

IN THE HIGH COURT OF FIJI
AT LAUTOKA
CIVIL JURISDICTION

HBC 08 of 2016

BETWEEN : **SALASEINI DENARAU**
PLAINTIFF

AND : **THE COMMANDER OF THE REPUBLIC OF FIJI**
MILITARY FORCES
1ST DEFENDANT

AND : **ATTORNEY GENERAL OF FIJI**
2ND DEFENDANT

Appearances: Mr Eroni Maopa for the Plaintiff
Mr J. Mainavolau for the Defendants
Hearing: 14 and 15 June 2018
Date of Ruling: 27 May 2019

JUDGEMENT

INTRODUCTION

1. The plaintiff in this action is the widow and personal representative of the estate of the late Mr. Serevi Vananalagi ("Serevi"). Serevi died on Wednesday, 25 February 2015. He was only twenty seven years of age.
2. On that fateful day, Serevi was cutting an empty fuel drum using an acetylene torch when the drum exploded in his face. He died instantly.
3. At the time of his death, Serevi was an Able Seaman (31917 ABS S.V) in the Fiji Military Forces' Naval Division.

4. The incident happened at his workplace at the Naval Division Workshop at Walu Bay in Suva.

THE STATEMENT OF CLAIM

5. At paragraph 6 of the statement of claim, the plaintiff alleges negligence against the 1st defendant. She then pleads that the 1st defendant had breached his duty of care by failing:
 - i. to provide safe place of work.
 - ii. to take any or adequate measure to make the workplace reasonably safe for the deceased to work.
 - iii. to prevent the exposure of the plaintiff, while engaged with his work, to a risk of damage or injury, and from unusual damages of which they knew or ought to have known.
 - iv. to provide safety clothes and equipment to the deceased during the course of employment.
 - v. to take any or reasonable care to see that the deceased would be safe to use any equipment in the work place.
 - vi. to provide supervision or qualified supervisor at all times during the course of employment.
 - vii. to take any adequate or effective precaution to ensure that no explosion would occur whilst working in the work place.
6. In paragraph 7, the plaintiff pleads that the 1st defendant had breached his duty of care by the above failures. It appears that the above is pleaded as a common law cause. She then pleads that the 1st defendant was:

“hence also in breach of his statutory obligation under the Health and Safety at Workplace Act”.
7. I take that to mean that the plaintiff’s cause of action is premised on (i) a breach of a common law duty of care and (ii) a breach of the statutory duty under the Health and Safety at Work Act.
8. No specific provision of the Act is pleaded. Notably however, the defendants have not raised any issue with this in their submissions or in their defence. The plaintiff goes on to plead special damages as well as general damages and compensation

under the Workmen's Compensation Act and Interest under the Law Reform Miscellaneous Provision) Death and Interest Act.

9. I accept that while a breach of statutory duty may not necessarily also establish an employer's common law breach of duty to provide a safe system of work, it may be good evidence in an action for negligence at common law.

THE STATEMENT OF DEFENCE

10. Every paragraph pleaded in the statement of defence is a blanket denial of every corresponding allegation in the statement of claim. Effectively, the statement of defence denies the allegation that the 1st defendant owed a duty of care to the late Serevi, let alone, that any duty of care was ever breached.

BOARD OF INQUIRY

11. The basic facts as to how Serevi died are not really in dispute. A Board of Inquiry was convened two weeks after the accident on 12 March 2015 to investigate the circumstances surrounding the accident. The inquiry was conducted by Order of the Chief of Navy
12. A written Report was made following the inquiry. The Report was tendered through DW1 during cross examination and marked PEX8. It sets out the Board's findings and recommendations.
13. The Board's findings, conclusions and recommendations are set out in paragraphs 4 to 9 of the Report. I reproduce these below:
 - 4) *This Board of Inquiry found that:*
 - a) *31917 AB S Vanalagi sustained fatal injuries and possible internal injuries due to the explosion of the 200L drum he was trying to cut using acetylene gas (Exhibit A).*
 - b) *On the said day before the sports parade, the sailor, while working outside the boilermaker workshop, had filled the empty drum with water to remove the sediments and contents of the drum. He attended the parade with the drum overflowing with water. Upon his return, he proceeded to empty the drum,*

turned it upside down, marked the area which was to be removed and began to cut it.

- c) There was visible oxy-acetylene torch cutting marks on the bottom of the drum as shown in Exhibit B. Due to the nature of the drum (enclosed) and the fact that the content was not fully removed, an explosion occurred as the result of the addition of heat and flame.
- d) The condition of the drum after the incident showed that its content exploded when the deceased, AB Vanalagi started cutting the bottom part of it. The explosion ripped the other end of the drum, propelling it upwards hitting the roof of the building (Exhibit D).
- e) The deceased, after attending the parade, resumed working without notifying his superiors or supervisors. The technical department heads were not aware of the job and the tasking orders given to the sailor.
- f) The workshops machineries switches are all inside the workshop, accessible by all and machineries are prone to being abused as well as used without the knowledge of the technical officer.
- g) The deceased, while being an experienced welder and fabricator, neglect to follow standing procedures where he was supposed to have notified his superiors. The order or tasking given to him by a senior officer is still a lawful command and it does not give him the right to by-pass standing operational procedures as well as channel of reporting.

Conclusion

- 5) All personnel should be reminded that safety measures are put in place and enforced for the very fact that lives can and will be harmed if they are ignored.
- 6) The Heads of Department play a very important role in every aspect and nature of work in this institution. Proper communication, proper handling of work, ensuring and enforcing safety should be part of every task carried out in any department.
- 7) Standing operating procedures should be read, understood and signed by all engineering personnel prior to commencement of attachment or work when posted as well as refresher training during every beginning of the year.
- 8) A copy of the technical branch Standard Operating Procedures could not be located for the technical workshop SOP.

Recommendation

- 9) The following are recommended:

- a) *With effect immediately, all future tasks of any nature that will involve the Technical Branch personnel or equipment assigned to its inventory will first and foremost be made known to the Manager Technical Services (MTS). Through this, MTS will delegate who will carry out the task, how and when it is to be done. This will ensure that all tasks are carried out effectively and safely using the correct tools and equipment while observing all the safety measures.*
- b) *All personnel are to be reminded of the safety procedures and measures in place in this institution, their field of work and the consequences before proceeding to carry out any tasking.*
- c) *A copy of the technical branch SOP is to be located ASAP, or else drafted so that the three workshops, ME, EM, as well as ET are to have a copy of their own SOP derived from the main technical branch SOP.*
- d) *The main technical workshop office is to have a set of breakers so that the machines cannot be operated by any personnel passing through or intend to use them for other purposes without proper approval from the technical officers.*

14. In paragraphs 9 to 15 of their written submissions, the defendants submit as follows:

- 9) *The Defendants maintain their position that they are not liable for Serevi's death at the naval base. Evidence was articulated clearly by DW1 and DW2 that the Plaintiff was solely responsible for his death.*
- 10) *The Court heard that Serevi ignored safety procedures whilst working on the empty drum.*
- 11) *According to the Defendant's evidence, Serevi flooded the empty 44 Gal Pre-mix drum with fresh water. He then turned the drum upright having some water removed. Serevi tried to cut the bottom with acetylene gas with fume still trapped inside the drum.*
- 12) *In DW2's evidence, Serevi tried to rush the work and forgot the safety procedures. DW1 and DW2 both testified that for such task on a drum, Serevi was required to use a chisel to open the drum instead of gas which is easily vulnerable to the fumes trapped in the drum.*
- 13) *DW2 testified that he was Serevi's supervisor and as his supervisor, he had not instructed Serevi to work on the drum on the day of the incident. He said that any instructions given to subordinate officers are always in writing. He said that subordinates are required to fill a form before carrying out any task and the completed form has to be endorsed by the supervisor. In Serevi's case, no such written request came from him to DW2 concerning the subject task.*

- 14) *DW1 and DW2 both testified that Serevi would have known of the safety procedures involved for opening a drum as such and that he should and ought to have abided by them.*
- 15) *On the basis of this evidence, we the Defendants submit that it was due to Serevi's carelessness and disregard for safety procedure that resulted in his fatal accident.*

ISSUES

15. The parties executed a pre-trial conference minutes on 03 November 2016. The issues which they have agreed should be determined by this Court are as follows:
 - 7) *Whether the death of the deceased was caused due to 1st Defendants negligence?*
 - 8) *Whether the deceased paid insurance to Dominion Insurance but the 1st Defendant failed to pay the Plaintiff the funds?*
 - 9) *Whether the 1st Defendant paid the Plaintiff funds deducted towards the FMF Mataivalu Saving Account?*
 - 10) *Whether the Plaintiff is entitled to workmen compensation under the Workmen Compensation Act?*

THE LAW

16. As I have said, both the common law and Fiji's Health And Safety At Work Act 1996 impose a duty on any employer to provide a safe system of work in the workplace.
17. Section 4 of the Act provides that the Act shall bind the state¹. Section 9 of the Act provides as follows:

Duties of employers to their workers

- 9 (1) *Every employer shall ensure the health and safety at work of all his or her workers.*
- (2) *Without prejudice to the generality of subsection (1), an employer contravenes that subsection if he or she fails—*
 - a) *to provide and maintain plant and systems of work that are safe and without risks to health;*
 - b) *to make arrangements for ensuring safety and absence of risks to health in*

¹Section 4 provides:

4. This Act shall bind the State, including Government departments and statutory authorities.

- connection with the use, handling, storage or transport of plant and substances;*
- c) to provide, in appropriate languages, such information, instruction, training and supervision as may be necessary to ensure the health and safety at work of his or her workers and to take such steps as are necessary to make available in connection with the use at work of any plant or substance adequate information in appropriate languages—*
 - (i) about the use for which the plant is designed and about any conditions necessary to ensure that, when put to that use, the plant will be safe and without risks to health; or*
 - (ii) about any research, or the results of any relevant tests which have been carried out, on or in connection with the substance and about any conditions necessary to ensure that the substance will be safe and without risks to health, when properly used;*
 - d) as regards any workplace under the employer's control—*
 - (i) to maintain it in a condition that is safe and without risks to health; or*
 - (ii) to provide and maintain means of access to and egress from it that are safe and without any such risks;*
 - e) to provide and maintain a working environment for his or her workers that is safe and without risks to health and adequate as regards facilities for their welfare at work; or*
 - f) to develop, in consultation with workers of the employer, and with such other persons as the employer considers appropriate, a policy, relating to health and safety at work, that will—*
 - (i) enable effective cooperation between the employers and the workers in promoting and developing measures to ensure the workers health and safety at work; and*
 - (ii) provide adequate mechanisms for reviewing the effectiveness of the measures or the redesigning of the said policy whenever appropriate.*
- (3) For the purpose of this section, any plant or substance is not to be regarded as properly used by a person where it is used without regard to any relevant information or advice relating to it's use which has been made available by the person's employer.*
- (4) Any employer who contravenes or fails to comply with any provision of this section shall be guilty of an offence and shall be liable to a fine of not more than \$100,000 in the case of a corporation or \$10,000 in any other case.*

18. That an employer has a common law duty to set up a safe system of work and for seeing that safety standards are enforced, is trite.

19. In Pape v Cumbria County Council [1992] 2 All ER 211, the issue arose as to whether the fact that an employer which had provided rubber gloves as a safety measure to employees who handled chemical cleaning products, had thereby discharged its common law duty of care to provide a safe system of work. It was held that simply supplying the rubber gloves was insufficient to discharge that duty, which was non-delegable. The duty extended to taking reasonable care to ensure the safety equipment was appropriately understood, and the risks of handling strong chemical cleaning products with unprotected hands should have been brought to the employee's attention.

20. In Latimer v AEC Ltd [1953] AC 643, the employee factory worker slipped on the slippery factory floor and sustained injuries when a heavy barrel he was moving fell and crushed his ankle. The factory floor had become slippery after some flooding. Notably, the employer had mopped the floor, put warning signs to warn that the floor was slippery, and even placed saw dust to make the floor as safe as possible for the workers. The English Appeal Court held that the employer had taken all reasonable precautions to minimize any risk to its employees and had not breached its common law duty of care. To expect the employer to shut down the entire factory, which was the absolute foolproof way to ensure safety, was not reasonable. This case is often cited as authority that an employer only had to take steps to minimise risk that a reasonable person would do in the circumstances.

THE EVIDENCE

21. Whether or not the defendants were negligent rests ultimately on whether or not there were safety procedures in place at the naval workshop in Walu Bay where the fatal accident occurred.

22. If so, whether Serevi was aware of these procedures and if he were, whether or not he failed to follow them on the fateful day in question.

23. The evidence of DW1, Chief Petty Officer Meli Namasala is interesting. He is now Storeman. He said that, as Storeman, his daily duties now entail *inter-alia* handing

out tools to Engineers which they require. This appears to be a control measure which was not in place at the material time in this case.

24. DW1 said that on the morning of 25 February 2015, he saw Serevi outside the Fabrication Workshop. Serevi was filling out a 200-liter drum with water from a fine hose. That was around 10.00am. DW1 said Serevi was wearing safety overall and boots. DW1 specifically said that he saw the drum overflowing with water.
25. DW1 said 25 February 2015 was a Wednesday. It was their Sports Day. As is the usual routine on every Sports Day, the Officers worked in the morning and broke for an early lunch at 11.00 am. At 12.00 pm they assembled for the sports parade.
26. DW1 specifically said in chief that, usually, after the parade, *“those with urgent jobs would go back to complete their jobs”* while the rest participated in various sports activities.
27. DW1 himself went back to his workshop after the parade where he continued to work on something he had been working on. He said the Naval Division Walu Bay Depot had three or four workshops for the different branches of the Engineering Division.
28. He said that when he went back to his workshop after the parade, he could see, and was aware of Serevi, outside the neighboring fabrication workshop. DW1 said Serevi had emptied the 200-litre drum of water and was beginning to cut it using a gas torch. A loud explosion followed moments later. DW1 described in detail how shaken and stunned he was, and how he rushed to the scene to help. He saw Serevi’s face badly disfigured. He also described the full impact of the explosion.
29. DW1 said what caused the explosion was the naked flame from the torch coming into contact with gas in the drum.
30. DW1 said he would have used a cold chisel instead of a gas torch to cut the drum.
31. Asked in chief why Serevi had to fill the drum with water, and whether that was normal procedure, DW1 said filling water is a safety procedure to ensure that any flammable or explosive gas in the drum is displaced.

32. Asked why Serevi would be cutting the drum, DW1 said;

"I think he wanted to cut the drum to use to test for outboard engine".

33. DW1 said he has never seen an Engineer try to open a drum using gas torch.

34. DW2 WO1 Rakai has had 34 years experience in the Navy. He said he figured after the accident that the drum which Serevi was cutting used to contain pre-mix fuel. Serevi had filled the drum with water and then emptied it immediately before he started to cut it. The correct procedure was to fill the water up to the brim, empty it, and then fill it up with de-greasing fluid before cutting it. The de-greasing fluid clears the drum of any residual flammable gas.

35. DW2 further said that on the day in question, the de-greasing fluid was locked in the store which closed at half day for sports. In cross-examination, DW2 confirmed that the SOP was missing and it was now being re-written.

36. I believe DW2's evidence was given with the wisdom of hindsight. I note that DW2's interview which is part of the Report makes no mention whatsoever of the de-greasing fluid. He simply says Serevi "tried to rush the work and forgot the safety procedure". However, there is no evidence before me that this procedure is set out in any SOP.

37. The statement of One IC Baro is also annexed to the Report. His statement says inter alia:

After the parade I went back to what I was doing (outside the air conditioning and refrigeration workshop) cleaning the dismantled engine parts. One time I turned I saw him emptying the drum and turn it upside down. He was proceeding to mark the bottom of the drum. Seeing what he was doing, I gathered that he was going to cut the bottom part of the drum with oxyacetylene gas as its equipment was laid out for use, so I went back to my work

38. Baro's statement does not appear to sense anything untoward or unusual in what he had observed of Serevi's actions immediately before the accident.

39. DW1 said in chief that some officers would use equipment in the workshops to do their own private jobs, however, in cross examination, he reaffirmed that he had seen Serevi work on the drum during official hours early in the morning of 25 February 2015. I do not accept that Serevi was doing a private job at all material times.

40. The Report of the Board of Inquiry found that Serevi had attended the Sports parade after lunch. He then went back to the workshop later to resume work. However, he did this without notifying his supervisors or superiors.

The deceased, after attending the parade, resumed working without notifying his superiors or supervisors. The technical department heads were not aware of the job and the tasking orders given to the sailor.

41. The Report, interestingly, also found that the machineries and switches were all inside the workshop and were accessible to all.

The workshops machineries switches are all inside the workshop, accessible by all and machineries are prone to being abused as well as used without the knowledge of the technical officer.

42. However, the Report still found that Serevi neglected to follow standing procedures when he went to the workshop after the parade on the day in question.

The deceased, while being an experienced welder and fabricator, neglect to follow standing procedures

43. As to what the standing procedures are, the Report appears to state as follows:

..... he was supposed to have notified his superiors. The order or tasking given to him by a senior officer is still a lawful command and it does not give him the right to by-pass standing operational procedures as well as channel of reporting.

44. Curiously, at the time of the Inquiry which was two weeks or so after the accident, the Standard Operating Procedures (SOP) of the technical branch could not be located. This is highlighted in the Recommendations of the Report.

A copy of the technical branch SOP is to be located ASAP, or else drafted so that the three workshops, ME, EM, as well as ET are to have a copy of their own SOP derived from the main technical branch SOP.

45. The Report also recommended the following control system to ensure that the machines in the workshops are only used with proper authorization. This recommendation, obviously, was made following the finding that the machines were accessible to all without any proper system of control in place.

The main technical workshop office is to have a set of breakers so that the machines cannot be operated by any personnel passing through or intend to use them for other purposes without proper approval from the technical officers.

46. In my view, a safe system of work required a clear SOP about the acceptable method for cleaning a fuel drum and also a clear direction about the method to cut it open. It also called for the taking of reasonable steps to enforce the direction (see in **Bankstown Foundry Pty Ltd v Braistina** [1986] HCA 20; (1986) 160 CLR 301 (13 May 1986)).

FINDINGS OF FACT

47. I make a finding for the following facts:

- (i) on the morning of 25 February 2015, Serevi went to work.
- (ii) he was tasked to cut a 200-litre petrol drum for whatever reason, most probably to use to test outboard engines that were brought in for repair.
- (iii) on the morning in question, before lunch, during official hours, he filled the 200-litre drum with water using a firehose, to the point that the drum was overflowing.
- (iv) he left the water running from the hose into the drum and overflowing when he went to have lunch at 11.00 a.m. and later for the parade at 12.00 p.m.
- (v) after the parade, we went back to the workshop where he had left the 200-litre drum overflowing with running water from the firehose.
- (vi) he emptied the drum.
- (vii) and then, he began to cut it using a gas acetylene torch.

- (viii) at some point before cutting the drum, Serevi would have entered into the workshop, obtained the gas acetylene torch, connect it to the gas supply, and then bring it outside, where he would use that equipment to cut the empty drum.
 - (ix) the drum exploded.
48. There were no Standing Operational Procedures.
49. I accept the evidence of **DW1** that normally, officers who have urgent tasks to complete would disembark after the parade and return to their stations to complete whatever unfinished work they have. I am inclined to believe that Serevi, on the day in question, was tasked to complete cutting the 200-litre drum.
50. Serevi had filled the empty fuel drum with water to the point that it was left overflowing with running water for what I estimate to be between two or four hours or so.
51. The evidence of **DW1** is that filling an empty fuel-drum with water is standard safety precaution to rid the drum of any lingering explosive gas. That was all that Serevi knew. **DW1** said nothing of the de-greasing fluid which **DW2** spoke about. The fact that a senior officer like **DW1** said nothing about that suggests that even he was unaware of it. I believe that **DW2** spoke about the degreasing fuel with the benefit of hindsight, rather than on the basis of any relevant SOP.
52. I note that **DW1** and **DW2** both said that they would use a cold chisel and a hammer to cut open an empty fuel drum rather than an acetylene gas torch. However, there is no real evidence before me that there were some SOP in place which mandated that an acetylene gas torch should not be used and that a cold chisel and a hammer was to be the only method of cutting open an empty fuel-drum.
53. In the absence of such real evidence, and in light of the finding in the Report that the laboratories were accessible to all officers, I am inclined to the conclusion that Serevi was allowed to cut the drum using the gas torch.

54. There is certainly no suggestion in the evidence that the work that Serevi had carried out was not in the scope of his employment.

VOLENTI NON-FIT INJURIA

55. The defendants refer in their written submissions to Smith v Baker & Sons [1891] AC 325, Bokoci v Kumar HBC Suva, Fiji, 374/92 and Osborne v London and North Western Railway Co. 21 Q.B. D. 220 at 224. They also cite a passage from Street on Torts at page 189 (no proper citation given).
56. All the above cases, and the passage from Street on Torts, are about the defence of *volenti non fit injuria*.
57. Notably however, the statement of defence does not specifically plead *volenti non fit injuria*.
58. In Smith v Baker & Sons [1891] AC 325 Lord Watson (in a passage relied on by the defendants, said as follows:
- “The question which has most frequently to be considered is not whether (the Plaintiff) voluntarily and rashly exposed himself to injury, but whether he agreed that, if injury should befall him, the risk was to be his and not his master’s. [Whether continuing at work knowing of the danger is an assumption of the risk] depends...upon the nature of the risk, and the workman’s compensation with it, as well as upon other considerations which must vary according to the circumstances of each case.”*
59. I agree that for *non volenti non fit injuria* to apply, Serevi must be shown to have had full knowledge of the particular risk in question, and to have freely and voluntarily consented to it. The onus is on the defendant to establish these.
60. The defendants submit (as I have set out above) that there were safety procedures in place which Serevi ignored. The evidence of DW2 is that *“Serevi tried to rush the work and forgot the safety procedures”*.

61. The Board Report (PEX8) points out that Serevi was an experienced Welder and Fabricator. He was well aware of the risks involved in cutting a fuel drum using a gas torch.
62. In terms of the standing operational procedure, Serevi "*was supposed to have notified his superiors*" before undertaking any work.
63. However, as I have said above, there is absolutely no evidence before me that there was a system of work in place. The Standing Operation Procedures Booklet was nowhere to be seen at the time the Board of Inquiry wrote its Report some two weeks later and the workshops where all the equipment and apparatus were kept was freely accessible to all and sundry.
64. It is hard to say if Serevi willingly exposed himself to the risk. After all, he did fill up the drum which he left overflowing with running water for quite some time. Again, this is an accepted safety procedure to rid an empty fuel drum with explosive gas.
65. In my view, if there was an SOP in place about any particular method of cleaning or cutting an empty fuel drum which Serevi disregarded, that would be sufficient to establish *volenti-non fit injuria* or even contributory negligence.
66. Indeed, the evidence which the defendants rely on in relation to their allegation of *volenti non fit injuria* does no more than highlight that there was no system of work in place, and even if there was one, that the defendant took inadequate steps to enforce.

COMMENTS

67. Both the common law and Fiji's Health And Safety At Work Act 1996 impose a duty on any employer to provide a safe system of work in the workplace. This duty entails *inter alia* an obligation on the part of the employer to provide safety equipment and to take reasonable care to ensure that the safety equipment was appropriately understood, and that the risks of the job is brought to the attention of every worker.

68. The employer must take all reasonable precautions to minimize any risk. The duty entails setting up an adequate safety procedure in the workplace. If a safety procedure is in place, and if it is adequate, the employer must still enforce it. A failure to enforce such procedures constitutes a breach of duty under the Act and also under common law.
69. I find that the defendant had breached their duty of care under the Health and Safety At Work Act and also under common law.

COMPENSATION

70. The plaintiff plead special damages as well as general damages and compensation under the Workmen's Compensation Act and Interest under the Law Reform (Miscellaneous Provisions) Death and Interest Act.

Special Damages

71. Special damages are monetary losses actually suffered up to the date of judgment and must be specifically pleaded and strictly proven. In this case, Ms. Denarau claims \$7,000-00 in special damages made up of funeral expenses.
72. Section 11 of the Law Reform (Miscellaneous Provisions)(Death & Interest) Act specifically allows damages to be awarded in respect of funeral expenses incurred by the party for whose benefit the action is brought.
73. The plaintiff is the personal representative and the sole beneficiary of the estate of Serevi. She is entitled to claim for funeral expenses.
74. In Fiji, some courts have awarded damages for funeral expenses even in the absence of specific supporting evidence. In **Jona Moli -v- Dr Frances Bingwor & Others** Suva High Court Civil Action No. HBC 335/1998, Mr. Justice Pathik awarded \$2,200 for funeral expenses in lieu of the full \$3,500 claimed:-

"We are all familiar with the customs of the various races in Fiji and in the context of funeral there are certain expectations and obligations which have to be fulfilled. It is only right that reasonable expenses ought to be allowed without requiring the plaintiff to

produce receipts and proof of each items of expenditure as is required for the purposes of proving special damages."

75. I follow the approach of Pathik J in Jona Moli but considering that it was made twenty years ago, I would increase the sum to \$3,500 for funeral expenses only.

Damages under the Law Reform (Miscellaneous Provisions) (Death and Interest Act)

76. An award under the Law Reform (Miscellaneous Provision) (Death and Interests) Act is made for the benefit of the deceased's estate based on lost years. Even if a plaintiff finds difficulty in establishing a claim based on dependency under the Compensation to Relatives Act, the Court may still award damages under the Law Reform (Miscellaneous Provision) (Death and Interests) Act².
77. And even if an award had been made under the Compensation to Relatives Act, that award is usually merged with any award made under the Law Reform Act³.

Loss of Expectation of Life

78. In Fiji, the Courts have awarded damages for loss of expectation of life at \$2,500⁴. I award the same in this case.

Lost Years

79. A claim for lost years accrues to the estate of the deceased under the Law Reform (Miscellaneous Provisions) (Death & Interest) Act⁵.

² (see Sunil Chandra -v- Ram Narain Civil Appeal No. 134 of 1990; Hari Pratap -v- Attorney General of Fiji and Anor Suva High Court Civil Action No. HBC 95/1986; Somari v. Attorney General Civil Appeal No ABU 0026/1980; Daya Ram -v- Peni Cara and Others (Civil Appeal No.50 of 1992))

³ see Navunisaravi v Kumar (supra) citing Davies & Anor v. Powell Duffryn Associated Collieries Ltd [1942] AC 601.

⁴ (see Prasad v Hakim (supra); Subamma -v- Chandar Court of Appeal Civil Appeal No. ABU 0056/83; Hari Pratap -v- Attorney General Court of Appeal, Civil Appeal No. ABU 0014/1992 (\$2,500-00) and Aluslo Daino -v- Attorney General, Suva High Court Civil Action No. HBC 0515/1996,(\$2,500-00)

⁵ As Byrne J observed in Lotherington-Woloszyn v Savou [1995] FJHC 131; HBC 0489j.93S (31 July 1995), a claim:

.....by the estate under the Law Reform (Miscellaneous Provisions) (Death and Interest) Act commonly known as the claim for "the lost years". This head of the claim was confirmed as being valid in the House of Lords in Gammell v. Wilson & Others (1981) 1 ALL E.R. 578. This decision was followed by the Court of Appeal in Fiji in Daya Ram v. Peni Cara & Others (Fiji Court of Appeal No. 50 of 1982: judgment March 1983) where the Court said:

"Accordingly the claim on behalf of a deceased estate for loss of earnings for lost years is now firmly established as on the same footing as the same claim by a living person, subject to the reservation as to deduction of personal living expenses.

80. Master Udit summarized the conventional approach for assessing damages for lost years in Prasad v Hakim [2008] FJHC 359; HBC370.2006 (19 December 2008) as follows:

[33]. *The conventional approach to the assessment of damages for the lost years is thus arrived at as follows:-*

- (a) *the deceased net earnings as at the time of the death.*
- (b) *from the net earnings, a deduction must be made of the deceased's personal earnings.*
- (c) *the sum in para (b) is then multiplied by the actual number of lost years, that too is to be ascertained by the Court taking into account the contingencies and vicissitudes of life.*

81. From the evidence of DW3 Lieutenant Mere Vunimono, and from the pay slips tendered in Court, I take the deceased's net earnings at \$459.90 (four hundred and fifty-nine dollars and ninety cents) per fortnight.
82. No evidence was placed before me as to what Serevi's career progression and related wage increase would have been like if he had lived (cf. Maka v Broadbridge [2003] FJCA 31; ABU0063.2001S (30 May 2003), so I will not speculate any further on this.
83. Serevi was twenty seven years of age when he died and in my view, had a working life expectancy of at least twenty eight years – if 55 years is considered to be the retirement age. The courts however rarely fix a multiplier above 18 and I agree that 16 would be a suitable multiplier in this case⁶.

⁶ As Byrne J noted in Lotherington-Woloszyn v Savou [1995] FJHC 131; Hbc0489j.93s (31 July 1995):

It is unusual for the multiplier to be more than 18. Counsel for the Plaintiff helpfully gave me a list of multipliers awarded in various cases and submits that in this case the appropriate multiplier is 16. On the other hand Mr. Krishna submits that the multiplier should be 8. I consider that number far too low. Interestingly in Cole v. Crown Poultry Packers Ltd. where the deceased was a skilled electrician aged 38 at the time of his death the trial judge fixed the multiplier at 16 and this was upheld on appeal. There are numerous other cases referred to in Kemp & Kemp Volume 3 at p.63021. In this case I consider the appropriate multiplier to be 16.

Calculation Table for Lost Years

Nett per fortnight	\$459-90	
(deduction for deceased's personal earnings) @ 30% fortnightly pay	$\$459-90 \times 30\%$	\$137.97
Balance left for estate for lost years	$\$459.90 - \$137.97 = \$321.93$	$\$321.93 \times 26 \text{ fortnights} \times 16 = \$133,922.88$

84. DW3 Lieutenant Mere Vunimono gave evidence about the following deductions in Serevi's pay slip:

<i>i-Taukei Fund</i>	This is a Social Club deduction which is compulsory which is not re-fundable. When a member passes, the fund makes a donation to the family.
<i>Army Medical Scheme</i>	This assists in medical expenses such as pharmaceutical costs. This is non-refundable upon death.
<i>Dominion Insurance</i>	This is a compulsory Group Cover (life cover). A payment is made upon death. \$20,000 was paid to the plaintiff.
<i>BSP Life</i>	This was taken out by Serevi personally at his own option.
<i>Mataivalu Savings</i>	Not compulsory. A credit loan facility to which members contribute fortnightly. Serevi contributed \$100 per fortnight. DW3 said she understood Serevi had a loan debt from the Savings which was outstanding when he died. This loan debt was offset against his entitlement, and so there was a zero balance to him.

85. The only question I ask is whether or not the \$20,000 already paid to the plaintiff should be deducted from the \$133,922.88 assessed for loss of life. No submission was made by the Counsel at this point. I think the payment should be deducted.

ORDERS

- (i) I make the following awards in favour of the plaintiff against the defendant:
- (a) \$ 3,500.00 in special damages.
 - (b) \$ 2,500.00 for loss of expectation of life (which I add to rather than subtract from the award for lost years)
 - (c) \$133,922.88 for lost years pursuant to the Law Reform (Miscellaneous Provision)(Death & Interests) Act.
Less \$20,000 from Dominion Group Insurance Cover.
TOTAL \$113,922.88
- (ii) I also award costs and interest as follows:
- (d) 7% p.a interest on \$113,922.88 under section 3 of the Law Reform (Miscellaneous Provision)(Death & Interests) Act from date of filing of the writ of summons and statement of claim.
 - (e) 4% post judgement interest on the above sum under the Imperial Judgements Act 1838 (UK) and section 22 of the High Court Act.
 - (f) Costs which I summarily assess at \$1,000-00.




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Anare Tuilevuka
JUDGE
Lautoka