Neutral Citation Number: [insert NCN]

Claim No: 058DC861

IN THE COUNTY COURT AT CHELMSFORD

Chelmsford Justice Centre
Priory Place, New London Road, Chelmsford CM2 0PP

Date: 8 June 2026

Before :

HHJ DUDDRIDGE

- -

Between :

SARA KAWSAR

Claimant

- and -

THE COMMISSIONER OF POLICE OF THE METROPOLIS

Defendant

- -

Laura Giachardi (instructed by **Oakwood Solicitors**) for the **Claimant**
Ian Stebbings (instructed by **DWF Law LLP**) for the **Defendant**

Hearing dates: **16, 17, 18, 19, 20 March 2026**

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Approved Judgment

This judgment was handed down **8 June 2026**

Introduction

1. I shall refer to the parties as "C" and "D". I mean no disrespect by this abbreviation.

2. C was employed by D between May 1995 and 31 March 2022. She started in an administrative role. In 2005, she became a police constable. In November 2015, she became a trainee detective constable and was assigned, by her choice, to the Child Protection Team (also known as the Child Abuse Investigations Team or CAIT) at Barkingside Police Station.

3. As set out in more detail below, C's case is that, in December 2016, she was assigned to an investigation during which she interviewed a complainant who had been abused by her stepfather during childhood. This reminded C of abuse she had suffered as a child and triggered a decline in her mental health. On 20 May 2017, a psychiatrist diagnosed Recurrent Depressive Disorder and Post Traumatic Stress Disorder. After that, D referred C to their Occupational Health (OH) adviser, who advised on 7 July 2017 that C should be temporarily removed from any role dealing with violent crime, sex crime and child abuse. Further assessments after that gave similar advice and stated that she should be permanently removed from such roles. C's case is that D was on notice of her vulnerability to psychiatric injury by the end of 2019 but, after that, repeatedly failed to take reasonable steps to implement the OH recommendations, or to ensure that her line managers were aware of her history and the need to protect her from exposure to themes of violence, child abuse and suicide. As a result, her line managers from time to time were unaware of the OH advice and tried to assign her to unsuitable roles or locations so that she repeatedly had to challenge them and explain her position. This caused further deteriorations in her mental health. She decided to retire early on 31 March 2022, when she was fifty. She would otherwise have retired when she was fifty-five, in 2027.

4. C therefore claims that D breached its duty to take reasonable care to prevent her from suffering from psychiatric injury, causing her to suffer further injury and to retire earlier than she would otherwise have done. She claims damages for personal injuries including for pain, suffering and loss of amenity (PSLA) and special damages, the largest elements of which are past and future lost earnings and the loss of pension scheme benefits resulting from her early retirement.

5. D admits that it was on notice that C had a predisposition to psychiatric injury. It does not expressly state when it was first on notice but, as C's pleaded case is that the "actionable period" related to events after 13 December 2019, I infer that D's admission relates to that period. D denies breach of duty, causation and quantum.

6. I heard the trial over five days from 16 March 2026 to 20 March 2026. C was represented by Ms Giachardi of Counsel and D by Mr Stebbings of Counsel. I am grateful to both for their assistance.

7. I have a trial bundle consisting of four lever arch files including the pleadings, witness statements, expert reports, C's employment and medical records and other documents. During C's evidence, D produced a copy of performance notes C completed as part of her detective training and a copy of notes of a meeting. However, Ms Giachardi

objected to those documents, which had not previously been disclosed, and Mr Stebbings withdrew his (oral) application to rely on them.

8. I heard oral evidence in support of C's case from C, her former partner Marc Witham and another former police officer, Carol McCullock. C also relied on the witness statement of Elizabeth Dales, who was not called to give evidence. D called Detective Inspector (at the time, Detective Sergeant) Lisa Brothwood, who was C's line manager between 13 July 2016 and 30 December 2017 and again between 13 February 2018 and 27 May 2018. During that second period, it appears that DI Brothwood had administrative responsibility for managing C but had no day-to-day interaction with her. Her evidence was therefore limited to events in 2017. D did not call any of C's other line managers, or any other witness who could speak to events during the "actionable period" after 13 December 2019.

9. I also heard oral evidence from each party's expert psychiatrist, Dr Gibbons for C and Dr Francis for D. They gave their evidence concurrently, answering questions that I put to them based on a list of proposed questions agreed by Counsel, rather than in response to adversarial cross-examination[1]. This allowed them the opportunity to explain their opinions and expand on their reasoning in dialogue with each other as well as with me. I found the process very helpful in illuminating their evidence.

10. I shall set out my impressions of the witnesses later in this judgment.

The Background

11. C was born on 17 January 1972. According to her evidence, from the age of four she witnessed domestic abuse between her parents and suffered physical and emotional abuse from her father and sexual abuse from her uncle. She left home at the age of eighteen and went to Liverpool. After working temporarily in a factory, she found employment as a typist for Merseyside Police, where she worked for about five years. When she was nineteen, her mother died, but she only learnt of her death after her funeral and so could not attend. In her witness statement, C describes her years in Liverpool as the happiest time in her life. However, it appears that she suffered from episodes of poor mental ill health during this period. A letter from Dr Price, an in-house psychiatrist, dated 5 November 2018 records that she told him that she first became unwell when she was eighteen or nineteen and tried to commit suicide, and an entry in her historical medical records ("Lloyd George notes") dated 26 November 1993 states "*Under stress not happy at work. Cannot cope...Depression...*". In her oral evidence, C said the first of those references was to an incident when she accidentally drank too much alcohol, not to an intentional attempt at suicide. She said she could not remember the second reference or having a period of depression while she was in Liverpool. However, she did accept that she had suffered from depression before she started to work for D, although she could not remember what type of depression she suffered from and said she had not been diagnosed until May 2017.

12. C started working as a member of D's civilian staff in May 1995. She was employed in the Criminal Justice Unit, liaising between the Officer in the Case (OiC) and the Crown

[1] Referred to colloquially as "hot-tubbing".

Prosecution Service (CPS) to prepare papers for Court. On 13 February 1996, she completed a health questionnaire in which she answered "No" to whether she had ever had mental ill-health, nervous breakdown or nervous disability.[2]

13. It appears from C's medical records that she suffered an episode of mental ill-health related to her work and childhood abuse in 2001. A handwritten record in her Lloyd George notes dated 15 March 2001 states "...*Incident assault as child ... from 7 ... Works in CID office for police ... Having flashbacks ... now 32 years ago ...*" and a handwritten entry the following day includes "*Ref CMHT...*". A letter from her GP, Dr Dhillon, dated 2 April 2001 records that C had reported abuse from age 7 to 14 years by her "...*older brother who is now 33 years ...*" and that her work in the CID office involved her coming across rape cases, she was having quite vivid flashbacks, and had even contemplated suicide. In July 2001, CMHT closed her file after she did not respond to correspondence.

14. In 2005, C became a police constable. In the medical questionnaire dated 10 November 2004, she answered, amongst other things, "*No*" to whether she had had anxiety or depression or any other mental illness. According to her witness statement, in 2006/ 2007 she dealt with a victim of indecent assault. She was affected by this, feeling overwhelmed with sympathy and unable to stop thinking about what had happened to the victim. She states that she told her line manager, who responded that it was the nature of the job and, if she couldn't deal with it, the job was not for her. She says she moved on and learnt to build resilience but did not forget the comment, which she found insensitive.

15. In October 2008, C's GP recorded that she had postnatal depression with symptoms including low mood, not feeling attached to the baby, poor sleep, memory and appetite, weight loss but not suicidal ideation. The GP prescribed Citalopram.

16. During 2010, C took her Sergeant's Exam Part 1. She was unable to progress to Part 2 due to funding cuts[3]. But she was made Acting Sergeant and deployed to the Safer Transport Team.

17. On 15 June 2010, C's GP recorded that C had low mood, was feeling angry with flashbacks and nightmares, related to childhood sexual abuse by a family member between ages 7 to 14, she had tried coping with her feelings but was unable to do so and having suicidal ideation – "*... overdose but states would not do anything as has a child...*". She had been off work for a week due to her symptoms. At some point, her GP referred her to West Essex Mind for counselling, which she had completed by 8 September 2010.

18. Further GP notes dated 2 July 2010 recorded that she was feeling better from a mood point of view. Her employers were not sympathetic to her symptoms of motion sickness. According to C's oral evidence, she developed motion sickness when travelling at the rear of buses during her work as a transport officer. She was referred for an OH

[2] She answered "Yes" and gave some further information in response to a question about whether she had ever suffered from migraine, but I do not consider that to have any significant bearing on the issues I have to decide.

[3] Her Sergeant's Exam Part 1 expired after five years, and she repeated it successfully in 2017, but she did not achieve promotion to Sergeant before she retired.

assessment on 12 July 2010. OH notes dated 20 July 2010 record that her symptoms included "*low mood suicidal intentions, not attempted...*" and "*During ... travel on buses ... migraine, motion sickness.*" She was placed on recuperative duties. On 26 November 2010, her GP recorded that she had motion sickness and, if she continued in the role, she might suffer a recurrence of depression. She said that she was then deployed to the construction site at what is now Westfields Shopping Centre in Stratford, where she worked between May 2011 and December 2011, but she was removed from those duties because she fell pregnant.

19. On 31 January 2012, C's GP recorded "*Stress at work ... Now 14/ 40, team stretched taking it out of her ... Can't sleep wanted tabs...*".

20. On 26 September 2012, after the birth of C's second child, her GP made a further note of "*low mood*", but on 24 October 2012 recorded that her mood was much better. However, on 18 December 2012, a prescription was issued for Sertraline, 50 mg, half a tablet twice per day. On 25 February 2013, her GP increased the dose of Sertraline to 50 mg and noted "*... feeling depressed ... low mood, doesn't think sertraline 25 mg is helping her at all, find it hard to go back to sleep after child wakes her up at night, doesn't feel bonded with child ... sometimes thoughts of taking an overdose.*" On 18 March 2013, the GP recorded "*... Feel better with sertraline 50 mg, mood and sleep improved, enjoys looking after baby, baby goes to nursery in daytime."* In her oral evidence, C said that her post-natal depression following the birth of her second child had been worse than her previous post-natal depression.

21. After her maternity leave C returned to work in about February or March 2013. She initially worked in the prisoner processing team. During 2014, she was deployed to the Community Safety Unit at Forest Gate Police Station, dealing with domestic abuse cases. In her statement, she states that she enjoyed that role. However, it appears that she experienced a further period of stress at work and mental health issues during that year, although it is not clear from her witness statement whether they happened before or after she started working at Forest Gate. On 5 August 2014, her GP recorded "*...Depression interim review --- Events at work triggered mood, wean herself off, feel over edge, want to restart tab, req some time off work to go back to right frame of mind ... Stress at work ... Employers not v helpful and obstructive as want her to do night shifts which are difficult with young child, they not listening, unsure of being targeted because dealing with equality issue at work ...*". C was signed off as unfit to work but, the following day, the GP recorded "*...Doesn't want to take time off for 2 weeks, req to delete the yesterday sick not[e] as was at work yesterday ... Doesn't wish stress to be on note, req migraine headache and anxiety, stress worsening her anxiety symptoms, feel more anxious and moody....*" On 12 August 2014, her GP recorded "*... Doesn't wish to restart tablets as feel they make her worse before her periods ... Keen to try counselling ... stress at work ... Feeling better, happier going back to work.*"

22. In November 2015, C passed the Detectives' exam. She chose to undertake the Trainee Detective Constable (TDC) programme at the Child Protection Unit in Barkingside. Prior to starting, she underwent psychological screening. Noreen Tehrani (Counselling and Trauma Psychologist) reported on 31 October 2015 that C was "*Psychologically capable to undertake their role ... gets satisfaction from her role at work. There is no evidence of any significant stress. There are no significant trauma symptoms. [C] is*

very good at organising and getting things done and is very good at taking care of her health and wellbeing."

23. C was required to complete a TDC workbook during her training. According to her statement, she managed to complete it and submit by December 2016. It was signed off in April or May 2017 and she became a substantive Detective Constable. She obtained a lot of job satisfaction from her role, which it appears she was performing without any significant issues until the triggering incident in around December 2016. As set out above, in that month she was involved in a case in which she interviewed a victim of familial sexual abuse, which triggered memories of the abuse she had suffered.

24. On 21 February 2017, C's GP noted "*... Advice about treatment given ... Discussed options of SSRI again and counselling, will try both ... Low mood ... Feels very down for about 4 – 5 months, getting worse and worse, get angry easily and more irritable, tried some evening primrose oil, no stress in life are present ... Sleeping a lot, feeling tired still, appetite up and down, has had some suicidal thoughts but no intentions ...*".

25. C does not refer to that appointment in her statement and she gives few details of the case which caused the decline in her mental health, but states "*The circumstances were very similar to what happened to me as a child and the victim was the same age as me. I remember when interviewing the victim, I had tears in my eyes. I tried so hard not to show my emotions, but it was difficult because the victim was sobbing. I just wanted to give her a hug and tell her she is safe now. I could not do that as I had to remain professional. This caused me to suffer a relapse in my mental health as the subject matter brought memories of my own abuse and childhood trauma. I began to get flashbacks and bad nightmares. I tried so hard to rise above it but as the months went by my mental health continued to deteriorate. I spoke to my line manager about it, but she said "You've got some annual leave coming up, when you come back you will be okay.*"

26. According to DI Brothwood's statement, she and C had a conversation of that kind in April 2017. She states that, during March 2017, D underwent significant organisational change when 32 policing areas were merged into 12 Basic Command Units (BCUs). As a result of these changes, the Child Protection Unit at Barkingside was disbanded and the police officers working there were redeployed to either Romford or Ilford; C was redeployed to Ilford. Several officers were unhappy with the change, and some took sick leave. DI Brothwood states that C was resistant to the change, and she specifically recalls her saying on one occasion "*I'm not going!*". In her oral evidence, she maintained that C had said that, although she could not remember anything about the immediate context in which it was said (other than the background of structural changes I have referred to). C denies having said that and said that she was happy to be transferred to Ilford, and this was not the cause of her going off sick. In her statement, DI Brothwood says that, on 3 April 2017, C requested an OH referral due to suffering depression. She was due in work the following day and then had two weeks annual leave booked. She said her issues were not work related and that she had suffered with similar in the past. During the conversation, she said she had felt like jumping off a building but then said she didn't mean it. She also said she had arranged a doctor's appointment and was on medication. DI Brothwood advised her to go home and enjoy her annual leave. Two days after that, DI Brothwood sent C a text asking if she was OK. C responded saying "*I haven't killed myself yet*". DI Brothwood replied saying that

she was sending two officers to C's address to check on her. That prompted C to call her and tell her that she did not mean that comment and did not intend to harm herself.

27. On 18 April 2017. C reported sick and remained absent from work until August 2017. On 26 April 2017, her GP noted "... *No improvement yet with SSRI, physical abuse as a child ran away from home, struggling with work in police, not sleeping well interrupted, appetite okay, feels like jumping off building stopped by thoughts of children.*" At a further consultation on 12 May 2017, her GP noted "...*feels low, tearful, has some suicidal thoughts of overdose no plans ... Feels let down by work and occ. health, plan increase dose of sertraline 100 mg."*

28. C arranged privately to see Dr Rena Gupta, a Consultant Psychiatrist at the Priory Hospital, Chelmsford on 20 May 2017. Dr Rena Gupta took a history which referred to "...*Physical and emotional abuse from her father and her sister ... Witness domestic violence ... Later on she was also sexually abused (touching) by a family friend of several occasions ...*" C's symptoms included low mood, lack of energy, poor motivation, attention and concentration, flashbacks and nightmares of her past trauma, irritability with a low threshold to get angry, suicidal thoughts varying in intensity, feeling hopeless and worthless and experiencing paranoia, avoidance behaviour, for example avoidance of sex and Asian people as her father is of Asian origin. Dr Gupta diagnosed Recurrent Depressive Disorder, current episode moderate with somatic symptoms, and Post Traumatic Stress Disorder. According to C's oral evidence, this was the first time when she was actually diagnosed with these conditions, notwithstanding reference to depression in earlier GP records.

29. D referred C to OH in May 2017. She had a telephone assessment with Jackie Sanu on 8 June 2017, who noted amongst other things that C had reported sick with depression and admitted to having had a low mood and headaches for at least 10 years, her mental and emotional wellbeing started to deteriorate in December 2016 and she described how a case she had started dealing with reminded her of events in her childhood which she had not disclosed to anyone. She described symptoms consistent with those described to Dr Gupta, including suicidal thoughts but said she had no plans. She was offered an urgent referral to D's in-house counselling service but declined as she was happy with the support she was receiving from her GP. The notes from that consultation state, in block capitals, that C "*DOES NOT WISH FOR HER LINE MANAGERS TO KNOW ABOUT HER DIAGNOSIS OR CONDITION*." The Management Advice Report prepared following that consultation stated that a return to work plan would be prepared once there was a return to work date. Ms Sanu was unable to comment on prognosis as C was still receiving treatment. She said that the MPS specialist would be in a better position to comment.

30. On 7 July 2017. C had a telephone appointment with Jackie Sanu at which they discussed a phased return to work for when she was certified fit to return. Ms Sanu's notes record "*She should avoid shift work due to her symptoms and treatment. In addition, she should in my opinion be removed from any role which deals with violent crime, sex crimes and child abuse.*"

31. In her statement, C says that management ignored OH advice and she remembered DS Brothwood saying that the OH advice was "...*only recommendations, and we do not*

have to adhere to them." She repeated that in her oral evidence, although she did not state in either her written or oral evidence when it happened.

32. On 10 July 2017, C's GP noted an episode of "DSH" (deliberate self harm), which C did not feel was the right thing to do. She had suicidal thoughts, but her children were a protective factor. The notes refer to proposals for a phased return to work and a possible need to change C's medication because she found that she was sleeping during the day.

33. C had a further consultation with Dr Gupta, who wrote to her GP on 15 July 2017. C continued to report low mood, suicidal thoughts and feelings of worthlessness. She had noticed an improvement with regards to emotional outbursts and tearfulness. Her flashbacks and other PTSD related symptoms had also reduced in intensity and frequency. Her sleep pattern had changed, and she was experiencing early insomnia with broken sleep. Dr Gupta proposed the addition of a small dose of zopiclone or zolpidem, or augmenting her current anti-depressant with a another anti-depressant, namely mirtazapine, or to add on a small dose of quetiapine "*... which in the longer term if she is able to tolerate this we can increase the dose gradually and this can help with the mood swings and depression ...*". Following this letter, C was prescribed quetiapine 25mg at night on 26 July 2017.

34. On 20 July 2017, C emailed DS Brothwood and PC Marks to request reasonable adjustments in line with the OH recommendations. She had a further telephone assessment with Jackie Sanu on 26 July 2017 at which they discussed a return to work on 14 August 2017. The notes from that assessment record that the return to work would be on reduced hours, 4 hour days x 4 days per week with Wednesday off. "*She should not work shift work due to her erratic sleep pattern and side effects of her medication. Also, she should temporarily be removed from any role which deals with violent crime, sex crimes and child abuse. With regards to which role will be suitable, this will need to be discussed with the officer and also with HR*."

35. According to C's statement, she had a telephone call with DI Brothwood to discuss this advice on 27 July 2017. They then met at the Epping Starbucks on 2 August 2017 to discuss her role when she returned to work. DI Brothwood said she had "*no idea*" but would speak to DI Peel who was in charge of Safeguarding and was responsible for all decisions regarding relocating staff. DI Brothwood's statement also refers to such a meeting but does not state when it happened. She says it was arranged in line with policy that supervisors should visit staff who have been off for a certain period of time, and the purpose was to discuss C's welfare, recovery and to devise a return to work plan. She says that C told her about her past issues and the areas of policing that triggered memories and psychological issues. C said she intended to return to work on 4 September 2017 and asked DI Brothwood to confirm what role she would be in. DI Brothwood said she would discuss it with DI Peel and let her know and that C should report to DI Peel at 9 am on 4 September 2017 to receive back to work instructions as DI Brothwood was on night duty that day[4].

[4] As the following paragraphs show, there is some variance between the chronology given in DI Brothwood's statement for when C returned to work and the dates in C's evidence and the contemporaneous records which show that C initially returned to work on 14 August for a few days and then went on annual leave until September. But the variations are not significant in themselves and are likely explained by inaccurate recollection due to the passage of time.

36. On 2 August 2017, C sent an email to DI Brothwood and Jackie Sanu referring to the meeting earlier that day and stating "*... I still feel anxious that a job has not been found for you [*sic*] outside of the Safeguarding team. I feel sick and cannot face the prospect of returning into the Safeguarding environment. I cannot see a position in that office that would NOT in some way expose me to types of crimes/ victims that have resulted in me being in this position. On reflection I am surprised that OH are expecting me to return to the same office. I ask that HR intervene to find me a position where I do not have to be in the Safeguarding team or deal with any work involving emotional and physical abuse.*" After asking for a move on welfare grounds to a "victimless" office such as financial crimes, she stated that she was still happy to return to work on 14 August but would rather work from JB (Barkingside Police Station). In her statement, C says that DI Brothwood called her following that email and said, amongst other things, "*... you can't pick and choose where you want to work ...*". She asked C to report to Ilford Police Station on 14 August 2017 at 9 am and speak to DI Peel.

37. Contemporaneous documents show that C returned to work on 14 August 2017. She was initially given time to catch up on her administration and processing her emails. On 18 August 2017, she sent an email to OH saying "*Coming back to work has made my mental illness worse because I have been put back in the environment exposed to listening to people talking about cases relating to abuse ... when I asked to work from another office until a role is found [for] me I was told You can't pick and choose where you want to work from.*"

38. C then went on annual leave until 7 September 2017. It appears that DI Peel had told her that, on her return from annual leave, she would be working at Romford Police Station under Acting Sergeant Jon Matthews. This was not confirmed in writing while she was away. On her return, she found that she was still placed in the Safeguarding office at Ilford. According to DI Brothwood's evidence, she told C that she would not have to sit in the Safeguarding office at Ilford Police Station but could work anywhere in the building where she felt comfortable. C's statement says that she found a side office to work from but was told by DI Yilani to work from the main Safeguarding office. C says that when she told DI Brothwood (who at the time was a Sergeant and therefore of a lower rank than DI Yilani), DI Brothwood responded "*it's out of my hands*". DI Brothwood's statement says that the first time she saw C in the office after her return to work, she was sat with the Safeguarding team, which DI Brothwood found odd given their previous conversations. In her oral evidence, she said that, if C had raised the issue with her she could have spoken to DI Yilani to explain the situation, albeit she recognised that, as the senior officer, DI Yilani would have taken the decision where C should work.

39. On 8 September 2017, C spoke to DI Brothwood and told her that the environment was affecting her mental health. DI Brothwood said she did not know what the role working under AS Matthews was but asked her to report to Romford on 11 September 2017. When C reported on 11 September 2017, she was told to work from the Safeguarding office researching on wanted offenders for violent crime, domestic and sexual abuse.

40. C had a further consultation with Dr Gupta who wrote to her GP on 11 September 2017. That letter stated that C had "*... Deteriorated somewhat over the last few weeks, One of the reasons for this is because she went back to work on 14 August 2017 but*

unfortunately she realised that her workplace had not been able to make the necessary adjustments and change their environment ... her current environment and work leads to a significant impact on her mental health in a negative way due to past traumas ..." C also had a further OH review with Jackie Sanu on 12 September 2017, who noted "*[C] remains very upset as she described how management are not adhering to OH recommendations that she should temporarily be removed from any role that has to do with sexual crimes, child abuse or violent crimes.*" It appears from the notes that Ms Sanu was still awaiting a report from D's inhouse psychiatrist, Dr Pitkanen, who had seen C on 4th September 2017.

41. On 15 September 2017, C planned to take an overdose at work but instead reported sick. She attended her GP who offered to sign her off sick until a suitable role had been found, but she did not agree to be signed off. She later spoke to DI Brothwood, who informed her that the Detective Chief Inspector would not allow her to return to work until she was certified as fit by her GP. C also emailed OH on that day to inform them what had happened. On 16 September 2017, she sent an email to DI Brothwood in which she said "*I came back to work on 14th August feeling a lot better and was pleased to be back. Since being back, and having been placed in the CSU environment researching on violence related crimes, it triggered negative thoughts in my head again. I feel like I'm being punished and mentally tortured by being placed back in the Safeguarding environment. The Job is to blame for their lack of support and understanding and making my condition worse, just when I thought I was on the road to recovery."*

42. On 21 September 2017. C was informed by DI Brothwood that she would remain in Safeguarding, putting arrest packages together under AS Matthews. She was again placed in the Safeguarding team, working on domestic abuse cases. She received an email that day from AS Matthews asking her to working on prioritising GBHs. On the same day, her GP noted that she was prescribed Quetiapine 100 mg at night and Sertraline 200 mg daily. C sent an email to OH referring to the medication increase and saying that the GP "*is quite concerned how the MPS are handling my situation by not making reasonable adjustments to my condition.*" On 22 September 2017, C sent AS Matthews an email in which she said the role was not suitable for her as it could trigger negative thoughts. She made an application to be redeployed.

43. On 25 September 2017, C sent a formal grievance letter to D. The contents of that letter show that she had not seen the report from Dr Pitkanen by that date. However, on the same day Dr Pitkanen wrote to Ms Sanu. In that letter, he noted that C's symptoms had been precipitated in December 2016 by a case which reminded her of her own background. "*Her current symptoms remain significant with hypervigilance easy startle reaction, agoraphobia, nightmares and flashbacks as well as daily episodes of anger, tearfulness and agitation. She said Quetiapine helps her to sleep but she remains highly anxious during the day.*" He said, "*My overall impression is that [C] suffers from PTSD and Recurrent Depressive Disorder, current episode moderate ... Currently I do not think that she is fit to work in the Safe Guarding Team or in operational policing however she would be able to engage in non-operational, non-confrontational, non-public facing duties.*"

44. After some chasing on C's part and further emails to OH and HR, the grievance was resolved informally, and C received an apology on behalf of D. From 3 November 2017,

she was placed in a non-operational role in a Forensic Conversion Team where she remained until the end of 2019. According to her statement, during this period she considered herself on the road to recovery and noticed a significant improvement in her mental health. However, she continued to receive care from Dr Gupta and her GP, and to be reviewed by OH and D's in-house psychiatrists and OH clinicians.

45. On 15 January 2018, Dr Schenk, an OH clinician stated that C was "*permanently unfit to return to safeguarding or children's issues.*"

46. On 20 January 2018, Dr Gupta wrote to C's GP. C was continuing to experience symptoms, including flashbacks (the frequency and intensity of which had reduced since she started on medication, as had the other symptoms), nightmares, being hypervigilant and displaying avoidant behaviour such as not going out because she felt that there were people walking behind her. She continued to have mood fluctuations and suicidal thoughts, was still self-harming but the frequency had reduced significantly. She had other symptoms such as an erratic appetite and poor concentration and motivation. She had received 3 sessions of CBT (cognitive behavioural therapy) but had not found it helpful and she and her therapist had agreed that she would benefit from a longer-term psychodynamic approach. She continued to present with symptoms related to PTSD and this had led to a recurrent depressive episode. Dr Gupta advised that Quetiapine could be gradually increased by 50 mg every few days to reach a dose of 300 mg. On 29 January 2018, she was prescribed Biquelle XL 50 mg increasing by increments of 50 mg to a dose of 300 mg at night. On 13 February 2018, Quetiapine 25 mg was added, increasing by increments of 50 mg to a dose of 300 mg at night.

47. Dr Schenk referred C to D's in-house psychiatrist Dr Price, who reported on 5 March 2018 that "*the long term assessment is that [C] will be at a high risk of relapse if she is involved in work that relates to sexual crimes or sexual or domestic abuse and I think given her vulnerability and fragility, this should be considered a long term restriction.*" On 30 April 2018, C had an appointment with Dr Schenk who noted "*She remains really quite depressed and with her complex problems of PTSD.*"

48. On 26 May 2018, C had a final appointment with Dr Gupta who wrote to her GP stating amongst other things "*... Started having some private psychotherapy sessions ... Continues to feel low in her mood first thing in the morning ... Motivated reasonably enough to continue with her work and she has increased her hours ... Self harm done 1 occasion since I last saw her in January ... Continues to have suicidal thoughts but again the intensity and frequency of them have reduced significantly...*".

49. On 12 July 2018, C's GP recorded that C was having private psychotherapy but was not sure it was helping. She felt worse after sessions. Work had settled and she felt much better since her line managers had changed.

50. On 3 September 2018, C had a review with Dr Schenk, who made a referral to Dr Price, noting "*...actually feeling a little better. Suicidal thoughts have decreased ... Would like to see our psych again ... I think this is sensible, just in case things become worse again.*" Dr Schenk also drafted an Adjusted Duties Capability Report which stated that C "*... remains fit to work in an office environment, in a role that she knows but I think she is permanently unfit any chance of returning to operational policing*", and that she

was unable to deal with workplace stress and non-physical confrontation of a normal policing role, and significant trauma.

51. On 5 November 2018, Dr Price reported "... *[C] told me that compared to last year her mental health has recovered a little ... She is currently managing her current role. She continues to avoid potential triggers that could affect her mood and anxiety. She should not be involved in any roles connected with sexual abuse or sexual trauma. She should avoid also having to deal with suicide ... It is not likely that she is going to make any significant improvement in her mental health that's going to enable her to return back to fuller duties.*" Dr Price's report refers to C having told him that, over the summer, she had had suicidal thoughts on a couple of occasions when she had gone to catch a train and thought about what it would be like to jump in front of a train, but she had never had strong intent.

52. C continued to be prescribed Sertraline and Quetiapine. In May 2019, she was able to wean herself off Quetiapine.

53. At about this time, C's line manager left. She emailed her new line manager but received no response. According to her statement. this caused her anxiety as she did not know who to go to if she needed support to arrange leave, with HR requests, or to notify D about her upcoming back operation. On 5 July 2019, she emailed DS Mitchell to ask him for assistance. On 26 July 2019, she met with a new line manager, DS Lee, who was unaware of her history despite having access to her OH records. She therefore had to explain her mental health history to him. She states that this caused her unnecessary stress and she was overwhelmed with stress, frustration and anger as she felt that the history leading to the 2017 grievance was repeating itself and she was beginning to relieve the previous incident even though it had already been resolved through a grievance.

54. C had an OH review on 1 August 2019. The OH report dated 16 September 2019 recommended that her adjusted duties should continue and said "*the restrictions remain valid in that she is not to have direct contact with members of the public, she is not to partake in JRFT, OST and frontline Aid. She is not to work late shifts, nights or a rotating shift pattern. Please make reference to the OH doctor capabilities report dated 3.9.18. her current role seems suitable in meeting her capabilities.*"

55. On 16 October 2019 C took leave of absence for her pre-planned back operation.

56. On 13 December 2019, C attended a 40 day sickness management case conference via Microsoft Teams to discuss her heath and restrictions. As set out above, D admits that, by this date, it was on notice that C was at risk of psychiatric injury if it did not take reasonable steps to protect her. C said that she was intending to return to work on 6 January 2020. She was advised that her role was being reviewed and she would be moved to a new role as a Crime Advisor in the Operations Room but was told that a job description would be emailed to her later that day. According to her statement, she received that email at 14.32 the same day and immediately noticed that the subject line contained the word "Safeguarding". She felt completely numb and disconnected from everything and could not bring herself to eat for the rest of the day. She kept telling herself "*Don't be hasty, this can be sorted*", and sent an email to DS Lee on the same day, explaining her concerns about the new role and referring to the advice of

psychiatrists that she should not be involved in safeguarding roles. Later that evening she took an overdose of 10 paracetamol.

57. On 18 December 2019, C had a meeting with OH who referred to the earlier psychiatric advice and said "*It was recommended that she should not be involved in any roles connected with sexual abuse or sexual trauma. She should also avoid roles that deal with suicide. This is a permanent recommendation and therefore the guidance remains unchanged. When looking for suitable alternative role for the officer, this guidance should be taken in top consideration.*" The same day, C emailed DI Grafton explaining that she felt that she was back to square one explaining herself to different line managers. He responded on 19 December 2019 "*I know, I have had two previous officers that I have line managed who have suffered from quite significant mental health due to childhood trauma ... The continuous repetition to different people is completely unhealthy...".* He said that DCI Copley would make the final decision about officers suitable for the Crime Advisor role.

58. Notwithstanding the concerns C had expressed, she was informed that she was to be given the Crime Advisor role, However, she was told that this was not an investigative role, but she would be there to give advice and deal with Computer Aided Dispatch Scanning. She was told that if matters came up from "first look" about which she was not comfortable giving advice, the case could be passed to a Safeguarding officer to complete the review. She emailed DI Grafton stating that the thought of going into that environment had triggered an episode of depression and reiterating her concerns that it would not be possible to avoid exposure to issues that could cause a relapse in her mental health. She referred to the fact that she had overdosed on numerous occasions when working in that environment and could not predict that it would not happen again. DI Grafton responded, repeating that it was not an investigative role and if any matters came up that on first look she did not feel able to deal with, she could pass them to others to deal with. C says that nothing DI Grafton said made any difference. She knew from her previous experience that D would always prioritise business needs over the human impact of their decisions. Everything she had raised in her 2017 grievance came flooding back and she felt despair, anger and deep frustration, causing her to physically lash out at herself, pulling her hair out in anger.

59. According to her statement, on 18 December 2019, C drove to her local train station in Old Harlow and stood on the bridge for 30 minutes, looking down, contemplating jumping. The thought of her two boys held her back. She returned home and went to bed without saying goodnight to anybody.

60. On 20 December 2019, C saw her GP who noted "... *low mood, been feeling lower again, work not supportive of her mental health which she feels makes it worse, been off since had operation in October, took 10 paracetamol wanted to go to sleep and forget about it, not actively suicidal but had harmful thoughts about OD. Children protective factor, but felt sick and had pr bleeding fresh on toilet paper. they want to put her back into safeguarding team.*" The GP signed D off work.

61. On 2 January 2020, DS Lee contacted C proposing a return to work date of 13 January 2020 and requesting further information to consider an extension of pay request. She responded to say that she had no return to work date as yet and referred to her attendance at the GP after taking 10 paracetamol, trying to blank everything out and go to sleep

having seen the email with Safeguarding in the subject line. She mentioned her history of mental health and OH assessments and said "*... in terms of a meaningful role, no reasonable adjustments have been made despite the Equality Act applying to my ongoing psychological issues. Placing me back in an environment where Safeguarding issues will be discussed is highly likely that I will be a high risk of attempting suicide as per Dr Price's report.*"

62. On 3 January 2020, C saw her GP, who noted "*Low mood, quite low yesterday thinking maybe this year is the year she will end her life ? slow overdose because she won't feel it...*" She was certified unfit to work for a further 42 days. C emailed that sick note to D, stating "*My GP assessed me today and stated until I get the correct medication from the MHT, I am not fit to return to work. Unfortunately, the blame lies with work for my depressive episodes. I did try to explain, but no one was listening to me which resulting in my taking an overdose.*"

63. At about this time, C contacted Remploy, a workplace mental health support service operated through DWP, to seek their support. According to her statement, Remploy tried to contact a number of officers responsible for managing her but they failed to respond.

64. On 3 February 2020, C emailed DS Lee and DI Grafton to inform them that she intended to return to work when her current sick note expired on 17 February and asked where she should report for duty and if a meaningful role had been found for her. On 10 February, DI Grafton informed her that she would be working in the Forensic Conversion Team but could not return to work until her risk assessment had been completed.

65. On 12 February 2020, C had an appointment with consultant psychiatrist Dr Mitesh Shah, who concluded that she was suffering with mild depression and PTSD and recommended an increase in medication. She saw her GP on 14 February 2020 who noted "*Quetiapine has been started moved to different dept at work feeling much better and ready to go back under care of psychiatry. Plan return back phased.*" Later that day, C emailed DS Lee to inform him that her GP had said that she would be fit to work subject to undertaking a phased return as recommended by OH on 18 December 2019. A phased return would assist her GP slowly increasing her medication over time and for this to take effect and settle.

66. C returned to work on 17 February 2020, in the Forensic Conversion team. According to her evidence, no stress risk assessment was carried out.

67. On 25 February 2020, OH reported that C would be able to work full time on completion of her phased return to work but advised that it would be supportive for her to work her full time hours in 8 hour shifts over 5 days.

68. On 22 June 2020, C sent an email to DS Lee saying "*I have not been well. My depression is taking over my life, so it is taking me a bit longer to get things done. The medication I was put back on is still not up to the right dosage yet so please understand if I get things wrong. I am having a bit of a moment.*" DS Lee responded that she should work at her own pace.

69. During this period, C had been working at home. She was due to return to the office to work in July 2020. In preparation, she submitted her roster, explained her mental health circumstances and asked that her shift pattern be adjusted to 7am to 3pm, consistent with the medical and OH recommendations. She was subsequently told that D would not support that shift pattern. This led to a Teams Meeting with DI John Arnold, DS Lee and Federation Representative DS Dave Campbell. At that meeting, DI Arnold agreed that the earlier decision to place C in the role of Crime Advisor had been a mistake given the potential risks it posed to C's mental health. He advised that he would be led by OH recommendations. On 22 July 2020, C emailed DS Campbell a screen shot of the OH referral and advised that SLT would not agree a shift pattern. She advised that the proposed shift pattern was temporary until she came off Quetiapine. It is not clear from her witness statement whether this email was before or after the Teams Meeting, but she goes on to say that she felt like she was stuck in an endless cycle, repeating the same things over and over again. It was exhausting, draining her both mentally and emotionally. Each conversation and dismissal (of her concerns) brought back painful memories of the treatment that had led her to raise her earlier grievance. History was repeating itself and she found the weight of it unbearable.

70. On 31 July 2020, C spoke to the OH physician, Dr Haseldine. His report noted that C's current role was to be disestablished and there were concerns about what role she would be moved into. He advised that a move to a role that involved potential exposure to Safeguarding matters, sexual abuse, sexual trauma or suicide would significantly affect C's wellbeing and recommended that her duties should remain restricted in line with the earlier advice. He also recommended that she continue to work from 7 am to 3 pm to accommodate the effects of her medication and wellbeing.

71. C was then on annual leave until 1 September 2020. On 21 August 2020, C received an email from DS Lee which discussed her pending return to work but did not state what her role would be. She replied to the email asking about her role but received no response. This made her extremely anxious. She had sleepless nights, fearing that she would be punished for speaking out by being placed back in a safeguarding environment.

72. Upon her return to work on 1 September 2020, C was placed in the Burglary and Robbery Investigation Team, investigating crimes. On 17 September, she emailed her then line manager to advise that, in view of her restricted duties, which including not dealing with the public, she should not be placed in a role where she was allocated named suspects as she would not be able to follow through such cases to arrest, interviews and Court appearances. She explained that she was feeling very stressed having to cope with this whilst still adjusting to her increased medication, and that both the Chief Medical Officer and OH had advised that she should not be placed under any stress that might trigger further episodes of mental ill health. DS Katete responded that he was not aware of the full details of C's health but if her situation was worsening, she should seek medical attention and report in sick on days when she was not fit for work. C replied that reporting in sick was not a viable option for her as her sickness record was already being monitored and she did not trust "the Job". Later that day, she had a discussion with DS Katete in which he informed her that she could remain the OiC for the crimes allocated to her. When she questioned whether she should be required to go to court, having been advised by OH to avoid public facing and confrontational roles he responded dismissively "*they only want to see an OiC at Court*". C forwarded him

a copy of her OH report, but he did not respond. She states that his handling of her complaints and concerns was inappropriate and caused her further stress, anger and intense headaches.

73. On 21 September 2020, C was allocated a suspect who had been arrested on 19 September 2020. During a search of his phone, an indecent image of a child was discovered. This caused her mental health to deteriorate and she had flashbacks, nightmares and sleeplessness. She spoke to DS Katete and emailed him a risk assessment the same day, informing him that this should have been carried out on her return to work but had not been done. She did not receive a response and no risk assessment was undertaken with her. She felt completely disregarded.

74. On 22 September 2020, C again took an overdose of 10 paracetamol, wanting to forget the stress that she was feeling.

75. On 25 September 2020, Acting DI Luke Hampton emailed C advising that DS Lee and DS Katete would work together to complete a stress risk assessment and he would ask them to address this as a priority, but it was never done. C completed it and sent it to DS Katete, but received no response. On 28 September, she received a further email about the investigation in which she had come across the indecent image of the child. She emailed OH, later forwarding the email to DI Hampton, referring to having taken 10 paracetamols on 22 September and asking why her line managers were not following the advice of the OH doctors.

76. On 28 September 2020, DI Hampton made a further referral to OH. In that referral, he stated that he was "*not sighted on what I am told is a lengthy history of OH referrals*". He said that C's adjustments had recently been relaxed, they were hoping that she might have been able to return to the office on a more limited basis, and she had been allocated a number of crimes to investigate from home and referred to the contents of her email to him dated 22 September. He then said "*I am concerned that the current investigative role is having a detrimental effect on [C's] health. I need advice as to what tasks she can practically undertake. It seems that the investigation of crimes with the stresses that carries is not compatible with [C's] health. It seems her adjustments will need to be reviewed and amended.*" In her statement, C states that DI Hampton included misleading and incorrect information in that referral, including that she was a public facing officer and that her restrictions had been relaxed. C says that any such relaxation of her restrictions had never been discussed with her.

77. On 30 September 2020, DI Hampton emailed C to say that he and DS Lee were in the process of completing a risk assessment. The investigations in her name would be re-allocated and no further investigations would be allocated to her as he could not guarantee that there would be no further reference to things that would cause distress to her.

78. C saw Dr Haseldine again on 5 October 2020, whose report noted what had happened since 1 September and advised that C should be able to return to work in the office in about one month, should be eased back into the office in a phased manner, and should remain on the previously recommended adjusted duties. A meeting should be held with C to discuss the way forward.

79. On 8 October 2020, C returned to work but a risk assessment was not carried out beforehand and she found she had no meaningful role to perform. On the same day, DS Katete informed her that CI Wratten had found a role for her and she should receive a phone call. After further emails and meetings which C felt were not making progress, she had a meeting with the Borough Commander at her request on 15 October. She was then referred by CI Wratten to DS Paul Trevers, who was a suicide lead and she found supportive and compassionate.

80. On 16 October 2020, Remploy emailed DI Hampton, DS Katete and CI Wratten about C's situation but did not receive any response. C states that she felt disregarded, worthless and expendable.

81. C then pursued an application for a voluntary transfer. According to her statement. at some point before 11 November 2020, CI Wratten had informed her that they had exhausted all roles for her in the BCU and he was happy for her to have a voluntary transfer. She states that she was not involved in the decision making and this affected her wellbeing. The previous overdoses, the grievance repeating itself and "all of it" weighed heavily on her and she lived in constant fear that history would repeat itself, that each change in management would bring back the same disregard for her wellbeing.

82. However, on 9 December 2020, DS Trevers informed C that a new LI Management Support Unit was being set up and asked her whether she would be interested in joining it. She responded on 16 December 2020 advising that she was waiting to be posted by the adjusted duties panel.

83. On 11 January 2021, C emailed Christina Yiangou (at HR headquarters) stating that she thought that staying on at EA would be detrimental to her mental health and indicating that she was intending to take early retirement. However, on 18 January 2021, she emailed DS Trevers again asking him to contact workforce planning to escalate her transfer due to a change in line manager, as she was anxious that the same issues would manifest again. On 19 January 2021 she received an email from Maria Pantell (Ms Yiangou's successor) stating that central posting panel had been unable to accommodate a posting for her.

84. On 21 January 2021, C emailed DI Hampton stating "*I have decided to cut my losses and put my papers in September this year ... Remaining in the MPS that will always be detrimental to my mental health. Since you have been my 2nd line manager, it has been better for me. I cannot overcome or forget what I was put through. EA is a constant reminder of that treatment.*" She states that, after reassurances from DS Trevers, she accepted the role at the Management Support Unit, where she remained until March 2022. She found him an exceptional leader and says that she experienced no depressive episodes while working under him. It appears from her medical records that she continued to take Quetiapine and Sertraline, although she weaned herself off Quetiapine towards the end of 2021.

85. In August 2021, C applied for promotion but her application was rejected because of the number of sick days she had taken. In her oral evidence, C characterised herself as a hard-working officer whose ambition to become a Sergeant was frustrated by management's failure to follow OH advice and recommendations.

86. At about the same time, C learnt that DS Trevers would be leaving the management support unit to take up a promotion in March 2022. She says that she decided at that point to leave her employment, because she was fearful of new management making the same mistakes as in the past to the detriment of her mental health. She describes her state of mind as follows: "*It happened before, and the fear of it happening again weighed on me. I was tired of living on edge, tired of waiting for something I couldn't control, tired of asking myself, when will it be the next time?*" On 14 February 2022, she received a letter from Assistant Commissioner Nick Ephgrave, QPM, asking her to delay retirement. In her response she stated: "*The reason I have decided to take early is because the failures of supervisors who did nothing to support me when I became ill after been* [sic] *exposed to a child protection case that triggered depression. Rather than supporting me, managers deteriorated my condition by going against OH advice and doing what was best for the business needs*. *This treatment went on for 3 years whenever there was a change in line management. I strongly believe if I had received the right support, it would have enabled me to remain as an operational officer. Unfortunately their actions resulted in two overdoses which I cannot forget, therefore I have cut my losses by taking early retirement as soon as I turned 50 to prevent this from happening again. After all, from my experience, history always repeats it itself* [sic] *in the MPS.*" She then referred to the fact that, if it had not been for DS Trevers, she would not have stayed. In her oral evidence, she said she could not put herself through another change of line manager and people not reading OH reports; that was the reason for her early retirement.

87. After retiring from D, C worked from 20 June 2022 to 18 February 2023 as Deputy Designated Safeguarding Lead at Burnt Mill Academy. In her oral evidence, she said she had left because they had offered her the role of Designated Safeguarding Lead, which she did not feel she could fulfil. After a break in employment, she worked 3 days per week for the NHS at a Child Development Centre, processing autism referrals between 7 March 2023 and 31 May 2023. That job came to an end because it was a temporary role. After another month's break in employment, she worked as a Pastoral Administrative Officer at Ongar Academy from 3 July 2023 until 25 May 2024. She said she had left that role following a dispute about pay. She could not remember where she had worked immediately after that but she worked at Tower School as an Autism Practitioner between 27 August 2024 and 24 April 2025. She was unemployed between 24 April 2025 and July 2025, when she started working as a self-employed gardener. At the trial, she told me that she had stopped that business and was about to start working in an administrative role for A to B Cars in Harlow, which provides transport to and from schools for children with SEND. It appears that she has not been prescribed Quetiapine since weaning herself off in early 2022 but has continued to take Sertraline at a slightly reduced dose.

Evaluation of the Witnesses

88. C's evidence is set out in a lengthy witness statement running to 214 paragraphs over 38 pages and containing numerous references to contemporaneous documents. Much of my summary of the background is taken from her witness statement, as well as her medical notes and relevant documents.

89. Mr Stebbings cross-examined C extensively on matters that took place before the "actionable period", including before she had joined D and before she had become a detective, and about the various jobs she has taken since retiring from D. He asked only a small number of questions about the actionable period between 13 December 2019 and 31 March 2022, and C's evidence about that period was mostly unchallenged. This is consistent with D's decision to call only DI Brothwood to give evidence, and not to call any of the officers who were C's line managers during the actionable period.

90. Mr Stebbings submitted that C was not a reliable historian. It is true that there are aspects of her evidence, in particular about events before she joined the police or in the more distant past (such as whether she had attempted suicide when she was 18 or 19 or had "accidentally overdosed" on alcohol, and whether she had suffered from depression when living in Liverpool) which are inconsistent with the contemporaneous records, and that those records themselves contain some inconsistent reporting of her history. It appears that she did not disclose her history of depression or other aspects of her medical history fully on the health questionnaire when applying for employment with D in 1996, or when she applied to become a police officer. Her explanation for this, that she had not been (formally) diagnosed with depression before 2018 was not convincing, given that she had previously consulted GPs about her mental health. I think it more likely that she felt well at the time of her application but was conscious that disclosing her previous episodes of poor mental health might harm her progress. Mr Stebbings and Dr Francis both picked up on some inconsistencies in her medical notes about the person who had abused her during childhood – stated in different records to be her uncle, her brother or a family friend. However, in relation to that particular area of inconsistency, it is commonplace in personal injury litigation for medical notes taken by treating doctors to contain basic errors. I agree with Ms Giachardi's submission that it is not difficult to see, for example, how "*brother*" could be an erroneous note based on C saying "*father's brother*". On the other hand, there are numerous references in the medical notes, including some which date from long before the triggering event in 2016, to her having suffered childhood abuse from a relative. For those reasons, I am not satisfied that inconsistent description of the perpetrator in medical records is the result of unreliable reporting by C or casts doubt on her credibility.

91. Dr Gibbons stated, in her oral evidence, that it is rare for patients to give consistent information about their mental illness, partly because they lack insight and partly because early trauma and mental illness affect how memories are formed and stored. Of course, that evidence does not suggest that C's account should be treated as reliable: those are reasons why C's recollection of events and the course of her mental health may be unreliable even though honestly given. However, in relation to events after the triggering event, much of C's witness statement was carefully cross-referenced to, and therefore corroborated by, the contemporaneous correspondence and documents.

92. When giving oral evidence, C's demeanour was generally rather "flat" and unemotional, which may be a side effect of her medication, although she did become upset enough to need a break at one point in her evidence. She answered the majority of questions straightforwardly: "that is correct" or "I disagree", with an explanation for any disagreement. In general, I consider that she was a credible and reliable witness.

93. Based on DI Brothwood's evidence, a central hypothesis that Mr Stebbings put to C was that, along with other officers based in the CAIT at Barkingside (which C herself referred to as a "Gucci" role), C was resistant to the restructuring in 2017 and did not want to move. Rather than D causing her injury, C was angry that she could not get her own way and frustrated at the delays and bureaucracy she encountered when dealing with D, and that was what led to her periods of sick leave and eventual retirement. Mr Stebbings put that, contrary to her case, D had done everything it could to assist her. C denied that thesis. She denied that she had ever said to DI Brothwood, about the restructuring, "*I'm not going!*" She said that OH had done their best to assist her, but her line managers had let her down by failing to follow their recommendations. Every time she had a new line manager, they did not know her history or the OH recommendations and she had to go through it all over again. DS Trevers' promotion was not the trigger for her retirement as such: it was D's repeated failures to ensure that her new line managers understood her situation in advance. She was in recovery while DS Trevers was her line manager, but she could not face going backwards because of history repeating itself when he left.

94. I shall address DI Brothwood's evidence that C said, "*I am not going!*" below. However, I accept C's evidence that she did not leave because of general frustration with D rather than because of her mental health. C's illness and the OH recommendations are well-documented. As a result of C's grievance, before the actionable period, D accepted that it had failed to handle C's illness and her need for adjustments appropriately and apologised. I find it surprising that D has not called any evidence from any of C's line managers during the actionable period, or anybody else, who could give evidence that might contradict C's account of what happened during that period. Therefore, C's evidence about that period is largely unchallenged. It is also corroborated by the contemporaneous emails and other documents in the Bundle. In the absence of any other explanation, I consider that I am entitled to infer that D chose not to call any of those witnesses because their evidence would not have helped its case.

95. I therefore accept C's evidence that there were repeated occasions when her line management changed and her line managers were unaware of her history, the OH recommendations and the adjustments that had been put in place in response to those recommendations, and they failed to implement those recommendations or carry out risk assessments on her return to work after periods of sickness. For example, the history I have set out above shows that, in September 2020 her line managers were clearly unaware of her OH history and recommendations. This led directly to the situation where, notwithstanding OH had recommended that she be given restricted duties to avoid exposure to Safeguarding, abuse or suicide, including not dealing with the public, she was required to handle a case that led to her being exposed to an indecent image, triggering flashbacks and an overdose of paracetamol. Ever after that, her line manager told OH, incorrectly, that C's restrictions had recently been relaxed, without informing himself about her OH history, despite her emails to him referring to it.

96. To support her case, C relied on evidence from Ms Elizabeth Dales, who was not called to give oral evidence, Mr Marc Witham, her former partner from whom she separated during 2025, and Ms Carol Ann McCullock, another former police officer who is also pursuing a personal injury claim against the Defendant. They each made very short witness statements.

97. Ms Dales' evidence is hearsay because she did not give oral evidence. Additionally, both her and Ms McCullock's evidence about how D treated C is hearsay because it is based on what C told them rather than their own observation. Their evidence each confirms that C confided in them about the difficulties she was having with her mental health and D. However, as there is no dispute that D was on notice of C's mental health difficulties and Ds own contemporaneous documents provide evidence of the investigations undertaken by its OH advisers and in-house medical practitioners, their evidence does not take matters much further forward. Indeed, Mr Stebbings asked Ms McCullock only a handful of questions. For those reasons, although I have no reason to doubt Ms McCullock's evidence, I did not find it to be of any significant assistance. Similarly, whilst I did not have the opportunity to evaluate Ms Dales' reliability, her evidence was also of limited assistance.

98. Mr Witham was a truthful witness doing his best to assist the Court. He and C had been in a cohabiting relationship since 2007 and have two children together but, sadly, had separated by the date of trial. According to his evidence, C confided in him very little about her history or the difficulties she was having in her employment with D. Although his witness statement corroborates C's account in general terms – for example, C was not herself in 2016 and 2017 but was sleeping early or during the day and disengaged from family activities, was seeing a psychiatrist during 2017, made some improvement after her role changed following her grievance but then worsened again when planning to return to work after her back operation – he gives very little detail about these matters. He was unaware of her suicidal thoughts at the time, and only learnt about them later, because she did not mention them. Significantly, in his oral evidence he said, and I accept, that C was not frustrated with D generally, but with her line managers who were unaware of the OH advice. C had discussed this with him because he has line management responsibility in his work, and he advised that she needed to escalate things if her line manager was not responding.

99. DI Brothwood was also a truthful witness doing her best to assist the Court but, as I have explained, her evidence is limited to what happened in 2017 and therefore does not deal with the most relevant events. As I have also mentioned above, there are some variances between her evidence and the contemporaneous documents, but these are not significant and are likely to be attributable to the passage of time.

100. On the controversial issue of whether C ever said, "*I am not going!*", in her statement D1 Brothwood says that C was very resistant to the changes (that followed the restructuring) and she specifically recalls her stating, on one occasion "*I'm not going!*". However, the only context she gives is the general discontent with the proposed move from Barkingside, leading to high levels of sickness and OH referrals. DI Brothwood provides no further details in her statement about the specific circumstances surrounding the single occasion when she says C made that comment: for example, where it took place, whether anything prompted the comment, C's demeanour when she made it, who she made it to, who else was present. She was unable to give any further details in her oral evidence. She said that her recollection was generally patchy. In my view, it is unlikely that she has a specific recollection of C making the disputed comment because, if she did, I would expect her to recall at least some of the surrounding

circumstances. This does not merely go to the reliability of DI Brothwood's recollection. The circumstances are potentially significant because they might show whether any such comment was no more than office banter exchanged in a light-hearted way, a frustrated throwaway remark, or something more serious; any of those might be possible based on DI Brothwood's limited evidence. On the other hand, C was adamant that she had not made that comment and was not unhappy with the move. Given that a number of officers were discontented, took sick leave and sought OH referrals, it is quite possible that DI Brothwood has associated a comment made by another officer with C, because C took sick leave and was referred to OH at about the same time. In the circumstances, I am not satisfied on the balance of probabilities that C made the comment attributed to her.

101. The significance of that finding is that I do not accept the gist of D's case, based on DI Brothwood's evidence, that C took sick leave and sought OH referrals because she did not want to move from Barkingside, rather than because she became ill as a result of her exposure to the triggering case in late 2016. As DI Brothwood accepted during her oral evidence, she did not contemporaneously raise any concerns that C's illness was really a cover for her dissatisfaction with the move, and this was not suggested in any OH or internal psychiatric report. Furthermore, in my view, this part of D's case is difficult to reconcile with its admission that it was on notice of C's predisposition to psychiatric injury: it is implicit in that admission that D accepts that C suffered from psychiatric illness because that is the basis for her predisposition to psychiatric injury.

102. As I have already pointed out, DI Brothwood was unable to give any significant evidence about events after the end of 2017 and D did not call any other witness who might be able to do so. In her oral evidence she confirmed that her impression was that C was a hardworking and ambitious officer. She agreed that D is the largest police force in the UK, employing over 40,000 officers. However, when asked whether there were many roles that do not involve safeguarding, child abuse, suicide or operational policing, she said that safeguarding transcends all roles. The Forensic Conversion role had been created for C but was an administrative role to help her recovery, rather than a long-term role suitable for a detective: all policing roles are operational. She agreed that, as C's line manager, she had access to C's OH history and recommendations, as did other line managers and that, from May 2017, D was aware of C's requirements and the risk to her mental health. She could not recall having seen C's grievance, or the reports of the various in-house medical practitioners who had provided advice. She accepted that she could not assist with what had happened after 13 December 2019.

103. Despite the contemporaneous medical evidence that C was suffering from psychiatric disorders, Dr Gibbons and Dr Francis disagreed as to whether C had in fact suffered any psychiatric illness. I shall deal with that disagreement in the next section of this judgment. However, I accept that C's genuine, subjective perception is that she suffered psychiatric illness following the triggering event in 2016 for which she required treatment and the adjustments to her work recommended in the OH reports, and that she suffered further episodes of illness as a result of the anxiety caused when her line managers were unaware of or did not follow OH recommendations on the various occasions described in her witness statement. I am satisfied that, from her point of view, the trigger for her early retirement was her fear that, when DS Trevers was promoted, history would repeat itself and she would become ill again as a result of having new line

managers who did not know her history. I shall consider in due course whether her resignation was a reasonable response to and/ or reasonably foreseeable consequence of D's actions.

The Expert Evidence

104. Dr Gibbons examined C on 26 April 2023, and prepared a report dated 30 April 2023 and a supplementary report responding to questions[5], dated 3 February 2024. Dr Francis examined C on 15 April 2025 and prepared a report dated 30 April 2025 and answers to C's questions dated 6 August 2025. The experts provided a joint report dated 17 October 2025. As noted above, they gave oral evidence concurrently.

105. Dr Gibbons' main report contains editorial highlighting and comments (for example, at paragraph 24 there appears, in brackets "Remove this paragraph and replaced [sic] with below highlighted in green"). In her oral evidence she said that she was not responsible for these: it appears that a fee earner or other employee of C's solicitors made them in order to suggest corrections to Dr Gibbons that were not followed through before the report was served. However, Dr Gibbons confirmed that the report sets out her honest opinion about the matters she was asked to report on.

106. Dr Gibbons is a consultant psychiatrist and consultant psychotherapist, a national director for Priory Group and chair of patient safety. Her specialist areas include suicidal ideation and non-suicidal self-injury and suicide. She has been undertaking expert reports since 2002, prepares between 100 to 250 reports per year and has given evidence in Court in personal injury cases on about ten occasions. She is typically instructed on behalf of claimants with about 5% of her instructions coming from defendants.

107. Dr Francis is also a consultant psychiatrist. His experience includes working in a psychiatric intensive care unit and working as a forensic registrar in a medium secure unit for high-risk offenders, preparing fitness to plead and pre-sentencing reports for use in criminal proceedings. He has been providing medical reports in civil cases since 2013, writing about 40 to 50 reports per year, and has given oral evidence in such proceedings three times in the past two years, and twice in the ten years before that. He has also provided work capability assessments. About 80% of his reports have been for defendants.

108. In her main report, Dr Gibbons states the following conclusions, amongst others:

a. C had post-traumatic stress disorder 6B40 (PTSD) which was moderately severe between 2017 and 2018 and again between 2019 and 2020, then at a moderate level between 2020 and 2022, and was at a mild level when the report was prepared. C had depression 6A70 which was at a severe level in 2017 to 2018, 2019 to 2020 and then at a moderate level and continues at a mild to moderate level.
b. These disorders were as a result of all the work-related stress described (by C).

[5] I assume the questions were put by D, although the supplementary report does not identify who asked them.

c. C's childhood trauma would have made her vulnerable to these difficulties.
d. Dr Gibbons recommends a year of psychodynamic psychotherapy, amounting to 42 sessions allowing for the therapist's holiday.
e. If C engages fully in the treatment, Dr Gibbons would expect a significant improvement over the 18 months after the start of further treatment.
f. C was in suitable employment for her (as at the time of the assessment) but would not be able to return to similar work to what she had done in the police force. Being in a stressful work environment will retrigger her depression and PTSD. Her employment prospects are affected because she cannot cope with a stressful work environment.
g. C's current symptoms of mental illness will make her more vulnerable to further mental illness in future.
h. Each of the following conduct by D made a material contribution to C's injuries:
    i. The failure to follow the advice of OH and Dr Price given in 2018 by proposing to deploy C in a safeguarding role in January 2020;
    ii. The failure to support C in her return to work in February 2020;
    iii. The failure to support C's return to working in the office environment in July 2020;
    iv. The failure to support C in her return to work following her annual leave on 1 September 2020;
    v. The failure to support C's return to working in the office environment in or around October 2020.
i. However, Dr Gibbons acknowledges that the factual issues on which the above conclusions depend are matters for the court, not her.

109. Dr Gibbons sets out the following further opinions in her supplemental report:
a. The stress at work was the trigger for C's problems. The underlying cause was her childhood trauma, but this was dormant and not the cause of significant medical illness until this point. There was not significant mental illness before this event of any sustained nature. C's vulnerability was present but had not been manifest.
b. The trauma in childhood was the most significant contributing factor to C's vulnerability, but the death of her mother would also have increased her vulnerability.
c. C's vulnerability impacts on the type and extent of the work she can do but she should not (otherwise) be prejudiced on the open labour market.
d. It could not be said that, before C started working with the CAIT in 2017, she was aware of any risk that the role would impair her mental health amounting to a voluntary assumption of such risk.
e. C could not have foreseen a risk at that time, given her medical history. For many people childhood trauma is a total surprise and shock when it emerges later in life.
f. D should not have foreseen the risk or conducted any risk assessments when it accepted C's application and making the job offer (presumably, the offer of deployment to CAIT). Many people have childhood trauma and work consistently, and C had worked for many years in the police without issue before the index events.

110. In my view, that last observation of Dr Gibbons (referred to in paragraph 109 f. above) is not quite accurate. It is clear from the history set out above that, before

December 2016, C had suffered from previous episodes of mental health in which her childhood abuse was recorded as a factor: in March 2001 (before she became a police constable), June 2010 and the incident she refers to in 2006/ 2007, as well as a number of other episodes of depression in which her childhood abuse was not recorded as a factor. However, this does not undermine her opinion that D could not have foreseen C's vulnerability at the time it deployed her to the CAIT; it is not alleged that D could or should have done so. But that is of little significance in itself, given that D admits it knew of her vulnerability during the actionable period.

111. Dr Gibbons provides little explanation for her conclusions beyond her recitation of C's presentation at her assessment and account of her injuries, and some selective references to her medical and OH records. In her oral evidence she said that she had formed her own opinion of diagnosis based on her assessment of C, but her conclusion was supported by the contemporaneous records and other experts. She said she agreed with the diagnoses of the previous doctors who had diagnosed depression and PTSD and that there was a "*huge amount of medical corroboration*" for that diagnosis. She was confused by the apparent complexity (introduced by Dr Francis's opinion) as the evidence was, in her view, very reliable and consistent that C had classic symptoms of depression.

112. As noted above, Dr Francis does not agree with Dr Gibbons' conclusions. Whilst his report is significantly longer and more detailed than the report of Dr Gibbons[6], and therefore difficult to summarise, his essential conclusions are:

a. C does not have a mental illness: she does not meet the diagnostic criteria for depression or PTSD, and her history is inconsistent with depression.
b. Rather, she has traits of ADHD, which affect how she adapts to stress. Negative psychological well-being (stress) is distinguishable from mental illness. However, it appears that Dr Francis carried out an ADHD assessment without first telling C that is what he was doing.
c. C's difficulties were associated with her response to stressful circumstances, which was not outside the norm ("*what might be expected*"), rather than any mental illness. Maladaptive responses to stress are not necessarily symptoms of illness.
d. The alleged breaches of duty by D caused workplace stress but not psychiatric injury.
e. C's records contain a number of inconsistencies, including factual discrepancies such as the identity of her abuser, as well as differences between what she reported about her symptoms and behaviour from time to time. Whilst his report does not expressly state that these were evidence of malingering, paragraph 18.2.3.2 appears to invite consideration of that possibility: "*General psychiatrists are usually reluctant to make the diagnosis of Malingering. In this case, there is a history of multiple narrative inconsistencies, extreme reporting/*

[6] Dr Francis' report is 77 pages not including the expert's declaration and a further 35 pages of appendices, whereas Dr Gibbons' report is 14 pages not including the declaration. Some of that difference in length is because Dr Francis has included lengthy, detailed and helpful summaries of, for example, his interview with C, the history and evidence in the case, and C's medical records, but his reasoning is also explained at some length.

performance on tests, and incongruity between a patient's claimed distress and objective findings associated with such a diagnosis." That paragraph has a footnote referring to a publication with the title "Detection and management of malingering in a clinical setting."

f. On the other hand, unreliable testimonies are also associated with ADHD due to underlying response styles.
g. It is likely that C has an insecure adult attachment style, which affects nearly half the population, attributable to her adverse experiences in childhood. Such an insecure attachment style is associated with difficult emotional and behavioural responses when under stress. Combined with her "*acknowledged and unmanaged ADHD*" these are more likely causes for her general, sub-optimal well-being in the context of difficult to manage situations in the workplace.
h. There is also evidence on MRI imaging of physical changes to C's brain which are likely to affect mood and emotional regulation – although those scans have never been followed up diagnostically with a neurologist.
i. From a psychiatric perspective, it is difficult to justify any functional impairment. Dr Francis cannot identify any psychiatric disability.
j. C's periods of absence ("*disengagement with work attendance*") were secondary to dissatisfaction with the responses of D, not secondary to any specific functional impairment because of the symptoms of illness.
k. There is no identifiable mental illness directly related to psychiatric injury attributable to the index incident from which there has been or would need to be any recovery. It follows that there is no (medical) treatment that Dr Francis would recommend, and no medical prognosis. Conclusion of the litigation is likely to assist with adaptation to and resolution of the situation causing C's non-pathological stress.

113. Dr Francis' reasons for considering that C did not have depression or PTSD are set out in detail at paragraphs 18.1.3 and 18.2.2 respectively of his report. In summary:

a. Diagnosis of depression requires the presence of symptoms "*clearly in excess of those required to make the diagnosis*", which are "*seriously distressing and unmanageable*". Diagnosis of a patient who has suffered significant loss, that would be expected to produce distress, requires a clinical judgment as to whether the patient's expressions of distress are outside of what is culturally normal. A change in mood due to depression will be varying little from day to day, definitely abnormal for the patient, uninfluenced by circumstances and not predominating in any particular situation. For a presentation of anhedonia consistent with a depressive illness, there should be a lack of interest in almost all activities of daily life. As compared with these criteria, C's history included continuous, reasonable levels of social functioning compared to pre-index event activity with respect to domestic functioning, relationships, social leisure, gainful occupational functioning and family maintenance. There was no justification for the view that C's response to loss was culturally extreme or out of context. The history was of fluctuations in C's mental well-being dependent on the status of her work situation rather than unvarying and abnormal low mood independent of her circumstances. Whilst Dr Gibbons diagnosed a mild to moderate depressive episode in April 2023, her report contained no description of the core symptoms required to justify this such as pervasive low mood largely

uninfluenced by circumstances, significant problems with energy, lack of interest in almost all daily activities, significantly impacted sleep, appetite, cognitive problems, distorted thoughts, lack of drive or motivation. C had demonstrated continued interest in various aspects of life rather than a lack of interest in almost all activities of daily living. The Montgomery Asberg Rating Scale administered by Dr Francis during his assessment did not suggest the presence of depression. So far as anxiety is concerned, there were no contemporaneous objective indicators of anxiety (such as posture, movement, eye contract, speech or descriptions of distorted/ excessive worry) recorded indicating an anxiety disorder, in contrast to understandable concerns about work, pension and D's actions.

b. The necessary characteristics for a diagnosis of PTSD were not present.

    i. The diagnosis requires exposure to an event of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. The index event in this case (i.e. the triggering event in 2016) was not necessarily likely to be considered an event that may give rise to PTSD. It did not have features that made it likely to do so in the context of the range of exposures that C would have encountered since her childhood.
    ii. Dr Francis would expect a patient suffering from PTSD to have a history of persistent remembering or reliving the stressor by intrusive flashbacks, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor. In November 2018, Dr Price recorded that C was awake associated with ruminations twice per week. This was "*not particularly recurrent distressing*" or a description of intrusive, dissociative, horrific reliving associated with significant elevated levels of physiological arousal. When he assessed her, C denied any reliving of past events and stated that her reliving experiences in 2019 were related to her experience of dealing with D in 2017 rather than her exposure to catastrophic trauma. There were no contemporaneous records by any of the clinicians she saw that justified the presence of trauma related flashbacks. Her recurrent preoccupations and nightmares related to how she had been treated by D and her pension entitlement, rather than any extreme threat or danger likely to cause distress in almost anyone. They were not of a nature that would ordinarily be associated with PTSD and were more consistent with understandable reflections on adversity than psychopathology of PTSD.
    iii. PTSD is manifested in actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor). These features are expected to be persistent and associated with efforts to avoid. C's history did not contain any consistent examples of this behaviour beyond C requesting placement change. There was no suggestion that those circumstances resembled or were associated with the stressor. This was not a horror/ fear based, phobic type avoidance consistent with PTSD. The suggestion of non-specific avoidance of social spaces lacked persistence and was not

horror/ fear based phobic type avoidance associated with PTSD. C's reported to Dr Gupta in May 2017 that she avoided Asian men: Dr Francis appears to question how likely it would be that avoidance arising from physical and sexual violence perpetrated by men would lead to avoidance of an entire ethnic group[7], which suggests that Ms Kawsar may have thoughts related to culture that are difficult to deal with, but they do not represent those associated with PTSD.

iv. A patient with PTSD will have either (1) an ability to recall, either partially or completely, some important aspects of the period of exposure to the stressor or (2) persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following: (a) difficulty in falling or staying asleep; (b) irritability or outbursts of anger; (c) difficulty in concentrating; (d) hyper-vigilance; (e) exaggerated startle response. Hypervigilance features will be marked, intense and prolonged. Dr Francis considered there was no suggestion that C had difficulty recalling details of the index events and had no persistent symptoms of clinically significant/ abnormal increased psychological sensitivity/ arousal specifically related to a catastrophic trauma being experienced.

114. There was no significant agreement or narrowing of the issues in the joint report, each expert holding to the views they had expressed in their primary report. I note that, under the heading "Causation", Dr Gibbons was of the view that pre-existing trauma was brought up by work related stress: therefore, the incident in late 2016 was the trigger for the deterioration in C's mental health at that time. Dr Francis' opinion was that the workplace events were not catastrophic or exceptionally threatening, and C's reactions were not of the type to cause psychiatric injury. Dr Francis therefore appears to have focussed on the nature of the material to which C was exposed at work when considering whether that material caused C's mental illness: his view being that the workplace events did not fit the criteria for causing PTSD or mental illness. Dr Gibbons' starting point was C's childhood trauma, which was reactivated by the triggering incident in late 2016, causing her mental illness. There was a similar dichotomy of views in their oral evidence, with Dr Gibbons emphasising her diagnosis of Complex PTSD as set out below.

115. The oral expert evidence of the experts occupied almost a full day of the trial. Each held to the views expressed in their reports. Dr Gibbons said that she had found Dr Francis' report and detailed summary of the medical notices very helpful and had a "more nuanced formulation" of her opinion as a result. However, it appears that her opinion was stronger in the light of that summary: she said she had rarely seen a case in which there was such clear evidence, including diagnoses by four psychiatrists and two OH clinicians. As I have already noted, she said she was confused by the complexity of Dr Francis' analysis. In her view, it was not complicated, there was a "huge amount" of medical corroboration, C was on high levels of medication, she had classic symptoms of depression, and the evidence was very reliable and consistent over time. Insofar as there was inconsistent reporting in the medical notes, that was explicable on the basis that practitioners do not always have time to take detailed notes; symptoms of depression, anxiety and depression fluctuate and therefore may be reported differently

[7] His reasoning at paragraph 18.2.2.9 is not clear but this appears to be what he is saying.

from time to time; and mental illness affects the patient's insight and the way in which memories are formed and retrieved so that they rarely give consistent information about their mental illness.

116. The experts agreed that C had a history of childhood trauma and vulnerability but continued to disagree as to whether that history had given rise to any symptoms meeting the diagnostic criteria for mental illness. The key points of difference between them were as follows:

a. Dr Gibbons said that C was on the maximum dose of Sertraline and a significant dose of Quetiapine, which is not normally used in the treatment of depression. She considered this was evidence that C's depression was severe. Quetiapine tended to be used to "take the edge off" anxiety but 150 mg was a significant dose and it tended to be used for major depression or bi-polar disorder. Dr Francis said that there is a dosage range between 50 mg and 200 mg at which Sertraline is effective but no necessary correlation between the dosage of Sertraline and the severity of symptoms. As for Quetiapine, the British Association of Psychopharmacology advised that doses below 200 mg only work as a sedating antihistamine. It was not uncommon for it to be prescribed to help with sleep[8]. Dr Gibbons maintained that she and many of her colleagues believe that the higher the dose of medication, the worse the illness. In her experience 200 mg of Sertraline together with 150 mg of Quetiapine was evidence of significant illness.

b. Dr Gibbons considered that the evidence showed C had previously had some depression which had not been recognised, including some post-natal depression, but had been functioning quite well until the end of 2016, when the trigger event caused a serious period of PTSD and depression which had been documented by Dr Gupta and OH. Their notes recording that C reported nightmares and flashbacks suggested that the diagnosis of PTSD was fitting. C's anxiety about returning to the workplace was symptomatic of avoidance. The reports of her suicidality, including going to a bridge and taking overdoses, were signs of psychiatric morbidity which needed to be taken seriously. C was also quite paranoid, thinking that people were watching her, which might be why she was prescribed Quetiapine[9]. C's vulnerability in the past and her reaction to the trigger event suggested that she had Complex PTSD, which arose when the patient had experienced early trauma which affected the development of their personality early on, but re-emerged later in life. A minor event could be a sufficient trigger for a patient with Complex PTSD. Such patients particularly use dissociation and avoidance to cope, are much more vulnerable to later psychiatric illness, inter-personal and relationship difficulties and find it difficult to open up and share. Dr Francis accepted that C's history included childhood trauma and disturbance of relationships with her primary attachment figures. He said this often has significant impacts on how people get on with relationships and manage normal stress, but is not necessarily a psychiatric disorder: about 40% of people have an insecure adult attachment style, presenting with distress.

[8] It appears the Dr Gupta initially prescribed Quetiapine to help with sleep but considered that it might also be useful in controlling C's mood swings: see paragraph 33 above.

[9] However, see footnote 8 above.

There was a background of vulnerability, but C's records did not necessarily suggest that there were episodes of depression. Depression tended to be over-diagnosed because doctors want to give patients showing distress something that will help them. There was evidence that C had shown a degree of distress that had resulted in primary care practitioners prescribing anti-depressants: that in itself would lead C to think that she was being treated for a mental health condition. C had presented to health professionals with complaints relating to her mood every two years before 2016, but her presentation was quite general and vague. There was a lack of evidence of persistent low mood regardless of circumstances, with a loss of interest in all activities, low energy levels and lack of motivation. Rather, C had shown intermittent distress and actions such as going to a bridge or taking an overdose prompted by such distress, in response to stress and dissatisfaction with work. This was consistent with an insecure adult attachment style (leading to maladaptive responses to stress) rather than a psychiatric disorder. So far as PTSD was concerned, Dr Francis considered that there was a lack of evidence of symptoms of PTSD such as hypervigilance; he acknowledged that C had reported feeling that she was being followed but said there was no "hypervigilant narrative" to attach that to. It was not clear to him what the aetiology of the supposed PTSD was. C's self-report of wanting to avoid environments involving safeguarding was just that: it had not been properly explored in the OH assessments. C's self-reporting was insufficient to justify a diagnosis. Her employment in roles at schools where there was a higher chance of exposure to safeguarding issues was inconsistent with her reporting that she wanted to avoid such exposure. Dr Francis acknowledged that he was disagreeing with all the other doctors who had seen C but said he was the only one who had been through her records in detail.

c. Dr Francis considered that taking an overdose of 10 paracetamol was not a significant act of self-harm. He postulated that, as a police officer, C would have understood that it was not serious. Dr Gibbons disagreed with this view and said that taking 10 paracetamol could cause significant harm.

d. Dr Gibbons said that, in her experience, the symptoms of patients with chronic depression fluctuate over time and may therefore be reported differently over time. Both the ICD and WHO manuals spoke about a fluctuating course. C's reports of feeling a bit better or feeling really well at times were consistent with PTSD. Dr Francis disagreed. His view was that the diagnostic criteria state that depressed mood does not vary significantly from day to day. Dr Gibbons said that those criteria were for acute depression not chronic depression to which Dr Francis responded that chronic depression is not recognised in the diagnostic manual; a patient either has depression or they don't. He also said he disagreed with the (common) description of "low-level depression" and said that depression is either mild, moderate or severe. Feeling sad about something bad that had happened in the past was appropriate; it was not a PTSD response.

e. Dr Gibbons thought that the timing of the expert reports might make a difference to the experts' opinions. She had seen C in 2023 when she had formed her own opinion that C had Complex PTSD and depression, whereas Dr Francis had seen her two years later in 2025, by which time she might have improved. Dr Francis

thought that this should not make a difference as the experts both had access to the same contemporaneous records and a judgment about how C was in 2022 should not be altered by when the experts saw her. Dr Gibbons' assessment in 2023 was not sufficiently close to 2022 to be representative of how C was in 2022. C had improved after leaving the police force, which Dr Francis said showed an evolving presentation inconsistent with depression. Dr Gibbons thought that the pattern of behaviour over time was consistent with depression and PTSD, because going back into the situation would exacerbate the depression and re-trigger the PTSD. Dr Francis said that that presupposed that there was a baseline of depression being exacerbated, but if C felt "OK" when out of the situation, that was not consistent with depression.

f. The experts disagreed about the significance of inconsistencies and lack of information in the medical records. Dr Gibbons said that it was rare in practice for medical professionals to be able to make complete and detailed notes of all that was said in a consultation and, as set out above, explained that inconsistencies in reporting by patients with mental illness arise because of the way in which the illness affects memory. Dr Francis criticised the lack of detail in the medical records, which he considered fell short of good practice. He did not accept that inconsistent reporting could be explained by the impact of mental illness on memory and recall and said there were stark differences between what C had reported and the fundamental aspects of the diagnosed disorders. The only specific differences he mentioned orally were C's ability to respond to an email on 13 December 2019 (see paragraph 56 above and sub-paragraph g. below) and Mr Witham's apparent unawareness of what she was going through when she had discussed things with him from an OH perspective. He said there was no evidence of cognitive impairment and that several aspects of C's evidence did not align.

g. Dr Gibbons considered that C's description of events and her reaction to them and state of mind in her witness statement provided good evidence for PTSD. They showed frustration, anger, self-harming behaviour, and pulling hair which were part of depression and PTSD. She described feeling trapped and unable to get away from the source of anxiety. These were not symptoms of (ordinary) anger and frustration at her employer. In a patient with Complex PTSD, the failure of their employer to listen to them and make adjustments would induce numbness and panic. C's dissociation, numbness and overdoses were symptoms of depression. It was not possible to separate her trauma from her feelings about D not responding to her needs. Dr Francis said that C's early trauma and association of behaviour types with that trauma accounted for her strong emotional responses to adversity, including her self-harm, without the need for further diagnosis. Her reactions were consistent for somebody with her sort of background and were longstanding behaviours that had started in the 1990s. Her ability on 13 December 2019 to send a coherent email to DS Lee, within 40 minutes, responding to the email containing the word "Safeguarding" (see paragraph 56 above), was unusual and inconsistent with her evidence about how she had reacted when she received that email. He considered that there were psychodynamic rather than psychiatric reasons for C's reactions.

h. As to causation, Dr Gibbons said that C had functioned well before the trigger event. She had been holding down her relationship and managing at work until that event. The trigger event had caused functional disabilities leading to the inability to work and breakdown in her relationship. Dr Francis said that C had had presentations with low mood in 2010, 2012, 2014 and 2016 and had not functioned without such complaints for a long time. Even allowing for periods of post-natal depression in 2010 and 2012, she had problems before the trigger in 2016. Dr Gibbons thought that C's breakdown following the trigger event was not foreseeable to C or D. However, C would have recovered within a year if D had acted appropriately in response to the OH reports. She would have remained vulnerable but would not have had two further episodes of ill health leading to early retirement. There was a causal relationship between D's failings and C taking early retirement, because C feared becoming unwell again and was fearful of having to disclose her history again. Dr Francis reiterated that, even discounting C's episodes of post-natal depression, she had still had several episodes of mental instability, and he would have expected that to continue, because the past is a good predictor of the future. It is difficult to understand what would have changed if D had followed the OH advice. He said that the period of stability C had during her last role with D underlined his view that her episodes of mental illness coincided with dissatisfaction about her role in the police. He considered that, in medical terms, the implementation or non-implementation of the OH recommendations made no difference.

i. Dr Gibbons said that the prognosis for C had improved. She needed to undergo the psychodynamic psychotherapy that Dr Gibbons had recommended. The prognosis was good if she engaged in that therapy, which would take two years assuming 42 sessions per year. C needed to get over the breakdown of her relationship with Mr Witham and to obtain and sustain work; her inability to sustain work was part of her long-term symptoms. Assuming that C suffers from mental illness, contrary to his view that she does not, Dr Francis said that 70%-80% of patients with depression recover within 6 months. However, in C's case, the prognosis was affected by concurrent vulnerabilities such as the breakdown of her relationship, the need to re-engage with work, this litigation, and the potentially destabilising effects of psychotherapy. The length of her depression was also a factor which made the prognosis poor. He did not recommend pharmacological intervention and said that Dr Gibbons has greater expertise in talking therapy than he does, but he would be concerned about whether C has the right characteristics to engage in such therapy. He considered that there was no reason why C should not be able to return to work until normal retirement age.

j. Finally, Dr Gibbons questioned whether it was appropriate for Dr Francis to carry out an ADHD assessment without C knowing that was what he was doing as it is a challenge to the patient's identity. She said that such assessments take 90 minutes to 2 hours, with feedback from family, school reports and other sources. ADHD does not provide an alternative explanation for C's psychiatric illness. Dr Francis said there was no reason to treat diagnosis of ADHD differently from other psychiatric disorders and that he was in a strong position of expertise to make such a diagnosis.

117. Clearly, each expert is appropriately qualified and has significant experience both in treating patients and in preparing reports in a forensic context. There is no difference in their qualifications and experience which, by itself, means that I should prefer the opinion of one over the other.

118. However, on the balance of probabilities, I prefer the opinion of Dr Gibbons. At the most basic level, this is because of the number of different psychiatrists, OH and other medical practitioners who have consistently agreed that C has PTSD and depression. As Ms Giachardi pointed out in closing submissions, the four psychiatrists who saw C between 2017 and 2020 came from different clinical backgrounds (Dr Gupta saw C privately through the Priory, Drs Pitkanen and Price were employed by D and Dr Shah was an NHS consultant). Drs Gupta and Shah were both treating C; Drs Pitkanen and Price were advising D about C's condition, whether she was fit for work, and what adjustments should be made for her. The implication of Dr Francis' report is that they each misdiagnosed C. In my judgment, that is extremely unlikely, even allowing for the fact that Dr Francis was able to review the whole of C's history in detail.

119. As Ms Giachardi pointed out, C's treating physicians had also documented a fluctuating presentation, with C showing improvements over time and worsening of her symptoms at times when her line managers were unaware of or failed to respond appropriately to her needs. Dr Francis suggests that this is inconsistent with depression, but it clearly did not cause any of the psychiatrists who saw C contemporaneously to question or alter their diagnosis. In my view, it is important to bear in mind the particular function that those psychiatrists were discharging. Unlike Drs Gibbons and Francis, none of them was reporting on C's history *ex post facto* in a forensic context: they were either treating C or advising D in real time. I accept the sentiment expressed by Dr Gibbons to the effect that Dr Francis was over-complicating things. The simplest, and most likely, reason for the consistency between the various psychiatrists and other clinicians who saw C contemporaneously is that their diagnosis was correct. I do not accept the implication of Dr Francis' evidence that all four psychiatrists would, in effect, have offered C a "convenient" diagnosis out of a desire to help solve her problems, rather than because they thought it was the correct diagnosis: I agree with Ms Giachardi's submission that it would have been potentially negligent to diagnose and prescribe medication unless the diagnosis was appropriate. The fact that Drs Pitkanen and Price were in-house psychiatrists advising D is a further reason why they are unlikely to have taken such an approach.

120. I also bear in mind that C was receiving treatment, including the prescriptions of Sertraline and Quetiapine and periods of time off work: that treatment is likely to have brought about periods of recovery which would explain C's improved symptoms from time to time, and relapses triggered by exposure to stress in connection with D's failures to implement the OH recommendations on her returns to work or to the office after periods of time off or working from home.

121. Although there are some inconsistencies in C's medical records, and the information recorded is in some cases lacking in detail, in my experience of personal injury cases, that is not at all uncommon in notes kept by treating practitioners. I accept Dr Gibbons' evidence about the reasons why psychiatric patients may give different accounts from time to time and that treating practitioners do not always have time to

note everything. I do not consider that the inconsistencies or lack of details in the notes are sufficient to call into question the consistent diagnosis by the different psychiatrists who C consulted. In my view, the mere fact that Dr Francis considers there is certain evidence missing from C's records does not mean that these psychiatrists were all wrong.

122. So far as PTSD is concerned, as mentioned above, the focus of Dr Francis' attention appears to be on the lack of a sufficiently traumatic event in 2016 to trigger PTSD. However, I accept Dr Gibbons' evidence that, when diagnosing Complex PTSD, it is C's background of childhood trauma that is important, with a relatively minor event in 2016 being sufficient to cause that trauma to re-emerge resulting in a decline in C's mental health.

123. I do not consider that the fact that C has undertaken employment in schools with some responsibility for safeguarding is inconsistent with her suffering psychiatric injury as a result of exposure to safeguarding when in D's employment. The contexts are wholly different. In the school setting, C's function is likely to have been administrative and concerned with proper procedures and record keeping, unlike the investigative role of the police where, even when performing essentially administrative tasks such as preparing files for court, there was a daily risk of exposure to safeguarding and related issues involving or arising from criminal conduct.

124. Fundamentally, therefore, I prefer Dr Gibbons' opinion because it is straightforward and consistent with the diagnoses made by other psychiatrists who saw C in different contexts contemporaneously with her employment. Dr Francis' report is a thorough and detailed *ex post facto* analysis but is overly elaborate and inconsistent with those earlier diagnoses. In her closing submissions, Ms Giachardi submitted that he gave the impression in oral evidence that he was "trying to win", implying that he was overly combative. I did get the general impression that he wanted to have the last word, was unwilling to make concessions, and that he was perhaps striving a little too hard to prove his hypothesis that C did not have a mental illness. There are two further respects in which, in my view, his report is open to criticism. First, I agree that it was inappropriate for him to have carried out an ADHD assessment without informing C or her solicitors that he intended to do so and obtaining their agreement. Whether or not he was well-placed to carry out the assessment (as he said) is beside the point. It does not appear that such an assessment fell expressly within the ambit of his instructions. Such a diagnosis could potentially impact C significantly and require treatment, but Dr Francis is not her treating psychiatrist. It also potentially placed C at a forensic disadvantage (as Dr Gibbons had reported two years previously and had not been asked to carry out any such assessment). In my view, if Dr Francis thought it needed investigating, he should have flagged it up as such, rather than proceeding to carry out an assessment that was outside the scope of his instructions. Secondly, if he considered there was evidence to suggest that C had fabricated any of her symptoms (i.e. evidence of malingering), he should have stated that directly rather than hinting that it was a possibility in the way that he did in his report. On their own, these matters would not have led me to prefer Dr Gibbons' evidence, but they add some weight to the reasons I have given above for doing so.

Matters of Law

125. There is no dispute about the relevant law.

126. D owed C duties of care, including to provide a safe system and a safe place of work, and to take reasonable care that C did not suffer reasonably foreseeable psychiatric injury by reason of the requirements of her work[10]. Although the duties of care owed by employers arise in tort and contract, such claims are in substance governed by the tortious rules and C has pleaded them in tort. She has separately pleaded the contractual implied term of mutual trust and confidence, but her claim is essentially based on negligence. Furthermore, D was subject to the Management of Health and Safety at Work Regulations 1999, which included obligations to carry out an assessment of health and safety risks to which C was exposed at work, take preventive or protective measures, and provide her with appropriate health and safety surveillance and information. Whilst no direct cause of action arises under those regulations, they are relevant when considering what amounts to reasonable care and breaches of them may be relevant evidence of negligence.

127. Although the same fundamental duties apply to psychiatric injury as to other types of personal injury in the course of employment, case law has recognised that liability for psychiatric injury presents particular difficulties because many types of work are inherently stressful and employers are entitled to assume, in the absence of any information to the contrary, that employees who are qualified and competent to undertake such work are also resilient enough to cope with that inherent stress. Furthermore, it is necessary to distinguish being subject to or affected by occupational stress (which is an unavoidable feature of many occupations), from being injured by such stress. The relevant principles guiding liability for psychiatric injuries were summarised in the "practical propositions" set out at paragraph 43 of the judgment of Hale L.J. in Hatton v Sutherland [2002] EWCA Civ 76; [2002] ICR 613, which were endorsed by the House of Lords on appeal in Barber v Somerset [2004] UKHL 13, albeit Lord Walker said that they were to be treated as providing useful guidance rather than having statutory force. Those practical propositions are as follows:

> "(1) There are no special control mechanisms applying to claims for psychiatric (or physical) illness or injury arising from the stress of doing the work the employee is required to do (para 22). The ordinary principles of employer's liability apply (para 20).
>
> (2) The threshold question is whether this kind of harm to this particular employee was reasonably foreseeable (para 23): this has two components (a) an injury to health (as distinct from occupational stress) which (b) is attributable to stress at work (as distinct from other factors) (para 25).
>
> (3) Foreseeability depends upon what the employer knows (or ought reasonably to know) about the individual employee. Because of the nature of mental disorder, it is harder to foresee than physical injury, but may be easier to foresee in a known individual than in the population at large (para 23). An employer is

[10] D's Defence appears not to formally respond to C's pleaded case that D owed her these duties, but they are conventional and uncontroversial.

usually entitled to assume that the employee can withstand the normal pressures of the job unless he knows of some particular problem or vulnerability (para 29).

(4) The test is the same whatever the employment: there are no occupations which should be regarded as intrinsically dangerous to mental health (para 24).

(5) Factors likely to be relevant in answering the threshold question include: (a) the nature and extent of the work done by the employee (para 26). Is the workload much more than is normal for the particular job? Is the work particularly intellectually or emotionally demanding for this employee? Are demands being made of this employee unreasonable when compared with the demands made of others in the same or comparable jobs? Or are there signs that others doing this job are suffering harmful levels of stress? Is there an abnormal level of sickness or absenteeism in the same job or the same department? (b) Signs from the employee of impending harm to health (paras 27 and 28). Has he a particular problem or vulnerability? Has he already suffered from illness attributable to stress at work? Have there recently been frequent or prolonged absences which are uncharacteristic of him? Is there reason to think that these are attributable to stress at work, for example because of complaints or warnings from him or others?

(6) The employer is generally entitled to take what he is told by his employee at face value, unless he has good reason to think to the contrary. He does not generally have to make searching inquiries of the employee or seek permission to make further inquiries of his medical advisers (para 29).

(7) To trigger a duty to take steps, the indications of impending harm to health arising from stress at work must be plain enough for any reasonable employer to realise that he should do something about it (para 31).

(8) The employer is only in breach of duty if he has failed to take the steps which are reasonable in the circumstances, bearing in mind the magnitude of the risk of harm occurring, the gravity of the harm which may occur, the costs and practicability of preventing it, and the justifications for running the risk (para 32).

(9) The size and scope of the employer's operation, its resources and the demands it faces are relevant in deciding what is reasonable; these include the interests of other employees and the need to treat them fairly, for example, in any redistribution of duties (para 33).

(10) An employer can only reasonably be expected to take steps which are likely to do some good: the court is likely to need expert evidence on this (para 34).

(11) An employer who offers a confidential advice service, with referral to appropriate counselling or treatment services, is unlikely to be found in breach of duty (paras 17 and 33).

(12) If the only reasonable and effective step would have been to dismiss or demote the employee, the employer will not be in breach of duty in allowing a willing employee to continue in the job (para 34).

(13) In all cases, therefore, it is necessary to identify the steps which the employer both could and should have taken before finding him in breach of his duty of care (para 33).

(14) The claimant must show that that breach of duty has caused or materially contributed to the harm suffered. It is not enough to show that occupational stress has caused the harm (para 35).

(15) Where the harm suffered has more than one cause, the employer should only pay for that proportion of the harm suffered which is attributable to his wrongdoing, unless the harm is truly indivisible. It is for the defendant to raise the question of apportionment (paras 36 and 39).

(16) The assessment of damages will take account of any pre-existing disorder or vulnerability and of the chance that the claimant would have succumbed to a stress related disorder in any event (para 42)."

128. A number of those propositions relate to occupational stress in the abstract. C's case is that her vulnerability arose not from stress in general, but from her specific history and the risk of her encountering subject-matter in the course of her work that would trigger her mental ill-health. It is clear from propositions (2) and (3) that, in all cases, foreseeability of psychiatric injury is a threshold question in determining whether the employer had a duty to take steps to avoid such injury. However, as mentioned above, D admits that it was on notice of C's predisposition to psychiatric injury during the "actionable period". In the light of the background set out above, that admission was properly made: it is clear that D knew well before December 2019 (when the actionable period relied on by C started) that C was at risk of psychiatric injury if the adjustments recommended by OH to the nature and conditions of her work were not implemented. Foreseeability of psychiatric injury is therefore not in issue.

129. In Barber v Somerset, the House of Lords said that the standard of care was that of the conduct of the reasonable and prudent employer, taking positive thought for the safety of his employees in the light of what he knew or ought to have known. Lord Walker said, at paragraph 65:

"He must weigh up the risk in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probable effectiveness of the precautions that can be taken to meet it and the expense and inconvenience they involve. If he is found to have fallen below the standard to be properly expected of a reasonable and prudent employer in these respects, he is negligent."

130. As Ms Giachardi said during her closing submissions, the issue of foreseeability arises separately in relation to the damages that C may recover if D is found in breach of its duties. In Yapp v Foreign and Commonwealth Office [2014] EWCA Civ 1512, Underhill LJ, giving the judgment of the Court of Appeal said at paragraph 84:

> "It was accepted that the essential question in contract is whether the damage in question was of a kind which was "not unlikely" to result and that in tort it is whether damage was reasonably foreseeable; and that the former test requires a higher degree of likelihood of damage occurring than the latter."

Later, at paragraph 99 (1), Underhill LJ said:

> "...at the risk of spelling out the obvious, the test of foreseeability in that context [whether a duty of care arose] must be the same when it comes to damages: if the risk of psychiatric injury is sufficiently foreseeable to require reasonable steps to be taken to mitigate it it must also be sufficiently foreseeable to require compensation if it arises."

At paragraph 119 (4) he said:

> "...In order to establish whether the duty is broken it will be necessary to establish ... whether psychiatric injury was reasonably foreseeable; and if that is established no issue as to remoteness can arise when such injury eventuates."

131. Those observations about remoteness of damages are directed at the foreseeability of damages arising from psychiatric injury in general terms: they do not address the question whether any specific head of damages is too remote because it was not reasonably foreseeable. In this case, C's larger claims for loss of earnings and pension rights are potentially controversial, because she decided to take early retirement when she learnt that DS Trevers was to move to take up a promotion, at a time when her psychiatric health had been improving or stable for some time while working under him: not because of any alleged further breach of duty at that point, but because she feared that there would be further issues of the kind she had previously experienced. However, Ms Giachardi submitted that D had not pleaded that losses flowing from C's early retirement were unforeseeable, and therefore irrecoverable, and should not be permitted to raise that issue at trial without having pleaded it. I shall return to this later.

Breach of duty

132. As I have explained above, D did not call any witness who could give evidence about events during the actionable period and C's evidence about what happened during that period is largely unchallenged and is corroborated by the contemporaneous documents and records. I accept C's evidence about those events.

133. As I have also explained, I prefer Dr Gibbons' evidence that, following the triggering event in December 2016, C suffered from Complex PTSD and depression to Dr Francis' evidence that C did not suffer from any psychiatric illness.

134. D has admitted that, by December 2019, it was aware of C's predisposition to psychiatric illness and could therefore foresee that such illness might result if it did not take reasonable care to protect C from roles or exposure to subject matter that might trigger such illness. The history I have set out shows that C was vulnerable to mental illness before 2016, having had a number of episodes of less disabling depression, including post-natal depression, before then. It is not suggested that D was aware of this vulnerability before the triggering incident in December 2016. However, by 13 December 2019 it clearly knew that she had a vulnerability falling within sub-paragraph 5 (b) of Baroness Hale's "practical propositions" in Hatton v Sutherland, as it has admitted. It was therefore under a duty from that date to take reasonable care to ensure that C did not suffer reasonably foreseeable psychiatric injury by reason of the requirements of her work.

135. As Ms Giachardi submitted, by December 2019, D had also received detailed recommendations as to the adjustments that should be made to C's role and duties to support and protect her, including for example: in July 2017, OH recommended that she should not work shift work and should be temporarily removed from any role involving child abuse; in September 2017, Dr Pitkanen advised that C was not fit to work in the safeguarding team or operational policing; in January 2018, Dr Schenk advised that she was permanently unfit to return to safeguarding or children's issues; in March 2018, Dr Price advised that she was at risk of relapse if exposed to sexual or domestic abuse and this should be regarded as a long-term restriction; in September 2018, Dr Schenk prepared an adjusted duty capability report which said that C was fit to work in an office environment but permanently unfit to return to operational policing and that she was unable to deal with workplace stress, non-physical confrontation and trauma; in November 2018, Dr Price said that she should not be involved in any role dealing with sexual abuse or suicide; in September 2019, just before C went on leave to have back surgery, OH reported that the restrictions remained valid. Therefore, D had a significant amount of information about C's mental health and the recommended adjustments she required before the actionable period started.

136. Mr Stebbings submitted, in his skeleton argument and closing submissions, that C could not show that D had breached its duties of care to her. He submitted that the contemporaneous documents showed that D took appropriate and responsible steps to assess the risks to C when it became aware of them and to protect her from those risks, including referrals to a number of in-house medical practitioners, the obtaining of OH reports and engagement with outside mental health and vocational support providers such as Remploy. He suggested that the evidence showed that D implemented "*systematic risk management [which] demonstrates responsible, supportive action in line with policy obligations.*" He also referred to D's "*suite of employer policies and employee handbooks that lay out in detail the standards, procedural protections, action plans for mental health, and absence/ return to work policies. These demonstrate not only that the relevant policies were in place but that except in so far as [C] can prove otherwise they were followed and provided a comprehensive welfare and support framework.*"

137. I do not understand there to be any dispute that D had systems and policies in place for dealing with employees suffering from mental illness: it would be surprising

if an employer the size of D did not have comprehensive policies for assessing and mitigating the risks of both physical and psychiatric injuries. It is clear from the history I have set out that D repeatedly arranged OH reports and referrals to inhouse psychiatrists and other clinicians for the purposes of those reports. However, C's case is not that D failed to have such systems and policies in place, but that it failed to take reasonable steps to follow the advice given by OH or otherwise to ensure that she did not suffer psychiatric injury. Furthermore, it is difficult to see how D can rely on its policies and systems in themselves in circumstances where it upheld C's grievance in 2017: the very fact that she had to pursue a formal grievance to ensure that D took her concerns seriously is evidence that its policies and systems were not effective before that grievance. It does not follow that they were not effective after then, but it does show that the existence of policies and systems is not, on its own, an answer to C's claim.

138. After that, during the actionable period, the history I have set out shows that there were repeated occasions when D: failed to ensure that her line managers were aware of C's history and the OH recommendations when planning for her return to work even though, according to DI Brothwood, they had access to C's OH history (December 2019 and January and September 2020); failed to carry out risk assessments prior to her return to work (February 2020 and September/ October 2020); failed to engage with Remploy after C had involved them (January and October 2020); were dismissive about C's own concerns whilst being unaware of the OH recommendations (DS Katete in September 2020); misunderstood or misrepresented those recommendations and sought advice from OH that had already been given repeatedly (DS Hampton in September 2020); decided to deploy C to roles despite her raising concerns that they were unsuitable and incompatible with the OH advice (December 2019 and September 2020); and refused to make adjustments to her shift pattern to support her medication regime (July 2020). D has not provided evidence from any of C's line managers or other witnesses who could address or explain these failings. As set out above, I consider that I am entitled to infer that the reason is because those witnesses would not have assisted its case.

139. In his closing submissions, Mr Stebbings referred to the OH report on 8 June 2017, recording that C stated that she did not wish for her line managers to know about her diagnosis or condition. He also referred to the incident when she had returned to work in September 2017 and was instructed by DI Yilani to work in the main office. He said that C had not raised this with DS Brothwood but had gone sick the following day instead. He submitted that these two episodes showed that C was unlikely to have been pro-active in informing D of her problems and needs during the actionable period.

140. There is a dispute about exactly what happened: see paragraph 38 above. However, even if DI Brothwood's account is correct, I am unable to accept that submission, because those events preceded the actionable period by over two years. Whatever C said and did in 2017, by December 2019 D knew about her diagnosis, her predisposition to mental illness, and the need to make the adjustments advised in the OH report. Furthermore, contrary to Mr Stebbings' submission, the evidence shows that C was pro-active in raising her concerns with D: she pursued her grievance in 2017 to ensure that D acted on those concerns, and she repeatedly raised her concerns with her various line managers, and others, during 2020, but they were not properly addressed,

leading her to feel that she was not being listened to and was constantly having to repeat herself to new line managers, which in itself further undermined her mental health.

141. Mr Stebbings submitted that changes in line management are simply a feature of employment, particularly in a large, ranked organisation such as D, where line managers may frequently move to new roles or take promotion. I agree with that submission as far as it goes, but I also agree with Ms Giachardi's submission that there were reasonable, not unduly burdensome, steps D could have taken to address that problem: for example, by providing C with a long term single line manager who was familiar with her history and to whom she could report directly if she had concerns, deploying her permanently to a role where exposure to safeguarding, abuse and suicide would not arise, or implementing a system of handovers of line management to ensure that new line managers were made aware of C's history and the reasonable adjustments she required. D has not provided any evidence that it took, or considered taking such steps, or that such steps would have placed an unreasonable burden on D's resources. Furthermore, DI Brothwood's evidence that she remained C's line manager for a time after 2017 but had no further contact with her suggests that D did not have an appropriate structure of line management that ensured that an appropriate officer actually took effective day to day responsibility for C's management, including addressing the OH recommendations: again, D did not call any witness who could explain or contradict this inference.

142. In those circumstances, I am satisfied that, during the actionable period, D persistently failed to take reasonable care to prevent C from suffering from further psychiatric injury.

Causation and remoteness

143. I accept Dr Gibbons' evidence that the triggering incident in December 2016 caused C's breakdown in 2017, but this could not have been foreseen by either D or C. However, I also accept her evidence that D's breaches of duty during the actionable period materially contributed to C's injuries (see para 108. h. above). I therefore find that those breaches of duty caused C to suffer further psychiatric injury.

144. As I have set out above, the question whether D's breaches of duty caused C to take early retirement is a more difficult one, because her health had been stable or improving during the months when she was working under DS Travers and her decision to take early retirement was prompted by learning that he would be moving to a different role. However, whilst factual causation is a question of fact rather than opinion, I accept Dr Gibbons' evidence that, in psychiatric terms, there was a causal relationship between those breaches and C taking early retirement (paragraph 116. h. above). In my judgment, the question has to be considered in the light of the whole of C's experience since she was first diagnosed in 2017, rather than limited to the circumstances at the time C decided to retire. As she explained in her letter to Assistant Commissioner Ephgrave in February 2022:

> "*The reason I have decided to take early is because the failures of supervisors who did nothing to support me when I first became ill after being exposed to a child protection case that triggered depression. Rather than supporting me,*

managers deteriorated my condition by going against OH advice and doing what was best for the business needs. This treatment went on for 3 years whenever there was a change in line management. I strongly believe if I had the right support, it would have enabled me to remain as an operational officer. Unfortunately their actions resulted in two overdoses which I cannot forget, therefore I have cut my losses by taking early retirement as soon as I turned 50 to prevent this from happening again. After all, from my experience, history always repeats itself in the MPS."

145. Given the repeated failings leading to C's grievance in 2019, the further breaches of duty after that referred to above, and that C had previously contemplated early retirement but had decided to remain only after receiving reassurances from DS Trevers, I accept that C decided to retire for the reasons given in that letter: because she feared that history would repeat itself, leading her to suffer further injury. This was a reasonable response in the light of the whole of her history. At first blush, it may not appear that that response was prompted by any specific breach of duty; however, as set out at paragraph 150 below, I am persuaded by Ms Giachardi that, given C's particular history, D should have taken pro-active steps to prepare for and address DS Trevers' move with C. Although C suffered her initial injuries before the actionable period, I am satisfied that she would not have retired early but for the breaches of duty that took place during the actionable period. Therefore, I find that factual causation is established between D's breaches of duty and her decision to take early retirement.

146. As to legal causation, in his skeleton argument, Mr Stebbings submitted that it was not reasonably foreseeable that C having suffered sexual abuse during her childhood would firstly apply to D to become a police officer, then apply to a specialist department investigating traumatic abuse to children, then carry out work within that department without any problems, only for a particular case to trigger flashbacks and mental health episodes resulting in personal injury. D could not have foreseen that a particular case would set in motion a chain of events that would cause C's mental illness. As set out above, I have accepted Dr Gibbons' evidence that it was not foreseeable to C or D that C would suffer psychiatric injury as a result of the triggering event in 2016. But those submissions miss the point because they do not address C's case as to foreseeability: it is not C's case that D should have foreseen the events referred to in those submissions, or that she might suffer her initial psychiatric injury in 2017. Her case is that, by the end of 2019, D could reasonably foresee that she might suffer further psychiatric injury if it did not take reasonable steps to prevent such injury. D has admitted that case and it is therefore not open to D to argue that further psychiatric injury after 13 December 2019 was not foreseeable.

147. In his closing submissions, Mr Stebbings submitted that it was not reasonably foreseeable that C would take early retirement, rather than enquiring who her new line manager was and ensuring that they were aware of her needs and would provide the support she needed. Therefore, her losses flowing from her early retirement were too remote.

148. In response to this argument, Ms Giachardi pointed out that D's Defence admitted foreseeability of injury and put C to proof as to breach of duty and causation, and its Counterschedule stated that causation was not admitted; but neither the Defence

nor the Counterschedule had expressly put in issue the foreseeability or remoteness of losses flowing from C's early retirement. She therefore submitted that D should not be permitted to raise this argument, because it had not been pleaded. A defence that C's loss of pension and loss of earnings were too remote was an obvious line of defence that D should have pleaded if it wished to raise it. Had D pleaded it, that would have affected the way in which C had prepared the case: for example, C had submitted her retirement request by uploading it to D's HR system. She did not have a copy, and D had not disclosed it. That document was highly relevant to the question of remoteness. C's witness statement would have set out in more detail what she had told D at the time, had D pleaded this issue. Ms Giachardi submitted, in any event, that C's early retirement was foreseeable in the particular circumstances of this case, not least as she had previously announced her intention to retire early but had been dissuaded from that course by the assurances given by DS Trevers. It was foreseeable that, if D was not proactive in managing the situation when DS Trevers changed role, C would make the decision to retire early.

149. I agree with Ms Giachardi that D should have pleaded remoteness if it wished to rely on this argument. The primary function of statements of case is to identify the facts in issue, although PD 16 para 12.2 permits parties to plead points of law. However, the question of remoteness, which turns on the reasonable foreseeability of the losses under consideration, is a context-sensitive issue of mixed fact and law, not a question of pure law. In my view, if D wished to raise this issue, it should have denied that the losses were foreseeable and set out its reasons why in accordance with CPR 16.5(2); the issue is not implicit in its non-admission of causation. The failure to plead it expressly is likely to have affected the way C and her advisers approached the case and placed C at a forensic disadvantage for the reasons Ms Giachardi outlined. In my judgment therefore, D should not be permitted to take the point in submissions at trial.

150. However, even if that is wrong, I agree with Ms Giachardi that it was reasonably foreseeable, having regard to the particular history of this case set out above, that C would take early retirement if D failed to pro-actively manage her situation following the decision that DS Trevers would be redeployed. It is implicit in Mr Stebbings' submissions that there was an onus on C to enquire who her new line manager would be and ensure that they were acquainted with her needs and that it was sufficient for D to be essentially reactive. In my judgment, this was not sufficient to comply with D's duties of care, particularly in view of the history of previous failings, meaning that C had been required to repeatedly explain her history and needs to new line managers, who then failed to engage appropriately with them. I agree with Ms Giachardi that D should have been pro-active in taking steps to manage the situation and reassure and protect C when preparing for DS Trevers' redeployment. Other than Assistant Commissioner Elphick's letter asking her to reconsider, D has not provided evidence as to any pro-active steps that it took or explaining why it failed to do so.

151. I therefore find that C's early retirement was reasonably foreseeable and the losses flowing from it were not too remote.

152. In passing, I should mention that D's pleaded case included the defence of *volenti non fit injuri*a, based on the allegation that C chose to expose herself to the risk

of psychiatric injury by applying to join D, and then for the role with the CAIT, despite her history. Although D did not abandon that defence, Mr Stebbings did not develop it in his closing submissions. As I have accepted Dr Gibbons' evidence that neither C nor D could reasonably have foreseen the emergence of her illness as result of exposure to the triggering case at CAIT, this particular line of defence cannot succeed.

Damages

153. I therefore find that D is liable to compensate C for the psychiatric injuries she suffered during the actionable period and for the losses she has suffered as a consequence of those injuries, including taking early retirement.

154. Based on Dr Gibbons' evidence that C is doing better and has a good prognosis for recovery with professional help, Ms Giachardi submitted that C's case falls with Chapter 4 (B) of the Guidelines[11], "Post-Traumatic Stress Disorder", bracket (c), "Moderate" £10,810 to £30,580: "*In these cases the injured person will have largely recovered, and any continuing effects will not be grossly disabling*." But she also invited me to consider bracket (b) "Moderately Severe" £30,580 to £79,080: "*This category is distinct from (a) above because of the better prognosis which will be for some recovery with professional help. However, the effects are still likely to cause significant disability for the foreseeable future. While there are awards which support both extremes of this bracket, the majority are between £38,000 and £49,040.*" She submitted that this indicated that C's case fell towards the top end of bracket (c). She also submitted that, although C had existing psychiatric vulnerability, this was not a case where D's breaches of duty had exacerbated an underlying condition; D's breaches of duty had made a material contribution to C's injury. The onus was on D to show that there was a good reason to apportion the different causal effects of her underlying vulnerability and D's breaches of duty, but the experts had not suggested any basis for doing so. I agree with those submissions.

155. However, the introduction to Chapter 4 (B) states: "*Cases within this category are exclusively those where there is a specific diagnosis of a reactive psychiatric disorder following an event which creates psychological trauma in response to actual or threatened death, serious injury or sexual violation...".* C's initial psychiatric injury – the Complex PTSD and depression she suffered after the triggering event – were not caused by D's breaches of duty, and her case is that she suffered from those conditions for nearly three years before the actionable period. Damages for PSLA are therefore to compensate her for the effects of the further psychiatric injury and continuing ill health she has suffered due to D's breaches of duty during the actionable period, rather than the initial injury. In my view, that scenario does not fit easily within what is contemplated by Chapter 4B.

156. I also note that in the introduction to Chapter 4 ("Psychiatric and Psychological Damage"), the Guidelines state that some of the brackets in Part (A), "Psychiatric Damage Generally" include an element of compensation for PTSD. In my view, C's circumstances fit better within this part, bearing in mind that the initial PTSD is excluded from consideration as it was not caused by D's breach of duty. However, I am

[11] *Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases*. I have referred to the 18th Edition, which has been published between the trial and the completion of this judgment.

satisfied that, but for D's breaches of duty, C's mental health would have improved and stabilised and she would not have retired early.

157. Part (A) states that the factors to be taken into account in valuing claims in this Part are: (i) the injured person's ability to cope with life, education and work; (ii) the effect on the injured person's relationships with family, friends and those with whom he or she comes into contact; (iii) the extent to which treatment would be successful; (iv) future vulnerability; (v) prognosis; and (vi) whether medical help has been sought. Bracket (c) "Moderate" £7,740 to £25,190 states: "*While there may been the sort of problems associated with factors (i) to (iv) above, there will have been marked improvement by trial and the prognosis will be good. Cases of work-related stress may fall within this category if symptoms are not prolonged.*" Bracket (b) "Moderately Severe" states: "*In these cases there will be significant problems associated with factors (i) to (iv) above, but the prognosis will be much more optimistic than in (a) above. While there are awards which support both extremes of this bracket, the majority are somewhere near the middle of the bracket ... Cases of work-related stress resulting in a permanent or long-standing disability preventing a return to comparable employment would appear to come within this category.*"

158. Given the prolonged nature of C's symptoms after the start of the actionable period, the effect they had on her family relationships and that they led her to leave employment to which she would not be able to return for health reasons (if it was otherwise available to her), it could be argued that her case falls within bracket (b) but, bearing in mind the degree of recovery since she retired early, the good prognosis for the treatment recommended by Dr Gibbons, and that the award of damages is for the further injuries since 2019 not the initial injuries and their effects before then, I consider that this case falls towards the very top end of Chapter 4 (A) (c). I award £25,000 damages for PSLA.

159. So far as special damages are concerned:

a. C is entitled to recover loss of earnings based on the difference between what she would have earned had she remained working for D until she would otherwise have retired on 17 January 2027, and what she has actually earned since she took early retirement. As at 20 November 2025, the date on her updated Schedule of Loss, her past net loss of earnings was £83,362.18. Future loss of earnings from that date to 17 January 2027 was predicted to be £50,384.19 but that figure will require updating as C was about to start new employment when the trial commenced.

b. C is entitled to compensation for the loss of the pension rights she would have accrued had she remained in D's employment until 17 January 2027. In closing submissions, Mr Stebbings referred to a spreadsheet, which he said had been provided by Capita, calculating her total future pension loss at £258,049.06. Ms Giachardi accepted that calculation, subject to C giving credit for the lump sum and pension payments she has received as a result of taking early retirement, in the total sum of £98,000. I agree with Ms Giachardi that C is only required to give credit for that sum against her claim for loss of pension, not also against her

claim for lost earnings, because the purpose of damages is to put her in the position she would have been in had she retired on 17 January 2027. By retiring early, she lost both her salary and the pension rights she would have continued to accrue. She is required to give credit for the earnings, and the pension benefits she has received since retiring, to put her in the same position she would otherwise have been in, but neither should be double-counted. Subject to Counsel checking the above figures, I will award loss of pension benefits on the basis of the spreadsheet, giving credit for the benefits actually received.

c. Ms Giachardi said that C did not pursue the loss of future death in service benefits as she had not taken out an alternative life assurance policy to cover her until 17 January 2027, when those benefits would have lapsed in any event.

d. D did not admit the claim for future treatment costs, but Mr Stebbings did not press this in closing submissions. It is reasonable for C to claim these costs based on Dr Gibbons' evidence and I will therefore award the sum claimed.

e. There is no dispute as to the claims for travel expenses and prescription charges and I will award these sums.

f. It is not clear to me whether C is pursuing the claim for a Smith v Manchester award as this was not expressly referred to in Ms Giachardi's skeleton argument or closing submissions. But, although Dr Gibbons' evidence is that C would not be able to return to work similar to her employment with D, I doubt whether such an award would be appropriate in this case, for two reasons. First, C became unable to undertake similar work as a result of the psychiatric injury she suffered before the actionable period, and therefore not as a result of D's breach of duty. Second, on retirement from the police in 2027, it is not likely that C would have been able to take employment of a similar nature to the work she did in the police in any event. However, I will hear further argument on this issue if C does wish to pursue it.

160. Subject to that issue, for the reasons set out in this judgment, I find in favour of C and I will award damages in accordance with the above paragraphs. Since I circulated the draft of this judgment, Ms Giachardi and Mr Stebbings have provided me with an agreed draft order giving effect to it, which I approve.

HHJ DUDDRIDGE
8 June 2026