[2006] IEHC 222

THE HIGH COURT

NO. 2305P/2005

BETWEEN

INGRID CORBETT

PLAINTIFF

AND
QUINN HOTELS LIMITED

DEFENDANT

Judgment of Finnegan P. delivered on the 25th day of July 2006.

1. On the 17th July 2000 the Plaintiff was leaving the Defendant's hotel premises, the Hillgrove Hotel Monaghan, when she tripped and fell and sustained injury. Liability is admitted.

2. A booklet of medical reports obtained on behalf of both the Plaintiff and the Defendant was agreed and handed into Court and in addition Mr. Leo Vella gave evidence.

3. The Plaintiff is a housewife. She was born on the 9th February 1960 and is now forty six years of age. She is a married woman with one child aged nine years. Her husband is a member of the Defence Forces.

4. The medical reports present a very confused picture indeed and my principal task is to determine which of her complaints have been shown as a matter of probability to have resulted from her fall.

5. Some of the injuries present no difficulty:-

1. Nose. In the fall she sustained a 2 cm laceration to the nose which was sutured, some abrasions and a contusion and a undisplaced fracture of the nasal bone without deviation of the septum. All these injuries have resolved with no residual scarring or adverse sequelae.

2. A laceration to the upper lip. This has resulted in a 2.5 cm stellate scar between her lip and the nose. The scar is just visible at conversation distance but is clearly visible on closer inspection.

3. Teeth. The upper left central incisor has lost one fifth of the crown structure which required repair. The upper right central incisor was intact but was slightly mobile in its socket: it is no longer mobile. There is a possibility that one or both of these teeth might die as a delayed reaction: however having regard to the passage of time this is not now likely. In terms of future treatment I think it sufficient if a sum of €500 was allowed to take into account the possibility that the treatment will be required. The injury to her teeth caused the Plaintiff considerable discomfort. For some twelve days she was unable to eat solids and unable to open her mouth sufficiently wide to drink and took sustenance through a straw. She complained of other dental injuries but has failed to satisfy me in relation to these that they existed or were caused by the accident.

4. Chin. She sustained lacerations and abrasions to the chin which did not require treatment and which have healed.

6. The Plaintiff sustained injuries to her knees and to her left shoulder the extent of which have proved very difficult to assess or indeed to explain. As a result of this the Defendant made an application pursuant to section 26 of the Civil Liability and Courts Act 2004 contending that the Plaintiff gave evidence that was false or misleading in a material respect which she knew to be false or misleading. I refuse that application as while the Plaintiff's evidence was indeed misleading I am satisfied that she gave her evidence honestly believing the same to be true and that she had not intended to mislead the Court in any respect. She suffers from distressing symptoms in both her knees and shoulder which she attributes to the accident but which attribution has given rise to differences of opinion between medical experts as to the likelihood of her present symptoms being explained by her fall or indeed existing at all. I deal with each of these injuries now in turn.

The Knees.

7. Following the fall the Plaintiff was taken to Monaghan General Hospital. Both knees were bruised and excoriated. While the Plaintiff claims to have sustained lacerations this is not supported by the medical reports. However there is no doubt that the knees required dressings. On inspection there are some scars on the knees but I do not accept that these were caused by the accident. There is however an area of very slight discolouration on the knees which I accept as related to the accident. I arrive at this conclusion on the basis of the medical reports of her general practitioner Dr. Maria Murray and Liam J. McMullen Consultant Surgeon at Monaghan General Hospital. It appears from the report of Mr. McMullen, and I accept, that for three weeks following the accident knee discomfort caused her difficulty in walking. When examined by Mr. McMullen in January 2001 her knees were clinically normal with very slight crepitus on the left hand side at full flexion. She complained of difficulty in going down stairs and going down hill. On further examination by Mr. McMullen in 2002 she complained that the left knee had locked in late January 2002 and caused her extreme pain and following which incident she was housebound for three days. Descending stairs caused her pain in the knee. MRI scans of both knees were normal.

8. The Plaintiff attended Peter J. O'Rourke who examined her on the 26th September 2002 at Letterkenny General Hospital. She complained of bilateral anterior knee pain with the left side being worse than the right. Her ability to walk was limited due to fatigue and pain. On examination the contour of both knees was normal. There was no effusion. There was no instability of the ligaments. Examination of the menisci was not possible due to the patella femoral pain particularly on the left. There was crepitus over the medial and lateral femoral condyle and the medial lateral patella facets. X-rays were normal. Her condition is consistent with bilateral chondromalacia probably traumatic in origin. The appropriate treatment is physiotherapy and with physiotherapy the symptoms should gradually subside.

9. The Plaintiff attended Mr. Thakore on the 13th August 2003. She complained of constant pain in both knees mainly on the left but with a recent increase in right knee symptoms. The knees occasionally lock. Steps were causing her a difficulty and she was unable to kneel. Her walking is much curtailed. Mr. Thakore found her to be somewhat depressed as a result of her complaints. On examination the left knee was more painful than the right. Movements were restricted with some crepitus. However there was no muscle wasting. Menisci and ligaments were intact. There was no instability. His opinion is that the complaints are probably related to chondromalacia probably traumatic in origin. The appropriate treatment is physiotherapy. Mr. Thakore reviewed the Plaintiff on the 22nd September 2005. She still complained of her knees being symptomatic. The left knee was not locking as frequently but would

occasionally swell: otherwise there was no improvement. She still could not kneel and still had difficulties with steps. On examination movements of the knee were full but with some pain at the back of the knees. She had some patella femoral pain.

10. The Plaintiff was seen by Mr. Michael A. Maloney on behalf of the Defendant in July 2001. She was then attending physiotherapy for her knees. She complained of difficulty in walking at times and in negotiating stairs. On examination there was very minor crepitation on movement of both knees. They were not swollen. The joints were normal with full pain free movements.

11. The Plaintiff was examined by Mr. L. A. Vella on the 13th August 2003. She complained that her knees were giving her great difficulty when walking and that she is more or less housebound. She was doing exercises for her knees. She was unable to kneel. On examination there was a full range of movement of the knees. Mr. Vella noted no crepitation. However the Plaintiff complained of a lot of pain when her knees were touched. In his opinion the Plaintiff probably had some scraping and superficial and deep bruising to her knees and he would have expected her injuries to resolve within a short period of time. She appeared to be tender all around the knees and was reluctant to move her knees and this made examination very difficult. He noted that she was able to walk normally. Mr. Vella reviewed the Plaintiff on the 2nd June 2004. She complained of pain in her hips. She could only walk 100 yards after which the knees became sore. His opinion is that the Plaintiff sustained minor injury to her knees from which she has recovered. Mr. Vella finally saw the Plaintiff on the 19th July 2006. She was able to walk at that time without limping and able to stand on each leg and turn. She would not allow a full range of movements of her knees and hips as she complained of pain. Her injuries should have recovered a long time ago.

12. Mr. Vella gave evidence to the like effect of his medical reports.

13. On behalf of the Defendant the Plaintiff attended Mr. Darragh E. Hynes. He saw her on the 22nd September 2005 when she continued to complain of symptoms in the knees. During the course of his examination the Plaintiff did appear to have alternate levels of stiffness in her knees and shoulder. He found it surprising that she should continue to have symptoms in the knees at this remove from the accident. It is possible that she suffers from chondromalacia.

14. I have the evidence of a private investigator Mr. Connolly who produced video evidence taken between October 2003 and March 2004. In relation to the Plaintiff's knees the video showed her able to walk for a protracted distance briskly and without any apparent difficulty. My conclusion on the evidence is that the Plaintiff sustained contusions and abrasions to her knees which caused her considerable difficulty for perhaps one month. As a matter of probability she has sustained to a mild degree chondromalacia which causes her occasional but not significant discomfort. Perhaps related to the low mood recorded by Mr. Thakore she concentrates overly on the injury to the knees and subjectively believes her symptoms to be a great deal worse than they really are. In these circumstances it is appropriate that I award her damages on the basis of the injuries actually sustained – abrasions and contusions which caused serious difficulty for perhaps four weeks thereafter gradually reducing and disappearing: however she developed chondromalacia from which she suffers mild and occasional symptoms but which on the evidence of the video shown to the Court does not in any way interfere with her ability to walk briskly. I take the view, as is often the case, that with the resolution of these proceedings she will cease to concentrate on her injuries and I expect her condition to resolve, perhaps with the aid of some physiotherapy, in the short term.

The Shoulder

15. In the fall the Plaintiff abraded her right shoulder. She had pain in the left humerus and was unable to lift her left arm. In 1989 she developed symptoms in the left shoulder for which she attended a specialist. The symptoms resolved without treatment over a period which lasted anything from one to three years without any specific diagnosis or treatment. When she attended her general practitioner on the 21st July she was unable to elevate her left arm above 60° due to pain in the upper humerus. From the report of Mr. McMullen it would appear that the area became increasingly uncomfortable. She had five sessions of physiotherapy in an attempt to attain full mobilisation of the upper limb. By January 2001 movements of the shoulder and arm were restricted and in particular she had difficulty in elevating the hand above her head. She was only able to place the dorsum of the left hand over her first lumbar vertebrae. On examination on the 17th May 2002 she could only abduct the arm to 70°. He recommended physiotherapy.

16. Mr. O'Rourke saw the Plaintiff on the 26th September 2002. She complained of decreased movement and pain on abduction of her left shoulder. She could use the arm by keeping it close to her side but had difficulty in lifting the arm away from her side and in abducting and flexing it because of pain. She was unable to lie on the left shoulder. Her sleep was disturbed. On examination the shoulder was normal in appearance, movement was restricted active abduction and flexion being 70° - 80°: passive abduction was normal, internal rotation and external rotation were limited, power was reduced secondary to pain. No abnormality could be found on examination. It was not possible to determine whether there was an impingement due to the Plaintiff's reaction to examination. He recommended an MRI scan of the shoulder but none was carried out at this time. As a clinical examination was not helpful there was a possibility of damage to the rotator cuff.

17. The Plaintiff attended Mr. Thakore. He examined her on the 13th August 2003. She had had physiotherapy to her left shoulder which helped somewhat. She remained restricted in household chores and in looking after her son. She still could not lie on the left hand side and her sleep was disturbed. On examination movements of the shoulder were restricted. There was some crepitus. There was no muscle wasting and no focal deficit in the upper limbs. Mr. Thakore felt that there was probably some impingement. Her symptoms pointed towards rotator cuff syndrome either due to rotator cuff damage or ongoing tendonitis of the rotator cuff. He recommended an MRI scan.

18. An MRI scan was carried out on the 2nd June 2004 on the left shoulder. This showed degenerative changes at the AC joint with bony impingement on the underlying supra spinatus tendon and an extensive partial thickness tear of the distal tendon with marked thinning of the tendon fibres and high signal along the articular surface. There was tenderness consistent with a labral tear and in the opinion of Mr. Thakore this indicated that the Plaintiff has degenerative changes in the AC joint but bony impingement on the underlying supra spinatus tendon and a partial thickness tear of the distal supra spinatus tendon with evidence of a labral tear. Her condition may have pre existed the accident and been exacerbated by it or may be a recent injury. There is evidence of impingement. Arthroscopic assessment was required but the Plaintiff was unwilling to have this. Arthroscopic repair and decompression would improve function leaving her with low key pain and stiffness. Mr. Thakore again saw the Plaintiff on the 5th October 2005. He found minimal wasting of the strap muscles of the left shoulder. The Plaintiff was tender over the front and side of the left shoulder. Movements were occurring mostly at the shoulder girdle rather than at the shoulder itself. Movements were restricted. He again recommended arthroscopic assessment.

19. Mr. Maloney saw the Plaintiff on behalf of the Defendant. On the 21st July 2001 she stated that the condition of her left arm had improved considerably. Movements of the left shoulder were full in range and free of pain and crepitation. He found the Plaintiff to be mildly histrionic about her injuries.

20. Mr. Aidan Lynch saw the Plaintiff in relation to her shoulder injury again on behalf of the Defendant. His report is dated June 2003. Her original complaint in relation to the left shoulder as recorded by him is that she complained of an ache in the front of her arm for a number of weeks which then became intermittent. She denied any previous shoulder pain. Her present condition was that she suffered from an ache in the anterior aspect of the left arm varying with activity. On examination she claimed that she could not flex her arm beyond 90° or abduct beyond 70°: however she had a full range of rotation at both shoulders. There were no abnormal neurological findings. He felt her condition would improve with exercises and that there was no reason for her to have any problems in her shoulder at that time.

21. Mr. Vella saw the Plaintiff on the 13th August 2003. She complained of inability to lift her arm from her side and of difficulty in getting dressed. On examination she was tender in the forearm and upper arm but there was no deformity of the arm. Movements were limited because of a complaint of pain. It was impossible to determine by examination what was wrong or whether any abnormity existed. Mr. Vella reviewed the Plaintiff on the 2nd June 2004. She complained that her arm ached a lot but that she could use it. Carrying anything heavy gave her pain and she felt power was reduced. On examination she was unable to elevate the left shoulder above the horizontal because of pain. He believed that she sustained a minor injury to her left arm and that she had fully recovered and he understands that all surgeons agree with this view.

22. Mr. Darragh Hynes saw the Plaintiff on behalf of the Defendant on the 22nd September 2005. Again movements were restricted by pain. She said that she was unable to carry items and that the upper arm was constantly sore. On examination movements were restricted. Mr. Hynes had access to Mr. Thakore's report on the MRI scan carried out in 2004. He concludes as follows –

> "I find I difficult to co-relate this ladies history of ongoing symptoms, recent clinical examination and the MRI scans of her shoulder. It would appear that she did suffer a soft tissue injury to her shoulder at the time of the fall in July 2000. It appears that an MRI scan of her shoulder was undertaken in September/October 2002 which apparently was normal (note: he is incorrect in this). She had a subsequent MRI scan undertaken in June 2004 which showed degenerative changes and partial rotator cuff tearing."

23. On the evidence I am satisfied that no MRI scan was carried out in September/October 2002. However in his clinical experience the clinical findings are not in keeping with the MRI scan finding of June 2004. On examination it was difficult to assess the shoulder clinically. Her functioning in the left shoulder appears to alter from time to time. His view is that the Plaintiff sustained a significant soft tissue injury to her shoulder in the fall but he would have expected her symptoms to have resolved within two to three years of the injury occurring and she should not have a significant long term problem in the shoulder as a result of the injury sustained. Mr. Hynes received a consultation report from Mr. Colville dated 3rd January 2006 as a result of an examination by Mr. Colville on the 11th October 2005. He found Mr. Colville's clinical examination to be broadly similar to his own. There is no evidence of muscle wasting which would generally be seen in patients with significant restriction of activity and use of their shoulder. It is unlikely that the Plaintiff's symptoms are as significant as she would report.

24. Mr. Colville saw the Plaintiff on the 3rd January 2006. She stated that she was in absolute agony with her shoulder and could do nothing. To carry shopping causes her pain. She was taking pain killing medication almost every day. Her sleep was upset. On examination he found her to be in good general health. Examination of the left shoulder revealed no muscle wasting. The range of movement was difficult to assess. She appeared to be unable to move her shoulder to any degree. The measured girth of the arm was normal. There was no neurological deficit. In his opinion the Plaintiff's symptoms are somewhat excessive given the lack of positive clinical findings such as wasting. A further assessment by way of arthroscopy to confirm findings would be required. If there is significant impingement decompression would relieve a lot of the symptoms. He has difficulty in understanding the severity of the symptoms and her apparent inability to move her shoulder to any degree. Physiotherapy might do this.

25. The medical reports present a difficult picture for me. Taking the medical reports as a whole I am satisfied that the Plaintiff sustained an injury in the fall to her left shoulder. She is left hand dominant. I have no clear explanation as to why she should have pain at the humerus. However the MRI discloses an injury to the rotator cuff and superspanatus muscle. The Plaintiff had a previous injury or condition in the left shoulder in 1989 which recovered. In these circumstances I think it most likely that she exacerbated a pre existing injury in the fall. Ordinarily this would have recovered within a period of some years perhaps three years. However the Plaintiff overly concentrates upon her injuries perhaps because of the pending litigation which has been hanging over her for some five years now. I am unable to accept that she has significant pain or discomfort at this time and I expect many of her symptoms will resolve with the resolution of the litigation. From the video evidence it seemed to me that the Plaintiff was careful of her left arm and tended to carry her shopping in her right arm. I accept that she is to some degree careful of using the left arm but I think she is over careful in relation to the same because of her own perception of the injury. Significantly there is no muscle wasting: this indicates to me that the Plaintiff makes much greater use of the left arm than she believes to be the case. With some physiotherapy and more vigorous use I think it likely that she will regain her pre accident condition very shortly.

Quantum

26. Because of the nature of this case I do not propose apportioning damages between the several injuries sustained by the Plaintiff. Having regard to the views which I have expressed in relation to the Plaintiff's symptoms I am satisfied that an appropriate award for pain and suffering to date and into the future for the injuries which the Plaintiff has satisfied me she sustained in the accident is €47,500 to date and €7,500 into the future. In addition she is entitled to the sum of €500 for future dental expenses and the sum of €3,000 special damages which have been agreed. Accordingly I award the Plaintiff the sum of €58,500.