Neutral Citation Number: [2009] IEHC 382

THE HIGH COURT

2002 13555 P

BETWEEN

KATHERINE SINGLETON

PLAINTIFF

AND

BRIAN DOYLE

DEFENDANT

JUDGMENT of Mr Justice Michael Peart delivered on the 31st day of July, 2009.

This is an assessment of damages for the plaintiff who sustained injuries following an accident which occurred on the 12th February 1999, when the car in which she was travelling as a front-seat passenger suffered a severe impact by another car being driven by the defendant.

Liability is not in issue, and it is accepted by the defendant that she was wearing her seat-belt.

Nevertheless she sustained significant personal injuries, from which she still suffers *sequelae*, and in all probability will continue to do so indefinitely, given the period of time which has passed to date since the accident occurred.

The plaintiff informed the defendant in Replies to Notice for Particulars that in 1990 she had suffered injuries in a previous accident in England, when a car collided with the rere of her vehicle, and that in January 1994 she had fallen at her home and sustained a fracture to an ankle. The 1990 injuries have some bearing on the present case, and I will come to that. Medical reports in relation to these injuries was provided by the plaintiff by way of discovery of documents. The 1994 injury has no bearing on the present case.

The plaintiff's evidence has been that following the accident on Friday the 12th February, 1999, she was taken to Loughlinstown Hospital by ambulance, and that she was in a severe state of shock at that time and was having difficulty breathing. She was given oxygen to assist her, and it was not thought necessary to have any x-rays taken. After a few hours she was discharged home without having been admitted.

By Sunday 14th February, 1999, she had developed pain in her neck, left shoulder, and low back, in addition to an irritation in her left eye. She felt generally unwell, and had vomited.

On Monday the 15th February, 1999, she attended her General Practitioner, Dr. William O'Connell, who, while he still attends the surgery for a few hours a week, has otherwise by now retired from practice. He provided a report dated 15th September, 1999, in which he has reported the plaintiff's visit to his surgery on this date, and has recorded that she was complaining of pain on the left side of her neck, and in her left shoulder and left arm, pain and stiffness at the back of her left shoulder, severe pain in her left periorbital area, severe nausea and vomiting, acute insomnia, general anxiety and stress.

In her own evidence, the plaintiff stated that she had also complained of pain in her low back, but that complaint on the 15th February, 1999, has not been noted by Dr. O'Connell. On examination by Dr. O'Connell on the 15th February, 1999, she was found to have 50% diminution of neck movements. There was no neurological deficit found, and no fractures identified. Medication, including for sleep, was prescribed and she was referred for physiotherapy, but Dr. O'Connell reports that while she had three sessions of physiotherapy, she did not find it helped.

His report states that when he saw the plaintiff again on the 14th September, 1999, she complained, inter alia, of severe pain in her low back and that she was unable to bend. His examination on that date revealed diminished neck and back movement of 60%.

The plaintiff states that she believes that she mentioned low back pain to Dr. O'Connell on a date earlier than 14th September, 1999. Dr. Buggle, a general practitioner in Dr. O'Connell's practice, gave evidence and he believes that it is quite possible that low back pain may have developed later than the other symptoms. In his own report dated 24th April, 2009, which was prepared from Dr. O'Connell's surgery notes, he has stated that on the 15th February, 1999, the plaintiff had complained of back pain, but when cross-examined, he accepted that this was an error.

The plaintiff's evidence has been that by May, 1999, her pain levels had worsened, and that the pain in her back by then was "excruciating". The physiotherapy sessions had not provided any improvement, and she was by then depressed about her condition. She attended Dr. Buggle on the 31st May, 1999, according to his report dated 24th April, 2009. In that report he states that she now had increased pain in her neck, and that her right side was by then affected.

She saw Eamonn P. Kelly, Consultant Orthopaedic Surgeon, on the 20th January, 2000, at the request of her G.P. His report notes that she complained of persistent symptoms in her neck and shoulders and that her right forearm was her biggest problem. He states that on examination her cervical spine showed an almost full range of movement, no focal neurological abnormality, and that an examination of her shoulders showed that the rotator cuffs were working and there was no impingement. An x-ray of the cervical spine was normal. However, his report dated 4th October, 2000, notes that she had a bone scan on the 7th March 2000, which was normal, but that an MRI scan of her cervical spine on the 18th February, 2000, indicated "*a right-sided postero-lateral disc herniation with foraminal encroachment*". He stated in his evidence that the reason why he had sought an MRI scan was that since the plaintiff was reporting persistent pain in her

neck and arm he wanted to rule out a disc protrusion or undiagnosed fracture.

Mr. Kelly saw her again in September, 2008, when she was complaining of left shoulder pain, having already had a number of injections into the shoulder which had not resolved the difficulty. An MRI scan of the shoulder was done, and later he saw her and decided that she had signs of subacromial impingement or inflammation in the upper part of the shoulder. In due course he carried out an arthroscopy of her shoulder in April, 2009, and carried out a subacromial decompression whereby he removed some of the bursal tissue and some of the bone underneath the tip of the shoulder, and made satisfactory progress thereafter. He stated in his evidence that there was a relationship between neck pain and this type of shoulder dysfunction. He believes that the plaintiff is likely to develop shoulder problems with ongoing age, and that he would attribute long term degenerative changes in her shoulder to age.

When cross-examined by Mr. McDonagh, Mr. Kelly stated his view that the shoulder pain and carpal tunnel pain which the plaintiff developed can be linked back to the present accident because they can be associated with neck pain. While Mr. O'Rourke has expressed a different view, Mr. Kelly remains of his view that there could be linkage. However, the plaintiff through her counsel has stated that the carpal tunnel condition is not part of this case.

He was referred also to the fact that in his report dated 4th October, 2002, he referred to the past history of an accident in 1990 and that she was diagnosed at that time as having "*post-traumatic stress syndrome and suffered from flashbacks from this accident*". He stated in his cross-examination that the plaintiff had told him about the previous accident, and that she would have told him about the physical injuries arising from that accident. However, there is no mention of those injuries in the past history in his report, and he was asked why if such a history was given by the plaintiff he did not record these in his report, to which he responded by saying that he had recorded "*the ongoing positive complaints she had at the time [he] first saw her*". He believes that the plaintiff gave him a full history.

Mr. McDonagh referred also to the fact that Dr. Buggle had stated her symptoms in 1999 as suggestive of disc herniation prior to the 1999 accident, and asked Mr. Kelly would that not have been relevant information that should have been given to him. He thought that it might have been. He agreed also that in the seven examinations which he had done on the plaintiff he reports no reference to back pain, but he stated that he deals mostly with upper limb problems, and that any complaint which the plaintiff may have had in relation to her back was not relevant to what he was seeing her for.

Mr. Kelly did not agree that because there was no neck muscle spasm and that when he saw her for the first time in January 2000 there was no neurological abnormality or cervical disc problem, the spine was not injured in the 1999 accident. He also would not agree that because in the immediate aftermath of the 1999 accident no skull or spinal tenderness was found present it followed that there was no injury in that regard. He accepted that the initial clinical examination did not demonstrate any significant injury to the cervical spine. He was referred to the injuries and complaints in the neck and shoulder areas following the 1990 accident, but was of the view that the shoulder difficulty at that time was different in nature to the complaints at the time he saw her, the former being what he called "*of a radicular type nature*", and the latter being "*a secondary phenomenon, which is bursitis or rotator cuff arthropathy which occurs because of the constant irritation in the shoulder area*".

In relation to the carpal tunnel syndrome he stated that this can be trauma related, and he disagrees with Mr. O'Rourke in that regard, and when asked was he surprised to learn that the plaintiff had had carpal tunnel symptoms prior to the accident in 1999, Mr. Kelly stated that he was not as "*patients can have either sub-clinical or mild disease worsened by the accident because of a double crush phenomenon*".

On the 3rd April, 2000, the plaintiff saw Mr. O'Rourke, having been referred by Mr. Kelly in relation to pain in her right hand. His report dated 11th October, 2000, states that the cervical disc protrusion at C6/7 revealed on the MRI Scan explained her continuing symptoms, and he recommended a discectomy and anterior fusion of her cervical spine at C6/7. That surgery was performed successfully and her recovery from it is described in the report as "uneventful". That surgery involved the harvesting of some bone from her hip for insertion into the disc space, and she was in hospital for three weeks.

While from a medical point of view she had an uneventful recovery from this surgery, she herself in her evidence described how it was necessary in the aftermath of the operation to remain in a lying position on her back for about two weeks during which time she was unable to drink anything or leave the bed to go to the bathroom. But she experienced immense relief thereafter, though she developed a problem with her voice, stating that she could not communicate properly, and she noticed after she returned home that her voice would go for no reason. Mr. O'Rourke has reported that this voice problem was due to the surgery. He has also reported that there is an increased risk of degenerative changes developing in the disc above and below the fused segment, though the risk is described as minimal and has stated in his report that "*the chances of symptoms developing related to this are virtually nil*".

She wore a soft collar for several months after her return home. Certain modifications were made to her house to accommodate her difficulties, such as putting in a level entry shower, having slopes instead of steps, and putting handrails around the house. She was unable to carry things. She described her neck at this time as being very tender and sore. She continued to have difficulties with her right arm also. She has needed help ever since with washing and drying her hair.

She described how she developed left low back pain and spasm gradually after her return home. She put this down to the fact that she was sitting down at home much more than prior to the accident, and she sought treatment from her general practitioner, who gave her morphine injections. In May, 2001, she was reviewed by Mr. O'Rourke and he has noted that she reported intermittent back pain and that she had stated that it had been present since the accident but that it had deteriorated in the months prior to May 2001. It was in the lumbo-sacral area and extended into her buttocks. An x-ray of her lumbar spine at that time showed no abnormality, and an MRI scan of the lumbar spine done in July 2001 revealed no significant abnormality. She attended Mr. O'Rourke again in July 2001 and September 2001 when she continued to report persistent low back pain, but was reassured that there was no abnormality, and that rehabilitation of her spinal muscles was what was required.

In his evidence to this Court, Mr. O'Rourke stated that as the MRI scan of her lumber spine showed no significant abnormality such as disc prolapse her back problems were probably due to inflammation in the facet joints of the back, and she was referred to Dr. Gallagher, a pain specialist.

Her general practitioner, Dr. O'Connell referred her to a pain specialist, Dr. Hugh Gallagher, because of her back pain. He gave her lumbar facet joint injections in December 2001 and February 2002. She achieved some temporary relief as a result of these injections.

In relation to her ongoing back symptoms, Mr. O'Rourke has stated in his report dated 22nd October, 2003, that while she has subjective complaints in relation to her neck, right shoulder, right upper limb and low back region since this accident "*there is no objective evidence of serious problems in these regions" and that "symptomatic treatment*" i.e. physiotherapy and painkillers, is the appropriate way to manage her. When he gave evidence to this Court he stated that as far as the future is concerned, the plaintiff's present condition is likely to persist indefinitely and that given it is now ten years post-accident there is no medical treatment which is likely to provide any improvement.

Mr. McDonagh cross-examined Mr. O'Rourke, who confirmed that when he saw the plaintiff first on the 3rd April, 2000, he had not obtained a pre-accident medical history. In other words he was not aware of anything in relation to the 1990 accident. He explained that she had been referred to him for surgical intervention by Mr. Kelly, but that if he had seen her immediately after the present accident it would have been different. Mr. McDonagh referred to the complaints which the plaintiff had following the 1990 accident according to pleadings in the action resulting from that accident, namely whiplash with pain in her neck, shoulders, parasthesia of the right hand and fingers, pain in right wrist and elbow, and psychological dysfunction. Mr. O'Rourke agreed that these complaints resembled the complaints which she had at the time he saw her in 2000. In his report dated 22nd October, 2003, he stated that "*she reports that she did not suffer with arm pain or back pain prior to the accident*". He was asked whether the plaintiff had misled him by not disclosing the pre-accident medical history, but he expressed the view that her past history ten years previously was not really relevant to any treatment he was advising, and would not have altered that treatment. He also said that the 1990 MRI scan had "*absolutely no relevance to what [he] was looking at and dealing with in 2000*". He accepted that the complaints in 1990 were indicative of a problem ten years previously, but that there was no disc prolapse in 1991 and there was a prolapse in 2000. He agreed, however, that the prolapse could have occurred at any time between 1991 and the accident in February 1999, and that the plaintiff would have had a vulnerable neck prior to the 1999 accident.

Mr. O'Rourke was also referred to the fact that on examination in the immediate aftermath of the 1999 accident no spinal tenderness was found, and Mr. McDonagh asked whether this indicated therefore that there had been no injury to the cervical spine in that accident. Mr. O'Rourke said this was not necessarily the case. Neither would he accept that for a disc prolapse to occur there must be trauma. In fact he went on to say that while neck pain and whiplash are very common, it is rare for them to progress to disc prolapse, which he stated is "a very unusual condition", being more common in the lumbar spine.

I should perhaps mention at this point that the plaintiff had developed pins and needles in both hands. This complaint was investigated by Mr. O'Rourke as reported by him in his report dated 21st March, 2002, where he states that because he suspected median nerve compression at the wrist he arranged EMG studies which were carried out in October 2001, which confirmed marked slowing in the median nerves at both wrists. She was admitted to Cappagh Hospital on the 9th January, 2001, and a right carpal tunnel release was performed. A similar procedure was carried out to her left wrist in June 2002. However, Mr. O'Rourke has concluded that the median nerve symptoms cannot be attributed to her accident.

She also developed at a much later stage some symptoms in her left shoulder which Mr. O'Rourke describes as a subacromial impingement problem, and which he says cannot be attributed to the accident.

In his report dated 6th May 2008, Mr. O'Rourke states that following her cervical discectomy, the pain in her right arm settled temporarily, but then recurred. She had had injection treatment from Mr. Gallagher for this, but in 2005 she eventually attended Dr. Conaill McCrory, Consultant Pain Physician, under the terms of the National Treatment Purchase Fund Programme. He reports in his report dated 24th March, 2009, that she attended him in September 2005 and was complaining of recurring pain in her back and neck – the back pain being worse than her neck pain. His examination revealed reduction of lumbar extension and tenderness at L4/5 and L5/S1 areas but with no neurological deficit. Her cervical spine examination revealed left side tenderness with a reduction of movement at all plains, again with no neurological deficit.

Mr. McCrory offered her bilateral lumbar rhizolysis first of all for her back pain. This was performed in October 2005, the outcome of which he describes as very positive. In view of that positive outcome, Mr. McCrory advised a rhizotomy which he describes as "*a neuro-destructive procedure for making this treatment last longer*". A right side lumbar rhizotomy was performed in November 2005, and the left in December 2005. By March 2006 the plaintiff was reporting great satisfaction with the result of these treatments, but was by then again complaining of neck pain, and in due course Mr. McCrory recommended similar procedures for her cervical spine, and in September 2007 she underwent a left side cervical rhyzotomy. By July, 2008 the plaintiff told Mr. McCrory that she then had no neck or back pain, and he discharged her from his clinic.

While these treatments seemed to have produced the desired result, the plaintiff has described the procedures variously as "horrific" and "torture" and that she was in severe pain throughout them.

During all these years she was also attending her general practitioner for various complaints. Various painkillers and other medication was prescribed from time to time as described by Mr. Buggle in his report dated 24th April, 2009, and in his evidence to the Court.

The plaintiff has stated that since this accident she had had very disturbed sleep, and in fact feels that she has not had a full night's sleep since the accident because of pain and discomfort.

Prior to this accident the plaintiff helped her husband in his business, she helped look after her mother, and she took in stray animals to look after them. In addition she enjoyed gardening very much, and was always busy. She feels limited now as far as these activities are now concerned.

She continues to have pain at the back of her neck on the left side, and her left shoulder.

She still experiences pain in her back, and after a day must often lie down.

Her social life has been disrupted. She stated that she does not have a social life, and stated that the problem with her

voice has contributed to this because in social situations it can go if she has to raise her voice at all.

She continues to take painkillers and also Prozac, and takes medication also to help her sleep.

The plaintiff has a history of depression going back to shortly after her father died when she was aged 14. That passed gradually, but returned about twenty years ago following a previous accident in 1990. In due course that in turn subsided and she felt much better prior to this present accident in 1999. Prior to the present accident she had been prescribed anti-depressants but was on a moderate dosage – not heavy.

It seems to be a reactive depression, and it has returned once more following the latest accident. She has been prescribed Prozac for that. She has herself stated that she has not been diagnosed as suffering any Post Traumatic Stress Disorder as such. She has not made too much of her depression in this case. There is little mention of it in Dr. Buggle's report, though in the history section he notes that she felt very depressed in September 1999 and that a colleague prescribed Prozac. Other parts of his report refer to the plaintiff's distress about her condition, rather than depression as such. In his oral evidence Dr. Buggle stated that in the three years following this accident she was depressed as a result of it, and that since that time there were other matters in her life which may have been affecting her mood.

Previous injury to neck and back

I have already referred to the fact that the plaintiff suffered personal injuries in a previous accident in 1990. It is important to refer to those injuries. The car which she was driving on that occasion was hit from behind, causing a whiplash type injury. She suffered pain to her neck, right shoulder and right arm, including some tingling and numbness in the fingers of her right hand. The nerves in her neck which were affected were those at C7 and T1, according to a medical report. There is a reference in a report dated 17th December, 1991, that she had developed pain in her left leg also. She was also depressed at that stage and had been referred to a psychiatric clinic and was prescribed an anti-depressant. She was also suffering from insomnia, anxiety, loss of enjoyment of life and loss of self-confidence. An orthopaedic report in June, 1992, discloses that x-rays of her neck were reported as normal at that time. The same report notes that on examination her lumbar spine was normal, as was her straight leg raising test, and there were no neurological deficits found. An MRI Scan performed showed no evidence of any disc degeneration, disc damage or disc prolapse. Nerve conduction studies were carried out in relation to her right arm and again these were normal. But depression was noted.

In general it is fair to say that her symptoms after that accident were in the main related to her upper body and right arm, even though she had some complaints in relation to her back as noted. She appears to have experienced very significant psychiatric difficulties also, including depression and panic attacks, and for which she received a significant amount of treatment. A feature of her anxiety and panic attacks seems to have been that she experiences nausea and vomiting.

A large number of medical reports have been disclosed by way of discovery in relation to the injuries and *sequelae* from the 1990 accident. Back pain is referred to in some of these - for example, one dated 29th April, 1996, from Dr. O'Moore who notes that she gets occasional low back ache provoked by bending, but it is noted also in that report that this is occasional and "is not a great problem".

I have probably set out sufficient detail about the injuries and sequelae from the first accident in order to provide a context for some of the cross-examination of the plaintiff by Bernard McDonagh SC for the defendant in the present case.

Cross-examination

Under cross-examination, the plaintiff confirmed that an invalidity payment which she is receiving from the United Kingdom up to the present time, and which she disclosed in her Replies to Particulars filed in October 2000 in these proceedings, is paid to her on account of ongoing depression. She had been in receipt of this payment for some years prior to the present accident.

She was asked also about the carpal tunnel problems for which she received treatment in January 2001 and June 2002. As I have said already this difficulty cannot be linked by Mr. O'Rourke to the present accident. But Mr. McDonagh referred to the fact that in her direct evidence she had stated that she had not had any problems with her wrists previously before the present accident, and then referred to the report of Dr. O'Moore whom she had attended in September, 1992 after the 1990 accident and that she had complained, inter alia, of tingling, pain and numbness in the right fingers and wrist, and that Dr. O'Moore has stated that she may have right carpal tunnel syndrome. He referred to another report at that time from a Mr. Hollingdale who noted that after the 1990 accident she had complained of this numbness and tingling in her right hand. Another report was referred to in the same vein. Mr. McDonagh suggested to her that her recollection of these matters was therefore incorrect when giving her direct evidence. She said that these problems had disappeared for years, and this is why she had not recollected that.

Mr. McDonagh referred also to her complaints in 1990 of right cervical pain, as well as left leg pain and pain in her right shoulder, but again she said that all those problems had settled. He referred her to Mr. O'Rourke's report dated 8th September, 2003, where he reports that the plaintiff had told him that she "*did not suffer with arm pain or back pain prior to the accident [i.e. the 1999 accident]*". There was a good deal of controversy between Counsel about whether this line of questioning was unfair given other matters referred to in the report, but Mr. McDonagh returned to the question after some time, and asked whether she could recall saying this to Mr. O'Rourke, to which she responded that she could not recall telling him this but that "*if he has it in his report I must have*".

Mr. McDonagh asked her also whether it was correct that she had had no problems with her left arm, left shoulder or left side of neck prior to the present accident, to which she said that she did not believe so, though she went on to say that she had had the whiplash injury in 1990 to her neck and shoulders, but nothing like she suffered after the 1999 accident. Mr. McDonagh suggested that once more her recollection was wrong, because a report from John Byrne, Orthopaedic

Surgeon who noted that she was complaining, inter alia, of severe pain in her neck, on the left side of her neck and down into her shoulder.

She was asked also if she had had any back pain prior to February 1999, and she replied that she did not recollect any although she added that she had told Mr. O'Moore (a doctor who she attended in the aftermath of the 1990 accident) that she had some back pain, but that it was not the same as she was presently suffering and had not been sent for any tests or surgery in relation to it.

Mr. McDonagh referred the plaintiff also to the report of Dr. Gary Brow, Consultant Surgeon at Loughlinstown Hospital where the plaintiff was brought by ambulance after the present accident, and he referred to the fact that Mr. Brow refers to the casualty notes for that date which notes that she did not lose consciousness, had no head injury or drowsiness and that "*the notes record that there were no complaints*", and that since all tests were normal she was advised to return to casualty if there were any developing symptoms. She did not go back until the 18th February 1999, but had visited her GP on the 15th February, 1999. She said that the reason why she had not gone back to the hospital on the 15th February, 1999, was that she had no way of getting there, and was vomiting severely.

She was asked if she had ever had vomiting episodes prior to this accident and she said "*absolutely not*". However Mr. McDonagh put it to her that in November 1998, she had attended at St. Michael's Hospital, Dun Laoghaire for nausea and vomiting. She replied by saying that she may have suffered from nausea, but that "*it certainly wasn't vomiting – this was vomiting*". Mr. McDonagh referred to a letter to her GP from a Dr. Cumarasamy of St. Michael's Hospital dated 12th November, 1998, in which he states that the plaintiff was seen by him at the Outpatients Department and "*continues to complain of nausea and vomiting, mainly around the time of her period. She is under a lot of stress……*". She accepted that she had these symptoms around her period and that she had had a hysterectomy to resolve these problems.

I have referred earlier to the fact that Dr. Buggle's report stated that on the 15th February, 1999, the plaintiff had reported, *inter alia*, back pain, but that he accepted that there was no mention of this in the surgery notes and that he had made an error in stating this. The plaintiff was asked about when she had first reported back pain, as those surgery notes and Dr. O'Connell's report mention back pain only at a visit by the plaintiff on the 14th September, 1999. Mr. McDonagh suggested therefore that this was the first date upon which she ever reported back pain. However she replied that she told Dr. O'Connell about it earlier than that date, but that her neck pain would have been her main concern since February 1999, but stated also that her back pain started immediately after the accident in February 1999, and that she had been prescribed painkillers for her shoulder but that these tablets deal with all areas of pain. Mr. McDonagh referred also to the fact that when she was referred to Mr. Kelly in January 2000, and that his examination referred only to pain in her neck, shoulders and right arm, and that there is no mention in that report to any reported pain in her back. She again stated that at that time her principal concern was her neck because she was in so much pain in that area. She was referred to the fact that in his report dated 4th October, 2002, Mr. Kelly noted that she had had a previous accident in 1990 and that she had been "diagnosed as having post-traumatic stress syndrome at that time and suffered from flashbacks from this accident", and asked why she had not informed Mr. Kelly about the problems which she had had with her cervical spine following the 1990 accident when giving her history. She responded by stating that at the time they were soft tissue injuries only as evidenced in the reports at that time. While she accepted that it may well have been relevant information, it was some ten years previously and as far as she was concerned had nothing to do with her symptoms after the present accident. She did not connect the two accidents in her own mind when speaking with Mr. Kelly, according to her evidence.

She was referred also to the fact that Mr. Kelly had reviewed her in March, 2000, on which occasion he notes in his report that she had had an MRI scan of her cervical spine in February 2000 – just one month previously, and he asked why she did not appear to have mentioned to Mr. Kelly on that occasion that she had had similar symptoms after the 1990 accident. She replied by stating that those symptoms in 1990 were not similar since her present symptoms were in relation to bone injury. She was referred to the fact that in his evidence Dr. Buggle had also stated that her symptoms prior to this present accident were consistent with a disc herniation, but she denied that she had misled any one in relation to that matter, and disagreed with that she had any disc herniation following the 1990 accident. She was referred also to the fact that Mr. Frank McManus by whom she was examined on behalf of the defendant would also say that her symptoms were consistent with either disc herniation or disc protrusion. At this point she stated that in fact she had in her possession a copy report of an MRI Scan taken of her cervical spine in October, 1991 which indicated a normal cervical spine at that time. That document had not been included in the discovered documents relating to the 1990 injuries. The hospital concerned had apparently indicated that the relevant records had since been destroyed. But the plaintiff had obviously received this copy of the MRI report. It is clear from the document that the cervical discs appeared normal at that time, and that there was no evidence of disc protrusion. Mr. O'Rourke was asked to comment on that MRI report when he gave his evidence, and he stated that this showed that she had a normal cervical spine, no prolapse and no significant degenerative changes in her cervical spine in 1991.

During her direct evidence the plaintiff had referred to the fact that she had seen Dr. O'Keeffe, a pain specialist, in relation to ongoing pain in March 2004. He has not given evidence to the Court but a report has been provided which is dated the 4th March 2004, being one day after the plaintiff attended him on the 3rd March, 2004. In his report, he states her then complaints as being neck pain radiating into the right arm, and low back pin radiating into the right leg. Under previous medical history he notes that she had a "previous accident" and then notes "*however, there were no sequelae from this*". Under cross-examination she confirmed that she would have said this to him.

As I have already mentioned, the plaintiff was referred to Dr. Hugh Gallagher, pain specialist, by her GP, Mr. O'Connell because of ongoing back pain. He saw her first on the 16th November, 2001, which was after she had recovered from her cervical spine surgery. His report dated 13th April, 2002, states that the history given to him was that following the accident she complained of neck and low back pain. In fact the plaintiff says that this is incorrect in that she made no complaint of back pain at that point. However, Dr. Gallagher says that he got this information from the plaintiff. He refers in his report to the fact that the MRI scan of her lumbar spine and discs was normal, and that she had had a good response to facet joint injections which he gave her on the 19th December, 2001 and on the 14th February, 2002.

When he saw her on the 8th March, 2002, she complained of left low back pain and pain in the right gluteal area and with a VAS level of 7/10 indicating a severe level of pain. He noted that she was tender over her lumbar facet joints, especially on the left side, but that her sacroiliac joints do not appear to be painful. He noted also that the movement of her legs during a straight leg test caused low back pain on both sides, and that her muscle power in her lower limbs was decreased due to her back pain, but with no sensory deficit. He stated in his direct evidence that his main conclusion was

that she had a mechanical low back pain due to joint problems in her low back, most likely due to facet joint dysfunction or injury following her accident.

He noted that her response to physiotherapy had been limited, largely because of her pain. He went on to report that chronic pain often has a psychological element, and that she would benefit from a comprehensive evaluation by a psychologist with a specific interest in chronic pain and PTSD, and that she was not at that time ready for the sort of interdisciplinary pain management programme, comprising physiotherapy, occupational therapy, psychology, patient education, stress control and relaxation techniques. He concluded in his report that the plaintiff is likely to have pain on a daily basis into the future, although with lower VAS scores, and that this will be amplified by the psychological stress caused by the accident and subsequent suffering.

In his evidence to the Court Dr. Gallagher stated that he referred her to Dr. O'Keeffe for rhizotomy treatment as the equipment for that procedure was not available to him at that time. That type of treatment was eventually carried out, as already mentioned, under the National Treatment Purchase Scheme by Dr. McCrory. He stated in his evidence to this Court that rhyzotomies have an effect of limited duration, and that she may require further treatment in this way in her lumbar spine in the years to come, possibly within five years, and possibly within two years.

Mr. McDonagh referred to the history of injury noted in his report and to the fact that he notes that back pain was one of the complaints made by the plaintiff at the time of this accident, even though there is no reference to that pain in the hospital notes. Mr. Gallagher stated that he had not seen those notes or spoken to Dr. Brow at Loughlinstown Hospital, but that he had been given that history by the plaintiff. However he stated also that since he was seeing a patient with a chronic pain problem, rather than an acute problem, the past history was not particularly relevant to the long-term outcome. He was not particularly surprised that in the immediate aftermath of this accident there was no spinal tenderness found to exist, as in his view these symptoms can develop in the weeks and months following an accident. Neither was he particularly surprised also that x-rays and an MRI scan had not revealed any structural abnormality, because he feels that these scans and x-rays do not permit a visualisation of the facet joints.

However, Dr. Gallagher had not been aware that the plaintiff had had back problems prior to this accident and following the earlier accident. He felt that this information would have been relevant but would not have altered his treatment plan. He was asked by Mr. McDonagh what other conclusions could he come to given the absence of any objective evidence of low back injury, bearing in mind the age of the plaintiff (she was aged 52 when he saw her first). He stated that she was at an age when degenerative changes in the low back can arise, but that there can be severe degeneration without pain, and also minimal degeneration with a lot of pain. He expressed the view that her accidents would have contributed to her back problems, even though the MRI scan showed no significant degeneration. When asked by Mr. McDonagh whether this was simply a classic case of wear and tear-type degeneration, he responded that her symptoms were more severe than one would find from degeneration alone, and that there was specific localised pain in the facet joints. He did not believe that if he had had access to previous medical records and reports it would alter his opinion.

Dr. Gallagher was asked to comment upon Mr. O'Rourke's opinion that the plaintiff's complaints were purely subjective, and not borne out by any objective evidence found on scans and x-rays, and on Mr. McManus's view that her symptoms result purely from degenerative changes, to which he stated that there is no evidence on her scans of degenerative change. He stated also that the problem with chronic pain is that there is often no objective clinical data, and that the plaintiff did have limited function and a moderate degree of impairment and his findings indicated problems with her facet joints which improved following injections into the facet joints.

In his report Dr. Gallagher had concluded that the recent accident had exacerbated her previous neck condition, and he was asked what he had meant by that. In reply he stated that the plaintiff undoubtedly had a complicated history with a previous history and post-traumatic stress, and that in such circumstances treatment can be difficult, and further that post-traumatic stress may be chronic because other traumas in life can flare up. But he went on to say that he could only take the history as it was given to him, and she had said that she had no symptoms remaining from her previous accident prior to the 1999 accident. He had been aware that at the time of the 1999 accident she was still having treatment for depression.

On behalf of the defendant, Mr. Frank Manus, Orthopaedic Surgeon gave evidence, based on his two reports dated respectively the 18th February, 2009 and 17th April, 2009. In his reports Mr. McManus considers that the link between any lumbar back pain and the present accident is tenuous. He has referred to the absence of back complaints at or in the immediate aftermath of the accident, or to either Mr. O'Rourke, Mr. Kelly or Mr. O'Keeffe, and that the first reference to back pain is her attendance with her GP, Mr. O'Connell in September, 1999. In his view the onset of back pain is due to degeneration. He noted also Mr. O'Rourke's remark in one of his reports that the linkage by the plaintiff of lumbar pain to this accident is entirely dependent on the history provided by her. He opined that it was very unclear whether the plaintiff did in fact injure her back in this accident. He considers the symptoms to be classically degenerative, and that she had developed these degenerative changes following the 1990 accident and possibly by 1992. He would have expected her to be symptomatic very quickly after the 1999 accident if her back had been injured in that accident.

When giving his evidence to this Court, Mr. McManus stated that even though the plaintiff did not have symptoms or pain in her neck and back in the immediate aftermath of the present accident when she attended at Loughlinstown Hospital, it was nevertheless possible that she sustained an injury in these areas. Her past medical history was relevant to that in that she had similar problems previously.

Mr. McManus was asked about the plaintiff's examination by Mr. Kelly on 20th January, 1999 when he found that her cervical spine had an almost full range of movement, no focal neurological abnormality, with rotator cuffs in the shoulders working normally, and no impingement. He stated that on the basis of that examination there was no clinical evidence of a significant loss of function in her cervical spine. However, the MRI of her cervical spine taken four weeks later showed a large right side posterolateral disc herniation. Mr. McManus would have expected her to be complaining of pain in her neck, reduced range of movement, pain into her arm and altered sensation in the light of this when she was seen by Mr. Kelly on the 20th January, 2000. I should just refer to the fact that in one of his reports, as already set forth above, Mr. Kelly stated that the reason why he ordered an MRI scan was because the plaintiff was reporting persistent pain in her neck and arm he wanted to rule out a disc protrusion or undiagnosed fracture.

Conclusions

There has been evidence in this case, as I have outlined above, that the plaintiff is a poor historian, but in my opinion the consequence of this is not such that she should be penalised in the award of damages or otherwise. In general I accept her bona fides and her credibility should not be cast in doubt as a result. Her cross-examination has revealed that she failed to inform some of her medical professionals of precisely what sequelae she suffered as a result of the previous accident in 1990. It must on the other hand be borne in mind that this previous accident occurred some nine years ago prior to the present accident, and was one from which she was of the view that she had recovered completely. This is not a case in which she has failed to disclose that accident to the defendants. I have set out the nature of the controversies which have arisen in this regard. These matters were put to the relevant professionals, and I am satisfied that while some may have found it helpful to have been told of various features of the previous injuries and the sequelae, none has said that it would have affected the nature of the treatment which they offered or recommended to the plaintiff in relation to the present injuries. This is not a case in which the Court should regard the plaintiff s having deliberately and materially concealed relevant information from her medical advisers in an effort to either exaggerate her claim, mislead the Court or mislead those medical personnel or to induce or enable them to give evidence which she knows to be false or even misleading.

I will say at the outset that the plaintiff is not seeking to be compensated in this action in relation to any carpal tunnel symptoms and treatment which she received in relation to that. As Mr. McCartan stated, this is not in the case.

Neither is the plaintiff seeking compensation in relation to treatment she received for a sub-acromial impingement found to exist in her left shoulder. The evidence has been that this is not related to the accident.

In the aftermath of the February 1999, she suffered nausea and vomiting. In so far as it may have been suggested that this was something unique to this accident, that is not so. I mean by that it appears from discovered medical reports related to the 1990 accident that she was prone to nausea in the years following that. She has stated that this nausea that she was prone to in previous years was of a lesser order than the severe vomiting that she experienced after the 1999 accident. The latter appears to have been stress-induced. It is also the fact that there were reasons over and above this accident which have caused her severe stress and worry. But I will take into account the fact that the 1999 accident will have caused her additional stress and that it in all probability induced severe vomiting. It is a consequence of the 1999 accident to an extent at least, even though she was somebody vulnerable in that regard. I will take that into an account in a general way when assessing damages.

In addition the plaintiff was someone who has been unfortunately prone to depression. However this predates the 1999 accident and she has received medication for that over many years. Following the 1990 accident she suffered from post traumatic stress disorder. I am satisfied that in all probability the sequelae of the 1999 accident will have affected her adversely in that regard also, but in relation to her depression, but again I must bear in mind that there have been other features in her life which would have contributed to that even if this accident had not occurred. I will take that aspect of the case into account to an extent only, and in a general way when assessing general damages.

She also suffered a lot of sleep disturbance, and while she may have been prone to that also prior to the accident it is reasonable to conclude that to an extent some of it is related to the injuries which she suffered in this accident, and again I shall take that into account to a extent at least when assessing damages.

Her neck injuries

I have set out the evidence fully in relation to the nature of these symptoms and the delay in the onset of the more serious neck symptoms, as well as the history of neck injury from the 1990 accident, and I will not repeat it.

She undoubtedly injured her neck and shoulder areas in the 1990 accident, but I am satisfied that by 1999 she was fully recovered from those soft tissue injuries. She had an MRI scan of her cervical spine after the 1990 accident in October 1991, and this shows that it was normal at that time.

She injured her neck and shoulder area in the 1999 accident. In the immediate aftermath of the accident these were treated as being soft tissue only and she was given appropriate medication. She was not admitted to hospital and no x-rays were deemed necessary. I have set out the evidence in that regard. But her neck significantly disimproved in the months after the accident. By February 2000, one year post-accident she had an MRI of her cervical spine which revealed a disc herniation as described above. This led to surgery where a discectomy and fusion operation was carried out at C6/7. While she endured a good deal of discomfort in the aftermath of that surgery she achieved a good recovery and a successful outcome. I am satisfied that on the balance of probabilities in the light of the evidence which I have heard and which I have set forth fully this disc herniation was a result of the 1999 accident, even though there was a delay in the onset of the more severe neck symptoms until about May 2000. The fact of that delay does not according to the evidence I have heard mean that it cannot be related back to the accident in February 1999.

Voice

I have set out the evidence that she had difficulties with her voice after the fusion surgery. That was distressing for her and affected her in several ways. It is reasonable to compensate her for those difficulties, as they are a consequence of the fusion surgery performed at C6/7 in 2000. It is not a major feature of this case but it is there nonetheless.

Cervical Rhysotomy

Linked to her neck injury is also the fact that she had a rhysotomy carried out in her cervical spine. That was successful, and while another has been recommended the plaintiff has so far not undergone that since she found that procedure to be very painful and uncomfortable. It is reasonable to attribute the need for that procedure to the 1999 accident also.

Her low back

It is this aspect of the plaintiff's claim which gives rise to the main difficulty in this case. I am satisfied that she did not make complaint to her doctor in relation to low back pain until September 1999 which was about seven months post-accident. Dr. Buggle accepted that the reference to an earlier complaint of back pain which he referred to in his report was an error by him and not borne out by the surgery's notes, although the plaintiff herself is of the view that she mentioned it earlier than September 1999. The question is whether, in view of the delay in the onset of back symptoms they can reasonably be linked to the accident in February 1999. There is evidence to support both sides of that argument. She had some back complaints in the aftermath of the 1990 accident, but that is a long time ago, and had resolved well before the 1999 accident. Mr. O'Rourke has stated that on his examinations of the plaintiff there was no clinical or other objective evidence to support her complaints of back pain. Nothing has showed up on x-rays or MRI scan to indicate a reason for them. He regards the symptoms as being subjective only, in the sense that the only support for them was the plaintiff's own complaints in that regard. I have set out the evidence which I have heard in relation to this controversy and there is no need to repeat it now. I must decide the matter on the balance of probability. In that regard I am persuaded by the evidence of Dr. Hugh Gallagher which I have summarised above. I will not repeat it now. He was not surprised that nothing showed up on x-rays and MRI in relation to her back. His opinion is that her symptoms result from problems in the lumbar facet joints, and that this would not show up on x-ray or MRI scan. He is persuaded that while the plaintiff is over-weight and had existing degeneration in her lumbar spine, she has become symptomatic as a result of the accident, even though there was a delay in the onset of symptoms. He is struck by the fact that she responded to injections and to bilateral rhysotomies of the lumbar spine, even though on a temporary basis. Having considered the evidence, including that of Mr. McManus for the defendant, I conclude that as a matter of probability her back problems are related reasonably to the 1999 accident, but I take into account the fact that she was predisposed to back difficulties because of existing degeneration and her weight gain.

Taking all the features of this case into account as described both in the evidence summarised and the conclusions I have reached, and the fact that she will continue to suffer back pain well into the future, and will require ongoing treatment of one kind or another in relation to it, I assess general damages as follows:

Past pain and suffering - €120,000

Future pain and suffering - € 35,000

Special damages

There has been some controversy in relation to the claim for special damages, particularly in relation to a claim for €9853.36 for travelling expenses to doctors. The total claim is for €14,142 which includes medical treatment. I am satisfied from the rather sketchy evidence in relation to the travel expenses claimed, that not all of that can be attributed to this accident. The plaintiff has had a very large number of visits over the years to her doctors, but a good deal of this may well be unrelated directly to this accident. I will make allowance for that in an unspecific way, by allowing a sum of **€10,000 in respect of special damages**.

There will therefore be judgment to the plaintiff against the defendant for the sum of **€165,000.**