IN THE GRAND COURT OF THE CAYMAN ISLANDS
HOLDEN AT GEORGE TOWN

Cause No: 751/2003

BETWEEN:

KATHLEEN FICHNER

PLAINTIFF

AND:

THE PROPRIETORS OF STRATA PLAN #16

DEFENDANTS

Appearances:	**Mr. Delroy Murray of Murray and Westerborg for the Plaintiff** **Mr. Shaun McCann and Mr. Gary Hendrikse of Campbells for the Defendants**
Before:	**Hon. Justice Charles Quin Q.C.**
Heard:	**22nd – 24th September 2009 and 27th and 28th May 2010**
Plaintiff's written submissions filed:	**18th June 2010**
Defendants' written submissions filed:	**8th and 23rd June 2010**

RULING

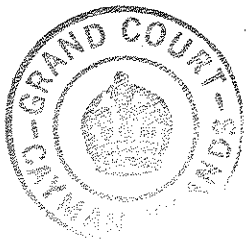
1. The Plaintiff's claim arises out of an accident which occurred on the 27th November 2000 whilst the Plaintiff was on holiday in the Cayman Islands and staying at the Seagull Condominium Complex owned and operated by the Defendants.

2. On that date the Plaintiff returned from the beach and was rinsing off in the fresh water outdoor shower installed for guests to use prior to entering their rooms on the complex as the Defendants' management required.

3. Whilst the Plaintiff was showering, the shower drain directly beneath the showerhead collapsed, causing the Plaintiff to fall into the shower drain and thereby twisting her left knee.

4. On the 16th November 2003 the Plaintiff issued a Writ of Summons and a Statement of Claim, claiming damages against the Defendants by reason of the negligence and or breach of duty or care by the Defendants, which caused the aforesaid accident.

5. On the 29th January 2008 the Plaintiff obtained judgment by consent against the Defendants, thereby leaving the only question before the Court to be one of quantum for the personal injuries, loss and damage sustained by the Plaintiff by reason of the Defendants' negligence and breach of statutory duty.



PLAINTIFF'S POSITION

6. On the 4th November 2008 the Plaintiff represented by her new attorneys, Murray & Westerborg, filed an amended Statement of Claim in which she set out her particulars of injury being minor abrasions, ecchymosis and contusions to her right side. The Plaintiff sustained a twisting injury to her left knee. The injuries to her left knee caused her to suffer occasional episodes of buckling and generalized complaints, which were finally diagnosed as a torn meniscus and contusion in the medial tibial plateau. The Plaintiff's amended Statement of Claim pleaded that the Plaintiff was deemed to require, and received, surgical arthroscopy of the left knee, a partial meniscectomy and chondroplasty.

7. Aside from the particulars of injury pleaded in the Plaintiff's Statement of Claim the Plaintiff avers that she will need further medical attention, including the replacement of her left knee and that, although there is evidence of a pre-existing medical condition, the injuries sustained on the 27th November 2000 may have exacerbated the pre-existing medical condition.

8. The Plaintiff in her Statement of Claim dated 16th November 2003, and in her amended Statement of Claim dated the 4th November 2008, claimed special damages in the sum of US$12,548.00 to include airfares, costs of accommodation, loss of salary and medical expenses. In her amended Statement of Claim the Plaintiff claimed future medical expenses and future loss of earnings.

DEFENDANTS' POSITION

9. On the 12th November 2008 the Defendants filed their amended defence in which they admitted liability but averred that the Plaintiff was deemed fit to return to work after the surgical arthroscopy of the left knee, partial meniscectomy and chondroplasty.

10. The Plaintiff's injuries were limited to the bruising of her left leg and a torn medial meniscus in the left knee. The Defendants aver that the injury to the left knee was successfully treated by Dr. Mark Seckler ("Dr. Seckler") and that the Plaintiff had made a full and complete recovery.

11. The Defendants also aver that the Plaintiff's need for further medical treatment should be discounted by reason of the fact that she would have required a knee replacement in any event. Further, the Plaintiff's medical complaints after Dr. Seckler's treatment related to her patellofemoral condition and had nothing to do with the accident.

ISSUES

12. The Court has to determine the quantum of general and special damages arising as a direct result of the Defendants' negligence and breach of statutory duty.

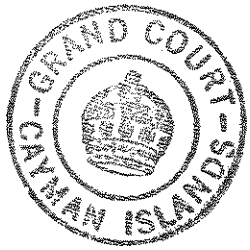
13. In order to determine the quantum of damages it is necessary for the Court to review and analyse the medical treatment and various reports submitted by several doctors.

14. The Court has to decide:

i. What were the injuries sustained by the Plaintiff as a result of the accident?

ii. Is the Plaintiff in need of further and continuing medical treatment as a result of the accident?

iii. Should the Court reduce the Plaintiff's award by reason of the fact that she had a pre-existing medical condition?



CHRONOLOGY OF THE MEDICAL TREATMENT RECEIVED BY THE PLAINTIFF

15. The Plaintiff arrived at the Defendants' property on the 20th November 2000. The accident occurred on the 27th November 2000.

16. On the day of the accident the Defendants asked the Plaintiff whether she wanted to attend the hospital for examination. The Plaintiff decided that she was unsure about the standard of care provided at the George Town hospital and she therefore declined to go there and decided to wait to be to be treated by her own doctors with whom she was familiar. Consequently, for the remaining two days of her holiday she rested inside the Defendants' complex with ice on her legs.

17. Upon the Plaintiff's arrival home in New Jersey, USA, she contacted her physician, Dr. Miguel Cherciu ("Dr. Cherciu") to have her leg and knee which were still swollen and painful, checked. After this examination Dr. Cherciu sent the Plaintiff off to have an MRI done on her left knee.

18. On the 9th December 2000 a Radiologist, Dr. Janet Spector ("Dr. Spector"), conducted an MRI examination on the Plaintiff. Dr. Spector's report said that the posterior cruciate ligament ("PCL") was intact. Her report stated that the anterior cruciate ligament ("ACL") was intact in its proximal and mid portion, however, the distal portion was not well demonstrated and a partial tear could not be excluded. Her report also stated that no definite meniscal tears were demonstrated, although there was some high signal noted in the posterior horn of the medial meniscus, which did not definitely contact the articular surface.

Dr. Spector said that this likely represented intrameniscal myxoid changes. She noted that the patella, disal quadriceps tendon and patellar tendon were intact. Dr. Spector added that the patellar cartilage was normal.

19. Upon receipt of Dr. Spector's MRI report, the Plaintiff's physician, Dr. Cherciu, then referred the Plaintiff to Dr. Manuel Banzon ("Dr. Banzon"), an orthopaedic surgeon for further examination.

20. On the 20th December 2000 the Plaintiff attended Dr. Banzon who gave the following report.

21. Dr. Banzon said an examination of the knee showed minimal effusion. His report stated that there was no hypermobility of the patella, and that there was tenderness over the medial joint line. Dr. Banzon's report stated that Lachman, Drawer, and Pivot Shift tests were essentially negative. McMurray's sign was, however, positive, permitting both external and internal rotation. The MRI showed an osteochondral fragment involving the medial tibial plateau. Dr. Banzon's diagnosis was a partial ACL tear and a left osteochondral defect.

22. On the 16th January 2001 the Plaintiff was seen by Dr. Seckler who specialized in sports medicine, arthroscopic surgery and knee and shoulder reconstruction. Further x-rays of her leg and knee were done. Dr. Seckler's report stated that the MRI by Dr. Spector had shown a grade II tear in the posterior horn of the Plaintiff's medial meniscus, and a small osteochondritic defect in the medial tibial plateau, consistent with the meniscus injury.

Dr. Seckler found slight effusion with mild patellofemoral symptoms. Dr. Seckler reported that the Plaintiff had positive lateral and medial joint line tenderness, with the medial greater than the lateral. Dr. Seckler also reported that the Plaintiff's provocative tests were positive and that she was ligamentously completely intact. Dr. Seckler agreed with Dr. Spector and confirmed that the Plaintiff had a small osteochondritic defect in the medial tibial plateau and a grade II, if not grade III, meniscal tear. Dr. Seckler said that because the osteochondritic defects were small, they should be left alone and would heal on their own. Dr. Seckler finally confirmed that the patellofemoral aspect should be addressed with quad strengthening in the post operative period. Dr. Seckler recommended an arthroscopy of the left knee to address the torn meniscus.

23. On the 28th February 2001 under anaesthetic the standard arthroscopic portals were made. The medial hemijoint was entered. Dr. Seckler reported that the medial femoral condyle and the medial tibial plateau were normal. He noted that there was a tear in the posterior horn of the medial meniscus. Using an upbiting punch, a partial meniscectomy was performed. Using a full radius aggressive shaver, the rim of the meniscus was balanced and saucerized to a stabilized edge. In addition the arthroscope was placed in the intracondylar notch. The ACL and PCL were visualized to be normal. In addition, with the leg in a modified figure four, the lateral hemijoint was entered. It was noted that the lateral femoral condyle, lateral tibial plateau, lateral meniscus and popliteus tendon were normal. Dr. Seckler's diagnosis was that there was a left knee medial meniscus tear and patellofemoral syndrome after which the medical operations of a surgical arthroscopy of the left knee, a partial meniscectomy and a chondroplasty were done.

24. On the 15th March 2001 Dr. Seckler wrote to the Plaintiff's physician, Dr. Cherciu, and stated that 15 days after the arthroscopy of the Plaintiff's left knee she was doing very well. The portals were healed nicely, neurovascularly intact, with no signs of infection. Dr. Seckler also stated that the Plaintiff had a good range of motion with good quad strengthening. He again confirmed that she had a torn medial meniscus and patellofemoral syndrome. He also confirmed that she underwent a partial meniscectomy and a chondroplasty to the patella. Dr. Seckler recommended that the Plaintiff strengthen her quadriceps to protect the patellofemoral joint and initiated formal physical therapy.

25. On the 26th April 2001 Dr Seckler again saw the Plaintiff and confirmed that the Plaintiff's torn meniscus was resolved by the arthroscopy. He also confirmed that she had significant patellofemoral syndrome, for which the mainstay is continued physical therapy. Dr. Seckler noted that the Plaintiff had stopped the physical therapy. Dr. Seckler confirmed that the Plaintiff's portals had healed nicely, were neurovascularly intact, with no signs of infection or effusion. He said the Plaintiff had no joint line tenderness. Her meniscal provocative tests were negative. She was ligamentously intact. He did note that she had an increased patella tilt and confirmed that she had patellofemoral crepitus and a positive inhibition. Dr. Seckler said that he was going to reinstate formal therapy since the essence is quad strengthening without irritating the patellofemoral joint and hamstring flexibility.

26. On the 25th September 2001 the Plaintiff again saw Dr. Seckler. Dr. Seckler again noted that the Plaintiff had stopped therapy. On questioning the Plaintiff he discovered that the discomfort was all parapatellar with clicking, there was no swelling and there was one episode of buckling. He again confirmed that on physical examination the portals were healing nicely, neurovascularly intact, and that she had a full range of motion, with no effusion. Dr. Seckler confirmed that the Plaintiff had no joint line tenderness. The meniscal provocative tests were negative. Dr. Seckler said ligamentously, the Plaintiff was intact, however, the Plaintiff did have patellofemoral creptius. Dr. Seckler explained to the Plaintiff that the patellofemoral problem is chronic and would always be there. He again advised her to keep her quadriceps strong and her hamstrings flexible. He recorded that the Plaintiff understood his advice and was willing to comply.

27. Dr. Seckler saw the Plaintiff on the 2nd April 2002. He again referred to the injury being a torn meniscus, for which he performed the arthroscopy of her left knee. He noted that her pre-existing patellofemoral syndrome had no bearing or relationship to the torn meniscus. He confirmed that the meniscus was a result of the twisting injury she sustained while taking an outdoor shower and stepping through a wooden grate. Dr. Seckler confirned that the two injuries were completely separate entities. He said that the injury in the shower exacerbated her pre-existing patellofemoral syndrome. He said, however, that the pre-existing patellofemoral syndrome did not predispose the Plaintiff to tearing her meniscus.

28. On the 13th August 2002 the Plaintiff was examined by Dr. Stephen Berkowitz. The Plaintiff provided Dr. Stephen Berkowitz with an account of the accident of the 27th November 2000 and a history of the medical treatment she had received up to that date. The Plaintiff confirmed that she had the MRI at the request of her doctor, Dr. Chericu. She also recalled that she had been seen by Dr. Banzon who, after consultation, had recommended arthroscopic surgery. The Plaintiff also reported the treatment and diagnosis she had received from Dr. Seckler and the fact that he had recommended quad strengthening and hamstring flexibility, which had to be done at home due to physical therapy benefits ceasing.

29. Dr. Stephen Berkowitz confirmed that the MRI of the left knee, dated the 9th December 2000 revealed a posterior horn tear of the medial meniscus, osteochondral defect of the medial tibial plateau and chondromalacia of the patella, Grade II to III.

30. Dr. Stephen Berkowitz found that the Plaintiff's ambulation and gait were non-antalgic. He said there was no foot drop. He said the Plaintiff was able to heel-toe and tandem-walk without difficulty, and was able to do a good squat with some end point pain. He had no other pertinent abnormal findings.

31. In relation to the left knee he said there were no signs of calf or thigh atrophy. Dr. Stephen Berkowitz said the scars were well-healed from the previous arthroscopic surgeries. He found the range of motion was full in active and passive flexion and extension. He said there was medial joint line tenderness, but no patellofemoral tenderness.

He found there was no tenderness along the tibial cubicle and no lateral joint line tenderness. He found there was no increased heat, swelling or crepitus on range of motion test. He said the Plaintiff had a negative Lachman's test, a negative McLaughlin sign and no varus-valgus instability. Having taken her history and read the MRI of Dr. Spector and the reports of Dr. Seckler, Dr. Stephen Berkowitz found that the Plaintiff had post-meniscectomy syndrome, chondromalacia of the patella, and an osteochondral defect of the medial tibial plateau of the left knee. Dr. Stephen Berkowitz found that the Plaintiff could return to work. He found that if the Plaintiff were develop any sign of post meniscectomy osteoarthritis, she would be a candidate for some synivisc injections.

32. On the 17th September 2002 the Plaintiff had a second MRI – this time, performed by Dr. Debra Loeb ("Dr. Loeb"), another Radiologist. Dr. Loeb noted that the lateral meniscus was intact. She also noted that the anterior and posterior cruciate ligaments (ACL and PCL) were intact. The distal quadriceps tendon and patellar tendon were intact and the medial and lateral collateral ligament complexes were also intact. Dr. Loeb's view was that there was joint effusion, a contour abnormality posterior horn of the medial meniscus, which could be post operative. She also noted that there was some spurring of the patellofemoral joint and spurring of the joint margins was also seen medially and laterally.

33. On the 16th December 2003, after the Plaintiff's second MRI, Dr. Seckler provided a detailed medical report. He confirmed that on the 28th February 2001 she underwent a partial medial meniscectomy and a chondroplasty to the patellofemoral joint. He confirmed that her post-operative course was essentially unremarkable. He confirmed that 15 days after the operation the Plaintiff had a good range of movement and good quad strength and that the plan was to continue strengthening her quadriceps to protect the patellofemoral joint and to initiate formal therapy. He confirmed that, again, he had to reinstate formal physical therapy since quad strengthening is the mainstay of her therapies. Dr. Seckler reported that on the 25th September 2001 he explained to the Plaintiff that her patellofemoral problem was preoperative and it would always be there. He advised her that she needed to keep her quadriceps strong and her hamstrings flexible. Dr. Seckler confirmed that this was not a cure but it was the treatment of choice to make her more comfortable and functional.

34. On the 12th September 2002 the Plaintiff was still complaining of increased pain around the patellofemoral joint. Dr. Seckler said there was no evidence of any new trauma. He said his examination was essentially normal, other than the patellofemoral concerns. He noted that the Plaintiff did have significant quad atrophy which was indicative of the fact that she had not been adequately strengthening her quadriceps, although she stated that she had. He noted that there was a 2 to 3 cm difference in the quadriceps girth. He said that the she still had persistent patellofemoral syndrome, with a possible re-tear of her medial meniscus, and he recommended that she re-start physical therapy.

35. On the 1st October 2002 Dr. Seckler again recommended that the Plaintiff continue with physical therapy, both formally and on her own, and that she must maintain the programme forever. He advised the Plaintiff that she must regain the strength of her quadriceps musculature, as that would be mainstay to protecting the knee with the patellofemoral syndrome.

36. Dr. Seckler last saw the Plaintiff on the 25th September 2003 and confirmed that her physical examination showed continued patellofemoral syndrome, and that there were no meniscal signs or concerns. Dr. Seckler confirmed that the patellofemoral syndrome was permanent. He also confirmed that the meniscus was torn, which results in a partial meniscectomy. He said the patient does not re-grow new meniscus and there was a percentage of loss of the Plaintiff's meniscal function and shock absorbing properties. Dr. Seckler confirmed this with respect to the articular cartilage, due to the fact that the articular cartilage deteriorates and, when there is damage to that cartilage, there is no regeneration or cure, and the deterioration is therefore permanent.

37. Dr. Spector confirmed that the posterior cruciate (PCL) was intact. She noted that the anterior/inferior aspect of the ACL was not well identified on sagittal imaging. Dr. Spector noted that the patellar tendon was intact and that the patellar retinaculum was intact. She noted that the lateral meniscus was intact. Dr. Spector's impression was that there was some mild abnormal signal within the posterior medial meniscus without change from 2002. She said that although it is not completely identified on sagittal imaging, intact fibres were identified on coronal imaging.

38. Some time in late 2003 or early 2004 the Plaintiff returned to see Dr. Banzon. On the 2nd February 2004 the Plaintiff was referred by Dr. Banzon to Dr. Spector, the Radiologist, for another MRI.

39. On the 17th February 2004 the Plaintiff visited Dr. Banzon again as a follow-up to the MRI. Dr. Banzon reported that the left knee showed a partial rupture of the ACL, a hypermobile patella, and a patella alta, although Dr. Banzon said the patella alta was not accident-related, nor was the hypermobile patella. However, Dr. Banzon said that the hypermobile patella was aggravated by the quadriceps' atrophy, which ensued following the injury and subsequent arthroscopy. Dr. Banzon's diagnosis on the 17th February 2004 was of a torn medial meniscus, with a partial rupture of the ACL and a hypermobile patella. Dr. Banzon advised the Plaintiff that she may wish to consider arthroscopic surgery to evaluate the new joint.

40. On the 21st May 2004 the Plaintiff again visited Dr. Banzon and told Dr. Banzon that since the last visit her knee was worse. Dr. Banzon diagnosed an internal derangement of the left knee and a partial ACL tear, and recommended further arthroscopy surgery.

41. On the 17th June 2004 the Plaintiff underwent surgery by Dr. Banzon for partial medial and lateral meniscectomy and a condyloplasty. Dr. Banzon's medical report of the surgery on the 17th June 2004 stated the Plaintiff was originally scheduled for a possible ACL reconstruction, but he found, during the arthroscopy, that the ACL was found to be intact.

Dr. Banzon found that the lateral meniscus was torn – involving the posterior horn but the ACL was normal. The medial meniscus showed a partial meniscectomy from the prior surgery. Dr. Banzon reported that he did a partial lateral meniscectomy and a condyloplasty, which was done on the lateral tibial plateau area.

42. On the 23rd June 2004 Dr. Banzon again saw the Plaintiff. He advised that she should start up physical therapy. He also confirmed that the Plaintiff was able to work.

43. On the 3rd August 2004 the Plaintiff attended Central State Medical Centre and was treated by Dr. Cynthia Koscis ("Dr. Koscis"). Dr. Koscis reported that the Plaintiff had received an injury whereby a foreign body had entered her leg whilst she was cutting grass. The foreign body was a metallic piece of thick calibre wire, which had entered her left thigh through a 2-millimetre puncture wound, causing injury in the lateral anterior upper thigh where there was an 8x3centimetre ecchymotic area with an abrasion. Dr. Koscis had to remove this foreign body which had become impaled in her left thigh. The Plaintiff was in great pain and the site was very deep, and the doctor was concerned about vascular injury. The foreign body was successfully removed.

44. On the 23rd August 2004 the Plaintiff again visited Dr. Banzon who found, from his examination that the quadriceps discrepancy seemed to be improving and advised her that she was to continue with physical therapy.

45. On the 23rd September 2004 the Plaintiff again visited Dr. Banzon who noted that her left knee was a little better. He further found that the left knee did not show any evidence of any swelling. There was no instability. Lachman's Drawers and Pivot Shift were negative. Dr. Banzon recommended continued physiotherapy.

46. On the 25th October 2004 the Plaintiff again visited Dr. Banzon. He advised that there were symptoms of chondromalacia of the patella and recommended that Plaintiff continue with physical therapy.

47. On the 22nd November 2004 the Plaintiff again visited Dr. Banzon. Dr. Banzon noted that the Plaintiff was improving as far as the left knee was concerned. He said the quadriceps mechanism was almost recovered from the injury and the surgery and said there was no limitation of range of motion of the left knee. On that date he advised her that she should continue with the exercise programme and reminded her that she may need a total knee replacement in the future because of the progression of the arthritis. Dr. Banzon's final diagnosis was a torn medial and lateral meniscus, a partial ACL tear, and, hydromalacia Grade III of the lateral tibia plateau.

48. On the 7th October 2005 the Plaintiff visited Dr. Michael Greller ("Dr. Greller") complaining of pain in her right hand. In addition, the Plaintiff complained that pain in her right knee started recently. The Plaintiff informed Dr. Greller that her right knee hurt, but did not feel like the pain in her left knee, which she had had some time before. Dr. Greller's examination and x-rays of the Plaintiff's right knee were all negative. However, he noted that there were some mild degenerative changes in the CMC joint of her right hand, which led to osteoarthritis. Dr. Greller recommended a thumb splint and exercises for the right knee.

49. On the 16th November 2005 the Plaintiff went to see Dr. Greller again. He diagnosed CMJ joint arthritis of the right wrist.

50. On the 9th December 2005 Dr. Banzon prepared a comprehensive report of all these visits. He reported that because of the injury incurred on the 27th November 2000, the Plaintiff sustained a tear of the medial meniscus, which was addressed by Dr. Seckler. Dr. Banzon went on to state that the Plaintiff had developed a partial tear of the ACL, causing some degree of instability which eventually caused a tear of the lateral meniscus. Dr. Banzon confirmed that the lateral meniscus injury was not present during the time of the first arthroscopy. It was Dr. Banzon's view that because of the partial meniscectomy, the partial ACL injury, and, subsequent stiffness of the knee, the Plaintiff had developed Grade III chondromalacia of the tibial plateau. Dr. Banzon's opinion was that the patient will probably develop post-traumatic arthritis of the left knee within 10-15 years.

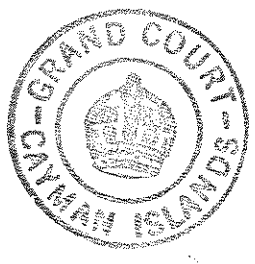
51. On the 26th March 2007 the Plaintiff saw Dr. Banzon when he confirmed that his diagnois was that the Plaintiff had sustained a torn medial and lateral meniscus and now early arthritis in the left knee. His treatment was a painkilling injection of depo-medrol and xylocaine.

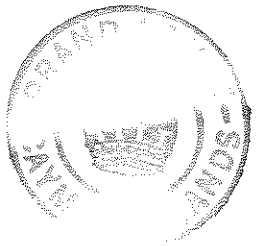
52. On the 10th April 2007 the Plaintiff saw Dr. Banzon when he diagnosed Tricompartmental arthritis in the left knee and gave the Plaintiff an injection of orthovisc.

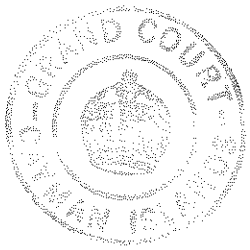
53. On the 18th April 2007 the Plaintiff saw Dr. Banzon and received another injection of orthovisc.

54. On the 26th April 2007 the Plaintiff again saw Dr. Banzon and received another injection of orthovisc.

55. On the 13th May 2008 the Plaintiff was examined by Dr. Gregg Berkowitz, a colleague of Dr. Banzon. Dr. Gregg Berkowitz diagnosed that the Plaintiff had osteoarthritis in her left knee and injected orthovisc without any complications.







ANALYSIS

56. I revert to the questions I posed at paragraph 14 above. In addition to the core bundle and medical bundle with many medical reports from several different doctors, I have also heard live evidence from the Plaintiff, the Plaintiff's husband, Dr. Banzon, Dr. Greller and Dr. Frank Smith ("Dr. Smith").

57. It is common ground that the injuries set out in the Plaintiff's Statement of Claim and amended Statement of Claim were sustained by the Plaintiff as a result of the negligence and breach of statutory duty of the Defendants.

58. The Plaintiff pleaded in her Statement of Claim and amended Statement of Claim that she suffered a torn meniscus and contusion in the medial tibial plateau, which required and received surgical arthroscopy of the left knee, a partial meniscectomy and chondroplasty. The Plaintiff herself sought to rely on the medical reports of Dr. Seckler and Dr. Stephen Berkowitz dated the 2nd April 2002 and the 13th August 2002, respectively.

59. From my review of Dr. Seckler's reports, the Plaintiff's concerns relating to the meniscus had been resolved, but the injury exacerbated the pre-existing patellofemoral syndrome, which will persist. Dr. Seckler stated in his report dated the 16th December 2003 that the problems and concerns are permanent. Dr. Seckler stated "anytime a meniscus is torn and results in a partial meniscectomy, human being does not re-grow new meniscus, thus there is a percentage of loss of her meniscal function of shock absorption properties."

Dr. Seckler continued to state that with respect to the articular cartilage "as that deteriorates and damages, there is no regeneration or cure and this is permanent as well."

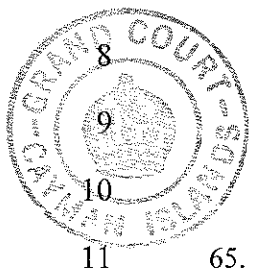
60. Accordingly, as submitted in the Defendants' trial note dated the 22nd September 2009, the Plaintiff sustained a torn meniscus which was treated surgically in February 2001 and resolved. An exacerbation of the pre-existing patellofemoral syndrome was possibly accelerated by the accident, although it is difficult to pinpoint with any definitive accuracy the rate of acceleration.

61. However, the Plaintiff, through the evidence of Dr. Banzon maintains that in 2004 he diagnosed her as suffering from a torn lateral meniscus of the left knee and a marginal but surgically insignificant tear of the ACL – which Dr. Banzon avers is a direct result of the Plaintiff's accident on the 27th November 2000.

62. This is the sharp conflict in evidence which the Court has to resolve. Were the injuries which Dr. Banzon diagnosed in 2004 sustained by the Plaintiff as a result of the accident? Dr. Banzon and Dr. Greller suggest that they were, whilst the evidence of Dr. Smith and the reports of Dr. Seckler and the three MRIs suggest that the injuries were those pleaded by the Plaintiff in her Statement of Claim and amended Statement of Claim. There is an absence of medical evidence or any other evidence to support Dr. Banzon's contention that the injuries which he identified in 2004 were as a direct result of the Plaintiff's fall in 2000.

63. It is Dr. Banzon's evidence that he saw the Plaintiff on the 20th December 2000. At that time he stated that there was perhaps a possible tear of the medial meniscus. Dr. Banzon recommended conservative treatment although he did not rule out the fact that it may require arthroscopic surgery.

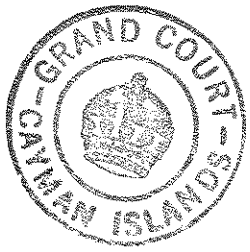
64. Although there was no evidence that the Plaintiff had sustained a torn lateral meniscus, Dr. Banzon, acting on the complaints of the Plaintiff, states that her lateral meniscus was torn and accordingly, on the 17th June 2004 he performed a lateral meniscectomy and a chondroplasty



65. Although Dr. Banzon had previously recorded that the ACL was torn, he found that the ACL was, in fact, normal. In his witness statement Dr. Banzon avers that as a result of the said accident the Plaintiff now suffers from tri-compartmental osteoarthritis of the left knee and osteoarthritis of the "right (sic) left knee". These are irreversible conditions which will require treatment and medication for the remainder of her life.

66. I turn now to answer the questions I posed myself in paragraph 14 (i) and (ii). Aside from the fact that the Plaintiff did not plead, in either her Statement of Claim or her amended Statement of Claim, that the accident caused the torn lateral meniscus, or any partial ACL tear at the tibial insertion, this Court finds on the evidence before it that it the only injury the Plaintiff sustained as a direct result of her accident was a torn medial meniscus, for which she was properly treated by Dr. Seckler. This Court also accepts, on the evidence before it, that the injuries sustained may have exacerbated the pre-existing patellofemoral syndrome.

Finally, this Court finds on the evidence, that the Plaintiff is likely to require further treatment and need medication.



REASONS FOR DECISION

67. Three MRI's were conducted on the Plaintiff's left knee, none of which showed any tear to the lateral meniscus.

68. Dr. Banzon in his report dated the 9th December 2005 stated that the Plaintiff had developed a partial tear of the ACL causing some degree of instability which eventually caused a tear of the lateral meniscus. However, under cross examination Dr. Banzon conceded that the ACL had retained its integrity and was still intact and therefore his diagnosis on the 9th December 2005 was incorrect.

69. In addition, Dr. Smith confirmed that this diagnosis must be incorrect because when Dr. Banzon examined the Plaintiff on the 25th October 2004 and the 22nd November 2004 there was no limitation of range of movement in the left knee.

70. All three MRI's confirm that the lateral meniscus remained intact. On the 10th February 2004 Dr. Spector carried out the third MRI. Dr. Spector confirmed that the posterior cruciate ligament is intact. The anterior-inferior aspect of the ACL is not well identified on sagittal imaging, although it is seen on coronal imaging and is likely intact." Dr. Spector also said this was unchanged compared to the prior study. Dr. Spector also confirmed that the lateral meniscus was intact. She found that there was some mild abnormal signal within the medial meniscus without change from 2002.

71. In cross examination by the Defendants' counsel, Dr. Banzon was unable to challenge the MRI evidence of Dr. Spector and Dr. Loeb, and he could not challenge the diagnosis and treatment of Dr. Seckler. Indeed Dr. Banzon stated in his evidence that what he had to tell us was speculative, and further, that it was speculative that his diagnosis of a torn lateral meniscus was a result of the accident.

72. I have to say, with the greatest of respect to Dr. Banzon, I prefer the consistent and clear evidence of Dr. Smith. Dr. Banzon's evidence is riddled with inconsistencies and errors – particularly in relation to which knee was the subject of his treatment. On numerous occasions Dr. Banzon referred to the right knee when he meant the left knee, and also the left knee when he meant the right knee. These mistakes were included in his medical reports and in his witness statement, where he described the left knee as the right knee on at least three occasions.

73. Dr. Smith agreed with the diagnosis and treatment recommended, and acted upon, by Dr. Seckler. Dr. Smith said the torn meniscus would normally show up in an MRI and agreed with Dr. Banzon that an MRI may be only 70-90% accurate. However, Dr. Smith gave the Court a very detailed explanation of what takes place in an arthroscopy. The arthroscopy is done through a fibreoptic tube – 5 millimetres in diameter. It goes into the joint through a small stab wound and looks at different angles. Dr. Smith explained how the fibreoptic lens looks and covers and visualizes every part of the joint. The arthroscopy is attached to the camera and produces an exhibit on the screen, which magnifies what is viewed by 20 to 30 times through visualization. The arthroscopy opens the space and sees the lateral department of the knee to ensure that you can see it clearly.

It enters the lateral hind joint. Dr. Smith explained that the medial and lateral departments are called the hind joint. He confirmed that Dr. Seckler would be able to see with direct vision and on the screen. The probe manipulates tissue to ensure that there are no hidden lesions underneath the meniscus, even in the margins. Dr. Smith explained that although parts may appear normal, there may be underlying problems in the small crevices, and that is why the arthroscopy conducts a very extensive probe of the articulate cartilage. Dr. Smith's evidence was entirely consistent with Dr. Seckler's description of the arthroscopy in his report dated the 28th February 2001.

74. It is clear from the evidence before me that MRIs found the lateral meniscus to be intact and further, and even more importantly, Dr. Seckler's arthroscopy also found the lateral meniscus to be normal and intact.

75. Dr. Smith confirmed that on the evidence of the MRI and Dr. Seckler's report, all structures were normal. He also confirmed that if there had been injuries they would have shown up. He was clear that the patellofemoral syndrome was in existence before the accident and would not have been caused by the accident.

76. It is clear from Dr. Seckler's reports that the operation he performed was successful. This was confirmed by Dr. Smith, who said that the Plaintiff had recovered as much as she could from the torn meniscus repaired by Dr. Seckler.

77. Dr Smith explained that the patellofemoral joint was already in trouble with chondromalacia. It was flat rather than a 'v'. Accordingly, Dr Smith confirmed that osteoarthritis would arrive earlier than otherwise would have happened. In this respect, Dr. Banzon and Dr. Smith seem to agree.

78. When Dr. Smith first saw Dr. Banzon's note that the lateral meniscus was found to be torn he thought it was a typographical error. Dr. Smith said there is no justification for the partial diagnosis, especially when all the evidence showed the meniscus to be normal. Accordingly, it was Dr. Smith's view that any new tear was unrelated to the accident. Dr. Smith was clear that the later meniscus injury was not present during the time of the first arthroscopy and that there was no reason for a lateral medial tear to appear as a result of the injury. This Court accepts Dr. Smith's evidence on this point.

79. Dr. Smith's evidence is that Dr. Banzon's finding on the 5th December 2005 was entirely inconsistent with what he found on the 2nd October 2009. In December 2009 the ACL is fine. It is intact. Dr. Smith is of the view that one can rely one hundred percent on the arthroscopy and ninety percent on the MRI. He accepted that MRIs sometimes miss lesions, and this often depends on the skill of the radiologist and the quality of the MRI. However, the image of the arthroscopy will show all manner of tears.

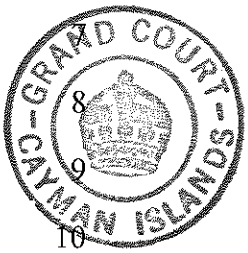
80. Furthermore I am extremely surprised that Dr. Banzon in his reports never refers to the piece of metal in the Plaintiff's thigh, which was treated by Dr. Koscis. In his evidence Dr. Banzon said there was a pin in the Plaintiff's left foot, and he said that it had no direct relation or effect to the thigh or the knee. Firstly, there was no pin or foreign body ever found in the Plaintiff's left foot. Secondly, the metal piece was an irregularly shaped thick calibre wire, not a pin, measuring 4.5cm in length and 2 cm in diametre. Thirdly Dr Koscis' report described the site of the injury as very deep and there was a very real concern that the Plaintiff would sustain vascular injury. The thick metallic piece had gone deep into the muscle, causing injury to the Plaintiff's lateral interior upper thigh and not to her left foot as stated by Dr. Banzon.

81. In this regard, I find Dr. Banzon's evidence to be incorrect and further, he seems to completely ignore this serious injury to the Plaintiff's left leg. Fortunately for the patient it did not cause any vascular injury and it was successfully removed. However, Dr. Smith said this injury had a significant effect on the quadriceps and their function. He described it as being "extremely unfortunate". The Court finds this unfortunate injury to be very relevant as it must, to some extent, have hindered the Plaintiff's recovery.

82. What is apparent from all the doctors' reports is that it is very important for the Plaintiff to continue her physiotherapy and to strengthen her quadriceps. This unfortunate injury not only affected the thigh, but it also prevented her from doing her exercises for some time.

83. Accordingly, I entirely reject Dr. Banzon's evidence that this unfortunate and freakish injury would have no effect on her left knee.

84. This freakish injury to the Plaintiff's thigh would have a very damaging effect on her recovery. I have noted that throughout Dr. Seckler's reports and other doctors' reports that, on several occasions, the Plaintiff had stopped her physiotherapy and had stopped her exercises. It is plain to the Court that the exercises were a vital component of the recommended treatment in order to strengthen the quadriceps and keep the hamstrings flexible. These exercises will protect the knee and mean that the Plaintiff will not need any knee replacement surgery as early as she would, had she not performed these exercises. It is regrettable that the Plaintiff had to be reminded to re-start physical exercises on a number of different occasions.



85. I find on the evidence before me that there is no evidence, other than Dr. Banzon's evidence, that the Plaintiff sustained a lateral meniscal tear.

86. The three MRIs performed by Dr. Spector and Dr. Loeb did not show any lateral meniscal tear. Dr. Banzon's own physical examination of the Plaintiff did not show any lateral meniscal tear, and Dr. Seckler's examination and arthroscopy did not show any meniscal tear.

87. To answer the question posed at paragraph 14(i) above, I am satisfied that the evidence before me confirms that, as a result of the fall sustained by the Plaintiff, she suffered a torn medial meniscus which exacerbated her pre-existing patellofemoral syndrome.

As a result, she underwent surgery by Dr. Seckler to her left knee on the 28th February 2001. Dr. Seckler confirmed that the injury exacerbated the per-existing patellofemoral syndrome, but that her torn meniscus had resolved within a few months of the operation.

88. To answer the question posed at paragraph 14(ii), it is clear that the Plaintiff will require further, and probably continuing, medical treatment as a result of the accident.

89. Dr. Smith in his evidence stated that injections are good and very much less invasive than joint replacement. He added that so long as they are effective they can be good. Dr. Smith said the patient can have a brace with which to walk and that it was in her interest to prolong her own joint for as long as possible.

90. Dr. Smith urged caution with a full knee replacement. He said the main reason for this is that there is no going back once you have undergone a full knee replacement. Furthermore, Dr. Smith said there is a risk of infection, a risk of failure and a risk of fixation of the implant to the bone. He said there are risks of complications and it is in the Plaintiff's interest to prolong a good use of the knee and take conservative measures.

91. Dr. Banzon said the Plaintiff is at risk of requiring a total knee replacement, and he put this risk at ninety-five percent.

92. Again, I accept the evidence of Dr. Smith in this regard.

QUANTUM

GENERAL DAMAGES

93. The Court finds the particulars of injury to be exactly those claimed in the Plaintiff's Statement of Claim and amended Statement of Claim, namely, that she suffered a torn meniscus and contusion in the medial tibial plateau, for which she required and received surgical arthroscopy of the left knee, a partial meniscectomy and chondroplasty.

94. I have observed the Plaintiff give her evidence and agree with the Defendants' expert, Dr. Smith, that there was no exaggeration or effort on her part to embellish the symptoms about which she complained. There was no doubt that she suffered pain at the time of the accident, although not so severe as to cause her to visit the George Town hospital at that time. However, I do accept that the injuries have resulted in pain and discomfort for her. In addition her leisure activities of walking, water skiing, riding bicycles are all diminished and she, in her evidence stated that there had been a deterioration of spousal intimacy. In particular, the Plaintiff stated in her evidence that she can no longer carry her granddaughter downstairs, or, indeed at all. I also accept the Plaintiff's evidence relating to her loss of amenities as it was, in large measure, supported and corroborated by the evidence of her husband, Joseph Fichner.

95. Both parties' counsel have helpfully referred me to the Judicial Studies Board's "*Guidelines for the Assessment of General Damages in Personal Injury Cases*" 9th Ed 2008. The Plaintiff's counsel argues that her injuries can only be classified as severe and draws the Court's attention to the "severe" category which allows for an award of £44,500.00 to £61,500.00 for "serious knee injury, where there has been a disruption of the joint, gross ligamentous damage, lengthy treatment, considerable pain and loss of function, and, an arthrodesis or an arthroplasty has taken place or is inevitable."

96. It is noteworthy that the second and less "severe" category includes *"(a) leg fracture, extending into the knee joint causing pain which is constant, permanent, limiting movement or impairing agility and rendering the injured person prone to osteoarthritis and the risk of arthroplasty."*

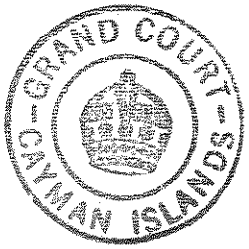
97. Defendants' counsel refers me to the same authority, but submits that the Plaintiff's injuries come under the "moderate" category, which is M(b)(i) and covers "injuries involving dislocation, torn cartilage or meniscus, or which accelerates symptoms from a pre-existing condition, but which additionally result in minor instability, wasting, weakness or other mild future disability leading to awards in the range of £9,500 - £17,000.

98. I note that the Plaintiff walks without any aid and, as Dr. Smith confirmed, does not require a walking aid in the form of either a crutch or a walking cane.

99. I have reviewed the JSB's "Guidelines" and the cases submitted to me from both counsel, but I must state, in my view, the Plaintiff's claim for personal injuries, loss, and loss of amenities comes within the "moderate" category. Although, in light of her pain, suffering and loss of amenities I am prepared to make an award at the top end of the "moderate" category at £17,000.00 which at today's rate of exchange is the equivalent of CI$21,390.16.

100. It has been accepted in several previous Grand Court cases that this Court can take judicial notice of the higher cost of living in the Cayman Islands as compared to the UK.

101. In light of this Court's decisions in ***Hammer v. Martin & Sheckles***[1] and ***Archer v. UBS***[2], I think it is fair and reasonable to add an increase of 10% to take into account the higher cost of living in the Cayman Islands and consequently I make an award for damages for pain, suffering and loss of amenities in the sum of CI$23,529.18.



[1] 1992-3 C.I.L.R. N 20
[2] 2009 CILR 531

FUTURE MEDICAL EXPENSES

102. It is common ground from all the medical evidence put before this Court that, as Dr. Stephen Berkowitz stated when he examined the Plaintiff in December 2002, she will be a candidate for Synvisc/Hyalgan/Supartz injections. Dr. Stephen Berkowitz also expected residuals with respect to her progressive joint pain and subsequent need for further treatment.

103. It is apparent from the evidence that the Plaintiff suffered from a pre-existing patellofemoral and it is common ground that the injuries she sustained on the 27th November 2000 exacerbated this condition. It would therefore appear that the pre-existing patellofemoral disease was accelerated by two to four years.

104. It appears that all doctors agree that injections are good for the Plaintiff's condition and I accept Dr. Smith's evidence that these injections will cost approximately $1000.00 per annum. I also accept Defence counsel's submission that I should take a media period of three years.

105. The Court finds it extraordinary that Dr. Greller does not note the injury to the Plaintiff's upper left thigh muscle in 2004 and that Dr. Banzon describes it as being of no relevance.

106. I prefer and accept the evidence of Dr. Smith who states, "The entry point had been laterally, and passed almost across the medial side of the Plaintiff's quadriceps – causing significant muscle damage. The muscle does not heal as muscle tissue, but heals as scar tissue, which significantly impairs the function of the muscle." As Dr. Smith said in his report dated the 17th November 2009, he does not state that this was the sole cause of her problems but he noted it was a significant contributing factor and must certainly be deemed to cause some of the deterioration in the function of the quadriceps.

107. On examination of the Plaintiff's knees in September 2009 Dr. Smith found the power in the Plaintiff's right knee normal in both extension and inflection and classified those areas as grade 5 out 5. However Dr. Smith found that "*The left knee was only grade 3 (in) power, for quadriceps and hamstrings, out of 5.*" This indicates that the Plaintiff's left knee was significantly compromised.

108. Dr. Smith also reported that the muscle wasting requires aggressive attention. This should include regular physiotherapy, taping of the patella, electrical stimulation of the muscle, especially the oblique head of the vastus medialis, plus instruction to taping and consideration for an unloader brace for the left knee.

109. Dr. Banzon states that the Plaintiff is at risk of developing the need for a total knee replacement. Dr. Smith agrees that this is true, but adds that this is not entirely or necessarily the result of the accident in 2000.

110. Should the Plaintiff require a knee replacement, the Defendants cannot be expected to bear the entire cost of such replacement. First, the Plaintiff's pre-existing condition may well have led to her need for a full knee replacement at some time. Dr. Smith puts it at between 10 and 15 years. Secondly, I find on the reports and evidence that the Plaintiff did not always comply with Dr. Seckler's repeated advice to continue with physical therapy and the exercises to strengthen her quadriceps. Thirdly, there is the intervening, and highly unfortunate, lawnmower incident, where the Plaintiff's left thigh muscle was damaged by the piece of metal entering the thigh muscle, for which, again, the Defendants cannot be held responsible.

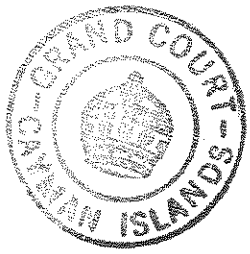
111. Dr. Banzon's estimate of US$55,000.00 was not supported by any documentary evidence, but based mainly, as he said in his evidence, on his experience. Dr. Smith was of the view that Dr. Banzon's estimate for a knee replacement operation and rehabilitative costs was grossly exaggerated to an outrageous degree. Dr. Smith's evidence of such an operation at Cayman Orthopaedics amounted to CI$18,500.00 for a total knee replacement, and further medical costs would be CI$300.00 per year. Indeed, Dr. Smith was the only witness to provide documentary evidence, which was in the form of the Medicare codebook, which provided guidelines for physician's fees and medical costs.

112. The Court noted that in Dr. Banzon's first witness statement dated the 10th August 2009, he estimated that the Plaintiff's rehabilitative and medical costs would be approximately US$35,000.00 per annum. I note that he inserted the US$35,000.00 in manuscript.

113. Then, sometime in September 2009 in his supplemental witness statement, Dr. Banzon again estimated the Plaintiff's rehabilitative and medical costs at US$35,000.00 per annum. It was only during this trial that Dr. Banzon accepted that he meant US$35,000.00 in total. However, to make this mistake twice, and to allow it to remain uncorrected for almost 12 months, understandably caused the Defendants and their advisers some serious concern.

114. I have been impressed by Dr. Smith's clear and reliable estimate of future medical expenses and find that his figures, as set out in his report dated the 17th November 2009, seem fair and reasonable to both the Plaintiff and the Defendants. Accordingly, having reviewed the Medicare Codebook and, from the figures provided by Cayman Orthopaedics, I find that knee replacement surgery would cost CI$15,000.00 for the prosthesis surgeon, assistant and anaesthetist, together with a hospital fee of CI$4,000.00 to allow for a prolonged stay. This amounts to a total of $19,000.00.

115. Accordingly, for the above reasons, set out in paragraph 110, I think it is fair to order a figure of two-thirds of the CI$18,500.00 – making a sum of CI$12,333.33 for this heading.



116. Accordingly, for future medical expenses I award the following:

i. Cost of injections an annual basis for three years: CI$3,000.00;

ii. 2/3 the cost of the knee replacement: CI$12,333.33;

iii. Cost of further physiotherapy: CI$3,000.00;

iv. Total: $18,333.33.

PAST MEDICAL EXPENSES

117. I note that the Defendants do not challenge the Plaintiff's claim for High Marks' "Plaintiff's Medical Insurance Subrogated Claim" in the sum of CI$533.00 and accordingly, I so award.

118. The Plaintiff's claim for the Blue Cross Blue Shield of Illinois Subrogated Claim in the sum of CI$4,851.19 relates to medical treatment after Dr. Seckler's treatment and therefore, in light of my findings above, cannot be attributed to the liability of the Defendants.

FUTURE LOSS OF EARNINGS

119. The revised schedule of loss, which was provided by the Plaintiff's counsel to the Court and to the Defendants on the 24th September 2009, contains no claim for the loss of earnings. The Plaintiff's undated trial note at Tab 17 of the Core Bundle states, "There is no indication that she suffered a diminution in salary as a consequence of the injury." Further, the Plaintiff did not refer to loss of earnings, either in her witness statement dated the 2nd April 2007, nor in her evidence before the Court in September 2009.

120. Accordingly, this Court makes no award for future loss of earnings.

121. The Plaintiff's attorneys in their written submissions filed on the 18th June 2010 submit that the Plaintiff is likely in the future to suffer a severe disadvantage in workplace and the Court should accordingly award a sum of US$25,000.00 to guard against such an eventuality. I find on the evidence before me that this particular claim is grossly inflated.

122. Although there is no evidence at present to suggest that the Plaintiff has sustained any diminution in her income, it is accepted that her injuries sustained in the accident on the Defendants' property in November 2000 may prevent her from discharging certain functions as proficiently as she would have done prior to this accident.

123. As the learned authors of McGregor On Damages, 17th Edition, note at paragraph 35-077 page 1213:

> *"A cluster of four further court of appeal (UK) decisions appeared very soon after (Smith v. Manchester) and showed that* ***Smith v. Manchester*** *had put the head of damages on the map."*

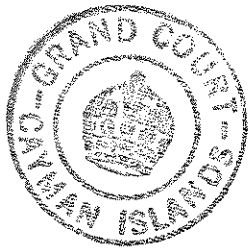
As McGregor points out at paragraph 35-079:

> *"Many times the court has spoke of the problem of arriving at an appropriate figure. Thus Auld L.J. referred in* ***Dhaliwal v. Hunt*** *[1995] P.I.Q.R. Q56 to a remark of Megaw L.J. in an unreported case, that the assessment of damages under this head usually involves, "nothing but a guess."*

While in the early ***Moeliker v. Reyrolle & Co***[1] Browne L.J. said:

> *"It is impossible to suggest any formula for solving the extremely difficult problems involved in ... the assessment. The judge must look at all the factors which are relevant in a particular case and do the best he can."*

124. It is my view that the Plaintiff's injury is likely to make it difficult for her to perform certain functions which she otherwise would have been able to perform, had the accident not occurred on the Defendants' property. Accordingly, in an effort to take this handicap into account, I make an award of CI$3,000.00 under this head.

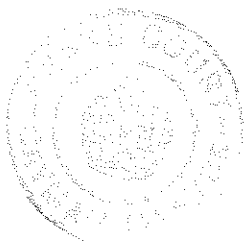


[1] [1977] 1 W.L.R. 132 at 142

OUT OF POCKET EXPENSES

125. It is very difficult to assess the Plaintiff's out of pocket expenses because she accepted, under cross examination, that, due to a number of inconsistencies, she was unable to give a precise figure in respect of her out pocket expenses. The Plaintiff's Statement of Claim and amended Statement of Claim, claims for the cost of airfares, cost of apartment, loss of salary (now abandoned) and medical expenses, but does not particularize any out of pocket expenses. I cannot accept that the airfares on the 30th November 2000 or the cost of the apartment should be attributed to the Defendants.

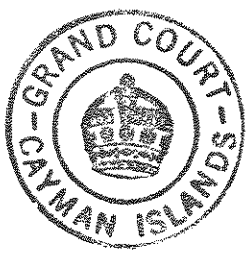
126. In addition, unfortunately, the Plaintiff did not provide this court with any details of her out of pocket expenses – either in her Witness Statement dated the 2nd April 2007 or in her evidence to the Court. All that remains for the Court in this regard is contained in the Plaintiff's counsel's written submissions, claiming US$6,257.97 (CI$5,074.16) on documents in the Plaintiff's bundle but not produced by the Plaintiff in her evidence. On the other hand, the Defendants' Written Submissions admit CI$24.60 for out of pocket expenses. I do take into account that the Plaintiff came across as an honest witness who was not embellishing her claim. In order to be fair to both parties, and in light of the absence of particularity in the Plaintiff's pleadings, witness statements, and, evidence, I make an award for CI$2,549.38 under this head, which I consider to be fair and reasonable to both parties.



CONCLUSION

127. The Plaintiff is awarded the following sums:

Item		US$	CI$	CI$	CI$	CI$	CI$
General Damages GD			**$21,390.16**	**$21,390.16**			
	10% increase for cost of living differences		**$ 2,139.02**	**$ 2,139.02**			
Subtotal GD					**$23,529.18**		
	GD Interest at 2% per annum from the date of the Writ of Summons (16.11.03) to the date of this Ruling		**($470.58 p.a. x 6 9/12 yrs.) $2,823.48+ $352.94 = $3,176.42**	**$ 3,176.42**			
Total GD						**$26,705.60**	
Special Damages (SD)							
	SD Future Medical Expenses	$	**$ 3,000.00+$12,333.33+$3,000.00 = $18,333.33**	**$18,333.33**			
	SD Past Medical Expenses	$	**$ 533.00**	**$ 533.00**			
	SD Future Loss of Earnings	$	No award	----			
	SD Out of Pocket Expenses	$	**$ 2,549.38**	**$ 2,549.38**			
	Smith v. Manchester award		**$ 3,000.00**	**$ 3,000.00**			
Total SD						**$24,415.71**	
Total Award							**$51,121.31**



128. Accordingly I award the Plaintiff the sum of CI$26,705.60 for General Damages and CI$24,415.71 for Special Damages, making an overall total of CI$51,121.31, and interest thereon to be included in the final Order.

129. On the 31st August 2010 I dispatched my Draft Ruling to the parties' attorneys. On the 2nd September 2010 I received confirmation that the Defendants had, pursuant to GCR O.22, paid the amount of CI$70,000.00 into Court on the 22nd July 2009. At that time I was also made to understand that the Notice of Payment into Court and the Lodgement Schedule were served on the Plaintiff's attorneys on the 23rd July 2009.

130. Having heard from both parties' attorneys in relation to the Notice of Payment into Court, I order that the Plaintiff is to have her costs up to and including the 14th August 2009 paid by the Defendants, and that the Defendants are to have their costs paid by the Plaintiff from the 14th August 2009 to the date hereof.

131. In light of the two earlier awards of indemnity costs against the Plaintiff, and my Order in relation to costs, subsequent to the Payment into Court, I order that there be a stay of execution of this Judgment until final taxation.

Dated this the 8th day of September 2010

The Honourable Justice Charles Quin Q.C.
Judge of the Grand Court