[2022] **JMSC Civ 10**

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN THE CIVIL DIVISION

CLAIM NO. 2008 HCV 03051

BETWEEN	**CLIFFROY FRANCIS**	**CLAIMANT**
AND	**HECTOR GILPIN**	**DEFENDANT**

Mr Ian Davis and Ms Tashawna Grant instructed by HollisLaw Attorneys-at-law for the Claimant

Defendant absent and unrepresented

Heard: January 13 and 24, 2022

Assessment of Damages - negligence

MOTT TULLOCH-REID, J(AG.)

BACKGROUND AND EVIDENCE

[1] This matter is one of some antiquity. When the Claimant was eight years old he was injured in a motor vehicle accident. He is now almost 26 years old. When the matter came up before me for damages to be assessed on January 13, 2022, counsel for the Defendant, Mr Linton Walters, sent word to the Court through Mr Ian Davis that he was ill. When contacted by the Court to find out if someone could hold for him given the antiquity of the case, Mr Linton indicated that he had no objection to the Court proceeding with the Assessment of Damages in his absence and so I proceeded with it.

[2] Evidence was given by the Claimant, Mr Cliffroy Francis, his mother, Maria Brown and Mr Dalton Campbell who had driven Mr Francis to school on the morning of

the accident. Their evidence is contained in their respective Witness Statements all filed on March 18, 2018.

[3] Mr Francis is a landscaper. He works at the University of the West Indies. He says that he does not remember well. He had to learn to walk again after the accident, he had to repeat his grade and was exempted from doing GSAT. In answer to questions posed by me, Mr Francis indicated that he was not able to walk or talk for approximately 1-3 weeks after being discharged from the hospital. He has not been able to lead a normal life since the accident because he speaks with a stutter and as such finds it difficult to communicate with his friends. He cannot speak as fast as they can so he is often not able to interject and comment when he wants to. He says his head hurts him especially when he bends down to do weeding. Bending down to do weeding also causes him to be dizzy. He has never had an epileptic seizure since the accident. His ears still hurt him and he takes Panadol to relieve the ear and headaches. The Panadol only helps sometimes.

[4] Mr Campbell gave evidence next. His evidence was limited to how the accident happened. Liability is however not in issue.

[5] Ms Brown was next in giving evidence. Her evidence in chief was contained in Witness Statement filed on June 28, 2011 and May 18, 2018. In questions posed by the Court to clarify conflict in both witness statements, Ms Brown stated that she paid $8,000 per month not per week for the care for Cliffroy when he was discharged from the hospital and she returned to work. She said she had to buy extra clothes for Cliffroy because his hand was broken and so she had to purchase stretchy clothes for him. I will return to this later. She said Cliffroy could not walk for 2-3 weeks after he returned home from the accident and could not talk for approximately 3 weeks after being discharged from the hospital. She said when he started to speak, his speech was “blurry” and he still continues to have this issue. She said his siblings were helpful to him in getting him to speak again. She says she has not taken Cliffroy to the doctor in a while. When he is in pain, she

just gives him Panadol as that is what the last doctor told her to do. She says he gets headaches when he is bending down or if he gets "heated up" (I take that to mean when he gets irritated). She said she buys pain medication once per week and buys approximately 6 – 10 packs of Panadol but she says they are used by everyone in the household, not just Cliffroy. Ms Brown also noted that Cliffroy went to work with her for approximately one month after he was discharged from the hospital.

MEDICAL EVIDENCE

[6] The Claimant relied on the medical reports prepared by Dr James Liburd of UHWI Hospital dated June 28, 2006 (Exhibit 1), Dr Khia Duncan of UHWI Hospital dated April 22, 2008 (Exhibit 2), Dr Rory Dixon dated July 6, 2011 (Exhibit 3), Dr M De Santos dated July 22, 2016 (Exhibit 4) and the report from the Radiology Department, UHWI dated September 17, 2015 (Exhibit 4B). All these documents set out the injuries sustained by the Claimant. The injuries are as follows:

a. Loss of consciousness with no associated vomiting
b. Bleeding from the right ear
c. Twitching of the face thought to be focal seizures
d. Glasgow coma score was 6/15
e. Multiple abrasions to the left upper limb and right lower limb
f. Deformity of the right humerus
g. Fracture of the right arm held in plaster cast which had healed satisfactorily and had attained maximal medical improvement
h. Lower respiratory tract infection
i. Bronchospasm on a background of pulmonary contusion
j. Asphastic
k. Right otalgia secondary to Eustachian tube dysfunction
l. Old blood in the right external auditory canal

m. Pressure ulcer to back of head now healed leaving two areas of alopecia on the occipital region of the scalp representing less than 1% skin surface area
n. Scar to back of head
o. Two scars on frontal region of scalp corresponding to the burr holes
p. Head injury with basal skull fracture

[7] Dr Liburd's report was prepared one year post the accident. Dr Liburd is associated with neurosurgery department, UHWI. He reports that the Claimant had spent two weeks in the ICU after which he was discharged from the hospital. His visits to the out-patient clinic saw continued improvement. He spoke with slurred speech. His mother reported to the doctor that Cliffroy was doing well in school and interacting well with other children. He was expected to function normally and no further neurosurgical procedures were foreseen. His slurred speech could continue and there was a possibility of late onset seizures or personality or cognitive impairment in the future. His recovery was described as being outstanding and his good outcome pleased the doctor.

[8] Dr Duncan reports that Cliffroy had right sided earache and examination revealed he had old blood in his ear canal. This seemed to have cleared up eventually as the audiogram done indicated that Cliffroy was hearing in the normal limits. He was discharged because he no longer complained of otalgia. This was in 2008, 3 years after the accident.

[9] Dr Dixon is an orthopaedic surgeon. He reports that Cliffory's right hand healed well and there was no resulting disability. He said the neurosurgeons would indicate if there was residual disability from Cliffroy's head injuries. None was given and the Claimant's attorneys-at-law would have had more than enough time to obtain that detail. In any event, Dr Liburd had praised Cliffroy's good outcome and so I can only conclude given the evidence before me that Cliffory had no residual disability associated with his basal skull fracture. Dr Dixon assessed the Claimant's PPD as 2% and that is just taking into account the scars to the occipital

region, which he says are not debilitating and which do not affect the Claimant's self-image significantly.

[10] Dr De Santos reports that the Claimant needed intracranial pressure monitoring and no further intervention was needed except that. He progressed well but returned in 2015 with headaches. MRI of the brain showed chronic ischemia which was post traumatic. This means he probably was not getting enough blood flow to the brain to meet his metabolic demand. He was discharged with analgesics to follow up early. There is no report that he did any follow up. The MRI findings were otherwise unremarkable.

General Damages

[11] Mr Davis relies on several cases on his client's behalf. I have read them all but found the case of **Dudley Burrell (bnf Margaret Hill) and anor v United Protection Limited and anor** reported at **Khan's Vol 4 page 182** most helpful. In that case the plaintiff had a fracture of the base of skull with moderately severe cerebral contusion. He was unconscious for two days then irritable, had periorbital swelling and discolouring of his right eye, right subconjunctival haemorrhage with no visible peripheral border, 7cm abrasion of the anterior abdominal wall, 4cm laceration to back of his right knee and abrasions to both knees. He had to be fed initially with a nasogastric tube, was aphastic, had difficulty keeping up in school, laughed inappropriately, was diagnosed as having an impaired intellectual function. He fidgeted, was slow in processing information, had poor memory, was deemed "slow" and was functioning below his age cohort. His PPD was not assessed.

[12] Mr Francis' injuries were similar as it relates to the basal skull fracture. There is no evidence that he had a cerebral concussion. The doctors do not say how long he was unconscious for. Based on the evidence given by the Claimant and his mother and the reports of his doctors, Mr Francis' outcome was not as serious as Mr Barrel's. There is no report of him having to be fed via tube, there was no report

of any inappropriate behaviour. Dr Liburd, who prepared the medical report one year after the accident, said "*His mother reported that he has been doing well at school and is interacting well with other children*". Dr Rory Dixon, with whom he consulted 6 years after the accident said "*Cliffroy is presently in Grade 9 and academically is on the same level with the other students… He reported that he had attempted many sporting events and does dancing for recreation…. Cliffroy Francis sustained head injury and fracture of the right arm which incapacitated him for at least six months."*

[13] It appears from the doctors' reports that Mr Francis had a good recovery. He was not left with the sequelae which the other boys on whose judgments he relied were left. For this, he should be grateful as he has done better in his recovery than they did. We do not know why one person slips and falls and ends up paralysed but another who slips and falls gets up and walks away without any complaint. When the latter happens, we should rejoice so too I expect there to be rejoicing on the part of Mr Francis and his family that his injuries did not leave him with any very serious debilitations. I am mindful of his complaint about recurrent headaches and earaches which bother him even now, so many years after the accident. He says he suffers from memory loss which was not discussed by any of the doctors who saw him. He says he has slurred speech. I spoke to him and could hear and understand him well. I did not observe any slurs or defects in speech. I must say however that our discussion was not a lengthy one and as such I can make no conclusions on his speech and will rely on the statements made by the doctors in their reports and on Mr Francis' evidence. He has not had any epileptic seizures and that is a good thing.

[14] Although there does not appear to be any critical debilitation, I am mindful of the fact that the injuries Mr Francis sustained were of a serious nature and that by virtue of those injuries he suffered. While he was in the hospital he had to undergo surgery, he developed an infection, he had an ulcer, he was left with scarring. His arm was broken (but I note it was not his dominant arm). He had to deal with that pain. He, who once could speak and move about, had to relearn those actions.

That is the end result of an accident that was caused by the negligence of the Defendant.

[15] In the **Dudley Barrel case**, the Court awarded the plaintiff the sum of $1,372,000.00 for his pain and suffering and loss of amenities. This award updated to $9.6M when the CPI for November 2021 which is 114.96 is used. Based on the fact that I am of the view that the Claimant's disabilities arising from the injuries were less serious than Mr Barrel's the sum will have to be discounted.

Special Damages

[16] Receipts were admitted into evidence in support of the Claimant's claim. These were named exhibits 1a and 1b for medical reports, 5a-5p for follow-up treatment at UHWI and invoice for services rendered at UHWI when the Claimant was hospitalised. Ms Brown's evidence is that the invoice was not paid because she did not have the money to pay for it. She says the hospital has contacted her for payment but she does not have it so she has not paid it. Also admitted into evidence was receipt from Apex x-ray and ultrasound, Exhibit 7, receipts for helper Exhibits 8a-8g, receipts for taxi-fare to transport the Claimant to school, Exhibits 9a-9d, receipt issued by Winchester Surgical Services, Exhibit 10 and receipt for serving documents, Exhibit 11. Receipts for transporting the mother to and from the offices of HollisLaw by taxi were not admitted into evidence.

[17] Total medical expenses (UHWI) based on receipts **$7,713.00**. There was a receipt in the amount of $4,500.00 for consultation at Winchester Surgical Services. The sum appears to have been paid by HollisLaw on behalf of the Claimant. The receipt was admitted into evidence. However, again the amount was not pleaded and such it will not be allowed.

[18] Ms Brown indicated that she purchased clothes for the Cliffroy amounting to $4,000.00. She presented a receipt for the amount for pampers and extra clothing, which appears to be signed by her. The receipt was not allowed as I am certain that stores in Papine from which she said she purchased the clothes would provide

a receipt and it would not be signed by her. I am not a handwriting expert but the signature as appears on the receipt is very similar to Ms Brown's signature. In any event, the item claimed was not pleaded as an item of special damages in the Particulars of Claim.

[19] With respect to the extra help. The evidence is that the Claimant spent 3 weeks in the hospital. Both Ms Brown and Mr Francis gave evidence that after Mr Francis was discharged from the hospital he went to work with his mother until he learnt to walk and talk again. They both said it took approximately 3 weeks for the Claimant to walk again after he was discharged. If that is the case, it is not likely that a helper would be taking care of Mr Francis at home for the month of April as he would be at work with his mother. The receipt for April 2005 is not allowed. I do however find that if the mother went to work, she would need to have someone assist her with the child. The Defendant did not file an objection to the receipts being tendered and so they were allowed. However, in the Particulars of Claim, only $12,000 was claimed for a 6-week period.

[20] Transportation expenses of $16,000 per month for round trip travel to school by taxi from September 2005 to December 2005 were admitted into evidence. I should point out to the Claimant that I am very aware that school is only session for 3 weeks in September and two weeks in December so I am somewhat concerned that receipts were produced for the entire months of September and December. In any event, the Claimant did not claim sums for transportation to and from school. The only transportation that was claimed was for trips the mother made to the hospital for 3 weeks @ $2,500 per round trip. A total of $7,500 is claimed. In her witness statement her evidence differs and she says she paid $16,800 in all for her transportation costs during that time. Since only $7,500.00 was claimed that is what will be allowed. I believe the sum is a reasonable amount if she was to be transported to and from her home every day for a period of 21 days.

[21] The invoice issued by UHWI is allowed. The sum owed to the institution by the Claimant amounts to $350,727.63. The sum is to be paid directly to the institution by the attorneys-at-law for the Claimant when the Defendant pays the judgment debt.

[22] Special Damages must be specifically pleaded and proven. The receipts are there but the pleadings are not there to ground the claim with respect to the total medical expenses, extra help or transportation costs. I am therefore making the award for only that which was pleaded. The Defendant would have had had no notice of the Claimant's intention to claim the full amount unless amended pleadings were filed or the usual phrase "and continuing" was inserted into the original claim. Special Damages as claimed in the Particulars of Claim filed on June 17, 2008 in the amount of **$380,640.63** is granted.

Interest

[23] Interest is granted at the discretion of the Court pursuant to the **Law Reform (Miscellaneous Provisions) Act**. In this case, the matter was commenced in 2008 and based on the minute sheets on file have had a place in the court's system for approximately 13, years. In 2011 an application was made to set aside the default judgment. The application was not followed through with and parties agreed to go to mediation. Mediation was not done and so in 2014 an application was made by the Claimant to dispense with mediation. Mediation was dispensed with on June 4, 2014 and the Court ordered that the matter proceed to Assessment of Damages on December 8, 2014. On every occasion that the matter came up for Assessment of Damages except for when it was wrongly listed on one occasion, the reason for the adjournment was related to the Claimant. I am therefore not minded to grant interest on General Damages up to today. I will grant interest on General Damages and Special Damages up to December 8, 2014 when the matter was to be heard and on which day the minute sheet reflects that the matter could not proceed because the Claimant had not filed documents or list of authorities.

[24] My orders are as follows:

a. The Defendant is to pay the Claimant General Damages in the amount of $5,000,000.00 plus interest at 3% per annum from June 23, 2008 to December 8, 2014, Special Damages in the amount of **$380,640.63** plus interest at 3% per annum from March 3, 2005 to December 8, 2014 and costs in the claim in the amount of $100,000.00.

b. The Claimant's attorneys-at-law are to deduct the sum of $350,727.63, which is owed to the University Hospital of the West Indies by the Claimant, from the amount paid by the Defendant to the Claimant. The sum deducted (i.e. $350,727.63) is to be paid by the Claimant's attorneys-at-law to the University Hospital of the West Indies by manager's cheque.

c. The Claimant's attorneys-at-law are to file and serve the Formal Order.