

THE HIGH COURT

[2017 No. 11618 P.]

BETWEEN

JOANNE O'SULLIVAN

PLAINTIFF

AND

AGNIESZKA BROZDA, MARY COUGHLAN & JASON COUGHLAN

DEFENDANTS

JUDGMENT of Mr. Justice Barr delivered on the 12th day of March, 2020

Introduction

1. This action arises out of a road traffic accident (RTA) which occurred on 27th August, 2016, near Hazelwood Shopping Centre, Glanmire, Co. Cork. The plaintiff was a front seat passenger in a motor car owned by the second defendant, which was being driven by her boyfriend, the third named defendant, at the time. A vehicle owned and driven by the first named defendant collided into the rear of the vehicle in which the plaintiff was travelling. While liability was initially contested between the defendants, that had been resolved prior to the hearing of this action, in circumstances where the first named defendant accepted liability for the accident. Accordingly, the action proceeded as one for assessment of damages only.
2. The plaintiff is currently 31 years of age, having been born on 11th November, 1988. She was 27 years old at the time of the accident. She was employed in the HR department of a major bank based in Dublin. She was a bad candidate for involvement in an RTA, as she had had serious surgery to her neck and skull some weeks prior to the accident on 1st June, 2016. She was recuperating from that surgery at the time of the accident.
3. At the trial, the defendant strongly relied on the proposition that this was a "low impact" collision. They relied heavily on two matters in this regard, being firstly, photographs of each of the vehicles after the accident, which did not show any major structural damage to either vehicle, and secondly, the fact that the repairs to the vehicle in which the plaintiff had been travelling amounted to only €249.70. The plaintiff did not accept that it was a very minor impact. She stated that there was a loud bang, her vehicle was shunted forward, her head was propelled forwards and then backwards striking the headrest and her right knee struck the dashboard, causing an injury to her knee. Accordingly, she disputed the defendant's assertion that the impact was very minor.
4. The plaintiff's case is that her neck was in an extremely vulnerable condition, having regard to the fact that she had undergone extensive surgery involving the back of her neck and the base of her skull some 11 weeks earlier. For that reason, the trauma to the soft tissues of her neck and shoulders was considerably worse than would otherwise have been the case, had she been in a healthy state at the time of the accident. It is the plaintiff's case that she has suffered a severe soft tissue injury to her neck, to her shoulders and to her lower back as a result of the accident. There was also an injury to her right knee. In addition, while she had been suffering from headaches for some considerable time prior to the accident, these were considerably exacerbated by the accident and she continues to experience severe headaches to the present time.

5. In an effort to alleviate these symptoms, the plaintiff has undergone extensive treatment from a pain specialist. She has had sixteen interventions from him to date on eight occasions, together with three courses of Botox injections and an injection of fremanezumab administered by a neurologist. In addition, she has had extensive physiotherapy and acupuncture treatment. She has also experienced psychiatric difficulties in the form of depression and PTSD, for which she has been prescribed antidepressant medication. She has had cognitive behavioural therapy and some counselling. Notwithstanding all the treatment received to date, the plaintiff has been unable to work since January 2016, which was prior to the accident. It is envisaged that she will only be able to return to work on a phased basis over the next two years.
6. In a nutshell, the defendant does not accept that the plaintiff has been injured to the extent which she claims, as a result of the RTA. While it is accepted that the plaintiff was a bad candidate for such an accident, due to the fact that she was in the post-operative rehabilitation phase, the defendant does not accept that there was any serious exacerbation of her post-operative condition as a result of the minor impact between the vehicles.
7. Broadly speaking, the defendant's medical witnesses accepted that she suffers pain at present and was not malingering in the usual sense of that term; however, they maintain that her case is unsustainable for a number of reasons. Firstly, even allowing for the weakened state of her neck muscles and ligaments due to the surgery, the impact of the RTA on those soft tissues was minor and as such would only have led to a minor exacerbation of her symptoms, lasting for a number of months at most. Secondly, the plaintiff's continuing complaints cannot be accounted for by such a small RTA, due to the fact that according to the defendant's medical witnesses she has a full range of movement of her neck, shoulders and lower back; there are no neurological signs of injury and all her imaging and scans have been largely clear; all of which indicates that there was no major structural injury as a result of the accident.
8. Thirdly, the defendant's experts maintain that the plaintiff is somewhat hysterical in nature, or is prone to catastrophizing the extent of her injury and disablement, as shown by her behaviour prior to the time of the accident and as demonstrated by certain tests carried out by the defendant's physiotherapist, which indicated that she was prone to catastrophizing and also that she tended to subjectively overestimate her level of disability, when on observation, she had a greater range of movement than her own subjective evaluation thereof. Fourthly, the defendant's experts state that insofar as the plaintiff continues to experience pain, that pain is not due to any physical injuries sustained in the accident, but at this stage over three years post-accident, is more likely to be due to psychological factors. Fifthly, the defendant's experts are of the view that given the psychological cause of her pain, further pain intervention is not necessary and she would be better served by returning to ordinary activities and in particular returning to work. They are of the view that there was no reason why she could not have returned to work before now.

9. The foregoing is merely a brief overview of the positions taken by each of the parties. This is an unusual case in that the plaintiff was under medical supervision in the months and weeks prior to the accident. In particular, she was under the care of Ms. Rachel Ormond, chartered physiotherapist, who had been instructed to advise the plaintiff on a home exercise programme as part of her post-operative rehabilitation. The Court was greatly assisted by the evidence given by Ms. Ormond in relation to the plaintiff's pre-accident and post-accident condition.
10. This case raises important and difficult questions in relation to the nature of chronic pain and whether a defendant, who was liable for an RTA which caused exacerbation of pain in the acute stage, can be held liable for chronic pain which ensued in the years thereafter.
11. Save for one aspect, the plaintiff's claim for special damages was largely uncontroversial in terms of quantum. However, the defendant disputed her liability to pay such items and in particular denied that she was liable for the loss of earnings aspect of the plaintiff's claim.
12. Finally, the Court had to consider an application pursuant to s. 26 of the Civil Liability & Courts Act 2004, whereby it was alleged that the plaintiff had fraudulently sworn an affidavit of verification in respect of her loss of earnings claim, when she knew that it was false and misleading in a material respect.

Background

13. Having regard to the very considerable dispute between the parties in relation to the plaintiff's post-accident injuries and disablement, it is necessary to look at the plaintiff's pre-accident condition in some detail.
14. The plaintiff suffered with migraine in her early teenage years. However, this did not appear to be either frequent or severe. Circa 2008, she was involved in an RTA when she was a rear seat passenger in a car, which was being driven by her brother. The car was rear-ended. The plaintiff sustained a soft tissue injury to her lower back. She had symptoms for a number of months. Her legal action was settled at the PIAB stage.
15. The plaintiff qualified with a first class honours degree in commerce from UCC in 2011. She obtained a first class honours masters degree in food marketing the following year. After college she worked with a company called EMC for two years. She was initially recruited as a HR coordinator and was promoted after eight months. Her new role involved training existing employees and also new employees coming into the company. She was also involved in setting up new contracts of employment for those entering the company. The plaintiff then took up a HR generalist position with the Peter McVerry Trust in Dublin. In this role she was involved in setting up the Sage IT system for the company.
16. In January 2015 she saw a job vacancy in the HR department with KBC Bank. She obtained the position and commenced working with them in January 2015. She did well in the job and in August 2015 she was promoted to HR team leader, a role in which she

was supervisor over three/four people. Her position was at assistant manager level within the bank.

17. In November 2015, while the plaintiff was retrieving post from her post box, on straightening up she struck her head against an electricity box, which was located above the post boxes. This caused a small graze to her head. The plaintiff stated that she did not take much notice of it at the time. That weekend she went to Galway with friends. She developed a headache in the days after that incident. Her headaches persisted. The plaintiff went to her GP, who initially diagnosed a sinus infection and prescribed some medication. She returned to her GP one week later when the headaches did not subside. At this stage the GP prescribed antibiotics. The plaintiff stated that she went home to Cork for Christmas 2015. Her headaches persisted over the holiday period. In January 2016, she returned to her GP in relation to the continuing headaches. Her doctor advised that she should go out of work as she may be suffering from post-concussion syndrome. The plaintiff stopped working in January 2016. The GP arranged for an MRI scan to be carried out.
18. The MRI scan revealed a pineal cyst. On account of this, the GP referred the plaintiff to Mr. Chris Lim, consultant neurosurgeon. On reviewing the scan, he was satisfied that the cyst was not greatly significant, although it needed to be monitored. However, he observed that the plaintiff had a Chiari malformation (grade 1) at the base of her skull. That was a malformation of her brain, whereby a portion of the brain grew downwards from the base of the skull into the area of the spinal cord at the top of C.1 vertebra. Mr. Lim had a further MRI scan carried out. He was satisfied that the cause of the plaintiff's ongoing headaches was the Chiari malformation. After considering her options, a decision was made that the plaintiff would undergo surgical treatment by way of a foramen magnum decompression, which was carried out on 1st June, 2016.
19. Mr. Lim described this operation in his evidence. It involved making a wider opening at the junction between the base of the skull and the top of the C.1 vertebra. In order to do that, he had to make an incision from the back of the skull down to approximately the middle of the neck. He then had to cut through the tendons and muscles surrounding the upper vertebrae in the neck. These had to be dissected and removed from the bones of the skull and the spine. Mr. Lim stated that they are a strong muscle group. When that had been done, he then removed a portion of the posterior part of the bone of the cervical spine and part of the foramen magnum in the occipital bone, measuring approximately 4 – 5cm x 3cm. The purpose of the operation was to widen the channel so as to enlarge the area and allow spinal fluid to flow freely without being impeded by the tonsil of brain which had grown downwards. The operation also involved opening the outer covering of the brain known as the "*dura*", to enhance enlargement of the area. The *dura* is a thick structure, which was cut with a scalpel for approximately 2 – 3cm. This made a larger opening and enhanced circulation.
20. The next step was to begin the closing-up stage by closing the various layers of muscles. This was done by means of soluble sutures, 30 in all. Finally, the outer layers of the skin

were closed. Mr. Lim stated that the operation itself went well and lasted for between 2 – 3 hours. In the immediate post-operative period, one would expect a patient to experience nausea and considerable pain. This could last for a number of weeks. Thereafter, the pain would ease and they could begin gentle mobilisation. Manual physiotherapy would not normally begin until three months post-surgery. It was anticipated that in the ordinary course, the plaintiff would not have returned to work until the end of 2016.

21. The plaintiff was seen by Mr. Lim for a review at six weeks post-surgery on 14th July, 2016. At that time, she told him that she had been very miserable for the first five weeks after the operation. However, she stated that she had made considerable improvement in the week prior to seeing him. That was the normal post-operative course. He stated that the plaintiff was quite good when he saw her at that examination. The next step in her rehab was to commence anti-inflammatory medication and begin gentle, non-manual physiotherapy. Mr. Lim stated that he next saw the plaintiff some two weeks later at the end of July 2016, when she called into his rooms to hand in a scan. She had improved further by that time.
22. The plaintiff was first seen by Ms. Rachel Ormond, chartered physiotherapist, on 29th July, 2016. In a letter to Mr. Lim dated 8th August, 2016, Ms. Ormond gave the following account of the plaintiff's presentation at that examination:

"On objective examination on 29/07/2016 Joanne presented with poor posture with her head tilted in a slightly lateral orientation to the right. Active range of movement of the cervical spine was grossly restricted as one would expect with ranges as follows: Flexion 60%, extension 30%, rotation 70% bilaterally, lateral flexion 50% bilaterally. Her surgical scars were noted to be healing. She presented with significant weakness of the posterior cervical stabilising muscles, worse on the right side. She has been shown exercises to improve the stability of the posterior cervical, sub-occipital and deep neck flexor musculature in addition to strengthening exercises for the peri-scapular muscles. She has not received any manual therapy. I would appreciate if you could give guidance as to when manual therapy may be permitted to commence at your kind convenience."

23. At the first consultation, Ms. Ormond gave the plaintiff a programme of home exercises to help strengthen her neck muscles. She next saw the plaintiff for a quick review on 5th August, 2016, at which time the plaintiff reported that she had improved further and was managing her exercise programme.
24. Ms. Ormond saw the plaintiff again on 22nd August, 2016, which was five days before the accident. On objective examination at that time it was noted that she had recovered a significant degree of cervical movement, which was recorded as follows: flexion 80%, extension 50%, right rotation 85%, left rotation 85%, right lateral flexion 50%, left lateral flexion 50%. Ms. Ormond was satisfied that these findings demonstrated that the plaintiff had begun to make significant progress with her post-surgical rehabilitation.

25. In evidence, the plaintiff stated that by 22nd August, 2016, she had made considerable improvement. She had recovered a significant degree of neck movement. Her headaches were reducing and her neck pain had dramatically reduced. She had been able to go out with friends and had gone to a show and had met up with a manager from work and other friends. She felt that she was on the road to getting back to normal. Mr. Lim had told her that by December 2016 she would be able to return to work.

The Accident on 27th August, 2016

26. The plaintiff stated that she and her boyfriend were travelling in his mother's car. Her boyfriend was driving and she was sitting in the front passenger seat. They were on their way to his nephew's birthday party. They were stopped at a junction at a "stop" sign, when she suddenly felt the car go forward and there was a loud bang, then the car stopped. The plaintiff stated that her head went forward and then back and hit the headrest. She felt immediate pain in her neck and head, and between her shoulders. She was able to get out of the car unaided. She was very worried about how this might impact on her recovery. She was crying and was upset about her recovery from her previous surgery. She also experienced pain in her right knee, which had struck the dashboard.
27. The Gardaí were called and came to the scene, as did an ambulance. However, she refused to go in the ambulance. Instead, they proceeded on to the nephew's birthday party. However, they only stayed there for about 20 minutes. By then the pain in her head, back and neck had increased, so they went to the A&E Department in the Mercy Hospital, Cork. They took x-rays, which were clear for bony injuries. Analgesics were prescribed and the plaintiff was discharged.
28. Neither the plaintiff's boyfriend, nor the first defendant, gave evidence at the trial of the action. The only other evidence in relation to the severity of the impact between the vehicles, were the photographs of the two vehicles which were handed into court in evidence. They showed very minor damage to the rear of the vehicle in which the plaintiff was travelling, which was a 2013 Ford Focus. The Court was also furnished with photographs of the front of the first defendant's vehicle, being a 2002 Peugeot 205. There appeared to be minor denting to the front number plate, although it was hard to know whether that had been done in the accident, or may have been of long standing. The only other evidence was the repair bill for the vehicle in which the plaintiff had been travelling, in the sum of €249.70.
29. No engineering evidence was called by either party.

Evidence On Behalf Of The Plaintiff In Relation To Her Injuries

30. The plaintiff stated that in the days following the accident she was in considerable pain. There was a lot of pain in her neck and back. She had been prescribed diazepam by the A&E Department, which she had taken, but she was still in a lot of pain in her neck, back and in her right knee. She also had a lot of pain in her lower back. The pain extended up her whole spine. Her headaches were also more severe than they had been prior to the accident and were constant in nature. She also felt dizzy and nauseous.

31. On 31st August, 2016, the plaintiff attended the physiotherapy practice and was seen by Ms. Ormond's partner, Ms. Long. She recorded that the plaintiff's posture was markedly antalgic, with pseudo-winging of the left scapula and marked elevation of the right shoulder girdle. There was complete reversal of the normal lumbar lordosis, with para-spinal muscle spasm noted bilaterally in the thoracolumbar region. The range of movement of her neck was assessed as follows: flexion 50%, extension 10%, right rotation 60%, left rotation 60%, right lateral flexion 50%, left lateral flexion 50%. Ms. Long also noted the active range of movement in the plaintiff's thoracic spine as follows: flexion normal, extension nil, right rotation 60% with pain, stiffness and spasm, left rotation 60% with pain, stiffness and spasm. Movement of the shoulder joints was within normal limits, though pain was reproduced over the scapulae at end of range of internal rotation bilaterally.
32. Ms. Long noted that tenderness was reproduced and hypo-mobility was detected on passive mobilisation of the facet joints of the thoracic vertebrae between T.1 – T.10 at the intervertebral and facet joints bilaterally. The cervical facet and intervertebral joints were not assessed via passive mobilisation on that date due to her previous surgery. Trigger points of tenderness and muscle spasm were detected in the upper and middle fibres of the trapezius rhomboid, erector spinae scalenei and sub-occipital muscles bilaterally. Reflexes in the upper limbs were noted to be intact and brisk bilaterally, with normal power detected on assessment of myotomes.
33. Range of movement of the lumbar spine was recorded as follows: flexion 50%, extension nil, right lateral flexion 75%, left lateral flexion 75%, both of which were limited by pain and spasm. Tenderness was reproduced and hypo-mobility was detected on passive mobilisation of the facet joints of the lumbar vertebrae bilaterally. Increased resistance was noted on passive mobilisation of the L.4 and L.5 segments in particular, which was suggestive of discal involvement at these levels.
34. Ms. Long noted that trigger points of tenderness and significant spasm was detected in the lumbar para-spinal and gluteal musculature. Neurological examination was normal, with myotomes and reflexes noted to be intact and symmetrical in the lower limbs.
35. Ms. Ormond stated that of note here was the diminution in the range of movement of the cervical spine, together with the addition of limited movement in the thoracic spine and the onset of severe limitation of movement in the lumbar spine. There was also loss of lumbar lordosis, which she thought was probably due to muscle spasm. The lordosis was completely reversed, which was indicative of muscle spasm in the area. The plaintiff had also reported a significant deterioration in both the severity and duration of her headaches since the accident. Overall, Ms. Ormond stated that this represented a significant deterioration in her condition since she had been last seen, some five days before the accident.
36. Ms. Ormond stated that there was then a small gap between that time and when she next saw the plaintiff, which was due to the fact that the plaintiff had been called back by the hospital for a further CT scan, due to a suspected fracture of one of the thoracic

vertebrae. However, that was out ruled on subsequent scanning. The plaintiff re-attended with Ms. Ormond on 9th September, 2016. At that time, she continued to complain of severe headaches, neck pain, shoulder pain and back pain. In addition, she complained of pain in her right knee, which the plaintiff stated had struck against the dashboard of the car at the time of the impact. At that time Ms. Ormond made a working diagnosis of cervico-thoracic and lumbr hypo-mobility with findings implicating neural irritation at the L.4 and L.5 levels consistent with whiplash associated disorder based on the objective assessment findings. In relation to the plaintiff's right knee, a working diagnosis of patellar tendinopathy and medial compartment strain was made, though the possibility of periosteal trauma to the femoral condyle was suspected. The working diagnosis of tendinopathy was confirmed on MRI carried out on 25th October, 2016. Due to the intervening road traffic accident on 27th August, 2016, manual therapy, which had been due to commence in early September 2016, was not proceeded with. Instead, due to the deterioration in the plaintiff's condition, Ms. Ormond referred her back to Mr. Lim.

37. The plaintiff was seen by Mr. Lim on 13th October, 2016. By that time, she had been prescribed antidepressant medication due to low mood, which she said was caused by the deterioration in her condition. She had had four sessions of counselling. She told Mr. Lim that she had suffered an increase in her headaches and considerable pain on the right side of her spine. She said that he told her that the RTA had compromised her recovery and therefore they would have to review the date on which she might return to work.
38. In evidence, Mr. Lim stated that when he saw the plaintiff on 13th October, 2016, she had significant neck and shoulder pain with associated headaches. He was of the view that while she had been making a good recovery from her surgery on 1st June, 2016, the RTA on 27th August, 2016, had increased her neck and shoulder pain and headaches. Unfortunately, due to the operation, she had been in a vulnerable state when she had had the accident. The injury was a soft tissue injury to the area that had been compromised due to the surgery. It was an area that was particularly vulnerable to trauma. He was of the view that the complaints which she had at that time were caused by the RTA.
39. Mr. Lim decided that the best course was to refer the plaintiff to a pain specialist. On 13th October, 2016, he referred the plaintiff to Dr. Donal Harney, consultant in pain medicine at Mercy University Hospital, Cork. His referral letter was in the following terms:

"Could you kindly see this pleasant 27-year-old lady in your rooms. She underwent a posterior fossa decompression for a symptomatic Chiari 1 malformation back in June 2016. Unfortunately, she was involved in a car crash in August which has compounded her recovery. She seems to have suffered a whiplash injury and she has been complaining of significant neck and shoulder pain associated with headaches. I would be grateful if you could see her in relation to same."
40. Considerable significance was placed by the defendant on an assessment carried out by the plaintiff's Dublin based GP on 20th October, 2016. That assessment was recorded in a medical report dated 24th November, 2016, furnished by Dr. Sheila Byrne, which was

admitted in evidence. In that report, Dr. Byrne stated that she had been told about the accident by the plaintiff's boyfriend, Mr. Jason Coughlan, on 2nd September, 2016. She spoke to the plaintiff by telephone on 9th September, 2016. The plaintiff informed her that following the accident her mood had been low and that she had felt tearful and had low motivation. They discussed her mental health and concluded that the plaintiff did not require antidepressant medication at that time, but that the issue could be revisited if necessary.

41. Dr. Byrne noted that the plaintiff attended one of the other doctors at the surgery on 16th September, 2016, and was prescribed antidepressant medication (Escitalopram 5mg) due to a deterioration in her mood. She was also advised to attend counselling. Dr. Byrne received a telephone call from the plaintiff on 30th September, 2016. The plaintiff told her that she was unable to attend in person because she felt unable to travel from Cork. She reported that she was attending physiotherapy twice weekly and also that she was attending counselling, as advised. The plaintiff stated that the physiotherapist had advised her to request some muscle relaxant medication to try and ease her significant muscle spasm. Dr. Byrne prescribed some diazepam. The defendant placed considerable emphasis on the following paragraph from her report, which dealt with the plaintiff's presentation on 24th October, 2016:

"On 24/10/2016, Ms. O'Sullivan attended me to say that she was making good progress with her physiotherapy, and that she no longer required muscle relaxant medication. Her overall range of movement at her neck and back was improving steadily and her pain was lessening. As a result, her mood was also improving. However, Ms. O'Sullivan reported that she still had ongoing pain in her right knee that required further investigation. Ms. O'Sullivan had banged her right knee off the dashboard during the accident. I arranged for her to have an MRI scan done."

42. Dr. Byrne concluded that report by giving the following opinion and prognosis:

"Based on that fact that Ms. O'Sullivan was undergoing treatment in the form of medication and physiotherapy at the time of the accident in August 2016, it is very difficult to give an accurate prognosis. It is my medical opinion as her GP that Ms. O'Sullivan suffered a significant setback in her post-operative physical recovery, and that the added pain and anxiety following the accident had an adverse effect on her mental health. I would hope and anticipate that Ms. O'Sullivan will make a complete recovery from the injuries she sustained in the road traffic accident in August 2016. However, at present, I am unable to be more specific with a timeframe for this recovery."

43. The plaintiff was first seen by Dr. Harney, the pain specialist, on 22nd November, 2016. She complained of persistent ongoing left-sided neck pain radiating to the left shoulder, in addition to lower back pain and pain in the right knee. She stated that physiotherapy intervention, particularly with respect to the right knee had helped significantly and her lower back pain had eased in the interval between the date of the accident and the date of that review. Her major issue was pain with respect to the left side of the neck and left

shoulder. Examination revealed marked tenderness at the facet joints on the left side at C.3 – C.6. There was also mechanical allodynia in the distribution of the right and left greater occipital nerves, slightly worse on the right than on the left. Dr. Harney stated that his clinical impression was that the plaintiff was suffering with ongoing whiplash associated disorder as a consequence of the road traffic accident on 27th August, 2016. Her most significant pain was in the distribution of the facet joints on the left side at C.3 – C.6 and also in the distribution of the left and right greater occipital nerves. This was taking into consideration the Chiari 1 malformation, for which she had undergone foramen magnum decompression surgery on 1st June, 2016, with excellent results. Dr. Harney arranged to carry out treatment on the plaintiff's neck the following month.

44. A number of things happened in December 2016. Firstly, the plaintiff stated that she fainted when in her bathroom, due to the level of pain in her head. She was detained in Cork University Hospital for two weeks after that incident. During that time she felt that her head was spinning and that her brain was "*flipping*". She stated that the pain in her head was very severe. She stated that it was a very tough time in her life. Secondly, she had experienced severe headaches after riding on a Ferris wheel. Thirdly, on 23rd December, 2016, she received her first treatment from Dr. Harney at the Bon Secours Hospital, Cork. He performed a pulsed radiofrequency lesioning (PRFL) on the left and right greater occipital nerves at 42 degrees centigrade for four minutes. That was done to help manage her severe headaches. In addition, he also performed simple left and right C.3 – C.6 diagnostic facet joint blocks. The plaintiff stated that lesioning of the occipital nerves was done under sedation and was administered by needle. She found that a frightening procedure. It was also quite painful, as were the facet joint blocks. She had been given morphine for the pain. Unfortunately, she had no immediate relief from her level of pain. She stated that she felt very low at that time. She had told her father that perhaps she would be better off if she had died of cancer, as that would have been an end to her pain.
45. The plaintiff was seen by her family GP in Cork, Dr. Donovan, on 30th December, 2016. He stated that she was complaining of considerable pain in her neck and shoulders and also complained of severe headaches. He felt that her condition was due to her surgery and the superimposed injury from the RTA. He felt that the RTA was a significant component in her symptoms. In addition to neck and shoulder pain, she also complained of lower back pain. He was of opinion that she had been vulnerable after the surgery and that the RTA was highly significant.
46. The plaintiff was reviewed by Dr. Harney on 7th February, 2017. She was still complaining of headaches, but had made good progress in relation to her neck pain. Clinical examination revealed pain in the distribution of the left greater occipital nerve and to a lesser extent in the right greater occipital nerve. Facet joints left and right side C.2 – C.7 were not overly tender on that occasion. His clinical impression was that the plaintiff was suffering with predominant severe left-sided greater occipital nerve neuralgia and to a lesser extent right sided greater occipital nerve neuralgia. She had responded to diagnostic facet joint block on the right side at C.3 – C.6. He advised her that further

treatment would be necessary. He also advised the plaintiff to continue seeing Ms. Ormond. She was commenced on half beta Prograne 80mg once daily to help manage her headaches and was advised to continue with Amitriptyline for management of pain.

47. On 21st April, 2017, Dr. Harney performed PRFL of the left and right greater occipital nerves. The plaintiff was reviewed by him on 6th June, 2017, when he noted that she had gleaned some relief from the treatment which she had received in April 2017.
48. On 1st September, 2017, Dr. Harney again performed PRFL of the left and right greater occipital nerves. He also performed left and right C.3 to T.1 nuchal line injection. The plaintiff was reviewed on 17th October, 2017, at which time she reported that the treatment given on 1st September, 2017, had not improved her pain significantly. Her major issue at that juncture was right sided greater occipital nerve neuralgia and ongoing hemichranial pain on the right hand side.
49. The plaintiff was next seen by Dr. Harney on 8th December, 2017, at the Bon Secours Hospital, Cork. On that occasion the plaintiff underwent IV Lidocaine 400mg and Ketamine 50mg infusion over two hours.
50. In her evidence, the plaintiff stated that at best, she only got temporary relief from her symptoms as a result of the treatment given to her by Dr. Harney during 2017. She never got any lasting benefit. She continued to experience considerable pain in her neck and back, and had severe headaches. She had also been prescribed a large amount of medication in an attempt to ease her pain. She had been on Candesartan for approximately eight months. She had also been on Amitriptyline, Palexia, Propranolol, Flunarizine, Pregabalin and Oxynorm.
51. There had been some improvement during 2017, in that she had been permitted to return to driving by Mr. Lim in February 2017. She had continued with her physiotherapy and had started walking up to 30 minutes per day. She had gone to the local pool to do a programme of aquatic exercises. She was treated by the physiotherapist on a regular basis in the intervals between treatment from Dr. Harney. She could not receive physiotherapy treatment immediately after receiving his treatments. After the treatment given to her on 1st September, 2017 by Dr. Harney, the plaintiff reported an improvement in relation to her cervical spine and left scapular pain, but stated that her headaches had remained static. She had also suffered an exacerbation of lumbar region pain, with associated radicular symptoms to the lower limbs. In Autumn 2017 she tried a course of acupuncture treatment with Dr. Diarmuid O'Connell. Unfortunately, a positive initial response was not sustained and acupuncture treatment was discontinued.
52. When reviewed by the physiotherapist on 8th January, 2018, the plaintiff reported no improvement regarding her headache symptoms and reported that her left-sided scapulae/thoracic and lumbar spine pain with associated lower limb symptoms, had deteriorated without physiotherapy treatment. She had been unwell over the Christmas period with a respiratory tract infection. On 2nd February, 2018, the plaintiff was admitted to the Bon Secours Hospital for a further Lidocaine and Ketamine infusion. In

addition, the plaintiff underwent a trial of Cefaly, external neural modulation in an effort to manage her headaches, improve her sleep and her mood. This was a headband which provided electrical impulses to the brain. The plaintiff stated that she tried it for one month and found that it helped with her headaches and with sleep. It is not clear whether it was continued after the trial period. My impression is that for some reasons it was not.

53. The plaintiff was reviewed by Dr. Harney on 20th March, 2018, at which time her major issue was pain in the left shoulder and pain in the distribution of the left suprascapular nerve. She was also complaining of pain in the facet joints on the right side at C.2 – C.6. An MRI of the cervical spine on 28th March, 2018, revealed the previous surgery and a minimal stable disc bulge at C.5 – C.6. MRI of the left shoulder on the same date revealed mild rotator cuff impingement, without rotator cuff tear or subacromial bursitis.
54. The plaintiff was reviewed by Dr. Harney on 20th April, 2018. He performed PRFL of the left suprascapular nerve and also performed left-sided C.2 – C.6 diagnostic facet joint blocks. Her right sided facet pain on that occasion was not too bad.
55. The plaintiff was reviewed again on 21st September, 2018, at which time Dr. Harney performed targeted facet joint blocks on the right side at C.2 – C.6. He also performed PRFL of the left suprascapular nerve and also left and right sided L.4 – S.1 diagnostic facet joint blocks. A repeat MRI of the left shoulder on 23rd October, 2018, revealed a supraspinatus tendon which was attenuated. There was no acute tear or tendon retraction. The infraspinatus and subscapularis tendons were intact. There was no joint effusion or bursitis noted. An MRI of the lumbar spine on the same date revealed a broad posterior disc bulge at L.4 – L.5. There was no evidence of nerve root compression.
56. The plaintiff was also reviewed by her GP in Cork during 2018. On 5th January, 2018, she was seen by Dr. Jordan, one of the doctors at the practice. She complained of ongoing headaches, left-sided rib pain for two weeks due to a respiratory tract infection. She was continued on Amitriptyline 10mg, four times a day and was also on Candesartan as prescribed by Dr. Harney. The plaintiff was reviewed by Dr. Jordan on 27th March, 2018, at which time it was noted that her mood was very low and she was sleeping very poorly. She described herself as lying in bed for hours awake and would sleep into the late hours of the morning. He felt that she had low mood due to her other medical difficulties including the accident. He increased her antidepressant medication of Escitalopram to 15mg per day. The plaintiff was reviewed by Dr. Jordan on 18th May, 2018, at which time she was complaining of what he thought was an acute migraine attack. He was aware that she had had migraine as an adolescent. He referred her to Dr. Sean O'Sullivan, consultant neurologist. On 9th July, 2018, the plaintiff was reviewed by another doctor in the practice, Dr. Cronin. She advised that the plaintiff continue taking the antidepressant medication.
57. The plaintiff was seen by Dr. Donovan on 14th September, 2018. At that time, she was seeing Dr. O'Sullivan in relation to chronic headaches. He had administered Botox injections across the entire circumference of her skull, broadly following her hairline. She

had received three courses of Botox in the period 2018 – 2019. Each course would consist of approximately 31 separate injections.

58. The plaintiff was reviewed by Dr. Donovan on 27th November, 2018, at which time he noted that she was continuing on Hypovase 2 at night from Dr. Harney and Topamax 25mg a day from Dr. O'Sullivan. She continued to be symptomatic with headaches. Dr. Donovan stated that he was aware that she had had surgery in June 2016, but he felt that they were now dealing with the effects of the road traffic accident. He felt that it was a post-traumatic headache, which was an exacerbation of her previous condition and had been caused by the road traffic accident. He noted that at that time she was very distressed by her inability to cope with the demands of everyday life and in particular her inability to return to work.
59. As noted previously, the trial of Cefaly (Transcutaneous Electrical neuro-muscular device for the treatment of migraines) in February 2018 produced beneficial results. When the plaintiff saw Ms. Ormond at that time, she reported a reduction in headache severity and improvement in her sleep pattern. When she presented on 8th March, 2018 she complained of an exacerbation of lower back pain with right proximal lower limb pain, which the plaintiff attributed to losing her footing while walking on snow in early March 2018. She received weekly treatment from the physiotherapist throughout March and April 2018 with an improvement in lumbar and lower limb symptoms. Unfortunately, her progress was adversely affected by the development of acute dorsal right foot pain of apparent insidious and sudden onset in April, 2018. X-rays revealed findings suspicious of a stress fracture of the third metatarsal of the right foot, caused by suspected vitamin D deficiency. The fracture was managed conservatively and the foot was placed in a boot and crutches were provided to the plaintiff.
60. Repeat cervical facet joint injections at the end of April, 2018 were helpful in that whilst the plaintiff's headache severity remained unchanged, she reported a reduction in cervico-thoracic scapular pain. Unfortunately, by the end of May, it was feared that the use of crutches was having a negative impact on her cervical symptoms. When reviewed by Ms. Ormond on 6th June, 2018, the plaintiff had been advised by the fracture clinic that she could dispense with the use of crutches. It was hoped that that would yield a positive effect on her cervico-thoracic symptoms.
61. The plaintiff had had to desist from driving due to the fact that it caused exacerbation of the soft tissue injuries to her spine, particularly to the lower back. However, by May, 2018 she had returned to driving, but could only drive for periods of up to 30 minutes, otherwise there would be a severe increase in her back pain. Overall, she felt that she had made some improvement in some areas. Her knee problem had resolved. However, if she walked too far she experienced knee and back pain. Her lower back remained quite painful at approximately 5 – 7/10 for pain. Her headaches were still at a level of between 7 – 9/10 for pain. Her neck and shoulder pain was rated by her at 7 – 8/10 depending on what activity she did.

62. The plaintiff stated that while she had not been able to make any attempt to return to work, she had done other things to occupy her time. She had done an eight-week interior design course and had also done a six-week mindfulness course to help her cope with her pain and lift her mood generally. She found both of these beneficial. Her first series of Botox injections had been administered by Dr. O'Sullivan in December, 2018. She did not get much relief from the first course of Botox injections, but the second course, which was administered some twelve weeks later, did provide some relief. The pain in her head decreased to approximately 5/10, which was the lowest score that it had been.
63. Moving into 2019, the plaintiff was reviewed by Dr. Harney on 25th January, 2019. At that review he performed simple left-sided C.2 – C.6 diagnostic facet joint blocks and PRFL to the left suprascapular nerve. He reviewed the plaintiff again on 26th April, 2019, at which time he performed left and right L.3 – S.1 diagnostic facet joint blocks and left and right C.3 – C.6 diagnostic face joint blocks under image guidance. He also administered a left-sided C.7 – T.2 paraspinal injection. He noted that one week following these interventions, the plaintiff developed severe acute lower back pain and had severe lower back spasm. MRI of the lumbar spine on 27th May, 2019 revealed stable imaging.
64. The plaintiff was seen for a fifteenth time by Dr. Harney on 11th June, 2019. At that time, she reported severe left- and right-sided lower back pain, left-sided neck pain and left shoulder pain. She reported that her headaches were very severe. He noted that the plaintiff was seeing Dr. Sean O'Sullivan, Consultant Neurologist for treatment of her headaches/transformed migraine and was receiving Botox therapy. She was also on Topamax and Folic Acid. She was taking Escitalopram for management of her low mood. Clinical examination revealed tenderness of the facet joints on the left and right side at L.3 – S.1, marked tenderness of facet joints on the left side C.3 – C.6 and reduced movements of the left shoulder in adduction internal rotation and abduction external rotation. There was also tenderness in the distribution of the left and right greater occipital nerves and also nuchal lying tenderness left and right side C.3 – T.1. There was no evidence of nerve root tension signs in either right or left upper limb, or right and left lower limb.
65. Dr. Harney's clinical impression at that time was that the plaintiff had ongoing whiplash associated disorder as a consequence of the RTA on 27th August, 2016. That was with the background of foramen magnum decompression for management of Chiari 1 malformation on 1st June, 2016. She had made excellent progress with respect to her decompressive surgery. The plaintiff continued to suffer with persistent ongoing daily headaches/transformed migraine and was under the care of Dr. Sean O'Sullivan for management of same. She also had persistent ongoing neck pain in the distribution of the facet joints on the left side at C.2 – C.6 and ongoing pain in her left shoulder, consistent with rotator cuff tendinopathy. She also had persistent ongoing lower back pain, with tenderness in the facet joints left and right side at L.3 – S.1 on clinical examination.

66. At that time Dr. Harney felt that the plaintiff's prognosis in the medium to long term was poor in view of the ongoing persistent pain. He thought that she would continue to suffer with ongoing pain in the medium to long term. She had not been able to return to work and he envisaged that she would not be in a position to return to work for some time. He noted that she had suffered significantly from a psychological perspective, with significant low mood directly as a consequence of the accident on 27th August, 2016.
67. Dr. Sean O'Sullivan, Consultant Neurologist, also gave evidence on behalf of the plaintiff. He stated that in the period 2018/2019 he had administered three courses of Botox injections, totalling 93 separate injections in all. Unfortunately, while there was some limited benefit from the second course of Botox injections, there was no lasting beneficial result from this treatment. When he examined her on 3rd September, 2019, he found that she had tenderness to palpation over the posterior cervical muscles and left shoulder muscles including the trapezius. There was reduced range of horizontal neck movement beyond 60 degrees from the mid-line, particularly looking over her left shoulder. She had an elevated BMI. Visual acuity was 6/12 bilaterally. Otherwise, neurological examination was normal, including visual fields, eye movements, fundoscopy, screening tests for pronator drift and ataxia, tandem gait, reflexes and plantar responses.
68. Dr. O'Sullivan's opinion was that the plaintiff had sustained a traumatic brain injury on 27th August, 2016. Her symptoms were consistent with post-traumatic exacerbation of an underlying chronic daily headache, post-traumatic grade 2 whiplash associated disorder (WAD), post-traumatic shoulder and lower back pain, all of which resulted from her RTA. He noted that the plaintiff had had a history of chronic daily headaches prior to the accident, but the severity of her headaches had deteriorated immediately after the accident. She did not have lower back pain prior to the accident, that had only developed after the accident. She had mild neck pain prior to the accident, but her neck pain had deteriorated after the accident.
69. He did not feel that further investigations were required at that point. He noted that an apparently normal MRI brain and cervical spine scan was entirely compatible with post-traumatic headache. The injuries sustained in post-traumatic headache and WAD were often microscopic, affecting the nerve cell functioning, without necessarily altering their gross appearance on routine MRI scans.
70. In terms of a prognosis, Dr. O'Sullivan felt that it was unlikely that the plaintiff would make a full recovery. This was due to the fact that a small but significant minority of patients would have persisting problems. Almost 25% of patients would have persisting headaches at four years after trauma. For that proposition he referenced a paper by T.A.D. Seifert and Randolph W. Evans, *Post-Traumatic Headache: A Review*, published in *Curr Pain Headache RAP* (2010) 14, pages 292 – 298.
71. Dr. O'Sullivan was of the view that while it was difficult to predict the prognosis of post-traumatic headaches with accuracy, on an individual basis the plaintiff had been having post-traumatic exacerbation of her baseline headaches for over three years. As such, she would be considered likely to become one of the 25% of people with refractory or

persisting headaches as described in the medical literature. He was of the opinion that her headaches would persist for at least the next two years, despite the treatment measures which had been undertaken to date. He felt that it was unlikely that she would make a full recovery. He hoped that she would make a partial recovery over the next two years, but she was likely to require frequent analgesic use for her headaches and back pain beyond that time. Doing the best that he could, he estimated that 50% of her headaches at this time and continuing into the future, could be attributed to the RTA.

72. Dr. O'Sullivan noted that in September, 2019 the plaintiff had been commenced on fremanezumab injections for migraine headaches. She had made some improvement on that new form of treatment. He was hopeful that if that improvement was continued, she would be in a position to return to work on a phased basis in the next two years.
73. When the plaintiff saw the defendant's physiotherapist, Ms. O'Mahony on 25th September, 2019, she described her daily routine; she told her that she was living with her boyfriend in Cork. He did all the household chores, such as washing, hovering and changing the bed clothes. She stated that she had tried to do some of these tasks, but the pain was worse when she did so. She was able to do light housework such as cooking, but she tended to get very fatigued from standing, or looking down, such as when chopping vegetables. She had not driven since May, 2019, due to a lumbar spine injury when getting dressed one morning. In general, her father or brother would collect her and bring her to her parents' house every day to spend time with her family so that she was not on her own at home, while her boyfriend was at work. She would play with her nieces and nephews at her parents' house when they were there. They were aged 12, 7 and 3 years. She told Ms. O'Mahony that she would like to return to work and be able to carry out everyday tasks, but could not do so at that time due to the pain that she was experiencing and the fear of the pain that she would experience if she performed those activities.
74. In her evidence the plaintiff stated that at present, she continued to experience very severe headaches, severe neck pain radiating into her left shoulder and pain in her lower back. Her range of movement in her neck and lower back was severely restricted. She continued to take anti-depressant medication in the form of Escitalopram, 15mg daily. She also attended counselling. She was not able to exercise much due to her pain and accordingly her weight had increased substantially. Overall she felt that her life had been turned upside down since the accident. She stated that she would very much like to return to work, but was simply not able to do so, given her current level of pain. She felt that she had no purpose in life at present. She had missed out a lot in her career and in particular had missed opportunities for promotion since August, 2016.
75. That concludes the account of the plaintiff's symptoms, disablement and treatment since the time of the accident.

Evidence Of The Plaintiff's Medical Experts

76. The primary evidence given by the plaintiff's medical experts in relation to their diagnosis and treatment of her injuries has been set out above. In this section of the judgment the

Court will outline the evidence given by the plaintiff's medical witnesses on the issues in contention between them and the experts retained on behalf of the defendant.

77. In cross-examination Dr. Harney accepted that he had first seen the plaintiff after she had undergone both her surgery and had been involved in the accident. He accepted that the surgery itself was relatively serious in nature. It was put to him that according to the letter written by Ms. Ormond on 8th August, 2016, the plaintiff had significant ongoing difficulties as a result of the operation at that time. He accepted that she did have ongoing difficulties, but stated that she had made good progress since the operation on 1st June, 2016. By July, her range of movement had returned to a reasonable level, although it was still limited. He stated that in his experience most patients would improve dramatically in terms of headaches after such an operation. Although that would take time, as the recovery period post-operation could take a number of months.
78. It was put to the witness that according to the letter furnished by the plaintiff's Dublin based GP from an assessment on 20th October, 2016, she had made very considerable improvement in her condition by that time, which was after the accident. Dr. Harney stated that when he saw the plaintiff in November 2016, she was in significant distress as outlined in his first medical report. He could only say that her pain was very severe when he saw her, particularly her occipital nerve pain. He accepted that, broadly speaking, most people would make a recovery within approximately four – six months from such surgery in the absence of any other intervening trauma. However, a cohort of people have significant ongoing pain and the plaintiff was in that category. He accepted that the treatment which he had administered to the plaintiff had not produced any lasting beneficial result. He stated that it was just a fact that some patients do not respond well to treatment. It was put to the witness that the defendant's expert, Professor O'Sullivan, was of the opinion that the plaintiff would have been better without receiving the level of treatment that she had. Dr. Harney stated that there were two arguments as to which was the best approach for a doctor to adopt; one was to leave the patient alone and the second was to attempt to treat the symptoms. Interventions were not done lightly by a pain specialist. They are done with a view to helping the patient. He stated that he would only do an intervention if it was warranted in the circumstances. He felt that such treatment had been warranted in this case. However, he accepted that the plaintiff had persistent ongoing neuropathic pain as a direct result of the accident.
79. It was put to the witness that Professor O'Sullivan would state that sometimes patients get "*medicalised*", meaning that they go around to various doctors trying to get relief and effectively end up back at square one without making any improvement. Dr. Harney accepted that that can happen. In this case, the plaintiff still had pain notwithstanding his interventions. However, he stated that it would have been remiss of him not to do the interventions, when it was a proven fact that a lot of patients do well on such interventions and in addition, such interventions also serve a diagnostic role.
80. It was put to Dr. Harney that the collision had been a low impact collision, with barely any visible damage to the vehicles and such damage as there was to the vehicle in which the

plaintiff was travelling, was very minor, as the repair bill came in at just under €250. In such circumstances the defendant's experts found it hard to see how the plaintiff could have suffered such significant injuries as a result of such a collision, whereby she claimed that she had suffered multiple symptoms for over three years since the accident. It was put to the witness that the defendant's experts were unable to understand how the plaintiff could have suffered the extent of injuries alleged by her from such a minor impact and how she could have required all the treatment that she had had since the accident. The defendant's experts did not allege that the plaintiff was not injured in the accident, but they were of the opinion that she was not injured to the extent that she alleged. Dr. Harney stated that he would see a lot of patients after low impact collisions, who developed severe neuropathic pain and for some of these patients the pain continues for longer than two years and is chronic. The plaintiff was in that category, in that she had had chronic pain for more than two years. He had seen the plaintiff relatively early after the accident and had administered appropriate treatment and yet she still had significant pain.

81. It was put to the witness that the defendant's experts would say that there was no evidence of trauma to the plaintiff's head as a result of the accident. Dr. Harney agreed, but stated that the plaintiff had suffered a soft tissue injury and beyond that had developed severe neuropathic pain. She had significant occipital neuralgia. He had done his best to treat it, but it persisted. He stated that the occipital nerve ran from the C.2 level up into the scalp. He had no doubt that it contributed to her ongoing headaches. He stated that she had severe headaches when he first saw her. It was put to him that headaches had not been mentioned in his medical report until he saw her in December, 2016. Dr. Harney disagreed, stating that she was very tender in the occipital nerve when he saw her in November, 2016. There was tenderness in the area on examination and she complained of severe left neck and shoulder pain.
82. It was put to the witness that if she had developed post-traumatic headaches, the defendant's experts would say that they would normally be seen quickly after the traumatic event, and where no such headaches had been mentioned in his report in respect of the November 2016 assessment, they were probably not significant at that time. Dr. Harney disagreed, stating that he had noted significant left-sided neck pain and the plaintiff was tender in that area and there was also pain and tenderness in the occipital area in December 2016. It was also of significance that headaches were specifically mentioned in the referral letter from Mr. Lim dated 13th October, 2016. Dr. Harney accepted that he had not specifically mentioned the aspect of headaches at the November 2016 assessment. He stated that the patient had severe neck pain and was tender in the area of C.2 – C.3 which can give rise to headaches.
83. It was put to the witness that the defendant's doctors and in particular the defendant's physiotherapist, would give evidence that the plaintiff had a greater range of movement than that exhibited under examination. He was asked whether in such circumstances, there was a psychosomatic element to the plaintiff's presentation. Dr. Harney stated that he did not think that there was. The plaintiff had good self-efficacy in trying to get on

with her life. She had engaged well with her rehabilitation programme as directed by him and her physiotherapist. He was satisfied that the plaintiff genuinely wanted to improve and wanted to return to work. He was of the opinion that she will return to work in due course. He accepted that it was valid to try to objectively verify a patient's account of their physical capacity, but this plaintiff had demonstrated good self-efficacy in attempting to get back to full activity. He agreed that a return to work would be very beneficial for her, both financially and socially. It would be a positive development, but would have to be done on a phased basis and built up over time.

84. In re-examination Dr. Harney stated that there was significant tenderness in the occipital nerve in 2016. For that reason, he had injected the occipital nerve in December, 2016. That was primarily done to target the plaintiff's headaches. They had been referred to in the referral letter for Mr. Lim and were the primary target of his treatment in December, 2016. His opinion was that the plaintiff had suffered a whiplash disorder as a result of the road traffic accident, which had led to occipital neuralgia in her neck going into her head with associated headaches, together with shoulder and lower back pain.
85. In cross-examination, it was put to Mr. Lim that from the photographs of the cars after the impact, the level of impact in the RTA was very minor. It was put to him that the pressure applied to the plaintiff's neck in such an impact would have been similar to the pressure that might have been applied by a physiotherapist treating her neck. Mr. Lim did not agree with that proposition. He stated that an accident was an unexpected event, particularly in a low impact collision and if the passenger is wearing a seatbelt, then the only structure that takes the impact is the neck. It also had to be borne in mind that the plaintiff suffered soft tissue injury to her cervical spine, when it was already susceptible to injury due to the surgery in June 2016.
86. Mr. Lim agreed with the defendant's doctors that where there is a soft tissue injury, that would normally resolve relatively quickly. However, when her condition deteriorated and she had returned to see him in early October 2016, he had referred her on to Dr. Harney for appropriate treatment. He did not have any further input into her treatment since that time. He agreed that the injury in the accident was predominately to her neck. He also agreed that the content of Dr. Byrne's report from the assessment on 20th October, 2016, indicated that she appeared to be doing quite well at that time. He agreed that generally most of her symptoms involved neck pain.
87. It was put to Mr. Lim that usually one would expect post-traumatic headaches to come on relatively quickly after trauma, but that here there was little mention of headaches until after December 2016 and that that suggested that they were less likely to have been caused by the accident. Mr. Lim agreed that the further out the headaches were, the less likely they were to be related to the accident. However, he pointed out that in his referral letter to Dr. Harney, he had made specific mention of headaches and Dr. Harney had given an injection to the occipital area to specifically address the headaches.
88. In cross-examination, the plaintiff's Cork based GP, Dr. Ciarán Donovan, stated that the plaintiff's family had been patients of his practice for over 35 years. He had known the

plaintiff since she was a child. She had had a lot of procedures as a result of the injuries sustained in the accident. Her life had been completely disrupted. He was of the view that she was a very genuine patient. He stated that she was a genuine person who, following the RTA, had been in a quagmire of medical difficulties. He was of the opinion that the accident was the cause of these difficulties. He accepted that in 2018 his partner in the practice had made a diagnosis of migraine type headaches. The plaintiff had had some small history of migraine when she was an adolescent. In his report he had said that she was suffering from depression and aggravation of migraine type headaches. He accepted that he knew the difference between post-traumatic headaches and migraine headaches and had described them as being of the latter type.

89. It was put to Dr. Donovan that given the evidence of minimal car damage as a result of the impact, it was difficult to ascribe all her medical difficulties to the accident. Dr. Donovan disagreed. He stated that the plaintiff was only shortly post-serious neurosurgery at the time of the accident. Accordingly, she was not in the normal category of a healthy person, who might be involved in such an accident. A rear-end collision was unexpected. He stated that he would often see people who had had very minor accidents, such as missing their footing on a step and it could give rise to neck pain. While he accepted that there did appear to be improvement at the time she had seen her Dublin based GP in October 2016, improvement was not always linear over time. He had seen people improve, then reach a plateau and then subsequently disimprove.
90. When he saw the plaintiff on 2nd October, 2019, she continued to be symptomatic and had psychiatric difficulties. She continued to have significant pain. She articulated a wish to return to work, but was unable to do so. She stated to him that she would love to return to work, but she simply could not manage it. He stated that she had a desire to get on with her life and return to work.
91. In re-examination he was asked about the opinion of the defendant's physiotherapist that the plaintiff was prone to catastrophizing her level of pain and disability. Dr. Donovan stated that he did not feel that the plaintiff was catastrophizing at any stage. She had always been keen to return to work and get back to her life. The doctors who had referred her to Dr. Harney and Dr. O'Sullivan, had done their best to treat her by making such referrals and the specialists would not do the procedures which they had done, unless they were warranted. In summary, he was of opinion that her ongoing difficulties were caused by the RTA. She had had serious surgery in June 2016, but he felt the changing point was the RTA in August 2016.
92. Evidence was also given by Dr. John Denehy, consultant psychiatrist. He had seen the plaintiff on one occasion on 14th September, 2017, at the request of PIAB. Having taken a detailed history from the plaintiff, he was of the view that she was suffering a moderately severe depressive episode, whereby she had difficulty sleeping, had appetite disruption, alhedonia, a pervasive death wish and fleeting thoughts of self-harm. In addition, due to the fact that she had nightmares, anxiety when driving, avoidance behaviour, a feeling of detachment from people, emotional numbing and hypervigilance,

he diagnosed her as having PTSD. At the time that he saw her he felt that she would benefit from cognitive behavioural therapy (CBT). He subsequently had a conversation with the plaintiff outside the court on the day of the hearing and was aware that she had had a course of CBT with Mr. Liam Hurlihy.

93. In cross-examination, Dr. Denehy accepted that she had not been referred to him at any stage for treatment by her GP. He had only seen her on behalf of PIAB. He was not aware that she had had any difficulties with sleep before the accident, or that she had been given medication for such condition prior to the accident. When he saw her in September 2017, he thought that she had moderate difficulties with her mental health due to the depression and PTSD. He thought that her symptoms had reached the threshold for a diagnosis of PTSD, because she had sufficient relevant symptoms for a reasonable length of time. However, the PTSD was only present for a few months after the accident. It improved after about three months. However, it appeared that her depression continued for some considerable time. He found that with soft tissue injuries, patients tended to follow a fluctuating course. They could present well on a particular day on examination, but it was necessary to look at their condition over a longer time period.
94. In cross-examination, Dr. Sean O'Sullivan, consultant neurologist, was also asked about the assessment carried out by the plaintiff's Dublin based GP on 20th October, 2016. He stated that that was a snapshot from a particular day. It was necessary to look at a patient's condition over time. It was possible for them to have good and bad days. The condition that her skull and neck had been in at the time of the accident, being a weakened post-operative condition, could give rise to symptoms from even a small impact. He accepted that most people would recover from soft tissue injuries within approximately a year, but there were outliers beyond that cohort. If a person had a particular vulnerability at the time of the trauma, there was an increased chance that they would be in the cohort who had refractory symptoms. It was very difficult to predict what would happen on an individual basis.
95. He accepted that generally one would expect symptoms following an accident to come on relatively quickly. However, their importance may increase if certain symptoms remain and other injuries subside. Symptoms would usually come on within one week after an accident, but they may not be the priority at that stage. He accepted that the plaintiff did have headaches before the accident. He felt her headaches were probably migraine type headaches, but the Chiari malformation would predispose a person to headaches. He was aware that she had had migraine in her youth. He was of opinion that 50% of her ongoing headaches were due to the RTA.
96. He was asked what should be drawn from the fact that there was no mention of headaches to the Dublin based GP in October 2016. Dr. O'Sullivan stated that he could not comment on what the plaintiff told her GP on that occasion, or what the GP may have recorded at that visit. He could only say what complaint she made to him when he saw her in 2018. There could be reasons why such a complaint was not recorded by the GP; there may have been time constraints, or if the plaintiff attended with some other more

pressing complaints, such as neck or low back pain, that could explain the absence of any reference to headaches. It was put to the witness that when she first saw Dr. Harney there was no mention of headaches. He stated that that depended on the context of the referral. When she was referred to him in 2018, it was in relation to headaches, so he did not focus on the neck and back complaints to any great extent.

97. Finally, the plaintiff's physiotherapist, Ms. Ormond was asked about the alleged discrepancy between the plaintiffs reporting of pain and limitation of movement and her observed movements as recorded in the report furnished by the defendant's physiotherapist, Ms. O'Mahoney. Ms. Ormond accepted that pain was a subjective element, but clinicians would look for physical signs on the part of the patient when performing movements, such as signs of effort or distress. She stated that she had the opportunity to observe the plaintiff in the waiting room when she was waiting for treatment. Often the plaintiff was not able to sit, but would be pacing the room, or standing against a wall, even though there were seats available. She was confident that the plaintiff was not putting this on as an act for her, as the plaintiff was often unaware that she was being observed, as she was reading a magazine, or looking at her phone.
98. Ms. Ormond accepted that the photographs indicated that the car damage was very minor, which could indicate a minor accident. However, in her experience there was little correlation between the extent of car damage and the injury that may be caused to a passenger. She had seen patients cut out of cars and brought to hospital on spinal boards and yet they had managed to walk out of the A&E Department some hours later with relatively minor injuries. Alternatively, she had seen occasions where patients had been involved in minor impacts, which had given rise to prolonged symptoms.
99. Ms. Ormond stated that she had seen the plaintiff on a relatively frequent basis from before the accident up to the present time. She had found that the plaintiff had limitation of movement of the neck, shoulder and back as recorded in her report. She could not understand how the defendant's expert, Dr. Kaar, had found that she had a full range of movement throughout her spine. She had assessed the plaintiff on a frequent basis and she did not have that range of movement on clinical assessment. She did not have normal range of movement for a person of her age. She stated that when carrying out a clinical assessment if a person complains of pain, the therapist would accept that, but they would also look for physical signs such as grimacing, sweating, breathlessness and they would also look for objective signs on palpation eg. muscle spasm and disc resistance, which could not be faked by the patient.
100. She was of the view that the plaintiff was an excellent patient. She was well motivated in relation to her rehabilitation and was willing to try whatever exercises were prescribed for her. She had good insight into her recovery, but pain was a huge barrier for her. Overall she was disappointed that such little progress had been made over the years as a result of multiple treatments, but given that her neck was significantly compromised at the time of the accident, one had to expect slow progress. Her progress had been variable to date. She had had some good periods, but equally she had had bad periods. The main hurdle

was her pain level. There was secondary sequelae from that, such as sleep disturbance and low mood and they can have an effect on the pain level. She would be hopeful that a recovery could be made within a further two to three years.

101. In her report, Ms. Ormond referred to the 4th edition of *Management of Common Musculoskeletal Disorders*, by Hertling & Kessler, published by Lippincott, Williams & Wilkins (2006), where the following definition of chronic pain was given at page 53:

"Chronic pain is described as a persistent pain that is not amenable to treatments based on specific remedies or to routine methods of pain control. It does not serve a biologic purpose indicative of tissue damage or irritation. In chronic pain the body is unable to restore its physiologic functions to normal homeostatic levels. Chronic pain often produces significant changes in mood (e.g. depression) and lifestyle. Unrelieved pain may produce a decline in the persons routine activities and participation."

102. The authors noted that migraine and tension headaches were very common chronic pain complaints. The authors set out the theories of pain which have been adopted through the years; beginning with the Specificity Theory put forward by Von Frey in 1894, followed by the Pattern Theory proposed by Goldschneider in 1894. That was followed by the Gate Control Theory in 1965. The most recent theory was that proposed by JD Loeser in *Concepts of Pain* published in 1984. Hertling & Kessler described that model in the following terms:

"Loeser proposed a biopsychosocial model of pain that suggests the phenomenon of pain can essentially be divided into four domains: nociception, pain, suffering and pain behaviour. Nociception is the detection of tissue damage by transducers in the skin and deeper structures and the central transmission of this information by A – delta and C fibres in the peripheral nerves. Pain thereby is the perception and interpretation of the nociceptive input by the highest parts of the brain. Suffering is the negative affective response to pain. It may be difficult to differentiate suffering from fear, anxiety, isolation or depression. Lastly, pain behaviour is what an individual says or does (e.g. taking medications) or does not say or do (e.g. job absenteeism), which leads others to believe that individual is suffering from noxious stimuli. Only pain behaviours are observable and measurable. Culture and environmental consequences influence pain behaviours. According to this model one can experience or demonstrate some elements of the model in the absence of others. In chronic pain, pain behaviours and suffering often exists in the absence of nociception."

Medical Evidence On Behalf Of The Defendant

103. Evidence was given on behalf of the defendant by Mr. George Kaar, consultant neurosurgeon. He saw the plaintiff on behalf of the defendant on one occasion on 13th August, 2019. He had previously examined the plaintiff in February, 2018, on behalf of Irish Life PLC in relation to a permanent health insurance policy, or income protection

policy held by her. However, his evidence solely related to the assessment carried out on 13th August, 2019.

104. When he saw the plaintiff in August 2019, she complained of constant headaches, which were worse than they had been before the RTA. They were worse on the right side. She also complained of lower back pain, which had been improving up to May 2019, but she had put her back out while dressing at that time. She had been in bed for four weeks during the summer of 2019 due to lower back pain. She also complained of shoulder pain. Her weight had increased by 21kg. She was not able to go to the gym and she was not able to work. Mr. Kaar stated that on clinical examination he could not find any discomfort being exhibited when walking, sitting or lying. She had a full range of movement in her neck without spasm. Extension movement of the back was slightly reduced. Balance and gait were normal. He had reviewed the imaging scans in her case, which were essentially normal, save for the operative treatment that had been carried out in June 2016. He noted that due to that operation, she was symptomatic at the time of the road traffic accident.
105. Overall, he felt that the RTA was a very minor one with very little damage done to either vehicle. There was nothing to indicate that there would be significant symptoms arising from the accident. Subsequent investigations did not show any additional injury. If there was a minor strain of her muscles and ligaments surrounding the spine, the symptoms would have been maximal after the accident and would have improved thereafter. The natural course of a minor strain injury would be that there would be marked improvement over time, usually over three to six months at most. Thus he was of the opinion that any injuries sustained in the accident would have recovered within a short period, because the reported scans did not reveal any injury. He did not think that the RTA was a major factor in her subsequent symptoms.
106. Mr. Kaar was further of the view that the level of the plaintiff's complaints of pain were out of proportion to his physical examination of her. He was not able to localise her symptoms. He could not find any spinal instability. He felt that her symptoms were unexplained. He was of the opinion that she had symptoms of chronic pain syndrome, which was a functional issue.
107. He stated that post-traumatic headaches were normally maximal within days of the accident and would then get better. Some 80 – 90% of the population generally suffer headaches and 20% of the population have persistent headaches, but these are not due to any accident.
108. He was asked to comment on the view expressed by Dr. Sean O'Sullivan that the plaintiff had suffered brain damage at a micro- or cellular-level and that it was this damage that was causing her symptoms. Mr. Kaar stated that if that were the case there should be minor symptoms. He did not agree that 50% of her headaches were due to the RTA.
109. In cross-examination, Mr. Kaar stated that he was not sceptical of the plaintiff's symptoms as such, but he was sceptical of these symptoms being caused by the RTA. He

could not understand how her symptoms could be caused by that event. He accepted, that she had neck, shoulder and lower back symptoms and headaches.

110. Mr. Kaar stated that he was aware of the correspondence leading up to the operation on 1st June, 2016, and the correspondence thereafter. He did not disagree with the decision which had been made to carry out that operation. The plaintiff had had a difficult time in the weeks following the operation and manual therapy was not scheduled to start until September 2016, even without the intervening road traffic accident. He accepted that Ms. Ormond had found that the plaintiff had improved post-operatively up to the time of the accident and then there had been a deterioration in her condition and an increase in her headaches, with the onset of lower back pain after the accident.
111. Mr. Kaar stated that pain specialists treat pain. Pain was defined by them as being a disease, it was not a post-traumatic condition. Accordingly, he was of the view that the symptoms which the plaintiff had, were the disease itself. There were a lot of background psychological factors effecting this disease. In this case there was a tendency for the plaintiff to develop symptoms after minor trauma, as shown by the fact that she went out of work following a minor blow to the head in November 2015. He was of the view that there was an element of overreaction on the part of the plaintiff in relation to the injuries sustained in the accident which, together with a loss of fitness and the ongoing court case and secondary weight gain, were all contributing to her ongoing pain.
112. Mr. Kaar stated that he was not saying that the plaintiff was exaggerating her symptoms. He accepted that they were real to her. However, he was in court to deal with the causation of those symptoms. His disagreement was in relation to the cause of those symptoms.
113. The plaintiff had suffered chronic headaches since November 2015 and had been out of work since January 2016, both of which were long before the road traffic accident. He was of the view that she was suffering from chronic pain disease before she had either the surgery in June 2016, or the accident in August 2016. The degree of Chiari malformation was quite mild. There were no neurological symptoms; yet she had had chronic pain ongoing for over six months prior to the operation.
114. Mr. Kaar stated that he was not aware of any changes in either physical examination, or on MRI scanning, between the road traffic accident and the present. The scans had all been stable. He stated that if it had been a serious rear ending impact on a person who had had surgery in the recent past, a scan would have shown haemorrhage, ligament damage and a possible spinal fracture. He accepted that one might see loss of lumbar lordosis and muscle spasm for a few weeks. He said that it was hard to understand how that could last for a number of months.
115. It was put to this witness that the various witnesses called on behalf of the plaintiff had stated that she was doing everything possible to return to work. Mr. Kaar stated that it was not clear why she could not work at this stage. The longer pain continued, the less likely it was that a person would do any work. He accepted that the plaintiff's neurologist

believed that she could return to work on a phased basis within a further two years; however, it was hard to see why that had not occurred within two years subsequent to the accident. He could not understand why a further two years was required at this stage. He accepted that she was doing her best to manage her symptoms, but it was not possible to implicate the road traffic accident as being responsible for the symptoms.

116. In re-examination the witness stated that on the basis of the letter from Dr. Byrne in October 2016, the plaintiff was getting better at a point that was two months post-accident. She should have returned to work at that stage. If the GP was right, she was recovering from her surgery and from any possible injuries sustained in the accident.

117. In his medical report, Mr. Kaar had given the following definition of chronic pain:

"Chronic pain is a clinical syndrome completely different from acute pain. Chronic pain and disability become increasingly dissociated from the physical problem and become increasingly associated with emotional distress, depression and adaptation to chronic invalidity. The assessment of pain and disability usually depends on the patient's own subjective report of the pain and physical restrictions.

Pain which is not localised, continuous pain, intolerance of treatments, restrictions of day-to-day activities and overreaction and restriction as a general response to examination indicate psychological factors are generating pain or that there may be exaggeration."

118. Later in the report Mr. Kaar stated that persistent unexplained restricting pain for longer than six months, lack of response to treatments and restriction for work are all features of chronic pain behaviour, a functional disturbance rather than a physical one. It was the severity of symptoms and restriction for work, rather than the severity of an injury, which was the outstanding feature. He stated that the development of chronic symptoms was likely to be multifactorial. There was significant history of headache, significant neck pain and symptoms secondary to surgery in this case and there may have been background stresses in relation to work. There was ancillary gain in not working. There was previous compensation for "whiplash". It was likely that the plaintiff had lost a considerable amount of fitness. It was not unusual for mechanical symptoms from the spine to increase where exercise was discontinued. There was also ongoing litigation and the prospect of compensation, which brought their own stresses and would tend to augment symptoms.

119. Evidence was also given by Professor Michael O'Sullivan, consultant neurosurgeon in Cork University Hospital. He saw the plaintiff on one occasion on 27th April, 2018. At that time, she complained of headache, inter-scapular pain, neck pain, lower back pain and knee pain. She said that the accident had exacerbated her symptoms. Her complaints in relation to headaches were of vertex headaches, meaning headaches at the top of her head. On examination she had no abnormal neurological signs, spinal movement was full and free. Radiology imaging did not disclose any significant injury.

120. Professor O'Sullivan was of the view that her headaches were of a post-traumatic origin from the time that had bumped her head against the ESB box in November 2015. He did not think that her headaches at that time were due to the Chiari malformation, because such headaches are percussive headaches, i.e. they are brought on by sneezing and other head movements.
121. In relation to her ongoing headaches, it had to be noted that she had had headaches prior to the accident and from the damage to the vehicles, it appeared that minimal force had been applied to the vehicle in which she had been travelling and therefore minimal force had been applied to her head. It was put to the witness that Mr. Sean O'Sullivan was of the view that 50% of her headaches were due to the RTA due to possible micro-trauma in the brain. Professor O'Sullivan stated that it depended on the type of headache. Here she complained of vertex headaches, but she did not strike the vertex of her head in the accident, so it was possible to infer that the headache was not caused by the RTA. If the headache had been caused by the RTA it would have been a cervicogenic headache. Dr. Harney had treated her for that, but it had not worked, which implied that the headache was not in fact of that type, or caused by the RTA. If she had hit her head against the headrest, any resultant headache would have been maximal for two weeks post-accident and then would have settled within a period of approximately six months.
122. In relation to her post-surgery progress in June 2016, her assessment by Ms. Ormond on 29th July, 2016, was consistent with a reasonable post-operative recovery being made. Given the assessment by Dr. Byrne in October 2016, he would be satisfied with that level of progress if there had been no accident. When he saw the plaintiff at approximately 18 months post-accident, her back and neck movements were full.
123. In cross-examination Professor O'Sullivan stated that after the accident the plaintiff's subjective interpretation was that her symptoms were worse, but her neurological tests were normal. However, when the findings made by Ms. Ormond were put to him, he accepted that the physiotherapist had reported a deterioration in the plaintiff's condition post-accident. He accepted the findings that had been made by her on her assessments. He accepted her findings and her interpretation of those findings.
124. It was put to the witness that Dr. Harney had given the plaintiff multiple injections in the area of her neck. He accepted that he had done occipital nerve blocks; that would have been for occipital neuralgia, however, the plaintiff was complaining of vertex headaches. He would refer a person for occipital nerve blocks, if there were symptoms of occipital neuralgia. He accepted that Dr. Harney had done the treatment in an effort to relieve her headaches.
125. The witness accepted that the plaintiff's complaint of an increase in her neck pain after the road traffic accident, was supported by the evidence of Ms. Ormond, Dr. Harney and Dr. O'Sullivan. He accepted that it was likely that there was some soft tissue injury to the neck, which had been operated upon previously. He did not take issue with that operation, however the subsequent course of the injury to her neck was beyond his experience. He accepted that there was a temporal relationship in relation to the onset of

more severe neck symptoms, but with a clear MRI scan, he would have expected any such exacerbation to have resolved within six months. When it was put to the witness that a scan would not pick up damage at the cellular level, he stated that to have an axonal type injury to the brain, one would need a very severe impact leading to loss of consciousness. He pointed out that Dr. O'Sullivan does not deal with traumatic brain injury.

126. It was put to the witness that any neurologist would be aware that when examined under histology, cellular injury can cause symptoms. Professor O'Sullivan stated that this was getting somewhat outrageous; they were suggesting that there would be histopathological examination of the brain in a patient who did not have a brain injury. The plaintiff had a vertex headache, not a cervicogenic headache. However, he accepted that she complained of a cervicogenic headache after the accident. He thought that there had been vertex headaches after striking her head in November 2015 and some cervicogenic headaches after the road traffic accident.

127. He referred to conclusion number four in his report which stated as follows:

"Her headache was exacerbated by a road traffic accident on 27.08.016. She has undergone multiple interventions by Dr. Donal Harney which resulted in partial relief of the cervical pain and no relief of the headache."

128. The witness stated that that conclusion related to cervicogenic headaches, which were exacerbated by the RTA. She had had such headaches as a result of the surgery in June 2016, which were then exacerbated by the RTA. He accepted that the plaintiff's neck pain was worsened by the RTA as found by Ms. Ormond and by Dr. Harney. The neck pain got partial relief from treatment. In terms of overall trauma to the plaintiff's neck, there had been severe trauma to it as a result of the surgery in June 2016 and then minimal trauma to it as a result of the RTA in August 2016. He accepted that there had been an exacerbation in her neck symptoms due to the accident, but he expected that exacerbation to have lasted only six months.

129. He accepted that the symptoms of neck and shoulder pain which were referred to at conclusion five in his opinion and which he deemed to be consistent with a diagnosis of soft tissue strain, referred to soft tissue injury in the road traffic accident. He accepted that that was treated with intervention, with only partial relief, from such intervention. He accepted that the lower back soft tissue strain referred to at paragraph 6 of his conclusions, had been caused by the RTA.

130. Professor O'Sullivan accepted that the plaintiff continued to suffer the symptoms of which she complains. However, he thought that much of her symptomology was from the affective component of pain, so it was difficult to say what would happen after the litigation was over. If the component was affective, then that should be managed from a psychological aspect. He did not dispute that she had had extensive treatment, but if that had been unsuccessful and if there was a significant affective component, then she should attempt to "de-medicalise" and return to normal activities. He had advised that

she should return to everyday activities as far as her symptoms would allow. He had advised a gradual return to work.

131. In re-examination he stated that he was of the opinion that a return to work would improve her condition substantially, as it would be beneficial for her socially, physically and mentally. He stated that when he had examined her, she had no neurological findings. The scans were clear and she had full movement of her spine, so there was no reason why she could not return to work immediately.
132. Finally, evidence was given by Ms. Lowry O'Mahoney, chartered physiotherapist. She qualified as a physiotherapist in 2010. She saw the plaintiff on one occasion on 25th September, 2019, for the purpose of carrying out a functional assessment of her.
133. Ms. O'Mahoney stated that her conclusion was that the plaintiff reported pain and restriction of movement at a higher level than was actually warranted. She reached that conclusion for a number of reasons. Firstly, on physical examination the plaintiff's range of neck flexion was less than Ms. O'Mahoney had observed of the plaintiff while she was filling in a questionnaire prior to commencing the physical part of the assessment. During that period, while the plaintiff was sitting in the waiting room, she was able to sit with her neck flexed, while the clipboard was resting on her knee for an appreciable period of time.
134. Secondly, on examination, lateral rotation of the neck was limited bilaterally, whereas when carrying out other tasks such as pushing and pulling objects, she was able to look to the left without apparent discomfort. Thirdly, when doing the cardiovascular step test, whereby she had to step on to a box at a preordained rate for a set period of time, her level of reported effort and pain, did not match her physical signs. In other words, while she reported pain and difficulty completing the exercise, there was no corresponding evidence of effort or pain, by means of breathlessness, sweating or facial expression.
135. Fourthly, the plaintiff had been administered the standard pain catastrophizing scale as devised by Sullivan, Bishop & Privik, which was a recognised scale which had been validated and used in over 700 independent tests. On that scale she scored very highly, reaching a total of 97%, which was broken down into rumination on symptoms 96% percentile, magnification of symptoms 93% percentile and helplessness 98% percentile. Patients who scored highly on this scale tended to overestimate the degree of pain and the negative aspects of performing certain activities. Ms. O'Mahoney stated that the old model of treatment focused on the morbid injury, but in more recent times treatment took account of different factors in recovery, such as social and psychological factors. There was evidence that CBT can be effective in dealing with catastrophic thinking. Exercise therapy could also be beneficial in bringing about rehabilitation, as there was evidence that such therapy could increase function and decrease pain. She also recommended a graduated return to work, as that would provide exercise and a social outlet for the plaintiff and would also have psychological benefits for her.
136. In cross-examination Ms. O'Mahoney stated that the surgery to the plaintiff's neck in June 2016 had been significant surgery. She accepted that the surgery involved considerable

cutting of the soft tissue structures around the cervical spine in the area of C.1 and into the base of the skull. She accepted that the plaintiff's neck was in a weakened state and that the soft tissue structures therein were also weakened post-surgery. She accepted that muscle spasm was generally a preventative mechanism, which would arise following injury. She accepted the findings that had been made by Ms. Ormond, that the plaintiff's condition had disimproved after the RTA. She did not take issue with Ms. Ormond's finding that that disimprovement had been due to the RTA.

137. She stated that on her assessment of the plaintiff's range of movement, she had found limitation of movement in all plains except for right neck rotation. The left arm had limitation of movement and reported discomfort. She had enquired from the plaintiff as to what treatment she had received and the plaintiff had given her an account of the various interventions that she had had from Dr. Harney and Dr. O'Sullivan. However, she did not know exactly where the facet joint blocks had been carried out. She accepted that her collation of information in that regard was somewhat deficient. She accepted that she might have collected more information about where the treatment had been administered. She was aware that multiple treatments had been given by Dr. Harney and that the plaintiff had also received treatment by way of Botox injections from Dr. O'Sullivan. She was also aware of some of the medication that the plaintiff was on, as she had a list of that medication.
138. She stood over the comments that she had made in relation to the plaintiff's catastrophic thinking. The scale that had been administered, had been widely accepted in a large number of studies. These had shown that catastrophic thinking can affect a patient's recovery. Such thinking is an overestimation by the patient of their pain and how it affects them. It is based on an emotional response of the patient to the trauma. So it is not just the morbid aspects of recovery that one looks at, one also looks at the social and psychological effects. She agreed that that aspect should be assessed by a psychologist or psychiatrist and in particular, it is they who should direct the appropriate treatment for it.
139. In re-examination it was put to the witness that there were three possibilities which could be revealed by testing; the first was that a patient was deliberately exaggerating their symptoms; secondly, that the patient had the disability which he or she believed she had, i.e. it was confirmed on testing; and thirdly, the patient believes that they have a level of disability and cannot do certain things, but on testing it is shown that the patient is not as bad as he or she thinks she is. Ms. Lowry thought it was the third proposition that was relevant in this case. The plaintiff's view of her level of disability did not match the level of functionality that she had found on testing. She had not carried out any assessment of her headaches. It was purely an assessment of her functionality on the day that she carried out the assessment.
140. That concludes the summary of all the evidence given in this case.

The Application pursuant to s. 26 Of The Civil Liability & Courts Act, 2004

141. At the conclusion of the case, Mr. Lynch SC on behalf of the defendant made an application that the Court should dismiss the plaintiff's action on the basis that she had sworn an affidavit of verification in respect of her claim for loss of earnings, which affidavit she knew was false or misleading in a material respect and that she knew it to be false or misleading when swearing the affidavit.
142. The basis for this application arose out of Supplemental Particulars of Loss which were served on behalf of the plaintiff on 25th May, 2019. In those supplemental particulars, the plaintiff put the defendant on notice that she had been assessed by a firm of rehabilitation consultants and their findings had been particularised in particulars which had been previously delivered to the defendant. The particulars went on to state that based on the vocational and rehabilitation assessment carried out on the plaintiff, they were now in a position to give the capital value of her future income loss as calculated by their consulting actuary. The supplemental particulars went on to effectively paraphrase the report which had been furnished by the actuary, Mr. Nigel Tenant. His report had set out a range of figures based on various assumptions as to whether (a) she continued in her current position with her employer, KBC Bank, (b) she was promoted to the position of section manager within the bank and (c) she was promoted to the position of section manager and was on the maximum pay scale applicable to that role.
143. The supplemental particulars made an assumption that if the plaintiff could work two days per week for her employer at her pre-accident rate, she would have an earning capacity of $\frac{2}{5}$ of her previous salary of €44,500 gross per annum. Based on these assumptions, a range of losses for the remainder of her life was given at €501,468; €852,566; or €1,116,830. The particulars then went on to specify what deductions and allowances had been allowed for in reaching these calculations. Finally, the report prepared by the actuary dated 20th May, 2019, was enclosed with the supplemental particulars.
144. On 20th September, 2019, the plaintiff swore an affidavit of verification in which she swore that the assertions, allegations and information contained in the Supplemental Particulars of Loss dated 22nd May, 2019, which were within her knowledge, were true. Furthermore, she swore that she honestly believed that the assertions, allegations and information contained in the supplemental particulars, which were not within her knowledge, were also true.
145. It is noteworthy that in a further notice of Supplemental Particulars of Loss dated 9th October, 2019, the plaintiff modified the claims set out in her previous Supplemental Particulars of Loss by stating as follows:
- "(1) The plaintiff continues to be out of work due to her injuries, indicative values for the capital value of the plaintiff's possible future income losses were previously furnished herein on 22nd May, 2019. The indicative values which were furnished for the assistance of the Court were based on assumptions which may be varied subsequently by medical evidence as regards the plaintiff's prognosis and proportion of disability attributable to the accident.*

(2) *A suggestion has been that the plaintiff may be ready for a graduated return to work in the future with a view to resuming fulltime work. The plaintiff awaits a final recommendation from her medical advisors in this regard. The issue of the plaintiff's capacity for any graduated return to part time or possibly eventual fulltime work is under consideration and will be subject to medical evidence and advice."*

146. The plaintiff swore an affidavit of verification in respect of the Supplemental Particulars of Loss dated 9th October, 2019, on 10th October, 2019.
147. When opening the case at the commencement of the hearing of the action, Mr. O'Mahoney SC on behalf of the plaintiff stated that while at its high water mark the plaintiff's claim for loss of earnings came to approximately €1.1m, that was based on the assumption that the plaintiff had a severely restricted earning capacity for the rest of her life. He stated that he was not in fact seeking damages that level. It would be a matter for the Court as to what figure should be awarded for future loss of earnings, based on the medical evidence which would be given in relation to her future capacity for work.
148. Finally, on the second day of the hearing of the action on 15th January, 2020, the plaintiff served a notice of further Supplemental Particulars of Loss setting out various figures which would be applicable if the plaintiff made a graduated return to work over the next two years.
149. Senior counsel for the defendant stated that in circumstances where the plaintiff had never formally withdrawn her claim to future loss of earnings at its high water mark of €1.1m, and where the evidence led on behalf of the plaintiff at the trial was to the effect that the plaintiff should be able to make a phased return to work over the next two years, the affidavit of verification which she had sworn on 20th September, 2019, in respect of the Supplemental Particulars of Loss dated 22nd May, 2019, which included the range of figures for future loss of earnings up to a maximum of €1.1m, was a false and misleading affidavit within the provisions of section 26(2) of the Civil Liability & Courts Act 2004. In effect, he submitted that the plaintiff swore an affidavit of verification in respect of a claim for future loss of earnings, which she clearly knew was not maintainable at the time that she swore that affidavit. If the Court were to hold with him on that submission, then section 26 of the 2004 Act mandated that the entirety of the plaintiff's claim should be dismissed.
150. In the alternative, senior counsel submitted that even if the Court did not hold with him on that application, the swearing of such affidavit in those circumstances, had to be a huge issue on credibility for her claim, as it constituted a vast overstatement of her position in relation to her loss of earnings.
151. In response, Mr. Creed SC on behalf of the plaintiff submitted that the defendant's application was entirely misplaced. He submitted that the Court had to have regard to the specific provisions of the subsection which provided as follows at section 26(2) of the 2004 Act:

"(2) *The Court in a personal injuries action shall, if satisfied that a person has sworn an affidavit under section 14 that –*

(a) *Is false or misleading in any material respect, and*

(b) *That he or she knew to be false or misleading when swearing the affidavit,*

Dismiss the plaintiff's action unless, for reasons that the Court shall state in its decision, the dismissal of the action would result in injustice being done."

152. Counsel submitted that not only would the Court have to find that the affidavit of verification was false and misleading in a material respect, but would also have to find that the plaintiff knew it to be false or misleading when swearing the affidavit. He submitted that there was no basis on which the Court could reach a finding against the plaintiff on either, or both of those requirements.
153. Counsel further submitted that when one had regard to the Supplemental Particulars of Loss dated 22nd May, 2019, all they were doing was putting the defendant on notice of the capital value of the plaintiff's future loss of earnings claim in the event that the Court were to hold that her earning capacity was substantially diminished for the remainder of her life. That had been established as a result of the vocational assessor's report, which had already been furnished to the defendant. All the Supplemental Particulars of Loss dated 22nd May, 2019, did, was to furnish the defendant with notice of the actuary's calculations of the capital value of her future loss of earnings based on various assumptions as to whether or not she would have gained various promotions in the interim. The particulars were doing no more than setting out the content of the actuary's report and indeed a copy of that report was furnished with them.
154. Mr. Creed SC submitted that it was entirely permissible and commonplace for plaintiffs to put forward a range of figures for future loss of earnings based on various contingencies as to whether they were likely to have got various promotions but for the injuries sustained in the accident and to take account of other contingencies, such as future earning capacity.
155. Counsel further submitted that the Court had to have regard to the further particulars of loss which were served on 9th October, 2019, which made it clear that the figures given in the previous notice were indicative values for the capital value of the plaintiff's possible future loss of income. Finally, he submitted that the plaintiff had never made the case at the trial that she would never work again and accordingly the figures which had been given in her previous particulars of loss of income were irrelevant, having regard to the evidence tendered at the trial of the action. In these circumstances it was submitted that there was no basis on which the Court should make an order pursuant to section 26 of the 2004 Act dismissing the plaintiff's action.

Conclusions on the s. 26 Application

156. Having considered carefully the impugned pleadings in this case and the submissions of counsel on the application that the Court should dismiss the plaintiff's action pursuant to

section 26 of the Civil Liability & Courts Act 2004, the Court is satisfied that there is no basis for that application. The Court has reached that conclusion for the following reasons. The Court is satisfied that at the time when the Supplemental Particulars of Loss dated 22nd May, 2019, were served, there was a basis on which the plaintiff could reasonably put forward the case that she would never be able to work more than two days per week for the rest of her life. That conclusion was based on the report furnished by O'Sullivan & Devine, rehabilitation consultants; the conclusions in their report had been set out in previous supplemental particulars, which had been served upon the defendant. The notice of Supplemental Particulars of Loss dated 22nd May, 2019, merely set out the capital values of the future loss of earnings based on the scenario as presented by the vocational assessors. In other words, all the particulars of loss did was to set out what the capital value of that loss would be in the event that the plaintiff was only able to work for two days per week and therefore there would be a loss of earnings depending on whether one took her future earnings to be measured against her earnings at the time of the accident, or took account of a possible promotion to the position of section manager on the minimum wage applicable, or was promoted to that role on the maximum applicable salary.

157. The particulars then gave a range of figures whereby the loss was calculated depending on which level of earnings was used. Effectively what the Supplemental Particulars of Loss were doing, was merely paraphrasing the content of the actuary's report. A copy of the actuary's report was furnished along with the Supplemental Particulars of Loss. I accept the submission made by Mr. Creed SC on behalf of the plaintiff that it is usual and appropriate practice for a plaintiff to deliver particulars of loss on that basis. This puts the defendant on notice of the range of figures that may be allowed by the Court, depending on what findings the Court should make in relation to the future earning capacity of the plaintiff. Those findings would only have been made when the Court had had the opportunity to hear both the plaintiff's doctors and the defendant's doctors in relation to her capacity for work in the future. Accordingly, it seems to me that it is quite normal and appropriate to give a range of figures in this regard.
158. The point was made by senior counsel on behalf of the defendant that in swearing the affidavit of verification on 20th September, 2019, in respect of those Supplemental Particulars of Loss, which contained a claim for the capital value of future loss of earnings at a high water mark of €1.1m, the plaintiff had sworn an affidavit that was false or misleading in a material respect and when she knew that it was false or misleading at the time that she swore the affidavit. I do not see any basis for that contention. The question of the plaintiff's future earning capacity and by extension, her future loss of earnings, was a matter that was somewhat up in the air at the time that she swore the affidavit. This was due to the fact that the question of her future capacity for work was only being clarified as one approached the hearing of the action.
159. In the event that there was any confusion in that regard, I am satisfied that the Supplemental Particulars of Loss served on 9th October, 2019, which clearly put the defendant on notice that the previous figures given in the notice dated 22nd May, 2019,

were purely indicative values and would be dependent on the medical evidence to be given at the trial of the action, made it clear to the defendant that this was an evolving situation which had yet to be clarified. I am satisfied that in these circumstances there was no attempt by the plaintiff to make a claim to a level of damages for future loss of earnings to which she was not entitled. She had merely pleaded her future loss of earnings at a range of values, including up to its high water mark and had made it clear that the ultimate figure that would be claimed by her would be dependent upon the medical evidence to be given at the trial of the action.

160. That position had been made clear in the Supplemental Particulars of Loss delivered on 9th October, 2019, and was reiterated in the opening statement of senior counsel on behalf of the plaintiff at the commencement of the hearing of the action. In these circumstances, there is no basis for the assertion that this plaintiff has attempted to mislead either the defendant or the Court by swearing the affidavit which she did on 20th September, 2019, in respect of the Supplemental Particulars of Loss dated 22nd May, 2019, and accordingly I refuse the defendant's application.

Conclusions

161. Having considered the extensive evidence in this case as outlined earlier in this judgment, I have reached the following conclusions on the substantive issues between the parties. I am satisfied from the evidence given by Mr. Lim that the surgical treatment which the plaintiff had for the Chiari 1 malformation on 1st June, 2016 was serious surgery, which involved considerable disruption to the bones at the base of the plaintiff's skull and at the top of C.1 and also involved substantial displacement of the muscles and ligaments in her neck. Accordingly, I find that her neck was significantly compromised as a result of that operation.
162. I accept the evidence of Mr. Lim that at the six-week assessment post-surgery and when he saw the plaintiff two weeks later, she was making good progress in her rehabilitation from the surgery. I accept the evidence of Ms. Ormond that from her assessments carried out on 29th July, 2016, 5th August, 2016 and 22nd August, 2016, that the plaintiff was improving. Based on this evidence, I find that the plaintiff had been making good progress post-surgery and was following the expected recovery path after such surgical treatment up to the time of her involvement in the road traffic accident on 27th August, 2016. I find that but for the road traffic accident, that in all probability the plaintiff would have made a full recovery from the surgery within approximately six months from the date of surgery and that she would have returned to work at that stage, meaning that she would have returned to work in or about January, 2017.
163. I find that the plaintiff's condition deteriorated significantly as a result of the RTA on 27th August, 2016. That conclusion is reached on the evidence given by Ms. Ormond, who saw the plaintiff both before and after the accident. I accept her evidence in relation to the assessments which she carried out of the plaintiff both pre- and post-accident. Indeed, her assessments and findings at that stage, were accepted by the defendant's witnesses. The fact that there was marked deterioration in the plaintiff's condition is further supported by the action taken by Ms. Ormond in referring the plaintiff back to Mr. Lim due

to such deterioration. It is also supported by the decision made by Mr. Lim after reviewing the plaintiff on 13th October, 2016 to refer her to the pain specialist, Dr. Harney. From this evidence, which I accept, it is clear that there was a marked deterioration in the plaintiff's condition in the weeks and months following the accident.

164. The defendant accepts a number of important things in this case. Firstly, she accepts that the plaintiff was a bad candidate for a soft tissue injury to her neck due to her being in the post-operative stage after significant surgery to her neck, at the time of the occurrence of the accident. Secondly, she accepts that some soft tissue injury to the neck was caused by the RTA. However, based on the evidence of the car damage as provided in the photographs of the vehicles after the accident and the repair bill in respect of the repairs to the vehicle in which the plaintiff was travelling, the defendant disputes that any major forces were inflicted upon the plaintiff's neck in the collision and accordingly disputes that any major injury was caused thereby. Thirdly, and perhaps of most importance, the defendant's witnesses accepted that the plaintiff has the symptoms of pain of which she complained at the hearing of the action. They do not allege that she was deliberately exaggerating her symptoms.
165. I do not think that one can extrapolate from the photographs of the car damage that there was not a significant impact between the vehicles. There was no engineering evidence called by either side in relation to the forces that may have been transmitted by the impact between the vehicles in this case. Accordingly, I must do the best that I can on the evidence before me. The only evidence of the actual impact, was that given by the plaintiff. Neither the first named defendant, nor the third named defendant, were called to give evidence at the hearing of the action.
166. I accept the plaintiff's evidence that she heard a loud bang upon impact and felt her head being propelled forward and then backwards, and that she struck her head against the headrest. It is also significant that the plaintiff suffered an injury to her right knee, when it struck against the dashboard as a result of the impact. That injury was documented after the accident. It is indicative of the fact that the impact was significant.
167. In considering the effect of the impact and its ability to cause the injuries of which the plaintiff complains, one has to keep in mind that the plaintiff's neck was significantly compromised at the time of the accident. The Court cannot make assumptions as to the likely degree of injury that may arise from a low speed impact between the vehicles, because the plaintiff was not in a healthy state at the time that the trauma was inflicted on her neck. Accordingly, one has to be wary of making assumptions as to how a normal healthy person might or might not react to such a collision and applying such assumptions to the plaintiff.
168. In fairness to the defendant's medical experts, they do not base their opinions solely on the photographs of the car damage and the repair estimate; they also base their opinions on the fact that the scans taken of the plaintiff's neck after the accident were largely clear, allowing of course for the changes thereon which were due to the previous surgery. They also base their opinion on the findings made by Professor O'Sullivan and Mr. Kaar of

full movement in the plaintiff's cervical and lumbar spine when they examined the plaintiff. However, one has to remember that these doctors saw the plaintiff on one occasion each in respect of this case in April, 2018 and August, 2019 respectively.

169. I prefer the findings of Dr. Harney and Dr. Sean O'Sullivan, which were made much closer to the time of the accident. In addition, they had the benefit of seeing the plaintiff far more frequently over the following years. Based on their evidence, I am satisfied that the plaintiff's condition deteriorated significantly in the days and weeks following the accident to such extent that Ms. Ormond referred the plaintiff back to Mr. Lim. When he saw the plaintiff on 13th October, 2016, he was sufficiently concerned to write a referral letter to Dr. Harney on that date.
170. In addition, it is noteworthy that immediately prior to the accident the plaintiff's complaints largely concerned neck and shoulder pain and headaches, whereas post-accident she also complained of thoracic and lumbar pain and knee pain, together with a deterioration in her neck pain and headaches. I am satisfied that the findings made by Dr. Harney in November, 2016 were consistent with a soft tissue injury to the spine caused by the road traffic accident. The fact that her presenting symptoms were significant is evidenced by the fact that Dr. Harney commenced treatment of the plaintiff in December, 2016. It is also significant that he found tenderness in the area of the occipital nerve. The treatment administered by him in December, 2016 was designed to treat the plaintiff's headaches. I am satisfied that these were cervicogenic in nature and were caused by the RTA.
171. Accordingly, I find that the plaintiff's condition was significantly exacerbated by the RTA in August, 2016 in terms of her neck and shoulder pain and headaches and also by the additional new complaints in relation to thoracic and lumbar pain and knee pain.
172. It is undeniable that the plaintiff has undergone extensive invasive treatment from Dr. Harney and Dr. O'Sullivan, which was both painful and distressing for her. I accept the evidence of the GP, Dr. Donovan, that in making referrals to specialists, GPs are doing their best to treat their patients' symptoms. In administering treatment, the specialists are also doing their best to alleviate the patient's pain and disablement. I accept the evidence of Dr. Harney that he would only do treatment which he felt was warranted. While some of the defendant's doctors may have questioned both the level and nature of the invasive treatment given to the plaintiff, that is a difference of opinion between doctors. It does not mean that the plaintiff was wrong to undergo the treatment that was advised to her by Dr. Harney and Dr. O'Sullivan. Merely because one of the defendant's doctors, who saw her on only one occasion, may have treated her differently, is not relevant to the question that this Court must consider.
173. Both Mr. Kaar and Professor O'Sullivan accepted that the plaintiff was suffering the symptoms of pain of which she complains at the present time. There has been no suggestion that she has deliberately or consciously sought to exaggerate her symptoms, or fraudulently claim compensation for injuries that are not genuine.

174. The defendants main attack on the plaintiff's case is on two grounds: firstly, they say that such a minor impact could not have caused the injuries complained of by the plaintiff. However, I am satisfied from the plaintiff's progress from the surgery in June, 2016 up to the time of the accident in August, 2016 and from the onset of the deterioration in her symptoms, together with new symptoms after the accident, that on the balance of probabilities, that deterioration and the onset of new symptoms were caused as a result of the accident, notwithstanding that there may have been a relatively minor impact between the vehicles.
175. The Court is concerned by the findings made by the defendant's doctors that the plaintiff had a good range of movement in her spine when they examined her. The plaintiff was seen by Professor Michael O'Sullivan on 27th April, 2018, at which time he found that she had a full range of movement in her neck, shoulders and lower back. Those findings have to be seen in the context that only seven days earlier on 20th April, 2018, the plaintiff had been seen by Dr. Harney in the Bon Secours Hospital, where she had received PRFL to the left suprascapular nerve and left-sided C2 – C6 diagnostic facet joint blocks. According to Ms. Ormond, the plaintiff had reported a decrease in her cervico-thoracic and scapular pain after that treatment. That improvement lasted until May when, possibly due to the use of crutches for her fractured toe, she reported a negative impact on her neck condition. Accordingly, it would appear that the findings made by Professor O'Sullivan, were probably due to the beneficial effect of the treatment administered by Dr. Harney on 20th April, 2018.
176. When the plaintiff was seen by Mr. Kaar on 13th August, 2019, he recorded that she had a good range of movement in her neck, although she complained of some soreness in the mid-cervical area and in the left trapezius. There was no muscle spasm or tilting. There was restriction of extension in the lower back, but flexion was good. Those findings have to be contrasted with the findings recorded by Dr. Harney when he saw the plaintiff two months earlier on 11th June, 2019, at which time she reported ongoing severe left- and right-sided lower back pain, left-sided neck pain and left shoulder pain. She reported that her headaches were very severe. Clinical examination on that occasion, revealed tenderness in the facet joints on the left and right side at L3 – S1, marked tenderness of the facet joints on the left side at C3 – C6 and also reduced movements of the left shoulder in adduction internal rotation and adduction external rotation. There was also tenderness in the distribution of the left and right greater occipital nerves and nuchal line tenderness left and right side at C3 – T1. There was no evidence of nerve root tension signs in either right or left upper limb, or right and left lower limb.
177. The findings made by Mr. Kaar also contrast sharply with those made by Dr. Seán O'Sullivan when he saw the plaintiff on 3rd September, 2019, which was about three weeks later, at which time clinical examination revealed tenderness to palpation over the posterior cervical muscles and left shoulder muscles including the trapezius. There was a reduced range of horizontal neck movement beyond 60 degrees from the midline, particularly looking over the left shoulder.

178. When examined later that month on 25th September, 2019, by Ms. O'Mahoney, there was limitation of movement of the lower back in flexion and extension, which was limited by an increase in pain. The plaintiff had normal range of movement in the lower back on lateral flexion, but reported an increase in pain when performing that movement. There was limitation of movement of the neck in flexion and extension with a reported increase in pain. Right rotation was normal, with an increase in reported pain and there was a reduction in left rotation of the neck. Ms. O'Mahoney further noted that on carrying out certain tasks, the plaintiff appeared to demonstrate a greater range of movement in the affected areas, than she had admitted to during the examination.
179. In considering this aspect of the case, the Court accepts the evidence given by the plaintiff's medical advisors, and in particular by her Cork based GP, Dr. Donovan, and her treating physiotherapist, Ms. Ormond, that she is a genuine and well-motivated patient. Insofar as there is a conflict of evidence between the two doctors who examined the plaintiff on behalf of the defendant and the plaintiff's medical advisors in relation to her disability and in particular the range of pain free movement of her spine, I prefer the evidence of the plaintiff's doctors and physiotherapist in this regard. I am satisfied that she has followed a fluctuating course, whereby her symptoms have waxed and waned over time, but overall I am satisfied that she has experienced the pain and disablement as described by her in her evidence and as described by the various medical witnesses who gave evidence on her behalf.
180. The second area of attack is that even if it is accepted that the plaintiff was a bad candidate for an accident involving injury to her neck, any soft tissue injury thereto would have been of relatively short duration, such that her ongoing complaints can only be explained by the fact that she has engaged in catastrophic thinking in relation to her level of pain and disability; such that her pain levels are not as high as she thinks and she is not as restricted in her movements as she thinks.
181. According to Mr. Kaar, chronic pain is a disease in itself, not a post-traumatic condition. He is of the opinion that the plaintiff had that disease prior to the accident, as evidenced by her overreaction to striking her head against the electricity box in November, 2015 and going out of work in January, 2016. He is of the opinion that the plaintiff's current complaints of pain, which he accepts, are due to this disease, rather than to any soft tissue injury suffered in the accident. His hypothesis on this aspect is supported by the findings of Ms. O'Mahony on her administering of the catastrophic pain scale.
182. In considering this issue, I do not think that the plaintiff is deliberately catastrophizing either her injuries, or her symptoms of pain. I accept the evidence of Dr. Donovan, who has known the plaintiff since childhood, that she is a genuine, well-motivated person, who is keen to get back to a normal life and to return to work. That opinion is supported by the evidence of Ms. Ormond, who stated that the plaintiff was at all times compliant in relation to her treatment regime and was keen to get back to work as soon as her symptoms would allow. That is also supported by the fact that the plaintiff made contact

with her employer to enquire about the possibility of returning to work on a phased basis and/or part time basis.

183. All the evidence before the Court has been that the plaintiff has been compliant with all treatment regimes prescribed to her. She has undergone extensive treatment from the pain specialist and from Dr. O'Sullivan. She has had extensive physiotherapy treatment from Ms. Ormond, acupuncture treatment from Dr. O'Connell and cognitive behavioural therapy from Mr. Hurlihy. She has engaged in swimming and walking in an effort to rehabilitate. She has taken extensive oral medication as prescribed. She has attempted to be active by engaging in an eight-week interior design course and a six-week mindfulness course. She has also assisted friends with the preparation of their CVs. There is no evidence before the Court that the plaintiff has ever engaged in any activities which were incompatible with her reported restrictions.
184. It is also noteworthy that the plaintiff is very well educated. At the time of the accident she was doing well in her job with KBC Bank. She was in a steady relationship with her boyfriend, which has lasted to the present time. There was no history of any psychiatric illness. Life was going well for her. In these circumstances the Court is satisfied that there is no question that the accident may have provided a convenient "*bus stop*" for her to leave her pre-accident life and adopt a different lifestyle.
185. Having watched and listened to the plaintiff give evidence, the Court is satisfied that the plaintiff did not attempt to exaggerate her level of disability. She gave evidence in a calm and rational manner. She did not put on an act for the Court by grimacing, rubbing her neck or back, or not turning her neck. Indeed, when that very fact was put to her in cross-examination, she said that while she had managed to give evidence for a number of hours in the witness box, she had experienced severe pain when she went home and had had to go to bed. The Court accepts that evidence.
186. On the issue of whether the plaintiff's symptoms of chronic pain are due to the road traffic accident, or are a separate disease in itself as postulated by Mr. Kaar, the Court prefers the evidence of the plaintiff's treating doctors: Dr. Harney, Dr. O'Sullivan and Dr. Donovan and the evidence of her treating physiotherapist, Ms. Ormond, who are all of the view that her symptoms stem from the road traffic accident. Their evidence is supported by the temporal onset of symptoms after the accident. The fact that the symptoms have lasted for a longer time than may be the norm, can be explained by the fact that the plaintiff's neck was in a significantly weakened state at the time of the accident.
187. I accept the evidence of Dr. Sean O'Sullivan that the fact that the plaintiff's MRI scans are largely clear, is explicable by the fact that damage may occur at a cellular level, which can produce symptoms, while not showing on imaging. It is also noteworthy that the opinions expressed by the defendant's witnesses were based on one examination by each of them of the plaintiff at a considerable remove from the date of the accident; whereas the evidence from the treating doctors was based on their interaction with the plaintiff on a large number of occasions over a protracted period. In such circumstances, the Court prefers their opinion of the extent and causation of the plaintiff's symptoms.

188. However, even if I am wrong in that, if I were to accept the defendant's medical evidence at its high water mark and find that her ongoing pain and disablement are largely caused by psychological factors, such as an over estimation of perceived or anticipated pain; once a Court can be satisfied that a plaintiff is not deliberately exaggerating or malingering, and of that I am satisfied in this case, the defendant has to take her victim as she finds her. In other words, if the victim happens to be a person, who had had significant surgery to her neck in the weeks prior to the accident and if I were to accept that she were prone to suffer chronic pain due to her tendency to catastrophic thinking, as long as that was not done deliberately, the defendant must compensate the plaintiff for the chronic pain from which she suffers.

189. In the paper referred to by Ms. O'Mahoney, "*The Pain Catastrophizing Scale: Development and Validation*" by Sullivan et al., the authors came to the conclusion that magnification, rumination and helplessness appeared to be the features which determined which patients were likely to be catastrophizers. While their reaction to pain may well be different to that of other patients, the pain is nevertheless real. In the general discussion part of the paper the authors stated as follows:

"Although the present study was not intended as a test of a particular theoretical model linking the different dimensions of catastrophizing, at a descriptive level, magnification, rumination and helplessness share features with primary and secondary appraisal processes that have been discussed in relation to coping with stress (Jensen et al., 1991; Lazarus & Folkman, 1984). For example, magnification and rumination may be related to primary appraisal processes in which individuals may focus on and exaggerate the threat of a painful stimuli. Hopelessness may be related to secondary appraisal processes in which individuals negatively evaluate their ability to deal effectively with painful stimuli. Indeed, Jensen et al. (1991) have proposed that catastrophizing may be viewed as a negative appraisal of pain. As a function of a learning history characterised by excessive exposure to painful situations or exposure to others' catastrophic reactions to pain, individuals may develop enduring beliefs or schema about the high threat value of painful stimuli or about their inability to effectively manage the stress associated with painful experiences (Turk & Rudy, 1992). The high test – retest correlations of the PCS (pain catastrophizing scale) are consistent with the position that individuals may possess enduring beliefs about the threat value of painful stimuli.

Rumination accounted for the largest proportion of variance in the PCS. The items making up the rumination component reflect an inability to suppress or divert attention away from pain – related thoughts. The role of attentional factors in catastrophizing has been noted by several investigators. Heyneman et al. (1990) have reported findings suggesting that catastrophizers may be impaired in their inability to make effective use of distraction strategies. Spanos et al. (1979) have suggested that catastrophizers may fail to attend sufficiently to their coping strategies. It is possible that pain – related thought intrusions or excessive focus on pain sensations may interfere with catastrophizers' attempts to invoke strategies

to reduce their pain. Indeed the data from Study 2 suggests that catastrophizers use as many coping strategies as non-catastrophizers; however, for catastrophizers, the use of coping strategies is not associated with pain reduction."

190. As seen from this extract, previous experience of pain is relevant. In this regard it is noteworthy that the plaintiff had had an experience of severe neck pain in the five weeks immediately post-surgery.
191. In addition, as noted by Ms. Ormond in her report, a combination of chronic spasm and over activity leading to shortening of the anterior neck musculature and overstretching and weakening of the posterior neck and scapular muscles, contributes to the development of postural dysfunction and as a result, the normal lordotic curvature of the cervical spine is caused to be flattened or reversed. She noted that such a finding was revealed on the MRI scan of the plaintiff's cervical spine. She noted that these adaptive soft tissue changes also result in a gross reduction in active cervical movements which were demonstrated on the assessment carried out by her. Thus, it can be seen that there is an interaction between the mental component and protective postures adopted by the plaintiff, which can actually end up increasing rather than reducing pain in the long term. Thus, while the opinion of defendant's doctors, that there is a large psychological component in the symptoms of chronic pain suffered by the plaintiff, may well be right, that does not of itself mean that the pain which the plaintiff is experiencing does not exist.
192. Accordingly, even if I were to find that the plaintiff's chronic pain is a disease in itself, which was due primarily to psychological factors within the plaintiff, I would have to find that such chronic pain arose due to the fact that the plaintiff had that inherent psychological susceptibility at the time that she had her accident. In legal terms she would be seen as being a person who had an "eggshell skull" and the tortfeasor must take his victim as he finds him. This principle has long been accepted in Irish law. It was described in the following terms by Clarke J. (as he then was) in *Walsh v. South Tipperary County Council* [2011] IEHC 503 at paragraph 5.6:

"In the oft quoted case of the injured party with the so-called "eggshell skull" it can, on occasion, turn out that, due to some weakness or predisposition, a particular injured party suffers much more severe consequences from a relatively innocuous incident than might at first sight be expected. However, it again remains the case that, if personal injury is a foreseeable consequence of whatever wrongdoing is concerned (say the negligent driving of a motor vehicle), then the fact that those injuries may, in the peculiar circumstances of the case, be much more severe than might have been expected does not deprive the injured party from an entitlement to recover whatever may be appropriate for those injuries."

193. I am satisfied that in this case personal injury was a foreseeable consequence of the accident. That being the case, the fact that the plaintiff may have had a more severe injury than might be expected in the normal run of cases, due to a predisposition on her part towards catastrophic thinking, as a result of which she has gone on to suffer chronic

pain, does not prevent her recovering compensation from the defendant in respect of that pain. The defendant had to take this plaintiff as she found her on the day of the accident. Accordingly, I find that even if the hypothesis put forward by the defendant's medical experts were to be accepted, that would not deprive the plaintiff of compensation in respect of her ongoing chronic pain and disablement.

194. It may well be that going forward, the plaintiff's best route to full recovery may lie in a multi-disciplinary approach, with a strong emphasis on the psychological modalities of treatment in the form of CBT, specialist mindfulness therapy and also including exercise therapy as recommended by Ms. Ormond, along with such pain intervention both oral and by injection, as maybe necessary. However, these are decisions for the plaintiff's treating doctors.
195. Turning to the issue of damages, I find that following the operation on 1st June, 2016, in the absence of the road traffic accident the plaintiff would have suffered headaches and neck pain on a diminishing scale for approximately six months. One cannot say for certain that she would have made a full recovery within that period, but on the evidence available in relation to her condition post-surgery and prior to the time of the accident, I am satisfied that she was making good progress in that period. However, even without the accident, she would have experienced some symptoms during that six-month period and would have been unfit for work until the end of the year. Accordingly, for the period from 27th August, 2016 to the end of 2016, the plaintiff is only entitled to be compensated for the exacerbation of her condition which arose as a result of the accident.
196. I am satisfied on the evidence, which has been set out in extenso earlier in this judgment, that the plaintiff has suffered constant, and at times severe, pain in her neck, shoulders and lower back since the accident and also had knee pain. In addition, she has had persistent headaches, which, according to the evidence of Dr. Sean O'Sullivan, which I accept, 50% of these are due to the road traffic accident. In respect of all of these conditions she has had the extensive treatment as outlined earlier in the judgment.
197. I find on the evidence of Dr. Dennehy that the plaintiff suffered depression and post-traumatic stress disorder after the accident. The PTSD was of relatively short duration. The depression was moderate and has been persistent since the time of the accident. The plaintiff continues to be prescribed anti-depressant medication. I have had regard to the fact that treatment for her psychiatric illness has been given by her GP, who did not feel that the intervention of a psychiatrist was necessary.
198. I accept the plaintiff's evidence that she has been unfit for work since the accident. I find that from January, 2017, her inability to work was due to the effects of the road traffic accident. Her evidence in relation to her inability to work is supported by all the medical experts called on behalf of the plaintiff. I prefer their opinion to that of the defendant's medical witnesses and find that she is indeed unfit for work. I accept their evidence in relation to the limitations of movement in her cervical spine that they found on the various assessments carried out by them. As the treating doctors, they saw the plaintiff on a frequent basis. In addition, having regard to the nature and extent of the treatment

given by Dr. Harney and Dr. O'Sullivan, it is reasonable to presume that the plaintiff would not have been fit for work in the aftermath of such treatment.

199. In terms of the future, the prognosis is somewhat uncertain. Dr. Harney has stated that in his opinion the plaintiff will require further treatment in the form of ablation of the occipital nerve and she may need nerve stimulation, which would have to be carried out abroad. Dr. O'Sullivan is hopeful that the most recent treatment which he has administered will give lasting benefits. It is hoped that if beneficial results are obtained from this treatment, the plaintiff will be in a position to return to work on a phased basis over the next two years. All the medical witnesses were in agreement that a return to work would have considerable beneficial effects for the plaintiff on a number of fronts.
200. On the basis of that evidence, I find that on the balance of probabilities, with the appropriate multi-disciplinary treatment, the plaintiff will make a reasonable recovery from her symptoms of pain, so as to enable her to return to work and lead a relatively normal life in the next two years.
201. In assessing general damages both to date and into the future, I have had regard to the Book of Quantum. However, I have not found it of great assistance in this case, because this case involves multiple sites of injury, which were superimposed on an already weakened neck. In addition, there is the existence of psychiatric injury in the form of transient PTSD and ongoing depression.
202. In summary, this young woman has had her life totally disrupted for the last three years. Her injuries have affected her in every aspect of her life. She has been rendered very considerably disabled during this period. She has undergone very extensive treatment. Taking all of these matters into account I award the plaintiff general damages to date in the sum of €96,000. Having regard to the matters outlined above, I award the plaintiff general damages for the future in the sum of €50,000.
203. In relation to special damages, I award the following sums: €17,648.98 for medical and other expenses to date. It was agreed between the parties that in regard to the level of the plaintiff's earnings prior to the time of the accident, her net loss of earnings per annum would amount to €33,315.96. In respect of the period from January, 2017 to date, being three years and two months, I award the sum of €105,480.54.
204. The amount to be awarded for future loss of earnings is difficult to assess. We do not know what progress the plaintiff will make in her attempts to return to work, nor at what exact time she will be able for various amounts of work, such as two days per week, three days per week, etc. Having regard to the fact that she has not worked for the last four years and given her level of disability at present, it may be necessary for her to start returning to work slowly, perhaps on a voluntary basis. Perhaps she might find work with a family or friends' business, or in a charity shop, where she would not have to work under pressure and where she could take rests and days off as necessary. It may be possible thereafter to build up to full working in the market place on a phased basis. If the plaintiff were not to work at all over the next two years, she would suffer a net loss of

earnings of €66,631.92. Given her current levels of pain and restriction in activity, I cannot see her earning much in the next year. Thereafter, it is somewhat up in the air what her earning capacity will be over the following year. Doing the best that I can, I propose to allow 50% of her loss of earnings on a total incapacity basis over the next two years, which amounts to a loss of €33,315.96.

205. Adding these heads of damages together, gives a total sum of €302,445.48. The plaintiff is entitled to judgment for that sum against the defendants. I will hear the parties on whether the judgment should be against all the defendants, or only against the first named defendant.