SUPREME COURT OF QUEENSLAND

CITATION:	*Stockwell v State of Queensland* [2003] QSC 471
PARTIES:	**BRETT RAYMOND STOCKWELL** (plaintiff) **v** **STATE OF QUEENSLAND** (defendant)
FILE NO/S:	SC No 6031 of 2002
DIVISION:	Trial Division
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court
DELIVERED ON:	19 December 2003
DELIVERED AT:	Brisbane
HEARING DATE:	1, 2, 3 December
JUDGE:	Holmes J
ORDER:	**Judgment awarded for the plaintiff against the defendant in the amount of $194,546.13**
CATCHWORDS:	DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES – PERSONAL INJURIES – GENERAL PRINCIPLES – where hospital failed to properly catheterise plaintiff following surgery – where plaintiff had pre-existing conditions – what damages to be awarded
COUNSEL:	Mr K N Wilson SC with him Mr S A McLeod for the plaintiff Mr P A Freeburn SC for the defendant
SOLICITORS:	McInnes Wilson Solicitors for the plaintiff Tress Cocks & Maddox for the defendant

[1] The plaintiff seeks damages for a bladder injury caused by negligence in his post-operative care at Prince Charles Hospital. He underwent an operation on his right shoulder on 25 June 2001. A failure properly to attend to his micturition needs after the operation, despite his complaints of discomfort and pain, led to his suffering distension and consequent atony of his bladder, leaving him unable to empty it without catheterisation. The evidence of Dr Winkle, a urologist, which I accept, was that, given the passage of time since the injury was suffered, it is very unlikely that his bladder function will now improve. Consequently, the plaintiff will need to self-catheterise each day for the rest of his life. The defendant, while admitting negligence, takes issue with the extent of the damages claimed. The assessment of

damages is rendered relatively complex by the need to take into account medical problems from which the plaintiff suffered prior to the bladder injury, and his irregular work history.

The plaintiff's work and medical history pre-2001

[2] The plaintiff was born in February 1969. He completed his senior certificate in 1986 with unremarkable results, except for a very high achievement in art. On leaving school he obtained a position as a junior graphic artist; but, he said in evidence, having worked for about 12 months, he took the view that he was underpaid for the level of work he was required to perform. Having raised that with his employer without favourable response, he decided instead to undertake a hairdressing apprenticeship at his mother's hairdressing salon. He began that apprenticeship in 1988 and completed it in 1992. He did not like the responsibility of looking after the salon when his mother was absent, as happened from time to time, and decided, on finishing the apprenticeship, to take a break from hairdressing.

[3] The plaintiff next obtained a casual job as a caretaker/cleaner at a bingo hall. During this period he began to suffer from alcoholism and developed a habit of binge drinking which affected his employment over the next decade. He described a weekly pattern of drinking heavily for four days of the week, followed by three days of feeling ill. After a period of about 9 months casual work at the bingo hall, the plaintiff injured his back lifting a container of detergent and spent about 9 or 10 months off work on workers compensation payments.

[4] In 1993 the plaintiff obtained a six month contract working as a stable hand in Japan, through contacts his father and brother had in the racing industry. He completed the six months, but felt isolated and lonely and decided to return home rather than take up another contract. During this period he had very little occasion to drink, but he resumed binge drinking on his return to Australia. In 1994 he obtained a casual position as a corrective services officer, but he found doing night shifts at the jail alone somewhat alarming. After six months he concluded that the job was stressful and the environment unpleasant, and he ended that employment.

[5] With the assistance of Centrelink, the plaintiff undertook a hospitality course at a local business academy, which trained him for work as a food and drinks waiter. He did casual work as a waiter at functions at hotels and clubs over a period of 10 to 12 months during 1996. There were, he conceded, a couple of occasions when he was not able to take work as a waiter because of the effects of alcohol consumption. During that period he also assisted his mother on occasions when she was busy in her hairdressing business. He had worked with his mother an odd day here or there, he estimated about 4 times a year, earning about $150 in total. His tax return for the 1996/1997 financial year (the first in time to be put in evidence) shows a gross income of about $2,300 from employment and another $7,112 received by way of social security benefit.

[6] At some point in 1997 the plaintiff was admitted to the Royal Brisbane Hospital Alcohol and Drug Dependency Service for a four-day detoxification programme. Between February 1998 and June 1998, at the suggestion of an employment agency associated with Centrelink, the plaintiff undertook a course at Innisfail which gave him a Certificate in Tropical Aquaculture. He found it impossible, however, to obtain work in the aquaculture industry, and returned to Brisbane. For the

1997/1998 financial year his income consisted of $7,517 from Social Security benefits and a small amount ($33) by way of interest. There was no income from personal exertion shown on his return.

[7] With his mother's assistance, the plaintiff opened his own hairdressing salon in the suburb of Hendra. His 1998/1999 tax return reflects his commencement of business. His income from the business, net of expenses, was $2,369. He received $3,428 in Social Security benefits. The business was not a success. The plaintiff estimated that he carried it on for about 12 months, but because of his binge drinking was unable to function properly. There were occasions when he was unable to present himself at the salon for work because he had been drinking all the previous night. The business ceased when the plaintiff, inebriated, fell from a ledge and broke bones in his feet, resulting in his spending about three months in plaster.

[8] In July 1999 the plaintiff began to consult Dr Andrew Christensen, a psychiatrist. According to a report Dr Christensen wrote in September 2001, the plaintiff recounted suffering from depressed mood for a period of twelve years, and described sleep disturbance, suicidal thoughts and anxiety attacks which he experienced "especially in the morning when he was preparing to face the day." He gave a history to Dr Christensen of past use of marijuana and amphetamines, as well as alcoholism. Dr Christensen diagnosed him as suffering from major depression and commenced him on anti-depressants; but as a result of the emergence of hypermanic symptoms, he made a further diagnosis of bipolar affective disorder and began to treat the plaintiff with lithium. He also prescribed Campral, a medication designed to reduce craving for alcohol, but it does not seem that that was effective.

[9] In the 1999/2000 financial year the plaintiff received, as his only income, sickness allowance from Centrelink in the amount of $8,458.84. He declared himself bankrupt in November 2000. According to the account the plaintiff gave to Dr Mulholland, a psychiatrist who examined him for medico-legal purposes, the bankruptcy resulted not only from the business failure but also from excessive spending during a manic phase.

The plaintiff's pre-injury work and medical history in 2001

[10] On the plaintiff's evidence, matters had improved considerably during 2001 prior to his hospitalisation for shoulder surgery. Early in the year, he enrolled in a fine arts course at the Gateway TAFE College. An academic history report in respect of the plaintiff's arts course shows that of 23 components, 13 were satisfactorily completed by mid year. Two were recorded as withdrawal from the course without participation. The remaining eight were full year subjects to which the plaintiff did not return after his bladder injury mid year, so they bore a notation indicating "competency not achieved". It is not possible from these results to form any real view of the plaintiff's competence as an artist.

[11] While he was undertaking the art course, the plaintiff did some casual work as a storeman, making up crates for freight. A group certificate shows that he earned $981 gross in that employment. He said that he also, during the first half of 2001, assisted his mother for a couple of hours, from time to time, in her hairdressing salon. In this period the plaintiff received an offer of employment in the funeral industry. He was introduced by a family connection, Ms Leanne Bateman, to Mr Graeme Crawley who was proposing to set up a funeral business in Queensland. Neither Mr Crawley nor Ms Bateman knew anything of the plaintiff's history of

alcoholism, depression or bipolar affective disorder, nor of the irregular nature of his past employment. After two informal meetings four weeks apart, Mr Crawley offered the plaintiff the position of "Funeral Director and Consultant". The job title does not seem to have had much meaning. The business structure, as it ultimately emerged, consisted of Mr Crawley with four employees, (one of them Ms Bateman), each of whom was given the title.

[12] The job offered to the plaintiff was a casual position, described in the Funeral Services Award as "funeral services employee grade 2". Mr Crawley proposed that the plaintiff would receive $350 gross per week, and would have a three month probationary period. The award provided, in addition, for a "stand-by allowance": an employee required to be on call (as Mr Crawley's employees were, for one in every three weeks) was entitled to a nightly allowance. Currently the award allows $11.33 per night. If there actually were a call out, overtime was to be paid for a minimum of two hours. There was also the prospect of earning commissions. Ms Bateman explained this process. If an employee persuaded an individual to prearrange his funeral with the company paying for it in advance, he was entitled to a $50 commission. If he were able to bring what Ms Bateman described as an "at need" funeral to the company, the commission was $200.

[13] The plaintiff accepted the position offered. Because his shoulder operation was imminent, it was agreed that his employment should be deferred until he had undergone the surgery and a period of convalescence. It was anticipated that he would need to be able to carry coffins or corpses, so that it was necessary that his shoulder be fully healed. But there was a difference between how he, on the one hand, and Mr Crawley and Ms Bateman on the other, viewed the job offered. The plaintiff said he regarded the position merely as a casual part-time job to assist him with money as he completed his art course. He explained that because the business was just beginning, the job was likely to have been "very patchy". He expected some night work, collecting bodies from hospitals and mortuaries, with a couple of hours spent, on days off and weekends, trying to secure funeral commissions. Mr Crawley and Ms Bateman were unaware of his intention to continue with the art course as a career path, and seemed to have regarded the job as a full time position, although casual.

[14] Once he had decided to get involved in the art course, the plaintiff said, "Life was just great". He enjoyed the course, and expected it to "catapult [him] into a career either in fine arts or in digital technology". He felt he was among his peers, and in their company no longer felt, as he put it, that he was "sort of strange." On 28 April, he decided to give up alcohol, and in May he undertook a two week course at a religious retreat, which reinforced his commitment to abstinence.

[15] The plaintiff's contemporaneous account of his mental state as given in consultations with Dr Christensen in this period was not quite so rosy. In the six months prior to his hospital admission, the plaintiff saw Dr Christensen on 9 occasions. He attended a consultation on 11 January; no detail was given as to its content. On 1 February 2001 Dr Christensen noted that the plaintiff had applied for the art course. He was still having some depressive episodes, but was going to church and using herbal remedies as a means of dealing with his alcohol problems. On 15 February there had been a sharp deterioration in his mood because of some conflict with his girlfriend. He had been admitted to hospital with severe chest pain, which had no organic basis. He was prescribed Prozac.

[16] Two weeks later, on 26 February, the plaintiff was exhibiting anxiety about the commencement of his course. He was using alcohol and smoking marijuana. His Prozac prescription was increased. On 5 March he was reporting anxiety about his course and had been using Serepax to deal with it. He had been in some drinking sessions with his brother, and was concerned about his own tendency to aggression, which he himself described as reflective of "small man syndrome". On 19 March the plaintiff was again reporting anxiety about the TAFE course, and his Prozac was increased once again. He was seen on 23rd April; no detail was given of that visit. The next consultation with Dr Christensen was on 28 May. The plaintiff was then reporting his decision to give up alcohol and his experience of the religious retreat programme. He described himself as feeling more relaxed and not as pressured to perform. He did not see Dr Christensen again until after the operation and bladder injury.

The surgery and post-operative treatment

[17] The plaintiff was admitted to the Prince Charles Hospital on 25 June 2001 for shoulder surgery. In one of the medical reports, the procedure is described as excision of the outer end of the right clavicle to resolve a non-union of pseudoathrosis. On the plaintiff's account, after the surgery he felt the need to urinate but could not achieve micturition. Despite his requests, delays of several hours elapsed before he was relieved by catheterisation. He said that he was in extreme pain as urine built up in his bladder. A Royal Brisbane Hospital report, prepared no doubt with the assistance of the Prince Charles Hospital notes, shows that the plaintiff was first catheterised at 6 am on the day following the surgery, and was not catheterised again after that for another fifteen hours.

[18] The plaintiff, still unable to urinate, was discharged two days after the surgery with an in-dwelling catheter and urine collection bag, and given a referral to the urology section at the Royal Brisbane Hospital for the following week. However, about two days after his discharge, he began to experience severe pain, and noticed blood in the urine bag. He went straight to the Royal Brisbane Hospital and was admitted for about three days. He was taught there to self-catheterise and sent home with catheters and gel for that purpose. He has been self-catheterising ever since.

The plaintiff's account of his physical problems and their psychological effects

[19] The plaintiff's first and major complaint was of incontinence associated with the need to catheterise. The other concerns he identified were a decline in sexual performance; the embarrassment associated with catheter use at public venues; and recurring urinary infections. As to the incontinence problem, the plaintiff said that a minute or two after the catheter was removed there would be a further dribble of urine from his penis, over which he had no control. There had been occasions when a small wet patch was left on the front of his trousers as a result. He found that humiliating. In examination in chief, he said the problem did not happen daily; but in cross-examination, he said it occurred on probably one in every three occasions of catheter use.

[20] The plaintiff said that he had attempted to get himself back to work in hairdressing on about four occasions between September and the end of 2002, working with Ms Margaret Hayes, a friend of his mother, and on a couple of occasions around the middle of 2003, working with his mother. During the period in 2002 he had felt anxious and lacking confidence, and that was worsened considerably by an

experience of incontinence which caused him to walk out of the salon immediately. He had had the same experience working for his mother in the middle of 2003.

[21] The earlier experience was confirmed by Ms Margaret Hayes, with whom the plaintiff had worked, although she seemed rather confused as to whether it had happened in September 2002 or September 2001. At any rate, she said that she had worked with the plaintiff on about three occasions before his bladder injury, and had found him to be a good hairdresser with an outgoing personality and a rapport with his clients. When she had worked with him post-injury, which she estimated to have been on four to six occasions, she found him apprehensive and ill-at-ease with the clients. On one occasion he left the salon and returned with a urine stain on the front of his trousers. He finished his hairdressing work, then left and returned with his trousers changed. Later that morning, he came to her in a state of some distress, and they agreed that he would not continue with the work for the day.

[22] The plaintiff's mother, Margaret Stockwell, gave evidence of a similar incident, which she said occurred about Christmas 2001. She said that the plaintiff had been working at her hairdressing salon, gone to the toilet and come back with marks on the front of his jeans. I am doubtful, however, that this incident really occurred. The plaintiff gave no evidence either of working with his mother in December 2001 or of any such incident at that time; he said that the incident of that kind had occurred mid-2003. It is also noteworthy that Mrs Stockwell made a six page statement to her son's solicitors in February 2002 dealing with the effects of his injury, and made no reference to any incontinence problem or any incident of the type described by her in evidence. On the other hand, if an incident of the kind described by the plaintiff had occurred in the middle of this year, one would expect that, had Mrs Stockwell known of it, she would have remembered it.

[23] While I accept that the incident involving incontinence and embarrassment occurred while the plaintiff was working with Ms Hayes, I do not accept the evidence of a second, similar incident in his mother's company. I am inclined to think it is the product of discussion between the plaintiff and his mother of his difficulties and a (possibly unconscious) re-rendering by them, in a different context, of the incident with Ms Hayes.

[24] I am also sceptical about the significance attributed by the plaintiff to the incontinence problem, which it seems to me has become the subject of much greater emphasis over time. It was mentioned in a report of Dr Christensen dated 7 September 2001, in a reference to the plaintiff's fear of anyone noticing "any of the incontinence that sometimes happens afterwards", and there were allusions in the doctor's notes at the end of 2001 to the plaintiff's concern that he might become incontinent when he was out with other people. But it did not feature at all in the first two interviews the plaintiff had with Dr Mulholland in March 2002. Dr Mulholland set out in his report a list of "residual physical features" affecting the plaintiff: his inability to void, the need to self-catheterise, the fact that he had not thus far had any infections, a decrease in libido, an inability to achieve satisfactory erection and his need for Viagra in those respects.

[25] Later, however, in an interview with Dr Mulholland in September 2002, the plaintiff described "uncontrollable dribbling" causing "massive embarrassment" and precluding him from work with the public. It emerged in evidence that Dr Mulholland had got from this interview an impression that the plaintiff's incontinence took the form of a frequent leaking which could occur at any time.

There were similar complaints to Dr Byth, another of the psychiatrists who reported on the plaintiff, in May 2003, of "leaking and dribbling which [the plaintiff] found socially embarrassing", and to which he ascribed a fear of returning to any study or work environment. It seemed to me that there had been a noticeable increase, in the course of the past fifteen months, in the emphasis placed on the problem, and a magnification of its impact to create the impression that the plaintiff suffered from unpredictable, major and frequent incontinence. That culminated in the plaintiff's evidence, in which he relied largely on the incontinence problem to provide a justification for his failure to seek employment and to support a claim of social withdrawal.

[26] I am also disinclined to accept the plaintiff's evidence as to the proportions of the problem, in terms of both frequency and effect, for this reason: he has never raised it with any urologist in order to establish its cause or any possible means of correcting it. When questioned about his failure to do so, he said that he had spoken of it to his psychiatrist and general practitioner, but they had not referred him to any specialist. But he had regularly seen his treating urologist, Dr Roger Watson, until about six months prior to trial, when he was advised that he required only six monthly check ups in the absence of any change in his situation. He had never, he admitted, raised the question with Dr Watson.

[27] Dr Winkle, also a urologist, who examined the plaintiff in December 2001, gave a report dated 18 March 2002 describing the plaintiff's difficulties in which no reference is made to incontinence. Nor was it mentioned in his evidence. Dr Winkle had also arranged a urodynamic assessment of the plaintiff by another urologist, Dr Peter Mactaggart. The latter's report, dated 21 February 2002, was tendered by consent. It dealt with the plaintiff's reduced bladder sensation and inability to void, but contained no reference to incontinence.

[28] When cross-examined on his failure to mention the problem to any urologist, the plaintiff's response was, "I am not at a stage where I want to get around wearing incontinence pads like an old man of 90 because of something that someone else's negligence has caused". In fact, Dr Hirst, a urologist called on behalf of the defendant, said that the only sensible explanation for incontinence immediately post-catheterisation was that some urine was dropped in the urethra as the catheter was being withdrawn. The solution was the same as for men who experienced some urine dribbling after ordinary urination: that was, a movement of the finger along the urethra to ensure complete voiding. It seems extremely probable, then, that any incontinence problem that the plaintiff has, has a simple remedy. What is of even more note is his studious avoidance of any inquiry to that end. My impression was that, in an effort to maximise his damages, the plaintiff had exaggerated an existing but relatively minor problem, and had deliberately avoided any step which might provide a solution.

[29] The plaintiff said that he self-catheterised 7-10 times a day. He explained that his urologist had told him that it was better to catheterise more, rather than less, and that the more water he could drink, the better the prospect of his bladder working again; but the use of the catheter was painful, and more so in winter, because the catheter tube tended to attach itself by suction to the side of the bladder and had to be moved about. It does not seem, however, that such frequent catheterisation is in fact necessary. Dr Winkle estimated that the norm was between 3 and 5 times a day, a rate consistent with what he was told of the plaintiff's catheter use for the

purposes of his report of July 2002; Dr Hirst said it was somewhere between 4 and 6 times a day.

[30] One of the problems identified by the plaintiff was the development of urinary infections. He said that in the last six months he had had three infections, but there might have been others undetected. There were instances where he attended doctors or hospitals and was told, after providing a urine sample, that there was no problem; so he had not always sought medical treatment. Instead he drank cranberry juice, because he had been told that its anti-oxidant properties assisted as an anti-bacterial measure. On other occasions he had seen his general practitioner and been prescribed antibiotics. The infections were painful and generally were symptomatic for 8 – 10 days.

[31] Again, I am wary of the plaintiff's assertions as to the frequency with which he has suffered from infections. Dr Mulholland's note in March 2002 was that he had suffered none at that stage. The plaintiff's claimed eschewing of medical assistance is convenient to explain away the absence of medical record, but makes little sense given the claimed duration and painfulness of the infections.

[32] The plaintiff said that his bladder problems had made him disinclined to socialise. In addition to the incontinence concerns, there had been two occasions when he had been jeered at while washing his catheter bag in a public toilet. He spent most of his days at home watching television and went out very little, in contrast to his behaviour pre-injury, when he was outgoing, and socialised, even during the period in which he had stopped drinking. His mother described him prior to June 2001 as optimistic and enthusiastic. There was, she said, a marked improvement in his personality from 1999, once he came under the care of Dr Christensen and was treated for bipolar disorder. Whereas before he had been very erratic, his problem was now being dealt with, and he was enthusiastic about doing something with his life. He had a very good social life, went out a lot, and enjoyed mixing with people. Since the accident he had become very withdrawn and emotional.

[33] Prior to 2001, the plaintiff had had one long-term relationship, which lasted about 8 years, with a woman some 15 years his senior. She had also been given to drinking a good deal. That relationship had ended around 2000. While it lasted, he said, they had had sex on a daily basis. After the break up of the relationship he had had a series of what he described as "one-night stands", and had had sexual intercourse weekly until his admission to hospital for the shoulder surgery. After the bladder injury he had had a relationship lasting from November 2001 to January 2002, but had found that he was unable, without the assistance of Viagra, to maintain an erection. He attributed the ending of the relationship to his depleted sexual performance. He had not had sex since, notwithstanding his desire to. He regarded his urinary problems as presenting too great an obstacle to forming another relationship. He did, however, consider that attendance at a brothel might assist him to resume sexual activity.

[34] The plaintiff's evidence that he retained his sexual drive, while finding it difficult to meet women and to perform sexually, was somewhat inconsistent with what appeared in the medical reports as the history he had given to the psychiatrists examining him. To Dr Byth in May 2003, he said that his libido was reduced. According to Dr Lawrence's report, written for medico-legal purposes in November 2002, he told her that he had "no sexual drive or desire, no real interest". Dr Mulholland recorded, in his report of 4 April 2002, that the plaintiff "reported his

libido to be zero". That was confirmed in a later report of 4 October 2002, in which Dr Mulholland set out what he was told in a telephone conversation two days earlier with the plaintiff: "that his basic sex drive (i.e. libido) was there when he was in that relationship [i.e. from November 2001 to January 2002] but described that it has gone to 'zero' since January 2002".

[35] The plaintiff endeavoured to explain these various notes as resulting from a mistake on his part as to the meaning of "libido": he had confused it with performance. However there are quite specific references to loss of sexual drive, and I do not accept that each of these reporting psychiatrists was under a misapprehension as to what he was talking about. I think it more likely that the plaintiff's evidence is influenced by the prospect of the substantial damages which he seeks for attendance at a brothel, to satisfy what he now claims to be his strong sexual drive.

The psychiatric evidence

[36] The psychiatric consequences of the plaintiff's injury are difficult to isolate. Dr Christensen considered that it had caused an exacerbation of the depressive aspect of his bipolar disorder. His view of the contrast between the plaintiff's pre- and post- injury states is illustrated by two reports he completed for Centrelink in connection with the plaintiff's sickness benefit. In the first, dated 1 February 2001, he indicated that the plaintiff suffered from bipolar affective disorder which was long-term (i.e. likely to persist for at least two years). He was likely to return to a part-time job within six months (for at least 8 hours per week) or to study for at least 15 hours per week within six months; he was likely to return to full-time work (for at least 30 hours per week) between six to 12 months. He described the condition as "fluctuating" and "intermittent". In the second, prepared in December 2001 Dr Christensen again indicated that the plaintiff's condition was long-term; he described it as "fluctuating" and "constant". He also gave a second diagnosis of alcohol dependence in remission. He indicated that the plaintiff was not likely to return to part-time or full-time employment for more than two years.

[37] In October 2001, Dr Christensen was sufficiently concerned about the plaintiff's mental state to provide him with a letter of referral to the psychiatric ward at the Royal Brisbane Hospital. The letter explains the plaintiff's feelings of confusion and anger produced by the bladder injury and the fact that at that time his risk of suicide had increased. Although Dr Christensen said he had sent Mr Stockwell to the hospital, he was not admitted, and Dr Christensen instead increased his medication and continued to treat him without hospitalisation.

[38] Dr Christensen said that there was a psychological basis for the plaintiff's complaints of impotence. The plaintiff had described to him concerns as to how possible partners might see him when they discovered his need to use catheters, and his fear that he would be embarrassed by incontinence. Those features, he thought, played a major role as a psychological factor inhibiting sexual performance. Dr Christensen said, on the basis of the plaintiff's presentations to him, that he appeared to have had an increasing tendency towards social withdrawal with continuing anxiety and depressed mood. He had prescribed a tranquiliser, Seroquel, as a partial mood stabiliser. The plaintiff was increasingly preoccupied with his bladder problem and the way others saw him, particularly given the prospect of being under scrutiny in litigation. It was not necessarily the case that that would improve when the litigation was concluded. Dr Christensen had attempted some

cognitive therapy with him, without much success; that might improve slightly once the case was concluded.

[39] Dr Christensen referred to an incident described by the plaintiff, in which, at some time after a mediation in July 2003, a woman came to his mother's hair salon with an envelope for him. He was not there, but she returned later in the day, and gave him an envelope in which there was a card containing two "scratchy" lottery tickets with a note from a person whose name was unfamiliar. The plaintiff formed the view, quite possibly correctly, that this was a form of surveillance by the defendant's insurer, and was upset by it. Dr Christensen confirmed that the plaintiff's concerns about his conduct of himself in public were exacerbated by the incident. Counsel for the plaintiff submitted that no-one but the defendant's insurer could have had an interest in doing such a thing, and invited me to draw the inference from the fact that the defendant had disclosed the receipt of two privileged surveillance reports in August 2003 that this was indeed the negligent act of the defendant. However, I do not think that the evidence is sufficient to support such a finding on the balance of probabilities; and even if I did, I would consider any compensable harm minimal. At the highest, there was some temporary upset for the plaintiff, which is not said to have had any effect on his underlying psychiatric disorders.

[40] Dr Christensen said that, given the plaintiff's bipolar disorder, he would, in the ordinary course, have required monitoring, probably monthly. He was presently seeing the plaintiff fortnightly. He considered that the plaintiff's mental state had worsened since December 2001, and he did not think him likely to return to the workforce within the next couple of years. The plaintiff was likely, as a consequence of his depression, to have had a decrease in the level of his ability to care for himself and function on the domestic front.

[41] Dr Christensen's diagnosis of bipolar affective disorder was supported by the other psychiatrists called for the plaintiff, Drs Byth and Mulholland. Dr Mulholland considered that, as at September 2002, the plaintiff was still suffering from a chronic low-grade depression in the context of his bipolar disorder, and it was likely that his bladder problems were contributing to that depression. Dr Byth's diagnosis was likewise of bipolar affective disorder and of substance abuse disorder, principally alcoholism, which he said as at 20 May 2003, appeared to be currently in remission. Dr Byth expressed doubt that the plaintiff would have had such a recurrence of depression had it not been for his injury in 2001, and also expressed the view that he would have been able, but for it, to return to the workforce or remain in his art course. However, that was on the basis of a perception of the plaintiff's position pre-injury which did not entirely accord with reality. He was under the impression that the plaintiff had improved considerably and had been coping well from around 2000, once Dr Christensen started treating him with medication for bipolar disorder, that he had stopped drinking by 2001, and that he was by the time of his hospitalisation "leading a more stable, productive, directed sort of life by then". He did not realise that the cessation of alcohol abuse was as late as 28 April 2001. Dr Byth considered that the effects of the motor vehicle accident – the plaintiff complained of continuing upset from neck pain and headaches – were also contributing to his depressive state.

[42] Dr Lawrence, who examined the plaintiff for the defendant, questioned the correctness of the diagnosis of bipolar affective disorder. She regarded the

plaintiff's mood variations as more probably attributable to substance abuse. Her view was that the correct diagnosis was one of personality disorder combined with substance abuse disorder. The plaintiff might have suffered from an adjustment disorder with anxious mood in the period immediately after his injury, but it should have settled quickly. She considered his current complaints of psychological symptoms to be, in all probability, consciously exaggerated and likely to resolve with the end of litigation.

[43] Dr Lawrence was dubious as to whether the plaintiff's alcohol dependence was in remission, because in October 2001 a Gamma Glutamyl Transpeptidase **(**GGT) test showed a raised level of the enzyme in the liver, which was likely to be produced by alcohol use. Dr Lawrence accepted that antidepressants could have the effect of raising GGT levels; but, she pointed out, the Epilim which the plaintiff was taking was shown to be present in very low quantities, and could not account for the raised GGT levels. She considered that the plaintiff suffered from poly-substance abuse disorder, the relevant substances including amphetamines, marijuana, and alcohol. The disorder was likely to manifest itself by use of different drugs at different times. The plaintiff had declined to undergo any further urine drug screening, despite her request.

[44] On his own admission, the plaintiff had been given to some illicit drug use both before and after the injury. He said that he had experimented with marijuana socially before the injury, and used amphetamines possibly twice. Post-injury, he had used amphetamines eight times to try to improve his mood. He had not used marijuana for six to twelve months prior to trial. He said he had got to a point with smoking cannabis where he thought it was becoming too much of a support for him, and gave it up completely, as he had done with alcohol.

[45] Dr Mulholland reported that the plaintiff told him in March 2002 that he was using cannabis three times per week, and amphetamines weekly. In evidence, Dr Mulholland confirmed his hand-written note of a current use of amphetamines weekly. The plaintiff denied having said that he was using amphetamines weekly; his use was, he claimed, monthly. A urine drug screen undertaken at Dr Mulholland's request detected methamphetamines. Dr Christensen was not aware of the plaintiff's amphetamine use at that time.

Other injuries

[46] There are some other complicating medical features to the case. The plaintiff, as already described, required surgery to his right shoulder in June 2001. He has subsequently had surgery on his left shoulder, although there was no evidence as to when that occurred or what was entailed. It is likely that both of those events would have restricted his capacity to work and perform household tasks at least for some short time. Perhaps more significantly, in September 2002 he was involved in a motor vehicle accident which appears likely to be the subject of litigation. His evidence was that a car struck his vehicle on the right, causing his head to hit the steering wheel and his knee to strike the dashboard. He said that he had sustained a whiplash injury. Over the six weeks prior to trial, the intensity of his headaches (which had been "really bad") had decreased, his neck was less stiff, and his knee, which had given him problems in the cooler months, was no longer doing so.

[47] The defendant tendered by consent two reports from Dr Richard Williams, orthopaedic surgeon, in respect of the plaintiff's injuries from that accident.

According to his first report of 3 March 2003, the plaintiff was taken by ambulance to the Royal Brisbane Hospital and treated for what appeared to be fractures at C7 and T1 as well as an injury to the medial right knee. He later underwent physiotherapy, which relieved his knee pain but exacerbated his neck pain. Later he was referred to Dr Jim O'Callaghan, a pain specialist, for facet joint injections. He had tried a number of analgesics without effect. As at March 2003 he was suffering cervical spinal pain with bilateral trapezial radiation, upper and lower limb sensory disturbance and disturbed temperature sensation. He also complained of ongoing intermittent knee pain and occasional swelling and giving way of the knee joint. Pain regularly woke him at night. He reported having difficulty breeding tropical fish because of cervical spinal pain and was said, although the plaintiff disputed this when cross-examined, to have reported that he was able to "pursue most activities of daily living although some cause significant neck pain". Dr Williams' prognosis at that stage was for continuing cervical spine discomfort over a period of up to two years. The right knee symptoms would stabilise over time.

[48] In October 2003 Dr Williams examined the plaintiff again. He had received facet joint injections to the cervical spine on 4 March 2003, which produced one week of pain relief, but reported that since then his neck and knee pain had intensified significantly. He was seeking an appointment with the chronic pain clinic at the Royal Brisbane Hospital. He described his neck pain as "9/10" in intensity, with occipital headaches. His knee joint gave way, swelled and locked. He described difficulty hanging washing on the line, making beds and driving. He was unable to do his washing, which his mother undertook. He was still having difficulty breeding tropical fish, particularly lifting buckets of water.

Findings on the psychiatric and physical effects of the injury

[49] While as I have said, I do not accept a good deal of the plaintiff's evidence about the sequelae of the bladder injury, I do accept that it has had serious and continuing effects on him. The need to self-catheterise for the rest of his life is a significant consequence, of itself likely to have some inhibiting effect on his social confidence. I accept that incontinence was a source of great embarrassment to him in the incident that Ms Hayes describes, and that it is an ongoing concern, albeit a much less serious one than he portrayed.

[50] The preponderance of expert evidence is to the effect that Dr Christensen's diagnosis of the plaintiff as suffering from bipolar affective disorder was correct. I accept that evidence, and I accept that the injury exacerbated the plaintiff's tendency to depression, as did the 2002 motor vehicle accident. I do not accept the picture of the plaintiff pre-accident portrayed by his mother, of him as vastly improved under the care of Dr Christensen from 1999, enthusiastic and very social. That seems to me rather to underplay the continuing effect of alcohol in his life up to at least 28 April 2001, and certainly fails to recognise the problems of anxiety and low self-esteem with which the plaintiff was grappling in the first part of 2001.

[51] Something was made by the defence of variations in the plaintiff's account to the various medical practitioners of when precisely he gave up drinking. Although 28 April was stressed by both the plaintiff and his mother as significant, it was not recorded by any of the psychiatrists who interviewed him and Dr Christensen said that he was not aware of any particular date as significant. However that may be, I am satisfied that the plaintiff did make some sort of decision at the end of April 2001 to stop drinking, and that his attendance at the Bethel retreat for two weeks in

May was effective in achieving that result. There was, of course, only a very brief period of perhaps six weeks or so between the conclusion of that course and his hospitalisation, and it is difficult to judge from that limited period what may have happened in the future.

[52] While there is some evidence in the form of the urinary screenings results to suggest that the plaintiff may later have relapsed into alcohol use, I do not think it is sufficiently compelling to make a finding to that effect. Consequently, I accept that he has abstained from alcohol use from May 2001. That in itself brings, as Dr Christensen said, some complications. He described the plaintiff as always concerned about how others saw him, and regarded his alcohol use as a manifestation of social anxiety. The plaintiff complains of social withdrawal as a result of his injury. It seems probable that that he would have experienced some difficulty in social interaction in any event, purely by reason of giving up alcohol, with its disinhibiting effect. I accept that the need to catheterise is itself a significant disincentive to social interaction but I think it likely that it combines with the withdrawal from alcohol use, in the context of pre-existing anxiety and low self esteem, to reduce the plaintiff's willingness to socialise. Indeed, as Dr Christensen said, it may be that the need to catheterise in turn provides something of a deterrent from alcohol use, in that the plaintiff no longer wants to frequent venues such as hotels.

[53] While I have not accepted Dr Lawrence's view as to the absence of any bipolar disorder, I think that she is correct in ascribing to the plaintiff a substance abuse disorder which may or may not be in remission. Given his history he was and is likely to continue to be at risk of relapse, if not into alcoholism, into other forms of drug abuse. I do not accept that the plaintiff's post-injury use of amphetamines and cannabis can be attributed to the bladder injury; it seems to me that his admitted use of amphetamines (in respect of which I accept as correct Dr Mulholland's note of it as weekly) and cannabis is consistent with his past history of dependence on intoxicating substances of one kind or another. That drug use is likely to have contributed in the past to mood disturbance, as Dr Lawrence said; and if it recurs is likely adversely to affect the plaintiff's psychiatric state.

Pain, suffering and loss of amenities

[54] The plaintiff should be compensated for the past and future discomfort of catheterisation and the awkwardness and embarrassment associated with it, and for an increased propensity to urinary infection; and for an exacerbation of the depressive component of his existing bipolar affective disorder beyond what might ordinarily have been expected of the normal progress of the disorder, allowing also for the effects of the motor vehicle accident. He should also be compensated for the loss of libido, probably resulting from depression, reported to doctors, and for his loss of confidence leading to a psychological difficulty in maintaining an erection.

[55] As to the last, it was proposed that damages be awarded in an amount of $47,000, reflecting the cost of weekly visits to a brothel for five years. That, I think, is inappropriate, given the entirely speculative nature of the proposal. The plaintiff had never been to a brothel; it was not known whether it was likely to meet his needs; and Dr Christensen put it no higher than that it was "worth a punt". The plaintiff's account of loss of sexual drive to the psychiatrists who saw him also detracts from the prospect of his undertaking regular brothel visits. In any case, the loss of sexual performance is not the result of any physical incapacity; it is a

psychological barrier which may well be overcome. In the circumstances the proper approach is to allow for the plaintiff's loss of libido in the award for pain, suffering and loss of amenities, while also allowing some amount for Viagra tablets, as a means to restore actual performance, in an award for future expenses.

[56] In my view, taking into account the plaintiff's pre-existing difficulties, the prospect which existed in any event of his relapsing into substance abuse, and allowing also for the impact of the motor vehicle accident in which he was involved, the appropriate award for pain, suffering and loss of amenities is $60,000. Interest should be allowed on a third of that amount as past pain and suffering, which at 2% for 2.5 years gives another $1,000.00.

Special damages

[57] Most of the special damages claimed by the plaintiff were admitted, with exceptions in respect of certain travelling expenses and pharmaceuticals. Mr Wilson's submission for the plaintiff, in maintaining the appropriateness of an award for all items, was that his client had given evidence that this was a list of his special damages; and in the absence of challenge in cross-examination, it was to be accepted. I do not think that the evidence went that far. The plaintiff was asked if he could identify the document "as a schedule of special damages which you prepared" and responded "yes that would be about right". That does not seem to me to amount to an adoption of the schedule as true and correct, and some of the plaintiff's evidence in fact contradicted his claims in it.

[58] The defendant did not admit travelling expenses for 60 attendances upon Dr Christensen, arguing that the plaintiff's pattern of consultation was much the same before and after the injury. It seems probable, notwithstanding what the actual attendance figures may be, that, given the effects of the injury on the plaintiff, he attended on Dr Christensen more than he would otherwise have done. I will allow $200 (a third of the $600 claimed) as representing a rough estimate of what might have been the difference.

[59] There was an objection to the claim for pharmaceuticals consisting of Panadol, Serepax, Diazepam, Lovan, Macrodantin and Seroquel, on the basis that the plaintiff would in any event have been taking Serepax, Diazepam and Seroquel, or an equivalent, as he was before the surgery, and he had in his evidence said that he was no longer taking Lovan and Panadol. In respect of the Serepax, the plaintiff said that he only took it when he was going through a bad period of anxiety, and that does seem rather similar to the position in March 2001. He was not currently taking Panadol and gave no indication of any period for which he had taken it. Similarly, he was not taking Lovan, and there was no evidence that he had paid for it in the past. It was clear from the plaintiff's evidence that he had not had to date to pay for Seroquel; it had been provided by Dr Christensen in the form of pharmaceutical company samples. I will allow an amount of $100.00 as representing the plaintiff's increased expenditure on tranquillisers, anti-depressants and analgesics.

[60] In the absence of any medical support for the consumption of cranberry juice, I do not think that the amount claimed, $850, should be allowed. The plaintiff said that he used one or two tubes of lubricating gel per week. Dr Winkle, on the other hand, estimated use at one tube per fortnight, resulting in a cost of $117 per annum. I will allow this item for the past at double that estimate, giving an amount of $585.00 for

2.5 years. The claim for Macrodantin, an antibiotic used to treat the plaintiff's urinary infections, is properly made and allowed.

[61] On that basis, the award for special damages consists of the admitted past Health Insurance Commission benefits at $3848.85, a further allowance of $750.00 for medical expenses not shown on the HIC notice of benefit, travelling expenses at $854.70 and the cost of pharmaceuticals at $713.20. Interest will be allowed on the last two amounts at 5% for 2.5 years, giving a further $195.98.

Future costs of catheterising and treatment

[62] Dr Winkle estimated the following costs as applicable to the plaintiff's future catheterisation requirements: $260 per annum for catheters; $117 per annum for lubricating gel; $130 per annum for urinary tract ultrasounds; $105 per annum for urological consultations; $246 per annum for urine cultures; and, assuming two urinary infections a year, $44 for antibiotics and $60 for doctors' visits. I accept all of those estimates as an appropriate measure of what the plaintiff is likely to require. They total $962 per annum, or $18.50 per week, giving, discounted at 5% over a 44 year period (the plaintiff's life expectancy), a figure of $17464.00.

[63] There was also a claim for future psychiatric treatment in the form of an additional 14 visits per annum, future travelling expenses in that regard and future psychiatric medication, totalling something in the order of $90,000. While the extent to which the plaintiff is likely to require additional psychiatric treatment and medication by virtue only of his bladder injury is extraordinarily difficult to predict, it does not seem to me that it is likely to be of those proportions. I would allow a figure of $25,000 in this regard as a global sum; that would equate, roughly, to allowance of those claims for five years. As already indicated, I do not think it an appropriate case to allow the cost of brothel visits, but I do consider an allowance should be made for a year's supply of Viagra to assist the plaintiff in regard to his sexual difficulties. Allowing for fifty-two tablets for a year at $74.40 per tablet, and applying a 5% discount, one arrives at a figure of $3794.40.

Past and future economic loss

[64] I think it is most unlikely, for a number of reasons, that the plaintiff would have retained the job with Mr Crawley for any length of time. Firstly, he had not in the past demonstrated any capacity to stay at employment for any appreciable period; secondly, he had made it clear that his art course was his primary interest; thirdly, the prospects of his lasting beyond the probationary period if his various undisclosed problems came to the fore were not good; and fourthly, the need to have two shoulders operated on must at least have caused a substantial disruption in the employment. Some of those factors also militate against the prospects of his having found employment during the period to date, as does the disruption to earning capacity which must have been caused by his injuries in the motor vehicle accident.

[65] None of the psychiatrists who were called in the plaintiff's case ruled out the prospect of his being able to work in the future. Dr Christensen thought it unlikely in the next couple of years. In his April 2002 report, Dr Mulholland said that the plaintiff should be capable of work in the future provided he co-operated with psychiatric treatment, although in evidence he said that it would be difficult for the plaintiff to return to work with the public while he retained his concerns about

others' perceptions of him. Dr Byth considered that the plaintiff's "usual work" as a hairdresser or art student would be moderately impaired.

[66] I am unconvinced that the plaintiff's problem with incontinence operates to the extent claimed, so as to hinder his return to the workforce. But, in any case, the plaintiff's extremely low rates of earning in the past are strong evidence against the likelihood of his maintaining a steady income in the future, absent the injury, even when one allows for his abstinence from alcohol to date. Any impairment in earning capacity must be taken in that context, in the context of his pre-existing and continuing psychiatric problems, and with some allowance for the effects of the motor vehicle accident, which are not entirely dissipated.

[67] Because of all those factors, it is not possible to arrive, on any mathematical basis, at figures for past and future loss. Instead, I will allow a global award for past economic loss of $10,000 and an award for the future of $50,000. The prospect of superannuation contributions being made on the plaintiff's account, given the casual and random nature of his employment in the past was and is not strong; but I will allow 8% of the past award as past loss of superannuation benefits, and 9% of the future award.

Past and future care

[68] The plaintiff's mother gave evidence that the plaintiff, who lived with her and her husband, required 14-15 hours per week assistance, and had done so since his return from hospital in mid 2001. Prior to his injury, she said, he cooked for the family (which at times also included her second son), did his own washing and ironing, cleaned around the house, worked in the garden and cleaned the pool. Since his injury he tended to commence tasks but not complete them, because of his irritability. She and her husband now completed all those jobs around the house and yard. She also assisted the plaintiff with a hobby he had of breeding tropical fish.

[69] I have a good deal of difficulty accepting that the plaintiff was as active and assiduous in household tasks pre-injury as Mrs Stockwell claimed, given his own evidence about his binge drinking. The other difficulty with her evidence is the complete failure to distinguish between tasks which can be characterised as performed for the plaintiff, and those done for the maintenance of her own property, or the provision of assistance to the rest of the family. Another complicating feature is that the plaintiff would probably have required some assistance in respect of the period after each of his shoulder operations in any event. His injuries from the motor vehicle accident must also have had a considerable impact; certainly, Dr Williams has recorded a claim that he has suffered a loss of physical ability to carry out tasks because of it. Taking all those matters into account, I allow an amount for past care of $5,000 (representing a little more than 2 hours per week) and a future amount of $10,000. Interest is payable at 5% on the amount for past care.

[70] In accordance with what I have set out above, I award damages as follows:

Description	$
Pain and Suffering and loss of amenities	60,000.00
Interest at 2% per annum on $20,000 for 2.5 years	1,000.00
Special damages - HIC, travelling, pharmaceutical	6166.75
Interest on out-of-pocket expenses at 5% p.a. for 2.5 years	195.98
Future treatment & pharmaceuticals	46258.40
Past loss of wages	10,000.00
Past loss of superannuation contribution at 8% of award	800.00
Loss of future earning capacity	50,000.00
Loss of future employer superannuation contributions at 9%	4,500.00
Past care	5,000.00
Interest on past care at 5% p.a. for 2.5 years	625.00
Future care	10,000.00
TOTAL:	**$194,546.13**

Protection order

[71] Dr Mulholland, in his reports, raised a concern as to whether the plaintiff was fit to manage any large sum of money because of the risk that he might, in a manic phase of his bipolar disorder, embark on a spending spree. On the basis of that concern, I considered whether a protection order should be made under s 67 of the *Public Trustee Act* 1978. However, I was reassured by the evidence of Dr Christensen, who said that the plaintiff had, on his observation, been capable to date of looking after his money, but that if he did become manic he, Dr Christensen, would ensure that the Public Trustee was advised and the appropriate application made. I do not propose, therefore, to make any order.

Order

[72] I give judgment for the plaintiff against the defendant in the amount of $194,546.13. I will hear the parties as to costs.