[2015] JMSC Civ 200

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

CLAIM NO. 2013 HCV 05544

BETWEEN DELORIS BRISCOE CLAIMANT

AND JAMAICA URBAN TRANSIT COMPANY LIMITED 1ST DEFENDANT

AND OMAR MITCHELL 2ND DEFENDANT

Ms. Kimberley Facey instructed by Bignall Law for the Claimant.

Ms. Georgia Hamilton instructed by Georgia Hamilton & Company for the first Defendant.

Heard: 17th July, 4th and 9th September, 2015

Damages – Assessment – Credibility - Proof of Special Damages

CRESENCIA BROWN BECKFORD, J

Introduction

[1] On the 18th day of October 2012 the Claimant Deloris Briscoe was a passenger in a Toyota motor car travelling along Trafalgar Road in parish of St. Andrew. This motor car was involved in a collision with a Jonckheere Motor

Truck owned by the 1st Defendant Jamaica Urban Transit Company Limited and driven by the 2nd Defendant Omar Mitchell.

[2] The Claimant contends that she suffered injury, loss and damages and incurred expense as a result.

[3] Liability has been admitted by the 1st Defendant and as a result, Judgment on Admission was entered for the Claimant against the 1st Defendant on the 28th November 2013 with damages to be assessed and costs to be taxed.

[4] Though admitting liability, the 1st Defendant has vigorously contested the nature and extent of the Claimant's injuries.

The Claimant's Case

[5] I find the evidence presented by the Claimant to be incongruous if not inconsistent, and in that regard there is much force to the submission of counsel on behalf of the 1st Defendant that the Claimant is not credible. I will examine the evidence, not exhaustively, but sufficient to indicate the basis of my findings.

[6] The Claimant's evidence is that following the accident she was taken by the police to Apex Medical Centre where she were seen and treated by Dr. Karen Rajpat. She had been experiencing pain to her neck, back and legs. Dr. Rajpat subsequently prepared a medical report which was admitted into evidence on the Claimant's case.

[7] Dr. Rajpat indicated that the Claimant complained of neck pain radiating to her right arm and hand, with numbness, parasthesiae and weakness in the right upper limb, as well as headaches. Her observation and examination of the Claimant revealed an emotionally distraught woman in significant distress holding her neck stiffly. She found notably moderate limitation of flexion, extension and

lateral rotation of her neck, with some weakness in the right upper limb. Xray of the spine did not reveal any acute bony or disc injury.

[8] She assessed her as having moderate whiplash of her neck and she was prescribed oral and topical analgesics as well as a soft collar for two weeks.

[9] Knee pain was therefore first indicated in her consultation with Dr. Andrew G. Ameerally on the 17th May 2014. On that occasion the Claimant gave a history of left knee pain, though she had no pain on the occasion of her visit to Dr. Ameerally. Dr. Ameerally's report is also exhibited on the Claimant's case.

[10] This knee pain is of significance. In her further history to Dr. Ameerally – the Claimant in cross examination said his report accurately reflected what she said to him – Dr. Ameerally reported that the Claimant developed left knee pain and later uncontrollable pain and was unable to walk, causing her to be admitted to hospital for pain management and subsequently placed on sick leave for six (6) weeks.

[11] Amazingly, nothing of this event and its associated trauma and costs made its way into the Claimant's witness statement which stood as her evidence in chief. It could be that this injury had resolved itself, leaving the claimant suffering only from the back pain mentioned in her witness statement, but I maintain such significant trauma would atleast relevant to her claim for pain and suffering.

[12] The Claimant's case is also remarkable for the absence of a medical report, receipt, or any form of documentation from this hospital where she was admitted.

[13] This, of course, was not the situation in Roy v Jolly **[**2012**]** JMCA Civ. 53 as posited by the Claimant's Attorneys. In Jolly's case, receipts from the doctor

who treated Mr. Roy were tendered into evidence and it was accepted by the learned Resident Magistrate that he had received the injury. It was in those circumstances that the failure to tender a medical report was not considered to be adverse to Mr. Roy's case.

[14] Continuing with Dr. Ameerally's report, the history provided by Ms. Briscoe to him continues to be incongruent with her evidence. The report was prepared the day he saw the Claimant, May 17, 2014. The report is indicated as a final report, that is there is no indication that follow up visits to him would be required.

[15] The Claimant's evidence is that she continued to make follow up visits to Dr. Ameerally. No further report from him has been presented but perhaps more importantly, not even one receipt evidencing such a visit has been presented.

[16] There is no indication either from Dr. Rajpat or the Claimant that she was started on physiotherapy at Apex Medical Centre as reported in Dr. Ameerally's report. I will say more on the question of physiotherapy later. There is further incongruence in the Claimant's evidence for the absence of any explanation for information contained in the various receipts admitted into evidence in support of the Claimant claim for special damages. The receipts indicate visits to:

(1) Dr. Jerome Stern, Andrews Memorial Hospital on January 4, 2013. There is no evidence he was seen in relation to the injuries she received on the 18th October, 2012.

(2) Dr. Mark Minott, Manuchant Medical Centre on January 23, 2013. Again there is no evidence Dr. Minott was seen in relation to injuries sustained on 18th October, 2012.

[17] There is also a receipt for Spine Xray done on September 9, 2014, subsequent to the visit to Dr. Ameerally, the last doctor indicated that the Claimant saw in respect of this claim. There is no evidence as to why such an expense was incurred.

[18] It is worth nothing that at paragraph eight (8) of her witness statement, the Claimant states "…. despite physiotherapy and medical treatment administered by Dr. Rajpat and Dr. Ameerally…." adverting to no other medical treatment.

[19] The Claimant despite the extent of the pain and suffering chronicled in her evidence sought no further medical treatment after initial treatment by Dr. Rajpat. Her visit to Dr. Ameerally was occasioned by the need to be evaluated for the purpose of writing the medical report. There is not even the indication of the use of non- prescription medication for pain management.

[20] The Claimant's evidence is that she attended some seventeen (17) sessions of physiotherapy. There is no indication of the period of these sessions save the six (6) receipts presented over the period Janaury 15, 2013 to February 11, 2013. In light of the Claimant's visits to other doctors, the Claimant would have failed to prove on a balance of probabilities that these physiotherapy sessions relate to the injury sustained on the 18th October, 2012. Physiotherapy not having been recommended by Dr. Rajpat, it was incumbent on the Claimant to say why and how she came to do these sessions.

[21] It is clear that Dr. Ameerally's report is based on a reported history and not on an objective assessment. No further tests were carved out. His objective physical examination indicated normality in all areas observed. However, this too is inconsistent with the Claimant's complaints made in her witness statement dated 29th December 2014.

Conclusion

[22] In the circumstance of such dissonance in the Claimant's evidence I am constrained to the view that the more accurate reflection of the Claimant's injuries is contained in the medical report of Dr. Rajpat.

[23] There is no reliable evidence of any period of incapacity or any disability.

[24] After a full review of the authorities presented, house presented on behalf of the 1st Defendant would be more useful as a guide to the appropriate award in the instant case.

[25] In that regard the injuries of **Ms. Pamella Thompson in the case of Pamella Thompson et al v. Devon Barrows** et al (Unreported) C.L 2001/T143 (Cor. Campbell J.) most closely resemble the instant claimant. Ms. Thompson was diagnosed with mild whiplash injury to the neck and had pain to the neck, lower back and shoulder with incapacity for four (4) weeks. The award of two hundred and fifty thousand dollars ($250,000) special damages has a present day value of five hundred and sixty three thousand two hundred and fifty dollars ($563,250.00).

[26] As the Claimant here suffered moderate whiplash injury which I consider more serious, this award will be increased. I find that a reasonable award for pain and suffering and loss of amenities is seven hundred thousand dollars ($700,000.00).

[27] In so far as special damages are concerned, I would allow as proved by receipts tendered into evidence the following;

(1) Doctor's visit $2600.00.
(2) Medical Report $50,000.00.
(3) X-ray $3500.00.
(4) Prescription on the 18th December, 2015 - $2311.69.

[28] The rest of the claim for special damages is disallowed for the failure by the Claimant to create a nexus between those receipts, detailed earlier, and he injury sustained on the 18th October, 2012. Special damages must be strictly

proved, not only in respect of the expense incurred, but that such expense was occasioned by the negligence of the defendant.

[29] Special damages is therefore awarded in the amount of $57,411.69.

Order

Damages are therefore assessed as follows:

Special Damages

$57,411.69 with interest thereon at 3 % from the 18th October, 2012, to the 9th September, 2015.

General Damages

Pain and suffering and Loss of Amenities $700,000.00 with interest thereon from the 14th October, 2013 to 9th September, 2015.

Cost

After hearing submissions as to costs, it is ordered costs to be agreed or taxed.