Neutral Citation: [2016] IEHC 45

THE HIGH COURT

[2013 No. 12774 P.]

BETWEEN

MARTIN RUFFLEY

PLAINTIFF

AND

CAHILL RYAN AND DANIELLE RYAN

TRADING AS LALA INVESTMENTS

DEFENDANTS

JUDGMENT of Mr. Justice Barr delivered on the 28th day of January, 2016

Introduction

1. This action arises out of an accident which occurred on 12th June, 2012, when the plaintiff fell from a scaffold, while working in the course of his employment with the defendants. The plaintiff was employed as a general handyman/maintenance man at the defendants' property at Stacumny House, Celbridge, Co. Kildare. At the time, he was cutting ivy from the upper portion of the house. When he was stepping from a ladder onto the scaffolding, the scaffolding moved and the plaintiff fell approximately 14ft onto a concrete surface below. Liability is not in issue in these proceedings.

2. In summary, the plaintiff claims that he suffered severe soft tissue injuries to his neck, right shoulder, lower back, right hip and right leg. He also alleges that there was a wedge fracture of the T11 vertebra. He alleges that in addition to the injury to these areas, he has also suffered from Post Traumatic Stress Disorder and depression. He now walks with a limp and uses a crutch to help him get around.

3. In essence, the defendants' case is that there has been no structural damage to the plaintiff's spine. It is alleged that he has given inconsistent findings on examination by various doctors retained on behalf of the defendants. It is alleged that his injuries are somewhat psychosomatic in nature. The defendants make the case that the plaintiff has not actively engaged in any rehabilitation programme and in particular they maintain that if he had participated in a pain management programme after the accident, he would have made a satisfactory recovery from his injuries.

4. In these circumstances, it is necessary to set out in some detail the plaintiff's account of his injuries and the evidence of the doctors appearing for both sides.

The Plaintiff's Evidence

5. By way of background, the plaintiff stated that he had left school having completed the Intermediate Certificate. From 1977 to 1979, he completed training as a stores operative through ANCO in the Irish Ropes factory. He then joined the Irish Army, where he remained for nine years. During this time, he was mainly involved in driving and looking after weapons; he also did some office work. He did two tours in Lebanon in 1980 and 1983. He left the army in 1988, holding the rank of corporal. After this, he worked in a waste company and also worked at decorating and driving a taxi. He started work with the defendants in 2009, as a general maintenance man. He also had some security duties.

6. His pre-accident earnings were approximately €479 net per week. In addition, he was provided with a house by the defendants and they paid for his utilities and petrol. The plaintiff stated that he was very happy in this job and he got on well with his employers.

7. On 12th June, 2012, the plaintiff was cutting ivy from the walls of the house. He ascended a ladder and was just stepping onto some scaffolding when it moved causing him to fall 14ft to the ground below. After the accident an ambulance was called. A brace was put on his neck and back and he was brought to James Connolly Memorial Hospital. X-rays were taken at the hospital, which revealed that there were no fractures of the spine. He was kept in hospital overnight and was given a lot of painkillers. He stated that he was in severe pain at this time.

8. On the following day, he had to be helped out of bed and helped to walk. He had a brace on his back at this stage. He stated that he had extensive bruising all down the right side of his body. Photographs were taken of the bruising some one to two weeks after the accident. These were presented to the court and showed extensive bruising in the right hip and buttock area. He stated that the bruising lasted for three weeks. He also had blood in his urine for a period of two weeks after the accident.

9. The plaintiff stated that he became very depressed. This was due to the fact that he could not return to work. He had flashbacks to the accident and had nightmares at night. He found it very difficult to sleep. He stated that he wanted to get back to work. However, he was physically in severe pain. He went to his GP who gave him NSAIDs. Due to severe pain, he returned to his GP, who prescribed further medication. He told the GP that he felt depressed. The GP prescribed Lexipro and Effexor. He also made an appointment with a psychiatrist.

10. Since the accident, the plaintiff has required a substantial amount of medication including the following: Difene, Stilnoct, Effexor, Arthrotec and Atacand. He also is required to use a Butrans Patch for pain control.

11. His GP arranged for an MRI scan to be taken at Cappagh Hospital. He also had some physiotherapy sessions in the hospital at that time. However, he was not able to continue with these due to severe pain. The physiotherapist stated that it would be unwise to continue with treatment due to his level of pain.

12. The plaintiff states that in the weeks and months following the accident, he experienced severe pain in his lower back, right shoulder, neck, right hip and right leg. The plaintiff states that he continues to have constant and at times severe pain in the

affected areas. The pain is aggravated by standing, sitting and walking for any length of time. He is required to use a crutch to get around. He stated that he uses the crutch because if he did not do so, he would lose power in his leg and would fall. The plaintiff stated that all these symptoms were continuing to the present time.

13. The plaintiff became frustrated due to the failure to adequately treat his ongoing symptoms. In order to find out what was causing these symptoms, he had a number of MRI scans carried out. At the relevant time, he was involved in a relationship with a Lithuanian woman. When he went to that country with his partner, he availed of the opportunity to obtain MRI scans because one of his partner's relatives worked in a hospital. In all, the plaintiff has had the following x-rays and scans:-

4/6/12 X-ray of hip

4/9/12 MRI of lumbar spine in Cappagh Hospital

4/9/12 X-ray of the pelvis

5/4/13 MRI of lumbosacral spine, hips and sacroiliac joint in Lithuania

8/4/13 MRI of lumbar spine in Lithuania

3/10/13 MRI of lumbar spine, Naas Hospital

19/2/14 Three MRI scans of hip joints, right shoulder and lumbar spine in Lithuania

14. The plaintiff was referred by his solicitor to Mr. Imran Sharif, Consultant Orthopaedic Surgeon. He was examined by this doctor on 29th September, 2012. The plaintiff informed the doctor that the pain in his upper back gradually improved and settled down after about four to six weeks. The plaintiff had an MRI scan of his lumbosacral spine. This was carried out on 4th September, 2012. It did not show any fractures; however, it did show some degenerative changes in the lower lumbar spine, but this did not show any major disc prolapse. It also showed right sided mild disc bulging with moderate right sided foraminal stenosis, but no major pressure on the nerve root. An MRI scan of his hips was carried out as well. This did not show any internal derangement of the hip joints. The plaintiff complained of aches and pains in the right side of his lower back, right thigh and hip area. This had not improved and the plaintiff was very frustrated. He told the doctor that he felt depressed. Mr. Sharif noted that the plaintiff was on antidepressant medication at that time. The plaintiff reported that the pain radiated down to the bottom of his calf with some numbness, along with pins and needles in his toes.

15. On examination, Mr. Sharif noted that the plaintiff walked with a limp and was using crutches. Movement of his lower back was restricted. He could bring the tips of his fingers to just above the knee joint and complained of pain in the right side of his lower back. He was wearing a heat pad belt to control his pain symptoms. This gave him temporary relief from his symptoms. He was found to be markedly tender over the right lower facet joints. Straight leg raise on the right was about thirty degrees with sciatic stretch test positive. There was an area of altered sensation over the right gluteal region as well as on the outer aspect of the right hip and there was no loss of sensation. There were no other neurological deficits. Examination of the upper back was normal.

16. The doctor noted that the plaintiff's personal and social life had been affected since the accident. The plaintiff felt very depressed and frustrated at the time of that examination. He had been a very active person and used to do heavy duty work. Since the accident, he was not able to do any kind of work at all. The plaintiff could not walk, and he could not sit for more than ten minutes or so without having to get up and stretch his back. The doctor noted that the plaintiff had to rely on painkillers and antidepressants since the accident. His sleep at night had been disturbed. He had put on approximately 4kg in weight since the accident. Pre-accident he used to keep fit by going to the gym and going for walks. He was not able for this after the accident and he had not been able to return to work.

17. Mr. Sharif was of opinion that the plaintiff's symptoms on the right side of his lower back area were probably related to nerve root irritation in the right side of his lower back. This may have been related to the disc prolapse as seen in the lower two levels, but he noted that the plaintiff was markedly tender on the lower facet joints as well. He recommended that the plaintiff should consider having an epidural injection to his hip and lower back area.

18. The plaintiff underwent an epidural injection at the Hermitage Clinic in 2013. The plaintiff stated that this did not give him any relief from his symptoms. He continued to be symptomatic when he was reviewed by Mr. Sharif on 29th January, 2014. At that examination, the plaintiff stated that he continued to experience pain and discomfort in his lower back and hip area. He was having what he described as physiotherapy treatment once a week at that stage. He was also taking a number of different types of painkillers to control his symptoms as prescribed by his GP. Mr. Sharif noted that he had MRI scans done in Lithuania as well as at Naas Hospital. This appeared to show mild anterior wedging of the T11 vertebrae which Mr. Sharif thought was probably related to the accident. The symptoms around that area had long since resolved. The plaintiff stated that he continued to experience severe pain in the right side of his lower back, right buttock area, as well as down to his right knee. This was associated with pins and needles and numbness in the leg.

19. Examination of the cervical spine and upper back was fully normal. Movement of the lower back was markedly restricted. He could bring the tips of his fingers to just below his knee joints and complained of a lot of pain on the right side of his lower back. There was marked tenderness over the lower two facet joints and SI joint ligaments. SLR on the right was about thirty degrees and the sciatic stretch test was positive. There was again altered sensation over the right hip region; this was the area where the plaintiff landed. His range of movements of the right hip were painful.

20. Mr. Sharif stated that he believed that the plaintiff was involved in a serious accident. He was of the opinion that the plaintiff would have long-term consequences arising from the injury and his long-term prognosis was guarded. He stated that the plaintiff's current symptoms were related to the right side of his lower back and the depression would probably continue to annoy him for a long time. Mr. Sharif recommended that the plaintiff should not go back to the work that he was doing before the accident. It was recommended that he should obtain a report from an occupational therapist. Mr. Sharif stated that at this stage, the plaintiff had progressed into a chronic pain situation and he strongly recommended that the plaintiff should be referred to a pain clinic. As the plaintiff had a medical card, Mr. Sharif recommended that he should be referred to the pain clinic in St. James's Hospital where he could be assessed and have injections which would control his symptoms. In the meantime, he recommended that the plaintiff should get a report from the consultant pain specialist, Dr. Joseph Fitzgerald, in the Hermitage Clinic, as he believed that the plaintiff would require ongoing, long term, pain management.

21. In relation to the plaintiff's mental health difficulties, he was seen on nine occasions at the Celbridge Adult Community Mental Health Service, between 2nd November, 2012, and 12th March, 2013.

22. The plaintiff came under the care of his GP, Dr. Peter Moran. He first presented on 14th June, 2012. At that examination, he complained of significant pain affecting his lower back and right hip. The doctor noted that the plaintiff was in a very distressed state and had a very large ecchymosis over his right hip together with a reduced range of movement. He referred the plaintiff for further x-ray, which again revealed marked soft tissue swelling in keeping with acute soft tissue haematoma, but no acute fracture or dislocation. Follow up examinations were carried out in late July and August 2012, when the plaintiff again complained of significant pain affecting his back and hip. He complained of constant pain even when resting. He also had symptoms associated with Post Traumatic Stress Disorder. He complained of tiredness, fatigue, loss of interest, loss of energy and loss of libido. The GP recommended a low dose of antidepressant medication and he made referral to the orthopaedic services.

23. The plaintiff was reviewed by Dr. Moran in November 2012. The plaintiff again complained of persistent pain affecting his lower back and pain across his buttock and hip, while standing or walking. The pain was constant even when resting. The plaintiff also had persistent insomnia, disturbed sleep, panic, palpitations at night and constant rumination, worry and apprehension, a sense of dread, and poor concentration. He avoided social contact. The doctor stated that this was all in keeping with Post Traumatic Stress Disorder. The doctor advised increasing his anti-depressant medication to 20mg and arranged for a referral to the local psychiatric services.

24. The plaintiff was reviewed on 6th December, 2012. He complained of chronic ongoing pain affecting his back and lower legs. He was unable to sleep. Despite all the usual treatments, including multiple medications, he had not made any recovery. Examination of his back revealed the straight leg raising test to be ninety degrees, with no evidence of neurogenic disease.

25. Dr. Moran reviewed the plaintiff again on 13th February, 2013. The plaintiff complained of urinary problems in terms of urgency and incontinence. Of note, he had a history of hypertension, which was well controlled and was associated with marked Post Traumatic Stress Disorder. The doctor examined the plaintiff's prostate gland, which was slightly enlarged but otherwise normal. Urine examination was negative.

26. Final examination by this doctor occurred on 28th June, 2013. He noted that the plaintiff had sustained a major fall during the previous summer, where he suffered soft tissue injury to his right hip with secondary prolonged Post Traumatic Stress Disorder. He complained of persistent insomnia, disturbed sleep, panic and palpitations, concentration disturbance and feeling a sense of dread. He was in constant pain and used a crutch. The doctor noted that neurological examination was normal. The plaintiff still complained of chronic pain affecting his lower back and hip. The doctor was of opinion that the plaintiff had sustained a very severe soft tissue injury to his right hip following this accidental fall. It was also evident that the plaintiff sustained a marked Post Traumatic Stress Disorder following the traumatic event. Despite multiple treatments offered and expert attention, the plaintiff continued to complain of pain.

27. In February 2013, the plaintiff came under the care of Ms. Mary Lawlor, psychotherapist. He had been referred to this lady by his solicitor. She interviewed the plaintiff on 4th February, 2013. The plaintiff told her that he had difficulty sleeping. Most nights he was awoken by nightmares. In the nightmares, he dreamt about falling and sometimes falling off a cliff. He would be covered in sweat. He had panic attacks. His heart was racing. He felt like he was going to have a heart attack. He was sweating and felt very anxious. He also stated that he was hyper alert. He thought that he heard noises outside the house. He was jumpy all the time, especially at night. He also reported feelings of panic. If he saw someone climbing up a ladder, he would get very panicked. He stated that it was like a rush to the head, he would have to get away from that place as quickly as possible. He told Ms. Lawlor that he tried to control his breathing when his heart started pounding very fast. He reported flashbacks to the incident. He stated that the feeling of falling was fairly constant. He stated that he had become very moody and was irritable with his family. He could become very angry, to the extent that he felt like hitting the children. He was fearful of taking out his anger and frustration on the children, as they might stop visiting him. He had withdrawn socially and told Ms. Lawlor that there were days when he did not want to talk to anyone or answer the hall door. He told Ms. Lawlor that he had suicidal thoughts about two months previously. He felt like his life was over and he did not see the point in going on. He believed that the medication he was taking had helped relieve those thoughts. He found himself daydreaming all the time and had difficulty concentrating. He stated that he remained in a lot of physical pain despite three months of physiotherapy. He was frightened of being hurt again. In addition, he was constantly fearful that something bad was going to happen to him.

28. Ms. Lawlor was of the opinion that the plaintiff was suffering from Post Traumatic Stress Disorder following the accident. She believed that the constant physical pain served as a reminder of the incident.

29. The plaintiff told her that prior to the accident he had been an active and very fit man. He had good health and seldom visited a doctor or took medication. He had successfully managed his life for fifty years. Ms. Lawlor believed that he was shocked and was unable to handle himself or his life at that time. He was constantly fearful in his own home, suffering with panic attacks, and he was in constant pain with anxiety and was unable to move on. The plaintiff reported that he had lost faith in the support he had to date and believed that he may never get better. He told the therapist *"I seem to be getting worse. There doesn't seem to be anyone with an answer except tablets".*

30. The plaintiff also sought treatment from a Mr. Gerard Loftus. Mr. Loftus describes himself on his note paper as *"acupuncture – herbs – sports therapy – hypnotherapy – reflexology – kinesiology & pain management, NLP and SBT".* He was very anxious to point out to the court that he was not a physiotherapist or a psychologist. Indeed, it appeared that the only qualification which he had, was a qualification in acupuncture, which he stated he had obtained having completed a four year course at Inchicore College, Dublin. When pressed on the matter, he was not able to name the body which had actually given him the certificate or qualification at the end of the course.

31. The plaintiff attended with Mr. Loftus on a weekly basis. He would receive some form of physical treatment for which Mr Loftus would charge €60. He also underwent hypnotherapy for which he was charged €80. Mr. Loftus stated in evidence that he had been paid the sum of €7,970.00. He stated that the plaintiff's solicitor had discharged this amount to him. Subsequently, however, this figure was amended by the plaintiff's counsel to €3,720.00. No explanation was forthcoming as to why the higher figure had been initially claimed.

32. In an undated report headed *"Physiological Assessment"*, Mr. Loftus stated that he had been treating the plaintiff at least once a week with massage, heat, acupuncture, muscle energy techniques and advice for strengthening exercises. He stated that with so many structural problems, which were not being addressed by higher authority, i.e. operations of some kind, his treatments would be ongoing.

33. In a subsequent report from an examination on 10th January, 2014, he stated that from a physical point of view, he needed to encourage the plaintiff to take positive steps to bring about change. He stated that he had placed the plaintiff on a programme for hydrotherapy, working in water with specific exercises with isometric and isokenetic movements. In relation to the plaintiff's emotional state, he had given the plaintiff deep relaxation techniques to reinforce positive affirmations to alter his state of mind to address his past trauma, i.e. the unfortunate accident that devastated his belief system up to that moment. He stated that the accident had created a whole new world for the plaintiff thus creating the following conditions: stress, tension, anxiety, panic, mood disorders, fatigue, sleeplessness, worry, anger, fear, helplessness and hopelessness. He stated that it would take time and patience to create harmony and balance both mentally and physically for the plaintiff. He needed the support of his family and friends. In the meantime, the plaintiff had to rely on this crutch for everyday life and, according to his surgeon, will have to get cortizone injections for the rest of his life. Mr Loftus was of opinion that the plaintiff would require drugs for both physical and mental anguish.

34. Mr. Loftus issued a further report from an examination on 13th August, 2015. He noted that the plaintiff continued to experience significant psychological problems. He was giving treatment to the plaintiff in the form of hypnotherapy and reassurance, to deal with these conditions.

35. When the plaintiff returned for review by Mr. Sharif on 5th September, 2014, he brought Mr. Loftus with him and introduced him as a physiotherapist. Mr. Loftus strenuously stated during his evidence that he was not a physiotherapist and had never held himself out as such. However, the only explanation he could offer for the fact that Mr. Sharif noted him as being a physiotherapist in his third report, was that it may have been due to what the plaintiff told him at that examination. The plaintiff stated that he had brought Mr. Loftus to the consultation because he tended to forget things that he wished to say to Mr. Sharif. At that consultation, the plaintiff stated that he had continuing symptoms in his right hip, right thigh, lower back, upper back and right shoulder. Mr. Sharif noted that the plaintiff told him that he had right shoulder pain since the accident. Mr. Sharif noted that this was clearly mentioned in the notes from Blanchardstown Hospital, which he had received earlier that year. He noted that the plaintiff had approximately thirty sessions of physiotherapy. He had physiotherapy continuously on the right shoulder. Mr. Sharif was informed that the shoulder would go into spasms on and off and that physiotherapy tended to ease this off. He had had an MRI scan of the right shoulder which was done on 19th February, 2014, in Lithuania. This was reported as showing some arthrosis of the AC joint with signs of tendonitis of infraspinatus and subscapularis tendons with bursitis.

36. In relation to his current symptoms, the plaintiff told Mr. Sharif that he continued to have a problem with his right shoulder, which was affecting him a lot. His lower back was quite painful and the pain radiated down to both legs and would go to his heels, the right being worse than the left. The plaintiff had an epidural injection in 2013, but this did not give him much relief from his symptoms. The doctor noted that the plaintiff continued to use a crutch on the left side and had not been able to go back to work since the accident. He continued to have pain on the right outer aspect of his right hip. Movements of the right shoulder were restricted and painful, particularly in the area of the right AC joint. Mr. Sharif noted that he had signs and symptoms of Subacromial Impingement Syndrome and was markedly tender in that area and stressing this joint produced symptoms. Other than that there were no signs of any muscle rupture.

37. Examination of the lumbosacral spine revealed that SLR bilaterally was about seventy degrees. Other than that there was no other abnormality. The plaintiff was found to be markedly tender on the lower two facet joints and the SI joint ligaments.

38. Examination of this right hip revealed that movements were painful on internal rotation and abduction. He complained of pain on the outer aspect of the right hip and was markedly tender on the insertion of the gluteus medius minimus on the trochanter area, i.e. insertional tendopathy. Examination of the neck and upper back was normal.

39. Mr. Sharif noted that the plaintiff remained symptomatic. On inquiring about the shoulder pain, the plaintiff told him that the other pain was bothering him more and he forgot to mention about his right shoulder; however, this had bothered him continuously since the accident. The plaintiff had not been able to return to work. His "physiotherapist", Mr. Loftus, had encouraged him to go swimming, especially walking in the pool with hydrotherapy, which seemed to help him. The doctor was of opinion that this was progressing into a chronic pain situation. He strongly recommended that the plaintiff should be seen by an occupational therapist and an occupational physician to see exactly what kind of work the plaintiff would be able to return to.

40. Regarding the lower back, he recommended that the plaintiff should be seen and treated by a pain specialist. In this regard, he recommended that the plaintiff should be seen by Dr. Joseph Fitzgerald, Consultant Pain Specialist in the Hermitage Clinic. He stated that it was possible that his right shoulder symptoms may be helped by injection treatment. He noted that the last MRI scan of the shoulder did not show any major rupture of the shoulder muscles. Treatment with injection at this stage would be the best choice for him.

41. The MRI of the hip did show rupture of the gluteus medius tendon. It was a partial tear and this would require injection as well under ultrasound guidance. Mr. Sharif noted that the recent MRI scan did not show any major disc prolapse, other than broad and bulging discs and, as he had not responded to the epidural injection, Mr. Sharif believed that the plaintiff required facet joint blocks by a pain specialist. His overall impression was that the plaintiff's symptoms would be ongoing. The long-term prognosis was guarded in his case.

42. In relation to his continuing psychological symptoms, the plaintiff was reviewed by Ms. Lawlor on 26th January, 2015. She noted that the plaintiff had attended for physiotherapy on a regular basis between 10th April, 2013 and 26th November, 2013. When reviewed in January 2015, the plaintiff told Ms. Lawlor that he felt let down and was angry all the time at the consultants and everyone. He told her that he felt *"hurt by the system – money is the only way you get things done".* He told Ms. Lawlor that he had been attending Mr. Gerard Loftus weekly for assistance with his physical pain and monthly for hypnotherapy support. However, he reported that sleep disturbance was "worse than ever". He stated that he was experiencing violent nightmares every night, which had got worse in the last six months. He stated that he would wake up sweating: *"It's in 3D in my head. I keep falling in the nightmare".* He was sometimes unable to catch his breath when he awoke. He told Ms. Lawlor that he was constantly anxious and perpetually worried about the lack of money. He had lost interest in life. He no longer attended football matches and had given up playing music. He had become isolated from friends and no longer went out socially.

43. The plaintiff reported that he had been quite isolated at Christmas 2014 and had suicidal thoughts. He stated that he was thinking of *"ending the whole lot. I was going to hang myself at home".* He stated that he did not tell anyone how he was feeling. He stated that a phone call from his son steered him away from his suicidal thoughts. He had spoken to his GP, Dr. Caffrey, who was in the process of referring him to the Tus Nua Resource Centre, Co. Kildare. He stated that his relationship with his partner had ended in September 2014, because of his anger. He reported that his concentration was very bad. So too was his memory. He stated that he spent a lot of time staring into space.

44. Ms. Lawlor stated that it was her opinion that the plaintiff was suffering from Post Traumatic Stress Disorder and chronic pain since the accident. He was taking prescribed medication for the depression and pain. He had been unable to return to work. Although he stated that he made progress when he was attending for psychotherapy, he reported that he had regressed in the last fifteen months. He stated that he had "no faith in the system". He asserted he was told by a psychiatrist in the Mental Health Service that they could not treat him, as he needed psychotherapy. He was doubtful that he would receive the appropriate therapy and support in Tus Nua. He believed that he needed a referral to a psychotherapist for treatment. He stated that he was living *"day to day"* and was somewhat hopeful that his referral for pain management would assist him with his physical pain.

45. Ms. Lawlor was of opinion that the plaintiff continues to be depressed and suffer from Post Traumatic Stress Disorder. She noted that he was in constant pain, which was a reminder of the incident. She recommended that he should engage in appropriate psychotherapy to assist him to deal with the depression and symptoms of Post Traumatic Stress Disorder.

46. The plaintiff was seen by Dr. Valeria Pollard, Consultant in Pain Management and Anaesthetics on 26th November, 2014. She noted that the plaintiff presented with pain in the lumbar spine, which radiated to his right hip and down the posterior aspect of the right leg and then radiated into his foot to all of his toes. He described a constant, dull, aching, nagging, annoying, sharp, shooting, burning, throbbing, distressing pain. This pain was aggravated by standing, sitting and walking for any length of time. The pain was reduced temporarily by physiotherapy and by topical rubs. He stated that this pain was 9 – 10/10 in severity on the visual analogue pain scale. He experienced parensthesia and numbness radiating to his right lateral thigh. He stated that his right leg frequently became dead and he loses power in his leg. He stated that he experienced urinary frequency. The plaintiff used a crutch to mobilise. He stated that he used this crutch because if he did not do so, he would lose power in his leg and fall. The plaintiff stated that he did not have any problem with his low back, right hip or right leg before the accident.

47. Dr. Pollard noted that the plaintiff also experienced right shoulder pain, which radiated into his neck. The pain also radiated into his right elbow. He described constant tight cramping pain, which became sharp and darting in nature. The pain varied from 6 – 10/10 in severity on the visual analogue pain scale. The pain was aggravated by lifting objects and the plaintiff stated that he could not lift his arm above his head since the accident. The plaintiff stated that he had reduced power in his right arm. The plaintiff was right hand dominant. He denied any problems with his shoulder or neck prior to the accident.

48. Dr. Pollard noted that the plaintiff had become depressed since the accident and he suffered from Post Traumatic Stress Disorder. He had seen a psychiatrist and undergone hypnotherapy. She noted that he had been unable to return to work since the accident.

49. Dr. Pollard noted that the plaintiff had had seven MRI scans and two sets of x-rays. On examination, she noted that the plaintiff walked with a markedly antalgic gait, favouring the right. He used a crutch to mobilise. He was unable to raise his knees to his hips, particularly on his right. Flexion was reduced to 45 degrees and extension, bilateral rotation and bilateral abduction were markedly restricted. Facet joint manoeuvres also provoked pain. The plaintiff's SLR was 30 degrees on the left and 10 degrees on the right, positive provocative for back pain and right leg pain. Sacroiliac distraction tests were positive and he was unable to abduct and internally rotate his right hip. His left hip range of motion was also restricted because of back pain. Palpation of the lumbar spine revealed marked tenderness throughout the entire lumbar spine. Dr. Pollard could not localise tenderness to any particular area. He was also tender in his right sacroiliac joint and right hip.

50. Dr. Pollard noted that the plaintiff's neck range of motion was good, apart from left lateral rotation and abduction, which produced right-sided neck and shoulder pain. The plaintiff's right shoulder range of motion was markedly restricted in all ranges. The plaintiff was tender to palpation throughout the entire right cervical spine. There was tenderness in the left cervical spine. There was tenderness throughout the trapezius musculature in his suprascapular and periscapular region on the right side. He was tender in the AC joint. There was also tenderness within the shoulder joint to palpation. The plaintiff was also tender in his left upper and periscapcular trapezius musculature.

51. Dr. Pollard was of opinion that the plaintiff had suffered injuries to his low back, right hip, neck and shoulder in the accident. The MRI scan of his lumbar spine had shown spinal stenosis and spondyloarthrosis. She was of opinion that the plaintiff should be referred to a neurosurgeon to further assess the persistent low back pain. She noted that the MRI scan of the right shoulder had shown arthritic changes in his AC joint on the right side. There were also signs of tendonitis in the right shoulder joint. She was of opinion that referral to an orthopaedic surgeon would be warranted. The MRI scan of the hip joint had shown a partial tear and bursitis in the hip musculature.

52. Dr. Pollard noted that the plaintiff continued to experience significant pain and he remained dependent on pain relieving medication. His response to physiotherapy had been limited. He had also become depressed and suffered from PTSD as a result of the accident. She was of opinion that the plaintiff would benefit from a multidisciplinary pain management programme. However, his prognosis was guarded given the chronicity of his symptoms. It was possible that he would continue to have ongoing symptoms in the future.

53. The plaintiff was reviewed by Dr. Pollard in March 2015. He had not had any further treatment. He had been transferred to her clinic in Beaumont Hospital. He was awaiting treatment there. In the pain management programme, he would get an input from a psychiatrist and also from a physiotherapist who specialises in pain management. Dr Pollard was of opinion that he may require hip and shoulder injections. He may need nerve block or facet joint block injections. She stated that at that stage, some three years since the accident, it was probable that they would be managing his pain rather than curing it. In relation to work, she felt that it was extremely unlikely that the plaintiff would return to manual work. When pressed on this opinion in cross examination, Dr. Pollard stated that she would be optimistic that with the appropriate intervention in the course of the pain management programme, that the plaintiff would improve. She could not say if he would be able to return to his pre-accident employment, but hopefully would have improvement in his pain. She thought that he would be fit for light work. In re-examination, she stated that while she was hopeful that the plaintiff would improve, he will have ongoing pain. This would mean that he would only be fit for sedentary work; he would not be fit for his pre-accident work. This would depend on whether the multidisciplinary approach worked. It would be necessary to treat the plaintiff's psychiatric issues as well as his physical symptoms.

54. Evidence was also given by Mr. John Thornhill, FRSCI, Consultant Urologist. He saw the plaintiff in August 2013, on a referral from his solicitor. The plaintiff denied any previous injury in this area. He said that at the time of the accident he noted that there was blood in the urine. He did not mention this in Connolly Hospital. The hospital notes did not mention any urological history, but a labstick urine test did show +2 of blood in urine at that time, which supported the plaintiff's claim of haematuria. For approximately three weeks after the injury, the plaintiff developed a reduced urinary flow, and an intermittent post micturition dribble. He also would get up twice at night and more recently had some bed-wetting. In addition, the plaintiff described reduced libido and loss of erections; he said his sperm just leaked out. On examination, from a urological viewpoint, there were no signs on examination; in particular genitalia, prostate, abdomen and groins were normal to examine.

55. Mr. Thornhill stated that from a urological point of view, the plaintiff had haematuria at the time of the accident. If he had developed obstructive symptoms since that accident, then he must have investigations to out rule the development of a urethral stricture as a result of urethral trauma at the time of his accident. Having said that, if there was no evidence of urethral obstruction, it may be that the plaintiff had simply developed prostate symptoms since the time of the accident considering his age. Regarding his loss of libido and erectile dysfunction, it would be hard to explain why this would be caused by the accident on a physical basis, but his Post Traumatic Stress Disorder could be relevant. Likewise, his antidepressant medication can have the side-effect of erectile dysfunction, loss of ejaculation and loss of libido. Further tests, in particular an ultrasound scan of his renal tract and a flexible cystoscopy, were required to accurately define urological issues and future prognosis.

56. A medical report from Mr. Jabir Nagaria, Consultant Neurosurgeon, was submitted in evidence. The doctor reviewed the relevant MRI scans. The plaintiff had had an MRI scan of the lumbar spine in Lithuania. The finding on that scan showed that the physiological lumbar lordosis was somewhat straightened and mild scoliosis was noted to the left. At T9/L1 there were degenerative changes noted of the intervertebral spaces. No spinal cord stenosis was observed. On T11 vertebral body on the right, a 9mm haemangioma was found, which was an incidental finding. No other bone growth was noted. At L1/S1 moderate osteocondrosis and spondylosis was noted. At L4/S1, significant spondyloarthrosis was noted. Covering plates were uneven with multiple Schmorl's nodes. Discs were slightly reduced. Wide dorsal bulging was noted, which was surrounded by minor dorsal osteophytes. L1/S1 central lateral moderate degenerative spinal canal stenosis were evident. There was moderate narrowing of the intervertebral spaces noted from L1/5 on the right and L5/S1 on both sides. Nerve roots and paravertebral issues were normal.

57. An MRI of the right shoulder in Lithuania showed uneven hardened surfaces with degenerative changes noted of supraspinatus tendon. Subscapularis with no tear was observed. Biceps was in normal position, although the S1 was increased at the rotator interval. No tear noted. Increased volume was evidenced in sheath, shoulder joint and bursa areas. Labrum glenoidale was unremarkable. Arthritic changes with inflammation processes were noted in the AC joint. Slight narrowing of the subacromial spaces was observed and in conclusion the doctor noted arthrosis and arthritis of the AC joint, signs of tendinosis of infraspinatus, subsacpularis, biceps muscle, tendonitis, tenosynovitis and bursitis and increased fluid volume in the right shoulder joint.

58. The doctor noted that an MRI scan of the hip joint on 19th February, 2014, in Lithuania was reported as showing no changes in the sacroiliac joints, symphysis pubis area and pelvic bones. Small fluid strips were noted in the subgluteal bursa region on both sides. Moderate tendinosis was noted of gluteus medius and gluteus minimus on both sides. Partial tear was noted of gluteus medius tendon on the insertion about 0.7x1cm. The doctor was of opinion that there was mild subgluteal bursitis on both sides, tendinosis of gluteus medii and minimi and partial tear of the gluteus medius tendon.

59. An MRI scan of the lumbar spine taken on 8th April, 2013, in Lithuania showed physiological lumbar lordosis somewhat straightened. Subcondral sclerosis was noted. Bone growth in the joints was evident. There were moderate signs of scoliosis noted, with curvature to the left. T12/L1 disc was unremarkable. L1/L2 showed a moderate bulge.

60. An MRI scan of the lumbar spine carried out on 31st October, 2013, in Naas General Hospital, showed that at L1/L2 there was a mild posterior disc bulge. At L2/3 there was a mild posterior disc bulge. At L3/4 there was a mild to moderate disc bulge. At the L4/5 level there were mild posterior and right sided disc bulges, causing mild encroachment of right sided foramen with no significant stenosis. At L5/S1 there was a mild posterior and broad based disc bulge and the combination of the disc with the degenerative changes at this level caused moderate encroachment of both exit foramina with no significant stenosis. There was mild anterior wedging of the T11 vertebrae.

61. In an addendum to the report on 30th April, 2015, Mr. Nagaria noted that the plaintiff was complaining of significant walking difficulty, mainly pain in the right gluteal and buttock region and he also had a mildly exaggerated thoracic kyphosis. His right shoulder movements were significantly restricted. The plaintiff was also complaining of a dead arm. The doctor thought that he was clearly describing what appeared to be pain in the right C6 nerve root distribution. The pain seemed to be starting in the right side of the neck. He had a tendency to rotate his neck to the right hand side with pain in the trapezious region and had pain radiating and affecting the thumb and the index finger. The plaintiff advised that he always had a feeling of deadness in that arm and the neck pain had been present since the fall on 12th June, 2012.

62. Mr. Nagaria stated that clinically the plaintiff had a twitch in that area and it appeared that he had clearly got a C6 radiculopathy. His MRI scan confirmed degenerative changes at the C5/6 level and some degree of right sided nerve root compression. In addition, his MRI scan of the lumbar spine showed a mild scoliosis to the left and deforming osteochondrosis at the thoracic 9/12 vertebrae and marginal osteophytes and degenerative stenosis at the L5/S1 and severe stenosis at the L5/S1 left sided foramen.

63. Mr. Nagaria surmised that the plaintiff seemed to have sustained a musculoskeletal type of injury to his lower back, with what appeared to be a sub-gluteal bursitis, leading to quite severe pain in his gluteus medii region. He did not have any significant nerve root pain in relation to that, but did have severe musculoskeletal pain both in his lower back and also from this gluteus medii, which appeared to be in direct relation to the injury that he sustained.

64. The doctor stated that in addition he also sustained a right sided shoulder injury for which Mr. Sharif provided a report, but, in addition, he also had what appeared to be right sided nerve root symptoms, which the plaintiff advised had always been there, with neck pain and a feeling of deadness in the arm, but more laterally he had started complaining of right sided C6 nerve root pain. The neck pain was, again, of the musculoskeletal variety, but more laterally he had developed nerve root pain in that distribution.

65. A medical report was also handed in from Dr. Gerard Caffrey, to whom the plaintiff moved as his GP. He noted that the plaintiff had been started on the medication Palexia. He was currently on Seroquel 50 Nocte, Prozac 40 mane and Effexor 150 mane from Dr. Alan Byrne, Consultant Psychiatrist. He noted that the plaintiff was being investigated by Mr. Michael Murphy, Consultant Urologist for urinary symptoms, which date back to the time of the fall. He was being referred by Mr. Sproule to Mr. Martin Murphy, Consultant Neurosurgeon and to Dr. Heffernan, Pain Specialist. It is not clear to the court whether the doctor is mistaken in relation to these doctors, as these doctors were not called in evidence, nor was any medical report submitted in evidence from any of them.

66. Dr. Caffrey reviewed the plaintiff on 2nd October, 2015. The plaintiff had stated that his life had changed dramatically since the accident. Prior to the accident, his only medical condition was hypertension. At the time of the examination, he suffered from right shoulder, neck, right gluteal and lower back injuries. In addition, he suffered from depression and urinary problems. He had not worked since the accident. His mobility was severely limited, his social life was non-existent and he stated that he rarely left the house. When asked to rate his pain on a scale of 1-10, 1 being his pre-accident pain and 10 being that in the immediate aftermath of the accident, the plaintiff put his shoulder pain at 6-7, neck pain at 7-8, gluteal pain at 8-9 and lumber sacral pain at 8-9.

67. On examination of the shoulder, there was severe limitation of all right shoulder movements. In relation to the neck, pain was

elucidated on all neck movements at the limit of their range of movements. In the right hip, there was painful limitation of right hip movements. In the lumbosacral spine, there was severe limitation of all lumbar sacral movements. Right and left straight leg raising was limited to 45 degrees.

68. In his summary and prognosis, the GP stated that the plaintiff had fallen from a scaffold on 12th June, 2012, resulting in injuries to his right shoulder, right gluteal muscle, neck and lower back. He subsequently developed urinary problems and depression. It was over three years since his accident and in the interim he had attended numerous consultants and had extensive investigations and undertaken a wide range of treatments. To date, however, his condition had remained largely unchanged. The doctor stated that at this juncture, it was hard to be optimistic about further meaningful improvement.

69. Evidence was also given by the plaintiff's brother, Colin Ruffley and by his sisters, Lorraine Ruffley and Ann Holmes. They were impressive witnesses. I am satisfied that they gave a truthful account of the plaintiff's pre-accident and post-accident presentation. Taking their evidence in the round, they painted a picture of the plaintiff prior to the accident as being a man who was very active and engaged in his work. He was friendly and outgoing. He enjoyed participating in family occasions, particularly as members of the family would play musical instruments on such occasions. The plaintiff used to play the guitar. The witnesses stated that the plaintiff was a very obliging man, who would help them in any way that he could. He would help with DIY and maintenance work. Lorraine Ruffley stated that the plaintiff had always been her protector, when she was growing up. He would give her a few bob to help out from time to time. It was stated that pre-accident, the plaintiff was happy, hardworking and got on with life.

70. All three witnesses painted a dramatically different picture of the plaintiff since the time of the accident. He had become very withdrawn and isolated. Lorraine Ruffley would call around to his house to help him do household chores whenever she could. She stated that she had seen a big change in the plaintiff since the accident. Her brother, as she knew him before the accident, had gone. Now, he was just very quiet all the time. Mr. Colin Ruffley stated that he would see the plaintiff on a very frequent basis. He stated that the plaintiff had aged fifteen to twenty years since the accident. He was not the same person as before the accident. At that time, he had been very good-humoured and would go to matches with his brother. He would follow inter-county Gaelic football matches when Kildare was playing. He said that the plaintiff was not the same man anymore. He was very quiet and withdrawn. His inability to do things affected him all the time. Mr. Ruffley said that he would try to see the plaintiff every day just to keep an eye on him.

71. Evidence was also given by Mr Trevor Cruise, the estate manager at Stacumny Estate. He stated that the estate had been sold to new owners. There were four people working on the estate at present. He stated that prior to the plaintiff's accident, the plaintiff had done a lot of physical work, such as painting, decorating, and cutting ivy. He also provided security duties and driving duties on occasion. He stated that after the sale of the estate, all the previous staff who were available were kept on by the new owners. The plaintiff was the only one not to work for the new owners. One of the members of staff was seventy-one years of age and he was still employed on the estate. Nobody from the old staff had been let go. Mr. Cruise confirmed that the plaintiff's old house was still available on the estate and was, in fact, used by the housekeeper.

72. Evidence was also given by Ms. Ciara McMahon, a vocational assessor. She stated that she saw the plaintiff in September 2014. He gave her a full work history. He told her that in 2009, he had taken up employment at Stacumny House. He was paid €479 per week net and also had his utilities provided. Prior to the accident he had been well able for the demands of his work and also enjoyed hobbies such as swimming and going to the gym.

73. Since the accident, the plaintiff complained of pain at the base of his neck and in his right shoulder. He also complained of pain in the lower back and in the right buttock and going into the right leg. He described this as a "dead leg" and described a loss of power in the right leg. He had difficulty sitting, standing, climbing stairs, bending, stooping or carrying heavy weights. He had limited mobility in that he needed a crutch to mobilise. He was also limited in the driving that he could do.

74. Ms. McMahon noted that the plaintiff needed help with various chores at home. She felt that he was very limited in the work that he could do. She stated that if the plaintiff participated in a pain management programme and if this was successful, he may be fit for light work of an unskilled nature. Perhaps he would be fit for light security work. Pay for this type of work would be the minimum wage of circa €337 per week. However, she stated that it was a difficult market and employers were unlikely to choose an older man who had a history of illness or injury. She felt that his prospects were quite limited.

The Defendants' Evidence

75. Evidence was given by Mr. Frank McManus, FRSCI, on behalf of the defendant. He saw the plaintiff on 14th January, 2014. By that time, the plaintiff had had a number of x-rays and a number of MRI scans both in Ireland and in Lithuania. The plaintiff had also had an epidural injection administered by Mr. Sharif, FRSCI, in 2013. The plaintiff told Mr. McManus that he had been getting physiotherapy treatment. The doctor assumed that he had been getting this treatment from a chartered physiotherapist.

76. Mr. McManus stated that he would prefer if patients were referred to a Chartered Physiotherapist for treatment. He further stated that it was unusual for a patient to travel to Lithuania for the purpose of obtaining MRI scans.

77. At the examination, the plaintiff complained of pain in the right thigh, radiating into the right leg. He also had problems with the anal sphincter, but this had come on much later after the accident. The doctor thought that this was an unusual complaint. Examination revealed limitation of movement of the back. The plaintiff was not able to extend his back backwards at all. The plaintiff complained of lack of sensation in the anal sphincter, but muscle tone was normal on examination. During the examination, the plaintiff told the doctor that he had Post Traumatic Stress Disorder. The plaintiff also complained that his right shoulder on occasion can be tender. He stated that he did stretching exercises relevant to the lumbar spine and shoulder first thing in the morning. The plaintiff also stated that the pain in his back necessitated him having injections from his GP on a regular basis, on average every two weeks.

78. Mr. McManus stated that it was difficult for him to explain the neurological symptoms that the plaintiff reported at that time. Given the reported MRI scans and the distribution of the complaints of pain, because they involved different lumbar nerves, it was therefore very difficult from an anatomical perspective alone to explain the symptoms complained of by the plaintiff. Mr. McManus stated that it would be necessary for him to view the relevant MRI scans. However, on the basis of his assessment carried out in January 2014, he was of opinion that the plaintiff had sustained soft tissue injuries, possibly to his lumbar spine. He had not regained active extension of the lumbar spine despite the fact that he attended on a frequent basis with his *"physiotherapist"* at that time. He stated that it would be necessary for the plaintiff to understand the responsibility to rehabilitate and to carry out his exercises in a diligent manner. Mr. McManus did not think that the plaintiff had sustained a neurological injury. He had difficulty explaining the complaints of sensory impairment having regard to the distribution of these complaints.

79. By letter dated 25th February, 2014, Mr. McManus commented on the report furnished by Mr. John Thornhill, Consultant Urologist.

He found that report somewhat surprising, as the plaintiff did not sustain a straddle type injury to his perineum. In these circumstances, he did not know how the plaintiff could possibly have injured his genitals when he fell 14ft on 12th June, 2012. He was of opinion that there may be some psychological causation for the plaintiff's symptoms, rather than a physical one, on the basis of his understanding of the mechanism of the injury.

80. Mr. McManus went on to state that the plaintiff undoubtedly hurt himself, but he did not fracture anything and therefore, by definition, he sustained soft tissue injuries. He stated that the plaintiff's neurological symptoms were very difficult to explain purely on an anatomical basis. It was his opinion that the plaintiff was not rehabilitating to a significant degree. The plaintiff was in his fifties and had enormous potential to improve with traditional rehabilitation, but he had to accept the responsibility to do so himself.

81. By letter dated 13th March, 2014, Mr. McManus commented on an MRI scan which had been forwarded to him. These scans confirmed extensive degenerate disease of the lumbar spine, extending from T11 down L5/S1. The entire lumbar spine had degenerative disc disease. He also noted on the scan a previous old injury with a minor compression of the eleventh thoracic vertebra, which was probably post traumatic in origin. However, when he saw the plaintiff, there was no history of previous injury. In his opinion, the MRI scans clearly confirmed a minor wedge compression of T11.

82. The plaintiff was reviewed by Mr. McManus on 22nd April, 2015. The plaintiff was using a crutch on the left hand side when he entered the consulting room. Mr. McManus thought that he looked depressed. He now required treatment for his neck; however, at the first examination there had been no reference to any neck injury or neck pain. On the basis of the history that he had given, he did not complain of any injury to his neck. Mr. McManus asked the plaintiff as to whether or not he had injured his cervical spine, because at the time of the initial consultation with the plaintiff, there was no history of him having sustained an injury to his neck. In response, the plaintiff stated that his neck had always niggled him and approximately three months after the accident, the pain on the left side of his neck had increased significantly and he described this pain as a stabbing like pain in the cervical spine. He stated that because of these symptoms he had had further physiotherapy both to the neck and to the lumbar spine. The plaintiff also stated that he had pulled a muscle at the back of his hip at the level of the greater trochanter and this had been diagnosed on an MRI scan carried out in Lithuania. In essence, the plaintiff confirmed that he had had eight MRI scans in all and had three visits to Lithuania where he was assessed.

83. With regard to the lumbar spine, the plaintiff stated that he had ongoing complaints of pain in his lumbar spine which was constant. A massage could help on occasion. He could not get comfortable at night and he needed to use his crutch, even around his own home. He complained of an inability to either sit or stand comfortably for long periods and he complained of pain radiating into his right leg. He could not explain when the pain in his right leg might occur.

84. With reference to his neck, he stated that over the past three months he had increasing complaints of pain in the left side of his neck, which was a fairly constant pain. There were no associated neurological symptoms in his upper left limb. On questioning, the plaintiff stated that his neck was not symptomatic in axial profile, i.e. when sitting with the weight of his head resting on his neck. Mr. McManus did not feel that the plaintiff had any significant neck symptoms. The plaintiff stated that he felt much worse since he was initially examined by Mr. McManus. This did not surprise Mr. McManus, as the plaintiff used a crutch on this occasion and looked depressed.

85. On examination, movements of the lumbar spine were restricted. His ability to flex was limited to forty-five degrees and he could not extend his spine at all. Rotation and lateral flexion was half of the normal that one would expect for a man of his age. He complained of pain at the extremes of movement. Mr. McManus stated that when he asked the plaintiff to stand, he had put his hand onto his desk for support. Mr. McManus told him to stop doing this. The plaintiff did not like being told that. He complained about Mr. McManus to the medical council. His complaint was assessed by the committee of the medical council and they found no case to answer. Mr. McManus stated that his report was done before the complaint was made.

86. On examination of the lower back, Mr. McManus was of opinion that neurologically, the plaintiff was satisfactory. Straight leg raising was negative and neurological examination of the lower limbs was normal.

87. Examination of the plaintiff's neck indicated he had half the normal range of movement in all plains which one would have expected for a man of his age. Examination of the right shoulder indicated a diminished range of motion. At best, the plaintiff had two thirds of the normal range of abduction internal and external rotation and flexion and extension.

88. In reaching his opinion, Mr. McManus noted that on reviewing his notes of the initial attendance with the plaintiff, there was no history given of any problems with the cervical spine. The significance of the plaintiff's cervical spine symptoms was totally unclear, because had the plaintiff suffered an injury to his cervical spine in June 2012, that might be responsible for symptoms that had persisted up to 2015, he would have had to sustain a significant neck injury and that was not the history that was given to him.

89. Mr. McManus was of opinion that it would be necessary for him to review all the MRI scans in the case. On the basis of his clinical notes, the plaintiff appeared to be deteriorating which was difficult to understand, acknowledging his relative youth and the fact that when he saw the plaintiff initially, he told him that at one stage he was considered to be the fittest man in the Curragh when he was in the army.

90. Mr. McManus stated that he was not convinced as to the level of the rehabilitation that the plaintiff was involved in, because when he examined the plaintiff, he tended automatically to reach out to the adjacent desk for support which, in his opinion, confirmed that the plaintiff was not carrying out his exercises on a diligent basis, because he should not be unstable on his feet acknowledging his age and the fact that balance was a function of the middle ear and it had nothing to do with the trunk.

91. Mr. McManus wrote a supplemental medical report dated 20th July, 2015, when he had been given the opportunity of reviewing the MRI scans. The first series available to him was dated 12th June, 2012, and were plain x-rays. These x-rays confirmed that the plaintiff had established degenerative disease of his right acromioclavicular joint. The x-rays also confirmed that no fracture occurred with reference to the lumbar spine, which was evident on the plain films which were compatible with the plaintiff's age. X-ray examinations of the pelvis were also carried out and in Mr. McManus's opinion these x-rays showed no evidence of a fracture.

92. The second series of images carried out were dated 31st October, 2013, and specifically these were MRI scans of the lumbar spine. These scans demonstrated extensive degenerative change in the lumbar spine. This was more marked at T12/L1, L1/2 and L2/3.

93. Having regard to the fact that the plaintiff had been informed in Lithuania that he had sustained a fracture of T11, Mr. McManus paid particular attention to the MRI scan in the area of T11. He found that the angle of kyphosis at T11 was 7.1o. The angle of

kyphosis at T12 was 7.2 o . The angle of kyphosis at L1 was 7.8 o . All three intervertebral bodies, T11, T12 and L1 showed minimal wedging. In his opinion, this was not traumatic and was, in all probability, due to Scheurmann's osteochondritis, which was an adolescent developmental disorder that occurs in young adult males associated with a round shouldered appearance. The fact that the angle of kyphosis was similar in each vertebrae clearly indicated that this was not compression. In addition, the radiological appearance of the vertebral bodies on the scan showed no evidence of vertebral body deformity other than the kyphosis as stated. In Mr. McManus's opinion, the plaintiff did not sustain a fracture of T11.

94. The third series of diagnostic images were carried out Lithuania on 2nd April, 2015. An MRI of the pelvis was taken. There was no radiological evidence of any muscle tear at the back of the right hip.

95. An MRI of the cervical spine also carried out in Lithuania on the same date was reviewed. This clearly confirmed that the plaintiff had degenerative disease of his cervical spine more particularly at C5/6 and there was some evidence of ligamentum flavum hypertrophy leading to an area of stenosis at C5/6.

96. Two further MRI scans of the neck were carried out on 4th February, 2015, in the Vista Clinic which confirmed no change in the appearance of the cervical MRI carried out on 2nd April, 2015. The doctor was also provided with copies of an MRI scan carried out on 1st April, 2015, again of the cervical spine. This scan was carried out in Lithuania and showed no change in the radiological appearance of the cervical spine.

97. Mr. McManus stated that in essence the MRI scans, and the original x-rays, did not demonstrate a fracture, but did demonstrate degenerative disease of the lumbar spine, with evidence of old standing Scheurmann's osteochondritis. With reference to the cervical spine there was an area of degenerative change at C5/6 with associated ligamentum flavum hypertrophy leading to a segment of stenosis at the level of C5/6 involving the diameters of the cervical spine.

98. Mr. McManus was of opinion that if the plaintiff participated in a pain management programme, this was designed to control pain and would allow the person to rehabilitate. It was necessary to move the injured areas. If the plaintiff had had proper physiotherapy treatment after the accident, he would have expected that the plaintiff would have been able to get back to work. He was of the view that even now, if the plaintiff did a pain management programme, it was likely that he would be able to get back to full work in time.

99. Mr. McManus accepted that inflammation of the facet joints would not show up on plain x-rays or MRI scans. It would be necessary to have a bone scan to show this condition. He accepted that the plaintiff had fairly extensive degenerative changes in his spine and this probably involved the facet joints as well. He had disc bulging at nearly every level. This would make him more prone to injury. Where there was a soft tissue injury superimposed on pre-existing degenerative changes, one would expect recovery within twelve to fifteen months. If there was inflammation of the facet joints, this would lead to pain and would make it more difficult to recover. Inflammation of the facet joints would usually affect the leg. Mr. McManus accepted that the plaintiff's complaints were referable to the accident. However, he should have had physiotherapy from a chartered physiotherapist. The plaintiff went to Mr. Loftus for treatment. If a person went to a chartered physiotherapist for treatment, the therapist would have qualifications in relation to the structures of the spine. It would have been preferable that the plaintiff be seen by a chartered physiotherapist. If someone had held themselves out as being a physiotherapist, when they were not qualified as such, that would be fraud. In this case, the plaintiff had treatment from Mr. Loftus, Mr. McManus did not know what treatment he had received. If he had wanted treatment from a physiotherapist, he should have gone initially to his GP. The GP would then refer him on for treatment by a chartered physiotherapist.

100. Mr. McManus accepted that, on occasions, treatment from an allied practitioner can be beneficial. Some people go to physical therapists or to spinologists. Mr. McManus stated that he would prevent his patients from going for such treatment. He did not have any particular problem with people having treatment in the form of acupuncture. However, he accepted that people are free to have whatever treatment they felt was most beneficial for them.

101. The plaintiff had been advised that if he underwent a pain management programme, the doctors anticipated that he would make improvement. Mr. McManus stated that he would expect significant improvement following such treatment. In relation to his capacity for work, Mr. McManus stated that if he saw the plaintiff in a year's time and if he was symptom free, then he would not place any restriction on his returning to work.

102. It was put to the witness that Dr. Pollard and Mr. Sharif thought that the plaintiff would improve on a pain management programme, but that certain activities would remain contraindicated. Mr. McManus did not agree with that. He thought that significant improvement would probably be made. He did not agree that the plaintiff would not be able to do heavy manual work in the future. However, he stressed that the plaintiff would have to participate fully in the rehabilitation programme. The plaintiff would have to cooperate to a significant degree in order to achieve rehabilitation. If he was clinically normal on examination at the end of the pain management programme, he would be fit to do heavy work. When Mr. McManus saw him, he was not able to do certain movements because of reported pain.

103. Mr. McManus was of the opinion that if the plaintiff was physically fit, he would be infinitely better. He stated that the plaintiff would have to work at his rehabilitation programme. He accepted that by going on the pain management programme, this would lead to improvement in his condition. He was of opinion that the plaintiff's symptoms were due to a lack of mobility. If the plaintiff was physically active and doing his exercises, he would improve. He had no doubt that if the plaintiff rehabilitated and underwent a pain management programme, he would improve significantly. He accepted that he might be left with a residue of pain. However, if he was clinically normal on examination, he would not restrict the plaintiff's working capacity.

104. The plaintiff told him that he was on six prescription drugs at the time of the examination. He gave a list of the medication. He was taking Lexipro, Tramadol, Diclac, Difene, Stilnoct, Effexor, Arthotec, and Aticand. He also wore a Butran Patch. This medication was on prescription from his GP.

105. Mr. McManus stated that the complaint in relation to the anal sphincter was a serious complaint for a spinal injury. However, he tested this area and found it to be normal. He stated that this complaint surprised him, as it indicated a significant spinal injury. If there was impaired anal tone, as a result of spinal injury, this would be a dreadful injury. He stated that it was odd that this came on much later.

106. In re-examination, Mr. McManus stated that if the plaintiff was his patient, he would be disappointed if he did not get back to doing full-time work. He stated that there was nothing wrong with the plaintiff's shoulder the first time he examined him.

107. Evidence was also given by Prof. Jack Phillips, Consultant Neurosurgeon, who saw the plaintiff on 19th August, 2015. At that time, the plaintiff complained of lower back pain radiating into his right leg and foot. This was most pronounced in the area of the lower back and the right buttock. The plaintiff furnished him with a list of the medication that he was on at that time. He stated that this was somewhat unusual. Prof. Phillips noted that the list was quite extensive. He stated that it was unusual for a GP to prescribe such an amount of medication, because it was apparent that some of them were not working. In such circumstances, one would question whether the right diagnosis had been made.

108. Prof. Phillips noted that the plaintiff had extensive degenerative changes in his spine. He did not think that the plaintiff needed any surgery. He had not had extensive pain intervention at the time of his examination. Clinical examination on 19th August, 2015, revealed a pleasant, cooperative man with a rather flat effect. The plaintiff ambulated into the consulting room using a crutch on the right hand side. His movements were slow and purposeful. He had an antalgic gait favouring the right hand side, with alternating movements extending to his right leg with a spastic format. Clinical examination revealed that he had a functional weakness of the right foot, with marked inability to dorsi flex or plantar flex his foot. There was a moderate weakness in inversion and eversion. All movements were tremulous and varied with variable motor power. The plaintiff was unable to lift his right knee against resistance in a sitting position.

109. Examination of the lumbar spine revealed an almost rigid back. There was almost no flexion movement. He was unable to rise on his toes or rock back on his heels. Reflexes were intact. There did not appear to be any definite sensory disability.

110. Following examination of the lumbar spine, the plaintiff informed him that he had neck discomfort. These symptoms were not referred to in the initial part of the consultation. Examination of the neck revealed moderate stiffness in all plains. Mr. Ruffley then referred to his right shoulder. He stated that he had restricted movement. On examination, there were elements of mild frozen shoulder on the right hand side. The plaintiff was adamant that both the neck symptoms and the shoulder symptoms arose as a consequence of the fall on 12th June, 2012.

111. Prof. Phillips stated that when the plaintiff exited his consulting room. He was holding the crutch in the opposite, left hand side. He had normal power on his right foot with normal dorsi flexion and plantar flexion when ambulating.

112. Prof. Phillips stated that when he saw the plaintiff on 19th August, 2015, he appeared to be significantly disabled using a crutch on the right hand side to ambulate. Movements were slow and cautious. He had an antalgic gait favouring the right side initially. There were conflicting signs on examination. There was a variable, sometimes marked weakness of the right foot, which was unexplained on an anatomical basis in the absence of L5 root dysfunction in the lumbar spine. When ambulating exiting the consulting room, he had normal power in his right foot. In addition, when exiting, he held the crutch in the opposite left hand side. There was no wasting of the calf muscles. The plaintiff also appeared to have elements of neck restriction and right shoulder restriction. He did not report any neurological disabilities.

113. Prof. Phillips stated that from a neurological point of view the plaintiff appeared significantly disabled on clinical examination. However, the findings were conflicting and unexplainable in the context of what appears to have been soft tissue injuries only, which occurred following the fall on 12th June, 2012. There was no doubt that the injury at the time was significant and that the soft tissue bruising was extensive. However, he was of opinion that the plaintiff did not suffer a neurological injury. The plaintiff had extensive widespread degenerative changes in his lumbar spine. These changes, coupled with a relatively sedentary lifestyle, undoubtedly gave rise to subjective symptoms of discomfort with restricted movement. The widespread degenerative changes did not result as a consequence of the fall. He noted the report furnished by Prof. Eoin Kavanagh, Radiologist, dated 15th July, 2015. Prof. Kavanagh in his summary stated that the imaging studies of the lumbar spine, cervical spine and pelvis, showed evidence of multi-focal degenerative changes. He did not see evidence of an acute osseous injury or soft tissue injury. On the MRI scan of the lumbar spine from 2013, there was some minimal wedging of the superior end plate of T11 without accompanying bone oedema. This was a chronic finding which may be related to prior traumatic injury. He stated that the plaintiff presented with elements of Post Traumatic Adjustment Disorder which may be adversely affecting his ability to fully physically rehabilitate.

114. In the course of his evidence, Prof. Phillips stated that in his opinion the plaintiff was disabled because he had not been fully physically rehabilitated. He had disuse symptoms. He accepted that the plaintiff's symptoms were real to him. However, there was a psycho-somatic component. In his opinion, the plaintiff required treatment in the form of cognitive behavioural therapy and participation on a pain management programme. Prof. Phillips stated that by referring to the injury as being psychosomatic in origin, this meant that the plaintiff interprets that he has a disability, but there is no structural reason for this. There is a subjective element, being what he perceives as pain. There is also an element of depression and financial worries, which would feed into the situation. However, he was of the view that the plaintiff will get better with appropriate treatment. He noted that Prof. Thakore was of the opinion that the plaintiff had an adjustment disorder. This can be treated by therapy. He accepted that there was some element of psychiatric injury. He was of the view that if the plaintiff participated in a pain management programme then on balance of probabilities, he will return to normal activities, although he may not be able to lift heavy weights.

115. In cross examination, Prof. Phillips accepted that the injuries are real to the plaintiff as he perceives them. He experiences the symptoms and so they are real for him.

116. In relation to the facet joints, Prof. Phillips stated that people can strain the facet joints on activity. However, they will get better over a period of time. He had experience dealing with jockeys, who had fallen from horses, in which they suffer a strain of the facet joints. They will normally be able to ride again in six weeks. He did not agree with Mr. Sharif that the pain was caused by inflammation of the facet joints. If the person had a fall, this could disrupt the muscles and soft tissues in the spine and the facet joints. However, this will recover spontaneously in a number of weeks. Prof. Phillips could not explain the plaintiff's symptoms at this stage.

117. It was put to the witness that a person could have soft tissue injury to the spine, which could cause pain from that injury for a number of years. The witness disagreed with this hypothesis. He stated that one would have to ask in the absence of structural injury, if pain continued for a long time, could this be due to failure to rehabilitate? He accepted that it could be a genuine pain. The pain could linger if the person adopts a sedentary lifestyle which prevents recovery. This could be seen as a downward spiral. The person may not exercise due to pain, which leads to disuse of muscles, leading to more pain, which leads to less activity. A person can have severe pain from a musculoskeletal injury in the early aftermath of the accident. If they do not rehabilitate, they will have ongoing pain.

118. Prof. Phillips stated that in the absence of a spinal fracture, or a slip disc, or a neuropraxia, the injury to the back will be soft tissue in nature. If the pain lasts, one would have to ask why this was so. People who have soft tissue injuries and who have pain for years afterwards, if the person changes their lifestyle and does not rehabilitate, the pain will continue. The pain can be from disuse of

the muscles. If the person had soft tissue injury and an injury to the spine, which had degenerative changes, caused by a fall from 14ft onto concrete, this would cause swelling and bruising. The skin on the soft tissues will recover in time. One would have to ask why the plaintiff has pain all over his body. There was no evidence of fracture or disc prolapse or neurological injury. In such circumstances, it was difficult to know where the cause for his symptoms lay. They can have a temporary effect on the facet joints leading to pain and spasm. This will settle and return to its pre-accident state if there is positive rehabilitation. Prof. Phillips was of the opinion that the plaintiff had got over his initial injuries. He was not able to explain why the plaintiff was not better at this time. He noted that the plaintiff was unwell and unfit. He accepted that for him, the symptoms were real. If the plaintiff participated in a pain management programme, he would expect him to improve and it would be mysterious if he did not improve. He thought that lifting excessively heavy weights would be contraindicated.

119. In re-examination, Prof. Phillips stated that it was always difficult to assess the subjectivity of pain. If a person had other stresses in their life, this can increase their pain. In this case, there was a conflict between the level of reported pain and the structural components of the spine.

120. Evidence was also given by Prof. Jogin Thakore, Consultant Psychiatrist. He saw the plaintiff on 20th March, 2015. The plaintiff told him that he had been having physiotherapy treatment on a weekly basis. The plaintiff had gone to his GP and had been referred for psychotherapy from Ms. Lawlor. He had also attended Dr. Johnson, Senior Registrar in Celbridge Mental Health Services as an outpatient from November 2012 for approximately two months. Prof. Thakore stated that in his opinion the plaintiff fulfilled the criteria for an Adjustment Disorder with mixed mood and anxiety symptoms, in particular, being nervous and jittery, with low mood and disturbed sleep. He could detect no symptoms of Post Traumatic Stress Disorder or Major Depression.

121. Prof. Thakore was of opinion that if the pain management programme was successful, he would be hopeful that the psychologist thereon would give the plaintiff specific options for dealing with pain. The plaintiff's pain reminds him of the injury and if the pain is removed, this would have a positive impact on this mental state. The psychologist will train the plaintiff how to manage his pain and move on. He was of opinion that if the plaintiff makes a physical recovery, he should be able for gainful employment from a mental health point of view.

122. In cross examination, Prof. Thakore said that the plaintiff told him that he suffered from anxiety, low mood, and nightmares. In his opinion, the plaintiff did not fulfil all the criteria for PTSD. This condition could arise where a person was a witness, or experienced a risk of serious bodily harm. It would also require that other symptoms be evidenced. The plaintiff did not have sufficient symptoms to qualify as PTSD. The doctor accepted that the fall was a frightening accident, when the plaintiff may have feared grave personal injury.

123. The doctor stated that if the plaintiff gave the pain management programme a chance, he had seen improvement being made by patients undergoing such a programme. The psychologist on such a programme can help people to move on from their injuries.

Conclusions

124. There is a substantial difference of opinion between Dr. Pollard and Mr. Sharif on the one hand and Mr McManus and Prof Philips on the other hand. Having carefully considered all the evidence, I prefer the evidence of the treating doctor, Dr. Pollard, and Mr. Sharif.

125. I am satisfied that the plaintiff has suffered a significant injury as a result of this accident. While he has been to see a large number of medical specialists, it is unfortunate that it is only late in the day that someone has taken responsibility for putting in place a rehabilitation programme for the plaintiff. Dr. Pollard has directed that the plaintiff should be treated on her multidisciplinary pain management programme. This will involve a psychologist, a physiotherapist and Dr. Pollard, working together to deal with the plaintiff's psychiatric and physical complaints. She is hopeful that if the plaintiff engages with this programme, he will make significant improvement in his symptoms.

126. Prior to Dr. Pollard taking control of the situation, it appears that he was seeing a number of specialists on referral from his GP, and at the same time was seeing a number of specialists on referral from his solicitor. To an extent, I feel that this man has fallen through the cracks in relation to his medical treatment. That was not his fault. I accept that he went to Lithuania to obtain MRI scans privately, not in an effort to bolster his case, but rather in an effort to get some definitive answer to his ongoing problems.

127. Since the accident, he has also come under the care of Mr. Loftus. He seems to have received some benefit from this alternative treatment. I do not criticise the plaintiff for availing of this treatment, if he found it beneficial. However, it does seem to me that there was an onus on Mr. Loftus, as the treating therapist, to refer the plaintiff back to his GP, if his symptoms did not improve. Mr. Loftus did not do this. While that was regrettable, it is not something for which the plaintiff can be blamed.

128. It may well be that there is an element of psychosomatic pain in the plaintiff's presentation. However, the defendants' doctors accepted that his symptoms were real to the plaintiff. Prof. Philips on behalf of the defendants stated that in the absence of a structural injury, if pain continues for a long time after the accident, it could be due to a failure on the part of the plaintiff to rehabilitate. However, he accepted that there could be genuine pain. The pain can linger if the patient adopts a sedentary lifestyle, which prevents recovery. He may not exercise due to pain. This leads to disuse of the muscles, leading to more pain, which in turn leads to less activity. The person can have pain in the form of a musculoskeletal injury in the early aftermath of the injury. If they do not engage in a rehabilitation programme, they will have ongoing pain.

129. I am satisfied that the plaintiff's pain is genuine. It may well be that the pain has lingered this long, due to the fact that heretofore the plaintiff has not been put onto a multidisciplinary pain management programme. Dr. Pollard has come on board and has enrolled the plaintiff in her clinic. She clearly accepts that the plaintiff has chronic pain, such that he will benefit from a pain management programme. It is to be hoped that in a year to eighteen months, he will make substantial improvement in his condition. I accept the evidence of Mr. Sharif and Dr. Pollard that the plaintiff will never return to heavy work, but will in time be fit for light work.

130. As noted already, the court was impressed with the evidence from the plaintiff's brother and sisters. Their evidence was that prior to the accident, the plaintiff was a happy and energetic man, who had always worked throughout his life. This was supported by the very complementary reference which was furnished by Ms. Danielle Ryan in respect of the plaintiff's work at Stacumny House. I also accept the evidence of the plaintiff's brother and sisters that since the accident, he has become a different man. He is physically disabled and has become withdrawn.

131. On the basis of their evidence, I am satisfied that the plaintiff is not putting on an act for the court, but is indeed affected by ongoing pain and disability in the manner described by these witnesses. I accept the evidence of Ms. Lawlor, which was to the effect that the plaintiff has suffered Post Traumatic Stress Disorder and depression. I note the evidence of Prof. Thakore taking issue with

the exact diagnosis, but accepting that the plaintiff had suffered from a psychiatric injury in the form of an adjustment disorder. Insofar as there is a difference of opinion between Mr. Lawlor and Prof. Thakore, I prefer the evidence of Ms. Lawlor. I am satisfied that the plaintiff is indeed suffering from PTSD and depression. It is noteworthy that both his physical and mental conditions will be addressed as part of the pain management programme. I also note that the plaintiff continues to be prescribed a significant amount of anti-depressant medication by his GP.

132. I am satisfied that the plaintiff has not deliberately tried to exaggerate his symptoms. I accept that he has suffered significant pain since the accident. This has affected him in all aspects of his life. I accept that he experiences pain on a daily basis. He walks with a limp. He is restricted in the work that he can do. He has also suffered a significant psychiatric injury in the form of PTSD and depression. In the circumstances, it will take some time into the future for him to achieve a reasonable recovery. Indeed, I note the evidence of Dr. Pollard that it is possible that the best outcome that may be achieved by the pain management programme, may be that the plaintiff learns to deal with his pain and move forward with his life, rather than actually curing the pain completely. In these circumstances, I award general damages to date in the sum of €60,000. In respect of general damages for the future, I award the plaintiff €40,000.

The Plaintiff's Special Damages
133. It is appropriate to deal first with the plaintiff's loss of earnings claim. At the time of the accident, he was earning an annual salary of €30,000.00 gross. This equated to a wage of €577 gross per week, being €478 net per week. In addition, the plaintiff also received accommodation in the form of a two bedroom house on the estate and his utility bills were paid by his employer.

134. The first period in respect of which a claim was made, was for the loss of earnings suffered in the period from the date of the accident until the date of the actuary's report in November 2014. The plaintiff's actuary gave evidence that the loss of earnings during this period was €71,985.00 less the amount of wages actually paid during this period €22,508.00 giving a loss of €49,477.00. He deducted the amount of recoverable benefits to date in the sum of €28,638.00, giving a net loss of €20,839.00, which had increased slightly to €22,500.00 in November 2014.

135. In cross examination of the plaintiff's actuary, it was put to him that the plaintiff had, in fact, been paid from the date of the accident up until the time that he was made redundant in July 2013. If that was the case, the loss of earnings from July 2013, to November 2014, were €34,675.00. From this sum, the amount of the recoverable benefit would have to be deducted in the sum of €28,638.00, giving a net loss of €6,037.00.

136. Unfortunately, this latter proposition as put forward by the defendants was not put to the plaintiff in the course of cross examination. Neither did the plaintiff deal with this specific period in his evidence in chief. In the circumstances, where the plaintiff has not established whether or not he was paid in the period after the accident and before he was made redundant, I cannot accept the figures as put forward by the plaintiff's actuary. However, neither did the defendant establish that he had been paid during this period. In these circumstances, I consider that the fairest thing to do is to split the difference between the amounts put forward by the plaintiff and by the defendants. Accordingly, the plaintiff is entitled to €14,268.50 as loss of earnings in the period from the date of the accident until November 2014.

137. The next period for which a loss of earnings claim was put forward, was the period from November 2014 until November 2016. It was submitted that the plaintiff will remain unfit for any work during this period. As the plaintiff has only just commenced on the pain management programme, it seems to me reasonable to find that he will remain unfit for work until November 2016. The appropriate multiplier for the capital value of a loss of €478 per week for this period is €101. This gives a capital value of €48,278.00.

138. The next period for consideration is the period from November 2016, until the plaintiff reaches the age of sixty-five. There is a divergence of opinion between the medical experts as to whether the plaintiff will be fit for any work after he completes the pain management programme. Dr. Pollard stated that she was not able to say whether the plaintiff will be able to return to work, but she was hopeful that with completion of the pain management programme, he will have significant improvement in his pain. She thought that he would then be fit for light work. The defendant's experts, were strongly of the view that if the plaintiff cooperated with the pain management programme, it should be possible for him to return to work without restriction. I prefer the evidence given by Dr. Pollard in this regard. It seems to me that given the level of the plaintiff's symptoms and disabilities since the time of the accident, both in relation to his physical symptoms and his mental health, a good outcome will be achieved if he is able to do light work, when he has completed the pain management programme.

139. In these circumstances, the evidence of the plaintiff's vocational assessor was that if the plaintiff succeeded in finding suitable light work, he would probably only receive the minimum wage of €337 per week. When this is subtracted from the net pre-accident earnings, it gives a loss of €141 per week. The appropriate multiplier for the period November 2016 to the plaintiff's sixty-fifth birthday is €432. This gives a capital value for the loss of €60,912.00.

140. This figure for loss of future of earnings is based on the assumption that but for the accident, the plaintiff would have worked at his job in Stacumny House until retirement at age sixty-five. This assumption takes no account of thw risk that the plaintiff may have been made redundant at some time before he heached his 65th birthday. Indeed such eventuality had beecome a reality when the plaintiff was made redundant in 2013. While I accept that on that occasion he would in all probability have been kept on by the new owners if he had been fit enough to do the job, this was not guaranteed in the event that the new owners decided to sell the house, or scale back the operation at some time in the future.

141. It seems to me that there must be some reduction along the lines of a *Reddy v. Bates* [1984] ILRM 197 deduction to take account of the risk that the plaintiff may have lost his job at some time prior to his reaching retirement age. In the circumstances, it is appropriate to make a deduction of thirty-three per cent to take account of this risk. Accordingly, the sum for future loss of earnings after November 2016 will be reduced to €40,057.00.

142. The plaintiff also has a claim for loss of accommodation. Under his contract of employment, he was provided with a two bedroom house on the Stacumny Estate. The utility bills were also discharged by his employer. The value of these benefits was put forward by the plaintiff at €250 per week.

143. The defendants argued that this sum was somewhat large and that in reality, such a property in Co. Kildare would only have a value of €100 or even €50 per week.

144. I prefer the evidence of the plaintiff's witnesses, Mr. Byrne and Ms. McMahon in this regard. It seems to me that the figure of €250 is reasonable, when one has regard to the size of the house and also to the fact that the utility bills were discharged by the employer.

145. For the period 5th July, 2013, to 27th November, 2014, the loss was assessed as €250 x 73 giving a loss of €18,250.00.

146. The plaintiff also maintained that he had suffered a loss of these benefits for the rest of his life. The court has to have regard to the fact that Stacumny Estate was sold to new owners and the plaintiff was made redundant in July 2013. However, I accept the evidence of the estate manager, Mr. Cruise, to the effect that the new owners kept on all the existing members of staff on similar terms to those which they had enjoyed under the previous owners. I note also that the two bedroomed house continues to be used by a member of staff employed on the estate and is presently used by the housekeeper. I am satisfied that on the balance of probabilities, if the plaintiff had not suffered his accident in June 2012, he would in all likelihood have been kept on by the new owners after July 2013. I am further satisfied that his terms of employment would have been similar to those which he had with the previous owners. In the circumstances, I find that the plaintiff has suffered the loss of accommodation from November 2014 into the future.

147. Mr. Byrne, the plainitff's actuary, stated that the appropriate multiplier for the period November 2014 to the plainitff's retirement age is €549. Accordingly, it was argued that the loss can be measured at €250 x 549, giving a loss of €137,250.00. However, for the reasons stated above in relation to the future loss of earnings claim, regard must be had to the risk that the plaintiff might have lost his job, including the accomodation element thereof, prior to reaching his sixty-fifth birthday. For this reason, it is appropriate to make a deduction of thirty-three per cent to take account of this risk. This gives a figure of €91,408.00 for the loss of future accomodation and utilities.

148. The sum of €3,720.00 has been paid as treatment fees to Mr. Loftus. The defendants argued that given the lack of qualifications held by this gentleman, his treatment fees should not be allowed. While it is certainly the case that Mr. Loftus was not a physiotherapist or a psychologist or psychotherapist, he did nevertheless provide treatment to the plaintiff. In the circumstances, I am satisfied that this sum properly forms a part of the plaintiff's claim for damages.

149. Finally, there are agreed special damages in the sum of €7,500.00.

Summary of Damages
150. In summary, I award the plaintiff the following damages:-

General Damages to date €60,000.00

General Damages into the future €40,000.00

Past loss of earnings to November 2014 €14,268.50

Loss of earnings November 2014-2016 €48,278.00

Loss of earnings November 2016-age 65 €40,057.00

Loss of accommodation Jul 2013 – Nov 2014 €18,250.00

Loss of accommodation Nov 2014 – age 65 €91,408.00

Fees to Mr. Loftus €3,720.00

Special Damages (agreed) €7,500.00

Total €323,481.50