IN THE HIGH COURT OF JUDICATURE AT MADRAS

DATED : 30.06.2014

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THE HONOURABLE MR.JUSTICE S.MANIKUMAR

C.M.A.No.1912 of 2014
and
M.P.No.1 of 2014

The Managing Director,
Tamil Nadu State Transport Corporation Limited,
Villupuram. ... Appellant/ Respondent

vs.

K.Chakrapani ... Respondent/ Petitioner

Civil Miscellaneous Appeal filed under Section 173 of the Motor Vehicles Act, 1988 against the award and decree, dated 29.01.2013 made in M.C.O.P.No.4436 of 2009 on the file of Motor Accidents Claims Tribunal (IV Small Causes Court), Chennai.

For Appellant : Mr.A.Babu

J U D G M E N T

In the accident, which occurred on 02.11.2009, a 60 year old man, who was travelling as a passenger in a Transport Corporation bus, bearing Registration No.TN-32N-1143, stated to have suffered a fracture of shaft of humerus left and anterior dislocation of right shoulder and treated as inpatient for 22 days in three different spells in Government Stanley Hospital and continued as outpatient till 12.04.2011. According to the respondent, he was also hospitalised for 12 days in Government Royapettah Hospital, Chennai. PW2-Doctor, who clinically examined the respondent, has also observed that the respondent has sustained grievous injuries and took treatment. On perusal of Ex.P.2-Discharge Summary, the Claims Tribunal has recorded that the respondent sustained anterior dislocation of right shoulder and fracture of shaft of humerus left for which closed reduction of right shoulder and ORIF with plating for left shaft of humerus were done on 20.01.2009 in Government Stanley Hospital and he was treated as inpatient from 02.11.2009 to 30.11.2009. Thereafter, he was treated as outpatient from 12.04.2011. Ex.P.3 is the outpatient note book. On perusal of Ex.P.4-Discharge Summary, the Tribunal has also recorded that the respondent was hospitalised between 10.01.2011 to 13.01.2011 in Government Stanley Hospital, Chennai, and thereafter treated as

inpatient between 30.05.2011 to 10.06.2011 in Government Hospital, Royapettah, for non union of fracture of shaft of humerus left and once again, he had undergone a surgery on 30.05.2011 and ORIF with PO with bone grafting was done. Ex.P.6 is the X-ray taken at the time of his examination. During clinical examination, PW2-Doctor has also observed that despite surgeries, fractured bones were malunited and that the muscle power grade III on left arm and forearm movements were restricted and that the respondent has difficulty in grip and lifting heavy objects. Considering the discomfort and based on his observations, PW2-Doctor has assessed the extent of partial permanent disablement as 50%, in the left hand. As PW2 was not the Doctor, who treated the respondent, the Claims Tribunal has reduced the extent of disablement to 40%. Though at the age of 60 years, he claimed to have earned Rs.200/- per day, the Tribunal was not inclined to accept the same and no compensation has been awarded towards loss of earning. However, the Claims Tribunal has awarded Rs.90,000/- under the head disability compensation, Rs.35,000/- for pain and suffering, Rs.13,500/- under the head loss of income during the period of treatment. Rs.5,000/- for transportation, Rs.5,000/- for extra nourishment and Rs.1,000/- for damage to clothes.

2.At the time of accident, the respondent/claimant was aged 66 years. Degeneration of bones and malunion, in case of fracture, to an aged person, cannot be ruled out. Therefore, the extent of disablement assessed by the Doctor, on account of malunion of the fracture, cannot be said to be manifestly illegal. Besides considering the situs of injuries, nature of treatment, response to the same, and the age being one of the factors, which decides as to whether there would be proper union, non-union or malunion of the fractured bones, the extent of disablement fixed by the Court cannot, be said to be erroneous. At this juncture, this Court deems it fit to extract from the medical texts, as to what are the cases of malunion and non-union of bones and the treatment given by the Doctors.

> "A malunion is a broken (fractured) bone that has healed in an unacceptable position that causes significant impairment. A nonunion is a fracture that has failed to heal after several months.
>
> In malunion, the bone may have healed at a bent angle (angulated), may be rotated out of position, or the fractured ends may be overlapped causing bone shortening. Malunion may be caused by inadequate immobilization of the fracture, misalignment at the time of immobilization, or premature removal of the cast or other immobilizer. Nonunion has several causes. The broken ends of bone may be separated too much (overdistraction), which can occur if excess traction was applied. There could have been excessive motion at the fracture site, either from inadequate

immobilization after the injury or from having a cast removed prematurely. Muscle or other tissue caught between the fracture fragments also can prevent healing, as can the presence of infection or inadequate blood supply to the fracture site. Bone disease (e.g., bone cancer) also can prevent healing.

There are two types of nonunions: fibrous nonunion and false joint (pseudarthrosis). Fibrous nonunion refers to fractures that have healed by forming fibrous tissue rather than new bone. Pseudarthrosis refers to nonunions in which continuous movement of the fracture fragments has led to the development of a false joint. Certain types of fractures are associated with a high risk of nonunion, such as fractures of the wrist (carpus), including scaphoid bone; certain fractures of the foot, including navicular fractures and Jones (diaphyseal) fractures of the fifth metatarsal; shoulder long bone fractures (proximal humerus fractures); and some shin bone (tibial) fractures.

The severity of the injury is a strong factor in the healing process. Individuals who have had a severe traumatic fracture, large displacement between fracture fragments, and fractures where the bone was broken into many pieces (comminuted fracture) are at an increased risk of nonunion. Open or compound fractures also are at risk of malunion or nonunion. A condition called compartment syndrome can occur when sever trauma leads to such a degree of swelling that the blood supply is compromised. The result is muscle death around the fracture site and inadequate bone repair.

Risk: Certain lifestyle and health factors may interfere with bone healing. These include smoking, excessive alcohol use, poor nutritional status, poor general health, fitness deficits, and diabetes. Other factors contribute to loss of bone strength and make healing more difficult. These include use of nonsteroidal anti-inflammatory drugs (NSAIDs), use of corticosteroid drugs, other drugs such as anticonvulsants, and the thyroid hormone replacement, thyroxine. Individuals of European or Asian ancestry who have increased risk for osteoporosis and elderly individuals are at increased risk for poor bone healing. Women who have experienced early menopause, late menarche, or the loss of their ovaries, are at increased risk for bone weakness.

Diagnosis

History: History is of a fracture that may or may not have been treated by a physician. The individual may report pain, swelling (edema), instability, or deformity at the site of a previously broken bone. If the fracture was in a lower extremity, the individual may report difficulty bearing weight through the limb.

Physical exam: The exam reveals the deformity of a malunion or the instability of a nonunion. Touching with the hands (palpation) may reveal tenderness.

Tests: Plain x-Rays demonstrate the fracture malunion or nonunion. CT Scan, MRI, or bone scan may help further define the condition.

Treatment: Most malunions and nonunions require open surgery to realign the fracture fragments into their normal anatomical position (open reduction) and stabilize the fracture by use of metal plates, rods, screws, and/or wires (internal fixation). Bone graft material may be placed in the surgical site to stimulate fracture healing. Some cases, whether treated surgically or with noninvasive techniques (closed reduction), benefit from the use of electrical, electromagnetic, or ultrasonic stimulation to promote fracture healing and bone growth. Electrical stimulation may be administered by a self-contained device surgically implanted internally at the fracture site or by multiple electrodes placed over the skin near the fracture site. In some studies of fractures of the radius, lateral malleolus, and tibia, low-intensity pulsed ultrasound treatments administered through the skin adjacent to the fracture site have been shown to speed healing. Malunion is treated by surgically breaking the malunion (osteotomy), followed by ORIF. Infection requires surgical removal of any infected bone or tissue (débridement), followed by intensive antibiotic treatment.

Treatment of nonunion may be complemented with a synthetic bone graft or one that is obtained from the individual (autograft, autogenous graft), from another individual (allograft, homogeneous graft), or from an animal (xenograft, heterogeneous graft). Newer approaches are using recombinant bone morphogenic protein and bone marrow aspirates. Bone marrow may be harvested from the individual's hip bone (iliac crest) and injected directly into the fracture site guided by external imaging (fluoroscopy). Treatment of

pseudarthrosis involves removal (resection) of the false joint tissue before placement of the bone graft. Treatment of delayed unions and nonunions may also include functional bracing of the fracture site.

In some instances (e.g., some fractures of scaphoid), nonunion causes only slight problems, and the condition is left untreated. Likewise, malunion may be left untreated if it causes little or no functional deficit. For example, clavicle fractures may be allowed to heal in an imperfect but acceptable alignment ("bayonet" apposition) without resulting functional loss. Similarly, mild angulation of a humerus fracture does not impair use of the upper extremity.

Prognosis: Treatment of malunion by ORIF usually has a good outcome. Osteotomy can reduce deformity and relieve functional impairment, but this places the bone at risk of fracture. Minor degrees of malunion are common and may not have a significant effect on function or appearance.

Bone grafting usually is a successful treatment for nonunion, especially in the long bones of the body. Electrical and electromagnetic bone growth stimulators continue to progress and are especially advantageous in management of infected nonunions and in situations where surgery is not advisable. Low-frequency ultrasound therapy may decrease fracture-healing time in lower extremity nonunions by as much as two months. Bone marrow injection into the site of nonunion may resolve the nonunion without need for further surgery.

Complications: A malunion can result in a functional impairment with limited mobility. Any malunion can put increased stress on other joints causing pain and/or accelerated wear. Major degrees of malunion can cause impairment in function and significant deformity and can lead to degenerative arthritis. Malunion in a finger can interfere with the use of other fingers. Nerve damage can occur, especially with an elbow fracture.

A malunion in a leg can result in an abnormal gait.

A nonunion may be painless, but the fracture will be unstable and the bone less strong. Nonunions in a lower extremity may result in reliance upon assistive devices (e.g., crutches, wheelchairs) for mobility.

Return to Work (Restrictions/ Accommodations): The restrictions and accommodations are determined by the specific fracture, the severity of the malunion or nonunion, and job requirements. If surgical correction is necessary, work duties may need to be modified temporarily to avoid use of the affected limb.

3.As per the Medical Texts, some of the aspects to be taken note by a Doctor, in the case of failure to recover are,

Regarding diagnosis:

- Does individual have a malunion or a nonunion?
- Does individual report pain, instability, or deformity at the site of a previous fracture?
- Has malunion or nonunion been confirmed by x-rays, bone scan, or other imaging studies?
- Have conditions with similar symptoms been ruled out?

Regarding treatment:

- Was adequate time allowed for bone to heal?
- Did individual require functional bracing of the limb?
- Did individual require ORIF?
- Was bone graft done? Bone marrow injection?
- Did individual use low-intensity ultrasound? Electrical bone stimulation?
- Was rehabilitation program prescribed? Was individual compliant?

Regarding prognosis:

- Does individual continue to have risk factors for delay of fracture healing (e.g., corticosteroid use, smoking, malnutrition)?
- What are individual's functional limitations as a result of the malunion/nonunion?
- Is individual active in physical therapy or rehabilitation program?
- Does individual have any comorbid conditions that could influence length of disability (e.g., diabetes, bone cancer, osteoporosis)?
- Has individual experienced any complications, such as nerve damage, abnormal gait, or degenerative arthritis?

Is individual's employer able to accommodate necessary restrictions and work modifications?"

4.Reverting back to the case on hand, it could be seen that after the accident, the respondent has underwent a surgery on 20.01.2009 in Government Stanley Hospital, Chennai. Again, he underwent treatment between differrent spells (i) 02.11.2009 and 30.11.2009, (ii) 10.01.2011 and 13.11.2011, and (iii) 30.05.2011 and

10.06.2011 in Government Hospital, Royapettah. A 60 year old man, who sustained a fracture of shaft of humerus left with implant, would have experienced severe pain and suffering at the time of accident. He had underwent two surgeries. Considering the nature of injuries, treatment and the period of hospitalisation, as outpatient, Rs.30,000/- awarded under the head pain and suffering is less. Compensation of Rs.5,000/- awarded under the head transportation is less. Compensation of Rs.5,000/- under the head extra nourishment is less. With the extent of disablement in the left hand, there would be certainly loss of amenities, for which, the Claims Tribunal has not awarded any compensation. As per the Full Bench decision of this Court in Cholan Roadways Corporation Ltd., Kumbakonnam vs. Ahmed Thambi and others reported in 2006 (4) CTC 433, is as follows.

> "14. Loss of amenities : The next head of non-pecuniary loss is 'loss of amenities'. Besides damages for the pain and suffering sustained by a plaintiff by reason of his injuries, damages may be awarded for the losses sustained by him. Loss of amenities covers deprivation of the ordinary experiences and enjoyment of life and includes loss of the ability to walk or see, loss of a limb or its use, loss of congenial employment, loss of pride and pleasure in one's work, loss of marriage prospects and loss of sexual function. In India loss of marriage prospects and loss of enjoyment of life are awarded separately. Damages under this head are awarded whether the plaintiff is aware of the loss or not. They are awarded for the fact of the deprivation, rather than for the awareness of it."

5.The Claims Tribunal has not awarded a just and reasonable compensation under the head attendant charges. The respondent has been hospitalised for nearly 34 days. Considering the nature of injuries and the period of treatment, he would have taken the assistance of somebody. No compensation has been awarded under the head attendant charges. A sum of Rs.90,000/- (@Rs.2,000/- per percentage of disability) awarded under the head disability, cannot be said to be manifestly illegal, in the light of the decisions of this Court in Prahalath Jasmathiya v. V.Sankaran reported in 2009 (5) MLJ 1549 (Mad-Noc) and the Managing Director, Tamilnadu State Transport Corporation (Kumbakonam Division II) Ltd., Trichy Vs. S.Kannappan, reported in 2007 (2) TN MAC 1. On the whole, the quantum of compensation of Rs.1,49,500/- awarded to the respondent/claimant, cannot be said to be a bonanza.

6.Despite the cost of living in the year 2009 and repeatedly, when fair chances are given to the Corporations by this Court, the Managing Directors of the Transport Corporations mechanically file appeals, which not only causes loss to the Corporation, by making payment by way of Court Fee, in a matter which is not called for, but also protract payment of compensation to the legal representatives of

the deceased/injured, as the case may be. During the process and time taken for filing an appeal, the Corporation also loses considerable interest. Therefore, having regard to the attitude of the Managing Director, in challenging the quantum of compensation, which is less this Court deems it fit to award cost Rs.20,000/- to be paid by the Managing Director, Tamil Nadu State Transport Corporation Limited, Villupuram.

7.In the case on hand, the quantum of compensation is the only challenge in this appeal. There is no merit in this appeal. Hence, the Civil Miscellaneous Appeal is dismissed with cost of Rs.20,000/- (Rupees twenty thousand only) to be paid by the Tamil Nadu State Transport Corporation Limited, Villupuram to the respondent/claimant. Consequently, connected Miscellaneous Petition is also closed.

Consequent to the dismissal of the appeal, the appellant - Transport Corporation, is directed to deposit the entire award amount, with proportionate accrued interest and costs, less the statutory deposit, to the credit of M.C.O.P.No.4436 of 2009 on the file of Motor Accidents Claims Tribunal (IV Small Causes Court), Chennai, within a period of four weeks from the date of receipt of a copy of this order, if not deposited earlier. On such deposit, the respondent/claimant is permitted to withdraw the amount by making necessary applications.

Sd/-
Asst.Registrar (J)

/true copy/

Sub Asst. Registrar

mps

To

1 The Motor Accidents Claims Tribunal
(IV Small Causes Court), Chennai.

2. The Secretary to Government
Transport Department
Fort St. George, Chennai-9

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and M.P.No.1 of 2014

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