Judgment Book

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

COMMON LAW

SUIT NO. C.L. 1989/G045

MERDELLA GRANT

VS

WYNDHAM HOTEL COMPANY (TRADING AS WYNDHAM ROSE HALL BEACH HOTEL AND COUNTRY CLUB)

Garth McBean instructed by Dunn Cox Orrett and Ashenheim, Attorneys-at-Law for the plaintiff

Robert P.D. Baugh for the defendant

HEARD: February 27, 28, March 5 and July 8, 1996.

WALKER J.

The plaintiff is now 54 years of age. She is by profession a registered nurse. She was employed as a nursing supervisor by the defendant for several years at its hotel known as the Wyndham Rose Hall Beach Hotel and Country Club situated in Montego Bay in the parish of St. James. On March 19, 1988 she went to work as usual arriving at her post at about 7 a.m. Later that morning she was supplied with a chair for her use by an employee of the hotel. This action resulted from a request made by the plaintiff some three months earlier for a replacement for an "old, tattered chair" which she had been using. She described this replacement chair in detail but could not say whether or not it was a new chair. She went on to testify that having received this chair she dusted it and proceeded to sit on it in a way which she described and which this Court finds was in every respect normal. However, no sooner had she done so, the chair collapsed beneath her tilting backwards in the process and causing her to fall backwards, her head finally coming to rest against a couch which had been positioned behind the chair. Eventually the plaintiff

managed to get up after manoeuvring herself in order to do so. Then she observed that the upper part of the chair had separated from the base of the chair. Now in pain and being alone she immediately summoned help which came in the form of the house-keeping manager from whose department she had originally requisitioned the chair. According to the plaintiff, upon the arrival of the house-keeping manager she said to him "Look at the chair you gave me". At this time she saw the manager place his hand on the chair as if to examine it. As he did so she observed two screws fall from the chair to the floor. The next thing that happened was that the manager contacted the maintenance department from where the chair had been supplied. Soon an employee of that department arrived on the scene and the following dialogue ensued between both men:

Manager: What kind of chair this you bring to give the nurse to sit on?"

Employee: "Is only the upholstering me do."

Manager: "You screw up the chair?" (while showing the employee the 2 screws that had fallen from the chair)

Employee: "The screws short and I tell them to buy screws at Crichton Brothers and they say maintenance will cut screws and give me."

After this discussion the employee left the scene taking away the broken chair with him.

Immediately following this incident the plaintiff experienced pain but continued working until April 11, 1988 as she explained in answer to the call of duty and, also, because she did not then appreciate the seriousness of her injury. On that date she suddenly became immobile while on the job and had to be taken to hospital where she was admitted and remained for seven days on bed rest and traction. The cost of this period of hospitalization was $3,202.00. During this time she experienced severe pain throughout her entire body, particularly in the back and legs.

She was given physiotherapy and was unable to walk upon discharge. At home she remained on complete bed rest for three weeks, unable to feed herself, turn her neck or walk without assistance.

By consent of the parties 3 medical reports were tendered on behalf of the plaintiff and admitted in evidence as exhibits 1,2 and 3, respectively.

Exhibit 1, the medical report of Dr. Chang, read, inter alia, as follows:-

> "Ms. Grant was seen by me on the 11th April, 1988, she complained of severe back pain extending into both legs. She gave a history of falling on the 29th March, 1988. The pain intermitent but increased in severity since the 10th April, 1988.
>
> On examination the patient had
> - Tenderness over the lumbar area
> - Limitation of movement of both legs in all direction.
>
> X-ray showed rotation of L4
> She was treated with Analgesics and was referred to the Orthopaedic Surgeon."

Exhibit 2, the report of Dr. Cheeks read in part as follows:-

> "I saw this patient for the first time on 11th May 1988 at the request of Dr. P Herard who had been treating her for back pain. Miss Grant stated that she hurt her back on 29 March 1988 when a chair collapsed under her. The pain was initially felt in the lumbosacral region and had subsequently radiated to her left flank. The oral analgesic feldene had been prescribed with partial relief in her symptoms but these had once again worsened when she attempted to do physical work, and for the first time she began to notice that the symptoms where affecting the left leg.
>
> When I saw her the pain in the back was still present and was aggravated by sitting and especially by movement. Rest in bed alleviated the pain.
>
> EXAMINATION
>
> She was of healthy appearance and appeared to be in good general health apart from her presenting complaint. The blood pressure was normal at 135/85 with a regular resting pulse of 60 per minute and no clinical evidence of anaemia or lymphadenopathy. Routine analysis of the urine yielded no abnormality.

"She walked gingerly with a slight forward stoop and indicated a point in the left buttock two inches lateral to the spine of L5 as the site of her maximum pain. Forward flexion of the spine was markedly reduced but there was no scoliosis or pelvic tilt and I was quite unable to detect any sensory, motor or reflex changes in her legs. My impression was of an acute strain but the focal tenderness of the area to the left of L5 led me to request fresh xrays of the lumbar spine because the films which had accompanied her from Montego Bay were of poor quality. The repeat xrays revealed a fracture of the transverse process of L5 on the left. Since this was a "stable"injury I recommended the use of analgesics combined with cold applications and gentle physiotherapy, with arrangements for follow-up.

She was next seen on 07 Sept 1988 and said that she was still troubled by back pain but that it was more noticeable in the legs which were intermittently affected by 'pins and needles' and she could not sit comfortably. The area of focal tenderness previously noted was still present but the straight leg raising was measured at 75 degrees bilaterally.

This positive sciatic stretch test combined with radicular symptoms in the legs raised the possibility of injury to a lumbar disc which was now beginning to herniate causing lumbar root irritation, and I therefore decided to have a CAT scan myelogram carried out to seek radiographic confirmation of a slipped disc. The test was carried out on 28 Oct 1988 and no evidence of slipped disc was seen - the only noteworthy finding being the presence of a healed fracture of the transverse process of L5.

When she attended for review on 21st December 1988 her spine was a little more mobile and she was feeling better. Sitting for long periods or doing housework tended to produce back pain but on the whole the condition was improving.

CONCLUSION

Miss Grant suffered an acute lumbar strain in association with a fracture of the transverse process of the fifth lumbar vertebra of her spine. The associated soft tissue injuries as well as the fracture of the transverse process will heal fully in time, and the strength nor the stability of the spine is compromised."

Exhibit 3, Dr. Dubuc's report stated, inter alia:

> "This patient was first seen on the 28th June, 1989 because of a residual low back pain irradiating into her left leg and the history of a fall on a chair that broke in March 1988 seems to be the first problem that occured at that time; prior to March 1988, this patient did not have any back problem and was able to work as a nurse.
>
> Since then there were many work stoppages and back pain with sciatica kept her from considering herself normal and able to function as she did previous to that fall of March 1988. The neurological exam at that time showed an L5 sensory deficit on the left side, a positive Valleix sign on the left sciatica, a contra-lateral straight leg raising at 60° provoked pain on the opposite side and the left SLR was at 45°. To confirm the diagnosis of a herniated disk at L4-L5, a magnetic resonance was requested and done at hospital St-Luc in Montreal on the 5th of July, 1989. This showed a median hernia at L4-L5 with degeneration at L3-L4. On the 7th of July, 1989, this patient was hospitalized and brought to the operating room to confirm this disk problem at L3-L4 and L4-L5 with discography. L5-S1 was also studied and found to be normal. Treatment was done with the injection of 1cc of Chymopapain at each of these 2 levels, L3-L4 and L4-L5. The sciatic pain was improved immediately and the low back pain gradually became better although there is at this time still some residual problem.
>
> The usual off work for such a procedure, chemonucleolysis, is of 3 months in a job such as hers and a permanent disability usually also follows. It is yet too early after her treatment to consider the evaluation of this permanent disability."

In addition to these three doctors the plaintiff saw Dr. Fray in Mongeto Bay between the years 1989 - 1994. She also consulted Dr. Vendryes who prescribed physiotherapy, gave her analgesics and had several counselling sessions with her. Initially she had physiotherapy on a daily basis and later four times monthly. Nowadays the plaintiff has physiotherapy twice yearly. She has four sessions at a time at a cost of $500.00 per session.

Presently the plaintiff is employed to the Hart Group of companies on a part-time basis. She has been so employed since April, 1994. In this job she started at a salary of $650.00

per session. In 1995 she saw Dr. Fray on three occasions at a total cost of $3,000.00. She saw Dr. Fray again once in 1996 at a cost of $1,500.00. Dr. Fray ordered a brace for which she paid a sum of $2,200.00. During the period of her incapacity the plaintiff paid for the services of a household helper at a rate of $600.00 per week. The plaintiff said that today she is not able to work for longer hours than she does. She is completely exhausted at the end of each work day. Nowadays she is unable to sit or stand for a long time without discomfort and pain in the lower back and legs. She is not able to do any housework on account of pain, nor is she able to walk or carry any weight in her arms for a long period of time. She finds difficulty in getting in and out of a car. She owns a car but cannot drive for long journeys or turn her head around when reversing. She cannot lie in bed on her back or stomach, or sit up in bed to watch television.

Dr. Delroy Fray, a registered medical practitioner and orthopaedic surgeon, gave evidence on the plaintiff's behalf. He testified that he first saw the plaintiff on May 30, 1994. Then she complained of low back pain radiating to left leg. Clinical symptoms fitted a case of herniated disc at the L5-S1 level. Plaintiff was unable to walk at this time. The doctor said that he gave her an injection and advised bed rest and physiotherapy. He saw her again on December 29, 1994 at which time she presented with left side sciatica. He saw her for a third time on May 17, 1995 when he found that there was chronic herniation of the L4-L5 disc. She could bend over to one foot off the ground. She could straight leg raise to 80° on the right and 50° on left. The latter was evidence of leg compression which produced pain. Power tone and reflexes sensation were normal except for an absent left ankle reflex. Dr. Fray assessed the permanent disability of the plaintiff at 25% of the total person. In the doctor's opinion her condition will worsen with time. Treatment

was bed rest and physiotherapy for the rest of her life. He estimated that she will need to see him at least twice each year for the rest of her life. The plaintiff will necessarily have to retire early from her present employment and should choose a sedentary job for the future. For her, lifting was forbidden. Prolonged standing and sitting will tend to aggravate the plaintiff's condition which he was prepared to confirm. The doctor said that his findings were consistent with the history given to him by the plaintiff. In 1994 the doctor said that his charge to the plaintiff was $1,000.00 per visit. Today, if the plaintiff's problem is severe, an injection at a cost of $1,000.00 and tablets costing about $500.00 will be necessary. If not severe, she would need only tablets for relief. Finally Dr. Fray said that he had seen the medical reports of the other doctors, exhibits 1,2, and 3, and he was firm in stating that none of these reports would cause him to alter any part of his evidence given in these proceedings. This then was the evidence adduced on behalf of the plaintiff.

For the defendant no witness was called and Counsel, Mr. Baugh, was content to proceed notwithstanding that fact.

The first issue which must, therefore, be resolved is that of liability. Treating with this issue, Mr. Baugh submitted in effect that the plaintiff's version of the circumstances surrounding the events of March 29 were inconsistent with the injury of which she complains. Furthermore, said Mr. Baugh, such medical evidence as was adduced on the plaintiff's behalf was not confirmatory of her injury. In any event, Mr. Baugh contended, the plaintiff was, herself, contributorily negligent in continuing to work at her job after the events of March 29 and, also, in failing to have x-rays taken timeously as advised by Dr. Reynolds. Mr. Baugh submitted

that by exerting herself while at work on April 11 the plaintiff aggravated her injury and, in so doing, contributed substantially to her medical condition. It was Mr. Baugh's submission that the plaintiff, being a registered nurse, should have known better and not behaved in this way. I disagree wholly with these submissions of Counsel. I find as a fact that the medical evidence adduced on the plaintiff's behalf fully confirms the plaintiff's injury which is, itself, entirely consistent with her account of the circumstances in which she sustained that injury. As to the question whether or not the plaintiff was contributorily negligent, I find that this was not so. In my assessment the plaintiff was at the time of her accident, and in all probability still is, a very conscientious worker. As such, and not fully appreciating the full extent of her injury which was not immediately apparent, she continued to work at her job for some thirteen days before finally breaking down. In my opinion no blame whatsoever attaches to her for having done that. The plaintiff was, altogether, a most credible witness. She was articulate, honest and precise in all that she said. It is my finding that having been supplied with a chair to replace the one that she had been using in the course of her employment she proceeded, in a normal way, to sit on the chair. She could not be expected to have anticipated that in doing so the chair would have collapsed to the floor, as it did, causing what turned out to be serious injury to herself. The cause of this mishap is crystal clear on the evidence given by the plaintiff and which I accept as representing the truth. That evidence is contained in the dialogue between the defendant's house-keeping manager and the employee from its maintenance department earlier quoted in this judgment. In my opinion this evidence shows that the chair supplied to the plaintiff was defective and unsafe for her use. On her part the plaintiff had every reason to expect that she would have been furnished with a reliable chair, and she did

nothing in attempting to use it which could attach any measure of blame to her for what happened. In these circumstances I, unhesitatingly, resolve the issue of liability wholly in favour of the plaintiff.

Now comes the more difficult question of damages, particularly general damages, payable to the plaintiff.

Dealing first with the plaintiff's claim for special damages the Court awards a sum of $61,610.35 detailed as follows:-

For loss of earnings at $2,500.00 per month for a period of 18 months from April, 1988 to October, 1989 less redundancy payment of $14,000.00 -	$31,000.00
For taxi fare to Doctors' Hospital	80.00
For 6 visits to Physiotherapists at $120.00 per visit	720.00
For 15 visits to Dr. Herard at $120.00 per visit	1,800.00
For 2 visits to Dr. Cheeks in Kingston at $500.00 per visit	1,000.00
For transportation to St. Joseph's Hospital and back 11/9/88 - 14/9/88	1,000.00
For transportation to St. Joseph's Hospital and back 27/9/88 - 29/9/88	1,000.00
Expenses for ambulance to Eureka Medical Centre for Myelogram	120.00
Fees paid to Dr. Herard	1,250.00
Fees paid to Dr. Cheeks	400.00
Hospital fees paid to Doctors' Hospital	3,292.00
Hospital fees paid to St. Joseph's Hospital	1,163.35
Cost of myelogram on 28/10/88	2,375.00
Fees paid for x-ray	150.00
Cost of physiotherapy	3,860.00
Cost of prescription	2,000.00
Cost of household helper from 1991 to 1993 (104 weeks at $100.00 per week)	10,400.00
	$61,610.35

Regarding the Court's award for the cost of household helper, this award is made on the basis of the evidence of the plaintiff which I accept and which reveals that the plaintiff lived with her brother-in-law to whom a household helper was employed and whose services, it must be assumed, the plaintiff had at no cost to herself up to the time of her brother-in-law's death in 1981. Thereafter, the plaintiff being still unwell as a result of her accident, would, in my judgment, have been obliged to employ household help at her own expense. Such help she would have been entitled to retain up to at least December 1993, at which time she had sufficiently recovered to be able to return to work. I make no award to encompass any period of time beyond December, 1993 as I think it reasonable to conclude that the employment by the plaintiff of help beyond this date would not necessarily have a causal connection with her accident.

I come now to the area of general damages. Under this heading the plaintiff is entitled to an award for pain and suffering and loss of amenities of life. What shall it be? Several cases, most of them reported in Mrs. Khan's Reports, have been cited to me by counsel for the plaintiff. Not surprisingly, none of them is on all fours with the instant case. Seldom, if ever, is this so. The most apposite of these was the case of Pogas Distributors Ltd. et.al. v Freda Claire McKitty Supreme Court Civil Appeal No. 13/94 in which judgment was delivered on July 24, 1995. In this case Dr. Crandon's medical report on the plaintiff, a 33 years old masseuse, read in part as follows:-

> "There was slight weakness (Grade IV power MRC) of the left leg. She also had wasting of the left deltoid and the left leg with a 2cm calf girth difference, the left being smaller than the right. There was sensory loss over the right leg to pinprick and light touch but vibration sense was unimpaired and coordination was normal. She had generalized hyper-reflexia with an inverted left supinator jerk, a left extensor plantar and an equivocal right plantar response. There was a full range of motion of the cervical spine.

> "In my opinion, there was clinical evidence of a mild myelopathy with a C5 level root lesion, all the result of the injury and consequential damage to the spinal cord and nerve root. I arranged for a Magnetic Resonance Image (MRI) scan which was carried out in Florida on 18.5.93. This study demonstrated mild foraminal narrowing on the left at C4/5 and bilaterally at C5/6. No abnormality of the spinal cord was demonstrated. There was no evidence of continuing compression of the spinal cord.
>
> She has suffered a cervical spine injury and has residual neurological deficits as a consequence of damage to the spinal cord. The MRI findings are not inconsistent with this opinion with respect to this patient whose injury occurred 6 years ago. In my view she has suffered a permanent partial whole person disability of 20% (AMA). Further improvement in her neurological function is very unlikely."

In his oral evidence given at the trial Dr. Crandon elaborated on his medical report as follows:-

> "The significant findings on examination were weakness of left side of the body, this was mild and numbness on the right side of the body. In addition the reflexes were abnormally-brisk and the plantar response was normal. Plantar is a reflex of foot on hitting the sole of the feet.
>
> There was an abnormality of the sup-inator reflex - It affects the left arm of the patient.
>
> As masseuse - the sup-inator loss would not adversely affect one in this business of masseuse.
>
> I found wasting - reduced muscle of left deltoid muscle and the left leg.
>
> There was a 2cm reduction in calf-girt. Wasting may follow weakness - but not the other way around.
>
> I did not find any other abnormalities. The weakness on left side can affect job of masseuse."

Professor Sir John Golding also examined the plaintiff and his affidavit evidence read in part as follows:

> "On examination she was found to have a good range of cervical movement with some discomfort on full flexion. There was a full range of motion of all the joints of the upper and lower extremities. There was no sign of abnormality of the central nervous system. Sensation, power and reflexes were equal on both sides.

"There was a slight lump on the medial border of the tibia at the junction of the upper two thirds and lower third. New radiographs showed that this had been the site of an undisplaced fracture which was solidly healed. There was no evidence of a fracture of the fibula.

Radiographs of the cervical spine were taken in full flexion and extension. The general alignment of the cervical vertebrae was good and there was no evidence of an old healed fracture of any of the vertebrae. There was some increased mobility between the fourth and fifth cervical vertebrae which suggested that ligamentous damage at the time of injury had been the cause of her initial neurological signs and symptoms. There was now no sign of the healed fracture of the pedicle of left? fourth or ? fifth cervical vertebra noted by Mr. Dundas and mentioned in his report.

I concluded that Mrs. McKitty had made a good recovery from moderately severe injuries to her cervical spine. Although there is now no sign of neurological abnormality, late neurological sequelae to such an injury have been reported which would suggest a permanent impairment rated at 5% of the whole person would be reasonable. There is no impairment relative to the left lower leg.

Subsequent to my medical report of November 18, 1993, I received copies of a medical report by Mr. G.G. Dundas dated October 9, 1992, and an M.R.I. Examination and report dated 19th May, 1993.

From Mr. Dundas' report, it is apparent that Mrs. McKitty's clinical appearance and signs have reduced considerably during the past year. This suggests that she has now reached M.M.I. and can be considered as now having a whole person impairment of about 5% to which must be added a factor for the possibility of late sequelae developing due to the definite damage to her cervical spinal cord.

I would consider a total of 10% would be a fair estimate of her whole person impairment."

In the event the learned trial judge awarded the plaintiff a sum of $1,000,000.00 for pain and suffering and loss of amenities. This sum was reduced to $600,000.00 by the Court of Appeal which found that the method of assessment employed by the learned trial judge was based on a wrong premise. In my judgment the instant case is

somewhat more serious than McKitty's case, not alone because of the prolonged period of pain and suffering of this plaintiff, but also by reason of the extent of the greater permanent partial disability (estimated at 25%) with which she has been left. In these circumstances, I award the plaintiff the sum of $1,400,000.00 using the most current consumer price index which I am authoritatively advised as at April, 1996 stood at 948.8.

The next sub-heading under which I have to consider an award of general damages to the plaintiff is that of loss of future earnings. On this aspect of the matter I am satisfied that Mr. Baugh's submission is correct. Mr. Baugh submitted that the plaintiff failed to prove a loss of future earnings and I find as a fact that this is so. Accordingly, I make no award here.

Next comes the plaintiff's claim for compensation for future expenses which are likely to be occasioned by her injury. On Dr. Fray's evidence which I accept the plaintiff's condition will worsen with the passage of time and she will require physiotherapy for the rest of her life. She will also need to consult with him (Dr. Fray) or, one must presume, some other doctor at least twice each year for the rest of her life. Disagreeing, therefore, with Mr. Baugh's submissions I do consider that the plaintiff is entitled to an award of damages in this regard. As proposed by Mr. McBean, I accept a figure of 5 as the appropriate multiplier for determining this aspect of the matter and I award the plaintiff a sum of $50,000.00 computed as follows:

For visits to Doctor twice yearly for a period of 5 years at $1,500.00 per visit	$15,000.00
For cost of physiotherapy for 8 sessions per year for 5 years at $500.00 per session	20,000.00
For cost of injections and tablets for 5 years at $3,000.00 per year	15,000.00
	$50,000.00

In the final result, therefore, there will be judgment for the plaintiff in a total sum of $1,511,610.35 with costs to the plaintiff to be agreed or taxed. Interest on the sum of $61,610.35 at a rate of 6% per annum from March 29, 1988 to the date of this judgment. Interest on the sum of $1,400,000.00 at a rate of 6% per annum from the date of service of the Writ of Summons to the date of judgment.