THE HIGH COURT

[2015 No. 983 P.]

BETWEEN

ANNE KEANE

PLAINTIFF

AND

CAROLINE MOLONEY

AND

PAT KEOGH LIMITED (A COMPANY IN LIQUIDATION)

AND

MICHAEL O'REGAN

DEFENDANTS

JUDGMENT of Mr. Justice McDermott delivered on the 8th day of March 2018

1. The plaintiff is a married lady born on 4th November, 1964. On the evening of Saturday 27th October, 2012 the plaintiff was driving her car, a volkwagen passat, on Nicholas Street, Limerick. She had stopped at a junction to turn right when the defendant's vehicle, a Nissan primera, collided with the rear of her stationary vehicle as a result of which she claims to have suffered personal injuries loss and damage. There is no doubt that there was a collision. It was dark at the time. The plaintiff described how the car seemed to jerk forward and back on impact. She was initially in shock when she got out of the car. After about ten minutes she approached the driver of the car behind her. There were two girls in the car. She inquired about their wellbeing. The first defendant, the driver of the vehicle indicated that she was not injured and did not know what had happened. The gardaí were called. The plaintiff got back into the car. The front bumper of the defendant's car was slightly deformed and the paintwork was slightly cracked above the number plate at the right of centre.

2. The court is satisfied that the impact damage was consistent with a minor collision which did not involve a great deal of force. The only damage sustained to the plaintiff's vehicle was to the area beneath the number plate which was photographed and presented in evidence. The screw on the number plate of the defendant's car was said to have damaged the bumper of the plaintiff's car. In order to leave the imprint which is very slight, Mr. Hassett, an engineer, stated that the plastic flexible element of the bumpers of each car must have made contact. The metal bars behind each bumper held up. The coming together of the two plastic bumpers would cause a jolt. The limited nature of the damage and impact is indicated in the cost of repair to the plaintiff's car, €280.00 including labour. This was described as a standard charge that would be incurred in any repair shop for the removal of the bumper, its repair and repainting.

3. The force of the collision was said to be so limited by the defendants that it could not possibly have given rise to the injuries of which the plaintiff now complains. Mr. Foy, a forensic injury engineer called on behalf of the plaintiff indicated that he had reviewed all of the research materials which examined the potential correlation between the nature and severity of motor-vehicle collisions and physical injuries that might be expected to result therefrom. He addressed those collisions examined at speeds of zero to five kilometres in which 25% of cases resulted in physical injury. However, it was submitted by the defendants that the likelihood of the plaintiff and her husband, who also claimed to have been injured in the collision, being amongst that limited class who would sustain such injuries was even less likely and that such an occurrence was highly improbable. The plaintiff's husband has also initiated proceedings claiming damages for personal injuries arising out of the accident.

4. The plaintiff claims that as a result of the accident she suffered injuries to her neck, back and left shoulder. She also claims that she suffered post traumatic stress symptoms. She made no complaints of physical injury at the scene. The following morning she awoke feeling sore and stiff in her neck.

Previous History

5. The plaintiff had been involved in the workplace since the age of twelve. She had been a catering assistant and cleaner. She was clearly a hard-working person. She attended for duty on a daily basis with her catering employer. For a period she maintained two jobs in that she would later on the same working day carry out cleaning duties for a different employer. She was employed as a canteen assistant at the time of the accident. She obviously enjoyed the confidence of her employers during her working life and I am satisfied that she was a person who was reluctant to take time off work even when ill, and was a reliable employee.

6. The plaintiff was married in 1983 and had four children now aged 34, 31, 26 and 24. On 30th January 1990 she suffered a fall and suffered neck and back injuries. In 1998 she had a road traffic accident. It is clear from the evidence that she injured her neck in the fall and the road traffic accident. Between 1998 and 2009 she continued to experience neck problems. She accepted that she had a nineteen year history of problems with her back and neck. However she still continued and was not prevented by her complaints from continuing with her work.

7. The plaintiff's medical records were produced and from these it is clear that in or about 2007 and 2008 she was suffering from low back ache. On 25th March, 2008 it was recorded that she had been off work for three weeks due to lower back ache. Back examination was very painful however the doctor could not see anything clinically wrong with the plaintiff's back. On 11th April, 2008 Dr. Murray, her general practitioner, noticed pain in the left paracervical region. She was tender in the left paracervical musculature and difene gel was prescribed. On 15th April, 2008 the plaintiff felt no better. Though somewhat improved she was still tender in the left paracervical region. She was referred to a physiotherapist. On 9th May she was still complaining of neck pain. She had not attended a physiotherapist because she had no resources to do so. She found medication helpful. The area of maximum pain was on the left scapula. Movement to the shoulder and neck aggravated the pain. Neck movement was restricted. The doctor thought that this might be attributable to cervical pathology.

8. On 13th May, 2008 Dr. Murray noted persisting neck and shoulder pain. The plaintiff did not have physiotherapy and a certificate covering her absence from work was given from 8th May, 2008. She continued to suffer these symptoms in June, 2008 and was

prescribed medication to relieve her condition through August and September. The next relevant entry in her doctor's notes was on 30th December, 2009. An x-ray taken the previous day was normal. She was given an injection and Nurofen and her shoulder symptoms resolved.

9. On 3rd June, 2010 she attended Dr. Mulcahy with major back pain and tender upper parathoracic musculature.

10. On 25th April, 2012 the plaintiff suffered an upper back injury due to a strain sustained in the course of her employment while working in a kitchen. She was prescribed medication. She was out of work for five days. There are no other relevant entries in the surgery notes concerning her complaints in relation to shoulder, back and neck pain. There are however numerous entries in relation to other ailments and complaints from which suffered over the years.

11. Dr. Murray summarised the plaintiff's medical history concerning her neck and upper back. The plaintiff injured her neck following a fall in January, 1990. She injured it again in a car accident on 8th July, 1998. She had recurring neck to upper back pain until 2009. She had not presented with upper back or neck pain since then and she denied a history of same over that period of time. This was apart from one incident on 25th April, 2012 when she presented with a "sprain" to her upper back which resulted in five days off work.

12. The court is satisfied that from in or about 2009 to the time of the accident the plaintiff was not seeking treatment and did not appear to be troubled by the low back pain, upper back/shoulder pain or neck pain for which she attended Dr. Murray in the years 1990 to 2009. The court is satisfied that she made a good recovery from the injuries which she sustained in 1990 and 1998. In addition I am satisfied that the incident involving a strain of her back in 2012 was an isolated one from which she recovered within five days.

Post accident symptoms
13. Following the accident on Saturday 27th October, 2012 the plaintiff attended Dr. Ali at Crescent Court Dooradoyle on 29th October. She informed him that she had trapezius pain on both sides. He considered that she had spasm in her shoulder muscles. He noted that her movements were normal.

14. The plaintiff then attended with Dr. Murray on 2nd November, 2012. She stated that she had pain since the accident in her shoulders. There was ongoing pain in the upper thoracic and intra-scapular areas. She could not sleep with the pain described. The pain was in the upper thoracic area mostly over the right trapezius muscle. There were no bruising and no deformity. Neck movement was about 10% restricted in all directions. Her lower back was normal. Dr. Murray considered that she was suffering from neck muscle pain. He indicated in evidence that on examination the patient was suffering from intra-scapular pain of a generalised nature between both shoulder blades. On palpation the pain extended out to her shoulders and into her right trapezius area. She went back to work for a number of months until June 2013 but the nature of her work which involved a lot of lifting made it impossible to continue because of the pain.

15. Dr. Murray saw the plaintiff on 17th January, 2013. At that stage she continued to complain of left lateral paracervical pain everyday. She rated the pain at a high level of 8 on a spectrum of 1 to 10. She had trouble sleeping and awoke during the night with the pain. She used analgesic sprays and rubs in addition to local heat applications.

16. Dr. Murray noted tenderness over the mid fibres of her left trapezius muscle. All cervical movements were reduced to 50% of normal and movement at that level exacerbated her pain. Neck shoulder abduction also significantly exacerbated her trapezius muscle pain. Upper limb neurological examination was normal. He directed analgesics home exercises and physiotherapy in the future. He considered that the injuries were consistent with her accident but did not direct any further investigations. He expected a full recovery. He could not estimate at that time the period within which that might be achieved.

17. On review on 22nd August, 2016 the plaintiff informed Dr. Murray that she continued to have left neck and shoulder pain everyday. She had been unable to work since June, 2013. She had attended the general practitioner over twenty times during that period. She had been treated with analgesics, physical therapy and intra-articular and intra-muscular injections for pain.

18. An MRI scan was carried out on 11th December, 2014 some two years after the accident.

Results of the MRI scan

Left shoulder MRI
19. Mr. Stafford, a consultant radiologist observed some degenerative change at the left acromioclavicular joint and minimal joint capsulitis. He observed some minor inferior joint osteophytosis with some likely impingement of the superior musculotendinous junction of the supraspinatus tendon. There was significant downward sloping of the anterior inferior acromion which is a common anatomical variant associated with impingement tendonitis. The plaintiff had been born with a pre-disposition to impingement on the tendon. There was some high signal identified within the mid and distal supraspinatus tendon and a minor anterior subacromial bursitis was observed. These findings were consistent with impingement tendonitis at the site. There was no retraction or tear of the supraspinatus tendon identified. It was possible that the plaintiff may have had some clinical but silent pre-existing impingement of her supraspinatus tendons which was aggravated and further progressed as a result of the accident of October, 2012.

Cervical spine MRI
20. There was a loss of lordosis in the cervical spine consistent with muscle spasms. It was inconclusive as to whether this was of long standing or could be attributed to the injury. There was some minor compression deformity of the superior end plates of C4, C5 and C6. Moderate degenerative change was identified within the C5/6 disk space with some loss of vertical height of the space. Moderate broad based disc bulging was identified posteriorly at C5/6 without giving rise to any chord depression.

21. There was a moderate size osteophytosis projecting into the lower anterior exit foramina bilaterally. This gave rise to a long standing predisposition to symptoms if the area suffered trauma.

22. Mr. Stafford concluded that the MRI of the cervical spine carried out over two years after the accident demonstrated a loss of lordosis in the cervical spine region consistent with muscle spasm. The presence of muscle spasm in a post traumatic setting was consistent with an underlying muscular ligament or soft tissue strain injury in the cervical spine region. He noted the clinical findings in the aftermath of the suggested accident in October 2012 as documented by Dr. Murray and Mr. Gilmore.

23. Two years after the accident it was difficult to determine if compression deformities in the superior end plates of C4, C5 and C6 bodies were of long standing or whether the accident could have attributed to some minor compression deformities of these vertebrae. I am not satisfied that the plaintiff has established that these changes were the result of the accident but rather they are

more likely to be of longstanding when considered with the other medical evidence.

Dr. Brian Spillane
24. The plaintiff was examined by Dr. Spillane, a sports and orthopaedic physician. In his first report, he outlined the plaintiff's medical history and her description of the accident. The plaintiff told him that following the accident she suffered left shoulder pain radiating to her neck. She was prescribed painkilling medication and anti-inflammatory gel. She remained in work until June 2013. She then had to cease work because of pain which had become gradually more pronounced. She then started physiotherapy treatment and attended for approximately ten sessions. At the time, she was complaining of recurring left sided neck pain radiating to her left shoulder which was aggravated by sitting for long periods of time. It was "niggling most of the time". Physical work or a long walk aggravated her complaints. The pain made her irritable. She had no complaints concerning her lower back. She considered that she was not able to go back to work. She was working in the canteen which involved a lot of heavy lifting of pots and pans and also had to push heavy trolleys.

25. On examination, Dr. Spillane found that the plaintiff had a full range of pain free movement with no localised tenderness in the left shoulder. Resisted movements in the left shoulder were strong and pain free.

26. Left rotation was limited by 75% and right rotation by 50% in the cervical spine. These movements were both uncomfortable at the extremes of motion. The patient revealed a subjective tenderness over the left paracervical and left mid-trapizius musculature. There was no neurological deficit in either of her limbs. She continued to take painkilling medication when her symptoms were more severe. However, this was not every day. Dr. Murray had injected her shoulder shortly before the examination on two occasions which provided some temporary relief.

27. Dr. Spillane was satisfied that clinical examination of the plaintiff's left shoulder was normal which may have been due to a response to Dr. Murray's injections. Her neck movements were very restricted and painful. Her MRI scan confirmed pre-existing degenerative changes in her cervical spine which may have been aggravated by the accident. Having considered the photographs of the vehicles taken after the accident and the motor assessor's reports, he concluded that there was a relatively low impact which he did not expect would cause any long terms problems for the plaintiff. He was satisfied that it was likely that she had fully recovered at that stage from any injuries sustained in the accident. He was satisfied that any ongoing complaints should be attributed to the natural progression of the pre-existing degenerative changes noted in both her cervical spine and left shoulders.

28. Dr. Spillane reviewed the plaintiff again on 26th October, 2017. She complained of recurring pain in the muscle extending from the left side of her neck to the left shoulder. She says that this "builds up" when sitting watching television for too long and was also uncomfortable when she was in bed. For relief, she massaged it herself or applied a hot water bottle while in bed. She had a lower level of discomfort when she was physically active and mobile. She has no arm or hand radiation of her symptoms. She does not suffer with headaches and has no actual pain in her left shoulder. However, she had some "bad days" when her pain was more severe. She regularly attended her general practitioner and took paracetamol and applied an anti-inflammatory gel. She stated she was unable to change bedclothes or hang out washing and does not use the hoover. She has discomfort from blow-drying her hair and is unable to stand over the sink for too long. She said she was unable to walk her two large dogs and her husband and daughter were at home with her and helped with the chores. Once again he noted that she enjoyed a full range of pain free movement of the left shoulder and that resisted movements were strong and pain free. He also noted that rotation to either side of the cervical spine was limited by 30 degrees and uncomfortable at the extremes of motion. Palpation again revealed subjective tenderness over left para-cervical and left mid-trapezius musculature.

29. Dr. Spillane reiterated his conclusion that the plaintiff had suffered a temporary aggravation of pre-existing degenerative changes in her cervical spine after the accident. She also had some rotator cuff pathology in her left shoulder which was temporarily aggravated. He was satisfied that the symptoms responded to local steroid injections. He concluded that the plaintiff was genuine in her complaints but felt it unlikely that they were related to the minor impact. He also concluded that she was fit for light canteen work but not for heavy lifting or overhead work. However, he was of the opinion that this was a function of her current age related complaints rather than a consequence of the accident.

Mr. Michael Gilmore
30. The plaintiff was examined by Mr. Michael Gilmore, Consultant Orthopaedic Surgeon, on 2nd December, 2016. He set out the history given to him of the accident and of her attendance with Dr. Murray. Dr. Murray advised her to continue with tablets and Difene spray. She had been taking painkillers and Difene spray since. He gave her four to five injections to her left shoulder and she accepted that these helped but were only of assistance for two days at a time. At the time of examination, she took paracetamol, used a Difene spray and also took Valium F 5mg tablets. At that time, she complained that she could not work. She could not tolerate a bra strap on her shoulder. She could manage to dress provided she was careful what she chose to wear. She had difficulty with her housework and her daughter who was a hairdresser, assisted in doing her hair for her. She always had to sit leaning to her right for comfort to relieve pressure which she felt in the left shoulder. She heard and felt cracking noises in her neck when doing home exercises. She had undergone physiotherapy but could not remember how many sessions she had received. She acknowledged that this helped a lot. She does a home exercise programme. She used a hot water bottle to relieve symptoms.

31. On examination, Mr. Gilmore found that she had a full range of movement in the left shoulder but with resisted abduction and she also had positive impingement testing. Examination of the cervical spine indicated a 75% range of motion with some slight pain. She was tender in the left trapezius. There was no obvious neurological deficit in either upper limb. Mr. Gilmore concluded that the plaintiff had suffered soft tissue injury to her left shoulder and her neck in the accident, some four years previously and continued to have ongoing difficulties with both areas. He concluded that she required to attend a shoulder specialist or a pain specialist in relation to her left shoulder in order to receive more definitive treatment in the hope that this would help to alleviate her shoulder problems. However, because it was over four years after the accident, the prospect for any significant improvement was very slim. However, he felt that she probably would benefit from seeing the shoulder specialist. She did not do so.

32. Mr. Gilmore examined the plaintiff again on 19th February, 2018. Since then she had continued to take paracetamol and Difene spray. She continued to receive pain relief injections though it was quite a while since she had received the last one. Present complaints were the same as those referred to above. She complained of pain in the left side of her neck and shoulder and difficulty in sleeping.

33. Physical examination of the cervical spine showed approximately a 50% range of motion with pain and moving at the extremities. She was tender in the left trapezius and supraspinatus area but there was no obvious neurological deficit in either upper limb. The examination of her left shoulder showed slight positive impingement.

34. Mr. Gilmore concluded that since her last attendance with him the plaintiff had become somewhat vague about her medical

history. She had been seen by a number of people but could not remember their names or when she had her last injection and by whom it was administered. She had not seen a shoulder specialist as recommended. He concluded that it was likely that she would continue to have ongoing difficulties. However, he was not clear what further treatment had been given to her since he last saw her or what further treatment could be given to her to help alleviate her symptoms.

35. He accepted that he could detect no muscle spasm only tenderness on examination. The plaintiff informed Mr. Gilmore that while she did have cervical spine and lower back injury seven years previously, she had no problems at the time of the accident and had no problem with her left shoulder before the accident.

Mr. Dermot O'Farrell
36. The plaintiff also saw Mr. Dermot O'Farrell, Consultant Orthopaedic Surgeon, on 12th April, 2017. He also found on examination of her left shoulder a good range of movement with good power in the rotator cuff. Examination of the cervical spine confirmed a range of motion which was approximately 75% of normal in all directions. He noted that the patient had soft tissue injuries to her neck and left shoulder which did not require surgical treatment. He believed they should respond well to a combination of physiotherapy, home exercises and pain relieving medication as required. He anticipated that in the long term, the symptoms would improve. The pain was reported to have continued for over four years and this was usually a poor prognostic sign, meaning that the symptoms could continue indefinitely. There was no evidence of pathology in the shoulder or neck which would give rise to long term disability in her case. He did not consider her to be at risk of developing arthritis in her neck or shoulder as a result of the accident, and was unlikely to require surgery on the neck or shoulder as a result.

Mr. Michael Maloney
37. The plaintiff attended for examination by Mr. Michael Maloney, Consultant Orthopaedic Surgeon, retained by the defendants on 9th July, 2015. At that stage, she reported that she had received two injections to her shoulder. She found them to be of benefit. She had some physiotherapy which provided some relief especially for her shoulder pain. The two injections had been administered on 5th February, 2015, and 18th May, 2015. She reported that she had not hurt her neck in a previous road traffic accident. Mr. Maloney specifically raised this matter with her and knew of her previous medical history when he asked the question. She indicated that she had no trouble with her neck or shoulders prior to the accident. This was incorrect because she had suffered neck and shoulder problems following the accidents in 1990 and 1998.

38. Her complaints at the time of examination were that she had constant pain in her neck and both shoulders which was aggravated by lifting anything heavy. She used a special pillow for support. She had difficulty doing her hair and problems loading the washing machine. She was limited in the distance she could walk and felt pain after a short distance. She was prescribed anti-inflammatory analgesics.

39. On examination, Mr. Maloney found that the plaintiff's neck was in normal alignment and that she used it normally in conversation. There was no spasm in her muscles. She had localised pain in both trapezius muscles. She had limited flexion of her cervical spine, up to 70%. Extension was limited to 60%. Rotation to both sides was 40%. Lateral flexion to both sides was 30%. He considered 50% to be the average for her age. He felt that her movements in conversation were better than on examination and he believed that she exhibited symptoms of lack of cooperation with him in his examination. Tone and power in the muscles were normal. She had full movements of the right shoulder. Apart from a slight restriction of internal rotation and extension in placing her hand up behind her back by 20%, she had full movements of the left shoulder.

40. Mr. Maloney was satisfied that the plaintiff had a better range of cervical movements than those demonstrated on formal examination. He concluded that she had age related degenerative change in her spine and rotator cuff of the shoulder. He also concluded that the plaintiff suffered from some spondylosis of her cervical spine and possible mild inflammatory changes in the subacrominal bursae of both shoulders. He thought this might be associated with degenerative changes in the rotator cuff mechanism. The scans of her right shoulder supported this association and in his opinion these pathologies were age related. He believed that Ms. Keane was fit for her pre-accident employment but suggested full radiological assessment by way of MRI scan of her cervical spine before permitting her to return to work.

41. Mr. Maloney further reviewed the plaintiff on 6th April, 2017. At this stage, he had the benefit of the MRI scans which had been undertaken. He noted that clinical examination at the time of his previous report suggested that she had possibly aggravated some age related cervical spondylosis. He stated that the problem with her shoulder appeared to be an aggravation of an impingement problem (tendonitis of the rotator cuff mechanism). This was confirmed by the MRI scans. The plaintiff gave him a past history of involvement in a previous road traffic accident in which it was alleged she hurt her lower back but not her neck. However, Mr. Maloney was satisfied that from the papers furnished, she had a fairly extensive history of neck problems prior to the accident. Since last seen, the plaintiff had continued under the care of Dr. Murray and had two further injections into her left shoulder. This gave her some relief for a number of days but then she went back to "square one". The plaintiff informed him that she had been advised to undergo physiotherapy and had ten sessions and found it beneficial. However, he was not clear whether this was the same physiotherapy as referred to in his previous report.

42. She complained of constant pain on the left side of her neck. This was mostly at the top of the shoulder and was aggravated by all forms of physical activity. Sometimes when moving her neck, she could hear a click. She had pain in the left shoulder and difficulty raising her arm, doing her hair and carrying out other normal functions. She took paracetamol medication, two tablets three times a day and also continued to use Difene spray.

43. Mr. Maloney again noted that the plaintiff held her neck in normal alignment and used it normally in conversation. There was no spasm of her muscles. He found all movements to her neck were limited to 30% of normal. He also found that flexion, abduction and internal rotation in extension (hand up behind her back) were each reduced to about 80% of normal. The rest of her left shoulder movements were full. There was good function in the rotator cuff mechanism. There was no muscle spasm. Flexion of her cervical spine was limited to 60% and extension to 80%. Rotation was full. Lateral flexion was 60%.

44. Mr. Maloney noted a further deterioration in the range of her cervical movements. He was satisfied that examination clearly confirmed that there was considerable "functional overlay to this limitation of movement". The plaintiff was exaggerating the restriction of her movements and was deemed to be uncooperative in his examination for that reason. However, he could not exclude the possibility of some underlying degenerative age related spondylosis. He was satisfied such pathology could certainly be a source of neck pain. 20% reduction in certain shoulder movements was consistent with the radiological MRI scans available indicating evidence of tendonitis of the rotator cuff mechanism. However, it was his opinion that this was also probably age related but could have been aggravated by the accident. There is no clinical evidence of acceleration or worsening of the pathology as a result of the accident. He also noted that the attribution of neck and shoulder problems to underlying degenerative pathology did not exclude soft tissue injury at the time of the accident.

45. It is noteworthy that there was a considerable difference in the range of movements of the plaintiff's neck as demonstrated to Mr. Maloney on 6th April, 2017 (30%) and examination by Mr. O'Farrell on 12th April, 2017, some six days later which confirmed a range of movement of 75% of normal in all directions of the cervical spine. Mr. Maloney concluded that this disparity was attributable to his observation that there was a degree of exaggeration and non-cooperation with him in his clinical examination. The court was asked to infer that she was exaggerating her symptoms at that time. Mr. Gilmore accepted that this difference was not readily explicable.

Conclusion

46. The burden of proof lies on the plaintiff in relation to establishing that she suffered personal injuries caused by this minor collision on the balance of probabilities. The plaintiff also claims significant loss of earnings arising out of the accident because she has been rendered incapable of carrying out the only type of work for which she is qualified and competent. This loss is claimed up to her likely date of retirement which is said to be the age of 68.

47. In determining the level of damages to be awarded the court has taken into account the principles and factors set out in the judgment of the Court of Appeal in *Shannon v O'Sullivan* [2016] IECA 93 and the Supreme Court in *Kearney v McQuillen* [2012] IESC 43. The court is satisfied , having considered all of the evidence in the case of the following matters:-

(a) The defendant's car collided with the rear of the plaintiff's car causing a minor impact involving limited force and very little damage to either vehicle.

(b) The plaintiff suffered pain in her left shoulder and radiating from her left shoulder into her neck for which she attended a local general practitioner initially and then Dr. Murray, her usual general practitioner thereafter. She was not hospitalised.

(c) The plaintiff returned to work for a period up to June or August 2013. She was employed as a canteen worker which involved the lifting of heavy objects and pushing heavy trolleys. She could not continue with the work because of the pain she was suffering at that time.

(d) The plaintiff received some treatment in the form of painkillers and Difene gel. She was advised to avail of physiotherapy. She could not do so initially because she could not afford it. Subsequently she undertook a course of physiotherapy involving between ten and sixteen sessions.

(e) She received two injections into her left shoulder area to relieve the symptoms in 2015 and two further injections. She has continued to take some form of medication, paracetamol or Difene gel over the subsequent years up to the time of her examination by the various experts who gave evidence in the course of trial.

(f) The plaintiff has described functional disability in ordinary daily tasks including doing her hair, changing the beds in her home, cleaning the house, taking clothes to the washing line *etc*. which suggest a level of incapacity. The court is concerned at the plaintiff's tendency to exaggerate, particularly in her dealings with Mr. Maloney in respect of the symptoms of neck pain and limited movement at the time of her presentation in April 2017 and the incorrect history of absence of neck pain which she also gave.

(g) The MRI scan of the left shoulder indicated that the plaintiff had a minor inferior joint osteophytosis with some light impingement of the superior musculotendinous junction of the supraspinatus tendon. The plaintiff had been born with a predisposition to impingement on the tendons. Minor anterior subacromial bursitis was observed. The findings were consistent with some impingement tendonitis at the site. However, there was no retraction or tear of the tendon identified. A possibility existed that the plaintiff could have had clinical but silent pre-existing impingement of her supra-spinatus tendons which was aggravated as a result of the accident of October 2012. The court is satisfied that the plaintiff was a person who was susceptible to aggravation of this condition which was rendered symptomatic at the time of the accident.

(h) The MRI of the cervical spine indicated a loss of lordosis consistent with muscle spasms. There was some minor compression of the C4, 5 and 6. Moderate degenerative change was identified with the C5/6 disc space. There was a moderate size bilateral posterior lateral degenerative uncovertebral osteophytosis projecting into the lower anterior exit foramina bilaterally. This was said to give rise to long standing predisposition to symptoms if the area suffered trauma. The presence of muscle spasm in a post traumatic setting was consistent with an underlying muscular ligament or soft tissue strain injury in the cervical spine area. The court is not satisfied that the difficulties in C4, 5, 6 can be attributed as a matter of probability to the accident. However, I am satisfied that the accident gave rise to symptoms in the neck area of which the plaintiff complained at that time and subsequently.

(i) The court is also satisfied that the underlying difficulties identified in the MRI scans and later commented upon by the medical experts must be considered in the context of the likely development of symptoms of the type complained of by the plaintiff at a later stage in life, if the accident had not intervened. This is a significant factor which was referred to by Dr. Spillane and Mr. Maloney. In addition, the court is satisfied that the plaintiff had suffered previously from similar neck symptoms. She had injured her neck following a fall in June 1990 and again following a car accident in July 1998. She had recurring neck to upper back pain up until 2009. There was therefore a significant period during which she exhibited symptoms similar to those of which she presently complains.

(j) The court is satisfied that the plaintiff suffered personal injuries as a result of the aggravation of the underlying symptomology in her left shoulder and neck. However, she was not a person who was free from difficulties in her upper back and neck in the past. The court is also satisfied that she is a person who would have likely suffered from the symptoms of which she now complains at a later stage in her life. The court accepts therefore, the conclusions reached by Dr. Spillane, that the plaintiff sustained a temporary aggravation of pre-existing degenerative changes in her cervical spine and a temporary aggravation of a rotator cuff pathology in her left shoulder. I accept his conclusion that she had recovered fully from any injury sustained in the accident having regard to the relatively low impact described. I am also satisfied to accept that the attribution of her neck and shoulder problems to underlying degenerative pathology did not exclude soft tissue injury at the time of the accident as agreed by Mr. Maloney. Therefore, I am satisfied that the symptoms of which she complained for a period following the accident up to the end of 2016, were likely caused by the collision. At that stage, Mr. Gilmore recommended that the plaintiff consult a specialist in relation to her left shoulder or perhaps a pain specialist. He later noted following his second examination that no treatment whatsoever was sought in that regard in the intervening period. It is also clear that none was recommended by her general practitioner. Most of the

medical reports may be attributed to the legal requests made for examination and reports by the respective solicitors in the case. The ongoing treatment was of a relatively low level. In addition it is clear that the plaintiff did not at any stage suffer any very acute episode of pain that resulted in a marked deterioration of her condition over this period or required further medical intervention. The symptoms were of a continuing nature with which she appeared to cope albeit they prevented her from returning to her work which involved heavy lifting.

(k) The court is, therefore, satisfied that the plaintiff is entitled to general damages for personal injuries from the date of the accident until the end of 2016. There is a difficulty in identifying the precise point at which symptoms brought on or aggravated by the accident might be considered to have abated. The plaintiff for her part says that they did not stop. I am satisfied on the balance of probability that it is reasonable to conclude that the relevant period to be attributed to accident related symptoms should extend to the end of 2016 but that such symptoms of which she continued to complain or now complains are attributable to the degeneration in her underlying physical condition to which a number of the medical witnesses referred. In reaching that conclusion I am taking into consideration the incorrect history given to r. Maloney, the clear exaggeration by the plaintiff of her symptoms to him on physical examination, the disparity in the movement restriction identified within six days of their respective examinations by Mr Maloney and Dr. O'Farrell in April 2017 and the low level of medical intervention required or sought by her. Nevertheless, I am satisfied to accept and it is reasonable to conclude that the symptoms continued but with lesser intensity towards the latter end of that period to that now described by her in evidence. The court is satisfied that the plaintiff is entitled to be compensated for what is a moderate form of neck and shoulder injury during this four year period. In those circumstances, I am satisfied that the plaintiff is entitled to general damages in the amount of €40,000 for that pain and suffering. I am not satisfied on the medical evidence or that of the plaintiff to conclude that these symptoms continued with the degree of severity suggested beyond that period or if they did, that their existence is attributable to the collision as a matter of probability. I therefore decline to make an award for pain and suffering in the future.

48. There remains the question of loss of earnings. The court has been furnished with a loss of earnings report from a firm of chartered accountants and an actuarial report concerning the loss of earnings suffered by the plaintiff as a result of her injuries. The court is not satisfied that the claim for future loss of earnings should succeed on the basis of the findings set out above. I heard evidence from Ms Annette Shannon a chartered physiotherapist concerning the plaintiff's functional capacity and received a report from Roger Leonard a vocational evaluator on this aspect of the case. However, as already stated, I am not satisfied that the evidence establishes a basis upon which to make an award for future loss of earnings. The plaintiff is entitled to an award in respect of any loss of earnings established in respect of the four year period between the date of the accident and the end of December 2016.

49. The plaintiff was employed as a canteen assistant by Campbell Catering Ltd at the time of the accident. She was obliged to take sick leave in August 2013 because of the symptoms from which she suffered as a result of the accident. She found it impossible to continue with heavy lifting duties because of the injury. Her net weekly wage was approximately €313 during this period. She was out of work for 21 weeks in 2013. I accept that it is probable that her absence from work over the subsequent three years was also caused by the injuries which I am satisfied on the evidence continued to prevent her return to work during that period. During this period she received Illness Benefit in 2013 and 2014 and for a period in 2015. Thereafter she received an Invalidity Pension in 2015 and 2016. I am satisfied that she is entitled to recover her loss of net earnings as follows:

50. August 2013 to 31st December 2013 7,014

2014 17,368
2015 17,524
2016 17,628

59,534

This sum will be reduced by the deductible state benefits received during this period for Illness Benefit up to 17th June 2015 and Invalidity Benefit for the remainder of the relevant period. The net amount awarded for loss of earnings following those deductions is €24,256. The parties are agreed that this figure is accurately calculated. A further amount of €1,924.35 for items of special damage including medication for the relevant period is also awarded. The court will make a total award of €66,180.35 and costs.