



Neutral Citation Number: [2021] EWHC 1338 (QB)

Case No: QB-2018-005711

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/05/2021

Before:

HIS HONOUR JUDGE PEARCE
(Sitting as a Deputy Judge of the High Court)

Between:

STEPHEN LONG **Claimant**
- and -
ELEGANT RESORTS LIMITED **Defendant**

Marcus Grant (instructed by **Hatch Brenner LLP**) for the **Claimant**

Marcus Dignum QC (instructed by **Reynolds Porter Chamberlain LLP**) for the **Defendant**

Hearing dates: 22 - 26 February 2021, 1 - 2 March 2021

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HIS HONOUR JUDGE PEARCE

His Honour Judge Pearce :

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INTRODUCTION

Background

1. The Claimant, who was born on 24 May 1973 and is therefore now 47 years old, was injured in an accident at work on 22 March 2015. At that time, he was employed by the Defendant, a company based in Chester, as their Head of IT. On the day of the accident he and another employee of the Defendant, Mr Craig Jones (who was employed at the time as a Facilities Assistant, but now is the Defendant’s Facilities Manager), were involved in removing items from the cellar of premises known as the Old Palace in Chester. These premises had been occupied by the Defendant as offices, but which were to be handed back to the landlord. It is common ground

that, during the course of this work, the Claimant went to assist Mr Jones and, in so doing, struck his head on a low part of the ceiling of the cellar.

2. The Claimant contends that the accident caused a Traumatic Brain Injury (“TBI”) and that its aftermath has had a serious effect upon his life. He brings this claim against the Defendant for damages for personal injuries and consequential losses allegedly sustained as a result of the accident.
3. The Defendant admits its liability for injuries caused by the accident but says that this was no more than a bump to the head of a kind which people suffer regularly and which has led to no long-term consequences at all. In addition, the Defendant contends that damages should be reduced by reason of the Claimant’s alleged contributory negligence in respect of the happening of the accident.

The Trial

4. The trial took place in late February/early March 2021. By reason of the COVID-19 pandemic, it was agreed that much of the evidence and submissions should be heard remotely. However, the parties favoured the evidence of the Claimant himself being given in person. Given the serious allegations made against him by the Defendant as set out below and the importance of his credibility, it seemed to the parties that the interests of justice called for Mr Long to give evidence in person and for this reason the first day of the hearing was accommodated in the Royal Courts of Justice, with Counsel, the Claimant’s solicitor, the Claimant and the Claimant’s wife attending in person. Other people, including the Defendant’s solicitor and medical experts were able to attend remotely using the CVP system. The trial lasted in total seven days, of which a small part of the first day and the entirety of the final day was spent in dealing with submissions, the evidence spanning nearly 6 days, some of which were longer than the usual court day.
5. Whether it was strictly necessary for the Claimant’s evidence to be given at an in-person hearing is a moot point. Like Mr John Kimbell QC, sitting as a Deputy High Court Judge in Hyde et al v Nygate (One Blackfriars Limited) [2021] EWHC 684 (Ch), I have found that remote hearings generally allow the Judge to have at least as good an opportunity to assess the reliability and credibility of a witness as do hearings in person. Whilst there may be other reasons to hold attended hearings when circumstances allow, I have not found any reason to think that my ability to assess witnesses in a remote hearing is less than satisfactory. It certainly did not do so in respect of the witnesses who gave evidence remotely in this case.
6. During the trial, I heard from the following lay witnesses called for the Claimant:
 - i) The Claimant himself, who provided statements dated 6 June 2018, 4 September 2019, 17 January 2020, 4 March 2020 and 18 September 2020;

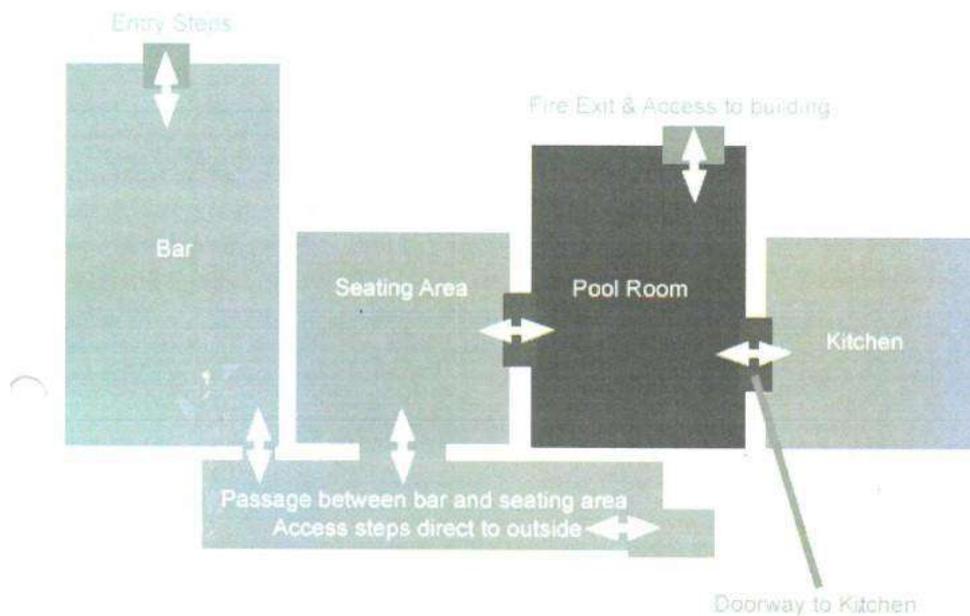
- ii) Mrs Andrea Long, the Claimant's wife, whose statement is dated 21 August 2019;
 - iii) Mr Peter Long, the Claimant's eldest son, whose statement is dated 28 August 2019;
 - iv) Mr Harvey Long, the Claimant's second eldest son, whose statement is dated 28 August 2019;
 - v) Ms Sophie Long, the Claimant's daughter, whose statement is dated 28 August 2019;
 - vi) Rev Anthony Long, the Claimant's father, whose statement is dated 9 September 2019;
 - vii) Mr Bernard McMahon, a former work colleague of the Claimant, whose statement is dated 5 August 2019;
 - viii) Mr Richard Smedley, an accountant who had provided professional services to the Claimant, whose statement is dated 7 August 2019;
 - ix) Mr Nicholas Weston, a former work colleague of the Claimant, whose statement is dated 30 July 2019;
 - x) Mr Paul Croston, a former work colleague of the Claimant, whose statement is dated 1 August 2019.
7. In addition, a statement of Mr Heinz Kneubuehl (another former work colleague of the Claimant) dated 15 July 2019 was relied upon by the Claimant. The Defendant did not challenge his evidence and it was not necessary for him to be called to give oral evidence.
8. The Defendant called Mr Craig Jones. His statement is dated 13 November 2018.
9. I heard from the following expert witnesses on behalf of the Claimant:
- i) Dr Philip Paul Nichols, consultant neurologist, whose report is dated June 2018;
 - ii) Dr Julius H Bourke, consultant neuropsychiatrist, whose reports are dated 14 June 2018 and January 2020, with a supplemental letter dated 30 October 2020;
 - iii) Dr Katherine Pierce, consultant neuropsychologist, whose reports are dated 22 June 2018 and January 2020;
 - iv) Dr SS Surethiran, consultant neuro-otologist, whose report is dated 3 October 2018.
10. I heard from the following expert witnesses on behalf of the Defendant:
- i) Dr Dominic Heaney, consultant neurologist, whose report is dated 17 April 2020;
 - ii) Dr Jonathan Michael Bird, consultant neuropsychiatrist, whose reports are dated 24 April 2017, 2 January 2020, with letters dated 22 May 2017 and 16 September 2020.
 - iii) Dr Yvonne McCulloch, consultant neuropsychologist, whose report is dated 6 April 2020.

11. Joint statements have been prepared between experts of like discipline as follows:
 - i) The neurologists, Dr Nichols and Dr Heaney, dated 10 July 2020;
 - ii) The neuropsychiatrists, Dr Burke and Dr Bird, dated July 2020 and a supplemental statement dated 10 November 2020;
 - iii) The neuropsychologists, Dr Pierce and Dr McCulloch, dated 7 July 2020.
12. The submissions and evidence first six days of the trial was transcribed and hence I have available to me that transcript as well as my own notes of evidence. The transcript appears to be largely accurate though inevitably there are occasional points at which it appears erroneous. In the verbatim quotations in this judgment, I have taken the passages from the transcript without correction, though have noted where I think the transcript may be inaccurate.
13. I have been assisted in preparing this judgment by the written submissions, both opening and closing, from counsel for both parties. I am grateful to them for the efficient manner in which they dealt with the case and for their clear submissions on issues which are far from straightforward in fact. I should express particular gratitude to Mr Grant for his written chronology, since I have lent heavily on it in the preparation of this judgment and indeed it forms the basis though is not the sole source of the chronological presentation of medical records below. I have divided this chronology between the passages of my judgment dealing with Issues 1, 2 and 4, as set out below (that is say pre-accident, the accident to the Claimant being made redundant and events since the redundancy). Where medical records are referred to in other parts of the judgment, the relevant references should be found within those three parts of the chronology.
14. The trial bundle in this case ran, with the addition of extra documents included during the trial, to 3,857 pages. These pages include many (though it would seem by no means all) of the Claimant's medical records. During the trial reference has been made to many issues, some of which it seems to me are of little if any relevance. It is inevitably the case that a judgment following the trial of this length, during which so much material has been referred to, will be selective in its reference to that material. That is not to say that other material has not influenced me in reaching the conclusions below.

The Claimant's case in summary

15. The Claimant has a history of work in the IT industry, both as an employee and running his own company. He obtained a job with the Defendant as head of IT starting on 30 June 2014, earning £50,000 gross per annum. The job was subject to a probationary period which ended in December 2014, following which his job was made permanent. His pay was increased to £51,000 per annum shortly after the accident.

16. At the time of the accident, the Claimant lived in Norwich with his family, but spent the week working at the Defendant’s base in Chester. His parents live in Shavington (near Crewe) and his practice was to stay with them whilst working.
17. It is common ground that, shortly before the accident, the Claimant became aware of circumstances that gave rise to the possibility that his job might become redundant. I deal with the detail of this further below.
18. The accident occurred on Monday 23 March 2015. The Claimant’s account is that he and Mr Craig Jones were in a hurry to carry out certain tasks before handing the building, the Old Palace, over to the landlord. They were in the cellar, an area described by him as having “domed” ceilings – the word “vaulted” might better describe them. The plan below, from page 2932 of the trial bundle, shows the approximate layout¹:



19. Mr Long states (and Mr Jones broadly agrees) that he was in the seating area, when he became aware that Mr Jones, who was in the kitchen, was struggling with a large and awkward object. Both the seating area and the kitchen were lit, but the room between, the pool room, was unlit. Mr Long states at paragraphs 37 and 38 of his witness statement, *“I rushed to help him by jogging because I didn’t want to hurt myself...My last clear memory before the accident is of seeing Craig strain himself and of me beginning to run towards him. I remember the impact. My next memory is of being upstairs on the ground floor sat in the window seat of the doorway on the ground floor.*

¹ There is another plan annexed to Mr Jones’ statement at page 888 of the bundle. It is slightly less clear, though contains the measurement of the maximum height of the ceiling being about 6’ and refers to a slight incline between the pool room and the kitchen. There are also photographs in the bundle which give a slightly clearer sense of the detail of the ceiling in the cellar, although unfortunately not at the location of the accident.

I remember that Craig was there. My next memory is of ringing Sharon Lloyd². I remember that I rang her but have no memory of the conversation. My next memory is of wiping my forehead with a bandage with a patch on it from the first aid kit and it was bleeding. My next memory is of taking the landlord's managing agent around the building...."

20. It would appear that the Claimant continued to work for the remainder of the day. He has no recollection of whether he attended the gym after work (as suggested by Mr Craig) but he recalls being at his parents' home that evening and suffering a "*strange tingling sensation all over my body.*"
21. On the following morning (Tuesday 24 March, the Claimant went to the Countess of Chester Hospital ("CoC") (which is, as the name might be thought to suggest, in Chester), probably after first attending his father's GP Practice³. He was discharged from the CoC on the same day with "*written advice*". It is common ground that that was probably head injury advice.
22. On Wednesday 25 March, he returned to Norwich, driving himself. He recalls stopping for a sleep, which he says was unusual.
23. The Claimant states that his next recollection is being on the bathroom floor at his parents' house vomiting. He states that this was Sunday 29th March, a date confirmed both by his wife and by his father as the day on which he travelled back from Norwich to Shavington. On the following day, he again attended CoC and was admitted until 3 April 2015. He then returned to Norwich and had some time off work.
24. He attempted a return to work on 20 April, but only lasted a few hours. On that day, he was told that he was to be made redundant and this took effect on 14 May 2015. The Claimant appealed the redundancy dismissal, by letter dated on or around 14 May 2015. The Claimant challenged the lawfulness of the redundancy process, apparently on grounds of disability discrimination⁴. It has become apparent⁵ that the employment claim had been settled by the Defendant paying £5,575 to the Claimant, on terms that were expressed to be "*without admission of liability.*"
25. Since the accident, the Claimant has complained of a variety of symptoms that have severely compromised his ability to work or to function normally, namely: memory problems, difficulties with concentration and problem solving; word finding difficulties; polyopia (multiple visual

² Sharon Lloyd was the Claimant's line manager.

³ I have not identified any medical record of that visit to the GP, unlike a similar visit prior to attending hospital on 30 March 2015, but both the Claimant and his father say that such a visit occurred and the statement in the Claimant's record from the CoC for 24 March 2015 "*Source of referral: Ref to A+E – other referrer*" would appear consistent with another medic having referred the Claimant to hospital rather than an attendance on the patient's own initiative.

⁴ He would have had too short a period of employment to challenge the redundancy on other grounds

⁵ Counsel for the Claimant was only made aware of this very shortly before the trial.

images); vertigo; balance difficulties; fatigue; anger; avolition; and light and noise sensitivity. These have, on his case, caused a severe depressive disorder.

26. The Claimant accepts that, at the time of the accident, he had a pre-existing medical history that has been diagnosed as fibromyalgia and which involves somatoform symptomatology. His claim for damages is formulated on the basis that he suffered a mild Traumatic Brain Injury (“mTBI”) in the accident that has developed into a Functional Neurological Symptom Disorder (FNSD) and Neurocognitive Disorder due to TBI with Behavioural Syndrome. He contends that, but for the accident, he would not have suffered FNSD. Whilst there was a probability that the Claimant’s pre-existing fibromyalgia/somatoform symptoms would have recurred, particularly in times of stress, this would not have interfered with his ability to work in a responsible and well-paid job. Further, whilst, absent the accident, the circumstances of his being made redundant may have caused a short-lived adjustment disorder, the redundancy would not have caused a severe depressive disorder of the kind or severity that he has in fact suffered.
27. On his case, he remains unfit to work at the level that he did prior to his accident, though recently (since his witness statements in this litigation) he has obtained paid employment as a gardener at a National Trust property in Norfolk, Felbrigg Hall, where he now works for 18¾ hours per week, earning £8,676 gross per annum.
28. In so far as his honesty and/or accuracy is in question, the Claimant contends that he has always attempted to give a true and accurate account of medical matters, but that to some extent this has been confounded both by the nature and the complexity of his medical history. It is contended on his behalf that his account of the accident and its aftermath is essentially consistent. In so far as the account of his redundancy and its significance is brought into question, the Claimant contend that that the Defendant has fundamentally misunderstood his explanation of discovering the possibility that he might be made redundant. In any event, the Claimant draws attention to the failure of the Defendant to adduce any evidence to contradict his account and the fact that the Defendant compromised his claim arising out of the dismissal in circumstances that could only be consistent with a realisation on the Defendant’s part that it might be found responsible for a dismissal that was unlawful on grounds of disability discrimination.

The Defendant’s case in summary

29. The Defendant is sceptical as to both the accuracy and the honesty of the Claimant’s account relating to the accident and its aftermath. It contends that his accounts are unreliable and at times contradictory. This is so in particular in relation to the circumstances of his redundancy, but extends to his description of medical symptoms which, the Defendant contends, is for a variety of reasons unreliable.

30. The Defendant relies on the combination of the eyewitness account of Mr Jones, various features of the contemporaneous accounts of the Claimant and the medical evidence as to the severity of the injury in support of its case that the Claimant suffered no, or no significant, TBI.
31. As to medical formulation, the Defendant denies that the circumstances of the accident were capable of, or did in fact, cause a mild TBI. In so far as the Claimant has genuinely suffered symptoms which he perceives to be organic and physical in nature, the Defendant contends that these are in fact an extension of a pre-existing condition, best diagnosed as a Somatic Symptom Disorder (“SSD”). The Defendant accepts as genuine at least some of the symptomatology of the Claimant, in so far as it is a consequence of a severe depressive disorder. But the Defendant contends that the cause of that disorder was the redundancy and/or underlying SSD rather than the accident on 22 March 2015.
32. Further, the Defendant contends that the Claimant has been dishonest in his account both to experts and the court of his symptoms and their interrelation with employment to the court. This dishonesty compounds his unreliability but also brings into play the concept of Fundamental Dishonesty and the effects of Section 57 of the Criminal Justice and Courts Act 2015.

The Issues in the Case

33. In his opening submissions, counsel for the Claimant set out eight issues which he contended the court needed to consider.
 - i) What was/were the diagnosis(es) and severity of the Claimant’s pre-accident health-related issues?
 - ii) How vulnerable was the Claimant to developing the cluster of symptoms that followed on from the accident in the absence of the index accident or equivalent non-compensable traumatic insult?
 - iii) What was the nature and severity of the mechanism of the accident?
 - iv) Did the Claimant sustain mTBI by reference to the Mayo classification?
 - v) Was the Severe Depressive Disorder that the experts agree developed from May 2015, caused by the accident, by his redundancy, or by a combination of the two?
 - vi) Was the Claimant’s assertion that his redundancy was a construct to get rid of him because he was injured an honestly held belief?
 - vii) Was the Claimant’s failure of performance validity tests on neuropsychological testing explained by unconscious processes or by conscious exaggeration?
 - viii) Should the award of damages be reduced reason of the alleged contributory negligence?

34. In his closing submissions, counsel for the Defendant formulated his case under the following headings:
- i) Fundamental dishonesty, in the light of lack of transparency/honesty about stress at work, his claimed belief that his redundancy was related to a TBI, and his assertions as to how he would have coped with the stress of redundancy absent the accident;
 - ii) Faking of symptoms by the Claimant;
 - iii) The Claimant's pre-accident diagnosis;
 - iv) The Claimant's post accident diagnosis;
 - v) Causation;
 - vi) Contributory negligence;
 - vii) Quantum.
35. As always, it is possible to refine and redefine the issues in the case as it proceeds. Further, the same issues may often be expressed in differing ways and grouped together differently. I am conscious that there is considerable overlap between the issues identified in each of these lists.
36. For the purpose of this judgment, it seems to me that the issues can most conveniently be grouped as follows:
- i) What were the Claimant's relevant pre-accident symptoms and diagnosis/ diagnoses? (Issue 1);
 - ii) What were the circumstances of the accident and its immediate aftermath? (Issue 2);
 - iii) What were the Claimant's symptoms and diagnosis/diagnoses in the immediate aftermath of the accident⁶ and what was/were their cause(s)? (Issue 3);
 - iv) What were the Claimant's symptoms and diagnosis/diagnoses from May 2015 and what caused them? (Issue 4);
 - v) Was any exaggeration by the Claimant of his injuries/symptoms deliberate? (Issue 5);
 - vi) Has the Claimant given an honest account of the circumstances leading to his redundancy, whether he believes that he would have been made redundant in any event and/or what his response to redundancy would have been absent the accident? (Issue 6)

⁶ I have taken this period to be up until the Claimant's redundancy took effect in mid-May 2015, on the basis that on any version of events that was a distressing event and that on the Defendant's case it became a superseding cause of the Claimant's problems, in so far as what was suffered prior to then was caused by the accident.

- vii) Has the Claimant has been guilty of Fundamental Dishonesty within the meaning of Section 57 of the Criminal Justice and Courts Act 2015? (Issue 7)
- viii) Should the Claimant's damages be reduced by reason of contributory negligence? (Issue 8)
- ix) What is the quantum of the damages that the Claimant should recover by reason of his injury and any consequential losses? (Issue 9)

THE EVIDENCE

Approach to the Lay Witness Evidence

37. It is a trite observation that the memory of witnesses may be undermined by a variety of factors. In the well known and often quoted passage from his judgment in Gestmin SGPS SA v Credit Suisse (UK) Ltd [2013] EWHC 3560, Leggatt J, as he then was, said in respect of evidence based on recollection:

"15. An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory.

16. While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.

17. Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flashbulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event. (The very description 'flashbulb' memory is in fact misleading, reflecting as it does the misconception that memory operates like a camera or other device that makes a fixed record of an experience.) External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which did not happen at all or which happened to someone else (referred to in the literature as a failure of source memory).

18. Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.

19. The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.

20. Considerable interference with memory is also introduced in civil litigation by the procedure of preparing for trial. A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does nor does not say. The statement is made after the witness's memory has been 'refreshed' by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall. The statement may go through several iterations before it is finalised. Then, usually months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.”

38. Similar issues as to the fallibility of memory and its ability to be distorted are addressed in Practice Direction 57AC “Trial Witness Statements in the Business and Property Courts,” which at paragraph 1.3 of the Appendix, headed “Statement of Best Practice in Relation to Trial Witness Statements”, states:

“Witnesses of fact and those assisting them to provide a trial witness statement should understand that when assessing witness evidence the approach of the court is that human memory:

(1) is not a simple mental record of a witnessed event that is fixed at the time of the experience and fades over time, but

(2) is a fluid and malleable state of perception concerning an individual's past experiences, and therefore

(3) is vulnerable to being altered by a range of influences, such that the individual may or may not be conscious of the alteration.”

39. That is not to say that the court may or should simply dismiss witness evidence when it is inconsistent with documents. As Floyd LJ said in Kogan v Martin [2019] EWCA Civ 1645 (citing the judgment of HHJ Gore QC in CXB v North West Anglia Foundation NHS Trust [2019] EWHC 2053 as to the caution to be exercised in applying the above passage from Gestmin in the particularly in the context of non-commercial disputes), “*a proper awareness of the fallibility of memory does not relieve judges of the task of making findings of fact based upon all of the evidence*” (emphasis in the original). This is particularly so where, as here, one is concerned with documents that are (largely) not created or attested to by the witness whose accuracy and/or credibility is an issue, but rather by third parties such as doctors who, whilst usually at least can be taken as intending to make an accurate record, inevitably introduce a degree of subjectivity into that which they record. Nevertheless, it seems to me that the court should have regard to those factors which may tend to distort witness statements, both in assessing the reliability of the witness evidence and in considering why distortions may have arisen.
40. In the expert evidence within this case, the experts have distinguished between true post traumatic amnesia (which is attributed to a failure to form continuous memory because of trauma) and memory attrition, described by Dr Bourke as the tendency forget less salient events that arise between more significant events. This is a distinction that may be more easily stated than identified, since post traumatic amnesia is often seen as involving islands of memory being formed in a sea of events in respect of which continuous memory is not laid down, whereas attrition of memory involves the contemporaneous laying down of memories of all events, but the subsequent fading of memory for less significant matters. Whilst all the experts broadly held that view as to the significance of post traumatic amnesia to memory, there is some difference of opinion as to how easy it is to distinguish between the two explanations for why memories may be missing.

The Lay Witnesses

41. As I have indicated, I accepted that it was desirable that I see Mr Long give evidence in person. This enabled me to make certain assessments of his evidence that may have been more difficult and evidence been given remotely by video link.

42. Mr Long was polite and careful in giving evidence. In their first joint statement, Dr Bourke and Dr Bird speak of the Claimant's pre-morbid personality. They describe him as having been "*perhaps obsessional, something of a perfectionist, fastidious and organised...*" This is in marked contrast to his post-traumatic state which is described as showing "*evidence of a general state of avolition and anhedonia, amotivation, irritability and at times antagonistic interactions with others, including members of his family.*"
43. Evidence of the pre-morbid personality traits described by the doctors was apparent in the Claimant's attempts in his oral testimony to rationalise matters and to explain parts of the evidence that might have seemed inconsistent. An example is the Claimant's explanation as to why he states that he was running round than walking at the time of the accident. As I note at paragraph 105 below, I gained the impression at this point that the Claimant might tend to give evidence based upon a rationalisation of what occurred rather than being based on a true recollection. This causes me caution in accepting his evidence when it is contradicted by other material.
44. In general terms, I did not form the impression that he was trying to tailor his evidence, although there are issues about his speed of movement at the time of the accident and a lump to his sternum, both addressed below, which might have been interpreted in this way. He dealt with the challenges of cross examination without any appearance of cognitive impairment or what at one stage was called "*brain fog*". He did not show any obvious signs of tiredness beyond that which one might expect of somebody who had travelled some distance to give evidence on important matters. There were no obvious speech or contemporary memory problems.
45. Overall, the assessment I made was that Mr Long appeared to be performing rather better than one might expect, having regard for example to Dr Bourke's account of the current symptoms in his report of January 2020 at paragraph 3.2.8 (based upon a re-assessment on 21 October 2019) and to the description of his post traumatic state in the joint statement of Drs Bourke and Bird. However, I am conscious that the impression that a person gives in the witness box is not necessarily a fair indication of their cognitive state. Furthermore, the Claimant accepted that his condition has continued to improve and accordingly a comparison with a description of his condition, based upon an assessment more than 16 months ago, may be unhelpful.
46. I do not consider that I can draw any strong conclusions as to Mr Long's current level of functioning, still less his historic level of functioning, from his presentation in the witness box. On the vital issue as to whether the Claimant has deliberately made untrue statements, there was nothing in the Claimant's demeanour to suggest that he was someone prone to lying or exaggerating. The issue of credibility requires careful analysis of what Mr Long has had to say various times, together with the circumstances in which he said it and a proper understanding of

his medical condition. It is necessary to compare the Claimant's evidence on a variety of issues, looking at what is supported or contradicted by other material, what is inherently plausible or implausible and what is internally consistent or contradictory. One must further look with care at the extent to which the Claimant's reliability or unreliability on particular issues may support or undermine the credibility of his evidence more generally. None of this can be deduced from his demeanour in the witness box.

47. In two respects, counsel for the Defendant alleges that there is evidence that Mr and Mrs Long have colluded in giving their evidence. Such collusion, in the sense of giving an account pursuant to an agreement to give false evidence or simply an account that was agreed between the witnesses, would, if proved, seriously undermine the credibility of Mr Long. For the reasons set out below, when dealing with the evidence of Mrs Long, I consider that the points made by the Defendant in support of the allegation collusion have some force in my assessment of the reliability of her evidence but do not impact upon my assessment of the reliability of Mr Long himself.
48. In assessing Mrs Long's evidence, I bear in mind that, as the long-standing wife of the Claimant, she is likely to wish to be supportive of his evidence. Much of what she knows of his condition must, inevitably, result from discussions with him. Insofar as she has independently observed features of his condition, her evidence in respect of that is likely to be influenced by those discussions, such that now it may be difficult to distinguish that which she genuinely remembers from that which she believes to be the case because of discussions with her husband. Though tending to undermine her reliability, this does not necessarily bear upon her genuineness or honesty.
49. The first of the allegations of collusion between the Claimant and his wife relates to his presentation to his General Practitioner on 6 May 2015 with what was suspected to be pain to the xiphisternum. The consultation and subsequent investigation have other significance, noted below, but the allegation of collusion relates to the trigger for the Claimant attending his General Practitioner with this complaint. Whilst there is no hint of this in either the medical note or the Claimant's witness evidence, Mr Long said in evidence that the presence of an abnormal lump on his chest "*was actually pointed out by my wife.*" In her evidence, Mrs Long made a corresponding comment about "*that thing in his chest which I found.*"
50. The second allegation of collusion relates to Mrs Long's account of a conversation with Mr Long relating to his discussions with Mr Redmond Walsh about redundancy. In his evidence, Mr Long described what he called the "*inadvertent discovery*" that his job might be at risk on 10 March 2015. His account of what he did after discovering this is set out in a document referred to an undated letter seeking to appeal his dismissal by the Defendant on 14 May 2015. The document

was sent to the Defendant shortly after the redundancy was confirmed on 14 May 2015 and for convenience I shall call it the “May 2015 Document.”

51. In the May 2015 Document, the Claimant speaks of contacting his line manager, Ms Sharon Lloyd, after he had made the “*inadvertent discovery*” of the risk of redundancy and thereafter being asked to speak to Mr Walsh about the matter. He goes on, “*In this conversation Redmond Walsh stated that he had been considering this for some time and had now decided that he was going to move forward with the group Head of IT role. He went on to state that this would not mean that my role was immediately redundant and that I was needed to manage Elegant Resorts IT teams and systems until the appointment was made and he would let the incoming individual make their own mind up about whether my role was required any longer or not. Redmond Walsh stated in this meeting that he did not consider me a suitable candidate for this Group IT role as he wanted to bring someone in with Travel experience.*” This alleged conversation is of great significance in this case, a fact known to the Claimant for some time. It is dealt with further below.
52. In oral evidence, Mrs Long’s said that Mr Long had mentioned the discovery to her in a telephone conversation. She said “...*it was like a really meaningless conversation because just says*⁷: “*Have a word with Redmond and he will talk,*” you know, “*you can talk about it to Redmond,*” and that is what Stephen did...” The “collusion” alleged between Mr and Mrs Long was in the assertion that, having made the discovery, Mr Long spoke to Mr Walsh and his concerns were assuaged, a point which, if correct, goes a considerable way to weaken the Defendant’s arguments that the Claimant’s redundancy was inevitable regardless of the accident, that the Claimant already knew it to be so prior to the accident and/or that in any event it was obviously not due to the accident.
53. Of the first of the allegations of collusion between Mr and Mrs Long in respect of their evidence, it is difficult to accept that they would have anticipated in advance of the trial that the Claimant’s xiphisternum issue was a matter upon which either would be cross examined. In the complex and long medical history of Mr Long, the reference to his xiphisternum is frankly very much at the trivial end of complaints. If the couple have colluded about this, one would expect them to have colluded about many other things. If there were evidence of collusion in other respects, this part of the evidence might be of a piece and therefore similarly an example of collusion. But as a discrete point in the case, it is singularly unpersuasive of collusion, especially as the possibly unlikely coincidence of the couple’s evidence can be explained in an alternative way, as noted below. On the second point, collusion seems to me to be excluded by the fact that Mr Long and Mrs Long did not give the same account of the incident. Had Mr Long said that he spoke to Mr Walsh at his wife’s suggestion, there might be some force in that (although of course that could

⁷ I understood Mrs Long to mean that she had said to her husband, “*Have a word with Redmond and he will talk*” or similar.

equally be consistent with that being the true account of matters). However two witnesses giving different accounts does not seem to me to be suggestive of collusion merely because either account tends to support a finding that is helpful to the Claimant's case but may be considered improbable.

54. In fact, there are two far more probable explanations of each of these incidents. The first is that each of the witnesses was doing their best genuinely to remember what happened and that they have each broadly given an accurate account. The second is that that Mrs Long has tailored her oral evidence to meet the account given by her husband (which was given on the day before she gave evidence). As these are the only two frank examples of suggested collusion between the witnesses, I reject the allegation that they had deliberately sought to give accounts that are consistent but untrue.
55. On the other hand, I note below another example of evidence given by Mrs Long (in this case relating to the Claimant stopping on a journey from Norwich to Cheshire in order to vomit) which appears to match that of her husband given for the first time by him in the witness box, yet that was not set out in her witness statement. Taking these three aspects of her evidence together, I consider it more probable than not that Mrs Long has tailored her evidence in the light of what her husband had to say. This, together with the other points made above, cause me to be cautious in placing any considerable weight upon Mrs Long's evidence. In so far as I feel able to do so notwithstanding that causation, I identify where I have below. However, I should make clear that caution is not based upon a finding of dishonesty on her part, but rather a concern that her account tends to follow that of her husband's rather than being based on independent recollection and is therefore unreliable. Had her honesty been a discrete issue in the case, I would have needed to explore this matter further; given that it is not, it suffices for me to conclude that I have concern about her reliability as a witness where her evidence is uncorroborated. This is not to say that I reject her uncorroborated evidence out of hand - for example, on one issue relating to the Claimant's alleged loss of the sense of taste and smell, I found her account convincing as noted below.
56. Each of the three of Mr Long's children who gave evidence, Peter, Harvey and Sophie, confirmed both that their father's mood and motivation had deteriorated during 2015 and that it had more recently improved. I was particularly struck by the comment from his daughter during cross examination that the voluntary work at Felbrigg Hall, that had led to paid employment "*has helped him to get into a bit of a routine and because obviously he is very like work-orientated, he enjoys working and being busy and things, so I think him volunteering and now in work it has given him like a purpose and a motivation.*" This spontaneous comment rang true and I accept the evidence of each of the three witnesses as to the deterioration in their father's condition in 2015 (which is

consistent with other evidence) and his recent improvement, with the proviso that, as each of them accepted, they knew very little of the detail of his health problems in around 2007-2008.

57. The Claimant's father, Reverend Anthony Long, gave evidence. His account was of some significance to the Claimant's condition both over the two days immediately following the accident and following his return to Shavington on Sunday 29 March 2015. Rev Long was careful in answering questions. If he were seeking to support his son's claim by giving false or exaggerated evidence, he had plenty of opportunities to add detail to his account when he was asked about events following the accident, yet he did not. Further, his measured answers gave no suggestion that he was prone to exaggeration, whatever temptation there might have been to do so out of family loyalty. I am satisfied that Rev Long was an honest and credible witness.
58. The Claimant relied upon the witness evidence of his former work colleagues, Messrs Kneubuehl, McMahon, Weston and Croston, and his former accountant, Mr Smedley, in part to substantiate his case that he was previously functioning well in his work. To that extent, the evidence was clearly both admissible and potentially of assistance. Its significance is extent undermined by the fact that most of the contact that these witnesses had with the Claimant was prior to the admitted and undoubted crisis in his health in 2007/2008.
59. The most helpful evidence in relation to Mr Long's more recent functioning was the one witness who was not called because not challenged, Mr Kneubuehl, since he was able to speak to Mr Long's presentation in particular in the period 2009 to 2011, which gave the "*lasting impression that [the Claimant] was very capable and efficient.*" I accept that this was an honest and accurate summary of how Mr Kneubuehl found the Claimant in this period.
60. The second purpose of calling Messrs McMahon, Weston and Croston (but not Mr Kneubuehl) was to support the Claimant's contention that his potential earning capacity was significantly greater than that which he was earning at the time of the accident (£51,000 per annum). Mr McMahon said that, if one were to recruit someone like Mr Long into the companies in which he is involved, it would be necessary to offer a package in the region of £150,000-£250,000 per annum together with share options; Mr Weston said that he would expect to pay Mr Long in the region of £150,000 per year; and Mr Croston, who considered himself to be employed in a role that Mr Long could fulfil, stated that he earns "*a six-figure salary.*"
61. In each case, the evidence of the witnesses is in the nature of expressing an opinion. It might be that each of them has some expertise sufficient to give opinion evidence, but that is entirely untested by the process of expert evidence being given by (usually) independent witnesses, whose duties to the court are very different from those of lay witnesses and whose expertise is made clear. None of these witnesses have carried out the kind of analysis that one would expect of an

expert witness giving evidence upon the Claimant's earning capacity, nor are any of the usual procedural protections in respect of expert evidence in place.

62. Their evidence on this issue can be looked at in a different way. Each of them bases his opinion on earning capacity upon his knowledge of Mr Long prior to the undoubted crisis in his health in 2007/2008 - indeed, in Mr McMahon's case, his knowledge of Mr Long was of a "rising star" some 15 to 20 years ago. If Mr Long were in fact capable of commanding a salary in excess of £100,000 (double what he was earning at the time of the accident) or as much as £250,000 (five times what it was earning at the time of the accident), one might wonder why he was working for the Defendant in so relatively an ill paid role. The Claimant's case is that he was doing work which satisfied him and that the level of earnings was only one issue. That may be so, but both Mr McMahon and Mr Weston agreed in cross examination that a person's current level of earnings would be a factor in determining the salary that would be offered in any new job.
63. I accept the evidence of these witnesses that, in their professional dealings with him, they found Mr Long to be competent and, extrapolating from historic experience, capable (all things being equal) of earning more than £51,000. But their evidence is incapable of supporting the conclusion that, but for the accident, the Claimant was capable of obtaining jobs earning in the range £100,000 - £250,000, on the grounds both that that is expert evidence upon which the Claimant has no permission to rely and that their evidence is insufficiently robust to support that conclusion. Furthermore, it is strongly arguable that, given the crisis in the Claimant's health in 2007-2008, all things are not "equal" and in fact his life, in particular his health, has taken a considerably different trajectory than they would have anticipated from their earlier knowledge of him.
64. Mr Craig Jones, who was called by the Defendant, gave his evidence in an entirely straightforward manner. The Claimant understandably does not suggest any motive on Mr Jones' part to misrepresent matters nor any obvious reason why his evidence should be unreliable. That said, there are certain details surrounding the accident and its immediate aftermath which require closer consideration having regard to other evidence in the case. I deal with this below.

The Expert Witnesses

65. In closing submissions, counsel for each of the parties was critical part of the expert evidence adduced by the other side. On behalf of the Claimant, Mr Grant was critical of Dr Heaney for seeking to incorporate requirements into the Mayo classification for TBI that cannot be found there. He also complained that Dr Heaney had scant regard to his duties to the court as an expert, as demonstrated by his willingness to reveal matters to the Defendant's legal team that has been discussed in the joint meeting but had not been set out in the joint statement. He criticised both Dr Heaney and Dr Bird for what he contended was an inadequate analysis of the issue of post-traumatic amnesia. He was in particular critical of Dr Bird for having initially reported on the

Claimant by way of review of medical records alone rather than medical examination. Mr Grant suggested that this was improper, if not unethical.

66. Mr Dignum QC for the Defendant was, in his own words, “*pretty uncomplimentary*” about Dr Pierce accusing her of “*batting for the Claimant*” and “*grasping for ways to make her evidence less damaging.*” He accused Dr Nichols of contending for a period of post-traumatic amnesia that was unrealistic. He suggested that Dr Nichols was occupying the ground of a postgraduate thesis, in contrast to Dr Heaney who was “*grounded in the real world.*” He described the evidence from both Dr Nichols and Dr Surenthiran in support of the fact that the claimant suffered a migrainous episode after the accident as a “*clear preplanned pincer movement.*”
67. In truth, experts for both sides could in principle be criticised for having failed fully to set out their opinions in advance of the trial and/or for having changed their opinion during the course of the case. My strong impression was that all the expert witnesses were seeking to assist the court in what they found to be a particularly difficult case. For reasons that I shall deal with later, the Claimant’s descriptions of symptoms are often florid with a distinctly functional air. The accounts have to some extent developed as the litigation has proceeded. It is not surprising that an expert dealing with such evidence and seeking to give a clear explanation of their opinion as to the probable cause and nature of the symptoms will find themselves considering new theories or at least will develop existing theories in light of the merging picture. Some parts of their evidence are more convincing than other parts. In particular where opinions were expressed for the first time in the witness box or during oral evidence developed beyond what was said in the reports and joint statements, the opinions are likely to be less convincing, if only because they are less thought through and are usually less well explored. However, I did not form the view that any of the experts was simply seeking to act as an advocate for the party instructing them; rather each was struggling with the challenges of a difficult case.
68. The attempt by Mr Dignum to cross examine on what Mr Heaney had told him about discussions during the joint meeting with Dr Nichols was, as Mr Dignum accepted, a misjudgement on his part. But, whilst CPR 35.12(4) effectively creates a privilege against reference to the contents of joint discussions during the trial, neither the Rules, the Practice Direction or the Guidance prohibit an expert telling the legal team that have instructed him about the contents of those discussions. I do not hold this matter against Dr Heaney.
69. As for Dr Bird having reported on the Claimant’s psychiatric condition without having seen him, Mr Grant referred to the so-called Goldwater rule, apparently a rule of American psychiatry that psychiatrists should not give an opinion on a patient that they have not had the opportunity to examine. Dr Bird agreed that one should be cautious about doing this and that it was possible to understand from the perspective of the patient how long it might be for a psychiatrist to diagnose

a condition that had never been diagnosed before, simply based on a review of medical records, without any face-to-face consultation. Whilst I share the concern about the wisdom (and possibly the ethics) of preparing a psychiatric report without seeing the patient face-to-face, it does not seem to me that, of itself, this undermines Dr Bird's evidence. I bear in mind however the argument advanced by the Claimant that Dr Bird reached a conclusion based on an assessment of the Claimant's condition without having seen him that may have influenced his subsequent opinions in the case.

THE LAW

Fundamental Dishonesty

70. Insofar as relevant, section 57 of the Criminal Justice and Courts Act 2015 ("CJCA 2015") provides as follows:

"Personal injury claims: cases of fundamental dishonesty

(1) This section applies where, in proceedings on a claim for damages in respect of personal injury ("the primary claim") —

- a. the court finds that the Claimant is entitled to damages in respect of the claim, but*
- b. on an application by the Defendant for the dismissal of the claim under this section, the court is satisfied on the balance of probabilities that the Claimant has been fundamentally dishonest in relation to the primary claim or a related claim.*

(2) The court must dismiss the primary claim, unless it is satisfied that the Claimant would suffer substantial injustice if the claim were dismissed.

(3) The duty under subsection (2) includes the dismissal of any element of the primary claim in respect of which the Claimant has not been dishonest.

(4) The court's order dismissing the claim must record the amount of damages that the court would have awarded to the Claimant in respect of the primary claim but for the dismissal of the claim.

(5) When assessing costs in the proceedings, a court which dismisses a claim under this section must deduct the amount recorded in accordance with subsection (4) from the amount which it would otherwise order the Claimant to pay in respect of costs incurred by the Defendant..."

71. In considering whether an allegation of dishonesty is made out, the court must bear in mind the following:

- i) The test for dishonesty is that set out in paragraph 74 of the judgment of Lord Hughes in Ivey v Genting [2016] UKSC 67:

“When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the Defendant must appreciate that what he has done is, by those standards, dishonest.”

- ii) The burden of proving that a witness has been dishonest, a proposition which is not self-evident, lies upon the party alleging it (see Robins v National Trust [1927] AC 515);
- iii) The standard for proving dishonesty in a civil case is the balance of probabilities (Secretary of State for the Home Department v Rehman [2001] UKHL 47, applying Re H [1996] AC 563);
- iv) However, an allegation of dishonesty is a serious allegation that will require appropriately cogent evidence to persuade the court (Re H op. cit.).

72. As to whether any dishonest conduct should be found to be “fundamental”, Julian Knowles J in London Organising Committee of the Olympic and Paralympic Games v Sinfield [2018] EWHC 51 at paragraph 61 conveniently sets out the law. Having reviewed the authorities, he stated:

“In my judgment, a Claimant should be found to be fundamentally dishonest within the meaning of section 57(1)(b) if the Defendant proves on a balance of probabilities that the Claimant has acted dishonestly in relation to the primary claim and/or a related claim ... and that he has thus substantially affected the presentation of his case, either in respects of liability or quantum, in a way which potentially adversely affected the Defendant in a significant way, judged in the context of the particular facts and circumstances of the litigation.”

73. In its defence, the Defendant reserved its position as to what injuries the Claimant had suffered as a result of the accident. By the time of the service of the Counter Schedule dated 18 September 2020, the Defendant’s position had hardened to the following:

- i) It was denied that the Claimant had suffered any injury (or at least any injury of significance) in the accident;
- ii) Insofar as an alternative explanation for any symptoms suffered by the Claimant was to be advanced, they were probably a continuing manifestation of a pre-existing condition, triggered by redundancy rather than the accident;

- iii) The Defendant proposed to explore the Claimant's genuineness at trial;
- iv) The Claimant had falsely represented to that his redundancy in April 2015 was or may have been accident related and that, absent the accident, the redundancy would not have caused him stress in any event.

74. In the Defendant's written skeleton argument, served for the purpose of trial, the Defendant added to this:

- i) That the Claimant was "*a demonstrably unreliable historian*" in respect of issues other than merely the circumstances of his redundancy;
- ii) That the Claimant appeared to be a man who exaggerates and therefore his evidence must be treated with the utmost caution.

75. During the trial, counsel for the Claimant at various points objected to lines of questioning by counsel for the Defendant on the ground that they went to issues of dishonesty that had not been pleaded. In this regard, I bear in mind the judgment of Newey LJ in Howlett v Davies [2017] EWCA Civ 1696. At paragraph 31 of his judgment, he said:

"Statements of case are, of course, crucial to the identification of the issues between the parties and what falls to be decided by the court. However, the mere fact that the opposing party has not alleged dishonesty in his pleadings will not necessarily bar a judge from finding a witness to have been lying: in fact, judges must regularly characterise witnesses as having been deliberately untruthful even where there has been no plea of fraud. On top of that, it seems to me that where an insurer in a case such as the present one, following the guidance given in Kearsley v Klarfeld [2006] 2 All ER 303, has denied a claim without putting forward a substantive case of fraud but setting out 'the facts from which they would be inviting the judge to draw the inference that the plaintiff had not in fact suffered the injuries he asserted', it must be open to the trial judge, assuming that the relevant points have been adequately explored during the oral evidence, to state in his judgment not just that the Claimant has not proved his case but that, having regard to matters pleaded in the defence, he has concluded (say) that the alleged accident did not happen or that the Claimant was not present. The key question in such a case would be whether the Claimant had been given adequate warning of, and a proper opportunity to deal with, the possibility of such a conclusion and the matters leading the judge to it rather than whether the insurer had positively alleged fraud in its defence."

76. During closing submissions, counsel for the Claimant made the valid point that the demands of ensuring that costs are proportionate means that a Claimant cannot be expected to incur cost in exploring factual issues in advance of a trial which are apparently peripheral, merely in order to

cover the risk that, at trial, the Defendant will cross-examine on those issues and seek to establish inconsistencies in the evidence which are then said to be evidence of dishonesty.

77. In my judgment, the court must be careful about drawing conclusions adverse to the honesty of a Claimant from evidence about peripheral issues, most particularly where the Defendant has not given adequate advanced warning of its intention to raise the particular issue. Indeed, having regard to the passage from Howlett v Davies referred to above, the court would doubtless consider preventing cross-examination in such circumstances, on the ground that fairly reaching a conclusion adverse to the Claimant and that therefore the cross-examination was inappropriate. This was the approach taken by HHJ Coe QC in paragraph 14 of her judgment in Pinkus v Direct Line [2018] EWHC 1671 (QB) and it is one with which I agree. I would have been minded to apply the same principle to cross-examination on peripheral matters which a Claimant has understandably declined to investigate, having regard to the need to conduct litigation at proportionate cost.
78. In this case, the Defendant has adequately given notice of its intention to explore the circumstances of the Claimant's redundancy. Ironically, the lack of investigation of this point has been arguably more on the Defendant side than it has been on the Claimant's (at least insofar as evidence placed before the court is concerned), a point of some significance on this issue, as identified below. However, I see no unfairness in the Defendant having been allowed to explore the issue and thereafter seeking to draw an inference of dishonesty from the evidence, given that this is a central issue in the case. Further, insofar as the court has been concerned with the genuineness of the Claimant's symptoms, his reliability as a historian has been an issue throughout the case. The alleged tendency to exaggerate has arisen more recently and in any event, as will be considered further, has been suggested at times to be a consequence of a somatic symptom disorder, rather than deliberate exaggeration. However, again, the accuracy of the Claimant's reporting is inevitably a central issue in this case. I am satisfied that, with the appropriate approach to the application of the burden of proof, as set out above, no injustice is done to the Claimant through the failure to raise this point more clearly or at an earlier point in time.
79. I should add that I have had regard to the judgment of Master Davison in Mustard v Flower [2021] EWHC 846 which was heard and decided after I heard the trial in this case and therefore was not referred to in submissions. I would agree with his analysis of the law, which is close to mine as set out above.

THE ISSUES**Issue 1 - What were the Claimant's relevant pre-accident symptoms and diagnosis/diagnoses?**

80. The following medical records set out the main events of note in the Claimant's pre-accident medical history. Except for the entry for 14 May 2008 (Dr Karbowinska-Majewska's Incapacity for Work Medical Report Form) all comprise conventional medical records relating to the examination and treatment of the Claimant. Where they are quoted verbatim, the passages appear in italics. Other passages not in italics are summaries.

- 3.3.90 **Discharge summary from Leighton Hospital:** *“This 16 year old boy was admitted via A&E with abdominal pain. All investigations were normal. The pain settled on conservative treatment and Stephen was allowed home well the following day.”*
- 17.12.92 **GP:** anterior knee pain.
- 26.01.93 **GP:** examination of joint under anaesthesia.
- 26.10.93⁸ **Out of hours GP:** ? passing blood per rectum. *No blood seen.*
- 29.01.99 **Dr Farrell, consultant rheumatologist:** *“... I gather that he has had pain in the hip and knee region for seven years after having an arthroscopy in London when he was told that various bits of bone had to be removed... It has since been painful and was worse last year... It is quite significant that although he has an eight-month-old child, he has had a sleep disturbance for 2 to 3 years,, getting a couple of hours sleep at night and usually getting up and walking around doing things after about 1 PM. I think this may be relevant... I would regard Mr Long's symptoms, in terms of his knees, as somewhat non-specific and I think may well be related to the fact that he has a chronic sleep disturbance, although not frank fibromyalgia. This is of course against a background of a long history of knee pain. I do not think there is anything to suggest that he has an inflammatory arthritis and I suggested that the most useful step would be to learn a quads exercise regime and build up his quads long-term and see him on a PRN basis.”*
- 19.04.06 **GP:** *“Acute tonsillitis also joint problems will return after bloods ...”* – erythromycin prescribed.
- 1.06.06 **GP:** *“had a chat to patient regarding multiple joint pain. Has had this since 18. Started with knee pains inv no diagnosis. Got worse over seven months. In all joints (ankles, knees, hips, wrist. Not in small joints) not swollen but feels like swollen. Stiffness in the morning esp ankles. No chest symptoms. No bowel symptoms. No sob. No past history of urethritis.... Advised will refer possibility of fibromyalgia.”*
- 9.06.06 **Referral letter from GP to rheumatology:** *“This gentleman presented with complaints of multiple joint pain since the age of eighteen. He initially started off with knee pain and was investigated with an arthroscopy, but no diagnosis was given. All joints in his hands and feet do not seem to be affected. He does not seem to have swelling or stiffness of the joints apart from his ankles which do tend to get*

⁸ Mr Grant QC suggested this note was dated 1999. I read it as 1993, though nothing significant turns on this.

stiff in the mornings. He seems to be feeling tired most of the time.....Mr Long is convinced that he has some form of arthritis....”

- 5.09.06 **Dr Pradeep, rheumatologist:** *“Thank you for referring this 33-year-old gentleman who is a business consultant. He has suffered with multiple joint pains since the age of 18 and tells me that he has had an arthroscopy for the left knee pain and some sort of minor surgery on the patella. He has always had achy joints and for the last two or three years he has had more pain affecting his feet, ankles, knees, wrists, hands, hips and elbows. He denies any neck or back pain. There is no swelling of the joints but the joints are stiff and can be stiff for up to 20 minutes. He has had some mouth ulcers recently but this is not a recurrent problem.... On examination of the joints there was no joint tenderness, no synovitis, he had eight tender points in the regions consistent with a possible diagnosis of fibromyalgia.... I have stressed the importance of regular exercise. I have also referred him for some physiotherapy...”*
- 31.01.07 **GP:** fibromyalgia.
- 31.01.07 **Dr Pradeep:** Diagnosis: fibromyalgia. Current medicines: ibuprofen PRN. Advised amitriptyline 10 mg at night for two weeks, dose increase to 25 mg subsequently. *“Currently he is still suffering with widespread pain and fatigue... I have explained the most likely diagnosis is fibromyalgia”.*
- 8.02.07 **GP:** Tonsillitis. Third episode in six months. Keen for a tonsillectomy. Explain may not cure problem. Erythromycin
- 13.03.07 **GP:** fibromyalgia. Says he has been diagnosed with fibromyalgia. Very exhausted. He is on amitriptyline. Plan: wants more amitriptyline, painkillers and rest.
- 12.4.07 **GP:** fibromyalgia pains all over, worse, like bee stings; amitriptyline was very successful
- 27.04.07 **GP:** *“fibromyalgia worsening. So weak had a fall recently. Tried working yesterday. Could not cope. Explained treatment difficult. Happy to try anything. Amitriptyline 75 mg at night. Add Co-codamol, zopiclone if cannot sleep...”*
- 19.06.07 **GP:** fibromyalgia pain ongoing. Add paracetamol. Increase amitriptyline to 100 mg. Increased tramadol to 400 mg, zopiclone prn awaiting rheumatology mid-July
- 18.07.07 **Prof McGregor, consultant rheumatologist:** *“Problem: chronic widespread pain. This man’s widespread joint symptoms continue at a level that is preventing him from working and driving. He describes getting out of bed as ‘a nightmare’. Symptoms involve the hands, elbows, hips, knees and feet. He feels that his thumb joints lock, he feels his hands are swollen and his knees are swollen at night.... Examination shows no signs of inflammation involving the peripheral joints... He was diffusely tender in the mid lower lumbar region... His degree of symptoms does not correspond with physical findings. The assessment that this is a manifestation of fibromyalgia is probably a reasonable one, however I think it would be worthwhile repeating investigations at this point to look for underlying inflammatory disease... His pain management is a problem...”*
- 30.07.07 **GP:** Patient reviewed in hospital 10 days ago and rheumatologist suggested changing his medication – MED5 till 26.08.07

- 05.09.07 **GP:** *“Discussion re-analgesia – only takes paracetamol. stop amitriptyline by decreasing for two days then leaving off before starting gabapentin and increasing dose up. Due back in rheumatology on 19/09...”*
- 13.09.07 **GP:** *“Triage hip pain – laterally – brewing but not so severe before. Poor sleep – nightmares. Sleeps when taking zopiclone. ? Side-effects of gabapentin or coming off amitriptyline so will now add back in amitriptyline at 50 mg. See rheumatologist next week as planned.”*
- 19.09.07 **Prof McGregor:** *“Problem: widespread pain ... He found that he needed all his analgesic medication and indeed had difficulty reducing his amitriptyline dose because of problems sleeping and nightmares. In the last two weeks he has been started on gabapentin. There has been no significant change in the pattern of symptoms...”*
- 25.10.07 **GP:** fibromyalgia ongoing pain. Titrate up gabapentin at 300 mg every three days until pain controlled up to 3.6 g daily, refer pain team. Await physio. Review one month. Sooner if problems.
- 20.11.07 **GP:** Fibromyalgia ongoing, gabapentin some improvement. Continuing to see physiotherapy and pain clinic MED 3 1 month fibromyalgia
- 19.12.07 **Dr Sanders, consultant anaesthetist at the pain management centre:** *“Many thanks for asking us to see this interesting gentleman who complains of widespread joint pain that has been present for approximately a year and has had a devastating effect on his life. His pain started really quite suddenly and has been progressive both in terms of severity and spread. Consequently he has been unable to work for the last six months and is now no longer employed as a business consultant. The pain has had a significant impact on his family life, where he lives with his wife and four children. I understand that he has been comprehensively assessed by the rheumatologists and has been commenced on a combination of amitriptyline, gabapentin, zopiclone, meloxicam, paracetamol and tramadol... This gentleman’s widespread pain has been called fibromyalgia and there is no particular reason to doubt this diagnosis. The effect of his pain has been dramatic on his quality of life and we discussed the psychological consequences of chronic pain today. I think ultimately he may well be a candidate for a pain management programme and, I think, should probably meet with our pain psychologist of an early stage... We discussed the role of medication. The dose of gabapentin has not really impacted on his pain and I think they should not be taken down to stop and be replaced with pregabalin. I would also consider adding an SNRI such as venlafaxine or duloxetine... We also discussed the use of tramadol. I would recommend that this is reduced...”*
- 10.01.08 **GP:** Medication review with patient pain management. Stop gabapentin. Start pregabalin, not keen on venlafaxine at present will consider slowly stopping tramadol later MED3 1/12 fibromyalgia
- 24.01.08 **GP:** Sore throat symptoms two weeks. White patch back throat and sore/red? Ulcer? Infection - Erythromycin
- 31.01.08 **Dr Sanders:** *“I was pleased to review Mr Long today, though sorry that he seemed quite sleepy on the increased dose of pregabalin. We had a long chat about his use of medication and I think overall he is very sensible. He clearly has a goal in terms*

of his business opportunity that has presented itself and hopefully he will be able to focus on this over the next few months and distract himself from some of his pain. I have suggested he reduce his pregabalin a little if his cognitive impairment does not improve over the next day also open (he has just increased the dose). I suspect he may be better off on a smaller dose of pregabalin in conjunction with an SNRI such as duloxetine..."

- 07.02.08 **GP:** allergy: pregabalin 25 mg; Had a chat to patient. Seen by pain team. ? Pregabalin caused mouth ulceration, so stopped, now advised venlafaxine
- 21.02.08 **GP:** Had a chat to patient. Venlafaxine helping, wants to stay on it at present, due to see psychotherapist next week
- 25.02.08 **GP:** Sore mouth. 2 cm x 0.5 cm ulcerated lesion on right, back of throat and small lesion on left. ? Pain clinic
- 06.03.08 **GP:** Improving with steroids so I feel no further action re-mouth ulcers
- 18.03.08 **GP:** *"MED3 doctor's statement 1 month fibromyalgia; had a chat patient copy of sick notes 20.12.07 - present date mouth ulcers re-occurred, will restart treatment will continue venlafaxine, seeing pain team early next month."*
- 03.04.08 **Dr Sanders:** *"I was pleased to review Mr Long and he seemed much better today. He has come to a sensible analgesic regime and the addition of the venlafaxine has been helpful. He is clearly busy with his new business and I am sure this is a positive development..."*
- 04.04.08 **Dr Christmas, clinical psychologist.** *"... He described having a very difficult year coping with the pain and with being signed off work, however things seem to have improved significantly in the last few months. He attributed this to the stabilisation in his medication regime and introduction of venlafaxine. I also feel that he has probably made some psychological shift in the past few months which has brought him into a position of being much more accepting of his pain. From a mood point of view, Mr Long described this as "not on top of the world", but much improved. He said that he has accepted that he has to get on with his life with the pain and has been working hard to rehabilitate himself physically and in terms of his psychological state. He said that his wife has commented that he is, at times, snappy and irritable which is a very normal reaction to chronic pain... he is about to settle in his compensation case against his former employers and whilst he still feels aggrieved at their behaviour, he is pleased to draw a line under the process. He is setting up his own business and is ready to launch it in the next two weeks. He hopes that his improved financial position once he is working again will have a widespread positive effect on his life. Mr Long recently attended hydrotherapy and found it very useful. He has his own pool at home and so will continue exercises this once the pool heating is switched back on (in a month). He walks his dog 1½ miles a day and has gradually build up his tolerance for walking from a starting point a year ago of only being able to walk around the block. He uses gym equipment at home once a week to maintain muscle strength. He was familiar with the principles of pacing and keeps himself steadily active but not overactive. Whilst he finds this frustrating he has accepted that jobs will now take him longer to complete. Overall I felt that Mr Long is coping exceptionally well with his chronic pain. He feels that he has only just emerged from a very difficult period and he preferred not to be discharged straight away. We therefore agreed that we would meet again in three*

months' time to review his progress and building upon the gains he has made in the last months..."

- 02.05.08 **GP:** General symptoms NOS says permanent mouth ulcers? Generalised symptoms non-specific bloods all normal
- 08.05.08 **GP:** Medication taken at that time: amitriptyline 100mg at night, zopiclone 7.5 mg one at night, tramadol – maximum 400 mg per day, venlafaxine – 37.5 mg twice a day and Meloxicam 15 mg pd
- 14.05.08 **Sarah Wood, clinical physiotherapy specialist:** *"...He presented with widespread joint pain which he reports has become more aggressive over the past two years. He reports that his pain can be aggravated by any activity or movement of walking. He described problems with a grip in his hands and that he regularly drops things. He has difficulty getting to sleep at night and is woken during the night mainly by pain in his shoulders and arms. First thing in the morning he has stiffness in his feet for approximately half an hour. He attended for a course of hydrotherapy to commence a graded exercise program... He reported that his hips felt more mobile but that his other joints were ISQ and he still experienced constant pain when walking. He reports that he is able to walk his dog for approximately 1¼ miles at a time... We talked about slowly increasing his exercise tolerance by referring him to a gym class... He failed to attend any of his gym classes and therefore has been discharged from the physiotherapy department."*
- 14.5.08 Incapacity for Work Medical Report Form completed by **Dr Karbowinska-Majewska, a Registered Medical Practitioner and approved disability analyst:**
"Description of functional ability:
Had an accident 1 week ago. They suffered a significant flood due to poor concentration and poor memory. Experiences moderate mood swings most days. Has become irritable every day. Was very concerned and did not sleep well because of coming here today. Very rarely goes out alone due to lack of motivation. Does not experience panic attacks. Feels uncertain about being able to cope with work. Keen to work but physical problems are the limiting factor...
Evidence to support the decision not to apply the mental health part of the assessment:
although the customer is suffering from mental health problems, in my opinion, the physical problems are significantly more disabling. The mental health assessment is therefore not required...
Assessment depression: moderate depression..."
- 27.06.08 **Dr Ferdousi, consultant in Oral Health Department:** *"... he mentioned recurrent oral ulcers which have been present most of the time for the last six months.... On examination there was a small 3–5 mm ulceration at the right soft palate which was healing and there was also a small ulcer on the tip of the tongue which was also healing. There were no neck nodes palpable.... He will be seen again in six weeks."*
- 2.07.08 **Prof MacGregor:** *"Problem: fibromyalgia/chronic widespread pain. Treatment: meloxicam, tramadol, venlafaxine, amitriptyline, paracetamol.... Positive reports from the pain clinic and Dr Christmas are noted. Mr Long reported a fluctuating level of symptoms today and in recent weeks has had particular problems with pain in his hands and arms ...It is conceivable some of the recent symptoms that he is*

reporting may be drug related, I am hesitant to suggest any changes today. I do not think further investigations at this point are warranted. He continues under the care of the clinical psychologists and I think is benefiting greatly from this. I have made no further specific recommendations today but will keep under review.... ”

- 4.07.08 **Dr Christmas:** *“I met with Mr Long for a review appointment today. You will remember that he has a diagnosis of fibromyalgia and when I last saw him in April he was managing his pain very well. He told me today that over the last months his pain levels have been increasing and he has been finding it difficult to manage. He is aware that he probably needs a medication review... He is experiencing problems with fine motor coordination... he was told by Professor McGregor his motor coordination problems might be attributable to his venlafaxine. Mr Long has been trying to set up his own business, in the hope that working in a self-employed capacity will be more manageable than as an employee. However he has hit various barriers in terms of setting up the business including some practical issues (he works a great deal with computers and using a keyboard and a mouse exacerbated the pain his hands and wrists)... He said that he would like to have some further support in helping him to manage exercise and pacing, and I have therefore put his name on the waiting list for pain seminars...”*
- 10.07.08 **GP:** *“...discharged from pain clinic and also seen in rheumatology last week. Told to come back to GP to change meds. Fine motor skill problems ? from venlafaxine so ? stop this – Professor McGregor suggested. Will increase amitriptyline up by 25 (mg), preferably after two weeks without venlafaxine. On top Meloxicam and also top doses of tramadol so cont...”*
- 14.8.08 **SHO to Ms Prince, Oral & Maxillofacial clinic:** *“I have reviewed this patient today in the oral health outpatient clinic with regard to recurrent oral ulceration...On examination no ulcers have been seen and there was no scar...”*
- 19.09.08 **Ms Pai, Oral Maxillofacial Department:** *“Mr Long was seen in Miss Princes’ clinic ... with regards to frequent recurrent oral ulceration which has been present for the past year. He complains about crops of ulcers numbering more than 10 to 12 at a time on his tongue and throat which are very painful and sometimes they are the size of a fingernail.... On examination today the oral mucosa looks soft, moist and healthy. There were no ulcers on the tongue....”*
- 11.11.08 **GP:** *Fibromyalgia flareup of chronic joint pains. On several medications with initial moderate improvement but got gradually worse over the last few days. Pain clinic referral. List of options does not seem very long. Try a short course of prednisolone.*
- 18.11.08 **GP:** *“Had a chat patient. Feels better ++ on steroids. One further week. 15 mg of prednisolone. I will write to rheumatology. ? what next, pt will contact the pain clinic ? seminars”*
- 22.12.08 **Prof McGregor:** *“Thank you for your letter about this man reporting a response in symptoms following the use of prednisolone. In the absence of any other objective evidence of inflammation, this is very difficult to evaluate given the fact that, as you say people with widespread pain for many causes of the report response to steroids. Looking at this man’s records my inclination would be not to use long-term steroids or anti-inflammatory agents to control his symptoms...”*
- 9.01.09 **Miss Prince, consultant oral and maxillofacial surgeon:** *“I have reviewed this man with regard to his recurrent oral ulceration. He tells me that he is generally*

better and I believe he recently had a course of oral prednisolone at the time he gave the Betnesol mouthwash. Following this his oral condition has significantly improved ...”

- 4.03.09 **GP:** Repeat prescription monitoring. Repeat medication for fibromyalgia. Also sore throat. Has ulceration over right tonsil. Tonsils enlarged. Amitriptyline, tramadol, benzocaine throat spray
- 22.03.10 **GP:** Acute tonsillitis. History of recurrent tonsillitis. Unwell five days, feverish and flulike. Complaining of painful throat and purulent tonsils last 48 hours – Erythromycin
- 8.07.09 **Dr Lapraik, SpR in rheumatology:** *“Diagnosis: probable fibromyalgia... He had a course of steroids in November last year, 15 mg daily for a week which he responded very well to. He felt this significantly improved his joint symptoms as well as making him feel generally well. Despite this response to steroids, he does not have symptoms that suggest an inflammatory arthritis. His most symptomatic areas at the moment are his hands. In view of this being the most symptomatic area present, I have organised for a musculoskeletal ultrasound to look for evidence of synovitis...”*
- 30.08.09 **Dr Lapraik:** recent x-rays and ultrasound scan of your hands are normal... No evidence of joint damage or joint inflammation... Blood tests from July are all normal apart from a slightly elevated liver test... No evidence at present of an obvious inflammatory arthritis...
- 19.04.10 **GP:** Earache symptoms. Complaining of left earache sudden onset 17/4/10, note started second course of antibiotics after telephone review for ongoing sore throat. On examination left auditory canal swollen red and eczematous. Will complete erythromycin – ear drops too
- 26.04.10 **GP:** Still struggling with? Pharyngitis, tender palpable submandibular glands, left earache and now also mouth ulcers. Has had two courses of antibiotics +1 week of eardrops (ear is slightly better). Patient says has had similar ongoing problems in the past.
- 24.06.10 **GP:** On examination parotid swelling. Swollen right-sided facial swelling for 24 hours – Ciprofloxacin (anti biotics)
- 25.01.11 **Mr Hadinnapola, oral maxillofacial surgeon:** he has been unwell with non-specific symptoms in his head and neck area for quite some time he has been checked out by my rheumatology colleagues in the working diagnosis is possible fibromyalgia. He now complains of swelling of his saliva re gland, difficulty swallowing and consular ulcers. He had a nasal endoscopy done which did not show anything very much untoward apart from enlarged tonsils. He had an ultrasound scan done with regards to the enlarged salivary glands which certainly does show diffused enlargement of both of his parotid and submandibular glands ...
- 28.02.11 **GP:** complaining of a painful swelling on right side of neck and face. Still ongoing. Awaiting biopsy... Ongoing pain with fibromyalgia. Asking for stronger analgesia. Using high dose tramadol (400 mg daily) and meloxicam, amitriptyline, previous

- use of gabapentin and pregabalin. Can try Butrans 10 whilst cutting down tramadol. We can review as required
- 1203.11 **GP:** biopsy of the lesion of salivary gland.
- 05.04.11 **GP:** Acute tonsillitis recurrence of tonsillitis. On examination pustular both tonsils left worse than right - Erythromycin
- 12.04.11 **GP:** telephone encounter with patient. Requesting further Butrans. Finding these helpful and no side effects, has been to pain management clinic in past and tried multiple medications. Has reduced amitriptyline to 75 mg at night. Wants to try and reduce further if possible.... Butrans 10 µg per hour once weekly.
- 19.05.11 **Dr Gaffney, consultant rheumatologist:** “... *Stephen is a 38-year-old business consultant who now works from home, having lost his job because of his illness. He has a young family and still enjoys keeping relatively fit by going to the gym. As you know, he has lots of unexplained symptoms, including chronic musculoskeletal pain with some swelling, early-morning stiffness, mouse/palate ulcers, parotid swelling (biopsy showing plasmacytosis) and mild acne.... Personally, I have difficulty attributing all of the symptoms to unrelated pathologies as the presentation certainly has a "flavour" of connective tissue disease...*”
- 09.08.11 **GP:** tonsillectomy
- 22.08.11 **GP:** Complaining of a headache. Had tonsillectomy two weeks ago, throat still sore. Sinuses painful. Feels hot and tense, ears also hurt. On examination tender right maxillary sinus, throat raw and red. Advised to continue Corsodyl can take naproxen for headache and Erythromycin to cover for sinusitis
- 05.09.11 **Dr Gaffney:** “...*Stephen underwent his tonsillectomy approximately four weeks ago but it is probably a little early to know how much better he is overall. He found the procedure quite traumatic but he's making a good recovery now, eating well etc...*”
- 24.10.11 **GP:** fibromyalgia recurrence of long-standing symptoms of aches all over, patient identified the symptoms as is usual fibromyalgia, seen recently by rheumatologist, follow-up in January. Advised to cautiously increase Butrans to 20 µg per hour. May even consider alternative approach like acupuncture.
- 15.11.11 **GP:** Patient reviewed. Ongoing pain, Butrans helps but makes tired. Awaiting rheumatology review. Then ? pain clinic, intolerant to pregabalin and gabapentin. Add paracetamol. Continue Butrans 20 µg/h but and buprenorphine P R.N. Patient will phone Dr Gaffney
- 06.02.12 **Dr Gaffney:** “*We have searched extensively for evidence of any specific underlying connective tissue disease... but to date have drawn a blank. It is clear that steroids modify his symptoms dramatically, would support inflammatory basis for these... I therefore started him on prednisolone 15 mg daily...*”
- 16.02.12 **GP:** muscle pain generalised myalgia/arthralgia pain continues. See rheumatology clinic letter seventh of February. They cannot identify the nature of the pain but suggested prednisolone and maybe even methotrexate in the future. Patient in tears.

Constant aches everywhere all the time. Difficult situation to manage. Can start with increased Butrans from 20 to 30 µg/hour then review one week.

24.02.12 **GP:** patient reviewed... Rheumatology review. Pain settles on Butrans patch and steroids... Butrans 10 µg/hour twice weekly buprenorphine 400 µg sublingual tablets. Zopiclone 7.5 mg, amitriptyline 25 mg prednisolone 2.5 mg

17.03.12 **Out of Hours Call Incident Report:**

“Reported condition: temp and sickness since yesterday – on lots of medications including steroids, not keeping them down. Feeling very cold today.

Consultation details:

History: Vomiting all day yesterday and feverish for 2 days. Has had a headache and a green tinge to vision. Feeling dehydrated. He is having investigations for an inflammatory illness. Has been taking prednisolone for 6 weeks but not able to tolerate at the moment. Other medication: meloxicam, amitriptyline, temgesic butrans patches. Feeling very unwell and concerned about medication.

Examination: Looks rough... ”

12.06.12 **Dr Gaffney:** *“Diagnosis: chronic pain of uncertain aetiology – unfortunately Stephen didn’t improve following a trial of prednisolone which he has now discontinued. He still complains of extensive chronic pain but, as before, there are no objective findings. On a positive note, his throat symptoms have improved a lot following tonsillectomy. His maintenance medication includes Butrans patches and sublingual Temgesic. I have arranged an MRI scan of his hands and if there is any evidence of synovitis, I would consider some immunosuppressive treatment... I have also asked Dr Mark Sanders to review him in the pain management centre... I explained to Stephen that there may not be a solution and that he needs to focus on coping strategies for pain self-management. He is still managing to work in progress with many aspects of his personal life. ”*

31.07.12 **Dr Gaffney:** MRI scan of the hand appeared normal

2.10.12 **Dr Porter, consultant in pain management.** Currently Mr Long is relying on buprenorphine supplementing it with Butrans patch. He also takes meloxicam, paracetamol and amitriptyline in varying doses. He has tried gabapentin/pregabalin but it was not particularly helpful... I do think that Mr Long's buprenorphine consumption is not sensible. At this point with normally consider converting him on to stronger appeared and our choice would normally be methadone or tapentadol.

2.01.13 **Lorraine Tweedy, specialist nurse practitioner at the pain management centre:** *“I reviewed Mr Long in the nurse led chronic opiate clinic this morning. I understand from Mr Long today that in actual fact he has stopped all his medication due to the intolerable side-effects he felt he was having, which included nausea and vomiting and cognitive impairment. Although he feels much better in himself, his pain control remains an issue. We discussed medication at some length and I understand previously Mr Long was taking tramadol which he would like to trial this again. I therefore wonder if you would be kind enough to prescribe him a mixture of 100 mg in a long acting preparation and 50 mg in short acting tablets that he can take up to a maximum dose of 400 mg daily. We discussed further pain management strategies and Mr Long is keen to attend our pain management seminars...”*

- 23.04.13 **GP:** medication review. Using Tramulief and tramadol up to 300 mg in 24 hours...
- 10.05.13 **GP:** patient reviewed emergency appointment. Aches and pains all over. No help with tramadol anymore. Worried. Will discuss with ENT as facial swelling over the parotid. No information. Warm to touch. Butrans 5 µg/hour transdermal patches. One every seven days.
- 31.05.13 **GP:** Patient reviewed. Feels pain is slightly better. Not taking Tramulief SR, only tramadol as prn, but feeling sick. Adding anti-sickness. No message from ENT. Refers urgent, bilateral carotid pain, back of throat
- 18.06.13 **GP:** Telephone encounter. Has been in a lot of pain, chronic inflammation of parotid gland which has been constantly swollen six years. Biopsies negative. Has not booked for pain seminars yet, get in touch as he was offered methadone but can be done by pain clinic only. Patches made him sick and had stopped them two weeks ago.
- 21.06.13 **GP:** Refer to pain clinic. Pain and symptom management not getting much relief from opiates. Plan restart amitriptyline?? Venlafaxine?? Mirtazapine and refer to Dr Notcutt regarding Subutex. Amitriptyline 10 mg. Increasing dose to 30 mg over four weeks.
- 21.06.13 **GP Referral letter to Dr Notcutt at the Pain Clinic, James Paget Hospital, Great Yarmouth:**
- “I am wondering whether you would be able to help with managing this patient’s pain. He is quite complex case and has been unsuccessfully managed by the pain clinic and the department of rheumatology here at Norwich for many years. He has had various investigations with nothing actually been turned up. He has very clear and multiple widespread joint pain and more recently parotid swelling which actually prevented him working. He even had a biopsy of his saliva gland which was negative. He has been tried, as he would expect on the various range of medications and currently is on Tramulief SR 100 mg, Meloxicam and tramadol 50 mg as needed. He also takes some zopiclone at night-time... As is often the case with these patients when they are quite complex, they tend not to respond to the usual range of medication is available to us... I am going to try him on amitriptyline as I think it is quite a good drug at night-time...”*
- 24.07.13 **Lorraine Tweedy:** *“I reviewed Mr Long in the nurse led opiate clinic this morning. I understand Mr Long’s pain became significantly worse three weeks ago and you kindly started him on amitriptyline 25 mg at night. Today is the long tells me that this has helped significantly but he is unable to tolerate morphine due to nausea and vomiting. He has restarted his tramadol at 100 mg per day with 50 mg for breakthrough pain. Mr Long tells me he is taking the maximum dose of 400 mg daily. It is very apparent that Mr Long is keen for his medication not to escalate any further and again we had a discussion about pain management seminars which Mr Long is going to book today before he leaves the clinic. I wonder also if it would be worth converting the short acting tramadol to a long acting preparation ...”*
- 12.10.13 **A&E attendance:** Attended A&E department with a complaint of injury to ankle. Diagnosis sprain/ligament injury ankle joint. History: off roading in jeep last week. Walked in slight limping gait. Left ankle caught under jeep seat when it rolled.

- 24.12.13 **Sarah Lister, Pain Physiotherapist at Pain Management Centre:**
“Today Stephen completed the second of our two pain management seminars. He completed an activity diary which showed a sensible balance of busy and quiet times. However it is clear that he is quite frustrated at an apparent lack of identifiable aggravating easing factors and as a result of this finds it difficult to plan activities. He has found zopiclone effective in helping him sleep at night however this is limited to 6 hours maximum per night. Although he spends time resting whilst watching television he does not actively use any relaxation techniques and is interested in learning about these. Stephen describes low motivation with regard to exercise partly because he feels he has lost so much of his previous fitness since the onset of his pain. He describes one of his key long-term goals to be able to jog again. Stephen has not had any physiotherapy input for over three years and is very keen to learn some appropriate exercises to both help ease his back and progress his fitness ...”
- 22.01.14 **Sarah Lister:** *“I reviewed Stephen in my physiotherapy pain management clinic today. Since completing our pain management seminar, Stephen has been experiencing an exacerbation of his back pain which has continued for the past three weeks, although is gradually subsiding. He reports his back feels very stiff and tight despite attempting gentle exercises he has been unable to progress due to the pain. He is very keen to resume gentle work at his home gym but is struggling due to the pain...”*
- 8.05.14 **GP:** Sore throat symptom and headache, one week. Getting ulcers in his mouth. Has had tonsillectomy. Temperature today normal. On examination: throat: mild erythema, no pus, a couple of aphthous ulcers in the mouth. Patient already on high dose of analgesia – change meloxicam to diclofenac
- 29.05.14 **GP:** Medication review with patient. He is having issues with pain relief as it is not controlled with current medication. Seems to be experiencing a lot of muscle spasm. Plan:... To try muscle relaxant...
- 20.06.14 **GP:** *“Complaining of pain. Has fibromyalgia and pain is worse again. Sharp pains in knees and ankles. Previously has not tolerated gabapentin or pregabalin. Has been on higher doses of amitriptyline and tolerated that fine. Increase amitriptyline to 30 mg nocte and after three days to 40 mg nocte if needed.”*
- 11.07.14 **GP:** repeat prescriptions: amitriptyline 10 mg, zopiclone 7.5 mg, paracetamol 500 mg twice four times daily.
- 4.09.14 **GP:** Fibromyalgia. All stable on medications. Has titrated up amitriptyline as he has been advised and this is now on 50 mg nightly which seems to be suiting him.
- 6.02.15 **GP:** *“Feels need to increase amitriptyline as not working as well anymore. Wants to do slowly as strong affect in the past. Given 10 mg tablets. Also uses zopiclone when away with work and not working anymore. Would like alternative. Try zolpidem...Feels lump, sore has come up over the past two weeks. Feels like xiphisternum – but is sticking out and tender. Will arrange ultrasound scan...”*
- 3.03.15 **GP:** Ultrasound scan – soft – Painful xiphisternum – There is slight regularity of the cartridge outline of the xiphisternum and some low-grade associated

hyperaemia. This is non-specific but could represent a minor traction condition –
Dr Marshall, consultant radiologist

81. The Claimant’s corresponding working history is dealt with at paragraphs 5 to 23 of his first statement. In summary, he had worked in a variety of roles in IT since leaving university, sometimes employed by others, sometimes in companies that he had set up or on a freelance basis. His working life was disrupted by health problems from 2006 to 2011, though the only prolonged period of being out of work was in 2007. His employment with the Defendant had started in 2014. He had served a probationary period and then had been taken on in a permanent role. He states that he had a full attendance record with the Defendant. The Defendant has not disputed this despite having the means to do so if it wished. Further, in a questionnaire provided by the Defendant to Scottish Provident after his employment was terminated, it is asserted “*no previous sickness absence.*” Accordingly I accept the Claimant’s assertion as to his full attendance record.
82. However, on 10 March 2015, the Claimant says he made the discovery that his job was at risk of being made redundant referred to on the issue of collusion above. The circumstances of that discovery are set out further at paragraphs 170ff below.
83. Before turning to the expert evidence within this case, certain points can it seems to me properly be made simply from a lay review of the medical records:
- i) The Claimant is a relatively frequent attender at his General Practitioner and has had multiple referrals to other medics. Indeed, he acknowledged in cross-examination that he was not slow to seek medical treatment where he felt it was called for.
 - ii) Except for the report of Dr Karbowinska-Majewska, no attending medic diagnosed the Claimant with depression prior to the accident, notwithstanding frequent attendances (including on a physiotherapist on the same day as the examination by Dr Karbowinska-Majewska).
 - iii) Dr Karbowinska-Majewska’s diagnosis of moderate depression lies ill with her assertion that it was unnecessary to refer the Claimant for treatment, in particular where it must have been apparent that any depression was not in fact being treated.
84. There is no significant disagreement in expert opinion on the issue of the Claimant’s pre-accident diagnosis save as between the neuropsychiatrists.
85. The neurologists noted that he had been diagnosed with fibromyalgia. Dr Heaney considered that the history of chronic pain with prescription of pain killers was relevant to symptoms after the accident. Dr Nichols indicated that the diagnosis and management of fibromyalgia does not fall within the usual expertise of a neurologist and deferred to rheumatological opinion. He considered that the potential impact of the pre-accident symptoms on the Claimants symptoms after the

accident fell within the domain of the neuropsychologist and/or neuropsychiatrist rather than the neurologist.

86. The neuropsychologists agreed that there was no evidence that the Claimant suffered neurological or neuropsychological disorder prior to the accident. They defer to the neuropsychiatrists on issues of pre-existing psychiatric symptomatology. They noted that he had previously reported cognitive difficulties and fatigue in the context of pain management and analgesia but that there was no evidence of continuing cognitive difficulties the time of the accident. They noted that, while he reported that the symptoms of fibromyalgia had resolved prior to the accident⁹, the medical records indicated that he continued to be prescribed medication for pain symptoms and sleep problems.
87. The neuropsychiatrists, Dr Bourke and Dr Bird, agree that the Claimant had a history of what Dr Bourke calls “*somatoform vulnerability*”, defined by him as a “*propensity to develop symptoms in the absence of an established alternative medical diagnosis to explain their cause*”, or what Dr Bird calls “*physically unexplained symptomatology, with disproportionate and persistent thoughts about the seriousness of his various symptoms.*” The issue between them is as to whether his pre-accident condition is properly diagnosed as a Somatic Symptom Disorder (“SSD”). The diagnostic criteria for this condition are set out in DSM5 as follows:
- “A. *One or more somatic symptoms that are distressing or result in significant disruption of daily life.*
- B. *Excessive thoughts, feelings or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following: 1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms. 2. Persistently high level of anxiety about health or symptoms. 3. Excessive time and energy devoted to these symptoms or health concerns.*
- C. *Although any one somatic symptom may not be continuously present, the state of being symptomatic is persisting (typically more than 6 months.)”*
88. ICD10 says of somatoform disorders: “*The main feature of somatoform disorders is repeated presentation of physical symptoms, together with persistent requests for medical investigation in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient...*”
89. Dr Bourke notes evidence of distress in the presentation of symptoms prior to the accident but indicates that this reduced once a diagnosis of fibromyalgia was made. He considers that the Claimant’s condition was brought reasonably under control by summer 2014. Whilst there may

⁹ This being the account given to Dr Pierce.

have been a tendency for the fibromyalgia to recur particularly in response to stresses, the Claimant's post-traumatic symptoms are better diagnosed as a Functional Neurological System Disorder (FNSD), consistent with a pre-traumatic vulnerability to functional symptoms as demonstrated by the history of fibromyalgia, together with a depressive episode. Dr Bourke considers that the Claimant has also developed an SSD but that this has only arisen since the accident. For reasons set out below, he considers that the diagnosis of SSD could only properly be made once the Claimant's depressive order began to abate.

90. Dr Bourke was cross examined about the pre-accident medical records with reference to the statement in ICD10 referred to at paragraph 88 above. In particular, he was taken to the following:
- i) The discharge summary of 3 March 1990 relating to abdominal pain. He agreed that this indicated that the Claimant was complaining of abdominal pain and investigations were essentially normal.
 - ii) The note of 26 October 1993 (or 1999) relating to passing blood per rectum. Dr Bourke agreed that the note said, "*no blood seen.*"
 - iii) The letter from Dr Farrell of 29 January 1999, which is the first reference to fibromyalgia, though followed a referral for anterior knee pain.
 - iv) The GP referral letter of 9 June 2006 referring to the Claimant's belief that he was suffering arthritis. Dr Bourke commented that he thought this was a typical presentation of someone with joint pain and did not necessarily indicate "*overriding and unnecessary disproportionate anxiety.*"
 - v) The attendance at the oral health outpatient clinic on 8 August 2008, recorded in the letter of 14 August 2008. Dr Bourke agreed that no ulceration as noted then, but pointed to the GP entry of 25 February 2008 which recorded the presence of a lesion which was 2 cm x 0.5 cm.
91. Dr Bourke said of the Claimant's medical history that "*this is not somebody with a chronic somatising history...this is somebody with bona fide identifiable symptoms....These are not meaningless complaint over which he was not reassured. They were complaints that gave him discomfort and as a consequence of that discomfort he attends at his GP and asks for assistance. There was nothing unreasonable about it and there is not documentation actually anywhere, I do not think, referencing his levels of anxiety or concern...*"
92. Dr Bird on the other hand considers that the variety of pre-traumatic symptoms, together with the associated anxiety and focus on health concerns is indicative of Somatic Symptoms Disorder that preceded the accident. In support of the diagnosis of a pre-existing SSD, Dr Bird draws attention to a series of pre-existing medical complaints, summarised in the first joint statement as follows:

“His complaints to his GP, walk-in clinics, specialist clinics, A&E Departments and other emergency clinics pre-accident included the following:

- *Unexplained abdominal pains for which investigations were undertaken*
- *Multiple unexplained joint pains (rather than the muscle pains which are typical of fibromyalgia)*
- *General malaise*
- *Headaches*
- *Back pains*
- *Sleep disturbances*
- *Symptoms felt to be “somewhat non-specific” but not frank fibromyalgia*
- *Feeling out of sorts*
- *Altered sensation in his toes*
- *Fatigue*
- *Being so weak he had a fall*
- *Various cognitive impairments*
- *Problems with fine motor skills*
- *Nightmares*
- *Psychological complaints including irritability, anxiety, depression and exhaustion*
- *Throat complaints and mouth ulcers after a tonsillectomy with no evidence of problems*
- *He further mentions the complaint of a lump in the chest which in fact is, he says, a ‘normal anatomical feature’.*”

93. During cross examination, Dr Bird was referred to the section dealing with SSD in DSM5, in particular Diagnostic Criterion B (see above). He was asked what the evidential basis was for reaching the conclusion in this first report that the Claimant had shown such excessive thoughts, feelings or behaviours prior to the accident, when he had not had an opportunity to see the Claimant before the report was prepared. He replied that he felt able to do so *“on the basis of probabilities and on the basis of what I had been able to access in the way of information about Mr Long.”* Slightly before this, Dr Bird had said as to the assessment of a patient’s thoughts and feelings that *“actions often speak louder than words, and certainly words about feelings,”* suggesting that the records may give a more reliable account of thoughts and feelings than the patient themselves¹⁰. It is interesting to note that, in Dr Bird’s second report (for the purpose of which the doctor had had the opportunity to speak to Mr Long) there is relatively little reference to the Claimant’s thoughts and feelings about his pre-traumatic history, limited to a passage on page 4 of that report which deals primarily with the fibromyalgia (as to which diagnosis the

¹⁰ This may be thought to tie in with the comments of Leggat LJ at paragraph 18 of his judgment in Gestmin, quoted above.

Claimant said he “*wasn’t convinced*”) and a reference to a swollen gland, “*like a massive hamster cheek*”¹¹.

94. I take from this that that Dr Bird’s conclusions about the Claimant’s thoughts and feelings relating to his historic health concerns are drawn not from the Claimant’s own account of matters (which as he identifies may be unreliable) but from the medical records. Whilst this approach may in principle be justified, the problem on the facts of this case lies in identifying precisely which elements of the medical history demonstrate such thoughts and feelings. Dr Bird commented in his oral evidence that most of the doctors from a variety of specialisms who had seen the Claimant had “*come to a conclusion that whatever they were being presented with was either atypical or else it was perhaps completely unexplained.*” The second half of this sentence is somewhat difficult to justify from the notes themselves. No doctor describes the Claimant’s symptoms as “*unexplained*” apart from Dr Gaffney, but he used the word on 19 May 2011 in a context of suggesting a connective tissue cause. On 6 December 2011, Dr Gaffney stated that the investigation for a connective tissue disorder has not been productive although the use of steroids was reducing symptoms. On 12 June 2012, he noted that steroids seem to be unsuccessful in relieving symptoms. This note is the closest that any medic comes within the medical records to making the kind of observation that might support Dr Bird’s conclusion. However, even that note is far from clear in its conclusion, nor do I have the benefit of expert rheumatological opinion as to the significance of what Dr Gaffney has to say.
95. On behalf of the Claimant, Mr Grant contrasts with Dr Bird’s assessment of the medical records other material that suggests that, notwithstanding a history of somatic symptoms, the Claimant’s fibromyalgia (or whatever terms one wants to give to his perceived symptoms) had abated with careful management. The Claimant had been weaned off opiate medication in late 2012/early 2013 and was managing on Amitriptyline to deal with chronic pain issues and medication to help with sleep problems. The evidence shows that the Claimant had a good working record and was able to maintain full time employment. For example, the Defendant confirmed in a questionnaire from Scottish Provident completed after the termination of his employment that the Claimant had “*no previous sickness absence.*”
96. Further, barring the complaints that were diagnosed as fibromyalgia (and any associated low mood or depression), the Claimant’s symptomatology as set out in the medical records at paragraph 80 above appears generally to have had a physical element, identifiable on examination

¹¹ That phrase is not put by Dr Bird in inverted comments, but I take the phrase to be a quote from the Claimant rather than Dr Bird’s own words given that the words “*hamster cheeks*” appear in inverted commas later in the paragraph and that the phrase seems an unlikely one for a medical doctor.

or by investigation. This is notable in particular in respect of his complaint of parotid problems, ulcers and the chest problem associated with the xiphisternum.

97. Of course, the Defendant points to the fact that the course of the symptoms was not entirely without periods of aggravation. The Claimant's condition was described as "*worse again*" on 20 June 2014 and on 6 February 2015 there is reference to the need to increase amitriptyline and to change the Claimant's treatment for insomnia from zopiclone to zolpidem. But the Claimant says that these are examples of his manging the fluctuating course of his symptomatology rather than demonstrating the kind of excessive thoughts, feelings or behaviours typical of a more generalised SSD.
98. In so far as the Defendant relies on the isolated reference to depression in the report of Dr Karbowinska-Majewska, Mr Grant pointed out that it was counsel for the Defendant, not the medical experts instructed on its behalf, who was placing emphasis on this matter. The medical experts accepted both that the entry was isolated and that, if it were correct that Dr Karbowinska-Majewska had diagnosed a moderate depression, it would be surprising that she thought it did not need treatment in the context of a person who was not otherwise being treated by a psychiatrist or a psychologist.
99. It is easy to understand from Dr Bird's analysis both of the Claimant's medical history and of the nature of SSD as a fluctuating condition that had he or another psychiatrist assessed the Claimant's thoughts and feelings during the period prior to the accident that they might have concluded that there was evidence of "*excessive thoughts, feeling or behaviours related to the somatic symptoms or associated health concerns*" and concluded that the Claimant met the criteria for SSD. But I am not persuaded, even on the balance of probabilities, that such evidence would have been found:
- i) The Claimant's undisputed evidence of a good recent working history for several years before the accident supports the conclusion that the problems apparent in the mid 2000s had been brought under the control;
 - ii) The evidence as to problems in the early 2010s appears to be consistent with a period of bringing opiate use under control rather than the kind of ebbing and flowing of SSD;
 - iii) The Defendant is not able clearly to show which aspects of the medical records show the kind of "*excessive thoughts, feelings or behaviours*" that are said to meet the criterion. The flares up of pain in 2014 and 2015 appear to have been isolated and not to have affected the Claimant's working capacity. The most obvious evidence of what might be thought to be thoughts feelings or behaviours characteristic of SSD appears to me to be the Claimant's presentation since the accident. However, that obviously risks confusing matters that post date the accident and may have been caused by it with the situation that

pertained prior to the accident. (In fairness to Dr Bird, I should make clear that he has not suggested that the Claimant's thoughts, feelings or behaviours since the accident can be taken as an indication of his condition prior to the accident.)

100. In my judgment, the Claimant's case on this issue is more persuasive. The Claimant has a history of somatic symptoms, probably most conveniently termed fibromyalgia, which have waxed and waned, with a period of relative crisis in the mid 2000s. This in turn led to a period of heavy opiate use, which caused its own problems but which the Claimant got over in around 2013. Since then, his condition had been largely well controlled with periods when problems have worsened and have required alterations in medication.
101. However, the other various symptoms complained of seem largely to have involved identifiable symptoms for which the Claimant was understandably seeking explanation. I reject the suggestion that the Claimant was, prior to the accident, suffering some more generalised somatic disorder that could properly be diagnosed as SSD.

Issue 2 - What were the circumstances of the accident and its immediate aftermath?

102. I have set out above the bare bones of the factual account of the accident and its aftermath from the Claimant. However, the detail of the accident and its aftermath are significant to several other issues in the case, in particular:
 - i) The reliability of the Claimant's evidence,
 - ii) The severity of his injury; and
 - iii) The allegation of contributory negligence.
103. The questions of particular note relating to the circumstances of the accident and its immediate aftermath are:
 - i) Prior to the accident, was the Claimant running or walking?
 - ii) Why did the Claimant move in the direction of Mr Jones?
 - iii) What if any external injury was apparent following the impact?
 - iv) Did the Claimant lose consciousness following the impact?
 - v) Did the Claimant suffer amnesia either for a period prior to the accident (retrograde amnesia) or for a period after the accident (anterior grade or post-traumatic amnesia)?

I shall deal with my findings on the first four of these question in this section. On the fifth question, I shall deal in this section with the evidence of Mr Long's presentation to non-medics (specifically Mr Jones, his father and his wife) in the immediate post traumatic period but will

defer my finding on the question to the next section, which deals with issue 3, because the issue requires consideration in light of the medical evidence.

104. The Claimant has given the following versions of his movements immediately prior to the impact:
- i) That he “*rushed to help ... by jogging*” (first witness statement, paragraph 37);
 - ii) That he was “*running*” (recorded in a letter from Dr Rittman dated 13 May 2015; paragraph 1 of the Particulars of Claim, repeated several times in cross examination; the word “*run*” is also used in the second attendance at the Accident and Emergency Department at CoC on 30 March 2015);
 - iii) That he was “*running ... at full pelt*” (Paragraph 3.5 of Dr Pierce’s first report). In cross-examination, Mr Long said that, by full pelt, he meant “*I was running as fast as I could to get to Craig.*”
105. The Claimant’s account as to why he says he was running or jogging (despite being pushed in cross-examination, he did not distinguish between the two words) appears to be based upon the belief that, unless his body and therefore head were moving up and down as a result of having both feet off the ground at times, he would not have struck his head on the ceiling. As the Claimant gave his evidence about his speed at the time of the accident (including the slight variations in his account noted in the previous paragraph), I gained the impression that his account might be based not so much on a clear memory of his speed of movement immediately prior to the accident, but of a retrospective rationalisation as to how he could have come to strike his head on the ceiling.
106. In contrast, Mr Jones’ account is recorded as follows:
- i) That he “*walked quickly towards me and banged his head on the door frame*” (statement prepared on 28th May 2015; similar words are used in the litigation witness statement, paragraph 4);
 - ii) That he “*walk(ed) into door frame*” (accident record, signed by Mr Jones on 27 March 2015).
107. During cross-examination, Mr Jones described his recollection of the accident as being “*reasonably clear*”. He accepted that, at the time of the accident, the Claimant and he were under pressure of time to complete their tasks in the Old Palace before handing the building back to the landlord. He also accepted that, whilst the room from which the Claimant came and the room in which he himself was standing were lit, the room in the middle, the pool room, was unlit. He accepted that the Claimant (who is about 6 feet tall) might have been able to walk through the doorways without striking his head on the ceiling, although noted the incline from the pool area into the kitchen area which would increase the chance of the person moving in the direction of the Claimant striking his head on the ceiling. Whilst he accepted that he could no longer remember

what had happened in the accident, he indicated that he would be minded to rely upon the account given much nearer the time of the accident on 28th May 2015.

108. The report to the Health and Safety Executive (“RIDDOR”), which is undated but was apparently prepared by Ms Lloyd, states “*what happened: ... An individual was in the basement kitchen lifting something. On noticing this individual lifting a colleague rushed (ran) to help him and ran into the top of the doorframe hitting his head....*”
109. I am satisfied that Mr Jones is correct in his recollection that the Claimant was walking, albeit quickly, rather than that he was running. I reach this conclusion for the following reasons:
- i) On this issue, I do not find the Claimant’s evidence persuasive. It is his case that in the accident, he suffered mTBI. Either that is correct, in which case a degree of confusion about the accident would not be surprising, or it is incorrect in which case it is arguable that other aspects of his evidence are unreliable.
 - ii) In contrast, whilst Mr Jones’ note may not have been wholly focused upon what the Claimant was doing, on any version of events he had a clear view in the direction of the Claimant and moreover did not suffer the shock and/or confusion that may have been consequent upon striking his head.
 - iii) Mr Jones gave his evidence in a perfectly straightforward fashion. He appeared to have high regard for the Claimant and I saw no reason to think that he was either deliberately or subconsciously motivated to give an inaccurate account of the accident.
110. I am not dissuaded from this conclusion by the Claimant’s rationalisation that in order to strike his head he must have had both feet off the floor, consistent with jogging or running rather than walking quickly; his argument as to the restrictions in Mr Jones ability to see caused by the middle room being in relative darkness; or the contents of the report to the Health and Safety Executive referred to at paragraph 108 above. On the first point, having viewed the photographs, I consider it perfectly possible that the Claimant could have struck his head whilst walking, given the vaulted nature of the doorways and Mr Jones’ evidence as to a slight incline into the kitchen. On the second point, whilst this may have caused some restriction invisibility, it seems to be unlikely to have had so great an effect as to prevent Mr Jones having a view that was clear enough to tell whether the Claimant was walking or running. On the third point, it is unclear where this account came from. It may well have been the Claimant himself who provided it, in which case it may have been subject to the same potential distortion as other accounts from the Claimant.
111. On any version of events, the Claimant’s purpose in going over to Mr Jones was to assist him. That is the account consistently given by the Claimant himself and is Mr Jones’ explanation for the Claimant’s actions at paragraphs 4 and 5 of his witness statement within the litigation. Whilst

it is not the explanation given by Mr Jones in his first statement of 28 May 2015, there is no other obvious reason as to why the Claimant should suddenly have approached him, in particular when Mr Jones accepts that he was “*struggling*” with the kitchen cabinet that he was moving. I therefore accept that the Claimant’s purpose in approaching Mr Jones was to provide assistance in circumstances where he considered that without such assistance Mr Jones might suffer injury.

112. The Claimant states in his witness statement that he remembers the impact and that his next memory is of “*being upstairs on the ground floor sat in the window seat of the doorway on the ground floor. I remember that Craig was there. My next memory is of ringing Sharon Lloyd.*”
113. The Claimant’s evidence is that he suffered a wound to the forehead after this accident. At paragraph 38 of his first witness statement, he refers to a memory that his head was bleeding after the accident and wiping his forehead “*with a bandage with a patch on it from the first aid kit.*”. Mr Jones accepted that he sustained a cut to the right side of the forehead (albeit that his acceptance was arguably somewhat equivocal). Mrs Long stated that he texted her a picture of his head (which supposes that there was something to be seen). Whilst there is no reference to a wound on either his first or second hospital attendances, it is more likely than not that there was some minor wound to which both Mr Jones’ and Mrs Long’s attention was drawn.
114. Following the accident, Mr Jones’ account is of the Claimant behaving in a relatively normal fashion, which the Defendant suggests, is inconsistent with even mTBI.
 - i) Having struck his head, the Claimant recoiled, rubbed his head and swore;
 - ii) Almost immediately the Claimant’s mobile phone (which had been left in the bar area) began to ring. The Claimant walked to the bar (through the pool room, seating area and passage visible in the plan at paragraph 1818 above) and answered the phone. The person on the end of the phone was Ms Sharon Lloyd, the Claimant’s line manager. Mr Jones (as a more junior employee) left them to have a conversation.
 - iii) The next that Mr Jones saw of the Claimant was him coming up the stairs from the cellar to the ground floor holding blue paper towels to his head.
 - iv) Mr Jones considered the Claimant to be in “a lot of pain” and suggested that he go home, but the Claimant insisted on remaining and played his part in the building handover.
 - v) At the end of the day, the Claimant said he was going to go to the gym.
115. While the appearance of the Claimant being in a lot of pain and the use of the blue paper towels suggested that the Claimant had suffered some injury, the Defendant makes the following points:
 - i) If the Claimant had suffered post traumatic amnesia, one would have expected a degree of confusion. Mr Jones did not note any.

- ii) The Claimant was able to carry on with his work, apparently dealing with the telephone call from Ms Lloyd and the handover of the building in a normal fashion;
- iii) The Claimant's stated intention to go to the gym suggests that the blow to the head had had no significant after effects.

116. In contrast, the Claimant's account is of immediate abnormalities:

- i) His purported recall of the accident is, according to his witness statement, extremely patchy. At paragraphs 38 to 47 of his first witness statement set out what he stated at that time he was able to recall. He specially states that his first memory after the immediate impact is of being on the ground floor of the building, sitting in a window seat of the doorway on the ground floor¹². There are significant gaps in those memories as well as inconsistencies between his account and that of Mr Jones, in particular as to when he spoke to Sharon Lloyd, who initiated that telephone call and when he attended to his forehead by wiping it.
- ii) The records summarised in paragraph 131 below show that, when the Claimant attended CoC on the following day,
 - a) He was variously recorded as reporting no loss of consciousness or loss of consciousness for one minute;
 - b) He reported both retrograde and anterograde amnesia
- iii) The records show that, when he was admitted to CoC on 30 March 2015:
 - a) Again he was noted as reporting loss of consciousness and amnesia at the time of the accident.
 - b) By now he was reporting vomiting and visual disturbance;
 - c) On neurological review by Dr Fletcher on 31 March 2015, the Claimant reported, "*Few seconds retrograde and 15 minutes post-traumatic amnesia.*" He described the visual disturbance as "monocular triplopia (vague) each eye."
 - d) In a clinical note timed at 11.30 on 1 April 2015, it is recorded "*LOC + for five minutes. Amnesia + .*"

117. It is the Claimant's case that he may have lost consciousness and that he probably did suffer post traumatic amnesia. It appears to me unlikely that he lost consciousness. Had he done so, Mr Jones would have been aware of it. It would have been a striking event and one that did not readily fade

¹² Mr Jones has no recollection of the Claimant sitting at a window seat, though does not say it did not happen. Assuming it to be an accurate memory this must have been a few minutes after the accident, if, as I accept to be the case, Mr Jones was accurate in his account of the sequence of events.

from the memory. Further, it is very unlikely, given my assessment of Mr Jones above, that he would have failed to recount this obviously important piece of information.

118. Further, I accept that Mr Jones is likely to be right about:
- i) The immediate phone call from Ms Lloyd, which the Claimant answered;
 - ii) The Claimant coming up the stairs from the cellar holding some kind of towel to his head;
 - iii) The Claimant insisting on continuing with his work, notwithstanding appearing to be in a lot of pain;
 - iv) The Claimant stating that he intended to go to the gym. (I in this regard, I note that the Claimant does deny saying this nor does he deny attending the gym. He merely says that he cannot recall either saying it or going there. Mr Dignum QC drew attention to the fact that in cross examination, the Claimant appeared to concede that he probably had gone to the gym. I took that to be a concession based upon the logic of Mr Jones' evidence that he said that he was going, rather than from any independent recall of going. The transcript supports my understanding.)
119. In each case, the clear and consistent recollection of Mr Jones, in so far as inconsistent with that of the Claimant, is to be preferred to the latter's imperfect recollection. The Claimant's apparent desire to complete his job of handing over the building is consistent with the description of his personality at various points in the evidence as somewhat perfectionist. Further, in cross-examination, the Claimant recalled some of the detail of the walkaround. It must however be noted that the evidence of Mr Jones does not suggest that there were no immediate symptoms following the accident. Both the use of paper towels and the appearance of pain are suggestive that, whether the Claimant was walking or running, this was an impact with some degree of force.
120. As to whether the Claimant suffered post traumatic amnesia, I find the inferences to be drawn from the evidence of Mr Jones less clear. For reasons identified below, it is arguable that amnesia may be missed in particular by the non-expert observer whereas the evidence of the medics who saw him in the immediate post accident period and who identified amnesia may be powerful. That is not to say that Mr Jones' evidence on the point is of no significance. However, it falls to be considered as part of the wider picture which is dealt with as part of Issue 3 below.
121. The manner in which the Claimant dealt with Mr Jones evidence of his saying that he intended to go to the gym (which evidence I accept, as indicated above) is of some significance. The Claimant has been aware of Mr Jones making this assertion since, at the very latest, the service of witness statements within these proceedings (September 2019). It would have been the easiest thing in the world for him to have given evidence that, whilst intended to go to the gym, in fact decided not to. Whilst such evidence might have been somewhat inconsistent with the islands of memory

referred to in his first witness statement, he has given evidence of other matters which suggest that the memories set out in the first statement are not complete. The fact that he has not sought to deal with the issue of gym attendance by purporting to recall and intention to go followed by a decision not to (which would have been almost impossible for the Defendant to disprove) is a pointer in the direction that he is not a dishonest witness.

122. I turn to the evidence as to what happened after the Claimant returned to his parents' home. The Claimant's recollection as recounted in the witness statements is hazy. He recalls being at his parents' home on the night of the accident and being "*aware of a strange tingling sensation all over my body which was strange and unpleasant and told me that something was wrong and that it was more than just a headache.*" He mentions a brief recollection of being at hospital the following day, a recollection of his having to stop to rest when driving back to the family home in Norwich (in cross examination he gave the further detail that his happened in the vicinity of Peterborough on the A47) and then of being on the floor of the bathroom at his parents' house, vomiting. From other evidence, this would appear to be a reference to the evening of Sunday 29 March. There is however no reference to events on the journey from Norwich to his parents' house in Cheshire.
123. In cross-examination, the Claimant gave a little more detail about what happened between the accident and his second visit to hospital on 30th March. It is not entirely clear, either from his oral evidence at the time all from the transcript, to what extent his account was based upon his independent recollection and to what extent it was drawn from what he has read all been told. Again, his evidence shows a tendency to rationalise what was happening to him, an example being his statement in respect of the abnormal feelings he developed on the night following the accident, "*During the night, that night, was when I realised that things were not right. Prior to that, you know, I mean I banged my head so I am in shock, you know, there is adrenaline going on, there are all kinds of things occurring which are suppressing exactly what is wrong with me at the time and it is overnight that I realise things are not right, not before then and just carried on.*"
124. Mr Long volunteered three further details of note:
- i) That on his return home, he had felt rough but had not complained of symptoms to his father but rather had gone to bed. This may in fact have been simply his understanding of other evidence, specifically that of his father, rather than an independent recollection.
 - ii) That he had stopped on the journey from Norwich to Shavington¹³ in order to vomit.
 - iii) That he had told his wife about this and asked whether the children had been ill.

¹³ As indicated above, probably on 29 March.

125. Rev Long said the Claimant returned at “*around teatime*” (which, might suggest that he did not go to the gym, because it was questionable whether he had sufficient time to do so, though this particular nuance of the evidence was not explored further), stating that he had been involved in an accident, eating a meal and going to bed. The Claimant said, in response to a question from his parents, that he did not know if he had lost consciousness in the accident. He did not mention double vision or being sick. Within his witness statement, Rev Long described the Claimant as seeming “*upset more than anything*” though in cross-examination he used the word “*agitated.*” The two formulations might suggest different presentation, although I do not think of anything turns upon this point and it does not court caused me to doubt my general sense that Rev Long was trying to assist the court in his evidence.
126. On the following morning, the Claimant complained of having woken during the night with a “*full body tingling sensation*” which caused him to be distressed – in cross-examination Rev Long said, “*he was frightened at what was happening to him.*” On the following day, when Rev Long attended the doctor then the hospital with his son, he described the Claimant as seeming to be all right at times but at other times to be unable to answer questions and to be confused. Having returned from hospital on 24 March, Rev Long stated in cross-examination (contrary to his witness statement) that his son spent another night with them. There was nothing particularly strange about his presentation, although Rev Long confirmed what others have said in evidence about Claimant tending to keep things to himself.
127. Mrs Long’s evidence within her witness statement was that, when her husband returned to Norwich, he “*spent the whole weekend in bed*” saying “*he didn’t feel right; he felt ill.*” He complained of a headache. Mrs Long says this behaviour was out of character and she was concerned about him travelling back to Cheshire at the end of the weekend, but her husband promised to take breaks if necessary.
128. In cross examination, Mrs Long was asked whether the Claimant said that he had been knocked out. She said that she had not asked him this, because she did not have the opportunity, he being asleep in bed the whole time. Equally they had not discussed him having visual problems or being nauseous. She did however say that, on his return to his parents’ house, he had texted to said that he had been sick on the journey: “*He got on the A50 and said he had been sick, and then he asked me had anybody else been sick and I said no, nobody had been sick, kids are all right, I am all right.*” It is notable that this incident is not referred to in the statements of either witness, yet Mrs Long gave evidence of a conversation having taking place in similar terms to those of her husband. This bears similarity to the evidence relating to the xiphisternum and to the discussion between Mr and Mrs Long about the conversation that Mr Long is said to have had with Mr Walsh. Whilst it is again possible that the similarity of their accounts flows from them both correctly remembering the incident, given the length of time since the matters complained of, it

is more probable that Mrs Long is taking her account from that of her husband. This again causes me concern about her reliability as a witness.

129. When the Claimant returned to his parents' house on the following Sunday evening (29 March), Rev Long described him as "*very quiet*." During that night he was "*violently sick*" and on the following morning Rev Long took the Claimant to CoC. His son was admitted and, according to Rev Long, "*we were told at that stage that they thought he had bruising to his brain but no bleeding*." This was not an account from the medics, but rather from the Claimant himself. On this admission, the claimant complained of visual symptoms and hearing problems. These were not matters of which he had complained on 23 March.
130. There is very little material from the lay witnesses as to the Claimant's condition after discharge from the CoC on 2 April 2015, not least because his witness statements concentrate on its condition at the time that they were signed, not the progress of his symptoms since the accident.

Issue 3 - What were the Claimant's symptoms and diagnosis/diagnoses immediately following the accident and what caused them?

131. I set out below relevant entries from the medical records covering the period between the accident and the Claimant's redundancy taking effect. I have also included reference to the redundancy process.
- 24.03.15 **CoC Emergency Department.** Head injury 2pm yesterday. No loss of consciousness. Vomited twice. Complaining of visual changes and headache. GCS 15/15. Head injury one day ago. Loss of consciousness. Amnesia antero and retro. Vomited +++. GCS 15. Alert, awake, orientated. No focal neurological deficit. States – diplopia. Normal CT
- 24.03.15 **CT report:** "*Head injury, LOC, amnesia, vomiting +++ visual disturbance. Normal CT.*"
- 24.03.15 **Discharge Summary from Emergency Department, CoC.** "*Presenting complaint: head injury 1/7, LOC for 1 min, Antero + retrograde amnesia, visual disturbance. AMT 4 (cognition)...score (out of 4) 4 ...Investigations: CT...No intra cranial haemorrhage, No skull fractures...GP Note: Head injury one day ago. Admitted for headache and vomiting. On examination, GCS 15, no focal neurological deficits. CT head normal. Discharged with written advice.*"
- 30.03.15 **GP record at Rope Green Medical Centre:** head injury – return to A&E today. Parents will take him. Malaise, intercurrent Gastroenteritis starting past few hours I feel – dropped in. History of fibromyalgia. Head injury one week ago. CT scan six days ago at COC. Works in Chester. Stays with parents in Shav in the week lives in Norwich. Said head scan was not normal he was told.
- 30.03.15 **CoC Emergency Department.** "*Head injury 1/52, vomiting. Came to A&E and had a CT on 24/3/15 which was normal. Since then has continued to have ongoing headache and feeling slow and muddled. Vomited started yesterday. About 20 times overnight. Last vomited at about 5 am. Had some right earache and*

discharge on Saturday. Headache appears to be worse if he moves his head or he lies down. No other symptoms of note. Previous medical history of fibromyalgia...He has been unable to work since. Medication record: amitriptyline, baclofen, paracetamol, tramulief, zolpidem.

History from patient: patient sustained a head injury last week. Was working to help a colleague carrying some heavy furniture and ran into a door lintel from a low ceiling. Was knocked out and had amnesia surrounding the event and vomited several times. Attended A&E at that time and had a CT head which was normal. Since then he has not been well. He has felt muddled and confused. Has a frontal right-sided headache that was worse on lying flat and not relieved by anything. He has been vomiting last night and is having trouble sleeping. He denies any limb weakness but does state non-specific visual changes – not decreased vision, not diplopia; sees multiples of things but this is the same regardless of whether one eye is closed or not; previous medical history fibromyalgia

On examination – slow and deliberate speed. Looks anxious. Speech not slurred. Easily distracted/forgetful. Gait normal no ataxia or unsteadiness. Impression: post-concussion syndrome.”

- 30.3.15 **CT brain scan.** *“Clinical indication: head injury one week ago. Ongoing worsening headache, vomiting and visual disturbance. To exclude intracranial pathology. ...Findings: no intracranial haemorrhage. Apparent thin isodensity in the extra axial space overlying the right frontal lobe is impression of cortical vessel rather than extra axial collection.”*
- 31.03.15 **CoC Clinical Note:** *“Diagnosis: post-concussion syndrome. Still having headache and neck pain. Bruising to right ear. Numbness to right face. Mono ocular diplopia of both eyes. Peripheral vision intact. Right face numbness...”*
- 31.03.15 **Neurological review by Dr Fletcher**¹⁴: *“Head injury on doorframe (running) at work eight days ago. Few seconds retrograde and 15 minutes post-traumatic amnesia. Since then headache, mentally vague, very slow, monocular triplopia, (vague) each eye, reduced concentration, muddled. He describes (vaguely) vision not quite clear. Previous history: medically unexplained pain and gland swelling. Diagnosed as fibromyalgia. I gather many tests negative. Had vomiting 48 hours ago – settled. Thinks ? right ear discharge... CT ? right occipital contusion ? is torcula of sinus. Diagnosis: likely all post-concussion syndrome. May take weeks (or months) to settle. I think scan is okay but am getting neuroradiology review. I suggest ENT review. I suggest if scan okay/ENT is okay that he goes home to rest....Local brain injury referral if no better in one month. He should not drive until feeling better. I have advised him of this. Please don’t release him until I’ve had the scan reviewed.”*
- 31.3.15 **CoC Nursing note at 18.38:** *“PT seen by Dr Fletcher CT reviewed by Walton informed that scan is normal.”*
- 1.04.15 **CT angiogram aortic arch and carotid.** *“Clinical indication: new onset of left-sided ptosis and monocular diplopia both eyes - post trauma. ? dissection... Conclusion: no vascular abnormalities identified.”*

¹⁴ It is common ground that Dr Fletcher is a consultant neurologist at the Walton Centre, Liverpool which is the regional specialist neurological unit.

- 1.04.15 **CoC clinical note at 09.45:** Feeling spaced out. Headaches feels worse this morning.
- 1.04.15 **CoC clinical note at 11.30:** LOC + for 5¹⁵ minutes. Amnesia + . No open wound or injury. Complaining of multiple objects when seeing straight. Feeling of numbness over the left lower face. Hearing reduced on the right side with noise. Feeling of some clear discharge from right ear. Associated with headache. Frontal region and right side of head.
- 2.04.15 **Countess of Chester Hospital Discharge Summary, 17:57:** *“Principal diagnosis on discharge: likely post-concussion syndrome. Reason for admission: presented with headache, confusion following head injury one week prior to admission, vomiting, having trouble sleeping, he complains of non-specific visual changes, bruising around right ear, right face numbness. On examination: bilateral monocular diplopia, right sensorineural hearing loss BG: fibromyalgia. CT head six days post-accident PTA was NAD...Recommendations: GP please send to local brain injury referral if not better in one month... The symptoms may take weeks or months to settle. He should not drive until he’s feeling better. He was advised about this. GP please note change of medications.”*
- 2.04.15 **CoC nursing notes:** *“On discharge: likely post concussion syndrome....Dr Rath to review CT head and carotid angiogram result.”*
- 9.04.15 **GP:** Head injury. *“Had bad head injury three weeks ago. Ended up being admitted a few days later with confusion and headaches. Apparently had small bleed. No letter as yet as was seen in Chester where he works. Vision not right – diplopia and ongoing headaches and nausea. is improving though. Wants to go back to work in Chester. Not fit for work – shouldn’t even be driving as double vision. Reluctantly agreed that currently not up to working and aware shouldn’t be driving. Needs to rest. I want to review before we get back to work.”*
- 9.04.15 **Email sicknote to Defendant by Claimant:** *“... The doctor is not comfortable in allowing me to come back yet, I am improving but not sufficient to return yet. I am still having hearing and vision issues along with headaches and sickness, which she is hoping will all improve in the next week. I will have a further review on the 17th at 8:30 to be signed back on...”*
- 16.04.15 **Mr Alkhaddour, ENT at CoC:** *“This gentleman sustained a head injury nine days ago after which he reported hearing loss and earache in the right ear. There is no change in the facial nerve function, there is no otorrhea. He has normal tympanic membranes and the audiogram shows right mixed hearing loss but he has normal tympanogram. However the comments from the audiologist are that the audiogram is not reliable. I explained the findings to him. I have reassured him that the facial nerve function is normal and that we need to repeat his hearing test after he has recovered from the recent head concussion.”*
- 17.04.15 **GP:** *“Head injury... Feeling much better. Still having headaches but more manageable. Vision much improved. Main problem is memory being currently poor. Very keen to go back to work - wants to be there, feels that would like to go back and see how goes, gradually increasing his hours. Discussed I would*

¹⁵ That is Mr Grant’s interpretation – it is possibly in fact “15”, as Mr Dignum put in cross examination.

probably advise further time off, but agreed that can go back as long as takes it slowly and if struggling then happy for him to be signed off.”

- 20.4.15 **Claimant’s witness statement and cross examination**¹⁶: The Claimant returned to work. He was given letter to say that his job was at risk of redundancy. In the Claimant’s words the Defendant then “*took my keys off me and threw me out of the building basically.*”
- 23.04.15 **GP**: “*Head injury (first). Ongoing difficulties. Only managed a morning at work and then had to leave. Concentration and memory poor. Right-sided headaches. Diplopia on near focusing which is being followed up next week in Chester. Documentation we have through from Chester states normal CT head. Likely post-concussion syndrome but feels making no progress at all and distressed by symptoms – refer neuro. In the meantime treat symptoms and refrain from work until improving...*”
- 29.04.15 **Mr Butcher, consultant ophthalmologist at CoC**: “*Mr Long still has considerable problems primarily for near with seeing multiple images that remain the same when one eye is closed. He describes these images as been clear and very distracting and orthoptic and physical examination has failed to suggest a cause... I can’t explain his symptoms on the basis of a physical examination so far and I assume they must be related to cortical visual processing... I have not asked to see him again.*”
- 30.4.15 **Claimant’s HR records**: A Consultation meeting took place between the Claimant and Michell Sephton and Helen Smith on behalf of the Defendant. The Claimant was told that the role of Head of IT was redundant.
- 5.05.15 **GP**: “*Head injury. Ongoing problems - only managed a couple of hours at work when went back so came back to see JB and got signed off a further two weeks. Is seeing neuro next week. Ongoing memory problems - got lost twice last week. Cannot concentrate. Headaches improving. Double vision ongoing.*”
- 13.05.15 **Dr Rittman, SpR in neurology at Norwich & Norfolk University Hospital (“NNUH”)**: “*Thankyou for referring this gentleman to the neurology clinic. He has a rather severe post-concussion syndrome following a head injury in March when he ran into a door... lost consciousness for possibly a few minutes and was amnesic for a few minutes after the injury. He did not go to hospital immediately but felt a tingling in his body that night and went to hospital the next day when he had a CT scan. One week later he was admitted again with worsening symptoms and spent a week in hospital before returning home.... He complains of diplopia, headaches and reduced sensation on the right side of the face. He has poor memory and concentration and has been lost once or twice in the car. He often forgets what he is doing, for example brushing his teeth. He has tinnitus. He is markedly angry and irritable, indeed his wife had sent with him a scribbled note in capital letters to this effect, which was not as premonitory personality. He has a past medical history of fibromyalgia....*”
- 13.05.15 **Dr Rittman** (writing to the Claimant about the appointment): “*we discussed the diagnosis of post-concussion syndrome. We discussed that this may improve that over a long period of time. I advised that you should not consider returning to work for at least three months but that you may not be ready to start work for at*

¹⁶ The date is corroborated by the note of the meeting of 30 April 2015 in the Claimant’s HR records.

least six months. I agree with your decision to limit your driving for the time being although there is no legal reason at the moment why you could not drive but I would be cautious about returning to this, particularly as you have been getting lost recently. We discussed the post-concussional symptoms of poor memory, difficulty with attending, irritability and anger problems. I have suggested that you contact Headway and gave you the contact details today ...”

A document attached to that letter is a typed list of symptoms and complaints which the Claimant says he prepared. “Multiple images in vision... Headaches... Sensation in my hand side of face, forehead down to cheek around eye... Pain to right-hand side head gives feeling similar to low blood pressure, makes me feel dizzy and feel awful this also makes me feel as if I could fall unconscious (happened twice)... When trying to think feels vacant makes me feel strange... Memory short-term terrible, even writing things down does not really help... Memory is the biggest issue for me... Remembering how to do things... Not a clue where to start... Getting lost... General confusion... Hearing right ear is reduced and high pitch noise heard all the time, occasional pain... Drinking: spilling from lip either still tipping Not closing mouth properly... Anger issues... Detached from reality, almost viewing what I am doing... Brushing teeth, forget what I have done... Would normally work 10 to 12 hours per day and only have around 10 days off in 12 months, I think about, now not even my thoughts.... Spots? Covered in them.”

14.05.15 The Claimant was formally dismissed by the Defendant on the grounds of redundancy

132. The importance of the medical evidence in the immediate post accident period lies in identifying whether the Claimant probably suffered a brain injury. If he did, the severity of that injury, whether in terms of severity of immediate symptomatology or by reference to the Mayo Classification dealt with below, is of lesser importance for reasons dealt with later.

133. The starting point for both parties in considering whether the evidence supports a diagnosis of brain injury is the Mayo Traumatic Brain Injury Classification system. The relevant part of this system is:

*“A. Classify as Moderate-Severe (Definite) TBI if one or more of the following criteria apply¹⁷:
...*

B. If none of Criteria A apply, classify as Mild (Probable) TBI if one or more of the following criteria apply:

- 1. Loss of consciousness momentarily to less than 30mn*
- 2. Post traumatic antegrade amnesia momentarily to less than 24h*
- 3. Depressed, basilar or linear skull fracture (dura intact)*

¹⁷ It is common ground that none of these apply here.

C. *If none of Criteria A or B apply, classify as Symptomatic (Possible) TBI if one or more of the following symptoms are present:*

- *Blurred vision*
- *Confusion (mental state changes)*
- *Daze*
- *Dizziness*
- *Focal neurological symptoms*
- *Headache*
- *Nausea”*

134. Three points should immediately be noted:

- i) The clear scheme of the Mayo Classification is to start with the first categorisation and to move on to the next only if the earlier is not met;
- ii) The criteria for Classification A are not met;
- iii) In respect of Classification B, it is not suggested that there was skull fracture, accordingly the diagnosis of mTBI, which is the case advanced for the Claimant depends on showing that the Claimant suffered loss of consciousness and/or post traumatic amnesia. I have already identified that the evidence does not support a finding that the Claimant lost consciousness and so whether the Claimant falls within the mTBI category depends on the evidence as to PTA.

135. Post traumatic amnesia is defined as the inability to lay down clear and continuous memory. Absent a clear period of amnesia, such as that consequent upon loss of consciousness, the assessment of PTA requires one to look at the person’s account of what they remember. It does not necessarily, on Dr Nichols’ evidence, involve a period of confusion. He described this as “*a common misconception...you can actually be lucid and alert and appear normal and yet still be within a state of post-traumatic amnesia...*” He stated that PTA can be missed by healthcare professionals, in this respect, relying on the paper by Meares et al, Identifying Posttraumatic Amnesia in Individuals with a Glasgow Coma Scale of 15 after Mild Traumatic Brain Injury (2015).

136. Dr Heaney on the other hand said that PTA is characterised by “*anterograde amnesia, disorientation and agitation.*” Mr Grant on behalf of the Claimant took Dr Heaney in cross examination to literature on the potential inadequacies of basing assessment of cognitive impairment in mTBI cases on Glasgow Coma Scale, namely Shores et al (2008) and Meares et al

(2015). He agreed that an assessment of brain injury could not be based on GCS alone. He agreed with the proposition that PTA “*can appear quite separately from disorientation and confusion in milder brain injury cases.*” However he added the caution that “*it is pretty unusual not to be associated with agitation, repetition, those types of symptoms.*”

137. The contemporaneous evidence as to post traumatic amnesia is, in summary as follows:
- i) CoC clinical notes and discharge summary on 30 March 2015 – pre-and post-traumatic amnesia;
 - ii) Admission to CoC on 30 March 2015 – “*had amnesia surrounding the event;*”
 - iii) Neurological review at CoC on 31 March 2015 – “*Few seconds retrograde and 15 minutes post-traumatic amnesia;*”
 - iv) Clinical note at CoC at 11.30 on 1 April 2015 – “*amnesia +.*”
138. As to the reporting clinicians, they formed differing views as to whether there was evidence of post traumatic amnesia:
- i) The Claimant’s account to Dr Nichols of his PTA is set out at paragraph 3.1.1 of the first report. Various incidents are mentioned and Dr Nichols describes these as “*rather vague snapshots of memory.*” In particular, the Claimant’s first asserted recollection after the impact was of sitting upstairs. Dr Nichols’ assessment at paragraph 4.1.1 of his report is of PTA present for more than 30 minutes but less than 24 hours.
 - ii) Dr Heaney records a similar account at paragraphs 3.1.20-29 of his first report, again noting the first recollection after the impact to be of the Claimant sitting at window seat upstairs. His conclusion however at paragraph 4.2.9 of his report is that the absence of evidence of loss of consciousness and/or disorientation or agitation after the accident is inconsistent with a period of PTA.
 - iii) Dr Surenthiran records the Claimant’s account at paragraph 3.01.1-3 of his report. The Claimant’s first stated recollection after the impact was of sitting in the reception area on the ground floor of the building at a window seat. Dr Surenthiran does not express any opinion on the issue as to whether the Claimant suffered PTA.
 - iv) Dr Pierce’s record of the Claimant’s account comes at paragraphs 3.5-8 of her first report. In particular, her note of the Claimant’s first recollection after the accident is of “*sitting upstairs with Craig.*” She describes the Claimant’s account at paragraph 5.5 of her report as follows: “*Mr Long’s autobiographical recall of the events subsequent to the index event demonstrates that he has very patchy but sometimes lucid recollections of immediate events (e.g. he recalls feeling ‘stupid and embarrassed’ about what had*

happened.) However, he has only intermittent memories of that evening and of the days immediately after the index even in the context of aversive symptoms i.e. nausea, dizziness, imbalance and severe headaches. In my view the gaps in Mr Long's recall are not typical of an extended period of post-traumatic amnesia given his ongoing orientation during this time."

- v) Dr McCulloch's record of the Claimant's account is at paragraphs 5.3.2-4 of her report. Yet again, the Claimant stated his first recollection after the impact to be of sitting at a window seat. He mentioned telephoning his boss. She concluded that his brief "loss of awareness" after the accident "*is likely to represent PTA [of] no longer than a few minutes."*
- vi) Dr Bourke's note of the Claimant's account of post traumatic amnesia comes in paragraphs 3.2.1.31.7-45 of his first report. Yet again, the first recollection after the impact given by the Claimant is of sitting on the ground floor at a window seat. He referred to telephoning his boss. He concludes at paragraph 4.0.2.4-6 of his report that this description "*suggests clear gaps in his memory for events in the immediate aftermath of sustaining the head injury....it is less clear if [the gap in the Claimant's memory after his first attendance at CoC] relates to memory attrition that has arise since (i.e. that he has essentially forgotten less salient events that arose in between various salient ones, such as hospital and appointment attendances) rather than it is reflecting a failure in the formation of continuous memory. In the balance of probabilities, the period of post traumatic amnesia persisted for 24-48 hours and possibly for as long as 10 days."* During cross examination, he stated that the "*most clearly defined period during which he seems to be amnesic is those first three to five minutes or whatever it may transpire to by, up to and including the first point at which he has a memory."*
- vii) Within his reports, both the desktop report of April 2017 and the report following examination in January 2020, Dr Bird refers to some of the accounts as to the Claimant's PTA, both from other attending medics and from the Claimant himself. He comes to no conclusion in respect of whether the Claimant suffered PTA other than describing the Claimant's comments as "*vague*", though in the joint statement says that no PTA followed the head injury.

139. I conclude from my summary of the evidence relating to post traumatic amnesia, including the evidence as to the Claimant's general post traumatic state, that:

- i) There is no evidence that the Claimant was in an obvious state of confusion after the impact;

- ii) However, it is possible for people to suffer post traumatic amnesia without showing any obvious signs of confusion;
 - iii) The Claimant never reported to medics that he had not suffered amnesia following the accident and when asked about it, he reported that he had.
 - iv) The Claimant has consistently given the same account of his first memory after the impact, namely sitting at a seat on the ground floor of the building. If this is an accurate recollection, it must suggest an intervening period of a few minutes which he does not recall, given the need for him to have had the time to do the actions listed at paragraph 118 (ii) and (iii) above, namely to walk to his phone, to take the phone call, to find and apply some kind of towel to his head and to walk from the cellar to the ground floor to the seat. It is impossible to be precise about the time required to do this, but from the general impression I gained of the size of the building, it seems unlikely that this could have taken less than 3 minutes even if the activities followed immediately one upon the other.
140. There was some debate as to the degree of force required to cause mTBI. I have recorded my finding that the impact involved “*some degree of force.*” I am not in a position to be more precise as to the force involved. Dr Nichols formulated the argument that it was the unguarded nature of the blow, the fact that it was unexpected and therefore no precaution was taken against it, that was the important part of the mechanism. Whilst I accept that, if one sees a blow coming and takes evasive action, impending impact may be avoided altogether or be of lesser severity. However, the fact that it was unguarded does not, it seems to me, in and of itself tell one how great the impact was. One could have an unguarded blow which was of minor severity simply because of the nature of the incident; equally one might not be able to avoid a blow that one sees coming, such that the force was considerable even though anticipated. In each case, the question must be about the degree of force. Dr Nichols said that it was not the punch that you see coming that knocks you out; I suspect that this depends on how hard the punch is thrown!
141. In his second report of January 2020, Dr Bird described the injury as being “*very mild*”, stating that it “*hardly ‘qualifies’ as a head injury at all.*” At paragraph 4.2.2 of his report, Dr Heaney states, “*depending on how fast Mr Long was moving, the mechanisms described is unlikely to cause significant neurological injury.*” Dr Heaney denied in cross examination that his opinion was influenced by what Dr Bird had had to say. More importantly, he accepted that he had experience of people with “*pretty innocuous head injuries...sustained in sport who have had enduring symptoms going on for many years.*”
142. I can see no basis to distinguish head injuries sustained during the course of sporting activities from those sustained in other circumstances, and I take it that Dr Heaney was simply giving

examples of his experience of sports injuries rather than seeking to distinguish the circumstance in which the injury occurred. It follows from this that evidence of the severity of the impact is a relatively poor indicator of the likelihood of a person suffering mTBI – of course the position might be far different if one were concerned with the more serious types of TBI, but that is not the subject matter of this case on any version of events.

143. I have borne in mind that the Claimant’s account of memory loss may in fact be mistaken or even deliberately wrong. In particular, three points are striking:

- i) In his account of his post accident recollections, the Claimant refers to two matters which could in fact be a remembering of things that happened in the period immediately after the accident. The first is of his having a phone call with Sharon Lloyd; the second is of him holding a bandage to his head. Both could be slight misremembering of similar incidents described by Mr Jones, in which case, his account of his first post traumatic memory would be inaccurate and this would undermine the evidence that he suffered any PTA;
- ii) The lack of any obvious confusion or agitation on his part is a pointer against his suffering PTA;
- iii) If I found the Claimant to be an unreliable or even dishonest witness as a result of other aspects of the evidence, this would undermine his evidence on this issue.

144. On the second of these points, a further matter arises. The Mayo classification, as noted above, speaks of PTA that is “*momentary to less than 24h.*” One might think from this that a period of a few minutes of amnesia after the accident would be clearly sufficient to meet this criterion. However, Dr Nichols was questioned on the basis that momentary PTA is not in fact consistent with mTBI. The logic of the point put by Mr Dignum QC to him was thus:

- i) The application of Mayo classification involves starting with the more serious and moving to the less serious;
- ii) The least serious category involves looking at a list of symptoms, such as blurred vision, confusion, dizziness, headache and nausea.
- iii) The text to the paper “The Mayo Classification System for Traumatic Brain Injury Severity”, Malec et Al (2007), refers to such post-concussive symptoms as being confirmed events if there was documentation of such symptoms for greater than 30 minutes;
- iv) Accordingly, to fall into Category C, the person would have to have such symptoms for more than 30 minutes;

- v) It would be surprising if a person had PTA without one or more of those post-concussive symptoms.
 - vi) Therefore amnesia could not be sufficient to meet the requirement of Class B unless it lasted at least 30 minutes.
145. In cross examination, Dr Nichols rejected that argument, referring to the wording of Malec et al which expressly refers to “momentary” PTA. Further, her referred to papers by Meares et al, “Identifying Posttraumatic Amnesia in Individuals with a Glasgow Coma Scale of 15 after Mild Traumatic Brain Injury” (2005) and Shores et Al, “The Diagnostic Accuracy of the Revised Westmead PTA Scale as an adjunct to the Glasgow Coma Scale in the early identification of cognitive impairment in patients with mild traumatic brain injury” (2008) in support of the proposition that patients may not present as disoriented, agitated or confused, yet still have suffered mTBI. Dr Heaney accepted this in cross examination.
146. In my judgment, so long as genuine PTA is found to have arisen, neither the length of the PTA nor the lack of other symptoms excludes the possibility of a diagnosis of mTBI. I accept that the lack of other symptoms may tend to suggest that the apparent amnesia is not in fact PTA at all. But that is conceptually different from saying that PTA of short duration is in fact not capable of giving rise to mTBI. The Mayo Classification makes clear that the accepted thinking (which was not disputed by any of the Defendant’s experts) is that even momentary PTA, so long as genuine, is a sufficient symptom to justify the diagnosis of mTBI.
147. Weighing these matters, I am satisfied on the evidence before the Court that the Claimant did suffer post traumatic amnesia for at least a short period, probably only a few minutes, after the accident. Even if the Claimant is otherwise unreliable or even a dishonest witness on certain issues, I find his early account of amnesia to medics on his first hospital admission to be compelling and his repeated account of his first recollection after the accident, that he was seated on the ground floor, to be powerfully consistent with that.
148. It follows that I am satisfied that there is evidence from which a diagnosis of mTBI in accordance with the Mayo Classification could properly be made. Nevertheless it is important to go on to consider the other symptoms of which the Claimant complained, both to see whether they support their contention that he did in fact suffer a brain injury and also to assess his reliability as a witness.
149. I turn to the other symptoms relevant to criteria B to see what evidence there is as to their presence. Within his first witness statement, the Claimant deals with the continuing problems in May 2018¹⁸ under the following 28 headings:

¹⁸ The same 28 headings are referred to in his second statement, where he updates the reader on his symptoms.

- i) Change in sense of smell
- ii) Change in sense of taste
- iii) Visual disturbance
- iv) Hearing loss
- v) Tinnitus
- vi) Headache
- vii) Dizziness
- viii) Nausea
- ix) Vertigo
- x) Fatigue
- xi) Sleep disturbance
- xii) Intolerance to noise
- xiii) Sensitivity to light
- xiv) Change in personality
- xv) Decision making (meaning Indecisiveness)
- xvi) Multi tasking (difficulties with this)
- xvii) Reduced motivation
- xviii) Reduced concentration
- xix) Difficulties with social monitoring
- xx) Problems with social control
- xxi) Problems with new learning
- xxii) Speech disturbance
- xxiii) Tremors
- xxiv) Blood pressure and nose bleeds
- xxv) Difficulties with mental arithmetic
- xxvi) Long term memory
- xxvii) Short term memory
- xxviii) Reality detachment

150. He also deals, under the heading “vestibular/epileptic seizures” with a variety of symptoms, including issues relating to mood.
151. The neurologists agree that many, if not all, of these chronic symptoms probably are not related to mTBI, though Dr Nichols considers that some may be a consequence of subtle ongoing brain injury. Both the neuropsychologists and the neuropsychiatrists agree that the Claimant’s perceived symptoms, in so far as genuinely suffered are, as the neuropsychologists put it in their joint statement, “*best explained by psychiatric and psychological dysfunction.*” Accordingly, the ongoing symptoms are of no assistance in determining whether the Claimant suffered brain injury at the time of the accident. However, having regard to the Mayo Classification immediate complaints of the following are potentially relevant and require further consideration:
- i) Blurred vision
 - ii) Confusion (mental state changes)
 - iii) Daze
 - iv) Dizziness
 - v) Focal neurological symptoms
 - vi) Headache
 - vii) Nausea
152. The Claimant has referred to visual disturbance on several occasions in the period immediately after the accident. On attending CoC on 24 March 2015, the Claimant is recorded as reporting “*visual changes*” at one time, “*visual disturbance*” at another. This is thereafter variously described as “*non-specific visual changes – not decreased vision, not diplopia, sees multiples of things*” (CoC Emergency Department of 30 March 2015), “*bilateral; monocular diplopia*” (CoC discharge summary on 2 April 2015) and “*monocular triplopia*” (Dr Fletcher’s review on 31 March 2015). It seems that the diagnosis settled on his suffering diplopia (or sometimes the synonymous “*double vision*”), as a result of which the Claimant’s driving licence was suspended (see paragraph 57.3 of his first witness statement).
153. In cross-examination, it was put to Mr Long that he suffered two different conditions, the diplopia which led to suspension of his driving licence and a separate vaguer issue of seeing multiple images. He did not accept this to be the case.
154. In terms of confusion and mental state changes, the initial CoC note described the Claimant as “*alert, awake, orientated.*” However, on his second visit to the hospital, he is recorded as describing himself as having felt “*muddled and confused.*” On examination, he was stated to look

anxious and to be “*easily distracted/forgetful.*” On 31 March 2015, Dr Fletcher noted “*mentally vague, very slow...reduced concentration, muddled.*” and confusion is mentioned in the discharge summary from CoC on 31 March 2015. Memory problems are mentioned in the GP note of 17 April 2015, but in the next GP entry, after his attendance at work on 23 April reference is made to concentration as well as memory problems. Memory problems are again mentioned in the GP note of 5 May 2015. Finally in this period, the Claimant reported to Dr Rittman on 13 May 2015 a wide range of rather more florid problems of mental state changes.

155. Neither daze nor dizziness are separately mentioned in the medical records, save by way of exclusion in the CoC emergency department record of 30 March 2015. No focal neurological symptoms are mentioned and again are excluded, this time in the first CoC attendance.
156. Headaches are mentioned repeatedly in the records, on 24, 30 and 31 March, 1, 2, 17, 23 April, 5 May (said to be improving) and finally in Dr Rittman’s letter from 13 May.
157. Nausea is mentioned “+++” in the CoC attendance on 24 March, as well as in the CoC admission on 30 March. It was of course also described by the Claimant himself and Rev Long. However, the Defendant has correctly pointed to the report from Dr McGlashen dated 17 January 2016, referred to below, in which it is said of the first attendance at CoC that “*vomiting was not a feature*” though vomiting is mentioned as a symptom of the second visit. I am satisfied that the Claimant’s account of being sick both overnight after the accident and on the night of 29 March, both incidents being corroborated by medical records and the second by Rev Long. The Claimant’s apparent assertion to Dr McGlashen in January 2016 that vomiting was not a feature of his first CoC visit is most probably explained as an error of memory, it being probable that his recollection now of vomiting on that first visit being a product of his memory being prompted by the notes. However, this error shows quite how inaccurate the Claimant’s recollection may be and simply adds to my caution in accepting his evidence in so far as it is not corroborated by more reliable sources. For example, I am not persuaded that he vomited during the journey from Norwich to Cheshire shortly before the second CoC attendance. Had he done so, I would have expected to see reference to it in contemporaneous documents, in particular the CoC notes on the second attendance.
158. As to the Claimant’s other complaints in this period, it is clear that the description became distinctly more florid on the second attendance at CoC than it had been on the first. The symptoms at first attendance appear relatively minor, limited to vomiting, visual changes and headache. At the time of the second, the Claimant was stating that his headaches had worsened and was also complaining of neck pain, bruising to the right ear, numbness to the face, hearing loss to the right side “*with noise*” and cognitive impairment. The medics considered more serious causes than mTBI such as a carotid dissection or encephalitis, both potentially fatal conditions. The symptoms

are arguably more florid again by the time of the consultation with Dr Rittman, when a whole host of symptoms are mentioned. In fairness to the Claimant, many of the developments lie in the Claimant's complaints of cognitive dysfunction, which all experts accept may come on gradually after brain injury. The Defendant understandably argues that this should cause the court to look carefully at whether the Claimant is exaggerating these symptoms and in fact suffered the symptoms at all. Certainly by the time of Dr Rittman's consultation, the symptoms had a distinct flavour of the psychiatric and psychological dysfunction referred to earlier.

159. During examinations for the purpose of the litigation, the Claimant complained of other symptoms in the immediate post accident period (although it is not always clear from the accounts of when he said the symptoms came on) including reduction in the senses of smell and taste, dizziness and balance problems, photophobia and tinnitus¹⁹. However, his accounts are not entirely consistent. For example, Dr Bourke records him as denying suffering dizziness immediately post-accident.
160. In the same period, changes can be seen in the Claimant's account of matters which may suggest he is an unreliable witness. For example the asserted length of loss of consciousness, which is said to be 1 minute in the discharge summary for the first CoC attendance, but 5 (or 15, depending on how one reads the note) minutes in the clinical note at 11.30 on 1 April during the second attendance.
161. On the Claimant's case, the deterioration between the two CoC attendances may be explained by the onset of migraine. Both Dr Nichols and Dr Surenthiran referred in their reports to the opinion that the headaches of which the Claimant complained were migrainous in nature. Each of them developed the theory of migraine as the cause of worsening symptoms in the week following the accident during their oral evidence.
162. Dr Nichols stated in cross examination that he considered the Claimant to have had a post traumatic migrainous episode prior to the CoC admission on 30 March 2015 which was the cause of significant vomiting and increasing headache. Absent a pre-existing history of migraine, he considered head injury to be a more probable cause of migraine than stress caused for example by the Claimant being aware of a risk of impending redundancy.
163. Whilst Dr Surenthiran accepted in cross examination that stress could be a cause of migraine, he did not consider it the probable cause here. Were stress to have been the cause, one would expect some history of migraine to show a vulnerability to developing it, as well as very considerable stress, possible with some other coincidental event such as illness. He did not consider this to be the picture here. He did not consider the fact that the headaches only became migrainous in nature

¹⁹ This may in fact be the same as the "noise" referred to on the second CoC admission.

in the week after the accident to exclude head injury as a cause, since such a development of headaches was not unusual. As he put it, “*Typically people will describe generalised headaches for a period of time and then they will start getting more characteristic headaches...*” He further thought that the Claimant’s associated complaints on his second admission to CoC, in particular right sided facial pain, polyopia and sensorineural hearing loss, were consistent with a migrainous condition.

164. Dr Bird agreed that the alleged symptoms of vomiting, visual changes and headache were consistent with a “*mild bump on the head.*” However, he did not accept that this was due to the kind of neurometabolic cascade described in some of the literature, saying that one would expect such symptoms to come on straight away if caused by the head injury and associated brain damage and that such a cascade of symptoms was in any event associated with a more serious injury.
165. Dr Bird did not accept the suggestion that the Claimant had suffered post traumatic migraines, stating that the force of the blow was simply not sufficient to lead to that consequence, and noting he had not been recorded as suffering migrainous headaches on attendance at CoC on either occasion. It was particularly striking that Dr Fletcher had not mentioned this. However, he did not exclude the possibility that the Claimant was suffering migraine, merely doubting it.
166. Dr Bird however considered the “*strange tingling sensation*” that the Claimant described on the night of the accident to be indicative of an alternative cause for at least some of his symptoms. During the course of his evidence in chief, he stated, for the first time, that he considered this symptom to be “*undoubtedly*” a panic attack. He accepted in cross examination that the Claimant had described the tingling sensation to him during his examination for the purpose of his report, yet he had not previously mentioned the theory that the Claimant suffered a panic attack. His explanation for this was that the accounts of the Claimant and his father in oral evidence had caused Dr Bird to think about the issue in more depth.
167. The account by Dr Bird of the Claimant suffering a panic attack or something akin to that is a superficially plausible explanation of his condition overnight. I am not persuaded that in fact such a finding would make any difference to other conclusions, but it would reasonably convincingly explain a somewhat odd symptom. If the theory is correct, it does cause one to wonder what caused the panic attack, unless it was something to do with the Claimant’s employment (which is dealt with below), it might suggest that the Claimant was panicking about the head injury he had suffered; if this is so it does suggest that the injury was of some significance to him and would contradict the suggestion that this was a trivial incident. However, I am not persuaded that this theory of Dr Bird was sufficiently well thought through to persuade me that it is probably the correct explanation for the Claimant’s condition overnight.

168. In respect of the possible explanation for a deterioration in symptoms thereafter as a result of the development of migrainous headaches, it is unfortunate that this theory was not put within the medical reports of Dr Nichols and Dr Surenthiran, since again this suggests that it was not well thought through and further the failure to give advance notice to the Defendant has prevented its experts from properly exploring the issue. Whilst I reject the suggestion of any “pincer movement” by the Claimant’s experts, it may well be the case that they have influenced each other in favour of this theory. But the reference to migrainous headaches was made in the original reports and the theory that they were a cause of deterioration was accepted as at least a possible explanation of vomiting by Dr Bird. Given the apparently different nature of the headaches on the Claimant’s return to hospital on 30 April, I accept the development of migrainous headaches as being at least possibly an explanation of the Claimant developing new symptoms.
169. As to the suggestion by Dr Bird that the Claimant’s deterioration in symptoms was caused by stress, quite possibly relating to his work, it is necessary to consider the Defendant’s argument that the circumstances of the Claimant’s redundancy are a more probable explanation for some or all of the Claimant’s symptoms and/or give a motive for the Claimant to have exaggerated his symptoms, given that, shortly before to the accident, the Claimant’s “*inadvertent discovery*” of the risk of redundancy had occurred. I turn therefore to considering the significance of the redundancy to the Claimant’s complaints.
170. The Claimant’s account of the circumstances of his redundancy closest in time to the accident, is contained in the lengthy document which forms part of the appeal documentation in relation to his redundancy, what I have called the “May 2015 Document”. It is the Claimant’s case that the May 2015 Document was drafted together with the assistance of employment lawyers. It sets out essentially four grounds of appeal:
- i) That the Defendant had failed to follow a fair process;
 - ii) That the terms of the Claimant’s redundancy were not clear;
 - iii) That the Defendant failed to make reasonable adjustments for the Claimant’s disability;
and
 - iv) That the Claimant had been bullied by Mr Redmond Walsh.
171. I have set out above a passage from the May 2015 Document in which the Claimant spoke of his response to the discovery of the possibility of redundancy. The document also deals with the Claimant’s account of his response to the discovery. Four passages are particularly significant for this claim:

- i) Under the heading “**Inadvertent discovery of Potential Group IT Director role 10th March**²⁰”:

“On 10 March 2015 I was inadvertently exposed to an email from Clarity Travel Management... Whilst in the process of fixing and testing send/receive for the email services on Redmond Walsh’s mobile phone. The email related to the job description of the Group Head of HIT (as it was at the time) the body of the email contained text which intimated that Clarity had added their requirements to the job specification...”

This discovery was extremely upsetting, it came totally out of the blue, I asked my direct line manager Sharon Lloyd if she knew anything about it, she said that she had only been made aware on the previous evening, she must have then spoken to Redmond Walsh about it as I was asked to go and speak to him about it.

In this conversation Redmond Walsh stated that he had been considering this for some time and have now decided that he was going to move forward with the group Head of IT role. He went on to state that this would not mean that my role was immediately redundant and that I was needed to manage Elegant Resorts IT teams and systems until the appointment was made and he would let the income individual make their own mind up about whether my role was required any longer or not.

Redmond Walsh stated in this meeting that he did not consider me a suitable candidate for this Group Head of IT as he wanted to bring someone in with Travel experience. My eight months with the company and the knowledge of group architecture and systems were apparently not suitable for this role.”

- ii) Under the heading “**Bullying Actions of Redmond Walsh**²¹”:

“There are many definitions of bullying and harassment. Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying and harassment can often be hard to recognise – they may not be obvious to others, and may be insidious. The recipient may think ‘perhaps this is normal in this organisation’. They may be anxious that others will consider them weak, or not up to the job if they find the actions of other intimidating. They may be accused of ‘overreacting’, and worry they won’t be believed if they do report incidents. How often does an incident have to take place before the company will regard it as bullying, once? More than once? There have been a number of occasions throughout 2014 and now into 2015 where the

²⁰ Emphasis in the original.

²¹ Again, emphasis in the original.

actions of Redmond Walsh have left me feeling intimidated, offended, undermined and demeaned. I have raised the issue of being bullied by Redmond Walsh informally with Sharon Lloyd...”

iii) Under the sub-heading, “*Trading Meeting 10th February 2015*”:

“During one part of the meeting I could not hear question from Michelle as there were a number of people having conversations simultaneously around the table. I apologise saying that I could not hear the question and Redmond snapped “well sit forward and listen then.” the tone in which it was said was one of contempt, this was noticed by number of members of staff around the table, some of whom approached me since the meeting to ask how I was feeling etc. The staff are generally fabulously supportive. I work extremely hard to support business and do not come to work to be abused or demeaned by any employee...”

iv) Under the sub hearing “*Inadvertent Discovery 10th March*”:

“Accidentally finding that your job is being replaced, because someone doesn’t think you are up to it, is incredibly humiliating. It is bad enough to become aware that conversations going on without your knowledge on replacing you. It is also an almost perfect way to undermine someone in their role at work.

I was extremely upset when this discovery was made, I have dedicated hundreds of hours and extra days to Elegant Resorts to make things happen with the limited resources I had available. It was crushing to discover how I was perceived by Redmond Walsh, this was further compounded by being told I would not be considered for the role being created to replace me.

My performance has been established as not being the issue. My lack of Travel Experience being given as the reason why I would not be considered.”

172. It is a striking feature of the May 2015 Document that, in parts at least, it is written in highly emotive terms. The passage under the sub hearing “*Inadvertent Discovery 10th March*” is perhaps the clearest example of this. Other sections of it are far more measured.

173. Mr Long was cross examined on the basis that this document appears to indicate that, as at the time of the inadvertent discovery on 10 March 2015, in other words less than two weeks before his accident, he had discovered that he was to be made redundant and that this was an obvious cause of stress for him. Indeed, he had described the discovery as “*incredibly humiliating.*” He responded that “*the redundancy process was not a done deal at that point, my redundancy was dependent upon somebody who had not yet been employed being employed and then making a decision on the future of my role. So I was not stressed about being made redundant because I*

did not see that as being a distinct possibility at that point in time.” Even if redundancy had been inevitable, he said *“I would not have found the process of redundancy stressful because [I] did not find the process of leaving my previous job stressful. It is not stressful because I knew I would find another job.”*

174. The Defendant contends that the Claimant’s explanation of this is implausible and indeed dishonest. In essence, three points are made.
- i) The suggestion that the Claimant was not “humiliated” at the time of the discovery on 10th March is inconsistent with his own language in the document.
 - ii) Even if the Claimant’s right to say that the final decision about redundancy was not made until after his accident the discovery of the threat of redundancy was bound to have been a stress or and, given his medical history, was a likely cause of symptoms such as those he has suffered since his redundancy.
 - iii) In his first report at paragraph 4.0.11.5, Dr Bourke, the neuropsychiatrist instructed on behalf of the Claimant, whilst dealing with events leading to the redundancy, stated: *“During my examination of the Claimant, I specifically enquired about whether he knew that he was likely to be made redundant. He told me that not only did [he] not know anything of this but that he had been involved at a management level in the restructuring of the company that Dr Bird refers to, help you identify where in the company these redundancies might be made. He added to this that the months running up the index accident included his probationary period, during which he received continuous appraisal. I have reviewed these records, which provide an appraisal of better than average performance that ultimately led to his position being made substantive in December 2014. His redundancy is not mentioned until a letter dated 20 April 2015, after the index event.”* Further investigation of this led to Dr Bourke producing his notes of the consultation, in which he had recorded *“denies reference to the possibility of redundancy.”* In cross examination, Dr Bourke accepted that this indicated that the Claimant was indicating there was no possibility of redundancy prior to the accident.
175. Of course, if the Claimant deliberately failed to refer to the threat of redundancy when discussing the relevant history with medics, most obviously Dr Bourke, in the circumstances set out above, that deliberate failure may have been motivated by the belief that the case that he was advancing, that the accident caused his symptoms, was not a genuine one. In other words, the resolution of issue 6 in the Defendant’s favour might support the resolution of this issue in its favour. On the other hand, if there is a favourable finding to the Claimant on this issue in that the Claimant’s redundancy was not in fact relevant to his subsequent symptoms, this may assist the court in determining whether his failure to refer to the redundancy was dishonest. Thus, the resolution of

this issue in the Claimant's favour might assist in the Claimant's favour on issue 6. It follows that in reaching my conclusion on both of these issues, I have had to bear in mind the relevant material and arguments relating to each of them to reach overall conclusions that can properly be derived from the totality of the evidence.

176. What is relevant for the current issue is whether the Claimant's redundancy rather than the accident was the cause of some or all of the symptoms which he may genuinely have suffered. The Defendant contends that the Claimant has believed from the time of the discovery in March 2015 referred to in the May 2015 Document that he was at significant risk of redundancy in 2015. Dr Bird's evidence, in his desktop report of April 2017, that such knowledge was likely to be a severe stressor. It is more likely than not that the Claimant deliberately suppressed reference to the redundancy because he in fact believed that redundancy was unrelated to the accident but that, because it was in his words an "*incredibly humiliating event*", it was a probable cause of ill health in any event.
177. The Claimant counters that the Defendant is misreading the May 2015 Document. At the time of the accident, redundancy was no more than a possibility. In particular, given what Mr Walsh had said about the role not being "*immediately redundant*" and the decision being dependent upon the appointment of a new group Head of IT (which in the event took some months), the Claimant did not consider himself at imminent risk of being made redundant at the time of the accident. It was only when he was in fact made redundant, after the accident but before a new group Head of IT was appointed that the extreme emotions referred to in the May 2015, that the extreme emotions referred to in the May 2015 Document were provoked.
178. Accordingly, it is necessary to consider the Claimant's reaction to his finding about the risk of redundancy and in particular whether the May 2015 Document reflects his state of mind at or around the time of the accident. There are several significant pieces of evidence, independent of what the Claimant has said during this litigation. that may suggest that this is not so.
179. First, the GP notes of 9 and 17 April 2015 both record him as being apparently keen to return to work. This does not lie easily with the emotive terms of parts of the May 2015 Document and suggests that at the time of those GP attendances he did not harbour negative feelings towards his employer.
180. Second, when Rev Long was asked whether he had been made aware of the threat of redundancy to his son in March 2015, he said that he had not but then volunteered that, when the Claimant had returned to the parental home with a view to returning to work on 20 April, the Claimant had arrived in a new car and was excited about going back to work. Rev Long presumed from this that his son was not anticipating being made redundant, since it would have been illogical to buy a new car had he seriously thought his job to be at risk. This was an entirely new piece of evidence

in cross-examination and, understandably, the Defendant was not able to put an argument that the witness had misremembered or mistaken things, still less that he was not honest in this account. I am cautious about laying emphasis on matters that arise in the middle of a witness's evidence like this, since there is a risk of evidential unfairness to the opposing party when they cannot deal with the point. However, I cannot ignore that it was said and I was struck by the open fashion in which Rev Long made the point. He seemed to have a clear memory of it and on balance I accept his account that, indeed, his son arrived in the new car when he returned to the parental home in April 2015 and that the Claimant gave no suggestion to his parents that his job was at risk from redundancy. Of course, one must bear in mind other evidence as to the Claimant's tendency to keep matters to himself.

181. Third, it is notable to see how the Claimant is recorded as expressing himself in the meeting on 20 April 2015. Of course this meeting shortly preceded him being, as he put it in cross examination, thrown out of the building. The note of that meeting does not suggest any of the emotion of the May 2015 Document, nor does it even refer to the previous "inadvertent discovery." If Mr Long's state of mind on the issue at that point was anything like was it set out in the May 2015 Document, it is difficult to understand why he did not apparently express any of that emotion or indeed anger in the meeting when redundancy is being formally addressed. If he expressed any emotion or anger, one would expect at least some reference to it in the note of the meeting.
182. Fourth, as Mr Grant pointed out in closing submissions, if the Defendant had any evidence to support the contention that the Claimant was showing sign of psychological illness prior to the accident, one would expect it to have adduced evidence to this effect. For example, it would be surprising if the kind of extreme reaction described in the May 2015 Document did not generate email traffic or other internal communications at the time of Mr Long's "inadvertent discovery" if the response was so extreme at that time. The Defendant has had the opportunity to produce such evidence, yet none is forthcoming.
183. Fifth, as I have commented already, the May 2015 Document is itself somewhat inconsistent in tone. The document certainly states that the Claimant was upset on making the discovery on 10 March 2015, and the passage, "*Accidentally finding that your job is being replaced, because someone doesn't think you are up to it, is incredibly humiliating*" is suggestive of an extremely adverse reaction to the discovery at that time. However, the tone of the document is that what Mr Walsh had to say to the Claimant was reassuring. This apparent inconsistency might be explained by the Claimant's case that he believed that he potentially had a future with the Defendant and that the question of redundancy was to be resolved some time in the future, when person was recruited to the new role. On this explanation, it was only when Mr Walsh essentially reneged on what he had to say in March 2015 by making the Claimant's job redundant forthwith in May 2015

that the extreme reaction occurred. Of course the May 2015 Document by definition post-dated those events.

184. I find these five points taken together to be powerful evidence in support of the Claimant's case that the May 2015 document is being misinterpreted and that his reaction to the redundancy risk only arose in May 2015. On the balance of probabilities, I accept that case. This being so, the redundancy risk was no significant stressor at the time of the accident and does not adequately explain the significant symptoms of which the Claimant complained in April 2015.
185. I return then to considering whether the Claimant suffered other symptoms falling with the Mayo Classification and if so whether they were caused by the accident.
- i) On the issue of visual disturbance, the Claimant complained of this from an early time and I am satisfied that the Claimant suffered some symptoms of visual disturbance.
 - ii) The Defendant has not seriously disputed that the Claimant has suffered headaches, merely doubting that the cause was the accident. I accept from the records that these have consistently been referred to and therefore are probably a genuine complaint.
 - iii) As to vomiting, I am satisfied that the Claimant's account of being sick both overnight after the accident and on the night of 29 March, both incidents being corroborated by medical records and the second by Rev Long. The Claimant's apparent assertion to Dr McGlashen in January 2016 that vomiting was not a feature of his first CoC visit is most probably explained as an error of memory, it being probable that his recollection now of vomiting on that first visit being a product of his memory being prompted by the notes. However, this error shows quite how inaccurate the Claimant's recollection may be and simply adds to my caution in accepting his evidence in so far as it is not corroborated by more reliable sources. For example, I am not persuaded that he vomited during the journey from Norwich to Cheshire shortly before the second CoC attendance. Had he done so, I would have expected to see reference to it in contemporaneous documents, in particular the CoC notes on the second attendance.
186. Taking my finding of PTA with the other symptoms referred to above, I am satisfied that the Claimant did in fact suffer mTBI in the accident, causing vomiting and visual disturbance apparent in the immediate post-traumatic admission, as well as the developing pattern of symptoms that had become apparent by the time of the second CoC admission on 30 April 2015, which on the balance of probabilities were caused by the development of migrainous headaches in the days following the accident. As to the developing symptoms thereafter, it becomes increasingly difficult to unpick the immediate physical consequences of the head injury from other causes. Further, in so far as other symptoms that were referred to by the reporting experts are concerned, I am not persuaded that the Claimant suffered symptoms that were not

contemporaneously reported in this first period. Given his admitted willingness to report what was wrong, coupled with the care that he took in reporting matters to Dr Rittman in particular, it appears to me that he is probably wrong to say that he suffered loss of the senses of smell and taste and/or photophobia in this early period, these not being recorded in the contemporaneous notes. It is more probable that the Claimant is, for whatever reason (as to which I shall consider further below) is misstating the symptoms that he suffered in this early period.

187. The position with dizziness and balance problems is less clear. In the list of symptoms given to Dr Rittman, it is stated, “*pain to RHS head gives feeling similar to low blood pressure, makes me dizzy and feel awful. This also makes me feel as if I could fall unconscious (happened twice).*” On the other hand, as is noted in the later chronology below, dizziness is reported as a “*new*” symptom by the GP on 27 August 2015. This would tend to indicate that any dizziness was a mild or intermittent problem.
188. The neuropsychiatrists agreed in their first joint statement that the Claimant began to develop a depressive disorder in May 2015. They note, in particular, the irritability referred to by Dr Rittman.
189. A specific issue arises as to the neuro-imaging carried out. As can be seen from the chronology above, the Claimant underwent a CT scan on 24 March 2015 which was reported as showing “*no intra cranial haemorrhage, no skull fractures.*” A scan on 30 March 2015 was reported as showing “*no intracranial haemorrhage. Apparent thin isodensity in the extra axial space overlying the right frontal lobe is impression of cortical vessel rather than extra axial collection.*” Dr Fletcher queried whether the CT scan show a right occipital contusion or merely was the torcula where the sinuses converge. A later MRI scan, performed on 29 May 2015 was normal. Dr Nichols considered that, with mTBI, imaging lacked sensitivity and therefore the normal imaging did not exclude widespread brain injury at a microscopic level. Indeed, in cross examination he added that even the more sensitive susceptibility weighted imaging (which was not undertaken here) might often be negative when such damage was present. Dr Heaney on the other hand considered the neuro-imaging to be reassuring and to provide, as he put it in the joint statement, “*strong weight to the view that not significant or enduring brain injury occurred.*” In cross examination, Dr Heaney stated the very injured brain with a lot of changes visible on MR scanning would likely involve the person having considerable neurocognitive deficit, whereas as a normal scan would typically be associated with someone who would be described as “*generally well.*” He accepted the proposition that it is possible to have a normal MRI scan yet in a person with clear neuropsychological evidence of brain injury, adding that the use of susceptibility weighted scanning would increase the prospect of picking up any signs of brain injury. Dr Heaney accepted that it was “*unsafe*” to exclude mTBI in the face of normal scanning.

190. However, the Claimant variously reported that he had had a “*small bleed*” (GP note of 9 April 2015) and the more sinister “*internal swelling and bleeding intracranially of brain*” (accident report of 20 April 2015). For reasons dealt with in issue 6 below, the Defendant contends that this is an example of the Claimant exaggerating his symptoms.

Issue 4 - What were the Claimant’s symptoms and diagnosis/diagnoses from May 2015 and what caused them?

191. The chronology picks up from the 18 May 2015 and continue to 27 June 2019. My understanding is that the records stop at that date not because of there being no further attendances, but simply because these are the most up to date records available.

- 18.05.15 **GP:** Has seen the neurologist. Has been told will need at least three months off work. Post-concussion syndrome. No changes in symptoms. Main problem is short-term memory loss. Gets angry at times. But otherwise feels mood is pretty numb. Not sleeping well. Has been made redundant. Increase amitriptyline.
- 15.06.15 **GP:** “*Feeling down. No improvement in memory and headaches have got worse. Money problems as not working and work have been difficult and made him redundant. Wife stressed. Constantly forget things and can’t concentrate on doing anything. Sleep not bad. No current plans for self-harm. But if no better in a month would consider topping himself. Add low dose of sertraline. Review three weeks.*”
- 17.06.15 **Dr Agarwal, neurologist at NNUH:** MRI scan performed on 29.05.15 did not show any significant abnormalities
- 30.06.15 **GP** to whom it may concern. “*Mr Long is currently suffering post-concussion syndrome after a head injury... suffering quite severe disability... affecting his memory and concentration...suffering a constant headache... double vision... constantly forgetting things and forgets recent conversations, dates and appointments... unsafe to drive... may be unable to concentrate for a long period of time...*”
- 6.07.15 **GP:** He is slightly more able to deal with the challenges facing him, but struggling to be positive. Getting a dry mouth, no other side-effects with sertraline. No real change in memory. Waiting to hear back from neuro re-appointment
- 27.07.15 **GP:** Memory not improved. Feels quite numb to everything. Neurologist has said cannot bring appointment forward. Bad headache past week. Stopping him from sleeping. No change in vision. Naproxen for headache. Increase sertraline (100 mg).
- 27.08.15 **GP:** ongoing problems, poor memory ongoing. Feels little things coming back, but generally memory very poor. Has also been having dizziness – new – when moves head feels unsteady on the walking not right and nauseous. Also feels that his face is distorted and swelling around left ear slightly around right – had for over 3 weeks. Headache no better with naproxen. Prochlorperazine for vertigo, 5 mg three times daily

- 8.09.15 **GP:** Nosebleeds since starting Stemetil. Both nostrils. Left today for nearly 3 hours though
- 16.09.15 **Dr Arthur-Farraaj, SpR in neurology, NNUH:** *“He is likely suffering from a post-concussion syndrome following a minor head injury... He has subsequently had a normal MRI brain scan. When he was first seen he was complaining of a number of symptoms including general tiredness, anterograde amnesia, problems with hearing and sleep. He was working as the head of IT but has been off work since March and it now looks like he’s going to be made redundant.. He reports that he still experiences the pain of the injury and that most of his symptoms are not improving. Worryingly, he has also mentioned that he has been feeling quite suicidal recently and even went to the extent of buying a rope... I think a lot of his symptoms may be being compounded by an underlying psychiatric disorder. If this is treated or ruled out then I think we could make a referral to the neuro rehabilitation unit at the Coleman hospital.”*
- 17.09.15 **GP:** *“Dr Farraj, neurology registrar called. Several suicidal thoughts and had bought a rope, but then said that this shocked him and was not going to actually do anything. Moderate suicide risk. Doesn’t think imminent risk but does need urgent psych review – children are protective factors.”*
- 18.09.15 **GP:** *“Long chat regarding mental health. Feeling very down. Can’t look past tomorrow and does not see hope in the future as not improving and can’t see that this will happen. Has been researching ways to kill himself. Has been out and bought a rope and knows where he would hang himself, bought it a week ago and has not acted on it - family are protective factor. Asked him to get rid of the rope and refused - said if he threw out the rope he would have to find another way to kill himself. Wife aware re low mood but not suicidal thoughts. No history of suicide attempts. No significant mental health history - I will call crisis team.”*
- 25.09.15 **Crisis Resolution Team (“CRHT”):** *“Stephen continues to engage with the crisis resolution team. He has no suicidal or self-harm thoughts... He does report some slight sedation from his mirtazapine...”*
- 25.09.15 **GP:** *“Seen crisis team daily currently – still thoughts of self-harm but has agreed to give treatment with them ago. Are assessing him from neurological side of things as well and have stopped his sertraline. No real change in mood. Memory ongoing problem.”*
- 9.10.15 **GP:** *“Still being seen by the crisis team daily. They are talking about possible short-term admission for medication changes and have changed into mirtazapine and he is struggling. He has been worrying a lot about BP since they told him it was high. Doesn’t feel memory improving, although to me does seem to have got better – able to talk about what is happening with crisis team and dates etc. USS reassuring so happy with this.”*
- 9.10.15 **CRHT.** Referred by Dr Needham (GP) on 18/09/2015. Suicidal thoughts/plans (not active). Head injury six months ago. Memory loss since this time. Made redundant/ consequent financial concerns. Low mood for a few months. Unable to see a future. Not sleeping, reduced appetite. Current medication: sertraline 100 mg, amitriptyline 100 mg, tramadol 200 mg twice daily, betahistine dihydrochloride 8 mg three times daily. Impression: the risk of suicide in relation to head injury, the restrictions that this is placed on his life and consequent self-

esteem issues. Taken on for monitoring of risks and to ascertain whether there is a depression was treatment following advice from middle grade doctor on call.

- 23.10.15 Discharge Letter from **Norfolk and Suffolk NHS Foundation Trust**. Date of admission: 12/10/2015; Diagnosis: (1) Moderate Depressive Episode with Somatic Syndrome [ICD-10 F32.11]; (2) Post-Concussion Syndrome [ICD-10 F07.2]. Date of discharge: 20/10/2016. *“Reason for admission: ... following urgent referral from GP due to increased suicidal ideation. He had no active plans but felt he could no longer cope at home. Had been with CRHT for about 4 weeks... Treatment, interventions and progress: ... On one occasion he was found with a belt around his neck but no ligature marks. No other self-harming behaviours... Mirtazapine was increased to 45 mg, although he reported no improvement on the previous sertraline 100 mg or the mirtazapine 30 mg. He reported a decrease of suicidal ideation and was happy to engage with the CRHT... We have not observed acute clinical symptoms of depression and it appeared that the suicidal ideation was becoming more from being fed up with his general physical presentation following hitting his head in March 2015 and remaining with poor memory and difficulties in concentration that seem to fluctuate...”*
- 29.10.15 **GP:** Mirtazapine 45 mg. Recent discharge psych, thoughts regarding self-harm, but no active plans. Discharge just over a week go. Seen crisis team once only in that time. Is seeing psychologist, however and she is doing further testing. Hoping that will be able to consider rehab.
- 6.11.15 **GP:** Ongoing issues with low mood, poor memory. Not sleeping well. Using zolpidem.... Clinical psychologist is referring to Coleman for rehab.
- 7.12.15 **Dr Durrance-Clarke, clinical psychologist:** *“... Stephen’s most significant deficit was in his working memory where his score only fell within the second centile and therefore extremely low. This means that Stephen’s current ability to temporarily store and manipulate information is very poor and fits with his described clinical difficulties... Suffered what appeared a relatively minor head injury but has since suffered ongoing physical and cognitive repercussions as a result. Understandably this has also had a significant impact on his mental well-being as he subsequently lost his job with an IT firm, has financial concerns and struggles with even day to day functioning. His tendency towards being someone who is easily critical of himself with high expectations means he can become caught in a negative cycle in terms of thoughts, feelings and behaviours. There is indication that some of the symptoms he describes may have a psychosomatic component although clearly the results above to demonstrate ongoing cognitive deficits. Understandably Stephen’s fear that he will not recover beyond his current function and the impact that will have on himself, his career prospects and his family...”*
- 24.12.15 **GP:** *“Suicidal ideation (first). Ongoing low mood, some suicidal thoughts ongoing, but no plans. Says he is unsure who to call if worsens over Christmas period.”*
- 7.01.16 **GP:** Suicidal ideation (review). Ongoing low mood. Feels he is clinging on till the rehabilitation appointment on Monday. Feels would be better off dead. Trying to battle against this thought. Family protective. No active plans.
- 13.01.16 **GP:** Suicidal ideation (review). Feels rehabilitation appointment was useful. They are organising occupational therapy and psychology but ? when. Feels suicidal

ideation increasing again, not to the stage as before (bought rope) but thinking through options of how to kill himself. No definite plans but feels he is on the same road as before. Does not want to be admitted as felt it achieved nothing. Agree no need for admission at this point but I feel needs assessment again as things are getting worse ? medication review from psychiatry also as feels mirtazapine which they started is not improving things.

- 17.01.16 **Dr McGlashan, Consultant in Rehabilitation Medicine**, The Colman Centre for Specialist Rehabilitation Services. *“Diagnosis: 22/03/2015 – head injury, secondary to collision with doorframe whilst running - resulting in post-concussion syndrome; fibromyalgia... he ran to help a colleague lift a heavy cupboard and struck his head on the door frame, which was in the basement. The only witness was the one colleague. He is unclear if he was knocked out and whilst he can remember the details prior to the accident, his next recollection is being upstairs. He reports being able to complete his work tasks, but it was overnight when problem started becoming apparent. He also managed to drive the 20 minutes from his workplace to his accommodation which was with his parents in Chester. In retrospect he describes this as "all a blur" and overnight he reports the development of strange sensations including his whole body feeling "tingly". These symptoms resulted in an admission via Chester A&E, where he was kept in for observation and had a CT scan, reportedly normal and was discharged later the same day. Vomiting was not a feature. The day after this, he drove a 4 hour journey back to Norwich on the Thursday (the head injury was on the Tuesday) and on the Sunday he drove back to Chester where he vomited overnight. He reports no second additional blow to the head. On the Monday (7 days after the original injury) he was readmitted via Chester A&E and re-scanned. His hearing was checked and reported to be reduced in one year. He reported double vision and nausea, and found that turning his head quickly was uncomfortable. He stayed in hospital for 4 days and was discharged and came back to Norwich. He stayed off work for approximately 3 weeks and on the first attempt to return to work, he managed 35 minutes before feeling unable to continue and a second attempt he reports being at work for 4 hours before being made redundant and was given 3 months' severance pay. Since this time, Mr Long has been struggling with fairly constant symptoms which he attributes to the head injury, involving day-to-day memory issues, poor concentration, headaches, double vision, impaired processing, disequilibrium on movement and intermittent tripping. He was seen by the neurology team on 30 May and an MRI scan was organised and reported as normal. He demonstrated ocular diplopia and reduced sensation in the right forehead (the blow to the head was to the left forehead) and tinnitus. It was also reported by his wife that he was angry and irritable. By the time of his next neurology review on 18 September, his mood had dropped significantly and he reported suicidal ideation, having bought a rope and having a plan for using it. This precipitated a crisis team assessment and voluntary admission... He had been started on mirtazapine which was rapidly increased to 45 mg at night. He was reviewed by a clinical psychologist, Dr Jamie Durrance-Clarke, who performed neuropsychological assessment which demonstrated: ...immediate memory 16th percentile, visuospatial/constructional 50th, language 22nd, attention 50th, delayed memory 0.9th, total 13th... Working memory 2nd centile, immediate memory 9th centile (visual worse than verbal), delayed memory 118th centile. This precipitated a referral to the Colman Centre service.... Current clinical status: Mood: Mr Long reported that his mood had become more vulnerable again since New Year's Eve, with recurrence of suicidal thoughts... He was anxious about the assessment today and has been seen by the GP last Thursday.... Mr Long reported that prior to the head injury he had no previous mood issues and that he felt all his current problems were due to the bang on the head. He was upset that the*

Mental Health Team had been looking for previous mood issues to attribute his difficulties to and did not agree with what had been put in his discharge summary... Sleep: Mr Long goes to bed at 10.30 at night and will get to sleep after midnight. He gets up to pass urine twice per night, which is usual for him... Headache: "all the time", from waking up in the morning to going to bed at night. Fluorescent lights are an aggravating factor... Cognitive function: "I cannot process information". Reports feeling easily overwhelmed and maths being problematic. Forgets sequences of tasks and multi-tasking impaired due to poor concentration. Reports walking into a room and forgetting why he is there. Has left the tap on within the house on frequent occasions and has also left the oven on and picked up hot objects from the oven. No other risk related activities reported. Feels memory is his main issue, with new learning being a major problem and also "knowing where to start" a task... Reports was previously a very process driven personality, rather than creative, but is finding his logical approach is now impaired... Drugs: amitriptyline 100 mg, baclofen 10 mg tds ... mirtazapine 45 mg nocte, paracetamol qds, zolpidem 5 mg nocte (previously tried Zopiclone), tramadol 200 mg SR... Summary: Mr Long experienced a blow to the head in March 2015, which has resulted in symptoms in keeping with a post-concussion syndrome. This has resulted in loss of his job and his range of symptoms involve disturbed vision, headache, altered sensation, variably impaired mobility and a range of cognitive issues including difficulty with fatigue, memory, multitasking, attention and processing, all of which are enduring symptoms. This precipitated a significant drop in mood with suicidal ideation including the means and plan.... I assured Mr Long that we see people in the service with this array of symptomatology and that there are things that can be done to help them improve and to offer support. Previous neuropsychological assessment has indicated difficulties in the areas as outlined... Plan: 1. Refer to psychology for assessment and management of PCS and subsequent mood disorder; 2. Refer to occupational therapy for functional everyday support with consideration to be given to longer term activity."

- 27.01.16 **GP:** Suicidal ideation (review). Ongoing low mood, not feeling actively suicidal, has mental health appointment next week for, along with psychology and occupational health the week after.
- 5.02.16 **Victoria Savage**, Norfolk and Suffolk NHS Foundation Trust. *"His priority was to change his mirtazapine as his eye condition has worsened to the extent that he is finding it unbearable. It was suggested that mirtazapine could be interacting with the amitriptyline he is prescribed for pain. I have advised that this should be changed back to an SSRI. Stephen felt sertraline was not helpful so I think he should try citalopram as alternative to mirtazapine... I did however warn him and that his eye condition could be part of a fibromyalgia flare and not necessarily change with the medication.... The frustration and sadness he feels is very much connected to his memory loss..."*
- 10.02.16 **GP:** Suicidal ideation (review)... Did not find assessment very helpful. Felt not individualised and that was told how he was feeling rather than this explored. Has psychology booked in regularly via Coleman. Feeling positive about this. Up and down with negative thoughts, not currently and no plans. Titrate onto citalopram, has already stopped mirtazapine without ill effects.
- 24.02.16 **GP:** Suicidal ideation.? Some progress. Feeling numb and ambivalent rather than desperate. Seeing psychologist. Suicidal thoughts still present but under control.

- 11.04.16 **Dr Cochius, Consultant Neurologist:** “... Symptoms following on from head injury that he had sustained in March 2015. It would appear that he ran into a low door frame and struck his forehead on the frame, possibly experiencing a brief loss of consciousness but the details surrounding the episode are a little unclear. He has been seen by the Neuro Rehabilitation team at common hospital and I am sure you have received a copy of their letter from January 2016, which outlines the ongoing problems in great detail. He continues to complain of memory problems, both short and long-term memory and persistent right-sided fronto-parietal headache, which is constant in nature, variable in intensity, often made worse if he is exposed to bright light or refusing a busy noisy environment. He also continues to complain of low mood and I see that his antidepressant medication has been switched from sertraline to mirtazapine and most recently to citalopram. I believe that he has had clinical psychology input from the Colman Hospital since February this year but also attended the psychiatric clinic at Hellesdon Hospital this year when his antidepressant medications were reviewed. His neurological examination today was normal, in particular his ocular movements were normal. In the limbs he had normal tone and power, his reflexes were 1 – 2+ and symmetrical throughout, both plant responses were flexor. There was no limb or gait ataxia. As you know his MRI brain scan was normal. I have tried to reassure him that there does not appear to have been any serious brain injury based upon both his neurological examination and his normal brain scan but that these sorts of problems that he is describing are not uncommon consequences of head injuries, from which people make a gradual recovery. I think he is best supported by the Neurorehabilitation environment. I do not feel that he requires regular attendance at the neurology department.”
- 14.04.16 **GP:** Suicidal ideation (review). Felt dismissed by neurology appointment was making progress but after his mood crashed and felt suicidal again. Psychologist Tuesday. More controllable now feels little improvement from citalopram. Wishes to increased dose.
- 22.04.16 **Colman Hospital Records. Alison Woods.** “... Described feeling more agitated and easily irritated by domestic frustrations and poor drivers although he feels this is very poor and he also reports feeling calmer. Stephen reported that citalopram was increased recently and he temporarily stopped his sleeping tablets he wondered whether tiredness could have increased as irritability ... ”
- 04.05.16 **GP:** suicidal ideation (review). Stable at present. BP has been a "distraction".
- 12.05.16 **Dr McGlashan:** “Diagnosis 22/03/2015: mild head injury secondary to collision with door frame whilst running, resulting in post-concussion syndrome; fibromyalgia. ... Behaviour and mood: Stephen describes himself as frustrated and irritable. He is short fused, triggers being the repercussions of his memory difficulties. Stephen also reports that other people's inconsiderate behaviour will trigger him. Stephen says he now is more likely to express his feelings verbally, whereas previously he would have held counsel. The episodes of irritability and anger occur mainly within the family but will involve others including strangers. From a low mood perspective, Stephen reports he is not “as bad” as previously, with less frank suicidal ideation. He will still ask himself “what is the point?” and has a sense of helplessness. Stephen reports that not knowing the endpoint regarding his recovery is difficult. On further questioning, Stephen confirmed he has no current plans for self-harm and feels he is more likely to speak to someone about any dip in mood should things escalate... Headache: Stephen reports his headaches have increased in severity. He describes them as right frontal and right

sided headache, with predominantly sharp pain which is constant, with exacerbation. He is light sensitive and noise sensitive and report occasional “spots before the eyes”. Stephen gets no neck pain, but may feel anxious with the headaches. Note he has previously tried gabapentin and pregabalin for his fibromyalgia symptoms, which both induced nausea. Stephen feels the amitriptyline is helping with his fibromyalgia symptoms.... Fibromyalgia: Stephen was on meloxicam but this was changed to baclofen a while back. He is unclear if the baclofen is helping. He remains on tramadol. He reports dry eyes, which is likely due to a combination of drugs with anticholinergic side effects.... Vision: Stephen’s visual distortion is unchanged, which he describes as being 3-D overlay of one image out of line with a second deeper visual image of an object. If he shuts one eye, he reports the distortion is improved but still present, therefore unlikely an ocular control issue.... Memory: Stephen reports ongoing significant issues with his day-to-day memory and feels this is the number one issue that he would like to have resolved. We discussed that it might be more of an attentional deficit, interfering with his ability to lay down new memories... Drugs: amitriptyline 100 mg nocte, baclofen 10 mg tds, citalopram 30 mg od, paracetamol, zolpidem 5 mg nocte, tramadol 200 mg SR bd, amlodipine 5 mg od.... Discussion: As has become evident in Stephen's discussions with Dr Alison Woods, clinical psychologist, Stephen sets himself very high standards and is very self-critical if he does not maintain high standards. We discussed the notions of being alert to and spending energy and time on self-criticism was actually taking up cognitive space that could be better used in supporting his memory and other activities. If Stephen were to cut himself a little slack but not habitually get annoyed and frustrated when things do not always go to plan, I indicated that I felt this would be positive, as there would be more space and energy left the using his areas of cognitive strengths, which would enable him to be more positively productive ...”

- 23.05.16 **GP:** See patient – symptomatic with blood pressure high... Awaiting rehab but Stephen states she suggested beta-blockers to see if would help headache also – seems sensible.... No change to mood, not currently suicidal. Keeping mood diary at present which he is finding difficult.
- 6.06.16 **GP:** Headaches much the same. Ongoing suicidal ideation but no planning or intent. Cannot see a way out of this at present. Having ongoing psychology support.
- 15.06.16 **GP:** “... *Increased suicidal thoughts, some intent last week but has been able to rationalise it. No active plans. Reports I am “on the list” for people to contact if this develops. Agreed med review needed. Does not appear citalopram is helping. Unable to increased dose any further as per letter from rehab. Refer back mental health urgently. Seeing psychology Fri and appt with me next week...*”
- 22.06.16 **GP:** “*Increase to 5 mg (ramipril) and review again two weeks. Ongoing parotid swelling? Slightly worse. Certainly thinks he has had it since tonsillectomy in 2011. Not yet heard mental health team – will let me know Monday if still heard nothing. Ongoing low mood with suicidal thoughts but feels slightly better after discussing with psychologist today. No active plans. Would certainly benefit from psychiatrist review.*”
- 11.07.16 **DVLA letter** revoking his driving license on the ground that he suffered from double vision

- 20.07.16 **GP:** has had ongoing double vision since the accident. Sees multiple images even with just one eye. Ophthalmologist in Chester last year. Nil they could find but said okay to drive. Did not try orthoptics etc to help. Just got DVLA banning from driving into improved. Refer ophthalmology for assistance ASAP as has had a "devastating effect". Seeing psych tomorrow, also seeing if Coleman able to help.
- 29.07.16 **Mr Puvanachandra, consultant ophthalmologist.** *"Thank you for asking us to see Stephen who had a traumatic experience earlier this year with ongoing symptoms for which he is receiving rehabilitation. He has been seen in Chester as you said by ophthalmology who found no evidence of problems. I am glad to say that from an ophthalmic point of view, Stephen is entirely fine. There is no evidence of binocular problems. His eyes are normal and he has 6/5 vision in each eye. His symptoms of multiple images are I think a post-traumatic stress type symptom. They are not organic in nature. The higher brain processing of vision I think is more at fault here.... I do not think he fits the double vision criteria that would exclude him from driving from the DVLA, but of course he needs to take that up with the DVLA and he can use this letter in correspondence with them..."*
- 01.08.16 **GP:** *"Holding on waiting to see psychiatrist. Mood low due to variety of factors. Suicidal thoughts present but controllable. Has seen eye clinic..."*
- 17.08.16 **GP:** Much the same. Has not heard regarding psychiatrist review... Has referral for driving assessment in hand. Does not see the point in appealing DVLA at this point.
- 1.09.16 **GP:** citalopram 20 mg once daily (GP records) - Venlafaxine 37.5 mg but I'm unsure about mixing it with other agents
- 16.09.16 **Mr Chojnowski, Consultant Orthopaedic Surgeon, NNUH.** *"Diagnosis: Right index finger PIP joint pain. Stephen has returned with a very good range of motion to the proximal interphalangeal joint of his right index finger when he injured a year ago. He however remains frustrated with the pain which he particularly feels along the ulna aspect of the joint ... I note from reviewing his clinical notes that he does have a post-concussion syndrome after injuring his head against the door frame in March 2015 and has seen a consultant in rehabilitation medicine. Part of his issues include significant anxiety..."*
- 19.09.16 **GP:** citalopram 10 mg once daily; ramipril 5 mg once daily– *"Finding coming off citalopram difficult. Mood low and withdrawn. No change to chronic suicidal thoughts.... Written instructions given for citalopram 10 mg this week with venlafaxine od, then stop citalopram next week and go on to venlafaxine bd. Review 10 days or SOS."*
- 29.09.16 **GP:** Headaches and slight drowsiness on changing medications but wishes to persevere. Some dark thoughts at times but controlling them. Psychologist currently off sick but should see him next week. Increased dose slightly and see again 10 days.
- 13.10.16 **GP:** Headache severe this week but also numbness right side of face... Trigeminal neuralgia? Try carbamazepine
- 26.10.16 **GP:** Suicidal ideation.

- 31.10.16 **Dr McGlashan.** “... *Headaches: Stephen reported that his headaches were very bad for to go and he saw his GP who started on carbamazepine which is now increased to 200 mg twice a day, which is taken the edge of his headache. Carbamazepine will also have an additional benefit of acting as a mood stabiliser. Stephen did not try the propranolol as previously suggested.... Antidepressants: Stephen has been switched from citalopram to venlafaxine and is currently on 75 mg in the morning and 112.5 mg at night. Stephen had previously been on venlafaxine and had previously noted some twitching of his fingers which is now recurred.... Nocturnal movements: Stephen reports that whilst he is asleep his wife reports that his limbs jerk/kick out. They also occur in the evening when he is very tired. These movements sound like myoclonic jerks.... Stephen reports he does "zone out" for a period of time and can stare into space and is able to be distracted from this. He reports he sometimes feels confused. These episodes been ongoing since his bang to his head and do not sound epileptic form in nature, but rather due to the fatigue and loss of attention.... Falls: Stephen reportedly loses balance and fall down curbs and he avoids uneven ground. Since starting on venlafaxine he stopped riding his bicycle due to balance.... Fibromyalgia: this has currently settled... Mood and anger management: Stephen reports increased frustration, especially with things going missing and minor things will make him lose his temper and he may shout and swear, but he does not get physically aggressive. He reports that he has had road rage... He was cycling to the Coleman... Stephen reports he wants to do things and go places but has increased anxiety regarding going to new places... Memory: Stephen reported a relapse in terms of episodes of flooding of the kitchen through forgetting to turn off the kitchen tap...*”
- 2.11.16 **Dr Umezina, locum consultant psychiatrist.** “*He was able to tell me that his depression started after a work-related accident in March 2015... He said that since this accident, his depression has worsened and he presently experienced poor memory and angry outbursts which are mainly directed at his family... He has been off work since March 2015 and the legal proceedings relating to the particular industrial accident...the company have admitted liability. From what he told me today it appears there has been a significant personality change in him. He reports his sleep as poor (five hours of broken sleep), but said his appetite was okay... He describes his motivation and energy as variable. He does entertain some guilty feelings... He denies any active thoughts of self-harm, suicide or harm to others... In terms of medication he has tried, he recalls having been on mirtazapine, sertraline and citalopram. He tells me that he is not happy with venlafaxine and associated this with some side effects... He appears to be struggling mentally now. He appears to have suffered personality change and his depression is getting worse. Having said this, he does have a lot of resilience and is trying to come to terms with his current situation and predicament.... Please follow my advice regarding how did reduce and stop venlafaxine and how the same time to introduce and increased trazodone... I have not given him a further psychiatric outpatient appointment. He has been given crisis information.*”
- 22.11.16 **East Anglian Drivability Driving Assessment Report:** In conclusion, based upon the evidence gathered on the day of the assessment, there appears to be no reason why Mr Long should not be able to drive safely
- 13.12.16 **Dr Mamutse, consultant neurologist.** “*Diagnosis: Functional myoclonus... You have referred him because of involuntary nocturnal body jerks... Medications include the following: trazodone 150 mg twice daily, carbamazepine 300 mg twice daily, ramipril 7.5 mg once daily, amitriptyline 50 mg at night, Tramulief 200 mg*

twice daily, amlodipine 5 mg and paracetamol 1 g four times daily.... I explained that his jerks are functional jerks, unrelated to damage to the neurological system... I have reassured that he does not have epilepsy and discharged.”

- 8.02.17 **GP:** Suicidal ideation. Low mood ongoing. Frustrated as does not know whether this is it long-term now. Not suicidal currently. Fleeting thoughts of ending it but no plans. Seeing caseworker and waiting review with Coleman as to the next plans
- 27.02.17 **Mr Chojnowski.** *“Diagnosis: chronic pain right index finger post collateral ligament injury. Approaching a year-and-a-half since the traumatic injury to his right index finger, Stephen continues to get severe pain associated with the proximal phalanx joint of the hand... We have discussed that he appears to have a significant chronic pain condition affecting the finger which otherwise remains very functional and has a good range of motion... His sleep is interrupted but he says by other things; not fingers. He does not take analgesia....”*
- 13.03.17 **GP:** Head injury. Bad news from DVLA. Go to ophthalmology consultant for direct letter to them. Feels "what is the point?" But no suicidal plans. ? being discharged from Coleman. Will ask if this can be delayed as no one to start rehab privately yet.
- 30.03.17 **GP:** Still feeling bleak about things. Weekly contact from psychologist. No current suicidal plans.
- 13.04.17 **GP:** Mood still very up-and-down. Catastrophising when things go wrong. Not actively suicidal. Carbamazepine 400 mg three times daily. Try increase carbamazepine.
- 24.04.17 **GP:** *“Suicidal ideation. Seen psychologist last Friday and disclosed to her that he had bought a rope again making plans for things to do though and says would not go through the due to the family. She feels he spirals downwards when ‘let down’ by somebody...”*
- 26.04.17 **GP:** Diagnosis: head injury. Mood still low. Has been calculating hanging himself so he can do it properly. Trying to work out what weights to use. Does not feel it is imminent but in-depth with planning. Agreed to referral back to mental health...
- 28.04.17 **Alison Woods, clinical psychologist.** *“I have been seeing Stephen since February 2016 for weekly specialist brain injury rehabilitation and psychology therapy. We are coming to the end of his rehabilitation package next month but several factors have recently triggered a re-emergence of suicidal thoughts intent and planning behaviours... These factors include changes and long delays with this compensation case, delays gaining his driving licence back, his inability to work currently and his very high expectations of others and consequent feelings of being easily let down and not supported and therefore more depressed and frustrated.... His planning around suicide has increased over the last few days... Stephen agrees that he needs long-term psychological therapy for emotional and psychological issues and crisis support due to increased level of risk which needs to be regularly assessed and monitored and the community to ensure that he is safe...”*
- 28.04.17 **GP:** suicide risk assessment: *“Stephen disclosed that he has bought a rope and now thinks about researching how to use it... No specific time disclosed... Stephen*

has considered a location but is unsure currently.... Stephen reports that he would consider action of things got worse.”

- 28.04.17 **GP:** suicide risk assessment. *“Current suicidal ideation, thoughts of hanging, has been researching various methods, history of similar actions which have previously resulted in hospital admission, states wife, children and dog as protective factors.... Taken on for him treatment for monitoring of mental state, review of current medications, referral for assessment the psychological therapies...”*
- 3.05.17 **Crisis Resolution Team Medical Review, Dr Martyn, Specialty Psychiatrist.** *“Stephen is able to talk to you mostly about his ongoing adapting to his memory problems. He is using eight memoirs etc but is still “flooding the kitchen three times per week”. He feels that he has come to the end of the input from Colman hospital... Well presented... No signs of self-neglect. Able to joke and self-deprecating manner appropriately... Feels he was “just about hanging on, feeling things were finally moving in the right direction” when he had two major setbacks. Agrees this is a crisis. Happy to increase antidepressant dose and engage with crisis resolution team. Diagnosis: post-concussion syndrome; recurrent depressive disorder...”*
- 4.05.17 **GP:** Under crisis team. Seeing every other day. Little change feeling more supported. However worried about longer term plans. Suicidal thoughts still constant but no immediate plans. Unable to tolerate 400 mg tablets of carbamazepine.
- 12.05.17 **Alison Woods.** *“... Diagnosis: Stephen was diagnosed with post-concussion syndrome following an incident in March 2015 in which he hit his head on the doorframe whilst at work. Stephen experienced several days of vomiting, headache and dizziness, although there was no loss of consciousness and brain scans were normal... Presenting problems: depression and suicidal ideation and planning activities... Anger management problems and frustration... Memory and concentration difficulties... Fatigue... Stephen is able to accept that some of his presenting difficulties are not related to his mild TBI and are related to premorbid coping style and personality factors... Ongoing concerns and risks: ... Persistent difficulties trusting others and fixed, inflexible attitudes to others with very high expectations of others (associated with a premorbid coping/personality style). Stephen presents at times with a sense of superiority and dismissiveness towards other people and their efforts (including within the therapy context at times) and at other times presents with a sense of vulnerability and low self-esteem. Stephen often expresses feeling let down by professionals around him whom he perceives as inadequate. As a result, Stephen often feels let down very easily by other people and concludes that others are not helping him and cannot be trusted to deliver on their promises which undermines his trust. This increases feelings of depression, despondency and hopelessness and at times increases suicidal feelings, intentions and planning behaviours.... Recommendations: psychological therapy/support to address the above personality issues... Continued regular community-based monitoring of his mental health and risk of self-harm/suicide.”*
- 17.05.17 **GP:** Much the same – up and down. Has been discharged by psychology... Crisis team still seeing. Difficulties with ongoing rehabilitation – had thought case manager would pay but now self funding. Ongoing suicidal ideation but keeps reading crisis plan to keep safe.

- 24.05.17 **Alison Woods:** *“I have now discharged Stephen Long from the CCSRS psychology caseload... I strongly feel that Stephen needs continued mental health support in the community to monitor his suicidal feelings and planning behaviours and I am glad that this is currently ongoing... I have also strongly recommended further assessment and therapy in the mental health team around premorbid problematic personality traits and coping strategies...”*
- 25.05.17 **GP:** Suicidal ideation. Mood up and down but feeling supported by crisis team
- 19.06.17 **Dr Durrance-Clarke, clinical psychologist:** *“... I feel that for Stephen at this point, rather than engaging in further therapy, the focus should be on filling his life with more meaning and activity again in order to provide with distraction and a positive sense of self-worth. Otherwise, the risk is that Stephen will become dependent on therapy as his only way of feeling able to cope with his thoughts and feelings, which is not the aim. Instead, the aim of therapy is to help empower the individual to feel able to cope with these feelings themselves. I would also recommend Stephen consider some of the courses on offer at the NSFT recovery college, some of which are co-facilitated by members of the psychology team...”*
- 19.6.17 **Dr Anna Swift, clinical psychologist.** *“Recommendations: it appears that Mr Long has received psychological input along with cognitive rehabilitation techniques. However, I wonder whether any of these interventions have been delivered with cognitive effort in mind. There may be value in engaging Mr Long in the treatment designed to increase awareness of effort and motivational factors. However, success and outcome will be dependent upon Mr Long engaging with this type of narrative rather than viewing his impairments as organic and related to a head injury...”*
- 22.06.17 **GP:** Discharge from crisis team. Things still up and down but better than they were. Still having suicidal thoughts but not constant.
- 29.06.17 **Dr McGlashan:** *“... Stephen reported that he is trying to remain positive and whereas previously his mind was crammed with suicidal thoughts, he now has more time for other positive mentation. He reports having done some positive things in the last week to 10 days, such as moving the fish tank, which had needed moving for a long time, moving his toolbox which is on wheels out of the garage and putting some things on eBay, all of which had a very positive effect... Stephen was the best I had seen in terms of eye contact, calmness and ability to communicate about his issues...”*
- 3.07.17 **GP:** Suicidal ideation. Feeling more positive. Case management moving along.
- 3.07.17 **Dr McGlashan:** ... unfortunately Mr Long's mood has plummeted ...most of the focus has been on supporting him with his mood as this has extended to suicidal ideation. From the disequilibrium perspective, Stephen continues to struggle. He reports difficulty walking straight lines and has trouble with uneven surfaces or slopes which he feels no longer naturally adjusts... I would be grateful if you could see Stephen and see if there is a vestibular component contributing to these symptoms...
- 11.07.17 **Dr Swift, clinical psychologist:** *“... on formal testing, Mr Long’s performance is extremely low and perhaps worse than when tested by Dr Durrance-Clarke. This level of global memory impairment and poor verbal skills and processing speed is*

not in keeping with the severity of injury sustained. The only explanation of this is reduced cognitive effort on testing and I suspect that his negative, self-critical beliefs regarding performance may be having an impact. It appears that Mr Long has received psychological input along with cognitive rehabilitation techniques. However, I wonder whether any of these interventions have been delivered with cognitive effort in mind. There may be value in engaging as long in the treatment designed increases awareness of effort and motivational factors. However, success and outcome will be dependent upon Mr Long engaging with this type of narrative rather than viewing his impairments as organic and related to a head injury. I would therefore recommend two sessions designed to assess engagement in this type of approach it would then be possible to determine whether a course of psychological therapy would be of benefit...”

- 14.07.17 **GP:** ... Suicidal ideation. Managing mood okay by keeping busy. Has not heard from well-being... Fell over two days ago and hurt foot....
- 1.08.17 **Ms Phillis, Lead Clinical Scientist’s Vestibular Assessment Report:** “...*Summary: Caloric testing did reveal a significant directional preponderance to the right which suggests a problem with the vestibular pathway but does not localised this to either peripheral or central pathology. From today’s testing we were unable to rule out a central pathology and some of the central concerns were indicated however we have identified that there is no permanent peripheral vestibular weakness. I do however feel that Mr Long will benefit from vestibular rehabilitation based on his significant motion and visual provoked symptoms. This has had a huge impact on his lifestyle and the HADS questionnaire was significant for both anxiety and depression...*”
- 17.09.17 **Dr Dilley, consultant neuropsychiatrist:** “...*Mr Long sustained a head injury with perhaps a short period of loss of awareness but no lengthy post traumatic amnesia or findings on neuro imaging either acutely or later on MRI.... He describes a number of ongoing somatic symptoms alongside cognitive complaints with predominant difficulties with memory and executive function. On balance I think it is most likely that a diagnosis of depression and anxiety are the most prominent mental state features which explain the constellation of symptoms which he describes. Certainly a head injury of the relatively mild severity that Mr Long experienced, would not explain the somatic symptoms which he has or any cognitive disturbance. Therefore I think that the most likely diagnosis is one of somatic symptom disorder and also of depression.... It would be most useful to establish a shared understanding of Mr Long’s difficulties through developing a clear psychological formulation through which he can understand his current diagnosis, the predisposing factors which make him vulnerable to this, which include pre-injury (perfectionism) as well as the ongoing maintaining factors for his symptoms. I would advocate a similar approach to that used in functional neurological disorders be used which at the same time provides compensatory strategies, cognitive impairments and also in turn manages mood...*”
- 08.11.17 **GP:**.... Really tired. Hardly went out during summer.... Mood lower, things due to tiredness. Thoughts of suicide and researched methods...
- 22.11.17 **GP:** ...Much the same.... No further plans for ending life. Just feels permanently low. Has wedding to attend this week, not looking forward.
- 6.12.17 **Dr Swift:** “...*Mr Long engaged well with the CBT aspect and was committed to completing tasks set and practising strategies. However, we discovered that there*

was very little gain or benefit other than a recognition that memory and word production is better with phonetic links than semantic cues. Mr Long understood the effect of activity on mood and at the time of this report, was using the gym more regularly albeit this was adversely affecting fatigue levels. Increased exercise leads to naps during the day which despite knowing may not be helpful, Mr Long felt unable to avert. In terms of cognitive therapy aimed at thought patterns of perfectionism and self-criticism, Mr Long's access to cognitions is limited and he feels he lives in a present orientated "bubble" whereby he thinks very little about the past or future. This was not amenable to change and this level of disconnection is likely to be a self-protection strategy. We have also been unable to make any real inroads into his illness beliefs. Whilst he understands the concept of cognitive effort or resources, his objective evidence is that there is 'something going on' and he believes his symptoms are not fully accounted for by mood or cognitive demand... I do not feel that any further neuropsychological intervention is likely to be effective and therefore feel further sessions cannot be justified..."

- 07.12.17 **GP:** Discharge from psychologist as no progress made. Feels quite a blow. Has legal appointment coming up. Stephen says wife concerned as unpredictable at home. No suicidal thoughts or plans at present.
- 10.01.18 **GP:** medication review. pain management to stop gabapentin. Patient not taken for three weeks. Start pregabalin. Not keen on venlafaxine at present. Will consider slowly stopping tramadol later but one thing at a time....
- 02.03.18 **Dr Dilley:** "... Prior to my consultation with Mr Long (14/02/2018), I was provided with a letter from Dr Anna Swift, consultant clinical psychologist, dated 06/12/2017. This reports that Mr Long had attended eight sessions of psychological treatment in which he had engaged well in the cognitive rehabilitation components of treatment, although it was noted. "However, we discover that there was very little gain or benefit other than a recognition that memory and word production is better with phonetic links than semantic cues. ... In terms of cognitive therapy aimed at thought patterns of perfectionism and self-criticism, Mr Long's access to cognitions is limited and he feels he lives in a present oriented bubble whereby he thinks very little about the past or future. This was not amenable to changes and this level of disconnection is likely to be a self-protection strategy. We have also been unable to make any real inroads into his illness beliefs. Whilst he understands the concept of cognitive effort or resources, his objective evidence is that there is 'something going on' and he believes his symptoms are not fully accounted for by a model cognitive demand." Mr Long himself reported that he has found psychological treatment "Okay" and that it had "helped with acceptance"... He reported that he was not "struggling with brain injury" but there remained difficulties in "moving on". I asked him directly what his explanation of his current symptoms was. Mr Long reported that he accepts that depression is part of "what is going on." But later acknowledged that "after three years, I am not accepting that depression is doing this". He explained that "I just accept the diagnosis," but when I asked him to explain what he had been told the diagnosis was, it was evident that he still continues to have illness beliefs regarding underlying neurological causes which make it hard for him, understandably, to accept the psychological formulation that Dr Swift and I have offered... We discussed his current treatment. He is taking a low dose of amitriptyline and also 1200 mg in divided doses of carbamazepine, which are very unlikely to be making any significant impact on his mood from the perspective of depression. However, he has clearly been on multiple medications in the past..."

Mirtazapine (2015), sertraline (2015), citalopram (2016), venlafaxine (2016) and trazodone (November 2016)... Mr Long presents with multiple persisting symptoms following a head injury without significant evidence of brain injury. In my opinion, the primary maintaining factors for his ongoing presentation are in the context of his mental health and it is my view that his diagnosis is akin to one of a functional neurological symptom disorder or somatic symptom disorder alongside current depressive disorder. His pre-existing perfectionist traits are also an important predisposing factor. He has had a number of treatments for mood, although I do not have information about the maximum doses of medications that he was treated on. It would seem sensible to consider augmentation strategies... Such strategies may include evidence-based augmentation approaches, including lithium and combination treatments. During the course of psychological treatment there has not been any evidence shifting his illness belief or his understanding of his presentation in the context of the psychological formulation and I do not think there will be any significant improvement in his mental state until Mr Long is at a point in his recovery where he is able to accept the relative role of psychosocial factors in maintaining his symptoms. To this end, I would agree with Dr Swift that there is no benefit in pursuing psychological treatment until Mr Long is ready to accept that improving psychological factors may have an impact on him rather than a concern about underlying neurological disorder. This is not an unusual position to be in, and I have treated many patients who have struggled to accept psychologically mediated maintaining factors in their presentation and have not been able to make significant gains in their recovery until they have been able to do this.

I think that in terms of the treatment plan going forwards, it would be useful for Mr Long to be referred to a consultant neuropsychiatrist in the NHS for ongoing follow-up ... ”

- 14.03.18 **GP:** Has reduced trazodone in view of starting another. He has not had a neuropsychiatrist so given copy. Aware will probably need referral for consideration of other medications. Stick to trazodone unless mood worsens, in which case, put dose back up.
- 22.03.18 **GP:** Feeling brighter, not so bleak. Thinks due to coming down with trazodone. Looks a bit brighter to. Continue on two at night to get to one month (02/04/2018), post dose reduction. If okay can then drop to 1 if keen to do so...
- 29.03.18 **Dr McGlashan:** ... Stephen reports that from a mental health perspective, he has been relatively stable for him, but he does have ongoing suicidal thoughts. Stephen decided to reduce his trazodone from 450 mg to 300 mg per day at his GP supported him well by offering and regular follow-up. Stephen feels this has been a beneficial action in that he is not as tired on this reduced dose and he is able to function better over the past few months since his dose reduction.... It was good to see Stephen again after a gap of nine months and it was evident that things had improved, albeit he still has some difficulties. We agreed that perhaps Stephen was being kinder to himself and more tolerant of his difficulties, using better routine, he is basing himself better and the family are also now more used to his presentation. Stephen feels that his speech and communication is also better, which is evident today. We discussed the role of the Colman centre and it was agreed that for the time being, it was appropriate to discharge Stephen from further follow-up. I would be happy to see him again for a further assessment and input once the medicolegal side has been completed...

- 3.05.18 **GP:** ... Some withdrawal symptoms from reducing trazodone but he wishes to proceed. Mood okay. Has had DVLA letter: brought up frustrations from before. Agreed to supporting letter...
- 21.05.18 **GP referral to CMHT....** Thank you for seeing this 44-year-old man has been suffering from depression and suicidal thoughts. Since a head injury three years ago.... His mood remains low, with thoughts of suicide (usually hanging). He has also been on venlafaxine, sertraline, citalopram and mirtazapine over recent years without any benefit. He is no longer having any community support and I feel remains low and at risk of suicide. I would be most grateful if he could be seen again and taken on for some community support...
- 21.06.18 **GP:** ... Doing okay. Has mental health appointment two weeks. Keen to see psychiatrist to help make further plans...
- 3.07.18 **Victoria Savage, Clinical Nurse Specialist:** “... *He brought with him a report from Dr Bourke who suggested mirtazapine or quetiapine... He feels that as he has previously tried mirtazapine, he would prefer to just try quetiapine.... Stephen seems a little lost. He is no longer able to work in his profession, where he was well paid, competent and respected. Both he and his wife Andrea have always been equal partners in the household, he is now at home taking more responsibility for household tasks. His loss of income has had a significant impact on their lifestyle. These losses and is ongoing symptoms from his brain injury are fuelling his feelings of hopelessness, and thoughts of suicide. Stephen's main goal is to improve his day-to-day life.... Please prescribe quetiapine, as recommended by Dr Bourke. My suggestion would be to start 25 mg nocte increased to 50 mg after 3 to 4 days.*”
- 9.07.18 **GP:** ... psychiatrist, suggesting starting quetiapine. Mood better than it was but not “happy” and still some fleeting suicidal thoughts. Okay to start. Explained side effects.
- 12.09.18 **GP:** ... mood up and down. More anxious than low. Trying to wean off tramadol... Increase quetiapine to 75 mg.
- 24.10.18 **GP:** ... mood dipped again.... quetiapine can go up to 150 mg – will do so, the next few weeks. No suicidal thoughts. Finding some value in voluntary dog walking...
- 17.01.19 **GP:** ... Mood still poor. Some thoughts of suicide, but no plans. Discuss crisis team but does not think would help so refused. Discussed support they could offer but he declined.... Planning to appeal PIP decision.
- 24.01.19 **Community Mental Health Nurse...** I reviewed Mr Long yesterday. As a mood appears to have lifted and he is not clear what the triggers to relapse or recovery are.... I have also booked a medication review with our consultant...
- 30.01.19 **GP:** ...a little better but mood still definitely lower and issues in relationship with wife. Having far less suicidal thoughts.
- 6.02.19 **Dr Pandey, Consultant Psychiatrist:** “... *quetiapine reduction 50 milligrams every week until stopped. Start vortioxetine 10 mg, amitriptyline 50 mg, carbamazepine 400 mg three times daily... Presenting with symptoms of*

depression and personality and behavioural disorders due to brain damage (post-concussion syndrome). He was deemed to have insight and capacity to make decisions... He acknowledged that his mood can change rapidly... We also discussed range of options for antidepressants and he did not agree to reconsider another trial of medications from SSRI, SNRI or mirtazapine. Discussed the possibility of stopping as amitriptyline and adding an antidepressant vortioxetine 10 mg. However, Stephen was not in agreement of reducing or stopping his amitriptyline as the previous attempt to reduce his amitriptyline made him suicidal...”

- 14.02.19 **GP:**.... Okay. Has come off quetiapine without problems.... Start vortioxetine as per letter.
- 20.02.19 **GP:** ... Doing okay? Mood a bit lower than when first started medications but not so bad now. No suicidal thoughts... Increased to 15 mg....
- 13.03.19 **GP:** ... Struggling with some side effects but wishes to dose up as planned. Mood low. Not suicidal. Discussed safety plan.
- 21.03.19 **GP:** ... Side-effects settled and feels in a better place. BP controlled. Itchy with meds. Should hopefully settle...
- 3.04.19 **GP:** ... Mood much the same but neighbour died suddenly, which has been a struggle. Going to the gym. Itching ongoing.
- 1.05.19 **GP:** ... mood remains on low side better than it was. No dark thoughts. Finding enjoyment in going to the gym. Has a meeting next week about possibly volunteering...
- 11.06.19 **Dr Pandey:** “...*Diagnosis: post-concussion syndrome; depressive disorder... Amitriptyline 60 mg...Stephen was on vortioxetine, developed hyponatraemia with sodium levels down to 126...Symptoms of low sodium can present in the form of headache, nausea, vomiting, muscle cramps, breathlessness, lethargy, confusion and disorientation...Stephen is aware that no antidepressant has been shown not to be associated with hyponatraemia. However, serotonergic drugs like SSRIs are more likely to cause hyponatraemia than tricyclic antidepressants or mirtazapine...I have made the following suggestions which include either increasing his amitriptyline from 50 mg to 75 mg or trial of mirtazapine 15 mg at night. Stephen was not able to remember whether he had tried mirtazapine in the past...The other option would be swapping his carbamazepine to sodium valproate...Agomelatine is also possible alternative antidepressant...”*
- 20.06.19 **GP:** ... Feels amitriptyline and mirtazapine not an option as not helped in the past. Agomelatine was preferable, but as I want to prescribe double red notification. So switch carbamazepine to sodium valproate. Sodium still low... Indapamide and restrict fluids....
- 27.06.19 **GP:** ... Mental feeling okay but still headaches and now some tingling both arms and feet

192. The witness statements of the claimant described a complex series of issues since the accident as noted at paragraph 149 above. The medical records, summarised above, show multiple references

to these various complaints, including dizziness and balance problems (first mentioned on 27 August 2015) and photophobia (first mentioned on 17 January 2016) noted above not to have been a feature of the medical records for the early period after the accident. The only symptom not to be mentioned at some point within the medical records before the court is the loss of sense of taste and smell.

193. It is notable that the Claimant's recent account, to all reporting medical experts, is of an improvement in his condition. This is further supported by the medical records above, in so far as there is a clear trend in that direction since the depths of the condition in 2018, albeit that the medical records stop abruptly in 2019 without charting the course of his symptoms thereafter.
194. The witness evidence from members of his family refers to significant changes in his condition and behaviour following the accident. Whilst I am cautious about accepting the detail of witness statements from members of the family, in circumstances where it is likely that their accounts are influenced by each other and by the Claimant himself, the consistency of complaints since May 2015 supports the contention that, whatever their cause, the Claimant has suffered a constellation of symptoms that have significantly affected his life. Whilst I do not disregard the possibility that some of the symptoms may have been exaggerated, I am satisfied on the balance of probabilities that the Claimant has suffered (or at least perceived that he has suffered) significant symptoms. The contemporaneous medical records provide the most reliable account of the symptoms, although in point of fact the Claimant's own account is not significantly different than what is recited in the records. As I have noted above, the loss of senses of taste and smell is the only of the Claimant's physical complaints that is not referred to in the records. It is easy to understand why that relatively subtle matter would be lost in the fog of his describing more serious symptoms. Having read the Claimant's statements and heard his witness evidence (as well as that of his wife – her evidence on this point is striking and credible), I conclude that it is more probable than not that these complaints are not feigned.
195. In considering the cause of those symptoms, it is a striking feature of the medical records that, during 2015, the Claimant's condition deteriorated rapidly, leading to suicidal ideation and inpatient treatment. The development of his symptoms from May 2015 into 2016 is, according to the neuropsychiatrists in their first joint report, associated with increasing evidence of depressive disorder. Antidepressant medication was prescribed in July 2015, with the dose medication being increased in August. By September, he was suicidal with hospital admission in October 2015. He symptoms came under control but low mood and intermittent suicidal ideation persisted after his discharge. The neuropsychiatrists have indicated that his mood disorder has remained "*symptomatic or recurrent sense*". These depressive problems, coupled with his premorbid personality type and the persistence of symptoms following head injury are agreed by the neuropsychiatrists to be the explanation of the Claimant's behavioural changes, described as "*a*

general state of avolition and anhedonia, a motivation, irritability and at times antagonistic interactions with others.” Dr Bird would add to this explanation his diagnosis of an underlying Somatic System Disorder.

196. Dr Bourke concludes that the Claimant continuing symptoms represent a Function Neurological Symptoms Disorder (FNSD). This diagnosis is based upon a pre-traumatic vulnerability to functional symptoms, as evident in the history of fibromyalgia, the onset of functional myoclonus and evidence of functional ophthalmic symptoms. He has also developed SSD, but only since the accident. He considers that these particular neurological symptoms would not have developed but for the head injury, although the Claimant would have been vulnerable to developing symptoms regardless of the accident given his history of fibromyalgia.
197. Dr Bird considers the Claimant’s presentation to be of an underlying SSD, which he considers to have been present since around 1990 and which has waxed and waned in time. He does not consider the evidence of myoclonus to be convincing (there is one mention in the medical records on 13 December 2016 and no other record of it on examination, the main source being the Claimant’s own statement).
198. The difference between the opinions of Dr Bourke and Dr Bird is a relatively subtle one, turning on whether a proper diagnosis of the Claimant’s pre-accident condition points to the conclusion that his post-accident symptoms, so far as genuine, would have been suffered in any event. It is striking that, whilst they obviously do not seek to usurp the court’s role as the fact finder in respect of the genuineness of symptoms, neither finds an explanation based on the fact that the Claimant is deliberately feigning symptoms to be more persuasive than the diagnoses they proffer.
199. For the reasons referred to above, I do not accept Dr Bird’s opinion that the Claimant suffered SSD which pre-dated this accident. It follows that the more persuasive diagnoses of the cause of the Claimant’s continuing symptoms are those given by Dr Bourke, namely FNSD coupled with SSD that has arisen following and on account of the accident,
200. In their joint statement, Dr Pierce and Dr McCulloch note that the Claimant’s reported symptoms are not typical of the sequelae of mTBI and, from the neuropsychological point of view, they are unable to explain those symptoms as having an organic basis. Further, they agree that, on neuropsychological assessment, the Claimant has failed performance validity testing. They suggest that the reason for this should be considered in the context of the evidence generally available and that the court should in particular bear in mind the possible contribution of psychiatric sequelae, the fabrication of symptoms in an attempt to deceive, and the exaggeration of subjectively experienced symptoms with a view to persuading people of the validity of those symptoms.

201. On the facts of this case, they disagree as to the probable cause of the underperformance. Dr Pierce attributes it to psychiatric dysfunction which is perpetuating his experience of cognitive impairment – he believes he suffered a brain injury and his depression contributes to factors such as reduced concentration, memory lapses, slow thinking speed and indecisiveness, which in turn play a role in underperformance in cognitive testing. These problems are exacerbated by his tendency towards self-criticism. She acknowledges that this does not exclude the possibility of some exaggeration on the Claimant’s part.
202. Dr McCulloch on the other hand considers that the Claimant’s presentation is suggestive of conscious mental processes affecting his performance. For example, his slow performance in reading simple words as to colour is not consistent with an unconscious mental process – it is not difficult to read words and therefore one has deliberately to slow down one’s reading to perform so poorly. Further, Dr McCulloch rejects the suggestion that depression can explain the Claimant’s poor performance given the material that shows that this would not be expected. Yet further, her report points to inconsistency in cognition testing which is suggestive of conscious exaggeration. Dr McCulloch does however accept that it is for the court to determine the cause of the deliberate exaggeration or misstating symptoms. She developed this point in cross examination, stating that the Claimant’s conduct on testing, if delivered, might be a consequence of an underlying somatic disorder²², suggesting that it might be the case that overstatement was because “*he wants ...people to take his reports of cognitive problems seriously...*”
203. Given that neither Dr Bird nor Dr Bourke favour an interpretation that that the Claimant’s purported symptoms are deliberately feigned rather than being an aspect of a somatic disorder and Dr Pierce’s explanation for why she considers that the Claimant’s failures on performance validity testing have a psychiatric explanation, it seems to me more likely than not that the features of the Claimant’s presentation suggestive to Dr McCulloch of exaggeration are more naturally explained by a tendency towards over emphasising symptoms that he does perceive than that they represent a conscious attempt to feign symptoms that he does not perceive.
204. In closing submissions, Mr Grant invited the court “*to find that the neuropsychological evidence provides... little more than a backdrop to substantiate the FNSD diagnosis made by Dr Bourke and Dr Heaney...*” That is an apposite way to put the same point – the Claimant’s tendency towards somatisation explains why it is that his account of symptoms differs from what one would expect in a condition that had an organic basis and further why his results on psychometric testing are not valid.

Issue 5 - Was any exaggeration by the Claimant of his injury/symptoms deliberate?

²² She is recorded as referring to “FMD”, which I think is probably an inaccuracy that should correctly read FNSD and SSD

205. There are two discrete areas of the Claimant’s evidence, not relating to the symptoms as such, but rather to his underlying condition and the consequence of the accident, where the Defendant has alleged that the Claimant has deliberately misstated the position.
206. The first relates to what the Claimant had to say about the scan results in May 2015. As I have indicated under the heading of Issue 3 above, the scanning was reported in terms that excluded any serious brain damage. However, the Claimant reported that he had had a “*small bleed*” (GP note of 9 April 2015) and “*internal swelling and bleeding intracranially of brain*” (accident report of 20 April 2015). The Defendant identifies these as examples of the Claimant deliberately misstating his condition. As Mr Dignum QC put it in cross examination to Dr Pierce, “*when he signs the document on 20 April, he knows he has not got a bleed and never has a bleed to his brain...*”
207. The reason for the Claimant describing his injury in this way was explored at some length in evidence. The Claimant’s account in cross examination was that he was told they were “*investigating a bleed or bruising at the back of my bran ... and that conversation went on for basically four days while I was in hospital and so that is where I got the impression ... that there had been some kind of intracranial bleed or, I mean the internal swelling is taken given that I had a head injury but the bleeding intracranially came from conversations with particularly there was a specialist from Liverpool who came in to see me, ordered specific CT scans and he was the person that said this is what we are looking at.*” It is common ground that Dr Fletcher, who carried out neurological review at CoC on 31 March 2015, had come from the Walton Centre in Liverpool and that the reference to a specialist from Liverpool is therefor likely to be a reference to him. As I have noted, Dr Fletcher did indeed query whether the CT scan showed a right occipital contusion, although was ultimately reassured that it did not. Mr Dignum QC contended that the medical records show that his reassurance took place on the day after the scan, 31 March 2015, not 4 days later. His basis for this submission is a nursing note at 18.38 on 31 March 2015 which state, “*Pt seen by Dr Fletcher CT reviewed by Walton informed that scan is normal.*” The Defendant takes that note as an indication that, after Dr Fletcher saw the Claimant on 31 March and raised the issue of whether the scan showed a contusion. He obtained reassurance from the Walton Centre and later saw the Claimant again. Whilst clearly this is a possible sequence of events, one might have expected that Dr Fletcher would himself have made a note if he had seen the Claimant again. The nursing note is also consistent with the nursing staff having reviewed the information that the scan was reassuring. If that was so, there is no evidence as to when the Claimant was reassured. On the other hand, a note from Dr Chakrabarty on 2 April 2015 states that the Claimant could be discharged after a radiology meeting to discuss his scan – that suggests that the reassuring message was not even able to the doctors until towards the end of the Claimant’s admission.

208. During questioning from me, Dr Heaney accepted that, had Dr Fletcher raised with the Claimant the suggestion that the scan might be abnormal and had the Claimant pressed Dr Fletcher on what the potential abnormality was, Dr Fletcher may have explained in a way that mentioned the concept of “*a bleed on the brain*” or similar. I cannot be satisfied on this evidence that any misstatement of the scan results from the Claimant resulted from a deliberate attempt to misstate the severity of his injury.
209. The second matter is the Claimant’s accounts to Dr Pierce and Dr Heaney of his fibromyalgia. Dr Pierce recorded at paragraph 2.8 of her report of June 2018 that the fibromyalgia “*had resolved and that he had not ‘flare ups’ of pain for years prior to the index accident.*” Dr Heaney recorded at paragraph 3.1.7 of his report that the Claimant said to him “*on direct questioning that in or around 2007 he had been diagnosed with fibromyalgia after experiencing joint pain and he had been treated in a pain management clinic. He told me that this condition did not cause any problems.*” In each case, it seems that the Claimant gave an incorrect account of the fibromyalgia. For example, on 20 June 2014, the Claimant’s GP reported “*has fibromyalgia and pain is worse again.*”
210. That said, there are pointers against concluding that the Claimant was deliberately misstating this condition to Dr Heaney. The severity of the condition was undoubtedly fluctuant, and the evidence summarised at paragraph 80 above tends to suggest that his condition as being much better in the 2-3 years before the accident than it had been in the previous 5-6 years. In the last direct reference to fibromyalgia before the accident, a GP attendance on 4 September 2014, the condition is said to be stable.
211. More importantly, the Claimant told Dr Bourke²³, Dr Bird²⁴ and Dr McCulloch²⁵ of the diagnosis of fibromyalgia, so if he was attempting to deceive doctors as to his medical history, his attempt was poorly executed. Given that the Claimant gave an account of his alleged fibromyalgia to other doctors (albeit that he disputed the account) it does not seem to me reasonable to conclude that his statement to Dr Heaney was an inaccurate one made with the deliberate attempt to deceive.
212. I have considered to what extent the Claimant’s account may involve deliberate exaggeration, not as a feature of a somatic condition, but rather simply overstating his symptoms so as to increase his damages. I have to accept the possibility that some exaggeration of this kind might have taken place. Some of the florid accounts given by the Claimant might be thought to be such. Any finding that the Claimant had misstated his case so as to increase his damages would be a serious allegation, to be determined on the balance of probabilities, but requiring compelling evidence.

²³ Paragraph 3.2.4.2 of Dr Bourke’s report of June 2018

²⁴ Page 4 of Dr Bird’s report of January 2020

²⁵ Paragraph 5.2.2 of Dr McCulloch’s report of April 2020

Three points lead me to the conclusion that I cannot be satisfied on the balance of probabilities that any particular account of his symptoms was deliberately exaggerated in this sense, rather than as a manifestation of an underlying somatic disorder:

- i) Given my judgement on the underlying cause of the Claimant's symptoms, namely FNSD and SSD in the context of a history of fibromyalgia, any particular apparent exaggeration may be explained by that medical history rather than a conscious attempt to exaggerate the claim;
- ii) In fact, there is some reasonable consistency between the various accounts of the Claimant as to the course of his symptoms;
- iii) The improvement in the Claimant's symptoms since 2018 suggests that he is not deliberately exaggerating his claim so as to maximise recovery.

213. I am fortified in this conclusion by the fact that, whilst the Defendant's case has not conducted its case on exaggeration by suggesting that the Claimant has repeatedly exaggerated his symptoms. Whilst the Defendant does contend that there have been some specific cases of exaggeration, which are considered below in issue 5, it has focused on defending this claim on the causation of the Claimant's symptoms and the significance of his redundancy, rather than saying that large swathes of his complaints are invented.

Issue 6 - Has the Claimant given an honest account of the circumstances leading to his redundancy, whether he believes that he would have been made redundant in any event and/or what his response to the redundancy would have been absent the accident?

214. I have set out under issue 3 above my reasons and conclusion that the tone of the document does not accurately reflect the Claimant's thinking as of 10 March 2015. I accept, for reasons given earlier, that the Claimant did not see his redundancy as an inevitability at the time of the accident.

215. It does not automatically follow from the finding on Issue 3 that the Claimant has not been guilty of dishonesty of this issue. It would be dishonest by the standards of ordinary people to give a deliberately misleading account of the circumstances of the redundancy even if the motivation in doing that were to bolster the Claimant's true belief that the redundancy was not inevitable and/or that the Claimant's ill health was not related to the redundancy.

216. But there are several puzzling features relating to the Claimant's redundancy. Whilst in part these flow from an apparent inconsistency in his account of the circumstances (which for understandable reasons plays a significant part in this case), there are other features which suggest that the court does not have a full picture before it.

217. The starting point is that the Claimant had only relatively recently been taken on by the Defendant as its head of IT. Whilst Mr Dignum on behalf of the Defendant sought to draw attention to some

weaknesses in the probationary reviews that had taken place, the Defendant had nevertheless felt able to offer the Defendant a permanent post shortly before the accident. Further, when the question of the redundancy arose, Ms Helen Smith said in an email to the Claimant, “*your performance isn’t in question.*”

218. However, the Claimant was made redundant some months before any potential successor was employed. Mr Jones (who cannot be expected to have detailed knowledge of such matters) accepted that Mr Long was made redundant in April 2015 but that his replacement did not come in until “*later that year.*” Mr Long’s own case (see paragraph 9 of his fifth witness statement) is that the new head of IT was appointed in August 2015. The Defendant has not sought to contradict that, even doubtless it would have available the evidence necessary to do so. Based on this evidence, I conclude that the new head of IT, who was in effect the Claimant’s replacement, albeit that the job may have been at a higher level, was not appointed until about four months after the Claimant was made redundant. This is strongly suggestive that the Claimant’s redundancy was accelerated, so as to take effect earlier than the true point of redundancy.
219. The Claimant’s account of the circumstances of his redundancy closest in time to the accident, is contained in the May 2015 Document. It is the Claimant’s case that the document was drafted together with the assistance of employment lawyers. It sets out essentially four grounds of appeal:
- i) That the Defendant had failed to follow a fair process;
 - ii) That the terms of the Claimant’s redundancy were not clear;
 - iii) That the Defendant failed to make reasonable adjustments for the Claimant’s disability;
and
 - iv) That the Claimant had been bullied by Mr Redmond Walsh.
220. It must also be borne in mind that the Claimant’s account in the May 2015 Document was available for the medical experts and the Defendant’s legal advisors to see. The very fact that it has only played a major role in this case at a very late stage notwithstanding that it has been referred to in disclosed documents throughout the litigation might suggest that it the document does not bear the significance that the Defendant contends for. But it does not necessarily follow from this that the Claimant was not trying to mislead people on this issue. For example his assertions about his redundancy to Dr Bourke which were taken as an indication that no possibility of redundancy had arisen before the accident might have been made by the Claimant in the context of his either having forgotten about the May 2015 Document or in the belief that the document would not come to light.

221. On balance however I am not persuaded that the Claimant’s failure to refer to the risk of redundancy, whether to Dr Bourke or more generally in this litigation was a deliberate attempt to deceive. I say this for the following reasons:
- i) I repeat that a finding of a deliberate attempt to deceive would require cogent evidence.
 - ii) Other aspects of the Claimant’s evidence, upon which I have commented, suggest that he is not someone prone to lying when the circumstances suit;
 - iii) For reasons set out under issue 3, I conclude that the extreme reaction to the risk of redundancy only arose in May 2015. It follows that the Claimant would not naturally associate his deterioration in health which had already occurred started by then with the redundancy;
 - iv) It would be understandable if the detailed sequence of events in respect of the redundancy have not been in the forefront of the Claimant’s mind during the litigation process, in particular if he does not attribute any health consequences to the redundancy.
222. In my judgment, it is more probable that the Claimant’s failure to refer to the redundancy as a possible cause of his ill health or, in the case of his consultation with Dr Bourke, even to acknowledge the risk of redundancy at all prior to the accident, is more probably a consequence of an unswerving conviction that it was the accident rather than the redundancy that has caused his various symptoms coupled with the failure to recall the detail of a redundancy process which in his mind was of no relevance to the issues in the litigation.

Issue 7 - Has the Claimant has been guilty of Fundamental Dishonesty within the meaning of Section 57 of CJCA 2015?

223. It follows from my conclusions under issue 6 that there is no finding of dishonesty here which could be described as “fundamental” and so issue 7 is resolved easily in favour of the Claimant.

Issue 8 - Should the Claimant’s damages be reduced by reason of contributory negligence?

224. Section 1(1) of the Law Reform Contributory Negligence Act 1945 provides:

“Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the Claimant’s share in the responsibility for the damage...”

225. Thus, the Defendant (upon whom the burden of proof lies) must show fault on the part of the Claimant which (*ex hypothesi*) together with the fault of the Defendant has contributed to the damage. The authorities, in the context of employers’ liability cases, warn against the finding of

fault where the conduct of which complaint is no more than momentary inadvertence not least to ensure that proper standards of safety for employees are not diluted (see, for example, Caswell v Powell Duffryn Associated Collieries Ltd [1940] AC 152). It might be added that the law, both through several reported decisions at common law and through the intervention of statute in the form of the Social Action, Responsibility and Heroism Act 2015, has shown a greater tolerance for the mistakes and misjudgements of those acting selflessly. It is not suggested that the Claimant's vote in any sense of the word, but it was exactly the kind of misjudgement that policy demands should not be treated to partially.

226. The Defendant points to what the Claimant had to say to Dr Pierce about the accident. At paragraph 3.5 of her first report, she recounts him saying that he felt "*stupid and embarrassed*" after the accident and that he had called his boss and told her that he had "done a stupid thing." Equally, in cross-examination, the Claimant accepted that it was "*silly*" to walk into a door frame. However, there is a considerable distinction to be drawn between silliness or stupidity upon injuring oneself and the kind of culpable fault necessary for a finding of contributory negligence. In every case of "momentary inadvertence", one might well be justified in thinking that one had done something that was "*silly*", but for reasons identified above the courts shy away from such a conclusion, in particular in the context of accidents at work.
227. On any version of events, this was a minor misjudgement by the Claimant, in the context of going to help a fellow employee. As he put it in cross-examination, "*I was ... moving at speed to help Craig, who I believe was actually going to hurt himself.*" There seems no reason to disbelieve that explanation for why he approached Mr Jones. He knew that the doorways were 'domed' and no doubt careful reflection would have led to a concern that he needed to be careful not to bang his head. But assuming that he was indeed moving to assist Mr Jones then, regardless of his speed of movement, it seems to me difficult to describe this as any more than momentary inadvertence. In my judgment, the Defendant fails to show any fault on the part of the Claimant sufficient to justify a finding of contributory negligence.

Issue 9 - What is the quantum of the damages that the Claimant should recover by reason of his injury and any consequential losses?

228. The Defendant's submissions on the quantification of damages have been relatively brief, since its focus has been on denying that the complex of symptoms described by the Claimant are genuine and/or are the cause of the accident.
229. The Claimant puts general damages at £45,000. This is based on the enduring symptoms described in his witness statements. The Claimant draws this figure from the Moderately Severe category of Psychiatric Injury in the Judicial College Guidelines for the assessment of General

Damages in Personal Injury Cases, a range of £17,900 to £51,460. The Defendant agrees with this category (assuming the Claimant's case on causation to be made out, as I find it to be) but contends for the lower figure of £35,000, given the risk of recurrent symptoms from the Claimant's underlying fibromyalgia. Were the Claimant not to be at such risk of recurrence of some symptoms in any event, I would have agreed with the Claimant's figure. However, given the risk of recurrence, that figure falls too high in the range of the moderately severe psychiatric condition. That said, a risk of recurrence of some symptoms from the underlying condition is of far less significance to the valuation of the claim than the actual severe symptoms that the Claimant has suffered. For these reasons, I allow the sum of £40,000 for general damages.

230. In terms of the calculation of loss of earnings, past and future, I have calculated the Claimant's claim for past losses to his 48th birthday, that is to say 25 May 2021.
231. I start first with the period of past loss. At the time of the accident, the Claimant was earning £51,000 gross, equivalent to £37,599 net. The Claimant claims past loss of earnings on the assumption that his salary after the accident would have increased to say £80,000 per annum gross, that is £55,043 per annum net, and takes a midpoint of £46,321 net. However, the only reliable basis for the calculation of loss of earnings but for the accident is the Claimant's actual earnings of £51,000 per annum net. For reasons I have identified above, the evidence as to potential earnings for the Claimant is both inadmissible and unreliable. It is true that the Defendant concedes a slightly higher figure of £55,000 per annum gross in its closing submissions for future loss earnings, but that is in the context of a much lower multiplier than contended of by the Claimant. However in taking a more strictly mathematical approach than the Defendant (which will lead to a higher multiplier), I calculate his loss of earnings but for the accident on the basis of the figure for his actual earning of £51,000 gross.
232. Taking the Claimant's loss of earnings from the date of termination of the accident to the date of calculation of past losses (25 May 2021), the period is 6.17 years. I take his gross past loss of earnings to be £51,000, that is £37,599 net per annum and therefore the anticipated earnings for his past loss would normally be $£37,599 \times 6.17 = £231,986$. From this figure there falls to be deducted the Claimant's actual receipts. It is common ground that he received £22,917 from the Defendant by way of pay, sick pay, holiday pay and redundancy compensation (see paragraph 52 of the Claimant's updated Schedule, a figure that the Defendant has not disputed). There also falls to be discounted any earnings from the Claimant's recent employment at Felbrigg Hall. Since that employment was only referred to in oral evidence, the Schedule and Counter Schedule do not deal with the earnings, either in terms of the amount of earnings for the period of employment. The figure put in opening by Mr Grant was of the Claimant actually earning £8,676 gross per annum from 4 January 2021. Doing the best I can on the scant information, I assume that the

Claimant has earned the net equivalent annual figure of £8,500 for the period of 0.38 years between his starting employment and the date of calculation of past losses. This gives a further deduction of £3,260.

233. The Defendant then contends for a further discount from the past loss of earnings claim. Given the evidence that, even on his own evidence, the Claimant has been and remains at risk of relapse regardless of the accident, the Defendant contends that the past loss of earnings should be deducted to reflect the risk that in any event the Claimant would not have been able to work over this period. In principle, this seems to me to be a legitimate argument. The Court is unable to say what would have happened over the past 6 years but for the accident. However there is certainly a risk that the Claimant's past ill health would have interfered with his working capacity in any event. However, I do not accept the Defendant's argument that the appropriate discount is 51%. This seems to suppose that, because there is evidence is that such a relapse would have occurred at some point, the discount must be greater than 50% reflecting that it is more likely than not that any relapse would have affected the Claimant's working capacity by preventing him from working between the accident and now. The evidence in my judgment does not go that far. There is some evidence that the Claimant may have suffered interference with his working capacity, but for the accident. Apart from the underlying risk of further symptoms of the underlying pre-accident condition referred to by the medical experts, Dr Bourke refers in his letter of October 2020 to the risk of the Claimant having suffered a brief adjustment disorder or acute stress reaction as a result of the redundancy in any event.
234. Some discount has to be given to the past loss of earnings claimant to reflect the risk that the Claimant's employment would have been interrupted. However, a better approach than that of the Defendant is to discount past losses by the 30% proportion referred to in a footnote to paragraph 235235(i) below, to reflect that one is dealing with a risk of relapse which might have interfered with the Claimant's employment, rather than a probability that this would have occurred. That discount should be applied to total "but for" earnings before deduction of the actual receipts, since the risk does not apply to these deductions. Accordingly, I calculate past loss of earnings at $\{(\pounds37,599 \times 6.17 = \pounds231,986) \times 0.70\} - \pounds22,917 - \pounds3,260 = \pounds136,213$.
235. The Claimant puts his claim for future loss of earnings as follows, set out in part within the updated Schedule of Loss in the trial bundle and in part in written closing submissions.
- i) At the time of the Schedule, the Claimant was 47 years old. The multiplier for a loss of earnings for a male aged 47 to retirement age 68 is 20.67²⁶. The contingency discount is

²⁶ Table 11 of the Ogden Tables, -0.25% discount rate

0.83²⁷. However, the Claimant concedes a discount of a further 0.25 points on that contingency discount, having regard to his pre-accident vulnerability, thereby reducing it to 0.58²⁸. Thus, the multiplier for earnings but for the accident is $20.67 \times 0.58 \approx 12$.

- ii) The Claimant's earnings capacity but for the accident, based on the evidence of former colleagues referred to above, was not less than £100,000 gross (£66,643 net). However, to avoid the risk of criticism for exaggerating his claim and having regard to actual earnings at the time of his accident of £51,000 per annum gross, the Claimant claims loss of earnings based on figure of £80,000 gross (£55,043 net).
- iii) This, but for the accident, the Claimant's anticipated earnings were $£55,043 \times 12 = £660,516$.
- iv) In his Schedule of Loss, the Claimant conceded a presumed residual earning capacity of £12,500 net pa, and a multiplier of 20.67 to which a discount factor of 0.27²⁹ was applied. However, now that he has secured part-time paid employment at Felbrigg Hall, he concedes that the discount for his residual earning capacity should reflect his employed status, that is a discount factor of 0.53³⁰. Thus the multiplier for residual earning capacity is $20.17 \times 0.53 = 10.69$. Applying this multiplier to £12,500 per annum net gives residual earnings of £133,625.
- v) Thus the Claimant claims $£660,516 - £133,625 = £526,891$.

236. In closing submissions, both written and oral, counsel for the Defendant conceded that the multiplicand being sought by the Claimant was reasonable given the Claimant's continuing ill health. However, he contended that the multiplier was too high and gave rise to too high a sum by way of loss of earnings, given that the Claimant is not, as he puts it in his written submissions, "*fully disabled*."

237. In my judgment, the Claimant continues to suffer a disability as a result of his injury for the reasons set out above. That disability will persist. I see no basis for concluding that the Claimant is less disabled than the "average" person within the categories considered in the Ogden Tables. Indeed, the various purpose of the Tables is to seek to avoid the excesses of under- or over-compensation. In Wells v Wells [1999] 1 AC 345 at 379F, Lord Lloyd said that the Ogden Tables should be "*the starting point, rather than a check*" and that "*a judge should be slow to depart from the relevant actuarial multiplier of impressionistic grounds*." However, I agree with the

²⁷ Table A of the Ogden Tables, male aged 45-49, not disabled, employed level 3.

²⁸ In written submissions, counsel for the Claimant described this as a 25 point discount. It might perhaps better be seen as a 30% discount, 0.58 being 70% of 0.83.

²⁹ Table B of the Ogden Tables, male aged 45-49, disabled, non-employed level 3.

³⁰ Table B of the Ogden Tables, male aged 45-49, disabled, employed level 3.

Claimant's concession that, given the Claimant was at risk of relapse of his underlying condition regardless of the accident, some discount is merited to the Claimant's discount of 30% referred to above appears on the face of it a reasonable estimate of that risk, given that it is only a relapse that would have led to loss of earnings that needs to be factored into this calculation. For these reasons, I consider that the appropriate multiplier is that for a male aged 48 to retirement age 68 of 19.66³¹, discounted by 0.58, for contingencies (which reflects the Claimant's argument in its Schedule of loss as set out above) that is a net multiplier of 11.40.

238. I have dealt in some detail above with the evidence that the Claimant relies on in support of a higher loss of earnings. As well as being inadmissible on the ground that the Claimant does not have permission to rely on expert evidence, it is in any event unreliable given that course of the Claimant's employment since the mid 2000s. Further, as Mr Dignum QC pointed out in closing submissions, the kind of figures cited by the Claimant and his witnesses as potential earnings are far higher than the average level of such earnings in the tables within the current edition of Facts and Figures. This indicates that the multiplicand being contended for by the Claimant would only be the level of earnings of the very highest achievers in his line of work. Given the Claimant's medical history and vulnerability to further periods of ill health especially in circumstances of stress, that level of earnings is imply unrealistically high.
239. The argument against forming too impressionistic a view applies both to the multiplier and the multiplicand. The best indicator of what the Claimant would have been earning but for the accident is what he was earning at the time of the accident. Accordingly, I calculate the Claimant's earnings on the basis of his actual earnings at the time of the accident of £51,000 per annum gross, £37,599 net. Thus I calculate earnings but for the accident at $£37,599 \times 11.4 = £428,629$.
240. Turning to the Claimant's residual earning capacity, again it seems to me that there is no basis to consider the Claimant to be other than disabled. The appropriate discount factor pursuant to Table B is 0.53. Accordingly the net multiplier is $19.66 \times 0.53 = 10.42$.
241. The Claimant contends for a residual earning capacity of £12,500 per annum net based on the minimum wage for full time employment. The Defendant contends for a figure of £30,000 per annum net. This equates to gross earnings of about £38,000 per annum.
242. In my judgment, there is no proper basis for a figure as high as that contended for by the Defendant. Indeed the evidence before the court in the form of the Claimant's actual earnings suggests that the figure conceded by him in the Schedule of £12,500 per annum net is on the high side. That said, the Claimant is currently only working part time. There must be a real prospect of increased working hours and on balance I take the Claimant's net residual earnings figure of

³¹ Table 11 of the Ogden Tables, -0.25% discount rate

£12,500 to be realistic. Thus, I allow $£12,500 \times 10.42 = £130,250$. Deducting this figure from the Claimant's "but for" earnings of £428,629 gives a net claim for future loss of earnings of £298,379.

243. The Claimant brings a modest claim for gratuitous care and assistance, based on the assertion that Mrs Long has both replaced parenting services that her husband would have provided and has set aside time to meet his practical and emotional needs. In addition the claim includes time spent in chauffeuring the Claimant when his driving licence was suspended.
244. The claim for care and assistance is put at 4 hours per week for a past period of 5.78 years (to December 2020). Given the well documented issues that the Claimant has had since the accident, which, for reasons given above, were on the balance of probabilities a consequence of the accident, the need for some care and assistance is easily justified. The claim is modest in terms of the number of hours. The hourly rate claimed is £7. This equates to around 75% of the aggregate day rate for the relevant period, based on spinal point 8 of the NJC pay scales. That rate is reasonable for the nature of the car involved. Hence I allow £8,416 for past care and assistance.
245. The Claimant claims sums in respect of case management and treatment costs totalling £15,754. Those figures are broken down in a spreadsheet from Ben Holden Limited within the bundle. It has not been disputed that the Claimant has incurred these costs, nor is their amount said to be unreasonable. The only issue is whether they can properly be said to have been caused by the accident. I see no reason to doubt the assertion that such costs would not have been incurred but for the Claimant's injuries consequent upon the accident and therefore I allow the sum claimed.
246. A claim is made for travel expenses in the total sum of £1,195. These are broken down in Appendix A to the Schedule of Loss. They relate to travel and hotel expenses relating to various medical appointments for the purpose of this litigation. The figures have not been challenged. Given that the Claimant has had to travel from Norfolk to wherever the appointments have been (mostly, if not entirely, London) for various appointments, the costs appear to me reasonable and allow the sum claimed.
247. The Claimant also claims, as both past and future loss, the interest on a loan that he took out in July 2017 to fund his rehabilitation. I accept that, following the judgement of the House of Lords in Lagden v O'Connor [2003] UKHL 64, such costs may in principle be recoverable. However the only material in support of this claim is the Schedule of Loss and Damage. As a statement of case, the contents of the schedule are not admissible in evidence at trial unless verified by witness statement. Here there is no witness evidence in support of the head of loss, nor any other material, such as expert evidence or disclosed documents, that substantiate the claim. Accordingly, this head of loss is not made out.

248. The joint statement of Dr Bourke and Dr Bird at paragraph 8 recommends that further treatment for the Claimant should focus on his mood disorder with a combination of pharmacological and psychological approaches. Given that the Claimant has paid for retreatment in the past it seems to me more probable than not that he will in the future take up treatment that may be recommended. The Claimant's approach to valuing that treatment is to seek a lump sum of £10,000. Subject to the issues of causation and genuineness of symptoms, the Defendant has not taken issue with that approach. Given my findings above, in my judgement the sum claimed is an appropriate award for such future costs.

249. I summarise the losses as follows:

General damages	£40,000
Past loss of earnings	£136,213
Past gratuitous care and assistance	£8,416
Past case management and treatment costs	£15,754
Past travel expenses	£1,195
Past finance costs	£0
Future loss of earnings	£298,379
Future treatment	£10,000
Future finance costs	£0
TOTAL	£509,957

250. Subsequent to the judgment being sent out in draft, the parties have agreed that the Claimant is additionally entitled to interest in the sum of £9,803 and the additional sum of £50,497 pursuant to CPR 36.17(4)(d).

CONCLUSION

251. For the reasons set out above, I am satisfied that:

- i) The Claimant has suffered significant injuries, as set out above, on account of his accident on 22 March 2015;
- ii) The appropriate award of damages on a full liability basis of the Claimant's injuries is £509,957;
- iii) In addition, the Claimant is entitled to interest in the sum of £9,803 and the additional sum of £50,497 pursuant to CPR 36.17(4)(d).
- iv) The Claimant's damage should not be reduced as a result of the alleged contributory negligence;
- v) The Claimant has not been guilty of fundamental dishonesty.

252. I make an order in the terms that has been agreed by the parties consequent upon my judgment.