JAMAICA

IN THE COURT OF APPEAL

SUPREME COURT CIVIL APPEAL NO: 112/89

BEFORE: THE HON. MR. JUSTICE ROWE - PRESIDENT
THE HON. MR. JUSTICE FORTE, J.A.
THE HON. MR. JUSTICE GORDON, J.A.

BETWEEN	ERNEST ALLEN HORACE ALLEN	DEFENDANTS/APPELLANTS
AND	MICHAEL CAMPBELL	PLAINTIFF/RESPONDENT

D.A. Scharschmidt, Q.C. and John Givans for Appellants

Ainsworth Campbell for Respondent

September 26,27 & December 2, 1991

Rowe, P.

On the 19th January 1987 the respondent was a passenger in a motor-bus, owned by Ernest Allen and driven by Horace Allen which while travelling along the Ewarton to Bog Walk highway in St. Catherine, overturned due to the negligence of Horace Allen and caused serious multiple injuries to the respondent. A writ of summons alleging negligence was filed on May 27, 1987, followed by a Statement of Claim served on January 21, 1988. No defence was delivered and on September 29, 1989 Harrison, J assessed damages as follows:

GENERAL DAMAGES

(1)	Pain and Suffering and Loss of Amenities	$297,520.00
(2)	Loss on the labour market	10,000.00
		307,520.00

SPECIAL DAMAGES $27,820.00

Interest was awarded on the $297,520 at 3% p.a. from 4/4/87 to 29/9/89 and interest on $27,820 at 3% from 19/1/87 to 29/9/89.

The award for pain and suffering and loss of amenities displeased both sides. The appellants complained that having regard to the injuries suffered by the respondent, the award under that head of damages was wholly erroneous and inordinately high. On the other hand, the respondent complained that the trial judge was in error when he found as a fact that the respondent did not suffer brain damage and made no award on that basis. Further that his claim for pain and suffering and loss of amenities, future loss of earnings, handicap on the labour market and loss of earning capacity was either neglected or under-assessed.

Michael Campbell, a hawker and pedlar, after the fashion of his father, suffered two major concentrations of physical injuries: (a) to both lower limbs and (b) to his face and head. There was evidence of residual brain damage leading to post traumatic epileptic fits which failed to impress the trial judge but as to which, as will become evident later, this Court took quite a different view as to the purport of some unchallenged medical evidence.

A parade of doctors testified. First there was Dr. Dennis Stephens, a Dental Surgeon; then came Dr. Imran Ali, an Orthopaedic Surgeon. They were followed by Dr. John Hall, a Specialist in Neurology, brain and related nervous diseases, and Dr. Neville Graham of the Neurosurgery Department of the Kingston Public Hospital. It is necessary to set out in full the evidence which came from these medical men.

Dr. Ali, the Orthopaedic Surgeon found the respondent suffering from the following:

INJURIES

(1) Laceration left temporal region of skull;

(2) X-Rays undisplaced fracture of left tibia;

(3) Comminuted fracture of right tibia and fibula with displacement.

TREATMENT

The fractures were manipulated and above knee plaster applied. X-Ray showed fracture of right leg unsatisfactorily reduced. It was re-manipulated and new plaster was applied on 29th January 1987. The injured man was discharged from hospital on 2nd February 1987 for treatment in the fracture clinic and there he was seen by Dr. Ali on several occasions.

On 16th March 1987 the plaster cast was removed. Then the left leg fracture was solid. The right leg showed delayed union. A patella tendon was applied to the right leg which was put in plaster cast below the knee. This plaster was removed on 4th May 1987 and the fracture was considered to be clinically solid. The patient was advised to partially bear weight on the right leg with use of crutches.

On 16th July 1987 the respondent re-fractured the right leg which was again placed in a plaster cast for six weeks. That cast was removed on 7th August 1987. Then the fracture was healing well and the patient was advised to partially place weight on that right leg.

DISABILITY

At the time of trial Dr. Ali found that the fracture of both legs were well healed. There was a big bump with slight anterior bowing at the fracture site of the right leg which was 1" short.

The left leg was well healed with a 3" scar on middle 3rd of left leg. The fracture was solid but the left leg was slightly

recurvatum opposite of anterior bowing of the right leg.

The left ankle was slightly stiff and the respondent walked with a limp.

Dr. Ali assessed the permanent partial disability in both legs and in each leg at 20%.

Dr. Ali opined that the injuries which the respondent suffered were serious and would cause much pain. In fact up to the time of trial the respondent complained of feeling pain from time to time at the fracture site, and in the opinion of Dr. Ali the respondent could have stiffness of the ankle and pain from time to time at the fracture sites and other parts of the body. Pain in the right leg could be due to the shortness of that leg. The anterior bowing of the right leg suggested mal-union of the tibia and fibula. The probability that the respondent would develop osteo-arthritis in the right hip was greater than for a normal person.

For ten months after the accident the respondent could not walk without assistance and his legs only became full weight bearing in October 1987. Prior to that, after his discharge from hospital, the respondent could move about to a limited extent but could not run or hop or jump, and for the future his ability to run or walk fast or climb would be adversely affected by inter alia, the stiff ankle. The injury to his frontal sinus could cause headaches if the respondent was exposed to the sun. Although the respondent could play cricket and football Dr. Ali did not think that he could do so very effectively.

In cross-examination Dr. Ali consulted his notes and with their aid answered that the respondent was conscious on admission to the Kingston Public Hospital. Dr. Stephens the Dental Surgeon made three statements in respect to the respondent's state of consciousness. In cross-examination he said he first saw the

respondent on March 23, 1987 at which time he had the hospital's notes on the patient which were made at the time of admission. He said, apparently in response to a question as to the contents of the notes, that it "would have been important to note state of consciousness of unconsciousness." Earlier Dr. Stephens had said of the respondent's injuries:

> "Injuries serious e.g. concussion reported."

His final remark on this area of inquiry was in re-examination, when he said:

> "Firm object could cause this fracture - hitting one in middle of face - not necessarily hard object.
> Force on the firm object would have to come together with considerable force.
> This kind of force could cause concussion."

We have juxtaposed the evidence of the two medical practitioners on the issue as to the state of consciousness of the respondent on admission to hospital so as to be better able to evaluate the evidence of the respondent who claimed that he was unconscious for a prolonged period following the accident.

Dr. Stephens found the respondent's injuries to be:

INJURIES

(1) Scar on left temporal area;

(2) Fracture of frontal nasal suture i.e. bridge of nose - juncture between head and face - horizontal - maxilla and frontal bones - middle 1/3rd of face detached from frontal bone. Fracture separated middle 1/3rd from upper 1/3rd face.

EFFECT OF THE FRACTURE

Respondent experienced difficulty when he closed teeth - bite - fracture usually accompanied by nosebleed. Dr. Stephens explained that the complaint of respondent that at time of trial he suffered tenderness in the area of fracture and had difficulty in chewing anything hard in food, led him to believe that total healing may not have taken place up to then. Each bite he said

disturbed the upper jaw which ordinarily does not move and that disturbance could delay healing. He said too that it was conceivable that any motion between the end of bones which make up wall of nasal cavity could cause the blood vessels to be traumatized with the likelihood of bleeding if there is any motion in the bony compartment which makes up the walls of the sinus. Dr. Stephens would expect nosebleeds to occur occasionally but saw no basic impediment to total recovery.

Dr. John Hall examined the respondent on June 12 and 22 1989. He received a history of the respondent being involved in a motor vehicle accident on 19th January 1987, that the respondent lost consciousness for nearly 24 hours, that respondent was suffering from headaches, had difficulty in walking, and had episodes of epilepsy since April 1989. Dr. Hall observed on June 12, 1989 during the interview with the respondent, that respondent was belligerent, aggressive, combative and almost un-cooperative. An examination of the central nervous system did not show any demonstrable focal abnormality. Ultrasound scan of brain was normal. Dr. Hall testified that in neurology one can relate belligerence to epilepsy. Without demonstrable focal abnormality, damage to left area of brain leads to belligerence and bellicosity. On 12th June 1989 Dr. Hall came to the conclusion that the respondent suffered a brain injury. The doctor had observed certain physical injuries to the respondent including an unsightly scar over the left temple to the hair-line and a linear scar to the zygomatic area. He knew also that the respondent had suffered demonstrable damage to the root of his nose and frontal sinus which heightened the possibility of nosebleeds.

Dr. Hall admitted that he received the history of unconsciousness from the respondent, that he did not cross-check with anyone on this issue and that unconsciousness was a decisive factor in his conclusion as to brain damage. He admitted further

that the absence of unconsciousness would colour his conclusion, that unconsciousness was an important factor to record on admission and that it was unlikely that unconsciousness for 24 hours could have escaped the doctors and nurses at Kingston Public Hospital. He said, however, that even if on arrival at Kingston Public Hospital the respondent was conscious, that did not necessarily mean that he was aware of his environment. For instance, it was reputed that the respondent had been taken first to the Linstead Hospital and from thence to Kingston Public Hospital but of this incident the respondent had no recollection. Finally, Dr. Hall said that his diagnosis of brain damage rested upon the history of unconsciousness, the scarring that he observed and the personality of the respondent at the interview. Dr. Hall accepted as true the history of the onset of epilepsy and said that in June 1987 the prognosis was the inescapable prospect of post traumatic epilepsy and personality changes. Left hemisphere brain injury, he said, could also result in early onset of parkinson's disease and pre-mature senility called alzheimer's disease. The presence of epilepsy raised the probability that both parkinson and alzheimer's disease will develop. According to Dr. Hall if the respondent develop alzheimer's disease he will be unable to earn a living and in the end will be subject to custodial existence. With epilepsy, he could continue to earn a living, provided he maintained a constant treatment regime.

To meet the strictures of opposing counsel that Dr. Hall's evidence was at best "hearsay upon hearsay", very late in the day Dr. Neville Graham was called as a witness. Dr. Graham admitted the respondent to the Kingston Public Hospital on July 5, 1989 and treated him for post traumatic epilepsy. He last saw respondent on Septemer 12, 1989. In hospital respondent had fainting spells and trembling and complained of pain inside of his head. The respondent was not convulsing while hospitalized. Dr. Graham,

said fainting spells and trembling are not always indicative of epilepsy either taken together or singly.

The notes of the trial would suggest that Dr. Graham was indecisive as to the indicia of epilepsy. He is recorded as saying:

> "Fainting spells not indicative of epilepsy. Trembling not indicative of epilepsy. Fainting spells and trembling not always indicative of epilepsy.
> To come to a diagnosis one needs history of patient.
> History provided by plaintiff.
> The history not the decisive consideration .. fainting and trembling - by itself - diagnosis epilepsy - not necessarily post traumatic.
> Loss of consciousness and trembling not necessarily epilepsy."

What was the history which the respondent was able to provide? His evidence was that the accident occurred between 10.30 a.m. and 11.00 a.m. on 19th January 1987 and he awoke in the Kingston Public Hospital the next day. He was unaware that he had been taken to Linstead Hospital. After his discharge from the Kingston Public Hospital the respondent said he visited a doctor in Linstead in September 1987 because he was feeling pain in his head and was asthmatic. He felt pain in his head sometimes for a whole day and sometimes not at all. It was because of pain in the head that he consulted Dr. Hall. Heavy dance music causes pain in his head.

Up to this point in the respondent's evidence there was no talk of epilepsy. The trial was adjourned to several months ahead and on its resumption the respondent gave evidence of suffering several blackouts accompanied by nosebleeds and trembling which necessitated his being hospitalized at the Kingston Public Hospital twice, at the University Hospital three times and at Annotto Bay Hospital once. Witnesses whom he called to support the fainting incidents were rejected by the trial judge as they did not corroborate any of the incidents testified to by the respondent.

Other material injuries suffered by the respondent but which were not referred to by the medical witnesses included bleeding from his penis upon urination which lasted for three weeks, sneezing with attendant nosebleeds in dusty conditions, nosebleeds and pain if exposed to hot sun, and scar with sunken hole in right leg.

In summary, the respondent's physical injuries caused him to be immobilized between January and October 1987. His leg was in a plaster cast up to May 4, 1987 and again for 3 weeks after July 16, 1987. He received physiotheraphy to strengthen weakened and wizened leg. For a time he had to be fed with drinking straws and could not chew any food. He cannot now walk long distances or stand for long periods, and suffers from recurrent pains. He is unable to play football or cricket.

Harrison, J awarded the sum of $297,520 for pain and suffering and loss of amenities. In doing this he appears to have accepted the evidence of the respondent and his medical advisers except as to the incidence of brain damage and the resultant post traumatic epilepsy. Mr. Scharschmidt argued that on the findings of the learned trial judge the award for general damages was out of line with awards made between 1982 and 1989, was wholly erroneous and inordinately high. We accept that a Court of Appeal will not interfere with an award of general damages simply because if it was a trial court it would have awarded a greater or a smaller sum. Only if the Court is satisfied that the award is wrong and seriously wrong will it interfere.

In **Simpson v. Gentles et al** page 12 of Khan's Recent Personal Injuries Awards made in the Supreme Court (hereafter Khan's Awards) the plaintiff suffered a severe crush injury to the right leg resulting in a below the knee amputation; he received a blow to the head and suffered post traumatic psycho-neurosis. An award of $70,000 in 1982 would re-value at $210,000 in 1989 according to the Consumer Price Index.

McIntosh v. Attorney General page 16 Vol. 2 of Khan's Awards, concerned a 25 year old plumber's apprentice who suffered gun shot injury fracturing the right femur and transecting the right femural artery leading to an above the knee amputation. An award of $100,000 for pain and suffering in February 1985 would re-value at $176,343 in September 1989.

Hart v. Smith page 14 Vol. 2 Khan's Awards, was decided on 13th January 1982. The immediate injuries suffered by that plaintiff were:

(a) Crushed right leg;
(b) Compound fracture of right tibia;
(c) Compound fracture of right fibula;
(d) Compound fracture of right femur;
(e) Laceration of right thigh;
(f) Laceration of right forearm.

The patient was hospitalized for 3½ months. His right leg was amputated below the knee and after treatment at the Mona Rehabilitation Centre he was fitted with a right leg prosthesis. An award of $40,000 in 1982 would now be re-valued at $110,000.

The three cases referred to above all concerned plaintiffs who having suffered fractures of a lower limb, lost a portion of the leg through amputation. We readily accept the submission of Mr. Scharschmidt that an amputation is a severe handicap and that fractures leading to the amputation of a leg are likely to carry more serious consequences than those which heal after treatment although some disability may be sustained by the patient. It does not seem to us that the award for general damages in **Hart v. Smith** (supra) ought to be cited or to be relied upon as providing a reliable guide for persons suffering comparable injuries. It is wholly out of line with other cases decided in the same period and appears to us to be inordinately low.

Oates v. Sewell & Facey page 10 Vol. 2 Khan's Awards decided on April 4, 1984 should not be relied upon in relation to the award of general damages for pain and suffering and loss of amenities. The plaintiff suffered lacerations to both legs over the lower third and compound fractures of both bones of both legs in the junction of the middle and lower thirds. After appropriate debridement and antitetanus and antibiotic therapy had been instituted the fractures were manipulated and casts applied. Healing was slow due to infection and the severity of the injury. The female patient experienced recurrent infections of the bone and she had a prolonged stay in hospital requiring repeated irrigations, curreting and debridement under general anaesthesia. She had to be transfused on several occasions. She was discharged from hospital on April 27, 1981 and attended out-patient clinic at the Kingston Public Hospital on several occasions. By October 1981 she was ambulatory with a crutch though her right leg was still not healed. She underwent surgery on February 19, 1982. Osteomyelitis developed and recurred leading to ulceration.

This patient was totally disabled from November 1980 to 28th September 1982 and her overall permanent partial disability amounted to 25% of the whole person. The award of $30,000 for pain and suffering and loss of amenities made in 1984 is strongly disapproved by this Court as being totally inadequate compensation.

In our view the cases referred to, except **Hart v. Smith** (supra), which related to amputation provide good comparative foundation for the assessment of the damages for the injuries to the lower limbs of the respondent as found by the trial judge in the instant case. We would, however, say that substantial additional damages would have to be awarded for the face and head injuries suffered by the respondent.

Marsh, J assessed damages on March 15, 1989 in **Harris v. McKinley** and awarded $280,000 for pain, suffering and loss of amenities. That plaintiff suffered:

(a) swelling of middle and lower third of both thighs;

(b) puncture wound to left tibia;

(c) fracture of both femora;

(d) shortening of both legs resulting in 'bowing' particularly on left leg.

Treatment included skeletal traction for 48 days. Patient was put in plaster cast up to groin on both legs. After discharge from hospital he received physiotheraphy for 5 months attending twice weekly. Permanent partial disability amounted to 10-15% left lower limb.

It seems to us that the award in this case represents the upper limit for injuries of this nature. However, in intensity and for discomfort, it seems to us that the physical injuries and resultant disability in **Harris v. McKinley** significantly exceed that of the respondent. We are constrained to say therefore, that had there been no Respondent's Notice, the appeal as to quantum would in all probability have succeeded.

As we said at the commencement of this judgment, the Respondent's Notice complained, inter alia, that the trial judge was in error when he failed to find as a fact that the respondent suffered brain damage. The trial judge might have been influenced by the very late time in the day when the respondent came with the claim for brain damage as evidenced by epilepsy but it nevertheless remained his duty to evaluate all the evidence on this issue.

Whether the respondent appeared conscious or not at the time of admission to the Kingston Public Hospital was not conclusive of the fact as to whether he had suffered a concussion and had

been unconscious for sometime immediately after the accident. The trial judge found that "the plaintiff was probably taken to Linstead Hospital at first and was then taken to the Kingston Public Hospital on 19th January, 1987." Did he then accept the respondent's evidence that he had no recollection of having been taken to Linstead Hospital? On this the trial judge was silent.

The trial judge held that "It is unlikely, when plaintiff states that after bus ran off the road he "not recall seeing anything else". If the respondent was truthful that he had no recollection of being taken to Linstead Hospital, why was it unlikely that after the bus left the road and having regard to the injuries the respondent received that the respondent had a temporary black-out?

It is unclear whether the trial judge was accepting or rejecting the respondent's evidence as to the illness suffered by him since April 1989 and the accompanying symptoms. In his findings the trial judge said:

> "Plaintiff suffered nosebleeds and trembling, first 'about 7 months ago' presumably since February 1989, admitted to Annotto Bay Hospital for 3 days; then Kingston Public Hospital for 3 weeks; 3 weeks after - University College Hospital for 3 days; two (2) weeks later taken to Spanish Town Hospital - Casualty - treatment with tablets. On 12. 6. 89 he in Kingston Public Hospital for 1 month nosebleed on each occasion and saline treatment. Plaintiff gave Dr. Hall history of epilepsy 'since April 1989' - no evidence to support. No such history arose from any treatment by any of the doctors in the several institutions. Court finds unlikely plaintiff had epilepsy; Defence witnesses Hunter and Watson in conflict as to 2 occasions of nosebleeds followed by hospitalization."

In this assessment of the evidence the trial judge made absolutely no mention of the evidence of Dr. Graham who treated the respondent at the Kingston Public Hospital in September of 1989 "for post traumatic epilepsy". He gave weight to the apparent discrepancy between what the respondent said in court as to the date of the onset of the epileptic fits, i.e. about February 1989 and what he told Dr. Hall i.e. that the attacks commenced about April 1989. At best this variation in the dates was de minimis. No weight, however, was attached by the trial judge to the evidence of Dr. Hall who said he formed his opinion on three bases (a) the history given by the respondent, (b) his observation of signs of physical injury to the respondent, (c) his assessment of the respondent's behaviour during the interview. We are therefore of the view that the learned trial judge did not give weight to credible, unchallenged evidence, which on probability proved that the respondent suffered from post traumatic epilepsy. His finding that it is unlikely that the respondent had epilepsy cannot stand.

We now turn to consider what quantum of damages should be awarded to the respondent for being subject to epilepsy. In **Jones v. Griffith** [1969] 1 W.L.R. 795, Widgery, L.J. suggested that damages for some types of epilepsy might be twice the conventional sum for the loss of a limb and as much as four times the conventional sum for the loss of an eye. Carey, P (Ag.) expressed the view in **Black v. Bhalai** S.C.C.A. 50/90, decided on July 15, 1991, that if there was an absolute certainty of the recurrence of an epileptic attack in that case, then an award in the proportion of one million dollars would be the ceiling amount. We think that Carey, P (Ag.) who was applying the principles in **Jones v. Griffith** (supra) would not demur, if we were to express a

preference for the proportioned relationship between the conventional sums awarded for loss of body parts as adumbrated by Widgery, L.J.

In this case there was no medical evidence to establish the nature of the epilepsy that is to say whether of the grand mal or petit mal type. Of the nature of epilepsy Sachs, L.J. in **Jones v. Griffith** supra, said:

> "Epileptic attacks are normally divided broadly into two **categories.** There are those which involve major convulsions of a highly unpleasant type and in those cases the person concerned is said to be suffering from grand mal. The other category consists of attacks of lesser degree, the person concerned being often said to be suffering from the petit mal type of epilepsy."

As everything depends upon the type of epilepsy from which a person is suffering, other decided cases involving epilepsy can have but marginal influence upon our decision as to quantum. In this case there was no satisfactory evidence as to the frequency of the attacks nor as to the likelihood of recurrence. Dr. Hall painted a picture of probable deterioration in the mental and physical state of the respondent if he developed parkinson's or alzheimer's diseases but the possible onset of one or other of these diseases due to epilepsy is in the language of Harman, L.J. "pure guess work".

Doing the best we could do with the evidential material before us and bearing in mind that damages should be awarded for the total injury suffered rather than on an itemized basis, we concluded that the award for general damages for pain and suffering including the onset of post traumatic epilepsy and loss of amentities should be increased to $400,000.

In the result we dismissed the appeal and allowed the cross-appeal. We set aside the judgment of the court below in part by varying the award of General Damages by the substitution of the sum of $410,000 for the sum of $307,520 with interest on $400,000 at 3% from 4th April 1987 to the date of trial with costs to the respondent to be agreed or taxed. In other respects the judgment of the court below was affirmed. These then are the reasons for judgment which we had promised to reduce into writing.

FORTE, J.A.

I agree.

GORDON, J.A.