THE HIGH COURT

[2014 No. 8182 P]

BETWEEN

ATTRACTA LENNOX

PLAINTIFF

AND
CLARE O'CALLAGHEN, AOIFE COX
AND THE MOTOR INSURERS' BUREAU OF IRELAND

DEFENDANTS

JUDGMENT of Mr Justice Keane delivered on the 20th December 2018

Introduction

1. On the 20 July 2012, a motor vehicle accident occurred on the Ballinteer Road, Dublin 16, close to the entrance to the Delbrook Park housing estate. The plaintiff, Attracta Lennox, had brought the car she was driving to a halt, when a car owned by Aoife Cox, which was being driven by Clare O'Callaghan, drove into the back of Ms Lennox's car, shunting it into the vehicle in front.

2. Ms Lennox has brought an action in negligence, seeking damages for the personal injuries that she sustained in that collision, against Ms O'Callaghan, Ms Cox and the Motor Insurers Bureau of Ireland ('MIBI'). I am told that the action against the MIBI has been discontinued, so I will refer to Ms O'Callaghan and Ms Cox together as the defendants.

3. The defendants admit liability in negligence and the action was tried before me as an assessment of damages.

Ms Lennox's injuries

i. *post-accident*

4. Ms Lennox did not seek medical attention on the day of the accident. That evening she began to experience a burning pain between her shoulder blades and, over a period of time, other symptoms developed. She attended her general practitioner on 3 August 2012, complaining of pain in her shoulder, rib-cage and between her shoulder blades and was prescribed anti-inflammatory medication. About four weeks after the accident, Ms Lennox began to experience pain in her right groin, radiating into her right leg.

5. Ms Lennox's GP referred her for an MRI scan of the lumbar spine and right hip, which was performed on 24 September 2012 at a clinic in Santry, Dublin, under the supervision of Dr Brian Hogan, a consultant radiologist. It showed evidence of a small annular disc tear and a small broad-based left posterolateral disc protrusion at the L5/S1 vertebrae in the spinal column, as well as multilevel minor disc degeneration, which was not perhaps unusual in a spine that was five decades old.

6. The plaintiff was examined by William Gaine, consultant orthopaedic surgeon, in his rooms in Sligo on 13 December 2012. Mr Gaine's various reports were admitted into evidence. He found her lumbar spine showed tenderness over the right sacroiliac joint, having noted that she had sustained soft tissue injuries to her neck and upper back, lower back and right shoulder, and an injury to her right hip. Mr Gaine noted that Ms Lennox gave a history of intermittent mild back problems in the past, but linked her sacroiliac tenderness to contusion in the accident. In evidence, Ms Lennox denied that she had given a history of anything beyond occasional back stiffness in the morning prior to the accident.

7. Ms Lennox was seen by Mr Gaine again on 22 April 2013, approximately nine months after the accident, having had six sessions of physiotherapy in the interim. He noted that she was still getting discomfort in her right buttock region that had got worse since January of that year. While generally mild, it was exacerbated by any physical activity, prolonged sitting and driving. She had recently received a sacroiliac joint cortisone injection but was still tender in the sacroiliac joint region.

8. Mr Gaines again examined Ms Lennox in October 2013. He recorded her as having had a good reaction to the sacroiliac joint injection she had received five months previously, though he found that she was still somewhat tender in the lower right lumbar and sacroiliac region. At that point, Mr Gaines expected Ms Lennox's symptoms to resolve within a further six to ten months, subject to the risk of relapse and the need for further physiotherapy or a repeat injection as may be required.

9. In 2014, Ms Lennox was referred to Dr Joseph Fitzgerald, a consultant pain specialist, at the Hermitage Medical Clinic, Lucan, County Dublin, who first saw her on 22 April 2014. Dr Fitzgerald's various reports were also admitted into evidence. Dr Fitzgerald concluded that she had facet and sacroiliac joint irritation and arranged for her to be admitted to the Hermitage Clinic for facet injections that were administered on 29 April 2014. Ms Lennox returned to Dr Fitzgerald on 30 May 2014 when her main complaint was a deep-seated buttock pain on the right hand side.

10. In August 2014, Dr Fitzgerald's opinion was that the low back pain and cervical pain that Ms Lennox had developed after the accident was consistent with a sacroiliac joint and soft tissue injury, which had responded to injections. Dr Fitzgerald noted the minor disc degeneration seen on the MRI scan but did not believe that it was the cause of her pain at that time. The prognosis was good and any future chronic symptoms could be managed with an exercise programme, physical conditioning and weight management. Injection treatments under radiological guidance might be helpful in providing some temporary, though not full permanent, relief. There would be some ongoing pain, which may not settle fully and which may necessitate some modification to Ms Lennox's work and leisure activities. Dr Fitzgerald did not expect Ms Lennox's symptoms to deteriorate further.

11. Under cross-examination, Ms Lennox acknowledged that she returned to golf after the accident and, indeed, succeeded in reducing her handicap from one of 26 in June 2011 to one of 23 by July 2015.

ii. *a serious turn for the worse*

12. Dr Fitzgerald produced a further report on 11 December 2017. In it, he notes that, in the intervening period, Ms Lennox developed a new onset of left sided leg pain in October 2015, which was independent of her lower back pain. Her symptoms quickly became worse. Dr Fitzgerald arranged for an MRI scan of her lumbar spine in November 2015, That scan confirmed a new onset disc lesion on the opposite side of the L5/S1 vertebrae to that disclosed by the earlier scan in September 2012.

13. Dr Fitzgerald performed a nerve root injection on Ms Lennox on 4 December 2015. In her evidence, Ms Lennox said that she found that procedure excruciatingly painful.

14. Dr Fitzgerald referred Ms Lennox to Donncha O'Brien, consultant neurosurgeon, for a surgical assessment because of the severity of her symptoms. Ms Lennox underwent a discectomy – the surgical removal of the whole or a part of an intervertebral disc - in January 2016. While she seemed to do well initially, she later suffered a recurrence of her symptoms. A subsequent MRI scan showed scarring along the nerve. Ms Lennox received further injections on 13 August 2016 but did not obtain any sustained relief.

15. In September 2016, Ms Lennox underwent lumbar nerve decompression surgery. Although, once again, she seemed to do well initially, follow-up imaging again confirmed scar tissue with a possible further recurrent disc prolapse, necessitating further surgical intervention when things did not improve.

16. Dr Fitzgerald saw Ms Lennox again in August 2017 when she reported that, while her leg pain had ameliorated on the left-hand side, she was experiencing residual back pain. Dr Fitzgerald arranged for further cortisone injections to be administered on 11 August 2017.

17. Ms Lennox returned to Dr Fitzgerald for a further assessment on 13 October 2017, by which time she was complaining of severe bilateral back pain at the level of the surgery that was axial in nature, which is to say that it was exacerbated by certain movements or postures. Dr Fitzgerald prescribed certain medications for Ms Lennox (including amitryptylene 25mgs) and discussed a facet joint rhizotomy with her. A facet joint rhizotomy, as I understand it, is a surgical procedure to sever or disable the root of the sensory nerve at the facet joint, to relieve chronic pain emanating from it. The procedure was performed on Ms Lennox's right side, her worst side, on 3 November 2017.

18. In his December 2017 report, Dr Fitzgerald noted that Ms Lennox had presented initially with low back pain following the accident and, after a time, had developed left-sided radiculopathy (meaning, a trapped or pinched nerve) secondary to disc prolapse, leaving her with mechanical back pain at the level of the back surgery she later underwent, together with some low grade sciatica (*i.e*. pain caused by irritation to the sciatic nerve, which runs from nerve roots in the lower part of the spinal cord through the buttock area into the lower limbs), related to the residual scarring. I gather that a disc prolapse is a spinal disc herniation, often referred to in layman's terms as a slipped disc, whereby a tear or fissure in the outer, fibrous ring of an intervertebral disc allows some of the softer material in the central portion of the disc to bulge out beyond the damaged outer rings.

19. Dr Fitzgerald concluded that Ms Lennox would need ongoing medication for some time and that there was unlikely to be a complete surgical solution for her symptoms. Surgical lumbar spinal fusion surgery would probably help her back pain but would do less for her leg pain. Spinal cord stimulation may be effective as a rescue therapy but would not give complete relief of symptoms and would most likely do more for her leg pain than her back pain. In either event, it was likely that she would be left with some with some chronic pain that will not disappear.

20. Donncha O'Brien, consultant neurosurgeon, gave evidence on behalf of the plaintiff. He first saw Ms Lennox on 23 December 2015, at the request of Dr Fitzgerald. Physical examination revealed stiffness of Ms Lennox's lumbar spine in flexion and extension. Mr O'Brien reviewed the set of MRI scans done on 18 November 2015 which showed a large left L5/S1 disc prolapse with some compression of the nerve root, and concluded that Ms Lennox needed a left L5/S1 microdiscectomy. Mr O'Brien carried out that surgery on 21 January 2016 and it went well.

21. Mr O'Brien followed up with Ms Lennox in March 2016, finding the leg pain caused by her sciatica had resolved. She was following a physiotherapy and rehabilitation programme that was working quite well.

22. Unfortunately, in July 2016, Ms Lennox experienced a recurrence of symptoms of low back, and left-sided leg, pain, which was quite severe. Follow-up imaging revealed some scar tissue around the left S1 nerve root. Mr O'Brien initially treated the problem conservatively with medication and other non-surgical treatments. Dr Fitzgerald did another left S1 nerve root block but the pain continued.

23. On the basis of Ms Lennox's severe discomfort, Mr O'Brien operated again in September 2016, performing a left S1 nerve root decompression. On follow-up in November 2016, Ms Lennox was doing extremely well with almost complete resolution of her sciatica.

24. In a report of New Year's Eve 2016, Mr O'Brien expressed the following opinion:

> 'Ms Lennox's symptoms date back to the road traffic accident of 2012. She had no back symptoms or difficulties prior to that. It is clear to me that she injured her back in the accident. This caused damage to the L5/S1 disc which initially resulted in pressure on the right S1 nerve root but unfortunately this changed to severe pressure on the left S1 nerve root over time (which can occur and is not unusual). Ms Lennox required operative intervention in order to alleviate her symptoms. It is clear to me that the accident is responsible for this and her pain and discomfort.
>
> At this stage Ms Lennox has had two surgeries on her back. The process of driving on a long commute to work would not be in her best interest and in fact a long journey to work would cause a recurrence of her symptoms. I would suggest she continue to work on at home and I have advised her on this.'

25. In a second report, dated 31 July 2017, Mr O'Brien recorded that, towards the end of 2016, Ms Lennox's symptoms deteriorated again. MRI imaging showed a large recurrent disc prolapse and she underwent a third operation on her L5/S1 disc. Ms Lennox did reasonably well for a short period but then developed another disc prolapse, at the same level, some weeks later, necessitating a fourth operation, which was carried out on 14 April 2017. When examined on 21 June 2017, Ms Lennox's leg pain had resolved. In that report, Mr O'Brien gave this opinion:

> 'Ms Lennox has had a terrible time over the last 2-3 years with severe, unrelenting recurring back pain which resulted in a total of 4 operations to rid her of this affliction. She had no back or leg symptoms prior to the accident. Whilst it is true to say she developed right-sided leg pain afterwards and subsequently developed predominantly left-sided leg pain it is the same disc which produces the left and right leg pain in this case. The disc prolapse at L5/S1 initially protruded more to the right and subsequently protruded to the left. In essence it is the same disc that was injured in consequence of the accident (L5/S1).
>
> The accident produced a whole series of events which impacted seriously on Ms Lennox in terms of the need for medical treatment, operations *etc*. Though she is well on the way to recovery she does work a number of miles from her home commuting over long distances to the Dublin area and I cannot see that continuing on a long term basis. I think she will have to restrict her work practices or seek alternative employment as a consequence. The negative aspects of the injury she sustained in the road traffic accident are pain and suffering requiring four operations. It has had a negative effect on

her ability to work during this time and will do so in the future.'

26. On 16 October 2017, Dr Fitzgerald wrote to Mr O'Brien concerning Ms Lennox. Dr Fitzgerald reported that her leg pain had diminished and that her main problem was with her lower back, mostly the right-hand side. Dr Fitzgerald had injected it recently and Ms Lennox had got some relief. Dr Fitzgerald expressed the view that Ms Lennox's symptoms at that time were from her facet joints.

The issues between the parties on the assessment

27. The principal issue between the parties is whether the symptoms that Ms Lennox began to experience in October 2015 and the disc prolapse subsequently identified in November 2015 as the cause of that pain, result from the trauma that she suffered in the accident or from continuing degenerative changes in her lumbar spine entirely unrelated to that trauma.

28. Two other issues were addressed in evidence and argument. The first of those concerns the appropriate basis for the calculation of the loss of earnings claimed by Ms Lennox. The second comprises a miscellany of arguments about various items claimed as special damages. I will endeavour to deal with each of those issues in turn.

i. *the conflicting views of the medical experts*

29. Martin Walsh, a consultant orthopaedic surgeon, was called as an independent expert witness by the defendants. Amongst other material, Mr Walsh had reviewed MRI scans, and radiology reports of studies of the lumbar spine of Ms Lennox dated 23 September 2012, 18 November 2015, and 6 July 2016, together with a report of 11 January 2017 on a more recent study of the lumbar spine.

30. Mr Walsh examined Ms Lennox on 12 October 2017. Ms Lennox provided Mr Walsh with a history broadly consistent with that already described. However, some aspects of that history are of note.

31. Ms Lennox told Mr Walsh that, in the immediate aftermath of the accident, she experienced pain in what he identified as the mid-thoracic region of her back, which, within a week began to extend towards her right lower lumbar/gluteal area with some radiation toward her right groin as well as the posterior aspect of her right thigh.

32. According to Mr Walsh, the September 2012 MRI scan reveals evidence of degenerative changes throughout the lumbar spine in particular at the L1/2 and, to a slightly lesser degree, L5/S1 level. At L5/S1, there was evidence of a small annular tear coupled with a mild central disc bulge which was deviating forwards to the left-hand side but not causing any nerve root compression.

33. Ms Lennox informed Mr Walsh that her back and right gluteal pain persisted and that, in October 2015, she experienced the onset of severe pain in her lower back and left leg which was of a completely different nature to what she had experienced following the accident.

34. Ms Lennox informed Mr Walsh that she had no problems with her back prior to the accident but Mr Walsh noted that the particulars of personal injury provided by her legal representatives on her behalf stated that she had experienced intermittent mild episodes of back pain in the past.

35. At the conclusion of his report on that examination, Mr Walsh expressed the following opinion:

> 'As a result of her accident on 20 July 2012, I believe that Ms Lennox experienced a flexion come extension stress to her cervical, mid-thoracic and to a greater degree her lower lumbar spine with pain primarily localised to the right L5/ S1 facet joint/right sacroiliac joint area.
>
> She subsequently made a good recovery from her neck and shoulder girdle problems but continued to experience significant difficulties in relation to her right lower/lumbar/right sacroiliac joint areas in spite of various treatments as outlined above.
>
> Problems involving the sacroiliac joint are notoriously difficult to resolve and I believe that the problems which she currently encounters in this area are in keeping with the trauma sustained. Hopefully, there will be some decrease in the intensity and frequency of the pain which she encounters in this area with ongoing swimming/mobilisation exercises over the next six/twelve months.
>
> I would see no role for repetitive injective therapies in the management of these complaints and furthermore, I am optimistic that she should also be in a position to gradually decrease her attendance with physiotherapy over the above time-span.
>
> Bearing in mind that the vast majority of disc prolapses occur without any history of trauma I believe that Ms Lennox's previously degenerative but asymptomatic L5/S1 disc became a source of complaint for reasons unrelated to her trauma in October 2015.
>
> Unfortunately, she has experienced considerable post-operative difficulties which fortunately would appear to be improving following her most recent surgical intervention in April 2017….
>
> At the present time, Ms Lennox has genuine disability in her lumbar spine which in part is related to her recent disc prolapse at the L5/S1 level which as stated above in my opinion is not attributable to the trauma of [the accident]. Irrespective of her symptomatic disc prolapse, I believe that as a consequence of the trauma of [the accident] that she more than likely would continue to experience some difficulties following prolonged periods of sitting and travel and that she would require intermittent use of analgesics/anti-inflammatory agents for relief. Furthermore, I would also recommend that she continue with a programme of mobilisation exercise for her lumbar spine/sacroiliac joint in tandem with regular swimming in an effort to reduce her level of complaint in this area.'

36. The defendants called Christopher Pidgeon, a consultant neurosurgeon, as an independent expert witness. Mr Pidgeon examined Ms Lennox on 8 August 2018, having had sight of her general practitioner's notes and of the various medical reports generated up to that point. In a report of the same date, Mr Pidgeon expressed the following opinion. Ms Lennox first presented after the accident as someone with a sacroiliac strain. Such strains are slow to heal and some lead to a complaint of chronic pain. The treatment is usually steroid injections to the area and physiotherapy. If two to three injections do not produce relief, further injections rarely do so. According to Mr Pidgeon's understanding that Ms Lennox's symptomatic disc herniation occurred in October 2015, that event was sufficiently remote from the accident that, in his opinion, the accident was not a cause of the disc herniation. After a number of

operations, the disc symptoms had largely resolved, leaving Ms Lennox with an ongoing sacroiliac strain. Treatment options for sacroiliac strains were undergoing trials with good results, which should lead to better treatment options becoming available in the medium term. Mr Pidgeon considered Ms Lennox fit for light work, but not for work involving heavy lifting or prolonged stooping or bending.

37. John O'Dwyer, a consultant neuroradiologist, was also called as an independent expert witness by the defendants. Dr O'Dwyer had considered the relevant medical records and, in particular, had conducted a review of the imaging of Ms Lennox's lumbar spine, before expressing the following opinion:

> 'The MRI scan of 23 September 2012 approximately two months following the accident showed a left sided disc bulge at L5/S1 on a background of degenerative change.
>
> There is further degenerative change throughout the lumbar spine.
>
> This degenerative change would have predated the accident.
>
> There was no cause for right-sided sciatica evident and I note that there was no complaint of left sciatica at this time.
>
> I could see no changes on this MRI scan attributable to the accident of 20 July 2012.
>
> I note onset of left sciatic pain in October 2015, MRI examination of 18 November 2015 showed a significant disc protrusion on the left side at L5/S1 compressing the left S1 nerve root.
>
> Following a number of surgical examinations, there was evidence of residual and recurrent disc protrusion and scar tissue with last MRI examination of 21 February 2018 showing a small residual or recurrent disc protrusion and some scar tissue at L5/S1 on the left and progression of degenerative change.
>
> Degenerative change at apophyseal joints at L4/5 is also evident on the scan of 23 September 2012 and would have predated the accident.
>
> On imaging criteria, it is difficult to attribute the disc protrusion demonstrated on 18 November 2015 to the accident of 20 July 2012.'

38. In his evidence to the court, Mr O'Brien said that the September 2012 MRI scan, which he had only recently had an opportunity to examine, provides support for his view that the accident damaged Ms Lennox's L5/S1 disc because it shows the presence of an annular tear there. The *annulus fibrosus* is the outer fibrous ring that forms part of each intervertebral disc, protecting the softer gel-like material at the centre. Mr O'Brien expressed the view that the trauma of the accident is the most likely cause of that annular tear, which in turn is the most likely cause of the substantial disc prolapse which was evident in the results of the next MRI scan of Ms Lennox's lumbar spine in November 2015. That disc prolapse was undoubtedly the cause of the new onset of left-leg pain that Ms Lennox experienced in October 2015.

39. However, the defendant's expert witnesses trenchantly disagreed with Mr O'Brien's view. Mr Walsh testified that the etiology (or cause) of an annular tear or fissure is almost invariably degenerative change and very rarely trauma. Moreover, in the rare instances where trauma causes an annular tear, the relevant stress is one of rotation, not flexion and extension - the type of stress to which Ms Lennox's back was subjected in the accident. In most instances, an annular tear or fissure is asymptomatic; over 60% of persons over fifty will have an area of disc where one is present. In summary, Mr Walsh said that while it was theoretically possible that the annular tear concerned was caused by the accident, it was 'more than probable' that it was already there when the accident occurred, due to degenerative change.

40. In addressing the point, Mr O'Dwyer testified that he could see no evidence of traumatic, as opposed to degenerative, change in the MRI scan of Ms Lennox's lumbar spine taken in September 2012.

41. Mr Pidgeon gave evidence that, in his view, there were a number of problems with Mr O'Brien's thesis that the accident caused the annular tear on Ms Lennox's L5/S1 disc, which led to the disc herniation that subsequently occurred there. The first is that the term 'annular tear' represents a known problem of nomenclature. 5% of teenagers and 50% of middle-aged persons have an annular tear. Mr Pidgeon pointed to the following extract from an article in the November 2014 issue of *The Spine Journal*, the official journal of the North American Spine Society, that dealt with issues of nomenclature concerning fissures of the annulus:

> 'As far back as the 1995 [North American Spine Society] document, authors have recommended that such lesions be termed fissures rather than tears, primarily out of concern that the word "tear" could be misconstrued as implying a traumatic etiology. Because of potential misunderstanding of the term "annular tear" and consequent presumption that the finding of an annular fissure indicates that there has been an injury, the term "annular tear" should be considered nonstandard and "annular fissure" be the preferred term. Imaging observation of an annular fissure does not imply an injury or related symptoms but simply defines the morphologic change in the annulus.'

42. Mr Pidgeon expressed the view that a massive trauma would be required to cause an annular tear in the true sense, suggesting - when pressed for an example - one such as involvement in a car crash at 80 mph while not wearing a seatbelt. Annular fissures, such as the one evident on Ms Lennox's L5/S1 disc in the September 2012 scan, are the result of change caused by ordinary wear and tear.

ii. *conclusion on the causation of L5/S1 disc prolapse*

43. The plaintiff bears the burden of proving every aspect of her claim to the applicable standard of proof, which is that of the balance of probabilities. Weighing the evidence as carefully as I can, I conclude that the cause of the significant disc prolapse that was the source of the new onset of left sided leg pain that Ms Lennox first experienced in October 2015 was not the accident in July 2012 but, rather, ongoing degenerative change that was neither triggered nor exacerbated by that accident.

44. I have reached that conclusion by reference to the preponderance of the expert evidence. One can only sympathise with Ms Lennox in having to endure the ongoing pain and discomfort associated with both the sacroiliac strain caused by the accident in July 2012 and the slipped disc caused by degenerative changes to her back that became manifest in October 2015. But I would be succumbing to a logical fallacy if I were to conclude that correlation implies causation.

45. Moreover, the law is clear. The defendants are liable to compensate Ms Lennox for the injury, loss and damage caused by their negligent conduct and no more. Further, as O'Neill J observed in *R.L. v Minister for Health* [2001] 1 IR 744 at 755, approving the decision of the United Kingdom House of Lords in *Jobling v Associated Dairies Ltd* [1982] A.C. 794 and applying that of the Supreme Court in *Reddy v Bates* [1983] IR 141, it is a well-settled principle that the occurrence of natural illness is one of the vicissitudes of life that a court must have regard to in the assessment of future damages.

46. Mary McGuire, a consultant psychiatrist, was called as an independent expert witness on behalf of Ms Lennox. Dr McGuire concluded that because of the necessity of various medications, surgical procedures and ongoing pain, Ms Lennox has developed a psychiatric disorder, specifically 'adjustment disorder with depressed mood.' However, as Dr McGuire acknowledged in her report and in her evidence, the serious deterioration in Ms Lennox's mood began in October 2015 when she developed severe pain from her slipped disc. Accordingly, I cannot be satisfied that Ms Lennox suffered any psychiatric injury as a result of the accident in July 2012.

iii. *loss of earnings*

47. There was a conflict of evidence on the calculation of the loss of earnings caused by the accident both to date and into the future.

48. Ms Lennox has been variously described as a bookkeeper and as an accounting technician. At the time of the accident, she was working from home, both in part-time employment with a firm in Roscommon and as a self-employed person. After the accident, she began to work two days a week for a firm in Dublin, from which she went on sick leave in 2014 before resigning in 2017.

49. Brendan Lynch, a consulting actuary, was called as an independent expert witness by Ms Lennox. He estimated Ms Lennox's loss of earnings as of 7 December 2017 in the sum of €58,000, increasing to €68,000 if interest was added at the rate set under the Courts Acts. That calculation was done in the following way. Ms Lennox's average income for each of the five years between 2007 and 2011, inclusive, was €37,640. The assumption was implicitly made that Ms Lennox would have continued to earn an income in accordance with that average but for the accident. Thus, Mr Lynch subtracted the income that Ms Lennox actually earned in each of the years following the accident from that average figure to arrive at a figure for lost income for each year. Mr Lynch stated in evidence that he selected the average annual income earned by Ms Lennox over the five year period prior to the accident as the basis for his calculations as that seemed to be the fairest thing to do. Of course, the elephant in the room in that regard is the 2008 financial crisis and the consequences that it had both for incomes generally and, presumably, for Ms Lennox's income over succeeding years.

50. Maura Carter, a consulting actuary, and Liam Grant, a forensic accountant, were called as independent expert witnesses by the defendants. Mr Grant reviewed the past and future loss of earnings claims advanced on behalf of Ms Lennox. He pointed out that her income (in common with that of almost everyone else in the State, it could have been added) had been declining steadily over the five years between 2007 and 2011 – from a figure of €45,135 in 2007 to one of €24,575 in 2011. Thus, the assumption that, but for the accident, Ms Lennox would have earned in each of the years after 2012 an income comparable to an average annual income calculated in significant part by reference to a period of unprecedented economic prosperity then over is plainly a false or distorting one.

51. To bolster that view, Mr Grant pointed to the fact that Ms Lennox's net income over each of the years 2011 to 2014 was broadly consistent: being €24,575 in 2011; €22,286 in 2012; €23,887 in 2013; and €24,304 in 2014.

iv. *conclusion on loss of earnings*

52. The logic of Mr Grant's analysis is compelling with the result that Ms Lennox has failed to persuade me, on the balance of probabilities, that she has suffered any loss of earnings as a result of the accident.

53. In considering future loss of earnings, the same logic applies. Moreover, I must have regard to the findings I have made that the defendants are not liable for any accomplished or future loss of earnings attributable to Ms Lennox's slipped disc and the degenerative changes in her back.

54. For those reasons, I conclude that the defendants are not liable to Ms Lennox for any loss of earnings.

v. *special damages*

55. The defendants raised objection to a number of elements of Ms Lennox's special damages claim.

56. In view of my finding that the defendants are not liable for the disc herniation that afflicted Ms Lennox in October 2015 or for the disc degeneration to which her lumbar spine is subject, the schedule of special damages will have to be significantly amended to exclude items associated with the diagnosis and treatment of those medical problems and with their consequences.

57. Ms Lennox acknowledged in her evidence that she had calculated figures for her husband's loss of earnings, while looking after her, without reference to his actual income as disclosed by his income tax returns, and accepted that those figures would have to be revised accordingly.

58. The defendants challenged the calculation of mileage expenses on behalf of Ms Lennox at (what was represented as) the civil service rate of €1 per mile. While I think that objection is well taken, no alternative rate was proposed and, for that reason and that reason alone, in all of the circumstances of the present case I propose to allow the relevant mileage expenses at that rate.

59. It will be necessary for the schedule of special damages to be amended in light of the findings I have made before the appropriate award can be finalised. In the first instance, the parties should seek to reach agreement in that regard.

Assessment of damages

60. Ms Lennox had just turned fifty at the time of the accident and was then divorced with three children. Happily, she remarried in 2014.

61. By reference to the findings I have made, a useful starting point in the assessment of general damages is Dr Fitzgerald's opinion, shared by the majority of the other medical experts whose evidence is before the court, that the low back pain and cervical pain that Ms Lennox had developed after the accident was consistent with a sacroiliac joint and soft tissue injury, which had responded to injections. The prognosis was then good and there was an expectation that any future chronic symptoms could be managed with an

exercise programme, physical conditioning and weight management. Injection treatments under radiological guidance might help in providing some temporary, though not full permanent, relief. There would be some ongoing pain, which may not settle fully and which may necessitate some modification to Ms Lennox's work and leisure activities.

62. The evidence of Ms Lennox is that she has continued to suffer ongoing pain and discomfort associated with the injury that she suffered in July 2012, quite distinct from that associated with the disc herniation that became symptomatic in October 2015. For example, upon examination by Mr Pidgeon in August 2018, Ms Lennox was still exhibiting marked right sacroiliac joint tenderness. That suggests to me that, quite apart from the other issues with her back, Ms Lennox would have suffered some loss of opportunity into the future associated with the necessary modifications to her work activities.

63. I share the view, expressed by McGovern J in *Murphy v County Galway Motor Club* [2011] IEHC 135, that the Personal Injuries Assessment Board ('PIAB') *Book of Quantum* is 'a useful guide but no more than that as each individual case must be assessed on its own merits.' Nonetheless, in accordance with the requirements of s. 22 of the Civil Liability and Courts Act 2004, I have had regard to it.

64. In general damages, to compensate Ms Lennox for her non-pecuniary losses, to include pain and suffering to date and into the future, I award the sum of €57,500.