COMMONWEALTH OF THE BAHAMAS
IN THE SUPREME COURT
COMMON LAW AND EQUITY DIVISION

2017/CLE/gen/00135

BETWEEN

SUSANNE ROLLE-TIEDEMANN

Plaintiff

AND

ELAINE COLLIE
RAYNELL COLLIE

Defendants

Before: The Honourable Madam Justice Tara Cooper Burnside (Ag)

Appearances: Roshar G. Brown of South-West Legal Services for the Plaintiff

Camille Cleare and Viola Major of Harry B. Sands, Lobosky & Company for the Defendants

Hearing Date: 14 December 2020

Personal injury – Road traffic accident – Defendant admitting liability – Assessment of damages – General damages for pain and suffering – Causation – Pleading and proving special damages

JUDGMENT ON
ASSESSMENT OF DAMAGES

INTRODUCTION

[1] This matter arises out of a road traffic accident which occurred on Friday, 15 July 2016 on the Frank Watson Boulevard near the service entrance to the Albany Resort and Spa located on the Western end of the Island of New Providence. The Plaintiff was a front seat passenger in a 2015 Suzuki Swift sedan that was driven by her husband and headed

in a westerly direction when that vehicle was hit on the right passenger side by a 2014 Kia Sportage SUV owned by the First Defendant and driven by the Second Defendant.

[2] The Plaintiff, who was 56 years old at the time, sustained personal injuries as a result of the accident. She was initially treated at Doctors Hospital in Nassau and was subsequently airlifted to Jackson Memorial Hospital, in Florida. On 13 February 2017, the Plaintiff commenced this action against the Defendants for damages in negligence.

[3] In the Statement of Claim indorsed on her Writ, the Plaintiff pleaded her case as follows:

"**STATEMENT OF CLAIM**

1. **At all material times the Plaintiff was a passenger in a 2015 Suzuki Swift vehicle, reg. no. 292795, driven by Mr. Euthal Rolle.**

2. **At all material times the First Defendant was the owner of a 2014 Kia Sportage SUV, reg. no. 289802 being driven by the Second Defendant when it collided with the driver's side of the vehicle in which the Plaintiff was a passenger.**

3. **The said collision was caused by the negligence of the Second Defendant as servant or agent of the First Defendant.**

Particulars of Negligence

(i.) **failing to keep any or any proper look out and/or to observe or heed the presence or approach of the vehicle in which the Plaintiff was a passenger;**
(ii.) **failing to keep any or any proper look out while overtaking;**
(iii.) **driving too fast; and**
(iv.) **failing to apply her brakes in time or at all and/or failing to steer or control her vehicle as to avoid the said collision.**

4. **By reason of the Second Defendant's said negligence, the Plaintiff has sustained severe personal injuries and has suffered loss and damage.**

Particulars of Injuries

5. **The Plaintiff, who was born on the 8th August 1960 and is now aged fifty six (56) years suffered a fracture of the right arm, dislocation of the left hip and an acute pulmonary embolism.**

Particulars of Special Damage

6.	**Loss of wages from 18th July 2016 to the 31st December 2016 at $3,683.33 per month**	**$**	**18,416.65**
	Hospital and doctors Fees	**$**	**484,176.72**
	Aids required for Plaintiff's recovery (wheelchair, commode, walker, sliding board)	**$**	**72.71**
	Physiotherapy from September 2016 and counting	**$**	**3,487.15**
	Home help's wages while the Plaintiff was incapacitated from 18th July 2016 at $60.00 per week and continuing	**$**	**2,490.00**
	Airfare (up to 18th Nov. 2016)	**$**	**1,417.95**
	House and pet sitter	**$**	**800.00**
	Hotel	**$**	**1,037.25**
	Medication from July 2016 and continuing	**$**	**759.56**
		$	**512,657.99**

AND the Plaintiff claims:-

i) **Special damages in the amount of $512, 657.99**
ii) **General damages**
iii) **Interest pursuant to the Civil Procedure (Award of Interest) Act 1992**
iv) **Costs**
v) **Any further relief as the Court deems fit and just"**

[4] On 24 April 2017, the Defendants filed a Defence in the following terms:

"DEFENCE

1. **The Defendants admit paragraphs 1 and 2 of the Statement of Claim save that the collision occurred at the driver's side of the vehicle in which the Plaintiff was a passenger and the Plaintiff is put to strict proof thereof. The Second Defendant says the accident occurred whereby the First Defendants vehicle**

impacted the passenger side of the car in which the Plaintiff was seated as a passenger.

2. **The Defendant denies paragraph 3 of the Statement of Claim and puts the Plaintiff to strict proof thereof. In particular, the Second Defendant denies that she was overtaking any vehicle as alleged. The Second Defendant says that she was turning into the entrance of Albany security at the time the collision occurred.**

3. **The Defendant denies that the injuries alleged to have been sustained as a result of the accident, in particular the acute pulmonary embolism, as pleaded in paragraph 5 of the Statement of Claim, were caused as a result of the accident and the Defendant further denies that any of the injuries as alleged or at all were sustained as a result of the negligence of the Second Defendant and the Plaintiff is put to strict proof thereof.**

4. **The Defendant denies the particulars of special damages as alleged in paragraph 6 of the Statement of Claim and puts the Plaintiff to strict proof thereof.**

5. **Save insofar as is hereinbefore expressly admitted or not admitted the Defendants deny each and every allegation of fact contained in the Statement of Claim as if the same were set out herein and specifically traversed seriatim."**

[5] On 22 October 2020, at a pre-trial conference, the Defendants admitted liability and the matter was set down for an assessment of damages on 14 December 2020.

THE EVIDENCE

Oral

[6] The Plaintiff and her husband, Euthal Rolle, gave evidence at the trial. When cross-examined by the Defendants' Counsel, Ms Cleare, they both struck me as credible and truthful. They appeared forthright and were not evasive in their answers.

[7] The medical experts who gave evidence for the Plaintiff were Dr Dane Bowe, an orthopedic surgeon and Dr Paul Ramphal, a cardio-thoracic surgeon. Both of them attended the Plaintiff.

[8] Ms Cleare accepted that Dr Bowe and Dr Ramphal were both experts in their field and she declined to cross-examine them.

[9] No witnesses were called by the Defendants.

Documentary

[10] The Plaintiff filed a Bundle of Documents (the "**Agreed Bundle of Documents**") on 28 January 2020 which was agreed in its entirety at the Assessment on the basis that all documents contained therein were admitted into evidence as to their contents, subject to relevance and weight. [See ***Colina Insurance Ltd v Enos Gardiner*** Civil Appeal No. 117 of 2015, per Crane-Scott JA at paragraph 96.]

RELEVANT LEGAL PRINCIPALS

[11] The principles which apply to the assessment of damages in a personal injury case were helpfully explained by Dunkley QC J. (Ag) in ***Farmer et al v Smith*** Bahamas Supreme Court Action No. CLE/gen/1798 of 2007 (unreported). He said:

> "30. ...[T]he object of an award for damages for PSLA in personal injury matters is "as nearly as possible to get at that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation" (as per Blackburn LJ in ***Livingstone vs. Rawyards Coal Co.*** **(1880) 5 Appeal Case 25)** and Lord Goddard in **British Transport Commission v Gourley [1956] AC 185.** The object of the court in awarding damages in tort for pecuniary loss is so far as possible to restore the victim to the same overall financial position as that in which he would have found himself if the tort had never been committed. However great its sympathy with the plaintiff, it is not entitled to give him an adventitious profit.
>
> 31. The tortfeasor in a personal injuries matter is liable for any exacerbation of preexisting conditions and is likewise liable for rendering previously asymptomatic conditions symptomatic since the tortfeasor must take his victim as he finds them. This point was confirmed by Lyons J in Olga Forbes v. Mario Smith CLE/gen/1388 of 2007. However, the tortfeasor is not liable for loss or damage unless he has caused or materially contributed to

the loss or damage. And the tortfeasor's liability for damages based on an aggravation of an injured party's pre-existing physical deficiency should take into consideration that deficiency: **Grand Bahama Construction Co. v. Kemp - [1997] BHS J. No. 7** (Bahamas CA) per Georges JA. In other words, while a tortfeasor must take his victim as he finds him he is not liable for any injury that was *not caused* by the accident: **Cutler v. Vauxhall Motors Ltd. [1970] 2 All ER 56 and McCoy v. Williams and another; Clarke v. Williams and another - [2014] 1 BHS J. No. 112. See also Brewster v. Davis (1992) 42 WIR 59.**

32. The loss or damage for PSLA is not susceptible of measurement in money. Any figure at which the assessor of damages arrives cannot be other than artificial and, if the aim is that justice meted out to all litigants should be even-handed instead of depending on the idiosyncrasies of the assessor, whether jury or judge, the figure must be 'basically a conventional figure derived from experience and from awards in comparable cases. The court should in general have regard to awards in the same jurisdiction or jurisdictions where social and economic conditions are similar: See **Wright v British Railway Board (1983) A.C. 773, Selvanayagam v University of the West Indies [1983] 34 W.I.R. 267 at page 273, also Lord Fraser in Li Ping Sun v Chan Wai Tong [1985] 1 Lloyd's Rep 87. And Taylor v. Nassau Guardian (1844) Ltd. - [2003] BHS J. No. 9. The Bahamas Court of Appeal in Neko Grant II v. Frederick R.M. Smith and Smith Point Ltd, Civil Appeal No. 32 of 2002** expressed the view that, at the time of the earlier cases supporting an uplift it was recognised that the cost of living in The Bahamas was higher than in England and thus adjustments were made upwards using the English awards as a base. However, the Court of Appeal concluded that it is now generally accepted that the cost of living in the U.K is higher than in The Bahamas, thus negating the need for a markup. The Bahamas Court of Appeal in **Kendal Barr v. Sunco Builders & Developers Limited Civil Appeal No. 57 of 2005** reaffirmed approach.

33. In a case where there are a number of separate injuries, all adding up to one composite effect upon a plaintiff, the judge, having considered the various injuries and fixed a particular figure as reasonable for each, should stand back and look at what should be the global aggregate figure and ask if it is reasonable

compensation for the totality of the injury to the plaintiff or to consider whether it would in the aggregate be larger than was reasonable. The judge should consider whether the award for PSLA should be greater than the sum of the parts in order properly to reflect the combined effect of all the injuries upon the injured person's recovering quality of life or, on the contrary, should be smaller than the sum of the parts in order to remove an element of double counting. In some cases, no doubt a minority, no adjustment will be necessary because the total will properly reflect the overall pain, suffering and loss of amenity endured. In others, and probably the majority, an adjustment and occasionally a significant adjustment may be necessary. Essentially, this involves an intuitive assessment of the suitability of the sum produced to compensate the overall condition of the plaintiff.: **Constable 614 Roy Cooper et al v. Beryl Grant Deveaux SSCiv App. No. 61 of 2007; Brown v. Woodall 1995 P.I.Q.R. Q36 at Q39; Wilson v Gilroy and Motor Insurers' Bureau [2008] NICA 23 and Sadler v Filipiak [2011] EWCA Civ 1728.**

34. Where there is a *chance* that the plaintiff will require future medical treatment it is suggested that the correct approach is first to ascertain (at present day value) the cost to the claimant of such an operation. That cost needs to be discounted twice, first to take account of the chance that the operation will not be required, and secondly to take account of the accelerated receipt by the plaintiff. Thus if the medical evidence is to the effect that there is a 75 per cent chance that the claimant will require the operation in 10 years' time, and that the present cost of the operation is £10,000, then the sum to be awarded would be £5,859, namely £7,500 (£10,000 x 75%) x 0.7812, the appropriate discount for an acceleration of 10 years at a discount rate of 2.5 per cent. It is more difficult when the medical evidence gives a range, or uses the expression "within 10 years". In such circumstances, practitioners are advised to ask the medical expert to be more precise so that the necessary evidence is available in order to allow the calculation to be made. Failing that, a more rough and ready method of assessment may be required: **See Shutt v. Island Construction Co. [1997] BHS J. No.104 and the extract cited from Kemp & Kemp.**"

THE PLAINTIFF'S INJURIES

[12] The first question to be determined is what injuries were suffered by the Plaintiff as a result of the accident.

[13] At paragraph 5 of her Writ the Plaintiff claims to have sustained a fractured right arm, dislocation of the left hip and an acute pulmonary embolism.

Fractured left arm

[14] In her witness statement made on 13 November 2019, the Plaintiff states:

> "3. I lost consciousness for a short while. When I regained consciousness, I saw my husband stumbling out of the car. There was a lot of smoke and an acidy smell. All the airbags in our vehicle were inflated. I was afraid the car would alight. I could not open my door because the SUV was right at it. I banged on the window and the driver of the SUV reversed. I was able to open the door. I opened my vehicle's door and tried to stand up. When I felt an excruciating pain in my left hip and I was unable to get out of the vehicle. I could not move the leg and suspected it was either broken or dislocated...The Police arrived approximately 30-45 mins after the accident...by this time, my left leg was very swollen, very red, and the pain was excruciating. The paramedics examined my leg. I left for the hospital in the ambulance while my husband remained at the scene to speak with the police.
>
> 4. Upon arriving at Doctor's Hospital, I was taken into the emergency room. I was immediately given morphine intravenously to ease the paid before I was taken on a stretcher to have x-rays and various other tests done. However, because the pain was so severe when I moved around, an attending doctor had me retuned to the emergency room until Dr. Dane Bowe arrived to examine me. I was given anesthesia. When I awoke, Dr. Bowe was there, as was my husband and my co-worker and friend, Kenya Bethel. Dr Bowe advised me of the course of treatment he had performed. My left leg was placed in a brace and I had to keep my leg elevated. I had to remain lying still in bed all day with my left foot elevated. I remained in Doctor's Hospital from 15th July to 20th July 2016."

[15] The Plaintiff did not lead any primary evidence to show that she suffered a fracture to her right arm. I note, however, that the Doctors Hospital Discharge Summary dated 20

July 2016 (the "**Discharge Summary**") contained in the Agreed Bundle states that her Primary Diagnosis/Clinical Impression included "*Colles' fracture of right radius*". I therefore reject the submission of Counsel for the Defendant that there is "absolutely no evidence whatsoever of a fracture of the right arm) or any injury to the right arm) of the Plaintiff". To the contrary, I find that the evidence establishes on a balance of probabilities that the Plaintiff suffered a fracture of her right arm as a result of the accident.

Dislocated hip

[16] At paragraph 2 of his witness statement, Dr Bowe confirmed that the Plaintiff was transported to the Accident and Emergency Unit of Doctors Hospital and first attended by Dr James Iferenta who referred the Plaintiff's case to him. He also confirms that she presented with a closed fracture-dislocation of the left hip and underwent a successful reduction of the left hip. In the Discharge Summary, the hip injury diagnosis is described as "*Hip dislocation, left*".

[17] The Discharge Summary corroborates the evidence of Dr Bowe and states that the Plaintiff's Primary Diagnosis/ Clinical Impression also included a "*Hip dislocation, left*". It further states that the Plaintiff, who was admitted on 16 July 2016, was discharged on 20 July 2016 and her Hospital Course, i.e., the sequence of events, was as follows:

> "**Hospital Course**
> **Course (Detailed)**
> *Uneventful closed reduction of the right hip dislocation in the ER at Doctor's hospital. Discussed observation of femoral head fracture and may require bipolar hip replacement. Placed knee immobilizer on affected side to prevent flexion of the left hip. Has neurological sequelea as a result of the trauma.*
>
> **Complications During Hospital:** None
> **Treatment Rendered:** Conservative Mx
> **Any New Allergies Discovered?:** No
> **Any INPT Adverse Drug Reaction:** No
> **Allergies:**
> **Coded Allergies:**
> Penicillin (Verified Allergy, Unknown, 15/7/16)"

[18] On the evidence before me, I find that the Plaintiff has, on balance, proved that she suffered a fracture-dislocation of her left hip which was caused by the accident. And as indicated in paragraph 5 above, the Defendants admit that the accident was caused by their negligence.

Pulmonary embolism

[19] In his witness statement, Dr Ramphal confirmed that on 29 July 2016 the Plaintiff was diagnosed with pulmonary embolism. His evidence in this regard is as follows:

> "2. The evening of the 29th July 2016, I was called to the Intensive Care Unit at Doctor's Hospital, Nassau. I met and spoke with Dr. Ntari Darville, Consultant Intensivist, concerning a female patient, Mrs. Susanne Rolle-Tiedemann.
>
> 3. It was explained to me by Dr. Darville that Mrs. Rolle-Tiedemann had been involved in a road traffic accident on 15thJuly 2016 and had been brought to DH and treated by Dr. Dane Bowe for a dislocated and fractured left hip. She was discharged from DH on the 20thJuly 2016 where she was given instructions regarding her care and followed up with Dr. Bowe on the 26th July 2016. However, she became concerned when she began experiencing shortness of breath and bouts of vertigo. As a result of the complaints of acute shortness of breath, Mrs. Rolle-Tiedemann was sent for an urgent CT scan of the chest.
>
> 4. The CT scan was performed and demonstrated an large Pulmonary Embolism (PE)(saddle) with bilateral smaller disseminated emboli likely from Deep Vein Thrombosis (DVT) in Mrs. Rolle-Tiedemann's fractured left lower limb. After discussion with Dr. Darville and Dr. Barry McCartney, and in view of her worsening respiratory function, the decision was made to intubate Mrs. Rolle-Tiedemann immediately and administer thrombolytic therapy. This is a medication given to dissolve blood clots, improve blood flow and prevent damage to tissues and organs. Without this treatment, or more invasive treatments such as open surgical thrombectomy, Saddle PE is often fatal.
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> 5. Pulmonary Emboli are blood clots that cause blockages in the vessels leading to the lungs, and often result in organ failure (lungs, heart, kidneys). A saddle PE blocks the circulation of blood from the heart to the lungs, and back to the heart, resulting in inadequate oxygenation of the blood, and causing the heart to overwork and can cause acute right-sided heart failure. In many cases, the diagnosis of saddle PE end *(sic)* in the death of the patient. Mrs. Rolle-Tiedemann was considered to be at a high mortality risk.

6. Dr. Darville and I spent some time speaking with Mrs. Rolle-Tiedemann about the results of the CT scan and the implications of the findings, as well as our recommendations regarding the treatment that she needed, including the need for immediate thrombolysis therapy. Mrs. Rolle-Tiedemann and her husband gave consent for intubation and initiation of thrombolysis therapy. After administration of the thrombolytic, Mrs. Rolle-Tiedemann was in stable condition.

7. Sometime later that same evening, Mrs. Rolle-Tiedemann's blood pressure became unstable, requiring inotropic support to stabilize the blood pressure and circulation to maintain adequate oxygen delivery to her tissues. An ECHOCARDIOGRAM (ECHO) was performed and demonstrated right heart dilatation and strain. She was given intravenous adrenaline and external pacemaker pads were placed. Mrs. Rolle-Tiedemann also began to manifest signs of renal function impairment. The plan at that time was to continue inotropic therapy and support and observe her progress for signs of stabilization. These issues and the management plan were discussed with her husband.

8. The treatment/management aim was to dissolve the existing blood clots and prevent new clots from forming. A number of chest CT scans were performed to monitor the status of the PE. The potential for contrast-induced renal function impairment was discussed with the patient's husband during the course of her hospitalization.

9. On the 31st July 2016, at approximately 12:00 pm, 48 hours after thrombolysis, I inserted a central venous pressure line and an arterial line, at the request of the intensive care specialist. This was done in order to continuously monitor her right heart function and her systemic blood pressure, and for continued administration of medications. For these percutaneous invasive lines, access was via the right subclavian vein and the left radial artery.

10. Mrs. Rolle-Tiedemann showed clinical improvement during the early hours of 1st August 2016. Her renal function had improved and the CT taken on 31st July 2016 showed a significant reduction in the large PE; the saddle PE had completely disappeared/dissolved; the clots in the left pulmonary artery had cleared; fewer clots were seen in the right pulmonary artery. Mrs. Rolle-Tiedemann remained sedated.

11. However, by the end of the day of 1st August 2016, Mrs. Rolle-Tiedemann's condition had deteriorated. The (sic) was a complication with the left lung. An x-ray of the chest taken in the early portion of 2nd August 2016 showed evidence of atelectasis of the left lung base (resorption of alveolar air with collapse of portions of the lung). This is a common complication of patients with mulit-organ (sic) dysfunction who are on assisted ventilation). Dr. Dean Tseretopolous, Mrs. Rolle-Tiedemanns' primary physician, as well as Dr. Don Deveaux and Dr. Michael Ntari Darville, were all made aware of this situation. Mrs. Rolle-Tiedemann's husband was notified about the change in her condition.

12. The FiO2 was at 80% at this time, and was soon increased to an FiO2 of 100%/. The postulate and conclusion was that despite anticoagulation, it was possible that more emboli were being sent to her pulmonary arterial tree. At that time, and *(sic)* INFERIOR VENA CAVAL FILTER (IVC Filter) was implanted to minimized *(sic)* the possibility of further large clots from entering the pulmonary arteries from any peripheral (lower limb) deep venous thromboses.

13. As a result of her acute respiratory failure, and after consultation with the entire team of doctors and with her husband, the decision was made to place Mrs. Rolle-Tiedemann on VENO-ARTERIAL EXTRA-CORPOREAL MEMBRANE OXYGENATION (VA-ECMO). Despite the FiO2 of 100% and maximal ventilator support, Mrs. Rolle Tiedemann was not able to adequately oxygenate her blood. ECMO is an invasive respiratory and circulatory support technique that uses a machine to pump blood to and from the patient's body, utilizing a warmer and an oxygenator (mechanical artificial lung).

14. Because Mrs. Rolle-Tiedemann's left hip had been fractured, the decision was made to insert the two ECMO cannulae (tubes) in her right femoral vein and artery. The groin vessels are the most readily accessible large-calibre vessels and are the usual site for this procedure. Without ECMO, the expectation was that Mrs. Rolle-Tiedemann would not have survived. As such, initiation of ECMO is often the last resort, when a patient's pulmonary function continues to deteriorate despite the best conventional treatments.

15. After continued monitoring of Mrs. Rolle-Tiedemann's condition, and after consulting with the medical team, it was decided that the best course of action would be to transfer her to and overseas facility that specialized in the treatment of such high-risk ICU

patients, and which had experience in managing patients who were on ECMO. Arrangements were made to transfer Mrs. Rolle-Tiedemann to Jackson Memorial Hospital in Florida.

16. On the 3rd August 2016, at approximately 4:16 pm, Mrs. Rolle-Tiedemann was transported by air ambulance from DH ICU to JMH ICU. Dr. Darville prepared a final report on the 3rd August 2016 describing the management."

[20] The CT Scan referred to by Dr Ramphal is contained in the Agreed Bundle. It states, *inter alia*,:

> "**CT PULMONARY ANGIOGRAM**
> High –resolution axial CT images were obtained from the level of thacic inlet to the level of diaphragm after bous IV contrast in PE protocol in a 64 slice CT scanner.
>
> Extensive acute pulmonary embolism is seen as a flat saddle embolus which connects the nearly occlusive clot in the hilar aspects of both pulmonary arteries (right>left). It further occludes the lobar arteries (inferior>superior) and many segmental branches on either side..."

[21] I find that the Plaintiff has proved, on balance, that she suffered a pulmonary embolism on 29 July 2016 in the circumstances.

[22] In her written submissions, the Defendants' Counsel states:

> "30. ... the Defendants by their Defence dispute that the Acute Pulmonary Embolism was caused by the RTA and the Plaintiff was put to strict proof."

[23] The prima facie test for causation in the law of damages is the "but for" test applicable to causation of damage generally in the law of negligence. Under this test, a head of damage is caused by the defendant's wrong if and only if it would not have happened but for the latter. If it would have occurred in any case the defendant is not liable for it. Nevertheless the limitations of this test must be noted. In particular, it may fall to be modified where there are two concurrent heads of loss and where other events may intervene to loosen or eliminate the connection between the defendant's wrong and the plaintiff's loss.

[24] In ***Athey v Leonati*** et al [1996] 3 SCR 458, a decision of the Supreme Court of Canada cited by Ms Cleare, Major J summarized the principles to be applied when the "but for" test is unworkable. He stated:

"14 The general, but not conclusive, test for causation is the "but for" test, which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant: *Horsley v. MacLaren*, [1972] S.C.R. 441.

15 The "but for" test is unworkable in some circumstances, so the courts have recognized that causation is established where the defendant's negligence "materially contributed" to the occurrence of the injury: *Myers v. Peel County Board of Education*; [1981] 2 S.C.R. 21, *Bonnington Castings, Ltd. v. Wardlaw*, [1956] 1 All E.R. 615 (H.L.); *McGhee v. National Coal Board, supra*. A contributing factor is material if it falls outside the *de minimis* range: *Bonnington Castings, Ltd. v. Wardlaw, supra*; see also *R. v. Pinske* (1988), 30 B.C.L.R. (2d) 114 (B.C.C.A.), aff'd [1989] 2 S.C.R. 979.

16 In *Snell v. Farrell, supra*, this Court recently confirmed that the plaintiff must prove that the defendant's tortious conduct caused or contributed to the plaintiff's injury. The causation test is not to be applied too rigidly. Causation need not be determined by scientific precision; as Lord Salmon stated in *Alphacell Ltd. v. Woodward*, [1972] 2 All E.R. 475, at p. 490, and as was quoted by Sopinka J. at p. 328, it is "essentially a practical question of fact which can best be answered by ordinary common sense". Although the burden of proof remains with the plaintiff, in some circumstances an inference of causation may be drawn from the evidence without positive scientific proof.

17 It is not now necessary, nor has it ever been, for the plaintiff to establish that the defendant's negligence was the sole cause of the injury. There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring. To borrow an example from Professor Fleming (*The Law of Torts* (8th ed. 1992) at p. 193), a "fire ignited in a wastepaper basket is . . . caused not only by the dropping of a lighted match, but also by the presence of combustible material and oxygen, a failure of the cleaner to empty the basket and so forth". As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants

remain liable for all injuries caused or contributed to by their negligence.

18 This proposition has long been established in the jurisprudence. Lord Reid stated in *McGhee v. National Coal Board, supra,* at p. 1010:

> It has always been the law that a pursuer succeeds if he can shew that fault of the defender caused or materially contributed to his injury. There may have been two separate causes but it is enough if one of the causes arose from fault of the defender. The pursuer does not have to prove that this cause would of itself have been enough to cause him injury.

19 The law does not excuse a defendant from liability merely because other causal factors for which he is not responsible also helped produce the harm: Fleming, *supra,* at p. 200. It is sufficient if the defendant's negligence was a cause of the harm: *School Division of Assiniboine South, No. 3 v. Greater Winnipeg Gas Co.*, [1971] 4 W.W.R. 746 (Man. C.A.), at p. 753, aff'd [1973] 6 W.W.R. 765 (S.C.C.), [1973] S.C.R. vi; Ken Cooper-Stephenson, *Personal Injury Damages in Canada* (2nd ed. 1996), at p. 748."

[25] The medical evidence regarding the *cause* of the pulmonary embolism injury is found at paragraph 4 of the Witness Statement of Dr Ramphal where he states *"[t]he CT scan was performed and demonstrated an large Pulmonary Embolism (PE)(saddle) with bilateral smaller disseminated emboli* ***likely from Deep Vein thrombosis (DVT) in Mrs. Rolle-Tiedemann's fractured left lower limb."***

[26] On behalf of the Defendants Ms Cleare contends that there is no factual determination of a radiologist as to a clinical finding of deep vein thrombosis. Additionally, they say that there are no facts before the Court by way of medical records or opinion evidence for the Court to determine what caused or materially contributed to the deep vein thrombosis.

[27] When one reviews the evidence, however, it is clear that, at the very outset of the injury to the Plaintiff's hip, there was a material risk of deep vein thrombosis developing. In his evidence Dr Bowe stated:

> "2. That on the 15th July 2016, Susanne Rolle Tiedemann was admitted to the Hospital. She was brought in by ambulance and seen through

the Accident and Emergency Unit by Dr. James Iferenta who referred her case management to me. She complained of level 9 pain in her left hip and being unable to fully extend the left hip. She presented with a closed fracture-dislocation of the left hip (femoral head-Pipkin type 1). Procedural sedation was performed in the ER that led to successful reduction of the left hip ie. she was given a local anesthesia and a splinter/cast was placed on her left leg.

3. Mrs. Rolle-Tiedemann was then admitted to the Hospital for pain control **and was given analgesics as well as DVT prophylaxis** and her left knee was placed in a knee immobilizer to prevent her from flexing the left hip."

[28] Further, based on Dr Ramphal's uncontroverted evidence, deep vein thrombosis developed in the Plaintiff's left leg, i.e., the same leg where the hip fracture-location occurred as a result of the accident.

[29] In her written submissions Ms Cleare refers to certain Jackson Memorial Hospital Reports, namely, the Paranesthesia Evaluation Report signed by Shane Cherry and Oscar Aljureon dated 8 August 2016 and 9 August 2016, respectively and the Cardiology Consultation Report of Dr Calva. Neither of those reports was referred to during the trial but they are contained in the Agreed Bundle of Documents and they indicate that the Plaintiff had not been compliant with physical therapy.

[30] In the Paranesthesia Evaluation Report, the history of the Plaintiff's illness is described as follows:

> **"History of Present Illness**
>
> 56 yo F ASA IV w/ recent hx of hip fracture with closed reduction approximately two and a half weeks ago, noncompliant with physical therapy. Admitted 7/29/2016 to ED at OSH in the Bahamas with c/o acute onset SOB, went into hypoxic cardiac arrest. CT scan confirmed large saddle PE with bilateral smaller disseminated emboli necessitating placement of VA-ECMO."

[31] Similarly, the Cardiology Consultation Report stated:

> "HPI: this is a 56 years old female who was transferred from *(sic)* bahamas to here after she presented there with acute SOB and fund to have a saddle PE. She had a car accident prior to that with hip fx and questionable compliance with physical therapy."

It is evident that the Plaintiff's noncompliance with physical therapy was sufficiently significant to be noted as a part of her history. However, there is no evidence before the Court to show the degree to which that may have contributed to the development of deep vein thrombosis in the Plaintiff's left leg.

[32] Dr Ramphal was the Plaintiff's attending physician when her pulmonary embolism was diagnosed and he was aware that the Plaintiff had suffered a fractured and dislocated hip as a result of a traffic accident. Dr Ramphal was also the physician who signed the Doctors Hospital Patient Transfer Form for the transfer of the Plaintiff to Jackson Memorial Hospital.

[33] I am satisfied that the plaintiff's hip fracture-dislocation created a risk that deep vein thrombosis might develop, and it eventually did develop. Although physical therapy might have lessened that risk, I find that, on balance, the Plaintiff's hip injury materially contributed to the development of deep vein thrombosis in the Plaintiffs left leg. Further, I accept the evidence of Dr Ramphal that such deep vein thrombosis was the likely cause of pulmonary embolism. In all the circumstances, I find that, on a balance of probabilities, the Plaintiff suffered a pulmonary embolism on 29 July 2016 as a result of the accident.

Pulmonary embolism - Treatment at Jackson Memorial Hospital

[34] The Operative Report signed on 4 August 2016 by Dr Ghodsizavd, the attending surgeon at Jackson Memorial Hospital, who is also identified on the Patient Transfer Form as the "Receiving Physician" at Jackson, states, *inter alia,*:

> "**DATE OF OPERATION**: 08/04/2016
>
> **ATTENDING SURGEON**: A. Ghodsizad MD
>
> **PREOPERATIVE DIAGNOSIS**: Pulmonary Embolism, right heart failure, s/p VA ECMO
>
> **POSTOPERATIVE DIAGNOSIS**: Same, s/p ecmo circuite change, s/p SFA perfusion cannula placement
>
> **PROCEDURE**: Emergent
>
> The [patient] was draped and prepped in the usual fashion. Time out was done. The venous and arterial cannula were clamped. A new circuite was connected to the patient and VA ECMO circulation was reestablished

without any problems...the sedation and paralytics, as well as the vent settings were optimized. The [patient] tolerated the procedure well.
A 5F limb perfusion cannula was positioned in the right SFA without any problems.

DESCRIPTION OF THE PROCEDURE: Emergency

ANESTHESIA: general

ESTIMATED BLOOD LOSS: 300 ccs

COMPLICATIONS: None"

[35] The Anesthesiology Consultation Preanesthesia Evaluation signed by Dr Shane Vincent Cherry and Oscar D'Aljure on 8 and 9 August, respectively, states, *inter alia*, that the Plaintiff's hemodynamic support had been successfully weaned and the plan was for decannulation. It also states that the Plaintiff's problem list was as follows:

- Acute respiratory failure
- Pulmonary embolism
- Hypertension
- At risk for injury
- Acute pain
- At risk for cerebral tissue perfusion
- Ineffective airway clearance
- At risk for infection
- At risk of pressure ulcer

[36] The Neurology Consultation Final Report signed by Dr. Diego Condes Diez Martinez and Dr Doraiswami Ramaswami Ayyar on 12 and 14 August 2016, respectively states:

> "...patient was on heavy sedation and as sedation was weaned off she began to have more movement. ..Currently the patient has been extubated, is off sedation and awake and alert. It is safe to say without imaging, which at this point we would no longer recommend, that the patient is not herniating and will progress well, regaining motor strength in the days to follow after experiencing a serious medical problem."

[37] On 25 August 2016 the Plaintiff was admitted to a Jackson Memorial Hospital Inpatient Rehabilitation Facility (the "**Rehabilitation Facility**") where she actively participated in an intensive rehabilitation program. The Post Admission Physician Evaluation signed by Dr Adriana Valbuena Valecillos on 26 August 2016 states, *inter alia*, that the Plaintiff was extubated from ECMO on 8 August 2016 and required at least three hours of therapy

five days a week for fourteen days. At page 2 of her report Dr Valecillos provided a prognosis as follows:

> "Patient's prognosis and expected level of improvement with inpatient rehabilitation admission is: Increase endurance to safely complete activities of daily living.
>
> Improve balance to decrease risk of injury while performing activities of daily living.
>
> Patient will improve in transfers to bed/wheelchair/chair and sit/stand in order to participate in activities of daily living.
>
> Patient will increase strength of affected side to assist/participate in activities of daily living and increase independence with dressing.
>
> Anticipated destination post discharge from inpatient rehabilitation is: community discharge without assistance."

[38] Dr Valecillos also indicates in her report that architectural barriers in the home were the only possible barriers to the Plaintiff's progress and discharge and it was anticipated that the Plaintiff would be discharged into the community without assistance within 14 days.

[39] The last report of the Plaintiff's progress at the Rehabilitation Facility presented to the Court is a Physical Therapy Inpatient Rehabilitation Daily Treatment Note signed by Jin Hong on 29 August 2016, which stated that the Plaintiff was able to propel a distance of 150 feet in a wheelchair and required a sliding board. The Treatment Note also stated that the Plaintiff was able to perform a sliding board transfer from w/c to mat without supervision and bed mobility with minimal assistance, although it was unsafe to perform toilet transfer and stair ambulation at that time.

[40] At paragraphs 18 and 26 of her witness statement the Plaintiff confirms that she was discharged from the Rehabilitation Facility on 9 September 2016 and returned to Nassau that month.

Other injuries

[41] In her supplemental witness statement, the Plaintiff claims that she has had additional medical issues since her discharge from Jackson Memorial Hospital. Her evidence in this regard is as follows:

> "2. Since my discharge from Jackson Memorial Hospital ("JMH") on the 9th September 2016, I have been admitted to Doctor's Hospital Health Services ("DHHS") in September 2019 for the

removal of my gall bladder. I spent three days in DHHS from Thursday morning to Saturday morning. I was off work for three days. I returned home Saturday and began working from home on Monday.

3. In September 2020 I began experiencing piercing back pain. When the pain would not lessen, I visited my general doctor, Dr. Angela Kunz. After my visit, I scheduled an appointment to have an x-ray of my back taken. The x-ray showed I had broken vertebrae. Around this time, I also had a colonoscopy and an endoscopy as well as a battery of other tests.

4. Sometime in October 2020, I noticed my right leg would become swollen and the swelling would not go down. From my July 2016 accident, I am accustomed to my right leg swelling to twice its regular size. However, I am also accustomed to the swelling eventually going down. I became concerned when I noticed that the swelling in my right leg remained for multiple days.

5. I visited Dr. Kunz another time. After my visit, I scheduled an ultrasound. *(sic)* Of my right leg. Because of the swelling, the ultra sound was inconclusive. It was recommended that I have a cat scan done instead. After receiving the results of the cat scan, Dr. Kunz telephoned me and advised me to go into DHHS for the weekend. I immediately spoke with my husband and packed a bag for my hospital stay.

6. A large blood clot had formed in my right leg. The clot was from my groin (where the ECMO machine had been inserted as a result of the July 2016 accident) to my knee. I spent approximately ten hours in the emergency room. I was admitted to DHHS on Friday 16th October 2020 and Dr. E. Duane Sands performed my surgery on Saturday the 17the October 2020. I spent seven days in DHHS.

7. Additionally, when the clot was located, it was discovered that my femoral artery and vein had fused over time. They had to be separated. A bypass had to be inserted to separate the blood vessels. Because the fused portion of the artery had to be removed, I also have an artificial femoral artery.

8. After I had been discharged, I awoke on the morning of the 31st October 2020. I noticed that I was bleeding from my mouth. I

> couldn't stop the bleeding. I called Dr. Kunz. An ambulance was called and I was taken by ambulance to DHHS. It was determined at DHHS that the bleeding was as a result of the blood thinners I had been prescribed. I am advised that I will have to be on blood thinners for the rest of my life."

[42] In her written submissions the Plaintiff's Counsel, Ms Brown, describes the additional injuries claimed by the Plaintiff as right thigh and leg injuries, psychiatric and emotional scarring, second large pulmonary embolism and physical and tissue scarring in the right groin area. However, no such injuries are pleaded in the Writ. Further, as submitted by Counsel for the Defendants, there is no evidence before this Court, by way contemporaneous medical reports or otherwise to support or verify the additional injuries which the Plaintiff claims to have suffered and a fortiori, no evidence to support a finding that such injuries were caused by the accident. Ms Brown refers extensively in her written submissions to certain findings contained in a report provided by Dr David N. Barnett, which apparently was filed by the Defendant on 3 May 2019 but Dr Barnett was not called as a witness to testify at trial. Additionally, Dr Barnett's report is not contained in the Agreed Bundle of Documents, was not otherwise admitted into evidence and was not even referred to in the course of the oral testimony given at trial.

[43] With respect to Ms Brown's submission, in particular, that the Plaintiff suffered physical and emotional scarring, this Court notes that there is a Psychology Services Evaluation signed by Gisela Aguila-Puente on 26 August 2016 when the Plaintiff was a patient at the Rehabilitation Facility, which states that the Plaintiff was "experiencing a reactive level of distress and anxiety which [were] appropriate at [that] time given the injury and serious life threatening complications". In that Evaluation the Plaintiff was described as "an excellent candidate for supported psychotherapy" but it was noted that there were no barriers to her progress or discharge. There is no specific diagnosis of a reactive psychiatric disorder in the circumstances.

[44] In the result, the evidence presented by the Plaintiff is insufficient to support a finding that additional injuries were sustained by her as a result of the accident.

SPECIAL DAMAGES

[45] Special damages must be specifically pleaded and proved. That is elementary. As Lord Diplock in ***Ilkiw v Samuels*** [1963] 2 All ER 879 put it:

> "Special damage in the sense of a monetary loss which the plaintiff has sustained up to the date of trial must be pleaded and particularized...In my view, it is plain law—so plain that there appears to be no direct authority, because everyone has accepted it as being the law for the last hundred

years—that one can recover in an action only special damage which has been pleaded, and of course, proved."

[46] In ***George Lubin v Miriam Major, Appeal*** No. 6 of 1990 (unreported), Henry P. in delivering the Judgment of the Court of Appeal authoritatively stated:

> "... a person who alleges special damage must prove the same. It is not in general sufficient for him merely to plead special damage and thereafter recite on oath the same facts, or give evidence in an affidavit without any supporting credible evidence aliunde, and sit back expecting the tribunal of fact to accept his evidence as true in its entirety, merely because the aforesaid evidence is not controverted, even though the particular damage in the sense of a loss having been incurred appears reasonably improbable and or the money value attributed to the said loss or damage appears unlikely and or unreasonable viewed in the context of the susceptibility of human beings in general to overestimate and exaggerate loss, damage and suffering without any intention whatsoever of being deliberately dishonest."

[47] As indicated in paragraph 3 above, in her Statement of Claim, the Plaintiff particularizes her claim for special damages as follows:

Loss of wages from 18th July 2016 to the 1st December 2016 at $3,683.33 per month	**$**	**18,416.65**
Hospital and doctors Fees	**$**	**484,176.72**
Aids required for Plaintiff's recovery (wheelchair, commode, walker, sliding board)	**$**	**72.71**
Physiotherapy from September 2016 and counting	**$**	**3,487.15**
Home help's wages while the Plaintiff was incapacitated from 18th July 2016 at $60.00 per week and continuing	**$**	**2,490.00**
Airfare (up to 18th Nov. 2016)	**$**	**1,417.95**
House and pet sitter	**$**	**800.00**
Hotel	**$**	**1,037.25**

Medication from July 2016 and continuing	**$ 759.56**	
	$ 512,657.99	

[48] Ms Cleare states in her written submissions and I wholeheartedly agree that there is no documentary evidence whatsoever before the Court to support any of the special damages pleaded.

Loss of wages/earnings

[49] I accept on the evidence that as a result of the Plaintiff's hip fracture and dislocation and pulmonary embolism, she was unable to work from the date of the accident until November 2016, after Hurricane Matthew, when she began working from 12pm to 5pm.

[50] In calculating an award for loss of wages the Court may have regard to the plaintiff's salary slips or evidence from the plaintiff's employer regarding the plaintiff's earnings. In this case, however, there is no evidence whatsoever before this Court regarding the amount of the Plaintiff's salary before or after the accident. I therefore find that the Plaintiff's claim for loss of wages in the amount of $18,416.65 is not recoverable.

[51] In her written submissions, Counsel for the Plaintiff also invites the Court to make an award in respect of the Plaintiff's future loss of earnings, even though such a claim was not pleaded in the Writ. For the reasons stated in paragraph 44 above, this Court declines to make such an award. There is no evidence of any diminution in the Plaintiff's salary and a claim for such an award has neither pleaded nor proved.

[52] For the sake of completeness, I wish to draw the distinction between a claim for loss of future earnings and one for loss of earning capacity. In ***Fairley v John Thompson (Design and Contracting Division) Ltd*** [1973] 2 Lloyd's Rep 40 Lord Denning MR helpfully explained (at page 42):

> "Compensation for loss of future earnings is awarded for real assessable loss proved by evidence. Compensation for diminution in earning capacity is awarded as part of general damages."

[53] In respect of a claim for loss of future earnings, the Court is therefore concerned with quantifying an item of special damage; whereas, for a claim of loss of earning capacity the Court is concerned with an item of general damages, which must be assessed by the Court based on the plaintiff's reduced eligibility for employment or risk of future financial loss.

[54] In the present case, in addition to there being no evidence of the Plaintiff's earnings pre or post the accident, there is no evidence that there is a substantial or real risk that the

Plaintiff, who was age 60 at the date of trial and still employed, will lose her present employment before the estimated end of her working life. The result is that any claim for loss of earning capacity would similarly be unrecoverable.

Hospital and doctors' fees

[55] It is clearly established on the evidence that the Plaintiff was injured and hospitalized for an aggregate period of approximately 7 weeks, being 11 days at Doctors Hospital (i.e. from 16 – 20 July 2016 and 29 July 2016 – 3 August 2016) and 38 days at Jackson Memorial Hospital (i.e. from 3 – 25 August 2016 in the hospital and 25 August 2016 – 9 September 2016 in the Inpatient Rehabilitation Facility). However, the Plaintiff's Counsel has put into evidence not one invoice to show that medical costs have been incurred. In relation to the hospital and doctors expenses incurred by her, the Plaintiff said this in her witness statement:

> "28. Throughout this ordeal, my insurance co-payments have totaled over $US700,000.00. My husband and I have used all of our savings and we are still receiving statements to be paid. Moreover, I have had to discontinue attending physiotherapy because I cannot afford the sessions. According to my insurance cover, I have reached the limit of my insurance coverage.
>
> ...
>
> My husband has not worked since 2016. There is only my salary. My illness has used almost all of our savings. We have invoices from IMG totaling more than $700,000.00. I have discontinued going to physiotherapy because I cannot afford the sessions and I can no longer use my insurance."

[56] Those assertions without more are insufficient to prove the Plaintiff's pleaded claim for hospital and doctors' fees in the sum of $484,176.72. I therefore find that the Plaintiff's claim for this amount unrecoverable.

[57] In paragraphs 48 to 54 of her written submissions, Counsel for the Plaintiff purports to give evidence from the Bar table and augment the Plaintiff's case in an effort to persuade the Court that the Plaintiff's medical expenses should be assessed at $846,503.88.

> "48. ...In her witness statement of the 28th January 2020, the Plaintiff's evidence at pp. 28 and 35, was that her medical insurance co-payments at that time exceeded $700,000.00. The actual figure is $703,076.88. This sum was the Plaintiff's portion of the total fees. What this means, is the cost of the Plaintiff's care was more than

$2,000,000.00. During the hearing on the 14thDecember, this evidence was not challenged by the Defendants.

49. The Plaintiff has not received invoices for her 2020 admission at DHHS. Upon admission, the Plaintiff was asked to place, what was for her, a sizable deposit. This is money that the Plaintiff and her husband withdrew from their savings. The Plaintiff estimates this seven (7) day at DHHS in addition to her physicians' costs will cost approximately $55,000.00 - $100,000.00.

50. Since the 14th December 2020, hearing, the Plaintiff was admitted to DHHS on the 4th January 2021 because of bleeding in her stomach. She will be administered blood transfusion/s on the 5the *(sic)* January 2021.This hospital stay requires another withdrawal from the Plaintiff's savings. The Plaintiff estimates that this hospital stay at DHHS in addition to her physicians' costs will cost approximately $10,000.00-$35,000.00.

51. Prior to the 4th January 2021 admission, the Plaintiff had a nurse change her dressing three times a week. The cost per visit is $60.00. The Plaintiff has accrued $1,020.00 in private nursing costs.

52. Prior to the 4th January 2021 admission, the Plaintiff had a physiotherapist come to her home once a week. The cost per visit was $300.00. The Plaintiff has accrued $3,600.00 in physiotherapy costs.

53. A phlebotomist visited the Plaintiff's home one day per week to draw blood. The cost per visit is $218.00. The Plaintiff has accrued $2,616.00 in costs to the phlebotomist.

54. The Plaintiff's physician has visited the Plaintiff at home six (6) times since the Plaintiff was discharged from hospital in October 2020. The cost per visit is $200.00. The Plaintiff has spent $1,200.00 in fees to her physician."

[58] While I note those submissions, I am constrained to disregard them. This Court may only act on the evidence received before it and there is no evidence to support a claim for medical expenses in any amount.

Medical aides, physiotherapy, travel expenses, medication and home help

[59] Similarly, the Plaintiff led no evidence, whether by her witnesses or documents contained in the Agreed Bundle of Documents, of the cost of medical aides required for her recovery, such as a wheelchair, walker, sliding board and commode. Further, no such evidence was led of costs incurred by her for physiotherapy, travel expenses (airfare and hotel), home help (including house and pet sitter) and medication. I therefore find that the Plaintiff is unable to recover the sums claimed for those items.

GENERAL DAMAGES

Pain, suffering loss of amenity

[60] The Judicial College Guidelines (the "**Judicial College Guidelines**") for the Assessment of General Damages in Personal Injuries Cases have laid out a range of awards based on a compendium of UK cases and these ranges are updated periodically through later editions. The latest edition is the 15th, published January 2020. Bahamian courts and practitioners often use the Judicial College Guidelines as a source of comparative awards in addition to supplement our own local body of awards.

[61] In assessing the award for pain suffering and loss of amenity I take each injury which this Court has found to have been sustained by the Plaintiff as a result of the accident in turn.

Fractured arm

[62] As indicated in paragraph 15 above, no primary evidence was given with respect to the Plaintiff's fractured arm injury. Furthermore, although the injury is evident from the Doctors Hospital Discharge Summary, it is neither mentioned in the medical report dictated by Dr Bowe on 15 July 2016 when she was admitted to Doctors Hospital nor in Dr Bowe's progress reports, all of which are contained in the Agreed Bundle of Documents. As a result, although it is evident from the Discharge Summary that the Plaintiff's primary diagnosis included a "Colles' fracture of the right radius", there is no evidence of the extent of that fracture or the manner in which it was treated. It may therefore be inferred by this Court that the fractured arm suffered by the Plaintiff was not a severe injury and did not result in any permanent or substantial disablement. I therefore find that the Colles' fracture of the Plaintiff's right radius constituted a simple fracture of the forearm.

[63] The Judicial College Guidelines assess simple fractures of the forearm under Orthopaedic Injuries at 7(f)(d) within the bracket of £5,630 to £16,380 (or $7,783 to

$22,645 using the current exchange rate of 1.3825, which will be applied throughout this Judgment).

[64] In my view, based on the evidence before the Court, an award of $7,783 in respect of the Plaintiff's fractured radius would be reasonable to note that the injury was sustained and some pain suffering loss of amenity was occasioned by it.

Dislocation of the left hip

[65] As indicated in paragraph 17 above, the evidence establishes that the Plaintiff was treated at Doctors Hospital by an "uneventful" closed reduction procedure and was discharged on 20 July 2016 after a five day hospital stay.

[66] At paragraph 6 of his witness statement Dr Bowe states that when the Plaintiff presented for her follow up visit he observed that the swelling in her left leg was reducing and while she still complained of pain, it was lessening.

[67] At paragraph 7 of his witness statement Dr Bowe indicates that he continued to treat the Plaintiff after her return to Nassau. He states:

> "8. Since her return to The Bahamas, I continued to treat Mrs. Rolle-Tiedemann. She requires close observation because there is a possibility that her femoral head my die and require either a total hip replacement or (sic) hemiarthroplasty.
>
> 9. Since her recovery, Mrs. Rolle-Tiedemann presents with no feeling in her right leg; swelling in the right leg and ankle; and unstable gait. I advised that continuing physiotherapy would improve her gait and reduce the swelling in her ankle and leg and lessen her reliance on using a walker and/or cane."

[68] However, there is no evidence as to when Dr Bowe last saw the Plaintiff since her return to Nassau in September 2016 or whether the possibility of requiring further surgery had diminished or increased in the ensuing four years since the initial operation up to the date of trial.

[69] In her witness statement, the Plaintiff says:

> "29. ...My right leg still swells and is numb. As a result, I am unable to drive...If I have anywhere to go during the day, I depend on my husband to take me.

30. ...I have been unable to wear regular pumps or ballet flats. I am only able to wear open, well padded, soled sandals.

...

32. No longer being able to drive has been the single most life changing result of the accident. Not driving has taken away my independence. I have been driving since I was eighteen (18) years old.

33. Additionally, my relationship with my husband has changed in other ways. I now have no feeling on my right side. There are activities that I enjoyed with my husband as a wife, that as a result of my injuries, have been negatively impacted.

34. I am unable to tend to my garden and my pets. Before the accident, I was always working in my garden. I painted the exterior and interior of my home. I built shelves in my home. I would bathe my five (5) dogs. I was able to do housework. I did not need to employ someone to assist me with cleaning my home. I was able to spend large amounts of energy into projects around my home. Since the accident, I am always tired and become easily tired. I cannot move around as ably as I used to."

[70] Additionally, while under cross-examination by Ms Cleare, the Plaintiff stated that she is unable to walk long distances without a cane and uses a cane when she goes out of the house.

[71] In her written submissions, Ms Brown submits that the Court should make an award of £5,000 in respect of the Plaintiff's left hip injury and £122,860 for what she describes as the Plaintiff's right thigh and leg injuries. She refers to JSB [10.3] and JSB [10.3](a), respectively.

[72] While it is unclear on what her proposal of £5,000 is based, it is evident that Ms Brown's submission contemplates that the Plaintiff's injury falls within the category of the most severe injuries to the pelvis and hips at the top end of the ***Heil v Rankin*** uplift, which is assessed by the Judicial College Guidelines at 7D(a)(i) within the bracket £66,890 to £ 122,860 (or $92,475 or $169,853). Injuries within this category are described by the Judicial College Guidelines as:

> "Extensive fractures of the pelvis involving, for example, dislocation of a low back joint and a ruptured bladder, or a hip injury resulting in spondylolisthesis of a low back joint with intolerable pain and necessitating spinal fusion. Inevitably there will be substantial residual disabilities such as a complicated arthrodesis with resulting lack of

bladder and bowel control, sexual dysfunction, or hip deformity making the use of a calliper essential; or may present difficulties for natural delivery."

[73] Ms Cleare submits that the Plaintiff's hip injury falls within the category 7(D) (b)(ii) of moderate injuries to the pelvis and hips, which the Judicial College Guidelines assess within the bracket of *£10,750 to £22,680 (or $14,861 to $31,355)*. According to the Judicial College Guidelines *"These cases may involve hip replacement or other surgery. Where it has been carried out wholly successfully the award will tend to the top of the bracket, but the bracket also includes cases where hip replacement may be necessary in the foreseeable future or where there are more than minimal ongoing symptoms."*

[74] I agree with Ms Cleare that the Plaintiff's hip injury should be categorised as moderate rather than as severe. However, due to the Plaintiff's continued reliance on a cane, I consider that her injury falls within the higher end of moderate injuries to the pelvis and hips at category(D)(b)(i), which the Judicial College Guidelines assess within the bracket of *£22,680 to £36,770 (or $31,355 to $50,834)*.

[75] In her written submissions, Ms Brown submits that an award by this Court which has regard to the Judicial College Guidelines should be adjusted upwards to take into account the relatively high cost of living in The Bahamas. However, as stated by the Lord Kerr at paragraph 42 of the Judgment of the Privy Council in ***Scott v The Attorney General*** [2017] UKPC 15, it is plainly impossible to take judicial notice of the difference in costs of living between The Bahamas and England. And if such an approach is appropriate, it can only be contemplated on the basis of evidence to establish the fact that there is such a difference in the cost of living between the two countries. There is no evidence in the present case to support such an adjustment.

[76] In ***Knowles v Rolle*** [2011] 2 BHS J. No. 15, a local case commended to this Court by Ms Cleare, a male, aged 45 maker suffered a fracture of the right femur and right tibia plateau. He was hospitalized and underwent surgery to repair the fracture. He was unable to work for 10 weeks. He healed well with slight discomfort in his right knee due to barometric changes in the weather. His permanent disability was 10% but did not prevent him from having a full working life. He was awarded $35,000 on 16 June 2011 for pain suffering and loss of amenity.

[77] Having considered the Judicial College Guidelines with respect to awards for moderate injuries to the pelvis and hips within the category 7(D) (b)(i) and the award by this Court in ***Knowles v Rolle***, I am of the view that it would be reasonable to make an award of $40,000 in respect of the Plaintiff's hip injury.

Acute pulmonary embolism

[78] The pulmonary embolism was life threatening but thankfully overcome.

[79] The Court was not provided with any local cases where an award for pulmonary embolism was considered and Ms Cleare submits that most of the cases in the United Kingdom involve patients who have died as a result of pulmonary embolism. In the case of ***Spencer vs Hillington Hospital NHS Trust*** [2015] EWHC 1058, cited by Ms Cleare, the plaintiff survived a pulmonary embolism and agreed damages at EUR17,500 in 2015. The issue before the Court was the negligence of the hospital in failing to advise the plaintiff of the risks of pulmonary embolism so that he could have caught it earlier. The symptoms of the pulmonary embolism were painful calves but the plaintiff did not associate it to his recent surgery and suffered damage thereby. The agreed damages of EUR17,500 equate to approximately $24,000.

[80] The case of **QD4530** (LexisNexisPSL Personal Injury Quantum Database), which was also cited by Ms Cleare, involved a failure to diagnose the plaintiff's pulmonary embolism. The plaintiff subsequently developed an auto immune disease and complained about the defendant's failure to make a diagnosis of pulmonary embolism on his first ambulance visit. The defendant accepted that there had been substandard care and general damages were awarded in the amount of £4,500 in 2007, which in today's value is approximately £7,000 (or $9,677).

[81] The third case of pulmonary embolism cited by Ms Cleare was **QD3874** (LexisNexisPSL Personal Injury Quantum Database), which was decided in July 2015. In that case, the plaintiff was a temporary patient admitted to the defendant's psychiatric unit and refused to eat or drink. This left him by the latter date(s) suffering malnutrition and dehydration when he was admitted to hospital very late on 8 April 2011. He was found also to be consequently suffering from urinary retention, urinary tract infection, renal failure, left leg deep vein thrombosis (leading to pulmonary emboli), exacerbated atrial fibrillation, confusion, agitation and disorientation. A permanent catheter was inserted. His condition was so severe that by 17 April 2011, his family was informed that he potentially had hours to live. Thankfully the plaintiff recovered and was moved to another care home on 16 August 2011. Negligence was alleged against the defendant and liability was admitted. The plaintiff claimed general damages, in addition to the cost of a prostatectomy provoked by the dehydration and distension of his bladder, as the plaintiff underwent this surgery on an urgent private basis due to urinary tract infections caused by his long term catheterisation. While the defendant admitted that their breach of duty led to deep vein thrombosis, pulmonary emboli, malnutrition, dehydration, renal failure, the need for catheterisation and thus the urinary tract infections, they denied that the prostatectomy was causally relevant, and argued that surgery would have been required in any event. The matter was compromised in the global sum of £20,000, with

a best estimate being that general damages were assessed at about £14,500 (or $20,046), with specials damage (consisting of a claim for the prostatectomy and other treatments) at about £5,500. This sum was approved by the Deputy District judge also on a global basis.

[82] In the present case, I am satisfied that the Plaintiff suffered greatly as a result of the pulmonary embolism. With this in mind and having regard to the cases cited by Ms Cleare, I consider that an award of $30,000 would be reasonable for the pain, suffering and loss of amenity due to the pulmonary embolism.

[83] In ***Simms v O'Reilly*** [1989] BHS J. No. 79, Malone J stated that award for pain and suffering and loss of amenity is "a global award". Thus, where there are separate injuries affecting different parts of the body, each injury must be taken into account in assessing the global sum; but it is not a case of assessing each injury separately and arriving at an overall total which is the aggregate of the several assessments.

[84] Similarly, PitchFord LJ, in delivering the judgment of the English Court of Appeal in ***Saddler v Filipak*** stated (at paragraph 35):

> "It is in my judgment always necessary to stand back from the compilation of individual figures, whether assistance has been derived from comparable cases or from the JSB guideline advice, to consider whether the award for pain, suffering and loss of amenity should be greater than the sum of the parts in order properly to reflect the combined effect of all the injuries upon the injured person's recovering quality of life or, on the contrary, should be smaller than the sum of the parts in order to remove an element of double counting. In some cases, no doubt a minority, no adjustment will be necessary because the total will properly reflect the overall pain, suffering and loss of amenity endured. In others, and probably the majority, an adjustment and occasionally a significant adjustment may be necessary."

[85] In the written submissions Ms Cleare submits that value of the general damages for pain, suffering and loss of amenity, if they are to include both the hip injury and the pulmonary embolism, should be in the range of $50,000. She also submits that the hip injury ought to attract an award of $35,000 if the Court finds that the causation of the pulmonary embolism has not been proved to be the negligence of the Defendants.

[86] A compilation of the individual figures is as follows:

Fractured arm	$	7,783
Dislocation of the hip		40,000
Acute pulmonary embolism		30,000

TOTAL	$	77,783

[87] Standing back to consider what should be the global aggregate award, I do not consider that the award for pain suffering and loss of amenity should be greater or lesser than the sum of $77,783 and I grant such an award accordingly.

Future medical expenses

[88] In her Writ the Plaintiff does not plead a claim for future medical expenses; however, Ms Brown submits (in paragraphs 45- 47 of her written submissions):

> "...the Plaintiff will require constant medical supervision to monitor her renal function as well as her haemoglobin *(sic)* function. She is at great risk of having renal failure (see Dr. Barnett's report at 0. 12, paragraph 22(v)). This risk has increased as a result of her recent diagnosis and surgery. The cost of renal care is expensive, and the Plaintiff's risk of complication is great...Allowing for complications, possible transportation to a foreign medical facility, frequent medical supervision and home help medical care, such expense is likely to be $1,000.000.00"

Here again, Ms Brown refers to a medical report provided by Dr Barnett, of which there is no evidence.

[89] The only evidence before the Court regarding the need for future medical care was that provided by Dr Bowe when he stated that the Plaintiff "may require" either a total hip replacement or hemi-arthroplasty. Ms Cleare describes Dr Bowe's estimation as a "mere possibility" and submits that the need for future surgery is too remote to be recoverable. She also submits and I agree that, in any event, there is no evidence of the likely costs of such a surgery to enable the Court to assess an amount to be fairly awarded if so inclined. The Plaintiff's claim for future medical expenses is rejected in the circumstances.

OTHER DAMAGES SOUGHT BUT NOT PLEADED

[90] In her written submissions the Plaintiff invites the Court to grant an award for the lost earnings of Euthal Rolle in addition to his loss of future earnings. She submits:

> "Euthal Rolle's loss of earnings
>
> 58. Mr Rolle's lost wages from the end of August 2016 to the present is calculated as follows:
> 31st August 2016 – 31st December 2016 @3,600/month = $14,400.00

31 December – present @ 48 months = $172,800.00

...

Ethal Rolle's future loss of earnings

62. Using the Ogden Actuarial Tables, Table 13 is used and the appropriate discount column (.25%) to identify the basic multiplier of 9.68.
63. Using the basic multiplier of 9.68 and using 0.60 from Table A to account for Mr. Rolle's contingencies (employments, education, disability status), 9.68 (Basic multiplier) x 0.60 = 5.81 (adjusted multiplier).
64. The adjusted table multiplier (5.81) is multiplied by Mr. Rolle's salary/yr ($43,200.00) = $250,905.60."

[91] I am completely lost as to how this Court may properly grant such an award. First, as indicated, the claim is not pleaded in the Plaintiff's Writ. And second, absolutely no evidence has been led to provide any basis upon which the Court may grant such an award or quantify it. I, therefore, agree with Ms Cleare that this claim cannot be recovered.

SUMMARY OF AWARD

[92] In the result, this Court grants the Plaintiff an award in the sum of $77,783 for pain, suffering and loss of amenity. For reasons already stated, no sum is granted in respect of special damages or any other item of general damages.

[93] The Court has discretion under section 3(1) of the *Civil Procedure (Award of Interest) Act* to award interest on an award of general damages from the date when the cause of action arose and the date of judgment. Further, in a case such as the present, which involves personal injuries and damages exceeding $3,000, the Court shall award interest unless it is satisfied that there are special reasons why it should not do so.

[94] Interest on general damages for pain, suffering and loss of amenity will usually run from the date of the issue of the writ and the rate of interest is of course within the discretion of the Court. Albeit, pre-judgment interest on general damages have historically been low and within the range of 2-3% per annum.

[95] In the present case, I exercise the Court's discretion to grant interest on the sum of $77,783 at the rate of 3% per annum from 13 February 2017, the date of the issue of the Writ, to the date of this Judgment, after which interest shall run pursuant to section 2 of the *Civil Procedure (Award of Interest) Act* at the statutory rate. Further, the Defendants shall pay to the Plaintiff the costs of this action, taxed if not agreed.

[96] In conclusion, I wish to record my gratitude to Counsel for their assistance on this matter and apologise for the time taken to produce this judgment.

DATED 29th day of October, 2021

Tara Cooper Burnside
Justice (AG)