**IN THE HIGH COURT OF JUSTICE**

**Case No:HQ16P01064**

**QUEEN'S BENCH DIVISION**

**HIS HONOUR JUDGE SAGGERSON (Sitting as a Judge of the High Court)**

14,15,16,17,18,21,22,23,24 and 29 May 2018

**BETWEEN:**

**KATHRYN HIBBERD-LITTLE**

**Claimant**

**and**

**EMILY CARLTON**

**Defendant**

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**JUDGMENT**
**Final: Handed Down 6 July 2018**

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***Introduction***

1 This is a claim for personal injury damages arising out of a road traffic accident. Liability is not in dispute, negligence having been admitted by the defendant at an early stage of the proceedings. The claim arises out of a rear-end collision on 29th March 2013 (Good Friday). The claimant (born on 16 April 1983, then aged 29) was driving a new Ford Focus. Her husband was the front seat passenger. She was caught in stop-start traffic queueing on a slip road leaving the M25 near Cobham in Surrey. The claimant and her husband ("Trevor") were on their way to a water park near Guildford where they intended to meet up with her sister and her family. At about 3pm her car was struck in the rear by another Ford Focus driven by the defendant. The airbag was not activated. The claimant was wearing a safety belt and did not strike her head as a result of the impact. There is no estimate of the impact speed from any lay or expert witness. The only recorded estimate of speed is in the A&E notes: "?30 mph". I infer from the traffic conditions on the M25 as well as on the slip road that this is a reference to an impression of the speed of the defendant's car when the claimant first saw it approaching in her rear-view mirror. The resulting estimate must originally have come from the claimant as nobody else (such as Trevor) was aware of the defendant's approaching car. I conclude that the defendant braked on the approach to the collision; which is verified albeit in the most general terms, by the defendant's own accident report form. There is no other evidence to help with this aspect of the case and I conclude from the nature of the vehicle damage, such engineering evidence as there is, and the inherent likelihood that the defendant would have been braking heavily as she says she was before the impact that the speed on impact would have been appreciably less than 30mph. There are photographs of the damaged vehicles (some of which I conclude must have been taken by the claimant herself on her smart 'phone in the immediate aftermath of the collision). Because of its age and low value, the defendant's car was written off; but the

claimant was able to drive her car home. The engineer's report describes the impact as "light" and the repair costs were modest.

2 The trial occupied 9 days of evidence and a day for submissions. I was assisted by comprehensive written opening and closing submissions by Counsel: Mr. Watt-Pringle QC for the defendant and Mr. Grant for the claimant. There were 14 trial bundles comprising in excess of 4,500 pages including reports from 11 expert witnesses, 10 of them medical experts; 9 of whom gave oral evidence. There were 13 factual witnesses[1] whose evidence was either called or, in a minority of instances, read. Not much was agreed. It is not possible to refer to every different strand of the evidence from every witness in this judgment but all the material has been taken into account.

***Summary of the Parties' Positions***

3 The Claimant claims she suffered a cluster of cognitive, behavioural and physical problems due to the accident in that she sustained a head injury; a diffuse axonal injury ["DAI"] together with post-traumatic stress disorder ["PTSD"] and associated agoraphobic consequences with panic attacks and obsessive-compulsive disorder type symptoms ["OCD"], all as a result of the collision. DAI relates to the shearing of the axons of the white matter of the brain at a microscopic level and is damage that is not always capable of detection on MRI or CT imaging. The claimant's case is that it can be caused by an acceleration-deceleration trauma not involving any impact to the head, and that that is likely to have occurred in this accident. The claimant also claims she has concussion of the auditory and vestibular systems resulting in vestibular migraine, hyperacusis and consequential deconditioning resulting from compromise to the neural pathways caused by a DAI. She also suffered a soft tissue injury to her neck and upper thoracic spine and some sort of injury to her left wrist and hand which it is claimed have left her with moderately intrusive intermittent symptoms of neck and upper back pain and tenderness and a reduction of power in the left thumb ("the orthopaedic injuries"). The claim is for £4.4 million.

4 The Claimant was a teacher. She returned to work less than a month after the accident (after the Easter holiday) but ultimately left the profession in July 2014 (resigning in May 2014) because she says she was unable to cope due the effects of her brain injury. Her PTSD and OCD were treated successfully but her cognitive, behavioural and some physical symptoms, such as disinhibited temper, fatigue, loss of organisational skills, loss of concentration, alcohol intolerance and headaches ("*a dull background headache … present all the time*"), amongst other things, persist. Her case is that:

> *"after the accident everything changed. I always seemed to be tired and my brain just didn't seem to function in the way it had before … I no longer seemed to be able to handle the pressure of the (teaching) job and I started to find it stressful, believing that it was only a matter of time before I was found out and sacked."*

[1] The claimant; her husband; her mother (Susan Hibberd – 3 statements)) and father (Graham Hibberd – 2 statements); Louise Fisher, Jason Griffiths, Emma Espin, Ann Perseh, Amy Arnold, Denise Birkett, Keith Miller – all of which date from mid-2016 onwards. Hayes & Glenn, the surveillance operatives were taken as read.

5 Whilst accepting that the orthopaedic injuries were (at least to a significant extent) caused by the accident, the defendant denies that the accident caused or materially contributed to any of the other consequences alleged by the claimant. Although the defendant does not accuse the claimant of being dishonest or of fabricating her symptoms, or consciously exaggerating them, she is put to proof that her subjective complaints are attributable to a DAI and an associated vestibular injury caused in the accident. The defendant maintains that the claimant is not suffering from a DAI or damage to the vestibular or auditory systems. The defendant's Counter-Schedule dated 26.01.18 puts it in this way:

5.1 *It is denied that the Claimant sustained a "very severe" diffuse axonal injury ("DAI") or any other brain or neurological injury in the accident, and [denied] that she has been left with "subtle and pervasive" cognitive and behavioural deficits*".

5.2 The defendant also accepts that there are no enduring psychological consequences and does not put forward a psychological or psychiatric explanation for the Claimant's reported enduring symptoms: "*It is denied that the Claimant developed PTSD with associated agoraphobia and panic attacks and Obsessive-Compulsive Disorder as a result of the accident. She has no current neuropsychological or psychological disorders as a result of the accident, which will impact upon her future functioning, and there is no risk of deterioration as a result of the accident. Nor does she require any treatment*."

5.3 The defendant relies on the apparent absence of contemporaneous or near contemporaneous records in treating doctors' and other records of symptoms commonly associated with brain injury. The defendant submits that it is for the claimant to prove that the accident caused the orthopaedic and organic brain injuries about which she now complains and that such injuries have caused the losses particularised in her most recent Schedule. It is not necessary for the defendant, so it is submitted, to put forward a positive case on causation or to put forward an alternative diagnosis of such enduring problems as the claimant has. On the defendant's approach the action has a value of only a fraction of what is claimed. The medical and causation issues are foreshadowed in more detail in the defendant's Schedule of Medical Issues.

***The Issues***

6 The following issues arise:

6.1 What injuries did the claimant suffer as a result of the collision? Did she suffer a Diffuse Axonal Injury with associated vestibular compromise and the Post Traumatic Stress Disorder, Obsessive Compulsive Disorder and orthopaedic injuries alleged?

6.2 If she suffered organic brain and vestibular injuries, did they cause her to give up her career as a teacher?

6.3 What loss has the claimant suffered as a result of the accident?

6.4 Is the claimant a reliable and accurate historian such that a temporal link can be established on the factual evidence between the accident and such enduring symptoms as she continues to experience?

7 It is submitted that the claimant is honest and reliable. If her evidence and that of her witnesses is accepted, the diagnosis of DAI made by experts called on her behalf is more probable than not. There is no other alternative organic diagnosis and no psychological pathology. Therefore, because the defendant

does not allege fraud the case turns substantially on a diagnosis made in the context of and on the strength of truthful and reliable evidence.

8 The defendant submits otherwise and relies on the decision of the House of Lords in ***Pickford v Imperial Chemical Industries*** [1998] 1 WLR 1189. In that case a full-time secretary claimed compensation for work-induced cramp of the hands due to repetitive strain. Her medical evidence was that her hand condition was an organic disorder, whilst the defendant's case was that it was psychogenic. The Judge was satisfied that the plaintiff was not a malingerer [1196 D & 1197 H]. He held that:

*"... the most that he could find on the whole of the medical evidence was that the condition of cramp of the hand due to repetitive movements (PDA4) might have an organic cause or a psychogenic cause, or a combination of both causes or one cause to begin with and the other supervening. He was disposed to hold that the respondent had a cramp of the hand, but she had failed to satisfy him that its cause was an organic one. She had also failed to satisfy him that it was caused by her typing work, as opposed to being merely associated with it." [1196 D – E]*

The claim was dismissed. The Court of Appeal overturned the judgment, but it was restored on appeal to the House of Lords. Having referred to the fact that there was an acute conflict in the expert medical evidence [1196 H], Lord Hope of Craighead held at 1201 A – E:

*"The majority in the Court of Appeal appear to have thought that the whole matter ought to have been disposed of by looking solely at the medical evidence. On their approach it was enough that the judge was unwilling to accept Dr. Lucire's explanation that the respondent's condition was conversion hysteria. That being so, as there was no other explanation, the conclusion was in their view inevitable that this was a condition which was organic in origin. I have already observed that in my opinion they were approaching the matter from the wrong starting point. But their disposal of this issue is open to objection on more fundamental grounds. In the first place what they were doing was to invert the onus of proof. The respondent's whole case was that her cramp had an organic cause. It was essential to her success that it was proved to have been caused by repetitive movements while typing. So, according to the ordinary rule, the onus was on her to prove that the cause which she had alleged was the right one. It was open to the appellants to lead evidence in rebuttal to the effect that its cause was a psychogenic one. But they did not have to prove that it was due to a conversion hysteria. Failure to prove this alternative explanation was a factor to be taken into account in the decision as to whether the respondent had established an organic cause, but it was no more than that. It still left open the question, in the light of the wider dispute revealed by the medical evidence, whether an organic cause had been established for the cramp so that it could be said to have been due to the respondent's typing work. It was precisely because he was unable to answer this question in her favour on the medical evidence that the judge turned for such assistance as it might offer to the other evidence."*

9 The defendant accepts that the absence of an alternative diagnosis, or a positive case on causation unrelated to the accident, are important factors to be taken into account; but submits that there is a catalogue of important

inconsistencies in the claimant's presentation to medical practitioners and improbabilities in her evidence, both inherent and when compared with the documents, which means that the claim is not proved. When looked at as a whole the defendant's case is that the claimant's evidence is inaccurate and unreliable and as a result the overwhelming part of her claim should not succeed. This unreliability is significant in three major respects. First, it has a direct impact on whether the claimant can prove important parts of her claim, such as loss of earnings and pension. Secondly, there is an impact on whether she can prove that she still suffers from enduring accident-related symptoms, and if so what they are and what effect they have on her life. Thirdly, her reliability is at stake when it comes to considering whether the retrospective post-traumatic amnesia assessments undertaken by various clinicians are themselves reliable when it comes to proving that the claimant suffered a diffuse axonal injury.

10 The claimant relies on the following passage from ***Pickford*** (at page 1200 A-C):

*"There is no doubt that in most cases the question of onus ceases to be of any importance once all the evidence is out and before the court. But in this case it was not so simple. As Lord Thankerton observed in Watt v. Thomas [1947] A.C. 484, 487 the question of burden of proof as a determining factor does not arise at the end of the case except in so far as the court is ultimately unable to come to a definite conclusion on the evidence, or some part of it, and the question arises as to which party has to suffer from this. From time to time cases arise which are of that exceptional character. They include cases which depend on the assessment of complex and disputed medical evidence, where the court finds itself in difficulty in reaching a decision as to which side of the argument is the more acceptable. I think that this was such a case, and that the judge was justified in reminding himself where the onus lay as he examined the evidence".*

11 Exceptional cases include those involving complex and controversial medical evidence where the science is too uncertain to enable the court to reach a conclusion other than one based on the onus of proof, but are not limited to such cases. Neither are they limited in my judgment, as the claimant submits, to those cases where two alternative causes are put forward (e.g. organic or non-organic). The onus of proof may have an important role to play in those exceptional cases such as the present where medical opinion is based on information provided by a historian such as the claimant whose reliability and accuracy generally are in issue, such that the credibility of the claimant is inextricably entangled with medical opinion provided to the court.

12 The defendant acknowledges that there is no over-arching (or any) allegation of fraud or fabrication on the claimant's part and accepts that none of the medical experts puts forward any positive material to the effect that the claimant is malingering or consciously exaggerating the type or the effects of the symptoms she alleges.

13 In this regard the decision of the Court of Appeal in ***Newman v Laver & Anr*** [2006] EWCA Civ 1135 is instructive. At paragraph 81 Rix LJ states:

*"In my judgment, there was no need of any blanket allegation of fraud, fakery or fabrication in the pleaded defence … The defence and its counter schedule of damages, together with the expert's reports … sufficiently put in*

*issue the defendant's lack of acceptance that [the claimant] had suffered the injuries and sequelae of which he complained… In truth there was no wholesale attack of fabrication, no general attack on [the claimant's] honesty … Instead, there was, as must occur at the close of many a trial, a detailed submission by reference to specific points which had arisen in the evidence as to why the judge should regard [the claimant's] credibility as being both at the heart of his claim and as being suspect. The submission divided its fire between specific allegations of falsehood, exaggeration, and inconsistency, to be balanced … against the lack of objective verification of the symptoms relied on."*

14 The defendant's case is that we are in very similar territory here. If anything, the range of disputes across all sections of the evidence in this case are wider than was the case in ***Newman***. The defendant maintains that across the whole range of disputes, the case on the claimant's reliability and accuracy has been adequately foreshadowed in the Counter-Schedule, the medical evidence and the written submissions advanced.

15 I accept that the defendant's approach is proper and viable. Where it leads remains to be seen. The absence of an alternative positive case on causation or diagnosis is an important feature of the case and must be taken into account in the context of all the evidence. However, the reliability and accuracy of the claimant (and other witnesses) must needs be approached, I accept, in a more nuanced way than by blanket allegations of fabrication or conscious exaggeration, particularly when much depends on the claimant's presentation as a witness (both in writing and in court) and where her accuracy and reliability is questioned in areas of the evidence other than those directly impacting on the medical issues. The issue of the claimant's accuracy and reliability are interconnected across the evidence in this case as a whole. Furthermore, the extent of the inconsistencies and inaccuracies relied on could not have been fully or even substantially apparent before the claimant had given evidence when the full impact of her evidence in the context of other evidence and documents would have become clear.

16 In my judgment it is at least open to the defendant to submit that if medical opinion about the claimant is substantially based on her accuracy, and her accuracy is questionable, then the medical conclusion may also be questionable regardless of whether a plausible alternative cause or diagnosis is forthcoming. This case is not all about the medical evidence. I note that several other brain injury decisions at first instance have been included in the trial bundles. These are cases in which the various claimants' expert witnesses were the same as in the present case and in each example, the claimant was (to a greater or lesser extent) successful in recovering substantial damages for brain injuries. It is not submitted on behalf of the claimant that these decisions are determinative of the outcome in this case, but rather that they are informative. The most pertinent of these is the most recent: ***Siegel v Pummell*** [2014] EWHC 4309 (Wilkie J) which shares many parallels with this case, and as it so happens, the claimant and Mr. Siegel have been friends for many years. Each of the cases in which judgments have been included necessarily turns on its own facts and those facts are applied to the medical evidence presented to the court. Accordingly, however informative they are, the assistance they provide on the outcome of other cases such as this one is limited. The judgment of Wilkie J shows that the decision in ***Siegel*** was, as

one would expect, due to any number of factors including the Judge's finding that Mr. Siegel was a consistent historian with regard to his symptoms, that he lost consciousness, that there was a rotational element in the injury mechanism caused by the impact, and that his was an accident that had caused significant damage to both vehicles and was not as minor as the defendant had suggested (it was no "mere bump"). Such considerations are all in play in this case.

***The Accident - Claimant's Evidence***

17 The Claimant's evidence extended over 2½ days. She made 7 witness statements and confirmed Part 18 Replies to requests for further information and her Schedules of Loss. The claimant also made a video and pain diary (between June 2014 and February 2015). She verified the documents at the outset of her "live" evidence after which she was cross-examined.

18 About the accident itself she says:

18.1 "M*y last memory before the collision is looking in my rear-view mirror and seeing the approaching car coming towards me at speed… The car behind me was unable to stop and drove into the rear of my car… The force of the collision was clearly substantial …"*

18.2 *"Just before the point of impact I remember bracing and gripping the steering wheel with both hands, pulling myself forward s and turning my neck to the right for some reason… I remember a sort of crunching sound … I do not remember the car being propelled forward (or) being restrained by the seatbelt. My first memory after the accident is being stood outside at the back shouting at the other driver… I can only assume I was rendered unconscious for a period of time. I know that I rang my father, but I have no memory of that either. In fact, I have very patchy recollection after the accident for several days."*

In her oral evidence the claimant demonstrated her brace reaction to the approach of the other car. She demonstrated clutching tightly at the steering wheel with hands at "ten-to-two" as if pulling herself forward with her left cheek close to the centre of the steering wheel (so that she was facing to her right). She said she had no recollection of the immediate aftermath of the collision and most of what she now says about that day is patched together from a few memories and what she has been told by her husband and mother. The claimant does not relate any memory of her head being thrown back from its forward flexed position as she describes turning to face the driver's side window of the car. There is no evidence that she hit her head on the head rest or at all. In oral evidence she recalled that she had shouted out "*Oh my God*" (thinking that the defendant was going to hit her car) but also thinking "we'll be alright" (or "*OK*" as in her witness statement). She adds the further memory of everything being black. She says that she recalls her husband responding "*What*?" and that everything happened very quickly. She attributes all her many, subsequent vicissitudes to this accident and its consequences.

19 She said that she had found it difficult to focus or concentrate on the completion of her witness statements, including that relating to the accident itself, because she struggled with "*big*" documents and was correcting and giving information for her first statement in the café where she was working at the time, although she had drafted parts of it herself before then. She confirmed that her recollection of events after the accident is at best patchy.

She says her first memory after the impact is of standing at the rear of her own car and her husband moving around by some fencing (she has no memory until then after the "crunching" sound); she recalls her sister's car driving past on the slip road and speaking to a man in a high-viz jacket (from the Highways Agency) and telling him her neck felt sore, but recognises that her recollection of post-accident events is "*vague and unreliable*". She has no recollection of taking any photographs, but I conclude she must have done; she declined an ambulance and she knows from what she has been told that she drove herself and her husband home, a journey of about 20 minutes (but has no memory of it). She states that she has no memory of being taken to hospital in Croydon with her husband later that afternoon by her mother and no recollection of being at the hospital (including being placed in head blocks) or going home afterwards. She confirmed that her physical symptoms came on within minutes of the collision.

***Trevor Hibberd-Little's Evidence***

20 The claimant's husband made 5 witness statements. His written evidence about the accident comes next to last in the sequence and is dated 14 December 2017, 4½ years after the event. He too was cross-examined. He says:

20.1 *"I suddenly remember hearing Kathryn shout out and looking across at her. She was gripping the steering wheel with both hands and had pulled herself forwards towards it and was looking to her right".*

20.2 He recalls exclaiming "*What*?" when the claimant first shouted out, but the collision was almost instantaneous with his question. He does not describe any reactive contrary motion of the claimant's head as a result of the collision even though he must have been looking directly at his wife at this moment and is confident *"every detail is ingrained in me"*. He hit his left knee on the glove compartment on the passenger side and his head had been resting on the passenger seat head rest. Afterwards it was he who exchanged details with the other driver and called the police (who referred the matter directly to the Highways Agency). Two men from the Highways Agency soon arrived at the scene. He describes the claimant as appearing to be in a lot of pain and not responding rationally to questions. She declined to go in the ambulance when it arrived and drove herself and her husband home. This, both the claimant and her husband maintain, was a bad decision. He says that both he and the claimant took accident photographs. The claimant's reluctance to accept this obvious proposition was difficult to understand, whether she recalled it or not. Before that Trevor recalls the claimant standing between her car and the defendant's exclaiming that the car was only a day old. Once home he says the claimant was in a lot of pain hence the decision to go to hospital, driven by the claimant's mother.

21 The orthopaedic evidence is of note on the question of rotation. Mr. Beavis in paragraph 54 of his Report says: *"The effect* (of the accident impact) *on the neck would have been to cause violent extension which would have brought her neck back from flexed towards the right to extended towards the left. There would then have been a reversal of this effect. In addition, it is quite likely that she would have had an asymmetrical hold onto the steering wheel"*. It could have been instructive to ask Mr. Beavis about this in the context of rotation, even if he has strayed into the realms of fact-finding, but

ill-health meant he was not available for the trial. Mr. Radford said in his oral evidence that he could not be so precise but speculated (and in the absence of any bio-mechanical evidence it must be speculation) that *"the biomechanical forces would probably involve a rotational element."* Dr. Allder and Dr. Heaney (the neurologists) also consider rotation in their evidence. The former proceeds on the basis that there was a rotational element in the mechanics of the claimant's accident; Dr. Heaney's clinical notes do not include a reference to rotation but in his evidence he considered that the force of the impact on the claimant would have had a more linear effect albeit with the claimant's head turned to the right. I took that to mean that the forwards and backwards movement of the head was likely to be linear with the head at a notional 45° angle to the direction of travel.

22 In the absence of any biomechanical evidence, the absence of any precise eye-witness account beyond the claimant's head being turned to the right as she braced herself, and the lack of any evidence (other than the photographs) about the likely precise point of impact at the rear of the claimant's car and the effect of a likely impact speed, I am unable to come to any conclusion other than that, in the absence of any evidence of any rotational impact forces on the car, the existence and extent of rotational forces on the claimant's head or neck are unknown and I am not, therefore, able to say whether any such rotational forces were significant.

23 From the evidence up to this point, of which the above is only a summary, I find as follows. This was a rear-end collision at a speed of something appreciably less than 30mph in anticipation of which the claimant braced herself by pulling herself forward as she demonstrated using the steering wheel (exclaiming "Oh my God" as she did so) whilst turning her head to face right towards the driver's side window. At this point she was silently reassuring herself that everything would be alright. She did not hit her head and there was no impact with the head-rest. The claimant did not lose consciousness. It is more probable than not that there was a reactive, backwards extension movement of her head and neck from the flexed, brace position she had adopted at the point of impact, the consequences of which included an element of acceleration and deceleration forces to the head. The airbags were not deployed. After the impact the claimant's husband, having got no response to his asking the claimant if she was alright, went to the driver's door and the claimant (having turned off the engine, released herself from her seat belt and opened the door) got out unassisted and went to the rear of the car protesting loudly to the defendant about the incident and the damage to her brand-new car. The claimant took some of the photographs at the scene including those on which her husband features and called her father. During this time the claimant already had begun to experience significant neck pain and stiffness, pain in the lower back and her wrists with particularly noticeable pain associated with her left thumb (probably the result of her gripping the steering wheel at the point of impact). She also had some seat-belt related discomfort to her chest. She drove home (a journey of about 20 minutes) and on arrival home her symptoms, particularly neck pain, remained noticeable and debilitating. For reasons that are discussed in the context of the orthopaedic evidence, I am unable to reach any conclusion on whether the mechanism of the injury involved any or any significant rotational forces.

***Medical records up to 2014 – Onset and Trajectory of symptoms***

24 On the journey home, I accept, the claimant was complaining a lot about pain in her neck and head and Trevor called "111" and the claimant's parents (this must have been on the journey home) and received advice that both should go to hospital. The claimant's mother was waiting for them on arrival home, or arrived soon after, and took them to the hospital in Croydon. Trevor says he could tell the claimant was in a lot of pain and her mother agrees, adding that the claimant walked very gingerly to her mother's car.

25 On arrival at the hospital the claimant was seen by the triage nurse and then by a doctor in A&E at 18.30. She was placed in head blocks. The hospital records note that she scored 15 on the Glasgow Coma Scale; that she had cervical spine tenderness and complained of neck pain, a severe headache, and tingling sensation in her arms. No loss of consciousness was recorded and no history of a head injury noted. Her pain score was recorded as 4 to 5 ("quite bad/moderate") on a scale of 0 and 10. The claimant was discharged home with analgesics.

26 Dr. Grace (neuropsychiatrist) was asked about checking for brain injury at A&E and said: *"any reasonably competent casualty doctor would cover the possibility of brain injury"* and added that she would be worried if the claimant's memory and orientation had not featured in the examination at A&E with a patient presenting as she did. I have no reason to think that the medical staff at Croydon University Hospital were not reasonably competent.

27 Trevor describes the claimant being in pain on the journey home from hospital and that for the rest of the evening she was not herself, being much quieter than usual and yet "*quite agitated*". He recalls that their friend Peter Siegel telephoned. They spent a quiet, restful Easter weekend at home and abandoned their plans to visit family. He also says: *"Kathryn has complained of a headache ever since the accident … She told me even before starting back at work that she felt like she had no energy. She also said she felt dizzy but I could not imagine what that had been caused by"*. I find this to be most unconvincing. Trevor would not be expected to offer a diagnosis, but to maintain that he could not imagine what the cause of persisting and apparently troubling symptoms might be is not realistic. The claimant did not return to the hospital or attend her GP concerning her injuries. I can only conclude that on returning from hospital, whilst the claimant was clearly having a bad time, complaints about dizziness must have come later. This is consistent with his statement about her balance in his first witness statement to the effect that *"this seems to have become exacerbated since her pregnancy"*.

28 Shortly after her return to school following the Easter break on 17 April 2013, the claimant was referred to the Occupational Health Department ["OH"] and was seen by an OH doctor on 17 May 2013. The following extracts are from the OH notes (with my added emphasis):

*"Initially painful and stiff: Better after 2 weeks; so went back to work at end of holidays. Still has constant dull pain at back of neck; better in mornings and worse by the end of the working day. Also aware of clicking…*
*… Drinks 3-4 cider/vodka/wine <u>every few weeks</u> … likes walking, sewing – lives with husband. Does school work in the evening: sits at table/on sofa.*

*Sits on sofa to watch TV (series) …up to 2 hours. At weekends does housework …*
*Says mood, sleep, appetite, energy, all OK. Likes (job?) not a lot, feels under attack by the government, but does not identify other workplace or non-workplace stressors when asked specifically".*

On examination she had some limited movement on extension of the neck and some muscular tenderness. No issues were raised with regard to her mental state. The impression of the OH doctor was that the claimant was fit to work and she was advised to continue with analgesia.

29 These notes are controversial, but I accept that, on balance, they are likely to be a fair reflection of the OH appointment. They describe the effects of an unpleasant, even stubborn, whiplash-type injury with lingering discomfort but little else of note. I find that these notes are consistent with the medico-legal orthopaedic report of Dr. O'Connor (but I note that Dr. O'Connor was not a witness in this action any more than the OH doctor).

30 On 4 October 2013 the claimant and her husband were referred by their then solicitor to Dr. O'Connor in the context of their then claim for damages in "Low value personal injury claims in road traffic accidents (£1,000 to £10,000)". Dr. O'Connor reported on 9 October 2013 on both the claimant and her husband. His report on the claimant is also controversial. He was originally a registered psychiatric nurse and his report contains a summary of what he was told that is similar, but more detailed, than that in the OH notes. The following extracts summarise the position (with my added emphasis):

30.1 *(Referral): Initially painful & stiff, better after 2 weeks, so went back to work at end of holidays. Still has constant dull pain "at back of neck", better in mornings and worse by the end of the working day. Also aware of clicking when moves the neck.*

30.2 *The Injuries: She recalls these commencing within ten minutes, intensifying over the next day or two, describing acute variable intermittent pain, stiffness and restriction of movement affecting the cervical, upper thoracic and lumbo-sacral spine, her left thumb and discomfort in both wrists and her chest wall with initial intrusive occipital headaches. Initially she experienced pins and needles in both upper limbs but this settled within a week or so. In general the acute phase lasted for around a two-week period. During that stage activities involved in day-to-day living and self-care were especially uncomfortable. Following the acute phase she describes all material symptoms continuing to slowly improve.*

30.3 *Present Symptoms: Waking up first thing in the morning she describes intrusive stiffness and aching at the back of her neck provoked by lifting her head off the pillow. Her left thumb remains painful when gripping or when bending her thumb … The clicking sensation she experiences in her neck during head movements I explained is benign … She teaches … and found the first few weeks difficult and uncomfortable with reduced standing …*

30.4 *Consequential effects: Her confidence driving declined with apprehension, anxiety, intrusive thoughts and expecting further accidents in similar situations.*

30.5 *Her sleep pattern was initially disturbed nightly with associated fatigue, … but this incrementally restored within a period of around two months. Her recreation of yoga remains on hold. She … is now around seven*

*[weeks] pregnant. She relied on her husband who, she explained, undertook most of the domestic activities predating.*

30.6 *(Prognosis): <u>After the acute phase she describes all material symptoms appropriately improving.</u> (She) is now around seven weeks pregnant and I would expect her material symptoms will likely cause unnecessary discomfort, particularly in the latter stages of her pregnancy. However, I am not expecting any complications in her pregnancy or the delivery. Her confidence driving declined but is slowly improving.*

He also notes: *"On direct questioning she confirms no recollection of any other related… accidents, injuries or symptoms".* He deals specifically with situational anxiety, her apparent recovery from headaches after 2 months and notes that the claimant presented *"without any obvious psychological impairment, anxiety or depression".* It is of note that the trajectory of the claimant's recovery from headaches after about 2 months is not consistent with other reports from the claimant that her headaches continued to be *"horrendous".* Dr. O'Connor notes: "*Following the acute phase she describes all material symptoms continuing slowly to improve".* The claimant's disturbed sleep pattern is discussed with associated fatigue and he describes these difficulties as *"…incrementally restored within a period of around two months".* In the context of sleep disturbance, no mention is made of flashbacks or intrusive dreams (but the claimant thinks she mentioned them). The prognosis, in summary, is good with gradual resolution of her symptoms expected within a matter of months. The claimant was pregnant at the time of this appointment.

31 Mr Patel, a treating physiotherapist, carried out his first assessment of the claimant on 8 February 2014 (this is very nearly a year after the accident). As part of the history he recorded in his notes: *"º[no] headaches/dizziness/double vision. Nil Neuro signs"* In an undated progress report Mr Patel stated that the claimant had progressed well with her neck and that she had been given a full set of exercises to continue at home. Her left thumb remained very troublesome. The claimant has reported to others that since the accident she had *"atrocious"* headaches and suffered dizziness *"big time*".

32 The claimant was extremely dissatisfied with the OH appointment and report. She says she had the impression that the doctor had his own agenda and that was to ensure she was not signed off from work. All she wanted, she said, was to be given some helpful exercises. She says she recalls (despite her memory problems) telling the OH doctor that she returned to work after 2 weeks (not that her condition started to improve after 2 weeks). She said she thought the doctor "*had made it up"* (the report, or parts of it) and was asking about things that had nothing to do with her neck injury (such as stress and tension). So dissatisfied with the experience was the claimant that she despatched a written complaint about the OH doctor on 3 June 2013 to the local authority. The complaint is informative. Clearly the claimant thought the OH doctor unsympathetic, but no complaint is made about his orthopaedic findings. Rather the complaint focuses on his intrusive questioning about lifestyle, anxiety and depression and the claimant's perception that his agenda was to root out "*scam artists*". What is curious about this is that, intrusive or otherwise, one would reasonably have expected this type of questioning to gain at least the beginnings of some insight into what the claimant says were persistent cognitive symptoms and fatigue that had been triggered immediately after the accident. She could reasonably have been expected to

have said something about them had they manifested themselves it the aftermath of the accident. She is reported (and she was alone at this consultation) telling the OH doctor that her neck was initially painful and stiff, but was better after two weeks and there was still a constant dull pain at the back of the neck, which was better in the mornings and worse by the end of the working day. She said that her mood, sleep, appetite and energy were all "*OK*". It is extremely doubtful that the doctor has merely assumed this state of affairs or made it up to defeat an assumed scam artist.

33 Of Dr. O'Connor's appointment, the claimant says she was almost mute during a joint consultation with Trevor (who did most of the talking). Trevor does not disagree. She said she thought Dr. O'Connor was an osteopath and only interested in orthopaedic problems with a view to planning a course of treatment (*"I am incredibly naïve"*), but yet *"I likely did tell him about my flashbacks and nightmares"*. Nothing is mentioned of them in the Report. She accepted that she was referred to Dr. O'Connor for the purposes of obtaining a report on her condition for legal proceedings and that she appreciated the importance of describing her problems fully and honestly. She said the doctor must have just assumed that all was improving because she returned to work after 2 weeks and, although she says she has little memory of this appointment, she also said, *"I did not think it was part of his remit"* to go beyond the physical injuries. However, she accepted that Dr. O'Connor was told that her fatigue was improving (*"but not gone away"*). Even if much of the information provided to Dr. O'Connor had come from Trevor, one might have expected that as the most closely affected third party and unencumbered by any stigma or natural reticence, he would have made some reference to what he now says he could see his wife was suffering from. In actual fact Trevor said: *"Kathryn told him about the symptoms she was experiencing at the time of the assessment"*. I find that Trevor's statement is likely to be more accurate. She is, however, reported as having given up her yoga. The picture becomes even more confusing when the Answers to Part 18 Questions were completed on 17 November 2017. The claimant was asked if she had provided Dr. O'Connor with true and accurate information. The answer is at best, prevarication. The claimant replies: *"His account, to the best of my knowledge is both true and accurate"* and she goes on to refer to Trevor and also back to an earlier witness statement. Either, Dr. O'Connor had recorded what he was told accurately, or the claimant is unjustifiably limiting her answer to information about the accident supplied by Trevor. If it is the latter, it is a sleight of hand that is unimpressive.

34 The claimant accepts she must have told Mr. Patel that she had no dizziness (although she did not think at that time it was caused by her whiplash injury and Mr. Patel was concentrating on pinched nerves) and that his record of "*No headaches*" was an error on his part given that she was suffering *"horrendous headaches"*. The claimant accepts that she did not say anything about double-vision to Mr. Patel (I infer he must have asked specifically about this given the mention of it in his notes) because she was not suffering double-vision but did suffer from "fuzzy" peripheral vision which she had not mentioned because he was a physiotherapist. I found this last piece of evidence extraordinary. Perhaps she might not offer fuzzy vision to a physiotherapist, but she was plainly asked about vision and double vision issues and decided not to speak of her compromised peripheral, fuzzy vision. She said: *"I'd like to say, it is very easy with hindsight to think that I should have told [Mr Patel] everything; I could have been treated earlier"*. It was Mr. Patel who suggested she keep a pain diary. One would have thought that

dizziness and headaches with or without "fuzzy" peripheral vision would be important in the context of a physiotherapy consultation where treatment and any recommended exercises could have uncomfortable and unpleasant consequences for someone suffering dizziness and headaches. The fact that the claimant did not mention dizziness (and it was positively excluded by Mr. Patel) is even more extraordinary, if indeed she was suffering from dizzy episodes (*"big time"* or otherwise) at the time, because she had had them before. One of the symptoms of the claimant's glandular fever as a teenager had been dizzy spells. Had dizziness been experienced again at the time the claimant saw Mr. Patel the symptoms are likely to have been of note and concern to her.

35 The claimant attended her GP during the year following the accident. Her enduring symptoms were not mentioned and there is a specific entry on 20 September 2013 to the effect that she has *"no long term medical problems"*. This is a strange entry had the claimant been suffering continued, severe accident-related problems (for example, a constant headache, balance and dizziness problems and chronic fatigue, to name but some of the main ones) even if the claimant's explanation that she considered what she thought of as her whiplash injuries were not a matter for her GP is credible (which in my judgment it is not). Moving the clock forward to October 2015 she is seen at her new GP's surgery in the country and it is recorded: "*in good health, not on any regular medication*". To appropriate a phrase of Dr. Heaney's in a different context, this entry is "*full of oddness*" if the claimant's history of the onset and trajectory of her symptoms is accurate, however low opinion the claimant may have had of GPs.

36 The medical records and information about the claimant's health status up to the beginning of 2014, and beyond, is consistent not only with her autumn 2013 business activities and career plans (as to which see below) but also with her ambition to start a family and move to the country in or about the autumn of 2013 for a more relaxed lifestyle

37 The claimant's written and oral evidence (including her pain diary) paints an entirely different picture to that of the medical information up to this point. The worst of her alleged continuous cognitive and behavioural problems were these. She maintains that she has had a constant headache (with peaks and troughs) since immediately after the accident; she has constantly suffered from pervasive fatigue which is *"something else"* (again, with ups and downs according to how much rest she can get); seriously compromised memory and organisational problems; she has become sensitive to noise; has significant balance problems and is prone to tripping or feeling on the verge of falling (requiring her to "ground" herself); has nightmares; is prone to be over-emotional and has lost fine control over her temper and social restraint. Her energy had gone, she says, together with her creativity and drive along with her multi-tasking ability. She also claims to have become less articulate since the accident and vulnerable to exploitation. She became obsessive in cleaning and checking routines and engaged in compulsive behaviour and rituals. She became intolerant of alcohol. These problems, it is submitted (and the above is only an outline), are attributable to a brain injury caused by the accident. Ms. Levett (the claimant's Behavioural Psychologist) provides a summary (the information for this dating from August 2015):

*"Physically she suffers from continuing neck and thumb pain, balance difficulties, and headaches. She also suffers chronic and debilitating fatigue,*

*aggravated by mental exertion. Cognitively she suffers from a range of functional cognitive deficits including deficits of various types of memory, concentration, organisation and planning, easy distraction, decision making, multitasking, logical sequencing, reading, tracking of group conversation, self-expression and word retrieval difficulties, mental arithmetic, new learning and social judgment. Such deficits are present in situations when they cannot be accounted for by anxiety and/or low mood… In association with the above difficulties the quality of her occupational, social, interpersonal and family life had been reduced by a sense of detachment from others, embarrassment at her psychological and cognitive difficulties, and social and psychological withdrawal".* [I will refer to these as the "enduring cognitive and behavioural symptoms"].

38 Trevor paints a similarly grim picture which he traces back to the accident; focusing particularly on the claimant's complaints of headaches and fatigue and her increasing, apparent inability to cope with her teaching responsibilities, particularly the administrative and organisational elements from when she returned to work after Easter 2013. The claimant's mother states that *"She had her accident and everything changed"*. The claimant complained often of headaches, she appeared permanently tired (even exhausted) and seemed to have lost her authority at work. She says: "*Gradually as time went on we noticed more symptoms …"*. Intriguingly, the claimant's mother wonders whether Trevor has also suffered some sort of brain injury as a result of the accident as he has displayed, she thinks, some of the same problems as his wife especially those centred on fatigue. The claimant's father agrees: "*Following her accident we noticed that Kathryn was a very different person"*. The other evidence from friends and colleagues is in similar, but even less detailed, vein. However, a common feature of all the factual evidence speaking of the claimant's apparent personality changes across a range of situations is that the witnesses (including mother and father) speak mostly of "*before*" and "*after*" the accident. Specific dates (even months or seasons) are few and far between. It is only the claimant and her husband who, but only up to a point, describe the onset of many of the enduring symptoms from the date of the accident onwards and their evidence about this lies very uneasily with all the contemporaneous or near contemporaneous medical information. I do not accept it.

39 Of interest is Dr. Allder's (neurologist) review of the claimant's symptoms over 2 years later (18 July 2016) as reported by the claimant covering this initial 12 month period.

39.1 *"[The claimant] never developed problems with smell, vision, hearing or vertigo… she never suffered any nausea*. (Later she reports vertigo and nausea when travelling).

39.2 *"[She] has not developed any impulsivity in terms of decision making…"* but had become more anxious and reliant on her parents. (By the time the claimant sees Ms. Levett in August 2015 she is reporting *"impulsive behaviours"*).

39.3 *Her motivation remains intact* (after a period when it did flag before her cognitive behaviour therapy).

These reported symptoms are consistent with the contemporaneous medical information. Dr. Allder also notes:

39.4 *"…she progressively developed paranoid anxiety over the 12 months following the accident…"*

39.5 *"[She] is also suffering from light sensitivity"*.

39.6 He notes self-reporting of flashbacks, dizziness, problems with short term memory, concentration, social sensitivity, mental and physical fatigue and word-finding with a period of post traumatic amnesia of between 2 and 3 weeks (with "snapshot" memories). Dr. Allder recognises the whiplash-type injuries and says: *"The neck and the headache very much went together…"* (and he refers to the pain diary kept by the claimant).

40 The pain diary (summer 2014 onwards, after Mr. Patel's involvement) describes continuing symptoms of neck, shoulder and head pain and it is not surprising that this appears to be visibly getting the claimant down. In summary, I accept Dr. Savundra's (an audio-vestibular expert) analysis of the video pain diary. It is unsurprisingly mostly focused on pain and there is no indication of audio-vestibular symptomology reflected in it.

41 Dr. Allder does not mention migraine and, further, the claimant reported to Dr. Grace (neuropsychiatrist) in September 2017 that she had not suffered from migraine, which is more than a strange curiosity given the focus on migraine in the report of Dr. Savundra only 6 months earlier.

42 I find that the claimant sustained a whiplash-type injury as a result of the accident that caused severe, acute neck pain with associated headaches and weariness in the months immediately following. I will return to the details of this, and the other orthopaedic injuries which I am satisfied were caused by the accident in due course, but it is hardly surprising that in the period following the accident she was less vivacious, energetic and outgoing than her family was accustomed to.

43 For reasons that I give below and discuss further in the context of the expert medical evidence, I am not satisfied on the balance of probabilities that the accident caused an organic brain injury with the cognitive and behavioural, and audio-vestibular symptoms that have been the central controversy in this action (whether attributable to DAI, related audio-vestibular pathway problems or otherwise). This conclusion arises from the unsatisfactory nature of the claimant's evidence as a whole, its inconsistency with medical records and its internal inconsistency, together with the absence of any clear timeline in the contemporaneous or near contemporaneous medical information.

44 The claimant's evidence and that of her husband, about what she reported and what happened at the relevant medical appointments up to February 2014, is so riddled with internal inconsistencies and is so lacking in coherence when compared with the documents that no reliance can safely be placed on it. I have reminded myself that consistency and coherence are not the same thing as uniformity or unanimity and that a few infelicitous lapses of recollection in the context of repeated history-giving are to be reasonably expected, as might be incidental errors in the transcribing of information into notes, records and reports. However, the claimant's narrative overall is so incoherent in my judgment as to defy explanation on these grounds. The reliability of the claimant's reporting of the constellation of her cognitive and behavioural symptoms allegedly having a temporal link with and thus reported as being caused by the accident is open to serious doubt.

45 I do not accept that the OH doctor, the medico-legal doctor and the physiotherapist involved up to February 2014 have all missed or neglected almost every aspect of the alleged neurological and vestibular consequences, or even the possibility of such consequences, which the claimant now complains were on a continuing trajectory since the accident.

46 The records of the OH doctor, the medico-legal doctor and the physiotherapist at certain points specifically note the absence of symptoms about which the claimant has subsequently complained and attributes to the accident. It is unlikely that the notes of absence of symptoms have been invented or represent errors on the part of all of these medical practitioners.

47 I reject the claimant's suggestion that in some respects the OH record has been made up. The claimant's evidence about what she or Trevor told these practitioners and what they recorded, is in my judgment, ragged and internally inconsistent. Both accepted that they knew they had been sent to see Dr. O'Connor to obtain a report on their injuries with a view to legal action. There is no good reason why a full description should not have been supplied and I find that it was and is reasonably accurately reflected in the records.

48 The positive conclusions regarding the absence of certain symptoms in Dr. Allder's report (e.g. no vertigo) supports the conclusion that a temporal connection with the accident is lacking in the case of major symptoms. I do not accept that symptoms such as paranoid anxiety, flashbacks, migraine, vertigo and light sensitivity would all have been omitted from reporting to all medical practitioners for the entirety of the first year after the accident had these symptoms manifested themselves at any time likely to be linked with the collision. I do not accept that "*atrocious*" headaches and "*big time*" dizziness could have been overlooked by medical practitioners or that the claimant was limiting herself to reporting what she considered to be within the specialisms of the practitioners she saw.

49 I do not accept that in circumstances where the claimant says she was experiencing severe and chronic, debilitating, potentially career-ending cognitive and behavioural symptoms she would have decided not to raise them even to a physiotherapist (Mr. Patel) or an "osteopath" (Dr. O'Connor) or at her OH appointment. I find this inherently improbable. She was a strong, professional woman quite capable of recognising (had it been the case) that there was a connection or at least a possible connection of some sort between her cognitive and behavioural symptoms and the accident. She must have had a layman's appreciation of this possibility from her friendship with Mr. Siegel and her involvement as a witness in his case.

50 The factual evidence of family, friends and colleagues is too non-specific, subjective and, at least in part, reliant on the claimant's self-reporting, to supply a timeline anything like sufficient to overcome the absence of any contemporaneous medical information supporting a link between the accident and the enduring symptoms alleged.

51 I reject the notion in this case that as a high-functioning, highly intelligent woman the claimant might simply have been "*pushing through*" her severe and chronic non-orthopaedic symptoms due to lack of insight, fear of the stigma associated with brain injury and the hope that it would all somehow go away. I also reject the idea that the confused, chaotic and internally

inconsistent evidence she gave about what happened at the 2013-2014 medical appointments and what she remembers saying or not saying at these appointments is only a reflection of the fact that she had indeed suffered a brain injury as a result of the accident. The claimant cannot have been concerned about the stigma of a brain injury she did not know she had, and given that dizziness (whether associated with balance problems or not), chronic fatigue and headaches could reasonably be associated with a whiplash-type injury by any layperson, there would have been no call for reticence about them at any medical appointment. In any event I cannot accept that medical practitioners would independently make so many positive mistakes (e.g. no dizziness; mood and energy "OK"), and this fits well with Trevor's memory that the claimant's balance problems had deteriorated since she became pregnant (given this comes from a statement in April 2016, I infer he means pregnant with Henry). This is indicative of an unexpectedly worsening condition.

52 When looked at in the context of the entirety of the other evidence, the possibility that it is an accident-related brain injury that has caused the claimant to be confused, inconsistent, and to forget to mention critical aspects of her injuries, which presents her unfairly as an unreliable historian, can safely be discounted.

53 Before I turn to the expert medical evidence I will deal with other aspects of the claimant's case that have caused me to doubt the reliability and accuracy of her evidence and show why I cannot accept that the claimant or her husband are reliable or accurate in the descriptions they give regarding the onset and trajectory of the critical non-orthopaedic symptoms they describe, or indeed, much else.

***Change of Career***

54 The following chronology is not controversial and provides a general background.

54.1 Following a long-term relationship with Trevor Little, the couple married in October 2012.
54.2 This was shortly after the claimant changed schools, leaving Camden to join the staff at Selsdon Primary School.
54.3 She and her husband went on a delayed "honeymoon" to Alaska in July 2013.
54.4 The Mug Tree Limited (her tea room business vehicle) was incorporated on 7 October 2013, of which after 6 November 2013 she was the sole director.
54.5 She resigned her teaching post in May 2014 (effective at the end of that summer term).
54.6 In June 2014 she withdrew from a proposal to take possession of commercial premises in Crowborough, having been in contact with property agents since at least November 2013.
54.7 The claimant and Trevor moved from Croydon to East Sussex on 7 July 2014.
54.8 She took possession of tea room premises in November 2014 in East Grinstead.
54.9 On 13 December 2014 she opened the tea room in East Grinstead (*The Mug Tree*).

54.10 After three unfortunate early miscarriages between October 2013 and March 2014, the claimant gave birth to a son, Henry, on 7 May 2016.

55 Trevor describes the claimant as headstrong and very independent. I accept that assessment. At the time of the accident the claimant was a primary school teacher employed at the Selsdon Primary School where she had been since the autumn term of 2012, having moved from Camden Primary School. She had a Master's degree in education (obtained with merit in March 2013) but otherwise, for one reason or another, her academic qualifications were undistinguished. She considered herself a committed and ambitious teacher; a high-flyer, and this view was shared by several others, although I have concluded that nobody had as high opinion of the claimant as she did herself. She describes her teaching career as "*glittering*" and "*flawless*". She considered herself "*very good*". To back this up she points to a post-resignation episode in 2015 where she says she was "head-hunted" for a senior SEN role but was unable to take it up due to her accident-related injuries.

56 It is worth pausing to consider this. As a result of her profile on social media, the claimant was approached and asked if she would consider applying for a senior SEN role at a handsome salary because her background seemed to fit the bill. I am sure that in a social or conversational context nobody would be unduly bothered about this being described as "head-hunting", but the claimant's explanation about this in her oral evidence is informative. She was very reluctant to accept that the approach originated from little more than a social media mail-shot (which it obviously was), but worse, whilst recognising that she did not at that time have the relevant qualifications or appropriate accreditation to undertake the role, she was absolutely confident that she could have secured the job and got the required accreditation and qualifications as she went along; in post. In cross-examination on this subject the claimant was treated very gently, but in my judgment her attitude to this "head-hunting" incident was, frankly, silly and unrealistic. Had she remained in teaching it is possible that she would have obtained the necessary qualifications for such a role, but the direction of her evidence on this (similar to her attitude about setting up and running a business) was that she as good as had the job if only her injuries had not got in the way. I inferred that she was more than a little envious of her former colleague Emma Espin who had made a not dissimilar move into the lucrative private sector in a special advisory role. What this small part of the evidence illustrates is that the claimant has an over-inflated idea of her pre-accident capabilities and a tendency to exaggerate and jump to unwarranted conclusions.

57 That is not to say she was not a talented primary school teacher. Clearly, she was. A number of witnesses (family, colleagues and friends) were called on her behalf and their unanimous view was to the effect that at both Camden and Selsdon she was well organised, hardworking, dynamic, confident and well-liked. She had, I accept, set her sights on promotion particularly within the area of special educational needs ["SEN"], and her move to Selsdon was designed to increase her profile as a team leader with a view to undertaking responsibilities for "whole school" development in addition to duties as a class teacher. Selsdon was a larger school and the claimant was head of year with ICT responsibilities. As her mother said, and I accept, teaching had been the claimant's life-long ambition and she thrived for some years. I find that this is an accurate, general (if subjective) overview of the claimant as of autumn 2012 when she changed schools. When the claimant announced a career

change in 2014 I accept this came as shock to everyone not least of all her profoundly disappointed parents.

58 Such objective assessments of the claimant as a teacher as there are support the proposition that the claimant was at the very least a perfectly good teacher whose ambition for advancement I infer was based on reasonable grounds even though the future was inevitably uncertain. Her former head teacher at Camden confirms as much. I note, however, that the performance indicators grading her attributes against specified teaching criteria were much the same before (September 2012) as they were after (September 2013) the accident. Indeed, the lower number of "Inadequate" results in 2013 is a small indication that by then she may have been doing rather better than she had the previous year. The claimant's ambition to progress as a teacher was thwarted, at least temporarily, in the autumn of 2013 when Mr. Wollaston, the head teacher, left Selsdon.

59 This is what the claimant says about her career change in her witness statements dated 18 March 2016 and 4 July 2017.

59.1 *"In July 2014 I took the decision to leave a profession that I dearly loved before I was pushed. It was the hardest decision that I have ever taken in my life, but one that I knew I had to make. I knew that I had to take on something far less demanding cognitively and I naively thought that running a small coffee shop might be the answer. (It) should have been a walk in the park for someone like me …"*

59.2 *"At the beginning I had the enthusiasm to get the shop off the ground and was working 6 days a week in order to do so, but this took its toll on my health and wasn't sustainable."*

59.3 *"Before starting the coffee shop I had a significant rest period. I had given up full time employment … in July 2014 and did not begin to work with the coffee shop until November 2014. This meant I was well rested and had plenty of opportunities to recover from the fatigue I had been experiencing … I was able to maintain a clean house as I had little else to do other than housework and some slight preparation of paperwork for the coffee shop."*

60 In oral evidence she said: *"suddenly I found everything difficult by early 2014 (between January and March) and could not catch up"*. She said it was difficult to put a time on her decision to change career but *"overnight I struggled with everything …but I was in denial that there was anything wrong"*. She also said, in language I consider to be worryingly close to the language of Ms. Levett: *"I hit a wall. I lost my engine; the motor"*. Summing up her position in a statement dated 14 December 2017 the claimant says: "*I do grieve for the person that I once was and the career that I had but Ms. Levett has helped me to come to terms with the new me…"*. This comes straight out of the psychologist's chair or a "soap opera" and is singularly unpersuasive. I was no more impressed with Trevor's observation (from his third statement in December 2017): "*I could see she was pushing herself through barriers of fatigue"*.

61 I do not accept the accuracy of the claimant's evidence about the circumstances leading to her career change or the reasons she has given for it. To put it mildly, her witness statements gloss over the detail of the change and how, as well as why, it came about. Her statements are, frankly, perfunctory

about this. The change could not have happened and did not happen *"overnight"*.

62 It cannot be said that her version of her career choice has been moderated over time. As recently as 18 December 2017 in the Care Report Ms. Kirby reports the claimant's position in these words: *"After finishing teaching [the claimant] and her husband decided to open a tea shop…"*. That is what the claimant must have told Ms. Kirby and bears not even a passing resemblance to the facts. The following is what I find is the more likely course of events.

63 Things did not go as well as the claimant would have hoped once she moved to Selsdon Primary School for the autumn term in 2012. Her mother's evidence is persuasive in this context. Before the accident, her mother said in oral evidence, that the claimant showed signs of disillusionment with teaching. This undoubtedly got gradually worse after the accident and was due, in part, to government targets and the "tick-box" approach to teaching that she thought had taken hold after the departure of the head teacher, Mr. Wollaston, in or about the early autumn of 2013, consequential on a negative Ofsted report. This type of disillusionment also caused Ms. Perseh (a deputy head at Camden and former colleague of the claimant's) to leave teaching and subsequently open a coffee shop. The evidence of Emma Espin (a junior teaching colleague at Selsdon) indicates that the head teacher, Mr. Wollaston, "jumped before he was pushed" (my expression, not quite hers). I accept this evidence and infer that the change of teaching style and approach (which the claimant accepts occurred) demanded by the interim head teacher at Selsdon contributed to a long process of dissatisfaction and disillusionment with teaching for the claimant. Emma Espin further states that after an initial period of grace, her impression was that relations between the claimant and the interim head and deputy head at Selsdon (this must have been autumn 2013) began to "*unravel*". That is a striking phrase and is indicative, in my judgment, of the circumstances that fuelled the claimant's disillusionment.

64 The long, slow process of increasing disillusionment began, I find, at about the same time as the claimant got married (13 October 2012). Perhaps more importantly by the autumn of 2013 (the accident intervening) the claimant's application to make a step-change in her professional status was (she says) "*frozen*" by the new leadership team at Selsdon Primary School. The claimant had been working towards and had applied to "pass through M6" (a point on the teachers' grading and salary spine) which would signal not only a salary increase but a recognition of progress towards promotion and leadership roles, particularly within the SEN specialism as the claimant wished. The claimant said that she was reliably informed that her application for advancement was "*faultless*" and that it had been supported by the previous head teacher. Before the latter's departure the claimant said she had been working with his encouragement and support. I find that she did precisely this and it must have been hard work on top of her other responsibilities within the school. The completion of her application and proposal for advancement was, she said (and I accept) a continuing process necessitating constant revision and updating and this must have been going on in the 3 months or so immediately after the accident. I find that the claimant was understandably extremely disappointed to be told (as she reports it) by the new Selsdon regime that her application was "*on hold*" indefinitely and that the school was henceforward to be geared towards a sharper focus on core curriculum taught

in a results-orientated way. When looked at in the context of what her mother said about pre-accident conversations regarding the claimant's concerns about how her profession was changing, together with what I find was the claimant's irritation arising out of perceived government meddling with teaching processes in 2012-13, and (as her mother confirms) her exasperation at being pestered (including out of hours) by ill-prepared student teachers whom she perceived to be incapable of taking clear direction; it is not surprising that by the autumn of 2013 the claimant began in earnest the process of deciding to leave the teaching profession and strike out in a new direction. Trevor's evidence that her paperwork seemed to increase exponentially (I infer he means as 2013 progressed) is consistent with this overview.

65 The claimant's explanation for the set-back in her teaching ambitions in the form of the freezing of her application to cross the "Threshold" is that all extra curricula activities and all applications for career progression were put on hold by the new leadership regime at Selsdon. However, I conclude that this is not supported by the documents and is not an accurate recollection or reflection of the reality. By an undated letter (I infer it must have been sent to the claimant soon after the new interim head took over at Selsdon in the autumn of 2013) the claimant was informed that she had not yet achieved the standards required to make her hoped-for new grade but that she should keep working at the process.

66 Much of what the claimant's mother says about the claimant's stress at school, her apparent feelings of loss of authority at school and her demoralized attitude is the result of the claimant's self-reporting and this, together with irritation about student teaching colleagues is, I find, as consistent with disillusionment as it is with any accident-related enduring symptoms, though no doubt in the summer of 2013 the picture was complicated by the impact on the claimant of the undoubted whiplash and psychological symptoms. I reach the same conclusion with regard to her father's evidence. Even when a symptom is noticed, for example: *"I noticed that she found it difficult to deal with loud and excessive noise and would retreat when this got too much for her,"* I find the example unhelpfully vague in time and context. His evidence about travel anxiety and "snappy" temperament is more specific, but the former is consistent with whiplash and the latter an accepted psychological problem caused by the accident.

67 Irrespective of the accident, events conspired to stir-up the perfect storm for the claimant. It so happened that a favourite café frequented by the claimant in the Croydon area ("Cupcakes") was closing-down (or had closed down) in the autumn of 2013. A friend of the claimant's, Frederique Pineau, had been employed there. Over a private dinner at the claimant's home (whilst both husbands were working night shifts) the 2 women hatched a plan to open, manage and run an establishment of their own, initially with the idea that it would be at the recently closed premises. This must have been on or about 12 October 2013 when the claimant was visiting the "Go Daddy" website with a view to purchasing web-hosting facilities. Their bid to purchase the lease was unsuccessful (as the witness statement of Mr. Miller confirms) but a plan was afoot. Ultimately it led to the opening of "The Mug Tree" in East Grinstead in December 2014 by the claimant on her own; Frederique having long since abandoned the project. For reasons given below I reject the idea that Ms. Pineau was intended, at least after some initial discussions, to play a central role in the business.

68 I find that the claimant's change of career had nothing whatsoever to do with the accident nor any injuries caused by the accident. On the contrary, I am entirely satisfied that the decision to purchase and run a business, ultimately The Mug Tree in East Grinstead, was a deliberate and voluntary choice of the claimant's, confounded as she saw it in her teaching ambitions, disillusioned with changes in teaching style at her school and her feeling of being beleaguered by bureaucracy, school politics, unsupportive colleagues and regulation and the resulting stress. This change of career and lifestyle would have occurred whether or not the accident had happened in March 2013. The claimant was cagey about revealing the business scheme to her parents and probably to her husband because she appreciated that this career decision would come as a disappointment to them (as it did). Trevor seemed to know very little of the business development plans. The claimant wanted to present her family with a *fait accompli*.

69 Being headstrong and making a decision to change career that turns out to be a bad decision, as I find is the likely explanation, is not remotely the same thing as acting impulsively as a result of a brain injury. All the evidential pointers in my judgment indicate that, consistent with her attitude to the "head-hunting incident", the claimant had an over-inflated idea of her business abilities and an equally unrealistic idea about how easy running a new business would be. The accident played no part in any of this.

70 The claimant and indeed her husband protest otherwise. The claimant's evidence (as it was teased out in Part 18 Questions and cross-examination) was to the effect that her equal share of the Tea Room business discussed with Frederique was to take shape in the form of herself as the person responsible for the administration of the business and the baking of cakes in the evening after school (supported by baking input from her father). This, initially, she felt she could "*easily*" do without compromising her professional responsibilities as a teacher and would be doing it for enjoyment, taking only her expenses out of the business. She intended to be a "*distance manager*". Once the full impact of the whiplash injuries dawned on her and she suffered the consequences of it as perceived by her at that time, she felt she could take a break for one or two years from teaching, run the café with help from her parents, a cousin and employed staff, and then "*pick up where she left off*" in the teaching profession once her accident-related injuries resolved as she says she hoped and expected they would. I note that little, if anything, of this was offered to any of the medical experts who together spent at least 20 hours taking personal histories from the claimant.

71 I cannot accept the claimant's evidence in this regard and find that she is not a reliable or accurate historian. I conclude that the claimant's evidence about her career change is based on her reconstruction of what she has persuaded herself would have been the position. This is probably due to the fact that running a small business proved more complicated than the "*walk in the park*" she says she expected and the business never thrived. It has caused the family to fall into debt. Her explanation that much of this period is lost to her and that many inconsistencies have arisen in her history due to accident-related problems with her memory and concentration, is unconvincing and improbable in my judgment in the light of the documents. Her evidence is not an accurate or reliable picture of the reality. I highlight the following reasons:

71.1 The claimant was and remains a naturally intelligent woman with a FSIQ of about 125-130, a level shared by only the top few percent of the population. If she believed that setting up a new business and running it would be a "*walk in the park*" or that it would be "*easy*" and something she could do at a distance or in the evenings after school, particularly if she was also seeking a step-change promotion in the SEN context, then this merely reflects the fact that her FSIQ is not matched by her common sense. The reality is that she was able to undertake much decision-making and preparation for the new business throughout 2013 (particularly the latter part), after the accident and whilst still teaching.

71.2 The search for suitable premises more convenient to her new home in the country (she was in communication with "Lawson Commercial" in this regard from at least November 2013 and probably I infer for some weeks before that); the completion of a business plan and the application for business finance (her loan application dates from 11 October 2013 and must have been in preparation for some time before) is consistent with a long-planned life-style change. In 2014 training, which she says, was underway for the establishment of a catering business, the continued search for premises, and making arrangements to take on the lease of *The Mug Tree* must have involved time, effort and focus. Such a level of activity is not consistent with what she claims was a "*long rest period*" before starting the tea room business in December 2014. Neither, I find, is it easy to reconcile with her later subjective reporting of continuing debilitating symptoms. It is much more consistent with the medical records up to spring 2014. Her activity is not consistent with impulsive decision-making. It is clearly part of a long-term, developing plan executed with care and forethought. It is, however, consistent with disillusionment with teaching; a decision to change course and lifestyle which the claimant was determined to pursue notwithstanding she was suffering from the effects of a whiplash-type injury.

71.3 She was investigating the Go-Daddy business hosting website as early as 24 June 2013 and I cannot accept her explanation that this was school-related. Had it been so it would have been relatively straightforward to demonstrate this.

71.4 On Tuesday 30 December 2014 a local newspaper reported on the opening of The Mug Tree tea room. The news report states how the claimant had decided to cast off the stresses of Ofsted inspections and government targets and that in opening the tea shop she was realising a dream. In quotation marks it reports the claimant's own words: *"It got harder and harder with all the government changes and the pressures. I reached the end of where I could go without going for promotion but that wasn't something I wanted to do. I didn't want to give up more of my life and I felt the time was right to do this".* The opening hours are advertised in the article as being between 11.00am and 4.00pm (which the claimant points out is one of several inaccuracies). Making due allowance for the fact that the East Grinstead Courier is not a publication of record and one would hardly expect the claimant to say she was opening-up due to the chronic effects of a road traffic accident, these unguarded comments are strikingly consistent with other documents (such as the business loan submission and the medical records); the events at Selsdon from the autumn of 2013 and what I find was a decision after marriage to start a family and move to a more relaxing lifestyle in the country. None of this is congruent with how the claimant describes her career change in her witness statement.

71.5 The Mug Tree Business Plan (the disclosed version is dated 1 November 2014). It is preceded by handwritten notes dated 17 October 2013. The

Business Plan is an important document. Of particular interest is the declaration: *"[The claimant] no longer wishes to remain in a highly pressurised career … Her … career had reached a plateau"*. This document also indicates that the claimant had been in touch with business advisors for over a year and she accepted that this must have been before November 2013. She also says (and I accept) that the document was prepared and completed over time (she cannot put a completion date on it). I accept that. Not only does the document strongly point towards long preparation involving discussion with business advisors, it also clearly points towards, and is consistent with, plans for tea rooms being at the forefront of the claimant's mind throughout the autumn of 2013. This would have involved thought and effort on her part, irrespective of the help I accept she must have received from Messrs. Dixon and Miller, her advisers at different times along the way. In addition, the document further illustrates the claimant's tendency towards self-aggrandisement, a trait seen in several parts of the evidence. In it she describes herself as running a craft group for 3 years; being a master tea tender, a barista and a semi-professional baker (none of which are accurate). In oral evidence the claimant gave an unsatisfactory explanation of paragraph 10.1 of the document: "What do you plan to do if your business fails?" to which she answers in the document: "*I will always have the option of returning to teaching…"* but explains in evidence "*I think it means that I always intended to return to go back to teaching with a strong team under me"*. She says this in order to make it fit with other parts of her evidence but it is, frankly, a ludicrous construction of the answer in the document. Mr. Miller (a senior loan fund manager with *GLE oneLondon* helping with an application for finance at an earlier stage of the business plan) did not even know that the claimant had had an accident or had been injured. He describes the claimant as *"vibrant"* and with sufficient enthusiasm for the business project. It is likely that the document was the result of a long collaborative process with advisers, but the claimant's explanation of it (for example, in the Part 18 Answers of 12 January 2018) is, in my judgment, improbable and her attempt to excuse unremoved "errors", which she excuses as *"poor choice of wording"* and by reference to her reduced ability to deal with long documents, has a hollow ring. I conclude from this that not only is the claimant prepared to say whatever she thinks is necessary to get what she wants, however much embellishment is required, but that she is prepared to put forward any explanation for a "poor choice of words" in a document such as this seemingly regardless of how realistic such explanations are.

71.6 Since the Tea Room opened the claimant has undertaken activities designed to increase its profile. Not all have proved successful, but the effort and commitment required is significant. She involved herself in a small business networking group and was awarded *"Mumpreneur of the month"* in May 2017; she and Trevor operate The Mug Tree Facebook page and she took significant steps to set up a "sling library" at the shop under the auspices of the NCT, abandoning the project due to the irksome levels of paperwork required, and also I accept, it was considered too much to take on.

71.7 There is no evidence that the claimant was about to be "pushed" out of the teaching profession as she claims. Such difficulties as she had at Selsdon in the autumn term of 2013 are, in my judgment, entirely consistent with the continuing effects of physical whiplash-type injuries coupled with the claimant's disappointment at not being promoted and concurrent

determination to secure for herself and her husband and future family a quieter, more countrified lifestyle whilst running a tea room.

71.8 The claimant's social activities in the 12 months following the accident are also consistent with the early medical records, and capability to undertake reasonably hard work teaching and planning a new business venture. This is illustrated by her personal bank statements which do not suggest that she was affected by a period of dense post traumatic amnesia nor the immediate onset of a cluster of seriously, debilitating cognitive and behavioural problems immediately after the accident. This is important because these activities provide further evidence, not only that the claimant was functioning at a reasonable level throughout this period, but also because few of these activities have given any of the family and friends witnesses specific cause to be concerned about the claimant's welfare. I would have expected some of the activities to trigger contemporaneous concern about the claimant's memory in the first 4 weeks after the accident if nothing else; or at least a measure of concern about her driving a car. There was none. Examples of the activities include these:

(1) From 2 April 2013 the claimant appears to be functioning at a perfectly unexceptional level. There is nothing very dramatic about this period but she is shopping, visiting restaurants and cafes and going on family outings (driving to Wisely on 7 May) as a matter of routine.

(2) There was a family trip to France in August and September 2013 for which the claimant was the driver (Trevor did not have a licence at this time).

(3) She also drove to a friend's wedding in the Midlands in October 2013.

71.9 This pattern of routine is certainly consistent with the claimant *"pushing through"* her problems if those problems were related to a nasty whiplash injury with modest psychological implications, but I do not accept that there was anything more to the claimant's injuries than this. The absence of any supporting evidence to the effect that driving was causing the claimant *"debilitating anxiety"* as she says it did, is also noticeable. Her husband, if no one else, might have been expected to stop her driving long distances if debilitating fatigue, dizziness or disorientation had manifested themselves in the period before the family holiday in France. The chronology of events reveals that the claimant was able to push through the effects of her injuries to a point when she returns from France in September 2013, returns to school, visits Dr. O'Connor and on top of that accelerates her preparations for a new business career. Enduring cognitive and behavioural symptoms cannot have affected her in the way she has since related whilst permitting this level of function and organisation.

71.10 The claimant's explanation of the undated letter from Susan Papas (the Selsdon interim head teacher) about her application to become a Threshold teacher is an example of the claimant's capacity for wishful-thinking. She unrealistically explains that the phrase *"…you did not meet all of the Teachers' Standards at this time*" supports the conclusion that all extra-curricular activities had been suspended and showed that projects outside the main curriculum had been suspended. This tendency for wishful-thinking is matched by her subjective interpretation when it comes to her explanations of what is to be seen on the video surveillance evidence, what she says about The Mug Tree Business Plan and her attempts to explain away the medical information up to February 2014.

71.11 Despite the claimant's insistence on the central role to be played by Ms Pineau in setting up and running the tea room, there is scant reference to Ms. Pineau in the documents aside from those relating to her one month stint as a Director of The Mug Tree Limited in October/November 2013 and I conclude that whilst a new business was initially planned as a joint venture between the claimant and Ms. Pineau, the claimant was taking the lead and perfectly prepared to go it alone when it proved too much for Ms. Pineau to continue, as it had by November 2013.

71.12 The assertion that the claimant was constrained to make a career change due to severe, chronic cognitive and behavioural problems suffered continuously since the accident is flatly contradicted by the occupation health, Orthopaedic and physiotherapy reports and GP notes up to early 2014.

71.13 I am satisfied that the same assertion is contradicted when the claimant's presentation as a witness is considered, particularly in the light of the fact that as a result of her friendship with Peter Siegel she would, more probably than not, have had particular insight into the possible causes of any cognitive and behavioural symptoms she suffered.

71.14 The evidence of Louise Fisher (a friend since 2006) was read, so the details of it could not be explored (especially dates, times and timelines) but she says: *"I was very surprised when I heard she was setting up the tea rooms. I thought baking cakes and running a tea room would be something (the claimant) might enjoy doing in the future, but it was not a project that I thought she would take on at this stage of her life."* I conclude from this that the idea of a tea room business is something that must have been openly discussed amongst friends, probably before the accident, even if only as a future ambition. This is further support for the conclusion that the business venture was not a sudden or impulsive decision or a necessary, reluctant reaction to the consequences of the accident as the claimant has implied. In her oral evidence the claimant said it was from early 2014 (January – March) that she found it increasingly difficult to cope at school. This is not consistent with the evidence of Emma Espin to the effect that the claimant had expressed her temptation to leave teaching in the run-up to and before the Christmas Holidays in 2013 (entirely consistent with some advanced planning throughout the autumn period).

***The claimant's presentation as a witness***

72 Despite saying in her evidence, on several occasions, that she was finding it difficult to follow the questioning through the many trial bundles; was confused and had difficulty with her memory and dealing with documents; my impression was that the claimant's subjective concerns were belied by the reality. She was articulate and self-possessed throughout her evidence and had no more difficulty finding her way around the large amount of documentation (including bank statements, medical notes, transcripts and reports) than anyone else. On more than one occasion she was able to draw Counsel's attention to a particular document or part of a document in order to make a point. On occasions she was adept at explaining away any adverse conclusions that might be drawn against her by detailed and lengthy alternative constructions of documents which she was shown, even though some of those explanations were contrived. She was able to physically handle the heavy trial bundles stored behind her right shoulder in the witness box without discernible difficulty, discomfort or confusion. She asked to be reminded of page references on a few occasions but no more than any witness

might be expected to do and no more often than several of the medical experts (for example, Dr. Grace had noticeably more difficulty negotiating the documents than did the claimant). Given the number of hours the claimant necessarily had to spend in the witness box, she appeared no more tired than one would have expected any witness to be under such pressure in such circumstances. She remained reasonably composed and focused throughout. Because of the nature of the medical issues that feature in this action I kept side notes (as her oral evidence progressed) of those occasions when she displayed outward signs of tiredness, confusion, or apparent headaches or eye strain (for example, by rubbing of the eyes). Although there are no capacity issues in this case, I considered at the outset whether the claimant might need to be accommodated as a vulnerable witness. However, even on the day when she forgot her glasses (and the court rose 40 minutes early to accommodate tired eyes despite her having managed for the best part of the day) I see that such side notes are few and far between over the course of her 2½ days giving evidence. Some of the expert witnesses in attendance at the trial commented (when their turn came to give evidence) on their impressions of her to the effect that what they saw was consistent with the symptoms of fatigue, headache, concentration and memory problems about which she still complains. In submission, Mr. Grant says on her behalf: *"None of the other witnesses demonstrated the poverty of mental stamina that [the claimant] exhibited in the witness box"*. I have to say that this is not an impression I shared and I reject it. Sitting at the back of the court as she did for the rest of the trial (through 6 days of complex and conflicting medical evidence) I noted that to all outward appearances she remained engaged. She was listening, taking notes and passing on instructions. That is not to say there were no signs of fatigue, but so there were from several others in the courtroom. For example, Professor Morris (a new grandfather) appeared to be having trouble staying awake when he was in court (he did so with apparent extreme signs of forced concentration) and I infer from his ponderous and sometimes rambling answers when giving evidence (for which he apologised) that he was having trouble focusing on the job in hand but he made heroic and successful efforts to do so as one would expect from a professional witness of his undoubted standing.

73 I found the claimant's evidence to be unsettling (due largely to its internal inconsistencies and inconsistency with documents together with the mismatch between her reporting of enduring symptoms and her actual presentation in court) and ultimately profoundly unsatisfactory. The claimant's honesty has not been impugned and I do not conclude that she is lying or malingering. The position is considerably more complicated and nuanced than that. It is her accuracy and reliability as a witness that have been subject to serious challenge (as the Medical Issues document and Counter Schedule foreshadow). I do not conclude that there has been any effort on the part of the defendant to challenge the claimant's case by innuendo or insinuation. In putting the claimant to proof it has been clear on all sides that the claimant's reliability and accuracy are what are at stake. I did not, when her evidence is looked at as a whole, find her to be an accurate or reliable witness and have been constrained to conclude that she no longer reliably knows herself what the accurate description of events and the consequences of this accident is. She cannot articulate (whether herself or by reference to other evidence) a workable timeline between the accident and the enduring cognitive and behavioural symptoms about which she later complained and in some respects, still complains.

***Surveillance***

74 A further illustration of why I found the claimant to be such an unsatisfactory witness comes from the questioning about the video surveillance evidence. She was only asked about a small selection of "out-takes" (5 in number) and the surveillance itself although covering parts of 16 separate days can't pretend to provide anything other than snapshots of her activities. At first, I was inclined to the view that this material was unlikely to be helpful. There are occasions on the more comprehensive material that was not shown in court, in which the claimant can be seen acting in a way that could be taken as being consistent to a modest degree with the cluster of medical problems about which she complains. What she was asked about in court related to two shopping trips to supermarkets with her family and three occasions when she is recorded working in her tea shop at the end of the day. Viewing the video extracts themselves (particularly when taken in the context of the whole of the surveillance) the claimant appears to be functioning normally for the most part, without any obvious difficulty related to her balance or any orthopaedic limitations. However, the claimant could have better days or may try and make the most of her (she would say) intermittently but seriously limited abilities. None of this would necessarily show on the surveillance evidence.

75 It was not the content of the video material that I found of particular interest but the claimant's response to it. I can only conclude from the claimant's comments about what she was shown on the screen (and in fact she offered many of her explanations without being asked specific questions), that she is deluding herself about what can be seen. She pointed to incidents of her using a supermarket trolley as a stabiliser (when she clearly was not); she explained trivial instances of standing back from shelves as examples of her coping with dizziness (when they were obviously nothing of the sort); she describes two instances of herself and her husband manhandling Henry into the back of a car as illustrative of her inability to cope on her own, when all the video shows is parents of a toddler with large amounts of shopping coping together in the way that innumerable couples do in supermarket car parks every day of the week. The excerpts shown of her working at closing time at the tea shop show she is clearing up at the end of a working day, lifting furniture and "A" boards (sometimes one-handed) and on one occasion with Henry carried on her hip. I would not have drawn any adverse conclusions about the claimant's reliability from such short extracts on isolated days but for the fact that the claimant took such unnecessary and unconvincing efforts to explain them away. At one point I got the impression (and this was underpinned by passing remarks of Dr. Savundra during his evidence) that it was claimant's case (although not said by her) that carrying a child whilst manhandling shop furniture was a positive thing in that the child would act as a counter-weight to help the claimant maintain her balance. In my judgment the carrying of the baby is not consistent with the claimant's evidence that there was an occasion when her balance problems caused her to fall whilst she was carrying Henry. Had she done so, I cannot accept that she would have taken any risks in this regard unless her balance problems had completely resolved. The reality is that what the claimant tried to explain away on the videos, simply show ordinary work-related activities being undertaken in a routine manner. The claimant's insistence to the contrary struck me as her protesting too much and looking for problems on the videos where there were none to be found. The impressions of the substance of surveillance evidence of Dr. Heaney, Mr. Radford and Dr. Vanniasegaram are consistent with my own conclusion.

76 There are occasions when the claimant is under surveillance, but does not leave her home or does not venture out until later in the day. This is at least as consistent with her childcare responsibilities as it is with her evidence that these occasions are illustrative of her being tired in the mornings. I reject her explanation. The obvious effort and levels of concentration required to complete her comprehensive review of the surveillance evidence in her witness statement of 21 March 2018 speak eloquently of the claimant's capabilities, not least of all her memory and concentration.

***Peter Siegel***

77 On the 5 March 2013, about 3 weeks before the accident, the claimant made a witness statement in another case; that of Peter Siegel. Mr. Siegel had been a reasonably close family friend since about 2000 with greater and lesser periods of contact between then and 2009. Mr. Siegel was injured in a rear-end collision in 2009 as a result of which he suffered DAI. The purpose of the claimant's evidence, and that of her husband, when they attended the Siegel trial in November 2014, was to speak of the effects of the accident on him. The claimant knew Mr. Siegel well enough to comment on his short-term memory problems, fatigue, confusion, difficulty in acquiring new information and increased social insensitivity. Mr. Siegel was successful and recovered in excess of £1.5miliion in damages. The coincidence of the accidents and some of the consequences between the two cases of these friends is obvious, but not necessarily sinister.

78 Mr. Siegel was contacted by telephone by the claimant's husband on the evening of her accident (a measure of how close the families were) and he visited the claimant not long afterwards. The two kept regularly in touch up to the date of the Siegel trial and beyond. The claimant says she recalls little if anything of this and says in her oral evidence that she did not discuss the two accidents or her injuries or symptoms with Mr. Siegel. Of subsequent meetings she said: *"We did not really talk about the similarities in the cases". "I did not think of it again to be honest,"* she said in the context of her own symptoms as against those she had described in Mr. Siegel. The penny, she said, never dropped, even in November 2014 when she gave evidence at the Siegel trial. She was blaming her own difficulties on a stubborn whiplash injury. Mr. Siegel never pointed out to her or Trevor any similarities and never suggested that the claimant should seek more than orthopaedic medical advice about them. So, the claimant says, she was not at any advantage in being able to make a connection between her symptoms the accident on 29 March 2013.

79 Whatever one might make of this evidence it sits uncomfortably with the answers to Part 18 Questions provided by the claimant on 17 November 2017 in which quite the opposite impression is created. The answers suggest that there had been conversations about their shared symptoms and that it was indeed Mr. Siegel who recommended the claimant instruct a specialist solicitor. If this is supposed to be the correct version of their discussions and it is intended to convey the impression that the penny only dropped 18 months or thereabouts after the claimant's March 2013 accident, I reject it as improbable.

80 Rear-end collisions are not uncommon. DAI may be controversial, particularly in a litigation context, as Mr. Grant puts it. The emergence of two such cases involving friends may be no more than an example of DAI being

more recognised now, where it would previously have been overlooked. Medical knowledge has advanced. Looked at in this way the emergence of two similar DAI cases involving friends involved in separate rear-end collisions may not be all that significant. What, in my judgment, is significant, is that neither the claimant nor her husband (save for one passing reference to a 'phone call in a witness statement) volunteered any background information about the Siegel case in the several witness statements prepared for the main action in this case. I find it inherently implausible that there should have been no discussion between friends and their families about the similarity of the cases or the overlapping clusters of symptoms in each case. I find it even more implausible that this overlap did not cause either the claimant or her husband to consider a link between the claimant's accident and her symptoms as it had been in Mr. Siegel's case. Had there been a close temporal connection between the March 2013 accident and claimant's continuing non-orthopaedic symptoms there would have been discussions and possible links drawn, and the penny would have dropped long before the claimant finished her evidence in the Siegel case on 14 November 2014. This is particularly so given that the claimant's pain diary was underway and had been since June 2014 on the recommendation of the physiotherapist, Mr. Patel, in circumstances where treatment had been of limited benefit. The Answers to the Part 18 Request is a more realistic version of likely events, but had to be pressed out of the claimant in that way, and is not consistent with the thrust of this strand of the claimant's oral evidence. Both the claimant's evidence and Trevor's lacked transparency and candour on this aspect of the case, and I considered them to be evasive about the real levels of contact and discussion with Mr. Siegel.

***The claimant's medical case***

81 I will come to DAI with associated neural pathway, audio-vestibular complications in due course. However, one of the exclusionary, diagnostic tools used to reach a diagnosis of DAI is an assessment of Post Traumatic Amnesia ("PTA"). In the absence of many other high-risk factors associated with the accident, PTA assessment has proved to be critical. In its final manifestation, the claimant's case is that she suffered PTA for between 2 and 3 weeks after the accident followed by a period of accelerating forgetting leaving the claimant with "islands" of memory once she began to emerge from the dense period of PTA. What is problematical about the claimant's description of the period of prolonged, dense PTA resolving to accelerating forgetting, is that it appears to have gone unnoticed by her husband (whom she was with constantly), her parents (whom she saw frequently but intermittently) or anyone else, and unreported. That is not to say friends and family noticed no symptoms at all but the symptoms that were noticed were consistent with other organic causes (e.g. whiplash).

82 Mr. Grant in his *Closing Submission* quotes at length from Professor Morris whose conclusion is put in helpful summary form and encapsulates the claimant's case:

*"In summary, on balance, she has brain injury caused by her accident and the mechanism for this is likely to be diffuse axonal injury, which affects the type of neurocognitive systems that are compromised in her case. This injury has led to cognitive and behaviour deficits that are supported by her cluster of symptom presentation in everyday life and the neuropsychological test results. Whilst the level of brain damage is technically severe, the symptoms can be classified as mild, but it should be stressed that mild symptoms can produce very disabling effects on a person, also in the context of high*

*intelligence and occupational and intellectual expectations. Her particular neuropsychological difficulties have been very disabling in terms of dealing with the demands of teaching, in particular the degree of use of memory, multi-tasking and nuanced decision making required, as well as the degree of stamina and energy required. It seems that Kathryn Hibberd-Little judged correctly that she could no longer function in her role as teacher, having made substantial effort to continue. In my view she had incomplete insight into her difficulties and the effects on her when she made decisions about life changes and this has led to her making perhaps the wrong decision concerning setting up a coffee shop business, something she previously would have been very capable of managing. Loss of insight and judgement are features related to brain damage and on balance she may not have been making aware decisions when she decided to change careers."*

83 In support of her lack of awareness, insight and poor decision-making the claimant relies in part on the investment made in the pet shop next door to *The Mug Tree* in 2016. Her father describes this as *"a bit of an impulse purchase not fully or properly thought through"*. I accept that this new, additional business venture was not thought through, but I reject the idea that it was impulsive. It turned out to be a financially catastrophic decision and is a further illustration of the fact that buying and running a business is not as easy as it sometimes looks. It was not, I find, impulsive because it was a joint decision with Trevor and the claimant's parents were available for appropriate cautionary advice. The fact of the matter is that the claimant and Trevor were "conned" by a crook (the pet shop manager). As her father says, the pet shop turned into a *"money pit"* and the financial losses sustained in this ill-fated venture coming at a time when the claimant was expecting her first child and the disappointing performance of the tea room despite all the time and effort that business inevitably took, no doubt increased the stresses and strains of family life throughout 2016 and 2017. Like the claimant's mother, her father wonders whether Trevor also suffered a brain injury in the accident. It is interesting that he raises this issue in the context of the pet shop purchase. In my judgment it is more probable than not that the disastrous pet shop venture has given rise to her father's impression, but it is probably a false impression. What is of further interest is that the family (mother and father) appear all too ready to attribute perceived cognitive and behavioural traits in Trevor (including chronic fatigue) to the accident in the absence of a shred of evidence to that effect. It is impossible to avoid the inference that the parents have too readily and unjustifiably attributed to the accident what they are told by the claimant of her condition and non-specific changes they have identified in her themselves.

84 The claimant's case is put substantially in this way. First, it is recognised that her own reliability and accuracy are vital and I am invited to treat her not only as an honest witness free of psychological pathology, but as someone who is accurate in the details of her evidence; and reliable. This approach to her evidence is particularly important in what the claimant reports of her history and symptoms to the medical experts in the context of retrospective PTA ["rPTA"] assessments. Secondly, on the assumption that she is an accurate and reliable historian, the medical conclusion arrived at by a process of elimination to the effect that DAI is a plausible explanation for her enduring problems, is one that becomes more probable than not given the absence of any psychiatric or psychological causes or an identified alternative organic cause of her enduring symptoms. If by this process her current condition is likely to be the result of accident-related brain injury, the many problems with

her evidence in other areas of the case are more likely than not explained by the impact on her focus, organisational abilities, concentration and memory by a brain injury, albeit coupled with a high-functioning desire to disguise these consequences from the outside world. I do not accept this.

85 I have so far dealt with the contemporaneous medical records, the claimant's activities in the summer and autumn of 2013 and the evidence about the claimant's change of career. In none of these areas of the evidence is the claimant's case supported by the documents. In several important respects it is contradicted by the documents. Nor does her evidence have any substantial corroboration from the all too general evidence of her family, colleagues and friends. There comes a point where the number of instances where the evidence is either not confirmed by, or is simply contradicted by other evidence, that it is impossible to place any reliance on the claimant's evidence at all. That point has been reached in this case.

86 The implications of this on the medical evidence are significant. In brief, the claimant's case on the expert evidence is that a plausible diagnosis has been identified. What else could be causing her myriad enduring symptoms? No alternative to the claimant's experts' hypothesis is forthcoming, so the submission goes, therefore, the only hypothesis provided is likely to be correct. This submission could only be compelling if the claimant's case did not rely so much on her own accuracy and reliability and if she was an accurate and reliable historian. This is because the medical conclusions reached with regard to a DAI are inextricably linked to rPTA assessments which themselves depend on the claimant's reliability and accuracy. It does not necessarily follow that the claimant's reliability in repeating her history to clinicians is as flawed as it is in other aspects of the evidence. Unfortunately, a review of the medical reports and consideration of the expert evidence shows that her reliability is equally flawed. Given that the medical hypothesis supporting the claimant's claim for damages for a brain injury relies so much on the claimant's accuracy, I do not accept the hypothesis. It is necessary to look at the expert evidence, and the many inconsistencies it highlights in the claimant's presentation.

87 When, as I have, I reject the hypothesis of a DAI and reject the medical evidence called in support of the claimant's case, I do so largely on the basis of the claimant's unreliability and her inconsistency, not because (save in one instance) the experts are inadequate or the hypothesis is medically unsupportable or implausible as a diagnosis in an appropriate case. However, this action is not all about the medical evidence.

88 It is convenient at this point to deal with a strange section of the evidence touching on the claimant's post traumatic amnesia. On discharge from the hospital it seems the claimant and her husband bumped into an old friend of his, Stephen Yates. At the time of signing her statement on 18 March 2016 the claimant maintains that she still had no recall of this event or who the person was. Trevor was keeping the name a secret as some sort of private game. This incident was on 29 March 2013, at a time when the claimant and Trevor say they were unaware of things like post traumatic amnesia and, therefore, unlikely that they were thinking about the difference between recall and knowledge which would become so important later on. Why Trevor would withhold the name of his old friend in this way, and for so long, I cannot begin to imagine. The episode is supposed to illustrate a distinctive incident which cannot be cued in the claimant's memory. I can only conclude, as is submitted

on behalf of the defendant, that this entire episode is contrived and unconvincing. I put this evidence, such as it was, to one side.

89 The claimant corrected one aspect of her recall. She said in her first statement that she had some patchy memories of attending a *Biffy Clyro* concert on Easter Monday 2013. In a later statement she corrected this. She did not recall the concert, but because she knew she had tickets she had assumed in her earlier statement that she went. This too is odd. At the time she signed her first statement the claimant was already familiar with the important distinction between recall and knowledge. I can't say what contorted thought processes led to the original error, if error it was, or what caused the correction. The same applies to the change in evidence in the later statement about what was recalled about the claimant and her dealings with the defendant at the scene of the accident. It is all very unsatisfactory and unconvincing.

***DAI – Medical Introduction***

90 The outline introducing DAI in Mr. Grant's written "Claimant's Opening" is a good place to start. '*Diffuse axonal injury is caused by a shearing injury to the brain tissue as the brain moves forward and backwards rapidly within the skull*'. (Allder). Academic authors, Smith & Meaney provide a more detailed description in their 2003 paper '*Diffuse Axonal Injury in Head Trauma*:

*'(DAI) is a "stealth" pathology of traumatic brain injury (TBI). Although found throughout the white matter, it comprises primarily microscopic damage, rendering it almost invisible to current imaging techniques. Yet, it is one of the most common and important pathologic features of TBI. It seems ironic that the size and organization of the human brain that allow us to design and drive automobiles are also our greatest liability of producing DAI in the event of a crash. Under the physical forces such as shear that commonly induce TBI, the human brain can literally pull itself apart. In particular, axons in the white matter appear poorly prepared to withstand damage from rapid mechanical deformation of the brain during trauma … The principal mechanical force associated with the induction of DAI is rotational acceleration of the brain resulting from unrestricted head movement in the instant after injury. This inertial loading to the brain induces dynamic shear, tensile, and compressive strains within the tissue leading to dynamic tissue deformation … For the development of DAI, the size of the human brain plays an important role because of the substantial mass effects during injury that result in high strains between regions of tissue. Under normal daily activities brain tissue is compliant and ductile to stretch and easily recovers its original geometry. In contrast, under severe circumstances, when the strain is rapidly applied, such as during an automobile crash, the brain tissue acts far stiffer, essentially becoming more brittle. Thus, rapid uniaxial stretch or "tensile elongation" of axons is thought to result in damage of the axonal cytoskeleton. This classic viscoelastic response to rapid deformation prompts a classification of dynamic injuries, in which the applied forces occur in less than 50 milliseconds. Accordingly, axonal injury is a dependent on both the magnitude of strain and rate of strain during brain trauma.'*

91 The authors also observed:

*'However, in survivors, DAI is virtually invisible to conventional brain imaging techniques, and is only hinted at if it is accompanied by macroscopic changes, such as white matter tears and parenchymal haemorrhage found in severe cases. The predominant pathology of DAI—microscopic axonal swellings—has proven extremely difficult to illuminate with non-invasive methods despite its extensive nature. Accordingly, patients and animal models with little macroscopic injury after diffuse brain injury typically have normal appearing images of the brain. This has led many to believe that axonal pathology is substantially underdiagnosed. Clinically, DAI is often a "diagnosis of exclusion" based on the inability of conventional imaging techniques to detect brain pathology despite overt symptoms, such as prolonged unconsciousness or cognitive dysfunction after brain trauma (Figure 3). Because of this diagnostic deficiency, the relative role of DAI in mild-to-moderate brain injury remains unclear.'*

92 In an earlier 2000 paper by the same authors they note:

*'The forces required to cause the tissue deformation inducing DAI are often misunderstood. A common cause of confusion is the types of forces required to induce axonal injury because DAI has been observed in cases of falls and assaults, as well as in victims of motor vehicle accidents. The contact forces that are produced when the head is struck by or strikes a hard object often produces focal effects alone (e.g., isolated focal contusion). However, in some circumstances, these contact loads may also rapidly accelerate and/or decelerate the brain, thereby inducing inertial forces throughout the brain. Alternatively, inertial forces such as those produced by rotational acceleration of the head during automobile crashes often culminate in the contact force of the head's striking the interior of the automobile. Thus, although the formation of DAI is produced by inertial forces, contact forces often cause the levels of acceleration necessary to produce DAI.'*

93 Subject to some disagreement as to whether DAI is a "stealth" pathology and whether more modern and sophisticated imaging techniques might be better placed to identify DAI than was the case in 2000 and 2003, the above introduction is not in dispute. DAI is not on trial in this action. Previous cases in the last decade or so illustrate that it is an established diagnosis in appropriate cases. The issue is whether the claimant has proved that she has it. In order to do so it is important that she is a consistent and accurate historian; that the evidence draws a clear temporal link between the accident and the onset of her symptoms and that those symptoms are consistent with DAI. Assuming the claimant (and Trevor, her husband) to be accurate and reliable and a temporal link is established, the absence of an alternative diagnosis is an important consideration, but not conclusive. I am not satisfied that the claimant is an accurate historian, neither am I satisfied that a reasonably clear temporal link between accident and enduring symptoms is established, but some of the enduring symptoms (assuming the claimant is accurate about those) are consistent with DAI. It remains necessary to look at the expert medical evidence because that throws a further shadow over the claimant's accuracy and the timeline. However plausible the medical hypothesis that the claimant is suffering a DAI, this plausibility is undermined if the claimant's case is based on inaccurate factual evidence.

***Imaging***

94 There are no images in the present case and so it is not surprising that imaging does not feature in the neurologists' Joint Statement. Dr. Allder says this:

94.1 *"Ms Hibberd-Little has not had any brain imaging but it is likely to be 'normal'. The published literature has shown that attempts to correlate visible lesions on any currently available routine imaging modality to clinical symptoms in patients with DAI have proved disappointing. The explanation offered in the literature is that the clinical deficits relate to a "more general compromise of the integrity of underlying white matter, which may connect topographically distinct regions".*

94.2 *"Even if Ms Hibberd-Little were to undergo 3T susceptibility weighted MRI, it is unlikely that this would demonstrate visible lesions. Susceptibility weighted MRI has a specificity of approximately 90%, which means that when it is positive there is a 90% chance that the patient does have diffuse axonal injury. However, it is important to note that it only has a sensitivity of 20%, which means that it only identifies 20% of patients who do have diffuse axonal injury."*

95 I understand that Dr. Allder's position is that because DAI, especially microscopic DAI, is not likely to show on scans there is nothing to be gained by scanning, however state of the art the scanning might be. This strikes me as putting the cart before the horse. Given that the academic authors recognise that DAI is a "*diagnosis of exclusion*" it would have been helpful to have imaging results in this exclusionary process, particularly if scanning had become more sophisticated in the 10 years between 2003 and the accident (and I accept Dr. Heaney's evidence that it had). There is even a possibility that imaging would reveal other potential causes for the claimant's enduring symptoms. It could in my judgment have forestalled the line of questioning about whether damage to the *fornix* was at the heart of the claimant's neuro-pathway problems. That might explain her condition (damage to the fornix being something that would have been more likely to show on imaging). Had there been imaging results, they may have been negative or neutral for microscopic DAI. That would not have been the end of the claimant's case. However, I conclude that the absence of imaging results begins to undermine the submission made on behalf of the claimant that her experts have engaged in *"rigorous* [exclusionary] *methodology"* in reaching the diagnosis they have.

***Neurologists (Allder[2] and Heaney[3])***

96 Dr. Allder concludes in his first written Report:

96.1 *"[The claimant] sustained a head injury at the time of the accident, with associated brain and psychological injuries. She has also sustained an audio-vestibular injury."*

96.2 *"… the published data relating to this area conclude that the specific trigger for a traumatic brain injury which could lead to diffuse axonal injury is a rapid onset, forward acceleration of the brain. The chance of*

[2] 18.07.16, 29.07.17, 17.11.17, 24.11.17, 04.12.17,18.03.18

[3] 25.09,17, 24.11.17.

*such an injury causing significant DAI is exacerbated if there is any element of rotation. This is a potential injury mechanism in this case."*

96.3 *"In my opinion, the presence of the neurogenic, physical and neuro-cognitive symptoms listed below (experienced acutely and sub-acutely) suggest a probability that [the claimant] suffered a subtle closed brain injury secondary to diffuse axonal injury"* (there then follows a list of 17 bullet points of symptoms).

97 Dr Heaney submitted an Opinion dated 29 September 2017 and concludes that the mechanism of the accident and the contemporaneous and other evidence (he had considered all the factual witness statements and most of the other medical experts' reports) pointed away from any significant PTA and the absence of loss of consciousness which (amongst other things) lead him to conclude that there was no brain injury or at worst, a minor concussion. As yet he concludes that on the assumption that the claimant's reports of enduring symptoms are correct they are medically unexplained and not caused by the accident.

98 I draw the following conclusions from the Joint Statement and the written and oral evidence of the neurologists.

98.1 The diagnosis of traumatic brain injury ("TBI"), including DAI, is ultimately a matter for the neurologists, albeit informed by other specialists, including psychologists. Diagnosis is a matter of clinical judgment by medically qualified clinicians.

98.2 Even apparently trivial accidents might cause TBI and DAI.

98.3 A diagnosis of DAI depends on the veracity of a patient's history across the whole range of symptoms affecting that patient and an overall consistency and coherence in the presentation of the patient is sought. Without a reliable history, a diagnosis "*does not get off the ground"* (Allder).

98.4 Structural scanning (however sophisticated) will not necessarily reveal anything of relevance.

98.5 One should be looking for a clear, temporal link between an accident and the reported symptoms.

98.6 Each case presents differently for each patient and none of the common symptoms of DAI is unique to DAI. There is a wide range of possible outcomes. Whiplash and DAI may be triggered by the same mechanism but are not related, even though symptoms may be common to both in some cases.

98.7 A wide variety of factors have to be considered in approaching a diagnosis, especially in the context of looking for a clear, temporal link. Those factors are:

(1) The pre-accident health of the patient (including memory) and in this case the neurologists agree that the claimant was healthy before the accident.

(2) The claimant did not lose consciousness.

(3) Dr. Allder's neurological examination of the claimant had been normal;

(4) The mechanism of the injury: if there are *significant* rotational forces involved in the trauma mechanism, DAI is

more likely than if there is no such rotation (though what degree or extent constitutes "significant" rotational forces remains obscure). Rotational forces might be associated with the collision itself or as a result of a patient's position within the vehicle or both;

(5) The presence of associated impact injuries (none present);

(6) Consideration of contemporaneous medical assessments and clinical examination. In this context it is common ground that a Glasgow Coma Scale ["GCS] test is nothing more than a starting point and too crude on its own to exclude DAI (the claimant's GCS was 15/15);

(7) The onset of relevant symptoms and the trajectory of recovery (symptoms would not be expected to deteriorate over time);

(8) The presence of post traumatic amnesia ("PTA"). DAI should never be diagnosed on the strength of a PTA assessment alone but it is a necessary tool. It is better if a prospective PTA assessment can be undertaken, but if it has not been done, the closer to the time of an accident a retrospective assessment can be made, the better (due to the passage of time and confusion caused by received information). Retrospective assessment of PTA is nonetheless viable and helpful when undertaken carefully with a recognised diagnostic tool and in such circumstances, can be just as useful as a prospective assessment – assuming the history given is accurate and consistent. The first retrospective PTA assessment is likely to be the most informative, if carried out appropriately and this can be the best single indicator of the severity of a closed head injury.

99 In the Joint Statement the neurologists say: *"We agreed that without specific high-risk factors such as side impact, significant rotational forces, or significant contact injuries, when a healthy individual is considered, low speed impacts are very unlikely to cause diffuse axonal injury."* Dr. Allder qualified this by noting that this was certainly true with respect to macroscopic DAI but "*less so*" for microscopic DAI, a distinction Dr. Heaney did not accept (preferring degrees of severity as a measure). Dr. Allder did, however, accept in his oral evidence that it was still statistically "*unlikely*". Within this agreement there is clearly qualitative room for manoeuvre. What is the range of speeds for a "low speed" impact and what constitutes "significant" rotational forces; how unlikely is "unlikely"? There is no bio-mechanical evidence in this case to assist with either the meaning of "significant" rotational forces or its application to the factual evidence; although I conclude that it must ultimately be a matter of degree to be assessed in the context of all the circumstances in any given case. I accept Dr. Allder's conclusion that it is *"not clear that the patient rotated"*. The only indications of impact speed are derived from the defendant's engineer's report describing the impact as "light" and my own inference that the impact speed must have been appreciably less than 30mph. How much more than a bump this collision was is impossible to say. However, it is agreed that none of these factors is conclusive one way or the other (e.g. *rotation is not vital"* according to Dr. Allder). Nonetheless, I find that none of the identified high-risk factors has been shown to apply in the present case. This makes the reliability of the

information presented as part of the process of taking a rPTA assessment together with the content of the rPTA assessments and the claimant's reliability and accuracy all the more critical.

100 Weighing up all the relevant factors in reaching a clinical judgment, Dr. Allder concludes that on the balance of probabilities the claimant sustained a DAI in this collision. Dr. Heaney, whilst recognising that such a conclusion is theoretically plausible, assuming that the claimant is an accurate historian and accurate on her description of enduring symptoms, considers that the claimant's case lacked the temporal coherence (amongst other things) to make it more probable than not. I prefer and accept the opinion of Dr. Heaney. Dr. Heaney's opinion amounts to this. Whatever the claimant's enduring symptoms may be proved to be, they are not attributable to a DAI (with audio-vestibular implications) caused by the accident.

101 In my judgment Dr. Heaney's opinion is anchored more securely and realistically in clinical experience and practise and is less theoretical and academic than that of Dr. Allder. Dr. Allder approaches his opinion from the perspective of exclusion without, in my judgment, sufficient regard to the whole picture. In recognising, as he did, that the claimant's case might fall within a small cohort of a small cohort (microscopic DAI with progressive amnesia whilst functioning apparently normally) and accepting that whilst this was not the norm: *"it can happen",* I came to the conclusion that Dr. Allder focused too much on theoretical plausibility and not enough on the kind of coherence in the overall presentation of a particular patient (the claimant) he agrees is essential.

102 Dr. Heaney was prepared to recognise the plausibility of alternative views to his own and to that extent I found him to be the more objective. He was cross-examined at length on many academic publications and demonstrated a full understanding of their implications. He was more realistic than Dr. Allder, I concluded, in noting their limited scope. He was properly sympathetic to the claimant's perceived predicament and presented his conclusions in a measured and considered fashion. He accepted that a diagnosis of a DAI was plausible (in the sense that it "*could not be eliminated*") but took all the surrounding features of the case into account in concluding it was not probable. I accept Dr. Heaney's conclusions. In particular I derive and accept the following from his evidence.

102.1 When assessing PTA retrospectively, the consistency of the history is important. Dr. Allder does not disagree. Dr. Savundra also said the history given by the patient was important (but thought that consistency could be compromised in someone with a brain injury).

102.2 Variations or lack of consistency in a history would cause concern that a patient's problems were not PTA or a DAI, but something else. Dr Allder agreed that inconsistencies and contradictions were relevant to the

overall coherence of a patient's presentation, and he accepted that overall coherence was important.

102.3 There was a lack of consistency or coherence between the claimant's reporting of symptoms in the early stages and her later rPTA assessments, including that undertaken by Gillian Levett.

102.4 He concludes: *"there is no contemporaneous evidence of PTA"*. He doubts Dr. Allder's contrary conclusion reached at an assessment 3 years after the accident. (Dr. McCulloch was of the view that the 4 years that had elapsed prior to her interviewing the claimant was too great to warrant any formal PTA assessment on her part).

102.5 Driving home, as the claimant did, for 20 minutes in a state of PTA, would be exceptional because of the level of confusion a patient would be expected to display.

102.6 Someone with the prolonged PTA claimed by the claimant would usually also suffer from some degree of loss of consciousness and would not be expected to score 15/15 on the Glasgow Coma Scale. He was not aware of any paper which recorded such a prolonged PTA without loss of consciousness.

102.7 Whereas he had seen patients who consulted their GP after losing two hours of memory, it was "*odd*" and "*remarkable*" that someone who had lost between two and three weeks should not have consulted her GP. Two to three weeks of PTA in a case such as this was anomalous and "*did not look right*".

102.8 Two to three weeks of PTA was likely to prompt questions in the afflicted person, such as "Why am I here?" There is no evidence of any reported episodes of this nature.

102.9 The onset and trajectory of the claimant's injuries was not right. It appeared from the pattern of reporting in the early medical appointments as well as histories given later, to be a deteriorating one and was not consistent with someone who had suffered a brain injury in the accident.

102.10 On meeting the claimant, it was clear to Dr. Heaney that she was a very competent person. He had the impression that she had already given her history several times to other practitioners and he noted her use of the description, "*snapshots of memory*", which was a phrase used in the medical literature. Dr. Heaney was rightly puzzled that the claimant seemed not to have knowledge (irrespective of any recall) of a trip to Brighton on 14 April 2013 until this was brought up with Ms. Levett in August 2015. The puzzlement derives from the fact that the claimant reports that *"her habit is to use Facebook every day or every other day"* and images relevant to the Brighton trip were on Facebook and yet the Brighton images went apparently unnoticed for 28 months.

102.11 Usually, in cases of DAI, a patient's mental processing speed would be affected. He considered this a more stringent marker for brain injury than loss of memory but he was prepared to defer to the neuropsychologists on this. It is agreed that testing indicates that the claimant's processing speed has been unaffected by the accident. (Although Ms. Levett thought otherwise in her Report dated 9 July 2016).

102.12 If there was injury to the fornix, this could, in some cases, be visible on scanning (even though the absence of a positive scan result far from conclusive). No scans were available.

102.13 The claimant's reference to the stigma attached to brain injury did not apply, since she said that she did not think that she had a brain injury, but that her problems were related to the whiplash injury.

102.14 Having been in court throughout the factual evidence and standing back to look at the entire case he concluded that the claimant's case was

*"full of oddness"* such that an exclusionary diagnosis of a DAI was less than probable.

103 Both neurologists recognise the importance of the rPTA assessments, not least of all the first rPTA assessment taken in this case 2 years and 4 months after the accident by Gillian Levett. Other rPTA assessments may not be as well-placed, but there were several others undertaken by various medical experts. It should be noted, however, that the claimant's case does not rest on rPTA assessment alone. Even so rPTA assessment has assumed a central role in this case in considering whether the claimant suffered DAI as a result of the accident.

***PTA Assessment***

104 The following is informative on the topic of rPTA assessments in the context of diagnosing traumatic brain injury ["TBI"].

*"The duration of PTA is still commonly assessed retrospectively by asking the individual with TBI to recall their first memory following the injury after the return of full consciousness. Although one study comparing retrospective estimate with prospective monitoring on the GOAT did not find a significant difference between methods in PTA duration, the reliability of retrospective estimation for a given individual is dependent upon the accuracy of recall, which can be confounded by recounts of others, confabulation, stress associated with trauma, and sedation or other injuries"* (Ponsford: 2014).

This must be seen in the light of King *et al*: 1997 (bearing in mind that this paper concerns comparative, successive results of PTA assessments by different, independent practitioners):

***"****the retrospective assessment of post-traumatic amnesia has reasonable reliability with a correlation coefficient of 0.79 and with 79% of patients being allocated to the same grade of severity by both assessors. This applied to all levels of severity and at various time points after injury … however … a significant minority of patients can be misclassified, with 2% being allocated to widely differing categories of severity by two different assessors. As would be expected, table 2 indicates that measurement was more reliable for longer durations of post-traumatic amnesia and when time intervals between assessments were shorter* **…** *The findings highlight some of the risks associated with relying solely on post-traumatic amnesia as a measure of severity in individual patients and in using it to define rigid taxonomies of severity. Certainly, post-traumatic amnesia should be used as a major factor when considering the severity of a patient's head injury, but it should not necessarily be the sole determining factor…*

*"In conclusion, measuring post-traumatic amnesia by retrospective questioning had a good reliability when the explicit method described in this study was used. The Rivermead post-traumatic amnesia protocol may therefore be a useful way of measuring the duration of post-traumatic amnesia in clinical practice. The protocol standardises the procedure of assessment that is associated with a 21% misclassification rate. In only 2% of cases however, is this category change of unequivocal clinical significance (a*

*change of over more than one category). This is probably as good as can be achieved in routine clinical practice*".

105 Miss Levett observed in her evidence that conducting a rPTA assessment: "*is difficult so has to be done carefully, but validity correlates highly with anything done contemporaneously 0.87 correlation*". Dr McCulloch accepted that proposition.

106 Whilst the above introduction to PTA and rPTA assessment is perfectly valid it is important in my judgment not over-state the scientific credentials of any process designed to take a patient's history in order to get a measure of the length of PTA. In ***Van Wees v Karkour & Walsh*** [2007] EWHC 165 (QB) Langstaff J said at paragraph 35:

> *"Although the length of post traumatic amnesia [has been described as the 'gold standard'], it is one of a number of means by which an estimation (no more than that) can be made as to whether an individual has suffered a head injury, and if so, and of what likely severity it is. I can understand the importance of it for the purposes of treatment. What is a good servant for those purposes becomes in my view a poor master in a compensation claim. I do not think there is any inherent magic … to the process of assessing the length of post traumatic amnesia … The task is a relatively simple one: identifying what memories an individual actually has following an accident, until the time of return of 'normal' memory".*

107 I agree with these sentiments. PTA assessment is only one tool in the diagnostic tool box and its retrospective assessment need not be over-complicated by high-sounding descriptions such as "structured functional analysis". What is important is the quality of the information that is put into such an assessment by the patient; the skill and objectivity of the taker of that information by means of appropriate questions and good note keeping (or better, recording).

108 Nonetheless, Dr. Grace and Ms. Levett agree in the revised (shorter) Joint Statement that "*The most reliable single indicator of the severity of head injury … is considered to be the presence and duration of PTA".* Ms. Levett concludes that there was a prolonged period of PTA; Dr. Grace says that such a conclusion is not consistent with the other evidence (including the contemporaneous medical notes and examples of inconsistent recall details provided by the claimant). The position in this case is that the claimant is so confused and unreliable in her reporting of her recall that the quality of the information provided to all the rPTA assessors is unreliable. The assessments are, therefore, unreliable. When one adds to that the difficulties that there are with Ms. Levett's status as an expert, I am not satisfied that it has been proved that the claimant suffered any period of post traumatic amnesia.

109 There are some transcripts of recordings of the claimant's appointments with the defendant's medical experts. Apparently, the claimant recorded most of her medical appointments with the experts on her iPhone but not all of them have survived. This is due to a computer hard drive malfunction.

***Psychologist and Neuropsychiatric evidence: Brain Injury (Levett[4] & Grace[5])***

110 The status, independence and objectivity of Ms. Levett (instructed to assist the court by the claimant as a Behavioural Psychologist) has, unfortunately, been another issue in this trial. Not for the first time. It is submitted that for a variety of reasons she has failed to comply with her overriding duty to the Court. She has acted both as an expert witness and as a treating psychologist. She conducted the first rPTA assessment on the claimant 28 months post-accident. On behalf of the claimant it is submitted that the defendant's personal attack on Ms. Levett regarding her objectivity and independence is precisely the sort of attack to which she has unsuccessfully been subject in previous cases and has little, if anything, to do with the substance of her methodology or her professional opinions. Such attacks failed then and should fail now. Given Ms. Levett's special interest and experience in cases such as this and her robust methodology, her opinions are valuable, objective, independent and reliable. My attention has been drawn to a number of previous judgments in cases where Ms. Levett's evidence was crucial and accepted; most recently *Siegel*. If only it was as simple as that.

111 Wilkie J. summaries the circumstances giving rise to Ms. Levett's then ambiguous professional status and in noting that she was then, as now, both expert and treating psychologist, he recognises that Ms. Levett's evidence needed to be treated with caution. Nonetheless, he concluded that there was no evidence to suggest in that case that Ms. Levett was anything other than objective in her assessments and in the light of the consistency between her opinion and other experts he was able to rely on it.

112 It is pointed out on behalf of the defendant that things have moved on since 2014. Attempts by Ms. Levett to appeal to the Court of Appeal against the Order (confirmed after a re-hearing by Haddon-Cave J) striking her name off the Health and Care Professions ["HCPC"] register have failed. ***L v The Health and Care Professions Council*** [2014] EWHC 994 (Admin). Since then Ms. Levett's membership of the British Psychological Society ["BPS"] has been terminated (or expired according to Ms. Levett). She continues to act as both expert and treating psychologist despite strong recommendation to its members by the BPS that such a dual role is usually unacceptable (although I do not construe this as an absolute prohibition). It is submitted that the potential conflict of interest that arises is particularly serious because Ms. Levett was struck off the HCPC register for failing to maintain proper boundaries between herself and a vulnerable patient. In other words, there is nothing ambiguous about Ms. Levett's professional status now.

113 An Application by the defendant for an Order to withdraw permission for Ms. Levett to provide expert opinion evidence at a case management stage of these

[4] 09.07.16, 29.09.17, 08.12.17

[5] September 2017 & November 2017

proceedings in early 2018, was unsuccessful. The issues regarding her status and objectivity are matters of weight to be considered along with all the other issues in this action.

114 It is not unfair to observe that my impression of Ms. Levett's response in her oral evidence to all this, is that she feels targeted and beleaguered by what she perceives to be personal and irrelevant attacks by insurers because she is the expert *par excellence* in the field of identifying and diagnosing brain injuries (e.g. DAI) and treating the psychological consequences of apparently minor road traffic collisions. This is due to her careful, structured functional analysis of a patient's presentation, not least of all in the area of rPTA. If she feels beleaguered, she has nobody to blame but herself.

115 In some ways Ms. Levett's evidence on the disciplinary front echoed that of the claimant's career change evidence, particularly when it came to explaining away potentially difficult documents and events. She describes herself in her CV as "Chartered Psychologist 1986". She accepts that she is not entitled to use the designation "Chartered" after her problems with the BPS but asserts that the information on her CV is no more than a reflection of the fact that in 1986 she was first "Chartered". I do not accept that this is what she intended. In my judgment her CV is clearly an attempt to create the impression that she has been a Chartered Psychologist since 1986 and remains so and remains in good standing with the BPS. When questioned pursuant to CPR 35 about her professional difficulties with HCPC and BPS, Ms. Levett was less than forthcoming about the details. Her explanations regarding dealings with the BPS including her expulsion or alternatively the expiry of her membership, her oral evidence were positively Byzantine. I asked her myself whether it would not have been better to have been totally "up-front" about her dealings with professional bodies and the status of her appeal against the Order of Haddon-Cave J (permission to further appeal having twice been refused). Her response was to the effect that she relied on legal advice and could not see how any of these matters impinged on her experience and expertise in this field or on her successful treatment of the claimant's psychological symptoms.

116 Whatever Ms. Levett considers to be the relevance of her dealings in recent years with the HCPC, the BPS and the courts with regard to her professional qualifications when considered alongside the work she has actually done in brain injury cases (both as expert and treating psychologist), I concluded that she lacked (at least on this occasion) the transparency the Court is entitled to expect of an expert witness. She was evasive and in my judgment lacked any insight into why any of this mattered (lack of insight in a different context having been a criticism of her in the statutory appeal proceedings before Haddon-Cave J). This is extremely disappointing, not least of all because it is not just the *fact* that Ms. Levett has had these disciplinary issues, but that she has pointlessly been less than open about them. For the reasons that he gave, Wilkie J. in *Siegel* felt that Ms. Levett's evidence had to be treated with caution. In the light of what has happened since then, and her evidence about it in these proceedings, it is my judgment that her evidence must be treated with suspicion. I used the word "disappointing" because it may well be that

none of Ms. Levett's professional difficulties have much to do with her experience and knowledge of brain injury cases or rPTA assessment. Her methodology is not criticised by other experts. The first rPTA assessment was carried out by her and it might, therefore, have carried some weight had it come from a transparently objective expert. It is equally disappointing because Ms. Levett's treatment of the claimant's psychological problems after the accident has not been impugned.

117 I am not satisfied that Ms. Levett is sufficiently independent and objective as an expert witness to be of any real assistance particularly with regard to her rPTA assessment. I consider there is a real possibility that she has allowed her specialist interest in this type of case to stray into advocacy, not so much on behalf of the claimant as an individual patient, but as an advocate for the identification of DAI brain injury in cases where previously none would have been found, including a case such as this where there is such a level of disagreement between the experts across all relevant disciplines. Ms. Levett's rPTA conclusions and her expert opinion are doubtful in my judgment. The results are doubtful on two fronts. First because of Ms. Levett's lack of independence and objectivity and secondly because she was taking a detailed history from an unreliable source (the claimant). As a result her rPTA assessment cannot realistically be considered as supportive of a brain injury diagnosis. I am not satisfied that the information she has gleaned from the claimant is accurate or reliable and I am not satisfied that Ms. Levett has taken all objectively relevant factors into consideration when conducting her rPTA assessment or when reaching her conclusions. In other circumstances it might have been of little concern that Ms. Levett was unable to recall herself (directly or from notes) how many assessment sessions she had with the claimant (was it 2 or 3 in July or August 2015?) and has not checked that the date of the accident given in her Report at one point is wrong: "*[The] accident happened after lunch on the 5 November 2013"*. This is careless given that the central purpose of the Report is to record the claimant's history. Ms. Levett says this about the information with which she was provided to reach her conclusions: *"Information was subsequently updated, feedback gathered and opinion reviewed during regular weekly treatment sessions starting in September 2015"*.

118 This highlights what I consider to be another serious problem: the troublesome overlap between Ms. Levett's function as an expert witness and that as a treating specialist. In all there were about 8 hours of Assessment and 22 of treatment (though more was charged for due to the claimant cancelling some appointments). The treatment was concluded several months before the Report of 9 July was written. I can only infer from this that Ms. Levett obtained relevant information and feedback from the treatment sessions in addition to her August 2015 assessment sessions, but it is not possible to work out with any precision what information derived from treatment has informed the expert opinion Ms. Levett has provided to the court. I cannot dispel a nagging concern that in adopting a dual function, Ms. Levett has allowed herself too readily to accept at face value information provided by an unreliable historian (the claimant). I was surprised to learn that it was not routine for rPTA assessments to be recorded in 2015-2016. Dr. Allder is trialling such a process now. The transcripts of recordings of medical expert

appointments that form part of the evidence in this case were taken by the claimant on her smart 'phone. There is no recording of any part of the Levett assessments. Perhaps had recordings existed, some of my concerns about Ms. Levett's objectivity would have been allayed. How much of her rPTA assessment was the result of leading or suggestive questions is impossible to know. I was also satisfied that Ms. Levett's evidence to the effect that she *"would have known"* when the claimant was referred to her that she had been a witness in the *Siegel* case and that *"I think Mr. Siegel told me he was concerned about someone he knew 'had it'* [DAI] verged on the evasive. Whether this was designed to protect the claimant from possible adverse inferences or to put distance between the *Siegel* case and this one, I can't say; but her evidence on this was unsatisfactory and I find, lacked candour.

119 Dr. Savundra (audio-vestibular specialist) was asked about dual roles as expert and treating specialist. He said:

*"I do not treat as an expert. Being an expert rules me out as a treating physician. It can be very complex to do both and it is not an acceptable position to be in".*

Professor Morris (neuropsychologist), when asked about it, appeared to be visibly appalled at the very idea of adopting a dual role, but was confident that the situation would not arise for him and he could see no reason for his ever departing from the guidance issued by the BPS.

120 My reasons for concluding that Ms. Levett's evidence lacked the necessary degree of objectivity and independence also include the following:

120.1 Ms. Levett alone among the experts identifies a period of retrograde amnesia. She reports that the claimant did not recall driving home on the day before the accident in her new car, what she did on that evening, waking up on the 29 March or any of her activities on the morning of the accident. However, the claimant told Dr. Allder that she had "*… a very good memory of all of the details up to the accident*." Retrograde amnesia is not a prerequisite of DAI but this highlights an important discrepancy in the claimant's recollection given separately to two different clinicians and is concerning when it comes to consider her reliability as a historian. Ms. Levett's functional analysis did not indicate that there was any cause to query the claimant's history in this regard. It is likely that Ms. Levett was over-eager to ascribe to the claimant's history of the day before a significance it did not deserve. She would not have had Dr. Allder's version of events when she wrote her reports but I did not detect any sign on the part of Ms. Levett that her conclusion might even be worth revisiting given the obviousness of the inconsistency once it emerged from totality of the evidence.

120.2 There are other inconsistencies that emerge from the various histories taken from the claimant by other experts. None of these different versions appeared to give Ms. Levett any pause for thought before or during the trial, so confident was she that her rPTA methodology was unimpeachable (or nearly so). I find that Ms. Levett had closed her mind to:

(1) the potential importance of inconsistencies in the claimant's history and reporting of symptoms;
(2) the need for reconsideration of her opinion in the context of an analysis of the comparative importance of the inconsistencies that there were;
(3) the need for a reflective re-evaluation of the claimant's history as given to Ms. Levett in the light of all the factual and expert evidence including these inconsistencies.

121 The inconsistencies in the claimant's history included these:

121.1 The claimant says in her first witness statement: *"My first memory after the accident is being stood outside the car at the back, shouting at the other driver that it was only a day old"*. She gave the same recollection to Dr Allder and Professor Morris. Ms. Levett, however, records the claimant's recollection at this point being of asking the defendant if she (the defendant) was alright. Much later the claimant made a further witness statement in which she said that she did not recall shouting at the defendant.

121.2 Despite telling Ms. Levett that she had no recall of the collision itself or the immediate aftermath, the claimant discussed the accident with Amy Arnold, a friend, a "*few days"* after the accident and described the mechanics of the accident. Even though Amy Arnold would not be expected to differentiate between recall and knowledge, it is of concern that this conversation about the mechanics of the accident apparently revealed no memory problems (to Amy Arnold) during the course of the discussion, particularly as even at that stage Amy Arnold was astute enough to notice that the claimant *"wasn't the same person"* (which I conclude is consistent with whiplash and post-accident headaches).

121.3 In her first witness statement the claimant says: "*I know that I rang my father, but I have no memory of that either*." Ms. Levett records being told that the claimant *did recall* (i.e. had a memory of) phoning her father from the scene of the accident. Dr. McCulloch was given a similar history. Another variant was given to Dr Grace where the claimant said she recalled being on the phone to her father, but not calling him.

121.4 Ms. Levett records the recollection that the claimant told the man in the hi-vis jacket that her neck was very sore. That is inconsistent with the claimant's later accounts that she had no personal recollection of the onset and development of symptoms during the first two weeks after the accident. In the context of Dr. O'Connor's appointment, she had said *"I have no memory of that period of time"* (talking about the development of her symptoms).

121.5 Ms. Levett records that the claimant had no recollection of being driven to A&E by her mother. The claimant told Dr Allder that she did recall this.

122 There are also indications in Ms. Levett's Report that the claimant's symptoms worsened in the months following the accident. It is accepted all round that a worsening of symptoms would not be expected. In Ms. Levett's notes she recorded: "*<u>Cognitive problems</u> Began to show when returned to school Sept 2013 w new Head*". In the Report this is treated as an example of

aggravation of already existing problems: "*Her difficulties became more debilitating when she returned to school in September 2013 for the winter term. … The additional strain aggravated the problems she had been experiencing since the index event.*" I would have expected Ms. Levett to be clear on the difference between "*began to show*" and "*became more debilitating*". Even if the former was a notation error I would have expected an explanation of that to justify the new formulation in the Report. It was obviously not a noting error. This is now explained by the "buffering" effect. That is, the claimant's high level of functioning was able to tolerate a certain amount of strain but with increased pressures piling-up in the new school year with a new team in charge, her coping strategies became increasingly overwhelmed or eroded. I don't accept this as plausible on the strength of Ms. Levett's evidence, though I have no doubt such "buffering" periods have been identified in other cases. The notes have been (unwittingly) "massaged" to make the result consistent or coherent with the necessary causal timeline between the enduring cognitive and behavioural symptoms reported by the claimant and the accident.

123 There are other indications of worsening symptoms. Ms. Kirby says in her Report of 18 December 2017: *"[the claimant] reports her vision has deteriorated and she struggles to see the television"*. This is the first reference to such a problem. It is also noted: *"She reports pain … down the front of her shins if she has to walk very fast"*. Pain in the shins is a new problem. Yet: *"[the claimant] does not have any problems with her upper limbs …"* so the apparently serious problem with her left thumb (see Mr. Beavis the orthopaedic expert's Report) is no longer an issue.

124 At the end of her summary of the cluster of the claimant's symptoms Ms. Levett says (after the psychopathology had been treated out):

*"Mechanism of injury, clinical history, and presence of brief retrograde amnesia and of post traumatic amnesia of over two weeks and possibly over one month, indicates that she has suffered at least a very severe head injury, with associated cerebral injury"*.

The problem with this is that:

124.1 The mechanism of the injury is difficult to be precise about save to the extent that it involved acceleration-deceleration to the head and upper body on a rear-end collision;

124.2 The clinical history Ms. Levett refers to cannot have included proper account of the clinical history as recorded up to the early part of 2014 (i.e. up to about the first anniversary of the accident) and I conclude that Ms. Levett has overlooked the important, potentially negative, effect this has on an assessment of the claimant's consistency and the coherence of her overall presentation;

124.3 There is only non-specific, general factual evidence from family, friends and colleagues supporting some of the enduring symptoms and several are not mentioned at all;

124.4 The presence of retrograde amnesia is a feature unique to the opinion of Ms. Levett (significantly absent on the conclusions of both neurologists), and in my judgment, it is indicative of the claimant's unreliability as a historian rather than a demonstration of any unique qualities enjoyed by Ms. Levett as a functional analyst and assessor.

124.5 Although not part of the clinical history, there is no substantial discussion about the claimant's career change despite the length of time Ms. Levett had in assessment and in treatment and claims to adopt a robust methodology. I cannot accept that the claimant's career history could not be cued, but more to the point, the claimant must have remained largely silent on the topic.

125 Neither Ms. Levett nor any other clinician can be expected to have appreciated the extent of the claimant's inconsistency with documentary evidence on topics such as her change of career. I am satisfied that, on balance, the claimant is likely to have been affected by dull headaches, intermittently becoming sharper and more severe (especially when she was tired) but I find little, if any, compelling evidence from family, friends and colleagues in support of the whole catalogue of enduring symptoms recorded by Ms. Levett set out in her Report of 9 July 2016 between paragraphs 109 and 221. I find neither the claimant nor Trevor reliable or accurate and I am far from confident that Ms. Levett is an objective commentator on the claimant's self-reported symptoms.

126 Dr. Grace is a neuropsychiatrist. Her evidence was impressive, less dogmatic than Ms. Levett's and I concluded she was readier to look at the presentation of the claimant in the context of the whole case (as she knew it) and was less determined that a single rPTA assessment could provide the appropriate diagnosis. I got the impression that Ms. Levett thought that her rPTA was more or less all that was needed to close the case in the claimant's favour. Dr. Grace has extensive clinical experience. She runs a clinic twice a week. She was firm and clear in her evidence without being dogmatic. She was not subject to any question as to her good professional standing. Her conclusions are consistent with those of Dr. Heaney. I accept her evidence in preference to that of Ms. Levett. I take the following from her evidence:

126.1 *"I can say with confidence that [the claimant] has not suffered a brain injury … I can't go any further than that … I was focused on the presence or absence of brain injury".*

126.2 *"[the claimant] presented with many non-specific symptoms … but she was not able to date the onset of her symptoms with any clarity … it is probably not a brain injury due to this lack of clear indications about onset…" "I see this sort of cluster of complaints all the time and it is not specific to DAI"* and some of the symptoms presented can be present in the "normal" population.

126.3 In the context of the "buffering effect" and patients self-blaming and regarding seeking help as a sign of weakness: this might happen but it happened *"vanishingly rarely".*

126.4 She accepted that she had far less time than Ms. Levett to do a rPTA assessment, but as one who had a memory of the crunching sound of the collision but no memory of the impact itself, it was her opinion that the claimant would be *"unique".*

126.5 By the time she saw the claimant, the claimant had already seen several clinicians and lawyers and was speaking herself of "PTA". The suggestibility of people should not be underestimated. She was not prepared to say that the claimant was malingering.

126.6 She accepted that the claimant was now presenting a cluster of symptoms that affected her quality of life, but in her opinion, the

symptoms taken together or individually were not exclusive to brain injury or a DAI.

126.7 She was asked about checking for brain injury at A&E and said: *"any reasonably competent casualty doctor would cover the possibility of brain injury"* and she would be worried if memory and orientation had not featured in the examination at A&E.

127 In another important respect I found the evidence of Dr. Grace to be congruent with that of Dr. Heaney namely, that in her considerable experience she had *"never"* encountered a patient with between 2 and 4 weeks PTA without the patient displaying signs of disorientation as to time and place, and being discernibly disorganised and incomprehensible to others. Whilst I accept that staff at the A&E department at Croydon hospital would not, and could not, have conducted the sort of assessment undertaken by the neurologists and Ms. Levett, I accept Dr. Grace's opinion that it is unlikely that, with a patient in head blocks, some basic assessment of the claimant's orientation would not have occurred (with the measurement of the GCS, however crude a tool that may be). The absence of any neurological concerns on the A&E record, therefore, strikes me as important.

128 Even assuming that neurological signs were missed at A&E due to the focus on the neck rather than the head, or for some reason neurological symptoms were not presenting, the evidence about the claimant's disorientation and/or chaotic behaviour in the period of dense PTA in the weeks after the accident can only be characterised as feeble. This probably explains why it was not the subject of any challenge. I take the following examples from the *Claimant's Closing Submissions* which reflect the high-point of the case on this issue. Trevor says that on the evening after the accident the claimant was "*not herself at all. She was much more quiet than usual and kept repeating that she was in pain and that she did not know how the accident could have happened. I was worried about her at the time because she was clearly not right and was acting out of character … She was also quite agitated all evening"*. Evidence from mother when driving the claimant and Trevor to A&E was to the effect that: "*I asked her some questions about the accident. Kathryn was quiet and not very communicative, which was out of character for her*". Her father recalled that she was "*in quite a state … too agitated to really tell me what to do*" in the conversation from the accident scene. Her friend, Amy Arnold, observed that she was unusually quiet when she visited a few days after the accident and that most of the details of what happened came from Trevor. Such general signs could be indicative of many things, including shock and pain.

129 I am not neglecting the evidence of friends, colleagues and family both called and read as part of the claimant's case, but in my judgment, one looks in vain at that factual evidence for any material that could lead to the conclusion that for several weeks after the accident, dense PTA caused the claimant to be discernibly disorientated, even if only intermittently and for short periods. The evidence about changes in the claimant's character and approach to life at non-specific times after the accident are equally consistent with the manifestation of the sort of personal dismay, pain and physical restriction that might affect any person with a serious whiplash-type injury. Dr. Grace's opinion supports such a conclusion. In any event I am not satisfied that the factual evidence amounts to reasonably grounded evidence of disorientation. I find that there is an absence of material disorientation or disorganised

behaviour, whilst recognising that, like most other aspects of the claimant's case, this is not conclusive.

130 Might this absence of disorientation be explained on the grounds (Dr. Allder) that some patients (1%) with a brain injury and PTA for 2-3 weeks can present normally to the outside world? There is always this possibility, but it is a statistically small one and can be discounted in my judgment, as improbable, in the light of all the other evidence. Could it be that the claimant's lighter workload in the summer term reduced the outward appearance of disorganisation or, indeed, disorientation, noting that the claimant would have been emerging from dense PTA at the very time she returned to work? This is also improbable. I also reject this as a partial explanation for her claimed ability to cope at work notwithstanding a cluster of other cognitive and behavioural problems that she claims continued throughout the summer term. I do not accept that such continuing difficulties would have gone unnoticed, or noticed only to the extent of the broad generalities contained in the evidence of family and friends.

131 I am not satisfied that many problems catalogued by Ms. Levett and Dr. Allder (and other experts) as having affected the claimant (resulting mostly from her self-reporting) since the accident find a place in the evidence of friends, family and colleagues (except Trevor and even he misses several). Some are, but others are not. I would not expect the evidence of family, friends and colleagues to be much more than anecdotal. I would not expect this evidence to be able to cover comprehensively an unbroken period from the accident onwards or be anything other than evidence providing "snapshots" of the claimant over time (to coin a phrase), but the evidence that there is, is too generalised to be very helpful. I cannot find any witness who has seen the claimant tripping over her own feet; acting as if dizzy to the extent that she has to "ground" herself; having apparent balance problems; overreacting to cracks in the pavement; exhibiting an exaggerated startle; having a problem reading or, in speech, retrieving words (in oral evidence the claimant did not do this anymore than anyone else – perhaps twice or three times) or expressing herself in a way that demonstrates a feeling of foreshortened future. There was no evidence of the claimant developing a stutter (a symptom unique to Ms. Levett's notes) or of deteriorating eyesight to the point where she has a problem looking at the television. Nobody appears to have witnessed an episode of the claimant's thumbs giving way (as opposed to Trevor saying they were weak) which was a problem noted by Ms. Levett but is absent from any orthopaedic report or record, and absent from Ms. Kirby's care report. I put little weight on generalised statements by such as Amy Arnold who says: "*I find she has difficulty multitasking now,"* not only because in the absence of concrete examples the statement is close to meaningless, but also because it is contradicted by the evidence suggesting that the claimant was teaching at school whilst at the same time taking significant steps to set up the tea room's business structure. No witness has given an example of a panic attack (as distinct from examples of irritability and "snappy" behaviour). The evidence about alcohol intolerance is at best unclear. The claimant maintains she has developed an intolerance and Trevor notes that her consumption is reduced since the accident because it has more effect, but in answering Dr. Heaney's questions the claimant implied that she did not consume alcohol very much anyway.

***PTSD and OCD***

132 It does not necessarily follow from the reservations I have about Ms. Levett's diagnosis of brain injury that her opinion about PTSD and OCD and her treatment work with the claimant is open to doubt. Unfortunately, both depend largely on the claimant's self-reporting of symptoms. When it comes to Ms. Levett's identification PTSD and OCD measured against recognised criteria I find that I cannot safely rely on her opinion. Dr. Grace was not prepared to accept that the claimant's symptoms as identified by Ms. Levett met the relevant criteria for PTSD or OCD (but was prepared to accept she displayed some "obsessive traits") and was, accordingly, not of the opinion that the claimant had either condition (even though DSM-IV had been supplanted by DSM-V and the wrong classification had been used). Dr. Grace's opinion was mostly limited to the comparison of symptoms against the relevant criteria in the context of whether the claimant passed the gateway test for the application of the label PTSD. *"I can say with confidence she has not sustained a brain injury, OCD or PTSD. I can't go any further"*. Dr. Grace was not satisfied that, whether or not a fear of death or serious injury was a gateway requirement (as it had been under DSM IV but not from 2013 in DSM-V), the criteria for PTSD under the DSM or the European standard were met. Ms. Levett was of the opposite opinion (although she too applied DSM IV or appeared to do so). Whichever DSM criteria apply (and it is DSM-V), or whatever label one puts on a diagnosis, the important issue is what symptoms the claimant has been suffering from and the onset of such symptoms and their trajectory.

133 I am not satisfied that the claimant was exposed to *"actual or threatened death or serious injury"* given that she reported thinking quite the opposite about the accident at the time, and the comparatively modest nature of the collision. I am not satisfied that she passes the gateway criterion for PTSD (DSM-V A). Ms. Levett sets out in some detail the ways in which the claimant reported symptoms relevant to the DSM-V criteria (paragraphs 191 and 192 of her report of 9 July 2016). Whether one designates this psychopathology as PTSD or something else hardly matters, but what does matter is whether these reported symptoms can be accurate. There is no difficulty with the reported travel anxiety and in this context, I am prepared to accept that this probably extended beyond travelling as a nervous passenger by car and included travelling on trains and other public transport. I also accept that this is likely to have been associated with some agoraphobic-like feelings and mild panic attacks on occasions. These elements of her psychopathology are also likely to have been associated with recurrent thoughts and feelings of stress and distressing dreams about the accident and linked avoidance behaviour. To this extent certain of the qualifying criteria under DSM-V B and C are satisfied as are elements of D (some irritability) and E together with F, G and H. However, as for the whole shopping list of symptoms which Ms. Levett describes as meeting *"the full criteria for PTSD…"* I do not accept that these are sufficiently supported by other witnesses or by the contemporaneous medical records. Neither are they consistent with the claimant's work or business activities in the summer and autumn of 2013 and beyond. The fact that the claimant's accident, to the layman, does not have the hallmarks of a PTSD-causing incident and the fact that her behaviour and early reporting of symptoms through to early 2014 do not, to the layman, seem to display the classic hallmarks of agoraphobia is merely incidental.

134 I accept that the claimant is likely to have suffered from a degree of obsessive compulsive disorder (or at least obsessive traits). This is supported by evidence of witnesses apart from herself (and included things like compulsive

cleaning, tidying, checking rituals at home and at work) and is consistent (as Ms. Levett acknowledges) with anxiety. Whilst this can be consistent with PTSD symptoms, PTSD and OCD are not inextricably linked. I note that Ms. Levett includes in her list of symptoms, obsessive behaviour in the form of the claimant's reaction to treading on cracks in the pavement. I cannot find any reference to this behaviour anywhere else in the factual evidence or medical information to February 2014. I can only conclude that this is an example of Ms. Levett unquestioningly accepting a statement from the claimant, of classic OCD behaviour, for which there is no other evidential support. I do not accept that any such behaviour was a problem for the claimant. However, on balance I am satisfied that OCD was a consequence of the accident despite Dr. Grace's scepticism.

135 Ms. Levett successfully treated the psychological sequelae including OCD and her treatment has not been the subject of any criticism (whatever label one puts on this psychopathology). I am satisfied that the psychological problems set out above were caused by the accident. The psychological symptoms had been treated to a substantial conclusion by the end of January 2016 when the claimant unilaterally stopped seeing Ms. Levett due to her pregnancy.

***Neuropsychological* (Morris[6] and McCulloch[7])**

136 Professor Morris concludes that on the balance of probabilities the claimant shows neuropsychological weaknesses in memory and executive functioning that "*are consistent with*" brain injury in respect of which her high intelligence has provided her with some cognitive reserve that enables her to maintain a degree of function. Dr. McCulloch does not agree and finds no evidence of brain damage based on the neuropsychological test results which, in her opinion, showed strong performance across a range of functions. She notes that the claimant's strong performances on intellectual functioning and her likely pre-accident intellectual functioning did not lead to a strong set of educational results.

137 Professor Morris and Dr McCulloch each carried out neuropsychological tests. Dr. McCulloch authored a comparative table of their respective results. I have already set out the summary of Professor Morris's conclusions from his Report earlier in this Judgment but the following can be derived from the Joint Statement.

137.1 PTA is associated with signs of agitation, confusion and disorientation and this was not a recorded feature in the immediate aftermath of the accident and the following weeks. (The only exception to this, I note, is father's evidence about the post-accident 'phone call which I do not regard as significant in the context of the bigger picture and evidence from Trevor about the immediate aftermath of the accident which does not strike me as being an exceptional reaction from anyone after a road traffic accident).

137.2 The claimant's current intellectual functioning is between superior (Dr McCulloch) and very superior (Professor Morris).

[6] 29.09.16, 01.11.17,03.04.18

[7] September 2017 & November 2017

137.3 The claimant's Verbal Comprehension Index (language function) is in the superior range and is very superior for vocabulary.

137.4 She does not show performance impairment on the cognitive domains of language, visuo-spatial-non-verbal ability, attention, working memory and processing speed. Her intellectual level is consistent with her likely pre-accident functioning.

137.5 On memory testing, Dr McCulloch's test results were superior for Logical Memory I and high average for Logical Memory II (as opposed, respectively to high average and average on Professor Morris's testing). Dr McCulloch concluded that her memory functioning does not show impairment from her expected ability level of high average to superior as shown on the Test of Premorbid Functioning and her Index Scores.

137.6 Each expert respected the other's testing protocols but preferred their own approach.

138 It was also accepted that is was normal for any patient to get a range of scores across different tests and that someone scoring well or very well on many tests might still get a low score in other test results. Professor Morris also recognised that a low score within a battery of tests (such as memory) was only consistent with brain injury, not diagnostic of it. The main focus of dispute between Professor Morris and Dr. McCulloch centred on that aspect of testing concerned with the Delayed Memory Index ("DMI").

139 Professor Morris also provided the following opinions:

139.1 The claimant's memory functioning "*tended not to match the higher ranges of her intellectual functioning*". He thought there was *"significantly reduced memory functioning from likely very good pre-accident level"*.

139.2 On comparing the importance of memory with processing speed in reaching an exclusionary brain injury diagnosis he said in his oral evidence:
*"I put memory on a par with processing speed. Memory is as sensitive in relation to brain damage, and is the most commonly found cognitive difficulty. But if talking about different patients, there are no consistent patterns between patients; one might show impairment on one but not the other. Speed of processing can be affected by DAI but so can memory. Memory relies on the connectivity and communication of information which can be affected by DAI but you get different results in different brain structures. I am not surprised that lower memory function is present but processing speed is preserved".*

139.3 On the frontal lobe paradox he said: "*those with higher intelligence appear to perform normally on the tests because the tests have to be consistently psychometrically reliable and may not be sensitive for intelligent people*". By this I took him to mean that intelligent people can perform better on the battery of tests overall than their actual level of cognitive impairment would imply.

139.4 On the facts, he accepted that he did not know anything about the *Siegel* case and that it would have been helpful to have had this information (though in what way he did not say).

140 There was some criticism of Dr. McCulloch because she did not apply WMS IV in unadulterated form (as had Professor Morris) but instead mixed and matched various testing protocols and had cut short the testing process (and adjusted some results accordingly) due to the claimant being tired. In the end

I find this is not as significant as it might have seemed. I am satisfied that the testing of both Professor Morris and Dr. McCulloch revealed a significant difference (described as a "mismatch") between her FSIQ and her score on the DMI (whatever the precise numbers were). Only a small percentage of the population (1.53%) would have such a distinctive discrepancy between these two measurements. Dr. McCulloch agreed that on the basis of a discrepancy of the order identified by both neuropsychologists, the explanation was (subject always to a rogue test result) either constitutional or due to damage caused to neural networks and connections associated with memory. However, she noted that the test results, as a whole, did not show any demonstrable impairment of the claimant's intellectual or cognitive functioning. With this in mind, I accept the thrust of Dr. McCulloch's evidence (as a matter of common sense) to the effect that there may be a host of reasons (tiredness, anxiety, boredom) why a patient might do worse than their actual potential on a test, but can never do better. Both Professor Morris and Dr. McCulloch agreed that the test results cannot tell the whole story and much depends on the patient's description of function and symptoms. Had the claimant been a consistent, coherent, accurate and reliable source of evidence about her social, domestic and professional background and the onset and trajectory of the enduring symptoms, it is the discrepancy between her FSIQ and the comparatively low score on the DMI that would have given the hypothesis advanced on behalf of the claimant added plausibility. This is particularly so when it is not suggested that the claimant was somehow fooling the tests. In my judgment this one aspect of the test results is not sufficient to outweigh all the other shortcomings or "oddness" in the claimant's case.

141 It will be apparent that this is a case where almost nothing is agreed and the interpretation of these test results is no different; but a common theme is emerging. I prefer and accept Dr. McCulloch's evidence as being more sharply focused on the presentation of a particular patient (the claimant), in particular circumstances and in the context of the evidence; as opposed to being attached to an academic hypothesis. That is not to say that the academic hypothesis is not respectable or "plausible", it is merely an observation that the hypothesis (an accident-related DAI) probably does not fit the facts of this case. This is for two reasons. First on causation because the evidence of onset and trajectory of enduring symptoms is inadequate and secondly on diagnosis because the balance of the expert evidence that I accept points away from brain injury. Both of these aspects of the case are closely concerned with the reliability of the claimant's evidence.

142 Dr. McCulloch said in forceful terms: *"I do not accept that there is compelling evidence of personality or behaviour changes after the accident* (from the factual witness statements). I share that conclusion. *"[T]here is some evidence in the witness statements but it is not strong"*. I agree and have already observed the unclear timelines in this evidence and its general, largely non-specific nature. The statements from the lay witnesses date from spring-summer 2016, already three years after the accident. I consider this to be very late in the day to be very compelling.

143 At several points the claimant's case seems to be facing both ways. On the one hand it is submitted on the claimant's behalf, that the factual evidence demonstrates clearly a constellation of behavioural changes including those relevant to memory (e.g. the evidence of her father). On the other hand, Professor Morris (for one) says that the claimant may be able to present an appearance of normal interaction with the outside world but her

compromised brain function is not consolidating memory (this is consistent with traumatic brain injury but also with epilepsy, he says). The factual statements, it is submitted, disclose material illustrating cognitive changes since the accident, but any failure to display the consequences of these to friends and family and the apparent ability to return to work at school may be explained by the frontal lobe paradox. This may also explain the good test results obtained by the claimant on WSM-IV or the alternatives deployed by Dr. McCulloch for executive function: problem solving, planning and multi-tasking in which Professor Morris accepts the claimant did *"relatively well"*. He said a patient can do the tests well but function may be poor in daily life.

144 There were several points during the trial when it seemed that the claimant was in an unassailable position; if she did poorly (in tests or evidence) it was indicative of a brain injury and if she did well (in any context) it was due to the frontal lobe paradox or "buffering".

145 Dr. McCulloch was prepared to accept that the claimant's presentation could be the result of damage to her neural pathways focused on memory, but concluded that this was only "*one hypothesis*". She was also prepared to accept that in times of rest patients might be less aware of enduring symptoms but added that her reading of the evidence was that the claimant remained active almost from the outset after the accident. I share that conclusion.

146 On a pragmatic level Dr. McCulloch concluded that as a teacher, in the summer term of 2013, had noise intolerance and all the cognitive and behavioural symptoms been operative at that time, the claimant *"would have hit a brick wall"*. I accept this evidence. Working in a classroom with 30 children under 10 (whether the class includes difficult children or not) would on the balance of probabilities have brought all the claimant's functional problems to the fore in an obvious way both to herself and her colleagues, probably more so than would have happened in a more office-based, adult workplace. The evidence of Emma Espin (referring to school in 2013) does not contradict such a conclusion. *"I found there were <u>occasions</u> when she <u>tended</u> to be a <u>bit</u> disorganised"*. (My emphasis). This is not "hitting a brick wall". However, I do not see anything in this evidence to contradict the inference that intrusive orthopaedic pain was playing a large part in the claimant's life at this stage. It may well be that others (as discussed by Ms. Levett, she having been a witness in several earlier cases) have persevered with brain injury for longer periods before "hitting the brick wall" but in the context of all the other evidence about the claimant's activities during the summer and autumn of 2013, it is likely in my judgment that in a classroom of 30, with additional leadership and technology responsibilities across the school, whilst also pitching her case for transformational promotion, the claimant could not have withstood the strain without hitting the metaphorical wall by the end of the summer term 2013. Furthermore, even when one gets to the factual evidence relating to early 2014 there is no substantial evidence that the brick wall was ever encountered.

147 Dr. McCulloch was right in my judgment to observe that *"we are social creatures"* and *"it is just not credible"* that the claimant would not have known and her family and friends would not have noticed that the she was in dense PTA. Dr. McCulloch was prepared to concede that there were parts of her long assessment of the claimant (about 2 hours 20 minutes) that had been misinterpreted when she came to write up her Report, but was clear that she had encountered difficulties with the claimant giving vague answers when

questioned about her symptoms; their onset and trajectory. She also accepted that in the light of other medical opinion, psychologically mediated causes for the claimant's problems were to be discounted. She remained firm in her opinion that the claimant's problems were not caused by the accident.

148 Dr. McCulloch's professional impression of vagueness is consistent with other parts of the evidence which have brought me to the conclusion that the claimant is unreliable and someone who distances herself from facts that do not suit her case.

### *Audio-Vestibular and Audiology* (Savundra[8] and Vanniasegaram[9])

149 Dr. Savundra conducted a battery of tests and concluded that the claimant sustained Post Traumatic Vestibular Migraine which he considered when taken together with her other reported symptoms was the result of an impairment of brain function. The Joint Statement confirms: hearing tests were normal (the claimant had excellent hearing), balance tests were within normal limits, no abnormality was seen in her eye movement and she had excellent cochlea function, Dr. Savundra concluded that the reported problems were processing issues of brain function. It is described as *"auditory and vestibular symptoms"* by reason of which she developed headaches, post-traumatic migraine, vertigo, imbalance, falls and fatigue and sensitivity to sound. He accepted that an accurate history from the claimant was *"hugely relevant*". He had seen no evidence in his testing to doubt the claimant's integrity. Like other experts he was not in possession of all the evidence available to the Court. He was of the opinion that the complaints about migraine (a headache so bad that the patient would want to retire to lie down) and dizziness were episodic and that the bad episodes were intermittent. As a result, he appeared unconcerned that dizziness was reported by the claimant to have petered out before she became pregnant (with her son Henry) as noted by Dr. Heaney, and did not think the apparent resurfacing of dizziness illustrated this symptom getting unexpectedly worse. The transcript of the claimant's consultation with Dr. Heaney shows that the claimant said: *"I did suffer big time from dizziness … not really* (a problem) *now"*. When asked when it petered out she said: *"…before I got pregnant I think … maybe a year, a year and a half after the accident. I mean I still do get it sometimes …"* Dr. Savundra was not aware that the claimant had reported to Dr. Grace that she did not suffer migraines and speculated that this might be because a layperson could think migraine involved aura, which the claimant did not experience. Aura, I have to assume from this, is different from the light sensitivity reported to Dr. Allder.

150 Dr. Savundra accepts that contemporaneous reporting of symptoms of migraine to medical practitioners can be "*important"* and "*very helpful"* and acknowledges the absence of such reports in this case (subject to O'Connor's reference to yoga being *"on hold"*, the suspension of which Dr. Savundra agreed was equally consistent with pain; and reduced standing at work in *"the first few weeks"*). He says as much in his Report: *"In order to establish the aetiology of any audio-vestibular pathology and to determine whether it is the result of an accident, it is important to establish whether or not the*

[8] 26.03.17, 01.12.17, 09.04.18

[9] 27.09.17, 23.11.17, 17.04.18

*symptoms are mentioned in the contemporaneous medical documentation"*. He goes on to review some of the contents of some of the contemporaneous medical notes (to early 2014) without further comment or analysis, save for observing that the records with which he has been provided are incomplete. There is no reference to migraine, vertigo, imbalance, falls or sensitivity to sound in the early medical records. This is a loose end in his evidence. He also agreed that he saw no sign of any balance deficit in the video evidence when the claimant was seen working at the tea room.

151 Dr. Savundra concludes that the claimant developed headaches, migraine, vertigo, imbalance, falls and fatigue and developed sensitivity to loud sounds as a sole result of the accident. He had access to reports from Mr. Beavis, Dr. Allder and Ms. Levett as well as some factual witness statements. His opinion must have been informed by the conclusions already reached by Dr. Allder and Ms. Levett and clearly by the self-reporting of the claimant.

152 Dr. Savundra has never suggested that any of the tests he undertook were more than suggestive, indicative or consistent with his diagnosis, and consistent with the diagnoses of Dr. Allder and Ms. Levett within the framework of which he was clearly working. None of the test results were diagnostic. He concludes: *"…the sole cause of [the claimant's] intrusive auditory and vestibular symptoms since the index accident is the trauma she suffered in the index accident. I have no evidence to support the opposite conclusion…she has post-traumatic migraine and post-traumatic vestibular migraine"* (with light sensitivity and visual motion sensitivity).

153 A fascinating by-product of Dr. Savundra's evidence was the beginnings of a new, alternative, potentially functional theory regarding the claimant's vestibular complaints, which alternative may or may not be attributable to an underlying structural abnormality. The claimant's reported symptoms are apparently consistent with Persistent Postural-Perceptual Dizziness ("PPPD"). This newly redefined functional syndrome (Popkirov et al: March 2018) requires no specific provocation and can persist independently of any lesional or structural disease. Anxiety and neurotic personality traits are associated with its onset and the syndrome can be the cause of balance problems and knee-buckling without falls (amongst many other things). However, Dr. Savundra says: *"I am not pushing PPPD as a diagnosis"* and this intriguing new syndrome was not explored in the evidence, save for a few moments in passing. This unexplored, speculative offering probably only underpins the difficulties encountered with diagnosing complex patients such as the claimant.

154 I do not accept Dr. Savundra's conclusions about the cause of the claimant's vestibular symptoms.

154.1 In my judgment Dr. Savundra is, to a significant degree, working backwards from the brain injury diagnoses of Dr. Allder and Ms. Levett, which I do not accept for reasons I have already given. This implication can be drawn from paragraph 6 of the Joint Statement, suggesting as I find it does that Dr. Savundra is also reasoning backwards from his acceptance that accident-related vestibular problems contributed to the Claimant's change of career. This allows Dr. Savundra to discount the absence of cotemporaneous medical complaints. In the same paragraph it is clear he is relying closely on the claimant's self-reporting of symptoms years after the event. Test results he describes as suggestive of

or consistent with these diagnoses do not take matters any further when the preferred evidence of Dr. Heaney is considered. Dr. Savundra had not seen Dr. Heaney's evidence at the time he wrote his Report (although he stood by his own Report at the trial).

154.2 The serious gaps in the contemporaneous medical information remain without any remotely satisfactory and acceptable explanation from the audio-vestibular evidence.

154.3 Consistent, accurate self-reporting of symptoms, the tracking of a clear timeline from the accident, is recognised by Dr. Savundra as important but it is absent in this case. Dr. Savundra does not and could not plug this vital link in the chain of causation.

154.4 The factual evidence, considered by Dr. Savundra as part of the paperwork provided to him, was necessarily one-sided and there is nothing in there about the all-important details of the claimant's work and change of career plans and activities throughout the second half of 2013 and 2014. Neither does there appear to be any mention of difficulties watching the television.

154.5 Regard must be had to the inconsistencies between some questionnaire answers provided by the claimant, Dr. Savundra's Report, and what is apparent from other parts of the evidence. Such inconsistencies are important. For example:

(1) Dizziness: the surveillance footage does not support the conclusion that the claimant is unsteady on her feet or subject to any of the balance problems which she relates.

(2) Dr. Radford reports the claimant walking appropriately without any apparent balance or unsteadiness traits and both Dr. Heaney and Dr. Vanniasegaram see nothing on the video surveillance material (the latter's viewing being limited) to corroborate vestibular symptoms.

(3) The indication given to Dr. Heaney that dizziness petered out before the claimant became pregnant (which would have been late summer 2015) is an entirely different version of events to that reported to other experts and is not consistent with her own statement at the same consultation with Dr. Heaney to the effect that dizziness petered out a year or maybe a year and a half after the accident (which would have been by the early autumn of 2014). These are further concerning discrepancies in the claimant's self-reporting.

155 Dr. Vanniasegaram was at a disadvantage. The claimant was so late for the appointment that it was shortened and lasted barely 20 minutes. However, although his opinion is more impressionistic than that of Dr. Savundra, it is, in my judgment, more realistic on the facts as they present themselves in this case. He said he was unable to provide a range of possible diagnoses because, bluntly, in his opinion *"I did not think there was any vestibular impairment*". Just as bluntly he thought the tests conducted by Dr. Savundra had *"no value at all"* and that noise intolerance had nothing to do with the vestibular system. He said that, in practice, he saw patients very frequently with and without noise sensitivity, whatever the test results revealed. He was no less sceptical about the value of questionnaires. The best they could hope to achieve was a list of subjective beliefs and in his experience results on such questionnaires were variable. He said in evidence that what he was concentrating on was the identification of genuine symptoms consistent with a balance dysfunction. As central and peripheral vestibular functions were

normal, vestibular problems could not explain the symptoms the claimant was reporting. He did not focus on any potential relationship between neural pathway compromise (processing) and the type of vestibular symptoms the claimant had reported. He was confident on a practical level that a patient such as the claimant was unlikely to persevere with symptoms justifying a Dizziness Handicap Inventory ("DHI") assessment (probably dating from November 2016 when she saw Dr. Savundra) in the severe handicap range without seeking medical advice about it in the 2 years or more between the accident and the claimant's referral to medico-legal experts.

156 Dr. Vanniasegaram remained of the opinion that any causal connection between reported vestibular symptoms and the accident would have resulted in some contemporaneous report to a medical practitioner in the first year after the accident. As he put it: *"A GP or physiotherapist may miss the nuances of my field; they may miss a diagnosis, but they would not overlook the complaint"*. He did, however, realistically recognise that, had there been a clear timeline and contemporaneous reports consistent with the claimant's reported symptomology, it was possible that the claimant's balance and dizziness problems could have been caused by an accident like the one the claimant experienced, but subject to the qualification that he considered that this was for the neurologists to determine.

157 Dr. Vanniasegaram's evidence is more limited than Dr. Savundra's, but it provides a measure of support for the conclusion that there is a distinct lack of any convincing timeline between the accident and the claimant's enduring symptoms (whatever those symptoms may be).

158 In my judgment the audio-vestibular expert evidence does not progress the case any further.

### *Orthopaedic* (Beavis[10] and Radford[11])

159 Unfortunately, Mr. Beavis had not seen the report of Dr. O'Connor when he wrote his own report; he agreed the Joint Statement some 2 years after (10 December 2017) he had last examined the claimant as against Mr. Radford's more recent examination in May 2017. Mr. Beavis was not able to attend the trial due to ill-health. The orthopaedic experts agree in the Joint Statement that the claimant's neck symptoms are compatible with those induced by a whiplash type injury; that a jolt to her lower back did not cause any significant injury or long-term pain and that she will not develop any symptomatic arthritis. The Joint Statement refers to tingling in the arms associated, I infer, with the neck injury, but Mr. Beavis's earlier reports pins and needles in both hands (worse on the *right*). Mr. Beavis also reports clicking in the neck. They note that *"… it is unusual for neck symptoms to become worse months or years later after this type of injury."* This was not the result of Dr. O'Connor's report (about which Mr. Beavis had reservations) but the claimant's statement to Mr. Radford (in May 2017) that her neck symptoms *"had recently become worse"*. On examination by Mr. Radford (May 2017) the claimant only had "*slight"* restriction of neck movement but had pain at the extremes. The jolt to her back was not of any long-term significance apart from some stiffness first

[10] 21.12.15, 23.11.17

[11] September 2017 & November 2017

thing in the morning. Mr. Radford accepted in his oral evidence that a delay of almost a year in getting physiotherapy was sub-optimal and that there is a small cohort of patients who only obtain short-term relief from physiotherapy, whose symptoms remain stubborn and do not fully recover. He was also prepared to accept that a perception of recent deterioration could be the result of a patient pushing themselves and feeling worse, rather than the injury becoming worse. As for the thumb, Mr. Radford accepted that it may not have got the attention it deserved in the immediate aftermath of the accident due to the more intrusive neck symptoms. He remained of the view that the slight loss of joint space on the ulna side of the metacarpophalangeal joint of her thumb would be unrelated to the accident because it would have caused significant pain and swelling and, therefore, would have been apparent on the day of the accident; but he did accept that the claimant may have sustained some kind of strain to her left thumb.

***Care Needs Assessment & Costing*** **(Kathy Kirby[12])**

160 I have already made reference to some parts of Ms. Kirby's report in the context of inconsistent or worsening symptom complaints by the claimant. The purpose of Ms. Kirby's evidence was to identify the likely level of care and assistance the claimant had required and would need in the future, and to cost that care, on the assumption that she had suffered a severe brain injury.

161 On my findings it is only the past care element that calls for consideration. I am asked to draw inferences in the claimant's favour on the basis that the defendant did not serve the Report they obtained from another expert in this area. I decline this invitation. I am satisfied that some additional domestic care and assistance would have been offered due to the whiplash and psychological sequelae of the accident. However, whatever the extent of the care needed, I find, not unusually, that the Care Assessment Report is really nothing more than guesswork when it comes to assessing the hours given in gratuitous care. There is little evidence as to what was actually done by way of care, by whom and when. Given that Trevor undertook much of this family's domestic work before the accident, I find that 5 hours a day for 10 days followed by 3½ hours for a further month, and thereafter 1 hour per day are nothing more than figures plucked from thin air. The same applies to the imaginative approach taken to the care and assistance needed whilst the claimant is preoccupied with running and ultimately closing down her failing business. I don't doubt Ms. Kirby's care experience, nor her long experience of writing care reports, neither is there any room to question the hourly rates but I don't find any reasonable support for the hours allocated to this aspect of the claim in the factual evidence and I did not find Ms. Kirby's evidence threw any light on this.

162 The accrued gratuitous care aspect of the claim is inevitably impressionistic in the absence of a time and motion study; and impressionistically is how I intend to approach the relevant award.

163 Were the question to arise, I don't find the figures for future care and assistance any more scientific than those for past care. Occupational therapy would not be necessary for a woman in the very top range of intellectual functioning even after the accident, and the proposal for a Case Manager is just as unconvincing, especially where the duties described are mostly bureaucratic and in my judgment, frankly vacuous. Even if it were to be found

[12] December 2017 & 10.04.18

that a brain injury had been sustained it could be no more than a DAI with relatively mild enduring consequences and would not justify the therapies or professional intervention that Ms. Kirby specifies. In fairness to Ms. Kirby I daresay she was instructed on a worst case scenario and has estimated the hours required and applied costings accordingly.

164 A substantial part of the claim relates to the risk attendant on the claimant developing dementia in old age. The only evidence about this is from Dr. Allder. A patient with a DAI is at greater risk of suffering dementia than someone in the general population sharing the same characteristics without DAI. The risks advised in Dr. Allder's opinion are put into figures with the help of Ms. Kirby and find their way into the claimant's Schedule. The claim amounts to very nearly £1m on the assumption that there is a significant risk that by the time the claimant is 75 she will need 24 hour care.

165 This aspect of the case was not explored in any great detail. No doubt the claimant would say that is because Dr. Allder's expert opinion was not challenged on this issue.

166 I am not satisfied that the evidence produced has been sufficient to prove even on the balance of probabilities that there is such an increased chance of any dementia, being of a type, degree or with symptoms of the sort that would require the high levels of intervention foreshadowed in the claimant's schedule of loss (even on the loss of chance basis put forward). In this part of the evidence there were far too many medical loose ends and unanswered questions. This aspect of the claim is speculative.

***Conclusions***

167 I reach the following conclusions.

168 I am satisfied, it being admitted, that the index accident was caused by the negligence of the defendant.

169 I am satisfied on the balance of probabilities that the claimant sustained a whiplash-type injury of some severity in the accident, with clicking in the neck (now occasional) together with an injury to her left thumb and hand. There were also minor seat-belt and soft tissue and lower back problems that were troublesome in the early weeks after the accident.

170 I am also satisfied on the balance of probabilities that headaches were a by-product of the whiplash injuries and that whilst headaches attributable to the accident have shown improvement in line with orthopaedic expectations (though proved more stubborn than was hoped) she remains more susceptible to headaches (occasionally severe) than she was before the accident.

171 I infer that due to the orthopaedic injuries and the resulting pain, in conjunction with the negative impact this would have had on her mobility and general feelings of well-being in the short term, that she is likely to have had occasional episodes of dizziness (not intrusive or frequent enough to be worth reporting to her doctor) and that the constellation of these orthopaedic injuries when taken in conjunction with aspects of PTSD, OCD and anxiety will have caused her to be socially more subdued and in turn "snappy" (particularly at home) as well as giving the appearance from time to time of

being “a bit” less well organised and “bubbly” than people were accustomed to.

172 I am satisfied on the balance of probabilities that she suffered some sequelae consistent with aspects of PTSD (but not PTSD) and OCD. There was also a period of situational (particularly travel) anxiety. These psychological symptoms were successfully treated and in full remission by the end of January 2016.

173 I am also satisfied that, in combination, the orthopaedic and psychological injuries would have caused a degree of fatigue and loss of energy of the sort the claimant was unused to. This, I infer, would have been more troublesome than it should have been given the long delay in her getting first, physiotherapy support and secondly, psychological treatment (CBT). Anything of this nature attributable to the accident was, on balance, likely to have resolved along with the psychological symptoms.

174 I am satisfied on the balance of probabilities that the claimant continues to be affected by the neck injury in particular, with some discomfort at the extremes of movement but that between October 2013 and the end of 2015 the orthopaedic consequences of the accident had gradually resolved to the sort of nuisance level that is unfortunately likely to endure; a possibility recognised by Mr. Radford and foreshadowed by Dr. O’Connor.

175 It follows from the above that the injuries are significantly more serious than is submitted on behalf of the defendant.

176 I am satisfied on the balance of probabilities that the claimant’s change of career and her abandonment of teaching would have happened by the end of 2014 irrespective of the accident and was not caused by the accident; neither was the accident a materially contributing factor in her decision. I am satisfied that this is the case whether or not any brain injury were to be established. No claim for loss of teaching earnings or pension, therefore, arises.

177 I am satisfied on the balance of probabilities that such enduring cognitive and behavioural problems as the claimant continues to experience were not caused or materially contributed to by the accident.

178 I am satisfied on the balance of probabilities that the claimant did not suffer a brain injury, and in particular did not suffer from PTA, or a DAI *as a result of the accident*.

179 It has not been proved on the balance of probabilities to my satisfaction that the claimant has a brain injury and, in particular, I am not satisfied that it has been proved that she has a DAI.

180 In the light of the above conclusions there is no justification for any damages based on the alleged increased risk of dementia or for any continuing care, case management, therapies or equipment.

181 I am not satisfied that the claimant has enduring cognitive or behavioural symptoms, or alternatively, if she does, the confusion in and unreliability of her evidence makes it impossible to assess their scope and effect save that they are considerably less serious than, for example, Ms. Levett has reported.

182 I am satisfied on the balance of probabilities that the claimant is not dishonest, nor is she malingering or consciously exaggerating, but I am equally satisfied that, on balance, that she is unreliable, inaccurate and very confused as a historian with regard to her career, the onset of her allegedly enduring symptoms, the development of such symptoms, the continuity of such symptoms and the trajectory of such enduring symptoms, as well as the description and effect of them on her everyday life and work; specifically in the provision of post traumatic amnesia assessments, but also generally.

183 On the basis of the claimant's confusion, inaccuracy and unreliability I am not able to identify with any precision what few, if any, cognitive and behavioural symptoms remain, neither does the evidence reveal a specific, alternative cause of such problems as she says she now has.

184 Even if there had been a proved causal connection between the accident and the claimant's decision to leave teaching, any resulting loss of earnings and pension would have to take into account that the chance of the claimant achieving deputy headship (or senior SEN role at a broadly equivalent salary) after 5 years of the accident date could not have been more than 70% and the prospects of headship after 10 years from the accident could not realistically have been greater than 50%. These percentages more realistically reflect the many potential intervening vicissitudes of family and professional life and given that she was determined to set up a tea room in any event, on this counter-factual basis, I conclude she would more likely than not have done this by the time she was 50 even if she had remained in teaching.

185 I am not satisfied, even if a DAI had been caused by the accident, that the risk of dementia to the extent justifying this substantial part of claim has been proved.

186 Accordingly, there must be judgment for the claimant for a sum assessed as appropriate to the findings set out below.

***Damages***

187 The whiplash injuries were injuries of some severity. Treatment by physiotherapy was not commenced for nearly a year after the accident and that is likely to have led to a sub-optimal result. The claimant suffered a period of severe pain and restricted movement for some weeks after the collision. This, I find, was associated with dull, background headache with peaks of sharp severity when tired and some clicking in the neck. I conclude that, on balance, it is likely that the expected path of recovery (e.g. O'Connor; Radford) was over-optimistic and that whilst the claimant had reached some resolution of the worst effects of the neck injury by October 2013 the background symptoms (discomfort, headaches and fatigue which I accept are likely to have been continuing consequences of these injuries despite optimism that a resolution would present itself) are likely to have continued, albeit on a slowly diminishing scale for appreciably longer than was hoped or expected even by Mr. Radford. The physical consequences of this whiplash injury and the effect on the claimant's overall well-being should not be underestimated, but on balance, I find it more likely than not that there had been a substantial resolution of accident-related whiplash symptoms by the time the tea rooms opened in December 2014 and continuing improvement after that, leaving the claimant with a residual but annoying continuing level of minor inconvenience. This is reflected in a residual level of intermittent

discomfort in circumstances where she is more prone to headaches than before the accident and more susceptible to feelings of fatigue (occasionally overwhelming fatigue) for short periods. I am also prepared to infer that the whiplash injuries and the associated symptoms would have caused at least subjective feelings of dizziness in the weeks immediately following the accident but that this problem had petered out and resolved by autumn 2013 at least in any way attributable to the accident.

188 It is clear in my judgment that the claimant did sustain an injury to the left thumb. Whilst the experts are not in agreement as to precisely what this injury was I am satisfied on the balance of probabilities that it was a jarring or alternatively wrenching injury that was probably overlooked at A&E and because of the secondary nature of this problem it has mostly been of only marginal concern. I did not get any sense from the claimant that this injury was anything more than a mild, continuing irritant and there was no evidence to the effect that it had a serious, negative impact on the running of her tea room business. It was not a problem that manifested itself when the claimant was in the witness box and does not feature in the Care Report of Ms. Kirby from which I conclude that any difficulty has long been reduced to a nuisance level.

189 I am satisfied that the claimant suffered symptoms consistent with some of the criteria associated with PTSD (including some re-living of seeing the defendant in her rear view mirror before the collision) in addition to obsessive compulsive disorder. This was coupled with a period of anxiety, particularly situational anxiety with travelling especially in cars (initially whether as driver or passenger but resolving gradually to nervousness as a passenger). These psychological problems were successfully treated by January 2016 (within 3 years of the accident) and I am satisfied that in addition to the orthopaedic injuries they would have proved troublesome and intrusive.

190 It is difficult to strip out of the claimant's confused and confusing factual history and the experts' reports filed principally with regard to DAI with neural pathway vestibular associations, a coherent alternative, accident-related narrative with regards to the scope and extent of the claimant's injuries. Doing the best I can, as reflected in the above summary, and having regard to the Judicial College Guidelines (14th edition 2017) sections 7A(b); 7I(z); 4B(c); 3A(c)[headaches] I arrive at the following global award for pain, suffering and loss of amenity accounting for all the matters canvassed above. The appropriate figure is: £25,000.00.

***Special Damage***

191 The following aspects of the claim for special damage are proved.

191.1 Ms. Levett's fees for the successful treatment of the psychological injuries. Stripped of those elements of Ms. Levett's charges that relate to cancelled or "no show" appointments as well as the assessments that formed the foundation of her expert evidence, the claimant had 22 hours of treatment sessions at £200.00 per hour yielding a total of £4,400.00.

191.2 An award of damages reflecting the notional cost of gratuitous care is justified but I find that the figures claimed in the Schedule are ambitiously over-optimistic in circumstances where the medical evidence

reveals that Trevor did a lot of the housework and domestic chores even before the accident. The Schedule attempts to calculate figures within specific time periods attributing specific hourly rates in circumstances where little time has been spent in the evidence describing with equal precision what was done by whom and when. Even so, I am satisfied that up until January 2016 (the end of the Levett treatment), Trevor and the claimant's parents would have devoted more time and energy to assisting the claimant in a manner that was outside the ambit of ordinary family life after which any impact the accident had in this regard would have fallen away; especially with the birth of Henry in May 2016. I do not attempt an approach as outwardly scientific as that in the claimant's schedule there being too many evidential uncertainties. Accordingly, in my judgment this is a case where it is appropriate to award a single lump sum to reflect what I have concluded for the claimant to hold on trust for Trevor and her parents. That sum is £10,000.00.

191.3 For travel costs; staff cover; the satellite navigation unit and child seat I award £1,194.00 but the claims for removal costs and trading-in the car I find these are not made out.

192 I am not satisfied on my findings that any future losses arise.

193 Interest accrues on general damages at 2% (£25,000.00) from the date proceedings were served and on special damage of £15,594.00 which I assess at 1% to bring matters up to date. This will be £500.00 and £155.94 respectively. I will hear submissions on these calculations should it be necessary.

194 There will be judgment for the claimant in the inclusive sum of £41,249.94.