Neutral Citation Number: [2005] IEHC 473

THE HIGH COURT

[2001 No. 7674P]

BETWEEN

SHANE McFADDEN

PLAINTIFF

AND
AISLING WEIR

DEFENDANT

Judgment delivered on the 16th day of December, 2005, by Mr. Justice Declan Budd

Background

1. The plaintiff at the time of a road accident on 7th August, 2000, was then a senior insurance manager aged 50, having been born on 15th October, 1949, and is now 56 years of age. He and his wife Sophia have been married for twenty four years and they have resided for the last eighteen years in a very well maintained bungalow set on an acre of fine garden outside Saggart in County Dublin. The house is well situated with spectacular views towards Rathcoole and its environs. They have two children both of whom still live at home, being a twenty one year old daughter, who works as a receptionist in a communications company in Tallaght, and a son of eighteen years who has deferred starting college this autumn. On 7th August, 2000, the plaintiff was returning in his 1994 Mercedes car with his wife from Carlow where they had both been playing golf. For most of his life the plaintiff has been an avid golfer having at one time played off a four handicap. In August, 2000, he was captain of his local golf club, Newlands, which involved him in a considerable commitment to the club. He took much pleasure from playing on courses all over Ireland, both for the purposes of recreation and socialising and also as an enjoyable part of his job as a Senior Executive Sales Manager and Assistant Director of Allianz, which is a recent amalgam of a number of insurance companies. In particular the former Church and General was part of the group and it would have historically had a considerable number of ecclesiastical clients among its customers countrywide.

2. The plaintiff had responsibility for keeping in touch with the clientele all over Ireland and no doubt one reason why he particularly liked and was good at his job was that as a tall, handsome, fit, able and conscientious employee with a love of sport and the outdoor life, he particularly enjoyed dutifully visiting clients around the country. Being of sociable and personable character, competent and well organised, no doubt he relished meeting clients and having a game of golf with them on the great golf courses of Ireland.

3. The plaintiff was returning home with his wife after the Bank Holiday weekend and had stopped in a line of traffic on the Naas dual carriageway heading in the Dublin direction, about opposite to the Ambassador Hotel. He was stationary in a line of traffic governed by red traffic lights at the turn off to Kill village, which is in to the part of the village closest to Dublin. He and his wife were returning from playing golf in a mixed competition at Carlow Golf Club where he is also a member. He had slowed and stopped opposite the Ambassador Hotel in a tail back when he saw in his rear view mirror a car coming fast from behind. The sight of this speeding car caused him to brace himself. The defendant's car was a Nissan Micra which drove into the rear of the defendant's Mercedes with such a fierce impact that it pushed the plaintiff's car into a Transit Van in front of it. Such was the force of the crash caused by the defendant's Nissan Micra that the Mercedes was so damaged both in front, rear and side that it had to be written off. When one considers the relative weights of the cars involved one can only wonder at what the speed or other factors involved were that caused such a ferocious collision involving four or even five vehicles.

4. Not surprisingly, liability has been admitted. The case comes before this court for assessment of quantum of damages. The plaintiff was wearing his seat belt and indeed it was his wife who had to lean over and undo his seatbelt because, after the impact, the plaintiff found that he was unable to move. He had sustained injury to his spinal cord giving rise to transient tetraparesis. Realising to his horror that he was unable to move from his neck down, he told his wife to get somebody to pull him out if the car should go on fire. He was trapped in the car in fear of fire for over an hour with the temporary paralysis preventing him from moving either his arms or his legs. He also sustained dental injuries from the whiplash movement of his head and this caused damage to his upper and lower teeth. It was the obvious trauma to his cervical spine which caused concern to the medical attendants who arrived. They managed to release him from the car and took him by ambulance to Naas Hospital. By the time the ambulance arrived at Naas, the plaintiff was starting to regain movement of his feet. After five hours in the hospital he could manage to move, eventually being able to walk again. Naas Hospital was full that night and the Registrar allowed the plaintiff to go home, as there was no bed for him, but this was on condition that he come back at 8 a.m. in the morning which he duly did. The Registrar then studied the x-rays, re-examined the plaintiff and referred him to Mr. JP McElwain, the orthopaedic surgeon, who saw him that day being 8th August, 2000. The plaintiff was complaining of numbness in both his hands and in both his legs. By then he had a full range of movement of his neck on flexion and extension but he did still have some pain on lateral flexion and rotation to the right. He had slight blunting of sensation of the index and long fingers. X-rays confirmed considerable degenerative changes in his cervical spine. An MRI scan performed on 5th September, 2000, showed degenerative signal alteration and disc space narrowing involving many of the mid and lower cervical levels, particularly C3/4, C5/6 and C6/7. At these levels there was marked compromise of the spinal canal with impingement upon the cervical cord anteriorly and at the C3/4 level also posteriorly. A predominant abnormality was at C3/4 level, which appeared to be a focal central disc herniation, but at the other levels the appearances were more in keeping with cervical spondylosis. Mr. JP McElwain had him admitted to Tallaght Hospital on 25th September, 2000. The plaintiff still had tingling in both his hands and symptoms affecting the median nerve distribution and the flexor muscles of the wrists and hands. He had a tight stenosis with restrictive narrowing at C3/4 and a significant spinal cord compression at this level.

5. The plaintiff had been told to be careful and to take things easy from his time in Naas Hospital. By now in Tallaght Hospital he had to endure what was an unusual situation for him; he had incredible pain in his neck and shoulders. If he extended his head backwards he would get pins and needles and the further back he extended his neck, then the further down the pins and needles would go. They would start in his head, then go down his back, across his shoulders, down in to his arms and if he extended his neck further back, they would go down to his hands. From half way down the fingers to the tips on both sides, the fingers would go numb. It was like carrying a child on one's shoulders, the longer the child is there, the heavier it seems to become. He explained that it was a strain watching a computer screen or sitting for a time with his neck in a forward position, with pain varying in levels from maybe levels three to six, seven or eight if sitting for long periods. He said that at times it was easier to stand as he could lean his head back, which he would do while watching TV as far as possible. I noted time and again during the hearings that he quietly and unostentatiously adopted such a posture clearly in an effort to relieve pain.

5. Mr. McElwain referred the plaintiff on to his colleague, Mr. Esmond Fogarty in Tallaght Hospital, who reviewed the plaintiff on 1st October, 2000, when he was complaining of paraesthesia in both hands and the left shoulder and also complained of his legs "jumping" at night. Since the scans showed considerable narrowing at the diameter of the canal at C3/4 which was causing pressure on the cervical cord, Mr. Fogarty decided that the serious neurological consequences of the neck injury warranted referring him to Professor

Ciaran Bolger in Beaumont Hospital, the pre-eminent expert in complex spinal surgery at the National Centre for Neurosurgery.

6. Professor Bolger examined the plaintiff on 27th November, 2000. He took a history from the plaintiff. In due course I will make a synopsis of the evidence in respect of causation of the injuries suffered by the plaintiff as this is a seriously contested issue in this assessment. In order to facilitate the medical witnesses, there was sensible liaison between the legal representatives and it was agreed that the plaintiff would give his evidence first, to the extent of dealing with the circumstances of the accident and the aftermath thereof, as these had relevance to the genesis of the spinal problems in his neck, and also covering the circumstances of the x-rays, scans and MRIs (Magnetic Resonance Imaging) in respect of his spine as well as the clinical findings of the neuro-radiologists, neurosurgeons, and other medical doctors and rehabilitation experts dealing with his ailments. I propose to complete the narrative synopsis of the aftermath of the plaintiff's accident and to describe what was found on the x-rays, scans and imaging and also the findings during clinical examinations and during both the operations which were carried out on the plaintiff's neck by Professor Bolger, the leading neurosurgical expert in respect of complex spinal surgery. I then intend to go through the evidence of the Consultant neuro-radiologists called respectively by the plaintiff's and the defendant's counsel. The neuro-radiologists Dr. John A. O'Dwyer and Dr. John Thornton, both practise in the Department of Radiology of Beaumont Hospital. With the advent of judges sitting in personal injury cases without a jury, it is easier to facilitate witnesses, particularly medical experts who have operating, teaching and conference commitments. With the cooperation of the lawyers it was possible to deal with the parts of the plaintiff's evidence relevant to the evidence of Professor Bolger and of Mr. Chris Pidgeon. I have set out the evidence of the neuro-radiologists before dealing with the evidence of the neuro-surgeons, Mr. Pidgeon and Professor Bolger. In doing this I am aware that I will be describing the evidence of these witnesses out of the actual chronological sequence in which they were called. I am also conscious that it is essential that a judge should view the evidence in the case in its entirety. I am particularly conscious that the evidence of a number of other witnesses may have a crucial bearing on such issues as causation and also on further contentious issues, such as the situation with regard to the aspect of the plaintiff's present and future capacity to do remunerative work. For example, on the issue of causation, while I am very conscious that Liam Reidy S.C., counsel for the defendant, sensibly made it quite clear that everyone accepted that the plaintiff had suffered from no symptoms at all prior to the impact causing the hyper-extension injury in the accident on 7th August, 2000, nevertheless the evidence given by the plaintiff himself, by his wife Sophia McFadden and by Dr. James Clarke, the family GP, about his being a very fit, healthy and active sports man, playing a round of eighteen holes of golf on most evenings during the summer months preceding his accident, does seem very significant in confirming his asymptomatic and energetic condition before the collision. Furthermore, Mr. McFadden is a finely built man, 6ft 3ins in height and of strong build, and he prided himself on carrying his golf bag, which to some of us lesser mortals might seem a tough penance in this era of battery powered caddy cars, even for a person who habitually and frequently used to play golf many evenings after work. Bearing in mind that the plaintiff was only aged fifty at the time of the impact to the rear and then the front and side of his car, one can perhaps understand why in his fitness and prime vigour he preferred to carry his golf bag and all the gear in it on his shoulder. The significance of this digression is that the evidence is that, after the accident, there were considerable signs revealed on the imaging of degeneration in the plaintiff's neck, including stenosis of the spinal canal and the presence of a prominent osteophyte protruding towards the spinal cord at the C3/4 level. If the plaintiff had not been fortunate enough to have been asymptomatic, previous to 7th August, 2000, in respect of the condition of his neck, then I think it is only common sense that he would not have been able to shoulder and carry his golf bag during the many rounds of golf which he played in all weathers on a large variety of courses throughout the years preceding his accident. However, I do not have to rely on my reflections on this aspect but regard this merely as confirmatory of the plaintiff's evidence that he was very fit and healthy, and certainly asymptomatic and pain free, before the collision. He had been able to do household chores, and to manage a large garden of about one acre which according to the witnesses, expert in rehabilitation, had all the appearance of formerly having been as well maintained as was the bungalow. It is accepted by all that the plaintiff was fit and active both in his working capacity, his domestic role and in his sporting activities. I stress this aspect as it does have a significance from the point of view of the issue of causation which I shall tackle in due course.

7. First I propose to complete a summary of the narrative. Secondly, I shall set out the plaintiff's background and education, his life history and also his working and sporting track record to date in order to give a description of his personality and an understanding of the man who came into court to make a claim for compensation on 25th May, 2005, in respect of the injuries which he suffered through no fault of his own, and the results of which afflict him at present and are likely to affect him with chronic pain and suffering for the rest of his days. The defendant's contention is that with the previous state of degeneration in his neck, the plaintiff was lucky to have been without symptoms before the accident and these were likely sooner or later although, according to Mr. Pidgeon, putting a date on this was like gauging the length of a piece of string. It is necessary to venture into the rarefied atmosphere of complex spinal neurosurgery and neuroradiology because the treating surgeon ,who twice operated, refutes this likelihood and contends that it was very much more likely that the plaintiff would have worked to normal retirement age of 65 but for traumatic injury on 7th August, 2000. This is in order to learn, from the experience of neurosurgeons and from the findings of research in the medical literature, what is likely in the particular circumstances of this case to have happened to a person who has a degenerative condition of the neck and then subsequently has a whip lash type injury when his car received a severe impact from behind which shunted the Mercedes into a transit van in front. This violent collision caused acute pain in his neck and transient paralysis. Soon he suffered the onset of symptoms associated with the presence of an osteophyte near the thecal sac protecting the spinal cord and with the existence of stenosis of the cord and the gradual increase of pressure on the cord. This leads to the aftermath of the injury and the need for and the effectiveness of operative interventions to relieve such symptoms as were caused by the compression. Then it will be appropriate to consider the aspect of mitigation of injury and damage by the plaintiff, particularly in the light of the defendant's suggestion that the plaintiff's good pension provision has given him a motive to avoid remunerative work, bearing in mind that the trustees of the relevant pension fund can consider reducing his pension if it were to turn out that he is able to earn money now from doing some job and is actually doing remunerative work without permission of the trustees. Since he was retired on the grounds of ill health and his incapacity to do his job, if he were to turn around now and show a capacity to do insurance brokerage work, or some other part time job or even to set up his own consultative work from home, then this could, at the discretion of the trustees, affect his pension. However this is based on the contention put forward on behalf of the defendant that the plaintiff is now capable of and in the future will be fit to do a job in order to earn an income and thereby could have reduced the amount being sought from their client in respect of loss of income. I propose to examine the evidence on which the defendant's premise is based that the plaintiff's secure pension provision gave him a disincentive to work and that this was the reason why he supposedly had made a decision and opted not to seek to take up gainful employment in respect of which it is alleged that he should have been competent to cope. I propose then to set out the evidence which the plaintiff claims shows that he no longer has the capacity to do gainful employment and that with his medical record, he would have severe difficulty in ever finding future employment, let alone being capable, with the damage done to him, of managing to do such a paid job. I shall then analyse the particular comment and statement in the evidence of Professor Bolger on which the defendant's counsel have placed considerable reliance. This remark was characterised by counsel for the plaintiff as being a comment taken out of context and of a type which did not justify the building up of a flimsy and insecure theory grounded on such a basic false premise, which in any event was hedged around with pre-conditions and provisos which would be very unlikely to be satisfied.

8. After that I shall deal with the defendant's suggestion that the plaintiff was seeking unjustified enrichment. In particular there was an attack on the adducing of expert evidence from Paula Cashman, an experienced specialist in occupational therapy and

rehabilitation, who gave a very comprehensive and detailed report and indicated the types of aids and requisite appliances to assist the plaintiff's mobility and independence of activity and the sort of alterations needed in the house, for example to the lavatory and in the bedroom, to facilitate the plaintiff with his particular impairments and his requirements caused by his injury. These suggested implements and adaptations are to try to help the plaintiff to mitigate his loss and to regain some of his former independent style of life in respect of going to the lavatory, having a shower, having a good night's sleep in an appropriate bed with an orthopaedic mattress, and by obtaining a suitable perching stool and trolley in the kitchen to help him in the preparation and the bringing in of food from the kitchen. Counsel for the defendant raised an objection to this evidence and suggested that the plaintiff himself in his evidence had not indicated his need for certain of the alterations and aids, such as a higher raised lavatory bowl and grab rails, a walking stick and a pick up stick for such things as golf balls or small objects on the ground. In view of this challenge to the need for the provision of these items, I propose to deal with the objection to the evidence of the rehabilitative expert and the more salient criticisms in respect of individual items suggested by her as being suitable and necessary for this particular plaintiff.

9. Counsel for the defendant also criticised the provisions in s. 2 of the Civil Liability (Amendment) Act, 1964, as allowing "unjustified enrichment" of the plaintiff and as being unfair to his client. Counsel for the plaintiff with his experience in this area of law from previous cases gave short shrift to his opponent's plea on this score on behalf of the defendant and her insurers. He pointed out that this was the long-standing law of the land in assessing damages in an action to recover damages in respect of a wrongful act resulting in personal injury not causing death in regard to any sum payable in respect of the injury under any contract of insurance and any pension, gratuity or other like benefit payable under statute or otherwise in consequence of the injury. Michael Gleeson S.C. is correct that both age old common law and modern statute law support his case. In view of the plaintive arguments put up by counsel for the defendant and the present remorseless and effective public relations exercise on behalf of the insurance lobby, it may be useful and opportune to set out why the common law in this country and subsequently the Oireachtas, with its wisdom and sense of justice, has in Section 2of the Act of 1964 long since recognised over the years that it was only fair that an individual who has been damaged by a tortfeasor, whom the insurance company has contracted to indemnify in return for payment of premiums, should not be allowed, without some exceptional justifying peculiarity, as in *Dennehy v. Nordic Cold Storage Limited*, (Unreported Hamilton P. High Court, May 8th 1991), unfairly to gain an advantage from a sum payable in respect of the injury under any contract of insurance or any pension, gratuity or other like benefit payable under statute or otherwise in consequence of the injury. The reason for this is that such a benefit in all likelihood arose because the plaintiff was either the source of payment of the premiums for the insurance policy provision and the pension or like benefit or had entered into a contract of employment, in consideration that these very premium payments would be part of the emoluments and attraction of his contractual employment.

10. One further aspect which warrants special analysis in this case is the submission by counsel for the defendant, who complained of the "enormous loss of earnings claim" and submitted that the Court should look coldly at the suggestion of no earning capacity. It is germane also briefly to consider the role of actuarial calculations in the Irish Courts and the linkage to general damages, in a case such as this.

11. In this case a loss of earnings figure of €125,000 to the end of May, 2005, has been agreed, subject to the plaintiff adequately proving that he was unable to work and that Allianz, as his employer, is entitled to recover from the plaintiff the full payment of his salary which Allianz has very properly made in the time since he has been unable to work after his second operation on 18th November, 2003, to 20th May, 2005. The position is quite clear from the Employee Handbook at para. 7.10 which is headed "Salary Recovery":

> "In the event of an employee being injured by a third party rendering them unfit for work it is company policy to request that a claim for salary paid during absence be included in any subsequent action for damages or recovery of expenses and be refunded to the company".

12. The plaintiff has been paid on foot of this responsible policy by the employer and it is clear that the plaintiff was bound to include this as part of his claim in this action and that he accordingly must repay this sum to his former employer. This is no hardship to the defendant or her indemnifier as this is part of what must have been in contemplation when the defendant paid her premiums for indemnity in this very respect from her insurer. There seems to be no moral principle which would justify the insurer then being unjustifiably enriched by avoiding making restitutionary payments to restore the plaintiff to his former situation insofar as possible in respect of the earnings which he would have lost but for the beneficent policy of his employer. This links in to the plaintiff's contractual arrangement with his employer to repay the sums which he has been paid in lieu of salary which he would have earned but for the injury inflicted on him by the wrongful act of the defendant tortfeasor.

13. Having disposed of this forlorn complaint of the defendant's counsel and having explained the fair and commendable scheme of salary recovery, at the appropriate time in due course at a later stage, I propose to review shortly some of the recent decisions on the aspect of general damages. For now, it suffices to say that this is a case in which the plaintiff's incapacities are ameliorated by appropriate aids and appliances. However these in this case can only alleviate the plaintiff's problems in a very minor way but, even to that extent, they are undoubtedly valuable to him. They are very worthwhile in helping him to keep and maintain his independence in every day living and thereby to preserve his self respect and to reduce his deprivation of or reduced enjoyment of the amenities of life. There is also the consideration in this case of the sums calculated making use of actuarial figures, of the extent which the effect that the award of such figures should have on the general damages up to the present and for future pain and suffering, and for loss of enjoyment of life and reduced amenities of life to the plaintiff. In this context, I think that the continual perseverance of considerable pain and the likely persistence of this pain in the future, with the chronic suffering which this entails for the plaintiff, is a peculiar feature to be considered in this particular case in due course.

14. Continuing the synopsis of the plaintiff's operations and his tribulations, I now deal with Professor Bolger's examination on 17th November, 2000, and his findings at that time, and then his discussion of the options in respect of surgery with the plaintiff and their coming to a consensus in favour of the more conservative and less drastic option of the two alternatives proposed and under consideration to deal with the perilous condition of the plaintiff's neck. Professor Bolger had to warn his patient that a fall and jarring of the neck could cause damage resulting in quadriplegia. The existence since the whiplash injury on 7th August, 2000, of the symptoms of the pins and needles in both hands, involving all the fingers except for the little fingers and with paraesthesia also in the left shoulder on neck extension, were all continuing indications of nerve damage. The plaintiff also had a complaint of reduced power in his left arm and hand and weakness of the left leg with jumping and jerking of his legs at night. In the review of the plaintiff's MRI scans there were three levels of disc disease, being at C3/4, C5/6 and C6/7. Professor Bolger took the view that the main problem was at C3/4 where there was an osteophyte and considerable narrowing of the diameter of the canal with high signal within the spinal cord. At C5/6 and C6/7 the diameter was narrowed but not so significantly. On the basis of these findings Professor Bolger advised an anterior cervical decompression which was performed at operation on 6th December, 2000. It was noted at the time of surgery that there was a large osteophyte, pointing towards the back of the neck, at this C3/4 level, which was drilled off with a good decompression of the spinal cord. I propose to return to deal in greater detail with particulars of this operation and the effects thereof, and the diagnosis of the causes of the symptoms according to the opinions of the various medical experts. For the purpose

of the narrative, the severe paraesthesia and the numbness, which affected both hands and feet and the plaintiff's neck on extension, eased after the first operation but these symptoms did not resolve completely. On examination for review of the plaintiff on 15th January, 2001, Professor Bolger found that the plaintiff's reflexes were generally brisk but not as crisp as previously. The operation wound was well healed but he continued to have continuing weakness of the left arm and the left leg and he had on-going neck pain; however, the electric shock sensations, the severe pain in the arm and the numbness had to a large degree settled. On review by Professor Bolger on 5th November, 2001, the plaintiff was noted to have returned to work and even to be playing some golf, although with difficulty and discomfort. He continued to suffer neck pain radiating to the shoulder, especially at night and this interfered with his ability to sleep, and in addition his symptoms of pain and left hand side weakness were significantly exacerbated when he became fatigued. He had difficulties in driving and in doing household tasks involving elevation of his arm above the neck. He had on-going intermittent difficulty in moving his left leg which was slow to respond to activity and tended to drag when he was tired. Professor Bolger concluded that while the plaintiff's clinical condition would appear to have considerably improved, he was still having significant continuing problems such as reduced sensation on the left hand side and on the same side there was a general small reduction in power. Professor Bolger pointed out that, while it was nearly a year since the decompression operation, it was well known that a patient may continue to improve for a period of about twenty eight months from the time of decompressive surgery. By report dated 9th July, 2002, Professor Bolger stated that the plaintiff's overall condition appeared to have stabilised and there had been little improvement in the mean time. The plaintiff over the last eighteen months continued to suffer discomfort in his neck radiating to the shoulder, especially when he turns in bed at night time. While the pain was less than before his operation, it was still present and was interfering with his sleep. He still had ongoing problems with weakness on his left side and was finding it problematic when driving in to work, in that he was having difficulty at the end of the journey in moving his left leg. He was finding that he was tending to drag his left leg when he was tired. He was still having some numbness in the tips of his fingers. While he had managed to get back to playing golf, he was still having problems in that by the end of the round of golf he was very tired and generally unable to move. Also he still had difficulty in doing household tasks which involved elevating his arm above the level of his neck. Professor Bolger felt that, as it was now about eighteen months since the decompressive surgery, the plaintiff had reached "a stage of medical finality". He stated that the plaintiff might well be able to continue some work. However if the patient found that this was too onerous, then he, as medical adviser, would support an application for early retirement. It should be noted that the neurosurgeon reached this opinion by July, 2002, being well aware of the plaintiff's determination to rehabilitate himself so as to return to work and to playing golf.

15. The plaintiff's symptoms deteriorated during the latter part of 2002 when, in particular in November and December, 2002, onwards, he developed severe hand pain centred upon his middle and ring fingers of each hand and a return of sensory symptoms, with increasing difficulty in performing his work. At his desk he suffered from pressure and also pain, especially in his neck, when sitting for any length of time, particularly at meetings, and he experienced increasing difficulty in concentrating on tasks because of severe pain. The plaintiff also found increasing discomfort in going to and from work because of his difficulty in driving, which requires a neck-forward posture which he finds extremely difficult to maintain.

16. The plaintiff was reviewed by Dr. Blanaid Hayes, Consultant Occupational Physician, on 15th November, 2002, and in her report dated 25th November, 2002, she concluded that the plaintiff was suffering from mild to moderate clinical depression and anxiety symptoms as evidenced by nightmares, reliving of the accident, symptoms of "road rage", loss of interest and disaffection, irritability and sleeplessness. She advised anti-depressant treatment and counselling as part of his recovery programme. Professor Bolger organised nerve conduction studies in view of the sensory symptoms in the hands but these did not show any evidence of any carpal tunnel compression. The plaintiff had an MRI scan on 4th April, 2003, which showed disc space narrowing at C3/4 with evidence of the previous surgery in December, 2000, but there was also some high signal within the cord consistent with gliosis (overgrowth or scarring of the tissue that supports elements of the central nervous system). There was also the degenerative change still at C5/6 and at C6/7, with a combination of disc protrusion and osteophyte formation, and this also involved severe canal stenosis at C5/6 with less severe canal stenosis at C6/7. At both levels there was quite marked bilateral exit foraminal narrowing. At C3/4 there was some persistent prominent osteophyte to the left side indenting the thecal sac but the cord did not appear compressed and there was CSF (cerebro-spinal fluid) surrounding the cord. There was moderately severe exit foraminal stenosis on the left and milk stenosis on the right at this level at C3/4. In his report dated 11th August, 2003, Professor Bolger related that on examination he found that there continued to be reduction in sensation on the left hand side in the C4/5/6/7 distribution. There continued to be a global reduction in power, on the left hand side, at the level of C4/5 and his reflexes continued to be brisk in the arms and legs and also plantars (downward movements of the big toe) were still down going. Nerve conduction studies were organised in view of the sensory symptoms in the hand but these did not show any evidence of any carpal tunnel compression. Professor Bolger went on to report that it was his opinion that the plaintiff "continues to suffer from severe degenerative change in the cervical spine initially rendered symptomatic by his involvement in an accident…". Although the plaintiff had made initial significant improvement following the decompression operation on 6th December, 2000, he had been left with significant residual symptoms which had been slowly resolving and stabilising by July, 2002. However, then there was a further deterioration around Christmas, 2002, with, in particular, a return of sensory symptoms in the hands, and increasing pain and difficulty in performing his work.

17. After lengthy discussion with the plaintiff, Professor Bolger advised on further radical surgery with a multi-level decompression in an attempt to relieve the pressure on the cord. Accordingly, on 18th November, 2003, the plaintiff had a second operation in Beaumont Hospital this time for a radicular decompression of his cervical spine from C3-C7 together with insertion of metal instrumentation and the performing of a cervical fusion for stability of his neck. This surgery was carried out under general anaesthetic over a period of nine and a half hours (compared to a period of one and a half hours for his initial surgery in December, 2000). Unfortunately, after the surgery the plaintiff contracted a severe wound infection. On 3rd December, 2003, three days after his discharge from hospital, he was rushed back to Beaumont Hospital where he was initially treated with intravenous antibiotics for a period of two weeks as an in-patient. Thereafter the plaintiff attended Beaumont on a weekly basis for ten weeks to have the wound checked and dressed and also for blood tests. During this period and for a further eight weeks he was unwell and on antibiotics. It took three months for the wound to settle and he continued on antibiotics for a further month as a precaution. During all of this time the plaintiff was severely debilitated and this complication hampered his recovery. On 5th May, 2004 Professor Bolger reviewed the plaintiff and found that the plaintiff's fingers were less numb than previously, his toes were also less numb and that his hand pain and stiffness were considerably less. Nevertheless he was continuing to have severe ongoing problems, being unable to sit and read for longer than five to ten minutes or to sleep well because of ongoing severe neck pain. The plaintiff had tried his best with his exercise regime and had been able to walk about four miles a day and was continuing with physiotherapy but he had been unable to return to golf. As for work Professor Bolger wrote:-

> "I had a long discussion with him about his work and to be honest I do not think he is going to be able to continue to work in a high pressured environment with a lot of travel etc. and I do not think this would be in his best interests in the long term and I have expressed that view to him. As you know he is keen to return to work but really I think in the long term he is not going to be able to sustain the kind of activity which he has sustained up to now."

18. On 1st June, 2004, Dr. James Clarke, the plaintiff's family GP, observed that the plaintiff was very down and that his symptoms had not improved greatly. The plaintiff was advised by all of his medical advisers including Professor Bolger and Dr. Blanaid Hayes

(Consultant Occupational Physician in Beaumont Hospital who saw the plaintiff on 13th May, 2004) that he was not fit to return to work and that he should not do so for reasons of safety. Dr. Hayes had first seen the plaintiff on 15th November, 2002, for assessment of his fitness to continue in his job. At that time he was complaining of a constant feeling of pressure on both his shoulders, intermittent darting pains in the post-auricular region, constant low grade lower occipital pain and constant fatigue. He was also having trouble with his left leg after prolonged inactivity, in that he needs to use his arms to mobilise himself, and his left leg frequently drags when he is tired and this has caused him to fall a few times. Sleep is also a problem as he frequently awakens during the night with pain. For the 18 months previous to her examination on 15th November, 2002, the plaintiff had been having osteopathy on the recommendation of Professor Bolger and this was a weekly programme over 18 months involving mobilisation of his neck and shoulders together with massage. He has also been taking a variety of analgesics and anti-inflammatories (Ponstan, Difene, Nurofen). Recently his GP started him on Zispin (an anti-depressant) which he took for three days and then stopped because of drowsiness. Over the past two years the plaintiff has been subject to recurrent chest infections which required antibiotics which was not usual for him. He was suffering from pains in his knees and ankles and occasional darting headaches. At that stage in November, 2002, he was feeling fed up, irritable at home, suffering from disturbed sleep with wakening from 2.00 a.m. and difficulty in getting back to sleep. He also suffered from nightmares and on occasion relived the experience of the accident. He found himself upset by drivers who flout the rules of the road and he had generally lost interest in things although his golf interests helped him to keep up his morale. He was having anxiety symptoms and finding it difficult to relax and he was also having dizzy spells and was worrying about his health. Dr. Hayes concluded that the plaintiff was suffering from mild to moderate clinical depression and anxiety symptoms as was evidenced by nightmares, flashbacks and reliving of the accident and definite "road rage symptoms" when driving. She agreed with his GP that he would benefit from anti-depressant treatment. She encouraged him to think seriously about this form of treatment and recommended reading material for himself and the members of his family so that they would all be aware of this problem. She believed that his depression with anxiety was currently impeding a fuller functional recovery. She suggested that these aspects of his care should be undertaken by Dr. Clarke who clearly had an expert interest in the area. In her second report dated 26th July, 2004, Dr. Hayes said that she had reviewed the plaintiff on 15th May, 2003, by when he had made no great progress, although he had read the book which she had recommended to him namely "Depression - The Common Sense Approach" by Dr. Tony Bates. He was continuing to complain of significant neck pain and stiffness which was troubling him at night time and he was also experiencing anxiety symptoms, mainly sweating, reliving of the terrifying experience of tetraparesis in the car and anxiety about his future, particularly at work. His sleep pattern was poor and he was guilty about his own perception of under-performance in his job. He had developed pain in the small joints of his fingers unassociated with swelling and worse at night. He had been back to Dr. Clarke who had started him on an anti-depressant which did not agree with him. He had then been referred to Dr. Camillus Power, Consultant in Pain Management, who started him on treatment with Amitriptyline which is an old anti-depressant which is often used in low doses for managing pain symptoms. However, this caused a problem as it made him groggy next day. He had also undertaken a gentle exercise programme under advice from Eileen Murphy, a well known physiotherapist of Heytesbury Street. Despite all of this, he was feeling no better and had sought further specialist advice regarding the hand pains from Dr. Moorehouse, Consultant Neurologist. I pause to ask, after reciting a part of the list of all those experts whom the plaintiff had sought out and had consulted in his determined and constant efforts to rehabilitate himself in his striving to return to work, was this the conduct likely from a person whom the defendant's lawyers suggest should be depicted as acting like a malingerer? Is he the type who opts to laze at home luxuriating in idleness, while enjoying the benefits of the generous pension provisions (which I might add, he had earned and were long before envisaged and paid for on foot of his contract of employment)? Dr. Hayes suggested that he explore the possibility of reducing his working hours. In this respect the plaintiff made it clear that his employers had been sympathetic and flexible towards him and clearly recognised that he had previously done his job assiduously and was never one to stop after the eight hour day, if there were more tasks to be done.

19. On 13th May, 2004, Dr. Hayes reviewed him again. He had clearly deteriorated in the previous year and had ongoing severe pains in both hands and was experiencing falls when his left leg had given way. Despite the further operation on 18th November, 2003, the length and seriousness of which was compounded by a hospital acquired infection, he was continuing to have severe sleep disturbance, being awakened by pain on any movement. He complained of stiffness and pain after less than half an hour in a seated position. Sitting and working while leaning forward over a desk was not possible as it required a neck-forward posture and this led to pain within minutes. He was now only able to read while lying on his bed. He was achieving significant progress with walking and was doing walks of four miles daily. He was having weekly physiotherapy, with the focus on a strengthening programme. He also complained that his concentration was poor and that, while his mood was a bit better, he continued to be somewhat frustrated and irritable. His balance was insecure and he was complaining of dragging of his left leg. He had not played golf since the previous August, 2003. On examination Dr. Hayes felt that the plaintiff had deteriorated. He was pale and had lost weight and had evidence of major recent cervical spine surgery with insertion of metal instrumentation at the back of the neck leaving him with a long scar. His neck movement was very restricted in all planes and he had reduced power in the left arm with slightly reduced grip in the left hand. There was also some weakness in the function of the quadriceps and foot dorsiflexors in the lower limbs. She noted that he was somewhat unsteady on his feet when climbing onto the examination couch and in getting out of the chair after prolonged sitting. She concluded that with the passage of the years and with further surgery and treatment he continues to be moderately severely disabled. It was clear to her at this stage that, despite his best efforts he was unlikely to make further significant progress in capacity to perform his work and because of this she considered that "it would be appropriate that he would be retired now on the grounds of ill health". He was "unlikely to be fit in the future to undertake the work in managing a sales team with all of the attendant responsibilities, car travel and administrative paper work which would be required". I have had the benefit of hearing Dr. Hayes's evidence in court as Consultant in Occupational Medicine and I will return to this and describe her response to the suggestion that the plaintiff had a capacity to do remunerative work and that the plaintiff could set up as an insurance broker or as an insurance consultant or in some similar agency using skills and contacts gained during his comparatively short career in the business of insurance. Perhaps I should say at this stage that not one expert in occupational medicine was called on behalf of the defendant to give a scintilla of support to this audacious contention. I should add that when the plaintiff first attended Dr. Hayes on 15th November, 2002, he told her that he was a manager with Allianz Insurance, which used to be Church & General. He had worked there for 15 years. He managed a sales team of 13 people and his role was essentially to support them. Normally this would involve travel once a week within the country by car and the rest of the time he would spend in an office attending meetings, doing reports, and dealing with email and telephone communications. He made clear that the company had been extremely supportive of him since the accident. He had been able to avoid the driving element of his work, apart from commuting to work which could take anything between one and two hours each way. I mention this because this confirms the plaintiff's frequently reiterated point that his employer, Allianz, had been most sympathetic, supportive and flexible in their attitude towards his trying to cope with his work. He was no longer able for much long distance travel and, while he put in what for others would be a normal number of hours at work before his second operation, he was no longer able to work with the same concentration for the very long and diligent day in which he had previously taken such pride, pleasure and enjoyment.

20. There was a minor issue between the parties as to the chronology in respect of the sentence in Dr. Hayes's report dated 25th November, 2002, at p. 3:-

> "He denies any specific job stress and feels he had always been well in control of his job. However, he is very conscious of the fact that he is not undertaking the full role (see above) and this worries him. E-working is not an option for him as

this is a people business. He has always enjoyed his work and been ambitious within it."

21. It was suggested by counsel for the defendant that this first sentence meant that at the end of 2002 the plaintiff was still saying that he had no job stress and was still well in control of his job. This seemed at the time to me to be a misconstruing of this phrase as the vital word used is "had" and I note that Dr. Hayes confirmed in evidence that it was her understanding that the plaintiff by this was referring to his prior and pre-accident condition. It is clear that he was in fact contrasting this with no longer being able to undertake his full role and responsibilities in November, 2002. Dr. Hayes said that she reviewed him again on 13th May, 2004, to assess his fitness for work and he had clearly deteriorated in the previous year with ongoing severe pains in his hands and with his left leg giving way. His physical disabilities in May, 2004, were such that he was not fit for work and she was not surprised when he was retired by his company on 31st March, 2005.

22. The two operations had resulted in little relief of pain. Before his first operation the plaintiff's balance was unsteady and he had significant reduction in left arm and left leg power as a result of which he fell frequently. The second and much longer and very serious operation (9½ hours) on 18th November, 2003, was an effort to try to prevent further deterioration, rather than to bring about a miraculous cure or recovery as Professor Bolger had made clear. After the operations the plaintiff still had weakness in his left arm and leg and continued to experience frequent intermittent falls when his left leg gave way. When seen by Professor Bolger on 5th May, 2004 and 29th July, 2004, the plaintiff was still having major ongoing problems according to the Professor's Report dated 13th November, 2004. His fingers and toes were less numb but he was having ongoing problems with his being unable to sit and read for longer than five or ten minutes, and with his lack of sleep because of severe neck pain. When reviewed on 13th September, 2004, he was still quite symptomatic with much pain in his neck, also a heaviness felt across the shoulders and he was finding it difficult to sit or stand for any length of time or to do any lifting. There was continued improvement in the power on his left hand side but still his main problem of pain was ongoing. The Professor believed that the plaintiff was continuing to suffer from severe degenerative change in association with his congenitally narrow spinal canal which was rendered symptomatic initially by his accident in 2000. Despite the two operations he had ongoing pain in the neck which was limiting his ability to sit or even stand for any length of time and his prognosis was poor in this regard. However, Professor Bolger added that he was referring the plaintiff to Dr. Valerie Pollard, Consultant in Anaesthetics and Pain Management, to see if her expertise in alleviation of the chronic pain could help.

23. The plaintiff duly attended Dr. Pollard's Pain Management Clinic at Beaumont Hospital on 24th January, 2005, complaining of a heavy sensation and aching pain which occasionally became shooting and throbbing in nature. The pain was located in his neck, where there was "metal hardware" from his second operation and damage to muscles separated and affected during surgery, and referred pains which radiated to both his shoulders and occasionally penetrated and ran down to his mid-elbows on each side. The acute discomfort and pain was worse at night and was aggravated by flexion of his neck, sitting for long periods of time and elevating his arms above his head. Movement and walking reduced this pain. Extension of his neck while he was leaning his head against an object such as a wall, also reduced this pain. This description confirmed my view, formed while observing the plaintiff standing in court and leaning against the back wall and the side walls of the room while extending his head back, that this was a measure he took in trying to relieve his suffering. He had done this while giving his evidence and this could be seen by counsel; however, I was aware, that during the several days of the rest of the case I could observe this unobtrusive but unusual movement which I regarded as being quietly performed for alleviation of pain. This was carried out, unostentatiously but frequently, in the rear of the court which was out of the line of vision of counsel, although no doubt observed by their solicitors and the registrar. Dr. Pollard had noted in her report dated 28th February, 2005, that the pain varied in intensity from 3 – 8/10 in severity on the visual analogue pain scale. Usually it was rated 6/10 in severity. He was suffering intermittent paraesthesia and numbness of all fingers of both hands. He felt that his left arm and left leg were weaker and he said that he frequently dropped objects from his left hand. He was right hand dominant. The plaintiff was taking Difene, an anti-inflammatory pain relieving medication, and Zydol, a pain relieving medication, Paracetamol, another pain relieving medication, and Temazepam, on an "as needed basis". Dr. Pollard examined the plaintiff's neck and found his neck range of motion to be markedly restricted. Extension, bilateral rotation and bilateral abduction (turning outward from the midline on both sides) were all restricted and provoked pain. Palpation of his cervical spine revealed tenderness throughout the cervical spine from C3 through C7 bilaterally. A number of tender points were palpable in the upper trapezius musculature on each side. Power assessment revealed a slight global decrease in left arm power as compared with the right arm. Reflexes were equal, bilateral and hyper-reflexic in both upper extremities. Sensory assessment revealed a decrease in sensation to light touch in the thumb and little finger of his left hand and there was hyperaesthesia in the left forearm and arm. Dr. Pollard confirmed that the plaintiff had sustained a whiplash injury to his neck in his accident which had resulted in the need for two operations on his neck, and that he still had significant ongoing pain and her opinion was that he would continue to have this in the future.

24. She said in evidence that on 17th June, 2005, she had given him two trigger point injections into his neck to try to give him temporary alleviation of his symptoms. She considered that the plaintiff was a genuine person who was in a lot of pain when she examined him on 24th January, 2005. Her expertise is in the areas of treating of a joint disorder along with muscle pain. She explained that with the metal in his neck she could only put the syringe needle into two of the three subject joints. It was significant that the site of the pain in his neck was the area most likely to be injured in such a collision and also to be the cause of the ongoing inflammation. It was unlikely that he would ever again be free of pain. She was optimistic that with injection therapy, medication and a pain management course she may reduce the level of pain.

25. The pain was from a combination of degenerative changes in the neck, facet joint involvement and muscular involvement. It was certainly the case that his ongoing pain is related largely to the musculature that had to be separated in order to gain access for the last operation. Professor Bolger often referred patients to her knowing that her expertise was in trying to alleviate pain in respect of facet joint inflammation and innervate muscles. When she does injections she not only does them in the facet joints but incorporates muscular injections and also does injections into the muscles outside and over the joints using a local anaesthetic and steroid mixture. Dexamethasone is the steroid utilised to reduce inflammation in the muscles, caused by the initial injury or by the effect of the moving or segregating of the muscles during the entry from in front in the first operation, and the entry from the back and insertion of the metal rods and screws for stability during the second and very long operation. When counsel suggested to Dr. Pollard that her success rate in alleviating muscular pain was very high, she rejected this and said that her success rate in reducing pain from muscular problems would be about fifty percent. She commented that she had been a pain management specialist for seven years and that not everybody with muscular pain could be treated with just injections alone. She also corrected the impression that her clientele were often athletes by stating that her patients were rarely athletes and that most in fact were patients with traumatic injuries or degenerative injuries.

26. Apart from having to take the medication mentioned above, the plaintiff has had to take Zimovane to help him to sleep and also, while he was undergoing antibiotic treatment for his severe wound infection for a period of almost five months following the second operation, he had to take Protium for his stomach. The plaintiff was suffering severe and unpleasant side effects as a result of his treatment including constipation, heartburn, stomach pains, cramps and bloating. The plaintiff continues to require intermittent pain relieving and other medication on a daily basis. By letter dated 7th February, 2005, Professor Bolger said he did not consider the plaintiff to be fit to return to his position as a sales manager with Allianz at that time and he doubted if the plaintiff would reach a

state where he was capable of returning to work. He thought that the plaintiff was capable of doing work which does not involve a lot of travelling and does not require him to sit or stand in one position for any length of time. The nature of the plaintiff's condition was that he finds it extremely painful to sit in any particularly flexed posture for any length of time, for example to sit in a car or to drive a long way or indeed to maintain any one posture. The plaintiff's symptoms have improved in relation to cord compression but unfortunately he now has a chronic state of pain in the neck and Professor Bolger could not see any early resolution to this. He concluded that for all practical purposes it was unlikely that the plaintiff would be able to return to his work as a sales manager. I return to and scrutinise this aspect of the plaintiff's future working and earning capacity below in the context of the submissions of the defendant's counsel about this aspect.

27. The plaintiff also required extensive dental repairs and reconstructive work as a result of injuries caused in the accident. A bite adjustment was required shortly after the accident and this was carried out by his dentist Dr. Ronan Owens in Naas. However the upper right lateral incisor was loosened because of the trauma which also caused an eccentric bite. The mobility of this tooth and bone loss around the tooth were caused as a result of the trauma in the road traffic accident. Both parties agreed that the report of Dr. Edward G. Owens dated 23rd July, 2003, a Prosthodontic expert whose specialist skill is in restoring teeth, could be taken as his evidence. However it became clear that his verbal testimony was important as his Report discussed several options. He said that drastic measures became necessary because of the looseness of this incisor and of the three associated and affected incisors. Accordingly, on 21st March, 2005, the plaintiff underwent extractions of these four teeth and received a provisional denture bridge for these teeth. The necessary implants will be done in due course and this surgery will involve a bone graft. Permanent bridge work should be completed in late 2005. I had the benefit of studying the report dated 23rd July, 2003, of Dr. Edward G. Owens as well as hearing his expert evidence as a specialist practitioner in prosthodontics or restorative dentistry which involves using crowns, bridges and implant supported crowns and bridges for dentures. The future cost of prosthodontic expenses was agreed at €14,200.00 and I noted with relief, which I expect will be shared by many brought up before the fluoridation of the water supply, that the recent improvement in materials has been so wonderful that it is likely that there will be no need to replace the long term restorations now contemplated when they are done in the future. I note in respect of this dental work and material, that if this work had been carried out as little as just over two years ago, the expectation would have been that the restorative work would need to be replaced at least twice more in the plaintiff's lifetime. The great improvements in anaesthetics and dentistry enjoyed, if that is the correct word in this context, by the present population of Dublin can certainly be compared favourably with the rudimentary painkillers and dental skills available to people in the times when Viking or Norman invaders were advancing past Kill in Co. Kildare, the scene of the plaintiff's accident, on their way to Dublin. Happily in this case the parties agreed that the report, dated 23rd July, 2003, of Dr. Owens could be taken as his evidence as this makes even more clear why such expert and extensive prosthodontic work was needed. He explained that the force of the collision probably caused the plaintiff's lower jaw to move to a more forward position and then contacted the teeth on the upper jaw which is fixed, delivering a trauma to the teeth. This loosened the four right upper incisors, making the upper right lateral incisor particularly mobile. It became untenable because the tooth was rendered mobile and loose by the trauma to the teeth. However, the problem was that the treatment of this upper right lateral incisor affected the three other incisors and so work had to be done involving all four teeth. Dr. Owens said that, in the absence of facial injuries, he assumed that there had been an eccentric closure of the lower jaw which had resulted in a banging together of the teeth in the accident and this caused the trauma of the rapid closing of the lower jaw against the upper teeth. Because there was 50% bone loss associated with the upper right lateral incisor, this made it necessary to treat the whole of the group of the four individual incisor teeth and the relevant part of the jaw, rather than just having to deal with the one tooth by a single implant. Dr. Owens explained that it would have been imprudent to proceed with a single tooth replacement due to the loss of bone in the area being so much that the risk of failure would be higher. The initial removal of the four front teeth has been done and a provisional bridge replacing the four incisors is now in place and this is supported by a tooth piece on either side of the space. The plaintiff is going to have to have a further surgical replacement of the implants and a subsequent restoration with a portion of gold for a four unit bridge construction. The implants are rods that are placed in the bone and they integrate by fusing to the bone in a similar way as a fracture heals. Once the implants integrate adequately then screws can be used to place super-structures that will carry the bridge. Two figures of €14,200.00 and an earlier figure of €1,200.00, for work already done, have emerged. I was told by both counsel that there was an agreed total of €15,400.00. It is clear that the plaintiff still has to face much further prosthodontic work, presumably with anaesthetics dulling at least some of the pain and giving some relief in respect of the unpleasant time spent during the procedures involved. Despite my reflection on the advances in anaesthetics and dentistry, I think that the pain and suffering involved in the dental damage caused by the trauma, involving a permanent loss of teeth, and the dental repair work to date would attract a figure of at least €7,500.00 and the anticipation and actual pain and suffering involved in the prosthodontic work to take place in the future so as to complete the temporary work already done, would attract a similar figure in respect of the further operations required, together with the further pain and suffering involved with implants having to be put into the bone in order to stabilise the four upper incisors together with the aftermath and future effects of this. Accordingly a figure of €15,000 in respect of general damages for all his pain and suffering and loss of amenities of life in respect of teeth should be included with this being divided equally between the amount of €7,500 up to the present and then with a similar amount of €7,500 into the future. This €15,000 should be attributed, along with a further €15,400 agreed for special damages, being in respect of the €1,200 for dental work to date and the €14,200 for the agreed cost of the further prosthodontic work. Accordingly, the cost of restorative dental work together with this aspect of general pain and suffering in respect of damage to teeth and jaw should attract in all €30,400.

28. Following the first operation on 6th December, 2000, the plaintiff went back to work on 29th January, 2001, initially on a part-time basis for two months. Because of his difficulties in coping with work, he took a holiday in June and July, 2001. He returned again to work in August, 2001, and carried on with difficulty until called for his second operation on 18th November, 2003. During this time he had worked a shorter number of hours and not at the same long and intense level as he had done previously, because he was suffering increasing pain from his injuries. Prior to his accident his work involved much travelling which he had enjoyed. This was severely curtailed after his injury. He had become more confined to his desk. Since his second operation the plaintiff has been advised by Professor Bolger, Dr. Blanaid Hayes, Dr. Valerie Pollard and his GP, Dr. James Clarke, who all say that he should not return to work. I should mention that counsel for the defendant have contended that Professor Bolger expressed a contrary attitude about the plaintiff's capacity to do some part-time, light agency work but this proposition is to magnify one conditional remark to gargantuan proportions and to ignore the Professor's oft repeated and clear opinion that the plaintiff was no longer fit for work. The plaintiff was retired on grounds of ill health by his employers with effect from 31st March, 2005, following a review of his medical condition and after consultation with his treating doctors by Dr. Walter Halley, the experienced company doctor.

29. The plaintiff has made every effort to maintain the exercise regime which was prescribed and he has succeeded in walking about four and a half miles each day and he has persevered with physiotherapy, osteopathy and occasional visits to the gym. When walking he finds that his left leg is stiff and slow to warm up but that, once he is into his stride, the leg loosens up. Since December, 2003, the plaintiff has succeeded in losing about three stone in weight, a remarkable feat showing his dedication to exercise and his determination to regain fitness and vitality. He attempted to play golf in February, 2005, but was in great pain and difficulty. He hopes that he will be able to resume his golf in the future but realises that he will have to adapt his game because of his physical impairments. The plaintiff had always been a keen gardener and had maintained his own large garden which is an acre in size. He has been restricted in the work he can do both in the garden and in the house since his accident, although he has been able to mow the

lawns on his ride-on mower. The plaintiff has been frustrated by being unable to carry out ordinary maintenance work and chores which he had hitherto done himself in the house and garden. The plaintiff's pain increases in severity if he has to maintain a head forward position, such as when driving or leaning over to read or to do paperwork. He prefers to carry out tasks and to meet people socially in a standing up position. When driving he tries to stop and stretch at frequent intervals, but this can be difficult in traffic and even on short trips to family and friends in the neighbourhood.

The Plaintiff's Background, Education and C.V.

30. The behaviour, character, philosophy of life, ethical and moral standards and lifestyle are all matters to be taken into consideration when forming a view of a plaintiff's personality which at times may be important in the assessment of a plaintiff's veracity, and also in gauging whether a person has a penchant for being economical with the truth and as to how careful and meticulous a person is to disclose the whole truth even against his own personal interest. A person's credibility may be a vital issue and at times it may be necessary to consider whether a plaintiff is a hardened, habitual complainer or by nature prone to perpetual exaggeration particularly about aches, pains and ailments. Vigilance is called for and wariness is necessary in respect of those prone to malingering. Accordingly the personal record of a plaintiff and information about his upbringing and education, his talents and what he has made of them, and his attitude and activities during his working career may all provide information which may give useful markers in evaluating a person's standards and credibility. Since a man's deeds may well speak louder than his words according to the old adage, it is useful to set out the features of the plaintiff's upbringing, education and career. The plaintiff was born on 15th October, 1949 in County Donegal and briefly attended national school there. His family soon moved to Dublin and he attended the local national school until sixth class and then went on to Moylepark College Secondary School in Clondalkin, where he did the Leaving Certificate in 1967 with honours in English, History and Geography, and showing a particular aptitude and interest in Maths and History. His father had joined the army during the Emergency in 1941 and had remained in the army until about 1966, he had been stationed in Donegal and was transferred to Dublin in or about 1954, which explains the family's move to Clondalkin. When the father retired from the army, he then went into the advertising business.

31. The plaintiff is a married man who lives near Saggart with his wife Sophia and a daughter who is working as a receptionist in a communications company and a son who has deferred going to college for the present. In August, 2000, he was a senior executive with Allianz, the insurance company, working as a senior insurance sales manager, being an Assistant Director and a member of the executive management team. His two children had attended Saggart National School before going on to King's Hospital in Palmerstown. He himself had taken over from Father Belton as Chairman of the Board in Saggart National School and it seems that this honorary role in the life of the community involved him attending at least four meetings a year of short duration, although he also liked to put in an appearance and make an input more often than this. He had started playing golf in Donegal at the age of about seven and he frequently played thirty six holes in a day and often was out on the course seven days a week. Golf had been the passion of his life ever since then. Indeed he was returning with his wife from Carlow Golf Club after playing there over the bank holiday weekend when the accident happened at Kill, Co. Kildare, on their way home.

32. The plaintiff explained that his father had been born in Butte City, Montana, U.S.A. His grandfather had been a mining engineer who came back to Ireland to reside in St. Columbs in Derry. In 1969 the plaintiff's family had emigrated to the USA and the plaintiff had stayed there for about ten years. He now had a sister in Oregon, another sister in Santa Maria and a sister and a brother living in San Diego. His sister Maureen lives in Dublin and works in Aer Lingus. One other brother is a manager in the Department of Justice and another lives in Philadelphia. He himself had returned to Ireland in 1974 for eight months and then went back to the USA. On his return to Ireland in the spring of 1976, he met his future wife Sophia. In December, 1977, he graduated from College in San Diego, which is about one hundred and twenty miles south of Los Angeles. In fact he had first attended the private Catholic University of San Diego and had then moved on to the State University of San Diego. The expense of the private College was an important factor as the plaintiff was working his way through college by doing such jobs as working for a title insurance company from 1pm to 9pm, then subsequently looking after a store room and stock room and delivering supplies. He looked after the post and did messages here and there. He also worked as a school bus driver which entailed driving physically and mentally handicapped children. He could do this job in the early morning and in the late afternoon and thus was able to attend lectures and classes in between times. Senior Counsel for the defendant elicited from the plaintiff that he had played on all the great golf courses in that area of California, of which I noted counsel had played on at least two. The plaintiff had majored in economics when he graduated in 1977 from the Business School in the University of San Diego which at the time was recognised as one of the top twenty US business schools.

33. The plaintiff returned from the USA twenty eight years ago and took a job as a sales representative with McNaughton Twist Steel Company on the East Wall. He was selling twisted steel reinforcement to major building contractors and dealing with architects, engineers and builders who are used to dealing with experts in their own field. He needed to know about the goods and be aware about the product and its uses or he would not have succeeded. He then moved to Rank Zerox who had a reputation for giving good training particularly to those, like the plaintiff, who are in a sales position. He moved up again in 1979 by joining the sales force in Johnson and Johnson. He familiarised himself with the products for selling purposes. The plaintiff worked hard in their hospital division which was an addition to their consumer division and their manufacturing division. The plaintiff was determined to do well and was soon promoted and worked on with Johnson and Johnson until 1986, when he moved to Galway Crystal for a couple of years on the invitation of Bill Tobin who had secured the support of AIB Investment Bank. With each move he had been climbing the ladder of promotion. He was then invited by a recruitment agency to join Smurfit Consolidated Plastics as general sales manager.

34. Subsequently he was telephoned about a job at Church and General Insurance Company in 1989 which would have been at an increased salary of €35,000 although the best selling aspect of this offer was the pension terms which were particularly attractive. Thus he joined Church and General as general sales manager in 1989. The insurance companies at that time were tending to merge and the plaintiff kept his position during the merger by which Church and General linked up with Insurance Company of Ireland. The plaintiff took over responsibility for the sales of insurance policies and for looking after the branch network, which was the money making part of the business. Church and General had been founded in 1902 as the Irish Catholic Church Property Company and changed its name to Church and General in the 1970s as it wished to expand into wider business. The plaintiff's role was to visit brokers with commercial and personal line schemes and he would be selling largely to brokers and to priests in diocesan administration who had expertise in their work. He was duly promoted and became an assistant director and a member of the management team from about 1998. The title of associate director came in after 1998. It was suggested to the plaintiff in cross-examination that he would have good contacts among insurance brokers and he responded to this by saying that the insurance business in Ireland was small and changing and that many of his contacts had now retired. It was also suggested that he was very personable and that he was the person selected to go out and entertain bishops and vicars-general and to play golf with them so as to further the company's business. He agreed that he did meet clients and that he did entertain both brokers and religious clients and met them in offices, on golf courses and sometimes for meals.

35. The plaintiff had also worked for Urneys in Tallaght before he went to Rank Zerox. It will be noted that, as a result of his diligent hard work and competence, with each move he was climbing the ladder of responsibility and seniority. Furthermore the first of many of the questions put to him in cross-examination was based on the premise that he was very capable in his job and personable and

liked by clients who appreciated his style, quickness of intellect and probably his good company on the golf course! Of course, the motive behind some of these questions was to establish that the plaintiff knew the insurance business well and had made good contacts in the few years since 1989 that he had been involved. No doubt this was an attempt to lay a basis for suggesting that the plaintiff could set up some sort of insurance brokerage firm or work in a brokerage or could cope with some part time work in an agency or consultancy type of business. My impression of the plaintiff's response to these suggestions was that, while he was very keen to rehabilitate himself and to get back to work of some sort, he had the common sense to realise that several of his contacts had retired and that the insurance business was changing. He explained that he would like to become involved in insurance again, if he could, but he was very aware of the difficulty that his participation would mean because of the driving, attending meetings, and taking notes, and he was not able to do these things competently at the present. He would have to talk to the medical experts as to whether in the future he was going to be fit to do any of those things. At present the advice from Professor Bolger and Dr. Hayes was that he is not going to be able to do these things for any reasonable length of time. He said that he was probably more concerned about how he would be in ten years "down the road"; if he was going to be able to walk then, if he was going to be able to play golf, and to do those things that everybody takes for granted. Indeed the plaintiff made it clear that based on what Professor Bolger says he, the plaintiff, had been told that he is no longer able for the job which he did before his accident. That accident was not his fault. His preference would and always will be to get back to work on a full time basis. However, he did not see himself ever achieving that. In fact, he did not know if he would ever be capable of even working on a limited basis. As for the charity work he was doing, the plaintiff said that he hoped to get on the board of Careline which is working with young people in Neilstown. The charity work which he was doing, did not involve his sitting at meetings at present. It was quite clear that the plaintiff felt that he had a duty to give back to the community by his participation and contribution; and also his doctors were encouraging him to keep up his involvement in golf to increase his fitness and mobility and also to use the type of work which he was doing for charity as a way of occupying and rehabilitating himself at his own pace and in his own time. Besides, having active interests and enthusiastic participation is a practical distraction from constant and debilitating pain.

Causation

36. Having set out the narrative of the facts in this case and having related the background and career of the plaintiff, the issue to be tackled next is the contentious matter of the causation of the plaintiff's injuries and the plaintiff's present and likely future problems. I am conscious that in giving the history much of this was derived from the evidence given by Professor Ciaran Bolger and from his medical reports dated 17th January, 2001, 5th November, 2001, 9th July, 2002, 11th August, 2003, 28th June, 2004, 13th December, 2004, and 7th February, 2005, respectively. This was unavoidable as the plaintiff's injury was clearly a case for the leading specialist in complex spinal neurosurgery. Hence the plaintiff was referred from Mr. JP McElwain, Orthopaedic Surgeon, to his colleague Mr. Esmond E. Fogarty who has expertise in spinal surgery. Mr. Fogarty, having examined the plaintiff and reviewed the x-rays and scans, recognised the seriousness and complexity of the plaintiff's neck problems and referred the plaintiff on to Professor Bolger in Beaumont, who took the history of the plaintiff, studied the x-rays, scans and imaging and then explained the dire seriousness of the situation in his neck to the plaintiff. The tale of events made it clear that the plaintiff had been a very fit and seemingly healthy man of fifty, well educated and intelligent, hard working and competent, happy in his domestic and family life and married for nearly twenty five years with a daughter and a son both well educated and flourishing. The Professor had to warn the plaintiff that surgery on his neck was required as the imaging showed that an osteophyte was protruding in to the spinal cord and there was stenosis in his spinal canal, so that there was a risk that if he sustained another impact as in a fall, for example, he could suffer damage to the spinal cord more serious than the transient tetra paresis which had paralysed him so that he could not move in his car after the fierce impact sustained on 7th August, 2000. Professor Bolger discussed the options in respect of surgery, with the first being to perform an anterior cervical decompression at the C3/4 level, including the drilling away of much of the osteophyte to give good decompression of the spinal cord. The second option discussed was to carry out a similar decompression and then also to stabilise the neck by fusions and the insertion of metal rods and screws. It was agreed between the surgeon and his patient to carry out the decompression at the C3/4 level. This was done in a one and a half hour operation by Professor Bolger on 6th December, 2000. When Professor Bolger examined the plaintiff about six weeks afterwards on 15th January, 2001 and in his first report dated 17th January, 2001, he gave his opinion which I quote:-

> "Opinion:
>
> > It is my opinion that Mr. McFadden suffered injury to his cervical spinal cord as a result of a hyper extension injury at the time of a road traffic accident on 7th August, 2000.
> >
> > Given the findings on the MRI scan I would consider that Mr. McFadden probably had changes of cervical degenerative disease prior to the road traffic accident. However, it was the presence of the cervical degenerative disease which meant the effect of the impact from the road traffic accident was to cause temporary paralysis of all four limbs and ultimately leave Mr. McFadden with left sided upper and lower limb weakness and the complaints of paraesthesia for which he required surgical intervention.
> >
> > While the changes of cervical degenerative disease may have been present prior to the accident, the chances of Mr. McFadden having suffered because of these changes had the accident not occurred is approximately 30% over the extent of his lifetime. Even in this case however, it would be likely that Mr. McFadden would have experienced a slow and steady deterioration in his symptoms and would have sought help before the development of any left sided weakness.
> >
> > I therefore consider that the road traffic accident is responsible for Mr. McFadden's current difficulties, his previous difficulties and the requirement for surgery. However, it must also be said that if the road traffic accident had not occurred there is approximately a 30% chance that Mr. McFadden would have suffered some symptoms at a future date and an approximately 10% chance that Mr. McFadden would have required surgery to the cervical spine at some time in the future".

37. Having set out the treating neurosurgeon's diagnosis of the situation based not only on the x-rays, scans and imaging but also on what he found on clinical examination and during the operations, I propose now to review the reports of Mr. Pidgeon, his neurosurgical colleague, being his reports dated 3rd September, 2001, 4th February, 2004, and 29th November, 2004, and to review the salient features of his evidence and that of the two consultant neuro-radiologists both based in Beaumont. In his first report dated 25th August, 2001, Mr. Chris Pidgeon noted that Mr. McFadden told him that "immediately after the accident he found that he was unable to move from his neck down and was taken by ambulance to Naas Hospital where he had a gradual return of movement. He was in Naas for some four to five hours and was then let go home following x-rays".

38. While Mr. Pidgeon refers to x-rays taken in Naas and an MRI scan done in Tallaght Hospital and a further MRI scan, having said that the plaintiff had some hyper-reflexia and was complaining of pins and needles on neck movements when first seen by Mr. Bolger, Mr Pidgeon states in his report dated 25th August, 2001:-

"His MRI scans are said to show a central disc protrusion at C3/4 with some retrolisthesis with narrowing of the spinal canal. There was also some degenerative changes at C5/6 and C 6/7."

39. I conclude from this that Mr Pidgeon had not actually reviewed the x-rays, scans and images himself, although he did have sight of reports prepared by Mr. Leo Vella, the A. and E. consultant, and some additional medical information provided to him by Professor Bolger. Mr. Pidgeon noted that the plaintiff told him that he had difficulty with chest infections since the surgery on 6th December, 2000, and had attended his GP, Dr. Clarke, for that. Furthermore, he observed that the plaintiff was off work as an insurance manager with Church and General Insurance Company for some three weeks following the accident and for some six weeks following his surgery and that he had taken an additional two months off in 2001 and that, although he was working, he was not yet working a full day. He also noted residual complaints including posterior neck pain and discomfort on neck movements, numbness in the finger tips, worst if he is tired or following prolonged sitting, as well as weakness in the left leg which feels heavy after prolonged driving and "drags" if he is tired. His left grip strength is diminished and he has some autonomic jerking of his legs particularly in the mornings, which are worse on the left side. The plaintiff said that he felt generally tired and that he had noticed that playing golf exacerbates his neck pain. Mr. Pidgeon noted a surgical scar high on the right front of the neck and found some left sided hyper-reflexia and some cervical crepitus present. The plaintiff's cervical spine rotation was reduced to about fifty degrees and the plaintiff confirmed to him that his left-sided weakness was present prior to surgery. In his opinion, Mr. Pidgeon stated that the plaintiff was involved in a road traffic accident and appeared to have significant degenerative changes in his cervical spine which he thought were likely to have been present before the accident; and the plaintiff appeared to have sustained some trauma to the spinal cord probably due to impingement from an osteophyte. Cervical spine surgery had been carried out and he anticipated improvement for about eighteen months from 6th December, 2000, after which further significant improvement was unlikely. He noted some residual spinal cord signs including objective and subjective indications of left limb problems and also neck pain. Finally then in August, 2001, Mr. Pidgeon stated that he would regard the plaintiff as fit for work as an insurance manager but he would accept that the plaintiff would have difficulty with work involving heavy lifting or prolonged stooping or bending and that driving long distances would cause him some discomfort. Mr. Pidgeon's second medical report is dated 31st January, 2004. He reiterated that he had had sight of reports from Mr. Vella and some additional information from Mr. Bolger and the previous narrative from the plaintiff. He does not seem to have been furnished with x-rays, scans or images or further reports but he did take a further history from the plaintiff whom he saw on 31st January, 2004. The plaintiff was wearing a cervical collar and told Mr. Pidgeon that he had been attending Dr. Camillus Power, a pain specialist in Tallaght Hospital, since he had been with him and that he, the plaintiff, had felt depressed and was in poor temper. He had begun to develop severe pains at the back of his head in 2003 and had been referred back to Professor Bolger. He was told that the images on his scans had shown deterioration and on 18th November, 2003, he had his second operation in Beaumont Hospital for a fusion of C3 to C7 with a posterior decompression and the insertion of metal rods and screws for neck stability. He was in hospital for some fifteen days but had to return with a wound infection and was readmitted for a further two weeks. He was placed on antibiotics which he was still taking in February, 2004. He has continuing difficulty with pain in the neck and shoulders and takes Difene and Panadol for that. He felt there had been no improvement in his symptoms since the fusion, indeed he continued to have difficulty with neck pain and he had restricted neck movements, numbness in the fingertips and feelings of weakness in the left leg and arm; furthermore he had now developed burning pains radiating down to the left thumb which pains were causing him sleeplessness. His concentration had deteriorated and he was tending to fall. He had noticed some hand stiffness and now was complaining of low back pain. He had been unable to play golf since August, 2003, and was worried about his job, as his position involved supervision of the sales force and a considerable amount of driving. There was some limitation in cervical spine rotation with some left C6 sensory blunting with left upper limb power diminution. The plaintiff also has scars on the front and back of his neck. Mr. Pidgeon added to his previous opinion that the lesion which was dealt with in the operation on 6th December, 2000, was an osteophyte, which is a bony degenerative change which would have taken some years to develop. He repeated his view that the plaintiff appears to have sustained some trauma to the spinal cord probably due to impingement on the cord from the osteophyte in the course of the accident and that, as symptoms continued after the discectomy and then deteriorated, the second operation was performed involving instrumentation. Recovery was complicated by an infection and he was concerned about the possibility of the instrumentation requiring removal if the infection persisted, but happily, this did not become necessary. He noted that the plaintiff made a complaint in February, 2004 and this was of neck pain and discomfort. Mr. Pidgeon accepted that the plaintiff would have difficulty with prolonged working at a desk or with extensive driving and suggested that a neuro-radiologist's opinion should be sought. He confirmed that he himself had not had sight of the scans.

40. Mr. Pidgeon saw the plaintiff again on 3rd November, 2004, and reported that the plaintiff told him that he had not improved much and that he, the plaintiff, had had discussions with Professor Bolger about further surgery. The plaintiff continued to complain of neck pain exacerbated by sitting, lying or leaning forwards; his hands were stiff and worst at night; both fingers and toes felt numb and he tended to drop things on occasion. The left side was still weak and he dragged his left leg when he was tired. His balance was poor; he had difficulty working above his head because of pain; he had problems sleeping with low back pain. The plaintiff said that he had been walking some four to five miles a day to improve matters and had lost some three stone in weight. He was attending both for physiotherapy and for osteopathy. He was no longer working and had largely given up golf. He was taking medication including difene, zydol, temazepam, paracetamol and occasionally tryptizol. I paraphrase the salient features of Mr. Pidgeon's opinion with my comment that surprisingly there does not seem much with which Professor Bolger would disagree. For example, both would agree that the plaintiff was indeed in an accident and appears to have had significant degenerative changes in his cervical spine and that these were likely to have been present prior to the accident. In the part of the neck subject to operation on 6th December, 2000, there was an osteophyte, that is a bony degenerative change, which would have taken some years to develop. Mr. Pidgeon went on to say that it was likely that the plaintiff had sustained some damage to his cervical cord, probably due to impingement on the cord from the osteophyte at the time of the accident. He noted that the plaintiff was continuing to have some symptoms relating to that and has had some objective signs of this in that there is some left sided hyper-reflexia.

41. Mr. Pidgeon thought it unlikely that there would be further improvement in respect of the weakness and the exaggerated deep tendon reflexes of the left limbs even with the passage of time. Initially the plaintiff had anterior cervical discectomy but his symptoms deteriorated and he then had further surgery and appears to have had a fusion and a posterior decompression. As to the principal complaint of neck pain, Mr. Pidgeon felt that it was unlikely there will be more improvement in respect of the neck pain with further passage of time. The plaintiff has not been able to continue working as an insurance manager and it is unlikely he will return to that occupation and it is accepted that he would have difficulty with prolonged working at a desk or with extensive driving. I comment again that there seems to be much consensus on all this between the neurosurgeons. No doubt Professor Bolger did enlarge on and confirm his opinion from his clinical findings and expand on the situation which was revealed during both operations and how this configured with what he had seen on the x-rays, scans and imaging. Mr. Pidgeon again pointed out that he had not seen the x-rays and made the point that it was important to have a neuro-radiologist's opinion about the nature and degree of the degenerative changes present. He added that it would be prudent to ascertain as to whether there is any possibility that these changes might have caused trouble in the course of time, even in the absence of the road traffic accident. I pause before reviewing Mr. Pidgeon's evidence given in court to observe that while Mr. Pidgeon's advice about a neuro-radiologist's Report was taken in that Dr. Thornton, the Consultant Neuro-Radiologist, was consulted and has both given a report and come in to give his evidence, nevertheless there is a dearth of evidence and no testimony of a definite nature has been adduced on behalf of the defendant as to when the plaintiff was

likely to have had difficulty even if he had gliosis (the scarring or overgrowth in the tissues supporting the central nervous system) before the accident.

42. Mr. Pidgeon gave his evidence on Wednesday 29th June, 2005, which was over a fortnight since Professor Bolger had given his evidence on Friday, 10th June, 2005, the fourth day of the trial. The defendant's solicitor had prudently engaged Gwen Malone's office to produce a transcript of the evidence and I am duly grateful for the provision of this transcript in twelve books to me. The interval in the hearings was caused by no fault of the parties or indeed of anyone else, but was because I had been rostered to hear an urgent Ryanair case which had proceeded in the mean time. The point which I make about this interval is that while Dr. John Thornton had been engaged to give the neuro-radiological evidence along with his colleague Dr. Anthony O'Dwyer, who was called on behalf of the plaintiff, nevertheless I do not think that the defendant has adduced any real evidence as to when the plaintiff, in the absence of trauma, was likely to have difficulty calling for and requiring surgical intervention, even if he did have degeneration and gliosis before the accident. This was despite the fact that Professor Bolger had dealt with this crucial aspect in his evidence and had discounted the existence of gliosis prior to 7th August, 2000, so there could be no illusions or vagueness as to the salient features of this diagnosis. I am aware that Senior Counsel for the defendant had diligently been out to Beaumont for consultation with the neurological experts and I am sure that this was helpful to my understanding of the significance of gliosis by reason of the questions posed to Professor Bolger, who was familiar with the x-rays including those taken just after the accident in Naas, and all the scans and imaging as well as having his clinical findings on his several examinations and what was observed and noted by him during the two operations.

43. Dr. John Thornton's report is undated. However as he reviewed the plain x-ray dated 7th August, 2000, the MRI dated 5th September, 2000, the CT dated 26th September, 2000, the MRIs dated 13th November, 2000, 3rd December, 2001, and 4th April, 2003, as well as x-rays dated 11th November, 2003, MRI dated 12th November, 2003, and CT dated 13th November, 2003, it is clear that his report was compiled after 12th November, 2003, and before 7th June, 2005, as his colleague Dr. John A. O'Dwyer had Dr. Thornton's report when he viewed the very same x-rays, scans and MRIs, with the addition of two sets of conventional x-rays of the neck taken at Beaumont Hospital on 19th November, 2003. These x-rays showed a posterior laminectomy performed at C3/4, C4/5, C5/6 and C6/7 and also transpendicular screw fixation with posterior rods. The x-rays taken on 2nd December, 2003, showed no change. Professor Bolger had performed the second operation which lasted nine and a half hours on 18th November, 2003, and this had involved fusions and stabilisation with rods and screws of much of the neck.

44. I quote from Dr. Thornton's report:-

"Plain films dated 7/8/00

> Plain film of the cervical spine shows diffuse degenerative disease involving the disc spaces. This is most severe at the C4/5 and C5/6 and C6/7 where there is disc space narrowing and some osteophyte formation which is evident anteriorly on the lateral view.
>
> At C3/4, there is slight retrolisthesis of C3 relative to C4. This is less than 20%. I see no definitive associated fracture here. There is no pre-vertebral soft tissue swelling at this point. Of note, the lowest level imaged is C6/7 disc space.

MRI dated 5/9/00

> The MRI confirms the presence of degenerative disc disease at C4/5, 5/6 and C6/7 with anterior osteophyte formation at these three levels but also with prominent disc osteophyte complexes posteriorly at C5/6 and C6/7 causing moderately severe canal stenosis partially effacing the CSF from around the cord. No convincing signal abnormality seen within the cord at this level. There is bilateral moderate to severe exit foraminal stenosis at these two levels.
>
> At C3/4, there is a large central disc osteophyte complex protruding posteriorly into the spinal canal causing severe canal stenosis with cord compression and some high signal within the cord. There is complete effacement of CSF from around the cord.
>
> There is associated hypertrophy of the ligamentum flavum posteriorly. As seen on the plain films, there is slight retrolisthesis of C3 relative to C4. The presence of both osteophyte and disc causing the thecal sac compression indicate that there are longstanding degenerative changes here."

45. A CT scan dated 26th September, 2000, of the spine and an MRI of 13th November, 2000, of the cervical spine confirmed severe canal stenosis with cord compression at C3/4 due to a combination of large osteophyte, projecting posteriorly from the vertebral body into the thecal sac, with associated disc causing the severe canal stenosis.

46. Dr. Thornton, having reviewed the later x-rays and scans concluded:

> "Overall from the initial plain film on the date of the accident, there is degenerative disease seen throughout the cervical spine with very slight retrolisthesis of C3 relative to C4. The MR imaging confirmed severe compression of the cord with gliosis at C3/4 and less severe canal stenosis at C5/6 and C6/7. Clearly this disease pre-dated the date of the trauma. *It is not unreasonable however to think that the trauma could have aggravated this process perhaps increasing the severity of the cord impingement at this level*. The pattern of the high signal within the cord at C3/4 has not changed over the subsequent years and I believe it was probably already present prior to the accident.
>
> With regard to the degenerative change through the rest of the cervical spine for which he subsequently went on to have spinal fusion, there has been no radiological change over the time interval from August, 2000 to November, 2003.
>
> There is nothing in the imaging to indicate that the clinical deterioration was due to the accident. Such deterioration would not be unexpected in the natural history of such degenerative disease." (My underlining).

47. I note that Dr. Thornton restricts himself to the images and does not mention at all the transient tetra paresis which lasted for up to six hours on 7th August, 2000, which certainly bears out the suggestion that "trauma could have aggravated this process perhaps increasing the severity of cord impingement" at the C3/4 level. His diagnosis seems to be confined to deductions from the imaging and accordingly does not take account of the clinical factors which Professor Bolger regarded as being of vital importance in assessing the pre existing condition and the effect of the impacts in the collision or of the previously asymptomatic condition of the neck and the

dramatic change with lighting up of paraesthesia and pain after the trauma.

48. In evidence Dr. Thornton used a screen to illustrate his interpretation of the imaging. On the plain x-ray taken on 7th August, 2000, he showed that between C3 and C4 there is a little narrowing of the disc space, "it is very slightly narrowed and there is a very slight backward step of the one above relative to the one below". He had previously described this in his Report as a slight retrolisthesis of C3 (above) relative to C4 (below) which was less than 20%. Lower down at C4/5 and C5/6 he indicated degenerative disc disease with narrowing of the disc space and with bony processes called osteophytes, which were visible at C4/5, C5/6 and just barely visible on C6/7, the lowest level imaged. He explained that osteophytes develop over a matter of years.

49. He then showed the image of the MRI scan taken on 5th September, 2000, about a month later, which gives more detail than the plain x-ray about soft tissue such as the spinal cord, the CSF (cerebrospinal fluid) surrounding the cord and the brain, as the CSF looks bright and white on the image. Degenerative disc disease, he said, could be seen where the disc space is narrow and there is a combination of disc bulging and osteophyte formation, particularly at levels C3/4, C4/5 and C5/6. It is seen as black bulging caused in the space between the vertebrae. He categorised the degenerative disease at C3/4 as severe and at C4/5 and C5/6 as moderate. Normally there should be a thick band of CSF extending all round the spinal cord as shown lower down. At C3/4, because of the degenerative disease impinging the narrowing spinal canal this fluid has been squashed away or effaced. When some thing comes in and causes narrowing of the spinal canal, it first displaces the fluid from around the cord and, as it gets more intrusive, it squashes the cord itself. When the cord is squashed or becomes compressed as in this case, you can see that there is some abnormal signal inside the spinal cord. There is a bright spot in the spinal cord tissue and a bright spot on an MRI scan in the cord would reflect, in this situation, either swelling (oedema) or scar tissue (gliosis). Oedema is an acute process and it tends to have happened recently and over time this swelling goes down. It is also called dropsy and is due to extra fluid inside the cell bodies or around the cell bodies. Eventually that fluid goes away and the cell bodies shrink in size and form scar tissue which is gliosis, in that there has been the death of some of the cells and so there is space which becomes filled with the scar fluid. Dr. Thornton then said that he had at this stage had the benefit of looking at later scans and the reason why he highlights the difference between acute oedema and long-standing gliosis is that acute oedema will change to become gliosis and, having seen the scans which have been performed subsequent to this one, he had seen no change in this area of signal abnormality, which means on the balance of probability this did not change and therefore it is at this point in time (meaning 5th September, 2000, about a month after the road traffic accident) already gliosis. It is a slow gradual process and would be in terms of months rather than days or weeks, and, if he were pressed, he would say three months. Having decided that it is gliosis, there is nothing to say as to how long it has been there or when it has happened. He can not tell if it has only been for six months or if it has been there for ten years. (He added: "I can tell that in my opinion it is (there) at least three months"). If gliosis was there before the accident then this was after a long sequence of degeneration. It is the displacement of the spinal fluid which happens first and then comes gliosis.

50. Counsel then informed me that it had been agreed between the parties that the radiologists should not deal with the clinical implications of the radiography and that this should be left as the preserve of the neurosurgeons. This had been applied apparently to the adducing of evidence when Dr. John A. O'Dwyer was giving his evidence earlier that day. This created a dilemma for me as I had heard the words in parenthesis in the previous paragraph. However, I have considered and taken cognisance of this added after-thought, that gliosis was there at least three months in the opinion of neuro-radiologist, Dr. Thornton, in reaching my conclusion on this aspect. It seemed to be a significant link in the theory of causation put forward on behalf of the defendant. I pause briefly to remark that Professor Bolger had the advantage of two other relevant factors in addition to and as well as the imaging studied by the neuro-radiologists. As the treating and operating neurosurgeon he has been familiar with the clinical findings and the actual situations revealed during both operations and examinations, and as well there is his knowledge of recent research studies in respect of the speedy formation of gliosis after traumatic osteophytic pressure on, and scarring of, tissues in the spinal canal.

51. Dr. Thornton then reviewed the later imaging and contrasted this with what was to be seen earlier. He said that in the operation on 6th December, 2000, there had been very tight narrowing of the canal and this had effaced and pushed away the CSF. Then, after the surgical decompression, there was CSF in the space around the cord, which he indicated by showing where there was now a white line which was continuous all the way down the spinal canal in the neck. Previously there had been a broken white line. At the level of the compression, there had been no CSF there. After surgery, there was some fluid around the cord giving it space. Dr. Thornton said that the analogy used by Mr. Reidy of an hourglass, as describing the shape, where there is an impingement effecting displacement of the CSF, was a good description when compared with the contrasting appearance of a healthy spinal canal where there is a line straight down of CSF. Dr. Thornton demonstrated on the MRI scan the hourglass effect, which is a narrowing of the spinal canal at the level of C3/4, where the space has been very confined causing the CSF to be effaced and the cord to be compressed. He highlighted a bright spot within the spinal cord.

52. The next MRI scan shown was done on 4th April, 2003, and this showed the outcome of the first surgery at C3/4 level. The hourglass effect was now less pronounced with CSF showing as white around the cord indicating that the space for the spinal cord has increased but there was still the same bright spot. Dr. Thornton said it was to be noted from the series of MRI scans that there was no other significant radiological change detectable. Indeed, the degenerative disease from his point of view did not look to be any different on the last scan from the appearance on the first scan. Perhaps I should interject that this lack of progression of degenerative disease and the absence of any other detectable significant radiological change is of interest particularly in determining the causation of the need for the second operation, in that it would appear that there was no increase in the spread of degeneration. The lack of progression of the degenerative changes between the operations seems to raise the question whether it was more likely that it was the traumatic effect of the collisions which caused the dire effect of pressure on the already compressed and narrowed spinal cord and this trauma was really the cause of the need for both operations, rather than previously asymptomatic degeneration.. This proposition is supported by the evidence that both types of operation were discussed before the first operation, the less drastic, was performed and both in essence had to be carried out to reduce compression on the spinal cord in the neck, which had been unscathed by pain or other symptoms, despite the presence of degenerative changes, before the fiercely traumatic impact on 7th August, 2000.

53. After the MRI scan of 4th April, 2003, Dr. Thornton next looked at the MRI scan of 12th November, 2003, and this again showed no change in respect of different aspects of the degeneration, the osteophytes and the disc and also the high signal in the cord indicating the gliosis, being the scarring caused by the previous compression of the spine. The squeezing together has been relieved but leaves the gliosis there. A CT scan of the neck on 13th November, 2003, demonstrated the osteophytic formation, as CT is best for bony detail rather than for soft tissue detail. Osteophytic formation was still shown at C3/4 level and also at C5/6 and C6/7.

54. In summary, with regard to the degenerative change seen on the initial x-ray on 7th August, 2000 and on the MRI scan in November, and indeed on the scans through to the most recent scan in November, 2003, as seen by him, Dr. Thornton said that there was no change or deterioration in the radiological situation. From this he concluded that the degenerative changes in their various forms, involving discs and osteophytes and the consequent narrowing of the spinal cord, were present for a long time and were remaining stable. This would have been a process which would have started many years ago. Under cross-examination Dr. Thornton

said it took a matter of years for osteophytes to develop. He said that he had not seen the studies referred to by Professor Bolger which reported that osteophytes can develop more rapidly within a matter of months. He agreed that long bones, when they fracture, have bony growth rapidly in comparison with years for osteophytes. He thought that if you have a fracture in the spine that you could have a more rapid progression of an osteophyte. He had not seen the studies which show that osteophytes can develop in months.

55. Dr. Thornton agreed that Professor Bolger was the expert in complex spinal surgery and that he was quite entitled to give his view taking the clinical picture into account. He then confirmed that in practice neurosurgeons actually look at all of the radiography and form their own views on the imaging. In fact in modern medicine almost all clinicians tend to look at the x-rays requested by them and form their own opinion about them. It can happen occasionally, although radiologists see a much larger number of radiographs, that a surgeon may see something on an x-ray or on a scan that had been missed by a radiologist. When it was suggested to Dr. Thornton that Professor Bolger had formed the opinion, taking into account all the imaging and the clinical picture, including the temporary paralysis, that the gliosis is likely to have been caused at the time of the accident, Dr. Thornton responded that, if the finding on the first scan (being taken on 5th September, 2000) was not gliosis, because this was too early (a month after the road traffic accident) for gliosis to have formed from it, then you would have to be saying it was oedema. Then it was put to Dr. Thornton that Professor Bolger did not dispute that as there was complete effacement before the accident of the CSF, then there must have been contact with or pressure on the spinal cord. Professor Bolger's explanation for this had been that he would not dispute that there could have been pressure on the spinal cord but this does not necessarily mean that the pressure was causing gliosis. In fact the Professor did not concede that this was causing the gliosis, as gliosis can result not just from compression but it can also come as a result of a sudden distortion of the cord. The clinical scenario in Mr. McFadden's case was of temporary paralysis and so Professor Bolger thought it was far more likely in this situation that the gliosis was produced at the time of the accident rather than predating it. He stressed that one should remember that the plaintiff was asymptomatic prior to the accident. Dr. Thornton replied to these suggestions by saying that gliosis was a stable condition and the transformation from oedema to gliosis would involve a change in appearance. His experience of gliosis was that it does not show up for three months after trauma and he believed from that, on the balance of probability, that the gliosis was present before the accident. He did not respond to a question as to whether he was relying on any text book in saying gliosis does not show up for three months.

56. Dr. Thornton did concede that it is possible that the accident was the cause of the gliosis. When asked if he had the clinical picture or was expert in a speciality that would allow the clinical picture to be taken into account, he replied that the radiological appearance is as it stands, and indicated that the clinical interpretation was to be left for somebody else. He did agree that it was possible that "gliosis was caused by the accident". In clarification Dr. Thornton said that a contusion based signal would have changed with the passage of time. The fact that there had been no change in signal led him to believe that it was gliosis and not an acute swelling process which he would expect to undergo change. Dr. Thornton accepted that Professor Bolger was conceding that it was gliosis, but added that Professor Bolger was also saying that the gliosis was actually caused by the accident. While Professor Bolger was also conceding all of the radiological findings and accepts the images but nevertheless then he, Professor Bolger, puts a different interpretation on them. This was understood by Dr. Thornton who then explained that gliosis was like a scar and could be from a haemorrhage, or from a contusion which resulted in oedema, or from an infarct, which is an abrupt blockage or occlusion of the blood supply. He explained also that gliosis may also be something which is radiologically present after a lesion, such as a tumour, has been removed surgically from the cord or brain or is treated by radiotherapy. Usually you would determine what a gliosis stems from by the range of findings surrounding it. For example, since in the area there have been degenerative changes compressing the cord, it is therefore more likely that gliosis here is caused by compression rather than by another incident, such as previous surgery having removed a tumour at this spot or because of a huge blockage of a blood vessel there.

57. Dr. Thornton accepted that, though there was pre-existing degeneration, this could have been exacerbated by the severe impact. He agreed at my request to deliver the scans and imaging to the hospital storage department and said he would request that they would be marked "not for destruction" in case of future need for them.

58. Dr. John A. O'Dwyer, the second consultant neuro-radiologist from Beaumont Hospital, was called by the plaintiff's counsel earlier in the same day as his colleague Dr. Thornton. I have set out their evidence out of time sequence so as to indicate more clearly the considerable areas of consensus between them and also the aspects on which they differ and then to contrast where they both differ, particularly Dr. Thornton, with the opinion of the treating neurosurgeon Professor Bolger. In his report dated 7th June, 2005, Dr. O'Dwyer stated that his report was based on the imaging studies and that he had read the reports of the Consultant Neurosurgeons Professor Bolger and Mr. Pidgeon and of his colleague Dr. Thornton. He prefaced his remarks on the imaging by noting that, initially following the accident, the plaintiff was aware of pain in his neck and realised that he could not move from the neck down and thereafter it was some five and a half to six hours later before he was able to move all four limbs again. After two operations the plaintiff was complaining of ongoing numbness and pins and needles in his fingers with pain in the neck and hands, being unable to sit or read for longer than five to ten minutes, finding difficulty with sleeping and having impaired sensation in his left hand and an overall reduction of power on his left side. Dr. O'Dwyer reports on all the images seen by Dr. Thornton and also on further x-rays taken on 19th November, 2003, the day after the second operation. He states that these further x-rays showed transpendicular screw fixation with posterior rods as well as a posterior laminectomy, being the taking out of plates of bone from vertebrae so as to expose the spinal cord and protective membranes, while removing degenerated intervertebral discs, as was performed at C3/4, C4/5, C5/6 and C6/7. Further x-rays on 2nd December, 2003, showed no change, which is noteworthy as indicating that after the second operation on 18th November, 2003, there has been much reduced, if any, further degeneration in the neck.

59. As to the x-rays taken on 7th August, 2000, in Naas, Dr. O'Dwyer's interpretation only differed in assessing there to be less marked degeneration at C4/5 compared to the disc degenerative change at C3/4, C5/6 and C6/7. He wrote that "no fracture is evident", whereas Dr. Thornton wrote "I see no definite associated fracture here". On the MRI dated 5th September, 2000, Dr. O'Dwyer noted severe constriction of the spinal cord at C3/4 appearing to be due to a combination of osteophyte and disc, and that this was causing severe compression of the spinal cord. Both noted high signal within the spinal cord but Dr. O'Dwyer commented that this could reflect the presence of oedema, fluid swelling secondary to a recent event or to scarring following on from the established degenerative process, whereas Dr. Thornton, while noting high signal within the cord at C3/4, made no such comment that this could reflect the presence of oedema or swelling from a recent event.

60. Both agree that the CT scan of 26th September, 2000, (6 weeks after the road traffic accident) shows a large osteophyte indenting the cord at C3/4. Again both agree that the MRI dated 13th November, 2000, shows disc and osteophyte indenting the cord at C3/4 with similar canal stenosis at C3/4 and C6/7 as shown on the previous first MRI. The next MRI on 3rd December, 2001, showed the surgery done at C3/4 with less compression evident, although significant abnormality with impingement still persisted. Both agree on this and that the canal stenosis at C5/6 and C6/7 levels is unchanged.

61. Both agree that the MRI scan of 4th April, 2003, shows improvement at C3/4 as the cord does not appear as compressed as before, with CSF visible around the cord. Both mention the persistent high signal within the cord at C3/4 but only Dr. Thornton

specifically remarks on this as "fitting with gliosis".

62. X-rays of 11th November, 2003, with views taken in flexion and extension, according to Dr. O'Dwyer, show very limited movement in flexion and extension and both agree that the degenerative changes remain the same.

63. A CT scan of 13th November, 2003, both agree shows persistent osteophyte at C3/4 indenting the canal with further osteophyte formation at C5/6 and C6/7. A further MRI on 12th November, 2003, both agree indicates that there is persisting indentation on the cord at C3/4, but the cord had surrounding CSF and was not as compressed as on the initial scans before the first operation; and C5/6 and C6/7 appear unchanged, meaning both have stenosis.

64. Dr. O'Dwyer concluded that the plaintiff had significant pre-existing disc degenerative disease on a background of spinal canal stenosis, with changes most marked at C3/4, C5/6 and C6/7. The high signal within the cord at MR, which had not changed over subsequent images, would indicate that there was scarring within the cord (at C3/4) prior to the accident. Imaging subsequent to the initial surgery showed a significant decompression of the cord at C3/4 level with persisting change at C5/6 and C6/7. Thus there is much consensus between the neuro-radiologists, although Dr. O'Dwyer did differ insofar as he did refer to the fact that high signal in the cord on the MRI scan on 5th September, 2000, a month after the accident, could reflect the presence of oedema secondary to a recent event or scarring from established degenerative process. Also Dr. O'Dwyer did add that on review of the reports of the neurosurgeons, it would appear to be clear that the accident rendered (formerly) asymptomatic degenerative disease and cord compression symptomatic.

65. In evidence Dr. O'Dwyer explained that he concluded from the imaging that gliosis was present before the accident mainly because subsequent scans, after the initial scan which showed high signal in the cord, up to the scan on 12th November, 2003, all showed that this had not changed. He concluded that if the abnormal signal seen on the first scan was a contusion that it might have changed over time. He said that he could not be certain of this but it was on this that he based his opinion that it predated the accident. He also took the point made by the clinicians that the plaintiff had no symptoms referable to this prior to the accident. Counsel for the defendant conceded that this (the prior asymptomatic neck) was accepted by everybody. In reply to the question "If the first signal was from a contusion then you would expect it to fade?" Dr. O'Dwyer said: "I thought it might change with the passage of time if it was due to an acute contusion. Now, it might be argued that it (the contusion) consolidated and became established but I cannot be certain of that." This is significant as this interpretation would accord more with Professor Bolger's clinical findings. When counsel for the defendant suggested to Dr. O'Dwyer that his professional view was that the gliosis was present prior to the accident, the neuro-radiologist was careful to correct this impression of certainty by saying: "That it probably was"; thus seeming to leave open the alternative construction postulated by Professor Bolger, albeit as being less likely on the imaging, while he himself thought there was likely to be gliosis pre-accident caused by impingement chronically affecting the spinal cord, though without causing symptoms. He approved of Mr. Reidy's clear description of a "white tramline", as depicting the CSF on each side of the normal spinal cord and then his making a contrast of this with the hourglass type configuration shown where the spinal cord is impinged upon and is subject to compression where the CSF is squeezed away and lacking.

66. Dr. O'Dwyer had noted that the MRI of 12th November, 2003, showed: "Persisting indentation upon the cord at C3/4, but the cord is not as compressed as on the initial scans". The explanation Dr. O'Dwyer gave for this was that, based upon imaging following the first operation in December 2000, there was an improvement in the MRI appearances which was sustained over subsequent MRI examinations at the C3/4 level, with the osteophyte gradually reducing in size. It had initially been surgically reduced on 6th December, 2000, but Dr. O'Dwyer's interpretation of the later MRIs was that the osteophyte became further diminished in size and that the compression was not as marked. He believed that there had not been an "imaging deterioration" between the first and second operation. "In fact, if anything, the imaging had shown some improvement, particularly at C3/4".

67. Professor Bolger had explained to the plaintiff before the second operation of 18th November, 2003, that this operation was to prevent a recurrence or progression of symptoms. Such surgery would be major and its purpose would be to stop deterioration in his condition rather than to cure residual problems. When asked if he could conclude from this that the trauma of this accident, from a radiological perspective, did not cause any adverse progression of the degenerative condition, Dr. O'Dwyer was careful in his answer saying:- "On imaging criteria I would agree with that". He explained this by stating that "on imaging criteria there had not been a progression of the degenerative change since the first MRI scan on 5th September, 2000, one month after the road traffic accident". This meticulous care in the choice of words seemed to underline the distinction being made between the clinician's decision to proceed on the one hand with the major second spinal operation on 18th November, 2003, on the basis of the recurrence and the progression of symptoms (since the road traffic accident), while, on the other hand, on the imaging criteria there had not been a progression of the degenerative change.

68. After the first surgery there seemed to be no advance in the degenerative process. There was reduced power on the left side in each examination. The cause of this could have been more swelling in the spinal cord at that level or from progress of the compression at that level. The further reduction over time of the osteophyte at C3/4 in the period between the operations seemed to bear out Professor Bolger's explanation that natural processes over time can produce defensive measures to reduce such bony growths and the effect of them.

69. Dr. O'Dwyer in evidence said that he concluded that if the abnormal high signal seen on the first scan was a contusion that it might then have changed over time. He could not be certain of that but it was on this that he based his opinion – which was that it pre-dated the accident. He then went on to say that he took the point made by the clinicians involved in this case, that the plaintiff had no symptoms referable to such a contusion prior to the accident and this was accepted by all. He answered a question as to whether "if the signal was from a contusion, would he expect it to fade?" by replying that he thought that the abnormal signal might change with the passage of time if it was due to a contusion. He then added that one might now argue that "it consolidated and became established", but he could not be certain of that. On reflection, presumably Dr. O'Dwyer is referring to the contusion as being capable of consolidating and becoming established as on the basis that it is the gliosis which is the cause of the abnormal signal. His remark about consolidation and establishment seems to indicate that the gliosis could not only have been present, albeit symptomless, prior to the 7th August 2000 accident, but this gliosis also could have been caused by the further violent impingement on the cord caused by the compression and by the osteophyte particularly with the pressures from the hyper-extension of the neck. During the whiplash injury, the osteophyte could have caused further contusion and then scarring, which Dr. O'Dwyer said could arguably have then become consolidated with prior gliosis and become established. This seems also to fit in, to quite an extent, with Professor Bolger's scenario that the damage was done by the traumatic injury in the road traffic accident which led to the need for both subsequent operations.

70. Mr. Pidgeon was the next witness then taken but, having set out the radiologists' contributions, I turn now to relate the salient features of the testimony of both of the neurosurgeons. Having had to derive the initial narrative of the case mainly from Professor Bolger's reports, in addressing the issue of causation it seems preferable to pick up on the evidence of Professor Bolger, the treating

surgeon, who gave evidence on 20th June, 2005. Before dealing with the main aspects of his evidence on causation, it would be helpful if I refer to a couple of legal points. First, it is important not to lose sight of the fact that the onus of proof rests on the plaintiff to satisfy the court on the balance of probabilities both on liability and quantum. Secondly, a further point worth making at this stage is that there is the principle of law that the defendant has to take the plaintiff as she found him on 7th August, 2000, whether he had a thick or eggshell skull, or a robust or frail neck. It is common case that before the road traffic accident the plaintiff had a vulnerable neck with some chronic latent degeneration which by consensus was causing him no symptoms whatsoever. This was despite the fact that his neck would have been constantly under test as he was a man who worked long and hard and also drove lengthy distances both for work and sporting purposes. Not only was he an avid golfer, playing 18 holes most summer evenings and often throughout the year, but he also actually prided himself on and preferred the carrying of his clubs, disdaining the facility made available by the invention of manual and mechanised caddy cars. This shouldering of his bag he could do back then with ease, as he was a tall, strongly-built man, well over six foot, who seemed the epitome of health and vigour and to be well able to bear a golf bag around 18 holes. One might be forgiven for thinking that this would not have been what the doctor, if aware of his vulnerability, would order for a man who had a neck with latent problems. I can envisage few more drastic ordeals for a suspect neck than the carrying of a bag full of clubs and all weather gear, and it makes clear that the concession that his neck was asymptomatic and painless before the collision was a sensible acceptance of a practical reality.

71. The initial narrative has related how the plaintiff came to be referred by Mr. Fogarty, Consultant Orthopaedic Surgeon with expertise in spinal surgery, to Professor Bolger whose pre-eminence in complex spinal surgery has been acknowledged by his medical colleagues in evidence and both his surgical skills and academic prowess are recognised by his being Professor of Clinical Neuroscience in Beaumont Hospital, the National Centre for Neurosurgery, and Head of the Department of Clinical Neuroscience in the R.C.S.I. Only two surgeons in this country regularly perform the second operation done in the plaintiff's case, of putting in plates and screws at the back of the spine. The plaintiff had sustained injury to his neck on 7th August, 2000, which had given him tetraparesis for about six hours from which he had made a partial recovery. Such temporary paralysis indicates that the spinal cord had received a significant blow in the accident. In terms of people who recover partially, this was very serious, being a condition known as "spinal shock". When seen by Professor Bolger on 27th November, 2000, the plaintiff had ongoing pressure on the spinal cord, as shown on MRI scan, and also weakness of his left side, while imaging showed impingement of and pressure on his spinal cord with stenosis of his spinal cord at C3/4. His condition was such that, if he had even fallen at home, he could have become paralysed and so he was booked in to Beaumont Hospital as a precaution. The narrowing was degenerative but the effect of trauma in the road traffic accident was to make the stenosis and pressure critical, because of his already reduced spinal cord diameter. Professor Bolger said: "As a matter of probability, if Mr. McFadden for example had an MRI scan the day before the accident, I would expect it to show the same level of degenerative change, the same level of spinal cord narrowing but I wouldn't have expected on probability to see the high signal inside the spinal cord itself. The high signal in the cord is usually an indication of repetitive injury to the cord or of a single injury to the cord. When you see this in degenerative disease, you usually see it at a level in the cord where there is instability. There wasn't instability at the 3/4 level. We are talking about probability rather than absolutes. On probability, given the fact that Mr. McFadden was rendered paralysed by the injury, I think it would be more consistent that this evidence of damage to the cord happened at the time of the injury."

72. The opinion of the operating neurosurgeon, the leading expert on complex spinal neurosurgery, who has studied all the x-rays and imaging and performed both operations and has examined the plaintiff over the years since his referral to him at first consultation on 27th November, 2000, is now explained. Professor Bolger's diagnosis takes into account the transient tetra paresis, the state of the degenerative disease in the neck including the stenosis and the osteophytic impingement and the important factor that there was not instability at the C3/4 level. There is consensus that the plaintiff's neck was asymptomatic prior to 7th August, 2000. High signal in the cord is usually an indication of repetitive injury to the cord or of a single injury to the cord. The lack of aches or pains beforehand in this active man's neck, despite his strenuous lifestyle and the existence of degenerative disease and stenosis of the spinal canal, and the lack of clinical instability at C3/4 found by the operating surgeon, all combine to reduce the likelihood of the high signal being caused by earlier repetitive injuries to the cord. Given the impacts in the collision on 7th August, 2000, and the more than five hours of transient paralysis of arms and legs and lower body, it is clear why Professor Bolger says it is more consistent that the damage to the cord happened during the injury in the collisions. This was probably when the intruding osteophyte pressed against the spinal cord when the neck was extended sharply in the first impact.

73. When asked about statistical probabilities, Professor Bolger said that 50% of the population at 50 years of age will have changes from degeneration which will show up on an MRI scan. Of that sub-group of the population who do have these changes, there are three further sub-categories:-

> 1. One-third of this sub-group will continue as they are if they have a pain, this goes on for many years neither any worse nor any better. If they do not have a pain, then they are likely so to continue painless. Since Mr. McFadden was asymptomatic, you would expect him to stay that way if he fell into that one-third.
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> 2. The second one-third are patients who will spontaneously improve if they have symptoms. The reason for this improvement in a degenerative condition is that, as the spine degenerates, it becomes stiffer and more rigid. As the spine becomes more rigid, one's symptoms actually become less. It is really the body's defence mechanism. You end up having a spontaneous fusion of your spine, and then as it fuses you get less symptoms. There is no relative movement between the bones in the spine. Movement normally is what induces the pain. Irritation of the nerves of the spinal cord or pressure can produce the pain as well. So 66.6% of people who have changes at the age of 50 either get better or stay the same.
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> 3. The remaining one-third will show a steady deterioration in their functioning. They get a gradual deterioration in their functioning and in their symptoms. What tends to happen is that one level or other of the degeneration that is in the spine becomes progressively worse and begins to produce symptoms. One-third of those in that one-third subgroup will actually require surgery at some stage, being roughly 10% overall of those who had degeneration – being 5% of the population and 10% of those who have degeneration at age 50.

74. These statistics are in both studies and in text books. When asked whether the level and extent of degeneration affects the extent of likelihood of persons finding themselves in the last 10% category, Professor Bolger replied: "It is one of the great conundrums for people who are researching this area, that there does not seem to be a correlation between the severity of the disease as shown on an MRI scan and the likelihood of somebody having symptoms. So you can have a very severely degenerated neck without any symptoms and yet many of the people who are operated on for symptoms will have a single level that is degenerated or one nerve that is compressed. … It is possible for a person with one level that is degenerated to require surgery, while somebody, who has multiple levels degenerated, never requires surgery. The studies show that there is no direct correlation apart from (at) the extremes. In other words if you have no degeneration or a very, very slight degeneration, it is very unlikely that you will need surgery. If you have severe degeneration, in other words the degeneration that would involve some instability in the spine, then it is more likely you would need surgery. But in between (in) that spectrum you can have people who have multiple level degeneration

in their neck who never have symptoms and people who have a single level that is degenerated who have symptoms that are so severe they end up having surgery." When asked about the plaintiff, he said that the plaintiff is not in the absolute extreme, he is somewhere in the middle but towards the severe end. He did have multiple level degenerative change on his MRI scan. Professor Bolger went on to say that it is impossible to predict the likelihood of the plaintiff deteriorating to such an extent that he would not be able to work before the age of 65 just from a person's MRI scan. Even if you considered that Mr. McFadden was destined to fall into the one-third of patients who develop significant symptoms in the course of time, you would expect that to happen over a prolonged period. It would be a slow and gradual deterioration. The symptoms may well have been bad enough eventually to prevent him working but they may equally have simply consisted of some pain or ache which would not have prevented him working. There would be only a one-third chance that he would have fallen into that group. Even if he fell into that group, Professor Bolger estimated that it would have taken five to ten years for him to have developed those symptoms. As a person with degeneration by the age of 50, he would fall into the 10% group that eventually require surgery so he had, but for the road traffic accident injury, a 10% chance of having to have surgery to which the corollary is that there was a 90% chance he would have completed his working life (unscathed by the surgeon's knife). If Mr. McFadden had had an MRI scan done which showed extensive degenerative change in his neck and had come in to Professor Bolger and asked: "Will I be able to work to 65, forgetting or excepting any trauma?" he would have been told that there would be a one-third chance that he would over the course of time develop symptoms and that they could range from an occasional ache to quite severe symptoms that would need surgery. The chance of him actually needing surgery overall in the course of time would be 10%. People sometimes find this difficult to understand when they see an MRI scan that shows very severe degeneration. Very few people actually end up needing surgery for this condition, which is so prevalent that many researchers consider it to be a normal part of ageing.

75. Since Mr. McFadden was very active and engaged in a number of pursuits which would require a lot of activity and he had not had any previous history of problems with his cervical spine, and as most people do complete their careers and it is only a small minority that end up having to have surgery, Professor Bolger believed it would only be some of this small group who would then end up not being able to continue to work. In his view, if the accident injury had not occurred, there would have been a very small probability of his patient not completing his career. An estimate of half of the people who eventually need surgery would put the figure at about 5%.

76. Professor Bolger said the plaintiff clearly needed surgery after his accident in August, 2000 and so he arranged for this. At the time he felt perhaps more radical surgery should be done given the nature of the problem, but the plaintiff was concerned about the serious nature of the level of surgery and, after discussion, they settled on doing what Professor Bolger felt was "the most minimal thing" they could do in order to try and prevent further injury to the spinal cord. This less radical option was simply to decompress the C3/4 level by coming in at operation from the front of the neck and by not putting in any form of instrumentation or doing any fusion.

77. The purpose of the first operation on 6th December, 2000, was to remove or reduce compression from the front of the spinal cord which is important because it controls motor movement. The patient already had weakness on the left side of his body and a minimalist approach would be at least to try and take the pressure off the front of the spine. This would be a fairly standard surgical process, operating from the right hand side of the front of the neck, moving the voice box and pharynx to one side, and the carotid artery to the other side, and then between the two of these sides, the surgeon gains access to the spinal vertebral column at C3/4 level and removes the damaged disc and any osteophytes from in front of the spinal cord. The larynx, the organ of voice, is below and in front of the pharynx and at the upper end of the trachea to which it serves as a passage way for air. The goal of that operation was to remove the pressure, caused by the bulging disc and osteophyte pressing on the cord, and from the front of the spinal cord, firstly to reduce the likelihood of any further trauma, such as a fall, causing permanent damage, such as paralysis, and then also, secondly, to try and increase the potential for recovery from the left sided weakness which the plaintiff was enduring at that time. The more radical surgical option discussed would have involved fusing C3/4 and indeed fusing several other levels in the neck. The reason for the need to fuse several levels would be because, if you operate on someone with multiple level disc degenerative disease on the one level and you destabilise this level, then you also destabilise the levels below this. If you destabilise the levels below and there is already wear and tear in those levels, the chances are that you will make the patient worse in time. These lower levels will continue to degenerate. The decision to do the more conservative operation was arrived at after discussion between doctor and patient after Professor Bolger had explained all the risks and the advantages and disadvantages. The advantage of the more major operation, if done straight away, would have been to stabilise the whole spine and to achieve decompression both from in front and from behind. Obviously, with bigger surgery, there are greater risks. There could have been much more of a risk of causing damage. Mr. McFadden was keen to have the minimum done that could be done. The minimum which could be done would be to take that pressure off the front of the spine. So they settled for that.

78. Professor Bolger described each of the two operations and the plaintiff's wish and determination to rehabilitate himself and his perseverance in making every effort to return to work. He was then asked what was the cause of the requirement for the first surgery and the second surgery, to which he replied that the requirement for the first surgery was to try and decompress the spinal cord to prevent further damage and to try and help with the recovery of the plaintiff's symptoms. The cause of them had been the trauma which he had suffered, particularly at the C3/4 level at the time of the accident. The requirement for the second operation was really the same. It was to try and further decompress the C3/4 level and then to address the consequences of this decompression at the C3/4 level by stabilising the rest of the spine. The cause of the need for all of that was the accident, it goes back to the same thing. The second operation was really to complete the job, because at the first operation it was decided to do the minimum. The first operation had left him with posterior compression at the C3/4 level. To tackle this, Professor Bolger needed to decompress that level further and then to fuse it. But in fusing at C3/4 level, this would be bound to put extra pressure on the other levels in his neck which were already degenerative, so Professor Bolger decided to incorporate the other lower levels into that surgery. It would have been unwise to decompress the level affected by the accident a second time without fusing the other levels because that would leave a level in the neck that had been decompressed from both in front and from behind. That is not a stable condition so it is necessary to fuse that level. If that C3/4 level is fused, then this puts "undue pressure" on the levels below that in the neck. The risk or likelihood then was that those lower levels would have deteriorated at a quicker rate and you would end up having to deal with them in the future. Since the fusing at C3/4 level was being considered as was needed, it became necessary also to fuse the levels below that.

79. After both operations the patient had a partial response of limited effect. After the second operation he had some improvement in his symptoms, particularly in relation to the symptoms in his hands but while his fingers were less numb and his toes were less numb and his pain and stiffness in his hands were less, these problems still persisted. He also had some further improvement in the power in his left leg, but he was still left with significant, severe and ongoing neck pain. The Professor recalled that again the plaintiff was very enthusiastic about his rehabilitation. He threw himself into activity to get going again and he continued to remain very keen to try to carry on at work. He was having significant problems with pain and sleeplessness and he was having problems with his mood because of frustration with not being able to concentrate, or to undertake long journeys and then to manage to do any business at the end of them. The Professor felt that really in the long term, the plaintiff was being unrealistic in terms of returning back to work. He was

putting himself under too much pressure in trying to keep up with meeting his same high standard of work as before. However, the plaintiff felt that he needed to keep going. The Professor had to advise him on several occasions that he should slow down a bit and that in the long term he had to be realistic about his capacity to return to work. Professor Bolger had written to Dr. Jim Clarke, the GP, about this on 17th December, 2001, (CB/JC/I), 20th December, 2002, (CB/JC/II), 4th February, 2004, (CB/JC/III), and 5th May, 2004, (CB/JC/IV). The Professor was concerned that his patient should avoid both long driving and concentrating for too long on documents while at a desk. He regarded as typical of the plaintiff that he had taken up some charitable work much of which he could do at his own home and to his own time and pace. The plaintiff was always concerned with being active and any time that the Professor set him a rehabilitation goal, he was enthusiastic about striving to achieve it. He was invariably always trying it in spite of his pain. The Professor added that this was not an attitude one always finds with patients. When asked if he thought the plaintiff can do part-time remunerative work as an insurance broker, the Professor responded cautiously by saying that it depended on what was meant by "can". The problem was that if the plaintiff does any activity which requires the maintaining of a posture with his head flexed forward for any length of time, then he is going to suffer considerably for this. Prolonged periods of sitting at a desk, working at a computer or driving a car are all exactly the kind of posture designed to make his symptoms worse as they each involve sitting with the head flexed forward.

80. The Professor said he did not know what would be involved as a part-time insurance worker. The patient would need to have control over being able to move about freely. Professor Bolger made it clear that he could not say how realistic it would be for the plaintiff to try to work as a broker meeting people about insurance and then having to stand up and walk around all the time or constantly having to move about while also trying to avoid sitting down. He cautioned that if the pain was bad, then the plaintiff's concentration would be affected. He conceded that perhaps it may be possible and added that, knowing the plaintiff, it would not surprise the Professor if he put his best effort into it. However, he did reiterate that the plaintiff's symptoms are and would be aggravated by those kind of activities.

81. Returning to the prognosis as to the condition of the plaintiff's neck, Professor Bolger explained his "one third scenario". The plaintiff has a one-third chance of being in the category of those with degeneration who will stay the same over a long period of time; secondly, he has a one third chance of being in the category of those with degeneration who have some slow improvement. Thirdly, he has a one third chance of being in the category of those with degeneration who have the prospect of further deterioration, particularly at the levels on which there had not been surgery. The Professor clarified that the fixations of the cervical vertebrae by bone grafts to immobilise them, being at C3/4, C4/5, C5/6 and C6/7, are all fused only at the back and not at the front of the spinal column.

82 Professor Bolger was cross-examined by Senior Counsel on behalf of the defendant and I summarise the aspects bearing on causation and also some matters peripheral to this. Dealing with the accident Professor Bolger agreed that in a severe collision, as described involving a whiplash injury, the plaintiff's neck would probably have been extended and then flexed and that the osteophyte at C3/4 level came in contact with the front of the plaintiff's spinal cord causing temporary paralysis. When you extend your neck you reduce the diameter of the spinal canal and the cord has to move. With a canal of normal diameter, the cord is bathed in fluid and there is nothing sticking in to reduce that diameter. But when a person has a constriction of the cord at that level and there is movement of the neck, particularly if this is sudden and forceful, the spinal cord then is forced against any constriction, whether that be a disc or an intruding osteophyte or a blood clot or whatever is the narrowing intrusion in the spinal canal. From looking at the MRI scan taken on 13th November, 2000, Professor Bolger was sure that the plaintiff had an osteophyte which he would assume, from its appearance on the imaging, was effacing the thecal sac and so he could state with absolute confidence that there was even less of a gap between the osteophyte and spinal cord when the plaintiff's head was thrown back (as when his car was shunted from behind). The cord would have moved and would have been pressed against the osteophyte, which was in front of it as the bony growth was protruding into the spinal canal in a posterior direction. My understanding of the mechanics of the collision is that the sudden severe impact from behind pushed the plaintiff's Mercedes car forward sharply. This would have caused the plaintiff's head to be thrown back in extension, so that the cord was pressed against the osteophyte which was pointing towards the back of the neck.

83. Counsel suggested that an osteophyte is a piece of bone which grows over a long period of time and was politely but firmly corrected by Professor Bolger who replied: "Not necessarily over a long period of time. It can start as an outgrowth of the bony growth cartilage or the bony articular cartilage. It can also come about because you get bony degeneration in a soft disc; so a disc can come out, the body can calcify that disc and that gives you an osteophyte. In animal studies we now know that they can come over a period much shorter than we previously thought, a matter of months rather than years. We used to say it was years, but it can actually happen over a matter of months…. It happens spontaneously. The initial thing happens spontaneously. It is fed by two things: the body has two tendencies to predispose osteophyte formation. The first tendency the body has, is that if you have degeneration in a joint, the body tries to stop the joint moving and it grows these osteophytes as bony spurs or outgrowths that will limit the movement. The second tendency the body has, is that in abnormal tissue the body tends to lay down calcium. So that if you have a soft disc, one for example that comes out, over time the body can lay down calcium in that and make it into a hard osteophyte. While this osteophyte (at C3/4) could be either, on balance, given the location, it was probably a disc that was bulging which ended up being calcified. This can happen over a period of months. While it is progressive, it is not necessarily on a continuum as even large osteophytes can regress. You can scan somebody at one stage with a large osteophyte and then scan again a few years later and the osteophyte will be gone. This osteophyte (at C3/4) had progressed before the accident from that of somebody's neck having a normal spine to somebody whose neck had a large osteophyte". Counsel referred to the MRI scan of 5th September, 2000, as described in Dr. Thornton's Report confirming "the presence of degenerative disc disease at C4/5, C5/6 and C6/7 with anterior osteophyte formation at these three levels but also with prominent disc osteophyte complexes posteriorly at C 5/6 and C 6/7 causing moderately severe canal stenosis partially effacing the CSF from around the cord. No convincing signal abnormality seen within the cord at this level. There is bilateral moderate to severe exit foraminal stenosis at these two levels". These were agreed by Professor Bolger to be examples of the two categories of osteophyte that he was talking about, one growing out from the bone and the other one growing from the calcified disc itself where it calcifies. At the three levels from C4 down to C7, Professor Bolger agreed that there was degenerative disc disease at C4/5, C5/6 and C6/7 with anterior osteophyte formation at these three levels, but also with the patient having prominent disc osteophyte complexes posteriorly at C5/6 and C6/7 combining to cause moderately severe canal stenosis which was partially effacing the CSF from around the cord. Within the thecal sac there is the spinal cord and surrounding it there is the CSF in which the brain and spine are bathed. The CS fluid has partially been displaced from in front of the spinal cord because of the presence of the osteophytes. So the fluid is being squeezed out, not totally but partially. The fluid is there primarily as a protection but it does play some role in nutrition from the fusion of stuff through it, but this is not a major role from that point of view. It is mostly there for protection. Pressing the thecal sac has a similar effect as pushing on a balloon in that the liquid in the sac goes on either side of and around the pressure point. This is what Dr. Thornton is describing when he talks about the CSF being pressed by these osteophytes at these three levels. Professor Bolger was prepared to say that the osteophytes were there before the accident in August, 2000. The critical osteophyte was at C3/4 level of which Dr. Thornton said:- "there is a large central disc osteophyte complex protruding posteriorly into the spinal canal, causing severe canal stenosis with cord compression and some high signal within the cord". There is complete effacement of CSF from around the cord. There is the bony outgrowth of the osteophyte and it impinges on the cord. Professor Bolger explained that if one looks at the spinal cord in cross-section, a normal

spinal cord on an MRI scan is a bit like looking at a fried egg, where the white of the egg is the fluid and the yoke of the egg is the spinal cord itself. In a normal person what one has is a yoke of egg that is sitting in the middle and a circular or nearly circular white of egg. What Dr. Thornton is saying is that the white of the egg in front of the cord is no longer circular, there is a dip into it, and that is because of the presence of the osteophyte. It was causing complete effacement of the CSF, which means there was no spinal fluid between the thecal sac, at least at this level, and the spinal cord before the accident. Since as Counsel said, all are agreed that the plaintiff had no problems and had no neurological symptoms from this osteophyte before the accident, then the gap that was there was miniscule. Then Counsel suggested that if there had been no accident and there was further growth in that osteophyte, the gap would have been bridged and he could have had neurological symptoms, Professor Bolger disagreed and explained that this assumes that if you get any contact between an osteophyte and the spinal cord or a nerve then you are going to have symptoms. In fact that is not the case. You can get marked compression of the spinal cord where the osteophyte actually grows into the spinal cord and even then not have symptoms. The critical factor seems not to be the degree of compression but the time period over which the compression develops. When you talk about neurological injury, the brain and the spine can accommodate pressure if it develops very slowly. So, for example, if you were to consider a brain tumour, if you have a benign brain tumour that is growing very slowly, it is possible for that brain tumour to reach an enormous size before it causes any symptoms, even though it is growing in the brain or pressing into the brain. Whereas something that happens much more quickly or grows much more quickly is much more likely to produce symptoms. So you can see people with osteophytes in their spine that nearly transect the spinal cord and they still have no symptoms. What seems to be the critical factor is not so much the extent, but the time period over which that happens. The reason is because the body accommodates over time to displacement of the spinal cord in the brain. Counsel then suggested that where one had contact between an osteophyte and a spinal cord that it was probably going to cause symptoms at some stage. Professor Bolger responded:- "No, that is the conundrum. That is why people are researching this extensively, because it would appear that people can have marked compression and have no symptoms and people with very minor compression can have symptoms."

84. When Counsel asked Professor Bolger if he agreed with Dr. Thornton that gliosis (meaning scarring) was there always before the accident at C 3/4, the Professor replied that not only did he not agree, but in fact he disagreed. He would not dispute that there could have been contact or pressure on the spinal cord causing complete effacement of CSF (cerebrospinal fluid) on the image, but that does not necessarily mean it was causing gliosis. While Dr. Thornton was saying that gliosis was probably already present prior to the accident, Professor Bolger said: "I disagree with him. Gliosis can certainly result from compression, but it can also result from a sudden distortion of the cord. And in Mr. McFadden's case the clinical scenario, regardless of just looking at the x-rays, was of a man who was temporarily paralysed. In that situation, I think it is far more likely that this gliosis was produced at the time of the accident than predating it. Remember, he was asymptomatic prior to the accident…. They are not mutually exclusive. We are talking about probability not a definite. I am talking about that, on the balance of probability, I would consider that that gliosis was caused by the accident". He agreed that he was at odds with Dr. Thornton and he supposed that "the difficulty that Dr. Thornton has, is in looking at images divorced from the clinical situation". I quote the next exchange between counsel for the defendant and Professor Bolger as it seems to go to the nub of the issue as regards the contentions in the conflict of diagnosis:

> "Counsel:- Q. As all radiologists have to do? They are not looking at the clinical picture, they are looking at what they see on the scans."
>
> Professor Bolger:- A. Absolutely. And if I was looking at the images, without having access to the clinical information, I would probably come to the same conclusion. But the critical thing here isn't the images. The critical thing is the clinical history and the marrying of the presence of gliosis on a scan, with someone who gives you a history of having actually become paralysed.
>
> Q. We can all see the force of that. …."

85. As for Dr. Thornton's note that there is associated hypertrophy (increase in bulk) of the ligamentum flavum posteriorly, Professor Bolger explained that the osteophyte and the disc complex is in front of the cord anteriorly. Posteriorly you are talking about the ligament at the back of the spine going over the joints in the back of the spine. It is causing some compression as well. It is overgrown. As for the effacement of the CSF from around the cord, Professor Bolger interpreted this by saying that it is in part due to the osteophyte complex pushing in from the front, and in part due to the overgrowth of the ligamentum flavum coming from behind. This overgrowth causing effacement then was from two sides, posterior and anterior, and Professor Bolger thought that this was there before the accident; as also was the slight retrolisthesis of C3 relative to C4, meaning that C3 was displaced backwards on C4 more than would be normal. It was agreed that the presence of the osteophyte and disc compressing the thecal sac indicated that there were probably long standing degenerative changes here but these things can happen over a shorter period of time. It was suggested that given the degenerative change completely affecting the cervical spine, it is more likely to have been a long standing thing; the Professor agreed with that. At operation he tried to remove the disc and the osteophyte that was sticking into and pressing on the cord from in front. It is not always possible to remove all of it particularly if you are not going to do an instrumented fusion. It is fused but he did not mean "fused" in terms of an instrumented fusion with the insertion of metal. He stressed that if you remove too much material, and you are not going to do an instrumented fusion, then you can cause instability. You are trying to remove enough of the material so that you create some space in front of the spinal cord between it and where the osteophyte was or any remnant of the osteophyte. This would reduce the compression. It was agreed that the MRI of 3rd December, 2001, about a year after the first operation, showed the cervical discectomy had left a part of the disc there and had achieved some decompression of the thecal sac. Probably the gliosis was the same. There was some good bit of improvement in symptoms after the decompression was effected at C3/4 level. The jumping in the legs, being one matter causing concern, had improved. He was still having discomfort around his neck, though the numbness in his fingers had improved. He could move his head at this stage without numbness going down his arms but he continued to be weak on his left hand side and to have pain. By March, 2001 he was still having pain in his neck and he had an increasing tendency to drag his left leg. He had tried swimming and to play golf, albeit badly.

86. Counsel questioned Professor Bolger about the second and third paragraphs of his opinion in his first report dated 17th January, 2001, about six weeks after the first operation, when he had written:- "while the changes of cervical disease may have been present prior to the accident, the chances of Mr. McFadden having suffered because of these changes had the accident not occurred is approximately 30% over the extent of his life time. Even in this case however, it would be likely that Mr. McFadden would have experienced a slow and steady deterioration in his symptoms and would have sought help before the development of any left-sided weakness. I therefore consider that the road traffic accident is responsible for Mr. McFadden's current difficulties, his previous difficulties and the requirement for surgery. However, it must also be said that, if the road traffic accident had not occurred, there is approximately a 30% chance that Mr. McFadden would have suffered some symptoms at a future date and there is an approximately 10% chance that Mr. McFadden would have required surgery to the cervical spine at some time in the future".

87. The Professor explained that it was most likely that the development of pain would have come usually before any motor weakness. In that case if the patient sought help for pain referable to the neck, he would obtain an MRI scan. If degeneration and

compression was seen on the scan then one would operate and hope by this to prevent the development of any weakness.

88. If a person has multiple level degeneration in the spine it is important to ascertain which level is causing the problem. It can be hard to be sure which level is causing the problem, so it is important that there is some characteristic of the pain or something is found which on examination points to a particular level which is the source of the difficulty. If you cannot do that, you could actually aggravate things by operating. He gave an example of a person with a problem at C7 level in the spine, and said that to confirm this, then there should be a pain that comes down the arm to the middle finger. If the problem is at C6 above this, then that is different and the pain will come down to the thumb. He stressed that you never just operate because you see something on an MRI scan; it has to be consistent with the clinical scenario. This is one of two types of pain you can suffer from problems in your neck. From a pinched nerve, radicular pain can come which can be quite specific as to from what level and from what root this kind of pain is coming. This sort of pain characteristically involves one nerve and goes along the autonomic distribution of that nerve. There is another kind of pain called myelopathic, which is pain caused by pressure on the spinal cord itself, not on an individual nerve. That pain is not as specific and can affect a number of segments at the same time; it comes from damage to the spinal cord itself, not from a nerve root. Typically that painful suffering will cause pain associated with the segments below the damaged part.

89. Having the combination of the plaintiff's complaints and the MRI findings, Professor Bolger could pinpoint the area which needed to be addressed and this was the area at C3/4. He agreed with counsel that he had in November, 2000, warned the plaintiff to be extremely careful as a fall or any kind of sudden injury to his neck could lead to paralysis. When counsel for the defendant suggested that the radiological findings (being seen on x-rays of the 7th August, 2000 and MRI scan dated the 5th September, 2000, CT scan dated the 26th September, 2000, and MRI scan of the 13th November, 2000) were all there before the accident, Professor Bolger corrected him and pointed out that they had differed on one particular finding by specifying one exception, namely "except for the gliosis, I think we disagreed on that point". They agreed that the gliosis is an indication of an area of contusion or damage to the spinal cord. While you can have that without symptoms, it is more likely to cause symptoms below that level (C3/4). When counsel suggested that this "specifically was not the major clinical or radiological finding that would have led to the … (diagnosis of urgent need for surgery)", Professor Bolger quickly corrected him and contradicted him by saying, "No, it is" and reiterated this. The inference from this was that this was a very important clinical finding and should be noted. Since the plaintiff now had gliosis and degenerative changes, Professor Bolger warned him to be careful and to avoid any risk of accident, such as a fall, the reason for his concern being the absence of any significant space between the spinal cord and osteophytic degenerative change in combination with the fact that he already had suffered an injury which had rendered him temporarily paralysed. The surgeon then explained why he would give that advice, but added that if somebody came to him without that history of paralysis, who just happened to have had those images from an MRI scan but had no symptoms, he would not necessarily be advising the patient to have surgery on the basis of the imaging on the MRI scan, no matter how close the impingement was to the spinal cord, if the patient was asymptomatic. He confirmed that it was his opinion that the accident had caused the damage of the residual gliosis as a result of injury to the spinal cord and he conceded that they both were in agreement about the degenerative changes (on the other hand) being present prior to the accident. When asked if the anatomy, meaning the dimensions of the osteophyte and of the spinal cord and of the spinal canal and the presence of the stenosis there at C3/4 level, was unchanged by the accident apart from the gliosis, Professor Bolger replied simply that one does not know. It could have been changed by the accident, but he would accept that the osteophyte was there prior to the accident, and as a matter of probability that the degenerative changes, including the size of the osteophyte, was likely to have been the same before the accident as immediately following the accident.

90. Normally one would not have an MRI scan of an asymptomatic patient. Professor Bolger would not operate on a mildly symptomatic patient unless there were enough symptoms not responding to conservative treatment, so that the risk involved in surgery becomes less than the risk of not intervening, and that is when one would consider surgery. This is not the sort of surgery to be undertaken lightly, insofar as the consequences of complications from the surgery are quite dramatic. So a patient who has a mild degree of pain that will settle with pain killers and which is not really restricting him, would not be a candidate for operation. If the patient has pain which is persisting, even though without left-sided weakness, then one would operate.

91. When counsel suggested that the plaintiff had severe spinal degenerative changes, Professor Bolger agreed, but when the proposition was put that where one has severe degenerative changes rather than minor degenerative changes, one is more likely to develop symptoms of some kind, the Professor refuted this by explaining that it does not work that way. This is because, as the degeneration gets more severe, one can suffer from less rather than more symptoms because the spine becomes less mobile. The more osteophytes you have, the less mobile the spine will be. The body produces osteophytes to try and restrict the movement. It is not only possible, but quite often, you can see people with very severe degenerative disease who do not have symptoms and on whom he would not operate. Going a step further, if you have a patient who has instability in association with degeneration, in other words the degeneration has not made the spine stable – sometimes it does not make the spine stable and you find people who have various degrees of forward subluxation of the bone, then those people are more likely to develop symptoms. The plaintiff's position is not as in this situation; he has retrolisthesis, which in Mr. McFadden's case is very minor and is at a single level. It is not like an unstable step-wise deformity. What is more significant is a forward subluxation, a partial dislocation of a joint, often with sudden acute pain.

92. Counsel suggested that with the level of degenerative changes in his neck, the plaintiff was going to develop symptoms one way or the other. The Professor responded quite emphatically that he thought that this was completely untrue. He asserted that this was not just his own opinion. He was at pains to stress that this was a matter which was well established. People fall into the categories which he had described. If it was so straightforward, one would have a very simple recipe for making decisions about operating on people, but we do not have that formula. When it was then suggested to him that with double impingement from both anterior and posterior levels on the plaintiff's thecal sac, with complete effacement of the CSF in his spinal cord, the plaintiff was going to have to undergo an operation one way or the other, without the traumatic intervention of the accident, Professor Bolger responded vehemently that he disagreed completely with this proposition. When he was further taxed with this suggestion of the inevitability of the plaintiff having to face an operation, being the real meaning behind why he said the plaintiff would have sought help before the development of any left-sided weakness, the Professor retorted that what he had actually said was that, even if the plaintiff was predestined to be one of the people who was going to develop symptoms, it would be likely that he would seek help prior to developing weakness. So this was not at all the same thing in that what he was saying was that he did not think the plaintiff necessarily would have developed symptoms. Even if he was destined to develop symptoms, he would have been likely to have sought medical intervention before they got so bad that he would have required surgery or have developed weakness. What the Professor was saying and stressing was that he did not think that the plaintiff was destined to develop symptoms and even if he did fall into the minority of patients who do eventually develop symptoms, he would be likely to have sought medical help before he would have developed weakness. I observed that the Professor was speaking emphatically and deliberately and he continued to do this again when responding to the next comment from Counsel which was this; "the trouble with all of that was your advice to the plaintiff to be careful, any fall could cause paralysis". The Professor responded to this by stressing that there was no contradiction there in what he was saying, as the plaintiff at the stage when that advice was given was no longer an asymptomatic individual. He was no longer a person with some mild pain. On the contrary, he was a man who has a weakness down the left side of his body with high signal in his

cervical cord on an MRI scan and suffering from chronic pain. A patient like that is completely different from people who come in to him when they had some pain down their arm when they were playing golf or another sport. This is a man who has already had damage to his spinal cord and is at significant risk of further damage, and this is particularly so because of other indicative features found. Of note in that respect, the Professor suggested, was both the tendency for the legs to jump at night time, which is a sign of spinal cord irritation showing that his cord was still being affected, and so also was the residual weakness still on the left-hand side. This put Mr. McFadden into a completely different category of patient from the normal patient who presents with degenerative disc disease.

93. When it was suggested that the cause of the plaintiff's condition was the fact that the spinal cord was restricted both front and back by advanced degenerative disease, Professor Bolger responded that he thought it was more likely that it was because a man who had constriction of his spinal cord both front and back then had a hyperextension injury which damaged the cord. He explained this by saying that once you have an injury, the scenario changes. He used the analogy of a person who sprains an ankle which will be black and blue to start with, but then will appear fairly normal after a couple of weeks. But for a long time afterwards, if you walk over uneven ground, you can re-sprain your ankle quite easily. That is a similar sort of scenario to the position in which the plaintiff found himself. He now had a damaged spinal cord, not a normal cord with pressure on it, but a damaged cord and any further injury to this would put him at more significant risk. He had already lost the reserve that would protect him from another fall. If you damage your neck enough to cause a hyper-extension injury to damage the cord, you have also damaged the ligaments and stretched the ligaments. In addition, you have also harmed the cord enough to produce a signal change on an MRI scan. This is a completely different clinical scenario when compared with that of a person with an MRI scan with mild symptoms, even where his CSF was completely effaced. The explanation given for this by Professor Bolger was that often he had several patients who came with multiple level degenerative disease in their spine. They might have nearly complete or total effacement of CSF at the C6/7 level on an MRI scan, but they are complaining of pain going in to their thumb. In that case, the Professor would consider it was more likely that a minor degenerative change at the level above, being C5/6, was causing the symptoms rather than the major compression at C6/7. Just because one sees something on a scan, it does not mean that it is or will be responsible for the symptoms. He made another point in that regard, being that osteophytes as well as growing will also regress. He explained that this has been extensively studied. A scientist called Juri Du Borack in Zurich has published widely on regression of osteophytes identified on MRI scans. Even very large osteophytes with time can shrink back. The body is a living organism and can remodel itself. If a patient comes in just with an osteophyte, even if there is compression, if he does not have symptoms from that osteophyte then Professor Bolger would not advise surgery which has the risk of paralysing him, particularly if there is no evidence that he is definitely going to go on and develop symptoms from that scenario. Mr. McFadden's situation is completely different. He had already had accident damage affecting and disrupting his former asymptomatic condition and he was caused transient tetra-paresis and afterwards was left impaired from the traumatic effect on his formerly vulnerable but pain free and active disposition. His situation only seems to be the same if one considers the MRI scan in isolation and without taking into consideration the previous condition and the clinical findings which are crucial elements. Professor Bolger stressed that what is completely different in this case is the clinical situation, and that the overriding feature in making a diagnosis and prognosis is the clinical factor. The Professor in his reports had made clear that the stenosis of the spinal canal was partly due to congenital reasons and partly from degenerative disease causing osteophytic growth and bulging of disc so that the narrowness of the canal made the spinal cord all the more vulnerable to the traumatic impact caused by the negligent driving and failure to stop her car by the tortfeasor defendant. This impact in all probability caused violent extension of the plaintiff's neck, causing contact with pressure from the osteophyte, pointing towards the back of the plaintiff's neck, which was the impinging on the spinal cord, causing transient paralysis and other more lasting impairments of the plaintiff such as left sided weakness and chronic pain.

94. I now turn to the reports and evidence in court of Mr. Chris Pidgeon, the Consultant Neurosurgeon who gave evidence after Dr. O'Dwyer on 30th June, 2005. This elapse of twenty days since Professor Bolger had given evidence was due to the exigencies of the Court List. The significance of the three week interval is that the defendant's advisers and experts had an extra period of twenty days after hearing Professor Bolger's thesis being expounded, in which to scrutinise, analyse and test his proposition as to the time sequence of the impingement of the spinal cord causing the transient tetra paresis on 7th August, 2000. They also were given further time to consider the likely cause of the gliosis, the scarring which Professor Bolger ascribed to the traumatic encroachment by the osteophyte and disc overgrowth caused in the whiplash injury at C3/4. I have already referred to Mr. Pidgeon's reports dated 3rd September, 2001, 4th February, 2004, and 29th November, 2004, and will set out the gist of his evidence given in court. Mr. Pidgeon explained that gliosis was a term used for scarring within the central nervous system, that is within the brain or the spinal cord. One must appreciate that damage to the central nervous system is cumulative in the sense that, if you get a cold, you usually recover fully from it, whereas if you damage part of your brain or spinal cord, if a cell dies, it is not replaced and cumulative damage leads to progressive loss of cells which, in turn, are not replaced. He explained that this is why Muhammad Ali is the way he is now. It is cumulative episodes of nervous system damage, each adding one to the other. So the presence of gliosis indicates that damage sufficient to cause scarring within the spinal cord has occurred. The spinal cord has little ability to repair itself and, therefore, that damage is significant. Degenerative changes produce bony knobbles. We are all familiar with people whose hands have worn out who have little bony knobbles across their knuckles. You find something similar in the neck when it wears out. These knobbles progressively squeeze the spinal cord, which means that wear and tear changes in their nature become slowly worse with the passage of time. Mr. Pidgeon did not have the opportunity to review the x-rays until "relatively recently" when he saw a single MRI plate. On the basis of the single plate he would regard the degenerative condition pre-existing the accident as severe. The plaintiff, irrespective of an accident, would have been very lucky not to have had symptoms, given cord gliosis. When Mr. Pidgeon was asked when, as a matter of probability the plaintiff would have had symptoms in the absence of an accident, he replied that this is one of those "how long is a piece of string questions". He would have thought, given the presence of cord gliosis, that the symptoms would inevitably have surfaced over a number of years. Even in the absence of symptoms, if the plaintiff had had an MRI scan done for some other reason and one had seen cord gliosis at the site of the stenosis of the spinal cord, he thought one would have recommended treatment. This intervention would not have differed in any major way from the first operation done by Professor Bolger. I pause to observe that, while the neurosurgeons seem to agree that the nature of the first operation was appropriate, Professor Bolger had indicated that he would not have operated on foot of what he saw on an MRI scan on its own, even if it was showing gliosis at the site of the stenosis of the spinal cord, without there being clinical symptoms or other signs as to which and where exactly the pain producing lesion was.

95. Counsel for the plaintiff objected at this point and again later that specific aspects of this evidence had not been put to Professor Bolger. However he remarked that he was not going to press this as a point preventing the continuation of the cross-examination on behalf of the defendant. I have mild doubts about this assertion, as I recall Professor Bolger being questioned about the first aspect and he made it clear that he would not operate merely on the basis of an MRI scan but would usually require indications from other symptoms of the source and reasons for a pain, weakness or reflex. I should add that, in any event, counsel did not press his objection to the point of saying that the questions should not be answered but he did several times submit that his objection should be noted. However, even with the later interventions to the effect that specific matters being adduced from Mr. Pidgeon had not been put to Professor Bolger, which objection was more cogent, this would not affect admissibility although it could certainly affect the credibility of the evidence. When he said "that wasn't put either", he then added, "but we will carry on". The question which

elicited that comment from Michael Gleeson S.C. was as to what Mr. Pidgeon attributed the deterioration which affected the plaintiff with quite severe pains in 2003, after the plaintiff had had a sustained period of improvement following his first operation on 6th December, 2000. Mr. Pidgeon, unlike Professor Bolger, ascribed the deterioration as most probably being due to continued degenerative changes. His reason was that the natural history of trauma to the central nervous system is that there is a sharp drop in the patient's functional ability at the time of the trauma. This then generally improves over a period of about 18 months. The patient may by no means improve completely but the usual time course is improvement over a period of 18 months and then, wherever the patient is at that stage, the patient tends to remain. However, the natural history of degenerative disease is a slow decline. A decline of three years or between two and three years after the event is more typical of a degenerative condition than it is of trauma. Mr. Pidgeon said he thought it more likely that deterioration ascribed to the plaintiff's degenerative condition led to the second operation.

96. Reference was made to the transcript [of Day II, p. 116, question 401] when the question suggested deterioration in summer 2003 was just a natural progression of the plaintiff's degenerative condition and was nothing to do with the accident. This had evoked the response from Professor Bolger that he would have to disagree with this completely. Counsel for the plaintiff said that of course this general point was put and was expected, but what was now being suggested was novel, being that the timescale and the level of progression and the speed of progression were all suggestive of the underlying degeneration as being the problem rather than the trauma from the accident, and that these points had not been raised with Professor Bolger. I make two comments about this joust between counsel. The first point is that the evidence of both neuro-radiologists is that the scans in late 2003, before the second operation, showed no radiological change over the time interval from August, 2000, to November, 2003, in respect of degenerative change through the rest of the cervical spine for which the plaintiff underwent the spinal fusion on 18th November, 2003. Secondly, Professor Bolger said that the second operation was not because of any progressive degenerative changes but was done to try to cope with the plaintiff's recurrent and chronic pain and his symptoms such as loss of power. This type of operation was an attempt to prevent any further deterioration in terms of his cord function, by removing the pressure at the back of the cord at the C3/4 level so as to try and give the cord at the injured level as much space as possible. The purpose of the second operation was to prevent matters getting worse. Professor Bolger said that you should not tell a patient you are going to improve things with this type of operation because quite often that is not the case, certainly in terms of cord function, as for example in the aspect of weakness in the arms or legs. Furthermore this is fairly major surgery to the back of the neck which involves removing muscles on either side. That is a very painful, destructive approach. This is necessary because, in order to stabilise the spine, one has to be able to get access so as to put in screws and rods. Professor Bolger accepted that the patient might feel worse since the second operation. Although the scans showed that technically the operation was a success, the outcome for the patient is not guaranteed. The surgeon is trying to stop things getting worse. Part of things disimproving is that the longer one suffers from chronic pain, the worse the effect is in terms of impinging on one's ability to function.

97. Reverting to Mr. Pidgeon's evidence attributing the need for the second operation as being because of deterioration to be ascribed to his degenerative condition, this seems to conflict with the description given by both neuro-radiologists of their findings on the MRI scans as to the lack of progression of the degenerative change through the rest of the cervical spine, apart from C3/4, being at the level of the first surgery. I regret that I do not have the benefit of Mr. Pidgeon's views on the state of progression, or indeed regression and static appearance on the imaging, in respect of which the x-rays and scans are apparently in Beaumont Hospital.

98. Mr. Pidgeon helpfully gave his findings on his last review of the plaintiff which I infer was on 3rd November, 2004, almost a year after his second operation. The plaintiff then had increased reflexes in his left arm and leg, blunting of sensation in his right hand and some limitations of his back movements. He had had stabilisation of his cervical spine with immobilisation of a fair portion of his neck including above and below the level of the stenosis. Mr. Pidgeon said that it is impossible to say which of the small structures within the neck is giving rise to his pain; it would be largely a soft tissue origin rather than a nervous system derived pain. Part of the problem may be post- operative, part could be due to a residuum of the trauma, part of it could be due to degenerative change and, of course, part of it is due to an individual's own reaction to pain, and the ability to withstand pain. The pain management course certainly could help but it will not cure the pain. The spinal fusion is from C3 down to C7 and removes movement in the fused segments but there are still some (unfused) segments above and below.

99. As for the plaintiff's capacity for work, Mr. Pidgeon said most surgeons prefer people of this type to be working because it provides an element of distraction from pain. The plaintiff's job involved a lot of driving and Mr. Pidgeon would accept that this could cause him problems. He would not regard him as completely unfit for work, as he would be able for some work but he, Mr. Pidgeon, could not claim to be an absolute expert on the content of the plaintiff's job but he felt that work would help him and divert him from his problems. Mr. Pidgeon, after hearing some of the items on the list of aids and appliances drawn up by Ms. Cashman, the expert on occupational therapy and rehabilitation, said he thought the list more appropriate to lumbar spine problems but he did not enlarge either on this difference or its significance or on any of the items on her list. Since Paula Cashman had studied all the medical reports and had carefully observed the plaintiff in his home and approached the matter of advice about aids and appliances with careful and considered expertise, in the absence of more specific criticism as to the inappropriateness of any of the items recommended by her, then I have no hesitation in accepting her carefully considered specialist advice in general as to what is appropriate, practical and realistic for the plaintiff to help him to mitigate his physical impairment and loss of independent living.

100. Under cross examination Mr. Pidgeon accepted that while he was a leading specialist in neuro-vascular surgery, Professor Bolger was pre-eminent in complex spinal neuro-surgery. He added a proviso, making the valid point that one must distinguish between, on the one hand, the expertise in the technical carrying out of complex spinal operations (in respect of which he would defer to his colleague) and, on the other hand, the ability to diagnose and give opinions in respect of which, with his experience, he was well qualified. While he was familiar with the American Journal of Neurosurgery, he was not conversant with the textbooks and literature referred to by Professor Bolger nor had he been given a transcript of his evidence. On this aspect I am grateful to the diligent, experienced and competent solicitor acting for the defendant arranging for the transcript to be supplied to me and it is perhaps churlish on my part to suggest that it may be that consideration might be given in the future, as suggested by counsel for the plaintiff, to the furnishing of the transcript of evidence given by a specialist, such as Professor Bolger including his references to the medical literature, to his neuro-surgical colleague Mr. Pidgeon. This could exist particularly in the unusual situation where the first expert has given his evidence and there has had to be an interval before his colleague comes to the court. In this period, consideration of and reflection on the clinical history and findings as narrated and on the medical research studies cited, might help to give an even further and more informed picture of the areas of agreement and points of difference in the diagnosis of the experts.

101. Mr. Pidgeon was aware of the statistics which had been referred to as identifying the subgroup of the population which has degenerative changes as being 50% of those of the plaintiff's age, and that this subgroup can be divided in turn into three equal subgroups of which one-third will stay the same, one-third will deteriorate and one-third will improve; so that, looking at the plaintiff on the day before his accident on 7th August, 2000, he then had a sixty-six per cent chance of staying the same or having no symptoms and a one-third chance of deteriorating. Mr. Pidgeon did not accept that the figures applied in the plaintiff's case as he considered that they referred to the bony changes in cervical spondylosis. His understanding was that the plaintiff was thought to

have had previously established gliosis. Unfortunately, Mr. Pidgeon had not been made aware either from the treating surgeon's reports or from the transcript of his evidence given almost three weeks before that his colleague Professor Bolger was of the view that there was no gliosis there before the accident or, if there was, that there were no symptoms from the gliosis prior to the fierce collision. I should mention that there was a skirmish between counsel on the wording but the gist of the contention put was that the period of temporary paralysis after the accident suggests that this traumatic incident was the critical event and actual damage to the spine in those moments caused the plaintiff to go from having no symptoms to complete tetra- paresis in the space of a few seconds. Mr. Pidgeon replied that temporary paralysis certainly would suggest that the spinal cord had taken an impact of some sort, such temporary paralysis does not, however, necessarily lead to gliosis and there is quite extensive literature involving American footballers about that. Nevertheless, the paralysis certainly suggests that the spinal cord took an impact and was damaged either transiently or permanently.

102. Having listened to the neuro-radiologists and to the neurosurgeons, I am convinced that on the balance of probabilities I should prefer the diagnosis and prognosis made by Professor Bolger. I particularly noted two remarks by Mr. Pidgeon, the first being that he thought that it was the timeframe that was critical in this, not the causation, and the second observation was that "clearly his spinal cord sustained an impact at the time of the road traffic accident". Mr. Pidgeon thus conceded that the plaintiff's spinal cord received injury and that he had abnormalities after this trauma which were not present before it in terms of physical complaints and signs, including the paralysis from which the plaintiff never fully recovered. Mr. Pidgeon confirmed that he did not dispute this, but what he was contending was that the plaintiff had evidence of a spinal cord injury present prior to the accident and that this was intrinsically a situation which was likely to deteriorate with the passage of time in the absence of the accident. I pause for a moment to contrast this with what Professor Bolger said to the effect that you can have gliosis without symptoms and that he did not think that the plaintiff would necessarily have developed symptoms in the absence of the traumatic accident. Indeed, when counsel suggested to him that, with the double impingement on his patient's thecal sac and with complete effacement of the CSF in his spinal cord, the man was going to have an operation one way or the other, Professor Bolger flatly contradicted this and said that he disagreed completely.

103. Returning to what Mr. Pidgeon said under cross-examination, when he was asked whether the degeneration in the neck would be slow over a very long period of time, he confirmed that this was the case and he said that it was certainly possible that Mr. McFadden would have continued to work and would have sought treatment when he got minor symptoms of some sort and these would have been treated and that he certainly would have been able to get to the end of his working career. When it was suggested to him that the deterioration of symptoms would be slow over a long period of time and this could be ameliorated by treatment, in contrast to a sudden change in the picture of his condition as a result of trauma, Mr. Pidgeon agreed that the plaintiff certainly sustained some damage as a result of the trauma. He said that he thought it was probable that if the natural progression had been allowed to occur, it was likely that the plaintiff would have completed his working career because the symptoms would have deteriorated over a long period of time and the plaintiff would have been assisted by treatment. He added that putting a time scale on this was "like gauging the length of a piece of string" and that he thought that the plaintiff would have had trouble prior to the age of 65 if he had gliosis in his mid-50s. I have set this out so as to show that perhaps there is not such a vast difference in the views of the two neurosurgeons except insofar as Mr. Pidgeon's view is premised on the existence of gliosis in the cervical cord before the traumatic collisions on 7th August, 2000, whereas by contrast Professor Bolger made clear that he believed there was no gliosis before 7th August, 2000 and, even if there was some gliosis before the traumatic collision and the tetraparesis, then it was very likely that such gliosis would have continued to remain without symptoms.

104. The first point to make about this is that the first x-Ray of the plaintiff's neck was taken at Naas Hospital on 7th August, 2000, and the first MRI scan was taken on 5th September, 2000, about a month after the accident. Both showed degenerative change and severe constriction of the spinal cord at C3/4 level and at that stage there was a high signal within the spinal cord which could reflect the presence of oedema fluid secondary to a recent event, or scarring secondary to the established degenerative process. Obviously there was no x-Ray or MRI scan done prior to the accident and it is the matter of diagnosis of the cause of the gliosis which is in contention between the two neurosurgeons. Professor Bolger is the treating neurosurgeon who twice operated on the plaintiff's neck and who is pre-eminent in this country as the expert on complex spinal problems. It was suggested to him that Dr. Thornton, the consultant neuroradiologist, had said that the gliosis was there before the accident. Professor Bolger said he disagreed with him on this. Gliosis can certainly result from compression but it can also result from a sudden distortion of the cord. In Mr. McFadden's case, the clinical scenario, instead of just looking at the x-Rays, was of a man who was temporarily paralysed. Since the plaintiff had been asymptomatic before the traumatic collisions, Professor Bolger felt that it was much more likely that the gliosis was produced at the time of the impacts rather than pre-dating them. It is clear that there was a ferocious impact which pushed the much heavier Mercedes forward, thus causing extension of the plaintiff's neck which would have brought the osteophyte into a position pressing on the spinal cord, already constricted by degenerative disc and stenosis. From the absence of symptoms beforehand, Professor Bolger, with all his practical experience of carrying out such complex neck operations, made it very clear that, in his view from a string of factors such as the sudden onset of the tetra-paresis, the left-side weakness, and the numbness and the pins and needles in the left hand, the likelihood was that the gliosis was caused at the time of the impact. Furthermore, recent studies and experience showed that gliosis could appear over a much shorter time than previously envisaged and that the likelihood was that this is what had actually occurred in this case. Professor Bolger is the only one of these neuro-experts who had full knowledge and understanding of both the clinical picture and the radiological imaging at his finger tips and I have come to the considered conclusion that, in all probability, his diagnosis and prognosis is far and away the most likely to be the true construction of the previous situation and the effect of the traumatic impacts. This is borne out by the fact that the degenerative change did not progress much, if at all, as confirmed by the two neuro-radiologists, between the first and second operations. Accordingly, I am satisfied that the traumatic impacts were the cause of the plaintiff's injuries, while at the same time recognising that the plaintiff did have a vulnerable neck because of the degenerative stenosis and the osteophytic growth. This said, the defendant has to take the plaintiff as she finds him on 7th August, 2000, that is as a man with a fragile neck, with latent problems which had always been symptomless and which had never stopped him from carrying a heavy golf bag on his shoulder around eighteen holes, and even perhaps as far as the door of the nineteenth.

105. I should perhaps enlarge on the principle of law that the defendant has to take the plaintiff as she found him on the day of the accident, whether he had a thick or eggshell skull, or a robust or frail neck. It is common case that the plaintiff on 7th August, 2000, had a vulnerable neck with some chronic degeneration which by consensus was causing him no problem whatsoever. This was despite the fact that his neck would have been constantly under test as he was a man who worked long and hard and drove lengthy distances both for work and sporting purposes. Not only was he an avid golfer, playing 18 holes most summer evenings and often throughout the year, but he also prided himself on and preferred to carry his clubs, despite the invention of manual and mechanised caddy cars. This he could well do as he was a tall, strongly built man, well over six foot, who seemed the epitome of health and vigour and was well able to shoulder a golf bag around 18 holes. One might be forgiven for thinking that this would not have been what the doctor, if aware of the vulnerability, would order for a man with a problem neck. I can envisage few more drastic ordeals for a suspect neck than the carrying of a heavy bag full of clubs and all weather gear and it makes the concession that his neck was asymptomatic and painless before the collision clearly a sensible acceptance of a practical reality.

106. On foot of the statistics given by Professor Bolger on the basis of research papers, it seems to me that on the balance of probabilities the plaintiff would have completed his career to his normal retirement age of 65 years. This is on the basis that even a person with degenerative change in his neck at the age of around 50, is likely to be in the two-thirds of those in whom the degenerative change either stays static or else actually improves by reason of the natural defences provided by stiffening of joints by bony growth which reduces movement and painful symptoms caused by such activity.

107. Again I think that there was considerable agreement between the two neurosurgeons that the plaintiff had spinal canal stenosis at the site of the gliosis and took a neurological hit at the time of the accident to that area. Of course, Professor Bolger takes the view that, while the osteophyte was there on 7th August, 2000, the gliosis came later as the damage causing the gliosis was only done on 7th August, 2000, and the scarring would have formed during the time between then and the subsequent MRI scans, the first of which was not done until about a month afterwards. Mr. Pidgeon agreed that there were sound reasons for not trying to deal with the lower neck problems at the same time as the compression at C3/4 during the first operation, as more fusions would have limited the neck movement and put more strain below the fusions and might well accelerate degenerative changes lower down. Both neurosurgeons favoured the option of not carrying out a long fusion at the first operation. Both agreed that the plaintiff would have difficulty with prolonged driving or having to sit at a desk or in any position with his neck forward, such as when gazing at a computer. While he could do some work, this would have to be at his own pace and with him being able to move about and with him not being beholden to others so that he would have to stay still, as at a meeting. He would have to be able to take breaks if he were sitting in a flexed position, such as when he would be driving for any long distance or trying to concentrate at a computer at work with his neck in a flexed position. In summary, on the critical point at issue, which is the question of causation, I am sure that the diagnosis of Professor Bolger is to be preferred as being based on not just the radiological images but also on the clinical scenario and from what he learned from his frequent examinations of the plaintiff and also from his findings during both operations.

108. Dr. James Clarke has been GP to the plaintiff's family for about seventeen years and he knows the plaintiff well. Dr. Clarke has supplied a medical report dated 1st June, 2004, and I have also had the benefit of hearing Dr. Clarke's vivid and graphic testimony. Over the years he had known the plaintiff to be a very fit and healthy man who was keen on many sports, including scuba diving, yachting, swimming, golfing and running. He was aware that his patient helped in the training of a rugby team on which his son played. He was one of the fittest of his patients and he only saw him rarely as a patient and then only with the odd viral infection. He confirmed that the plaintiff had never complained of or had any neck or back problems whatsoever previous to August, 2000. He was a perfectly healthy and well-adjusted man in the prime of his life and career. In the severe accident on 7th August, 2000, he had noted that the plaintiff was the driver of a car which was written-off and it had taken the fire services one and a half hours to extract him from his seat, during which time the plaintiff underwent a period of sheer terror both because he was in fear of fire and as he was paralysed from the neck down and did not know if this was permanent. Professor Bolger had written to Dr. Clarke by letter dated 17th December, 2001, about a year after the first operation when he reported that the plaintiff continued to have symptoms of a pressure sensation in the shoulders and a pain in the base of his neck and, although the left-side weakness had considerably improved as compared with before operation, he still had a tendency to drag his left leg, particularly when he was tired. Overall, he was still significantly impaired. Professor Bolger had explained that it would be possible to do further surgery to increase the diameter of the spinal canal but that, as he had already had a decompression at C3/4, it would probably be necessary to perform a spinal fusion, not only at C3/4 but also at C4/5 and C5/6. While further surgery was an option, Professor Bolger preferred to wait until at least eighteen months from the decompression to assess the situation. In the meantime he was encouraging the plaintiff to be as active as possible and to continue to try golfing and to persevere with swimming. He added that he did not think there would be any ready solution to the plaintiff's difficulty from a surgical point of view. Dr. Clarke noted that, while the plaintiff returned to work in January, 2001, he was still continuing to have significant weakness and pains radiating into the root of his neck and arm and he had also put on weight due to limited exercise. In May, 2001, the plaintiff was having difficulty in sleeping and also in sitting for any length of time and he was even having difficulty in coughing, due to neck pain. He tried numerous analgesics for his neck over several months, without success. The GP advised him to take two months off work in July and August, 2001, in order to rest and to concentrate on his recovery. He also attended physiotherapy. On 22nd November, 2001, he attended his GP with severe pain and was given analgesics and sleeping tablets. By this stage the plaintiff was very agitated by his symptoms continuing and his GP was concerned about depression. In December, 2002, Dr. Clarke prescribed an anti-depressant for him and on his recommendation the plaintiff consulted a Pain Specialist, Dr. Camillus Power, but no great relief was gained. Meanwhile, both Professor Bolger and the patient were reluctant as yet to have recourse to the very serious surgery required to effect a spinal fusion. However, increasing symptoms and pain brought the plaintiff to having a spinal fusion on 18th November, 2003. This surgery involved a radicular decompression of the cervical spine from C3 to C7, together with the insertion of instrumentation as well as the performance of cervical fusions. Unfortunately, within three days of his discharge, the plaintiff had to attend his GP with a severe wound infection and general debility and had to be rushed to Beaumont Hospital on 3rd December, 2003, where he was treated with intravenous antibiotics. This serious condition eventually settled after his being three months on strong antibiotics. Dr. Clarke was gloomy about the prognosis as the plaintiff had been making great attempts to rehabilitate himself but his symptoms had not improved much and he was "becoming very down".

109. Dr. Clarke noted that Professor Bolger had advised the plaintiff that he should retire fulltime from his job and that he, his GP, would fully support this. This is a significant factor because Dr. Clarke had known the plaintiff from long before his accident as being very fit, totally erect, with a good posture and an engaging personality. He now was suffering from psychological and physical sequelae, including depression, sleeplessness, anxiety, and flash-backs of the incident at the Kill traffic lights, as well as having to endure very intrusive recollections and memories at 4 a.m., with early morning wakening and being unable to return to sleep. The plaintiff had described the nightmares and wakening to him as being "a living hell". Dr. Clarke emphasised that he would put the plaintiff's claim high, on a pain scale being at seven and a half or eight out of ten. Dr. Clarke said that there was an irony in that he was keen that the plaintiff should take a break after his first operation but the plaintiff was so determined that he would try to return to work that he insisted on going back to his work in January, 2001. After his first operation the plaintiff had fought a great but losing battle with the aftermath of his injuries. His healthy mindedness and his strength of personality in trying to rehabilitate himself was beginning to be worn down. He had managed to stay in work until his second operation on 18th November, 2003. His efforts to rehabilitate himself had demonstrated the greatest effort of will on his patient's part. Dr. Clarke said that he himself would be driving at around 8 p.m. on the hill in Saggart and he would see Mr. McFadden out walking up the hill with a stick and the frequency and regularity of this always impressed the doctor. Dr. Clarke is an experienced GP and refuted in no uncertain terms any suggestion by anybody that the plaintiff was exaggerating his symptoms. He said vividly that "he is not the boy to cry 'wolf'". The GP also confirmed that there was no question of the plaintiff having suffered from gradual deterioration in his physical capacity but was suddenly stricken by the trauma of the road traffic accident. As his GP, Dr. Clarke confirmed that the plaintiff was very upset at not being able to go back to work after his second operation. When it was suggested to Dr. Clarke that the plaintiff was exaggerating his symptoms, particularly after the second operation, he replied with alacrity and emphatically that he would refute this absolutely one hundred per cent. Dr. Clarke said that the plaintiff was a very minor complainer and that he was the sort of man that, if he did complain, he as his GP, would listen. Furthermore, in his view, the plaintiff was no longer capable of working at this stage. As far as he, the GP was concerned, Mr. McFadden's case was absolutely genuine.

110. Under cross-examination, it was suggested to Dr. Clarke that there was a passage at the end of Professor Bolger's evidence from which it could be suggested that in his view the plaintiff would be able to hold down a particular sort of suitable job. I should say at once that I was very dubious about the construction which the defendant's counsel had put on Professor Bolger's remark, as it was subject to several provisos put into the question posed to the Professor who, in my considered opinion, was being meticulously careful in taking the limiting factors in the provisos into account when giving his reply. At all events, Dr. Clarke, as he put it, "knowing the man", was not prepared, even with the provisos, to agree to what he was told Professor Bolger had given as his opinion. In fact the GP said, "I would beg to differ with Professor Bolger, with respect, as his GP and knowing the man involved, as the plaintiff would not be able to drive distances nor would I be astonished if the plaintiff had gone to South Africa in order to recuperate". I inferred from this that the G.P. was sure that his patient would not be able for driving long distances because of neck pain, yet would be determined to put up with the pain of the long flight to Capetown as well as taking on the pain involved in playing golf, since all this was recommended to him as being necessary and useful for his recuperation. Dr. Clarke stressed that, in his view, the plaintiff was not fit for work such as involved flexion of the neck in order to concentrate for long periods on a computer screen. Dr. Clarke stressed that his patient had been a robust man whose confidence was shattered by a very severe accident and whose personality he had seen changing over the years from one of robustness, without a sign of depression or insomnia, into that of somebody who had lost his confidence and was not fit to return to work. This was the magnitude of what had happened to the plaintiff because of his injury.

111. This is an appropriate stage to analyse the passage in the cross examination of Professor Bolger which has been relied upon by the defendant's counsel to suggest that the plaintiff is capable of doing at least a part-time job. Professor Bolger had explained that the plaintiff had reached a plateau in his recovery and that he was going to be a man who has ongoing problems and particularly problems of pain. The Professor had said that if you are in chronic pain or you are in a lot of pain you can continue to do things for quite a while and particularly somebody like Mr. McFadden who is prepared to endure pain and keeps on pushing to do things. But there comes a point where it gets too much. The Professor thought that what subsequent things showed is that the pain did become too much and trying constantly to keep matters up was not helping him and that is why he ended up with the second surgery. It was suggested to the Professor that the plaintiff had been able prior to 2003 to hold down his job and to play his recreational activity of golf and had even won golf tournaments and was able to cut the lawn at home. The Professor responded to this by saying that Mr. McFadden had told him that he was playing golf and that he was working in his garden and that he was trying to hang materials outside in his garden and also that he was continuing with his work and continuing to see clients. But this, the Professor said, was all a matter of presentation. This was all couched against the background that this was causing him difficulty and he was enduring pain to achieve all that. The Professor said that there was a world of difference between somebody playing golf and somebody who has been advised to play golf and is doing this with and despite pain. The same goes for his activity in the garden and in driving. The main thrust of what the Professor was saying was that the plaintiff was doing this with much difficulty and he stressed that the plaintiff had considerable and significant ongoing problems. The plaintiff was managing to keep going despite the fact that he had pain at night time and could not sleep with this. Professor Bolger made it clear that the plaintiff was playing golf on his advice as it was important that the plaintiff should remain mobile. He has advised many patients to get back to playing golf but to avoid such things as jogging on the road, tennis or any game in which there is a heel impact. While one would tense muscles in the neck when one is hitting the ball in golf, this is for a very brief period. The main tension in the neck muscles is to hold the head steady for very brief periods and then you are walking along moving your head from side to side. You cannot walk over uneven ground as on a golf course without looking at where you are going, and so, in fact, it is very good exercise for people who do have problems with their neck. Professional golfers who cannot play because of neck pain are those suffering from radicular pain. This pain is coming from pressure on a nerve root which is affected by the swing. As you swing you are stretching the nerve root at the muscles, but this is not the kind of neck pain being suffered by the plaintiff. He is suffering from a second type of pain, the myelopathic pain, which is caused by damage to the spinal cord and this is an entirely different matter from the radicular pain from pressure on the nerve root. Professor Bolger stated that the surgery and treatment is not going to solve the underlying condition of the plaintiff. The underlying problem is that he had chronic pain and despite two surgical operations and attending a pain specialist he is still afflicted with pain and sitting or standing in one position for a long time is going to aggravate his condition. Professor Bolger also stressed that the plaintiff at various times has had problems in coming to terms with the pain and has been depressed at times. He asked rhetorically if one would buy much from a depressed salesman and said that the plaintiff had not escaped unscathed from the point of view of his personality.

112. Eventually counsel suggested to Professor Bolger that the plaintiff was a man who was playing golf, 18 holes, and who was doing charity work and parish work. He wanted an office in his house and could drive a car, at least short distances, and was able to walk four and a half miles a day. In February, 2005, he was able to go to South Africa and play nine rounds of golf in seventeen days. Professor Bolger responded that he had never said that the plaintiff is unfit for any work for the future but then he was not an employment expert. What he had said was that working at a high pressured level with a lot of sitting, a lot of meetings and a lot of driving for prolonged periods would not be in the plaintiff's best interests. I propose to quote the next two questions and answers as it seems to me that counsel for the defendants have chosen to select a construction of what the Professor said which, on a considered analysis, is not justified by the wording of the questions and answers:-

> "Q T4450: Would you agree with me that he would be able to hold down a job where he could himself, without being supervised by anybody else, operate on his level to his own speed and to his own flexibility in terms of sitting and standing and driving short distances, using the telephone or doing short term work at a desk. He would be able for that?
>
> A: That would be a far more reasonable thing for him to do.
>
> Q 451: So he would be self employed as an insurance broker possibly, subject to what the vocational expert says?
>
> A: I don't know what an insurance broker would have to do, but possibly, yes."

113. I have set out this dialogue as I think that counsel for the defendant construed these phrases too optimistically and ignored the proviso put in by counsel for the defendant about what the vocational expert says and also that Professor Bolger said that he himself did not know what an insurance broker would have to do and then added "possibly, yes". In short his remark was subject to three caveats; first, it was subject to what the vocational expert would say; secondly, he, Professor Bolger, did not know what the requirements of the working day of an insurance broker would be; and, thirdly, he reiterated the suggestion of this peculiarly exceptional type of job involving no supervision by anybody else, operating at one's own level as to speed and subject only to one's own flexibility in terms of sitting and standing and then driving only a short distance, using the telephone or doing short term work at a desk. While Professor Bolger did say that this would be a far more reasonable thing for the plaintiff to do, he then added "possibly" and not "probably". He was manifestly dubious as to the fitness of the plaintiff even to cope with this unique type of job. Furthermore many of the witnesses have stressed time and again that the plaintiff is a man who was determined to get back to fitness and to work and that the clear message is that, despite his best efforts, he has not been able to manage to do work properly since the second operation. I am satisfied on the basis of the evidence of Professor Bolger and Dr. Clarke that the plaintiff has done his determined best to rehabilitate himself and has pushed himself to try to become fit to work again. According to the medical experts the plaintiff has been very slow and reluctant to accept that he will not be able to return to his former work and lifestyle. In this view

I am supported in coming to the convinced conclusion that since his second operation the plaintiff has been unable, and will in the future be unable, to obtain or hold down a job as an insurance broker or indeed any other employment which would require working at a computer or driving distances or concentrating with his head in a flexed position. This conclusion is also based on the opinion of Dr. Blanaid Hayes, the Consultant in Occupational Medicine, and on the report dated 28th February, 2005, of Dr. Valerie Pollard, Consultant in Anaesthetics and Pain Management at Beaumont. The reports of Dr. Blanaid Hayes, dated respectively 25th November, 2002, and 26th July, 2004, give a short negative answer to the defendant's suggestion that the plaintiff should be fit for either the work of an Insurance Manager or of an insurance broker or some other peculiarly suitable occupation for a person aged in the mid fifties. He will have constant pain particularly if he has to remain in a position with head flexed forward working at either a computer or sitting at a desk or at meetings, or even driving his car. Counsel for the defendant audaciously suggested that Dr. Blanaid Hayes had said that if somebody dropped in and suggested ten or twelve hours a week for the plaintiff, he would be able for that. I have gone through Dr. Hayes's evidence carefully and certainly after the second operation I do not recall or find any phrases supportive of the proposition that he could manage ten or twelve hours of real work. On 13th May, 2004, she had said that at that stage he was clearly unfit for work despite a range of different treatments; indeed she expressed the view that:- "…he remained quite disabled and I felt that work at that stage was going to be out of the question for the future".

114. The plaintiff was retired from Allianz on 31st March, 2005, and this did not surprise Dr. Hayes in the least. In fact Dr. Hayes commented that the plaintiff was very slow to let go of the idea that he would not be able to continue working. Dr. Hayes pointed out that the plaintiff would not pass a medical examination for employment and in her view he would not be able to do a job for eight hours a day; she felt that perhaps he might manage two hours. She made the point that the plaintiff had attended Dr. Camillus Power who had prescribed anti-depressants as had the plaintiff's GP some time before. Indeed the plaintiff had been prescribed Zispin, which is a strong anti-depressant and besides taking tablets for depression, the plaintiff was also having to take sleeping tablets and various painkillers such Amitriptyline. Dr. Hayes said that there were two ways of treating depression, the first approach was to use chemical remedies and the second approach, which she favoured, was to use therapy, including education of the patient so that the patient understands the condition. When it was suggested to her that the plaintiff might be able to work on a basis of reduced hours, her response was that he would not be able for this as he was now a sicker man. She was very dubious as to whether any improvement would in the future be sufficient to render him fit for work. She suggested that the reality was that such a job as the defendants were postulating does not exist in the Ireland that we live in today. As for the suggestion that the plaintiff would be able to set up and manage an insurance brokerage, she very much doubted that this was feasible as good health is a vital prerequisite in setting up one's own business. Perhaps the most significant feature of this aspect of the case, namely the defendant's submission that the plaintiff is fit to earn by setting up some part time consultancy is simply shown to be "pie in the sky" by the defendant's failure to counter the explicit evidence of Dr. Blanaid Hayes, the Occupational Consultant. It will be recalled that counsel for the defendant suggested that the plaintiff could be self-employed possibly as an insurance broker, subject to what the vocational expert says. However, the defendants have never produced such a vocational expert to say that, having read the medical reports, this expert believes that the plaintiff could work even as a part time insurance or any other kind of broker. No such evidence of any such part-time brokerage or consultancy job was adduced by the defendants through such an expert vocational witness. In short, the interpretation put on Professor Bolger's final phrases is a rather strained and biased construction to suit the defendant's theme and lacks a basis in the medical evidence. Nevertheless Dr. Hayes stuck to her view adamantly, based on her experience and expertise, as to the serious and lasting impairment of the plaintiff's former robust capacity for strenuous work and activities.

115. It was suggested by counsel for the defendant that the phrase in her Report dated 25th November, 2002, indicated that the plaintiff denied "he had any specific job stress and feels he had always been well in control of his job. However he is very conscious of the fact that he is not undertaking the full role and this worries him". It was suggested that this meant that, after the accident, the plaintiff felt he was always well in control of his job. Dr. Hayes sensibly pointed out that she had used the word "had" and not "has" and that she clearly was referring to a time before the accident in respect of his lack of specific job stress and his having always been well in control of the job. At the conclusion of her Report dated 26th July, 2004, Dr. Hayes said that with the passage of the years and with further surgery and treatment the plaintiff continues to be moderately severely disabled. It was clear to her that despite his best efforts he was unlikely to make further significant functional progress and as such she considered that it would be appropriate that he would be retired now on the grounds of ill health. He is unlikely to be fit in the future to undertake the work of managing a sales team with all of the attendant responsibilities, car travel and administrative and paper work which would be required. She recommended that he be retired on the grounds of ill health.

116. The defendants, without calling a vocational expert, floated the idea that the plaintiff would be able to work as some sort of insurance consultant because of his knowledge of the insurance business and his good contacts. The plaintiff himself pointed out that he had only been in the insurance business for a relatively short part of his working life and that the insurance business had contracted of recent times, particularly in respect of insurance brokerage. Because of the specific suggestion that this would be a suitable line of business for the plaintiff to pursue on a part time basis, the plaintiff's counsel called Dennis Fogarty, an experienced senior person from the insurance business to give his views about the prospect of the plaintiff obtaining such work. Mr. Fogarty explained that there have been mergers of insurance brokerage firms and there are now more large firms. There are more regulations now and greater burdens on small firms so that with the existence of the IFS Regulatory Authority there is less incentive to set up a small firm. One would need at least €100,000 in order to start up such a first business as an insurance agent. Mr. Fogarty made it clear that there was a very slim chance of a person of 54 years with a disability being able to set up as an insurance broker. He envisaged that it would be unlikely that a person with physical problems who could only work for a few hours a day on some days a week would be able to cope with the demands on time and energy in setting up and sustaining such a business.

117. The view I have formed is that the suggestion that the plaintiff would be able to obtain gainful part time employment or to set up an insurance brokerage or like business is far fetched in the extreme. I am supported in this view by the evidence given by Dr. Valerie Pollard, the Consultant in Pain Management. In her report dated 28th February, 2005, she was of opinion that the plaintiff in February, 2005, still had significant ongoing pain and she was of the opinion that he would continue to have ongoing pain in the future. She proposed to give him trigger point injections to his neck which may give some temporary alleviation of his symptoms. In testimony she said that it was her opinion that the problem was a combination of degenerative changes in his neck, facet joint involvement and muscular involvement. It is obvious that the two operations would have caused disruption of the muscular tissues and treating this muscle pain and the inflammation of the facet joints was Dr. Pollard's area of expertise. The facet is a small, smooth flat surface on a bone at a place where it articulates with another. Counsel for the defendant suggested that facet joint problems was new to the case but Dr. Pollard pointed out that this was the area of her expertise and over the last seven years Professor Bolger had referred patients to her for her specialist pain management in respect of muscular and facet joint problems. She treats enervated muscles as well as facet joints including the muscles outside the joints. Her expertise is in treating muscle pain along with the treatment of joint disorder. At times she injects Dexamethasane, which is a synthetic substance resembling cortizol. It is a local anaesthetic and steroid mixture used as an anti-inflammatory agent. The purpose of the steroid is to reduce any inflammation in the muscle. When counsel suggested that she was being overly pessimistic in her prognosis and that her success rate with muscular problems was very high, she said that her success rate in treating muscular pain would be approximately 50%. Unfortunately the significance of her opinion is that the significant ongoing pain which Mr. McFadden is suffering which stems from muscular, facet joint

and inflammatory pain, as well as degenerative and muscular changes, is likely to continue in the future. Her treatment and anaesthetic injections will only give him temporary alleviation of his symptoms. This supports the prognosis of Dr. Hayes, as it is difficult to envisage a person suffering chronic pain in the future being able to concentrate on his work sufficiently to hold down a job similar to the one from which he had to retire because of his difficulty in performing his duties. It is much more unlikely that he would ever be able to set up a successful consultancy or an insurance brokerage.

Correspondence with Employer

> 118. I turn next to the correspondence between Brian Edmonds and the plaintiff in respect of the plaintiff ceasing to work for his sympathetic employer Allianz. The plaintiff has expressed his gratitude to Allianz for being a considerate employer. He was allowed much flexibility in respect of his hours of work and how he did his work after his first operation. After the second surgery the employer was again sympathetic. This is borne out by the course of the correspondence from Brian Edmonds, Personnel Manager of Allianz to Shane McFadden. His first letter dated 3rd February, 2004, to the plaintiff was addressed:-
>
> "Dear Shane,
>
> Hope you are progressing well and will receive the all clear in the near future."

119. Mr. Edmonds was writing to request his cooperation prior to returning to work in accordance with normal company practice. The plaintiff's doctor should confirm in due course that the plaintiff had fully recovered and was fit to resume employment. Authorisation was also sought for the company medical adviser, Dr. Walter Halley, to consult the plaintiff's doctor to clarify the situation in advance of a return to work and enclosed an authorisation for the plaintiff to sign and return at his convenience. On 15th March, 2004, Mr. Edmonds thanked the plaintiff for sending the authorisation for Dr. Halley to contact Professor Bolger and also for sending on a social welfare cheque, which I assume was payable to the employer as they had been continuing to pay the plaintiff's salary while he was out recuperating after the second operation. It was indicated that Dr. Halley would be in contact with Professor Bolger to arrange an up-to-date review of the plaintiff's condition and his prospects for a return to work. During conversation with Mr. Edmonds, the plaintiff had indicated a desire to return to work ahead of his 5th May, 2004, appointment with Professor Bolger. Mr. Edmonds pointed out that for the sake of good order, the employer wished to confirm that, in accordance with company policy, a return to work was based on medical confirmation that the plaintiff had made a full recovery, that he was fully fit for work and that there were no limitations on his ability to perform his normal duties. This position would be dealt with under advice from Dr. Halley, the company medical adviser.

120. Mr. Edmonds also drew attention to situations where a personal injury claim is being made against a third party and advised that it was company policy to request the plaintiff to include a claim for loss of wages in his claim against the third party defendant and to make a refund to the company in due course of the salary payments which the company had already paid to the plaintiff on foot of the provision with regard to salary recovery at para.7.10 of the agreement between the plaintiff as employee and the company as employer, as set out in the Employee Handbook of Allianz Ireland. This states:-

> "7.10 In the event of an employee being injured by a third party rendering them unfit for work, it is company policy to request that a claim for salary paid during absence be included in any subsequent action for damages or recovery of expenses and be refunded to the company."

121. Accordingly it is clear that the employer is entitled to request the plaintiff to include a claim for salary paid during absence in his action for damages or recovery of expenses against the defendant and that this sum recovered should be refunded to the company in due course.

122. On 14th May, 2004, Mr. Edmonds wrote to the plaintiff confirming that Dr. Halley had had a brief discussion with Dr. Bolger following the review of the plaintiff on 5th May, 2004. He advised the plaintiff that at this point the doctors felt that he was not fit to return to work and his progress towards full recovery would continue to be kept under review. With regard to the ongoing unavailability for work, Mr. Edmonds drew the plaintiff's attention to the fact that in accordance with company policy he had been in receipt of full salary to date and that as from 1st July, 2004, the provision states that salary and related benefits will be reduced by 50% pending a further review. In this situation the plaintiff should arrange to retain his social welfare benefit from 1st July, 2004. In the circumstances he invited the plaintiff to discuss his situation with Michael Carr, the Human Resources Director, who was available at any stage to meet the plaintiff. Both Professor Bolger and Dr. Hayes, the Consultant in Occupational Health, were concerned at the plaintiff's stoic determination to try to rehabilitate himself and to make himself fit to return to his work. Indeed, several of the experts treating the plaintiff referred to his reluctance to accept that in reality he would be unable to return to the work which he had so much enjoyed doing well. It is indicative of the plaintiff's reluctance to admit that he would never get back to his previous fitness and capacity for work and a tribute to his employer's flexible and sympathetic attitude that then several months elapsed. Then, eventually on 9th February, 2005, Shane McFadden wrote to Michael Carr, the "HR Director" of Allianz Ireland Plc., stating that they were in receipt of various medical reports concerning him from Professor Ciaran Bolger and Dr. Blanaid Hayes. As Mr. Carr knew, the plaintiff had been absent from work for fifteen months and it was unlikely that he would be returning in the foreseeable future as he was due to have further surgery in May and June of the year 2005. On the basis of the medical evidence provided by his doctors the plaintiff said he would like to be considered by the company as a candidate for ill health retirement. Mr. Edmonds responded to this request by letter dated 24th March, 2005, referring to recent discussions with Mr. McFadden and confirming the company's agreement to his request for ill health retirement in his particular circumstances effective on 31st March, 2005. The letter went on to state that his pension would be €48,257 per annum based on a final salary of €86,370 and it was noted that he was in receipt of State benefit. An option statement had been provided to the plaintiff and the company awaited his instructions. The various documents mentioned would be required by Mercer by 5th April, 2005. Pension in payment would be increased by the consumer price index (up to a maximum of 7.5%) from 1st July each year. Pension would be paid through Mercer from 1st April, 2005, to the plaintiff's bank account on the 24th of each month. He would retain his motor and household discounts and deductions will continue through pension. VHI subsidy would not be available but the plaintiff would retain 10% group discount and deductions could be made through pension. Life cover would remain in place until age sixty-five.

123. It seems to me from this correspondence that I must conclude that the company had been supportive and sympathetic to the plaintiff in his efforts to recuperate and to return to work. It is crystal clear that Dr. Halley, after discussing the situation with Professor Bolger, felt that the time had come to face the reality that the plaintiff would not be able for the work involved in his job in the future. After all the patience shown by Allianz and their encouragement of the plaintiff and keeping open his job for him for so long, it seems rather ironic that it is those representing the defendant who suggest that the plaintiff should do better in his efforts at rehabilitation and should be able to return to earning remuneration. This suggestion seems to fly in the face of, and contrary to, a welter of evidence to the effect that the plaintiff has made resolute and valiant efforts to rehabilitate himself. The plaintiff's own

response to this contention on the part of the defendant was, that he, the plaintiff, had had to leave a good job through no fault of his own. He might have added but courteously did not point out that his injury was caused by the tort of the defendant. As for the type of work which the defendants were suggesting that he could undertake, such as part-time insurance brokerage or consultancy, the plaintiff said that he would love to know where he could obtain that type of work. As for the day to day things which the plaintiff did in order to get fit, these were done at times which suited him and he would not be able to do them as part of a regime since "at this moment in time, I don't believe that I am capable of getting back into the work force, based on my present condition". In response to counsel's suggestion on behalf of the defendant that the plaintiff should try to do insurance brokerage work, the plaintiff said that there had been amalgamations within the insurance business affecting both brokers and companies and the day of the small single broker was gone and that a one man show setting up in business was simply not feasible. In response to Counsel's compliments about the plaintiff's qualities, the plaintiff remarked that the one quality which he, the plaintiff, no longer had was the quality of life. Counsel kept saying that the plaintiff had retired but the plaintiff politely suggested that Counsel should use the term "on grounds of ill health". The plaintiff did not want to retire; he was forced to retire. Finally, by letter dated 11th April, 2005, Hilary Haran of Personnel in Allianz Ireland Plc wrote:-

> "Re Shane McFadden PPS No. 3440998Q
>
> This is to confirm that Shane McFadden retired on 31st March, 2005, under our ill health retirement scheme."

124. It is a sad irony that it was the employers who, having acted sympathetically and responsibly towards the plaintiff, eventually came to the conclusion on the advice of Dr. Halley, having consulted the plaintiff's medical advisers, that the plaintiff, despite his strenuous and determined efforts, would not be able to perform his duties in the future. It must have been very trying for the plaintiff to have to listen to a string of questions in court which implicitly and explicitly suggested that he was malingering in failing to return to his job and to earn money by setting up some sort of insurance consultative business. In fact the plaintiff had only been in the insurance business for a comparatively short time and was doing rather specialist work in maintaining good relations with the ecclesiastical clients of the predecessor Church and General Insurance Company. It is quite clear that the plaintiff would have liked nothing better than to have regained his former energy and capacity for work. This view is supported by Professor Bolger and Dr. Blanaid Hayes and by the tenor of the correspondence from Brian Edmonds.

125. My conclusions on this aspect of the plaintiff's fervent desire to rehabilitate himself is further supported by the evidence of his wife Sophia McFadden and by the reports and evidence of both Patricia M. Coghlan BA HDE, Vocational Rehabilitation Consultant and Paula Cashman COT MAO TI BA OT, Occupational Therapy Consultant. Before outlining their evidence I think that a comment is warranted in respect of the plaintiff's self control and moderation in response to the tone and tenor at times of the tough cross-examination to which he was subjected. It was contended that the plaintiff was very competent and resourceful and that with his fortitude and ingenuity he could push himself to adapt his life to cope with his incapacities and his pain since the accident. The clear inference was the proposition that he was well able to get on with life and even to return to remunerative work. I think that this was a somewhat double edged proposition in that the plaintiff has made admirable efforts to rehabilitate himself. His perseverance in striving to regain his former fitness and confidence as testified to by Professor Bolger, Dr. Clarke, his GP, and Dr. Blanaid Hayes as well as by the rehabilitation and therapy consultants are all testimony to the fact that, given his determination and dedication to achieving his former robust health, the chronic pain which he was having to contend with while making his admirable efforts had to be substantial. This view is borne out by the evidence of Dr. Valerie Pollard, the Pain Management Consultant. Putting it euphemistically, the plaintiff was subjected to strong questioning about his ample and secure pension. The plaintiff patiently explained that he had given considerable weight to the Church and General Pension offer which was a strong attraction for him in accepting the Church and General letter of offer of employment. The plaintiff was also subjected to searching questions about his devoting time to charitable works and about his notion of the need to give back of his talents to the community, as exemplified by his work in Neilstown. Professor Bolger made it clear that he had strongly encouraged the plaintiff to devote time if he could to such charitable work and other activities, such as playing golf and holidaying in South Africa, as a way to distract his attention from his constant pain. At one point Counsel for the defendant made a jocular remark on the lines that such activities were alright as long as the defendant does not have to pay for the plaintiff's holidays. If one pauses for thought, then one might come to the conclusion that by following medical advice about being active and involved and keeping his spirits up, the plaintiff was rehabilitating himself. Indeed, he has consistently and with admirable fortitude kept himself active and has built up to walking four and a half miles each day. He has maintained his interest in social and sporting activities, despite his pain. In this context the famous article by A.P. Herbert "R v. Haddock; Is a Golfer a Gentleman" from *Misleading Cases in the Common Law* comes to mind:-

> "Is a golfer a gentleman?"

126. It will be recalled that, in the story, different orders in society under some archaic legislation were subjected to fines for swearing, with the amounts of the fine increasing in a ratio having regard to the station in life of the person uttering the oaths. My recollection is that the author's point was that when he was a golfer, he was not a gentleman at all and that the nature of his oaths bore testimony to this. I mention this by way of contrast in that at all times the plaintiff answered questions sensibly and with moderation and courtesy and was aware that Counsel for the defendant have at times a difficult role to play. This was despite the fact that some of the innuendos in the questions might have caused a less intelligent and mature person to react more brusquely. Clearly the plaintiff was a golfer and a gentleman.

127. The plaintiff's wife, Sophia McFadden, described how she was in the car at the time of the accident and did not realise at first that her husband Shane could not move. Before this collision, he had had endless energy and never took full holidays. He was involved in all kinds of sport and enjoyed the garden. He used to mow the lawn and this could take him four hours and he would then go out and play golf the next day. He became very upset and depressed about a week after the accident when he was told that he could be paralysed if he fell. After the first operation he had to be driven for about six weeks. He was very keen to go back to work and, when he did this, he came home exhausted. He was determined to go out and try to play golf but when he returned home he then would have to go to bed worn out. She noted the deterioration in him leading up to the second operation. He tended to get angry and had loss of patience. He was also twitching and had involuntary jerking movements which were becoming worse before the second operation. This operation took nine and a half hours. Afterwards he had to wear a hard collar, he was under strain and became anxious to get home. When he came home, it turned out that he had developed MRSA infection and had to be brought back into hospital again. The plaintiff was hoping to be able to return to work after the second operation and he set himself goals so as to achieve this. However, he had to sleep in a room on his own as his quality of sleep was non-existent, despite his being on sleeping tablets and painkillers. He became agitated, impatient and distressed. She knew by just looking at him that he would not be able to go back to work but he himself has never really accepted this. The plaintiff had been asked by the parish priest to become chairman of the Board of this small national school in Saggart and he was also involved in a local charity raising money for disadvantaged children. These are all part of his wish to play his part in the community. There are many things which he cannot do at home or do on a regular basis. She has to carry and lift things for him although she is slight. She was concerned as to what would happen in ten years time and felt that the future outlook was grim, particularly as he may well need further surgery. He was distressed at his disability and

embarrassed because, for example, he used to be in the habit of lifting the power caddy and the bags of clubs into the car and now he had been advised not to do this. As for the trip to South Africa, the plaintiff had done his best to enjoy this and the warm weather had helped his pain and the change had done him good.

128. I now turn to the evidence of Patricia Coghlan BA HDE who is an experienced Vocational Rehabilitation Consultant.

129. She visited the plaintiff's home at Coolmine, Saggart, Co. Dublin on 27th September, 2004. Her comprehensive report includes a social history of the plaintiff, his educational background and his employment, which history has already been set out to an extent under the heading of the plaintiff's background, education and curriculum vitae. I note from her history of his employment that he worked from 1967 to 1969 as a cost accountant at Urney Chocolates in Tallaght while at the same time he was attending Rathmines Technical College studying cost accountancy. When he returned to San Diego in 1974, where he completed his degree course in the period up to 1977, he worked full time as a bus driver and also part-time as a janitor to supplement his income. Between 1977 and 1989, when he secured employment with Allianz Insurance as a general manager, he had gained experience working with McNaughton Steel Company, Rank Xerox and Johnson and Johnson all in the capacity of a sales representative. From 1986 to 1988 he was a general sales manager with Galway Crystal and was responsible for setting up a sales force in the United Kingdom and also looked after their sales office in Boston. From 1988 to 1989 he was a general sales manager with Smurfit Consolidated Plastics before moving on to Allianz as a general manager. He was quickly promoted to Assistant Director and became a member of the Executive Management Team. He led a staff of twelve sales representatives and forty eight administrative staff and was responsible for eight branches right across the country. On 7th August, 2000, he was injured and suffered severe spinal problems and had cervical surgery on 6th December, 2000. He tried to get back to work. The company was very supportive of him and he was able to cut back on the amount of travel and driving which he had to do, but even commuting to the office was becoming difficult for him and this driving in traffic could take him anything between two and three hours each day. He had intended to continue working until he was sixty-five, the normal retirement age. If he had not suffered the dire neck injury, then there was always the possibility that he would be promoted to the post of Director. The problems of pain from his failed neck and left sided weakness continued to deteriorate and so by 18th November, 2003, he was in such severe pain and discomfort that he had to undergo a nine and a half hour surgical operation on his cervical spine. He worked hard after his operation to strengthen his neck but he continued to have problems and was eventually told by his specialists that he would not be able to continue to work in his former job. The plaintiff had led a full life and was an avid golfer since he was twelve years of age and at one time he had played off a handicap of four. He and his wife had enjoyed in the past travelling on a number of golfing holidays to South Africa and Europe. On his doctor's advice, the plaintiff has tried to play since his injury and subsequent two surgical procedures but this gave him a lot of discomfort and while at times he has not played for some months, on the advice of Professor Bolger he has persevered at the golf and adapted his swing, accepting that the exercise is good for his fitness and recuperation and a distraction from pain. His other hobbies which include socialising, gardening, DIY, going to the theatre and cinema have all been considerably restricted since his injury. He has, since his accident on 7th August, 2000, suffered from the aftermath of injury to his cervical spine. Degenerative changes in his neck together with the aftermath of his traumatic collision and the two spinal operations have left him with significant residual problems which affect him physically and psychologically and have caused him to become quite depressed. He has been assessed as being moderately to severely disabled and has been advised by his medical specialists to retire on the grounds of ill-health. Ms. Coghlan noted a number of functional limitations ascribed and relevant to the injuries which he sustained in the accident on 7th August, 2000. He has ongoing lower back pain which can cause a lot of discomfort, he has lost some of the power on his left hand side in both his leg and his arm. He limps and drops things out of his left hand easily. The grip of his left hand has become reduced and he complains of having numbness and pins and needles in his left hand in particular. He reports having pain and discomfort when sitting for long periods at a time and he complains also of getting pins and needles and numbness in his left leg. His balance is poor and he is unsteady on his feet when rising from a sedentary position. He describes having an uncomfortable pressure on both shoulders which radiates down from his neck into his shoulders and arms. He has difficulty rotating his head and neck and this makes it awkward for him when he is driving. He gets darts of pain in his head and he says that standing up too quickly causes a head rush. He has complained of having a ringing in his ears from time to time and he feels that he has to support his head at all times. He complains that his concentration has deteriorated, and pain and discomfort make this more difficult. His sleep is poor, at best he gets two hours at a time; he tires easily, has to take naps during the day and is awake at night. He has to take some pain killers for sleep relief. He starts his day by getting up in the morning with his family to have breakfast. He tries to keep to a physio routine and walks when he can. He is chairman of a local school and he likes to drop in to keep in touch with them and attends around five meetings per year. He has joined a charitable organisation, Careline and helps out with them whenever he can. He complained that he has also become extremely moody and grumpy but nevertheless his family support has been excellent although his disablement has been difficult for them too. He feels that his dignity and independence have been considerably affected and things are not the same for him or his family since his accident. As for the vocational implications, despite the plaintiff's efforts to return to work as a senior executive even at a reduced rate, his condition continues to deteriorate and he finds remaining in work increasingly more difficult. He has been assessed as being "moderately/severely disabled" and has been advised to retire from work on grounds of ill health.

130. As to the vocational implications, Ms. Coghlan wrote that:-

> "Given the extent of his residual problems and medical opinion, it is difficult to envisage that Mr. McFadden will ever get back to any form of meaningful employment. He is unlikely to satisfy the requirement for medical assessment examination where appropriate, and is unable to cope with any form of work that would require a physical input or a good standard of general health as a prerequisite."

131. At the end of September, 2004, the plaintiff presented as a man who continued to suffer from considerable problems as a result of his road traffic accident. These problems indicate that he remains incapacitated and unable to cope with his work demands or with returning to the open employment market. Ms. Coghlan expressed the view that at this stage the plaintiff was "more likely to remain unemployed than to return successfully to any form of employment". While she considered that Mr. McFadden did not present as somebody who is going to return fully to the open employment market, however she felt that he would benefit from being assessed by an Occupational Therapist to see if there are any aids or adaptations which might give him some relief and more independence around the home and to increase his tolerance levels and gradually improve the quality of his life. She recorded that he should be encouraged to seek an appropriate health routine of physio, occupational therapy and appropriate counselling to help him come to terms with his premature retirement and his ongoing physical and psychological problems. He should be encouraged to engage in rehabilitative employment when he can so as to help fill out the periods of long idleness which he is forced to endure. This type of employment would help his attempts to recover rather than his returning to employment. She recommended that he should contact various support groups and agencies for their help and advice and also they would benefit from his offering his own services on a voluntary basis to relevant groups. In her summary she said that as a result of the ongoing residual problems he had been forced to retire prematurely from his position at work. Ms. Coghlan felt that the plaintiff did not appear at the time of the assessment to be a person who would return to full time open employment. Accordingly he should be encouraged to avail of whatever aids and adaptations would make his life easier. He may even like to fill up his time with perhaps a new hobby, or voluntary work, to help fill up the long periods available that he now has to occupy. She made three positive suggestions. The first was that the plaintiff should be assessed by an

Occupational Therapist in respect of the support of aids and adaptations. Secondly, he should also seek an appropriate health routine of physio, occupational therapy and suitable counselling. Thirdly, he should consider working on a voluntary basis to help fill up hours now available. In verbal testimony the Rehabilitation Expert felt that the plaintiff was very devoted to his work and committed and that he was devastated at not being able to return to work at his former level. She explained that with his neck pain there would be severe and painful problems which could affect the plaintiff's concentration. Ms. Coghlan advised that the plaintiff was in a lot of pain at home and this could be difficult for him and for the whole family. A loss of employment can often cause huge problems for a family and the effect of this can delay the patient's rehabilitation and recovery.

132. The plaintiff had made several valiant attempts to return to work but was left to pick up the pieces in respect of the loss of his employment. She concluded that the plaintiff was not capable of any work of any description. He was in such pain and discomfort that he was having difficulties with the activities of every day life. She advised him to attend an Occupational Therapy Consultant and he did this by consulting Paula Cashman who advised him in respect of aids and supports around the house which could improve his everyday living and lifestyle. Ms. Coghlan regarded his golf more as a form of physiotherapy helping to maintain his physical health. As for the charity work, this likewise was a useful distraction and would keep him occupied and make up a little for his not being employed, and so she felt that doing the charity work would help him. He would have considerable difficulty in passing a medical examination for many occupations and he would have difficulty even in doing a computer course as he would probably have to drive there or sit concentrating at a desk. She approved of the plaintiff being engaged in a routine which allowed him to be flexible and to work at his own pace; unfortunately he would be unable to do this in any employment situation. Even if there were suitable jobs on a part-time basis, her view was that the plaintiff simply would not be fit to carry them out at the moment. He had tried several times to return to work and he had failed to find suitable work. The medical evidence was to the effect that he was in pain and that his condition had declined further. As for the suggestion that he should start his own self-employed business, in her view this would absorb much work and he would end up simply chasing up business and clients which would be very difficult at his fifty five years of age. She commended him for trying to arrange his lifestyle with the physiotherapy, the golf and charity work to give him an outlet for his desire to work. He had confirmed to her that he had intended to continue working until the normal retirement age of sixty-five years. She pointed out that insurance brokerage was not the plaintiff's area of expertise and that setting up a company involves a number of tasks such as finding premises, using contacts and drumming up business. The reality was that he was fifty-five years of age and had physical impairments. She could not recommend him to try to do a task of which she did not believe he was capable. She felt he was a genuine client who would have been working if he could. Physically Mr. McFadden was not capable of many jobs and a very real problem was that he has high standards and so it would be immensely more difficult for him if he found himself in a job which he could not manage to do properly. Ms. Coghlan emphasised that in all of the medical reports the experts had indicated that the plaintiff was unfit for work and had also recommended that he should maintain a routine of physiotherapy to keep him going at the same level. When that is factored into his day, then there was very little time left to do anything else even if he was able for it. As a vocational consultant she would not recommend to a client a plan to do take on a venture which she genuinely felt he could not do. This was a man who was very disappointed and deeply upset that he could not maintain the job that he was doing. Recommending this man to start off a new business, and to go on and develop that, would seem to her to be very unfair because she did not think that he was physically or mentally capable of doing this at the time when she met him. She was sure that if he could have done a job, then he would have tackled it. He was a man who liked to work and wanted to work. She felt he was a genuine client who would have done whatever job with which he could have coped. He was a man with a physical disability who was fifty-five years of age and had been out of work for two years. Her impression was that he had tried everything he could so as to continue to stay in work. His former employers were flexible and the plaintiff told her that he had tried everything he could to remain in work. It was suggested to her that his having a good pension provision was a serious disincentive to his finding it worthwhile to go out to work in the morning. However, Ms. Coghlan was adamant that the plaintiff was a man who would prefer to work rather than not to work. She emphasised that she was in a position to say, being a vocational rehabilitation expert, that she did not think that the plaintiff was capable of returning to full time work at all.

133. Counsel for the defendant suggested that the plaintiff's pension entitlements being satisfactorily valuable, were a strong disincentive to the plaintiff to go out and find a remunerative job, as this would mean that "his pension money would go out the window". This construction of the pension situation was challenged by the plaintiff's counsel who pointed out that it is unfair to say that the plaintiff would lose his pension money if he obtained a job earning remuneration, as the proper construction of the clause in the pension agreement is that the trustees could countenance a small amount of work and perhaps, if there was a real return to remunerated employment, they reserved the right then to make an appropriate reduction. It was unfair to suggest that it was a situation of "all duck or no dinner". What was actually stated under "early retirement pension" is that:-

> "The trustees of the scheme reserve the right to reduce or suspend your pension should you regain normal health or return to remunerated employment, if they feel this is appropriate."

134. When it was suggested to Ms Coghlan that this peril of reduced pension explains why he had taken up doing charity work rather than remunerated employment, she responded that the plaintiff took up the charity work as part of his rehabilitation and it is not "work" as such. While the pension aspects might discourage the plaintiff, nevertheless at the same time he has huge problems to overcome if he is to get back to any type of work. I have come to the conclusion on this aspect that there is overwhelming evidence that the plaintiff strove valiantly trying to make himself fit to be able to do his former work, but eventually and reluctantly after his second operation, he became worn down with the chronic pain and discomfort and, despite the sympathetic attitude of his employer, he came to the realisation that he could no longer cope with the demands of his job, particularly the aspects which involved sitting with his neck flexed either working at a computer or driving a motor car.

135. The plaintiff was recalled and explained that after his first operation he had gone back to work on a part-time basis in that he was working in the morning for a number of months. Then gradually he tried to build his work back up. He was hoping to do the same type of thing after his second operation to see how he would fare out. He made it clear that he had a good rapport with his company and that they were extremely kind and courteous to him throughout his illness and he, for his part, kept them aware of any medical reports and would have given them copies of these as this was only common courtesy on his part towards them. He indicated a desire to return to work on the basis of not working a full day to see how he would get on. He did not apply for part-time work, but he did request them to allow him to go back to work on the same basis that he had done after his first operation. He was asked by senior counsel for the defendant as to when he first discussed with Mr. Carr or Mr. Edmonds the terms and conditions of his ill health policy insurance. He felt that this was mooted at some time during 2004. He had been on antibiotics from November, 2003, after the second operation, until April, 2004. He was not sure whether he or Michael Carr had brought up the matter of the ill health pension. Senior counsel for the defendant asked the plaintiff about the pension benefits which he would receive in the event of injury and the plaintiff replied that injury or ill health never entered his mind during the period. The plaintiff made it clear that he was attracted to come into a company at thirty-eight years of age with a start on a guaranteed full two-thirds pension as this was phenomenal. It was a great incentive to take the job particularly at the age of thirty-eight and a half when he was looking forward towards his future. This was a very good ill health pension to be receiving immediately ten years before he would have expected to get it in normal course. He thought that his salary at the time when he left his job was €86,000 and his earnings in his last year were €127,000 or a little more.

The two thirds of salary was based on two thirds of the €86,000 and not on two thirds of the €127,000. Senior counsel for the defendant suggested that Professor Bolger had said that he had an opportunity, if he wanted, to do other work provided that this could be done on his own initiative and with him organising his own working environment. The plaintiff stressed that the point he had made was that at this stage he did not think he was capable of doing any particular work but he could not say what the situation would be in three or four years time. He knew in his heart and soul that he would not be able to function, even on a part-time basis, in the job in which he had been. Senior Counsel for the defendant said that there would be evidence from the defendant's side that medically the plaintiff was fit for the type of work described. The plaintiff replied that this was fine and he had no difficulty about this as he was only giving his own opinion. He explained that over the last six weeks he has had to do a lot of paperwork because of his father's death and that he does this while standing at the kitchen counter as he cannot sit at a table to do it. He had had to write various letters here, there and everywhere else. He knew that he had to write a paragraph, then walk away and then come back and focus again. He was not able to sit with his head forward for any length of time without getting into severe pain. When it was suggested to him that he was able to sit without a problem for up to an hour at the parish council, he replied that he attended meetings at the school for an hour and then he would have to stand up half way through. He did this quite regularly as he needed to move around.

136. It was suggested by Counsel that the plaintiff's ill-health pension would be at risk if he took up remunerative employment. I should explain that the ill-health pension under the scheme is calculated as if the member had remained in service up to normal retirement age. Consequently transferred members, such as the plaintiff, whose previous pension arrangement promised a retirement pension of two-thirds final pensionable salary, would receive a similar pension on ill-health retirement. There was a note on this to the effect that the trustees of the scheme reserved the right to reduce or suspend the pension should the pensioner regain normal health or return to remunerative employment, if they feel this is appropriate. I pause at this point to say that in fact no Consultant in Occupational Medicine was in fact called to contradict the opinion of Dr. Hayes that the plaintiff, despite his best endeavours, was not fit to carry on a remunerated job and, indeed, she made it clear that she thought that the plaintiff was doing well to keep up some of his activities in the community which were very much to be encouraged and were approved of by his medical advisers.

137. I now turn to the evidence of Paula Cashman Dip. COT, NAOTI, BAOT, the Occupational Therapy Consultant. Her assessment was conducted at Mr. McFadden's home in Coolmine on 15th December, 2004, from 10.30 a.m. to 12.30 p.m. Mr. McFadden expressed his appreciation of the length of her visit and the thoroughness of the history which she took from him. Subsequently she compiled a detailed assessment and an occupational therapy report and included a breakdown of the costs and of the recommendations which were completed on 18th January, 2005. Her report outlines the plaintiff's function in activities and tasks of occupational performance and outlines the occupational therapy recommendations for his current and some of his probable future needs and details the costs related to activities and tasks of this sort. Ms. Cashman is an experienced occupational therapist with expertise in the assessment and rehabilitation of people with all levels and types of disability. She has had nearly twenty years experience assessing people with severe disabilities in their homes, hospital or workplace and her practical experience has included dealing with the assessment of persons with neurological injuries similar to those of the plaintiff and the evaluation of the needs of persons with comparable severe physical disabilities. She has had much practical experience of dealing with the sort of limitations which the plaintiff has from his failed neck, left sided disability and related difficulties. Having read the medical reports and having visited Mr. McFadden in his home for two hours on 15th December, 2004, she has addressed a number of issues in her report. First of all she has considered his functional abilities, particularly in activities of occupational performance. Secondly, she has considered what technical aids and equipment Mr. McFadden requires now and is likely to need in the future to enable him to function as independently as possible. Thirdly, she has given consideration to the environmental modifications around him that the plaintiff requires and will require in the future so that he can perform again as independently as is feasible. Fourthly, she has considered the services which the plaintiff will require at this stage, and probably in the future, so as to look after himself and carry on with as much independence as practical. Apart from reading the medical and other reports furnished, Paula Cashman conducted an intensive occupational therapy initial interview by meeting with Mr. McFadden and then observing him and discussing his problems with him from 10.30 a.m. to 12.30 p.m. on 15th December, 2004. On the theoretical side, she consulted *Willard and Spackman's Occupational Therapy* (the edition by Hopkins H.L. and Smith H.D.) which deals with functional restoration regarding neurological injuries. She also had the benefit of consulting with other occupational therapists and physiotherapy colleagues working in the field of orthopaedics, including neurology, and took advice from them on their findings and practical experience. Paula Cashman included an impressive curriculum vitae of her experience and qualifications and a useful glossary of technical terms. The comprehensiveness of her report, the depth of her practical experience, her acute observations of the plaintiff, his personality and his domestic surroundings, were as formidable as was her clear and straightforward evidence with regard to his present disabilities and shortcomings, and the list and description of the aids and equipment needed by him to try to restore in some small way the former quality of life for him and his family, particularly in the context of their home. I should perhaps add a cautionary note that this court cannot compensate the members of his family, except and insofar as their discomfort at his inability to look after himself independently and his occasional irritation at his drastic change of capacity and life style, through no fault of his own and is then reflected back on himself as if in a mirror and affects him with a feeling of distress and helplessness. No doubt, even with his good temperament and mindful personality, his frustration at not being able to regain his former robust vigour and healthy, balanced lifestyle, must afflict him. I have no doubt that he has been deeply affected by his feeling of being a burden at times on his wife and two children. I am well aware of the adage about the street angel being a house devil. However, I was very impressed indeed by the evidence of Mrs. Sophia McFadden, his wife for almost 25 years, who vividly described his upset at not being able to handle baggage, for example, when they went on holiday, or when dealing with the putting of golf bags and caddy cars into the boot of the car. One can readily sympathise with the sense of humiliation of a formerly vigorous man, who prided himself on toting a heavy bag of clubs on his shoulder around eighteen holes, when he has to stand by and watch his petite wife struggling to lift a heavy suitcase or golf bag. No doubt his frustration at having to stand back at such moments must be a source of embarrassment and distress to him. It would be natural for him to be upset by her worry and concern about him, she having been told about the peril of his becoming paralysed in all four limbs if he should have a further traumatic jerk to the osteophytic growth pressing on the spinal cord in his neck, and it is understandable that this must have deeply affected this man of strong and balanced lifestyle, who suddenly found himself so vulnerable and having to be careful of himself, after being hit from behind on the Naas dual carriageway. I admired his self-control and self-restraint when he was repeatedly implicitly criticised by counsel for the defendant when, again and again, it was suggested that he was luxuriating in idleness on the basis that he had a good ill-health retirement pension and advantageous pension provision and these benefits were really the reason for him not taking up part-time, remunerative employment. Counsel for the defendant in this type of serious injury case have a difficult role to play, where a robustly fit, energetic and competent sportsman is stricken by injury which reduces him, even after two operations, to a shadow of his former physical vigour. Counsel for the defendant had prepared themselves well by consultations in Beaumont and the plaintiff was subjected to severe and, at times, abrasive questioning. Three aspects of this were particularly remarkable. First, the plaintiff had been an avid golfer since the age of twelve. After the accident and his first operation, Professor Bolger encouraged him to try to play golf and explained that, while tennis, contact sports or any sporting activity which would increase the risk of a traumatic fall would not be advisable, the exercise involved in walking a golf course and the muscular activity involved, in exercise of the body and movements of the neck, would be helpful in keeping the plaintiff fit, supple and mobile. Much was made of the fact that the plaintiff was able to play eighteen holes of golf. However, the plaintiff was a careful witness and explained that after his first operation on doctor's advice and for exercise and recuperation, he had striven to regain his fitness by trying gradually to return to golf. He worked at altering his swing

and adapting his game and even managed this to the extent that in summer 2002, the plaintiff and his partner had won a Scotch Foursomes at Foxrock Golf Club in a highly regarded competition for Dublin clubs. He agreed that he and his partner had won this playing on successive days over a week. His partner had driven well off the tee and they could choose the best drive to play and he only had to play every second shot. They had both played well and he was quite adept around the greens, which had helped them considerably. The plaintiff made it clear that trying to keep up playing golf was very important to him and that he had to alter his style to protect his neck and that, before his second operation and even after this, it was a struggle for him to complete a round of golf. He worked on improving his stamina and mobility so that he could walk eighteen holes of golf, particularly after a visit in February, 2005 to South Africa with his wife and friends with the intention of testing whether the walking and playing golf in warmer climes, on courses in Cape Town and along the Garden Route, would help his determined efforts to rehabilitate himself. When he came back from South Africa he had decided to take a rest from golf as he was not feeling well. In South Africa, while he had played eight or ten times, he had to ride a buggy and he also had a caddy to carry his bag.

138. However the plaintiff said that since 15th August, 2003, at least until his second operation, he did not think that he had managed to play all eighteen holes but rather since then he inevitably had to pick up his ball on certain holes. On the last Sunday in August, 2003, he had hurt himself on the course and had to come in after nine holes. He was due to drive to Sligo that evening in order to play at Rosses Point in a corporate golf day on the Monday. He was involved in the organising and so he had to ring up a friend to bring things like the prizes for him up to Rosses Point. He was unable to drive himself and, indeed, when he got home on the Sunday evening he needed help in order to get out of his car and into the house. He was so sore and in pain that he was confined to bed for three days after the Sunday.

139. His second operation had taken place, lasting nine and a half hours, on 18th November, 2003, with several fusions and the insertion of much instrumentation at the back of his neck with the purpose of preventing further deterioration. The second aspect on which the plaintiff was robustly questioned was as to why he had not pulled himself together and returned to remunerative work. The plaintiff confirmed that he had difficulty now with loss of power on his left-hand side, both in his leg and his arm. He was limping on his left side, and his left hand grasp was poor so he was dropping things. He also had ringing in his ears and these were all reasons which made it difficult for him to work. He had tried repeatedly to go back to work but he knew in his heart and soul that he could no longer go back and cope with work.

140. Counsel asked the plaintiff why he had converted his garage into an office for himself for the future. The plaintiff responded that this was an entirely mistaken conception as his garage was dilapidated and had to be demolished due to subsidence. He and his wife had decided that it would be useful to have a proper utility room and an office area for the house in which to keep the computer and records and a filing cabinet for domestic documents. It was suggested to the plaintiff that it was "the height of cheek" to present a claim for the cost of an office in his house to the defendant and at the same time say that he was not fit for remunerative work in an office. The plaintiff replied softly to this by saying that he did not think that any such claim for the cost of an office had been made. It transpired that no financial claim had been made against the defendant in respect of the cost of the adaptation of the garage into an office and study and that a mistaken impression had been taken from section 7 of Paula Cashman's report dealing with her assessment of the plaintiff's accommodation requirements. She had noted that, as the garage was in poor repair, the plaintiff proposed to leave half of the garage as a garage and to break a door into the television room and to add on a utility room and a large office and study for the plaintiff. However there was actually no financial claim whatsoever being made against the defendant in this respect.

141. When the suggestion was put to the plaintiff that he had brazenly presented a claim for the cost of an office in his house, while at the same time he was saying that he was not fit to work in an office, which proposition was based on a mistaken reading of the report, the plaintiff replied with admirable moderation and restraint that he did not think that any such claim for the cost of an office had been made and this was confirmed by his counsel.

142. Mr. Pidgeon had accepted that the plaintiff would have difficulty with prolonged working at a desk or with extensive driving and had confirmed that the plaintiff had been unable to continue working as an insurance manager and he thought that it was unlikely that the plaintiff would return to that occupation. Despite Mr. Pidgeon's opinion and the strong and consistent evidence from Professor Bolger, Dr. Blanaid Hayes, the Consultant in Occupational Medicine, the G.P. Dr. Clarke and Patricia Coghlan Rehabilitation Consultant, and Dr. Valerie Pollard, the Pain Management Specialist, the defendant's counsel kept postulating that the plaintiff should be capable of earning remuneration in some sort of light work, or part-time job connected with the insurance business. I am convinced by the overwhelming evidence, particularly the medical testimony that the plaintiff will not be able for any real practical earning work, although he would be well advised to keep up his interest in charitable work, which he can do at his own pace and without being under pressure, particularly where he can move around and exercise every few minutes and is not forced to sit at a computer or to remain in meetings when he becomes afflicted with chronic pain, as is more than likely.

143. The third aspect of particular contention was as to the appropriate witness to give evidence on occupational therapy matters and aids, equipment and alterations to the plaintiff's house. I have stressed this aspect because, when Paula Cashman's report was handed in, I was told that it could be taken as if given in evidence. However, there was no concession given by the defendant's Counsel that any item at all recommended by Paula Cashman was necessary to cater for the plaintiff's needs or could be attributed to the injury and damage which his client had done in the collision to the plaintiff.

144. One matter is glaringly obvious. Counsel for the defendant chose not to call any consultant in Occupational Medicine or any occupational therapist, but confined himself to challenging most if not every item suggested by Paula Cashman as being appropriate to remedy the loss of independence and quality of life caused to the plaintiff by the negligent driving and from the injuries suffered by the plaintiff. Furthermore, this criticism was made in the absence of any expert called or evidence adduced on behalf of the defendant and was made especially on the basis that the plaintiff himself did not deal with each aspect covered in the report of Ms. Cashman and did not complain about each matter and discuss every item. The plaintiff is not a rehabilitation expert, and is a man who is not by character given to complaining, but rather is a person who has confronted his misfortune and has striven to overcome his disabilities inflicted by the collision. Counsel for the plaintiff has chosen to prove this aspect of the plaintiff's case by very properly calling an experienced occupational therapist and a rehabilitatory specialist who can speak of the plaintiff's needs and requirements on the basis of considerable expertise and experience of advising in similar cases of dire injuries. I do not accept the objection by the defendant's counsel that the ground has not been laid for this report nor do I accept his suggestion that this aspect of the claim is of an open-ended nature. It seems to me that the plaintiff has called the appropriate expert evidence, which is an infinitely more satisfactory and objective way of dealing with this part of the claim about the aids and equipment required by the plaintiff. On this aspect, it is preferable that a person gives expert evidence whose speciality and professional experience is to identify what is required by this particular plaintiff in the circumstances of his particular needs, personality, physique and injuries. This must surely be the appropriate way of proving such a claim rather than having an inexpert and subjective assessment of his own requirements by the plaintiff. Paula Cashman has studied the medical reports and assessed the plaintiff carefully as to what equipment will best assist him to be independent. Indeed, the point can be made that the expert evidence of the experienced occupational therapy consultant is

eminently appropriate on this aspect as being about relevant ways in which the plaintiff can mitigate the damage done by the defendant to his way of life and to the loss of some amenities of his former lifestyle. From this point of view it could well be argued that all these aids and pieces of equipment are in financial ease of the defendant as they reduce the plaintiff's loss of independence and, for example, reduce his loss of control over his ability to cope with such personal tasks as going to the lavatory or taking a shower on his own. If devices, aids or implements can help him to button his trousers, or to get into or out of a vehicle or even to pick up a golf ball or tee or to help with the preparations for cooking then the benefits from reducing loss of dignity and restoring the dignity and sturdy independence of the plaintiff at minimal cost should be welcomed by both sides. Counsel for the plaintiff is correct in saying that it is for him to make the proper case on this aspect by adducing evidence. The occupational therapy expert is the relevant and crucial witness although, on some aspects, the plaintiff's personal view may have some relevance and may prove helpful and the defendant's counsel could have cross-examined Ms. Cashman and the plaintiff on any of the items in the list furnished or have called a witness as to the inappropriateness or lack of need for any item in respect of this plaintiff in his circumstances. The court is entitled to consider, assess and adjudicate on whether the items suggested by Paula Cashman are justifiably required by the plaintiff for the purpose of trying to attain restoration of the plaintiff to his previous condition, insofar as this is reasonably feasible. It was conceded that with his injuries the plaintiff does have difficulty with sexual activity since his injury. It is also reasonable to recognise that the plaintiff does have difficulties in dressing himself and has to sit on the bed in order to put his right leg into his trousers. The plaintiff has difficulty constantly with mobility and movement of his left leg. Counsel for the defendant has made the point that the plaintiff is a confident, resourceful and vigorous man and accordingly with his fortitude and ingenuity may well be able to push himself to adapt to a lifestyle which copes with his incapacities and pain since his accident and so he is able to carry on with life. However, there are two other aspects to this proposition. The first of these is that both the plaintiff and the defendant should welcome the expert advice given by the occupational therapy consultant as to the aids and equipments and alterations to such basic living requirements as the need for a suitably adapted shower and lavatory to facilitate the plaintiff in managing to retain his independence and self respect by being able to cope with his washing and lavatory needs on his own with the assistance of alterations to the existing facilities at minor cost. Secondly, the plaintiff has always actively engaged in work and many social and sporting activities so that aids to restore and keep up his mobility, such as the walking stick and the kitchen trolley should be welcomed. A lighter suitcase on wheels and a more suitable type of vehicle should all assist the plaintiff to retain capacity to move around and to comply with medical advice to exercise by walking and playing golf as well as being able to visit family and friends in the vicinity and to attend therapy sessions near home and to socialise and thus to participate and have distractions from the pain.

145. In summary, Michael Gleeson SC is correct in his submission that an appropriate way of presenting this aspect of the claim is to call Paula Cashman, Occupational Therapy Consultant, to present her report and give her evidence as to the plaintiff's capacity for independent living and the aids, appliances and equipment he will require now and in the future to enhance his present quality of life and to try in some small way to restore his capacity to perform the basic functions of living, and to restore his enjoyment of the amenities of life to some extent to the quality of lifestyle which he and his wife had earned by their hard work together and by their talent for enjoyment of work, recreation and domestic life. As for the defendant's criticism that the plaintiff himself should have gone in detail into each aspect of the evidence covered by Paula Cashman, I reject this suggestion. I agree with Mr. Gleeson that it is infinitely preferable that an acknowledged expert such as Paula Cashman should, with her skills and experience, assess what is appropriate and most efficient in practice for this particular individual plaintiff with his disabilities. She has read the medical reports and her advice builds on the information in these reports and in the report of Patricia Coghlan, the Vocational Rehabilitation Consultant. Both these experts have submitted comprehensive reports, including information about the plaintiff's social history, his educational background, his employment history, his hobbies and recreations, the extent of his injuries and the vocational implications of these and their aftermath. Their considered recommendations are much more likely to be helpful in assessing the situation and the appropriate options than the naturally subjective and untutored viewpoint of the plaintiff who is not used to having to make such assessments. On the one hand the court may place great reliance on the expert reports of these specialists, since they have studied the medical reports and life history of the plaintiff and the nature of his disabilities and have taken into account his hobbies, recreations, means of transport, work practices and what was involved in his former work and the set up in his home and garden, and also the present limitations of his daily routine and efforts to regain his former wide ranging lifestyle; on the other hand, it is clear that this does not in any way preclude the defendant from challenging any aspect referred to in the reports or advices of the expert, Ms. Cashman, in respect of items which she believes are necessary or useful to assist the plaintiff to regain his former capacity for independent living. I accept Mr. Gleeson's argument that having the comprehensive report on disability impact and the assessment of aids, appliances and care is useful, and perhaps essential, in order to avoid capriciousness in identifying what is required and what is not needed. It is significant that counsel for the defendant have refrained from calling any witness to counter the evidence of either the Vocational Rehabilitation Consultant or the Occupational Therapy Consultant but have subjected both them and the plaintiff to lengthy cross-examinations and criticism. For example, counsel for the defendant could have called an appropriate expert witness to say that the plaintiff does not need a walking stick or replacement rubber ferrules. Understandably they have chosen not to do this as it is clear that, with the plaintiff's decreased sense of balance and loss of mobility and the peril of paralysis if he suffers further traumatic damage to his neck if he falls, the added security given by the use of the walking stick is advisable. So it is understandable that they have not called witnesses to challenge the need for a walking stick for steadiness or a pick up stick to avoid any exacerbation of the plaintiff's neck pain when he is trying to play golf and has to pick up his golf ball or other items from the ground. I should emphasise again that Professor Bolger specifically praised the plaintiff for his fortitude endurance of pain and perseverance in trying to play golf for the purpose of keeping his body exercised and the Professor strongly approved the activity and movement of walking around the course as being particularly good for the plaintiff's mind and body and for keeping his shoulders and neck as supple as possible. Having set out why I do not accept the main thrust of the defendant's criticism of the manner in which the plaintiff's counsel have presented this aspect of the case, I now intend to turn to the specifics of the Occupational Therapist's report.

146. While I accept the thinking behind the report and the main thrust of the report, it seems to me that while accepting the specialist expertise of Paula Cashman, the defendant is perfectly entitled to question the need for and appropriateness of each and every item. Thus I accept in broad terms the validity of the suggestions made by the Occupational Therapist and bear in mind her huge experience and expertise, nevertheless I have considered each and every one of the items carefully taking account of the criticisms of some of the items made by the defendant's counsel. I have scrutinised each item, especially bearing in mind the precept that the plaintiff must minimise his loss, which at times may be facilitated by obtaining and using certain suitable aids and equipment to regain and maintain his independence in living, as practical. I also bear in mind that the onus rests on the plaintiff to prove that he is entitled to the cost as being justified of each of these items recommended by Paula Cashman. In particular, I think that this consideration should take into account the circumstances of the plaintiff and his domestic situation. I select several specific examples in this respect. First, counsel for the defendant made the comment in passing and in jest, perhaps, that a golfing holiday in South Africa was all very well unless his client had to pay for it. There have certainly been precedents in the past for the inclusion of a holiday with an accompanying person as a practical way of assisting an injured person's recuperation. Indeed in one well known case it was suggested that the accompanying person would require a further holiday alone to rehabilitate himself after the stress of being the accompanying person! While in the present case the plaintiff and his wife very sensibly did go on a holiday with friends to South Africa, no claim whatsoever for the cost of it has been sought from the defendant: I suspect that there is many a physician who would prescribe a golfing holiday on the courses along the Garden Route as a sensible way for an avid golfer, who is suffering from such a severe neck injury, to regain good spirits and some joie de vivre after the shock and realisation of the limitations on his former

capacity and the frustrations that such a change in lifestyle brings.

147. Paula Cashman's detailed report gives the basis for her findings and this report was in the hands of the defendant's solicitor so that the justification for her recommendations and the practicality of her suggestions could be addressed. She met the plaintiff near Citywest on 15th December, 2004, so that he could guide her to his home. She saw him driving his wife's jeep and she carefully observed his ability to get in and out of the jeep. He was a bit unsteady and she noticed that, when he alighted, he then had a slight impairment of his legs and back. She observed his moving towards the house and noted that his posture was quite stiff. She had already studied the medical reports. She asked him about how he was coping generally during her two hour discussions with him. He told her that before his accident he was playing eighteen holes of golf several evenings a week after his day's work and that golf was a main recreation for himself and his wife. Previous to his injury he had been competitive and liked to walk the course and to carry his own bag and that then in December, 2004, while managing a caddy car, he was able to play some golf. He explained that he was unable to do some of the chores which he had done and that he did not like to have to use a walking stick on the golf course and so he used his golf umbrella to avoid stumbling. She observed how restricted his posture was when he had to pick up the post dropped on the hall floor by the post man and she noted that he has limited rotation and mobility of his neck and shoulder, and has difficulty when standing up and in keeping his balance.

148. While she understood why he used an umbrella on the golf course where it would be appropriate, as a therapist she would prefer to see him using a walking stick with a rubber ferrule if walking on the road. For picking up golf balls or other items on the ground he would require a pick up stick. During her visit to the house Paula Cashman noted that the plaintiff needed a new chair. Although his present chair has a high back which gives good back and neck support, this chair has a swing and rocking effect and is not safe or suitable for Mr. McFadden. She also observed that after one and a half hours sitting in this chair, the plaintiff was very stiff and had difficulty in rising off the chair and in stabilising himself before he could walk. She noted his great difficulties with the left arm and shoulder range of movement and also that he was unable to raise his arms over his head on either side. He has very limited flexion and extension and rotation of his head, and has a huge problem with neck and shoulder rotation and movement. She observed that the plaintiff had difficulties in balancing and while he could lift his right leg up he could barely lift his left leg off the ground. While he found sitting for any length of time uncomfortable, with his neck and back becoming tired, he is able to stand for a time particularly when he leans back against the wall to obtain some relief.

149. As for the therapeutic recommendations, Paula Cashman felt that the present shower was unsuitable and that the plaintiff should have a level access shower with two twelve inch grab rails to be positioned one on either side of the shower. She recommended the shower should have a thermostatic control with anti-scald settings and that the floor of the bathroom should have non slip tiling or non slip altro-marine flooring for safety. She also recommended a Sherwood perching stool for the plaintiff in the shower. Such a stool would cost €95.27 and would require replacement every seven years. With regard to washing his hair, cutting his nails and shaving and dental hygiene the plaintiff made it clear that he could manage all of these at present. Paula Cashman recommended that his toilet seat should be raised four inches higher, as with his height at 6 ft 3 inches, this was a very important aspect of his rehabilitation and posture will be vital to him. A raise of four inches would provide better access for him so he does not have to "flop down onto the seat". This recommendation was criticised by Counsel for the defendant as being unnecessary. I accept the reasons given by the expert for this and unhesitatingly prefer the good sense of her reasoning and recommendation. In respect of seating, Paula Cashman said that the plaintiff would require a reclining lounge chair which would promote good posture and support as well as providing advantageous access, as the plaintiff would require at least ten different chair postures; she put a cost of €3,000 on this reclining chair which is obviously an important once off item which is necessary and reasonable. As the plaintiff likes to help in the kitchen, another Sherwood perching stool at a cost €95.37 to be replaced after seven years seems a sensible and practical item. He has already purchased a special bed and orthopaedic mattress and the cost of this once off item should be allowed. A wooden walking stick at a cost of €29.05 every ten years with ferrule replacement at a cost of €3.56 per annum and a pick up stick for picking up items off the ground at a cost of €15.36 all seem very reasonable and necessary. In the past the plaintiff and his wife have enjoyed holidays abroad and have tried to regain this aspect of their enjoyment of life by going to Paris in October, 2004, and by going to South Africa and to Spain. In Spain the plaintiff had to watch while his wife and friends played golf but he did enjoy the social life after the golf and accordingly the therapist has recommended the purchase of a lightweight case as appropriate and needed by Mr. McFadden, who may not always have a travelling companion with him. It will be recalled that his wife is petite and one aspect of his disability which has caused him particular anguish and embarrassment is having to stand back and leave her to struggle with heavy suitcases and awkward golf gear. The cost of a lightweight suitcase would be €250 with replacements every five years.

150. As for the plaintiff's transport requirements, the therapist noted that Mr. McFadden is tall (6ft 3"in height) and has difficulties with access to his two year old Saab. His wife has a jeep which he was driving when he first met Ms. Cashman and the access to this is easier for him than manoeuvring into a normal car. She discussed this with Mr. McFadden and he said that he was hoping to buy a Mercedes jeep for the future. She felt that Mr. McFadden would probably not pass the primary medical certificate to obtain tax concessions on the jeep but that he would benefit from and should have automatic transmission and both good high seating and easy access to meet his particular future needs.

151. The requirement for automatic transmission is justified on the basis of the difficulties which the traumatic damage to the plaintiff's neck and shoulder have caused him by way of difficulty in changing gears with a conventional gear stick. The therapist suggests that the added cost of an automatic jeep would come to about €1,000 per annum and that he would need to change the jeep every four years. On this basis Ms. Cashman has suggested that a once off sum of €8,000 should be permitted for this item. The defendant has chosen not to criticise this item specifically but presumably intended this item to be included in the generalised criticism as not really necessary, of all these devices recommended to help the plaintiff to regain some of his independence and mobility and to assist in trying to restore some of his former lifestyle. While acknowledging the advantages of and the need for a high seated jeep with automatic transmission from the point of view of the plaintiff, it seems that there may well be other advantages to the plaintiff and his family in having a second jeep as one of the household cars. After consideration, there should be some discount on this for family benefit; a sum of €4,000 in respect of the contribution towards the recommended jeep, rather than €8,000, would seem to be fair and reasonable.

152. Mr. McFadden was a very fit and versatile man with many skills gained while doing a variety of jobs while he was earning money to pay his way through university in San Diego. In the past if one of the family cars were to break down then I think that he would have been able to deal with changing a tyre or other running repair not requiring great mechanical expertise. I think that Paula Cashman is correct in suggesting that AA membership at an initial cost of €120 together with a subsequent annual bill of €99 would be sensible and justifiably necessary in order to deal with an emergency involving one of the family cars, this being a task which he would have been able to cope with himself in the past in all likelihood until his injury on 7th August, 2000.

153. Incidentally, I doubt if the modern car tyre can be changed at the side of the road, as often nowadays the nuts are firmed up so tightly that even a strong man using a manual wheel brace is unable to shift the nut. I suspect that the wheel brace used by hand is likely to join the starting handle as an item in the motor museum. I have already said that the plaintiff is a man of wide experience and

skills and has probably acted as his own AA man in the past and would have rescued himself or his wife and children if any of them had a breakdown before his traumatic accident. Again his injuries in the aftermath of the collision have accelerated the need for him and his wife to have the benefits of one of them being a member of the AA and, since this is in an effort to put him back in the position of coping with a motor car problem which he would have dealt with himself before his injury, I think that a recognition of this accelerated need on his part is best met by allowing an initial figure of €120 for a first year of AA membership and then a lump sum to cover the subscription of €99 per annum in the future.

154. As for heavy domestic duties and the maintenance of their large, well kept garden, I think that the sum for hired help for heavy jobs to date at €3,500 is reasonable. Since he has a ride-on mower and he can take the cutting of the grass at his own pace because he is less tied to time pressures, it is likely that he will manage much of the garden work himself. A backlog of work had accumulated over the time while he was indisposed after the accident and then again while he was incapacitated after the first operation in December, 2000 and also again in the period when he was particularly in pain before the second operation in November, 2003 and while he was recuperating after this. He has a large garden of one acre and while his brother helped him out it is perfectly understandable that the pruning had fallen behind and that there was a need for hired help to prune and cut back trees and shrubs and also to carry out heavy mulching after the three to four year period. As for painting and decorating, in respect of which the plaintiff used to undertake the jobs himself, it is very unlikely that a person with a failed neck will be able for such work, particularly with his incapacity to raise arms and work above shoulder level and accordingly the sum of €150 per annum would seem reasonable. His two children are still living at home. The daughter is working in the vicinity and the son may well attend college in Dublin and so there is a reasonable likelihood that one or both may continue to be at home for some years yet: At least at the weekend children of that age are prone to return with clothes for the wash and all the advantages of enjoying home cooking and comforts. There are many tasks around the house which the plaintiff with such a damaged neck condition is bound to have difficulty in doing, for example painting and decorating, bringing in fuel, moving heavy furniture and clipping high hedges and other chores which involve raised arm, repetitive movements. In the light of the degenerative condition in the plaintiff's neck, perhaps the time has come for him gracefully to accept a supervisory role in respect of the heavier tasks and to encourage the enthusiasm of the next generation with gifts of tool boxes, D.I.Y. courses at father's expense and other tactful hints. I think that it was the poet Robert Frost who wrote:-

> "Home is the place where when you have to go there,
>
> They have to take you in".
>
> 'The Death of the Hired Man' (1914)

155. The corollary to that aphorism is that it is to be hoped that the recipients of bed and board will wish to contribute by coping with some of the domestic tasks which are straightforward, not too time consuming and often enjoyable for robust youth, but which are too demanding for those of more mature years, particularly for those with impaired health and physique, however tough the recognition of this as a changed feature of one's life this reality may be.

156. There is no doubting the plaintiff's determination and desire to remain as independent as possible. Professor Bolger is strongly of the view that the plaintiff should do all he can to keep up his golf, both to try to retain his mobility and also to try to maintain the social life which he and his wife enjoy with their friends in their golf clubs. I think that good sense and a caddy car has to come to even the fittest of golfers with the passing of years and a powered caddy car becomes a necessary piece of equipment. No doubt the injury suffered on 7th August, 2000, has accelerated the need for the mechanical convenience of a caddy car for this ardent but injured golfing enthusiast. On Professor Bolger's advice, golf for the plaintiff is an essential way to keep both mind and body active, flexible and fit and thus to mitigate the damage done in the collision. The injury suffered has accelerated the need for a caddy car by many years for the plaintiff and so it seems fair and practical that the once off cost of £400 should be allowed. The plaintiff had enjoyed robust fitness and liked to shoulder his bag of clubs around eighteen holes in the months before the traumatic collision. The caddy car will enable the plaintiff to play golf and to enjoy the social scene associated with this. Without the caddy car then his reduced physical capacity for his recreational activities might well have led to his future being even more bleak than it appears at present, thus otherwise augmenting the damages for loss of enjoyment of the amenities of life for which he has been deprived through no fault of his own.

157. The occupational therapist recommends that the plaintiff should have goose down pillows at a cost of €50 per annum every two years. There has been no expert criticism of the actuarial sum of €454 in respect of this goose pillow item from the defendant. However there is clear evidence from the occupational therapist that Mrs. Sophia McFadden manages a well kept house and I have little doubt that the life expectancy of a goose pillow in her household would be for significantly longer than two years. Accordingly a figure of €302 would be fair for this item, being a deduction of about one third at €152. As for a light weight wheeled set of cases, it is probable that the plaintiff will wish to continue his practice of travelling to warmer climes, whether to the Algarve or to the Canaries or to South Africa, all venues suitable for golfing enthusiasts whose aching joints require warm dry weather to alleviate the soreness and pains caused by accident damage, and rheumatic pain which can come with passing years and which is particularly prone to afflict damaged joints. No doubt the plaintiff and his wife will be careful of their suitcases but experience would indicate that mishaps in baggage handling can mangle the strongest lightweight case in the most amazing ways.

158. I note that "Support Services Items" in Section 6 of the Occupational Therapist's Report entails a once off figure of €750 including travel expenses to cover three visits by a therapist advising on the bathroom, office extension, seating needs and the aids, appliances and equipment, all of which seems reasonable. Similarly the figures of €600 per annum to date at a cost of €40 per visit last year and in to the future in respect of physiotherapy and the same sum to date and into the future of €600 per annum in respect of osteopathy seems justifiable. Also the figure of €500 in respect of services from his GP for ten visits over the last 12 months at a cost of €50 per visit seems fair. I suspect that the traumatic damage done by the collision and the need for visits to the GP for painkillers, mean the actual amounts may well exceed this figure. The once off drugs payment at €11,730 seems a sensible figure and one would hope that the State in due course will shoulder part of this cost in future on a long term basis.

159. As for the adaptation of the garage with a view to adding on a utility room and a large study for the plaintiff, when this item was mentioned the plaintiff had at once made it clear that he was making no claim for this improvement to the house. A person of less careful and scrupulous sense of moral values and integrity might well have suggested that such renovation was for the purpose of adapting the premises to facilitate his damaged neck condition and have had an ergonomic evaluation of this addition to the house. The addition to the house was no doubt made for more comfortable living conditions particularly for the plaintiff. However the improvement of the house will increase the value of the house and enhance the pleasant lifestyle no doubt enjoyed by all the family in residence. I note that the plaintiff has not chosen to make any claim in respect of the study extension and I regard this as being a reflection of the conscientious fair-mindedness and scrupulous thoughtfulness of the plaintiff and his wife.

160. At present I do not seem to have the cost of the alterations required for the bathroom adjoining the main bedroom; perhaps this

figure has been agreed. Secondly €750 for the cost of the ergonomic report, mentioned in the last paragraph under future accommodation of Ms. Cashman's report dated 18th January, 2005, does seem to have been justifiably included. This ergonomic report is to ensure that the equipment and furniture put into the study are suitable for Mr. McFadden's particular needs for taking account of his difficulties.

161. Perhaps I may be permitted to make a comment about the recommendations about aids and equipment. The Japanese seem to be ahead of Europe in respect of the study of impairments and the application of biological science and practical studies of human needs. They have reclining lounge chairs which can provide many differing postures by simple mechanisms for adjustment. They also excel at the provision of gadgetry in respect of the ergonomic layout of bathrooms and lavatories especially for a person with individual special needs who wants to maintain independent control of coping with every day private bodily functions. Such studies and thoughtful adaptations can greatly reduce the scope of damage to feelings about privacy, and dignity and suffering in respect of loss of self respect often caused by reduced independence of lifestyle. Accordingly the court should be sympathetic to a claim for a modest sum to help the plaintiff to mitigate the devastating loss of independent living thrust upon him so unexpectedly as the result of the severe whiplash injury and damage to the spinal cord sustained by him in the collision on 7th August, 2000.

162. Ms. Cashman also commented that from her observations the plaintiff was in severe pain at times and she felt that his medical condition was such that he needed to use a stick on occasion. His wife said that, while he was not a complainer, the family could see that he was in pain. After the second operation in November, 2003, he had to wear a hard collar for a time and when he came home it transpired that he was suffering from MRSA to the extent that he became very ill and they had to rush him back into hospital. He had been hoping to get back to work after the second operation but she knew when he came home by looking at him that he would not be able to go back to work although he was very reluctant to accept that situation. There are many things that he cannot do at home which is sad for him as he is a proud and independent person who hates the idea of not pulling his weight in the community. Hence he accepted the chairmanship of the school board of a small National School in Saggart which role is not very physically demanding or time consuming. He also helps in a small charity raising money for disadvantaged children. She felt that the future outlook was grim. She recalled the dreadful time when he had the second operation which took 9 ½ hours and his slow partial recovery therefrom. She said that she was particularly concerned about the likely prospect of his having to have further surgery and I note from mentions of this in the reports that such a further operation may have to be sooner rather than later.

163. The final witness called on behalf of the plaintiff was John E. Byrne Consultant Actuary whose report is dated 11th February, 2005. Certain aspects of the plaintiff's claim can usefully be clarified before I turn to the figures envisaged in his actuarial report. First, I reject firmly a suggestion by the defendant's counsel that the plaintiff could or would have continued to work if not for the possibility that any earnings might be set off against a reduction in his benefits to which he was entitled by reason of the payment of his critical illness premiums as part of his package of emoluments. I am convinced that the plaintiff was determined to try to rehabilitate himself and to get back to his job and that he strove mightily to do this. However after chronic pain and two operations in the area of the spinal cord in his neck, with the second operation involving fusions and the insertion of metal instrumentation in his neck, he at last had to recognise the reality of the advice of his medical experts, as being that he would not be able to return to work in an earning capacity. The plaintiff is a man of conscience and good sense and he has taken Professor Bolger's advice and has tried to stay involved in golf for exercise and enjoyment as well as giving back of his talents to the community by working for charity and by doing his stint for the community by acting as chairman of a national school, which work he can manage as he can stand up and move around at meetings, and he can avoid having to remain with his neck flexed forward for any length of time.

164. Secondly, it was suggested by the defendants that the plaintiff would have had neck problems, regardless of his traumatic accident on 7th August, 2000. Counsel for the plaintiff successfully refuted this contention through the authoritative evidence of Professor Bolger and Dr. Clarke. Despite the prior degenerative change in the plaintiff's neck, Professor Bolger made a convincing diagnosis that it was the fierce impact in the collision on 7th August, 2000, when the plaintiff's Mercedes was severely hit from behind and propelled forward from a stationary position into the vehicles ahead, which caused the severe damage to the spinal cord in his neck. Due to the presence of congenital stenosis, augmented by degeneration in his neck, together with an osteophyte, the extension and flexion of the neck caused tetra paresis and in Professor Bolger's opinion, as the pre-eminent consultant neurosurgeon dealing with spinal cord injuries, the extension of the neck caused the osteophyte to impinge on the cord and this, and not previous degeneration, caused gliosis to form in the neck area at C3/4. Professor Bolger gave convincing evidence that, even with the presence of degeneration in the neck, the likelihood of the plaintiff having problems without such a traumatic incident was minimal, as less than 10% of those of the plaintiff's age with such a condition went on to develop such problems as would cause them to have to retire before the normal retirement age of sixty five. Even if the degeneration and stenosis did cause pain and problems for the plaintiff, the probability was that such problems as did arise could be dealt with by treatment and by operation and the plaintiff would be able to continue working to the normal retirement age.

165. Thirdly, while Mr. Byrne had given a further report with regard to the additional inflation in respect of medical appliances and aids recommended for and required by the plaintiff to ameliorate the impairments caused by the traumatic collision, counsel for the plaintiff quickly sought instructions from his client and conceded that the extra medical inflation figures in respect of such aids and appliances could be ignored. It was noteworthy that the plaintiff's reaction to the submissions made by counsel on this aspect of the claim was, in my assessment of him over the several days, of such quick understanding of the situation, that when consulted by his counsel, he, the plaintiff, at once conceded that he did not wish to contend for the higher level of inflation in respect of the aids and appliances. The plaintiff also having heard the arguments between counsel in respect of a claim for mileage allowance put forward on his behalf also quickly conceded that he wished to withdraw this aspect of the claim as he recognised the validity of the point when made by counsel for the defendant that this claim for mileage allowance was intended to cover actual expenses incurred on company business and it would be very complex indeed to segregate the profit element frequently built in to such allowances from this aspect. These decisions by the plaintiff reflected my view of his character, that he himself is meticulously careful not to embellish his claim and wishes that it should be put forward fully even to the extent of matters against his interest so that the matter is placed accurately and properly before the court. Finally perhaps I should make it clear that I prefer Professor Bolger's crucial diagnosis as to when the gliosis came into existence and I accept his view that the scarring occurred after the traumatic injury damage done in the collision on 7th August, 2000, with the scarring forming rapidly because of the extension of the neck and the impingement on the cord of the osteophytic growth. Even if there was some long-standing gliosis at C3/4 provisions to 7th August, 2000, which seems unlikely, then it seems quite remarkable that this remained so completely asymptomatic over the preceding years of degeneration and growing stenosis. If there was any pre-existing gliosis, then it seems likely this was consolidated with the gliosis caused by the accident trauma and the scarring of the cord caused by the impingement of the osteophyte compressing the cord with the sudden fierce extension and contortion of the neck.

166. I now turn to the submission made by Counsel for the defendant to the effect that the plaintiff was receiving payment on the double as he would be paid an ill health retirement pension under his employer's scheme. If a person in the plaintiff's position with Allianz was forced to retire permanently due to serious ill health or injury rendering him, on the basis of medical evidence satisfactory to the group and the trustees, permanently incapable of continuing employment with the group, an immediate pension becomes

payable. The pension is calculated as for normal retirement but based on the employee's total possible pensionable service to normal retirement age and final pensionable salary at date of ill health retirement. The ill health pension under the scheme is calculated as if the member had remained in service up to normal retirement age. Consequently transferred members, whose previous pension arrangement promised a retirement of two thirds final pensionable salary, would receive a similar pension on ill health retirement. The scheme at page 24 continues

> "NOTE:-
>
> *The trustees of the scheme reserve the right to reduce or suspend your pension should you regain normal health or return to remunerated employment, if they feel this is appropriate."*
>
> 167. The defendant has admitted liability not surprisingly in view of the fact that she collided with the plaintiff's stationary car with such an impact that she pushed the car forward colliding with the vehicle ahead which in turn struck the vehicle in front of it. Normally under the common law the tortfeasor has to compensate for the consequences of the injury caused by her negligence. Counsel for the defendant suggests that it is anomalous that the plaintiff should be paid his full salary up to age sixty five and suggests that this is a disincentive which is discouraging the plaintiff from returning to work. He suggested that the court should look with cool eye at the suggestion of no earning capacity on the part of the plaintiff. This latter point flies in the face of all the evidence from a string of doctors including Professor Bolger, the plaintiff's GP. Dr. Clarke, who had known the plaintiff for many years, and Dr. Blanaid Hayes, the only Consultant in Occupational Medicine called. Furthermore, the nub of the matter is that neither the employer's medical adviser, Dr. Walter Halley, or any of the plaintiff's own doctors were prepared to certify that he was fit for work after the second operation in November, 2003. All the evidence points to the plaintiff being of such character that he has striven mightily to try to recover his fitness and to return to work.

168. As for the other point, s. 2 of the Civil Liability (Amendment) Act, 1964, is to the effect that certain sums are not to be taken into account in assessing damages in a personal injury not causing death. Section 2 reads:-

> "In assessing damages in an action to recover damages in respect of a wrongful act (including a crime) resulting in personal injury not causing death, account shall not be taken of:-
>
> (a) any sum payable in respect of the injury under any contract of insurance,
>
> (b) any pension, gratuity or other like benefit payable under statute or otherwise in consequence of the injury."

169. This provision is similar to that applicable to wrongful death actions in s. 50 of the Civil Liability Act, 1961. Geoghegan J. in *Greene v. Hughes Haulage Limited* [1997] 3 I.R. 109 at p. 117 was of the opinion that the "whole purpose" of s. 2 "was to provide a corresponding statutory provision for personal injury actions to s. 50 (of the 1961 Act) which provided for equivalent non-deductions in fatal injury claims." Consequently it seems to be reasonable to assume that s. 2 "was intended by the Oireachtas to be interpreted similarly to s. 50 of the Act of 1961." As Geoghegan J. pointed out at p. 119 "the question of non-deductibility of insurance monies in a personal injury claim as distinct from a fatal injury claim was until 1964 in Ireland, and still is in England governed, solely by the common law and not by statute". The original leading case was *Bradburn v. Great Western Railway Company* [1874] L.R. 10 Ex. 1, in which it was held that payments received for loss of wages pursuant to a private policy of insurance should not be deducted from the lost wages claim of a plaintiff. The explanation of the Bradburn principle was put thus by Lord Reid in *Parry v. Cleaver* [1970] AC 1 at p. 14:-

> "As regards moneys coming to the plaintiff under a contract of insurance, I think that the real and substantial reason for disregarding them is that the plaintiff has bought them and that it would be unjust and unreasonable to hold that the money which he prudently spent on premiums and the benefit from it should inure to the benefit of the tortfeasor. Here again I think that the explanation that this is too remote is artificial and unreal. Why should the plaintiff be left worse off than if he had never insured? In that case he would have got the benefit of the premium money: if he had not spent it, he would have had it in his possession at the time of the accident grossed up at compound interest."

170. Geoghegan J. went on to comment that it may well have been that there was some uncertainty about when collateral benefits were to be deducted and hence came the perception that section 2 of the Civil Law (Amendment) Act 1964 was required. This notion despite the clear exposition by Lord Reid and the adoption of the Bradburn principle both by the High Court of Australia in *Graham v. Baker* [1961] 106 CLR 340 and by the Supreme Court of Canada in *Guy v. Trizec Equities Limited* [1979] 99 DLR (3d) 243 at 247. Paragraph 2a of the CLA 1961 confirms the common law rule that payments made in pursuance of an insurance policy are to be ignored in assessing the plaintiff's damages: see *Woodman Matheson and Company Limited v. Brennan* [1941] 75 I.L.T.R. 34. Michael Gleeson S.C. for the plaintiff said that counsel for the defendant was making a novel submission in asking the court to ignore and disapprove of the established law which is clear from both the common law and the provisions of section 2. As for the assertions of counsel for the defendant that there was unfairness to and double jeopardy for the defendant's indemnifier, it can be shortly stated that this would seem unfair to the plaintiff who made it clear that he was attracted to his job by the offer of substantial emoluments and provision for insurance protection against ill health. The principle is succinctly set out by Lord Reid and it would seem most unfair that a tortfeasor should escape having to pay compensation because the plaintiff in effect gave up additional salary in order to have a better pension and protection from loss of earnings in the event of ill health.

171. Counsel for the defendant rhetorically asked why the plaintiff could work after his first operation of discectomy and then could not work after his second operation? There is a simple answer to this in that Professor Bolger said that the second operation was to try to prevent deterioration and was an attempt to increase the stability of the plaintiff's neck. He could not hold out the miracle of a cure to the plaintiff but could only try to make the neck more secure by effecting fusions and putting in metal instrumentation at the back of the neck. The short answer is that the second operation was major, complex, and involving serious risk in proximity to the spinal cord.

172. Counsel for the defendant suggested that it was degeneration of the neck which had caused the state of the neck requiring the second operation. However, the radiologists agreed that the degeneration had not increased between the first and second operations. Professor Bolger is the pre-eminent neurosurgeon in respect of complex spinal surgery. He has given strong evidence from the clinical picture as well as having had all the imaging at his disposal for him to study. It was a pity that his colleague Mr. Pidgeon did not have an opportunity to view all the x-rays and scans. If the plaintiff had been damaged in the area of the spinal cord in his neck before 7th August, 2000, then it would seem strange that there were no symptoms prior to this date from gliosis which could have been there from ten years to a couple of months. The diagnosis by the treating surgeon that the fierce impact in the collision with the ensuing temporary tetra paresis and other symptoms such as paraesthesis and weakness being activated would all seem to

point to the correctness of the treating surgeon's diagnosis to the effect that the extension and then flexion of the neck in the collision caused the osteophyte to press on the cord and to cause the gliosis which was to be seen on the MRI scans subsequently about a month later. This accords with the fact that the plaintiff up to the accident was playing eighteen holes of golf most evenings after a long day's work and as a strong, fit and active man had the habit of carrying his golf bag.

173. As for the suggestion of unjustified enrichment there has been no evidence called on behalf of the defendant which would give credence to the suggestion that the plaintiff has been exaggerating his pain and difficulties in any way. In fact the evidence of all the doctors treating the plaintiff is quite to the contrary and suggests that the last thing the plaintiff would do would be to stay malingering at home in order to pump up his claim. The reality is that he has in fact striven mightily to make himself fit by walking four and a half miles every day and by doing his best to rehabilitate himself. Perhaps a simple point makes the plaintiff's case most clearly, when Professor Bolger said the plaintiff was "a man rendered from perfect health to paralysis within a second of impact".

174. As for mitigation of loss by the plaintiff the defendant's suggestion is that the plaintiff can work and should seek and obtain remunerative employment. Much time in this case was spent exploring the plaintiff's efforts to return to work but the only witnesses on this aspect to be called were by the plaintiff's counsel and these witnesses were Professor Bolger, Dr. Blanaid Hayes, Dr. Valerie Pollard and the rehabilitation experts Patricia Coghlan and Paula Cashman. The defendant's counsel suggested that the plaintiff might do insurance brokerage work but they adduced no evidence from any of their own witnesses about this. In fact Denis Fogarty, the insurance expert and Dr. Hayes nailed the lid down on the coffin of this suggestion of a part-time brokerage job. On the plaintiff's evidence, he would clearly be unable for such a job in the future, despite his determination to try to get back to work and his redoubtable efforts to rehabilitate himself and to keep on working as long as he did. He no longer has the capacity to find such a job as he could manage, and if indeed he could ever persuade an employer, who is aware of his CV and recent medical record and incapacity to take him on the payroll, the reality is that there is no likelihood of such a job as he could cope with being available even in Utopia. Certainly the defendants have called no vocational expert to give evidence about the availability of any such job which the plaintiff could obtain or hold down with his present vulnerability and difficulties. I have already indicated how Professor Bolger's comment about a suitable job has been taken out of context and distorted by ignoring the premise and provision on which it is based.

175. The plaintiff's own fortitude and optimistic "get up and go" attitude to making the best of things was typified by his remark, when asked if he could do work in the future:- "I can't do it at the moment. I know what my capacities are at the moment but I would be hopeful that I would be able to do something in the future." The medical prognosis is discouraging and the plaintiff is to be admired for the brave face he manages to portray. With regret I have come to the conclusion that in this case the probability is that the plaintiff will do well to keep up even the occasional stints of attending meetings or otherwise helping in charitable work for the good of the community. Particularly praise-worthy are his impressive efforts to act as chairman of a primary school board and his involvement in a charitable venture in the Neilstown area. Since it was suggested that the plaintiff was unjustifiably enriching himself, and was guilty of exaggeration, I think that it is only fair to record my considered assessment after sceptical scrutiny of the plaintiff and testing of the various allegations, which range from his being guilty of unjustifiable enrichment, to being idle at home as a malingerer, and to failing to set up a consultancy business to earn money; all this is despite the evidence of Dr. Blanaid Hayes in this respect, and also after consideration of the innuendos of exaggeration suggested against the plaintiff. Perhaps it will suffice if I say shortly that there has been no plausible evidential basis for any such criticisms of the plaintiff whatsoever.

176. I take cognisance of the Supreme Court's view that the general damages should represent fair and reasonable compensation for the loss and injury sustained by the plaintiff, taking account of the total sum awarded in respect of past and future loss or expense, ordinary living standards prevailing in the country, the general level of incomes and the things on which the plaintiff might reasonably be expected to spend money. *Synott v. Quinnsworth Ltd* (S.C.) [1984] ILRM 523 was decided at a time when the return on funds invested would have been much greater than at present. It was also stated that in addition, on the facts of a particular case, other matters may arise for consideration in assessing what, in the circumstances, should be considered as reasonable.

177. In *McEneaney v. County Council of the County of Monaghan and Coillte Teo* (Unreported, High Court, O'Sullivan J., 26th July, 2001) in his considered judgment, O'Sullivan J. dealt with the question of the appropriate rate to the applied in actuarial calculations in respect of the cost of medical aids and appliances as these rates were running at more than the prevalent rate of inflation. Happily this issue was not in conflict in the present case but it is helpful that O'Sullivan J. held that a reasonable equivalent to the €150,000 for general damages in *Synnott* would back in 1991 be a sum of £300,000. I note that Denham J. in *M.N. v. S.M.* on 18th March, 2005, remarked that she was satisfied that the equivalent figure then to the £150,000 of Synnott, is in excess of €300,000.

178. This remark seems unsurprising since O'Sullivan J. in his judgment in *McEneaney* on 26th July, 2001, after careful consideration of the change in value of money found that the equivalent would be £300,000 and that there is the further aspect that more than four years of some inflation have passed since July 2001, and there has also been the currency conversion into euro. Accordingly the equivalent of £300,000 back in July 2001, must be well in excess of €300,000 euro by now. Even back six years ago in 1999, Morris P. in *Kealy v. Minister for Health* [1999] 2 IR 456 at p 459 stated:

> "My own day to day experience in the courts ruling in infant settlements is the clearest possible test for me that the cap of €150,000 is no longer regarded as applicable by practitioners… In my view the correct measure of damages for the appellant for general damages for a lady whose life has been effectively ruined is £250,000".

179. I note that in *Gough v. Neary* [2003] 3 IR 92 at p 130 Geoghegan J said that the test to be applied by the Supreme Court as to whether it will alter an award of damages either upwards or downwards is a test of proportionality as explained by the judgment of Fennelly J. in the Supreme Court in *Rossiter v. Dun Laoghaire Rathdown Borough Council* [2001] 3 IR 578. At p 583 of the report Fennelly J said the following:

> "The more or less unvarying test has been, therefore, whether there is any 'reasonable proportion' between the actual award of damages and what the Court, sitting on appeal, 'would be inclined to give'."

180. The words of the inner quotations were taken from Pallen CB in *McGrath v. Bourne* [1876] IR 10 CL160, one of the great seminal Irish cases on damages. Another is *Foley v. Thermocement Products Ltd* (1954) 90 ILTR 92 at 94 (S.C.) in which Lavery J. reflected on the difficulty in assessing damages in a personal injury case and said:

> "It is especially difficult in a case where personal injuries are the subject of the claim. There is no standard by which pain and suffering, facial disfigurement or indeed any continuing disability can be measured in terms of money. All that can be said is that the estimate must be reasonable and different minds will inevitably arrive at widely differing conclusions as to what is reasonable. The task must, however be undertaken."

181. Acting on this, I have carefully and unobtrusively studied and scrutinised the plaintiff, his demeanour, appearance and bearing

throughout this trial and, having started from a sceptical position, having heard the witnesses about the plaintiff and his injuries, I too have been convinced of the genuineness of his evidence and of his seriously painful and vulnerable condition. Incidentally, I note that Dr. Valerie Pollard did say that the plaintiff's "pain varied in intensity from 3-8/10 in severity on the visual analogue pain scale. Usually it was rated 6/10 in severity." Furthermore, the evidence from Professor Bolger, Dr. Clarke, Dr. Hayes and Dr. Pollard is all strongly and reasonably expressed to the effect that it is highly unlikely that the plaintiff will ever be able to do remunerative work in future, however determined he himself may be in persevering in the hope of returning to some type of employability.

182. Finally I turn to the matter of figures in respect of quantum of damage.

183. **To date pain and suffering** for the trauma of the collisions on 7th August, 2000, in which accident the plaintiff suffered tetra-paresis, so that he was trapped with the fear of the peril of fire for one and a half hours before being extracted from his car by the fire brigade ambulance men. The plaintiff had the terror of having to sit, unable to move in the car and of still being paralysed after being put in the ambulance. For over a period of five and a half hours he gradually regained partial power. He then had the experience over days of having to undergo x-rays, MRI scans and examinations which led to the dire warning that his neck was in such a condition that an impact or fall could cause the traumatic result of his becoming a quadriplegic. The plaintiff had to undergo his first neck operation on 6th December, 2000, when the osteophyte damaging the spinal cord was reduced and the compression of the spinal cord at C3/4 was decreased. The injuries suffered to his spinal cord afflicted left him with left sided weakness and had a devastating impact on his lifestyle and his enjoyment of the amenities of life and affected his working, social, domestic and sporting life in a devastating manner. While I propose to allocate sums to particular aspects of the pain and suffering to date, I have also reflected on the global figures for each aspect of the case and for the total global figure having listed provisional figures against each heading. I have considered the individual figures which I have placed provisionally against each aspect and I have then considered the total figures in respect of pain and suffering to date and pain and suffering in the future together with the figures for special damages. Then I have also considered and reflected upon the total figure in the light of experience in other similar cases.

184. I note that s. 22(1) of the Civil Liability and Courts Act 2004 provides that the court shall, in assessing damages in a personal injuries action, have regard to the book of quantum under the Personal Injuries Assessment Board Act 2003. I note that s. 22(2) provides that s. 22(1) shall not operate to prohibit a court from having regard to matters other than the book of quantum when assessing damages in a personal injuries action. The book of quantum states that it contains a guideline of injuries and related values. It lists injuries and the levels of compensation. The guidelines relate to head injuries, arm injuries, neck, back and trunk injuries, and leg injuries. The highest level type of awards are spinal cord injuries, in relation to which it states:-

> "The courts set the maximum compensation with the exact value being based on a number of considerations: -
>
> (a) level of movement,
>
> (b) level of pain and suffering,
>
> (c) depression – level of achievable rehabilitation,
>
> (d) age and life expectancy, paraplegia up to €300,000 and quadriplegia up to €300,000.

185. The plaintiff has restricted level of movement with the need to take care of his fragile neck but a fall or jerk may paralyse him completely. He has a chronic and persistent high level of pain estimated as high on the pain scale by Dr. Pollard, the pain specialist, and by Dr. Clarke, his GP, who has high regard for the patient's valiant fight to carry on and to try to rehabilitate himself and keep fit despite being in much pain. The plaintiff has been on medication both for pain and to stave off depression. He is now 55 and will be afflicted with pain and problems of weakness and lack of mobility for the rest of his life. This chronic pain is a special feature of this case with its capacity to wear the patient's reserves down and to make life miserable as was stressed by Professor Bolger. The plaintiff has done very well to keep his fitness by walking and playing golf as prescribed by Professor Bolger, both for physical health and for preserving his morale and socialising.

186. The Supreme Court (Denham, Geoghegan and McCracken JJ.) in *M.N. v. S.M.* on 18th March, 2005, said this Book of Quantum was informative, but added in the context of that sexual abuse case: - "its usefulness is limited, however, by the fact that it does not relate to purely psychological damage, and it does not relate to injuries for sexual abuse. However, it does indicate that in the most serious injuries, paraplegia and quadriplegia, the general damages are the highest awarded and that in general such an award maybe up to €300,000". I have considerable reservations about the usefulness of the P.I.A.B. Book of Quantum as so much depends on one's assessment of the personality of the individual plaintiff and how devastating the effect of the particular injuries have been on such a person with the relevant particular circumstances and character. Furthermore in this specific case there is a very special element being the constant and debilitating aspect of incessant pain. I have had an opportunity over ten days at intervals to assess the plaintiff and I accept the medical evidence that he is in very chronic continual pain. The debilitating effect of such pain can be very serious. Professor Bolger commented on how such pain can sap away reserves of morale. It is not surprising that in this case Dr. Power and Dr. Clarke have had to treat the plaintiff for depression and certainly it is not unexpected that the plaintiff should be suffering from lowering of spirits and frustration at his inability to perform so as to be able to work in practice, with no hope of ever aspiring to the high levels of which he was previously capable. For the frightening impact in the collision, the transient paresis and the terror which this paralysis must have caused the plaintiff while he was trapped in peril and pain for one and a half hours in fear of fire in his car, I assess a figure of €15,000. The fear of a fall or the peril of a traumatic impact to his neck during the period between the road traffic accident and the first operation on 6th December, 2000, while the plaintiff had to be wary of any physical contact which could cause a jerk of his neck or any fall, either of which could cause paralysis and then the first operation, the discectomy with also the reducing of the osteophyte impinging on the spinal cord, €10,000. The period of increasing pain and instability of his neck up to 17th November, 2003, when he had the nine and a half hour second operation on his neck near the spinal cord in which stenosis was reduced and fusions were achieved in order to give more stability in the neck together with the insertion of metal to achieve this, €20,000.

187. The plaintiff also suffered chest infections since 6th December, 2000, his first operation, and clearly this new tribulation can be ascribed to his injury. The scars caused during and by the two operations, the first on the front of the neck and the other at the back are significant although the plaintiff clearly has not let these unsightly scars get him down, unlike the irksome nature of his other injuries. He has also suffered from tinnitus, which is a frequent and distressing result of such a neck injury. A sum of €10,044 would be appropriate, although arguably minimalist or conservative, as recognition for these after-effects of his injury and I allocate this under injuries to date for simplicity, while acknowledging that the scars, and probably the chest infections triggered by the first operation and the tinnitus all may persist.

Pain and suffering and loss of amenities of life in respect of teeth €7,500 to date.

188. In addition to this for all the pain, suffering, the psychological effects, depression and the loss of power on his left side together with the impairment of his capacity for previous strong healthy activities, including pain frustrating him in very private and intimate matters, and a loss of the amenities of life and the enjoyment thereof, a sum of €90,000, is appropriate, giving a total of €152,544 for general damages for pain and suffering to date:-

189. The **special damages to date for loss** of earnings from 7th August, 2000, to 20th May, 2005, have been agreed at €125,000. It should be borne in mind that the plaintiff has been paid his salary to 20th May, 2005 and accordingly this money for past loss may be earmarked for payment to the responsible employer who continued paying the plaintiff while he was in need.

190. Medical and hospital expresses to date €34,921

191. Dental expenses to date € 1,200

192. Travelling and Parking Expenses to date € 2,000

193. €38,121 €125,000

194. **€ 38,121**

195. €163,121

196. **€152,544**

197. €315,665

Future Losses

Future Special Damages
198. There is a figure for future loss of earnings at €658,000 which is calculated on an actuarial basis using a multiplier appropriate to the plaintiff's age with his having a normal retirement age at sixty five. The plaintiff will have future loss of earnings until he is sixty-five on the basis of Professor Bolger's evidence that, but for the traumatic collision and impact injury on 7th August, 2000, the plaintiff would in all likelihood have worked, as a very fit and healthy man, to normal retirement age of 65 years in very secure employment.

199. The next item under the heading of future damages is the critical illness premiums from date of retirement of €22,568. This is an actuarial figure in respect of the lump sum which the plaintiff should receive for compensation to him for the loss since March, 2005, up to his normal retirement age of sixty-five, of having the advantage of the employer paying his critical illness premiums for him.

200. The cost of future prosthodontic work is agreed at €14,200.

201. The final item under this heading of future damages is the future cost of such aids and appliances as are allowable to ameliorate the impairments to the plaintiff caused by the road traffic accident. The figure for the future costs of aids and appliances to ameliorate impairments caused by the road traffic accident is €78,300.

Future General Damages
202. As for **pain and suffering** in the future re dental injuries, including anticipation of further work and the anaesthetics, implants and anguish involved, a sum of €7,500 is appropriate. There is the prospect of a further serious operation near the spinal cord. I do not think that the P.I.A.B. Book figures are much help as they appear to be comparatively generous for some minor injuries but not really helpful except in the general indication that spinal cord injuries tend to attract highest figures. Here one is dealing with an injury to the spinal cord where the plaintiff is likely to continue to suffer from left sided weakness and constant pain and concern about the worrying vulnerability of his failed neck, with all the frustrations and the lowering of spirits which this can cause in a person who was, previous to injury, very fit and energetic, both at work and in recreation and in a wide range of activities. There is likely to be a drastic reduction in his capacity in performance of tasks in the house and garden, and in his enjoyment of the amenities of life. I think that the appropriate figure, bearing in mind the constant nasty pain and impaired capacity, for future pain and suffering, including the dental aspect, is €157,500.

203. Thus the total is €930,568 for damages in the future.

Summary of Schedule of Damages

Pain and Suffering to Date

Trauma of collisions on 7th August, 2000, entrapment in car in peril of fire in state of tetra paresis and fear of paralysis and fire and subsequent flash-backs and nightmares and insomnia resultant to these deeply traumatic recollections.	€ 15,000.00
Fear of future trauma to neck between road traffic accident and first operation on 6th December, 20000 and operation involving anterior discectomy and reduction of osteophyte impinging on spinal cord.	€ 10,000.00

Increasing pain and instability of neck leading to nine and a half hour, second, very serious operation near spinal cord to reduce stenosis and fuse vertebrae with metal rods and screws being inserted at the back of spine to achieve stability of neck.	€ 20,000.00
Chest infections since and from the operation, also annoying tinnitus and scars, obvious on front and back of neck	€ 10,044.00
Pain, suffering, psychological effects, including anxiety and depression, loss of power on the left side, weak left arm and hand and left leg limp. Loss of the amenities of life, paraesthesia and continual weakness and pain with need for frequent pain killers. Particularly the chronic, continual nagging and at times acute pain.	€ 90,000.00
Pain and suffering and loss of amenities of life in respect of teeth	€ 7,500.00
General damages for pain and suffering to date	€ 152,544.00
Special Damages to Date	
Agreed loss of earnings 7th August 2000 to 20th May 2005	€ 125,000.00
Medical and hospital expenses to date.	€ 34,921.00
Dental expenses to date	€ 1,200.00
Travelling and parking expenses to date	€ 2,000.00
Total special damages to date	**€ 163,121.00**
Total to date	**€ 315,665.00**
Pain and Suffering into the Future	€ 157,500.00
Pain and suffering and loss of amenities of life and enjoyment of life, including the dental aspect.	€ 658,000.00
Future Special	
Loss of earnings calculated on an actuarial basis	€ 22,568.00
Actuarial figure in respect of loss of employer's payment of critical illness premiums previously payable for plaintiff up to normal retirement age of 65 years from his actual date of retirement in March 2005	€ 78,300.00
Cost of alterations, aids and appliances to ameliorate impairments caused by accident. Figures are based on Paula Cashman's report and John E. Byrne's appendix setting out the capital value of future costs at a real rate of return of 3% and future investment income taxed at 20% on normal life expectation. The figures in the appendix are accepted, except for a deduction of €162.00 off the €454.00 for goose pillows and a deduction from the contribution towards the once-off cost of a jeep at €8,000.00 of €4,000.00 because of the family benefit therefrom.	€ 14,200.00
Cost of future dental work	€ 14,200.00
Total damages into the future	€ 930,568.00
Total	€1,246,233.00

204. I consider that the sum awarded of €1,246,233.00 for damages is fair and reasonable in all the specific circumstances of this case and that the sum is proportionate to and appropriate for the injuries suffered by the plaintiff.

205. Accordingly there will be judgment for the plaintiff in the sum of €1,246,233.00 and costs to be taxed in default of agreement.