Neutral Citation Number [2005] IEHC 18

THE HIGH COURT

Record Number: 2002 No 7452P
Between:
Michael O'Sullivan
Plaintiff

And

Mark Ryan

Defendant

Judgment of Mr Justice Michael Peart delivered on the 25th day of January 2005:

General Career background:

The plaintiff is a 46 year old man who lives in Midleton, Co. Cork with his wife and two daughters.

He has been a member of An Garda Siochana since 1977, becoming a Detective Garda in 1995/96. It so happens that five or six years ago, a Special Detective Unit was being set up for the Munster area under the direction of then Superintendent Timothy O'Callaghan. Its purpose seems to have been to carry out surveillance and investigate serious crime in the Munster area. That work involves what might be loosely called special operations when an event occurs when members of that elite unit will be called upon to do work giving rise to levels of overtime greater than would normally arise on ordinary station duties. Normal overtime restrictions do not apply in these situations, and the plaintiff has said that considerable overtime hours are worked by him and members of that team, as may be required. I will return to that matter in due course, as it is one of the matters seriously in issue in this case.

The plaintiff states that the work of this special unit can involve him in being out all night on surveillance operations, following suspects, driving at night without lighting, doing a special driving course. It also involves carrying firearms, and being able to use a handgun as well an Uzi machine gun. He said that it was not a seven day a week job in special operations, and that he would spend most of his time in Midleton, but that he could have to at short notice deploy elsewhere for as long as was necessary. Sometimes he would have to travel to Dublin for a few days or sometimes two weeks. It was not regular, and depended on what job had to be done. He mentioned the longest such assignment being a two month stint watching activity at a beach.

The evidence has been that the plaintiff was hand-picked by the then Supt. Callaghan, as being one of the best detectives in his area and ideally suited to the tasks required of this unit. The allegation now is that as a result of an injury to his left upper arm in a car accident on the 25th March 2002, he is likely to have to cease being a member of this elite Special Unit, since the injury will interfere with his ability to deal with violent confrontations with criminals, and also with his ability to use firearms to the level required. His former superior, Supt. Callaghan, now retired, has given evidence, as has the current Supt. Hayes that they have fears or concerns that the plaintiff's injury could compromise the safety both of the plaintiff himself, and those with whom he is engaged in operations of a dangerous kind, and that it is possible that he may have to take up work of a different kind, which does not expose him, and possibly others, to risk. If he has to do other work, he states that there will be a loss of overtime opportunity. I shall return to that also in due course.

It appears that these special operations happen every now and then, and in other times the plaintiff is engaged upon the more usual type of detective work, involving the investigation of crime, the interviewing of witnesses and suspects and so on. At that work, he states he would work more normal hours, with less overtime available. But the suggestion is being made also that even the normal type of detective work involving crime investigation and interrogation of witnesses and suspects may be inappropriate for him since there can be situations where confrontation with violent persons could be involved, such as when making an arrest, and that it would be more appropriate for him to take up an offer which has already been made to him, and declined, that he transfer to a job as a scenes of crime officer, where such risks would be absent.

Fitness:
Prior to the accident the plaintiff was a very fit man, who engaged in a good deal of physical activity, such as golf, cycling, indoor football, some squash and so on. He says that his ability to do some of these activities has been curtailed by the

accident, although he still plays a lot of golf and enjoys a certified playing handicap of 22. He enjoyed keeping himself fit, and says that he is now not as fit as he was. He does not play football any more because there would be a risk that he could injure his arm again or indeed his knee. The same would presumably apply to squash. I cannot see any evidence that he cannot at this stage resume walking and cycling though these activities would have been curtailed for some time following this accident.

The accident:
On the date of this accident the plaintiff was a passenger in a car being driven by a Garda colleague, the defendant. They were off duty, and had each attended a social function at a Golf Club at Fota, on the evening of 25th March 2002.

He states that at about 8.45pm on that evening, he left the function with the defendant as a passenger in the defendant's car. He was seated in the front passenger seat but by the time of this accident had not fastened his seatbelt. He states that his normal routine or habit would be to fasten his seatbelt when being carried in a car, except perhaps when on duty, but on this occasion he had not done so. It appears that there is a long lane or road leading from the Golf Club to the main road.

The plaintiff states that the defendant was driving too fast along this roadway, and that he turned towards him in order to tell him to slow down, but the car went off the roadway on the left hand side, and hit a tree. The car was written off in this accident. As a result of the impact, the plaintiff states that his head hit the windscreen, and his right knee struck the dashboard, and that his left arm struck against the pillar of the car on the passenger side. This pillar is located just behind the passenger seat, and the plaintiff believes that it is this that his left arm struck causing a nasty fracture at a point just above the left elbow.

The defendant on the other hand suggests that in fact the plaintiff's left arm more likely struck the front dashboard as a result of the fact that the plaintiff was not wearing his seatbelt and was turned towards the defendant at the time of the impact. The suggestion of the plaintiff is that if the arm was injured when it struck the pillar behind him, the fact that he was not wearing his seatbelt would be irrelevant, whereas, as submitted by the defendant, if it struck the dashboard, the seatbelt factor would be relevant to the cause of that injury. I will deal with that aspect of the case in more detail later.

The injuries sustained:

He was very frightened by this accident and was afraid he would not be able to get out of the car. There was a lot of smoke coming from the car. He was taken to A&E at Cork Regional Hospital by a man who came upon the accident shortly after it happened. He was treated for his injuries and released home on the following day, the 26th March 2002.

Dr. Stephen Cusack, Consultant in Emergency Medicine:
Dr. Stephen Cusack reports that the plaintiff was admitted under the care of Mr George Mullen, Consultant Orthopaedic Surgeon for an open reduction and fixation of a complex fracture of the left humerus. He notes also that the plaintiff had also sustained an injury to his right knee. He states in his report dated 4th October 2004 that in September 2004 an arthroscopy was performed on the knee and revealed the presence of degenerative change and a tear of the posterior horn of the medial meniscus.

He states at the conclusion of the report that *"it is quite possible for such injuries to occur independent of the use of seatbelts."* In his oral evidence he said more about this view. In his direct evidence he stated that the purpose of a seatbelt is to reduce mortality and the severity of injury, but that it does not mean that a person will not sustain any injury, and that it was quite possible for injury to occur even when a seatbelt is worn. When cross-examined he agreed that whether or not injury was sustained by a person wearing a seatbelt would depend on a number of factors, and that for example if another car hit the person's car on the left hand side the person would still be injured. It was put to him, on the other hand, that where there was a front impact, as in the present case, the forces of the impact are against the seatbelt and if it is worn it is more likely that the seatbelt will either eliminate injury altogether or minimise it. Dr Cusack agreed, and that where the evidence is that the plaintiff at the time of this accident was turning towards the driver of the car at the time of the accident, it was more likely that injury to the upper left arm would occur against the dashboard if the person was unrestrained in the seat by a seatbelt.

Dr Cusack was also asked to agree that in these circumstances it was also more likely that the plaintiff's right knee would not have been injured against the dashboard had he been wearing his seatbelt. Dr Cusack expressed the view that his knee injury may have occurred due to him bracing his right leg in anticipation of the accident, rather than by being thrown forward against the dashboard, but Counsel stated that there was no evidence that he in fact braced his leg before the impact.

He also stated that the tear of the meniscus found on examination is not something which would simply happen over time, but would require what he called "an event". It was suggested that it was perhaps something which happens very often in a sports injury, and he agreed that this was so, but there has been no evidence in fact that this plaintiff had suffered any sports

injury at his right knee prior to the accident, and if he had it would be something which he would know about.

I will return to that note when dealing with the question of contributory negligence.

Dr. Rosemary Hutch – GP: Report dated August 2002:

She states in her first report dated 28th August 2002 that she saw him first on the 26th March 2002. He was in great pain, was tired and in obvious distress at home. She recites in her report that on the previous day a plaster of Paris was applied to the left humerus fracture, which extended from his shoulder to his wrist, and his fingers were in a support. He had been provided with a powerful analgesic at the hospital, and she decided to give him also a non-steroidal anti-inflammatory analgesic agent.

The plaintiff's evidence regarding that day is that he had not slept the night before and was very tired and distressed. He had been worried about the prospect of surgery which had been discussed as a possible option. His wife took him home, and he stated that the pain was what he called "unbelievable" if there was any jolt of the car. He said that Dr Hutch, his GP called to see him. He recalls that his knee was sore and swollen at that stage, but that it was his arm that he was most worried about. He had to attend the hospital for x-rays about once every fortnight. The plaintiff stated that he had a very heavy plaster on for about seven or eight weeks and that this was changed to a lighter one after that. Dr Hutch states that the Plaster was removed about mid-May 2002. He complained that this plaster cast was extremely heavy and prevented him from exercising such as by walking. It was also uncomfortable in bed and he could not turn on his own. He was unable to shower for a period of three months until it was removed. He found all these restrictions very distressing and frustrating.

By August 2002 Dr Hutch was noting that the plaintiff still complained of a burning pain and hyper-sensitivity above his left thumb and index finger, and that he wakes at night when turning in the bed. In addition she notes that his hand swells. In July 2002 she noted that he could not move his left wrist, and was unable to wriggle his fingers and was able to straighten his elbow to 45 degrees. He had intensive physiotherapy following the removal of the plaster cast in order to gradually retrieve movement in the left arm due to immobilisation. He was also being referred for EMG studies (electrical conduction tests) of the nerves of his left hand.

Knee:
She noted that in April 2002 he complained of right knee soreness and swelling which had improved by the end of May 2002. It was still a little swollen on that occasion, but was otherwise stable. By 1st July 2002 she was of the view that his knee had fully recovered.

In her oral evidence she stated that on the day following the accident the plaintiff had mentioned his knee to her, but she felt that he was too unwell on that day for her to examine it.

Travel Anxiety:

Dr Hutch noted that the plaintiff had developed anxiety and expressed the view as of August 2002 that this might need some psychological intervention should it persist. In fact, in due course, the plaintiff attended Dr David Walshe, Consultant Psychiatrist in relation to what has been described as Travel Phobia, being a fear or anxiety when being driven in a car. I will deal with that matter separately in due course.

She has provided another report dated 2nd October 2004. She noted that *"he has almost recovered full use of his hand but has ongoing difficulties."* She noted that he complains of tenderness in the left elbow around the site of the fracture, as well as some restriction of flexion and extension. He also has some difficulty closing his fist, but can do so. She noted that his forearm gets tight, and he must loosen it up by movement of his hand. She also noted that he had some difficulties doing tasks with his thumb and finger such as tying a tie or twisting an Allen key.

She states that the arm injury kept him out of work until April 2003 when he returned to light duties with no confrontational exposure. Thereafter he returned to his normal pre-accident duties, and Dr Hutch notes that he has to be able to use a gun with both hands, and that he did a functional capacity test by ICOR Limited in this regard and passed, and that the conclusion was that he was fit to resume duty. She notes that he was found to have a reduced grip strength in his left hand which was 82% of his right hand. He is right hand dominant, and 82% was regarded as being within normal limits for a right dominate handed person.

She mentions that Dr Molloy and Mr Mullen have concerns about the possibility of osteo-arthritis developing, and states that she herself has concerns about the plaintiff's ability to defend himself in close combat or a confrontational situation because if he is struck in the left arm he may be rendered helpless. She is worried also that his left hand may not function to the required level if he needs to pull the trigger in order to save his life.

In her evidence Dr Hutch in addition stated that since at an earlier point in time had given some sort of certificate to the Garda Chief Medical Officer that the plaintiff was fit for duty, she felt under a continuing duty to contact him again now in order to voice her present concerns that the plaintiff is not fit to do his job. For some reason, not exactly clear to me, she feels that she must do this even though the plaintiff would not wish her to do so. Mr Curtin expressed the view that she would not need to do this in this unilateral way, unless perhaps she had a very serious concern. But she stated that she had discussed this matter with the plaintiff about transferring to forensics, and that she intends to tell the Chief Medical Officer of An Garda Siochana that in her view he is not safe to perform his duties. She is of the view that he is currently on a trial period to see how he gets on, but that he has already had an incident where he ran into difficulties handcuffing a fifteen year old. It was put to her in cross-examination that Mr Curtin would say that he is surprised that she would be of the view that the plaintiff was unfit for his work, but she said that she had concerns, but she accepted that at the end of the day it would be a matter for the Garda doctors.

She was also of the view that there was a risk of arthritis developing in the elbow since the fracture had extended into the joint. She agreed that the x-rays showed no arthritic changes, but she feels that there is a risk since the fracture went into the joint.

Under cross-examination, she stated that the plaintiff had always minimised his complaints about his knee, and agreed that she had expressed the opinion in July 2002 that the knee had recovered, but that in her view this was because he had been inactive since the accident, and that the difficulties arose after he began to be fully active again. That was her view. It was pointed out to her that it was almost a year after he returned to work that he complained again about his knee, and that at a consultation immediately before her referral about the knee to Dr Molloy she in fact has no note of a complaint by the plaintiff about his knee. She stated in relation to this that she did not note the complaint in her notes but that she was surprised that he still had problems in the knee.

In relation to all these views she stated that she would defer to the opinions of the specialists in the different fields.

In her evidence she stated that she would not have any difficulty with the plaintiff continuing with physiotherapy sessions on a once or twice monthly basis, since he finds them helpful.

Reports and evidence of George Mullen, Orthopaedic Consultant:

After admission to Cork Regional Hospital, the plaintiff came under the care of Mr Mullen. In his report dated 31st July 2002, some 4 months after this accident he notes that the plaintiff suffered a comminuted fracture of the middle and lower third of the left humerus with fracture lines extending to the left elbow joint. Examination revealed a radial nerve palsy giving rise to a wrist drop. Mr Mullen noted in this report that at the most recent examination the plaintiff did not appear to have recovered from this palsy and that the plaintiff was awaiting to undergo electrical nerve conduction tests in order to assess the function of the ulnar and medial nerves (Dr McNamara). He noted that the fracture of the humerus had united.

In his evidence Mr Mullen stated that on first examination of the plaintiff there were two medical options considered, namely an open reduction of the fracture or conservative treatment. The latter was chosen because of the established nerve injury and he did not wish to add a further insult to this injury by operating. He stated also that if the radial nerve is in continuity it will recover.

The electrical nerve conduction tests to which he referred were in due course carried out by Dr Brian McNamara and I will briefly set out his findings, and then return to the evidence and reports of Mr Mullen.

Dr Brian McNamara, Consultant in Clinical Neurophysiology:

In August 2002 the EMG testing was carried out by Dr McNamara, who gave evidence and has issued some reports on this matter. I will deal with this evidence shortly, but for the moment it suffices to say that in August 2002 he found a severe left radial neuropathy due to blunt trauma of the nerve, even though media and ulnar nerve conduction studies were within normal limits.

By December 2003 there was improvement in the left radial nerve, and he opined that: *"while function will continue to improve these findings imply that there is likely to be residual mild disability and discomfort. While Mr O'Sullivan will be able to perform most of the normal tasks of daily living, this may interfere with the performance of specialist tasks such as handling firearms which are part of his occupation as a member of An Garda Siochana."* This improvement had been to the level of 4 out of 5.

By October 2004 he reported that he had conducted a further test and found no further improvement had taken place.

He also gave oral evidence. He stated that the results of the tests which he carried out were consistent with severe bruising of the radial nerve which is close to the humerus. He stated that there was severe bruising and that the muscles had lost immediately a lot of nerve supply in this impact. He described a consequence of this to be what he called "a wrist drop" and that it would have impaired his ability to hold objects in that hand, and that finer movements of the fingers would be affected since a steady had is needed for these. He explained that the muscles involved are required in order to brace the hand in order to hold small things, such as a notebook. In relation to heavier objects there was increased possibility of dropping, and he stated that forceful movement of something such as a golf club could be adversely affected. The improvement which had taken place was not total and he did not see at this point in time that there would be any further improvement to the point of level 5.

Mr Mullen – cont'd:
Mr Mullen's next report is dated 12th May 2003. He refers to the electrical tests to which I have referred and says that they verify the presence of a recovering radial nerve palsy, and that the plaintiff is continuing to have physiotherapy and was showing marked improvement. He saw the plaintiff for the purpose of that report and states that the plaintiff himself stated that he was greatly improved in the previous six months. There is a reference to a "definite tingling sensation on tapping the distal left forearm". Mr Mullen stated that this was part of normal recovery and is in fact a positive sign related to nerve recovery.

Mr Mullen noted that the plaintiff flexes to 90 degrees, but has minus 10 degrees of flexion, with no evidence of wrist drop. He was hopeful that the plaintiff would recover full strength in his left arm.

Mr Mullen stated that until Dr Molloy referred the plaintiff to him in August 2004 in relation to his knee, the plaintiff had never made any complaint about his knee.

In his final report dated 28th September 2004, Mr Mullen noted that the plaintiff continued to complain of symptoms in his left arm, including tingling in his left hand, even though he also stated that the function of his left upper limb was normal, *"and he is able to carry out all duties expected of him by his employees".* Mr Mullen examined the plaintiff on 28th September 2004 and stated the results of this examination in the following way:

"*Left upper limb – there was no noticeable deformity. There was a full range of movements in his left shoulder. The patient was lacking approximately 5 degrees of full flexion of the left elbow and 5 degrees of full extension of the left elbow. He had full pronation and full supination. Finger pressure on the muscles in the proximal forearm give rise to some local pain and a tingling sensation experienced on the dorsum of his left hand. There appeared to be full power in the grip of his left hand. There is no evidence of residual weakness of dorsi flexion of the left wrist."*

The knee:
The plaintiff had been referred by Dr Molloy to Mr Mullen quite recently before the date of this report so that the plaintiff's right knee could be examined since the plaintiff was having problems with it. Mr Mullen did an examination under anaesthetic and an arthroscopy which indicated quite extensive degenerative changes affecting the medial femoral condyle of the right knee together with a tear of the posterior horn of the medial meniscus of the right knee. Certain procedures were undertaken at that procedure which Mr Mullen indicates will continue to give the plaintiff relief from his knee condition, but he could not at that point give a medium or long-term prognosis. In his direct evidence, Mr Mullen expressed the view that since the plaintiff had no knee problems with his knee before the accident, and no knee injury took place after the accident, the likelihood was that the knee problem was caused by hitting it against the dashboard in this accident. He stated that it was totally in accord with a front seat passenger hitting his knee against something solid on impact. He is also of the view that there will be problems in the future with the knee since it is a weight bearing joint. This progression may lead to pain at first, and it may be necessary eventually to provide a knee replacement, depending on the severity of the symptoms. He stated that he was not a knee expert but would think that a replacement may be necessary in 5-10 years, and that a replacement joint would have a life span of 15-20 years.

Cross-examination:
Mr Mullen agreed that from an early stage he had been happy with the plaintiff's recovery progress and was of the view that he would recover well. He stated that the plaintiff had no functional disability with his elbow and that any evident limitation of movement was very small (5% extension and 5% flexion)

He also agreed that it was not until August 2003 that he had been consulted about the plaintiff's knee. He felt that the plaintiff should be able to do his job as a Garda officer, but added that he would not be in a position to express a view as to the plaintiff's ability to use a weapon, since he had no expertise or knowledge as to what was required for that. But he expressed the view at a later stage of his cross-examination that the plaintiff should be able to use a handgun by the time his treatment concludes, but did not know about the Uzi gun as he did not know about that. As far as he was concerned there was nothing in his clinical notes to indicate that the plaintiff could not do his work.

Mr Mullen believes that the problems with the medial femoral condyle was a result of the plaintiff's knee hitting the dashboard, inspite of the evidence that the plaintiff was turning towards the driver at the time of the impact. He felt that the right knee would still have been facing the dashboard even if the plaintiff was turning towards the driver. But he mentioned that he did not believe that the cartilage aspect of the knee difficulties resulted from the accident.

Dr Michael Molloy, Consultant Physician/Rheumatologist:

His first report is dated 15th April 2004 and he sets out a summary of the plaintiff's history which adds nothing of significance to what we already know up to this point. On examination the plaintiff was seen to have a full range of movements in his cervical spine and shoulder, and in relation to his left elbow he noted that the plaintiff lacks 10 degrees of extension and 15-20 degrees on flexion with good rotation and with some weakness of dorsi flexion of the wrist and of grip in that hand as well as some loss of fine movement in his fingers. He stated that the continued existence of tingling meant that there was still some element of palsy remaining.

In relation to the plaintiff's knee he stated that the plaintiff had full movement with crepitus and evidence of anterior crusciate laxity.

In the "Opinion" in this report, Mr Molloy states that further improvement can be expected in the fine function of the hand, but that he might expect some residual restriction. He also states that the plaintiff is likely to develop osteo-arthritis in his elbow joint. He also stated that "there is some doubt about his ability to be able to return to his full active Garda duties in the foreseeable future." He noted that the plaintiff was most concerned about this and the prospect of the onset of osteo-arthritis in the future.

In a report dated 30th September 2004, Dr Molloy states that the plaintiff has three problems which he lists as follows:

1. Left elbow, which is stiff and uncomfortable and lacking full movement;
2. Pain and parasthesia in the left hand into the fingers, involving the ulnar distribution and the thumb on occasions and weakness of the forearm and grip on that side;
3. Right knee – the right knee was arthroscoped by Mr Mullen and he had a partial menisectomy carried out and he was found to have marked degenerative changes involving the medial surface of that right knee."

Dr Molloy noted that the plaintiff had gone back to work full-time but that he had difficulties and is concerned about his arm where he lacks movement in the elbow, has weakness and discomfort in the forearm, as well as some problems still with his right knee. Dr Molloy states that this knee *"has been giving him trouble throughout but which has been dealt with surgically now."*

Mr Molloy's conclusions are very pessimistic and are in the following terms:

"In my opinion, in view of the nature of his work, where his life and others' is at risk, I feel that it is unsafe for him to continue because of his left upper limb where the symptoms have not receded after three years and in a confrontational situation he would have difficulty coping with an assailant in protecting himself and others. The weakness, pain and discomfort he gets on activity would leave him very vulnerable and at risk. His right knee has marked degenerative changes from Mr Mullen's note, which means that his knee will get troublesome and worsen in the future with a question of a total knee replacement in the next five to ten years. On balance, I feel that he is unfit to continue his present job and as he is fully trained in the scene of crime and forensic work, this would be a more appropriate environment for him. To be exposed to an assailant or criminal in his present continuing state would leave him at risk of more serious injury. I would strongly recommend that he is changed from his present role to the scene of crime/forensic role and this would be more appropriate for him and it would also ensure that his expertise over the years would be fully utilised. He is a highly motivated man and very keen to remain at his present job but in my opinion it would be unwise to continue there into the future."

In his direct evidence he gave evidence consistent with this opinion and there is no need to set it out in any detail as far as his view is concerned of the implications for the plaintiff's ability to do his job.

He also stated that the plaintiff may need a knee replacement in the future, and that in his view the impact with the dashboard has produced the arthritic condition which might lead to knee replacement. Any degenerative changes in the knee which might have predated the accident were, in his view made symptomatic by the accident.

Dr Molloy was also of the view, when cross-examined, that the delay in the onset of knee symptoms was because for a

significant time after this accident the plaintiff was fairly immobile and that it was only when he began to resume significant activity that the knee problems came on. Dr Molloy referred to the fact that he had made complaint to Dr Hutch about his knee immediately after the accident. He is of the view that the knee injury would need a trauma for its occurrence and that this was not something which could simply have happened gradually over time.

He was cross-examined about his view that the plaintiff will not be able to do his job. He is of the view that the arm will be a problem. It was suggested to him that since the fracture of the humerus went into the joint only to a minimal extent this would in fact not become a problem as far as any onset of arthritis is concerned, but Dr Molloy thought the risk was there. As far as the strength in the plaintiff's wrist is concerned, Dr Molloy lays a good deal of emphasis on the fact that Dr McNamara's conduction tests has shown a permanent loss of function. He also remains of the view that the plaintiff cannot properly do his job inspite of the fact that the plaintiff passed the ICOR competency test and was passed fit for his job. Dr Molloy is nervous about the plaintiff being back doing his job, even though he had advised the plaintiff to go back to work as soon as he could.

It was put to him that Mr Curtin would say that the limitation of movement which the plaintiff has now and will continue to have, is of no functional significance. But Dr Molloy is of the view still that given this plaintiff's particular job, it is of significance.

Bernadette Whelan, Physiotherapist:

The plaintiff attended for physiotherapy first on the 17th June 2002, which is almost three months after this accident. His plaster cast had been removed and he had considerable restriction of movement in his left elbow joint, as well as his shoulder and wrist. He also had marked wasting of his deltoid muscle, the biceps, triceps and the extensor muscles of his left arm. He underwent intensive physiotherapy, three times a week until the 26th July 2002. The treatment was then reduced to two treatments per week. In addition to these treatments he was put on a home exercise programme, which he attended to very diligently and conscientiously. Ms. Whelan noted that he was responding very well and had regained a good deal of movement, and would continue to improve with further treatment from her and the home exercise programme.

She gave evidence of his continuing attendance for physiotherapy though it has become less frequent gradually, but she is firmly of the view that the plaintiff needs ongoing physiotherapy, inspite of Mr Curtin's view that the need for such treatment is now over and that home exercise is now sufficient. She explained very clearly how this need arises, and without setting out her evidence in detail, she has stated broadly that the plaintiff's arm still causes difficulties and that the sort of treatment which she can give him for that, is not something which he could do for himself. She is of the view that without the on-going treatment, perhaps once a month, his function in his left arm would deteriorate. She stated that while Mr Curtin may be of the view that further treatment will not contribute anything more to his further recovery, it was nevertheless still an important feature of maintenance of the arm. Dr Molloy in his evidence also said that in his view if the plaintiff did not continue with physiotherapy his elbow would stiffen up. He was of the view that the plaintiff definitely gets benefit from it.

I have to say that I was very impressed with the evidence of Ms. Whelan and am left in no doubt as to the positive benefits to be derived in the future from further physiotherapy from a maintenance point of view, even though the restorative function of physiotherapy has gone as far as it can do as far as muscle function is concerned.

Dr. David Walshe, Consultant Psychiatrist:

He dealt with what has been called Travel Phobia. This is a state of heightened anxiety which the plaintiff suffered from following this accident when being driven by another person. It suffices to say that the plaintiff was referred to Dr Walshe, and that he underwent some treatment from him, and that he made rapid progress and has improved greatly as far as this anxiety is concerned.

Dr Denis Kelly, Consultant Radiologist:

Dr Kelly was called to give evidence by the defendants. He has taken a look at the x-ray photographs taken after this accident of the plaintiff's as well as subsequently. He has also seen the MRI Scans of both the knee and the elbow taken in June 2004. He has expressed the view in his opinion that the fracture of the humerus has healed very well with no radiological evidence of traumatic arthritis, and that since it is a non-weight-bearing joint the risk of long-term osteoarthritis is "very low". In his oral evidence he stated there was, as a result of the accident, a very slightly increased risk of osteoarthritis developing because the articular surface was breached as a result of the impact to the knee.

Mr John Curtin, Consultant Orthopaedic Surgeon:

He was called by the defendants to give evidence. In his first report dated 16th December 2002 he stated that the fracture to the left humerus was soundly healed and that his nerve palsy was well on the way to full recovery. He states also in that report that the plaintiff was fit to return to his work as a Garda. I should just mention that in his oral evidence it seemed to me that he was not appraised of the exact nature of his duties as a Garda and that this opinion may have been expressed without the knowledge of the particular duties the plaintiff is engaged upon which I have already set out in detail. Mr Curtin at this stage noticed on examination that the plaintiff lacked about 15 degrees of extension, and elbow flexion was 100, 120 being normal. He noted full movement of the wrist and that the plaintiff had full power in that wrist. He noted that power in his fingers was 4, with 5 being normal. In his oral evidence he confirmed that at this first examination the plaintiff did not mention his knee injury at all. He also described the risk of arthritis in the elbow joint as "miniscule", even though he described the fracture itself as being a nasty one, complicated by a paralysis of the radial nerve.

By November 2003, he noted that he lacked 10 degrees of extension and 10 degrees of flexion in his left elbow. He noted that he had regained full power in his wrist and finger extensors and was able to make a full fist. In his oral evidence he stated that by "full power" the plaintiff had regained power 5, whereas previously he had been at power 4. He was of the view by then that his nerve palsy had recovered fully except for some minor alteration of sensation on the back of his left thumb. He also stated that while there was "some very minor loss of flexion and extension" it would not give rise to any functional impairment. He also stated that the plaintiff was fully fit for Garda duties and that there was no long-term risk of arthritis developing.

In a final report dated 23rd July 2004 he stated that the impact of the knee against the dashboard would not have caused the damage to the plaintiff's cartilage for which he was treated by Mr Mullen in 2004. I should say that Dr Kelly was asked about and he said that he would not say that it could not have happened in the accident, but nevertheless he was not saying either that it probably did happen then.

In summary Mr Curtin would be of the view that the plaintiff has fully recovered with no risk of arthritis and no need for ongoing physiotherapy, and that while Dr McNamara's nerve conduction test may show what will now be a permanent loss of nerve function, there is no clinical indication of this and that the plaintiff for all practical purposes has full function of the limb. He would also be of the view that the plaintiff's knee injury does not result from the impact in the accident.

In cross-examination it was put to him that his first examination of the plaintiff lasted a matter of four or five minutes, but he disagreed and said it would have lasted about ten to fifteen minutes. Mr Mullen was at the examination also since his rooms are adjacent to Mr Curtins. He agreed that when he was examining hm he did not know that the plaintiff was a Detective Garda attached to a Special Unit as described in evidence.
He was surprised to know now that by October 2003 the plaintiff was still undergoing physiotherapy, and is of the view that physiotherapy has no further place in the plaintiff's condition, since he has recovered as much as he will. In rel;ation to the deficit found by Dr McNamara in nerve conduction, Mr Curtin stated that after an injury, a nerve conduction test never returns to normal. But in the plaintiff's case there is no longer any reduction in muscle bulk, and he has a normal function on clinical examination.

It was put to Mr Curtin that the plaintiff has stated in his evidence that as a fact he experienced a difficulty recently trying to arrest a violent 15 year old. Mr Curtin was of the view that from a physical point of view he should not have any difficulty, but that after any fracture there can be a lack of confidence which will resolve in time. He has no doubt but that the plaintiff has full power in his arm and full muscle bulk on clinical examination.

He was also satisfied that even though the fracture went into the joint, it was only a linear extension and would not give rise to arthritis at a later stage. In relation to the views of Dr Molloy in this regard, he stated that Dr Molloy's specialty was in soft tissue injuries and he does not treat or operate on fractures.

In relation to the knee injury Mr Curtin was of the view that if it was the result of the accident the plaintiff would have become aware of it within a very short time thereafter. But it was put to him that the situation had been that immediately after the accident complaint had been made to Dr Hutch of bruising and swelling, and that having been sedentary for a time after the accident the knee began to give problems after he had become more active. Mr Curtin did accept when it was put to him that it was "possible" that the knee could have been injured in the impact with the dashboard when the patella impacted against the femur. But there is no doubt that he has some reservations about that when one takes his evidence generally.

In relation to a possible knee replacement, Mr Curtin stated that he was surprised if Dr Molloy had said that the knee would need to be replaced in 5 to 10 years time. He stated that the progression would be very slow and he could not see that he would need one within that time span.

Conclusions:

Contributory negligence:

The plaintiff accepts that he was not wearing his seatbelt at the time of this accident.

I am satisfied that the plaintiff was thrown forward by the impact against the tree. I am satisfied on the balance of probability that the plaintiff injured his left arm when it impacted against the dashboard rather than that he hit it against the heft pillar of the car as surmised by the plaintiff. The evidence is that he was turned at least to some extent towards the driver when the accident occurred. It seems to me that it is more than likely that the plaintiff's left arm was facing at least partially towards the dashboard and that it impacted severely against it causing the nasty fracture. The impact with the tree was a significant impact. The plaintiff also hit his head against the windscreen which makes it absolutely certain that he was thrown forward to a significant extent. His right knee also impacted with the dashboard. I have no doubt that the absence of restraint of the plaintiff by means of a seatbelt contributed significantly to these injuries including the knee injury. The suggestion that even if he had been wearing a seatbelt he would have hit his knee off the dashboard is not one which in my view can assist the plaintiff on any balance of probability test in relation to contributory negligence. The purpose of the seatbelt is to restrain the plaintiff from being thrown forwards, and also of course from being generally thrown about the car and even propelled out of the car altogether. It must in my view follow from the absence of wearing the seatbelt that the plaintiff has been guilty of a want of care for the purpose of s. 34(1) of the Civil Liability Act, 1961, as well in fact as being guilty of negligence, since the failure to wear a seatbelt is a breach of a statutory duty, and negligence for the purpose of the Act includes breach of statutory duty.

The particular injuries suffered by the plaintiff in this case are such as would, in my view, have been either significantly reduced or possibly eliminated altogether by the wearing of a seatbelt. On the balance of probability this plaintiff would have been restrained from being propelled towards the dashboard. One could speculate that he might have suffered whiplash instead, but that is mere speculation.

I am satisfied that the defendant has discharged the onus of proof upon him to demonstrate that the plaintiff has been guilty of contributory negligence and that damages should be reduced having regard to the degrees of fault of the plaintiff and the defendant.

I have no hesitation in reducing the award of damages in this case by 25%. Given the extent to which these injuries have been caused by the failure to wear the seatbelt, I would favour an even larger reduction in damages, but I feel constrained in that regard by what the Supreme Court has stated on this topic in **O'Sullivan v. Dwyer [1971] IR 275** where it is emphasised that damages are to be apportioned between the plaintiff and defendant on the basis of the *"moral blameworthiness of their respective causative contributions"* and not "*on the basis of the relative causative potency of their respective causative contributions to the damage"*. On this basis I will reduce the plaintiff's damages by 25%. There can be no forgiveness surely for a responsible and experienced member of An Garda Siochana failing to wear a seatbelt while being driven while off duty as in this case. A smaller reduction might be in order in respect of a person of capable of being credited with a lesser understanding of the importance and necessity to wear one. This distinction seems to be compatible with the concept of assessing the degree of moral blameworthiness.

The knee injuries:

Given the severity of this impact I am satisfied that in all probability, especially in the absence of evidence of any other likely cause, that the plaintiff suffered injury to his knee in this accident. The failure to wear the seatbelt meant that he was unrestrained when he was thrown forward and we know that he hit his right knee severely against the dashboard. There is no doubt in my view that he suffered bruising and swelling to the knee since he reported such to Dr Hutch the next day. I accept that the focus of everybody's attention at that time, and indeed for a good time thereafter, was the more significant injury to his arm. It is relevant to say at this stage and I will return to it at a later stage, that I have been impressed by the somewhat understated or even stoical way in which this plaintiff has dealt with his injuries. He has not attempted in any way to exaggerate his symptoms. He is highly motivated to his recovery and the resumption of his full Garda duties, and is fearful of any possibility that he may be required to change career path within the force. He may well have made little of his knee difficulties in a situation where he was much more concerned with his arm injury and its effects on his life. Dr Molloy is certainly of the view that the degenerative changes which already existed in his knee became symptomatic as a result of the accident, and that the plaintiff may need a knee replacement, whereas without the accident he should have been able to continue without one. Dr Mullen is of the view that since the knee is a weight bearing joint the arthritic condition will progress, albeit slowly. He also stated that depending on the effectiveness of any medical treatment he may receive for pain which might ensue, he might require surgery, but he stated that he was not an expert on knees. Mr Curtin's opinion about a knee replacement was that it was highly unlikely that he would need one during his working life, and that if he did it certainly was not on account of the impact with the dashboard. He did not think he would need one before the age of 60, and if he had one it should last him between 15 and 20 years.

I believe that the fact that the plaintiff was relatively inactive at first during his recovery meant that the knee became problematic only really when he began to be active again. I have no evidence that anything of significance occurred later to bring on the symptomology.

I am not however satisfied to the required degree that it is likely or probable that he will need a knee replacement in the short to medium term. I am not satisfied either that the accident will have been the cause of any such replacement should he have one. It is possible that he may need one before the end of his life but that is too far into the future to predict with any certainly or even probability. Certainly Dr Curtin's evidence is that the risk is that he may need one but not within 5 or even 10 years. Beyond that seems too unpredictable.

Need for physiotherapy:

I am completely satisfied that it is reasonable that the plaintiff should continue with physiotherapy for the future. If he were not to do so I believe his arm would remain a problem for him and would worsen, and could in fact lead to the sort of deterioration which would in all probability lead to the plaintiff being unable to continue with his present position in the Garda Siochana. I believe that it is in the defendant's interests from a compensation point of view to pay the sum proposed for future physiotherapy rather than have compensation assessed on the basis of future long-term disablement due to long-term difficulties with his left arm. I propose to deal with the matter on that basis.

Onset of arthritis in the elbow:

I am satisfied that the evidence from Dr Kelly and that of Mr Curtin is to be accepted in regard to the likely onset of arthritis in the elbow joint. They each described it in terms which suggests that there is little or no likelihood, much less a probability of such an event occurring. That will be a comfort to the plaintiff no doubt for the future. It is true that Dr Molloy has concerns about arthritis developing. I suppose that is natural given that the fracture did extend somewhat into the joint. But Mr Curtin has a great deal of experience of treating and operating on these joints, and it is his specialty, over a great many years, and I could not disregard his view in favour of Dr Molloy's, or indeed that of the plaintiff's GP Dr Hutch. Certainly no specialist orthopaedic has been proferred by the plaintiff to say that such an onset is probable.

I have little doubt but that the onset of arthritis in the elbow joint is remote in the extreme. I accept the expert evidence of Mr Curtin in this regard and also that of Dr Kelly who looked at the x-rays. Both described the risk as very low and minimal.

Likelihood of loss of overtime:

This is a matter on which medical opinions have been divided. Dr Molloy, the Consultant Physician and Rheumatologist who treated the plaintiff, and his GP, Dr Hutch are of the view that he is not fit to resume the particular duties involved in his position in the Garda Siochana, given what they consider to be a weakness in the plaintiff's left arm. Dr Hutch had given him a certificate of fitness but is concerned that she should now alter that opinion because of his on-going symptoms and is concerned for his safety and the safety of others with whom he may be working, if a situation arose in which he was required to use his firearm or carry out an arrest in a confrontational situation. Dr Molloy says that given the difficulties with the arm he would have difficulty lifting something heavy and would not be as capable as previously. His biggest worry also would be that some further impact to the elbow would cause further damage. Dr Molloy's view is that he would be at risk, and Dr Molloy would be nervous about him returning to his former duties.

There are factors to balance against these opinions, in my overall assessment of the probability of the plaintiff being permitted to remain as part of the elite force and as a detective generally, as opposed to being removed, or at least encouraged to take up some alternative position within the force, such as forensics where he would not be exposed to confrontation and the potential dangers feared by Dr Molloy and Dr Hutch.

1. The plaintiff's own motivation and determination. I heard evidence from Superintendent Callaghan who handpicked the plaintiff for membership of this elite Special Unit, because he knew his capabilities over a number of years. He spoke of the plaintiff in very glowing terms as a member of the Garda Detective Unit. Similarly, Superintendent Hayes who took over from Superintendent Callaghan when the latter retired. The plaintiff is quite obviously a man of exceptional ability, and motivation and who loves his work. He is someone who quite clearly his employers would be very sorry to lose from that part of An Garda Siochana. He is also a man of exceptional determination to continue with his present work, and has gone to great lengths to ensure as far as he possibly can that he will be able to continue doing his present work. He very much wants to see out his days in the force doing detective work, and certainly for the foreseeable future the work of the Special Unit as well as the other more normal or usual detective work.

2. The fact that he has passed the ICOR test and has been passed fit by Surgeon Collins who is the Chief Medical Officer of

An Garda Siochana.

ICOR Limited is apparently a company which tests, inter alia, members of An Garda Siochana in order to assess whether they are fit for duty. In the case of the plaintiff he underwent such a test, which took account of the particular characteristics of his position as a member of the Special Unit, in as much as the test included the ability to use a handgun and an UZI submachine gun. He was tested as to his ability to use these arms in respect of the left hand and right hand individually and then both hands together. He passed. I am not informed as to what other tests were carried out.

In addition, the plaintiff was passed fit by the CMO as I have stated. This is an important consideration, since the Court must be entitled to presume, in the absence of any evidence to the contrary, that he is the man who makes the decision as to whether the plaintiff is fit for duty, rather than someone such as Dr Hutch who may express a view of her own, or indeed Dr Molloy. Surgeon Collins presumably knows what it takes to do various Garda duties, including the plaintiff's and can make an assessment in the light of that knowledge and experience. There has been some suggestion, not explicitly stated in evidence, that certain unspecified "pressure" was brought to bear upon Surgeon Collins to pass the plaintiff fit to resume his normal duties. I have no idea what this means really, and the plaintiff did not elaborate upon what he stated, but the suggestion being made at the time by the plaintiff was that while he may have been passed as fit, he in reality was not really fit to do his job, but that he in some way prevailed upon the Chief Medical Officer to pass him fit.

Given the implications for the plaintiff and for others with whom he would work of his doing his job when unfit, and the possible consequences of that, it is not possible for me to take that at face value. I would have needed to hear from Surgeon Collins and he was not called. Neither were any other members of the Detective Unit or the Special Unit who work with the plaintiff.

For Surgeon Collins to certify a person as being fit, who in his professional and medical opinion was not, is something which the Court cannot be expected to accept without very specific evidence in that regard. Neither would it be fair to Surgeon Collins himself from the point of view of his professional reputation.

3. The fact that he has gone back to his former work and there has been no complaint about his performance, even tough Supt Hayes may have worries.

4. The fact that from a clinical point of view the plaintiff has no functional disability or loss of muscle bulk and strength, at least according to Mr Curtin whose area of specialty it involves. Even though Mr Curtin is called by the defendant and is not the plaintiff's treating doctor, the fact is firstly that Mr Curtin is called as an expert and that has certain well accepted and recognised implications. He is called to assist the Court, and not simply to be on one side or the other of the argument. He gives his evidence as an expert and with objectivity in the light of his clinical examination and findings. Some measure of allowance must be given to the plaintiff given that the evidence of Mr Curtin results from one or possibly fairly brief examinations of the plaintiff. But in this case the examinations took place in the presence of Mr Mullen who is the plaintiff's treating orthopaedic surgeon, and that is of some significance.

All the evidence and these factors lead me inexorably to the conclusion that the plaintiff has not discharged the onus of proof in relation to the probability that he will be unable to continue in his present duties. That means that I am not satisfied that there will be the continuing loss of overtime pleaded and apprehended.

Assessment of damages:

- General damages in respect of the elbow, knee and forehead to date: **€75,000**

- Future pain and suffering: **€20,000**

- **Special damages to date:**

  €6580 – doctors, x-rays etc;
  €4700 – physiotherapy to date;
  €30,737 – loss of earnings to date, based on an historical three year average;
  €11511 – future physiotherapy;
  Total: €53,528

Having made the necessary deduction for contributory negligence, there will therefore judgment for the plaintiff in the sum of **€111,396.**