Akhinur Nashu Kazi v Chong Siak Hong (trading as Hong Hwa Marine Services) [2009] SGHC 138

Case Number : Suit 587/2006, RA 423/2008

Decision Date : 08 June 2009

Tribunal/Court : High Court

Coram : Judith Prakash J

Counsel Name(s) : K Ravi (K Ravi Law Corporation) for the plaintiff; Pak Waltan (Rajah & Tann LLP) for the defendant

Parties : Akhinur Nashu Kazi — Chong Siak Hong (trading as Hong Hwa Marine Services)

Damages – Assessment

8 June 2009 Judgment reserved.

Judith Prakash J:

1 This is an appeal from an assessment of damages conducted by Lim Jian Yi, the Assistant Registrar ("the AR"). The plaintiff, who had sustained a fall in the course of his employment, had claimed general damages of $399,000 and additional special damages from his employer, the defendant. After nine days of hearing, the AR found the plaintiff's claims to be substantially lacking in merit and awarded him only $2,000 for contusions. Costs were awarded to the defendant. The plaintiff has appealed on all counts.

Background

2 The plaintiff is from Bangladesh. He was born, according to his passport, on 12 June 1970 but in court he said it was not his true birth date and that he was a few years younger. He is not well educated having had about three years of primary education and, prior to coming to Singapore to work in the late 1990s, had been employed in Bangladesh as a farmer.

3 The accident that gave rise to the present proceedings occurred on 27 September 2003. The plaintiff was then employed by the defendant as a construction worker. At the time of the accident, the plaintiff was doing some painting work at a worksite in Jalan Punai, Singapore where some construction work was being carried out. The plaintiff fell from a scaffold and landed flat on his back on the ground. He stated that he felt pain in his back, head, chest, abdomen, hip and elbow.

4 The plaintiff was then taken by ambulance to Changi General Hospital ("CGH"). According to the ambulance report, a friend of the plaintiff told the crew that he had fallen from a height of 1.5m. The crew themselves noted that the plaintiff was conscious and alert. He was hyperventilating with carpal pedal spasms noted and complaining of pain over his whole body. According to the hospital notes, the plaintiff claimed he had pain all over his body and refused to localise the site of the pain. Apparently, there was no loss of consciousness. X-rays of the head, chest, pelvis, left hip and elbow were done and were found to be normal. On examination by the attending doctor, the plaintiff was found to have sustained contusions of his left hip, left elbow and his back. He was fully conscious. There was no scalp injury and chest compression was not painful. Compression of the pelvic bone was claimed to be painful and there was pain when the left hip was moved. The neck movement was good and no bruises were seen. The plaintiff was given a painkiller by injection and he was then able to get out of bed and walk a distance of five metres independently. He was sent home the same night with pain

medication and given three days' medical leave.

5 On 1 October 2003, the plaintiff went back to CGH complaining of persistent headache, abdominal pain and left flank pain. Examination of the abdomen and conscious state were normal. He was warded in the hospital for investigation and discharged on 3 October 2003. According to the hospital's "Inpatient Discharge Summary", a CT scan of his head showed that there were no abnormalities. He was seen by the orthopaedic department for possible neck and loin injury arising from the neck and loin contusions. The summary stated that subsequently the plaintiff's headache resolved and he was able to ambulate. The summary also stated that the principal diagnosis was "stable head injury" while the secondary diagnosis was "contusion, abdomen" and "contusion, chest wall". Under the heading "Suggested Treatment" there was a notation that the plaintiff was to be referred to a neurosurgeon, Dr Charles Seah, for examination. On discharge, the plaintiff was given a further ten days of sick leave and two types of medication, Panadeine (for pain) and Stemetil (for nausea). The plaintiff returned to the hospital that same night complaining of weakness in both lower legs. On examination, his legs were found to be normal and he was not admitted again.

6 Ten days later, on 11 October 2003, the plaintiff reported to CGH again. According to the hospital notes, he complained of having had a headache for ten days, pain over the whole body and vomiting. The doctor in charge, one Dr Y M Ho, noted that the plaintiff had exaggerated grimacing with any touch. Dr Ho decided to admit him to the surgery department for observation again. He remained in hospital until 14 October 2003. The inpatient discharge summary this time made a principal diagnosis of post concussion syndrome. There was no secondary diagnosis. The CT scan was repeated and showed no abnormality. Under suggested treatment, there was a notation that the plaintiff should be referred to the neurosurgical department for post concussion syndrome.

7 The plaintiff went back to CGH on 13 November 2003. This time he was seen to be confused, agitated and disoriented. He was banging his head and eating the surgical mask. He was accompanied by his friends and brother and was admitted because he was so disoriented. The hospital wanted to carry out a psychiatric examination of the plaintiff but was not able to do so because his brother asked for him to be discharged before treatment was completed. The ostensible reason was lack of funds. Four days later, however, the plaintiff went back to the hospital complaining that he was unable to work and wanted medical leave. He complained of change of behaviour on and off and said he was easily angered. Examination showed him to be alert and rational and normal neurologically except for some pain over the back of the neck. The examining doctor extended his medical leave up to 26 November 2003.

8 The plaintiff thereafter continued to receive outpatient treatment at CGH. He was referred to the psychiatric outpatient clinic and seen there from 12 January 2004 onwards for cognitive changes following his fall. The psychiatric department made a diagnosis of Organic Brain Syndrome ("OBS"). According to psychological assessment done on 24 March 2004, there was impairment in his verbal and visuo-spatial functioning and he was functioning in the mildly retarded IQ range. Antidepressant medication was prescribed but it did not lead to an improvement in his mental state or level of functioning and he appeared, to that department, to be permanently incapacitated by his condition. Apart from the 38 days of leave that he had received post hospitalisation, doctors at the psychiatric outpatient clinic gave him a further 568 days of leave. His last medical certificate was for the period between 25 February 2005 and 27 May 2005.

9 The plaintiff's affidavit of evidence-in-chief was made in March 2008. He described his condition as follows:

> I still experience pain, giddiness and vomiting, persistent headaches, blurred vision, nausea,

spinal, hip and back pain, abdominal discomfort and various other somatic disabilities. As a result of the said accident, I also suffer from erectile dysfunction and am unable to have sexual intercourse. I also have some difficulty concentrating and remembering things. I also feel weak and tired most of the time and suffer from depression caused by the injuries sustained by me. But I am not of unsound mind and I am capable of managing myself with some difficulty.

The plaintiff's claim

10 Before the AR, the plaintiff claimed general damages totalling $399,000 and special damages of $50,000 and US$55,000. On appeal, whilst the heads of claim remained the same, the figures changed somewhat. Before me, the plaintiff quantified his damages as follows:

(A)	<u>For Pain & Suffering and Loss of Amenities</u>		
(1)	(a) Closed Head Concussional Injury	)	$ 50,000
	(b) Organic Brain Syndrome	)	
	(c) Post Concussion Syndrome	)	
	(d) Diffuse Axonal Brain Injury	)	
	(e) Cognitive Deficits & Memory Impairment	)	$ 25,000
	(f) Depression	)	$ 10,000
	Total of (a) to (f) $85,000 but in order to allow for overlap total claim reduced to:		$ 60,000
(2)	Erectile dysfunction	)	$ 50,000
(3)	Back injury and contusion of elbow and hip	)	$ 5,000
(B)	<u>Loss of Earnings</u>		
(4)	Loss of Future Earnings in Singapore (for eight years at $800 a month)		$ 76,800
	Loss of future earnings in Bangladesh (for eight years at $200 per month)		$ 19,200
(5)	Loss of Earning Capacity		$100,000
		Total	$284,600
(C)	Special Damages		

(a) Medical Expenses		$ 1,982.15
(b) Cost of Future Medical Expenses		$ 6,000
(c) Loss of Pre-trial earnings – 63 months at $800 per month		$50,400
(d) Transport expenses		$ 500
	Total	$57,482.15

The defendant's position

11 The defendant's position was that on the totality of the evidence, the plaintiff had failed to prove on a balance of probabilities that he had sustained the injuries as alleged. It had been shown that, more likely than not, the plaintiff had feigned the myriad symptoms complained of. His evidence lacked consistency and his demeanour and behaviour revealed deliberate acts of overt embellishment and exaggeration purposefully displayed in order to establish serious head and/or bodily injury. Additionally, the plaintiff's medical experts had not been able to support the plaintiff's claims that he sustained severe and bodily injuries, whereas the defendant's medical experts had shown that the plaintiff was exaggerating his condition and may have been malingering.

The evidence

12 The plaintiff relied principally on his own evidence and that of five medical witnesses. The defendant testified himself and also called two doctors, two friends of the plaintiff and a private investigator.

Medical evidence adduced by the plaintiff

The CGH doctors

13 The plaintiff called three doctors from CGH in connection with his visits to CGH and his treatment. These were Dr Peh Lai Huat, a psychiatrist and currently senior consultant, Department of Psychological Medicine; Dr Tan Poh Seng, Registrar Division of Gastroenterology; and Dr Goh Siang Hiong, Senior Consultant, Emergency Physician and Chief of the Department of Emergency Medicine.

14 Dr Goh Siang Hiong was called for the purpose of producing the CGH medical notes in court. The account of the plaintiff's treatment contained in [4] to [7] above comes from his testimony. Dr Goh read from the hospital's medical notes in respect of the plaintiff's visits to the accident and emergency ("A&E") department on 27 September 2003, 1 October 2003, 11 October 2003, 13 November 2003 and 18 November 2003. Dr Goh did not attend to the plaintiff during any of these visits.

15 Dr Tan Poh Seng gave evidence in relation to the plaintiff's visit to the A&E department on 13 November 2003. His report stated that the plaintiff was taken to the hospital for a disorientation problem and at the A&E department, he was noted to be confused. He was admitted for investigation of his abnormal behaviour. In the ward, a further history was taken from the plaintiff's friend and brother who said that he had been experiencing headaches and vomiting since his fall and that his behaviour had changed. The physical examination was limited as the plaintiff was not fully co-

operative. A psychiatry referral was made for psychiatric assessment of the plaintiff. On 14 November 2003, the plaintiff was discharged at his brother's request. Dr Tan stated that disorientation was not his area of expertise and as far as the gastroenterology department was concerned, the notes showed that his abdomen was tender when he was palpitated. This could have been due to many possibilities and there were no signs or investigation results that could lead to a proper diagnosis during his stay. Dr Tan did not examine the plaintiff himself but was referring to the inpatient clinical notes of the plaintiff's visit.

16 The most substantial witness from CGH was Dr Peh. Dr Peh produced a specialist medical report dated 7 July 2008. This was brief and the material it contained is set out in [8] above. Dr Peh had previously issued a "Medical Report on Traumatic Injuries for Workmen's Compensation" which had been submitted to the Ministry of Labour in April 2006. In this report, Dr Peh had described the plaintiff's injuries as "Organic Brain Syndrome (Post-Head Injury)". He also stated that among other injuries, the plaintiff had a change in personality and severe cognitive defects and as a result was unable to take care of himself. He recommended that 50% be awarded for permanent incapacity and indicated that the plaintiff was not capable of handling his own affairs. It should also be noted that on 30 April 2004, Dr Charles Seah of the Neurosurgery Department of CGH had issued a medical report for the same purpose in which he stated that the plaintiff had sustained a diffuse axonal brain injury causing mental changes. He had, however, certified that these injuries were not likely to result in any permanent incapacity. At that stage, Dr Seah had recommended that the plaintiff be reassessed by a psychiatrist or neuropsychologist in one year's time.

17 In court, Dr Peh stated that when the plaintiff first visited the psychiatric outpatient clinic he was attended to by a colleague, one Dr Winnie Ho, who had done the earlier assessments. According to the notes, on his first visit, the plaintiff was accompanied by a friend named Mizam Mina ("Mizam") who gave the attending doctor the plaintiff's history. Dr Peh himself only took over the case on 30 September 2004 and he treated the plaintiff until the last visit in July 2006, a total of nine occasions. When he saw the plaintiff, the plaintiff was accompanied by the same friend Mizam except for the last visit during which the plaintiff was accompanied by an unnamed person. Usually, during the visits, Mizam was the person who gave Dr Peh the history. When Dr Peh examined the plaintiff he spoke in English and sometimes the plaintiff tried to communicate in simple English but it was mostly Mizam who acted as translator.

18 When Dr Peh first saw the plaintiff, there was no change in his mental state from that described in the case notes. The plaintiff was apparently not being helped by the previous medication prescribed (mood stabilisers) and Dr Peh therefore ordered a blood test which indicated that the level of mood stabilisers in the blood was very low showing that the plaintiff may not have been taking his medication. Dr Peh stated that the diagnosis of OBS, as indicated by the case notes, was the opinion of his colleague and was also Dr Peh's own opinion when he took over.

19 Under cross-examination, Dr Peh confirmed that the case notes showed that in August 2004, the blood test showed that the plaintiff had been taking his medication but in October 2004 and in December 2004, the level of medication in the body was below the therapeutic range indicating that it was likely that he had not taken the medication as instructed. Thereafter, this medication was stopped. He agreed that his comment in his report that the antidepressant medication had not improved the level of functioning could have been the result of the plaintiff failing to take the medication. Dr Peh stated that all the history that he had taken about the plaintiff had been given to him by Mizam. The plaintiff himself could not communicate well in English though he sometimes tried to communicate in simple English.

20 Dr Peh confirmed that he himself had not performed any test to check for brain cell damage. He

proceeded with his treatment of the plaintiff on the basis that another department had performed the tests that had shown that there was brain cell injury. He was in fact relying on Dr Seah's diagnosis of diffuse axonal brain injury. Looking at the various medical reports, Dr Peh confirmed that the x-rays of the plaintiff's head had been normal. When the plaintiff was admitted on 11 October, the diagnosis was post concussion syndrome which indicated, Dr Peh said, that the plaintiff had brain cell injury. He noted that a CAT scan of the brain showed that there was no intracranial haemorrhage but commented that such a scan could not show whether there was brain cell injury or not. He agreed that the case notes indicated that no test had been conducted in November 2003 that had indicated that the plaintiff had brain cell injury. The doctor was shown the ambulance crew's report on the plaintiff stating that the plaintiff was conscious when they arrived and asked whether in the light of this report he had any doubt about the diagnosis of OBS. He replied that his colleague who had first treated the plaintiff had based the diagnosis of OBS on the referral that stated that the plaintiff had a head injury and this diagnosis of head injury had been recorded on the two discharge summaries issued by CGH. Dr Peh had agreed with the OBS diagnosis and after seeing the documents had no doubt about it.

21 Dr Peh agreed that no investigation had shown brain cell damage but he asserted that injury to the brain cells could be present even though not indicated on the CT scan. A scan would show bleeding or tumour in the brain but could not directly indicate damage to the cells themselves. As far as he knew, there was no test that could show whether or not damage to the brain cells had been sustained. He agreed that OBS is a term referring to a disturbance of mental function (demonstrated by cognitive deficits or change in behaviour) that has an underlying physical cause. He was asked whether he agreed with the neurologist, Dr Ho King Hee, appointed by the defendant's insurers, who had stated that in the plaintiff's case there was no severe head injury. His response was that it was not for him to say whether there was severe head injury or not because he did not make the diagnosis of head injury and based on the clinical notes he could not say that there was no severe head injury. To him, a "severe head injury" would be diagnosed from matters like physical damage, consciousness level or the after effects. He agreed that a fracture would be a severe injury but did not agree that where the physical examination showed nothing, the injury was not severe. In Dr Peh's view, the damage could be in the cell and not on the bone or in the bleeding blood vessel. After giving this evidence in cross-examination, the following exchange took place:

Q: You are saying that you are not in the position to link OBS to the severity of the head injury because this is in the realm of the neurologist?

A: What may not seen to be severe – like he did not lose consciousness or did not have a fracture – does not mean that he did not have a severe head injury to cause this OBS.

Q: OBS is when you have an underlying physical cause. Dr Ho says he can't find the physical cause because the head injury was not severe enough to lead to OBS. You are coming from the other direction. You conclude that there is OBS, therefore there must be a severe head injury. Is Dr Ho and your approach coming from different directions?

A: Yes.

Q: Is that the correct approach to reach the diagnosis of OBS?

A: It is one [of] the approaches that can reach the diagnosis of OBS.

22 Later in the cross-examination Dr Peh agreed that when he received the plaintiff's file and in all the treatments that he had administered, he did not investigate whether the symptoms that the plaintiff was displaying were caused by the accident. The plaintiff's head injury had already been evaluated by other specialists so Dr Peh did not further investigate the cause. He saw in the notes that a neurosurgeon had seen the plaintiff and that the latter's opinion was that the plaintiff had sustained a diffuse axonal brain injury which had caused his mental changes. Dr Peh referred to a workman's compensation report dated 30 April 2004 by that neurosurgeon, Dr Charles Seah. In the remarks column, Dr Seah had recorded "fell from height on 27 September 03, and admitted on 1 October 03, he sustained a diffused axonal brain injury causing his mental changes. Follow-up by neuro-psychiatrist and neuro-psychologist.".

23 Dr Peh gave a brief description of the plaintiff's behaviour when he presented himself to the psychiatric outpatient clinic on the 14 occasions on which he visited it:

> My colleague found that he was unshaven and dishevelled. He was distressed and was retching during the interview, and he had multiple somatic complaints. 16 January 04: dishevelled, unshaven, bad odour, anxious, dysphoric. 8 March 2004: dishevelled, unshaven, anxious, somatic complaint, dysphoric. 7 June 2004: pre-occupied, not forthcoming, dishevelled, did not answer. 2 August 2004: unkempt , bad odour, laughed to himself, talking to himself occasionally. 30 September 2004 : dishevelled, perplexed, does not respond to questions, grimaces, makes utterances. 29 October 2004: no eye contact, dishevelled, scratching his head, occasionally retching. 24 December 2004: uncommunicative. 25 February 2005: better eye contact, scratches his head frequently, able to understand simple questions, can give his name. 29 July 2005: brief eye contact, does not respond to contact. 27 October 2005: dishevelled, no eye contact or responses. 3 March 2006: dishevelled, not able to respond to questions, perplexed look. 27 July 2006: irritable mood, better eye contact, hair dishevelled, more responsive, dis-oriented in time.

24 Dr Peh confirmed that there are no tests in the field of psychology and psychiatry to test the veracity of a patient's complaints and presentation. He was shown in cross-examination a copy of the opinion of Dr Y C Lim, a psychiatrist appointed by the defendant's insurers. It was pointed out to him that Dr Lim had arrived at a different conclusion from his own on the authenticity of the plaintiff's complaints. His response was that Dr Lim had had access to more information than he himself had. He said that if he had had the same information, he would be prepared to revise his diagnosis. In re-examination, he confirmed that if there was no abnormal behaviour on the part of the plaintiff as observed in video footage of the plaintiff, then he would have revised his diagnosis.

The private medical experts

25 The plaintiff saw two doctors for the express purpose of obtaining medical reports which could be used to support his claim. They were Dr Calvin Fones Soon Leng, a consultant psychiatrist, and Dr Damian Png Jin Chye, a consultant urologist.

26 The plaintiff saw Dr Fones on 16 August 2006. The plaintiff was accompanied by his cousin who helped with translation into English and also provided additional information as to his recent functioning. Dr Fones was given a copy of the specialist medical report issued by Dr Peh as well as the inpatient discharge summary of the plaintiff's admission from 11 to 14 October 2003. The report issued by Dr Fones stated that the plaintiff was doing some painting on 27 September 2003 when he fell from a height of three storeys. He was unconscious immediately following the fall and remembered gaining consciousness only at the hospital. The report also stated that on 14 October 2003, a diagnosis of post concussion syndrome was made and since then the plaintiff had remained in

Singapore. He had been unable to work because of his symptoms and he continued to experience many discomforts, including headaches, giddiness, blurred vision, nausea, back pain, abdominal discomfort and various other somatic complaints. His mood had been depressed because of his symptoms and because of his lack of ability to work and function normally.

27 The report contained the following observations on the plaintiff and main conclusions arising from the examination conducted by Dr Fones:

(a) he appeared anxious and depressed in his mood but was conscious and alert and orientated to person, place and time;

(b) at one point, he retched violently and loudly but did not vomit;

(c) there were no psychotic symptoms;

(d) he suffered from post concessional syndrome following his head injury and also had somatoform pain disorder and secondary depression;

(e) his disability was substantial because the symptoms were uncomfortable and intrusive and they rendered him unable to work;

(f) he did not have marked cognitive deficits from his head injury;

(g) although there was a possible component of OBS giving rise to some cognitive deficits and personality change, this did not impair him to the point of affecting his self care;

(h) he was not of unsound mind and was able to manage himself and his own affairs;

(i) he would benefit from a trial of antidepressant treatment for at least nine months and psychological therapy and rehabilitation would be ideal; and

(j) the 50% disability estimated by Dr Peh was agreed to.

28 Under cross-examination, Dr Fones explained that he did not take steps to investigate whether the plaintiff had indeed suffered a brain injury because he had considered the information provided to him by the plaintiff's solicitors (as mentioned in [26] above) to be sufficient to indicate the same. He agreed that the skull x-ray and CT scan indicated that the plaintiff had not suffered a severe brain injury. He agreed that getting the correct history of a patient would be critical in deciding whether his medical opinion was supported. Dr Fones was shown the ambulance crew report and the discrepancy between it and the plaintiff's account of being unconscious was pointed out. Dr Fones later said that the assessment by the ambulance crew would have been somewhat cursory and would have referred to a more general description of the plaintiff not being unconscious but that the neurological assessment of conscious state refers to a more systematic assessment including whether the subject was able to give accurate responses.

29 Dr Fones explained to the court that a concussion was a brain injury arising from a trauma to the head. This may or may not result in documented abnormalities on a scan of the head. Whilst he agreed that the more severe the concussion was the more likely it was that the patient would suffer more severe disabilities and symptoms, that was not always the case in that there could be very

good recovery following a very serious injury to the brain and, conversely, an apparently minor injury to the brain may lead to serious or long standing neurological deficits. As regards the loss of consciousness, Dr Fones said that the plaintiff was hazy on this point and what he had specifically told Dr Fones was that he woke up in hospital and was told by staff and colleagues what had happened to him.

30 It was pointed out to Dr Fones that whilst the plaintiff had told him that he had fallen from a height of three storeys, in his affidavit the plaintiff had affirmed that he fell from the third level of a scaffold. Dr Fones thought there might have been a miscommunication between him and the plaintiff but this difference in the height of the fall did not, he said, have any real bearing on his assessment since he had based it on the premise that there was no documented fracture of the skull or CT scan evidence of bleeding or injury to the brain.

31 Dr Fones explained that somatic complaints are symptoms of discomfort in various parts of the body. "Somatoform pain disorder" is a clinical condition where symptoms of pain do not coincide with objective evidence of injury to the site of the pain. There is a psychiatric or psychological component to the origin of such pain. He explained that the difference between somatoform and malingering is that in the latter, there would be purposeful manufacturing of fictitious symptoms when a person knows that he is under scrutiny for the purposes of assessment. In somatoform pain disorder, the fluctuation of perceived pain and discomforts is a function of the prevailing emotional state. Thus, the key difference between the two conditions is the conscious manufacturing of symptoms (malingering) versus the unconscious increase or decrease of symptoms (somatoform pain).

32 In this case the doctor considered that the plaintiff's somatoform pain disorder arose from his headache combined with emotional factors such that focus on the headache became more and more persistent. As regards OBS, he had noted "possible" OBS because he did not document either cognitive deficit or personality change but felt limited by his ability to communicate with the plaintiff in his native tongue. He confirmed that the plaintiff had maintained eye contact with him. He did not appear dishevelled and did not display himself as talking to himself or laughing to himself.

33 Dr Fones said that his consultation with the plaintiff took about an hour and though he could not say for sure that there were no attempts by the plaintiff to exaggerate or embellish his account, Dr Fones had not at the time doubted the veracity of the account. He did admit that he considered the plaintiff's retching to be somewhat extreme at the time when the plaintiff manifested it in his office. It was suggested that the plaintiff was trying to stretch it and the doctor conceded that there was that possibility. At the time he had not felt that the plaintiff was malingering. However, the behaviours that the plaintiff had manifested in front of Dr Fones were somewhat less than those described by Dr Ho and Dr Lim. He confirmed that he disagreed with Dr Peh's conclusion that the plaintiff was of unsound mind and was unsure as to the basis of this conclusions and as to how the plaintiff had presented himself to Dr Peh on his visits to that doctor. Dr Fones also agreed that if it was shown that the plaintiff's mood was not depressed or that his sleep was regular, such facts would affect the accuracy of Dr Fones' diagnosis.

34 As regards the somatoform pain disorder, Dr Fones stated that he relied on the complaints of persistent headache, giddiness and blurred vision in the light of the normal CT scan to make this diagnosis. If there was evidence to show that the plaintiff did not have a persistent headache, did not experience giddiness, nausea or blurred vision, that evidence would throw the diagnosis of somatoform pain disorder into doubt. He agreed that many of the plaintiff's complaints were subjective. His starting point was that there must have been some head injury and there must have been some symptoms that arose from that injury.

35 Dr Fones was also asked about diffuse axonal brain injury. He explained that this usually refers to postulated damage to the axons of the neural cells following a trauma to the brain where the scans are usually normal, where there are documented symptoms arising out of the injury. It is postulated that the nerve cells are injured at a level that is not visible through the scans administered. Such damage occurs on a microscopic level which is only seen in a post-mortem. Diffuse axonal brain injury may at times lead to long term residual incapacity but for the most part it tends to resolve over time. Dr Fones stated that such injury would account for how the post concussion syndrome arose.

36 Dr Damian Png Jin Chye examined the plaintiff on 29 August 2006. The history given to him was that after the accident, the plaintiff had complaints of lower abdominal and loin discomfort and erectile dysfunction. Dr Png gave the plaintiff an injection in order to determine the cause of the erectile dysfunction. The result of this injection led Dr Png to believe that the dysfunction had an organic cause and therefore was likely to have resulted from the fall in September 2003.

37 Under cross-examination, Dr Png confirmed that he had examined the plaintiff only once, three years after the accident. The plaintiff did not volunteer any information to him about sexual disease. Dr Png explained that venereal diseases do not have a bearing on erectile dysfunction which has a psychogenic or organic cause or both. He explained if a man falls from a height and there is trauma and damage to blood vessels that could result in the dysfunction. The damage could be anywhere in the groin. From the medical reports, after the plaintiff's fall, there was a lower abdominal discomfort and contusion from the loin to the pelvis in the left hip. The dysfunction could, however, be caused by a trauma affecting the head, spine or the pelvis. Dr Png did not think it was likely that a beating that the plaintiff said he had received from seven men could have caused this trauma because after the alleged beating the plaintiff had been able to take a taxi. While he thought that the trauma was more likely due to the fall than to the beating, he agreed that there was an element of speculation on his part because he had not seen the medical report of the beating episode. The doctor also confirmed that he had understood that the plaintiff had fallen from a height of between four and a half and five metres. If the plaintiff had fallen from a height of one and a half metres, then he agreed that the amount of force to which the plaintiff's body would have been subjected, would have been less. Contusions resulting from a fall from a height tended to be more serious than if the patient were punched because punching would only cause localised injuries.

38 Dr Png was shown the medical report issued by Dr Goh Siang Hiong dated 11 August 2006 and based on the notes of the plaintiff's first admission to CGH which stated the plaintiff's injuries as being contusions of the left hip, left elbow and the back and that x-rays of various areas were all normal. Looking at this report, Dr Png stated that the likelihood of the fall having caused injuries that resulted in erectile dysfunction was lower than when he had first written his own report. He had taken into account in coming to his conclusions the letter from the plaintiff's lawyer which stated that the plaintiff was suffering from the dysfunction and that he had "back pain with severe pain with discomfort". In re-examination, Dr Png stated that even a fall from a height of one and half metres could have caused injuries to the left hip, left loin and back leading to the dysfunction if the plaintiff had fallen in an awkward position.

39 Dr Png was also shown certain documents from CGH which indicated that the plaintiff had been assessed and treated for syphilis in 2004. The plaintiff had not told him about this treatment but, in Dr Png's view, syphilis was not relevant to the dysfunction.

The defendant's medical evidence

40 The defendant's insurers had appointed Dr Ho King Hee, a neurosurgeon, to examine the plaintiff in mid 2006. They also required him to see a consultant psychiatrist, Dr Lim Yun Chin.

41 Dr Lim examined the plaintiff in June 2006. The plaintiff was accompanied by his brother and a friend who was able to speak some English. An interpreter from the Bangladesh Trade Commission was also present. Prior to the examination, Dr Lim studied the CGH discharge summaries dated 3 and 10 October 2003 and two medical reports for workmen's compensation issued in 2006. He also viewed two video tapes furnished by the defendant's solicitors. These tapes pertained to the plaintiff's behaviour when he was in the company of a friend in a coffee shop.

42 In his report, Dr Lim noted that the plaintiff had entered the clinic unable to walk on his own. He was supported by his brother and his friend and appeared "vacant" and "confused". Eye contact could not be established as the plaintiff looked down at the floor and conveyed the impression that he was oblivious of his surroundings. It was difficult to persuade him to talk. On one occasion, however, the plaintiff went into a rage and abused his companions. On another occasion, he appeared to correct the replies that they volunteered. Before the arrival of the official interpreter, the plaintiff presented himself as half sedated and making no eye contact and muttering incoherently. When he saw the interpreter he became alert. He was able to make eye contact with her when she was translating the questions to him and soliciting his replies.

43 The plaintiff told Dr Lim that his problem was giddiness and that if he tried to remember what happened at the time of the accident, he would get a headache. He stated he could not remember when he arrived in Singapore and his account of the accident was "fall down, can't remember", "feel pain". When asked where the pain was, he pointed to the back of his neck and directed his finger to the left side of his neck and said "everywhere is pain", "burning pain" and "cannot walk". He was asked some basic general knowledge questions and answered about half of them correctly. He became irritable as the interview went on and said he did not know his age.

44 Dr Lim was shown some video footage taken of the plaintiff. He commented that in the video, the plaintiff appeared absorbed in conversation with another man and was very focussed, animated, attentive and engaging. He was alert. He was relaxed and did not display irritability or make gestures that suggested that he was in pain. According to the information given to the doctor, the video footage was of an incident that took place on 8 June 2006.

45 Dr Lim's opinion was that despite the plaintiff's dazed demeanour during the interview, his overall behaviour and the clinical findings were not consistent with someone who was suffering from disorientation or gross cognitive impairment. Despite the overt embellishment of inability to respond to the questions, it was evident that he had an adequate grasp of the verbal exchanges conducted in his presence and that he was fully alert to his environment. From the medical reports, there was no evidence that the plaintiff had suffered from overt head injury or neurological complications following the accident. There was no evidence either of amnesia.

46 In Dr Lim's opinion, the plaintiff displayed an erratic constellation of symptoms that would not fit in a major neuropsychiatric disorder such as OBS. The absence of significant injury to the brain made it unlikely that OBS had occurred. The complaints of the loss of memory, confusion and cognitive decline (often associated with OBS) could not be satisfactorily verified during the interview given the plaintiff's attitude and lack of co-operation during the mental state examination. Dr Lim thought that the plaintiff was being wilfully unco-operative during the interview given his completely different actions and responses on a separate occasion (VCD evidence) when he thought he was not being observed. A discernible symptom that emerged during the interview was in the approximate answers given by him to the simplest questions that he appeared to understand. In the absence of clouding of consciousness and other psychiatric abnormality, malingering cannot be ruled out. Dr Lim concluded that he could not agree with the diagnosis of OBS in relation to the plaintiff.

47 In court, the doctor explained that "approximate answers" was a symptom displayed when a patient gives an answer in response to a question. The answer is called "approximate" because it appears that the patient knows the answer but is not able to give the actual answer but only an answer that seems to be quite close to the real answer. Most of the questions that were asked of the plaintiff were related to over-learned data, *ie*, information that Dr Lim expected somebody of the plaintiff's background to know. He did not ask for information that the plaintiff had never come across. He explained that in such a situation, if the patient responds to questions or information relating to over-learned data and he seems unable to give the right answer, a psychiatrist would tend to infer that the patient is malingering in the absence of confused state or other psychiatric abnormality. In this case, he had given the plaintiff the figure "4" to identify and he said it was "5". When given the figure "3", the plaintiff said it was "2" and when given "7" he said it was "6". The plaintiff had identified a $2 note as $1 but was able to correctly identify a $50 note. He was able to correctly identify three $50 notes and to add them to a total of $150 but when he was asked about his age, his reply was that he did not know and when asked to add two $50 notes, he said $0.

48 Asked to comment on Dr Fones' diagnoses of post concussion syndrome and somatoform pain disorder, Dr Lim explained that the symptoms of post concussion syndrome are subjective and are usually verbalised to the neurologist and psychiatrist. Usually, post concussion symptoms emerge against the background of head injury either minor or severe. A neurologist looks into evidence of head injury whilst the psychiatrist's role would be to alleviate the symptoms by counselling and use of medication. Dr Lim stated that because he had seen no documentary evidence that the plaintiff had any head injury, he found it difficult to accept that the plaintiff had suffered a post concussion syndrome. As for the somatoform pain disorder, there is the assumption that the patient has the pain but without there being a physical or organic basis for such pain. Hence, the pain is of psychological origin. Dr Lim commented that Dr Fones did not specify in his report what psychological issues existed that could have contributed to the pain and secondly, he did not suggest that the pain was related to any anatomical distribution. So it was difficult for Dr Lim to substantiate that somatoform pain disorder existed.

49 In cross-examination Dr Lim was shown the ambulance crew's report and the notation that the plaintiff had been hyperventilating and had carpal pedal spasms. He agreed that hyperventilating occurred when someone was feeling very anxious and that whilst carpal pedal spasms are a result of rapid shallow breathing they could also develop if someone was in pain.

50 As to his assertion that there was no physical evidence of any head injury sustained by the plaintiff, counsel showed him the discharge summary dated 3 October 2003 which said that the principal diagnosis was post concussion syndrome. Dr Lim then pointed out that in the same report, the CT scan result showed that no abnormality had been detected and commented that it was the most sophisticated medical technology available to detect evidence of even minute head injury. He then referred to the comment in the same summary that "subsequently headache resolved" and surmised that based on it the treating doctor was making a diagnosis that there was possibility of head injury but that at the time of his examination, there was no evidence of an injury that was deteriorating. He also stated that after establishing the diagnosis and giving the summary, the suggested treatment did not address the issue of the head injury any further; it simply requested a follow up in two weeks' time. That meant that the treating doctor wanted to ascertain what the development of the post concussion syndrome was.

51 Counsel for the plaintiff told Dr Lim that the plaintiff had been treated by Dr Peh and his colleague Dr Winnie Ho of the Department of Psychological Medicine and they had given him 491 days' medical leave. Dr Lim was asked whether this changed his opinion. He replied that in the medical certificates, the column for the diagnosis had been left blank and therefore he could not tell why the

certificates had been given. Secondly, in his understanding of clinical practice, when a patient comes with complaints, the doctor is not in the business of trying to tease out whether the patient is telling the truth. He said that if he had seen a patient in that condition, he would have given the patient medical leave if asked for. It was put to him then that the plaintiff must have suffered these disabilities for him to have obtained these medical certificates for such an extended period of time. He replied as follows:

> The doctor was put in the position that the patient came and reported symptoms, and as far as we know based on subsequent examination, there was no evidence of physical injuries. Hence it is based purely on the patient's complaint. And the doctor is put into the position that he has to trust the patient. I would suggest that the reason why the diagnosis column is not filled is that it is purely based on symptoms and symptoms do not make a diagnosis.

52 Dr Lim was asked about the various medications that had been regularly prescribed to the plaintiff by Dr Peh's department. He identified these medications as being of the type that were prescribed for patients who complained of psychotic experience and those who complained of depression. However, in his view, the dosage given showed that the doctor was prescribing in what is called an "off-label prescription" *ie* it would not be in accordance with the guidelines. According to Dr Lim, psychiatrists often do this and when they do so they tell the patient to use the medication whenever necessary *ie* whenever he has symptoms. This means that the symptoms are not regular or serious. The doctor is prescribing the medication for the symptoms complained of by the patient but is not convinced that a formal diagnosis exists. He was asked whether he himself would have given this medication, if he was the treating doctor and was not convinced of the diagnosis. Dr Lim replied:

> In psychiatry, the range of medication we have is very limited. We tend to give this medication for clear case of diagnosis at the right dosage for the right duration but we also give the same medication in much more minute doses at irregular intervals for symptoms. It is a standard practice.

53 In respect of the prescription of piracetam, Dr Peh had told the court that this medicine was given to the plaintiff as it is useful to help brain cells recover after an injury. Dr Lim did not agree that this was the use of piracetam. In his opinion, the drug was used to increase blood supply to the brain on the assumption that the more blood supply there is to the brain the more active the brain would be. He confirmed that the drug dilates blood vessels and is commonly used when patients suffer from a stroke. When Dr Lim was asked whether it would help if the blood vessels had been narrowed or compressed by a head injury, his response was that his own experience of this medication was quite negative.

54 When asked whether the medications indicated a consistent course of treatment by specialists at CGH, Dr Lim disagreed. He said that the medication became more non-specific. The original medication that was given – antidepressant, psychosis – appeared to have been discontinued in later months and the medicines shown to have been prescribed by April 2006 were piracetam and a vitamin, folic acid. These have a non-specific effect and it therefore appeared to him that by then the doctors have decided not to continue with the psychiatric medication any longer.

55 Commenting on the psychological evaluation of the plaintiff which took place in 2004 Dr Lim stated:

> The psychological assessment to elicit a person's psychological functioning is heavily dependent on the patient's understanding of English. It also depends on his level of cooperation. As a result it also [has] [a] very strong subjective element. This result was given as one paragraph and

there was no elaboration of how it was administered, whether it was done in English, or whether it was done with the assistance of an interpreter, and whether the interpreter was qualified or subjective. So I have misgiving as to the result, knowing the limitations of such an assessment tool. In retrospect, all the reports show there was no evidence of head injury from the time he was examined in the ambulance, and throughout the period of follow-up. This diagnosis of Organic Brain Syndrome ("OBS") is made on the supposition that there was damage to the brain. One cannot make a diagnosis if there was no injury or damage to the brain. It is very hard to support this diagnosis given that there is no evidence of brain injury or illness. Anti-depressant medication that was prescribed was never given to the dosage that one would expect someone suffering from depression would have. It was given in sporadic and sub-optimal dosages. [I] would not expect somebody in that dosage regime to respond to treatment for depression.

56 Dr Lim did, however, confirm that not all brain injuries can be detected by the CT scan. Minute injuries may not be visible on such a scan. Dr Lim was not able to comment on Dr Seah's diagnosis of diffuse axonal brain injury which he had not seen prior to his court appearance because the report contained insufficient details of how the diagnosis was arrived at. He also commented, however, that injury to the axon would manifest in neurological signs and if there were no such signs, either the injury was very mild or it would have recovered. He agreed that treatment with piracetam would help the axon. In re-examination, Dr Lim was shown a second medical report on traumatic injuries for workmen's compensation issued by Dr Charles Seah. This was dated 12 January 2006. In this, the description of the plaintiff's injury read "Fell from height at work. He sustained a head injury with mental changes suspected". Dr Lim's comment on this report was that Dr Seah had withdrawn himself from the finding of diffuse axonal brain injury to a more non-specific description *ie* head injury. He did agree, however, that the axon has capability for healing or restoration.

57 The defendant's expert neurologist, Dr Ho King Hee, also took a dim view of the plaintiff's complaints. He was supplied with a whole series of documents and medical reports relating to the plaintiff's accident and medical history and examined the plaintiff himself on 5 September 2006. The plaintiff was accompanied by his brother and the history was obtained from the plaintiff via an independent interpreter. The plaintiff told Dr Ho that he had fallen from a height of three storeys. He could not recall the date of the accident but stated that it had happened three years previously. He stated that he lost consciousness at the time of the accident and only regained his memory four to five hours later. The plaintiff listed his present complaints to Dr Ho to be:

(a) generalised headache starting within days of the accident and being constant, pulling in nature and severe and in intensity;

(b) constant rotatory giddiness and nausea;

(c) difficulty speaking for extended periods of time, with shivering, generalised weakness and "dropping" if he continued talking;

(d) inability to walk long distances;

(e) constant back pain in both upper and lower back radiating to the buttock but not the legs;

(f) erectile dysfunction; and

(g) impaired sleep quality.

He did not mention any memory or cognitive problems. He had no complaint of recurrent faintness or loss of consciousness. He had no problems with senses of hearing, taste and smell and was able to physically look after himself and go out by himself. He could climb one to two flights of stairs before needing to stop because of pain. He could only sit for five to ten minutes at a time because of back pain. He could climb ladders and bend over slowly.

58 After taking the history and carrying out a physical examination, Dr Ho's opinion was that it was unclear if the plaintiff did in fact sustain a head injury at the time of the accident. However, if the history of a fall from a height and subsequent loss of consciousness was taken at face value, it would be the case that a brain concussion would have occurred. Because the plaintiff had no neuro-imaging abnormalities or clinical deficits and was well enough to be discharged from CGH on the day of the accident itself, Dr Ho concluded that any head injury he sustained could not have been severe and the chance of post concussion syndrome occurring would not have been high.

59 In relation to the various diagnoses made previously in respect of the plaintiff's condition, Dr Ho had the following views:

(a) as the available history indicated that the plaintiff's day-to-day independent social interaction and functioning was quite normal and there was no history significant memory or cognitive loss, Dr Peh's assessment of 50% permanent disability was not applicable;

(b) the absence of a clear history of head trauma with loss of consciousness exceeding 30 minutes, post traumatic amnesia exceeding 48 hours and of neuro-imaging abnormality cast serious doubt on the thesis that the plaintiff's headache was related to a head injury sustained at the time of the accident;

(c) there was no clinical evidence of traumatic labyrinthine dysfunction which could cause chronic giddiness;

(d) the complaint of increased symptoms with prolonged speaking was inexplicable on an organic basis and the plaintiff's demeanour during the examination was contrived and unnatural;

(e) although the plaintiff's symptoms were completely subjective in nature and impossible to confirm or refute on examination alone, there were inconsistencies which led Dr Ho to believe that the plaintiff was consciously or unconsciously exaggerating the extent of his symptoms; and

(f) the plaintiff should be given a six-month course of antidepressant medication to normalise his mood and relieve his pain.

60 Dr Ho explained that by the word "inconsistencies", he was referring to the following matters that he had noted when he examined the plaintiff:

(a) the presence of clear effort fluctuation on motor testing;

(b) an abnormal straight leg-raising test [contrasted] with normal ability to sit with legs outstretched at right angles to the trunk;

(c) the absence of any muscle spasm or restriction of neck or back movement despite the complaint of severe pain; and

(d) the non-correspondence of his painful sites to the well-described fibromyalgia tender sites, indicating that his pain was most likely not myofascial in origin.

61 Under cross-examination, Dr Ho confirmed that he had examined the plaintiff only once and asserted that the examination would have taken approximately one hour because all his medical legal examinations take about an hour. Although he did not have the precise time of examination noted, he did not agree with the plaintiff's suggestion that the examination only took about 20 minutes. The report he had issued was evidence in itself of the time spent with the plaintiff.

62 The witness was shown the CGH discharge summary report dated 12 October 2003 and asked whether he disagreed with the principal diagnosis of post concussion syndrome. He replied that he did not have the set of facts that the doctor who made the diagnosis had before him at the time of coming to the conclusion and that generally before one could diagnose a post concussion syndrome with certainty, there must be clear evidence of a cerebral concussion. The material available to him did not, in his reading, establish that point. Dr Ho was also shown the plaintiff's medical bills which showed the various investigations, injections and medications given to the plaintiff over the years and the medical certificates issued. He was then asked he would vary his report on the basis of these documents. His response was that whilst the documents gave him a better idea of the plaintiff's treatment, his conclusions in his report were based on his personal impressions as obtained on his examination of the plaintiff and, therefore, stood.

63 Dr Ho did not agree with the diagnosis of OBS. He explained the term as referring to a disturbance of mental function that has an underlying physical cause. He assumed that Dr Peh made this diagnosis because he attributed the plaintiff's symptoms to the physical cause of brain injury. Dr Ho himself was not convinced from the documents available to him that head injury severe enough to lead to an OBS had occurred. It was also the case that the severity of symptoms of an OBS would be maximal immediately after the injury, resolving gradually thereafter. The absence of this temporal pattern of symptoms in the plaintiff's case led Dr Ho to question the diagnosis.

Other evidence

64 The defendant called two Bangladeshi witnesses who were acquainted with the plaintiff, being from his village in Bangladesh. The purpose of their evidence was to say that the plaintiff acted normally around them and was not of unsound mind. The plaintiff called a Bangladeshi worker, one Awalad Kazi. Mr Kazi heard about the plaintiff's accident whilst he was still in Bangladesh. When he came to Singapore, he heard about it again. Subsequently he met the plaintiff and they exchanged greetings. The plaintiff said that he was all right but that he had met with an accident. The plaintiff did not look like he had before: he was very depressed and quiet. Mr Kazi only met the plaintiff four times in five years in Singapore and none of those meetings had exceeded five minutes in duration.

65 The defendant also called Ms Yong Kar Yan, a paramedic in the emergency medical services branch of the Singapore Civil Defence Force ("SCDF"). She identified the ambulance report issued by the SCDF and confirmed that it contained the information about what the crew had found on 27 September 2003 when they arrived at 14A Jalan Punai. Ms Yong was asked about the sentence reading "According to the patient's friend, he fell from approximate height of 1.5m". She was not able to identify who had given this information as she said there were many friends there and the scene was chaotic. She confirmed she did not know the specific details of the accident, only its general nature.

66 The defendant himself gave evidence and he stated that he had taken the plaintiff, on his

discharge from CGH on 27 September 2003 itself, back to the workers' quarters at Geylang East. Over the next few days he became suspicious of the plaintiff and he wanted to keep a closer watch over him. He therefore installed a surveillance camera at the workers' quarters. He had about ten video tapes, some of which captured images of the plaintiff during his initial period of medical leave. The footage showed the plaintiff cooking and engaging in other ordinary activities like talking with his co-workers. The plaintiff himself when he was asked about these video tapes, confirmed that he was shown in these tapes but asserted that the video footage had been taken before his accident rather than after it.

67 More significant was the evidence given by Mr Louis Amalorpavanthan ("LA"), the principal investigator of GLA Claims Adjusting and Investigation Services, a private investigation agency. LA was appointed by the defendant's insurers on 8 May 2006 to carry out investigations and surveillance on the plaintiff. The surveillance of the plaintiff started on 16 May 2006 and continued until 19 June 2006. During this period, LA and his colleague saw the plaintiff on five days and managed to take video footage of him on most of those occasions. LA then prepared a report. Some of the salient observations in the report are the following:

(a) on the night of Friday, 19 May 2006, the investigators saw the plaintiff walking towards the back of a restaurant and entering its kitchen. He then came out again and had a casual conversation with a Chinese gentleman. Subsequently, they asked the plaintiff a question which he answered quickly and then left. Later they saw the plaintiff and another man (the plaintiff's brother) sitting on the curb outside the kitchen conversing. When the investigators walked towards the plaintiff, he got up and walked away. They saw him on two more occasions that night;

(b) on 6 June 2006, the investigators saw the plaintiff apparently working in a wine shop. After one investigator walked past the wine shop, the plaintiff came out of the shop to look for him. Later that evening, the investigators saw the plaintiff carrying a crate of beer bottles and loading them onto a van;

(c) on the night of 8 June 2006, the investigators saw the plaintiff sitting in a restaurant and talking to his friend. After about five minutes, the two of them were joined by the plaintiff's brother. Throughout the conversation, the plaintiff appeared very careful and alert;

(d) on 15 June 2006, the investigators were in their vehicle and when the plaintiff saw them, the plaintiff started to stagger and walked slowly behind the vehicle. The investigators then drove away and when they came back to their previous position they saw that the plaintiff was sitting on the pavement. They got out and approached the plaintiff and as he saw them, he started to knock his head with his knuckles. As they walked away, he lay down on the ground. Later he started to scratch his hair. Even later, at a time when the plaintiff was not aware that he was under surveillance, he started to press his hands onto his head and looked into the sky and later flung his food behind him; and

(e) on Monday, 19 June 2006, when the plaintiff was scheduled for an examination at the Raffles Hospital by Dr Lim Yun Chin, the investigators kept surveillance outside the hospital. They saw the plaintiff arrive there with two other Bangladeshi men. The plaintiff looked tired and occasionally pressed his hands against his head. He and his companions were alert. After the examination, the plaintiff and his companions walked to the Rochor Road bus terminal and then onwards towards Desker Road. They walked through the flea market and then went to a telephone booth at Rowell Road where the plaintiff made a phone call. Thereafter, they entered the Sapala Restaurant along Desker Road and the plaintiff was seen talking to a man behind the

counter.

68 LA concluded that his investigation had revealed that the plaintiff was able to conduct normal conversations; was able to work at a wine shop; was able to recognise LA even though he had only seen LA twice before; was able to respond quickly when he suspected that someone was trying to catch him on tape and was able to spot the pin-hole sized camera carried by one of the investigators. The plaintiff could hide when he saw the investigators and when he saw them he would act as if he was mentally sick. LA considered that the plaintiff was basically normal and was able to take care of himself. LA produced the video footage that he had taken and this was shown to the court. One notable feature of this footage related to the plaintiff's visit to Dr Lim on 19 June 2006. In Dr Lim's report and testimony, he had stated that the plaintiff had not walked into his clinic on his own but had had to be supported by his two companions. When he left, he was also helped by them. In contrast, the video footage showed the plaintiff walking independently and clearly not requiring any assistance from his companions.

69 During cross-examination, it was suggested to LA that when he had received a client's instructions as to what the client wanted to find out, he would go about piecing evidence together to satisfy the instructions. LA denied that suggestion. It was suggested to him that contrary to his assertion, the person who was working at the wine shop was the plaintiff's brother and not the plaintiff. The witness disagreed. He agreed that his evidence for stating that the plaintiff was working at a wine shop was that he had observed the plaintiff carrying a crate of bottles and loading it into a van parked outside the shop. He agreed that he did not subsequently ask the owner of the wine shop whether the plaintiff worked there. He was told that the plaintiff had testified that he went to the wine shop once to collect some pieces of cardboard so that he could put them on the ground and rest on them. The witness said that was not true as he did not see the plaintiff carrying any piece of cardboard during the time that he had the plaintiff under observation. LA was also asked many questions regarding his interviews with the defendant and other persons but it is not necessary to elaborate on these.

The findings below

70 Having heard the evidence and the submissions, the AR found the defendant's medical witnesses to be more persuasive than the medical evidence adduced for the plaintiff. He also found the plaintiff himself to be an unsatisfactory witness. To summarise the AR's holdings:

(a) he found Dr Ho King Hee's testimony and the conclusions Dr Ho reached in his medical report to be unshaken. Specifically, the chance of any post concussion syndrome was not high. The AR considered that there was no challenge to Dr Ho's conclusion that there was serious doubt as to the relationship between the plaintiff's headache and any head injury sustained at the time of the accident. He accepted Dr Ho's assertions that the complaint of increased symptoms was inconsistent with true nausea or respiratory distress, that there was no OBS and that the substantial inconsistencies in the plaintiff's test results showed that he was consciously or unconsciously exaggerating the extent of his symptoms;

(b) the AR noted that Dr Peh Lai Huat had prescribed medicine on the basis of tests done by other departments that apparently showed that he had sustained brain cell injury. However, there were no such tests that did indeed show such injury. The AR therefore found it difficult to accept that Dr Peh's prescriptions indicated that the plaintiff did indeed suffer the conditions or symptoms for which the medicines were prescribed. Dr Peh was not able to convince the AR that there was any substantive basis on which his diagnosis and treatment could be based. Additionally, Dr Peh had conceded, when shown Dr Lim's report, that if he had had the same

information as Dr Lim had access to, he would be prepared to revise his diagnosis;

(c) in relation to Dr Fones, the AR considered that his assessment of post concussion syndrome, somatoform pain disorder and secondary depression was largely based on the plaintiff's account of his own medical history. The objective tests done did not lead to any conclusion of disorder. The accuracy of Dr Fones' assessment would have been affected if the plaintiff or his cousin had exaggerated or made up the symptoms suffered. There were also a number of differences between the observations of Dr Fones and those of other doctors. Dr Peh had found severe cognitive deficits but Dr Fones found that there was no marked cognitive defect. Dr Lim and Dr Ho observed that the plaintiff had behaved at an abnormal manner but Dr Fones did not observe any abnormality apart from the retching behaviour. He also conceded that the inconsistencies suggested that the plaintiff was exaggerating. The AR therefore concluded that Dr Fones' diagnosis was speculative;

(d) in relation to Dr Damian Png, the AR accepted that his clinical tests had demonstrated that the plaintiff had erectile dysfunction and the only question was whether this condition was attributable to the accident. He found that the plaintiff had not proved from Dr Png's evidence that the condition was caused by the accident because:

(i) Dr Png's finding had been based on a fall from the third level of scaffolding and on reports of contusions found on the plaintiff's body;

(ii) Dr Png conceded that there was an element of speculation in his finding when he was told about the evidence relating to the height of the fall and the actual injuries sustained; and

(iii) the plaintiff's first complaint of erectile dysfunction was made three years after the incident.

(e) the AR found Dr Lim's evidence that the plaintiff was not suffering OBS, that malingering could not be ruled out, that there was nothing to substantiate a finding of somatoform pain disorder and the diagnosis of diffuse axonal brain injury was questionable, to be highly reliable. His interpretation of the medical certificates and the prescriptions given to the plaintiff was instructive. His evidence was highly damaging to the plaintiff's claim for any form of head injury;

(f) he found the defendant to be generally candid in his responses and the evidence of Ms Yong to be formal in nature, confirming the veracity of the ambulance report. He was not convinced by the evidence of the other Bangladeshi witnesses as he considered it was not reliable since they had not met the plaintiff often nor for extended periods of time; and

(g) the AR accepted the veracity of the main points of the private investigator's report which, he considered, only contained a small number of inconsequential errors. He also accepted that the recordings were properly made.

71 When it came to the plaintiff's evidence, the AR was rather scathing in his findings. It is worth quoting him in full. He said:

The Plaintiff's evidence was to a large extent unsatisfactory and his demeanour unpersuasive. He contradicted himself on many material areas during cross-examination; for instance on the issue of whether he lost consciousness after the fall and the severity of his forgetfulness. I also found him to be evasive on crucial points.

It was clear that he behaved very differently when in front of doctors and when he thought he was not being observed. During cross-examination, he initially seemed unable to withstand more than 15 to 20 minutes of cross-examination before he had ostentatious bouts of coughing and gagging, but as the days wore on, these afflictions became less frequent. Contrasting such severe symptoms with the video-footage taken of him when he thought he was not being observed, I found it difficult to believe that the symptoms he had displayed in my chambers were representative of his true condition.

Also, his complaints to doctors and his account of the accident (in particular the height from which he fell) differed from time to time over the few years after the accident. There were also inconsistencies between the doctor's reports and his accounts of the injuries and symptoms he had suffered.

72 The AR's conclusion on the damages claimed was as follows:

Conclusion

General damages: The only injuries I accepted that the Plaintiff had suffered as a result of the incident were the contusions on his left hip, left elbow and back immediately observed after the fall. All other injuries and medical conditions were either non-existent or not attributable to the incident. I note that the contusion injuries were not actually pleaded in the Statement of Claim. Nevertheless, I award a sum of $2,000 with interest at 5.33% p.a. to run from date of writ to date of judgment.

Special damages: The Plaintiff's brief recovery from his contusions would have been covered by MC and thus there was no loss of earnings during this short period. Any subsequent loss of earnings was not due to injuries sustained in the incident. Medical and transport expenses for the first A&E admission subsequent to the injury were not borne by the Plaintiff. There is thus **no award for medical expenses, loss of pre-trial earnings and transport expenses**.

I do not think that the Plaintiff's future earning capacity has been affected by the incident. No **award for loss of future earnings or loss of** earning capacity.

The appeal

73 On the appeal, counsel for the plaintiff went through the evidence again and argued that it established the complaints in respect of which the plaintiff had made his claims. Counsel for the defendant argued, equally strenuously, that the evidence supported the AR's findings. The main issue in the appeal therefore was a question of fact: whether the plaintiff had indeed suffered the injuries that he alleged he had. That is why I have set out the evidence in so much detail above.

74 It is generally accepted that an appellate court should not vary findings of fact made by a lower court since the lower court would have had the benefit of seeing the witnesses in person and gathering a first person overall impression of the presentation of the case and the evidence. Of course, the appellate court will interfere if it is convinced that the findings of fact made are not supported by the evidence. In this case, I find very little basis on which to disturb the AR's findings. In particular, his assessment of the lack of credit worthiness of the plaintiff himself was fully supported by the transcript of the assessment hearing. The plaintiff was evasive and prevaricated on even minor points. A flavour of his evidence can be seen in relation to his reaction to questions about his schooling:

Q: What is your highest educational level achieved in the village?

A: I'm uneducated.

Q: You have not gone to school at all in your whole lifetime?

A: I've gone to a village school, class 2 or 3.

Q: In other words, you've achieved Class 3 in the village formal education?

A: That's not a proper school, it is just a gathering of children.

Q: You have achieved Class 2 or 3 in village education?

A: Yes in a village school.

Q: Class 3 means 3 years of education in the village school?

A: No I don't go to the school every day.

Q: To achieve Class 3, how many years does it take?

A: How many days I gone to the school I do not know.

75 The plaintiff claimed that he had had a bad memory since the time of the accident. He was questioned on this issue and at one point the following exchange took place:

Q: At the earlier part of these proceedings, you said you had difficulty remembering things?

A: I do remember some things once in a while, but I may forget it again if you ask me again later.

Q: In other words, you have selective memory. Some things you want to remember sometimes, sometimes you want to forget?

A: It's not that I select and tell your goodselves anything. What I can remember I tell, but I might just forget again a while later.

…

Q: PBA Tab 1 [10]: In your Affidavit of Evidence In Chief you gave so much detail about your accident, such as there being two sets of scaffolding, the size of the paint container, how exactly you fell. You are again deliberately deciding that you want to remember the details of the accident?

A: At that point of time, I was able to remember things of my accident and all the incidents which happen. But as days pass by I have become worse. I can't recall things, the pain has become uncontrollable. I can't recall things on the spot. And if I start to think the pain is so terrible that I can't take it. When I have a pain at the back of my neck I have a very strong sharp pain which goes up right in my head and at that point of time I really cannot remember anything and I feel very uncomfortable.

It was interesting to note that this affidavit was made in March 2008 whilst when the plaintiff consulted the specialists earlier in 2006, he had been vague about the details of his accident. In particular he had told Dr Lim that he could not remember anything apart from the fact that he had fallen down and experienced great pain. It was odd, to say the least, that some two years later, he could recall the incident in greater detail.

76 It was clear from the various doctors' reports that the plaintiff was selective in what he told the doctors. Sometimes he said that he had fallen from a height of three storeys whilst at other times he said that he had fallen from the third level of the scaffolding. He was also insistent that he had suffered a loss of consciousness immediately after the accident although this was not reflected in the ambulance report or CGH's discharge summaries. When challenged about it, he varied his story on the loss of consciousness. In his affidavit of evidence-in-chief, there was no mention that he lost consciousness and it was therefore put to him that he had not lost consciousness. His reply was that he was told by his friend Imran that he was unconscious and it was only when his boss sprinkled water on his face that he regained consciousness. This was the first time he had mentioned his friend Imran and this account was also at variance with the account that he had given Dr Fones some two years earlier which was that he regained consciousness only at the hospital.

77 Altogether I agree with the AR's assessment of the plaintiff. The video footage and report of the private investigators were also highly persuasive and indicated that the plaintiff behaved entirely differently when he believed he was not being observed or examined. That being the case, the plaintiff's complaints cannot be taken at face value and one has to look at the medical evidence to determine whether they substantiate his position. In this regard also, I largely agree with the AR's analysis. The plaintiff was subjected to a whole battery of tests when he was first admitted to A&E department of CGH and then again during his two subsequent admissions. None of these tests showed any serious physical injury to the plaintiff's body from the fall. On the day of the fall itself, he was adjudged well enough to go home after a painkiller had been administered by injection and he was given only three days' leave. It is also notable that the thorough examination did not elicit any signs of injury to his scalp, not even a bruise. Subsequently, two brain scans showed that there was no internal bleeding of the brain or any swelling. Whilst Dr Peh testified (and Dr Lim, another psychiatrist confirmed,) that a brain scan will not show minute changes within the cell, Dr Ho, the neurologist and specialist in the brain, stated that the lack of neuro-imaging abnormalities in the brain indicated that any head injury sustained could not have been severe. This evidence is persuasive and supported, in my view, by the lack of any scalp injury, even a minor one.

78 I agree that, on balance, the evidence established that the plaintiff did not suffer from OBS or somatoform pain disorder or depression. If there was any diffuse axonal brain injury, which seems unlikely, the same would have resolved shortly after the accident. The medical evidence given was that this condition is capable of resolving itself. It was notable that although Dr Charles Seah originally diagnosed a diffuse axonal brain injury, he later changed this diagnosis to simply head injury. It is also notable that Dr Seah did not certify that the plaintiff had sustained any permanent incapacity. Dr Peh's determination that there was a 50% permanent incapacity was based on his

belief that the plaintiff had suffered a head injury and the manner in which the plaintiff presented himself at the outpatient clinic on numerous visits. Dr Peh and his colleague, Dr Winnie Ho, understandably accepted the apparent findings of other departments in CGH and saw no need to conduct independent investigations into physical injury. In any case, that was not their role as they were there to determine and treat psychiatric rather than physical conditions. Since Dr Peh's diagnosis was based on an assumption and on the way the plaintiff acted and both these factors were shown by other evidence to be unreliable, I agree with the AR that Dr Peh's diagnosis did not reflect the plaintiff's true condition. Dr Fones was in a similar position to that of Dr Peh in that he accepted information that he had been given by the plaintiff's lawyers and also took the plaintiff's account at face value though he did observe that the plaintiff's reaction seemed extreme. He conceded in court that if he had had the information available to Dr Lim, his conclusions may have been different. In this circumstance, his evidence too could not establish the somatoform pain disorder and post concussion syndrome.

79 Dr Ho's evidence was that the chances of post concussion syndrome occurring was not high given the circumstances of the plaintiff's injury and post-fall condition. This diagnosis was first made on 14 October 2003, the plaintiff's third visit to CGH. It was accepted by Dr Peh and his colleague, Dr Ho, who relied on investigations by other departments of CGH to establish the plaintiff's head injury.

80 The issue is whether post concussion syndrome actually arose. There was no sign of it initially. The ambulance crew reported that there had not been any lack of consciousness and on their arrival, the plaintiff was conscious and alert. The notes of his examination at the A&E department that same evening showed that the plaintiff was fully conscious, screaming, crying and shouting. It stated specifically that "apparently there was no loss of consciousness". The plaintiff was next seen on 1 October 2003 when his complaint, in relation to his head, was that he had a persistent headache. It is notable that the headache was resolved and the plaintiff was able to walk independently at the time of discharge. The diagnosis made on that occasion was "stable head injury". The diagnosis of "post concussion syndrome" was not made until the plaintiff's next visit on 11 October 2003 when he complained of a headache lasting ten days (*ie* from just after his previous hospitalisation ended) said he was unable to eat and had been vomiting. On examination, he was very anxious and retching. The head CT scan of his head showed no abnormality and on discharge he was referred to the neurosurgical department. When the plaintiff went in for the fourth time on 13 November 2003, he appeared confused, agitated and disoriented. He was admitted but discharged himself before treatment was completed. Five days later, the plaintiff visited the A&E department again. This time, he complained of change of behaviour on and off and said that he was easily angered. On examination, he was alert and rational and normal neurologically except for some pain over the back of the neck. He said that he felt he was unable to work and wanted medical leave. His medical leave was extended from 18 to 26 November 2003. From then on, the focus of the plaintiff's treatment seems to have switched to the department of psychological medicine.

81 Looking at the history set out above, it appears to me that if the plaintiff did have post concussion syndrome as manifested by his headaches and vomiting, the same would have resolved by 18 November 2003. On that last visit to the A&E department, no complaint of headache or vomiting was made but only a complaint of change of behaviour and irritability. Whilst the doctors at the A&E department might have accepted such complaints at face value, in view of my assessment of the plaintiff's behaviour (based on the medical examinations and the opinions of Dr Ho, Dr Lim and the AR's view of the plaintiff's behaviour in court), it is likely that he was, even at that time, exaggerating his symptoms. This would also have been indicated by his bizarre behaviour just prior to his admission on 13 November 2003 and his sudden discharge before he could be examined by the hospital psychiatrists.

82 Whilst I must accept the medical evidence that post concussion syndrome can develop some time after the initial injury, I must also bear in mind Dr Ho's opinion that it is unlikely to develop in the absence of certain pre-conditions, *ie*, loss of consciousness exceeding 30 minutes, neuro-imaging abnormalities and post traumatic amnesia exceeding 48 hours. The plaintiff did not have any of those conditions. Any post concussion syndrome that the plaintiff had would, therefore, have been mild and it appears to me that whatever symptoms the plaintiff displayed when he visited the CGH Department of Psychological Medicine from January 2004 onwards, those symptoms were not due to post concussion syndrome. Giving the plaintiff the benefit of the fact that CGH doctors saw it fit to admit him on three occasions and to make a diagnosis of post concussion syndrome, however, I would diverge from the AR's holding to the extent that I would make an award in favour of the plaintiff in respect of that period for mild post concussion syndrome. Apart from that I am in full agreement with the AR's findings that the plaintiff did not suffer from any condition arising out of brain injury including OBS, somatoform pain disorder, depression and extended post concussion syndrome.

83 I also agree with the rejection by the AR of the plaintiff's allegation that his erectile dysfunction arose out of the accident. The plaintiff showed himself to be completely able to voice any complaint that he had after the accident and to seek treatment for the same. He was not a stoic man and from the beginning he expressed a whole battery of complaints with vim and vigour. It was highly significant in my view, therefore, that the plaintiff did not complain to any of the doctors who treated him at CGH, including Dr Winnie Ho and Dr Peh, that he had erectile dysfunction. This complaint seems to have been made for the first time to his solicitors sometime in 2006 prior to their appointing Dr Png to examine him and confirm its existence.

84 In the result, while maintaining the AR's award to the plaintiff of $2,000 for contusions, I would add a further $2,000 for his headaches and nausea experienced for a few weeks after the accident. The plaintiff was given medical leave by the A&E department and I would award him loss of earnings for all medical leave given between 1 October 2003 and 26 November 2003, to the extent that he has not received any salary from the defendant for that period. The date 26 November 2003 was chosen as, on the plaintiff's last visit to the A&E department on 18 November 2003, he was found to have pain in the neck. Thereafter the plaintiff should have been fit to resume work and I agree that he is not entitled to recover any further pre-trial or post-trial loss of income. The plaintiff's earning capacity does not, on balance, appear to have been diminished and the video footage taken by LA shows that the plaintiff is capable of functioning completely normally in relation to work.

85 Apart from the holding in [84] above, the appeal must be dismissed. I will hear the parties on costs and on the quantum to be paid to the plaintiff in respect of his medical leave for the period indicated.