with the evidential task of proving those different facts, does not assume any legal burden of doing so. The legal burden continues to rest with the Claimant alleging the primary facts put forward to support the claim.

110. Where the Defendant asserts, as here, that a Claimant has acted fraudulently - deliberately misleading the court by her illness presentation and grossly exaggerating her symptoms, whilst the Claimant retains the obligation of proving her injury and such injury as the cause of her loss, the party asserting fraud has the obligation of proving not just the primary facts but any inferences the court should draw. Here, the amended defence at paragraph 2A, expressly asserts fraud.

111. Special caution and care needs to be taken where, what the Defendant asserts, amounts to serious or criminal behaviour on the part of the Claimant. This is sometimes referred to as an enhanced standard. However, there is often confusion as to what this means in practice. The matter has been discussed many times and was given special mention in the House of Lords by Lord Nicholls in *Re-H (Minors)*[45] – it has been discussed since. Broadly, the law approaches the matter in this way - in assessing what was more probable, the more serious the allegation, as a starting point, the less likely it is of having occurred – and so, as to the evidence needed to prove such an allegation, the more cogent on the facts, it needed to be. This notion has given rise to some confusion with suggestions that in the case of serious allegations, such as fraud, that in effect a criminal standard of proof arose. Any such notion has been clearly dispelled by the House of Lords in *Re-B (Children)*[46]. The passages in the speeches of both Lord Hoffmann[47] and Baroness Hale[48] make it now entirely clear, if there was any lack of clarity earlier, that in civil cases there is <u>only one standard of proof – the balance of probabilities</u> – however, in assessing whether the evidence put forward by the person charged with the onus of discharging this standard, succeeds, where what is suggested factually to have taken place, is <u>inherently improbable</u>, the court may well, '*to whatever extent felt to be appropriate*', require stronger evidence before being satisfied.

112. Applying that rule to the current facts where the Defendants allege malingering and gross exaggeration, whilst the standard of proof remains 'on the balance of probabilities', I do need to take extra care in assessing the evidence and exercise a degree of flexibility. I must allow for the fact that in the overwhelming number of personal injury actions, Claimants present to the court with genuine, albeit subjective accounts of their symptoms. Often to underline the extent of those symptoms, they can in effect over-emphasise the problems and down-play underlying/constitutional difficulties, to ensure they are properly compensated. This happens up and down the country and it is the skill of the court in separating out 'cause and effect', in relation to the injuries alleged. However, this is not to be confused with the malingerer or the Claimant intent on deliberately misleading the court – fraud. This in fact, although a matter before the courts, is much more uncommon. Ordinarily, people do not seek to support and present fraudulent claims, although, it is a well-recognised phenomenon. Where such facts are being asserted by the Defendant – the court should look for some cogent evidence, to find such fraudulent conduct, as being the more probable explanation of events. This is how I propose to instruct myself.

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45 [1996] A.C. 563 (586E-H)
46 [2008] UKHL 35
47 Para 15
48 Para 70

The lay evidence

113. In the course of hearing the Claimant's case, I heard from the Claimant, who in turn adopted and confirmed the truth of her 7 witness statements. I heard from the Claimant's husband Stephen and two of her sons, Martin and Stephen. I also heard from some of the Claimant's friends, Lesley Sharrard, Patricia Yeowart and Diane Hampson. Finally, I heard from Father Matthew Nunes, until recently, the Claimant's parish priest. All of the witnesses, confirmed the truth of their written statements.

114. I have read the written evidence of Lindsey Ryan dated 6th April 2012, the Claimant's solicitor – this was a statement given in support of an earlier application - she did not give oral evidence as her statement was unchallenged.

115. The Defendants' lay evidence was limited to a statement from Jeremy Ward, the director of 'Claims Process' for the Surveillance Group, dated 23rd May 2016, in relation to the video surveillance undertaken. Enclosed with the disclosed surveillance pack **(B1/342I-XLVI)** were the short statements from the surveillance operatives operating the cameras on the relevant days but I did not hear from them further.

116. My overwhelming impression of the Claimant in giving evidence from the witness box was that she was a confident and well prepared witness. She had obviously worked very hard on the case and read the relevant documents. I was not left with any doubts that she suffered any serious intellectual deficit[49] due to the effects of either her FMS or any functional overlay (properly so called). She gave evidence over a prolonged period (from mid-morning of day 1 to late afternoon on day 2). Her responses to a significant extent required her to recall and process information, stretching back over a number of years and she gave clear answers for the most part without hesitation. Her lack of recall seemed to surface when she was required to address an inconsistency. I will return to this. The manner in which the Claimant gave evidence is also worthy of note - outwardly, that she remained in some discomfort for most, if not all of the time she was giving her evidence. She frequently moved position, occasionally preferring to stand. Whilst I did make provision for some breaks (aside from the normal court breaks) in the evidence, my distraction in the evidence, probably meant, I did not rise with sufficient frequency to alleviate the discomfort the Claimant was suffering – for my lapses in this regard, I can only apologise. Nevertheless, I felt the Claimant gave a good account of herself. In part, this was not surprising, as she has for a number of years, held down a responsible post with HMRC to the time of her accident – and she is an intelligent woman.

117. The Claimant came across to me as a lady who knew how to 'play' the HMRC system with a view to maintaining her position within that organisation, protecting her interests, whenever she sensed they were being threatened. After all, she had come through the system over some 21 years. Her email communications with her line managers and HR personnel at HMRC both before and after the event, gave me the unmistakable impression that the Claimant knew how to 'fight her corner'. I will return to the diary a little later but as I shall develop, this was an example of this process.

118. I listened with interest to the evidence from members of her family – I found the evidence from both sons impressive – I was entirely satisfied that they had come to court to give a straight forward account and say how it was at home, when at times, they have either lived with or visited the Claimant. The Claimant's husband, although less articulate than his sons, in terms of his evidence, was entirely consistent with his sons. I

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[49] I will return to cerebral vascular issues later.

am satisfied he came to give me his best and most accurate account. Naturally, for a great deal of the time in question, as a merchant seaman, Mr Maguire was not at home but I was not left with any impression he was overstating the case, from his observations.

119. I was singularly impressed by the Claimant's friends – I accept as friends, it was their purpose to be supportive of the Claimant – they had gone to the trouble of providing statements and coming to court to support her. However, in respect of each, I was left with little doubt as to the genuineness of their evidence. They told it as they saw it and I accept the evidence without hesitation. Finally, I come to Father Nunes. He too was impressive and entirely reliable. His statement is short but to the point. He notes a definite change in the Claimant's demeanour and behaviour since late 2011. This is entirely consistent with what friends and family have stated and I have no doubts that outwardly, the Claimant does present to those around her, as a lady who does struggle with pain and discomfort probably affecting her mood, with restricted function and some limitation in her mobility – this is not a performance just for the edification of the Defendants and the court[50]. It reflects the Claimant's actual 'day to day' activity, depending on the state of her FMS and the issues I have touched upon within paragraph 76 above.

120. Turning to the evidence of Mr Ward, I found his evidence to be entirely straight forward and, whilst not involved in the actual filming of the Claimant, I found the answers he gave to a number of testing questions posed of him by Mr Grant, were perfectly reasonable. As both judge and practitioner, since the late 1980s, when the use of video surveillance evidence became in vogue in civil proceedings, I have had a lot of experience in assessing such evidence. The matters raised of Mr Ward and his responses followed to my mind, a well-trodden path.

Discussion

A pathological cause

121. Notwithstanding the agreed orthopaedic evidence, I find it very hard to credit that the Claimant can have suffered any significant pathological damage to her soft tissue musculoskeletal structure in the course of this accident. The MRI scan taken on 11th January 2012 did not suggest any ongoing inflammatory processes - they just revealed the legacy, many years in the making, of some underlying constitutional changes at C5/6 (neck) and over the lower lumbar and lumbosacral junction (low back). MRI is a very sensitive form of investigation in eliciting inflammation, given it highlights structural water content – there was no evidence of inflammatory processes seemingly ongoing 7 weeks after the accident, whatever the nature of the vibration assault the Claimant underwent on 25th November 2011.

122. I recognise that the effects of constitutional *spondylosis* on vertebral bodies and their soft tissue interconnections creates a measure of vulnerability to trauma, but whether that is expressed as a more enhanced pain response or delayed healing or a combination of the two – an inflammatory response is evident - not so, in the Claimant's case, 7 weeks *post*-accident. The record on clinical examination by Dr Barrow at the accident unit – allowing for the fact the Claimant has a history of low back pain (as I will come to), her physical presentation can only be seen as normal.

[50] I will return to the issue of subjective exaggeration later.

123. I cannot therefore account for the Claimant's presentation going forward as being due to any physical pathological process – that must raise the issue, as a primary explanation of (1) deliberate exaggeration (2) an overlaying functional presentation and/or (3) FMS.

124. A final thought on the pathogenesis of FMS – there is no single event, which later that day or the next, gives rise to FMS. It should not be understood like a pulled or strained muscle, with the development of a conventional pain response. It is a condition which evolves over time - in the numerous papers and publications made available for my perusal in this trial, not one I have read suggests otherwise. Dr McKenna confirmed as much and was at pains to emphasise, in his opinion, the development of FMS is signally accompanied by enduring sleep deprivation and fatigue. The effects of this can only happen over time. It was not argued by anyone that a lift accident in the morning can give rise to FMS the next day.

An earlier onset of FMS

125. The Claimant's diary record of her experiences the night of her accident, with pain throughout her back, across her shoulders, down her hips and legs, with developing arm and wrist pain would potentially satisfy a diagnosis <u>then</u> of FMS, if accompanied with muscle pain[51]. The Claimant's trip to the GP on 28th November 2011 referred to widespread back pain ("*...tender para-spinal muscles from neck down to lumbar region...*") but her diary entry for that evening (if reliable) again refers to hips, ankle, shoulders and having to sleep in a chair. The ongoing issue of repeated sleep disturbance (well evidenced in the diary notes) leads to the classical fatigue so characterising FMS. By 18th December 2014, the diary entry repeats 'widespread' pain. In the light of the later agreed statement of the rheumatologists that the Claimant did develop FMS and still suffers from it (whatever the nature of her *pre*-morbid vulnerability) this strongly points to her having developed a clinical presentation of FMS, almost immediately after the accident. Plainly those same symptoms perpetuate and were on the Claimant's account, unremitting (see diary entry for 18th January 2012) beyond the date of the MRI, that shows no inflammation – in short, the presentation then either has to be FMS or SSD (or a combination of the two) or the Claimant is a malingerer.

126. Dr Huskisson sought to argue that well prior to the accident, the Claimant was already exhibiting FMS. The rheumatologists agreed that the Claimant had demonstrated SSD but Dr McKenna, did not accept that FMS was clinically evident prior to the accident. So what were the widespread non-organic symptoms of which the Claimant complained to justify such a conclusion? I take up his own evidence on this subject:

a. Complaint of insidious incident of low back and hip pain (extending into the trochanteric areas) for which referred to physiotherapy in March 2011 (a repeating complaint from 2006) and <u>referring</u> into the lower limbs;

b. Complaint of costochondritis (chest pain) in September 2003;

c. Complaint of unresolved groin pain in June 2010;

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[51] See footnote 26 *supra*. In turn, Dr Huskisson referred to these diary entries in evidence as "*textbook FMS*".

d. Complaint of abdominal pain in August 2005 on holiday and then re-referred complaining of right iliac fossa pain in March 2006, with little found on investigation;

e. Complaint of neck pain (Dr Huskisson seemingly allied this into her history of road accidents set out under para 73 above);

Seen together, he took the view this was pain presentation from 4-5 sites and focussing on the pain diagram (**B3A/1097**) on 13th May 2011, he identified on his interpretation of this diagram, 16 different trigger points, low back/sacro-iliac crest, ankles, knees and thighs, front and back. He disputed there was any likely pathological explanation for such a presentation and therefore, this was in effect diagnostic of FMS[52].

127. Of interest, neither the reports of Dr Huskisson or Dr McKenna make reference to Ms Davitt's pain diagram of 13th May 2011. Dr Huskisson refers to the GP letter of 20th June 2011 (which presumably was in the GP records he saw). The joint statement does not refer to the pain diagram when they appear to disagree as to what the pre-accident symptoms were (**B2/345**) - yet that diagram is the best evidence of widespread symptoms without seeming pathological cause. Dr McKenna agreed that if there was widespread pain, sleep disturbance and fatigue <u>prior</u> to the accident that might suggest a diagnosis of FMS. In evidence, Mr Huskisson repeated his view with reference to the pain diagram - Dr McKenna confirmed that there was evidence at the time, the Claimant had poor sleep and he did agree that her history suggested low back pain referring down into the lower limbs but he disputed a diagnosis of FMS could be made on the back of this.

128. Plainly, in the light of the MRI scan findings of 2012, there would be no good pathological explanation for such a pain diagram. Whilst a localised pathology (not nerve root entrapment) might explain a 'referred' pain into the buttocks, it would not explain a radiculopathy along the L4 or L5 nerve distribution (to explain lower limb, knee and ankle pain).

129. As for the other sites of pain, identified by Dr Huskisson, it must immediately be observed that there is no temporal link or relationship to the development of any of the matters complained of. It might be argued that there was not much to explain the groin pain in 2010 or the right iliac fossa pain in 2006. However, the pleuritic pain was diagnosed as a chest infection, the neck pain followed on from road accidents, she had established underlying cervical spondylosis and earlier complaints seem to have well-established physical causes. Plainly, the anxiety issues the Claimant experienced after 1986, following her well established depressive illness do seem to have led to the diagnosis of atypical chest pain, panic attacks and her misdiagnosis of temporal lobe epilepsy. So whilst I can understand the general agreed observation of the rheumatologists that the Claimant had exhibited SSD, I am less than impressed that the constellation of complaints prior to May 2011, enforce a diagnosis of FMS.

Memory

130. The Claimant's memory issue was carefully considered. The Claimant asserted her memory was affected when she developed FMS and there is some anecdotal support for this from her family with confirmation from Father Nunes. The experts agreed that memory recall of important and specific events would not likely be affected although

[52] with some measure of hindsight.

some 'fog' or muddled thinking has been associated with FMS. The relevance of this relates not just to the Claimant's lack of recall (when Mr Ferris suggested it suited the Claimant) but to the clearly misleading and erroneous answers the Claimant gave in the course of her Part 18 responses relating to her former road and other accidents and her somewhat aberrant explanations as to why she got both the dates and detail wrong.

131. A Part 18 request was made on 22nd January 2016 about the Claimant's previous personal injury claims over the 10 years prior to September 2015 (**B1/46**). The Claimant replied on 12th February 2016 (**B1/47-48**) – in giving her replies, she attached an email of 1st February 2016 from the Direct Line Group. On 3rd March 2016, recognising she had got the details wrong, she sought to correct them (**B1/51-52**). The initial Part 18 request had been made because on 11th June 2015, the Claimant's solicitors, stated on her behalf:

"*...our client advised that she has not made any personal injury claim over the last ten years save for in relation to the RTA of July 2012...*" (**B1/52XXVII**).

In fact, as Kennedy's, the Defendant's solicitors knew full well, this was not correct - as they set out in pictorial form (**B1/52XXIX**). The errors had in fact been started when the Claimant gave Dr Huskisson erroneous information when he took her history of previous accidents, referring to a 1995 accident which in fact had occurred in 2005, seemingly explaining her error by linking it in with the date of the death of her sister in 1995. If this explanation was correct, it meant the Claimant had also completely misremembered the date of her sister's death[53] – the Claimant put it all down to memory dysfunction due to FMS.

132. Plainly, the Rheumatologists do not accept it as likely, an event such as the Claimant's sister's death and forgetting the date (to be 10-11 years out), is explained by FMS. So too, for the Claimant not to recollect her accident in 2005 and (x2) in both 2007 and 2009 (as she must have in giving instructions to her solicitors) could not be explained by her FMS. The Defendants argue it just exemplifies, in keeping with many litigants trying to make money out of the litigation process, a dishonest Claimant, who is simply not prepared to give an honest and accurate account about her previous accidents and claims.

133. I keep in mind here that I have not been referred to any psychometric tests conducted on the Claimant, to examine the Claimant's organic and functional memory abilities or her effort in undertaking the tests. Moreover, the issue of the Claimant's recent cerebral vascular events needs to be considered. The best evidence is that she has had 2 recent mini-strokes, against her well established history of hypertension and atrial fibrillation. I must not lose sight of the fact that now (as opposed to June 2015), there may be more reason to suppose the Claimant's memory is not as good as it was.

The consistency of medical examination – Mr Patel

134. If Mr Patel's examination findings on 9th August 2012 are taken at face value, given the diagnostic criteria for FMS, FMS was not in evidence at that time. As FMS depends on widespread muscle pain and as Mr Patel found just some minimal para-spinal tenderness in the lower cervical joints with some diffuse tenderness over the medial joint line of the left elbow, the diagnosis at that time is unsustainable.

[53] The Claimant's sister died in 2005.

135. Dr Saleh, who first diagnosed FMS on 21st January 2013, as he put it, found *'aches and pains'* all over with 18/18 positive muscular attachment points. Whilst the 2 clinicians are from different medical disciplines, there is bound to have been sufficient clinical overlap in the examination of joints, ligaments and muscle groups, for one examination to be still meaningful to another. To illustrate the point, there is no evidence Dr Saleh was aware of Mr Patel's clinical examination findings 5 months earlier (as it was undertaken medico-legally) but it would not have been an irrelevant finding at least as to the timing of the onset of the FMS, in the absence of the Claimant's diary notes and her personal history.

136. Mr Patel's findings then need to be put against the Claimant's self-referral pain diagram on 15th June 2012 (**B3A/1340**) as seen against the later diagram on 14th August 2012 (**B3A/1411**) undertaken by the physiotherapist, who described them as multiple 'static' joint pains with the patient taking *tramadol* and *naproxen* with the recommendation, the Claimant was better treated by the chronic pain team. Frankly, the pain diagrams cannot sit with Mr Patel's examination and it is difficult to explain, given their temporal proximity, the discrepancy.

The surveillance and the Claimant's consistency in presentation

137. Mr Fagg articulates the Defendants' concerns here. When he examined the Claimant on 1st October 2015, she presented with significant tenderness over her neck, trapezius and shoulder muscles – they were in effect hyper-sensitive to touch[54]. Her neck movements were but 25% of normal – so too, although he did not give a measurement, spinal movements were markedly restricted. A year earlier (13th October 2014), the Claimant had made a claim on the DWP for employment and support allowance (see para 90 *supra*) and her description of her condition was one of quite serious dysfunction with no good days – just able to drive an automatic car to get out of the house, with very restricted abilities to stand or mobilise requiring help for all tasks. This account was in keeping with a DWP health/fitness questionnaire filled out 3 months earlier on 2nd June 2014.

138. The DVD surveillance plainly shows a person who can drive alone, carry some shopping, push about a shopping trolley, walk about shopping areas, parks, supermarkets – seemingly, without difficulty and for prolonged periods. Movements can be seen, as commented on by Mr Fagg, which plainly exceed what he was able to elicit on his examination – her neck movements in her car, her back movements when out shopping. Her capacity to mobilise is seemingly much greater than she has stated to the DWP and far from needing help with almost all activities of daily life, she appears on the camera to be relatively independent in function and reasonably capable. I recognise that wheeling a trolley around the shops and picking items from the shelves does not require the same degree of physical effort, as cleaning your house and doing the garden.

139. As I have stated above, FMS is not a static condition – its effects will fluctuate depending on a number of variables - the extent of previous activity, any increasing levels of stress or anxiety, the extent of the given sleep disturbance and the levels of fatigue. Although it is only a relative 'snap shot', given the fact that no-one has lived with the Claimant, week in and week out since 2011, the Claimant's claimed condition and her restriction of function at home is largely supported by her family and friends. So, there is some evidence in consistency in presentation. The question is whether the picture the DWP and Mr Fagg in the course of his examination were presented with

[54] "*...vocalised pain and to gyrate even to light touch...*".

represents a fair reflection of the actual dysfunction and 'day to day' difficulties she encounters – or whether, the surveillance and her seeming capacity, more accurately reflects her usual norm.

The Claimant's underlying sensitivity

140. In a sense, part of the guess work in this case is taken out by reason of the fact that a number of clinicians have diagnosed FMS and the 2 relevant experts agree the Claimant went on the develop the condition (they just disagree on timing). Trauma is a poor prognostic factor for the development of FMS, with the links being somewhat tenuous. Whatever the underlying pathogenesis of the syndrome that becomes FMS and recognising that it is probably multi-faceted, an underlying constitutional sensitivity is plainly at the heart of it – and by definition, given the fact the Claimant has gone onto develop it, she had it.

141. As has been identified above (and as all the experts agree), the Claimant has a number of striking features in her premorbid experience which plainly added to her sensitivities – her extraordinary obstetric history, her experience of child physical and sexual abuse leading to her developing a mental health disorder in the form initially, of post-natal depression, which appears to have developed into an endogenous depressive illness. In turn, she went on to experience high levels of anxiety, which brought on panic attacks, presenting itself physically – i.e. by means of somatisation, as physical illness. This in turn led to her misdiagnosis of temporal lobe epilepsy (for which she was treated for many years) and a concern she may have developed cardiac dysfunction. The reference to SSD there is understandable.

142. The GP notes do tend to suggest to my reading of them, the Claimant appears to have displayed a slightly neurotic approach to her health – whilst plainly some of her complaints did have a sound organic basis – others did not. What to my mind cannot be ignored, when all of this is taken together, on any balance of probability, the Claimant was highly at risk of developing FMS, when there was a convergence of stress and anxiety (whether or not related to any physical condition) leading to sleep disturbance and the development of fatigue.

143. Looking forward in the Claimant's life, absent the accident, yet further sources of stress awaited here – occupational stress, as she strived to maintain in her late 50s/early 60s, her preferred career path with HMRC, when she obviously perceived, she was being side-lined and in effect, demoted as she struggled to gain her last qualification after many attempts – health stresses, in the light of her tendency to have every little thing investigated, tending towards somatisation and what appears to be the development of a genuine cerebral vascular decline (a problem experienced by many) in a hypertensive with atrial fibrillation, leading to her 2 mini-strokes in early 2016[55]. Overarching all of the above, will be the usual familial stresses we all experience with ageing, as life moves forward.

Findings of Fact

144. I start by reminding myself that it is for the Claimant to prove her case on the ordinary civil standard of proof. The Defendants so far as rebutting the Claimant's claim are concerned are not required to prove anything. Where and insofar as they assert

[55] This is important as it feeds into both stress of worrying about how the Claimant might cope at work, work stigmatisation, yet further loss of opportunity and loss of status – as well as the understandable worry of whether another more serious stroke might be around the corner.

fraud, they have the obligation of proving it. I am not required to address every factual issue raised by the parties, only those I determine are essential to the delivering of my conclusions

a. I accept the Claimant was the subject of a shocking and frightening incident on 25th November 2011, in the course of which she did suffer some shaking up, due to exposure to short-lived grinding vibration, which probably did give rise to some modest soft tissue injury. I prefer the approach of Mr Fagg in stating from a physical perspective, she suffered an insignificant spinal injury of no more than 3 months duration. The lack of any inflammatory activity on the MRI scan 7 weeks *post*-accident, supports that finding;

b. I find the Claimant suffered significant psychological trauma in the course of the event, which so agitated her mind so as to give rise to a clinical Post Traumatic Stress Disorder (309.81 **DSM V**, F43.1 **ICD-10 WHO**), which in due course followed a chronic course, remaining refractive to treatment. I accept the opinion of Professor Green that notwithstanding the prolonged therapy leading up to the end of November 2013 and the statement by Ann Smedley that the Claimant was happy to be discharged, having made 'very good progress' that the PTSD had not ended. Professor Green diagnosed the presence of ongoing PTSD clinically on 30th November 2013 (approaching the 2nd anniversary of the accident). I accept the nature of the Claimant's vulnerable personality made her prone to such a chronic course. There is insufficient evidence the PTSD has continued beyond the ending of her EMDR course in May 2016.

c. I find the Claimant also probably did develop an associated depressive disorder of 'mild to moderate' severity, which was still in evidence to Professor Green in late 2013. The fact that clinically, the Claimant was prescribed *Citalopram* to October 2012, which in turn was replaced by *Amitriptyline*, supports that diagnosis. I prefer Professor Green's analysis over that of Dr Bass.

d. Nevertheless, I accept Dr Bass's opinion that the Claimant was displaying SSD after the accident. I have no doubt and find this was just part of a continuum. I find, as agreed by both Dr Huskisson and Dr McKenna, that the Claimant had a pre-morbid history of SSD, as part of her vulnerable psychological presentation. The events immediately following the accident did reflect the Claimant somatising her psychological anguish, in the absence of a sound pathological cause of her subjective symptoms.

e. I do <u>not</u> find that the Claimant suffering a SSD and a 'mild to moderate' depressive disorder in combination with a PTSD are mutually exclusive conditions – I see no reason why as conditions, they cannot co-present.

f. I find there is a significant overlap between SSD and FMS, the former compounding the risks of developing the latter.

g. I find pre-morbidly the Claimant was significantly vulnerable to developing FMS. I reject Dr Huskisson's opinion that the Claimant had already developed full blown FMS prior to the accident. I find that whilst the Claimant had displayed longer term SSD pre-morbidly, these were not temporally linked and cannot be used to satisfy the diagnostic criteria for FMS. The low back complaint and referred pain into the lower limbs in May 2011 (the 'high water mark' of his

hypothesis), whilst a likely example of SSD, cannot I find, of itself, be categorised as FMS, as the distribution of the pain was not sufficiently widespread[56].

h. I find the Claimant's subjective presentation, as reflected in her diary notes after the accident, did genuinely reflect her experiences at the time but they are not a complete or entirely reliable set of observations. Self-evidently, I find the entries were selective and self-serving, designed to be used later either in the legal claim or as part of a later explanation to her employers as to why she was not fit for work. I find the absence of the gym information, in the light of the information given to the gym, to be a significant omission from such a diary.

i. I find on the balance of probability, the Claimant's immediate *post*-accident presentation and her reported physical symptoms were a combination of some genuine mild physical injury, significantly overlaid with SSD, due to the extent of her mental agitation, given her vulnerable personality. I find as the sleep disturbance continued and fatigue set in over the weeks following, it is probable FMS could be diagnosed, even though it was not formally diagnosed until January 2013.

j. Within 4-6 weeks after the accident (before she had finished recording the diary), I find it probable FMS was the primary diagnosis, alongside, an overarching depression and PTSD. As with all FMS presentations, it will have been following a remitting course with 'ebbs' and 'flows', worse at some times than at others.

k. I do not find that by the time of the May 2012 RTA, the Claimant had recovered from her FMS. Dr Rathbone's review on 4th April 2012, whilst reporting some improvement in the 'constant pain', still supported an ongoing widespread pain – so too, his later review on 11th May 2012. It is frankly inevitable given the course of FMS, that it still persisted on 26th May 2012. The Claimant's own pain diagram on 15th June 2015, which I find was a genuine attempt by her to localise her pain, showed this ongoing picture. Given the physiotherapist's clinical record of her examination on 14th August 2012, which only showed the same pattern as in the June, the physical examination findings of Mr Patel, against this overall background, were remarkable. This cannot be satisfactorily explained by the ebbing and flowing of chronic FMS. Given the later clear clinical findings of Dr Salih on 21st January 2013, it raises a significant question mark as to the adequacy and validity of Mr Patel's medicolegal examination and I reject it.

l. The later examination findings of Mr Patel in January 2014 also need to be considered. There is no contemporaneous comparison in the clinical records, save the later examination findings of Mr Braithwaite who examined on 18th February 2014, the following month. I find the examination findings in the two reports cannot sit together. I prefer the likely findings of Mr Braithwaite and again reject as unreliable, Mr Patel's findings.

m. Nevertheless, I find that at some stage in 2014, the Claimant is likely to have been subjectively exaggerating the effects of her symptoms and resulting disabilities. I note that the Claimant started attending a FMS group in April 2013, regularly seeing and relating to other FMS sufferers, engaging in regular fund-raising and other recreational activities with this group. The later filming of the

[56] See footnote 28 *supra*.

Claimant, in company with other FMS sufferers clearly shows, and I find, exaggeration – the Claimant's gait and pace of walking changed, once separated from her FMS friends. Other filming of the Claimant attending supermarkets and mobilising independently also show her to be more able than when in the company of her FMS friends – there was an almost sympathetic level of disability. This was not pathological and can only be seen as exaggeration.

n. The DWP form the Claimant filled out in June 2014 and the account she gave to Nurse Hove on 13th October 2014 suggested a level of dysfunction in 2014, which was not backed up by the surveillance on 18th and 19th July 2014 and 17th August 2014. In keeping with the above finding, this too suggests exaggeration.

o. I am satisfied on the balance of probability that this exaggeration did not vitiate the assertion that the Claimant does have a genuine FMS condition – I find she is not as incommoded as she presents. I have accepted the account of the Claimant's sons and her husband, which I accept supports her as to the fact of some ongoing dysfunction which restricts what she does around the house, cause her to be restless in finding comfortable sitting and the like but I propose to value her loss of amenity and any special damages for loss of services and the like after 2014, in the light of what I find is the Claimant's more significant capacity to undertake 'day to day' functions in keeping with the video surveillance. To do otherwise would be to ignore the surveillance.

p. I reject any suggestions that the operatives of the Surveillance Group have at any time, deliberately sought to mislead the court by selectively stopping the filming on occasions when the Claimant is displaying what to her case would be 'consistent' behaviour. Allowing for the fact that Mr Ward was not present during filming. I accept his explanations as to why filming may have been cut short.

q. On the question of the Claimant's memory, I accept a dulling of some of the detail, due to the effects of FMS and I bear in mind, as I have found, she was labouring under a functional disorder between 2012-2014 – this can also affect memory. However, I cannot be satisfied this explains the omissions of the Claimant and in failing straight away, to give accurate responses as to the accidents she had been involved in and what claims she had made for personal injury. The 'fog' of FMS might well have prevented some detail from being elicited but not amnesia as to 5 accidents and confusing the date of her sister's death by 10 years. In fact, all these details were very largely irrelevant to the matters under review and so it is difficult to assess what the Claimant's motivation may have been, in failing to give a more factually accurate reply. That raises the related issue of vascular dementia, which is just touched on as a consequence of the Claimant seemingly developing cerebral vascular disease. In the final analysis, I will not be influenced greatly in formulating my conclusions on credit, by these omissions but they do feed into the wider issue of whether the Claimant has proved she will have gone on working for HMRC into the future. A suspect memory contraindicates ongoing higher level audit work and the like.

r. I was unimpressed by the Claimant's assumption, if she had not stayed on with the Audit unit in Salford she would have moved to Liverpool, with a salary promotion, to senior officer grade, absent her passing the relevant MIIA modules. The evidence to support this was very thin – essentially, the late "say

so" by the Claimant, otherwise unsupported. I was also not persuaded that it was a matter of short time before the Claimant passed all of her MIIA modules, given the fact that she had already had a number of attempts and failed, and failed again in November 2011 with re-sits in June 2012. Moreover, in the event of the Claimant failing the M4 module in June 2012, given the fact they she had seemingly escaped the HR re-deployment pool only by playing her 'disability card' with an implicit threat under the DDA 2005, one wonders whether HMRC may have used that opportunity (if she failed her M4 module again) to deal with the threat of that issue arising, if the opportunity to re-deploy the Claimant arose later.

s. I reject the notion that the Claimant's loss of chance of future earnings with the HMRC, should be assessed on any salary above that which she was receiving at the material time. I find it is much more probable that the Claimant will have remained at her pre-morbid salary scale, for so long as she was able to remain working with HMRC.

t. I am very doubtful the Claimant will have escaped the crudesense of FMS in any event, absent the accident, over the longer term. I find that given the Claimant's obvious and significant mental health vulnerabilities I have already highlighted and the fact as I have found, that she was already displaying SSD in May 2011, it was not a great step, allowing for the fact as we now know that she is sensitised to developing FMS, to actually developing FMS. Here, it is overwhelmingly likely, it was not the very minor physical injury that was the marker for FMS, it was the anxiety and stress of the situation with effects on her sleeping patterns, she found herself in. So the situation must be considered, what if the Claimant had failed her M4 module and was re-deployed and found herself re-visiting her DDA 1995 threat – how stressful would that have been – might that have led to unpleasantness, stress and sleepless nights? In early 2016, having suffered 2 mini-strokes with issues about her long term memory recall, how stressful might that have been? Regardless of FMS, given her risks of developing a functional disorder more generally, what were her implications for working at HMRC? Standing back from those issues, I find on a balance of probability, the Claimant is unlikely to have continued working for HMRC beyond her 60th birthday by which time, she is likely to have developed significant issues with her health either as a result of SSD or FMS. I find therefore that is the 'long stop' to this claim.

u. Whilst I find the Defendants have proved an element of conscious subjective exaggeration, on the appropriate standard, this case is very far removed from that category of case, where I would countenance depriving the Claimant of her damages, in effect striking out her case for an 'abuse of process'. Such a power, as Lord Clarke emphasised delivering the judgment of the Supreme Court in *Fairclough Homes*, should only be exercised in very exceptional circumstances[57]. I am minded of the observation of Ward LJ in *Widlake -v- BAA Ltd*[58]. I take into account the Claimant's SSD issues and her neurotic tendencies, seen against her involvement with friends from the FMS group – this sets the scene for the Claimant's subjective exaggeration. I propose to assess any loss on the footing of the Claimant's displayed presentation during surveillance after 2014, which will assist in measuring any care and assistance the Claimant should recover for,

[57] *Fairclough Homes Limited -v- Summers* [2012] UKSC 26 para 33.
[58] [2009] EWCA 1256, paras 41-42.

allowing for the evidence I have accepted from members of her family and friends, who have been given snap shots into the Claimant's function. I will not anticipate any later costs arguments.

Valuation

Pain Suffering & Loss of Amenity

145. I approach this exercise taking into account a period of acceleration of FMS approaching 6 years. I allow for PTSD ongoing, albeit with periods when the effects of PTSD were improving in 2013 before relapsing, requiring the EMDR therapy to the end of that therapy in May 2016, a period of 4½ years. I also allow for a mild to moderate depression for 2 years. I take heed of the JC Guidelines (13th edition). I will assess general damages without uplift. If the parties agree an uplift applies, then the figure can be increased 10%.

146. Standing on its own, the FMS claim, allowing for an acute period to early 2014, but ongoing to say August 2017 (a period approaching 6 years) would be worth around £18,500. The PTSD, allowing for its refractive nature, the extent of the need for therapy can only be viewed as moderately severe but time limited, would be worth on its own around £16,000. The mild to moderate depression over 2 years would be worth £3,500 -£4,000 and the mild physical effects of the soft tissue injury £1,450. Standing back from the overall presentation of the injuries and the global nature of the disablement, I would allow an overall figure of **£26,500.** There will be interest on PSLA damages at 4%.

Loss of Earnings

147. I will assess the Claimant's loss of earnings from the date her employment came to an end on 1st March 2014 to date (2.827 years) at an annual net multiplicand of £23,461 (on the footing that I do not find the Claimant will have risen to a Senior Officer grade), with future loss to her 60th birthday to 7th August 2017 at 0.5 years – totalling **£78,455**. That leaves outstanding her full pay she received from her employers. If the employers have the right of recoupment, that sum will be recoverable. I understand the figure paid out to the Claimant by HMRC was **£69,941.42**.

148. On the explanations I have been given in the written materials, the Claimant directly contributed to an ill-heath pension and thus, is permitted to keep the benefits of that policy without giving credit for it, as an exception to the rule in *Parry-v- Cleaver* under *Pirelli General Plc -v- Gaca*[59]. It seems to me the Claimant is entitled to a declaration that this sum (£8,077.06) does fall outside the rule and thus, the Claimant does not need to give credit for it. The fact that credit appears initially to have been conceded in the first schedule, is not a bar to the Claimant correctly identifying the relevant principle and withdrawing the concession.

Past Care

149. On considering Mr Grant's written submissions, there is much substance to what he says. I recognise the effects of FMS do fluctuate and there is a price to be paid for

[59] [2004] EWCA Civ 373 per Dyson LJ para 51.

excessive activity. I also acknowledge the account of family members and the Claimant being somewhat 'house proud' with her husband spending regular prolonged periods at sea. I have little doubt in the early days, as her FMS developed and the Claimant had to learn the lessons of what her capacity for activity was, her care requirement will have been greater. I also accept it will have fluctuated – some days the Claimant will have felt better and been capable of greater activity than on others. I keep in mind it is easier to keep house if there are fewer occupants.

150. On the issue of generic cleaning, I accept the Claimant will have been limited and would likely have restricted herself to light dusting, some polishing and limited downstairs hoovering. I cannot see any reason why taking her time, the Claimant cannot have changed her sheets or carried the sheets to the washing machine and attended to the wash. Hanging out washing, such as sheets can be difficult with good use of the upper limbs required and I can accept, she may have depended on family members for this. So too making up a bed, requiring the filling of a duvet, necessitates upper limb freedom of movement. However, the hanging out of personal laundry can be paced and taken in short stages. Adult males should hang out their own laundry and take responsibility for it, in any event, regardless of the maternal figure developing FMS.

151. I struggle with the argument the Claimant was not capable, save when the FMS was at its worst, of doing any relevant shopping or was not capable of driving herself to the supermarket as required. Most of the large supermarkets provide for an on-line delivery service and delivery staff will carry in shopping, where it can be later unloaded and stored away. There is no evidence the Claimant felt the need to avail herself of this service. For the most part, I cannot see why she was incapable of washing crockery or cutlery. High shelves for heavier items might well have been difficult without assistance but while living on her own (in her husband's absence) with for the most part just one son at home, it would not be much to ask him to attend to that out of ordinary love and affection – and shared roles within a household. Food preparation might have been an activity the Claimant would not feel like, when her FMS was really active but I do not doubt she would be capable of most food preparation if it was properly paced. It must not be forgotten FMS sufferers still have to get on with everyday life, with many living on their own – they just find their own ways of accommodating their difficulties and that is the best advice and encouragement to secure the optimum outcome. In being at home all day and in not going to work (for which the Claimant is going to be compensated *supra*) she had time on her hands to pace her effort, and it was a requirement of mitigation, that she did it.

152. Outdoor activity, gardening and any relevant DIY will obviously have been more difficult, especially in the absence of the Claimant's husband. Seasonal and weather issues will restrict this claim to the 30 weeks of the growing season. DIY and internal decorating can continue but I note that to the date of the schedule on 7th June 2015, no claim was made for decoration.

153. In embarking on resolving issues such as this, I always find assistance in going back to the insightful judgment of O'Connor LJ in *Housecroft -v- Burnett*[60] and the passage of his judgment at 343h – 343f. As the passage is very well known I do not find it necessary to set it out. The sense to be found there has been commented on many times since and notwithstanding the clarification by the House of Lords in the later case of *Hunt-v-*

60 [1986] 1 All ER 332.

Severs[61] that contrary to the view expressed by O'Connor LJ, in confirming the position stated by Lord Denning MR in *Cunningham -v- Harrison*, that money recovered by the Claimant was to be held on trust on behalf of the person administering the care - the views expressed by the Court in *Housecroft* are still of persuasive effect. Indeed, this was the conclusion of the Court of Appeal in the case of *Evans -v Pontypridd Roofing Limited*[62]. So the test remains, what sum should be paid to the Claimant to enable her to make reasonable recompense to her husband, sons and other family members, having regard as to what rate would be paid to provide for the service on the open market. There have been no payments for commercial care.

154. I therefore turn to the issue of aggregate or composite care rates. There are examples of aggregate care rates[63] having been made in the past and these cases were referred to in the PBNA Handbook for many years prior to 2012/13. The reasoning of those Courts in allowing aggregated rates was really confined to family members looking after severely injured family members - for example, individuals with cerebral palsy, requiring constant round the clock care with quite unusual levels of commitment from family members both night and day – viz: the need for changes of bedding and clothing and attention in the night, most if not every night. By their very nature, such awards were exceptional and reflected the fact that the injured claimant needed to mark such extraordinary commitment by an enhanced payment.

155. This category of case was then treated as a green light for claiming aggregated rates in all cases, I have never agreed with this. The principles of *Cunningham*, exemplified in *Housecroft* for family members being compensated for giving up their time to care and support a family member, do not require, enhanced payments at night or at the weekends, unless the nature of the support given demands it. It will not be the case here. I will allow only basic care rates.

156. I allow a rate measured against NJC spinal point 8 for current purposes, less 25% to reflect the savings in class 1 NIC and basic rate income tax in the manner as broadly approved in *Evans* (per May LJ para 38).

Past & Future Care Valuation

157. The award is thus:

Date	**Hours/rate**	**Cost £**
25/11/11 - 25/05/12 26 weeks	Personal Care 8 hours @ £5.14 Shopping trips 2 hours @ £5.14 Domestic Assistance 16 hours@ £5.14 Gardening/DIY	

61 [1994] 2 AC 350.

62 [2002] PIQR Q5 per May LJ at para 24.

63 *A-v-B Hospitals NHS Trust* [2006] EWHC 1178 Lloyd-Jones J made a composite order – Sir Roger Bell *in Iqbal -v- Whipps Cross University Hospitals NHS Trust* [2006] EWHC 3111, followed the same approach.

	0 hours	£3,475
26/05/12 - 25/05/14 104 weeks	Personal Care 4 hours @ £5.19 Shopping trips 0 hours Domestic Assistance 12 hours @ £5.19 DIY/Gardening 1.5 hours @ £5.19	£9,446
26/5/14 - 31/1/17 140 weeks	Personal Care 4 hours @ £5.55 Shopping trips 0 hours Domestic Assistance 10 hours @ £5.55 DIY/Gardening 1.5 hours @ £5.55	£12,043 **£24,964**
Future care to 60th Birthday 26.85 weeks x 0.985	15.5 hours @ £5.81	**2,382**
TOTAL CARE		**27,346**

Miscellaneous Special Damages

158. I allow a sum for past travelling expenses, including car park costs at £500, £750 for past prescription costs for annual pre-paid prescriptions, £50 for postage. The total miscellaneous past costs are **£1,300**.

Works done to house

159. This claim is rejected. I am not persuaded such costs legitimately flow from the Claimant's PTSD. The added value to the house has not been quantified or credited.

Loss of Pension Rights

160. The Claimant will not have continued working with HMRC on balance, beyond the Claimant's 60th Birthday. Absent the accident, she would have been drawing her ill-health pension based on contributions paid from 5/12/89 - 7/8/17. As HMRC have confirmed the Claimant's defined benefits under the scheme (**B4/2598**) would have been:

gross Pensionable earnings x Reckonable service
80

The Claimant made 5.27% contributions to the scheme (on the most up to date information) until she left it on 31st March 2014. There can be no loss of pension right to her cessation of the scheme, as she continued receiving her salary (including her employers' contributions). Any loss will therefore be limited to the period from 31/3/14 - 7/8/17.

161. The Claimant at retirement reduced her monthly pension in favour of increasing her lump sum. But HMRC expressly enhanced her superannuation pay-out, as though she had continued working within the scheme to 60 years – in short, her pension payments were based on reckonable service to age 60[64] (the normal age of scheme retirement). There is therefore no loss of pension entitlement.

Gym Membership

162. This claim is refused. The Claimant lied on the gym membership application form. She was not fit to use it. She was not advised to join the gym. She never used it. Joining the gym was not reasonable mitigation of her damage in these circumstances.

163. Interest will be recoverable under the normal principles – on general damages @2% pa from date of service of the Claim Form to date of judgment and on all past losses at ½ the court special account rate from the date of the accident to date.

Outcome

164. There will be judgment in favour of the claimant in the sum of **£133,601**. If a contractual entitlement to recoup sick pay, the Defendants will have an additional obligation to pay HMRC **£69,941.42**. All sums will attract interest.

165. I direct under CPR PD 39A para 6.1 that no shorthand note shall be taken of this judgment, that copies of this version as handed down, shall be treated as authentic.

His Honour Judge P.R. Main QC

Manchester Civil Justice Centre

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[64] HMRC stated this added 3 years 128 days to her service (**B4/2599**).