BARBADOS

IN THE SUPREME COURT OF JUDICATURE

HIGH COURT

Civil Division

[Unreported]
Suit No: 2090 of 2005

BETWEEN

MARITA LOMPA	**-**	**PLAINTIFF**
AND		
JEVAN JUTAGIR	**-**	**DEFENDANT**

Before The Honourable Madam Justice Maureen Crane-Scott,Q.C.
Judge of the High Court

2009: January 28 & 29; February 3, 5, 23; March 10
2010: May 19

Ms. Sharon Edgecombe-Miller for the Plaintiff
Mr. Larry Smith in association with Mr. Derek Daniel for the Defendant

DECISION

[1] **Crane-Scott J:** On October 26th, 2005 Marita Lompa ('the Plaintiff') instituted proceedings against the Defendant for the recovery of damages in negligence for personal injuries and consequential loss arising from a motor vehicle collision which took place on 9th June 2001. The collision involved a taxi (Z-1284) in which the Plaintiff was a passenger and another vehicle (M-1462) owned and operated by the Defendant.

[2] On November 27th 2006 the Plaintiff obtained a Default Judgment against the Defendant pursuant to *Order 13* of the *Rules of the Supreme Court, 1982* on the ground that no Notice of intention to defend had been filed. The Defendant was also ordered to pay the Plaintiff's damages to be assessed together with costs.

[3] The Defendant's liability for the accident is therefore not in issue and the sole issue for the Court's determination relates to the quantum of damages to be paid to the Plaintiff.

The Evidence for the Plaintiff:

[4] The Court heard the oral testimony of three (3) witnesses who were presented in support of the Plaintiff's case. These were the Plaintiff and two (2) medical practitioners, Dr. John Gill and Mr. Winston Seale. Numerous medical reports, receipts and other documents were also put into evidence without objection.

[5] *Testimony of Marita Lompa:* The Plaintiff was duly sworn and stated that on the evening of 8 June 2001 she and a girlfriend had gone to the Ship Inn for a night out. At about 4:30 am in the early morning hours of June 9, 2001 whilst they were returning home, the taxi in which

they were traveling made a stop to allow them to disembark. They had only been parked for approximately 5 seconds when the Plaintiff heard what sounded to her like a loud explosion. She had been sitting at the back seat of the car and had been wearing her seat belt.

[6] The Plaintiff stated that at the time, she was unaware that the sound had come from the taxi in which she was a passenger. She testified that she saw people moving around the automobile in which she was sitting but she could not hear anything. It was only when she heard the siren of an ambulance that she realized that something was wrong.

[7] The ambulance took the Plaintiff to the Queen Elizabeth Hospital ("the Q.E.H"). On arrival at the Q.E.H. the Plaintiff was strapped to a stretcher and placed in a room. While there she was seen by a nurse but was left by herself for a long time before she was seen by a doctor. She was eventually seen by a female doctor whose name she could not remember. The doctor told her that X-rays would be taken and she was taken to the X-ray room where she was again left to wait. After a while, the Plaintiff grew impatient and decided to leave the QEH. She asked a nurse to contact a taxi driver who arrived at the Q.E.H. and took the Plaintiff to the Diagnostic Clinic on Bay Street at her request.

[8] Whilst at the Diagnostic Clinic the Plaintiff was seen by Dr. Irvine at 7:30 am on June 9th, 2001. She complained of soreness at the back of her neck and pain from her neck right down to her lower back. Pain killers were prescribed. Dr. Irvine also ordered X-rays and these were taken at 9:30 am that same day. The Plaintiff testified that she was seen by Dr. Irvine on one other occasion approximately 2 months after the accident and on this occasion an MRI was performed.

[9] After the Plaintiff was seen by Dr. Irvine she was next seen by Dr. Hadley Clarke. She visited him on two occasions during the week following the accident. Dr. Clarke diagnosed her with having a whip lash injury and prescribed painkillers.

[10] The Plaintiff testified that Dr. Clarke told her that he did not see any reason for her to continue to visit him because he was a surgeon specialist. Consequently, Dr. Clarke referred her to Dr. Hugh Roberts who she saw once a week for one year. At this time the Plaintiff continued to complain for pain in her neck and pain going down the spine and her left arm. She was given pain killers and Cataflam but, according to her, this treatment gave her little relief.

[11] Around July or August of 2002 the Plaintiff said she returned to Germany where she received similar treatment to that she had received in Barbados. According to her, whilst in Germany, she was given medication and also received counseling from a psychiatrist.

[12] The Plaintiff returned to Barbados in April 2003 and continued treatment at the Q.E.H. She was seen by a Trinidadian doctor who referred her to Dr. Winston Seale at the Q.E.H. The Plaintiff said she explained to Dr. Seale that on some days her pain was mild while on other days it was excruciating. In addition, she experienced weakness in her entire left side and on her return from Germany she started feeling pain and discomfort which made it difficult to stand or sit for long periods. She stated that Dr. Seale performed hand and leg raise tests on her and had prescribed painkillers and therapy.

[13] Dr. Seale then referred the Plaintiff to Dr. John Gill. According to her, she was still experiencing excruciating pain. The Plaintiff said she explained to Dr. Gill that she was experiencing insomnia and that her

left arm had gotten very weak over the years, so much so that she was unable to hold anything heavy in her hand. Injections were prescribed for her left arm.

[14] Dr. Seale also referred the Plaintiff to Dr. Cyraline Bryce, a psychiatrist. She received counseling from her for her depression. The Plaintiff explained to the Court that because of the medication and the pain she cried a lot and snapped at her daughter. This caused her to send her daughter to her dad for school in Germany, but her absence had made her lonely.

[15] In addition, the Plaintiff underwent 6 sessions of physiotherapy at the Q.E.H. with a Ms. Alleyne. She also saw Dr. Robert Jones for pain management.

[16] The Plaintiff also testified in her examination-in-chief that even after undergoing physiotherapy, the pain she experienced was excruciating if she tried to do chores in the house. For example, if she tried to reach up to a cabinet, she would feel a pain down her spine. Sometimes the pain was very sharp like lightning or like a knife going down her spine scraping away the flesh. When she bent over it would hurt from her neck right down her spine. She loved to wear high-heeled shoes and can no longer do so now without pain. Her sex life has been affected and she can no longer drive and cannot turn her neck.

[17] The Plaintiff testified about the effect of the accident on her ability to work. She stated that at the time of the accident she was in real estate management and was also a tour representative with Johnson Stables.

[18] Describing her employment in real estate management, she stated that she rented-out properties for clients and would also maintain the properties by arranging for the gardening and ensuring that the maids

were employed. She stated that due to the accident, she was no longer involved in property management. She can no longer drive and furthermore, property management involves working long hours and takes a lot of energy.

[19] She explained that she never had many local clients and that the owners of the properties she managed lived overseas. She would be advised when overseas visitors would be arriving in Barbados and was responsible for picking them up at the airport. She also had to arrange entertainment for them as well and would take the visitors to dinners and show them places of interest around Barbados. She would also organize vehicles for them and provide services of that sort.

[20] Her job as a property manager made her feel very good and she loved to work. After the accident she attempted to resume work but was unable to do so.

[21] The Plaintiff testified that following the accident, sometime around April, 2007 she also did some work for Johnson Stables as a tour representative. She did two (2) 4-hour tours around the island with Johnson Stables, but found that she could not continue since the work entailed a lot of sitting and getting in and out of the bus which irritated her spine. The steps of the bus were also quite high off the ground and she found that this also caused irritation. Additionally, she was unable to stand in the bus whilst the bus was moving.

[22] The Plaintiff explained that prior to the accident she had worked with Johnson Stables as a Tour Representative on a part-time basis. She indicated that she speaks German and did winter tours. She only worked when there were German tourists. She earned $30.00 an hour plus tips. She would usually work 4 hours and would be required to do

one or two tours per day. She did not work every day and sometimes would do 1 tour or 2 tours per week for Johnson Stables. This was over the 5 month winter season (November through April).

[23] The Plaintiff explained that her job with Johnson Stables did not affect her other work as a property manager. She testified that she stopped working with Johnson Stables on May 13, 2005 on the advice of Mr. Winston Seale who had given her an invalidity form. A letter dated April 10, 2008 typed on a 'Facilitators Unlimited' letterhead purporting to be signed by Wayne Parravicino in his capacity as a director of Johnson Stables & Garage Ltd and confirming the fact of her employment with Johnson Stables and stating her average earnings during the winter season, was put into evidence **(Exhibit "ML 1")** without objection.

[24] Turning to her real estate management business, the Plaintiff testified that she had worked for a Mr. Wolfgang Boehring and for a Canadian surgeon whose name she could not recall. She said she had one or two letters from the Canadian doctor confirming their arrangement. After she was shown a letter dated July 12, 2005, she stated that the surgeon's name was Mr. Michael Akpata. The letter was put into evidence as **(Exhibit "ML 2")** without objection. After refreshing her memory, she testified that she had found a client who had rented Mr. Akpata's a duplex at Heywoods Heights, Speightstown for a few months for which she had received $3,000.00.

[25] The Plaintiff stated that she had no other clients in her real estate business. She explained that Mr. Akpata owned 2 townhouses at Heywoods and a property opposite Mullins Beach. She took care of the rental of Mr. Akpata's 2 townhouses and the property at Mullins.

She was also required to make arrangements with the maid and the gardener as necessary. The Plaintiff did one rental for Mr. Akpata before the accident, but was unable to work after the accident.

[26] The Plaintiff testified that she visited Mr. Seale for 5 years between 2003 and 2008. She also underwent physiotherapy in 2004 or 2005 with Robert Jones initially at the Q.E.H. and later had pain management therapy sessions privately at his home.

[27] The Plaintiff gave evidence that she had visited Mr. Seale over a 5 year period between 2003 and 2008 both at the Q.E.H. and at his private practice. During this period, Dr. Seale referred her to Dr. Bryce, a psychiatrist who she has seen on two occasions. Mr. Seale also referred her to Dr. John Gill. She was still being seen by Dr. Gill but could not recall the date of her first visit to him. She however said that on her first visit, she had given him a letter of referral from Mr. Seale.

[28] She has seen Dr. Gill on several occasions and whenever she has an urgent problem she has him paged. Her last visit with Dr. Gill was in November 2008 when she had another painful episode in which her entire left side was paining.

[29] Describing her current condition, the Plaintiff testified that she experiences different sensations. Sometimes it is like lightening and sometimes there is numbness in her left leg. She does not experience pain everyday but it occurs quite frequently. It could occur once or twice a month. It could sometimes be at a level where she could ignore it. At these times, the pain would still be present but would be not be so acute as to cause her to cry or to have to take the pain medication prescribed by Dr. Gill or Dr. Bryce.

[30] According to the Plaintiff, her pain is affecting her mentally and physically. Physically it manifests along her entire left side which gives her a lot of problems along with her lower spine. The pain, she says, has affected her life because she has spent most of her savings on medical treatment. She has been trying to improve her condition in order to function as she has been used to.

[31] The Plaintiff also testified that she had not worked for the past 7 ½ years because she is not able to do so and no longer has an income. This fact makes her sad and depressed which in turn brings on pain which is even more excruciating.

[32] She is currently living with her daughter who has to cook and clean. Prior to the accident, she performed all the household duties.

[33] Describing her pre-accident condition and her current feelings, the Plaintiff stated:

"Prior to the accident, I was a very energetic, bubbly, happy social butterfly. I was in excellent, perfect health. I have no medical history apart from this incident. It makes me unhappy that someone has caused me pain. If I socialize now, it is a sit-down event. I like to dance and cannot do so now…."

[34] Turning to the necessity to hire household help, the Plaintiff testified that after the accident, she was forced to hire household help to perform all the chores she usually performed, namely, cleaning, ironing, laundry and grocery shopping. She hired household help between 2001 and July 2002 when she returned to Germany. The helpers came 2 or 3 times a week depending on how well she felt. She produced a bundle of receipts for expenditure on household help. The receipts were admitted in to evidence as **("Exhibit "M.L 3").**

[35] Next the Plaintiff indicated that she was claiming reimbursement for the cost of her taxi fares to and from the several doctors whom she had attended. She said she had paid cash to each of the taxis and had been issued with receipts. An agreed bundle of taxi receipts for the period 2001 and 2003 was entered in evidence as **("Exhibit "M.L 6").**

[36] Another bundle of taxi receipts for taxi services claimed after 2003 was also entered in evidence without objection and marked **("Exhibit "M.L 7").**

[37] The following documents were also identified and placed in evidence by agreement with Counsel for the Defendant, Mr. Smith:

i. letter dated 13.10/2005 from Robert A. Jones, PhD (Doctor of Alternative Medicine) confirming the existence of outstanding charges of $9,000.00 due to him for acupuncture therapy sessions, duly marked **("Exhibit "M.L 8").**

ii. Medical report of Dr. David Corbin, Neurologist dated November 20, 2001, marked **("Exhibit "M.L 9").**

iii. Medical Report of Mr. Hugh Roberts dated September 6th, 2001, marked **("Exhibit "M.L 10)."**

iv. Medical Report of Dr. M.D. Hoyos dated June 14th, 2001, marked **("Exhibit "M.L 11)."**

v. Letter signed by Mr. Greg Knight, dated April 26, 2008 describing his work as a rolfer and giving an estimate of costs and proposed treatment for Mr. Lompa's chronic pain, marked **("Exhibit "M.L 12").**

vi. Letter signed by Dr. Michael O. Akpata dated December 23, 2007 clarifying the nature of his business relationship with the Plaintiff in connection with his Barbados properties, marked **(“Exhibit “M.L 13”).’**

vii. Therapy Report prepared by Dr. Robert A. Jones, dated April 16th, 2005 including details of outstanding fees due, marked **(“Exhibit “M.L 14”).**

viii. Invoice issued by Mr. Winston Seale dated January 15, 2009, marked **(“Exhibit “M.L 15).”**

ix. Invoice of Dr. John Gill dated November 1, 2007, marked **(“Exhibit “M.L 16).”**

x. Invoice of Dr. John Gill dated January 30, 2009 in connection with Court attendance on January 29, 2009, marked **(“Exhibit “M.L 17).”**

xi. Invoice of Mr. Winston A. Seale dated January 30, 2009 in connection with Court attendance on February 3, 2009, marked **(“Exhibit “M.L 18).”**

xii. Medical Report of Mr. Winston Seale dated April 11th , 2005, marked **(“Exhibit “M.L 19).”**

xiii. Medical Report of Mr. Winston Seale dated July 12th, 2005, marked **(“Exhibit “M.L 20).”**

xiv. Medical Report of Mr. Winston Seale dated September 17th, 2006, marked **(“Exhibit “M.L 21).”**

xv. Bundle of Medical Invoices and receipts issued by Dr. David Corbin, Dr. Bryce, Mr. Hugh Roberts and MRI and physiotherapy receipts totaling $5,030.00, marked **(Exhibit “M.L 22”).**

xvi. Cash receipts totaling $187.61 evidencing payment by Marita Lompa for prescription medication, marked **(Exhibit "M.L 23")**

xvii. Note signed by Mr. Hugh Roberts setting out details of the Plaintiff's medical visits during 2001, marked **("Exhibit "M.L 24)**.

xviii. Medical Report of Dr. Sean Marquez, dated October 17, 2001, marked **("Exhibit "J.J. 1)."**

xix. Medical Report of Dr. Sean Marquez, dated January 16, 2002, marked **("Exhibit "J.J. 2)."**

xx. Summary Report of EMG/NCV Study conducted by Dr. Sean Marquez, dated January 8th, 2002, marked **("Exhibit "J.J. 3)."**

[38] The Plaintiff was cross-examined by Counsel for the Defendant Mr. Larry Smith. She confirmed that she was now 60 years old and that she would be 61 in May 2009. She confirmed that while she is able to enjoy dancing, she was not able to enjoy dancing as she used to do.

[39] She testified that she had travelled to Germany in the year 2002 and that she had made the lengthy journey without difficulty. She explained that she travels with a doctor's letter whenever she flies, and she always has wheelchair service and is given enough room on the flight to stretch out.

[40] She denied Mr. Smith's suggestion that she had not received medical attention whilst in Germany, but agreed that she had not provided the Court with any medical reports or with any information about having seen a psychiatrist whilst she was in Germany.

[41] The Plaintiff disagreed with Mr. Smith's suggestion that she had in reality only found 2 clients to rent Mr. Akpata's apartments and insisted that she had in fact found several clients for him. The Plaintiff was then shown **Exhibit "M.L.13"** in which Mr. Akpata had written to her attorney-at-law and advised that according to his recollection, the Plaintiff had recruited 2 rental clients for his properties and had been paid her commission in relation to those 2 introductions. She refused to accept that that was the position and insisted that she had introduced more clients to Mr. Akpata.

[42] Questioned about her claim to have operated a real estate business which had been negatively impacted by the accident, the Plaintiff explained that she had operated a website www.gemsheartsdesire.com out of Germany as well as from Barbados. She testified that prospective visitors to Barbados would contact her to find vacation accommodation for them. She would send them a photograph of the vacation property and if they liked it she would make arrangements to secure it for them for the period requested. She agreed that the business was operated sitting at a computer, but disagreed with Mr. Smith's suggestion that the job couldn't take more than 5 minutes to perform at the computer, adding that there was more to the business than that.

[43] Questioned about her former employment as a tour representative, the Plaintiff agreed that it was part-time. She denied that her employment with Johnson Stables was sporadic, but said that she worked during the winter seasons but could not recall how many times she had worked with them.

[44] Having been shown Exhibit **"M.L 1"**, the Plaintiff accepted that she had in fact only worked with Johnson Stables for 2 winter seasons between November 1999 until April 2001. She also conceded that during this period she did not work every day and in fact, only worked when German cruise ships came into port. She could not recall how often the German ships came into port, but said that it varied and that the ships mostly came in once a week.

[45] The Plaintiff testified that she had tried going back into the tour representative business after the accident, but that she had not worked with Johnson Stables again.

[46] Asked whether she had seen a doctor prior to the accident, the Plaintiff stated that she did not have a physician prior to the accident, but had medicals once a year in Germany. She agreed that her view that she was in excellent health prior to the accident was based on her belief.

[47] In answer to a specific question put to her by Mr. Smith, the Plaintiff denied being a cigarette smoker. She, however, conceded that she used to be a smoker and had stopped smoking for 10 years, but had started back smoking in May of 2008. She denied having told Dr. Marquez that she had started back smoking since the accident and agreed that if Dr. Marquez had stated this in his report, it would not be true.

[48] She could not recall having been given an injection while she was at the Queen Elizabeth Hospital on the day of the accident. Nor did she recall having been placed on a gurney. She however, said she had been strapped on a stretcher. She agreed that she had felt that she was being ignored. She denied the suggestion that she had walked from the

QEH over to the Bayview Hospital and insisted that she had been taken there by Velda, a taxi driver.

[49] She also denied a suggestion by Mr. Smith that she had told Dr. Marquez that she had been dissatisfied with the service she had received from Dr. Roberts.

[50] The Plaintiff also denied having done research on back injuries on the internet, but admitted that her daughter had done such research. She also denied having obtained information on back injuries from any source other than from a doctor. She also denied ever having told Dr. Marquez that she had been obtaining information from the internet and that she understood that there were treatments for her condition such as epidural steroid and surgery but that these were last resorts.

[51] The Plaintiff further denied that she had seen Dr. Marquez more than once or that she had ever had any conversation with him at all. She also denied that Dr. Marquez had informed her that she had suffered a whiplash associated disorder from which she was likely to recover within 6 weeks. She further denied that Dr. Marquez had ever told her that her that the only factors which would prevent her from making a full recovery were psycho-social or that her best chance of recovery was to undergo an exercise program and to keep as active as possible.

[52] Asked what Dr. Marquez had told her during the course of her visit with him, the Plaintiff said that she thought that he had an attitude because she had initially resisted his use of needles during a test he was about to perform on her. She explained that the misunderstanding had been resolved after he had explained the procedure to her daughter after which she had permitted him to perform the test. She however denied that Dr. Marquez had ever examined her.

[53] The Plaintiff denied Mr. Smith's suggestion that she was exaggerating the level of her pain. She also denied being angry about what had happened to her and suggested that it would be more accurate to say that she was disappointed. She however agreed that, after the way she had been treated, she wanted to have her day in Court.

[54] In her re-examination, the Plaintiff explained that she wanted her day in Court because she had tried on several occasions to explain to the Defendant's insurance company that she needed to have her medical expenses taken care of, but that they had refused to make any payments on account of these expenses.

[55] *Testimony of Dr. John Gill:* The necessary foundation having been laid, Dr. John Gill was tendered and accepted without objection as an expert witness in the field of surgical neurology.

[56] He testified that he had first examined the Plaintiff on 5 October 2006 (approximately 5 years 4 months post-accident) after she was referred to him by Dr. Winston Seale. The Plaintiff had presented with severe neck pain, pain in lower back and pain in left arm.

[57] After refreshing his memory from his notes, Dr. Gill stated that he had performed a clinical examination consisting of an evaluation of the Plaintiff's muscular skeletal system and an evaluation of her central and peripheral system. Having examined these systems, Dr. Gill said he had elicited findings and drawn conclusions.

[58] He testified that the Plaintiff was a middle aged woman of small stature who was slimly built. The Plaintiff's range of movement in her neck was restricted in all directions and there was moderately severe tenderness in the junction of the occiput (back of head) and the dorsal cervical spine(back of neck).

[59] Dr. Gill stated that he had subsequently prepared a medical report and was shown Exhibit **"M.L.4"** which he identified as the report which he had prepared.

[60] Dr. Gill stated that he had requested MR images of the Plaintiff's cervical spine which showed evidence of degenerative disease of the intervertebral disc and lateral zygophophyseal joints of the spine. There was no evidence of neurological compression in either study. Subsequent MR images were also undertaken of the Plaintiff's brain and showed no pathological changes.

[61] Dr. Gill informed the Court that he had assessed the Plaintiff to be suffering from what he termed, post-traumatic fibromyagic pain of the spine and of the extremities. He explained that typically the usual age of onset of degenerative disease of the spine occurs in the late 50's and early 60's. The disease, he said, can exist in an asymptomatic manner and it is a clinical fact that marked spinal degenerative pathology can be discovered in images of individuals who have no complaint.

[62] According to Dr. Gill, degenerative disease usually becomes symptomatic between the 6th and 8th decades of life depending on a combination of factors, including genetics, body habitus or environmental loads.

[63] Dr. Gill testified that based on his findings the Plaintiff had pre-existing degenerative disease of the spine which, based on what she had told him, was asymptomatic prior to her injury. However, in the absence of any information as to factors such as the Plaintiff's genetics or as to what environmental loads her spine might have

previously been subjected to, it was difficult to speculate as to when she might ordinarily have exhibited symptoms.

[64] Dr. Gill explained that trauma can also hasten and precipitate the onset of symptoms in a person with degenerative disease who was previously asymptomatic. For example, he said, such a person might develop pain of the extremities, stiffness of the joints or parastesia (disturbance of sensation in the extremities).

[65] Dr. Gill stated that he was not currently treating the Plaintiff and had last seen her on November 20th, 2008. He confirmed that he had treated her for her condition with combination of analgesic and anti-spasmodic medications. He had also advised her that she faced a future influenced by chronic pain the severity of which would fluctuate. Furthermore, it was his view that any intense physical activity would almost certainly exacerbate the spinal and extremity pain.

[66] He stated that he had informed the Plaintiff that with a view to mitigating the effect of her chronic pain, she should give consideration to consultation with and treatment by a specialist pain physician (a doctor who specializes in pain management procedures). In response to her request for rehabilitative therapy, he stated that he had also referred her to, Dr. Greg Knight, a rolfer (pain management specialist.)

[67] The following documents were duly identified by Dr. Gill and put into evidence without objection:

i. Medical Report of Mr. John Gill dated November 1st, 2007, marked **(“Exhibit “M.L 4).”**

ii. Referral letter to Dr. Greg Knight signed by Dr. Gill dated April 7th, 2008, marked **("Exhibit "M.L 5)."**

[68] Under cross-examination, Dr. Gill agreed that it was possible that a person with degenerative disc disease can experience pain every day. It was also possible that such a person would not experience pain every day.

[69] In answer to a hypothetical question put to him by Mr. Smith, Dr. Gill agreed that it was possible for 2 individuals both of whom had pre-existing degenerative disc disease but only one of whom had suffered a trauma to experience the same levels of pain. However, Dr. Gill also added that allowance would have to be made for the severity of the trauma suffered by the one individual.

[70] He expressed the view that the Plaintiff's pre-existing degenerative disc disease, prior to the trauma had been moderately severe. He confirmed that the degenerative disease was also called osteoarthritis (involving deformities of the joints and spine, laxity of the associated ligaments, and loss of water content from the intervertebral discs.) He stated that as a result of pathological changes, one would typically observe the growth of bony spurs, the loss of height and the loss of uniformity of the joint spaces.) He explained that it was this collection of pathological changes which are ascribed to the disease.

[71] Dr. Gill agreed that degenerative disease is normal in the life of a human being and explained that the severity of the disease would depend on the types of activities which a person undertakes in his or her normal living. He accepted that it was possible that a person who engaged in a lot of dancing would place a lot more load on the spine than a person who did not dance. He also agreed that the degenerative

changes would occur more rapidly in persons who smoked cigarettes. He also expressed the view that it was possible that the onset of the disease in a person who smoked would be outside the realm of the average person who would develop the disease in the normal course of his or her life.

[72] Dr. Gill confirmed that the Plaintiff had complained of lower back pain as well as neck pain. He accepted that one classification of lower back pain differentiated between mechanical back pain and compressive back pain but said that there were also other classifications. He agreed that mechanical back pain could occur where there was inflammation caused by injury to the disc or facet joint. He also agreed that disc degeneration was one of the commonest causes of mechanical back pain and that this type of back pain mostly affects the lower spine. He agreed that such pain may also be perceived in the buttocks and thighs but explained that the source of the pain originated in the spinal nerves of these areas.

[73] He confirmed that the static MR images which had been taken of the Plaintiff's spine had revealed no nerve root entrapment. He explained everything was as it should be, meaning that the nerves were seen to be free within the space normally occupied by the nerves.

[74] Asked whether having regard to the static MRI study of the nerves, he would have expected to find pain in the areas affected by those nerves, Dr. Gill expressed the view that human beings are dynamic and that pain was subjective. He explained that while modern technology had progressed to the use of dynamic MRI, the static MRI was all that was available to him in evaluating the Plaintiff's case.

[75] Questioned about whether he had tested the Plaintiff for "Waddell signs", Dr. Gill confirmed that he had not done so as recent medical literature had discredited some aspects of Dr. Gordon Waddell's work. He agreed that in the absence of the test having been performed, those who subscribed to Waddell's work would feel that a possibility of malingering may exist. He explained that degenerative disease had been observed in the Plaintiff's case together with the presence of bio-chemical substances (inflammation) juxtaposed to the nerves. He was satisfied that this could have been the cause of the Plaintiff's manifestation of pain.

[76] He accepted that he first saw the Plaintiff in October of 2006 in excess of 5 years after her alleged trauma and agreed that he could not speak to matters which had occurred before her visit. He also agreed that there was a possibility that the Plaintiff's treatment regime might not have been optimal and that if that were so her period of suffering would have been impacted.

[77] Dr. Gill confirmed that when he examined her more than 5 years after the alleged trauma, he had not found any pathology which one would ordinarily associate with a whiplash injury. He however agreed that when he first examined the Plaintiff, he had found pathology which one would ordinarily expect of a person who was suffering with degenerative disc disease and confirmed that the disease which he had diagnosed the Plaintiff to be suffering from was of a pre-existing nature.

[78] In response to Mr. Smith's suggestion that he ought to have tested the veracity of the Plaintiff's complaints by conducting "distraction testing", Dr. Gill stated that he did not believe that such tests were

reliable. Asked what steps he had taken to verify the Plaintiff's assertion that she was asymptomatic before the accident, Dr. Gill explained that he had taken the Plaintiff at her word that she had not experienced any symptoms of her pre-existing degenerative disc disease prior to the accident. He indicated that he had taken the Plaintiff at her word and could not speculate as to Mr. Smith's suggestion that there was a possibility that she might have been experiencing pain from her pre-existing degenerative disc disease.

[79] Dr. Gill agreed that, given the moderate severity of the Plaintiff's degenerative disc disease, it might have been helpful for him to have had sight of the Plaintiff's medical history. He further agreed that without the benefit of notes concerning her medical history, the Plaintiff's asymptomatic status *"lacked medical verification."*

[80] Re-examined by Counsel for the Plaintiff, Dr. Gill confirmed that he had taken the Plaintiff at her word, but added that a physician who does so, always does so at his or her peril.

[81] *Testimony of Dr. Winston Seale:* The final witness for the Plaintiff was Dr. Winston Seale. He was duly tendered and accepted without objection as an expert witness in the fields of orthopaedics and general surgery and gave additional evidence regarding the Plaintiff's medical condition.

[82] Dr. Seale identified three medical reports, Exhibits **("M.L. 19"), ("M.L 20")** and **("M.L 21")** dated 11 April 2005, 17 September 2006 and 12 July 2005 respectively, which he had prepared in respect of the Plaintiff.

[83] Referring to the first visit, Dr. Seale testified that he first saw the Plaintiff on 24 June 2003 at the Orthopaedic Clinic of the Queen Elizabeth Hospital (a little over 2 years following the accident).

[84] Dr. Seale stated that he first took a history of her complaints, including the doctors seen and the treatment she had received, after which he performed a clinical examination and made findings.

[85] Dr. Seale said that the Plaintiff had advised him that she had been involved in a car accident on June 8, 2001. She had also explained that she was sitting in the rear seat of a parked car, when another vehicle collided into the back of her car. She was wearing a seatbelt but recalled being thrown forward in her seat. She was taken to the hospital by ambulance and waited for a long time in the Accident and Emergency Department before being examined.

[86] The Plaintiff was then taken to the Bayview hospital where she was examined by Dr. Ann Irvine. X-rays were also taken and she was discharged with an appointment to be seen by Neurosurgeon, Mr. Hadley Clarke. He treated her and later referred her to Dr. Hugh Roberts. She continued under Dr. Robert's care for about one year and then was treated by Neurologist, Dr. David Corbin. She later returned to Germany where she lived prior to the accident and where she received treatment. She was also examined by Dr. Sean Marquez in 2002 and underwent EMG and nerve conduction studies.

[87] Dr. Gill was referred to page 4 of his medical report of April 11, 2005 **("M.L. 19")** where he had diagnosed the Plaintiff to be suffering from *"degenerative changes of the neck and back"* and had expressed the belief that *"the changes had preceded the accident but were probably quiescent(asymptomatic)"*. He confirmed that he still held this belief.

[88] Referring to the Plaintiff's X-rays, Dr. Seale stated that stated that the X-rays confirmed that she was suffering from spondylosis, arthritis which affects the spine. He explained that if the spondylosis of the cervical spine becomes more severe it can be associated with stiffness and pain. If the degenerative changes are there then spondylosis may give rise to pain with or without trauma.

[89] Asked how long it would ordinarily have taken for the Plaintiff to experience symptoms of her pre-existing degenerative disc disease had she not been involved in the accident, Dr. Seale stated that this would be difficult to predict and would depend on variables such as the Plaintiff's activities and her lifestyle. He testified that he could not give any indication as to when or whether the Plaintiff would have become symptomatic in the absence of the trauma and further stated that he could not say when or whether she would ever have suffered pain, minus the trauma.

[90] Dr. Seale was referred to his medical report of July 12, 2005 **("M.L. 20")** where he had made a final diagnosis of i) degenerative disease of the spine; and ii) Chronic Pain Syndrome following the accident of June 2001. He explained that a diagnosis of Chronic Pain Syndrome is used for persons with prolonged pain that does not respond to treatment. The nerve endings become changed and produce pain more often than usual. He explained that it is a vague diagnosis used to describe pain that it chronic and does not respond to treatment.

[91] Dr. Seale confirmed that his last official visit with the Plaintiff had been on October 17, 2007. He also explained that he had referred the Plaintiff to Dr. Gill in January 2004 and that after her second MRI on

August 27, 2007 he had again referred her to Dr. Gill to review the report and discuss the findings.

[92] Under cross-examination, Dr. Seale agreed that his diagnosis of Chronic Pain Syndrome had been made following his subjective view of the Plaintiff's condition. He stated that in his experience the diagnosis can be made where there is no anatomical basis for the pain, while in other cases, such a diagnosis may be made following, as in the Plaintiff's case, an acute injury to the neck and back.

[93] He agreed that nerve conduction studies can show whether or not the nerves are conducting electrical stimuli at a normal rate or whether there is some interference with the stimulus along the nerve. He agreed that a neurologist such as Dr. Corbin or Dr. Marquez would be in a better position to determine how the nerves are performing, but in his view, the nerve conduction study would not be helpful in cases of Chronic Pain Syndrome.

[94] Asked to explain the MRI findings of foraminal stenosis set out on page 3 of his April 11, 2005 **("M.L.19"),** Dr. Seale explained that foraminal stenosis results from degenerative changes which involve the narrowing (stenosis) of the aperture (foramen) in the vertebrae of the spinal column where nerves leave the spinal column and go into the various parts of the body.

[95] Using a copy of a diagram provided by Mr. Smith from the text ***"Medical Evidence in Whiplash Cases"*** by Andrew Richie, Dr. Seale explained the nerve distribution system and the correlation between various vertebrae along the spinal column and the nerve endings (dermatomes) in diverse parts of the body. He also described how narrowing of the foramen in the vertebrae of the spinal column due to

degenerative disease can cause pain to be felt in areas of the body serviced by nerves exiting the spinal column.

[96] Dr. Seale stated that based on the Plaintiff's history as related to him, the findings shown on the MRI would not have developed that quickly and that he had concluded that the Plaintiff's degenerative changes had developed prior to her accident.

[97] He agreed that he had seen the Plaintiff 2 years following the accident and that apart from what she had told him, he really had no medical report from any doctor as to how she was treated. Dr. Seale confirmed that her referral to him at the Queen Elizabeth Hospital had been from the Accident & Emergency Department and that he had no knowledge of the kind and quality of the medical treatment which the Plaintiff had received post accident. He declined to comment on whether the care which the Plaintiff had received post accident was adequate for the trauma which she had suffered.

[98] In answer to a specific question posed by Mr. Smith, Dr. Seale said that he was aware that there are some medical practitioners who can, in respect of a patient with pre-existing asymptomatic degenerative disease of the spine, give an estimate of an accelerated pain response of that patient following a trauma. However, he could not say how this is done.

[99] Dr. Seale stated that he was aware of the "Waddell signs", but had not performed the test as he had little experience with it. He agreed that such testing could be used to test the genuineness of a patient's complaints. He also agreed that where the "Waddell signs" are present, there is a possibility that the patient may be malingering, but he also stated that it was also possible that the patient could in fact be

feeling pain. However, he was aware from his own experience that patients do malinger.

[100] Dr. Seale was referred once again to his second report of July 12, 2005 **("M.L 20")** and to the diagnoses he had made of degenerative disease of the spine and Chronic Pain Syndrome. He confirmed that his finding of Degenerative disc disease had come from the MRI and that the only report of an accident in 2001 and of her treatment for the accident had come from what the Plaintiff had told him. He agreed that he could not speak to what her care had been following the accident and could not say whether she had treatment which would have aided her recovery.

[101] Asked why he had referred the Plaintiff to Dr. Bryce, Dr. Seale explained that sometimes people with Chronic Pain Syndrome have psychological problems as if one is experiencing pain every day, it would get you down. He expressed the opinion that psychological assessment and support can work wonders and sometimes not. In making the referral, he explained that he was merely reaching out to another modality to assist the patient. However, he confirmed that he had never received any findings from Dr. Bryce following the referral.

[102] Dr. Seale was referred to his final report of September 17, 2006 and asked to explain the reason for her painful responses during his examination of her left shoulder during her visit to him on August 28, 2006. Dr. Seale confirmed that he had found no objective pathology to explain her responses, but had only found that she was in pain. He admitted that he could not explain these episodes since any soft tissue injuries would long since have healed. He however, observed that the

presence of pain in the absence of nerve damage could not be explained other than by a diagnosis of Chronic Pain Syndrome.

[103] In his short re-examination, Dr. Seale confirmed that he did not feel that the Plaintiff was malingering.

[104] ***Assessment of Damages:*** The Court has approached the assessment of damages in this case by reference to the Statement of Claim and 9 heads of loss set out in the Plaintiff's written submissions prepared by her Counsel, Mrs. Sharon Edgecombe-Miller and delivered to the Court on February 23, 2009. The Claims have also been classified and are discussed under the appropriate sub-headings as hereinafter appear.

General Damages – (a) non-pecuniary losses:

[105] *(A) Pain, Suffering and (B) Loss of Amenities:* Counsel for the Plaintiff submitted that the evidence established that following the 2001 accident, the Plaintiff (who was never in pain and who had no eventful medical history prior to the accident) suffered injuries and pain as a result of the accident and still continues to suffer chronic pain which is worse on some days than on others. While she does not have painful episodes on a daily basis, the pain nevertheless occurs quite frequently.

[106] Counsel for the Plaintiff further submitted that the Plaintiff had suffered significant loss of amenities. She said that prior to the accident the Plaintiff would frequently go out with friends and enjoyed dancing.

[107] Mrs. Edgecombe-Miller urged the Court to take note of the medical reports of the several doctors who the Plaintiff had seen following the date of the accident in 2001. She mentioned in particular, i) the June

14, 2001 report **("M.L 11")** of Dr. Michael Hoyos who, she said, had seen the Plaintiff 2 weeks following the accident; ii) the September 6, 2001 report **("M.L 10")** of Dr. Hugh Roberts whom she had first seen 10 days post accident; iii) the November 20, 2001 report **("M.L 9")** of Dr. David Corbin to whom she was referred 5 months following the accident; and iv) the April 11, 2005 report **("M.L 19")** of Mr. Winston Seale who had seen the Plaintiff between June 2003 and January 2004 at the QEH Orthopaedic Clinic. He had also subsequently treated the Plaintiff as a private patient between July 2004 and September 2006.

[108] Mrs. Edgecombe-Miller drew attention to what she termed the "barrage" of pain medication which the Plaintiff had been prescribed which she said was indicative of the extent of her pain and suffering. She also drew attention to the fact that the Plaintiff had been referred for physiotherapy.

[109] Mrs. Edgecombe-Millar conceded that the evidence showed that the Plaintiff had been undergoing asymptomatic degenerative changes in her cervical and lumbar spine which pre-dated the accident. She accepted that the trauma which the Plaintiff had suffered in June 2001 had accelerated the onset of pain. However, she submitted that the evidence had not established the period of the acceleration.

[110] Referring to the medical reports of Doctors John Gill and Winston Seale, Mrs. Edgecombe-Miller submitted that both these doctors had found the Plaintiff to be suffering from chronic pain. In the case of Dr. Gill, Mrs. Edgecombe-Miller noted that in his report of November 1, 2007, **("M.L 4")** he had, in his clinical assessment, diagnosed the Plaintiff to be suffering from *"post traumatic fibromyalgic pain of the*

spine and of the extremities" and had further predicted that she *"is likely to be afflicted by chronic musculo-skeletal pain that is likely to be permanent."*

[111] She referred also to Dr. Seale's diagnosis of *"Chronic Pain Syndrome"* and referred the Court to the suggested range of awards for Chronic Pain Syndrome and Fibromyalgia set out in the ***Judicial Studies Board Guidelines for Chronic Pain.*** She also cited the English cases of ***Frank v. Cox 1967 Vol. 111 Solicitors' Journal @ p. 670*** and ***Lim Poh Choo v. Camden Health Authority [1980] A.C. 174*** and claimed an award under these heads in the sum of Bds$102,375.00.

[112] In his response under this head, Counsel for the Defendant, Mr. Smith submitted that the medical evidence of Doctors Gill, Seale and Marquez all supported the fact that the Plaintiff had been suffering from a pre-existing degenerative disc disease prior to the accident.

[113] Mr. Smith submitted that Dr. Gill had, in his evidence-in-chief, clearly stated that degenerative disease of the spine usually becomes symptomatic in the 6th to 8th decades of life. He pointed out that the Plaintiff was now 61 years and was (having regard to Dr, Gill's evidence-in-chief) at an age when she would in all probability have been suffering pain in any event.

[114] He contended that once Dr. Gill's evidence was accepted, the Court could properly find that the Plaintiff would have been suffering pain in any event and find that she would only be entitled to damages for the period of acceleration but not beyond the point in time when the disability would have been present in any event. He urged the Court to find that the Plaintiff's symptomology from her pre-existing

degenerative disc disease may have been accelerated by a period of 8 to 10 years.

[115] In support of this submission on acceleration, Mr. Smith referred to an extract from ***Munkman on Damages for Personal Injuries and Death, 11th Edition @ pp. 26-27*** under the sub-heading *"The acceleration of a pre-existing disability"* and an extract from the text, ***Medical Evidence in Whiplash Cases, edited by Andrew Ritchie @ pp. 215-216***.

[116] Mr. Smith also highlighted what he submitted were 'gaping holes' in the medical evidence which had been adduced in support of the Plaintiff's condition following the accident. He submitted that apart from the Plaintiff's evidence that she was in good health and experienced no pain prior to the accident, nothing was known of the Plaintiff's past medical history. Referring to Dr. Gill's evidence under cross-examination, that he had taken the Plaintiff her at her word that her degenerative spinal disease was asymptomatic prior to the accident, he submitted that this fact lacked medical verification.

[117] He pointed further to the absence of any medical evidence that the Plaintiff had received treatment in Germany during her visit there between August 2002 and April 2003. Nor was there any medical evidence to support her claim that she continued to suffer from the effects of the accident whilst she was there. He urged the Court, in the absence of medical evidence from Germany, to give little weight to the Plaintiff's claims that her condition persisted during the period she had been away in Germany.

[118] Mr. Smith also relied heavily on Dr. Marquez's medical reports of October 17, 2001 **("J.J. 1")** and January 16, 2002 **("J.J. 2")** based on

her visits to Dr. Marquez just over 3 months and 7 months respectively following the accident.

[119] Mr. Smith submitted that having regard to the acceleration of the Plaintiff's pre-existing condition, a fair award under this head should be in the range of Bds $35,000.00 to Bds$45,000.00. He however suggested that the award should be closer to the bottom end of the range. He cited in support, the cases of ***Downing v. A. & P. Appledore (Falmouth) Ltd -Kemp & Kemp, para E3-086; Brewster v. Thamesway Bus Co- Kemp & Kemp, para E2-032; Canning v. Roberts – Kemp & Kemp, para E3-068; Re Orford- Kemp & Kemp, para E3-036; and McKerchar v. Campbell- Kemp & Kemp, para E3-071.***

[120] Having reviewed the evidence together with the submissions of both Counsel and the authorities cited, the Court finds and accepts the following facts:

i. *Plaintiff's condition prior to the accident:* The Court accepts the Plaintiff's testimony that prior to the rear-end motor vehicle collision on June 9th, 2001 she was *"in excellent, perfect health"* and *"had no prior medical history"*;

ii. The Court finds, in addition, that the Plaintiff's view that she was in excellent health prior to the accident was based on her personal belief and the absence of any medical issues of which she was aware.

iii. The Court accepts that the Plaintiff had a routine medical once a year in Germany and that she had not been seeing a physician for any medical condition before the accident;

iv. The Court is also satisfied and holds that the Plaintiff's pre-existing degenerative spinal disease came to light only after the accident and following the results of X-rays and MRI studies taken after the accident;

v. In short, prior to the accident, the Plaintiff was unaware of the degenerative changes which were taking place in her spinal column and suffered no symptoms from the pre-existing condition;

vi. <u>*Soft tissue injuries post-accident:*</u> 5 days following the accident she was found to be in the acute stage of soft tissue injuries to her cervical and lumbar spines. X-rays of her cervical spine showed no fracture or dislocation, however severe multi-level spondylosis was revealed; *[per Dr. Michael Hoyos- ("M.L. 11")]*

vii. On her first visit to Dr. Hugh Roberts, 10 days following the accident, the Plaintiff was still complaining of pain in her neck and back. Her positive findings were confined to the musculoskeletal system and more specifically her neck and back;

viii. While Dr. Roberts' examination of her neck and back revealed no recent evidence of abrasions or overt deformities, the posterior inferior aspect of the Plaintiff's neck was very tender and all movements of her neck were markedly reduced due to the excruciating pain felt when attempting to do so. She also had pain radiating to both shoulders and intermittent pins and needles along with tingling;

ix. The Plaintiff was also found to be very tender in the region of L5 to S1. Movements of her back were also reduced because of pain experienced when moving in the active and passive modes; *[per Dr. Hugh Roberts- ("M.L. 10")]*

x. Four (4) months after the accident, following an independent clinical examination by Neurologist, Dr. Sean Marquez, the Plaintiff was diagnosed with neck, thoracic and low back pain following a motor vehicle accident;

xi. Dr. Marquez's opinion was that the most likely cause of her symptoms was a Whiplash-Associated Disorder, Grade II of the cervical, thoracic and lumbrosacral spines; *[per Dr. Marquez- ("J.J. 1")]*

xii. The Court accordingly accepts that all available medical evidence confirms that as a direct result of the accident, the Plaintiff suffered painful multiple soft tissue injuries to her neck and back;

xiii. Five (5) months following the accident the Plaintiff was still having tenderness of the para-spinal muscles in the lumbar, thoracic and cervical regions and the buttocks; *(per Dr. David Corbin- "M.L. 9")*

xiv. On November 19, 2001 (9 days after her initial visit to Dr. Corbin) the Plaintiff returned to Dr. Corbin's office and complained of a recurrence of pain in the low back after 2 days of activity at work; *("M.L. 9")*

xv. The Court is accordingly satisfied that during November 2001, approximately 5 months post-accident, the Plaintiff was still suffering pain and tenderness in the muscles of her

neck and back and was intolerant to moderate physical activity; *[per Dr. David Corbin- ("M.L. 9")]*

xvi. *Dr. Marquez's 2002 neurological examination and issues of malingering and "chronic illness syndrome":* The Court accepts that in January 2002 (7 months post-accident) the Plaintiff) underwent further investigations with Dr. Sean Marquez. *[per Dr. Marquez- ("J.J. 2")]*

xvii. The Court is satisfied also that both Marquez reports were issued by him at the request of the Barbados Fire & Commercial Insurance Company Ltd, in their role as the Defendant's insurers.*[per Dr. Marquez- ("J.J. 1") and("J.J. 2")]*

xviii. An EMG/Nerve Conduction Study was performed on 8th January, 2002, the results of which were normal;

xix. On January 4, 2002, MRI studies of the Plaintiff's cervical and thoracic spines were also undertaken and the results were evaluated by Dr. Marquez, together with copies of the MRI study of her lumbosacral spine performed on July 16, 2001;

xx. The MRI of her cervical spine revealed very mild spondylosis changes at C4-5 and C5-6 with mild neuroforaminal narrowing at C5-6. There was no evidence of any cervical spinal canal stenosis, nerve root compression, significant neuroforaminal stenosis, spinal cord compression or evidence of disc herniation;

xxi. The MRI of the Plaintiff's thoracic spine was found to be normal with no evidence of spinal cord compression, other intra-axial lesions of the spinal cord or disc herniation;

xxii. The MRI of her lumbosacral spine taken in 2001 was also evaluated. Dr. Marquez reports that the images revealed a very small, clinically insignificant central posterior disc protusion at L5-S1 and no evidence of lumbosacral nerve root compression, lumbar spinal stenosis or neuroforaminal stenosis; *("J.J. 2")*

xxiii. In his report of January 16th, 2002, Dr. Marquez expressed the view that there was no evidence of a cause for the Plaintiff's protracted low back pain and her sensory symptoms of the left leg; *("J.J. 2")*

xxiv. In his second report, Dr. Marquez expressed the view that typically, patients suffering from whiplash injuries Grades I and II would be expected to recover completely within 6 weeks, with no long term sequelae, irrespective of the severity of the Whiplash-Associated Disorder; *("J.J. 2")*

xxv. He suggested that the fact that the Plaintiff continued (7 months post accident) to experience symptoms was related more to what he said were numerous psychosocial factors present, coupled with what he termed the possibility of the effect of medicolegal factors consciously or unconsciously playing a role in her non recovery; *("J.J. 2")*

xxvi. Dr. Marquez expressed the view that the Plaintiff was not at risk for any long-term sequelae as a result of the motor vehicle accident and that her injuries had not placed her at

any increased risk for early degenerative disease "arthritis" of the cervical, thoracic or lumbosacral spines; *("J.J. 2")*

xxvii. He further concluded that she would not require further clinical follow up and was not a candidate for surgery, given the available clinical, electrophysiological and neuroimaging information; *("J.J. 2")*

xxviii. The Court finds the views expressed by Dr. Marquez in his second report *("J.J. 2")* regarding the possible causes of the Plaintiff's non-recovery to be both theoretical and speculative in relation to the Plaintiff and declines to make any findings of fact in relation thereto;

xxix. In particular, the Court observes that while Dr. Marquez's second report discussed and cited numerous medical references to support the possibility in the Plaintiff's case of 'sick role syndrome' and explained the gains which patients may obtain from adopting such behavior, Dr. Marquez clearly stated his belief that the Plaintiff was not malingering. *[see page 7 ("J.J. 2")]*

xxx. Dr. Marquez also stopped completely short of making any positive medical finding or diagnosis that the Plaintiff had in fact adopted the "sick role" or the "chronic illness behavior syndrome"; *("J.J. 2")*

xxxi. Additionally, as Dr. Marquez was not called as a witness for the defence, nor deemed an expert; and as he did not give evidence-in-chief and was not tested in cross-examination, the Court found that little weight could be given to his views suggesting the possibility of malingering by the Plaintiff and

the possible adoption by her of the 'sick role' or 'chronic illness syndrome.'

xxxii. For the same reasons, little weight could be given to Dr. Marquez's somewhat controversial opinion that "Chronic Pain Syndrome" is not a diagnosis in and of itself;*[see page 5 ("J.J. 2")]*

xxxiii. In the circumstances, the Court finds that at the date of her second visit to Dr. Marquez (7 months post accident) the Plaintiff had not recovered from the painful symptoms of the soft tissue injuries to her neck and back which she sustained in the motor vehicle collision on June 9, 2001;

xxxiv. *The 'missing"months - February 2002 to June 2003:* There is no clear indication from the evidence whether the Plaintiff required medical attention after her second visit to Dr. Marquez in January 2002 nor was any evidence led regarding what her condition was after that visit;

xxxv. Nevertheless the Court accepts the Plaintiff's evidence that in July/August 2002 (approximately one year after the accident) she left Barbados and returned to Germany;

xxxvi. The Court is satisfied and finds it reasonable that since the Plaintiff had ties to Germany, the country where she had lived prior to the accident, this was a good enough reason for the Plaintiff to have subjected herself to the rigors of the long direct flight in order to travel there.

xxxvii. The Court accepts the Plaintiff's evidence that prior to taking the flight she made the necessary arrangements with

the airline to ensure that she was given wheelchair service and enough room to stretch-out during the long flight;

xxxviii. The Court also accepts that the Plaintiff remained in Germany for approximately 10 months and returned to Barbados in June 2003;

xxxix. Despite the absence of a medical report from any German doctor which would have corroborated her evidence, the Court accepts the Plaintiff's evidence (unshaken by cross-examination) that she continued to receive medical treatment for her condition in Germany during the period she was away;

xl. The Court is satisfied that the fact that the Plaintiff continued to receive treatment in Germany was not hidden and was disclosed to Dr. Winston Seale at the time of her first meeting with him on June 24, 2003, a few weeks following her return.

xli. While Counsel for the Defendant suggested in cross-examination that she had not received such treatment, the Plaintiff was not seriously tested on this point and the Court accepts the Plaintiff's evidence that she continued to require treatment for her condition whilst in Germany;

xlii. The Court also accepts the Plaintiff's evidence that the treatment she received in Germany was similar to that she had received in Barbados and she had also received counseling from a psychiatrist;

xliii. *Diagnosis of Chronic Pain (post traumatic fibromyalgia and/or Chronic Pain Syndrome) following the Plaintiff's*

return to Barbados: The Court accepts the Plaintiff's evidence (not challenged in cross-examination) that that within 3 to 4 weeks following her return to Barbados she experienced another painful episode which caused her to seek medical attention at the Q.E.H. She was examined at the Q.E.H. by a Trinidadian doctor who referred her to Dr. Winston Seale at the Q.E.H. Orthopaedic Clinic.

xliv. The Plaintiff was seen by Dr. Winston Seale for the first time on June 24, 2003 at the Q.E.H. Orthopaedic Clinic. After taking her prior medical history, Dr. Seale performed a clinical examination and made certain presumptive diagnoses. Anti-inflammatory medication was prescribed and new X-rays were ordered of her cervical, dorsal and lumbar spines. MRI studies of her cervical and lumbar spines were subsequently ordered and she was referred to Mr. John Gill, Neurosurgeon;

xlv. The Plaintiff continued to be seen by Dr. Seale at the Q.E.H. Orthopaedic Clinic on July 22, 2003, November 18, 2004 and on January 6, 2004 during this time her symptoms remained unchanged; *[per Dr. Seale- ("M.L 19")]*

xlvi. Thereafter, the Plaintiff continued seeing Dr. Seale in his private capacity on 12 occasions between July 2004 and September 2006; *[("M.L 19") ('M.L 20") and ("M.L 21")]*

xlvii. Although the Plaintiff had been referred to Dr. John Gill by Dr. Winston Seale and was scheduled to be assessed by Dr. Gill on January 13, 2004, the Court is satisfied that it was not until a second appointment was arranged for her on

October 5th, 2006 that she actually visited Dr. Gill; *[("M.L 19") and ("M.L 21")]*

xlviii. In the meantime, sometime in early 2005, Dr. Seale **("M.L 19")** appears to have referred the Plaintiff to the hospital neurosurgeon who made the following conclusion in her Q.E.H. hospital file:

> *"Spondylotic changes of the lumbar and cervical spine, but there is no evidence of frank cord or root compression.*
>
> *Diagnosis: chronic pain secondary to the soft tissue injury."*

xlix. The Court accepts the Q.E.H. neurosurgeon's diagnosis of chronic pain and the medical opinion of Dr. Winston Seale expressed in his April 11, 2005 report **("M.L 19")** as follows:

> *"…all investigations had shown degenerative changes of the neck and back. I believe that these changes preceded the accident, but were probably quiescent. The sudden hyperextension of the neck and back aggravated the underlying spondylosis and set in motion an inflammatory reaction that produced her symptoms. Since then she has never settled to her pre-injury status."*

l. The Court also accepts Dr. Winston Seale's final diagnoses set out in his medical report of July 12, 2005 **("M.L 20")** which were unshaken during cross-examination at the trial that the Plaintiff was suffering from a pre-existing asymptomatic degenerative disease of the cervical and

lumbar spine and that she developed Chronic Pain Syndrome following the accident of June 2001;

li. The Court finds that the foregoing diagnoses are consistent with and supported by the evidence of Dr. John Gill who in his medical report of November 1, 2007 ("M.L 4") diagnosed the Plaintiff to be suffering from *"post-traumatic fibromyalgic pain of the spine."*

lii. The Court also accepts Dr. Gill's opinion, (consistent with views expressed by Dr. Seale) that it was likely that a consequence of the Plaintiff's soft tissue trauma was *to "activate the painful symptoms of the [Plaintiff's] pre-existing degenerative disease of the cervical and lumbar regions of the spinal column."*

liii. In summary, the Court holds that it is satisfied on the balance of probabilities that as a direct result of the motor vehicle accident in June 2001, the Plaintiff continues to suffer chronic pain. Further, such pain has been expressly diagnosed (by Dr. Gill) as Post Traumatic Fibromyalgic pain of the spine and of the extremities (and by Dr. Seale) as Chronic Pain Syndrome.

liv. *Long term effects of her injuries and loss of amenities:* While Counsel for the Plaintiff submitted that the Plaintiff suffered significant loss of amenities, was a social butterfly, enjoyed going out, dancing and socializing with friends, the Court is satisfied that the evidence in support of the loss of amenities is quite thin.

lv. Although in her evidence-in-chief, the Plaintiff testified that her sexual life has been affected and that she can no longer wear high-heeled shoes or dance without pain, under cross-examination she did concede that she can still enjoy some form of dancing and that while she still dances it is not like before. Apart from this, the Court is not convinced that the Plaintiff has placed before the Court evidence of the kind or weight to support her case that her loss of amenities are as significant as Mrs. Edgecome-Miller would have the Court believe.

lvi. The Court, however, accepts Dr. Gill's prognosis of the Plaintiff's condition and finds that as a result of the accident, although her soft tissue injuries have long since healed, it is more probable than not that the Plaintiff faces a future that will be influenced by chronic pain, the severity of which is likely to fluctuate. Furthermore, it is accepted that any intense physical activity will most certainly result in severe exacerbation of the Plaintiff's spinal and extremity pain.

[121] As the Court has found that the Plaintiff has developed and still suffers from what Dr. John Gill has termed, Post Traumatic Fibromyalgic Pain or, in the words of Dr. Winston Seale, Chronic Pain Syndrome consequent upon the motor vehicle accident of 2001, the Court is of the view that an award of $ 70,000.00 is an appropriate award for the Plaintiff's pain, suffering and loss of amenities for the reasons which hereinafter appear.

[122] In arriving at the global figure for the Plaintiff's pain, suffering and loss of amenities, the Court is satisfied that the Plaintiff suffered

Chronic Pain Syndrome (which may also be called Post Traumatic Fibromyalgia) which directly resulted from the accident in June 2001.

[123] Although the medical evidence also establishes that the soft tissue trauma to the Plaintiff's neck and back aggravated and activated the symptoms of the underlying degenerative disease of the Plaintiff's cervical and lumbar spines, no direct evidence was adduced from which this Court can establish with any degree of certainty, the likely period of the acceleration.

[124] Mr. Smith's invitation to the Court to find that that Plaintiff's painful symptoms of her pre-existing degenerative disease had been accelerated by a period of 8 to 10 years, was premised upon an inference which he invited the Court to draw from the Plaintiff's age at the date of the accident and Dr. Gill's evidence-in-chief that degenerative disc disease usually becomes symptomatic in the 6th and 8th decades of life.

[125] However, the evidence before this Court also is that the onset of degenerative disease depends in each case upon a variety of factors, many of which are unknown in relation to the Plaintiff. This Court is therefore (as Dr. Gill clearly was at the trial) unwilling to make any finding of fact as to when the Plaintiff would have been likely to have exhibited symptoms of her underlying disease. If the Court were to do otherwise, it would be engaging in speculation or even in divination which is certainly not the role of Courts.

[126] In the circumstances, the Court declines to accept Mr. Smith's invitation to find that the Plaintiff's symptomology from her pre-existing degenerative disease had been accelerated by a period of 8 to 10 years as he suggested.

[127] As the period of acceleration suggested by Mr. Smith was not established to the Court's satisfaction, the Court did not find the cases which were cited by Counsel for the Defendant particularly useful in setting the parameters for the award. Nor did Counsel for the Plaintiff provide any authorities to support her claim to an award of $102,375.00 under this head.

[128] The Court has, nonetheless, derived assistance generally from the suggested ranges for awards for Chronic Pain Syndrome and Fibromyalgia respectively in the ***Judicial Studies Board Guidelines for the Assessment of General Damages in Personal Injury Cases, 9th Edition*** and from the unreported Barbados Supreme Court cases of ***Barbara Weekes v. Chief Medical Officer et al [Unreported] H.C. B'dos Civil Suit No: 207 of 1998; 2010-02-22, Cheryl Alleyne v. Attorney General [Unreported] H.C. Civil Suit No: 358 of 2000, 2008-03-28*** and ***Heather Veronique v. Attorney General [Unreported] H.C. B'dos Civil Suit No: 791 of 2005, 2009-04-15***.

[129] The Court has found that the Plaintiff's soft tissue injuries, taken together with her resultant chronic pain and loss of amenities, are more severe than those in the ***Veronique Case*** but have not reached the level of severity in either the ***Alleyne Case*** or the ***Weekes Case.*** Furthermore, although the chronic pain which developed from the soft tissue injuries in the ***Weekes Case*** fell just short of being diagnosed as Fibromyalgia or Chronic Pain Syndrome, the loss of amenities suffered by Barbara Weekes were considered far greater than those which were established in this case. In the circumstances, an award of $70,000.00 is considered eminently reasonable compensation for the Plaintiff's pain, suffering and loss of amenities.

<u>General Damages – (b) pecuniary losses:</u>

[130] *(D)* *<u>Loss of Housekeeping Ability:</u>* Counsel for the Plaintiff submitted that given the chronic nature of the Plaintiff's pain, she would require household help in view of the fact that her pain was exacerbated by any intense physical activity such as bending and lifting. She submitted that the Plaintiff was claiming an award for future housekeeping expenses of $81,291.60, (or $30.00 per day x 3 times per week x 52 weeks) and using a multiplier of 17.37.

[131] The Court accepts that there is some evidence on which the Court may find that the Plaintiff required, and engaged household help in the period following the accident in 2001 until she returned to Germany in July/August of 2002.

[132] A bundle of 33 receipts **("M.L 3")** signed by at least 3 different household helpers and said to total $4,200.00 for past housekeeping help provided between 2001 and 2005 was put into evidence without objection at the trial. The Court has accordingly allowed the sum of $4,200.00 for past housekeeping expenses as special damages. *[See paragraph [149] below.]*

[133] The Plaintiff stated in her evidence-in-chief and the Court accepts, that after the accident, in the period 2001 to 2005, she employed household help for cleaning, ironing, laundry, grocery, shopping and *"all the chores [she] normally did"*.

[134] The Court is, however, satisfied that since no additional receipts were produced beyond 2005, there is an obvious gap in the evidence regarding the necessity for domestic help between 2005 and the year 2009 when she gave evidence at the trial.

[135] Although the Plaintiff testified at the trial that she was in 2009, living with her daughter who, she said, cooked and did the cleaning, it was unclear to the Court whether the daughter had provided such gratuitous help throughout the entire "missing" interval between 2005 and 2009.

[136] Additionally, no specific evidence was adduced (either directly from the Plaintiff, her daughter or her medical doctors) from which the Court could make a definitive finding of fact that the Plaintiff had lost her housekeeping ability and would consequently require domestic help in the future.

[137] In the circumstances, there is no factual basis on which the Court can properly make an award for future housekeeping expenses and no award is made under this head.

[138] *(E) Past and (F) Future Loss Earnings:* Counsel for the Plaintiff submitted that based on the evidence, the Plaintiff was claiming total annual earnings of $6,000.00 which she had received from her employment as a tour representative with Johnson Stables and from her real estate property management business. She claimed the sum of $48,000.00 as past loss of earnings for the 8 year period since the accident.

[139] Counsel for the Defendant submitted that the claims under both these heads had not been substantiated and should both fail. He submitted that it was obvious that the payment of $3,000.00 which the Plaintiff received from Dr. Akpata in May 2001 **("M.L 2")** was a "one-off" commission and was based only on services actually provided. He further contended that the Plaintiff had failed to adduce any supporting evidence such as bank statements or income tax returns to

support her claim that she in fact operated an ongoing real estate property management business.

[140] Turning to the Plaintiff's employment as a tour representative with Johnson Stables, Mr. Smith submitted that while it was clear that the Plaintiff worked at Johnson Stables as a German speaking tour guide between November 1999 until 2001, the letter dated April 10th, 2008 **("M.L 1")** signed by Wayne Parravicino as a director of Johnson Stables had given no details of the expected duration of the Plaintiff's arrangement with Johnson Stables. It was unclear whether it was an ongoing arrangement or whether it would continue only so long as German cruise ships came to Barbados. There was also, he contended, insufficient evidence before the Court from which the Court could infer that the Plaintiff would, in all probability, have worked at Johnson Stables in the winter season of 2001/2002 and beyond, had the accident not occurred.

[141] Regrettably, the Court finds that the Plaintiff's claim for past and future loss of earnings is woefully inadequate and largely unsubstantiated. The letter from Facilitators Unlimited signed by Wayne Parravicino **("M.L 1")** merely speaks to the 2 winter seasons between November 1999 and April 2001 when the Plaintiff earned Bds$9,000.00. The letter contains nothing from which the Court can infer that the arrangement which the Plaintiff had with Johnson Stable between November 1999 and April 2001 was an ongoing or standing arrangement which would have continued beyond April 2001 and into the foreseeable future.

[142] The Court might have been in a better position to quantify the Plaintiff's past loss of earnings, had someone from Johnson Stable

been called to testify at the trial, *inter alia*, as to the nature of their arrangement with the Plaintiff and, for example, as to how many German cruise ships had actually called at Barbados' shores in the several winter seasons which have elapsed between 2001 to the date of trial. But, regrettably, no evidence has been adduced from which the Court can infer that, but for the accident, the Plaintiff would have continued to be employed by Johnson Stable after her last engagement with them ended on April 2001.

[143] Turning to the Plaintiff's claim to have been a self-employed businesswoman and in receipt of income from her real estate property management business. Once again, the Court finds this claim to be unsubstantiated and is somewhat surprised that no effort was made to adduce other evidence to persuade the Court that the $3,000.00 which she received from Mr. Akpata in May 2001 was anything other than a "one-off" commission for services rendered in respect of a single transaction.

[144] In any event, Dr. Akpata's letter **("M.L.13")** clearly indicates that his recollection of their arrangement was that as of December 23rd, 2007, the Plaintiff had only recruited 2 clients for his villas. This fact reinforces the view that income from this client was, at best, sporadic and *ad hoc*. The Court is accordingly satisfied that the figure of $3,000.00 cannot be used (in the absence of other evidence) to support the Plaintiff's claim that she would have continued after the accident to receive average annual earnings in that amount from this source.

[145] The Plaintiff testified that she also found rental clients for another Barbados property owner, Mr. Wolfgang Boehring. Yet somewhat curiously, no supporting evidence of any kind was adduced as to the

nature of her arrangement with him, or as to her past earnings from him or as to the frequency for which she found clients for him. She also gave evidence about her internet website and the manner in which she was able to find vacation rental accommodation in Barbados for overseas clients. Disappointingly yet again, no supporting evidence was placed before the Court to substantiate her annual income (if any) from this source.

[146] In the circumstances, the Court declines to make an award for loss of earnings under either of these heads.

[147] *(G) Future Medical Care*: In his evidence-in-chief, Dr. John Gill testified that it was his view that the Plaintiff would benefit from consultation with and treatment from a specialist in pain management, and in 2007, he referred her for pain management treatment with Dr. Greg Knight, a certified rolfer in Rhode Island, United States.

[148]Due to financial constraints, the Plaintiff has been unable to undergo this treatment. The cost of the treatment, which typically involves 10 sessions, is US$1,300.00 or Bds$2,600.00. As the treatment was approved by her attending physician, Dr. Gill, an award is accordingly made in the sum of Bds$2,600.00 under this head to enable the Plaintiff to undergo the pain management sessions with Dr. Knight.

Special Damages:

[149] (D) Past Housekeeping expenses	-	$ 4,200.00
(C) Medical and related expenses	-	$ 29,288.00
Total Special Damages *(agreed)*	-	$ 33,488.00

[150] ***Summary of the Awards:*** In summary, the awards which the Defendant shall pay to the Plaintiff are as follows:

General Damages:

(A) & (B) Pain, suffering and loss of amenities	-	$ 70,000.00
(D) Future Housekeeping expenses	-	$ nil
(E) & (F) Past & Future loss of earnings	-	$ nil
(G) Future medical care	-	$ 2,600.00
Total General Damages	-	$ 72,600.00

Special Damages:

Total Special Damages *(Details at para [149])* - $ 33,448.00

[151] ***Interest:*** The above awards will bear interest on the Special Damages at the rate of 4% per annum from the date of the issue of the Writ until today and thereafter at 8% per annum until payment, and on the General Damages at the rate of 8% per annum from today until payment.

[152] ***Costs:*** The Plaintiff is entitled to her legal costs, certified fit for one attorney-at-law to be agreed or taxed.

Maureen Crane-Scott
Judge of the High Court