DCPI 1707/2005

IN THE DISTRICT COURT OF THE

HONG KONG SPECIAL ADMINISTRATIVE REGION

PERSONAL INJURIES ACTION NO. 1707 OF 2005

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BETWEEN

FU CHEUNG CHUN TOM (an infant)

suing by his mother & next friend,

WONG LAI NGA Plaintiff

and

MTR CORPORATION LIMITED Defendant

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Coram: His Hon Judge Leung in court

Date of hearing: 24-26 September; 17 October; 4 November 2008

Date of judgment: 6 March 2009

**JUDGMENT**

1. The family of Tom (the Plaintiff) live in Tsuen Wan. In the afternoon of 29 May 2005, then 8-year-old Tom together with his mother, Madam Wong, and his 16-year-old sister took the train from MTR (the Defendant)’s Tsuen Wan Station for their destination Causeway Bay. They arrived at the Admiralty Interchange Station. They got off the train and walked to the opposite platform for the Island Line towards Chai Wan. At that moment, the train bound for Chai Wan was already at the platform. The platform screen doors and train doors were open. In the course of boarding the train, part of Tom’s body was nipped by the closing train doors and/or the platform screen doors.
2. By his mother, Tom now claims damages for his injuries. Both liability and quantum are in dispute.
3. On Tom’s side, the mother was the only witness as to fact. During the trial, I had no chance of hearing or seeing Tom who is now 11 years old. MTR called Lau, the operator of the train in question, as witness.

**THE ACCIDENT**

1. According to the mother’s statement, she had to walk with a cane. The government medical report produced recorded that the mother injured her left toe in an industrial accident in 1998 and then her left foot in a traffic accident in 2004. She stated that Tom was nipped between the train doors and the platform screen doors. His back and half a leg were outside the train. Several passengers on board and on the platform helped to force the screen doors and the train doors open to release Tom into the train compartment. Tom had bruises on his back and leg. Tom cried non-stop.
2. Upon their arrival at Causeway Bay Station, the mother requested assistance from the concourse staff and reported the accident. The mother claimed to have a medical appointment at 5:30 pm that afternoon. The station staff allegedly advised her to leave first and to return later when the staff would summon the ambulance to send Tom to the hospital. An hour and a half later, they returned to the Causeway Bay Station. Tom was sent to the hospital by ambulance afterwards.
3. In her supplemental statement which was dated 2 months after her first one, the mother added, among other things, that the three of them did not rush to board the train and that Tom was nipped for 10 seconds before the passengers came to assist.
4. Lau admitted that he was not aware of the accident until his superior informed him when he was off duty that night. Lau recalled nothing unusual during his shift that day except that before he left the Admiralty Station at about the time of the accident, he did observe from the information system on his control panel that the doors of the second compartment were not completely closed. Details of this system will be explained below. He immediately responded by pressing the open-door button but at the very moment, the system indicated that the doors were clear of whatever that might have caused the incomplete closure. Lau then thought this might be one of those incidents of belongings of passengers getting nipped by the doors. He then started the train.
5. The station platform CCTV system captured the part of the platform outside the front of the train including the 2nd compartment at the moment of the accident. It somehow captured how the accident happened. I say ‘somehow’ because when viewing the recording, one would see that the images recorded proceed in the manner of frame by frame at an interval of 1 to 2 seconds. In court, the recording was played and the crucial part studied in detail frame by frame. Ms Tsang for MTR prepared a helpful and, in my view, accurate summary of these frames of images captured by the CCTV system. I find these to be the facts:

16:18 – 16:21 1st batch of passengers were waiting on the platform.

16:21:23 – 16:21:35 1st batch of passengers were boarding the train.

16:21:35 Platform was clear. Screen door light was still on.

16:22:12 – 16:22:32 2nd batch of passengers appeared and were boarding the train.

16:22:32 Platform was clear. Screen door light was still on.

16:22:36 Tom, his sister and the mother appeared, walking forward facing the front. The train was on their right.

16:22:38 The 3 of them were still walking forward facing the front.

16:22:39 The 3 of them turned to face the train and started boarding.

16:22:41 The mother was not seen. Tom and sister were boarding. But the other passengers were walking forward without any indication of intention to board the train.

16:22:43 Lower part of Tom’s leg was seen outside the screen doors. A few passengers appeared to be looking towards the train.

16:22:44 A very small part of Tom’s leg was seen outside the screen doors. A few passengers appeared to be looking towards the train. The screen door light was still on.

16:22:46 Tom’s leg was not seen. No passenger looked towards the train.

16:22:51 Screen door light was out.

1. Contrary to the mother’s evidence that Tom was nipped for 10 seconds before the other passengers came to help, the actual nipping happened and lasted as a matter of at most 3 seconds. While it could not be seen from the recording whether any passenger on board came to help as the mother said, clearly none of the passengers on the platform at the moment came to help as she alleged.
2. Contrary to the mother’s evidence that the Causeway Bay Station staff advised her to leave first and to return to them later, MTR’s Undesired Event Report on the date of the accident recorded that it was the concourse staff that offered to call for the ambulance but the mother refused and left the station. This was actually in line with her pleaded case. Yet, the mother said in court that this part of her pleading was incorrect.
3. Further, the investigation by the solicitors for MTR revealed that the clinic of the doctor that the mother allegedly visited that afternoon was actually not open for consultation in Sunday afternoon. According to MTR’s report mentioned above, when the mother returned with the children at about 7:00 pm, she claimed that Tom was shivering at SOGO Department Store. Upon her request, ambulance was summoned. Reference was also made to the information Tom gave to Dr Lo, the psychiatrist engaged on behalf of MTR, when the doctor interviewed Tom alone subsequently. According to Tom, they left Causeway Bay Station to shop at the SOGO Department Store that afternoon.
4. I find what the mother said about her medical appointment in that afternoon and what happened in the clinic is incredible. Notwithstanding the mother’s denial, Ms To for Tom did not maintain this part of the mother’s evidence in her submission.
5. The point is really this: If the mother considered it fit to continue their journey after the incident, whether to go shopping or not, this reinforces that Tom’s *physical* condition after the incident at least did not appear to be so serious as to warrant immediate medical care. Indeed according to the medical report of the hospital, only mild redness was found at the back of Tom’s left shoulder upon admission. Even assuming that the screen doors might have also nipped Tom’s leg, the fact was that nothing was mentioned in the medical report about his leg.
6. Seeing the mother give evidence and testing such evidence against the other evidence mentioned above, I find the mother had a tendency to exaggerate both the occurrence and the seriousness of the accident. I find that this incident of Tom being nipped by the train doors happened and lasted as a matter of a few seconds.

**WHETHER THE ACCIDENT WAS CAUSED BY MTR’S BREACH**

1. The causes of action pleaded were essentially negligence and occupier’s liability. But the particulars of breach, in my view, were pleaded in a prolix manner. Upon my pointing that out, Ms To sensibly reduced them substantially. On the evidence, Ms To abandoned a few more allegations during submissions. Both counsel agreed that the remaining allegations boil down to the following issues:
   1. Whether Tom had been warned of the closing of the doors by the announcement and beeping alarm.
   2. If yes, whether such warning was sufficient.
   3. Whether there was any other omission or wrong on the part of MTR that would in the circumstances amount to breach.
   4. Whether the door control system was safe.

**Warning**

1. The major dispute is whether there was the announcement warning the passengers to keep clear of the doors and the beeping alarm before the doors closed. This is a question of fact.

*The mother’s evidence*

1. In her first statement, the mother stated that when their train from Tsuen Wan arrived at the Admiralty Station, there happened to be a train at the opposite platform on the Hong Kong line. The impression she gave was that from that moment up to the accident, there was no warning announcement or beeping alarm. In her supplemental statement, the mother stated “以我所知” (meaning as far as she knew), they did not hear any beeping alarm. This sounds as if she was not certain whether she actually heard it or not. There was also no mention of whether she heard any warning announcement.
2. Towards the end of her evidence, she explained that these were her solicitors’ choice of words, not hers. She also suggested that her solicitors have cut down her original more lengthy statement. In my view, making the statement more concise and succinct hardly explains the alleged editing of relevant evidence the way the mother suggested.
3. In court, the mother at one stage even suggested that there was a light on top of the platform screen doors that should flash when the beeping alarm was on. Clearly there is only the Outside Door Indicator on top of the screen doors. There is no such thing as a flashing light.

*Lau’s evidence*

1. By the time of the accident, Lau has been a MTR train operator for 21 years. He explained the operation of the train doors in his statement. He also did so in court with reference to the photographs depicting the interior and the control panel of the operator’s compartment at the front of the train.
2. According to Lau, the train is installed with an Automatic Train Door Control System. Upon the train’s arrival at the platform, all the train doors will open and remain so for a preset duration before they close automatically. However the circumstances prevailing on the platform may require the train operator to prolong the waiting time to accommodate the passengers. In that case, the operator may have to change the operation mode from automatic to manual.
3. On the day in question, when Lau’s train was arriving at the platform of the Admiralty Station, there was already a batch of passengers on the platform waiting to board his train. When the passengers started to board his train, Lau observed that the Train Approach Indicator on his control panel was on. This indicated that another train along the Tsuen Wan Line was arriving at the opposite platform. This was the train from which Tom and his family came. Since this is the interchange station, Lau followed the company’s standing instruction and waited to receive those passengers who would be changing for his train.
4. Lau therefore changed the mode of operation from automatic to manual so as to keep the doors open for this other batch of incoming passengers. To make room for them, Lau also pressed the button for the announcement of “請勿站近車門通道” reminding passengers already on board to stand away from the train doors.
5. Inside the control compartment, there is a CCTV system showing the platform outside the 40 platform screen doors. Having stopped at the platform for over 80 seconds, Lau observed from the CCTV system that most of the passengers on the platform have boarded his train while some were apparently prepared to wait for the next train. He prepared to depart. He pressed the button for the announcement of “請勿靠近車門” reminding passengers to keep clear of the train doors. The beeping alarm followed. Lau then pressed the close-door button. The platform screen doors have been preset to close too when the train doors close.

*Discussion*

1. Ms To suggested that in fact Lau forgot to press the button for the announcement and beeping alarm before pressing the closing door button. The reason was that he did not habitually operate the train on manual mode. It was also his first trip of the day and therefore he had yet to adjust himself to the change of operation mode.
2. However, at the material time, after observing the situation of the platform, Lau followed the protocol and consciously changed the operation mode from automatic to manual. He further pressed the button for the announcement to advise the passengers on board not to stand near the entrance with a view to accommodating the incoming passengers from the train arriving at the opposite platform. All these could not be in dispute. What Ms To suggested was that whilst Lau consciously managed to do all these, he somehow failed to adjust himself to the manual operation and forgot to broadcast the warning announcement and beeping alarm. In my view, Ms To’s suggestion lacks credible factual basis and I do not accept it.
3. Lau had been a train operator for 21 years by the time of the accident. According to him, he has to attend a 3-day refresher course on the operation of the train every half-yearly. Lau was in good form and alert during his first round of duty that afternoon. I agree with Ms Tsang that it was unlikely that Lau somehow selectively forgot to follow through the standard steps before closing the train doors.
4. Tom or his elder sister was not called. But Ms To referred Dr Lo’s record in his medical report of what Tom told him. Tom apparently told the doctor that he did not notice any beeping sound. However the same sentence in the report also says that Tom even did not notice the door closing. In the same report under the section “Avoidance”, it was also recorded that Tom seldom used MTR and therefore he *did not pay attention to the beeping sound*.
5. Ms To submitted that it was unlikely that the mother would have ignored her limitation on movement and safety, if she had heard the warning. But was it really the case? If the mother were right, the other passengers boarding that train should have equally been unprepared for the closing of the door. The fact was that no other passenger boarding the train had similar accident at the material time. I am not prepared to accept that this was merely good timing for the other passengers or sheer chance. From the CCTV recording, one can also see that at the moment when the family of three sought to board the train, none of the passengers around them on that part of the platform had any indication of tendency to seek to board the train.
6. Seeing Lau and the mother give evidence, I am not impressed by the mother at all. On balance, I find Lau to be a more reliable witness and I accept his evidence. I find that Lau did follow through the standard steps and broadcast the warning announcement and beeping alarm before he closed the train doors.

**Whether warning was sufficient**

1. Ms To argued that the warning, even if broadcasted, was insufficient to ensure that the passengers would be free from the danger of closing train doors.
2. MTR is the occupier of the station and the train, both within the definition of premises under section 2(3)(a) of the Occupier’s Liability Ordinance, Cap.314. As to the degree of care, MTR must be prepared for children to be less careful than adults as provided in section 3(3)(a). As to whether the duty of care has been discharged, the warning of the passengers is not to be treated without more as absolving MTR from liability, unless in all the circumstances it was enough to enable the passengers to be reasonably safe. This is the effect of section 3(4)(a). The same considerations should be applicable in the context of MTR’s general duty of care towards the passengers.
3. What is not unusual danger or trap to adults might well be so to children. Warning that might be adequate and understood in the case of adults might not be so in the case of children. But if the danger or trap is not unusual to children as opposed to adults, no liability should attach to the occupier for failing to take any step to alleviate such danger other than what would have been reasonable in the case of adult: see *Charlesworth & Percy on Negligence* (11th ed) at 7-48.
4. Ms Tsang submitted that closing of the platform screen doors and the train doors was not an unusual danger or trap to children passengers. In my view, Ms Tsang is right unless the child is of such tender age that he or she may not be able to perceive the danger or to heed the warning. Yet in that case, the responsibility would have rested primarily on those who ought to take care of the child in using the train service. I endorse what was said in *Phipps v Rochester Corporation* [1955] 1 QB 450 at 472 (also cited in *Clerk & Lindsell on Torts* (19th ed) at 12-34):

“…… the responsibility for the safety of *little children* must rest primarily on the parents; it is their duty to see that such children are not allowed to wander about by themselves, or at least to satisfy themselves that the places to which they do allow their children to go unaccompanied are safe for them to go to. It would not be socially desirable if parents were, as a matter of course, able to shift the burden of looking after their children from their own shoulders to those of persons who happen to have accessible bits of land……”

(italic added)

1. At the time of the accident, Tom was 8-year-old Primary 2 pupil. I have no reason to doubt his ability to heed the warning. At least, the mother praised Tom as a clever and energetic boy before the accident. In any event, Tom was, or was supposed to be, under the care of his mother and his teenage sister at the time. As captured by the CCTV recording, Tom simply followed his mother and elder sister to board the train. As I found above, the mother did not heed the warning. Tom followed and the accident happened.
2. Ms To referred to the situation where the passengers may be subject to disability due to advance age and impaired hearing. But I do not see how these instances are relevant to judging whether the warning is sufficient in the circumstances of the present case.
3. The duty owed by MTR to the passengers is a reasonable one. I find that the announcement and beeping alarm are sufficient to prevent passengers from seeking to board the train when the doors are about to close.

**Whether there was any omission or wrong on the part of MTR**

1. Ms To submitted that Lau had failed to check the situation of the platform to ensure that the doors could be closed safely. But MTR did not really deny that the train operator had to do so. The warning was merely one of the standard steps that Lau needed to take before he pressed the button to close the train doors.
2. According to Lau, the train operator keeps himself or herself informed at all times by the installations inside the control compartment:
   1. As mentioned above, there is an Outside Door Indicator (ODI) above every train doors. The ODI is on when the doors open and remain in an open state.
   2. The ODI is connected with a Door Close Light (DCL) inside the control compartment. So long as there is a single train door that has yet to close completely, the DCL will still be on.
   3. In case the DCL is on thus indicating that not all the train doors have closed completely, the train operator is able to identify the precise door or doors in question from the monitor of a computerised Train Information System.
   4. Above every platform screen doors, there is a Door Open Indicator (DOI). Like the ODI above the train doors, the DOL will be on and remains so as long as the screen doors are open.
   5. As mentioned above, there is a CCTV system inside the control compartment showing the situation on the platform outside the 40 screen doors as well as the condition of the DOI on the screen doors.
   6. There is also a Platform Screen Door Status Indicator (PSI) installed inside the tunnel which the train operator could see from the control compartment. The indicator will be off upon the complete closing of all the platform screen doors.
3. As discussed above, Lau observed the CCTV, pressed the button for the warning announcement and beeping alarm before pressing the button to close the doors. However Ms To criticised that Lau failed to pay sufficient attention to the CCTV system to see Tom’s family.
4. It seems what enabled Ms To to make this suggestion was the viewing of the CCTV recording mentioned above. But it should be noted that the CCTV recording mentioned above and the CCTV inside the control compartment of the train are two different things. The CCTV recording shows in one screen what appeared on the specific part of the platform. In court, the recording was not just played but replayed to enable us to view the images frame by frame. What Lau saw was the spontaneous transmission of the images of the movement on the platform outside the 40 screen doors to the 4 screens of the CCTV system inside the control compartment. It is therefore not entirely fair to judge whether Lau ought to have seen what one can see from the CCTV recording now produced in court.
5. Even if we are to judge whether Lau should have observed the family of three at the time on the basis of the information we managed to obtain from the CCTV recording produced, I am not satisfied that Lau should be to blame for failing to spot them seeking to board the train.
6. According to Lau, he had reason to be relatively more concerned about the situation of the platform outside the 3rd to the 6th compartments of the train further down. Experience tells that passengers tend to rush into the train at that point on the platform. Further, from the moment at which the family showed any tendency to board the train to the moment when Tom was nipped and then his leg was no longer outside the platform screen doors, it was really a matter of seconds.
7. More importantly, after observing from the CCTV system that no more passengers tend to board the train, Lau did first broadcast the warning announcement and the beeping alarm before pressing the close-door button. Any passenger who was yet to or might still be considering boarding the train was supposed to refrain from doing so upon the warning. As Ms Tsang submitted, Lau or MTR should not be to blame if it was the passenger who did not heed the warning and still sought to board the train.
8. Ms To submitted that MTR ought to have been prepared for passengers who would not heed the warning. She referred to the case of a driver who is under the duty to be prepared for those road users who are not using the road in safe and proper manner. In my view, the context of Ms To’s example is different from the present case. Even assuming that her example is relevant, I would have thought that the driver might have to take such precautionary steps as the circumstances require. But I do not think that the driver should still be liable if he has actually taken the step to warn the other road users whom he foresaw might enter his way but the accident could not be avoided because such road users simply do not heed the warning.
9. Ms To also submitted that by expecting the train operator to take care of all the observation, MTR was putting the passengers at risk. MTR allegedly should have taken other measures such as assigning station staff on the platform to guide and to assist passengers. She referred to similar practice during weekday rush hours. In making this suggestion, Ms To seems to be assuming that the purpose of the station staff on the platform during weekday rush hours was to watch out the platform for the train operator or to prevent accident to passengers who choose to ignore the warning. I am not inclined to make the same assumption.
10. In my view, accepting what Ms To submitted would have been to put the standard of care on the part of MTR to exceed what reasonable duty towards all the passengers as a whole would require in the circumstances.

**Whether the door control system was sufficiently safe and proper**

1. Ms To suggested that the train doors and the platform screen doors should not start to close at the same time. Ms To also suggested that the train doors should have been able to rebound upon obstruction. It was suggested that it would be too late to rely on the train operator to notice from his control panel and to respond by pressing the button to open the doors.
2. It can be seen from the discussion above that the various installations inside the control compartment allow the train operator to observe any problem with the train doors and screen doors as well as to react expediently. As I found above, Lau did observe the specific train doors that did not close completely and reacted reasonably expediently.
3. The question is one of reasonableness. The burden to prove that the door control system is not reasonably safe and proper rests on Tom’s side. The train door system is by no means a simple one. I am not prepared to assume, not to mention to find, that its design is not reasonably safe or that the design suggested by Ms To is feasible and safe in the absence of any expert evidence in support.

**Conclusion**

1. Considering all the evidence, I am not satisfied that liability of MTR is proved in the present case.

**CONTRIBUTORY NEGLIGENCE**

1. It may be particularly hypothetical to consider the question of contributory negligence in the circumstances of this case. Considering only the scenario where MTR somehow should still be liable notwithstanding the warning and the control system in place, I am inclined to accept Ms Tsang’s submission that contributory negligence should be as high as 75%.

**QUANTUM**

1. For completeness, I proceed to consider the question of quantum assuming liability is established.

**Upon admission**

1. Tom was admitted to the Ruttonjee Hospital in the evening of 29 May 2005. According to the hospital’s record, Tom was found to be in a satisfactory condition. He had fever at 38.4°C and mild redness over the back of his left shoulder. He was discharged with panadol and analgesic balm. Permanent disability was not expected.

**Afterwards**

1. Nevertheless the mother took Tom to Adventist Hospital afterwards. On 2 June 2005, X-rays were taken of the cervical and T-L spine of Tom. Nothing abnormal was found.
2. Tom rested at home until he returned to school for the examination. On 16 June 2005, the mother took Tom to consult Dr Patrick Wong Kwok Shing, orthopaedic specialist at Adventist hospital. They consulted Dr Wong again on 25 June 2005. Various complaints about numbness in Tom’s lower limbs were made. However, Dr Wong’s report dated 24 April 2006 recorded that he had to repeatedly assure the mother that Tom has no significant orthopaedic problem. Dr Wong suggested Tom to seek opinion from paediatrician instead.
3. Due to complaint about dizziness, pain and paraesthesia of the thigh, MRI was recommended in June 2005. The mother first refused but eventually allowed Tom to undergo the scan in July 2005. The result was normal.

**Psychiatric condition**

*Dr Benjamin Lai*

1. The mother also took Tom to see the psychiatrist in Adventist Hospital in July 2005. According to the report of Dr Lai, psychiatrist, the mother complained that after the accident, Tom had bad dreams about being hit by MTR train, cried in the middle of night and was anxious about riding MTR train. Tom was said to be unhappy, aggressive and would hit the mother. Tom was also said to be avoiding having to travel by MTR.
2. In the year between July 2005 and July 2006, Dr Lai saw Tom on 13 occasions. Tom was *treated as suffering from symptoms* of a post-traumatic stress disorder (PTSD). Dr Lai prescribed medicine and encouraged the parents and Tom to attend integrated family service centre for psychosocial intervention and behavioural treatment in the form of exposure.

*Dr Sylvia Chen*

1. The psychiatric expert engaged on Tom’s behalf, Dr Sylvia Chen, examined Tom on 2 and 18 December 2006. In her report dated 23 January 2007, Dr Chen first recited the complaint about the aftermath of the accident made by the mother including the shock to Tom, his recurrent distressing nightmares of the accident, recurrent and intrusive distressing recollections of the accident, temper and relationship with the mother, persistent avoidance of MTR-related activities, academic deterioration and poor appetite as well as physical growth.
2. Dr Chen conducted the mental state examination with Tom in the presence of the mother as he refused to see Dr Chen alone. Tom appeared to be timid and unsure of himself. He said that he now feared being trapped by train doors again. He recalled that during the accident, he felt very painful and that he could not breathe. He was seized by intense fear that he might not be released and might die. He said that luckily the train did not move. He feared he might be trapped again and was scared whenever he thought about the accident. He would deliberately avoid catching sight of MTR by taking a detour. Anything related to MTR, including television broadcast, would remind him of the accident, making him relive the moment as if he was being trapped again. He was unable to concentrate in class because of the recollection. But the recollection had disappeared by then. Tom told Dr Chen that he now avoided playing with his classmates for fear that they might play train game.
3. Dr Chen used the Diagnostic and Statistical Manual of Mental Disorder (4th ed) by American Psychiatric Association (DSM-IV) as the reference text. Dr Chen diagnosed Tom to be suffering from PTSD caused by a life-threatening situation in the accident. She found the symptoms to have persisted. Apart from recurrent fear and avoidant behaviour, Tom’s social functioning has also been markedly impaired by his bad temper, irritability and social withdrawal. His academic results had deteriorated.
4. Dr Chen recommended psychiatric treatment. She opined that with further treatment, Tom’s symptoms would gradually subside. But owing to his young age at which the accident happened, the stunning impact would be expected to last for about another 3 years (from 2007), when maturation and growth spurt at adolescence would hopefully bring strength and recovery.

*Dr Lo Chun Wai*

1. 4 months after seeing Dr Chen, Tom was examined by Dr Lo, the psychiatrist engaged on behalf of MTR. According to his report dated 23 April 2007, Tom and the mother were seen together for 15 minutes and then Tom alone for about an hour and the mother for another 40 minutes. There were also available to Dr Lo the previous medical reports including that of Dr Chen.
2. Dr Lo recited the information provided by Tom when Tom was interviewed alone. When his homework related to MTR, Tom would think about the accident and felt like hearing the noise of MTR train run. This was not frequent. He also had thoughts about the accident when the television broadcasted news about MTR. He would then feel unhappy and cry. This happened about once in a couple of weeks. According to Tom, the mother was irritable in temper and likes to scold the family members. There were quarrel between him and the mother as well as between the parents. These made him feel unhappy and he had bad dreams about those. When he went to see Dr Lai, he tried to take MTR a couple of times as advised. But he just dashed into the train and took 3 stops. He felt anxiety while on board. Academically, Tom felt that the homework had become more difficult and he had problem catching up. But he is not too anxious about the results.
3. Dr Lo then recited the information provided by the mother including what she said to have happened after the accident on the day in question, how she took care of Tom, their visits to the hospitals, her observation of Tom’s emotion and behaviour at home as well as her personal background.
4. Like Dr Chen, Dr Lo adopted the criteria in the DSM-IV. Dr Lo agreed that Tom exhibited symptoms suggestive of PTSD for about a year. However he concluded that the full diagnostic criteria of PTSD had not been fulfilled. In particular, Dr Lo considered that the accident had an initially mild impact on Tom. The fever and the subsequent numbness of legs were not the result of the accident. Dr Lo opined that the misunderstanding of the mother had probably wrongly attributed these symptoms to the accident and had insinuated the complaints of Tom, resulting in his recollection of the incident, avoidance behaviour and anxiety symptoms.
5. Dr Lo opined that the symptoms of Tom are only partially related to the accident. The prognosis was considered to be good and the symptoms would likely resolve with time. He noticed that Tom had stopped seeing Dr Lai. He advised that Tom should be reassured and the medications that the mother allegedly gave him should be slowly tapered and then discontinued. He observed that the mother is probably a nervous person and would cast some influence on the child. Dr Lo recommended counselling by school social worker for Tom

*Dr K K Chung*

1. Dr Lai had apparently referred Tom to Dr Chung of Kwai Chung Hospital. Dr Chung’s report did not come until 3 weeks before the trial. Dr Chung first saw Tom on 23 April 2007. The clinical psychologist of the hospital saw Tom and his parents in August 2007. He agreed with Dr Lai’s diagnosis of PTSD.
2. By the time of his report, Dr Chung understood that the other intervention encouraged by Dr Lai mentioned above had never been sought for Tom. The mother appeared to Dr Chung to be soft and overprotective while the father was not involved. Both made no attempt to help Tom overcome the fear and inadvertently encouraged the perpetration of the emotional sequalae following the accident. The parents were said to share and to foster the idea that professionals were not helpful and that MTR should make necessary compensation. The mother impressed Dr Chung to be very neurotic. Tom was very resistant to seeing the clinical psychologist alone. Further psychological intervention was considered not feasible until the parents were ready to cooperate with the professional advice and Tom was willing to face the therapist alone.

*Discussion*

1. Dr Lai, Dr Chung and Dr Chen shared the same diagnosis of PTSD. Dr Lo disagreed, though he agreed in court that Tom exhibited symptoms of recollection, avoidance and anxiety suggestive of PTSD for over a year. Dr Chen and Dr Lo gave evidence in court and explained their respective opinion.
2. Dr Lo opined that the pre-requisite of a traumatic event did not exist. According to the DSM-IV, this pre-requisite requires that the victim has experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others. Dr Lo regarded the accident as falling short of this criterion because it involved a minor nipping. He partly drew inference from the fact that after the accident, Tom managed to continue to go shopping and to return only after more than an hour.
3. Dr Chen opined that the assessment was both subjective and objective. She agreed that the nipping was minor in terms of the consequential physical injury. I actually made the same inference earlier. However, what Tom told Dr Chen, and in fact Dr Lo too, constituted an event that Tom *perceived* to be threat to his life or serious injury at the moment. Indeed Tom continued his journey after the accident but Tom would have to follow the mother at the moment. Even Dr Lo recorded that Tom said he had cried and complained of fear while the family was at the department store. The mother then said Tom should go to see the doctor. The family then returned to the MTR station.
4. However Dr Lo emphasized that the constant repetition of these symptoms by the mother might have a rehearsal effect on Tom. Regarding this, I could see that the symptoms were indeed repeated in the mother’s complaints during the various consultations with the doctors. Dr Lo and Dr Chung also described the mother as neurotic. However, it was not that Dr Chen was not aware of this when she interviewed the mother and Tom. In court, Dr Chen agreed that the mother was both neurotic and depressed. Dr Chen was also concerned about conducting the interview with Tom in the presence of the mother when Tom was reluctant to see Dr Chen alone. Dr Chen was conscious that she had to ensure that the mother would not interfere in any way.
5. Dr Lo suggested the presence of the mother could have the effect of non-verbal interference. But considering the experts’ evidence, I am not prepared to infer and find that what Tom himself told the experts must be tainted by the suggested non-verbal interference by the mother. Hearing the experts in court, I somehow share Ms To’s concern that Dr Lo might have inadvertently passed his judgment on the mother’s credibility to an extent more than necessary for forming his opinion on Tom, notwithstanding his interview with Tom alone, i.e., the manner he considered to be desirable.
6. Considering the medical and expert evidence both on paper and in court, I accept that the circumstances justified the diagnosis of PTSD by Dr Lai, Dr Chung and Dr Chen.
7. Having said that, I accept Ms Tsang’s submission that whether this is a case of PTSD, it is more material to find out the actual and residual psychiatric condition of Tom. Ms To also seemed to acknowledge that the nature of sufferings and overall condition of the victim as well as the psychiatric treatment required could be identical for PTSD and Adjustment Disorder.

*The residual psychiatric condition of Tom*

1. While Dr Lai treated Tom as suffering from symptoms of PTSD, the contemporaneous receipts issued by the doctor during the period between September 2005 and June 2006 invariably recorded the diagnosis as *adjustment disorder*. In court, Dr Chen also confirmed that the medications prescribed by Dr Lai were primarily mild tranquilizers. Dr Chung apparently also prescribed medication of similar nature.
2. Dr Lai encouraged psychosocial intervention and behavioural treatment in 2005. However up to the time when Dr Chung saw the mother and Tom in 2007, the doctor understood that the family had not sought those treatment for Tom. In court, Dr Chen explained that it was also the duty of the treating doctor to work on the parents to help them become receptive of the recommended treatment. This might be true. However Dr Chen went on to suggest that perhaps Dr Chung might not have the time to do so. In court, the mother also alleged that according to Tom, Dr Lo threatened and forced him to say things which were not true during the interview. This, according to her, also caused his son to refuse seeing therapist thereafter.
3. In my view, the suggestion of inadequacy on the part of Dr Chung in working on the mother towards reception of psychological intervention was not a fair speculation without Dr Chung being heard. I also do not accept the mother’s excuse and attack on the professional integrity of Dr Lo.
4. In court, the mother suggested that she had in fact taken Tom to some free psychological consultation provided by charitable organisation in Tsuen Wan Plaza and consultation at a community centre referred to by the school social worker. But her evidence as to the precise nature and effect of the consultations was vague. She had also wanted Tom to continue psychiatric consultation but the government hospital made no arrangement. I am sceptical about this excuse too.
5. Regarding the impact of the accident on Tom’s academic performance, the mother has disclosed Tom’s pupil’s performance reports for 2004/2005 and 2006/2007. The report for 2005/2006 immediately after the accident was not disclosed. Tom is now at his Primary 6 but the most recent report was also not disclosed. Further, the 2004/2005 report contains the examination results of the 10 subjects taken whereas the 2006/2007 report merely contains the term assessment in 4 subjects.
6. In court, Dr Chen revealed that she was in possession of some other school records of Tom. She observed from these records that Tom’s handwriting had become messy as opposed to those before the accident. He had become forgetful and missed his homework. His concentration became affected but the extent was mild. His grade in English had improved whereas that in Mathematics had dropped. But there was no overall deterioration in his academic performance. There was no adverse comment by school social worker or teacher.
7. The experts confirmed that Tom’s symptoms have been improving. Dr Chen agreed that the symptoms would subside when Tom grows older. Yet she still considered Tom’s recovery to be unsatisfactory. For that, Dr Chen adjusted her assessment so that it would take one additional year before improvement would become significant. Neither expert expects permanent psychiatric disability.

**Pain suffering and loss of amenities (PSLA)**

1. A sum of HK$350,000 was originally claimed for the pain suffering and loss of amenities. The amount was reduced to HK$250,000 in the revised statement of damages. However when the trial began, the amount claimed was revised but this time upward to HK$500,000.
2. Ms To referred to the case of the various infant plaintiffs in *Lily Tse Lai Yin v The Incorporated Owners of Albert House* HCPI 828/1997, 17 September 2001. Awards in the range of HK$500,000 to HK$600,000 were made. In my view, these cases were far more serious than the present one in terms of the accident that the child was involved in, the trauma experienced by the child, the physical injuries sustained, the treatments entailed, the psychiatric symptoms, the existence and degree of permanent physical and psychiatric disabilities as well as the nature and the length of future treatment required.
3. Ms To also referred to *Ng Ka Ho v Yeung Kwok Leung*, DCPI 28/2004, 4 May 2005. In that case, the plaintiff sustained head injury and lost consciousness upon being knocked down by a van. His lack of normal reciprocal social interaction and communication was found to have persisted since childhood even prior to the accident. He suffered from mild residual symptoms of PTSD. But the current condition was a progression of the plaintiff’s Pervasive Development Disorder Unspecified (PDD) aggravated by the accident. The plaintiff suffered from mild residual symptoms of PTSD. HK$250,000 was awarded. The residual symptoms of the PTSD in that case were not really similar to those in the present case. The present case does not involve PDD. The extraordinary behavioural problems of the plaintiff in that case also did not exist in the present case.
4. Ms Tsang referred to *Limbu Saram Kumar v Cheng Man Chung* HCPI 382/2003, 4 April 2006. This case concerned a construction site worker rather than a child. The court did not accept that the DSM IV criterion for PTSD mentioned above was satisfied. Disregarding the exaggeration over and above the negligible injuries that the worker in fact suffered, the court awarded a lump sum of HK$50,000. In my view, this case is not particularly helpful either.
5. Considering the very mild physical injury, the actual psychiatric element in the case of Tom, his age and circumstances, I find the suggested award of HK$500,000 to be entirely out of the question. I am of the view that the award for PSLA hardly comes close to the original pleaded amount of HK$250,000 either. I would have been prepared to award HK$150,000, had liability been established.

**Special damages**

1. In her 2 statements, the mother was rather economical in her evidence regarding the quantum of damages being claimed.

*Extra value of care by parents*

1. This item of claim is based on the value of the time and effort spent by the parents on the care of Tom. It was suggested that such time and effort would have been spent some other meaningful ways. In principle, such claim may be allowed. However, it still needs to be substantiated by evidence.
2. An amount of HK$3,600 x 3 months is claimed. Nothing about this was mentioned at all in her statements. In court, the mother said that she used to work as an unlicensed hawker selling glowing sticks (between 6 pm and 3 am) earning HK$1,000 every night and as a garment retailer earning HK$8,000 per month. These were bare assertions. According to the medical report on the mother dated 14 December 2005, the mother has been consulting the hospital and complaining about persistent left foot pain. She was still walking with her cane. She had actually been granted sick leave until the day after Tom’s accident. Further it appears that the multiplicand of HK$3,600 and the 3-month period were notional. In court, the mother chose to attribute the pleading of such amount to her solicitors rather than her instruction.
3. Seeing and hearing the mother in court, I agree with Ms Tsang that the mother’s evidence in this regard is unreliable. I am not satisfied that this item of claim is proved.

*Cost of future medical care*

1. This is the claim for HK$18,000 for 3 years of monthly psychiatric consultation at HK$500 each. This was apparently based on the report of Dr Chen where she envisaged that the stunning impact of the accident was expected to last for about 3 years more. In court, Dr Chen adjusted her assessment and added one more year. She suggested both medication and psychological and behavioural treatment. In her submission, Ms To adjusted this item of claim to the lesser sum of HK$12,500 for 25 monthly consultation at HK$500 each.
2. In view of Tom’s past experience, I have no confidence that the mother will truly follow Dr Chen’s recommendation. Nevertheless, this probably should not be the reason for declining to make an award and thus depriving Tom of at least the chance of some further treatment.
3. The particulars of HK$500 per consultation and the alleged need for monthly treatment for the entire period did not come from Dr Chen. Ms To referred to what Dr Lai charged for his consultation in a private hospital. Ms Tsang referred to the cost of attending such consultation at the government hospital which was HK90. I would have been prepared to award a lump sum of HK$6,000 under this head.

*Extra tuition fees*

1. According to the pleading, it is *anticipated* that Tom’s academic performance *will be impaired* and therefore extra tuiton fee *will be needed* to compensate for the impairment.
2. According to Dr Lo’s record of the information provided by the mother, Tom’s elder sister also attended private tuition which cost her a lot of money. According to the mother in court, Tom attended 4 sessions of private tuition per week since 2005 for which she had also paid. If these were necessitated by the accident, she could not really explain why there was no claim for such presumably substantial amount. I tend to believe that Tom would have attended private tuitions even in the absence of the accident. I am not satisfied that future private tuitions, whether extra or not, were necessitated by the accident.
3. A lump sum of HK$10,000 is claimed. She again chose to deny any idea why her solicitors pleaded the amount claimed.As Ms Tsang pointed out, the only receipt available for alleged tuiton fee spent is a cheque in 2007 issued to a parent-teacher association. I am not satisfied that the amount claimed is substantiated by relevant evidence either.

*Medical and hospital expenses*

1. This item is again claimed in a lump sum. The amount was HK$30,000. With reference to the receipts produced, the calculations by Ms To and Ms Tsang respectively came to an amount in excess of HK$20,000. These included consultation with Dr Lai, psychiatrist, and Dr Wong, orthopaedist, X-ray of the spine, MRI of the brain, laboratory expenses and medications purchased from dispensary.
2. Ms Tsang criticised that the consultation with the specialists and special investigation were not justified. Ms To argued to the contrary and submitted the tests and examinations were carried out pursuant to the doctors’ advice. I agree that so long as the examination and treatment were carried out pursuant to medical advice, the fact that these were subsequently proved to be unnecessary or mistaken should not deprive the plaintiff of his entitlement to be compensated for such expenses. However this is not to say that the active and repeated consultations or the complaints to the doctors leading to such recommended examination should not be subject to scrutiny on the basis of reasonableness. I do share Ms Tsang’s scepticism about the manner in which the mother took Tom to consult the doctors in the past.
3. The receipts for medications were invariably issued by the same dispensary during the period between 2005 and 2007. However they merely describe the items as藥品 (simply medicine). Even the only receipt that provided the description was related to items like vitamin C and fever tablets purchased on the day after the accident. Dr Chen confirmed in court that the fever should not be related to the accident in the absence of injury to the brain. According to Dr Lo’s report, Tom also told him that he had fever and had been taking drug even prior to the accident. I am not satisfied that these medicines are proved to be necessitated by the accident.
4. I would have been prepared to allow a portion of the amount claimed. This would be a sum of HK$15,000.

*Travelling expenses*

1. A lump sum of HK$5,000 is claimed for the travelling expenses for attending the treatments. The mother explained that they had taken taxis. While not all the consultations were justified, I do not consider the amount claimed to be unreasonable. I would have allowed this amount.

*Tonic food*

1. A lump sum of HK$10,000 is claimed. But the receipts issued amounted to a larger sum.
2. The receipts disclosed revealed that substantial amount of money had been spent on靈芝孢子蜂膠. The mother confirmed in court that she purchased them during promotion by artists rather than pursuant to any recommendation by any doctors having seen Tom. Further, the receipts evidence that on one occasion, she spent over HK$3,600 on this item while on another occasion, she spent a total sum in excess of HK$7,000 on the same item on a single day. The other items evidenced by receipts are 深海魚油丸and 松果体 (purchased in the Mainland). Again, there is no objective evidence that these items were recommended by any doctors having seen Tom.
3. On established principles, I am not satisfied that there is sufficient credible evidence to prove that these items were necessitated by the accident. As the mother did not suggest that she had purchased any other tonic food for Tom, there is no basis for awarding any other reasonable notional amount.

**Conclusion**

1. Even assuming the liability is established, the award should have been as follows:

PSLA HK$150,000

Cost of future treatment HK$ 6,000

Medical and hospital expenses HK$ 15,000

Travelling expenses HK$ 5,000

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Total: HK$176,000

1. Until today, there would have been interest on general damages (PSLA) from the date of the writ at 2% per annum; and on special damages (costs of future treatment, medical and hospital as well as travelling expenses) from the date of accident at half judgment rate.

**ORDER**

1. Failing liability, the claim is dismissed with costs of the action, including any costs reserved, to MTR. Costs shall be taxed, if not agreed. For the avoidance of doubt, I certify the engagement of counsel. The Plaintiff’s own costs shall be subject to legal aid taxation. In the absence of any appointment within 14 days from today to argue costs, this costs order shall become absolute.

Simon Leung

District Judge

Ms Doris To instructed by Messrs Christopher K Y Wong & Co for the Plaintiff on the assignment by the Director of Legal Aid

Ms Alice Tsang instructed by Messrs Deacons for the Defendant