

THE HIGH COURT

[2023] IEHC 656

[Record No. 2022/199P]

BETWEEN

AIDAN CRUM

PLAINTIFF

AND

MOTOR INSURERS BUREAU IRELAND

DEFENDANT

JUDGMENT of Ms. Justice Denise Brett (*ex tempore*) delivered on the 21st day of November 2023.

Introduction

1. Over 4 years ago, on 1st February 2019, the plaintiff, Mr. Aidan Crum, experienced what he described in evidence as a quite terrifying fall and lengthy skid from his motorbike on a slip road driving onto the M1 motorway.
2. Liability for the plaintiff's crash lies with an unknown driver of a car which cut across him and the defendant, the Motor Insurers Bureau of Ireland is sued pursuant to its well-established agreement concerning untraced drivers. The action comes before me as an assessment of damages only.
3. Special damages are agreed between the parties in the sum of €8,000.

4. Medical reports submitted to court of Mr. Denis Collins, consultant orthopaedic surgeon on behalf of the plaintiff dated 25.10.19; 11.02.22; 2.3.22 and 30.09.23 and Mr. McGoldrick, consultant orthopaedic and hand surgeon dated 5.4.22 and 18.8.23, were agreed. In addition, Mr. Collins came to court and gave oral evidence.

Background Facts

5. Mr. Crum, a 56-year-old self-employed software engineer, gave evidence he was travelling by motorcycle from his home in Laytown Co. Meath at approx. 6:30am on a cold and dark February morning to his place of then work in Sandyford, a journey he had done many times and which he made via the M1 and M50 motorways. It took approximately 40 minutes.

6. The plaintiff was coming down the slipway at the Balbriggan interchange to enter the M1 when an erratic motorist cut in front of him without warning causing him to brake suddenly. The motorist then also braked, causing the plaintiff to brake again and ultimately fall from his motorbike with an approximately 200m skid along the roadway amongst heavy traffic. He said he came to a stop on his back with his head in a ditch and felt immediate pain in his left arm. He described that he “knew something was up” and, on taking off his protective biking gear could see his hand “hanging off at the end of his wrist”. He also injured his left ankle.

Injuries and Effect

7. The plaintiff was brought by ambulance to Beaumont hospital where X- rays of his left wrist revealed a comminuted intra-articular fracture with depressed intra articular fragments. The plaintiff is left hand dominant. X-rays of his left ankle revealed no obvious fracture and of his lumbar sacral spine, no acute injury. Notwithstanding the absence of a

fracture, the plaintiff outlined how very painful and debilitating his ankle was in the aftermath of the incident. He accepted that this injury had substantially resolved after approximately six months, albeit he remains with some residual difficulties today, nearly 5 years later, if required to stand for long periods.

8. The plaintiff's left wrist was manipulated in the emergency department (explained by Mr. Collins, to take the pressure off the nerves prior to surgery), whereafter the plaintiff was admitted to the hospital and came under Mr. Collins' care. The plaintiff underwent open reduction and internal fixation of his left distal radial fracture. In the course of the operation the plaintiff experienced an allergic reaction to a prophylactic antibiotic he had been given, Teicoplanin, and required resuscitation. This was understandably traumatic for the plaintiff to hear when he later woke up from his anaesthetic. He had an uneventful post-op recovery but is left with a 10cm longitudinal surgical scar extending up from his wrist.

9. The plaintiff was in hospital for a period of four days, during which time he was concerned about developing MRSA as a bed-neighbour had contracted the disease but fortunately he did not.

10. After his discharge home, his arm was in a splint and sling for approximately six weeks. He required a support on his ankle and his movements and general activities of daily life were restricted. He required intensive physiotherapy and was prescribed home exercises thereafter, which he carried and continues to carry out, in order to get movement into his wrist. The plaintiff accepted that he had not engaged with further professional assistance in this regard since 2019.

11. The plaintiff indicated that he would have taken time off work if that had been possible but as he is self-employed, the simple fact of life was that if he did not work he did not get paid and there was no other income coming into the family. He therefore returned to work within a week of the accident. However, to travel to work then took an hour and a half

as it required a car journey, with his wife available to drive, followed by a bus and then a Luas. The Plaintiff's work was impacted as he had difficulties using a mouse and keyboard, including the fact that he had to switch from his dominant hand to use a mouse with his right hand. The plaintiff has since switched consultancy and now works predominantly from home.

12. The plaintiff gave evidence of previously being very active in sport to which he has either been unable to return to or has returned on a more restricted basis. He explained how he could not perform weight bearing exercises on his wrist, such as press ups, at the gym. Swimming using the front crawl movement was painful as he struggled to pull through the water. Cycling on an uneven surface was too painful as the shock travelled up through the handlebars to his arms. Golf was painful every time he hit the ball, although he had tried pitch and putt. The Plaintiff detailed how he had bought canoes as a family sporting activity but had to sell them without ever having had the opportunity to enjoy them as a family activity due to the pain he was enduring as a result of the canoeing motion. Further, he referred to how his ability to help around the house was restricted.

13. The plaintiff agreed with Counsel for the defendant that modifications in each of these activities could assist with his return, and the plaintiff explained that he had attempted to do so in the case of cycling by changing the style of the handlebars of his bike. A lack of confidence in his wrist had also played an inhibiting part to his return. He is unable to regain the level of fitness he had enjoyed prior to the accident.

14. The plaintiff took pain killing medication for approximately three months after the accident but has avoided them since where possible. He gave evidence of having suffered sleep disturbance and encountered flashbacks of the accident for some time.

15. Mr. Collins, who is the plaintiff's treating consultant in respect of his wrist, gave oral evidence to tease out its medical effects and implications. Mr. Collins remembered the

plaintiff well due to the additional measures required in the operating room consequent upon his allergic reaction.

16. Mr. Collins outlined how important the distal bone is, explaining that it is the biggest bone in the wrist and responsible for transferring the load from the hand through the wrist to the arm and shoulder when a person is lifting or handling. He emphasised both the comminuted and intra-articular nature of the plaintiff's fracture, which he described as one of the most severe fractures of the wrist, and stated that, coupled with it being a high velocity injury, it would have been very painful, as it pulled on the median nerve (and hence the need for manipulation in the Emergency department). He commented that he has had the pain described as 10/10 by some patients with this injury.

17. Mr. Collins described the open reduction internal fixation operation undergone by the plaintiff, confirming that he had secured satisfactory alignment with plates and screws and the plaintiff had had an uneventful post op recovery. He highlighted how difficult physiotherapy would have been for the plaintiff and that although in a lot of pain "... he got himself back". He was of the view that the plaintiff had recovered a degree of functional movement in his wrist but not full movement. He demonstrated flexion, extension, pronation and supination, confirming that the plaintiff's residual and now permanent difficulty was with flexion, which was significantly reduced and extension, which was also reduced, but less so, such that he now achieved a range of movement of approximately 100° which was a reduced but functional range.

18. Mr. Collins advised against a further operation to remove the plates as, on balance, the additional surgery carried long-term risks, particularly to the nerves. He gave evidence that the plaintiff's current level of movement will be static and won't improve. He confirmed the plaintiff's complaints when cycling, describing the arm's shock absorber being through the wrist. He indicated that the plaintiff would have experienced pain and discomfort when

lifting, with a persistent limitation when heavy lifting, and an ongoing ache and discomfort when typing. He assessed the risk of arthritis at 10-15% in the future, and put the likelihood of further operation to fuse the wrist joint at very, very low.

19. Mr. Collins clarified that while his original report, in March 2019 made no mention of any difficulty with extension on clinical examination, this might not have been observed by him due to the swelling which would not have fully reduced by then. He unequivocally linked the reduced extension subsequently evident as arising from the injury that occurred on 1st February 2019. He highlighted the long-term difficulty the plaintiff will have with activities in load bearing on a flexed wrist. He explained that canoeing would be particularly difficult due to the extension that is required, though swimming would be encouraged even if requiring some technical adjustments in his stroke. He was of the view that golf should be possible.

20. I saw the plaintiff's wrist myself, including the 10cm scar running up his arm from the wrist. Mr. Collins manipulated the plaintiff's wrist to explain and demonstrate the reduction in his movement, which was marked in respect of flexion and in respect of extension less so but still noticeable.

21. Mr. McGoldrick reviewed the plaintiff on behalf of the defendant in April 2022, just over three years post-accident. He noted the reduced dorsi flexion movement in the plaintiff's left wrist as compared with the right. His subsequent review of the various contemporaneous X-rays was of,

“a very complex, comminuted dorsally displaced intra-articular distal radial fracture... that ... was at least a three-part intra articular fracture with a radial styloid fracture, and a separate ulnar based lunate facet articular fragment impacted on the ulnar radius. There was minor residual articular incongruity”.

Mr. McGoldrick was of the view that the plaintiff had a permanent diminution in movement of about 15°, with which Mr. Collins agreed. Mr. McGoldrick was of the view that, in the context of likely damage to the intra articular cartilage, there was a definite risk to the plaintiff of osteoarthritis long term, albeit not yet evident and likely to be on the lower end of the scale. In this regard, Mr. Collins, who had viewed the more recent X-rays, put that risk low, at 10-15%. Mr. McGoldrick noted the plaintiff “appeared to have adapted to the status quo”.

22. The plaintiff has provided no discreet medical legal report on his ankle injury. Mr. Collins had confined his comments to the wrist injury only, as the injury for which he had treated the plaintiff.

23. I accept the plaintiff’s evidence and that of Mr. Collins as to the nature of the left wrist injury and its effects on the plaintiff as outlined in evidence.

Principles to be applied

24. Determining an award of damages in this case is covered by the Personal Injuries Guidelines (“the Guidelines”). Both Mr. McGrath on behalf of the plaintiff, and Mr Condon on behalf of the Defendant made submissions in respect of the Guidelines. The relevant principles I must consider have been set out in the judgment of Coffey J. in *Lipinski (a minor) v. Whelan* [2022] IEHC 452, adopted by Murphy J. in *McHugh v. Ferol* [2023] IEHC 132, who also considered the relevant principles to be applied in measuring an overall ‘uplift’ for additional injuries. Both approaches were endorsed by the Court of Appeal in *Zaganczyk v. Pettit & anors* [2023] IECA 223 (Noonan J.) and were most recently followed by Stewart J. in *Coughlan v. CRG Construction Ltd & anors* [2023] IEHC 639, on 17th November 2023. None of those cases involved a wrist injury.

Dominant injury

25. The dominant injury in this case is easy to ascertain. Both sides agree and, in light of the contents of the agreed medical reports and the additional evidence of Mr. Collins, I find as a fact that the dominant injury suffered by the plaintiff was the comminuted intra-articular fracture of his left wrist with depressed intra articular fragments.

26. Wrist injuries are covered by section 7H of the Guidelines. Considerations affecting the level of an award are the same as those for an elbow injury (set out at section G) and are (with synopsis facts as found adjoining) as follows:

- (i) Age (56yrs);
- (ii) Whether the [wrist] is on the dominant arm (yes);
- (iii) Extent and duration of pain and suffering (very significant at the time. Since diminished but ongoing in respect of wrist and some mental health matters. In respect of ankle injury, substantially resolved but some residual. Scar permanent. Ancillary consequences on lifestyle and activities);
- (iv) Extent, nature and duration of all treatment required e.g. surgery (open reduction internal fixation), physiotherapy (significant in 2019 but none formal since. Home exercises ongoing) and medication (painkillers for 3 months, now only if required);
- (v) Cosmetic impact, where relevant (10cm scar on inside of arm. Visible but not significantly noticeable given its position under sleeves);
- (vi) Presence or risk of degenerative changes (potential risk of 15%);
- (vii) Impact on work (returned to work within a week for economic reasons but endured over double travel time each way. Able to work but only with modifications, including switching mouse use to non-dominant hand);

- (viii) Interference with quality of life and leisure activities (As above. Return hampered by lack of confidence with wrist. Restrictions requiring weight bearing through the wrist or modification of technique ongoing);
- (ix) Impact on independence and ability to self-care (limited in aftermath, back to normal now);
- (x) Psychological sequelae including depression (no formal psychological sequelae but oral evidence of mental health impact given by way of sleep disturbance; flashbacks and fear following news of resuscitation).

27. Both Mr. McGrath and Mr Condon made submissions on the category into which the plaintiff's injuries sit. The categories for wrist injuries are the following:

- a) Severe wrist injuries: Severely disabling wrist injury resulting in complete loss of function in the wrist such as where an arthrodesis has been performed. Deformity may increase the award depending on severity.
- b) Serious wrist injuries: Injuries less severe than those at (a) above resulting in significant permanent disability but where some useful movement remains.
- c) Moderate wrist injuries: Injuries less severe than at (b) above but where there is some permanent disability, such as a degree of persisting pain and/or stiffness.
- d) Minor wrist injuries Injuries which cause no permanent damage and do not result in permanent loss of function such as a Colles' Fracture, undisplaced or minimally displaced fractures necessitating the application of plaster of Paris or bandages.
 - (i) Where a substantial recovery or a recovery to nuisance level takes place without surgery within two to five years. This bracket will also apply to shorter term acceleration and/or exacerbation injuries usually between two and five years.

- (ii) Where a substantial recovery takes place without surgery between six months and two years. This bracket will also apply to short-term acceleration and/or exacerbation injuries lasting between six months and two years.
- (iii) Where a substantial recovery is made within six months.

28. Mr. McGrath and Mr. Condon also agreed that this injury was significant such that it could not be described as “minor” (i.e. H(d)) but neither was it “severe” (H(a)). I also agree with the exclusion of either end range of the categories. The parties differed somewhat thereafter as to into which of the middle categories the plaintiff’s wrist injury fell. The injury was to the plaintiff’s dominant hand.

29. Mr. McGrath enthusiastically advocated positioning the level of wrist injury at the top end of H(c) (moderate) or the lower end of H(b) (severe), given the ongoing nature of the plaintiff’s physical problems and limitations and the permanency in the reduction of the range of flexion and extension. Mr. McGrath emphasised the need to consider the effect this injury had on the plaintiff in the particular circumstances of the nature of his work and his sporting activities. This approach mirrors the sentiment of Noonan J. in *Zaganczyk* where he stated at para. 27, “...it is important not to lose sight of the global impact of all the injuries on the particular plaintiff concerned.” (emphasis added).

30. Mr. Conlon strongly disagreed that there could be any element of ‘serious’ (H(b)) in respect of the wrist injury where the plaintiff had regained functional use, albeit not full range of movement. The plaintiff had returned to work within a week and could use both hands to operate a computer. The risk of arthritis was very low, and then a possibility and not a probability. He argued that any level of award fell in the category of (H(c)), even if at the higher end thereof.

31. In respect of the plaintiff's left wrist injury, I accept the evidence as outlined above, particularly that of Mr Collins, as to the seriousness of the plaintiff's high velocity injury to his dominant hand which caused immense pain and find as a fact that it had the debilitating impacts described by the plaintiff, at least for the first year or so, improving but plateau-ing thereafter. Having observed the reduction in the plaintiff's flexion and extension of his left wrist, and accepting the evidence of Mr Collins that this reduction is now static, I find as a fact that the plaintiff's current range of movement now constitutes a permanent disability.

32. However, given that Mr Collins has measured the movement loss at 15% and confirmed that the plaintiff has achieved a functional range of movement, it is difficult to classify that disability as particularly 'significant' or as the plaintiff having only 'some' movement, as specified in the 'serious' category of H(b).

33. That said, I am not comfortable the description of disability falling within the 'moderate' category of H(c) describes the plaintiff's situation either. The use of the word 'some' similarly implies minor, as confirmed by the examples set out, just of 'pain or stiffness'. The plaintiff has more than pain or stiffness, he has a permanent restriction in movement which affects his lifestyle, activities and work and will do so in his future, notwithstanding that he made great efforts to rehabilitate after the operation. If permanently restricted movement (albeit less than 'significant' described as H(b)) was to be included in the disability envisaged by the 'moderate' category of H(c), the Guidelines could easily have so included and qualified. They do not. In addition, although low, both Consultants confirm the risk of arthritis given the fracture was intra articular. In the circumstances, and taking account of the submissions made by Counsel and the evidence adduced, I find the impact of the Guidelines on the award I have to make is inconclusive. If I have to make a finding of fact as to the category into which the plaintiff's injury falls, I find that his wrist disability falls

into the 'Serious' category H(b) - as the only one of the two referencing restriction of movement - albeit at the lower end, and I award the sum of €45,000 for this injury.

The Question of Uplift

34. Murphy J. outlined the correct approach, endorsed by the Court of Appeal in *Zaganczyk*, to assessing additional injury in *McHugh* at para. 24:

“It appears to me that a fair and transparent means of assessing what the uplift should be in any given case is to categorise each of the additional injuries according to the bracket that it would fall into were that the main injury and then discount the award to allow for the temporal overlap of the injuries. In this way, both parties can see precisely how the court arrived at its decision and the level of discount allowed for overlapping injuries. Any other method leaves the plaintiff and the defendant guessing as to how the court arrived at its decision.”

35. Mr. McGrath referred to three additional injuries which ought to merit an uplift; the plaintiff's surgical scar, the injury to his ankle, and the shock effect experienced by the plaintiff in the accident when sliding down a road full of traffic towards the M1, the flashbacks and memory he encountered and his distress on hearing of his resuscitation. Mr. McGrath confirmed that he was not asserting that the plaintiff had a psychological injury *per se*, and there was no medical evidence to so assert, but he did emphasise the oral evidence adduced by the plaintiff as to the effect on him. He emphasised the need to look at the overall nature and effect of the injuries on the plaintiff once I had considered the individual parts.

36. Mr. Condon disagreed that there was any psychological element to be considered in the award, noting the complete absence of any medical comment thereon. He highlighted a substantial recovery in the plaintiff's ankle within six months such that Mr. McGoldrick had described his examination as “unremarkable”. He decried any additional uplift for a scar but

if so, argued it would be close to the bottom end of the range. He highlighted that the plaintiff was back to work within a week, using both hands and had a very low risk, a “possibility” not a “probability”, of arthritis in the wrist joint.

37. Turning then to each of the three additional injuries in order of proposition.

Scar

38. As noted by Noonan J. in *Zaganczyk*, Part 10 of the Guidelines, at paragraph A(b), gives a very wide range of award for scars, including for what is described as a single noticeable scar, or several superficial scars of legs or arms or hands with some minor cosmetic deficit, the range being extremely broad. I have seen the plaintiff’s scar. While I note Mr. Condon’s argument demonstrating that differing awards have traditionally been given for a noticeable scar on a woman versus a man, ultimately, in this case, I believe the visibility of this longitudinal 10cm scar is the key consideration. The scar is noted by both Consultants in their examination of the plaintiff. It is a disfigurement, albeit the plaintiff did not indicate that the scar was particularly bothering him. Having viewed it, however, I find as a fact that it is not insignificant, and it is noticeable when his arm is uncovered.

39. Mr. Condon argued against any individual uplift for the surgical scar, advocating that it more properly fell within the consideration of the wrist injury as it was necessitated from treatment thereto. I disagree with this contention. If I am to apply the Guidelines, scars are not included with the attendant injury but rather are set out as a separate consideration. As such, upon separate consideration, I find as a fact that this scar is not insignificant, being easily noticeable at conversation distance if the plaintiff’s arm is upturned, but balanced with that is that the plaintiff himself, very fairly, has taken no major complaint therewith. As a measure of general damages if this scar was the plaintiff’s main injury, I would award the sum of €20,000 therefor.

Ankle

40. The plaintiff's ankle was injured in the incident although not a bony injury as the X-rays taken in Beaumont Hospital confirmed. He gave evidence of the pain and discomfort he experienced and the additional restrictions in the immediate aftermath of his accident. He accepted however that he had substantially recovered in about six months, subject to outlining some ongoing residual ache if he had to stand for lengthy periods of time. Both Mr. McGrath and Mr. Condon placed any ankle injury in the 'minor' category, but differed as to the subcategory as between section 7O(d) (i) of the Guidelines which states; "Where a substantial recovery or a recovery to nuisance level takes place without surgery within two to five years...", and 7O(d) (iii) which reads; "Where a substantial recovery is made within six months". In the absence of any medical report beyond the initial X-rays and the examination of Mr. McGoldrick as "unremarkable", I find as a fact that the plaintiff's ankle injury fell within 7O(d) (iii) of the minor category (€500-€3,000) but at the upper end thereof in light of the manner in which the injury was sustained and the cumulative impediment effect. As a main injury, I would award the sum of €2,500 therefor.

Psychological Injury:

41. Mr. Condon argued no award should arise for any psychological injury in the absence of any medical treatment therefor. However, I accept that the plaintiff suffered some degree of mental health implication as a result of the incident. He vividly described the experience of skidding down towards a motorway with traffic on all sides and the flashbacks arising therefrom. As set out above, the plaintiff recited sleep disturbance and the impact on his work and personal life, more acute closer to the incident, all of which I also accept. I find as a fact that the plaintiff experienced injury to his mental health, albeit not to the extent of requiring

formal treatment, the absence of which does not negate the evidence adduced as the ‘minor’ category expressly includes situations which required ‘no intervention’ as falling squarely at the lower end of the ‘minor’ category of 4 A (d): A full recovery will have been achieved. Considerations affecting the level of the award should include those listed above. In cases where only modest or no intervention was required in terms of treatment, damages should be very much to the lower end of the bracket. Other considerations affecting the level of award will include:

- (i) Duration of injury;
- (ii) Impact of the injury on daily activities;
- (iii) Extent of any treatment undertaken;
- (iv) Whether sleep was affected and if so to what extent.

42. The range of compensation is again broad, from €500 to €15,000. The ‘lower end’ does not mean the lowest and in all the circumstances, in light of the evidence given in respect of duration, impact, extent of treatment and sleep disturbance, I apply a value of €5,500 on any mental health or psychological injury suffered by the plaintiff, if this was his main injury.

43. I note that the plaintiff expressed fears concerning contracting MSRA when in Beaumont Hospital but I do not include that in any assessment under this heading. Fear of contracting a disease is not a compensable injury (as per the decision of the Supreme Court in *Fletcher v. Commissioner of Public Works* [2003] IESC 13) and no authority to the contrary was opened to me.

44. Having assessed each of the individual additional injuries as if they were a main injury, I must now consider what, if any, discount should be applied “to allow for the temporal overlap of the injuries.” The plaintiff gave evidence of the individual and cumulative effect of each of his injuries. While each is separate and distinct, temporally they

overlap in time and rehabilitation with the main injury. In the circumstances, and taking account of the approach suggested by Murphy J. above, I apply a discount of 25% to the cumulative total for the additional injuries (€28,000), making a sum of €21,000 uplift on the main injury above.

Conclusion

45. Combining the sums above gives a net award for general damages of €66,000 which I believe to be a proportionate overall figure to ensure the plaintiff is fairly and justly compensated for all his injuries, taking into account the Guidelines and the submissions thereon advanced by the parties. I am also satisfied of the proportionality of this award given that the Book of Quantum measures a 'moderately severe' wrist injury, at €54,200 - €70,100 and is close to 'severe and permanent' injury, commencing at €68,400. Special Damages are agreed at €8,000, such that there will be judgment for a decree of €74,000 in favour of the plaintiff, together with costs in the normal course but I will hear counsel as to the formal order in that regard.