THE HIGH COURT

[2014 No. 5355 P.]

BETWEEN

JOHN GARDINER

PLAINTIFF

AND

ZINC PROCESSORS LIMITED T/A SHANNONSIDE GALVANISING

DEFENDANT

JUDGMENT of Mr. Justice Barr delivered on the 7th day of April, 2017

Introduction

1. At the time of this accident, the plaintiff was employed by the defendant as a supervisor in the galvanising section of the defendant's plant. On 9th August, 2012 the plaintiff suffered serious injuries as a result of being hit by a load of metal items, which fell from a height and struck the plaintiff on the chest and shoulders. Liability for the accident is not in issue in the proceedings.

2. The defendant accepts that the plaintiff suffered multiple serious injuries as a result of the accident. There is not a great deal of controversy between the parties in relation to the physical and psychiatric injuries suffered by the plaintiff. The main areas of dispute are in relation to the following issues:

> *"(a) When the plaintiff had returned to work with the defendant in August 2013 doing non-physical work in the area of quality control, whether his decision to cease work in February 2015, was as a result of any physical or psychiatric injuries sustained in the accident.*
>
> *(b) Whether, having regard to the plaintiff's recovery to date and in particular, having regard to his most recent examinations by various specialists, he needed in the past, or will need in the future, the level of care as advised by the plaintiff's nursing expert.*
>
> *(c) Depending upon the courts findings on both of these issues, what financial losses or expenses have been incurred to date and will be incurred by the plaintiff into the future."*

The Accident

3. On 9th August, 2012, the plaintiff was employed as a supervisor in the galvanising section of the defendant's plant at Dronbanna, Co. Limerick. The plant is divided into three main areas: the "*Black Yard*", which is where steel items are brought into the plant. The "*Zinc Bath Area*", which is a very large bath full of molten zinc, above which is a gantry crane and from this hang steel items which are to be galvanised. The third area is known as the "*White Yard*" and it is there that the finished product is brought to dry and await onward transmission to the customer. On the day of the accident, the plaintiff was working in the zinc bath area. A load containing a number of large and heavy metal items was suspended above the zinc bath. Due to some fault in the apparatus, one of the hooks from which the load was hanging gave way, causing the load to swing downwards in a pendulum movement, with the load being suspended by only one hook. The plaintiff was struck forcibly on the chest and upper body by the swinging load. The load pinned him against a railing. He managed to crawl out from beneath the load to a place of safety.

4. As a result of the accident, the plaintiff suffered the following injuries: fractures of eight ribs on the left side, fractures of five ribs on the right side. Fractures at T2, T3 and T4, right and left pneumothoraces, a fracture of the left scapula, damage in the form of widening of the right acromial acromioclavicular joint, a left haemothorax and a tear of the supraspinatus tendon in the right shoulder.

5. The plaintiff stated that immediately after the impact, he could hardly breathe. He was in severe pain. He stated that he thought that he was going to die. He told a colleague, who had come to his assistance, that he did not think that he would make it. An ambulance was called and the plaintiff was transferred to the emergency department of the Midwestern Regional Hospital, Limerick, where he came under the care of Dr. Gareth Quinn.

6. The plaintiff was detained in hospital for ten days. A drain was inserted into the left side of his chest. No surgery was advised and the injuries were treated conservatively. On discharge, he returned home, where he was cared for by his wife, who had taken time off from her job, as a canteen supervisor, to care for him.

7. During this initial period, the plaintiff was grossly disabled. He required help with virtually all activities of daily living including, dressing, showering and going to the toilet. It was necessary for a commode to be provided upstairs, as the toilet in the house was located downstairs. He had great difficulty going up and down stairs. He required his meals to be prepared for him. He had great difficulty sleeping, as he could not find a comfortable position when in bed. He required pillows to prop him up. His wife slept in the spare room during this period.

8. The plaintiff experienced constant severe pain in his ribs, shoulders, upper back and neck, during this period. He required extensive painkilling medication on a daily basis. On discharge from hospital he had been given two "*bombs*" for pain as needed, as well as medication every four hours. After the first week, he returned to hospital, where he was given more medication and another "*bomb*", which was a device which enabled him to self-administer painkillers as required. The medication included Arcoxia for pain, sleeping tablets and also Tramadol for pain.

9. While in the hospital, the plaintiff's wife took a number of photographs, which revealed extensive bruising to the entire front and back of the plaintiff's upper body. In the months following his discharge from hospital, the plaintiff gradually began to mobilise. Initially, he was able for short walks to the park, which was approximately 0.5km from his house. In the beginning, his wife accompanied him on these walks. He would rest when he reached the park and when he returned home, he would have a cup of tea and rest further. Due to his injuries, the plaintiff has considerable difficulty breathing, which was particularly evident at night and prevented him from sleeping.

10. In the first six months after the accident, the plaintiff experienced panic attacks and flashbacks to the accident. The first panic attack occurred when he was weaning off the painkilling medication. He experienced a sensation where he could feel the steel hitting him on the back and he thought that he would not be able to get out from under it this time. A psychiatrist prescribed anziolitic medication called Effexor, 75mg daily. However, this made him extremely irritable. His psychiatrist told him to stop taking the medication. He was given a milder form of medication, which he found helpful. He found that loud noises would startle him and would remind him of the sound of the hook breaking and the sound of the load swinging down just before it hit him. The plaintiff's wife initially took two weeks from work to look after him and then she took a period of three months from work to care for him.

11. By Christmas 2012, the plaintiff stated that he had made considerable improvement. However, he continued to experience constant and at times severe pain in his neck, chest, shoulders and upper back. During this period, he had lost 1.5 stone in weight. While he had improved physically, he was still not able to socialise. He had lost all of his self-confidence and was not able to go out and meet people. He became very depressed at the level of his disability and in particular, by his inability to return to work.

12. In August 2013, the plaintiff returned to work in a new position which the company had created for him. This involved checking the finished metal items in the White Yard. Using a handheld monitor, he was able to ascertain the thickness of the coating of zinc at various points on the finished product. He then entered the results into a computer and generated a report which would be provided to the customer.

13. All the medical witnesses were in agreement that the plaintiff had showed considerable determination in getting back to work after such serious injuries. In a medical report dated 8th May, 2014, the defendant's orthopaedic surgeon, Mr. Michael Maloney, stated as follows in relation to the plaintiff's return to work:

> *"I admire Mr. Gardiner's determination to return to employment and the firm for finding a place for him with his incapacity. I cannot see him returning to his pre-accident employment".*

14. Two things of significance happened in November 2013. Firstly, Professor Masterson referred the plaintiff on to Mr. O'Farrell, in relation to continuing pain in his right shoulder. This doctor admitted the plaintiff to Croome Hospital as a day case, where he had an injection to the shoulder and possible manipulation of the shoulder joint. He also had physiotherapy treatment at this time. The injection to the shoulder caused an improvement in his symptoms for a period of approximately six months. However, the pain in his right shoulder returned after that time.

15. Secondly, in November 2013, the plaintiff hurt his shoulder, when assisting a colleague lift a gate at the factory. The managing director of the company, Mr. O'Brien, was not pleased that the plaintiff had been doing any manual handling work. He banned the plaintiff from working in the Black Yard. He stated that he told the plaintiff: "*You are to work from the head up. Not head down*", meaning that he was to act solely in an advisory capacity, and not in a manual role. The significance of this event is that it showed that the plaintiff was willing to try reasonably heavy work to assist a colleague, even though he was not meant to do such work. The plaintiff stated that he was somewhat unhappy doing his administrative role. He missed his work colleagues on the factory floor. He thought that they may have resented him for doing light work. He said that they occasionally slagged him that he had a "*handy number*". As a result, he stopped going for lunch in the canteen. He also felt that the defendant company had "*created*" the job for him. He felt that the quality control reports which he generated, where simply put on the shelf and ignored by the company.

16. The plaintiff also missed time from work due to respiratory complaints and numerous chest infections.

17. The plaintiff worked with the company from August 2013 until February 2015. During this time, he continued to require painkilling medication. However, he could only take this medication when he arrived at work, as it made him drowsy and affected his driving. He was seen by Mr. Gilmore, consultant orthopaedic surgeon on 25th March, 2014, at which stage he complained of pain in the left shoulder and a lot of numbness in the left side of his neck and left arm. He had a decreased range of motion in the right shoulder, with crepitus on rotation of the shoulder. He had a feeling of the left scapular area being twisted. He was on painkilling medication and was also on inhalers in respect of his breathing difficulties. Examination showed a significant decrease in the range of motion of his cervical spine, being less than 50% of the expected range. He was tender in the left trapezius and also at the right acromioclavicular joint, which was dislocated and there was crepitus on moving the shoulder. There was a decreased range of motion in the right shoulder and he had decreased sensation in the left C5 dermatome and also in the left little finger. His ribs showed him to be tender in the left posterior and lateral aspect.

18. Chest x-rays taken on 9th August, 2012, showed significant pneumothoraces bilaterally. A further x-ray showed a left sided chest strain in situ. A further x-ray on 11th August, 2012, showed that there had been some improvement in the pneumothoraces but the right side remained considerably collapsed. An x-ray taken on 16th August, 2012, showed similar changes with incomplete re-inflation of the lungs. An x-ray of the right shoulder taken on 7th November, 2012, showed dislocation of the acromioclavicular joint. A further x-ray on 11th January, 2013, showed the A.C. joint dislocation. An x-ray of the left shoulder was not clear and it was not possible for Mr. Gilmore to state categorically whether there had been any fracture of the scapula. An M.R.I. scan of the right shoulder on 21st February, 2013, showed significant disruption of the A.C. joint and pressure due to oedema on the supraspinatus tendon, which also showed a partial tear on the articular surface.

19. Mr. Gilmore noted that the plaintiff had sustained significant injuries to his chest and shoulders, particularly his right shoulder in the accident in August 2012. He continued to be quite disabled in relation to the shoulder. This shoulder had been injected by Mr. O'Farrell. Mr. Gilmore did not know whether the plaintiff had been followed up by Mr. O'Farrell, but if not, he suggested that the plaintiff should be reviewed by him with a view to considering arthroscopic assessment of the right shoulder and possibly carrying out debridement and acromioplasty and rotator cuff repair.

20. The plaintiff was reviewed by Mr. James Colville, Consultant Orthopaedic Surgeon, on 7th January, 2015. At that time, he complained that his left shoulder continued to give him trouble. He had a cramping feeling underneath the left shoulder blade. He took tablets every day for pain. He also took tablets to help him sleep at night. He had difficulty lying on his left side. He had not been able to return to any sort of fishing because the movement of his shoulder was painful. He had lost some movement in the left shoulder and he could not lift anything heavy. He had had an injection to the shoulder in Coombe Hospital and this had provided temporary relief from pain. As far as the right shoulder was concerned, the plaintiff described a noise in his shoulder, but the movement was good. He experienced pain going up into his neck on the right side and there was a click in his neck. This occurred when he moved his head from side to side, or turned it. He stated there was local pain and tenderness on the outer aspect of the right shoulder and he pointed to his A.C. joint.

21. On examination, Mr. Colville noted that the plaintiff looked in good general health. Examination of the cervical spine revealed a limitation of movement of no better than 50% in all directions. He complained of pain at the extreme of the range of movement. There

was no significant muscle spasm present and there was no neurological deficit in either upper limb. Examination of the left shoulder revealed a good range of movement. It was restricted by ten degrees in forward flexion and abduction. All other movements were within normal limits. There was no muscle wasting. The rotator cuff was within normal limits. The plaintiff complained of discomfort going through a painful arc of movement in forward flexion of about 30 degrees, between 60-90 degrees. The plaintiff also complained of pain up into the cervical spine on moving the left shoulder. Examination of the rights shoulder revealed it to be within normal limits, with the exception of local tenderness on palpating the A.C. joint.

22. Mr. Colville noted that the plaintiff had been involved in a very serious accident. It would have been considered life threatening at the time, but the plaintiff had done well with appropriate treatment. The plaintiff had residual symptoms which he thought were not surprising given the nature and severity of the injury.

23. In an addendum to his report dated 22nd April, 2015, Mr. Colville dealt with the findings on the M.R.I. scans. The M.R.I. scan of the neck showed degenerative changes at multiple levels with nerve root compression bilaterally and at more than one level. The scan of the right shoulder was carried out on 21st February, 2013, It showed evidence of an injury to the A.C. joint. A further scan of the right shoulder was carried out on 28th February, 2015, and again showed arthritic change in the A.C. joint and evidence of an injury to the clavicular end of the A.C. joint. Mr. Colville noted that based on this information, it was not surprising that the plaintiff had ongoing symptoms relating to his cervical spine, with referred pain to the shoulder blades. This would also account for the pain on certain movements of his cervical spine and lack of movement therein. As far as his shoulders were concerned, he recommended that the plaintiff should have an A.C. joint x-ray guided injection on the right side. He hoped that that would resolve the problem in due course. He also recommended that the plaintiff should have an x-ray guided injection of the left subacromial space. In the longer term, he anticipated that the residual symptoms in his cervical spine were likely to persist, but these were not entirely due to his accident. In a further addendum dated 14th August, 2015, he had the benefit of an x-ray report on the plaintiff's left shoulder, which had been carried out on 27th July, 2015. It showed degenerative change in the left A.C. joint. It was reported that there was a loose body in the right A.C. joint, there were also degenerative changes present.

24. The emergence of psychiatric injuries were noted in the examination carried out by the plaintiff's G.P. on 15th January, 2015. Dr. Gavin noted that over the previous year, the plaintiff had noticed increased problems with anxiety and depressive symptoms. He had returned to work in August 2013, which he felt was a positive step. Despite this, the plaintiff had been disappointed with his inability to take on the kind of work that he had done prior to the accident. The ongoing nature of his pain and its chronic nature had had an adverse effect on him. The sleep disturbance in particular was adding to his irritability and anxiety. Dr. Gavin was of opinion that as the period of his injury had moved from months into years, the chronic pain in the plaintiff's chest wall and shoulder, had started to wear him down. He had come to realise that a full recovery was probably not possible. The respiratory problems had shaken his self confidence. The plaintiff had become anxious, irritable and mildly depressed.

25. The plaintiff had reported decreased taste and smell since the accident, but this had resolved over time. His eyesight problems were also no longer an ongoing issue in 2015. Dr. Gavin was of opinion that the plaintiff had done very well, but would not recover completely from an accident of that severity. His physical situation had worsened over the last year. Following from this, his psychological wellbeing had been considerably damaged.

26. On 16th February, 2015, the plaintiff was reviewed by Mr. Gilmore. The plaintiff was disappointed because of his lack of progress since the accident. He continued to have a lot of pain in the left shoulder and also in the left arm and in his neck. The plaintiff complained that he had a feeling of a bone protruding from the right shoulder. This was the prominence at the dislocated right A.C. joint. He had inquired about surgery for this, but had been advised that it was not recommended. Mr. Gilmore noted that the plaintiff had been off work for the previous two weeks, because he simply could not manage, as he seemed to have tightened up in the cold weather. He told Mr. Gilmore that he hoped to be back at work the following week.

27. Examination of the neck showed a 60% range of motion with pain on pushing it beyond that level. He was tender in the left trapezius and also in the left intrascapular area. He had prominence in the right A.C. joint and pain and crepitations at this level on moving the joint. He had a positive impingement test in both shoulders, right and left. He seemed to have decreased sensation in the left little finger and also in the medial aspect of his left elbow.

28. Mr. Gilmore noted that an M.R.I. scan of neck showed that there was loss of normal lordosis and evidence of quite significant degenerative change at C3/4, 4/5 and 5/6, with some disc osteophyte bulging abutting, but not significantly compressing the spinal cord at any level. However, there was quite significant left sided foraminal encroachment at the C5/6 level particularly and at the C4/5 level there was foraminal encroachment on the right side. The M.R.I. scan of the right shoulder showed evidence of diffuse thickening in the subacominal bursa and an 8mm defect in the supraspinatus tendon, but with no retraction of the tendon. The A.C. joint was again very abnormal, but the acute changes noted at this level in the scan from 2013 had subsided. The M.R.I. scan of the left shoulder showed similar changes at the A.C. joint, but no evidence of any rotator cuff damage.

29. Mr. Gilmore noted that the plaintiff continued to have ongoing difficulties with his neck and both shoulders as a result of the injuries sustained in the accident. Clinical examination of the neck showed him to have restriction in the range of movement, which was to be expected given the changes noted on the M.R.I. scan, these changes he felt had not been caused by the accident, but may well have been aggravated by it. The plaintiff continued to have ongoing difficulties with his right shoulder at the A.C. joint and the dislocation in the joint had not changed, but the acute nature of it had subsided somewhat since the original scan in 2013. The plaintiff continued to have positive impingement testing in both shoulders. Mr. Gilmore was of the opinion that only time would tell whether any further treatment would be required to the shoulders, particularly on the right side, perhaps in the form of arthroscopic debridement and rotator cuff repair. Given that it was then two and a half years post accident, he felt that the likelihood was that the plaintiff would continue to have ongoing difficulty and would probably require further treatment for the right shoulder particularly, in order to help alleviate his symptoms.

30. The plaintiff was first seen by Dr. Catherine Corby, Consultant Psychiatrist, on 27th February, 2014. The plaintiff told her that his life had changed immeasurably since the accident. Due to pain in his shoulders and breathing difficulties, his exercise tolerance was limited. In particular, he had had to give up fishing since the accident, which had been his passion. He also stated that his mood had been low and that he was frequently irritable and angry. He had also lost a lot of self confidence. He complained of flashbacks to the sound of the crane hitting the steel. He had returned to work in August 2013 and stated that he found sounds in the workplace to be upsetting. Although not doing his pre-accident job, he was still regularly exposed to the area where the accident had occurred. He had experienced nightmares at the initial stages after the accident, but these were no longer a problem. He complained that his mood was low and the biggest change he noticed was that he lacked enjoyment of life. He had stopped socialising to the extent that he had done prior to the accident. His relationship with his wife had changed since the accident both physically and emotionally. Due to his physical and psychiatric injuries, he no longer had a sexual relationship with his wife.

31. Dr. Corby noted that the plaintiff continued to experience severe pain from his physical injuries, which restricted him in a number of everyday activities and also meant that he could not pursue his hobby of fishing. He required daily pain relieving medication. She noted that he no longer had a sexual relationship with his wife.

32. She noted that the plaintiff had suffered psychologically since the accident complaining of nightmares initially and he continued to experience day time flashbacks to the accident. These were triggered by loud noises, particularly at his workplace. She was of the opinion that he met the criteria for Post Traumatic Stress Disorder.

33. The plaintiff also suffered from depression since the accident. He worried about his future health and had a lack of enjoyment in life. He was apathetic and irritable and also felt angry. She felt that he would benefit from the introduction of antidepressant medication. His prognosis was guarded.

34. The plaintiff was reviewed by Dr. Corby on 29th January, 2015. The plaintiff told her that he had been prescribed antidepressant medication by his G.P. However, he only took this medication for one month, as he was not able to tolerate it and it had made him feel worse. He continued to work in an administrative role, which he felt was of a lesser capacity than had been his role prior to the accident. Occasionally, he had feelings of inadequacy. He told her that he was aware of danger in the workplace. When the crane moved, he could hear it first, before he saw it and his anxiety would increase at that time. He was aware that one slip of the machine and it could be fatal for the individual beneath it. He told the doctor that he enjoyed his work overall, but he missed the hands on role that he previously had. He also believed that the other workers may resent him for having an easier job.

35. He continued to experience day time flashbacks, particularly at work. If he heard a loud bang at work, he would startle and would be frightened. At night, he experienced reliving experiences once or twice a week. He worried excessively about problems in the workplace. He felt on edge a lot of the time. He described panic symptoms and he had attended his G.P. in relation to these. He also experienced shortness of breath in bed, as well as an increased heart rate and palpitations. He described his mood as low and could get irritable with people. He continued to take painkillers on a daily basis. He would take six Tylex per day and was also on sleeping tablets.

36. Dr. Corby noted that the plaintiff had not resumed a physical relationship with his wife since the accident. He believed that the pain in his shoulder would be too severe to engage in sexual activity and also his libido had been reduced since the accident. He continued to suffer psychologically. He presented with current depressive symptoms, with low mood, tearfulness, irritability and reduced interest and enjoyment. She thought that he would benefit from the introduction of antidepressant medication. She noted that he continued to struggle with Post Traumatic Stress Disorder. He experienced flashbacks in the workplace whenever he heard a loud noise. He also experienced nightmares about the accident. He was hyperaroused and hypervigilent in the workplace. Her prognosis for the plaintiff's future was guarded. However, she expected some improvement over time and particularly if he was prescribed an antidepressant medication that he could tolerate.

37. In February 2015, the plaintiff ceased work. He stated that he did this, because he found the demands of the work psychologically as being too difficult for him. He described how he was hypervigilent and was on edge all the time at work. Indeed, he was sometimes on edge from early in the morning as he prepared to go to work. He described how on one occasion, he drove up to the gates of the plant but could not physically force himself to drive through the gates. It was then that he made the decision that he would have to give up work completely.

38. In the course of cross examination, it was put to Dr. Corby that when she had seen the plaintiff on 29th January, 2015, some weeks prior to his ceasing work, that he had not mentioned to her that he intended to stop working. She stated that he had been unhappy in his job after the accident. He was struggling to cope with the demands of the work and in particular his presence in the area where the accident had happened. In addition, she noted that the plaintiff had witnessed two further accidents in the workplace, where a piece of metal had fallen onto an operative's foot, causing a crush injury to the foot and on another occasion, an employee had fallen from a teleporter. Both these incidents had a marked effect on the plaintiff's psychiatric state.

39. In cross examination, Dr. Corby was asked whether she had recommended that the plaintiff should leave work. She stated that she would not recommend a person should leave work, unless it was causing them significant distress. The plaintiff had tried his best to do the new job which had been made available for him. Unless there had been a major issue, she would not recommend that he should leave work. However, in this case, the plaintiff was not happy. He was turning up for work, but he was distressed. He was being re-traumatised, which was causing him to experience symptoms of P.T.S.D. and heightened anxiety.

40. She accepted that when she had seen the plaintiff in January 2015, he had not told her that he intended to leave work. He was having a lot of physical anxiety symptoms at that time and was struggling at work. He had always enjoyed being in the workplace prior to the accident. He had returned to work quickly after previous accidents. Work was a big part of his life. It was put to the witness that none of the plaintiff's doctors had advised him to give up work. She accepted that that was the case.

41. In his evidence, the plaintiff stated that he had had to give up work in February 2015, because he found the stress of working there too much. He was obliged to take pain relieving medication, but could only do so on his arrival at work, as the medication made him drowsy and he could not drive. When the medication wore off during the day, he would experience severe pain. He stated that he was exhausted at the end of the day and would go home, have his dinner and go straight to bed.

42. He stated that he also experienced considerable psychiatric difficulty with work. He stated that witnessing the two accidents had had a great effect on him. He became very frightened of being in the workplace. However, he accepted in cross examination that he had not told Dr. Corby, when he saw her in January 2015, that he intended to leave work the following month. He accepted that no doctor had specifically advised him to cease work. He accepted that when he had seen Mr. Gilmore on 16th February, 2015, he had not told him of his intention to leave work, but had told him that he hoped to be back in work the following week.

43. The plaintiff also accepted in cross examination, that the physical demands of his work were not that great. The sick certificates which he had submitted after February 2015, referred to shoulder, neck and back pain, but made no reference to any psychiatric problems. The plaintiff stated that he had had psychiatric problems at work for a number of months prior to February 2015. However, he accepted that he had not brought this to the attention of Mr. O'Brien and had not sought any time off from work. The plaintiff stated that he ceased work due to physical and psychiatric problems, although he did not admit the psychiatric problems to his employers. He accepted that he did not tell Dr. Quinn in July 2015, that he had stopped working. He accepted that Ms. Shanahan, the Chartered Physiotherapist who carried out the Functional Capacity Evaluation, had found that he was fit for light/medium physical demand work. He accepted that the quality control work which he did was light work.

44. The plaintiff stated that part of his distress was due to the fact that he thought that his work colleagues thought less of him,

because he was doing administrative work. He said that when he ceased work, he missed the work and missed being with his colleagues. However, his mental health had improved. He was not as irritable and was less anxious. He was asked whether he had ever considered going back to work. He stated that he had considered that possibility, but he was too afraid to go back to work because he feared being involved in another accident and might possibly be killed. He accepted that he had not contacted Mr. O'Brien about any possible return to work.

45. The plaintiff also accepted that he had not done any training to do any other work, nor had he looked for any alternative light work. It was put to the plaintiff that he had told Dr. Corby that he felt that he had a meaningless job, that his reports were being ignored and he felt that his work colleagues resented his doing light work. The plaintiff stated that that was what he told his psychiatrist. He felt that his reports were being ignored. None of his work colleagues complained about his work but they said "*you have a handy number*". He said that he was obliged in the course of testing the product to go out in all types of weather. He stated that he got a lot of chest infections. It was put to the witness that he had told Dr. Corby that he had ceased work, because he felt undervalued and felt resented; there was no mention of stress, fear avoidance, or psychiatric difficulties. The plaintiff said that there were a number of different reasons why he left work in February 2015.

46. Ms. Geraldine Gardner, the plaintiff's wife, stated that he had had to cease work in February 2015 due to the fact that he would panic once he got to the gate to the yard. This was after he had witnessed the two accidents at work. He was not afraid of work, but was terrified of working in the defendant's yard. She stated that he seemed more relaxed and at ease after February 2015.

47. Mr. Dermot O'Brien, was the manager of the galvanising plant at the time of the accident. He stated that he got on very well with the plaintiff. He stated that he relied heavily on the plaintiff's knowledge of galvanising. He stated that the plaintiff was a very good worker.

48. After the plaintiff suffered the shoulder injury in November 2013, while assisting a colleague to lift a gate, he had told the plaintiff not to do any work in the Black Yard. He was to confine himself to quality control inspections of the finished product and produce reports thereon. He denied that the job was "*made up*" for the plaintiff, or that it did not serve any useful purpose. He said that the quality control reports were a feature that was unique to their company and was appreciated by their customers. It gave the company an edge over their competitors. Since the plaintiff had ceased working with the company, they had hired another man to fulfil that role. He stated that the plaintiff's job was still open for him, if he wished to take it up and they would redeploy the other man elsewhere in the plant.

Conclusions on the Plaintiff's Cessation of Work in February 2015

49. It is clear from a consideration of the evidence, that there were a number of reasons as to why the plaintiff gave up work in February 2015. While the work itself was not physically demanding, the plaintiff continued to have psychical symptoms in his neck and shoulders. He continued to need painkilling medication on a daily basis. However, he could not take this before he left home, as it made him drowsy and affected his driving. He stated that he would experience severe pain when the medication wore off during the day. A secondary reason was the fact that the plaintiff did not particularly like being restricted to light work. He felt that his former colleagues resented the fact that he was doing a "*handy number*" and did not have to do any heavy work. He stopped going to the canteen due to a perceived resentment on the part of his fellow workers. The third and probably the most significant factor leading to his ceasing employment, was the psychiatric difficulties, which he was suffering. He stated that he found it very difficult to continue working at the plant, particularly after he witnessed accidents to two fellow employees. He stated that he would be in a state of anxiety for some time before actually arriving at work. During work, he would have flashbacks if he heard loud noises, or had to work near the scene of the accident. He became very frightened for his own safety while at the plant. His evidence of heightened anxiety and irritability was supported by the evidence of his wife.

50. There are a number of facts which support the proposition that the plaintiff had a strong work ethic. He had a strong pre-accident work history. He had worked continuously since the age of thirteen years. He had demonstrated a strong desire to work. In particular, he had had six previous accidents while working with the defendant company. None of these had resulted in any claim being made by him. He always returned to work within a short period. After this accident, where he had suffered multiple serious injuries, he had returned to work after approximately one year. This showed a determination on his part to get better and to get back to work. It was commented upon favourably by the defendant's medical experts.

51. The plaintiff's evidence in relation to his psychiatric symptoms being aggravated by being present in the defendant's plant, was supported by the evidence of Dr. Corby. She was also of opinion that his psychiatric symptoms had ameliorated considerably since he gave up work.

52. Taking all of these matters into account, the court reaches the following conclusions: the plaintiff was fit for light/medium physical demand work. This was supported by the medical evidence and by the evidence of Ms. Shanahan. The work which the plaintiff was given after the accident in the area of quality control was light work. The plaintiff has satisfied the court that he was well motivated to get better and to return to work. It is to his credit that he did so approximately one year after the accident, when many other plaintiffs would not have done so. I accept the evidence of the plaintiff, which was supported by the evidence of his wife, that it was primarily due to his psychiatric difficulties that he had to cease working at the defendant's plant in February 2015. I am satisfied that a combination of the loud noises at the factory, the witnessing of two accidents to fellow employees and the closeness to the scene of the accident, all combined to cause the plaintiff to suffer intense anxiety symptoms and symptoms of P.T.S.D. while at the plant. In these circumstances, I am satisfied that the plaintiff acted reasonably in deciding to give up work in February 2015. I am satisfied that his inability to work after that date, was due to the psychiatric injury suffered by him as a result of the accident.

53. In February 2015, the plaintiff was 57 years of age. Having regard to the fact that he has very little educational qualifications, I find that he is unlikely to be taken on by an employer when he can only do light work. I accept the evidence as contained in Ms. Elva Breen's report that in reality, the plaintiff is not likely to secure light work on the open market. Given his age, lack of educational qualifications and his physical limitations, I find that on the balance of probabilities, he is not likely to work again prior to reaching normal retirement age. In these circumstances, the plaintiff is entitled to damages in respect of his loss of earnings to date and for his loss of earnings into the future until age 67, which will be dealt with later in the judgment.

The Plaintiff's Progress 2015- 2017

54. On 28th July, 2015, the plaintiff was referred by his solicitor to Dr. Brendan Conroy, Consultant Anaesthetist and Pain Management Specialist. He noted that much of the plaintiff's pain was between the shoulder blades in his back, in the lower part of his neck and he also felt a sensation going up into his head of pain (almost describing headaches) which he found very worrisome. He also complained of shoulder pain, which had been bad on the right hand side.

55. Dr. Conroy noted that the plaintiff had a very supportive wife, but the relationship between the plaintiff and his wife had been

strained because of both financial and intimacy problems, which he felt was very understandable. He noted that the plaintiff had previously been a very healthy man, who enjoyed his work and was very motivated. On examination, he found the plaintiff very stressed and had poor eye contact. It came across that he felt guilty all the time. On examination, he had a slight decrease in the range of motion of the neck and was tender around C6/7 and C7/T1 facets. He was tender at the medial aspect of his scapula, in the area of the costotransverse ligaments around T4 going down (it could be facet as well). He also had pain in his right shoulder and he had tenderness in the A.C. joint.

56. Dr. Conroy discussed the option of giving the plaintiff some cervical facet injections, costotransverse ligament/thoracic facet injections and also suprascapular nerve pulsed R/F lesioning.

57. In subsequent correspondence dated 10th November, 2015, Dr. Conroy set out the costs of this treatment and the duration of any benefits from the treatment. With cervical denervation, you would expect to get three to eighteen months. From pulsed R/F lesioning of the suprascapular nerve in the shoulder area, just a couple of months.

58. In May 2016, the plaintiff was admitted to St. John's Hospital in Limerick where he had bilateral C6/7, C7/T1 cervical facets, left costochondral injections and also right suprascapular nerve pulsed R/F lesioning. Following that treatment, he was able to wean off some of his medication. The plaintiff was very happy with the results of that treatment. He was reviewed on 13th September, 2016, when he stated that he had got as far as the beginning of September, when the pain started to come back. Essentially, he got about three months of relief from the treatment.

59. Dr. Conroy discussed the treatment and the potential benefits of suprascapular nerve pulsed R/F lesioning. That was something that they could do going into the future. That treatment could be repeated every two to three months to get some prolonged relief, which would allow the plaintiff to have some physiotherapy treatment. Dr. Conroy stated that it would not alter the fact that he had A.C. joint type degeneration in that area. He hoped that the supraspinatus tear, as diagnosed by Dr. Stafford, would slowly resolve. In summary, the situation at that time was that there had been some benefit with injection treatment. He thought that two to three months relief was a good result. He noted that Mr. Colville felt that the plaintiff had an A.C. joint problem. Dr. Conroy stated that he could keep on doing suprascapular nerve injections to give the plaintiff relief going into the future, without any significant trauma to the shoulder itself and that was something that he was more than happy to offer, but he would not be able to fix the A.C. joint as such. That was something that would need to be repeated on a regular basis into the future.

60. On 8th December, 2016, the plaintiff was brought back into St. John's Hospital where a right suprascapular nerve pulsed R/F lesioning was carried out. He explained that this was a procedure that was done to knock out one nerve which supplies a significant proportion of the shoulder. Some estimates around 90% of the shoulder joint. It was very useful for pain, where there was difficulty in treating it in any other way. Patients, for example, who are not tolerant of surgery, or who had surgery and still had residual pain. It was not a perfect solution, but it was useful. He stated that they administered this treatment to the plaintiff and he got very good stimulation at a low voltage, implying that they were near the nerve, that was where they did the lesioning. He stated that if they were lucky, this procedure could give people improvement in their pain. It was not a cure, but it would give improvement in the person's pain for anywhere up to two and three months. It needs to be repeated on an ongoing basis, if the patient got a favourable result. He stated that at that time it was too early to see how long the plaintiff would get as a result of the procedure, but hopefully it would be an option they would have going into the future.

61. The plaintiff was reviewed by Mr. Gilmore on 8th September, 2015, just over three years since the accident. He complained of pain in the left interscapular area and was very uncomfortable there. He also complained of pain in the right shoulder. The left shoulder felt alright except for the pain felt in the interscapular area. He told the doctor that he had not been able to work since February 2015. Examination of the neck revealed that the range of movement was as before, with a 60% range of motion with pain on pushing it beyond that. He was again tender in the right and left trapezius and also tender in the left interscapular area. There was a clicking sensation on moving the neck. There was also a prominence and clicking at the right A.C. joint. There was variable alteration of sensation in the left little finger and to a lesser extent in the left ring finger. Mr. Gilmore was of opinion that he continued to have ongoing difficulties with his cervical spine and with his shoulder, which was then over three years post accident. He felt that the plaintiff would benefit from the injections into the A.C. joint which Mr. Colville had advised.

62. The plaintiff was reviewed by Mr. Gilmore on 31st March, 2016. Since his previous examination, he had had about five sessions of physiotherapy which was ongoing. He continued to require painkilling medication. However, he took Arcoxia as required, but tried to avoid taking this medication as it made him feel sick. He also took paracetamol occasionally. He was doing a home exercise programme.

63. He again complained that he had difficulty with the right and left shoulders and his neck. If anything, he felt that these areas were getting worse. He also experienced pain in the left subscapular area. Examination of the neck showed a 50% range of motion, with a lot of pain. He was tender in the A.C. joint on the right more than the left. He had restricted range of movements of the upper limbs, leading to pain in the left interscapular and scapular areas. He also complained that he had altered sensation in the left distal forearm and ulnar border of his little finger. Rotation of the thorocolumbar spine was poor. Forward flexion was to mid shin. Lateral flexion and extension were very poor. Straight leg raising, however, was normal bilaterally and there was no obvious neurological deficit in either lower limbs.

64. Subsequent to the examination, Mr. Gilmore had sight of the M.R.I. scans taken on 22nd April, 2016. These confirmed numerous fractures of the ribs posteriorly on the left side. There were also significant changes in the thoracic spine with both degenerative changes and modic changes in the end plates at T7, 8 and 9 with disc bulges at T6/7, T7/8, T8/9, T9/10 and T11/12, all of which seemed to give rise to some indentation at least of the thecal sac, if not of the spinal cord itself. However, there were no obvious changes of any significance in the spinal cord.

65. M.R.I. scan of the cervical spine dated 11th May, 2016, showed that there were degenerative changes throughout the cervical spine, with disc bulges at the C3/4, 4/5, 5/6 levels, which did indent both the thecal sac and the spinal cord. In the lumbar spine, there were degenerative changes throughout, with modic changes in the vertebral bodies also, indicating that these were of long standing, with significant narrowing of the L3/4 level, to a lesser extent the L4/5 level, and also of the L2/3 and L1/2 levels. At all of these levels, there was a moderate amount of disc bulging, which gave rise to some compression of the spinal canal and narrowing, but no definite nerve root compression.

66. Mr. Gilmore was of opinion that the plaintiff continued to have significant ongoing difficulties as a result of the injuries sustained in the accident in August 2012. He stated that not all of the degenerative changes had been totally caused by the accident, but they had certainly been aggravated and rendered symptomatic by it. At that stage, he felt that the plaintiff probably warranted assessment by a spinal surgeon to ensure that no further treatment might be indicated. Given the fact that it was then almost four

years since the accident, he felt that the likelihood was that the plaintiff would continue to have ongoing difficulties. Only time would tell what further treatment would be required and whether or not he would require any surgical intervention.

67. The plaintiff was reviewed by Mr. Gilmore on 4th October, 2016. The plaintiff continued to take Ixprim for his ongoing pain. He continued to be on inhalers, Singulair tablets and Serotide Discus for his asthma complaint. He also required sleeping tablets at night. In terms of his complaints, he stated that his situation was much the same as at the previous examination. He found that he was tightening up more around his shoulders and upper back. He was doing the home exercise programme three times a day and this would normally help to loosen him out. He was not able to work. Occasionally, he found he was very painful in the right A.C. joint.

68. Mr. Gilmore noted that since he had last seen the plaintiff, he had been treated by Dr. Brendan Conroy in St. John's Hospital and had had three injections in May – into his right shoulder, the base of his spine and the interscapular area. The plaintiff stated that these had given him very good relief for about two months. He was due to be reviewed again in December 2016. Examination of the neck showed a 50% range of motion, except for rotation to the left which was 75%, but all movements were accompanied by pain. He was tender in the right and left interscapular areas. There was decreased sensation in the left distal forearm, thumb and ulnar aspect of hand and forearm. His A.C. joint continued to exhibit crepitations on movement and was slightly prominent but did not require surgery. In the thorocolumbar spine, rotation to the right was less than to the left. Forward flexion was to mid shin. Lateral flexion and extension, all caused pain. Straight leg raising was tight but negative bilaterally. There was no obvious neurological deficit in either lower limb.

69. Mr. Gilmore noted that the plaintiff continued to have ongoing difficulties with his neck and back and right shoulder area as a result of the injuries sustained in the accident. He continued under the care of his own G.P. and under the care of Dr. Brendan Conroy. He would probably require ongoing treatment with them, at least in the short to medium term. Mr. Gilmore did not anticipate that there would be any significant change for better or for worse in his ongoing level of symptoms. The plaintiff would have to do his best to learn to adapt his lifestyle in order to accommodate these symptoms and limitations. From the point of view of any possibility of return to work as a galvanised steel worker, he did not see this as a possibility certainly at that time and given the fact that he had not responded adequately to treatment so far over a four year period, he felt that it was probably unlikely that the plaintiff would be able to return to such activity in the future. In terms of a future prognosis, Mr. Gilmore stated in his evidence that the plaintiff would have ongoing difficulties in his neck, shoulders and back. He would have to be very careful what activities he did. He did not think that the plaintiff would be able to return to his sport of fly fishing.

70. In relation to his psychiatric symptoms, the plaintiff was reviewed by Dr. Corby on 24th May, 2016, some three years and nine months post-accident. In terms of his mood, the plaintiff described it as being not so bad. He had responded well to antidepressant medication prescribed in 2015. However, he became low at times in relation to his physical limitations. He worried about the future in terms of how his injuries would progress and how he would possibly develop arthritis. He had been setting realistic goals for himself in relation to the physical activities that he could do. He was realistic and understood that he would never get back to what he was in 2012, before the accident. He continued to report having flashbacks to the accident. He had a very heightened startle response, especially to loud noises. When he heard a loud noise, he would have a flashback to the metal jib coming at him from behind. Even when he heard loud noises out on the street e.g. workmen using a drill, this would cause him to fear that he was going to be hit from behind. He would relive the experience of the accident. He still had nightmares. Dr. Corby stated that his startle response and reliving experience, were responses to noise. He continued to require medication. He was on paracetamol three times daily. He also took singulair tablets and a seretid diskus inhaler. He took two tylex at night and also took stilnoc at night.

71. In her opinion, Dr. Corby noted that the plaintiff continued to suffer pain on a daily basis related to his injuries. He took painkillers on a daily basis for his symptoms. He had also had a number of injections under the care of a pain specialist. He was functionally limited because of his injuries and had to obey certain limits in relation to activities. He continued to engage in rehabilitation exercises.

72. She noted that the plaintiff had ongoing psychological difficulties related to the accident. He suffered flashbacks and nightmares, but these occurred less frequently than before. They had less intensity than at the beginning following the accident. He was avoidant of certain unpredictable noisy places. She stated that he did not meet the full criteria for Post Traumatic Stress Disorder, because of the frequency of his symptoms and their intensity being lesser than in the past, but he did have post traumatic symptomology following the accident. Even though he was no longer exposed to workplace noises and feeling of risk associated with them, he continued to react to other noises in the environment, with a heightened startle response and experienced reliving phenomena every few weeks.

73. Dr. Corby stated that the plaintiff had previously been depressed following the accident, especially in relation to the injuries he suffered and the ongoing pain syndrome. He was aware of his physical difficulties and was actively engaged in a rehabilitation programme. He did not currently meet the criteria for a depressive disorder. His prognosis in the longer term was guarded, given the ongoing physical difficulties, as well as his inability to continue working, which was a very important part of his life.

74. The plaintiff was reviewed by Dr. Corby on 9th January, 2017. He continued to suffer pain on a daily basis and required painkillers regularly. He had been administered pain relieving injections from a pain specialist. He was limited physically and had been unable to return his much loved hobby of fishing, because of the accident. She noted that after the accident he had developed depression and Post Traumatic Stress Disorder. Although he had returned to work in an administrative role, he had had a very traumatic experience in the workplace and ended up leaving work in February 2015. He had been on illness benefit for a period of time and was then put on an invalidity pension. He found it very difficulty to accept the title "*invalidity pension*" as he did not want to think of himself as an invalid.

75. The plaintiff stated that over the previous few months, his mood had been very depressed. He was on medication when he went back to work and he stated that on some days he could not remember driving into work. He was on various painkillers, as well as medication for his breathing. He stated that when he had returned to work, he had the expectation and the hope that he would return to doing everything that he had done before the accident. He had suffered previous accidents in the workplace and had returned within as short a period as possible. However, he suffered a further injury while lifting a gate in November, 2013. He said that the boss spoke to him and advised him that he would not be able to continue on in the yard. He was given an administrative role at that stage. He indicated that he found the administrative work difficult as it was office based. In addition, he also found it difficult working within 70 or 80m from the area where he had his accident. He stated that he had witnessed two accidents in the workplace and these events had upset him greatly. Each time he witnessed an accident in the workplace, he was re-traumatised. He experienced ongoing flashbacks and nightmares to his own accident. He continued to have a heightened startle response and when he heard a loud noise, he became very anxious and suddenly fearful. He stated that after one of the accidents to a young man, he became fearful and was very upset. He would relive the hopeless feeling of his own accident, when he was exposed to similar events. He came to believe that in the future someone would die in the defendant's plant, because of all the accidents that had happened there.

76. The plaintiff indicated that his mood had improved since he was away from the workplace. While he had been at work, he had been hyperaroused and was aware of everything in the vicinity of where he was working in the plant. He stated that if he were to go back to the plant, it would bring the accident all back to him. When he was out of the workplace, he described how he did not think of the accident as much. He was experiencing reliving symptoms alternate nights every week. Since he left the workplace, he described how he had had flashbacks or nightmares once or twice a month. During the day, however, he startled easily, whenever he heard a loud noise. At night time if he heard a loud noise, he would sit up and he described himself as freezing on the spot. His wife had told him that he was in a sweat some nights. He stated that he had recently been required to visit the plant to attend a meeting with a health and safety officer and an engineer. The man had not turned up on time and the plaintiff was in the workplace longer than he had anticipated. He stated that he did not feel comfortable and had thoughts of escaping from the plant. He described how he had an ongoing low mood. He stated he would get stupid thoughts in his head sometimes and had a death wish. He was frequently tearful when certain reminders of the accident took place.

77. Dr. Corby was of opinion that the plaintiff continued to struggle with significant physical symptoms. He had physical limitations and was required to take pain relieving medication on a daily basis. Although he had been away from the workplace since February 2015, he continued to suffer ongoing Post Traumatic Stress Disorder, with a heightened startle response and relieving experiences to the trauma. When he had returned to the plant for an engineering inspection, he reported having an increased level of anxiety. Discussing his accident also increased the frequency and intensity of his reliving experiences.

78. Dr. Corby noted that the plaintiff continued to suffer from ongoing low mood and had become quite withdrawn from his wife in the recent past. He described an intermittent death wish. He was not currently on any antidepressant medication. She thought that it would be advisable for him to commence same. She stated that given that he was suffered from ongoing pain and ongoing depressive features, the reintroduction of an antidepressant was warranted. She had prescribed Duloxetine 30mg daily for one week increasing to 60mg daily thereafter for a trial period. She felt that his long term prognosis was guarded, given the chronicity of his pain symptoms and the life threatening nature of the accident he suffered, as well as the ongoing effects of the injuries. She did not anticipate that he would be able to return to the workplace given the severity of his ongoing psychological and psychiatric difficulties in relation to this traumatic event.

79. Dr. Corby noted that the defendant's psychiatrist, Dr. Sinanan, had suggested that the plaintiff might benefit from cognitive behavioural therapy. This was recommended for his depression rather than the P.T.S.D. The plaintiff had been to Abbey Physiotherapy Clinic and they had given him a C.B.T. programme, so he had already had that therapy. She did not feel that further C.B.T. would be that beneficial. Dr. Sinanan had also recommended that he might have therapy in the form of Eye Movement Desensitisation and Reprocessing (E.M.D.R.) in relation to his P.T.S.D. complaint. Dr. Corby noted that this was a treatment developed in the U.S. for P.T.S.D., for people who had seen visual traumas. This treatment can be useful to reduce the intensity of frequency of flashbacks. However, the plaintiff's reaction was caused by sounds rather than visual stimuli, so E.M.D.R. would not be that helpful for treating sound based flashbacks. She thought that the best strategy was to avoid places where there would be loud noises.

80. Due to breathing problems since the time of the accident, the plaintiff was seen by Prof. Jim Egan, Consultant Respiratory Physician in June 2016. Prof. Egan noted that he had no history of pre-accident breathing or chest difficulties. His lung function studies in 2014 were normal. Follow up lung function studies in 2016 showed a deterioration in lung function. These studies revealed that the plaintiff had constriction in lung function. The doctor noted that because of shortness of breath following the accident, the plaintiff had been put on Seretide inhaler and Singulair in 2013. Both of these agents were used for the treatment of asthma. The plaintiff complained of shortness of breath on exertion intermittently. He also complained of having panic attacks when he was sitting in a stuffy room where he experienced gasping and had to leave. He had episodes of being short of breath, where he could not breath properly. This occurred approximately two to three times a month. Associated with the shortness of breath, he was often light headed. He stated that he could become short of breath while watching television and had to leave the room. He also noticed that he was wheezy at night when trying to sleep. Since the accident, he had been susceptible to respiratory tract and chest infections, which were characterised by cough and phlegm production.

81. Prof. Egan was of opinion that the plaintiff had experienced significant mechanical trauma to his chest. Since then he had had symptoms consistent with (a) late onset asthma; and (b) hyperventilation syndrome. There was a direct relationship between his symptoms and the episode of trauma. The asthma had been precipitated in a dynamic fashion because of his chronic pain related to his accident. Normal lung function studies, did not preclude a diagnosis of asthma. His symptoms on some occasions were related to hyperventilation syndrome, which in turn was related to pain relating to the trauma. This was typically characterised by his shortness of breath while watching T.V. and having to leave the room, with an associated sensation of light headedness. In terms of causation, Prof. Egan was satisfied that there was a direct relationship between the accident and the onset of asthma. In terms of a prognosis, from a pulmonary point of view, the plaintiff would have a normal lifespan, but would be prone to asthma and infections. He would require inhalers and tablets from time to time.

82. In cross examination, Prof. Egan said that he had seen the plaintiff shortly before the report dated 2nd June, 2016. He stated that in light of the lung function studies which he saw recently, he was of opinion that the plaintiff had late onset asthma. He said this was somewhat different to what he had said in his report, due to the later lung function studies. It was put to the witness that the defendant's expert, Prof. Burke, was of the opinion that as the plaintiff had been a smoker for a large portion of his life, a large portion of his breathing difficulties were caused by smoking rather than by trauma. Prof. Egan did not agree with this assertion. He felt that the plaintiff's past smoking was not that significant, as his initial lung function studies were normal after he had given up the smoking. The symptoms only came on after the accident. He was asked as to whether it was relevant that the plaintiff had taken up smoking again and was a smoker at the present time. Prof. Egan stated that the plaintiff had not told him that. His understanding when he examined the plaintiff, was that he was not smoking at that time. He stated that if the smoking was intermittent, it would not be that relevant. His earlier lung function studies had been normal, so the earlier smoking was not relevant. He stated that often people would smoke in situations of stress. He had been aware that the plaintiff had been a smoker in the past. Prof. Egan stated that the lung function studies in March 2014, did not show any drop in lung function. However, the tests done in 2016, did show a deterioration in his condition which he thought was due to late onset asthma. The witness stated that he accepted that the direct trauma to the chest and lungs had been resolved but the constriction of the airways as shown on the subsequent scans was referable to the accident. He was of opinion that the reduced function on the 2016 test was attributable to the chain of events caused by the trauma of the accident. He stated that the deterioration in lung function was significant. The plaintiff had deteriorated in this area, despite being on the treatment and medication he was on since the accident. He stated that if a patient was doing well, it would be standard procedure to wean them off medication. It was put to the witness that the plaintiff had no symptoms when seen by Prof. Burke. His examination at that time had been almost normal. The witness stated that in eight out of ten cases, it was usual to find asthma patients who had normal lung function.

The Defendant's Evidence

83. The plaintiff was examined by Mr. Michael Maloney, Consultant Orthopaedic Surgeon, on behalf of the defendant on 23rd July,

2015. He noted that the plaintiff had ongoing problems with an impingement syndrome of the right shoulder. This was due to arthritic changes in the A.C. joint and degenerative changes in the rotator cuff. This predated the accident, but he had no doubt but that it was seriously aggravated by the accident. As the plaintiff did so well with the local injection, he felt that in time the plaintiff would benefit from arthroscopic debridement. The plaintiff also suffered a nasty fracture of the scapula. He noted that recent M.R.I. scans confirmed that the plaintiff had long standing arthritis of the A.C. joint. This probably contributed to his limitation of movements. Observation of dressing and undressing suggested that there was some functional element to the restriction of movement. Mr. Maloney noted that the plaintiff had limited movements of his cervical spine. M.R.I. scan confirmed that he had extensive degenerative spondylosis. He was of opinion that this predated the accident. Insofar as it was made symptomatic by the accident, it could be said to have been aggravated. The current findings were consistent with the radiological findings. There were no findings to suggest that it was accelerated or worsened by the accident.

84. Mr. Maloney stated that the plaintiff had made a good recovery from the fractures to his left ribs. The drain scar on the left side would be permanent. The plaintiff was somewhat "*barrel chested*", which might explain his increased incidents of chest infections but interstitial damage to lung tissue can not be excluded.

85. The plaintiff was reviewed by Mr. Maloney on 20th May, 2016, at which stage he complained that his neck was very stiff and sore most of the time. He continued to have pain in the right shoulder, but it was not as intense since the injection treatment. There was a bony prominence in the right shoulder. He had a dull pain all the time in his left shoulder. The area between his shoulder blades was very sore. If he turned quickly he would get a sharp pain in his ribs. He took analgesic medication as prescribed by his G.P.

86. Mr. Maloney noted that the plaintiff suffered a very nasty and frightening injury. The jib of the crane had hit him on the upper left side of his back. It fractured his scapula and crushed the side of his chest. He had associated soft tissue injuries to his neck and upper back and both shoulders. With the exception of left shoulder movements, secondary to the fracture of the scapula, overall he had recovered reasonably well from the actual fractures. The plaintiff had serious underlying degenerative pathology in his neck and in both A.C. joints of his shoulders. Mr. Maloney stated that as was often the case, the aggravation of the underlying degenerative pathology caused more problems than the actual fractures. He thought that little could be done about the aggravation of the underlying pathology caused by the accident.

87. The defendant also submitted a report by Dr. Phillip A. Hodnett, Consultant Radiologist, in relation to the M.R.I. scans of the neck, upper back and lower back. In summary, Dr. Hodnett had was of the view that the M.R.I. scan of the neck identified multilevel cervical spine degenerative disc disease and degenerative facet joint arthrosis, most advanced at C5/6 level with evidence of severe left neural foraminal stenosis evident on prior examination. The M.R.I. scan of the thoracic spine showed multilevel thoracic spine degenerative disc disease and facet joint arthrosis, without significant central spinal canal stenosis. M.R.I. of the lumbar spine also revealed multilevel disc degeneration, most advanced at the L4/5 level where broad based defuse disc herniation asymmetrical to the left exacerbated by degenerative facet joint arthrosis, resulted in moderate left neuro foraminal stenosis.

88. The plaintiff was examined by Dr. Kenneth Sinanan, consultant psychiatrist, on 2nd November, 2016. He noted that in August 2012, the plaintiff had been involved in what he thought was a life threatening accident and following which he suffered some shock. This was followed by symptoms of a P.T.S.D., with a depressive adjustment reaction to the pain and his changed way of life. On returning to work, he witnessed further accidents and they may have reactivated some of his symptoms to the point that sometime after that, he felt he could no longer work in his place of work, where people were exposed to danger. He described ongoing chronic pain, which was not yet fully controlled. Dr. Sinanan recommended that the plaintiff might benefit from reintroduction of antidepressant medication, together with C.B.T. and/or counselling, which could help him diminish his symptoms of distress and assist him to cope with his depression, by helping him to reschedule his life by setting up a new daily programme. He thought that eye movement desensitisation and reprocessing therapy might be helpful to reduce the flashbacks and nightmares. He stated that the plaintiff could use Viagra, or similar medication, to help him and could attend couples counselling or sex therapy to reactivate his sex life. He thought that with some or all of the above interventions, the plaintiff could get a good deal of improvement and could even get well enough to return to the workforce in a place where there would be no element of danger to him or others.

89. Finally, the plaintiff was examined by Prof. Conor Burke, Consultant Respiratory Physician, on behalf of the defendant on 30th April, 2014, and again on 12th October, 2016. In summary, Prof. Burke was of the opinion that the diagnosis in this case was significant post traumatic and indeed, life threatening respiratory injuries, but thankfully the plaintiff had made a full recovery from these significant injuries. He was left with a minor decrement in lung function and his cigarette history was entirely sufficient to explain these minor decrements, as all major indices of lung function were within normal limits. His lung function was not a restriction on any further occupational, or recreational activities beyond those applying to all workers. The only remaining issue was his medication requirement and in this regard, he would recommend attempting to wean this medication in accordance with the usual guidelines in this area, given the plaintiff's very good current results and in particular, given his absence of any significant respiratory symptomology.

Conclusions on Quantum of General Damages

90. In summary, the plaintiff suffered extensive serious injuries at the time of the accident. He was rendered totally disabled and experienced severe pain in the weeks and months following the accident. The plaintiff had pre-existing degenerative changes in his neck and shoulders. However, I accept the evidence of the plaintiff and of his G.P., Dr. Galvin, that prior to the accident, the plaintiff had been an extremely fit and active man. The degenerative changes were not causing him any symptoms at that time.

91. Prior to the accident, the plaintiff was able for heavy work in the galvanising section of the defendant's plant. While he had had six previous accidents at his place of work, none of these resulted in a claim and the plaintiff returned to work shortly after each accident. Thus, it is clear that he was a highly motivated man, who was eager to work.

92. As has been set out earlier in the judgment, the plaintiff was rendered totally disabled after the accident. He required the constant care of his wife, who had to give up her work for a period in excess of three months to look after the plaintiff. By early January 2013, the plaintiff managed to walk short distances. He began by walking 0.5km to the park and having rested there, he would walk back to his house. Thereafter, he gradually built up his walking tolerance.

93. The plaintiff returned to work with the defendant in August 2013. He continued at work even though he experienced significant pain in his shoulders and neck. He required analgesic medication on a daily basis. He could not take the medication prior to work, as it affected his driving. The defendant made light work available for him, compiling quality control reports. He was able for the work for a period of eighteen months, after which he had to desist from working due to ongoing pain and more particularly, severe anxiety and P.T.S.D. symptoms. The debilitating effect of his psychiatric symptoms has been set out extensively earlier in the judgment. The plaintiff was obliged to cease work in February 2015.

94. The plaintiff gave an account of a typical day at present, when he attended Dr. Corby on 24th May, 2016. He stated that he gets up at approximately 07:00hrs and has breakfast with his wife. He then drives her to work for 08:20hrs. He returns home and does some domestic duties. He collects his wife again at 14:30hrs. He attends various appointments. He engages in daily exercises, which had been shown to him by his physiotherapist. In the afternoon, he might go down to the river to look at other fishermen engaging in their hobby. He tends to stay in during the evenings and does not socialise as much as he had done prior to the accident.

95. One of the unfortunate sequelea of his injuries, is that the plaintiff has been unable to resume his hobby of fishing since the accident. This was his great passion. He would rise very early and drive to Co. Kerry where he would fish for the day. On occasions, he brought his wife to Killarney for the weekend. During the day he would fish and in the evening they would socialise with friends. All that is now gone. He misses it greatly. I accept the evidence of Mr. Michael Gilmore that the plaintiff will never be able to return to fly fishing again. While the plaintiff is able to walk down to the local river and watch others fishing, any person who has played sports will know that watching others play sport, is a poor substitute for actually participating in the sport itself. The loss of this recreational pursuit represents a significant loss from the plaintiff's life.

96. The plaintiff continues to have some symptoms of P.T.S.D. as outlined by Dr. Corby. Dr. Sinanan, the defendant's psychiatrist, has recommended certain medication, which the plaintiff's psychiatrist agrees might be worth a try. It would appear to be the case that, while the plaintiff had distressing symptoms while at his place of work, his symptoms have decreased since leaving work in February 2015. As noted by Dr. Corby in January 2017, the plaintiff suffers ongoing P.T.S.D. with a heightened startle response and reliving experiences to the trauma. When he returned to the workplace for the purpose of the engineering inspection, he had an increased level of anxiety. Discussing his accident also increased the frequency and the intensity of his reliving experiences. He suffers from ongoing low mood and has become quite withdrawn from his wife. He describes an intermittent death wish. It is hoped that the reintroduction of antidepressant medication will help ameliorate his symptoms. Dr. Corby's most recent opinion states that the prognosis is guarded, given the chronicity of his pain symptoms and the life threatening nature of the accident he suffered, as well as the ongoing effect of the injuries. Dr. Corby did not anticipate that he would be able to return to his former place of work, given the severity of his ongoing psychological and psychiatric difficulties. The court is satisfied that the plaintiff has significant ongoing psychiatric sequelea, which will be with him into the medium to long term.

97. Another unpleasant sequelea of the accident is that the plaintiff has not been able to have full martial relations with his wife since the accident. This has been caused by pain initially and subsequently by psychiatric symptoms. This constitutes a serious impediment to his martial relationship.

98. The plaintiff has also developed late onset asthma as a result of the accident. While the defendant's expert, Prof. Burke, ascribes much of his symptomology to his smoking for many years before the accident, Prof. Egan is of the view that, as his lung function studies were essentially normal in 2014, the plaintiff's smoking was probably not that relevant. I accept Prof. Egan's evidence that the trauma of the injuries sustained in the accident, set up a spiral of events, whereby the trauma of the accident caused significant injury to the lungs, which has led to a narrowing of the tubes in the lungs. The trauma to the lungs has set up a spiral whereby infection in the lungs causes the tubes in the lungs to become inflamed, thereby rendering it difficult for the plaintiff to breath. In addition, the plaintiff has become prone to suffer frequent chest infections. While the asthma and chest infections do not seem to cause the plaintiff inordinate difficulty at the present time, he is required to use an inhaler and take medication on a regular basis. Prof. Egan is of opinion that the plaintiff will require the use of inhalers and medication from time to time into the future.

99. In relation to the physical injuries, the plaintiff has been left at 59 years of age with continuing pain in his neck, upper back and shoulders, for which he will require injection treatment on an ongoing basis. Dr. Conroy has given the opinion that if the plaintiff gets two to three months pain relief from the injections, that will be a good outcome for him. It would appear that this treatment will be continuing into the long term.

100. In terms of work, while the plaintiff has been found fit for light/medium physical work, for the reasons already set out earlier in the judgment, I do not think that he is likely to obtain suitable employment on the open market having regard to his age, his physical limitations and his lack of educational qualifications. I find that on the balance of probabilities, he will never work again.

101. Taking all of these factors into account, I award the plaintiff the sum of €140,000 for pain and suffering and loss of amenity to date. I award the sum of €95,000 in respect of pain and suffering and the continuing disabilities as outlined above, which will continue for the rest of his life.

The Claim for Special Damages

102. The plaintiff and defendant have agreed a number of the past medical and treatment expenses in the sum of €11,750.

103. In respect of the claim for past loss of earnings, I have already determined that it was reasonable for the plaintiff to cease work in February 2015, and that this was due to his injuries sustained in the accident. I have further found that due to his injuries, the limitations on his work capacity, his age and his level of education, he had effectively been unemployable from the date of the accident until August 2013 and from February 2015 up to the trial of the action. In these circumstances, the parties have agreed that the appropriate sum for past loss of earnings is €78,927, less the appropriate R.B.A. amount, which at the date of judgment comes to €31,008.60, giving a net loss of earnings to date of €47,918.40.

104. For the reasons set out earlier in this judgment, I find that while the plaintiff is fit for light/medium work, on the balance of probabilities the plaintiff will not work again prior to reaching normal retirement age of 67. According to the report issued by Keogh Summers Chartered Accountants, the plaintiff would currently be earning €731.46 gross per week, had he not been injured. The net weekly equivalent of this sum, after tax, P.R.S.I. and U.S.C. deductions, is €576. As the plaintiff will not work again, his net weekly loss is this amount. I accept the evidence of Mr. Tenant, the actuary that the capital value of this loss from February 2017 to normal retirement date at age 67, is €211,580.

105. In relation to the future medical costs which will be incurred by the plaintiff, Mr. Conroy in his correspondence has stated that the costs of cervical denervation will be €1,000 per annum and the costs of suprascapular nerve pulse R.F. lesioning will be €2,800 per annum. Assuming a 1% real rate of return, the capital value of these costs come to €19,442 for the neck treatment and €54,438 for the shoulder treatment.

106. It appears that the plaintiff has current medication costs of €154.90 per month. Of this, the plaintiff has to discharge the drugs charge limit of €144 per month. Mr. Tenant has valued those costs on a 1.5% basis. I think that that is appropriate for these costs. The capital value of these ongoing medical costs for life is €31,669. This gives an overall capital value of medical treatment and medication costs of €105,549.

107. In addition to these treatment costs, it is likely that the plaintiff will incur G.P. fees of circa €250 per annum for the rest of his life. The capital value of this expense from February 2017 onwards is €4,860.

108. The remaining items concern the amounts that should be allowed for past and future care costs and whether it is appropriate for the plaintiff to be allowed the sum of €16,999.12 in respect of the cost of doing alterations to his dwelling. The defendants have agreed the quantum of the building costs, but not that they are properly claimable by the plaintiff.

109. In respect of the sums claimed for retrospective care costs, evidence was given on behalf of the plaintiff by Ms. Noreen Roche, Nursing Consultant. She set out the level of care that was provided to the plaintiff by his wife and brother in law and the level of care that was reasonably required by him at various stages, having regard to the extent of his disability in the months and years following the accident.

110. Ms. Roche's assessment of the plaintiff's retrospective care needs were set out at schedules 1, 2 and 3 in her report dated 30th May, 2016. Schedule 1 dealt with the first three months post accident. Given the severity and extent of his injuries, I think that it was reasonable to allow for the level of care set out at schedule 1. I accept Ms. Roche's evidence that the hourly rates set out therein, were based on the standard H.S.E. rates for day and night time care. Accordingly, I find that the sum of €11,433.24 is appropriate for that period of time.

111. Schedule 2 deals with the period, 18th November, 2012 to 31st August, 2013. This is the period starting three months post accident and ending with the plaintiff's return to work in August 2013. Ms. Roche noted that following the initial period of three months, the plaintiff was mobile within his home. However, he remained in severe pain. His upper limb strength was still poor and he required assistance mobilising outside his home. During this period he was extremely agitated and frustrated. Due to his pain levels, he was prescribed an increased dose of medication, which was administered and monitored by his wife. Her input during this period averaged four hours staggered assistance daily. The plaintiff remained largely confined to his home. He became extremely depressed. His wife contended that he had severe mood swings and exhibited anger outbursts which impacted on their relationship. Following a period, the plaintiff commenced physiotherapy treatment. He then began driving short distances. Ms. Roche has assessed that during this period the plaintiff would have required four hours care daily.

112. In cross examination, it was put to the witness that this was somewhat excessive, having regard to the fact that in January 2013, the plaintiff's G.P., Dr. Gavin, had noted that the plaintiff was not able to life a 10kg bag of potatoes. Counsel suggested that this was a somewhat modest limitation. The report further stated that the plaintiff was able to walk a lot. However, he was not able to do fly fishing, nor could he sleep on his left side. The doctor was of opinion that he was making a good recovery. Examination revealed that he had full movement of the neck and back but some limitation of movement in the right shoulder. The witness was asked, how in these circumstances the plaintiff could be seen as needing ten hours care per week. Ms. Roche stated that in her opinion, he needed one hour per day for domestic duties and the remainder of the care was for his bad days. His wife and brother in law helped him a lot during this period. His wife had had to help him with going to bed, going to the toilet and bathing. Counsel stated that none of that was mentioned in the medical reports at that time. Ms. Roche stated that he did require assistance at that time. His brother in law drove the plaintiff prior to the time that he resumed driving. When the plaintiff's wife returned to work, the plaintiff's brother in law provided assistance on an "*on call*" basis.

113. Ms. Roche stated that even when the plaintiff returned to work in August 2013, he still required assistance in dressing and getting out to work. Counsel pointed out that he had been able for work for a period of eighteen months and he had never said that he needed help to get out to work in the morning. Ms. Roche stated that it was her understanding that he had a sedentary job. She did not get into the specific details of his work with him. She did not ask him what he actually did at work. She was led to believe that he had a sedentary administrative job.

114. Counsel put to the witness that her assertion that the plaintiff needed care during the eighteen month period when he was working, was not borne out by the medical report furnished by Mr. Michael Gilmore from an examination on 25th March, 2014. At that time, the plaintiff had complained of pain in the left shoulder and a lot of numbness in the left side of his neck and left arm. He had a decreased range of motion in the right shoulder with a lot of crepitous in the right shoulder on rotation. He had a feeling of the left scapular area being twisted. He had not been able to return to any angling. Examination revealed there was a 50% loss of movement in the neck. He was tender in the left trapezius and also at the right A.C. joint, which was dislocated and showed crepitous on moving the shoulder. There was decreased range of motion in the right shoulder and the plaintiff had decreased sensation in the left C5 dermatome and also in the right little finger. His ribs showed him to be tender in the left posterior and lateral aspect. Ms. Roche accepted that there was no reference to a lower back component in the medical report, nor was there any reference to the use of a stick. However Mr. Gilmore had stated at that time, that the plaintiff continued to be quite disabled in relation to the shoulder. He felt that the plaintiff needed to be reviewed with consideration of carrying out a possible arthroscopic assessment of the right shoulder and perhaps carrying out debridement and acromioplasty and rotator cuff repair. In relation to the question of using a stick, the witness stated that she had seen the stick in the plaintiff's house and had asked him about it. She had been told that the plaintiff's wife purchased the stick to give the plaintiff added support when leaning on her, while descending the stairs. Ms. Roche felt that the plaintiff's pain in his back and shoulders would limit mobility and he would require the use of the stick on the stairs as the stairs, in his house were very steep. Counsel put it to the witness that the question of using a stick was not supported by the medical reports. The plaintiff did not use the stick, nor had he ever told any doctor that he needed one. Ms. Roche stated that he will not need the stick, if he is provided with accommodation downstairs, but he did require it when ascending and descending the stairs.

115. I am satisfied having regard to the extent of the plaintiff's injuries, that the level of his disability during the period set out in Schedule 2, justified the level of care as set out by Ms. Roche. Accordingly, I will allow the sum set out in Schedule 2 which totals €16,026.08.

116. Schedule 3 deals with the period from when the plaintiff started back to work in the defendant's plant in August 2013, up to the date of Ms. Roche's assessment in May 2016. Ms. Roche has allowed for ten hours care per week for this period. In cross examination, it was put to the witness that it was the plaintiff himself who decided to return to work in August 2013, albeit doing a job that only involved light work. It was put to the witness that the plaintiff had coped with the demands of this work for eighteen months. Ms. Roche stated that the plaintiff still needed assistance in dressing and getting out to work.

117. Counsel for the defendant put to the witness that her assessment of the plaintiff's care needs at that time i.e. when he was working for eighteen months, was not supported by the complaints made by the plaintiff to various doctors during this period. Counsel put to the witness the content of Mr. Gilmore's report arising out of the examination in March 2014. Ms. Roche accepted there was no reference to any lower back complaint, or to the use of a stick in that report. The witness accepted that the plaintiff had been capable of his light work at the plant for a period of eighteen months.

118. Counsel put to the witness the content of Mr. Gilmore's report arising out of the examination in February, 2015. Given the passage of time, the doctor felt that the plaintiff would continue to have ongoing difficulty and would require further treatment for the right shoulder in order to alleviate his symptoms. Ms. Roche stated that at this time, the plaintiff needed care, because he could not do upper limb tasks. He required the use of a stick on the stairs, in case he should stagger and fall. Due to his upper limb deficits and the narrowness of the stairs in his house, there was a risk of falling. It was put to the witness that this was not referred to in any of the medical reports. Ms. Roche stated that she had been out to the plaintiff's house and had actually seen the stairs, which were quite narrow.

119. It was put to the witness that when the plaintiff was seen by Dr. Quinn in July 2015, examination only revealed a mild limitation of movement in the right shoulder. The doctor was of opinion that the plaintiff had improved since last reviewed. In terms of a prognosis, he thought that the plaintiff would have pain in the shoulder in the long term. He was not fit to return to work as a steel worker, or for any job involving heavy labour, but he would be capable of jobs that did not involve heavy lifting or heavy physical exertion. It was put to the witness that as his only deficit was a slight limitation of movement in the right shoulder, he did not require the level of care as indicated by Ms. Roche. The witness disagreed and stated that on the basis of that report, the plaintiff did require both domestic assistance and personal assistance, in particular when showering and dressing. Counsel pointed out that his only limitation at that time, was a slight limitation of movement of the right shoulder, in which he had a 75% range of motion. Ms. Roche stated that when he had periods of pain, he would need the level of care recommended by her. She accepted, however, that the plaintiff was fit for light work at that stage. It was put to her that Ms. Shanahan found that the plaintiff could do light/medium physical activity. Ms. Roche accepted that assessment.

120. It was put to the witness that when the plaintiff was examined by Dr. Gavin on 19th February, 2016, he had complained of pain and disability, particularly in the right shoulder. He had had some physiotherapy treatment and he took the occasional sleeping tablet. He was also noted to have psychiatric symptoms at that time. Ms. Roche accepted this as an accurate assessment of the plaintiff's condition. It was put to her that on examination he had a range of movement in the right shoulder of 140 degrees out of a possible 180. The witness accepted that this was a significant range of movement. However, she was of opinion that the plaintiff still had difficulty getting dressed in the mornings. Counsel put to the witness that his range of movement in the shoulder joints was sufficient to enable him to dress. Ms. Roche stated that it depended on what he was wearing. Counsel asked her to indicate where in the medical report there was a suggestion that he could not dress, when he had a significant range of movement in the right shoulder and almost full movement in the left shoulder. Ms. Roche stated that he would have difficulty holding things above his head e.g. towel drying his hair.

121. It was put to the witness that the plaintiff had seen Dr. Quinn on the same day as he had been assessed by her on 21st April, 2016. At that examination, he had complained of pain in the right chest going into the neck. He told the doctor that he had medium pain in the shoulder and limitation of movement. However, he could do most routine domestic activities, once he avoided heavy lifting. Ms. Roche agreed with that summary, noting that the plaintiff would have pain setting fires and carrying buckets. Counsel pointed out that examination had revealed that he walked with a normal gait, he was tender in the lower back, his left shoulder was normal. His right shoulder was normal. Counsel asked, if the plaintiff had full movement in both shoulders, surely he would have no problem dressing? Ms. Roche stated that if the doctor found that the plaintiff had full movement in his shoulders, she could not dispute that. She stated that she did not have access to this report when preparing her report. She stated that despite Dr. Quinn's findings on examination on 21st April, 2016, the plaintiff would still require domestic assistance and personal assistance when having periods of acute pain.

122. When looking at the plaintiff's retrospective care needs, a number of things need to be kept in mind. The doctors are broadly in agreement that the plaintiff was rendered unfit for heavy physical work after the accident, but has been fit for light work. Ms. Shanahan, the Chartered Physiotherapist, who carried out the functional capacity evaluation, has found him to lack strength, but this has improved following completion of a rehabilitation programme. She has assessed him as being fit for light/medium physical work.

123. It should also be kept in mind that the plaintiff was able for the physical demands of his job in the area of quality control with the defendant company. The reason he had to give up work in February 2015, was mainly due to the P.T.S.D. caused by having to work in an area where he felt unsafe and where he was constantly reminded of his accident. While he did have pain in his neck and shoulders, which required him to take daily painkilling medication, he was able for the physical demands of his job.

124. The court accepts that the plaintiff cannot do any heavy work, such as lifting or carrying heavy loads, or manoeuvring large and heavy objects. The court also accepts that he cannot do tasks which require him to lift his arms above his shoulders. So he would not be able for cutting hedges, hanging wallpaper or painting ceilings. However, having regard to the findings on examination made by the doctors referred to above, the court is not satisfied that the plaintiff was disabled to such an extent that he required the personal and domestic assistance as set out at Schedule 3 of Ms. Roche's report. At a time when the plaintiff was capable of doing a full week's work, albeit of a light nature and when he could drive and go for reasonably long walks, the court is not satisfied that he required ten hours assistance every week. Accordingly, the court does not allow the sums claimed in Schedule 3 of the report. However, the court is satisfied that there probably were some DIY jobs and redecoration jobs which would have been undertaken by the plaintiff around the house, but in respect of which the plaintiff must have had to bring in tradesmen to do the work which he was unable to do because of his injuries. I propose to allow a modest sum of €6,000 to cover these expenses.

125. Ms. Roche has also advised that certain alterations be made to the plaintiff's house to enable him to reside there for the rest of his life. In an email dated 12th July, 2016, Ms. Roche advised that the plaintiff will require full accommodation at ground floor level, to include a toilet and shower room. She based her opinion on the fact that the stairs in the plaintiff's house is very steep and narrow. She thought that this would present him with particular difficulty as he gets older. In cross examination, it was put to her that no doctor, or other expert, had made any such recommendation. Ms. Roche stated that that may be due to the fact that she was the only person to view the stairs. She did not measure the goings and risings on the stairs, nor did she have any photograph of them. However, she was of the opinion that given their steep and narrow nature, they would constitute a risk to someone who was disabled. She was of opinion that due to his physical limitations and respiratory problems, it was necessary for the plaintiff's safety that he should move downstairs.

126. This plaintiff has suffered serious injuries to the upper part of his body. He continues to experience constant neck and shoulder pain, for which he will require treatment in the form of painkilling injections for the foreseeable future. He also suffered late onset asthma and suffers from frequent chest infections. The court is of opinion that these ailments while being serious, are not such as to greatly affect his mobility around the house. The court is not satisfied that the plaintiff requires accommodation on the ground floor. It may be that given the steep nature of the stairs, this will present a difficulty for the plaintiff as he gets older. If in time, the plaintiff reaches the stage where he cannot manage the stairs, that will be caused by the natural aging process, and the particular configuration of his house, rather than by the injuries sustained in the accident. Accordingly, the court does not allow the sum claimed for carrying out alterations to the plaintiff's house.

127. Finally, there is the question of future care costs. In order to see whether such care costs are likely to arise in the future, the court must have regard to the most recent evaluations and prognoses given by the various doctors. In this regard, Ms. Roche was at somewhat of a disadvantage, as she did not have access to the medical reports which post-dated her examination. It is not necessary to set out in detail the evidence given by the medical witnesses in relation to the plaintiff's current state, as this has been set out in detail earlier in this judgment.

128. Having regard to the evidence given by the medical witnesses as to the plaintiff's current condition and having regard to the most recent medical reports, the court is satisfied that the present position can be summarised as follows: the plaintiff is a 59 year old man, who continues to have constant neck, back and shoulder pain, which will require injection treatment on an ongoing basis. He has limitation of movement of the neck and shoulders. He also has respiratory symptoms and mental health issues. He cannot do heavy work, nor can he do his hobby of fishing. However, none of the treating doctors have said that the plaintiff will become disabled to such an extent that he will require domestic or personal assistance in the years ahead. In the circumstances, the plaintiff has not established a basis for allowing the level of future care as set out in Ms. Roche's report. Accordingly, the court declines to make any award in respect of future care costs.

129. As noted earlier when dealing with retrospective care costs, the court does accept that the plaintiff cannot do any form of heavy work, or work which involves overhead movement of his arms. It is reasonable to assume that there will be repair and decoration jobs around the house which the plaintiff would have done but for the injuries sustained in the accident. In the future, he will have to hire in tradesmen to do these jobs. In these circumstances, the court is of opinion that it is appropriate to allow the sum of €25,000 in respect of these future expenses. Adding the various heads of damages which have been allowed, this gives the plaintiff a total award of €675,116.72.