

REPUBLIC OF TRINIDAD AND TOBAGO

IN THE HIGH COURT OF JUSTICE

H.C.A. No. 3130 of 2004

Between

Damian Moreno

Plaintiff

And

- (1) Anthony Brusco
- (2) Sheldon Pierre
- (3) Motor and General Insurance Company Limited
- (4) Sanjay Singh
- (5) Chunsingh Roopnarine
- (6) The Great Northern Insurance Co. Ltd. Defendants

Appearances:

Mr. Azeem Mohammed for the Plaintiff

Mr. Ken Sagar instructed by Ms. Indra Ramdial

For the 1st, 2nd and 3rd Defendants

Mr. Sean Roopnarine for the 4th, 5th and 6th Defendants

Before The Honourable Mr. Justice Devindra Rampersad

DELIVERED ON: Wednesday October 7, 2009

JUDGMENT

The action:

1. This action was commenced on 19 November 2004 by the Plaintiff for damages occasioned to him whilst he was a passenger in the first named Defendant's motor vehicle on 28 May 2002 when it was involved in an accident. The Plaintiff's statement of claim was filed on the 15th day of February 2005 and although defences were filed for

the Defendants, liability was settled between the Defendants by a consent order on 31 October 2007 leaving only the issue of the assessment of damages for me to deal with.

2. In his statement of claim, the Plaintiff, who was almost 17 years old at the time of the accident, gave the following particulars of personal injuries:
 - 2.1. Cerebral concussion;
 - 2.2. Cervical muscular spasm;
 - 2.3. Lacerations to his face;
 - 2.4. Post concussion syndrome;
 - 2.5. Thoracic spine strain.
3. The Plaintiff gave particulars of his present complaints in his statement of claim as follows:-
 - 3.1. Pain in the upper back;
 - 3.2. Pain in the neck region;
 - 3.3. Unable to sit or stand constantly for more than 20 minutes;
 - 3.4. Headaches when exposed to sunlight;
 - 3.5. Unable to concentrate;
 - 3.6. Decrease memory;
 - 3.7. Easily fatigued.
4. He also gave particulars of special damages as follows:-

4.1. Medical expenses [continuing]	\$2,500.00
4.2. Traveling [continuing]	\$1,000.00
4.3. Police report and traveling	\$ 50.00
4.4. Loss of income in the future and continuing	[no figure given]

The evidence:

5. The Plaintiff himself, one Suresh Dookie and Dr. Henry Bedaysie gave evidence for the Plaintiff. No evidence was led on behalf of any of the Defendants.
6. The parties agreed to the following documentary evidence which were put into evidence by consent:
 - 6.1. Medical Report of the Couva District Health Facility (undated):-

This report indicated that the plaintiff was seen in the accident and emergency department of that facility on 28 May 2002. His examination revealed, inter alia, good neck movement, good movement of all limbs, multiple abrasions to the left cheek and 2 cm laceration to the right cheek. The wound was cleaned and sutured under local anesthetic and he was treated with a Diptheria Tetanus injection and Olfen. He was then discharged to the local health center for follow-up.

6.2. Medical Report of the Neurosurgery Department of the Port of Spain General Hospital dated the 20th August 2002:-

This report indicated that the Plaintiff was seen on Ward 24 on 7 June 2002. It indicated that he was involved in an accident one week prior having hit the back of his head and suffering a loss of consciousness. A complaint of occipital headaches was reported which was relieved with ibuprofen tablets. There were no signs of intracranial injury/bleeding and he was diagnosed as having a **post concussion syndrome** and discharged to clinic where he was seen on two further visits where **improvement was noted** [emphasis mine].

6.3. Medical Report of the North West Regional Health Authority dated the 26th of November 2002:-

This report recorded the plaintiff's claim to have been involved in an accident and to have suffered loss of consciousness. Physical examination revealed normal cardiovascular, respiratory and nervous systems and the diagnoses were sutured lacerations to his face, cervical muscular spasm and cerebral concussion. He was referred to the Port of Spain General Hospital for further management.

6.4. Radiology Consultation Report of the Eric Williams Medical Sciences Complex dated the 25th June 2004:-

This report, apparently commissioned as a result of upper spine pain, indicated normal anatomical alignment, density and disk spaces, mild dorsal curvature convex to the right, no evidence of paravertebral mass lesion and no evidence of vertebral anomaly seen.

6.5. Medical Report of R.U. Adams dated the 11th July 2004:-

This report indicated that the Plaintiff "*allegedly hit his head, left thigh and upper back with loss of consciousness and facial lacerations*". Examination showed tenderness at the T3 spinous process and there was an otherwise normal examination. An EEG i.e. an electroencephalogram showed minimal cerebral irritability and thoracic spine x-ray showed mild curvature. As a result, his findings indicated a **post concussion syndrome and thoracic spine strain**. The plaintiff was advised to do exercises and he was also advised to take Panadeine, stemetil and vitamins.

6.6. Medical Report of R.U. Adams dated the 18th July 2005:-

This report was further to Dr. Adam's previous report mentioned above. It was indicated in this report that the plaintiff had been reviewed periodically. Dr. Adams said that the plaintiff's headaches were less but were still present and that the plaintiff had continuing neck upper and low back pain and right shoulder muscle spasms. Again, the use of Panadeine and vitamins was advised along with Amitrptyline instead of stemetil. The findings of post concussion syndrome and spinal strain syndrome were mentioned and the plaintiff was assessed at 30% permanent partial disability.

6.7. A bundle of agreed receipts for medical expenses and a copy of the Plaintiff's out-patient clinic card.

7. Dr. Bedaysie was the first to give evidence.
 - 7.1. He gave a witness statement which was dated 16 February 2009. Besides stating in his witness statement that he was a fellow of the Royal College of Surgeons and that he specialized in the area of neurosurgery, his examination in chief comprised the following statement only:- *“The Plaintiff in this matter Damian Moreno has been my patient since the 29th of September 2004 and I have treated him since then and have prepared two (2) medical reports which are hereto attached and marked “HB1”.*”
 - 7.2. The medical reports referred to at “HB 1” were dated 7th October 2004 and 14th October 2008 and were not objected to by the Defendants. He was then cross examined by the attorneys for the Defendants on these medical reports.
 - 7.3. The medical report dated 7 October 2004 described the Plaintiff as **a secondary school student** who was evaluated by him on 29 September 2004 “for the purpose of medical assessment of *her* injuries (sic) sustained in a motor vehicular accident on 28th of May 2002.” [Emphasis mine] He went on in his report to say: *“Her (sic) present complaints are:-*
 - 7.3.1. *Pain in the upper back;*
 - 7.3.2. *Pain in the neck region;*
 - 7.3.3. *Unable to sit or stand constantly for more than 20 minutes;*
 - 7.3.4. *Headaches when exposed to sunlight;*
 - 7.3.5. *Unable to concentrate.”*
 - 7.4. He said further that there was tenderness at the T3 spinous process and that his clinical findings indicated that this patient had suffered post-concussion syndrome and thoracic spine strain. He said also that the resulting effects of post-concussion syndrome are intolerance to bright lights and loud noises, dizziness, decreased memory and concentration and easily fatigued. He then assessed *“his permanent disability at 20%”*.
 - 7.5. The medical report dated the 14th October 2008 by Dr. Bedaysie confirmed that the Plaintiff was first seen by him on the 29th of September, 2004 and had since been his patient. He reported that the Plaintiff’s present complaints were as follows:
 - 7.5.1. Head:

Constant headaches, throbbing temples, increasing in intensity with the heat of the day and stress levels, dizziness, short term memory, lack of concentration, impatient.
 - 7.5.2. Neck:

Pain in the neck, restricted movement, pain in the back, shoulders and arms, weakness of the arms.
 - 7.5.3. Arms:

A lot of pain from the neck radiating to the shoulders and arms, problems raising hand with lancinating pain from the shoulders to the elbow and fingers.

7.5.4. Back:

Pain along the spine radiating to the hips, stomach, butt and legs. Restricted movements of the hips and general weakness. Constant lancinating pain makes it difficult to stand or sit for more than 20 minutes. Unable to run or move briskly and lift anything heavy.

7.5.5. Sexual and Social Life:

General discomfort restricting socializing and sexual intercourse. Unable to run, jog or train at the gym.

7.5.6. Work:

As an estate worker long periods of sitting or standing causes a lot of pain. His job requires a lot of standing, when exposed to the direct sunlight he gets unbearable headaches causing him to halt work and rest for several hours. Patience level is very low. Lack of concentration, stamina and mental collectiveness lacking which is very essential to his job.

7.6. Dr. Bedaysie's finding was that, having considered the patient's medical reports, MRI scans and having treated him since September, 2004, he was of the opinion that the Plaintiff had suffered a moderate injury to his cervical spine resulting in a mild curvature. As the Plaintiff ages, he opined that it is expected that there would be degeneration of the disc which would require surgery to stop the deterioration within 10 years estimated at present-day prices to cost \$35,000.00. There was no objection to this evidence by the defendants. For his headaches/bodily pain, he recommended medication to continue for the rest of his life and also physiotherapy to help reduce pain once per month. He also said that the Plaintiff's amenities, social and sexual activities would also be restricted. His major problem, according to Dr. Bedaysie, was the post concussion syndrome which was a complex disorder of mild traumatic brain injury and that the Plaintiff had not responded well over the years to treatment. Symptoms of this type of injury include headaches, dizziness, fatigue, irritability, anxiety, insomnia, loss of concentration/memory, intolerance to light and noise, argumentative and stubborn behaviour. He suggested that, as an estate worker, the Plaintiff should not work more than 4 hours per day and was 50% permanently disabled. In relation to his basic day-to-day activities, his permanent disability was assessed at 25%.

7.7. In cross-examination by Mr. Sagar for the 1st, 2nd and 3rd named Defendants, Dr. Bedaysie stated that he saw the Plaintiff about 5 times between 2004 and 2008 but he had lost his file in moving his office about 3 years ago. As a result, he came to court without any of his records - relying only on his two medical reports. He said that when he first saw the Plaintiff, he also saw an EEG (i.e. an electroencephalogram) report done by Dr. Rasheed Adams which showed

minimal cerebral irritability and mild curvature of the thoracic spine. He went on to agree with Dr. Adams' diagnosis that the Plaintiff had suffered a post concussion syndrome and thoracic spine strain and, in fact, he admitted that he was prepared to treat the Plaintiff for what Dr. Adams was treating him for relying on the information given by Dr. Adams in his report. This suggests that he did no independent EEG or other such objective medical testing but merely relied upon and followed up on Dr. Adams finding because, as he put it, he had great respect for Dr. Adams and he agreed with his diagnosis and treatment. However, Dr. Bedaysie did carry out his own clinical tests and observations most of which were based on subjective responses to questions by the Plaintiff and were not based on objective testing of any kind. He indicated in his cross examination that he was able to recall that he observed the Plaintiff for about 1 hour on the first occasion that he saw him and that he observed him for more than an hour on the day that the 2nd report was done - all of this the Doctor was able to recall from memory without the benefit of his notes. He also admitted that when he did the report in 2008, he considered the EEG and report from Dr. Adams, the x-ray from the EWMSD dated the 22nd of June 2004 (even though he mentioned reliance on an MRI scan which he later accepted in cross examination was an error and that he really relied on the x ray). No further EEG or x-ray or non-clinical testing seems to have been done up to 2008. Not wanting to cast aspersions unduly on the doctor, I must confess that I am somewhat amazed by this aspect of his evidence. For him to have formulated his 2008 report, he says he reviewed the above mentioned reports and x-rays, etc. Yet, he said that he lost the file 3 years ago – that would have been since around 2006 which is about 2 years prior to the 2008 report. So, where did these reports/ x-rays, etc come from? Why did he refer to having relied upon an MRI scan when none seemed to be available? That was not explained by him although he did accept after continuous questioning in this regard that what he used was the x-ray and not the MRI scan. Would it not have been more correct for him to have said in his 2008 report that, when preparing the 2008 report, he relied on his 2004 report which was based on the EEG and other reports/x-ray which were available at that time? This position was in fact adopted by him in cross examination. When asked about the basis for the 50% permanent disability, he said it was based on the 2004 EEG by Dr. Adams and he admitted that he himself had done no other scientific testing after 2004. He also said that he also relied upon the clinical examination and the symptoms related to him by the Plaintiff and he did not think it necessary to have any further EEG done because the symptoms were present to indicate post concussion syndrome. He said there was no scientific test to verify post concussion syndrome since the syndrome may be present in a patient even if the patient's EEG showed up as normal although he admitted that an updated EEG would indicate whether the irritability on the brain had improved.

- 7.8. Under cross examination by Mr. Roopnarine for the 4th, 5th and 6th named Defendants, Dr. Bedaysie agreed that post-concussion syndrome was dependent on a concussion following a loss of consciousness so that loss of consciousness was necessary for this syndrome. When shown the medical report prepared on 28 May 2002 from the Couva District Health Facility, Dr. Bedaysie admitted that

there was no mention whatsoever about loss of consciousness in that report and that, in fact, he relied on Dr. Adams' report as the source of the information about the alleged loss of consciousness.

7.9. He was not asked about the finding of the Neurosurgery Department of the Port of Spain General Hospital that the Plaintiff showed signs of improvement after 2 clinic sessions in relation to his post concussion syndrome.

8. Suresh Dookie was next to give evidence:

8.1. His witness statement was prepared on the 15th of February 2009 and, quite curiously, merely sought to annex thereto a statement which he had previously prepared on the 2nd January 2008. That statement was annexed as "SD1" and it did not include any certificate of truth as prescribed under the rules. No objection was made to the use of this annexure as the witness' evidence in chief and in fact, he was cross-examined on it by both attorneys for the Defendants.

8.2. In essence, Mr. Dookie identified the Plaintiff as his nephew and said that the Plaintiff used to assist him on a part-time basis on weekends and during summer vacations on his citrus estate since 1997 for which he was paid \$75 per day until 2001 when the rate of pay increased to \$90 per day. In July 2004, he said that the Plaintiff returned to him on the estate where he regularly complained about headaches when exposed to the sun, upper back pain, neck pains and was unable to work for more than 30 minutes without taking a rest for about 30 minutes. He said he kept him employed due to the family relationship but he was more inclined to hire another person. He said that, at present [that is at the 2nd of January 2008 when he signed that statement], the Plaintiff worked a task 2 to 3 hours per day 5 days per week at \$30 per day. Other workers, he said, were working for \$125 per day.

8.3. In cross-examination, Mr. Dookie said that he had no banana estate but operated a citrus estate and that in 1997, when the Plaintiff began working with him, the Plaintiff was about 17 years old (this had to be incorrect as, from the Plaintiff's own evidence, he would have been only 12 years old in 1997 and would have been 17 in the very year that he was involved in the accident). It was then suggested to him by attorney for the 1st, 2nd and 3rd named Defendants that back in 1997 the Plaintiff was only 12 years old. He went on to say that he had no employment records to prove that the Plaintiff ever worked for him -- no income tax was deducted from his pay nor was any NIS deducted either.

8.4. He confirmed that the Plaintiff was now employed with him and worked for about 2½ hours per day. According to him, the Plaintiff worked from 6 to 8 or 8:30 am doing things such as picking the oranges on the lower branches of the trees and pruning the trees with a pruning saw. The Plaintiff, according to Mr. Dookie, did not carry a basket and really only just performed light duties. He went on to say that he kept on the Plaintiff because he did not want him to "be on the road".

8.5. I got the impression that the Plaintiff did in fact assist his uncle on the estate on occasion as a young boy but I do not accept that Mr. Dookie would employ the Plaintiff, who can only work for about 2 to 3 hours per day at present, in

preference to a fully enabled worker who could give a proper day's work for a proper day's pay (even though, as Mr. Dookie said, he was having difficulty in getting workers). Mr. Dookie struck me as being a person who was willing to assist his sister's son to keep him out of trouble (or off the streets as he put it) and, to my mind, to even assist him in these court proceedings. I was not convinced of the employment relationship between him and the Plaintiff especially in relation to the allegation that he was so employed since 1997. This is more so in light of the lack of credible or contemporaneous documentary evidence of the employment. At this juncture I feel compelled to make the observation that too often parties come to court seeking relief when they are involved, whether by choice or by circumstance, in practices which are contrary to the laws of the land. Up to now, the plaintiff is not on any documented payroll of this witness and there is no evidence of the payment of NIS, health surcharge or any other statutory payment or deductions in relation to this plaintiff. How then is this court supposed to make awards to parties when to do so would be to sanction these unlawful practices and to reach a finding based on this type of illegal behavior? I must admit that I have grave concerns about this continued practice and I am mindful of the duty of the court to deprecate such practices rather than to reward them. Any claim based on such practice must be very carefully scrutinized before it is at all accepted.

- 8.6. There were certain inconsistencies in Mr. Dookie's evidence as well. In cross-examination, he said that the Plaintiff came back out to work in 2002 as opposed to July 2004 mentioned in his statement. Further, in cross-examination, he said nothing about the Plaintiff having to rest for about 30 minutes after working for 30 minutes as was mentioned in his statement. Also, I remember the discrepancy in the Plaintiff's age at the time when he was first allegedly employed by Mr. Dookie - Mr. Dookie said that the Plaintiff was 17 years old at the time when he was first employed whereas that was the age he was when the accident in fact occurred. All in all, Mr. Dookie seemed to be a person who was not independent and who had come to assist the Plaintiff in his case.
9. The Plaintiff himself was the last witness to give evidence.
 - 9.1. In his witness statement, he said that he was born on 11 July 1985. That means he was almost 17 years old at the time of the accident on the 28th of May 2002.
 - 9.2. He said that after the accident he was unconscious and was taken to the Couva District Hospital and was then treated and transferred to the North West Regional Health Authority where he was also treated in the accident and emergency department. He gave no indication as to how long he was unconscious for. He said that he was in excruciating pain mainly to his head and face and his neck was paining terribly. Despite being administered with painkillers by the nurses, the pain kept coming back after about half an hour. This terrible pain lasted for about 6 to 8 months and was then reduced to a moderate pain which has continued to date.
 - 9.3. At present, he said that he still has constant headaches, throbbing of his temples and increasing in intensity with the heat of the day and stress level. He sometimes

has dizziness, short-term memory, and lack of concentration although he did not elaborate as to how often these bouts occurred or how they manifested themselves or even what he meant by those terms. He also said that he was very impatient and stayed away from bright lights or sunlight but did not say why. He said that the pain in his neck causes him restricted movements, pain in the back, shoulders and weakness of his arms and that he still has a lot of pain from his neck radiating to his shoulders and arms. He said that he has problems raising his hand with lancinating pain from the shoulders to the elbow and fingers. The pain along the spine goes down to his hips, stomach, butt and legs and he has restricted movements of hips and generally weakness. He went on to say that the constant lancinating pain made it difficult for him to stand or sit for more than 20 minutes and he was unable to run or move briskly and lift anything heavy.

- 9.4. He further said that because of the general discomfort he is restricted from liming with his friends, going to parties, dancing and socializing. He however did not say if he ever did those things prior to the accident and, if so, how often he did so. He says that sexual intercourse is uncomfortable and painful at times due to the pain and movements. He said he was unable to run, jog or train at the gym but does not say if he ever did that prior to the accident and, if he did, how often he did those activities.
- 9.5. He said that as an estate worker, sitting or standing, especially when exposed to direct sunlight, causes him pain and unbearable headaches causing him to stop work and rest for several hours. He said that from 1997 to around 2000 he worked with his uncle, Suresh Dookie, for \$75 per day and from 2001 to 2002, he worked for \$90 per day. He did not say, however, how often he worked and, according to his uncle, this work was merely part time employment on weekends and during the August vacation. In fact, he was still a minor when the accident occurred and, according to the report of Dr. Bedaysie, he was a secondary school student. He said that after the accident, for about 2 years, he did not work due to the pain he was having and when he returned to work in July of 2004 he was having great difficulty performing his job working for only 2 to 3 hours per day and receiving \$30 per day. He made mention of medication having been prescribed to him which costs about \$25 per day but that he was unable to afford this and was able to take these tablets for about 2 weeks only which gave him some relief.
- 9.6. His evidence in cross-examination was put to a severe test.
 - 9.6.1. Attorney for the 1st, 2nd and 3rd named Defendants was able to show, at least at that moment in court, that the Plaintiff was not suffering with any loss of memory as he was able to remember recent events and even to remember the meaning of words which he had learnt in school.
 - 9.6.2. The Plaintiff told Mr. Sagar that he dictated his witness statement to his attorney “word for word” which suggested a propensity for exaggeration since it is difficult to see how that was possible especially since he did not demonstrate comfort or familiarity with some of the words/phrases used e.g. the word “*radiating*”. Further,

much of the symptoms and complaints which he set out in his witness statement was couched in the same language and style as that used by Dr. Bedaysie in his 2008 report suggesting a “cut and paste” from the report rather than dictation by the Plaintiff.

- 9.6.3. He admitted that it was he who had told Dr. Bedaysie that the estate upon which he worked was a banana estate when in fact it was a citrus estate. Yet, despite this admission, he still tried, unconvincingly in my mind, to justify this misdescription as he tried to say that it was a citrus estate but there were also bananas there. That may be so but the impression when one says “banana estate” and “citrus estate” suggests the focus on one or the other and his attempt to wriggle out of the discrepancy by saying there were also banana trees there served to illustrate his tendency to be a little slippery rather than to just have said – “I made a mistake, it is really a citrus estate”.
- 9.6.4. He said he started working on his uncle’s estate since he was about 10 years old. He said he was not paid when he was 10 years old but when he was 12 he was paid about \$60 a day working from 6 am to 12 pm picking fruits, pruning and climbing trees. This is an incredible bit of evidence – that a 12 year old boy would have been working for \$10.00 per hour in the year 1997 doing estate work at a time when the minimum wage for an adult was less than that¹. I also bore in mind that his uncle gave evidence that his starting salary was \$75 per day and made no mention about paying \$60 per day for the Plaintiff at any time.
- 9.6.5. Even though he was in court when his uncle was giving evidence, he said that he was not paying much attention to what his uncle was saying and several bits of evidence given by his uncle, when referred to him, was greeted with a response that he did not hear his uncle say that e.g. he did not hear his uncle say that when he came to work he would get pain in his body and have to leave.
- 9.6.6. When asked about the brightness of the sunlight between 6 to 8:30 am he said he would work under the trees pruning and then went on to say that he would also wear a hat and sunglasses to allow him extra work time.
- 9.6.7. He said that he could not sit for long hours and that he sat uncomfortably whilst in court. It is to be noted that at about 11:30 am, during the cross-examination of Dr. Bedaysie, after the matter had commenced at 10:42 am, attorney for the 1st, 2nd and 3rd named Defendant pointed out to Dr. Bedaysie and to the court that the Plaintiff had in fact been sitting in court for all of that time (i.e. about 40 minutes as he put it) without complaint and it was only subsequent to that observation that the Plaintiff began making obvious signs of

¹ The minimum wage was increased to \$8.00 per hour in 2003 by Legal Notice 1 of 2003 from the \$7.00 prescribed by Legal Notice 40 of 1999. In 1997 it was less than \$7.00.

purported discomfort and of having to get up to go out of court. Until that time, I noted that there was no sign of fidgeting or discomfort by the Plaintiff.

- 9.7. The Plaintiff denied that he was exaggerating his claim and also denied that he could work for more than 2 ½ hours.
- 9.8. In cross-examination by attorney for the 4th, 5th and 6th named Defendants, the Plaintiff admitted that he did not mention anything in his witness statement about looking for any job anywhere else. It was also suggested to the Plaintiff that his mother, his sister and his girlfriend were persons who were in close contact with him and who saw how he was and how he reacted and he agreed that they were not called to give evidence.

The application to amend:

10. At the end of the case for the Plaintiff, attorney for the Plaintiff orally sought to make amendments to the statement of claim. This is despite the pre-trial hearings which were held on 21 January 2009, 25 March 2009 and 7 April 2009 when directions were given for the conduct of this matter at the trial fixed for 22nd May, and no application for any amendment was made at that time. When the matter began on 22nd May, no application for an amendment was made even though it ought to have been clearly obvious to the Plaintiff's attorney that there was evidence upon which he would have wanted to have relied but which was not a part of his pleaded case. No reason was advanced whatsoever for the failure to amend at an earlier stage. The application was refused especially since it would have introduced evidence which may have then required an adjournment of the matter to allow the Defendants the opportunity to get evidence to counteract the Plaintiff's amended position such as the possible medical examination of the Plaintiff to determine matters which were not a part of the pleadings over the course of the past 5 years or so (degeneration of disc, etc) and were not a part of the pleadings when the parties reached the consent on the issue of liability – see HCA No. 327 of 1977:- **Lomas Dwarika vs. General Truckers Transport Ltd** per Gopeesingh M. I also considered that the evidence in this matter had already been led and cross examination completed and to have allowed the amendment would have given the Plaintiff an unfair advantage since the matters sought to be introduced by amendment were not live ones on the pleadings and were therefore not explored and tested in cross examination.

Analysis of the evidence:

11. The Defendants had an opportunity to have had the Plaintiff examined by an independent medical practitioner to ascertain the veracity of his allegations and diagnosis. They failed to avail themselves of this opportunity and, in the circumstances, this court is faced with the Plaintiff's evidence along with that of his medical practitioner. It was suggested to the Plaintiff that he was exaggerating his claim which was denied. I am mindful of the effect of uncontroverted and unchallenged evidence - see my discussion on the law on the court's acceptance of evidence which was unchallenged in cross-examination in the case of HCA No. 66 of 2002:- **Debbie Mohammed v Archibald Bellamy, The Attorney General of Trinidad and Tobago and Ramnarine Sookdeo.**

12. On the other hand, I was not completely satisfied with the quality of the medical evidence given in this matter nor with the Plaintiff's evidence. I cannot understand why up-to-date EEG or MRI scan or other empirical evidence by way of scans or objective testing was not produced at the trial and, in saying so, I bear in mind the observations of Hamel-Smith JA in the case of **Seudath Parahoo vs. S.M. Jaleel & Company Limited**:- Civ App No 110 of 2001 as to the obvious need for the updating of medical reports. I also noted that Dr. Adams was not called even though his was the diagnosis upon which Dr. Bedaysie seemed to have acted and relied. Dr. Adams would have therefore been better placed to explain the reasons for his findings. At the end of the day, however, all of the medical reports mentioned below were admitted into evidence by consent for the truth of their contents and I therefore accept the findings contained therein which were based on objective and scientific testing and I placed more weight on findings which relied upon objective rather than subjective responses. This is because I formed the view that the Plaintiff was prone to exaggeration of his claim and of his symptoms having regard to the manner in which he gave his evidence at trial and the matters of concern and contradictions mentioned above and I therefore formed the view that it was likely that his responses to the doctor were not necessarily reliable. Also, I was not particularly impressed by the plaintiff's demeanor in the witness box. His evidence did not ring true and his tone and mannerism in the witness box gave to me an impression that he was not being truthful and forthright even when reviewing the recording of the same in the preparation of this judgment.
13. From the evidence, it seems that the initial diagnosis was a minor injury as set out in the 2002 reports. Later investigation however revealed a seemingly more deep rooted problem as outlined in Dr. Bedaysie's report. With respect to the percentages of disability referred to in the reports, I prefer to adopt the words of Kangaloo JA in the Court of Appeal in **Theophilus Persad & Capital Insurance -v- Peter Seepersad** Civ CA 136 of 2000, where he said:

'Permanent partial disability' is not a term of art in the context of the assessment of damages at common law and one wonders whether doctors have a common understanding of what it means as they tend to give percentage assessments which differ markedly, as in the instant case.

*The case of **Victor Cornilliac v Griffith St. Louis (1965) 7 WIR 491** sets out the matters to be considered by a Court in assessing damages for personal injury. They are as follows:*

- (a) The nature and extent of the injuries sustained;*
- (b) the nature and gravity of the resulting physical disability;*
- (c) the pain and suffering endured;*
- (d) the loss of amenities suffered; and*
- (e) the extent to which consequentially, the Plaintiff's pecuniary prospects have been materially affected.*

The “permanent partial disability” percentage is relevant to consideration (e) and possibly in a very general way to (b). An explanation of the effect of injuries on a person’s earning capacity in words as opposed to figures, would be of greater use to the Courts in their assessment of damages at common law. It is suggested respectfully that doctors set out in their reports, together with the basis for their conclusions, their opinion on how the injury suffered is likely to affect the lifestyle and earning capacity of the injured Plaintiff, and leave percentages of incapacity for Workmen’s Compensation cases.’ [Emphasis mine]

14. On the whole, I accept the objective clinical symptoms and observations recorded by Dr. Bedaysie in his 2 reports. However, there were areas of his evidence which were not as lucid as one would have wanted from an expert. For example, I would have expected suitable clarification on what seems to be a medical debate on whether loss of consciousness is absolutely necessary for a diagnosis of post-concussion syndrome² rather than his blanket statement that loss of consciousness is necessary for the condition and also, whether post-concussion syndrome is a permanent condition or whether it is likely to resolve over time and, if so, over what period of time in the case of this Plaintiff. Further, I needed to know if it was responsible for or indicative of any change in the Plaintiff’s brain. I also noted that he made no mention of whether or not psychiatric testing would have assisted in determining whether the Plaintiff’s symptoms were real or pretended – see the evidence of Dr. Adams in the case of **Parahoo vs. SM Jaleel** *supra*. Finally, in his 2008 report, Dr. Bedaysie referred to the Plaintiff not having responded well over the years to treatment but did not say what that treatment was.
15. In terms of the Plaintiff’s employment, I do not believe that the Plaintiff has proved on a balance of probabilities that his employment was affected in the manner in which he has pleaded his case in his statement of claim. As indicated above, I saw his uncle as a person coming to court to support his nephew's case and who did not impress me to be familiar with the facts or circumstances put forward on behalf of the Plaintiff in light of the several discrepancies and inconsistencies that I have mentioned above. His evidence was not convincing especially in relation to the employment of a 12 year old minor in 1997 who was being paid more than the minimum wage. Whereas one can understand an uncle's benevolence towards his nephew, I found it difficult to accept that an estate owner, who necessarily had to be a businessman, would find it to be good business sense to pay a 12 year old \$10 an hour in 1997 [or, more correctly as per his evidence, **\$12.50 per hour**, which is the \$75.00 per day he said he paid the Plaintiff divided by the 6 hours which the Plaintiff would have worked at that time] and pay that same person, who is now 24 years old, less than \$10 per hour for the roughly 2 1/2 hours work that he puts in on a daily basis. Crucially, the Plaintiff himself failed to impress me that he made any attempts to mitigate his losses and to find alternate employment or to find some other

² See “**Neurology and Trauma**” by Randolph Evans, 2006 at page 224 which says that post concussion syndrome may or may not involve loss of consciousness; “Post Concussion Syndrome” by the Mayo Clinic staff at Mayo Clinic <http://www.mayoclinic.com/health/post-concussion-syndrome/DS01020> which says that “Loss of consciousness isn't required for a diagnosis of concussion. In some cases, only a brief lapse of memory or a feeling of being dazed is experienced.” See also <http://neurology.health-cares.net/post-concussion-syndrome.php>

type of employment which may have been more suitable for him. In fact, there was absolutely no evidence in this respect whatsoever as the Plaintiff admitted in his cross examination.

16. Further, for the reasons mentioned above, I did not accept that the Plaintiff was a reliable witness as he seemed willing to bend the facts to suit his purpose [e.g in the discrepancy involving the type of estate that his uncle was carrying on] and made statements without any basis or foundation whatsoever to allow me to understand fully his difficulties and complaints. For example, he spoke about pain and discomfort **at times** during intercourse but did not give details as to what he meant by that such as whether this was something that happened all the time or what exactly "*at times*" meant. He spoke about the general discomfort restricting him from "liming" with friends, going to parties, dancing and socializing yet he did not give details as to whether in fact he was a person who used to "lime", go to parties, dance and socialize before the accident and how in fact the accident and the injuries he sustained had affected his quality of life in this regard. Further, in cross examination he accepted that his friends were free to visit him at his home. I also find it quite noteworthy that for a person who said that "*the constant lancing pain makes it difficult to stand or sit for more than 20 minutes*", he did not provide one bit of independent evidence of actually being treated with pain killers or any type of medication to help him deal with this type of constant pain prior to the October 2008 report of Dr. Bedaysie (more than 6 years after the accident) when he referred to, recommending the tablet Arcoxia, which is a pain killer, and physiotherapy to help reduce pain once per month. The use of the word "lancing" suggests a sharp piercing pain and one would expect some sort of specific treatment for that allegation. However, there is no evidence of receipts from pharmacies for painkillers, prescriptions for painkillers, receipts for physiotherapy, clinic cards for physiotherapy as recommended by the medical practitioners who attended to this Plaintiff or, for that matter, any evidence of any type of physiotherapy as recommended, etc. One may also have expected that someone close to the Plaintiff may have come to court to say that they had heard or seen the Plaintiff in obvious discomfort or unable to move or suffering in some obvious manner (whether crying out in pain or moaning or the like) in light of this constant pain but no one else came other than Mr. Dookie who spoke about complaints made by the Plaintiff as opposed to actual observations. So, do I believe that he would be required to take the recommended tablets of Arcoxia and Omeprazole for the rest of his life as set out by Dr. Bedaysie in his 2008 medical report? Having regard to all of the reports and the facts before me, I must admit that I have grave misgivings about this subjective allegation of this constant high level of pain which would have persisted for the last 7 years without any evidence of any prior treatment or medication. As much as I am loathe to second-guess Dr. Bedaysie, bearing in mind the Plaintiff's propensity for exaggeration/ incredibility in his evidence and his failure to give evidence of any type of treatment which he received, I am not minded to accept that the pain is so intense that he must take these tablets every day for the rest of his life especially since he has survived for 7 years without doing so and never even raised it in his pleadings.

The authorities cited:

17. The cases relied on by the Defendants were:

17.1. **Reid vs. Professional Marine Diving** HCA No. 2083 of 1979;

In this case, the Plaintiff sustained a fall and hit his buttocks as a result of which he was diagnosed with contusion, tenderness and discoloration on the ischial (buttocks) area, traumatic myo-tendonitis of the right hamstring and concussion to the spinal cord and the nerve roots ensuing from it in the lumbar and sacral regions but more marked on the right than the left. Examination did not show any condition treatable by surgery. The disability was found to be of a permanent nature with resulting sexual disability because of the area of sensory loss which contained the nerves associated with parts of the sexual act. He was awarded the sum of \$14,000.00 on 14 February 1985 for pain, suffering and loss of amenities – he gave evidence of playing football and doing karate prior to the accident which he was no longer able to do. I did not find this case particularly helpful at all.

17.2. **Richardson vs. Kiss Baking Company Ltd.** HCA No. 696 of 1996;

The first named Plaintiff in this matter suffered from loss of consciousness, right forehead laceration, neck and back pain, soft tissue injury of the neck and entire back. He suffered from headaches on a nearly daily basis lasting 2 to 3 hours with neck pain radiating to both shoulders and upper extremities together with numbness, heaviness and weakness of both upper extremities. The lower back pain radiates to the left lower extremity accompanied by muscle cramps and weakness on walking. MRI scan showed a bulge at disc L4-L5-S1. Findings included post-concussion syndrome and neck and lower back strain which may continue indefinitely and may be permanent. He was deemed medically unfit to work as an electrician with permanent partial disability assessed at 30%. Reporting by another specialist put these findings in question and this Plaintiff, who was able to resume work on a full-time basis as an electrician, was awarded the sum of \$35,000 on the 31st of January 2000 after considering the cases of Deonarine vs. Ramlal HCA No. 1350 of 1980, Pemberton vs. Hi Lo HCA No. 6036 of 1988, Mitchell vs. Wilson HCA No. 1825 of 1992 and Sookoo vs. PTSC HCA No S-883 of 1988 (Civ Appeal 21 of 1993)

17.3. **Retess vs. John** HCA No. 535 of 1982;

In this matter, the Plaintiff complained of headaches, dizziness, pains in the neck, shoulder and both arms with limitation of all neck movements. She was found to have an abnormality at cervical spine level and the complications were associated with a whiplash injury. The Plaintiff was found to be limited in functions relating to standing, sitting and other postural changes with severe pains in her left knee and severe headaches occasionally. She was awarded the sum of \$10,000.00 on the 19th July 1983.

- 17.4. **Harriott vs. Noel and Auto Rentals Ltd.** HCA No. S. - 2592 of 1985;

The Plaintiff in this matter suffered a whiplash injury to her neck with no bone injury. She complained of nervousness and headaches with pain in her neck on flexion and rotation. She was awarded \$12,000 on 22 September 1988. This injury was not similar to the one which had to be considered in the case before me.

- 17.5. **Hector vs. Bhagoutie** HCA No. S – 115 of 2000;

In this matter, the Plaintiff could not stand or bend for long without experiencing pain in the neck and shoulder as a result of his injury and was unable to participate in sports which he gave evidence of playing prior to the accident. He was awarded the sum of \$19,000 on 14 June 2006.

- 17.6. **Parahoo vs. SM Jaleel** CA No. 110 of 2001;

The injuries in this matter were listed in the judgment and included loss of consciousness, scalp lacerations, headaches, forgetfulness, poor concentration, back and shoulder pains, weakness on the right side of the body, they showed weakness, base of skull fractures, cerebral contusion with resulting right hemiparesis, post contusion syndrome, loss of smell and poor taste sensation, various lacerations and hematoma and other injuries and complaints. What was quite interesting in this matter was the court's discussion about the need for psychiatric testing to be done to help the doctor differentiate between real and pretended symptoms since the majority of his findings, as in the matter before me, were based on responses given by the Plaintiff and the doctor's finding of a 50% permanent partial disability was subject to a reservation of having the psychiatric tests done. The award of \$50,000 by the trial judge was upheld on 17 January 2003 by the Court of Appeal who did not find any ground to interfere with it. The injuries in this matter seemed to me to be of greater severity than in the case before me.

- 17.7. **Browne vs. Hunte** HCA No. S - 807 of 1971;

- 17.8. **Sohan vs. Hackett** HCA No. 513 of 1978.

In this matter, the Plaintiff suffered a narrowing of the disc below the 12th thoracic and the first lumbar vertebrae along with anterior wedging of the first vertebral body. He also had injuries to his left ankle and knee. He was awarded the sum of \$20,000 on 30 July 1984.

18. The cases relied on by the Plaintiff were the same as above along with:
- 18.1. Civil Appeal No. 136 of 2000:- **Peter Seepersad v. T. Persad & Capital Insurance Limited**;
- The Plaintiff in this matter sustained injuries to his back, specifically to the L5, S1, the 5th, 11 and 12 thoracic vertebrae i.e. T11 and T12. He did not undergo surgical treatment and he was unable to operate his taxi as a full-time taxi driver or as a mechanic. He suffered restricted mobility and could not lift heavy objects. He was unable to take part in limited recreational activities which he enjoyed before the accident but could lift his infant child or take walks as well as drive his car. His evidence was found to be exaggerated by the trial judge. He was awarded the sum of \$75,000 by the trial judge and this was upheld by the Privy Council [see reference below].
- 18.2. Privy Council Appeal No. 8 of 2002:- **Peter Seepersad vs. T. Persad & Capital Insurance Limited**.

The award:

19. The case of **Victor Cornilliac v Griffith St. Louis** (1965) 7 WIR 491 sets out the matters to be considered by a Court in assessing damages for personal injury. They are as follows:
- 19.1. The nature and extent of the injuries sustained;
- 19.2. The nature and gravity of the resulting physical disability;
- 19.3. The pain and suffering endured;
- 19.4. The loss of amenities suffered; and
- 19.5. The extent to which consequentially, the Plaintiff's pecuniary prospects have been materially affected.
20. I also rely upon the matters I discussed at paragraph 7 of my judgment in the case of HCA No. 66 of 2002:- **Debbie Mohammed v Archibald Bellamy, The Attorney General of Trinidad and Tobago and Ramnarine Sookdeo** (supra).
21. The nature and extent of the injuries sustained:-
- 21.1. I accept the uncontroverted evidence of Dr. Rasheed Adams that the Plaintiff suffered post concussion syndrome and thoracic spine strain. As mentioned above, this was the diagnosis upon which Dr. Bedaysie relied. I also accept that he suffered a 2 cm laceration to the right cheek and multiple abrasions to the left cheek. I am not convinced of Dr. Bedaysie's finding that there would be a degeneration of the disc over the course of time especially since he did not feel it necessary to evaluate the deterioration of the disc, if any, in 2008 when he did his last report, whether by MRI, x - ray or by other such testing so that I cannot find any scientific basis for this assertion.
22. The nature and gravity of the resulting physical disability:-

- 22.1. I do not accept the intensity of the continuing disability alleged by the Plaintiff as I had found him to be unreliable and prone to exaggeration. I therefore also have serious doubts as to the findings made by Dr. Bedaysie based upon whatever subjective symptoms were related to him by the Plaintiff.
23. The pain and suffering endured;
- 23.1. None of the medical reports which were put into evidence indicated such an extreme level of pain as is alleged by the plaintiff. However, there are indications that the plaintiff suffered pain even to the extent where he had to seek an x-ray of his thoracic spine in June of 2004 for upper spine pain. Yet, that x-ray did not show any serious injury consistent with the type of pain that the plaintiff complains of in this matter.
24. The loss of amenities suffered;
- 24.1. Again, I was not satisfied with the Plaintiff's evidence in this regard. I have no evidence of the Plaintiff's activities as a student prior to the accident in 2002 when he was almost 17 years of age. With the plaintiff's tendency to exaggerate, I am unable to comfortably come to any finding as to the effect that this accident has had on his quality of life.
25. The extent to which consequentially, the Plaintiff's pecuniary prospects have been materially affected.
- 25.1. Being almost 17 years old at the time of the accident and still attending school, I would have expected the Plaintiff to have presented evidence as to his academic training especially since, at 17, he ought to have been in 6th form at secondary school. No such evidence was presented. I cannot believe that this Plaintiff's aspiration was to have been a daily paid estate worker with his uncle for life and his failure to provide cogent evidence as to his training, his qualifications and his continuing education, if any, leaves a large lacuna in the Plaintiff's life and the future prospects. I must confess that I am not at all satisfied with the evidence as to the Plaintiff's pecuniary prospects and how it is affected, if at all. In the case of **Parahoo vs. SM Jaleel** *supra* Hamel-Smith JA said that in respect of loss of pecuniary prospect, a claiming party had to show that the injury was of such a nature that it rendered the party incapable of performing the job he was previously performing, or, for that matter, any other form of work whatsoever. If it rendered him incapable of performing the prior job but did not prevent him from doing other work, it was necessary to show that in order to mitigate his loss. The learned Justice of Appeal went on to say that, in discharging this onus, medical evidence as to the nature of the injury and the residual effect that the injury may have had on the claimant's ability to work is imperative. The burden being on the Plaintiff to prove this aspect, I have reluctantly reached to the conclusion that the Plaintiff has not done so.
26. Bearing in mind the evidence and the authorities, I award the sum of \$ 35,000.00 as general damages in this matter.
27. The need for future surgery:

27.1. This was an aspect of general damages which ought to have been pleaded – per Kangaloo JA in Civ App 146 of 2003:- **Mario's Pizzeria Ltd vs. Hardeo Ramjit** at paragraph 16. The fact that Dr. Bedaysie's evidence in his witness statement was not objected to by the Defendants does not necessarily mean that it must be accepted by me without amendment of the pleadings and the application for the amendment, which ought to have been most apparent several months before, was not made until the end of the case – after cross examination - and just before submissions. The need for the surgery in any event, was not, in my view, scientifically established. Without the benefit of proper updated testing by MRI or x-ray or other such means in 2008, I cannot see how it would have been possible for Dr. Bedaysie to reach to the conclusion that surgery may be necessary since I am not satisfied that he was in a position to have determined if there was any degeneration from 2004 to 2008 having failed to carry out any scientific testing at all at any time. Therefore, having failed to reach that determination, I cannot see how he can definitively say, or even on a balance of probabilities, that there would have been degeneration of the disc especially since he did not give evidence of a causal link between the post concussion syndrome and the thoracic spine strain on the one hand and any degeneration of the disc (the specific details of what disc having not been mentioned) on the other. As such, I am not minded to make any award in this category at all.

28. Special Damages:

28.1. The medical expenses were agreed in the sum of \$1,700.00.

28.2. There was no evidence of travelling so that claim is not allowed and neither was there any evidence of any police report and travelling for that so that claim is also disallowed.

28.3. Loss of income in the future and continuing was another claim made. As I have said, I was not satisfied with the quality of the evidence to show that this Plaintiff would be affected for life in light of his unreliable viva voce evidence. This, in any event, is a relief which falls under the general damages rather than special damages category.

The order:

Damages are therefore assessed as follows:

28.4. Total General Damages awarded in the sum of \$ 35,000.00;

28.5. Total Special Damages awarded in the sum of \$ 1,700.00;

28.6. Interest on Special damages to run from the 28th May 2002 at the rate of 6% per annum until the date hereof;

28.7. Interest to run on General Damages from the 19th of November 2004 at the rate of 12% per annum until the date hereof;

28.8. The costs of the action certified fit for advocate attorney to be paid by the Defendants to the Plaintiff.

Devindra Rampersad

Judge (Ag)