Neutral Citation: [2014] IEHC 359

THE HIGH COURT

[2012 9300 P.]

BETWEEN

PAUL HARDING

PLAINTIFF

AND

HENRY DENNY AND SONS (IRELAND) LIMITED

DEFENDANT

Judgment of Mr Justice Ryan delivered on the 17th July, 2014.

1. The plaintiff is now aged 35 years, his date of birth being the 27th November, 1978. He sustained injuries in the course of his work as a night loader with the defendant at its depot in Portlaoise on the 31st January, 2011. The case is an assessment of damages. The essential issue is how severe the injuries were. The plaintiff has been out of work since the accident happened but, in the period since it occurred, the defendant company closed down the depot and all of the workers were made redundant. The defendant's case is that the plaintiff had been dismissed for incapacity in September, 2012, so he was not entitled to redundancy on the closure in February, 2013.

2. The facts of the accident are that Mr Harding was working on his own doing his night shift at the depot. He was at the time of the accident, operating in the back of a closed rigid body truck when he slipped and fell, striking his neck and low back on projections in the vehicle as he went to ground. He was still at the lorry when a colleague arrived and helped him to the canteen where he had a cup of tea. At the end of his shift, Mr Harding drove himself home.

3. The plaintiff's account of the circumstances after the accident have shown some inconsistency, but I do not think anything turns on that.

4. Mr Harding went to his G.P., Dr. Lawlor, two days after the accident, on the 2nd February, 2011. He says that he was in pain from his neck and his low back since the accident and went to the doctor at the earliest time he could get an appointment. Dr. Lawlor noted the fall and Mr Harding's complaints of neck and back pain, but his first entry was about stress at work.

5. Mr Harding never went back to work. He attended the doctor's practice MedWise, nominated by his employers, at regular intervals where he saw Dr. Sim a number of times. On the 18th January, 2012, he was examined by Dr. Gleeson, the principal of the practice. Dr. Gleeson's report declared him fit to return to work.

6. The plaintiff's attendances on Dr. Sim run from the 17th February, 2011, to the 11th April, 2012. During this time the doctor continued to consider Mr Harding to be unfit to return to work and informed the company accordingly. The question of going back to some modified work was rejected by the employer on the basis that there were no such jobs available. Dr. Sim, in his first report of the 17th February, 2011, thought that the severity of Mr Harding's complaints was not consistent with the objective clinical findings. Nevertheless, he continued to investigate the plaintiff's condition and referred him for MRI scanning and orthopaedic consultation. It is evident from his reporting that Dr. Sim relied on the consultant orthopaedic surgeon, Mr Sparkes' opinion.

7. The MRI scan of May, 2011 revealed degenerative, bulging discs at L4/5 and L5/S1 in the plaintiff's low back region, but there was no nerve compression and no oedema.

8. The orthopaedic surgeon, Mr Sparkes, saw Mr Harding in August, 2011 and concluded that the plaintiff had had an exacerbation of the pre-existing disc condition and advised that he have a spinal injection. The plaintiff's evidence is that he could not afford such a treatment. In subsequent correspondence with Dr. Sim, Mr Sparkes expressed the view that returning to work would aggravate the plaintiff's condition and Dr. Sim duly confirmed Mr Harding's unfitness in his report of the 24th November, 2011.

9. By this time the company was concerned about the plaintiff's continuing absence. By letter and meeting in December, 2011, the management confirmed that the plaintiff's sick pay would terminate at the end of January, 2012, that no light work was available and that the company would not fund the injection treatment recommended by Mr Sparkes.

10. The plaintiff was examined by Dr. Deirdre Gleeson, the principal of MedWise, in January 2012, on behalf of the company to whom she reported. Dr. Gleeson found on clinical examination that the plaintiff appeared well and was not distressed. His vital signs were normal. He was able to squat and walk normally. There was good flexion of the spine and neurological examination was normal. There was no objective evidence of serious underlying spinal disease. Mental state examination was normal, as was the remainder of the examination. She reported that she had a long discussion with Mr Harding . She was of opinion that he had developed a chronic pain syndrome. He experienced an episode of mechanical pain a year previously and in the doctors opinion, sufficient time had passed to allow for him to recover from any acute injury. The MRI findings were of long standing and she felt it was reassuring that surgery was not required. She reassured Mr Harding that he had an excellent prognosis and that it was time to re-engage with the workplace. She thought that returning to work would be therapeutic and it bad for him to be out of work. She advised the plaintiff to return to work on a phased basis, beginning with two days a week and working up to five days. In her opinion he was fit to return to normal duties provided he adhered to a safe manual handling and good ergonomic practices. She cautioned the employer to ensure that he was appropriately trained and supervised in that regard.

11. At Mr Harding's last appointment with Dr Sim on the 11th April, 2012, he still felt that he was unable to return to work due to pains in his back. Mr Harding said that he was currently doing exercise and taking regular pain relief without much improvement, but he was no longer attending physiotherapy, having done extensive physiotherapy previously. Dr. Sim had a very full discussion it appears with the plaintiff. The penultimate paragraph of Dr. Sim's report to the company is as follows: -

> "I discussed all the above issues with him again today. We had previously discussed similar issues at his previous visits. I explained that he has chronic pain syndrome. Chronic pains frequently are multi factorial in nature. My view is that his condition did not warrant surgical intervention. I explained that medically he is fit to attempt a return to work so long as he adheres to a safe manual handling technique and doing reduced hours which I believe may be facilitated. However, he has ongoing tolerance issues which have prevented him from returning to work. Management of such issues going forward is through pain control. To date, he has failed to respond to medications and extensive physiotherapy. He may benefit from injection therapies as recommended by his specialist. He may also benefit from a form of psychotherapy (cognitive behavioural therapy) to help manage his symptoms. Accessing such therapies appears to be a problem at present due to cost factor. This will therefore impact on the chance of a successful return to work. Further occupational input in unlikely to give further benefit. I am unable to specify a return to work date but I believe it is unlikely he will do so in the foreseeable future unless he achieves better control of his symptoms."

12. The MedWise clinicians, Dr. Sim and Dr. Gleeson, were thus of opinion that the plaintiff had developed chronic pain syndrome. Dr. Gleeson believed, and testified in court to that effect, that the plaintiff should have gone back to work on a phased basis and that his pain would have gradually reduced and disappeared. The plaintiff would, in effect, have worked through his pain and thereby reduced and ultimately eliminated it. However, that depended on his willingness to get back to work and to work through the pain. Dr. Sim was of the view that Mr Harding was not going to do that in the foreseeable future and that is undisputed. These doctors were of the view that what began as a physical pain had now become a pain syndrome that needed to be dealt with, either by the plaintiff himself working through it or with the addition of some psychotherapy to overcome the problem.

13. Between the 8th December, 2011, and the 16th August, 2012, the plaintiff had a series of meetings with management of the defendant. The company wanted Mr Harding to get back to work but he was not willing to do so. He felt that he was being pressurised and there was a question whether he requested representation at the company meetings. The point is that there was impasse between the plaintiff and the company. Ultimately the company sent a letter dated 24th September, 2012, to the plaintiff dismissing him on the ground of incapacity. The plaintiff maintains that he did not receive the letter but the fact is that the company decided to dismiss him and proceeded on foot of the decision. And the issue is a limited one because the depot was closed down in early 2013 and all the employees were made redundant. If the plaintiff was still an employee at the time, he would have received a modest redundancy payment, but obviously that does not arise if he had been dismissed.

14. The plaintiff was referred by his solicitor to Mr John Rice, consultant orthopaedic surgeon at Clane General Hospital, and he saw him in March, 2012. On clinical evaluation on this occasion Mr Rice found that the plaintiff had deep tenderness in the spinous processes in his neck, a 50% reduction of forward flexion due to pain and stiffness and pain at the end range of flexion on each side. As to his low back, he had deep tenderness in the paraspinal soft tissues in the lower lumbar region bilaterally. He had a 50% loss of forward flexion due to pain and stiffness. On straight leg raising he experienced low back pain on the right side more than his left at about 40 degrees.

15. Mr Rice concluded that the plaintiff had sustained soft tissue injuries to his neck and low back, which were superimposed on a pre-existing, but asymptomatic, degenerative disorder of the lumbar region. The way forward lay with rehabilitating the neck and low back areas and he reiterated Mr Sparkes' recommendation of spinal injection treatment by injection. The purpose of this was to free the plaintiff's low back from pain for a sufficient period to enable him to undertake active rehabilitation. At that stage, March 2012, Mr Rice said:

> "That the plaintiff must be regarded as having a chronic occurring mechanical pain syndrome in relation to his lumbar spine and to a lesser extent, his cervical region. I have prescribed Lyrica for this gentleman and again advised him to work harder on exercises including possible swimming to see if he can regain a range of movement and tone up his muscles around his spine."

16. Mr Rice next saw the plaintiff in November, 2012. Since his previous examination, the plaintiff had had physiotherapy on seven occasions and had followed it up with a home exercise programme, including walking. He reported fluctuating symptoms in his neck and low back. His neck pain was not as bad, but he had recently found that cold weather made his low back pain worse. The plaintiff had normal range of movement of the neck and also of the low back.

17. In December, 2012 Mr Rice carried out injections of the tender facet joints in the plaintiff's lower lumbar region with steroids and local anaesthetic. In his report dated the 21st October, 2013, Mr Rice records that the plaintiff did not experience any benefit from the facet joint injections and did not recall any positive benefit even from the local anaesthetic aspect of the injection. He had carried out a home exercise programme, but reported ongoing problems in the neck and back that had not improved with time. On this examination Mr Harding reported recurring episodes of neck pain with headaches which can occur about three or four times a month and the headaches last usually about two to three days, but can last longer. They are preceded by neck pain. He also reported a constant low level aching pain the lumbar region. The pain was exacerbated by activities involving lifting or bending.

18. On examination in October, 2013, Mr Harding had a normal range of movement of his neck, but stretching the trapezius muscle reproduced pain. In his low back Mr Rice estimated that he had a 20% restriction of range of movement, because of stiffness. Mr Rice concluded, firstly, in relation to the plaintiff's cervical region, that he had injured his trapezius muscle and had a dysfunction of the muscles since his soft tissue injury which provoked recurring headaches. He advised the plaintiff to continue with exercises to ensure a range of movement in his neck. As to the lumbar region, Mr Rice opined that the disc prolapses seen at L4/5 and L5/S1 on the MRI scan of May, 2011, "represent injury sustained in his fall in January 2011". He felt that the plaintiff had an established pain pattern and would continue to experience mechanical pain in relation to his lumbar and cervical regions in the long term. The plaintiff would not be able to consider manual work and would have to look to sedentary occupation. He believed he had a significant long term risk of developing degenerative arthritis as a result of the injuries based on the conclusion that the lumbar discs were damaged in the accident of January, 2011.

19. Mr Rice's later conclusion as to the genesis of the disc pathology is quite different from his previous view and from that of Mr Sparkes, his orthopaedic colleague. It is also contradicted by the evidence of Mr Padraic O'Neill, the consultant neurosurgeon who examined the plaintiff on behalf of the defendant. I accept his earlier opinion, consistent with those of his colleagues, as being correct.

20. Mr O'Neill examined the plaintiff on the 27th June, 2013 and recorded that Mr Harding was unable to provide him with any details as to his clinical course from the accident until December, 2012. At the time of examination, the plaintiff said that his neck symptoms had largely settled, but he continued to complain of daily headaches and his low back pain had continued unchanged. Mr O'Neill commented that Mr Harding had not required any further medical review, investigation or treatment since December, 2012.

21. On examination, Mr O'Neill noted that the plaintiff behaved "in a somewhat functional and exaggerated manner and required considerable exhortation to maximise effort. He had voluntary restriction of lumbar sacral movements in all directions. Straight leg raisings was free bilaterally. There was no objective neurological deficit". Mr O'Neill did not have the MRI scan available to him when he prepared this report and he dealt with the scan in an addendum of the 8th November, 2013. He commented when he saw the scan that there was no evidence of any significant disc protrusion at the L5/S1 level. At L4/5 there was evidence of a right paracentral annular bulge.

22. Mr O'Neill's conclusion was, and is, that there is a large functional overlay in this case and that there would be no significant improvement in the plaintiff's symptoms until his case has been concluded. The natural remedial course for soft tissue injuries is gradual spontaneous resolution and Mr O'Neill did not consider that the MRI indications could have accounted for the plaintiff's complaints.

23. The plaintiff was examined by Dr. Shane Farrelly, occupational health physician, who reported in October, 2013 and testified at the hearing. His examination revealed normal range of movement of the plaintiff's neck, but with evidence of some stiffness at the extremes of the extension and lateral flexion bilaterally. He also noted evidence of trepedous at the extremes of the rotation of both shoulders, but there had been no suggestion that the plaintiff sustained a shoulder injury. In regard to the lumbar spine, Dr. Farrelly, found restriction in movement at 32%. He did however, find that straight leg raising of both legs was normal and he noted tenderness on palpation over the lower lumbar facet joints. He concluded that the plaintiff would not be fit to return to a role that would involve significant manual handling.

24. The plaintiff was also examined by Ms. Susan Tolan, vocational assessor and occupational therapist, who advised that on the basis of the plaintiff's reporting and the medical information with which she had been supplied, that he would have significant difficulties in securing employment in future. His ranges of options were restricted as compared with what it would have been if he had not had the accident and experienced the ongoing *sequelae* of which he complained.

Discussion and Conclusions

25. The primary issue in this case is how severe the plaintiff's injuries were and continue to be. The accident the plaintiff sustained was a relatively minor one. Mr Harding remained at his workplace until finishing time when he drove himself home. He did not go to the doctor for two days and when he did so, he also complained of stress at work. He had the injection carried out by Mr Rice, some sessions of physiotherapy and he does a home exercise programme.

26. There is no physical explanation for the plaintiff's ongoing complaints. The disc pathology in his low back was pre-existent and not caused in the accident, according to the medical consensus. It is true that Mr Rice alone among the doctors opined in his last report and in his evidence, contrary to what he had previously expressed, that the accident caused the disc prolapses, but I do not think that he has furnished a satisfactory rationale for that view, or indeed for his change of mind. Irrespective of how the disc condition came about, it still does not account for the plaintiff's problems. There is no nerve entrapment or impingement and no other explanation for the symptoms.

27. The injuries are accordingly soft tissue in nature and the natural progression is for resolution over time, but obviously a great deal depends on the rehabilitation undertaken by the injured party and his motivation. The recovery process is often prolonged in circumstances of litigation.

28. There is some reason to be uneasy about the case and whether Mr Harding is genuine. Dr. Sim was originally skeptical about his presentation, the fact that the plaintiff has demonstrated a full range of movement of his neck and low back over many, although not all, medical examinations, is a reassuring finding, but it is inconsistent with a presentation of severe pain and discomfort and disability and with a history of worsening symptoms. His complaints of severe headaches even migraine emanating from neck pain are a late feature of the symptomatology. For somebody who complains of the severe, and even worsening symptoms, Mr Harding has had little enough treatment. Mr O'Neill pointed to a long gap when he did not attend any doctor. He also concluded that the plaintiff had deliberately not co-operated in his examination and that the plaintiff had exaggerated his symptoms. Mr Harding would not countenance a return to work on a planned basis as suggested by Dr. Gleeson in January, 2012, a year after the accident. Even when it was made clear that his job was in jeopardy, he would not agree. He has not done any work since the accident, nor has he sought any. He is now engaged in looking after his mother who is ill, but that does not involve any heavy physical care. There is no evidence of muscle spasm being present on any medical examination.

29. There are features pointing the other way in the plaintiff's favour. There is no direct evidence of fraud or deceit. The matters put to Mr Harding in cross examination did not refute his claims. He was willing to undergo the painful injection therapy as suggested by Mr Sparkes and as eventually carried out by Mr Rice. Even here, however, it is a matter of concern that the plaintiff claimed to have got no pain relief from the procedure, whereas Mr Rice testified that he had confirmed with Mr Harding that he had got relief in the immediate aftermath of the procedure. That was a necessary element of the therapy because the doctor needed to confirm that he had located the injection in the precise site of the pain. If the patient had not confirmed relief by reason of the anaesthetic, Mr Rice would have re-injected at the right spot.

30. Mr Rice, Dr. Gleeson and Dr. Sim are in agreement that the plaintiff has a chronic pain syndrome. The purpose of Mr Rice's injection therapy and of any further injections that the plaintiff undergoes is to give him relief from any actual or perceived pain by anaesthetising the *locus* of the pain for a sufficient period to enable him to undertake the rehabilitation that is necessary for recovery in the absence of pain or discomfort. Dr. Gleeson takes the view that the plaintiff should have returned to work and battled through his pain to reach recovery and that he would have reduced and ultimately eliminated his pain and discomfort by doing so. Dr. Sim was of the view in his last report in April, 2012 that Mr Harding might need some therapeutic intervention of a psychiatric kind to overcome the pain syndrome. This evidence confirms the non-physical basis of the plaintiff's complaints.

31. I accept the evidence of Dr. Gleeson, who has great experience in the area of occupational medicine. I prefer her evidence to that of Dr. Farrelly, who I think was wholly reliant on the plaintiff's own complaints. Dr. Sim did not give evidence, but I had his reports by agreement of the parties and I find them helpful. I take into account his view that some psychiatric intervention may be required to bring the plaintiff to recovery.

32. I am not satisfied that Mr Harding is permanently disabled from work or is physically restricted in the kind of work he can do or could, with appropriate therapy, be able to perform. The plaintiff has not satisfied the onus of proof on the balance of probabilities that he has a long term condition causing severe pain in his low or in his neck or that he is now permanently unsuitable for moderate or severe manual tasks. My conclusions instead are as follows:-

(i) The plaintiff suffered minor injuries in this accident. He has had pain but not of a severe or disabling kind and he has

exaggerated it. Nevertheless, he does have some pain, which is now more psychosomatic rather than physical. The plaintiff does have a chronic pain syndrome, but it is neither irremediable nor permanent. Recovery depends on the plaintiff's full co-operation and he may need some therapeutic assistance.

(ii) He ought to have gone back to work following Dr. Gleeson's examination in January, 2012.

(iii) The plaintiff was irrationally fearful of returning to work for fear of a recurrence or exacerbation of his symptoms.

(iv) The defendant did not help by flatly refusing to countenance anything less than a return to full work without any adaptation.

(v) The plaintiff put his faith in the injections recommended by Mr Sparkes and was not inclined to anticipate recovering without it.

(vi) The accident did not cause the pathology in the lumbar spine demonstrated on the MRI scan.

(vii) The plaintiff exaggerated his symptoms to Mr O'Neill and otherwise behaved at the examination in a manner that was intended to be unco-operative.

(viii) Determination of this litigation will assist in Mr Harding's recovery.

33. I approach the assessment of damages on the basis that it is going to take the plaintiff some time get back to normal, but I note that he is now intent on changing course in his career to pursue a qualification and subsequent work in the area of computers. I think that getting back into education and training and subsequent work will do nothing but good for Mr Harding and his complaints will, as a matter of probability, begin to reduce in the near future and will progressively disappear.

34. I assess damages accordingly at €30,000 for pain and suffering in the past and €15,000 for the future. To this will be added the special damages.