IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

CIVIL DIVISION

CLAIM NO. 2016 HCV 00284

BETWEEN	**GAYLIA JOHNSON**	**CLAIMANT**
AND	**DALMIN FITZROY JONES**	**DEFENDANT**

IN OPEN COURT

Miss Shanique Gaye instructed by Xavier Mayne and Co. for the claimant.

Ms Jamilia Maitland instructed by Campbell McDermott for the defendant.

Heard: June 17, 2021 and July 29, 2021

NEGLIGENCE – WHETHER CLAIMANT SUSTAINED INJURY – ASSESSMENT OF DAMAGES.

PETTIGREW-COLLINS J

THE CLAIM

[1] The claimant filed a Claim Form and Particulars of Claim on the 26th of January 2016. She seeks to recover damages for negligence. The undisputed facts are that the claimant was the driver of a motor vehicle registered CJ 5701 which she described as a Frontier pickup. She was travelling with a passenger along the Runaway Bay main road. She stopped at the traffic light in the vicinity of the Runaway Bay Police Station in order to observe the red signal, when a Toyota Wish motor car, owned and driven by the defendant collided into the rear of the motor vehicle that she was driving.

[2] The claimant contends that there was a violent collision, whereas the defence's case is that there was a slight impact which did not result in any injuries to the claimant.

PRELIMINARY MATTERS

[3] Before addressing the details of the claim, at the outset, the Attorneys at Law advised the court that they were of the view that the defendant's statement of case was struck out for non-compliance with case management orders, based on an unless order that was made on the 15th of April 2021. Further enquiries by me revealed that the basis for assuming that position was that the defendant had not complied with the directive to file a witness statement. Further, that no submissions or list of authorities were filed by the defendant. However, I observed that there was in fact a witness summary filed on behalf of the defendant on the 2nd of July 2020. The apparent reason for enclosing that witness summary in a sealed envelope was the failure by the claimant to file a witness statement in compliance with the original case management orders made on the 1st of March 2018, which directed that witness statements were to be filed and exchanged on or before 6th of July 2020. The claimant's witness statement was filed on the 7th of July 2020.

[4] On the 15th of April 2021, at an adjourned case management hearing, the time for compliance with the orders made on the 1st of March 2018 was extended until May 25, 2021. Therefore, the initial non-compliance by the claimant was cured by that order.

[5] It is true that the witness summary was not in full compliance with rule 29.6 in that the reason for the failure to file a witness statement was not stated. No issue was taken with that fact. The court considers that that non-compliance was not fatal. I therefore on the basis of rule 29.6 of the Civil Procedure Rules (CPR) ruled that the summary should stand as filed.

[6] It was on the on the 15th of April 2021 that the order was made for the filing of skeleton submissions and list of authorities. There is no sanction provided in any rule or practice direction and none was created by the case management orders

made on the 15th of April 2021 or on any subsequent occasion, in relation to the filing of skeleton submissions and authorities to be relied on. The sanction stipulated on the 15th of April 2021, was in relation to case management orders made on the 1st of March 2018. The sanction was that the statement of case of the party or parties not in compliance with those case management orders would stand as struck out unless the parties fully complied on or before the 25th of May 2021 by 4:00 pm. A look at the case file revealed that the defendant had complied with the other case management orders made on the 1st of March 2018 such as the filing of listing questionnaire and pre- trial memorandum.

[7] It is on the basis of the foregoing observations, in conjunction with the claimant's Attorney at Law's assertion that the failure to comply was in relation to the filing of witness statements and skeleton submissions and authorities being relied on, that I took the view that the defendant's statement of case was not in fact struck out.

[8] I did not however permit the defence to rely on the witness summary as the defendant was not present at the trial. Counsel for the defence was permitted to cross examine the claimant based on the claimant's case as well as matters asserted in the defence filed, but was not permitted to put the defendant's case as disclosed in the witness summary.

THE LAW

[9] This is a case of alleged negligence in its simplest form. I shall not undertake any discourse on the law of negligence since that road has been well travelled. It will suffice to state the very basic elements that must be established. It is the claimant who has the onus of satisfying the court on a balance of probabilities that the necessary elements of negligence have been established. The claimant must prove

(a) The existence of a duty of care owed to the claimant by the defendant;

(b) Breach of that duty of care;

(c) That damage which is not too remote, resulted from that breach.

[10] It is trite law that all users of the road owe a duty of care to other users of the road. A driver is required to exercise reasonable care in order to avoid injury or damage to other road users. Reasonable care as it relates to driving is the care which an ordinary skilful driver would exercise in the circumstances. Such care of course includes, keeping a proper look out and observing all the rules of the road.

[11] An individual will be liable in negligence if breach of that duty causes damage. It is inarguable in this case as to whether there was a duty of care and whether there was a breach of that duty. Without some negligence, unless it was established that the defendant's motor vehicle was defective, it would not have collided in the rear of the vehicle being driven by the claimant. Those two elements, that is the existence of the duty of care and the breach of duty have been established. The question which arises is whether there was resulting damage flowing from the breach.

THE CLAIMANT'S EVIDENCE RE LIABILITY

[12] The claimant's evidence in chief is contained in a witness statement filed on 7th of July 2020. She stated that on 30th of July 2014, she was travelling in a Frontier pickup motor truck registered CJ 5701 in the direction of Runaway Bay. She was carrying a passenger in the front seat. She said she was travelling behind two motor vehicles. She saw a Toyota Wish motor car which was some distance away but it was the only vehicle travelling immediately behind her. She said upon reaching the town centre, the traffic light changed to red, and she stopped. She said whilst waiting at the traffic light, she felt a huge impact to the rear of her

motor truck. The impact pushed her, her passenger and the motor truck forward. She stepped on her brakes in an attempt to prevent her truck from hitting the vehicle in front of her. She said almost instantly, she felt a sharp pain to her neck. She said she emerged from the truck whilst holding onto her neck whilst the pain was increasing. She stated that as she got to the rear of her truck, she noticed that the Toyota Wish "had now run underneath the back" of her vehicle causing her truck to be raised slightly above the ground. Upon speaking to the driver, he explained that the accident occurred because he had been searching for a CD.

[13] She said that the incident happened close to the Runaway Bay Police Station and both herself and the defendant whose name she learned was Delmin Fitzroy Jones, went to the police station and gave statements.

[14] She said as a result of the collision, she was thrown forward without notice and she sustained injuries to her neck, lower and upper back. She said she did not see a doctor that evening because the doctors' offices in the area were closed. She stated that the following day, she was treated by Dr. Kumar Rampa at the Lifeline Medical Centre in Mammee Bay, St. Ann. She spoke about her injuries as diagnosed by Doctor Rampa, her resultant disabilities and her expenses. Those aspects of her evidence will be addressed under the relevant head of damages.

[15] The claimant was cross-examined. Asked if she had seen the vehicle that impacted her vehicle prior to the impact, her response was "yes." When asked how far away was that vehicle from her vehicle when she first saw it, she said maybe it was a foot or two. She also stated that the distance between her vehicle and the one in front of her was about 10 ft. When asked if at the time she saw the vehicle that hit her, if it had stopped or was in motion, she queried whether the question was being asked about before or after the impact. It was made clear to her that the question related to prior to the impact. Remarkably, her response was that the vehicle was stationery. Asked if she was wearing her seatbelt at the time of the impact, she said that she was. She explained that when the other

vehicle (the Toyota Wish) ran under her vehicle, the two rear wheels of her vehicle were raised off the ground. Asked about the damage to the vehicle she was driving, she said the entire bumper had to be repaired and replaced.

THE CLAIMANT'S EVIDENCE IN SUPPORT OF THE CLAIM FOR SPECIAL DAMAGES

[16] Regarding her claim for special damages, the claimant tendered in evidence four receipts, two of which evidenced payments to Dr. Rampa, one in the sum of $3,000, the other in the sum of $8,000. It was the claimant's evidence that she visited Dr. Rampa on two occasions; the day following the accident and on a subsequent occasion. The receipts from Dr. Rampa are dated the 31st of July 2014 and the 22nd of July 2015. The other two receipts were for $3,178.24 and $1,695.29. The receipt for $3,178.24 evidenced purchase of a cervical collar. The $1,695.29 was a payment for prescription items on the 31st of July 2014.

[17] The sums claimed in respect of special damages are $8,000 for the medical report, $23,584.00 for medical expenses, $10,000.00 for transportation expenses, $3,000 for a police report and $55,000.00 for loss of income

THE CLAIMANT'S EVIDENCE IN SUPPORT OF THE CLAIM FOR GENERAL DAMAGES

[18] The claimant tendered into evidence two medical certificates. The first is dated the 31st of July 2014, reflecting that she was given sick-leave from the 31st of July 2014 to the 4th of August 2014. The second is dated the 7th of August 2014 and reflected seven days' sick leave from the 6th of August 2014 to the 12th of August 2014.

[19] Initially, the claimant had said that she agreed that it was not correct when the doctor said in his report that he reviewed her on the 7th of August 2014. She also said that what is written in the doctor's report is based on one visit with him. However, in re-examination, she sought to correct herself and said that she had

also visited the doctor on the 7th of August 2014 when she received the second sick-leave.

[20] The claimant tendered in evidence a medical report from Dr. Kumar Rampa dated the 22nd of July 2015. Dr. Rampa stated in that report that he is the holder of a MBBS (Bachelor of Medicine and Surgery). He also said he has 5 years' experience working as a Medical Officer at the Casualty Department at the St. Ann's Bay Hospital and seven years as a Paediatric Medial Officer at the same institution. He also worked at the Lifeline Medical Centre since 2005 and he is fully registered with the Medical Council of Jamaica.

[21] He stated that he first saw the claimant on the 31st of July 2014 when she complained that the vehicle she was driving was hit from behind by another car. He said the claimant alleged that she was shaken and she sustained injuries to her neck. He stated her injuries to be tenderness to the neck region with no stiffness nor restriction of movement and he said that there was no radiation of pain or numbness to the limbs. He said she was treated with pain medication, a cervical collar and rest was advised. He also said X-rays and an MRI were advised. The doctor also stated that the claimant had no significant past medical history. His assessment of her was soft tissue injuries of the cervical spine and possible whiplash injury of the cervical spine.

[22] It was stated in the doctor's report that the X-ray showed that the claimant's cervical spine was normal and X-ray of the lumbar spine revealed mild osteoporosis and there was mild to moderate muscle spasm.

[23] The doctor said that upon his review of the claimant on the 7th of August 2014, she complained of pain near her lumbar region and that there was improvement of her neck pain. He again advised X-ray and a MRI. Under the heading, 'opinion and prognosis', the doctor said that the cervical spine injury impairment was 0% and the lumbar spine injury impairment was 3% and that the claimant's whole

body pain impairment was 10% which was described as being mild. He said that her injuries were consistent with the accident.

[24] In her witness statement, the claimant said that she was seen and treated on the 31st of July 2014 and the doctor made the following findings; pain in her lumbar region, neck pain and mild to moderate muscle spasm.

[25] According to the claimant in her witness statement, since the accident, she has experienced notable discomfort. She said she has experienced excruciating pain and that her neck and back were the primary sources of discomfort. She said she could not do the usual chores around her house and she was unable to sleep because of back pain and that on occasion she had to sleep on the floor because of the discomfort she was experiencing. According to her, there were occasions on which she was unable to get up out of bed to use the bathroom without assistance. She said that she still had difficulty lifting heavy objects and sitting for lengthy periods. (This was understood to mean up to the time of giving the statement.) According to her, her performance at work was grossly affected by this injury.

SUBMISSIONS ON GENERAL DAMAGES

[26] The claimant's Attorney at Law filed skeleton submissions. In addressing the question of general damages, she commended to the court the following cases:

- **Wilford Williams v Nedzin Gill and Christine Forrest** Khan's Vol. 5 page 148. Suit No C.L. 1999 W 169 Judgment delivered on November 28, 2000.

- **Talisha Bryan v Anthony Simpson & Andre Fletcher** 2011 HCV 05780. Judgment delivered March 13, 2014.

- **Irene Byfield v Ralph Anderson & others** Khan's Vol. 5 page 255. Suit No. C.L. 1996 B9 Judgment delivered September 18, 1997.

- **Earl Lawrence v Dennis Warmington** Khan's Vol. 5 pages 144-145. Suit No. C.L. 1998 1 138 Judgment delivered April 12, 2000.

[27] In **Wilford Williams**, the claimant suffered whiplash injury. The claimant was awarded $350,000 in general damages. As at March 2021, that sum updated to $1,763,023.26.

[28] In **Talisha Bryan**, the claimant suffered a whiplash injury and lower back pain. She was awarded $1,400,000.00. As at March 2021, that sum updated to $1,849,024.39.

[29] In **Irene Byfield,** the claimant sustained injuries to her chest, neck and back and minor abrasions to her lower leg and stomach as well as headaches. The claimant was awarded $300,000.00. This sum updated to $1,878,034.68 in March 2021.

[30] Finally, in the case of **Earl Lawrence,** the claimant sustained a whiplash injury, laceration to the legs down to the ankles, lacerations to the hands and lacerations to the back of the head. The claimant was awarded $450,000.00 which in March of 2021, updated to $2,365,776.70.

[31] The defendant's Attorney at Law in final submissions, has asked the court to be guided by the following authorities in making an award of general damages if any:

i) **Horrel Patterson v Econocar Rentals Ltd** (Suit No. C.L. 1991 P 146 reported in Khans Vol. 4 pages 162-165. The claimant in this case suffered shock, pain and tenderness on flexion and extension of neck and lumbar sacral spine, contusion of chest, pain on palpitation of chest, radiating pains down to leg and whiplash injury with involvement of sciatica nerve in left leg. Damages were assessed the 3rd of March 1995. The claimant was awarded $44,000 for general damages which updated to $424,424.78 as at May 2021.

ii) **Yvonne Shoucair v Hector Hinds & Levi Smith** Suit No. C.L. 1988/S186 reported in Assessment of Damages for Personal Injury 1st Edition page 84 that the claimant suffered whiplash and pain in face, neck and lower back for one week. Damages were assessed on the 27th of September 1990. The claimant was awarded $10,000 for general damages. This award updated to $473,913.05 as at May 2021.

iii) **Roy Campbell v Rendell Cameron** Suit No. C.L. 19988/C361 reported in Assessment of Damages for Personal Injury 1st Edition page 85. The claimant in this case suffered fracture of the No. 6 cervical vertebrae and whiplash injury. Damages were assessed on the 6th of February 1991. The claimant was awarded $16,800, this sum updated to $678,222.22 as at May 2021.

ASSESSMENT OF THE EVIDENCE

[32] The claimant's account, although not contradicted by evidence from another source as the defendant did not attend the trial, is not entirely credible. In her witness statement, she spoke of a "huge impact". However, her evidence in cross examination that the first time she saw the motor vehicle driven by the defendant which collided in the rear of the vehicle she was driving was when the vehicle was some two feet behind her and that it was stationary, renders it highly unlikely that there was a huge impact as she described. In the light of the defendant's case that there was an impact, the finding that the force of the impact was not as severe as described by the claimant, does not mean that she did not feel an impact that pushed her body forward.

[33] I find on a balance of probabilities that the claimant sustained injury during the incident. I am however firmly of the view that her injuries were quite minor. One basis on which I have come to this conclusion is that the claimant claims that she did not visit a doctor that afternoon because the doctors' offices in the area were closed at the time. The defendant's Attorney at Law pointed out in her submissions and this court takes judicial notice of the fact that there is a public

general hospital with an emergency department within a few miles of where the incident occurred.

[34] My finding is that the claimant did not view her injury as a matter of concern at the time and so made no effort to attend upon a doctor for medical care that afternoon. Also, when asked in cross examination whether she had done the MRI, the claimant stated that she did not, and also volunteered that the reason was because she could not afford to do so. Asked whether she had gone to therapy, her response was similar. Be it noted that the claimant gave her occupation as an Electrical Engineer. Asked by the court whether she was employed in that capacity for the company whose vehicle she was driving at the time, her response was "yes." It was also the claimant's evidence that she did not follow up with orthopaedic consultation as recommended by Dr Rampa. I find that the reason that the claimant did not undergo physiotherapy and failed to do the MRI or follow up with the orthopaedic consultation was that she must have formed the view that it was not necessary for her to undergo any further diagnostic procedure or treatment as she was not in pain or any significant pain in the days, weeks, months and years afterwards and up to the time of giving her witness statement as she claims.

[35] The submission by the defendant's Attorney at Law that the claimant's evidence was that she was never physically examined by Dr Rampa after the 31st of July 2014, is not entirely accurate. While that was the implication from her evidence initially in cross examination, she attempted later in cross examination to explain but was not allowed to. However, she later pointed out that she was mistaken and that she had in fact visited the doctor on the 7th of August 2014. The claimant was initially asked:

> "On how many occasions did you go to Lifeline?"
>
> Her response was "I went there twice, once for the report, once for the medical"

The question that followed was "What report?"

Her response was “the medical report”. The claimant went on to say that she went there twice, once for the medical report, and once for a doctor’s visit. She was later asked to confirm that the medical report was dated the 22nd of July 2015, which she did. She was also asked if she went to pick up the medical report on the day it was prepared or after. She stated that she did not go to pick up the report. She was asked:

“When Dr. Rampa said that he reviewed you on the 7th of August 2014 that is not correct if you went there only once. Do you agree?” She responded “Yes, I would agree.”

[36] She was thereafter asked if she agreed that when Dr. Rampa said he reviewed her on the 28th of September 2014, that would not be correct and she responded that she would not agree. Remarkably, she stated that she agreed that what was written in the report was based on one visit with the doctor. She disagreed that she did not go to the doctor to get the sick leave certificate.

[37] It has not escaped the notice of this court that the claimant did not present any receipts evidencing payment for visits to the doctor on the 7th of August 2014 and for the 28th of September 2014. Whereas I fully appreciate that there might be some other explanation other than that she did not in fact attend upon the doctor on those occasions, this court is left in some doubt as to exactly what transpired.

[38] In re-examination, when clarification was sought, the claimant stated that she had gone to the doctor on the 7th of August 2014 to get the second sick leave certificate. Ultimately, I was left with the claimant accepting that she was not reviewed by the doctor on the 28th of September 2014 even though the doctor stated in the report that she was examined on that date. I am fully alert to the fact that the incident occurred over 6 years prior to the time the claimant gave evidence and there is the likelihood that her recollection is faulty. She did mutter in the course of giving evidence that it was a long time ago and she didn’t

remember everything. What is clear is that the claimant's evidence in some regard collides with the contents of the doctor's report.

[39] The claimant's evidence about the doctor's diagnosis on the 31st of July 2014 of pain in her lumbar region and mild to moderate spasms is inconsistent with the findings of the doctor. The only diagnosis made by the doctor on the 31st of July 2014 visit, was tenderness to the neck with no stiffness or restriction of movement. The first reference made to the claimant's lumbar spine was that no abnormality was detected. That finding appears to have been made on the date of the initial examination, that is the 31st of July 2014. The medical report reveals that on the visit of the 7th of August 2014, the claimant complained of pain near to her lumbar spine. It was on the 8th of August 2014 that the X-ray of the lumbar spine is said to have been done. The finding of mild to moderate muscle spasm was based on that X-ray and was the first reference made to any muscle spasm. A diagnosis of muscle spasm is often made based on what is conveyed to the professional making the diagnosis unless some type of diagnostic test is done. Spasm involves pain or cramps which is usually a diagnosis made from an X-ray when there is severe spasm which would operate to distort the skeletal structure thereby making the spasm detectable by radiological imaging, which was the diagnostic tool employed in this instance. I am mindful that the medical evidence was not tested by cross examination.

[40] The contents of the doctor's report indicate that two X-rays were done, one of the cervical spine on the 31st July 2014 and an X-ray of the lumbar spine on the 8th of August 2014. The defendant's Attorney at Law has asked the court to take note of the fact that the claimant did not mention in her witness statement that any X-ray was done and that she did not produce any receipt evidencing payment for X-rays. I do find it odd that the claimant did not mention in her witness statement that she did X-rays. It is true that she also did not exhibit any receipts evidencing payments for X-rays. Attached to the claimant's notice of intention to tender into evidence hearsay statements filed on the 11th of March 2020, is what appears to be a receipt from Medi-rays Ltd Diagnostic Medical Imaging Centre evidencing

payment for a lumbar spine X-ray. It was said to be "for professional services rendered at Medi-rays on 16th of July 2014", which is a date prior to the accident which, it is not in dispute, occurred on the 30th of July 2014. There is a signature on it with the handwritten date 7th of August 2014, referencing the date of payment. I am mindful that this document was not in fact entered into evidence but it raises questions.

[41] As with the absence of receipts in proof of payment for a doctor's visit, I do not conclude that the failure to mention in the witness statement that X-rays were done, combined with the failure to produce receipts in evidence in respect of payment for X-rays means that none was done. It was open to the defendant's Attorney at Law to suggest to the claimant that no X-rays were done or to address the question of when, in cross examination and to give the claimant an opportunity to respond. That was not done. My main question certainly in relation to the X-ray of the lumbar spine was the date on which it was done. To find that no X-ray was done would also clearly mean that the doctor falsified the medical report.

[42] The case of **Cherry Dixon-Hall v Jamaica Grande Limited,** SCCA No. 26/2007, makes it clear that even in circumstances where a medical report is entered into evidence, without objection, it does not mean that its contents must be accepted without more. A judge is required to scrutinize its contents consider same in conjunction with all the evidence presented and thereafter make a determination whether any or all of its contents should be rejected.

[43] I reject the defendant Attorney at Law's submission that the medical evidence should be rejected on account of the gaps identified on the claimant's case. On a balance of probabilities, I accept the doctor's report with a caveat regarding the date of the X-ray of the lumbar spine. Especially having regard to what he reported as the findings of the X-ray of the cervical spine, I did not form the impression that that information was concocted. I would be extremely slow to ascribe unprofessional conduct to the doctor. I accept that the onus was

ultimately on the claimant to present a coherent case, but I do not think that the unexplained matters presented such a conundrum that cannot be overcome.

[44] The diagnosis of osteoporosis was clearly not a consequence of the accident but was a pre-existing condition. Even if osteoporosis could possibly result from an accident, it could hardly have developed within a matter of days. It is a condition that develops slowly over a matter of years. I cannot conclude in all the circumstances that any finding of muscle spasm was as a result of the accident. I am mindful that the doctor said that the claimant's injuries were consistent with the accident. However, I will confidently say that since the osteoporosis did not result from the accident and the doctor said that her injuries are consistent with the accident without excluding the osteoporosis being a result of the accident, then that aspect of the report is inaccurate.

[45] There is no evidence whether the muscle spasm is related to the osteoporosis. I do not believe the claimant's evidence about longstanding and continued suffering over a matter of years resulting from the accident. If it is that she experienced pain, this court cannot conclude that it began with or was as a result of the accident. Such evidence in my view represents an effort on her part to bolster her claim for an increased amount for general damages.

[46] The doctor's finding that the claimant's pain impairment was mild, that by the 7th of August 2014 the neck pain had improved and the finding that the X-ray of the cervical spine of the 7th of August 2014 was normal, are factors that this court considers in concluding that the claimant's injury was mild. The assessment that the neck pain had improved must manifestly have been made based on what was conveyed to the doctor by the claimant. The diagnosis of whiplash injury was not a conclusive diagnosis. That was clearly the doctor's provisional assessment made on the 31st of July 2014. He merely stated that there was a possible whiplash injury. That diagnosis the doctor said, was not confirmed by the findings on X-ray.

[47] Ultimately I am left with the claimant's injury from the accident being soft tissue injury to the cervical spine which manifested in tenderness (presumably from pain) but with no stiffness or restriction of movements, which pain had improved by the 7th of August 2014.

[48] The cases cited by both sides are in relation to claimants who suffered more serious injuries than the claimant in the present case. The case that would be of greatest assistance to this court is that of Wilford Williams and even so, the claimant in that case suffered a whiplash which is to be considered more serious than soft tissue injury which was improving by the 7th of August 2014. The defendant's Attorney at Law cited cases which I consider to be relatively old and for that reason, little or no reliance should be placed on them. In all the circumstances, the claimant is awarded general damages of $600,000.00.

[49] No police report was tendered in evidence, therefore the $3000 claimed for that report is clearly not recoverable. The claimant is entitled to recover $8000 paid for the medical report, $3000.00 for a doctor's visit, and the expenditure at the pharmacy. One of the pharmacy receipts showed a total expenditure of $8,739.71. Of this sum, the claimant paid $1695.29 out of pocket. The difference of $5801.45 was covered by the claimant's insurance and so she is not entitled to recover that amount. The claimant did not make any reference to the loss of $55,000.00 on account of loss of income in her witness statement. When asked in cross-examination whether she was paid for the period that she was on sick leave, the claimant responded that she did not remember. She clearly is not entitled to recover that $55,000.00 or any sums at all for loss of income.

[50] The claimant did not put forward any explanation as to how she incurred transportation costs of $10,000.00. She presented no proof of that expenditure. It is sometimes not practical to be able to produce tangible proof of such expenditure. However, it is not unreasonable that she would have incurred some expense on account of having to visit the doctor. She is awarded $5000.00 for transportation costs. Even though there are issues surrounding some of the

contents of the medical report of Doctor Rampa, the fact is, it is accepted that she visited the doctor and incurred costs in order to secure the report. The claimant is therefore awarded the sums evidenced by the receipts tendered in evidence which are $8000.00 for the doctor's report, $3000.00 for the doctor's visit, $1695.29 for the out of pocket prescription expense, $3178.25 for the cervical collar and $5000.00 for transportation cost. I am left with special damages in the sum of $20,873.54.

Orders

[51] In light of my findings, I make the following orders:

(i) Judgment for the claimant on the question of liability.

(ii) Special damages assessed at $20,873.54 with interest at the rate of 3% per annum from the 30th of July 2014 to the date of judgment.

(iii) General damages assessed at $600,000.00 with interest at the rate of 3% per annum from the 2nd of June 2016 (date of service of the claim form and particulars of claim) to the date of judgment.

(iv) Costs to the claimant to be taxed if not agreed.

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Hon. A. Pettigrew-Collins