COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

COMMERCIAL DIVISION

2011/COM/LAB/FP/00001

B E T W E E N

PHILIP HEPBURN

Plaintiff

AND

POLYMERS INTERNATIONAL LIMITED

Defendant

BEFORE:	**DEPUTY REGISTRAR OLIVIA BLATCH**
APPEARANCES:	Mr. Harvey Tynes KC, Ntshonda Tynes for the Plaintiff
	Mr. Raynard Rigby, and Mr. Greg Ebelhar for the Defendant
Hearing Dates:	10th June 2024

RULING

ASSESSMENT OF DAMAGE

[1.] A Judgment delivered by Justice Petra Hanna Adderley dated 8th December 2020 found that the Plaintiff was wrongfully terminated and was entitled to a sum under section 29 (1) (c) and ii of the Employment Act together with the interest at the statutory rate, according to section 3 of Civil Procedure Act, from the date the cause of action arose to the date of judgment. She further stated that the Plaintiff's claim for damages including his loss of medical coverage would be heard on the assessment of damage on the adjourned date. The matter was referred to the Deputy Registrar in March 2024.

[2.] On 10th June 2024, evidence was adduced in the Assessment of Damages Hearing and both parties agreed to file written submissions shortly thereafter.

Evidence

[3.] During the Assessment of Damages hearing, the Plaintiff relied on a witness statement filed on the 19th of January, 2024, a supplementary witness statement filed on the 30th day of April, 2024, Polymers International Limited Employment Policy Manual, Generali Worldwide Paramount Care Plan, Invoice from South Florida Spine Institute and Invoice from Sinai Medical Center.

[4.] The Defence relied on the Witness statements of Gavin Duncanson, James Pearson and Venentia Cambridge.

Plaintiff Submission

[5.] The Plaintiff's claim is for compensation for the loss of medical insurance coverage as a result of the termination of his contract of employment on the 3rd of July, 2009. The claim arises from an action brought by the Plaintiff against the Defendant for "wrongful dismissal".

[6.] At the assessment hearing, the Plaintiff relied on the case of **Robinson v Harman** (1848) 1 Ex Rep. 850 with the view that he is entitled to be placed, so far as money can do it, in the same position as he would have been in had the contract been performed by the Defendant.

[7.] The Plaintiff alleged that his contract of employment contained provisions by which he was entitled to medical insurance coverage as part of the Defendant's group medical insurance policy. Medical insurance coverage was provided by Generali Worldwide Paramount Care Plan. Further, where medical services were provided "overseas" the insurers would pay 80% of the combined cost of hospital charges and professional fees (including surgeon and anesthesiologist) after payment of a "deductible" by him in the sum of $200.00. In addition, the insurers would pay the sum of $250.00 per day up to a maximum of seven days in the event he was accompanied by a companion at the time of a hospital admission abroad.

[8.] In 2003, the Plaintiff slipped and fell while at the Our Lucayan Resort injuring his right wrist and lower back. The two injuries required him to receive medical care outside the Bahamas. In 2005 a surgical procedure was performed on his right wrist in Miami, Florida, and 80% of the balance of the charges were paid by the insurers after payment of the $200.00 deductible he paid.

The Plaintiff stated he was scheduled to undergo corrective surgery on his lower back at the Mt. Sinai Medical Center during the month of October, 2009 and arrangements were made for his wife to accompany him.

[9.] The Plaintiff stated his insurance coverage was canceled as a result of the termination of (his employment on the 3rd July, 2009 and he did not receive the surgery on his lower back.

[10.] Had the surgery on his lower back taken place the total cost would have been $93,270.00 as follows: Hospital charges: $48,000.00, Surgeon charges: $45.270.00 with the total being $93,270.00. After payment by the Plaintiff of the deductible in the sum of $200.00 the insurers would have paid 80% of the balance of the total $93,070.00 at $74,456.00 and the further sum of $250.00 per day for seven days or $1,750.00. As a result of the termination of his employment he lost the benefit of insurance coverage in the total sum of ($74,456.00 + $1,750.00) or $76,206.00 and the surgery on his lower back was never performed.

[11.] The Plaintiff sought damages in the sum of $76,206.00 together with interest thereon.

Defendants Submission

[12.] Counsel for the Defendants submit that the Plaintiff alleges that he was denied medical coverage for back surgery and he had insurance via Generali Worldwide at the time of his employment. However, the Plaintiff failed to bring a doctor to the assessment and did not present any documentation proving he needed surgery and that the insurer had granted permission for it.

[13.] The Plaintiff stated that he "was in the process of arranging the surgery prior to the termination of his employment" in the Amended Statement of Claim, which was submitted on July 13, 2015.

[14.] The submission is that the Plaintiff did not have any surgery arranged and suffered no loss as alleged. No evidence was adduced before the Court. In the witness statement filed on 19 January 2024, the Plaintiff stated he was scheduled to undergo corrective surgery on his lower back at Mt. Sinai Medical Center during the month of October 2009, yet no evidence was adduced by the Plaintiff to support the statement. During his cross examination, the Plaintiff was not able to state whether the doctor confirmed that he required surgery to the back. The documents presented were the estimate from South Florida Spine Institute and estimate from Mount Sinai Medical Center dated 22 June 2015.

[15.] Further submitted was that the estimate did not support the Plaintiff's claim that he needed back surgery. The Plaintiff was unable to present a letter or medical report from Dr. Hyde attesting to the fact that he needed back surgery. The Plaintiff could have easily requested and received a letter or report from Dr. Hyde in the same manner that he could have readily obtained the estimates mentioned above. The Court is urged to make the apparent conclusion that the Plaintiff does not need back surgery and lacks evidence to support the need for any such operation because no report was acquired and provided to the Court.

[16.] Additionally, the Plaintiff revealed two emails from Nelly Naguib dated February 6, 2008, which partially said, "I am setting up an appointment as soon as possible for Mr. Hepburn to see him for consultation and possibly surgery. Please send prior consult notes, X-rays, U/S, and MRI data from prior medical services." No emails were disclosed by the Plaintiff to show he attended the consultation or provided his medical records. The Court must accept that prior to Dr. Hyde making an assessment for surgery the patient must be examined. No evidence was adduced by the Plaintiff that he was examined by Dr. Hyde.

[17.] The emails from February 2008, which demonstrate that the Plaintiff only had a scheduled consultation with Dr. Hyde in February 2008, are among the contemporaneous records the Court is invited to consider more closely. Drawing conclusions from contemporaneous documentation was a topic the Court addressed in **The Ritz Hotel Casino v. Geabury** [2015] EWHC 2294.

[18.] Relying on conclusions derived from documentary evidence was wisely stated in Gestmin SGPS **SA v Credit Suisse (UK) Ltd and another** [2013] EWHC 3560 (Comm). 2011. The Court can also draw an inference in accordance with section 62(2) of the Evidence Act. The emails only allow for the reasonable conclusion that the Plaintiff did not see Dr. Hyde and that it was not established that he needed back surgery. The Plaintiff's claim for damages must be dismissed by the Court in the absence of such evidence.

[19.] In order to deduce an unfavorable conclusion from the refusal to call a witness, the English Court of Appeal established the following guidelines in the case of **Central Manchester Health Authority v. Wisniewski** [1998] Lexis Reference Number 18, which states:

1. In certain circumstances a court may be entitled to **draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.**

2. If a **court is willing to draw such inferences they may go to strengthen the evidence adduced on that issue by the other party or to weaken the evidence, if any, adduced by the party who might reasonably have been expected to call the witness.**
3. There must, however, have been some **evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.**
4. If the reason for the **witness's absence or silence satisfies the court, then no such adverse inference may be drawn**. If, on the other hand, **there is some credible explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his/her absence or silence may be reduced or nullified.**

[20.] Counsel for the Defendant urged The Court to infer the unfavorable conclusion from the Plaintiff's failure to call Dr. Hyde as a witness based on the aforementioned principles. When the Plaintiff was questioned about the estimates given, he attempted to imply that they represented approval for him to have back surgery during his cross-examination. The Court must categorically reject this. During cross-examination, the Plaintiff acknowledged that the doctor cannot decide to do surgery until he has seen the patient.

[21.] The Plaintiff produced evidence of the Generali Worldwide Paramount Care Plan (1) Pre-Certification is required for all hospital admissions, outpatient surgery, rehab, treatment for inpatient Mental Disorders, all scope procedures, MRIs, CT Scans and Companion Travel and Lodging. If Precertification is not obtained prior to the services being provided, coverage for all services (including admissions, surgery. scope, procedure and diagnostic testing) may be subject to denial or a reduction in benefits to 50%.

[22.] The Plaintiff did not present any proof that he completed the Pre-Certification process as required by the Policy. During his cross-examination, he attempted to imply that the emails from Nelly Naguib dated February 6, 2008, involved more than merely scheduling a visit with Dr. Hyde.

[23.] During cross-examination, the Plaintiff acknowledged that the claim might be rejected if pre-certification was not obtained. Counsel for the Defendant argued that the Plaintiff's evidence at the Assessment was insufficient to demonstrate that he received approval for the back surgery before he was fired. The Court has not been presented with any proof of such approval. The

Plaintiff has the burden of proof to establish the loss. He must discharge the burden and that sections 82 to 84 of the Evidence Act address the burden on the Plaintiff.

[24.] The burden of proof in any proceeding at the commencement thereof lies on that person who would fail if no evidence at all were given on either side, regard being had to the pleadings and other documents filed therein; but at any time in the course of any proceeding the burden of proof may be shifted to the person who would fail, if no further evidence were given on either side. The burden of proof as to any particular fact lies on that person who wishes the court to believe in its existence, unless it is provided by any law that the proof of the fact shall lie on any particular person.

[25.] The Court should find that the Plaintiff failed to discharge the burden on him (see **Gardiner v Emerald Bay Resort Limited** [2009] 1 BHS J NO. 25 and **Lockhart and Munroe v Mitsui Sumitomo Insurance (London Management) Limited and others** [201 O] 3 BHS J. No. 38).

[26.] The Plaintiff needed approval from the insurer, Generali World Wide, to undergo the surgery in accordance with the terms of the insurance plan, according to the witness statements of Gavin Duncanson, filed on January 25, 2024, and Venentia Cambridge, filed on January 29, 2024, and May 23, 2024. That is, in order for the Plaintiff to get the benefit, they have to fulfill the requirements for eligibility and pre-certification. The Court is encouraged to accept the testimony of the Defendant's witnesses since they were not cross-examined on a number of relevant facts that were stated in their witness statements.

[27.] During cross-examination, Venentia Cambridge's evidence from paragraphs 6 to 9 of her initial witness statement was not contested. Her supporting documentation states: Surgery and inpatient treatment were among the key advantages that needed a pre-certification or pre-authorization procedure. Before providing any services or medical treatment that requires pre-authorization, the employee or medical practitioner was required under this method to obtain prior authorization from the insurer. When medical necessity was proven but no pre-authorization was obtained or granted, many plans carried fines, particularly for scheduled treatments. The hospital or medical provider receives the precertification approval, which designates the insurer's authorization for the medical operation. The hospital will not give medical care without precertification clearance unless the patient said that he was covering the cost of the treatment himself. At the conclusion of the benefit schedule, in (1), you will find the standard pre-certification criteria for Generali Worldwide. All hospitals demand pre-authorization. Generali

Worldwide devoted an entire department to this purpose. Never would Generali Worldwide (or any other insurer) pay the full face amount of the medical quotations.

[28.] Venentia Cambridge's second witness statement is offered for acceptance in its whole by the court. The following is a list of the important assertions included in paragraphs 4 through 6: 41 observe that Mr. Hepburn claims to have gotten in touch with Melissa Sears, who then went out of her way to help him find an in-network specialist and schedule a consultation. The email makes it very evident that consultation is permitted. "Possible surgery" is mentioned. Nothing in the email that was presented with Mr. Hepburn's witness statement indicates any. The primary evidence of Venentia Cambridge also supports this.

[29.] No evidence was presented throughout the assessment to suggest that getting insurance clearance to have surgery was a given. In a similar vein, the Plaintiff's job did not involve any custom that would automatically approve surgical benefits. The Court is not in possession of any information indicating that the medical plan's benefits were automatic.

[30.] The evidence demonstrates that Generali did not authorize the Plaintiff to have any back surgery done. At the highest level, the evidence indicates that the Plaintiff was scheduled for a consultation, which it seems he did not show up for. 36. Considering the entirety of The Court is further invited to make no award for damages due to the failure of the Plaintiff to adduce cogent and credible evidence of a loss. Where no loss is shown to occur, the Court must make no award.

[31.] In fact, the Court must also accept that even if the Plaintiff had evidence of precertification that the Insurers would not have paid 80% of the cost of the surgery. The evidence of Venentia Cambridge is that 35-60% of the costs (not the estimated sums) would be paid. This too is confirmed by the Explanation of Benefits in the Defendant's Bundle of Documents.

[32.] The Court is invited to dismiss the claim of the Plaintiff for the reasons noted above.

LAW

[33.] A Plaintiff has a duty to mitigate his loss/damage. Losses that could have been prevented by the Plaintiff taking reasonable steps to prevent them are not recoverable. What reasonable steps are is a question of fact – **Martindale v Duncan** [1973] 2 All ER 355 applied.

[34.] The only general principles which can be applied are that damages must be fair and reasonable, that a just proportion must be observed between the damages awarded for the less

serious and those awarded for the more serious injuries, and that, although it is impossible to standardize damages, an attempt ought to be made to award a sum which accords "with the general run of assessments made over the years in comparable cases": **Bird v Cocking & Sons Ltd** [1951] 2 T.L.R. 1260 at 1263, per Birkett LJ: "He who asserts must prove".

ANALYSIS/ISSUES

[35.] The main issue is whether an award of monetary compensation ought to be granted to the Plaintiff and if so how much.

[36.] It is the Plaintiff's case that he was approved for Surgery and as a result of termination, he was unable to access his insurance. The Plaintiff relies on an undated quote for Laminectomy with Transforaminal Lumbar interbody fusion from South Florida Spine Institute in the amount of $45,270.00

[37.] The Plaintiff relies on the Patient Access International Service Price dated June 22, 2015, which details hospital, Pathology Anesthesia $25,000 in Implants in the Amount of $48,000.

[38.] The Plaintiff seeks a sum of $76,206.00 in addition to interest.

[39.] There is evidence before this Court as to the benefits to the Insurance Policy, in-network or not in the network.

[40.] The evidence before this Court is that a consultation was scheduled for the Plaintiff, however, there is no evidence to say that it was executed. Further, the email correspondence requests that all medical records be submitted. There is no evidence before this Court to state that the information was received by the medical institute.

[41.] The Plaintiff submits that he needed reconstruction surgery to his back, there is no evidence adduced or report exhibited to indicate that the Plaintiff was in approved for nor in need of a reconstruction surgery.

CONCLUSION

[42.] In considering the evidence before this Court and applying the principles mentioned before, I am satisfied that the Plaintiff should be put in the position he would have been in, so far as money could provide. However, this Court is not satisfied that the Plaintiff has established any loss. The compensatory principle is fundamental to the assessment of damages, and damages must reflect

the loss, if any, that the innocent party has suffered. Moreover, where there is evidence of direct loss that is recoverable as a component of compensation. Therefore, he who asserts must prove.

[43.] The Plaintiff has provided evidence in the form of estimates, to support his claim for damages concerning a back surgery. However, Plaintiff and Defendant agreed and acknowledged that without Pre-Certification, his claim may be refused or reduced to 50%. The Plaintiff by his emails has only established that he was approved for a consultation. However, there is nothing to establish that he was examined by Doctor Hyde nor referred for surgery and or approved. There was no doctor called to give evidence and establish whether he was referred for the surgery. Further, there was no reason given for not calling a medical expert. Nor to date, has the Plaintiff demonstrated any letter to determine the approval for the alleged scheduled surgery. Had his surgery been confirmed for October of 2009, certainly there would been some confirmation that the Plaintiff could've provided in support.

[44.] Moreover, there was no evidence adduced to demonstrate some contribution by the Plaintiff for insurance to which he may be entitled. Therefore, for the reasons above the Court is not satisfied that there was any approval, nor there would have been any medical benefit in either 80% coverage or 50%.

[45.] Having viewed the evidence before this Court and the principles to the assessment of damages and in these circumstances and because of the foregoing there is no award for damages.

[46.] I would invite the parties to produce written submissions regarding the appropriate order for cost.

Dated 16th October 2024

Olivia Blatch
Deputy Registrar