[2012] J MSC Civ 96

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

CLAIM NO. 2010HCV04881

BETWEEN	**PHEONA MCLEISH**	**CLAIMANT**
A N D	**JASON DALEY**	**1ST DEFENDANT**
A N D	**KERROL ATKINSON**	**2ND DEFENDANT**

Richard Reitzin instructed by Reitzin & Hernandez for the Claimant
Simone Jarrett & Kherie Osbourne instructed by Lightbourne & Hamilton for the Second Claimant

HEARD: 26TH September 2011, 28th November, 2011, 12th January 2012 & 5th July 2012

Road traffic accident – assessment of damages – whiplash injury – whether Defendant can be heard at assessment of damages hearing following upon entry of default judgment

CORAM: ANDERSON, K. (J.)

[1] The Claimant has claimed against the Defendants arising from injuries, loss and damage suffered by her arising from a traffic accident involving her, whilst she was a fare paying passenger in a motor vehicle which was at the material time, owned by the second Defendant being driven by the first Defendant. The accident was one in which the motor vehicle in which she was being driven at the material time, skidded, rolled over twice, left the roadway and landed on its roof. That accident occurred on December 18, 2004 at about 5:30p.m along the main road heading towards Balaclava in the parish of St. Elizabeth. That road was wet, at the material time. In the circumstances, the Claimant claimed damages for negligence as against both Defendants. Judgment in default of Acknowledgement of service was entered against

the Second Defendant on January 20, 2011 and thereafter, this Court made case management orders in respect of the assessment of damages hearing. Amongst those case management orders were that the Second Defendant shall be entitled to cross-examine the Claimant's witnesses and/or the Claimant herself upon the assessment of damages hearing and shall be entitled to make submissions to the Court vis-à-vis quantum of damages.

[2] In having made those particular case management orders, I was then abiding by an earlier Supreme Court Judgment of mine in the case Winston Johnson v Norbert Lawrence – Claim No. 2011HCV00547. That judgment of mine was however successfully appealed against, to the Court of Appeal and was overturned. In its Court of Appeal Judgment in the matter, as was rendered in: Winston Johnson and Norbert Lawrence- Supreme Court Civil Appeal No. 106/2011, the Court of Appeal has made it clear that a Defendant against whom a Default Judgment has been entered, has no right to be heard by the Court in relation to any matters other than those specified in Rule 12.13 of the Civil Procedure Rules and thus, cannot cross-examine witnesses, nor make any submissions as to quantum. In the circumstances, although I had earlier ordered that the Second Defendant could cross-examine witnesses and even though I did allow for this to be done at the assessment of damages hearing, I have not taken either cross-examination evidence or re-examination evidence adduced during the assessment of damages hearing, into account for the purpose of assessing damages herein. Also, I could not have taken into account of any submissions as to quantum as may have been received by this Court from the Second Defendant's counsel. In any event though, no submissions as to quantum were ever received by this Court from the Second Defendant.

[3] At the assessment of damages hearing, the Claimant's witness statement was accepted as her evidence-in-chief. In her evidence-in-chief, the Claimant gave evidence which makes it clear that she was only twenty-two (22) years old when the relevant accident occurred and that when the taxi that she was in on the relevant day rolled over twice, she ended up falling on her head and another passenger landed on

top of her. As a consequence of this, she immediately began to feel pain in her head, neck, shoulder, chest, lower back and both legs. It took about fifteen (minutes) before help came and she was taken out of the car. From there she went on that same day, to one Dr. Little. Thereafter, she was taken home by some persons who were then assisting her, these being the same persons who had taken her to Dr. Little. Dr. Little prescribed medication for the Claimant. On 20th Decernber, 2004, the Claimant was seen by one Dr. Williams who then made certain medical findings in relation to her and referred her to the Mandeville hospital for further assessment and treatment. On that same day, the Claimant visited the Mandeville hospital, whereat she was examined by one Dr. Steve Mullings. The Claimant was by that time, experiencing a painful right shoulder which she could not move because of pain and in addition, was suffering from headache, neck pain, chest pain and back pain and was also having difficulty swallowing. Dr. Mullings sent the Claimant to do x-rays and prescribed oral and typical anti-flammatory and oral antispasmodic medication. In about February of 2005, the Claimant once again returned to Dr. Williams for further examination, because she then had a swelling on her right shoulder and neck. She was then referred by Dr. Williams to the Orthropaedic Outpatient Clinic of the Mandeville hospital. The Claimant went to that orthopedic outpatient clinic, as she continued to experience persistent neck pain, headache, chest pain and weakness in her hand. She was also then wearing a soft cervical collar which one of her doctors had, by then, prescribed. The Claimant was feeling depressed then and up until the date of her statement, that being September 14, 2011. She has seen Dr. Steve Mullings more than once and she also has been seen by Dr. Dean Wright at the University Hospital of the West Indies. He examined her, prescribed medication for her and also made certain medical findings in relation to her. The Claimant once went for physiotherapy at the Mandeville hospital and during her physiotherapy treatment there on one day, she began to spit blood and had to then be sent to the Accident and Emergency Department there. The Claimant has experienced difficulty sleeping well at night, because of pain all over her body, including her back and also shoulder pain, if she sleeps on her side. The Claimant has given evidence in her witness statement, that up until the date of that witness statement, she cannot stand or sit for long periods of time. She still experiences pain particularly in her neck and

back, but also in her right leg, when she gets out of bed in the morning and she experiences pain in the swallowing of food. The Claimant has given evidence that the pain in her neck and back is a daily accompaniment to her life and plagues her every single day. At the assessment of damages hearing, the Claimant testified in response to a question posed to her by the Court that she is feeling pain "now in the back of my head, my right foot and to my back."

[4] The Claimant filed a Notice of Intention to tender hearsay statements contained in documents which pertained to a number of receipts/invoices and also six (6) medical reports prepared between March, 2005 and April, 2011, by six (6) doctors who have attended to and diagnosed the Claimant on various occasions during that period of time. The receipts referred to in the Claimant's Notice of Intention to tender document, were accepted by the Court as evidence during the assessment of damages hearing, as these documents were all served on both of the Defendants along with the Notice of Intention to tender document. At the assessment of damages hearing also, the medical report of Dr. Andrew Williams as dated May 16, 2005 was accepted by this Court as being an expert report and was admitted and marked as Exhibit 1. Also, the same was done with respect to the medical reports of Dr. Steve Mullings, as dated April 30, 2006. However, as regards the other medical reports which the Claimant is seeking to rely upon this Court had ordered during the last hearing date prior to delivery of Judgment as regards the assessment of damages hearing, as follows:-

> 'The respective medical reports as prepared by Drs. Lincoln Little, Dean Wright, Carlton Chambers and Andrew Ameerally, are to be prepared, filed and served as expert reports, in full compliance with the provision of Part 32 of the Civil Procedure Rules. Subject to there being compliance with this Order by or before January 31, 2012, each such report shall be accepted as expert reports and be admitted as such, into evidence at the assessment of damages hearing, being respectively then labeled as Exhibits 3,4,5 and 6 respectively.'

That was the last day during which evidence was led during this Court's assessment of damages herein. Judgment on the assessment was at the end of that Court day, insofar as this matter is concerned, reserved for a date to be announced.

[5] There has been compliance by the Claimant, with the Orders as regards the need for the respective medical reports to be prepared in the format as required by the relevant Rules of Court (Part 32 of the Civil Procedure Rules). Thus, such was complied with insofar as the medical reports of Dr. Andrew Amerally (dated April 14, 2011), Dr. Lincoln Little (dated 29th March, 2005), Dr. Dean Wright (dated November 16,2006 and Dr. Carlton Charnbers (dated May 16, 2009).

[6] There exists Affidavit evidence on file from the Claimant's Attorney as regards his efforts to locate Dr. Carlton Chambers and as to Dr. Chambers' medical qualifications and as to what he (Mr. Reitzin) has learned from another doctor, as to the current whereabouts of Dr. Chambers. Although this Court has noted the existence of this Affidavit evidence, which no doubt is being relied on by the Claimant, through his counsel, in an effort to enable the admission into evidence of the medical report of Dr. Carlton Chambers, nonetheless this Court cannot accept or act upon such affidavit evidence, this because, the Court cannot take into account that Affidavit evidence for the purposes of the assessment of damages hearing – as no order of this Court has been made, allowing for such to be done.

[7] It is to be noted that Dr. Chambers' medical qualifications and training are at least implicit in the medical degree which is referred to by the letters – MBBS which appear immediately below his signature at the conclusion of his report, coupled with, below that, his apparent specification of the medical position which he held as at the date when his report was prepared, this being – 'Senior Orthopaedic Resident.' It would I think, be pedantic of this Court not to consider Dr. Chambers' report as being an expert report, merely because further details of Dr. Chambers' medical training and experience has not been provided.

[8] In the circumstances, this Court will consider the expert reports of Doctors Little, Wright, and Ameerally, Mullings and William and Chambers for the purpose of assessing the general damages to be awarded to the Claimant. In that regard, this Court has noted that Dr. Little examined the Claimant on the day of the accident and concluded that he was then expecting her, 'to fully recover from the effect of her injury, which he diagnosed as being a case of 'soft tissue injury to the right shoulder.' Dr. Wright diagnosed the Claimant as suffering from 'an old cervical spine (whiplash) injury with; 'C3 spinous process fracture.' It must be stated at this juncture, that this Court is unclear as to exactly what this medical terminology means in reality, as of course, the doctor was not present at Court and regrettably, he did not explain this terminology in more readily understandable terms, insofar as a layman – which is what this Court is for that purpose, is concerned. Nonetheless, it does appear to this Court to be the only reasonable conclusion, that the Claimant was suffering from a fairly serious whiplash injury, at the time when she was examined and diagnosed by Dr. Wright. Following on this, it is also the only reasonable conclusion that can be made by this Court, that such whiplash injury arose from the vehicle accident which eventually gave rise to the Claimant's Claim against the Defendant and the Claimant's subsequently obtained Judgment in Default, as against the Defendant. Dr. Wright in having provided in his report, a medical prognosis for the Claimant, stated that – 'Based on her symptomatology, Ms. McLeish may continue to have moderate to servere neck pain intermittently for an undetermined period of time.' No assessment of any disability of the Claimant, was made by Dr. Wright, as Dr. Wright had in his report, stated that such report was a preliminary medical report, as the Claimant was as at the date of that report, still undergoing treatment. Dr. Wright thus stated in his report that, 'A final medical report can be requested at the completion of her treatment at which time an assessment of disability can be made.' To date, no assessment of disability in relation to the Claimant, has been provided to this Court by the Claimant, in any report from Dr. Wright. Dr. Andrew Ameerally has assessed the Claimant's permanent impairment arising from the injury suffered by her and has done so based on the 'Guides to Evaluation of Permanent Impairment 5th edition, table 18-7,' which is published by the American Medical Association and which has been attached to Dr. Ameerally's

assessment of the Claimant's impairment as is set out in his expert report. By virtue thereof, Dr. Ameerally has assessed the Claimant's impairment as being 'mild.' In classifying the Claimant's impairment as mild, it is to be noted that in the document attached to his expert report – this being the same document published by the American Medical Association, an assessment of mild impairment is to be given in circumstances wherein the individual demonstrates no or only minimal emotional distress in response to his or her pain, and the individual is not receiving treatment for pain on a regular basis and pain related limitations during physical examination are mild and appear appropriate, few pain behaviours (covert expressions of pain, distress and suffering, such as moaning, limping, moving in a guarded fashion, facial grimacing are observed during examination.)

[9] From the documents published by the American Medical Association and which are appended to Dr. Ameerally's expert report, it is clear to this Court that: (1) The evaluation of the extent of impairment is primarily done by virtue of answer given to a questionnaire, by the patient himself or herself thus, there is very little likelihood of the evaluation of impairment being primarily based on anything other than the patient's own answers to the questions posed. (ii) There is to be done by the doctor conducting the impairment evaluation, an assessment of the patient's behavior during the examination, in an effort, no doubt, to determine whether the behavior evinced by the patient is or is not consistent with the patient's answers to the questions posed and if it is consistent, the doctor will no doubt, assess such behaviour, along with the answers to the questions posed to the patient, in determining the extent of the patient's impairment. (iii) A score of 8, which is the score that the Claimant got, arising from her impairment evaluation which was conducted in that context, is noted by this Court as being far closer to a score of 0-6, which would have resulted in an assessment that the Claimant was suffering from no significant impairment as compared for example, with a score between 25 and 42, which would have indicated that the Claimant was then suffering from moderate impairment. Accordingly, this Court concludes that the Claimant's impairment, at least as at the date when she was examined by Dr. Ameerally, was certainly, at least by then, quite minimal and expected to further improve over time, to

the point whereby she would, as suggested by Dr. Little in his expert report, have been expected to fully recover. It is to be noted, in that regard, that the precise date when the Claimant was examined by Dr. Ameerally has not been made known to this Court, by means of any evidence whatsoever, either from the Claimant herself, or even from Dr. Ameerally, by means of his expert report.

[10] Based on the objective evaluation of the extent of the Claimant's impairment, as done by Dr. Ameerally, which was itself based on answers to questions, as were given by the Claimant herself, this Court accepts this evidence and Drs. Ameerally and Little's overall evaluation of the Claimant, as well as the determination as made by Dr. Wright in his report, that – **'Based on her sympotomology, Ms. McLeish may continue to have moderate to severe neck pain intermittently for an undetermined period of time.'** There exists no inconsistency between Dr. Wright's evaluation, when such is considered along with Drs. Little and Amerally's respective evaluations. Notably in this regard, Dr. Wright's conclusion in terms of prognosis, as above-mentioned, refers to a possibility (as expressed by the doctor in his use of the word – 'may'), but also and perhaps even more significantly, specifies no particular length of time for which such pain may be expected to continue to be or have been experienced by the Claimant, on an intermittent basis for. It should be borne in mind that Dr. Wright provided his report as regards his prognosis in relation to the Claimant and overall evaluation of the extent of the Claimant's injuries, quite some time ago, that having been November 16, 2006 Dr. Wright examined the Claimant on November 15, 2006. Thus, it is quite possible, perhaps even likely, that based on Dr. Wright's own then expressed prognosis in relation to the Claimant, that the Claimant may very well not have been experiencing the pain which she would no doubt have told Dr. Wright that she was experiencing, when she was examined by him on November 15, 2006. Even if she was then still experiencing pain on an intermittent basis, even Dr. Wright could not confirm that she was likely to have continued to experience same for any particular period of time thereafter. What is clear to this Court however, is that by the time when she was evaluated by Dr. Ameerally, the Claimant was largely, fully physically recovered, insofar as she was then only minimally impaired. This Court therefore does not accept the

Claimant's evidence that she was still experiencing pain in her neck and back, as at the date when she gave evidence at the assessment of damages hearing herein.

[11] The Claimant was examined by Dr. Williams on December 20, 2004. Dr Williams determined that the Claimant was suffering from pain and then had, 'torticolis' – this being apparently, a medical condition which this Court certainly has been provided with no explanation of. She was assessed as having tenderness in her spine and also in her neck muscles and her rib cage and at the angles of her jaw. She also then had an injury to her right shoulder which was determined by Dr. Williams as creating a painful full range of motion. Dr. Williams did not however, offer any medical prognosis in respect of the Claimant and has stated in his report that he did not do so, because he had not had the benefit of seeing any x-ray of the Claimant. This Court accepts the validity of Dr. Wright's evaluation of the Claimant, as and when such evaluation was conducted by him.

[12] It is in that overall context that the assessment of general damages must now be done. The Claimant's helpful written closing submissions which were provided to this Court, referred to a number of cases in which damages were assessed by this Court. In that regard, it is to be noted that one doctor - Dr. Wright, has suggested that the Claimant was determined by him to be suffering from a cervical spine (whiplash) injury with C3 spinous process fracture. Dr. Chambers though, has stated in his report that radiographs taken of the Claimant on April 4, 2005 – this having been four months after the occurrence of the accident which gave rise to this Claim, suggested a fracture of the spinous process of C4. Dr. Chambers though, immediately thereafter in his medical report, went on to state that the radiographs of April 4, 2005, did not conclusively show a fracture, but the clinician who reviewed the photograph thought that there was a possibility of a fracture. He also stated that no radiographs demonstrated a fracture and this was not shown on a Magnetic Resonance Imaging (MRI) scan. In that context, with this Court bearing in mind throughout this Court's assessment of the damages sum which ought to be awarded to the Claimant, that the burden of proof rests squarely on the Claimant's shoulders, on a balance of probabilities, it being very unclear to this

Court that there was in fact a fracture of the Claimant's C4 spinous process, the Court cannot accept Dr. Chambers' conclusion that there was in respect of the Claimant, a healed fracture of the C4 spinous process. Dr. Chambers in his report stated that initial radiographs did not show a fracture of the spinous process of C4 or C3, Dr. Wright's diagnosis that the Claimant had suffered an 'old cervical spine whiplash injury with C3 spinous process fracture,' is difficult for this Court to accept, because prior to having stated that in his report, this same doctor stated that, **'cervical spine radiographs of the 4th April 2005 reportedly showed an incomplete C4 spinous process fracture not seen on the film dated the 20th December 2004.'** There was no other evidence of injury or instability. The conclusion that there appeared to Dr. Wright, to have existed in relation to the Claimant, an incomplete C4 spinous process fracture, is no doubt supported by the initial findings of the radiographer who reported to Dr. Chambers. How though, it could have been concluded in respect of the Claimant, by Dr. Wright, that she had suffered a C3 spinous process fracture is entirely unclear and in fact appears to be inconsistent with that which he stated earlier in his report, wherein he referred to the Claimant then appearing to have suffered an incomplete C4 spinous process fracture, which was not seen on the initial radiographs which were taken on December 20, 2004. Thus, this Court is not prepared to accept that the Claimant did, at any time, arising out of the facts which have given rise to this Claim, suffer a C3 spinous process fracture. The medical evidence as provided to this Court, solely in the form of written medical reports admitted as hearsay evidence; simply do not support the drawing of such a conclusion by this Court.

[13] In some of the cases referred to by the Claimant's counsel in his written closing submissions, the respective Claimants either suffered, arising from their injuries, permanent partial disability, or permanent whole person disability, or at the very least, temporary complete disability and/or temporary partial disability. In the case now at hand though, the Claimant has not been determined by any doctor, as suffering from any permanent disability, either whole or partial, nor as having suffered from any temporary partial or whole person disability. Thus, with all due respect to the Claimant's counsel, I cannot properly adopt the approach that he has suggested in his written

closing submissions, this being that an average of the respective Court's damages awards in all of the cases referred to, should be applied by this Court and awarded to the Claimant herein. In any event though, applying an average figure cannot be a correct approach in assessing damages, because, the awards will of necessity, vary through the years, depending on the rate of inflation that exists as at the time when the damages are to be assessed, as compared with that rate at the time when the relevant similar type case was used by this Court as its basis for assessment of general damages.

[14] What this Court must it seems do therefore, in order to assess general damages herein, is find the case precedent which most closely resembles the extent of the injuries suffered by the Claimant in this particular case, albeit that if such precedent involved a finding by the Court in that case, that any disability whatsoever had been or is being, or will be suffered by the Claimant therein, then of necessity, the award of general damages in this case now at hand, must be lower, in real terms (that is, taking into account what was the award in the earlier case now to be relied on as a precedent in this case.) In that regard, this Court will rely on the case of Helen Gordon and anor. v Royland McKenzie – Suit No. C.L. 1997 G.025, as has been referred to in the Claimant's written closing submissions, as the precedent upon which it will place reliance, for the purpose of assessing the sum to be awarded to the Claimant, herein, as general damages. In the Helen Gordon case, the plaintiff had suffered whiplash pain centered around her neck and shoulder. She was assessed as suffering from a 3% whole person disability, which was likely to improve with time, but slowly. The plaintiff in the Gordon case had difficulty conducting her daily chores and also had difficulty sleeping on her right side. She was awarded by this Court, the sum of $400,000.00 as general damages. This Court is of the view that a sum of $375,000 would, in the circumstances, be an appropriate figure for the purpose of assessing general damages herein. The award in the Helen Gordon case was made by this Court, in July of 1998. This award is being made in June of 2012. The current Price Index in July of 1998 was: 48.37 whereas in April of 2012, this being the latest CPI figure published, it is 181.9 In the circumstances, arising from the necessary mathematical calculations, (such having

been rounded off to the nearest dollar) which have been done in that regard, the sum which this Court will award as general damages to the Claimant, herein, is :- $1,410,223.00. Such general damages are awarded to the Claimant for pain and suffering and loss of amenities.

[15] Insofar as the assessment of special damages is concerned it is, of course, the well-established rule that the same ought to be specially pleaded and specially proven, which is applicable. In that regard, in her Particulars of Claim, the Claimant has specifically pleaded six aspects of special damages and set out the respective sums being claimed for such aspects as follows – i) Hospital expenses - $46,100.00; ii) Medical expenses - $8,500.00; iii) X-rays - $1,800.00; and iv) Pharmaceutical expenses to date - $31,610.00; v) Medical Reports - $19,000.00; vi) Travelling expenses - $9,300.00.

[16] During the assessment of damages hearing, there were several receipts pertaining to various expenses related to medical and other matters arising from the facts which gave rise to the Claimant's Claim, which were not objected to by the Defendant, and this rightly so as the Defendant perhaps took the correct view from the onset, this being that arising from a Default Judgment having been entered against him he had no right to actively participate, in terms of being heard, on the quantum of damages to be awarded in the Claimant's favour. Whilst most of the receipts thereby admitted into evidence are legible, there are a few which are not, as all of the receipts so admitted, were copies. Nonetheless, this Court has done the best that it could have, in the circumstances, to calculate the respective sums which should be awarded in relation to each head of special damages.

[17] In the Claimant's witness statement, which was, during the course of the assessment of damages hearing, accepted by this Court as constituting her evidence-in-chief, the Claimant has, it should be noted, given no evidence whatsoever, as to any specific expenses incurred by her arising from her injuries as suffered. Nonetheless, this Court is prepared to accept that all of the expenses as have been specifically

claimed for by the Claimant in her Particulars of Claim, are expenses which must, as a matter of necessity, have been incurred by the Claimant in an effort to obtain medical treatment over a period of months, for her injuries. In that regard, various receipts were admitted as evidence at the assessment of damages hearing. This Court though, in awarding special damages, can do no more than add those receipts as pertain to respective aspects of the special damages as claimed and thereby determine the aggregate sum which should be awarded for each head of special damages as claimed. In that context, the respective aggregate sums as assessed by this Court in terms of each head of special damages are as follows:-

		$
1) Travelling expenses		4300.00
2) Medical Reports & Doctor's visits		39500.00
3) Pharmaceutical expenses		23637.15
4) Hospital expenses		42950.00
5) X-rays		1800.00
Aggregate Total	---	$112,187.15

[18] In the circumstances, this Court will award as the aggregate sum for special damages, the sum of $112,187.15. It should be noted that in compiling the respective aggregate sums as special damages in respect of each aspect of same which the Claimant has claimed for, this Court having not been provided with any original receipts as exhibits accepted as evidence at the assessment of damages hearing, had, as a matter of necessity, to calculate the aggregate respective sums for each aspect of special damages claimed for, using for calculation purposes, the copies of receipts which were introduced and admitted into evidence at the assessment of damages hearing and which were attached to the Claimant's Notice of Intention to tender hearsay evidence contained in documents. Some of those receipt copies were of a poor copy quality and in the circumstances; this Court found itself unable to take the same into account.

[19] This Court therefore awards to the Claimant in Judgment on her Claim, the following:-

(i) General damages in the sum of $1,410,223.00, with interest at the rate of 6% from the date (date of Service of Claim Form) until the date of Judgment on the Claim, that being January 20, 2011.

(ii) Special Damages in the sum of $112,187.15 with interest at the rate of 3% from the date of December 18, 2004 (Date of accident) until the date of Judgment on the Claim.

(iii) Costs of the Claim are awarded to the Claimant.

(iv) Claimant shall file and serve this Order on both Defendants.

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Honourable K. Anderson, J.