SUPREME COURT OF QUEENSLAND

CITATION:	*Mott v Crest Cabinets & Anor* [2004] QSC 096
PARTIES:	**JAMIE MOTT** **(plaintiff)** **v** **CREST CABINETS (ABN 285 0266)** **(first defendant)** **and** **CREST CABINETS (AUSTRALIA) PTY LTD** **(ACN 062 108 418)**
FILE NO/S:	S2264 of 2002
DIVISION:	Trial
PROCEEDING:	Claim
ORIGINATING COURT:	Supreme Court
DELIVERED ON:	21 April 2004
DELIVERED AT:	Brisbane
HEARING DATE:	23, 24, 25 February 2004
JUDGE:	Atkinson J
ORDER:	**Judgment for the Plaintiff**
CATCHWORDS:	DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES – PERSONAL INJURIES – LOSS OF EARNINGS AND EARNING CAPACITY – OTHER PECUNIARY DAMAGE – NON-PECUNIARY DAMAGES – PAIN AND SUFFERING – LOSS OF AMENITIES OR CAPACITY FOR ENJOYMENT – where orthopaedic injury to wrist of dominant hand – where psychiatric and neurological injuries as result of frontal lobe damage – cumulative effect of injuries MENTAL HEALTH – GUARDIANS, COMMITTEES, ADMINISTRATORS, MANAGERS AND RECEIVERS – APPOINTMENT – whether appointment order necessary *Guardianship and Administration Act 2000* (Qld), s 12 *Camm v Salter* [1992] 2 QdR 342, cited *Jackson v Bagwell* [1992] 2 QdR 390, cited *Knight v Breakwater Island Resort Pty Ltd* (unreported Supreme Court of Queensland Williams J 24 April 1995),

	cited *O'Brien v McMullen* [1999] QSC 208, cited *Stevens v Bodribb Sawmilling Co Pty Ltd* (1986) 160 CLR 16, cited *White v Combridge* (1984) 59 ACTR 18, cited
COUNSEL:	SC Williams QC and SJ Given for the plaintiff G O'Sullivan for the defendants
SOLICITORS:	Shane Ellis for the plaintiff Phillips Fox for the defendants

Liability

[1] The plaintiff, Jamie Mott, was a skilled cabinet maker who worked for the defendants, Crest Cabinets, installing kitchens. On 23 December 1999 Mr Mott was injured when he slipped on loose dust while he was cleaning up at the defendants' factory. He was on the mezzanine floor, which was a storage area, packing laminates away in racks. The floor space was covered with dust, debris and bits of timber. There were lengths of four inch by one inch pine on the floor. He slipped and fell backwards. As there was no balustrade he fell off the mezzanine level. His hip struck a piece of machinery called an Edge Bander and he then fell forwards and hit the concrete floor. When he hit the concrete he fractured his right wrist and hit his head fracturing his skull. This will be referred to in these reasons as "the accident".

[2] The mezzanine floor was 2.14 metres above the concrete floor. The raised storage floor was 1.67 metres wide for nine metres of its length and then narrowed down to one metre over the remainder of its length. Mr Mott was working in the region where the floor narrowed. Access to that floor was by a ladder. After Mr Mott's fall, a guard rail and balustrade were placed around the mezzanine floor.

[3] When Geoff McDonald of Geoff McDonald and Associates Pty Ltd prepared a report on the accident on 4 July 2003, he attended the defendants' factory and took photographs and made various observations. Mr McDonald is an expert in the fields of accidents, ergonomics and behavioural design. Although the balustrading had been added and the edge bander was no longer present, much of the rest of the factory was as it had been when Mr Mott slipped and fell. In particular, Mr McDonald photographed a build-up of fine sawdust material which was the type of dust that Mr Mott referred to in his description of the occurrence. Mr McDonald says that it is known that fine dust similar to that shown in the photograph can significantly reduce the grip of shoe soles on floor surfaces.

[4] The defendants admitted their negligence in this situation. The obligation to provide a safe place of work and a safe system of work existed in this situation notwithstanding that their relationship was based on the plaintiff's being an independent contractor rather than an employee.[1] Their failure to provide a balustrade along the side of the mezzanine floor was in breach of s D2.16 of Volume 1 of the *Building Code of Australia* 1996 and s 3.2.1.1, 3.2.2 and 3.4.1 of AS 1657 which is the Australian Standard for Fixed Platforms, Walkways, Stairways and Ladders – Design, Construction and Installation, 1992.

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1 *Stevens v Brodribb Sawmilling Co Pty Ltd* (1986) 160 CLR 16.

[5] The defendants argued that the court ought to find that Mr Mott contributed to this accident being responsible for contributory negligence of up to 20 per cent. There is no basis on which a finding of contributory negligence could be made and I am satisfied that Mr Mott did not fail to take reasonable care for his own safety in this situation.

Injuries

[6] Mr Mott suffered orthopaedic, neurological and psychiatric injuries as a result of the accident. Although these will be considered in turn, their effect on him was cumulative. He struck his right hip/buttock, right wrist and head. He was unconscious for a time after his fall. By the time the ambulance arrived, Mr Mott had been roused to consciousness but was confused and had no recollection of his injury. He was taken by ambulance to the Gold Coast Hospital. By the time he got to hospital, his Glasgow coma scale had improved to 14/15. He was noted to have a swelling of his right eye consistent with trauma but examination of his nervous system was normal. A CT scan of the brain was performed which showed a right fronto-temporal skull fracture and multiple petechial haemorrhages within the frontal lobes of the brain consistent with diffuse brain trauma. He had also fractured the wrist of his right hand, which was his dominant side.

[7] Mr Mott was then transferred to the head injury unit of the Princess Alexandra Hospital. He remained an inpatient of that hospital until 26 December 1999 under the care of Dr Adrian Nowitzke and Dr Lee Atkinson.

Neurological injury

[8] Mr Mott was re-admitted to the Gold Coast Hospital on 3 January 2000. He was suffering from headache, intermittent dizziness and "head spins". He had another CT scan of the brain on 4 January 2000 at the Gold Coast Hospital showing areas of swelling or oedema around the small petechial haemorrhages in the frontal lobe of the brain but these were otherwise resolving as appropriate. In the right frontal lobe there was an area of gliosis (a liquefaction) of a small amount of brain, presumably related to the same acute trauma. A follow-up CT scan was recommended. He was discharged on 4 January. Outpatient clinical notes on 20 January 2000 record, "Headaches … dizziness intermittent."

[9] He returned on 22 March 2000 complaining of dizziness, fainting, nausea, visual disturbance and headache. He did not complain about memory loss but appeared vague and had been told by work mates that he had forgotten things said to him. He was noted as having had a significant head injury and post-concussion syndrome. A third CT of his head was taken which showed ongoing resolution of the haemorrhages and the gliosis in the left frontal part of the brain related to the previous haemorrhage or contusion to that part of the brain. There were no new concerns noted. He was given appointments to return to the Gold Coast Hospital in April and May 2000 which he failed to attend.

[10] Mr Mott was reviewed by Jill Harding-Clark, a clinical neuro-psychologist, on 15 October 2001. He was scheduled to attend on 13 August 2001 but failed to attend with no notification. His de facto partner of one year accompanied him and provided collateral information where required. Mr Mott reported the following ongoing post-injury problems: right wrist pain when he used his wrist; right eye

pain, described as knife-like pains; tinnitus in his right ear; diplopia and blurring of vision; reduced sense of balance; nausea; reduced libido; dizziness; persistent headaches; disturbed sleep and nightmares; early insomnia; and fatigue.

[11] As well as these physical and sensory problems, he reported cognitive problems: difficulty understanding what people were saying to him; word-finding problems; difficulty with mental calculations; poor concentration; and short term memory problems. In addition, he reported affective and behavioural problems: common depression with regular suicide ideation; reduced frustration tolerance; and effects on his relationship with others.

[12] Ms Harding-Clark administered a number of tests on Mr Mott. The results of his neuro-psychological assessment indicated that he continued to experience post-concussional residual cognitive deficits. It was likely that persistent depressive symptomology was exacerbating those cognitive difficulties. His test performance was compromised at times by emotional lability and irritability, both of which were likely to affect performance motivation and ability to attend and concentrate. Other factors, such as ongoing pain and headaches and fatigue were also likely to exacerbate his cognitive problems.

[13] Ms Harding-Clark noted that the neuro-psychological assessment took place in a structured clinical environment relatively free from distractions and therefore performance deficits found in this context might translate to more significant problems in a functional environment such as the workplace where multiple demands were placed on cognitive resources. She formed the view that Mr Mott's cognitive deficits would become less problematic with effective relief from his depression and headaches. She recommended psychiatric review and associated medical management.

[14] Ms Harding-Clark noted significantly impaired attention span for auditory verbal information, difficulty manipulating information in working memory and attentional fluctuation. So far as memory and learning is concerned, Mr Mott had moderate to severe impairment in complex verbal learning and mild impairment in retention of visual information. He had some difficulties developing strategies to improve performance, particularly with regard to verbal tasks and occasional impulsivity in approach to tasks. The test for malingering, which would demonstrate whether or not Mr Mott was attempting to simulate memory dysfunction, was administered. It showed no evidence of malingering.

[15] Ms Harding-Clark concluded that Mr Mott's cognitive prognosis was guarded due to the level of his depression and the confounding effects of that on testing. She recommended he return for neuro-psychological follow-up assessment once his depression had been effectively managed in order to determine the true extent of possible residual cognitive deficits.

[16] A further CT of the brain was performed on 19 October 2001. According to Dr James Bodel, an orthopaedic surgeon who looked at the CT scan while he was examining other x-rays, the scan showed evidence of intracranial pathology in the region of the left frontal lobe. An MRI scan of the brain on 5 November 2001 also showed intracranial pathology. The MRI scan showed left lateral frontal cortical lesion, small in size. Dr Noel Saines, a neurologist was of the view that the MRI scan confirmed "the change in the left frontal cortex as well as a few other small

areas of white matter of the anterior hemispheres compatible with post-traumatic change."

[17] On 23 August 2002, Mr Mott consulted the North Coast Head Injury Service at Port Macquarie where he saw a social worker and experienced community rehabilitation worker, Bruce Robson. Mr Robson has endeavoured to support him in understanding the consequences of his injury, trying to ascertain his future plans, what assistance he requires and counselling in regard to his domestic situation. Objection was taken by the defendant to Mr Robson's expertise but he was, in my view, more than adequately qualified to give the evidence he gave.

[18] When Mr Mott first consulted the North Coast Head Injury Service he suffered from mood swings, short term memory deficits, dizziness, headaches and pain. He strongly desired to return to work. During the following six weeks until Mr Robson first reported to the plaintiff's solicitors, Mr Mott also displayed impulsivity, lack of logic in some issues, emotional lability in regard to anger and sadness, irritability, depression, high level of dependence and perseveration (repeatedly talking about the same thing and an inability to get off certain topics). He also advised of past attempts at suicide. Mr Robson said that most of the symptoms were "classical of a significant brain injury".

[19] In Mr Robson's opinion, Mr Mott's prognosis was guarded and would depend on neurological treatment and treatment for his depression. Although Mr Mott was very keen to return to work, Mr Robson thought that if there was no further major improvement in his condition, he did not anticipate Mr Mott's return to the workforce and would be concerned of how this would impact on his personal life. He was working in his trade as well as teaching martial arts prior to his injury and both those activities were beyond Mr Mott's ability after the accident. Mr Mott had indicated a desire to assist voluntarily at the local maritime museum but would, according to Mr Robson, require quite a lot of assistance for a successful future and as a result of his head injury he might not be able to continue because his level of frustration was high.

[20] On 17 October 2002, Mr Robson referred Mr Mott to Dr Henry Miller. Mr Mott was examined by Dr Miller on 14 November 2002. Dr Miller said that he has been left with headache and positional vertigo since the accident. The positional vertigo was likely to have originated from the right posterior semi-circular canal, judging by the Hallpike manoeuvre and his history. His most pressing complaint was the headache from which he suffered. Dr Miller said that the cognitive problems did not appear severe judging by the report of the neuro-psychologist, Ms Harding-Clark. Dr Miller was of the opinion that the vertigo should respond well to exercises he demonstrated to Mr Mott. Headaches of the magnitude suffered by Mr Mott were usually manageable by pharmacological measures but occasionally there are patients who respond poorly and cannot perform forty hours work weekly because of interruption by these symptoms. Dr Miller was unable to say whether or not this applied to Mr Mott.

[21] Mr Mott's symptoms since the accident have included multiple daily bi-frontal pressure type headaches arising suddenly and lasting about ten minutes, not associated with any autonomic features, and blurring his vision. He has had chronic neck discomfort. He also has had vertigo of two sorts: brief, precipitated by rolling onto his right side and thus likely to be of inner ear origin; and more prolonged,

lasting several minutes, coming on spontaneously, and thus possibly migrainous in origin. Insomnia and depression had been marked, enough to result in suicide attempts. Dr Miller said that Mr Mott returned to work for a while but the headaches and dizziness caused him to stop working.

[22] Dr Miller said that cognitive complaints were not prominent and the neuro-psychology report showed attention problems rather than focal deficits. Dr Miller said that attention problems had a better prognosis than other deficits as they are more likely to be caused by mood disorder, anxiety and headache rather than be the result of permanent injury to brain cells. Dr Miller said that during his interview with Mr Mott, while Dr Miller was distracted by a telephone call, Mr Mott developed a distressing frontal headache which resulted in a flushed face and injected conjunctivae. Systolic blood pressure was 120. General neurological examination was normal. Specifically, despite complaints of poor balance, he had a normal tandem gait and was able to march on the spot with eyes closed without rotation. Hallpike manoeuvre with right ear down brought on no nystagmus but he developed dizziness when fatigued. The same manoeuvre on the left had no effect.

[23] Considering his neurological symptoms alone, Dr Miller thought it was likely that Mr Mott should be able to return to full time commercial employment as a cabinet maker unless his depression was major. If depression proved a major impediment, assessment and treatment by a psychiatrist would be useful.

[24] Mr Mott was examined by another neurologist Dr Noel Saines on 29 November 2002. Mr Mott described to Dr Saines ongoing severe headaches which commenced in the right temple, spread across the forehead to the left temple, then extended over the cranium. The pain became severe and pounding for a few minutes intermittently through the day and he sometimes lost awareness of his surroundings. Mr Mott also complained of intermittent spinning sensation in the head provoked by head movement which was present everyday and seemed to occur mainly when he rolled over to the right in bed, stood or looked up. Mr Mott complained of it being a "seasick feeling" with accompanying nausea and some blurring of his vision. He also complained of stiffness in his neck and a painful right wrist. He described being depressed, moody and often angry with a short temper, having a patchy memory and often thinking of committing suicide.

[25] Dr Saines could find no ready explanation for the severity and persistence of Mr Mott's headaches although he said the marked tenderness over the scalp in the anterior region and less so over the posterior cervical soft tissue would suggest there was a large component of muscle contraction/tension at the bases of these headaches. Dr Saines thought that Mr Mott's significant mood disorder was likely to be contributing to the persistence of his various symptoms.

[26] On 3 January 2003, Mr Robson reported that Mr Mott's depressed mood had noticeably improved over the past few months due to his being on anti-depressant medication. He had also gone to victims' counselling for the abuse he suffered much earlier in his life. While the abuse was not directly related to his head injury, it appeared that his head injury may have lead to his re-experiencing some of the affects of the abuse. His impulsivity, lack of logic in some areas and emotional lability had all improved. Mr Mott had been accepted onto the Disability Support Pension. He reported that his dizzy turns had reduced but his headaches continued as before.

[27] On 7 February 2003, Mr Robson said that while Mr Mott continued to improve, especially with his emotional responses to stressors, his future progress of a cognitive/learning nature would take substantial time and effort.

[28] Mr Mott was referred for audiological and vestibular investigations. His audiological report was unremarkable. The electronystagmography ("ENG") and caloric testing showed that all responses were within normal limits except for the caloric tests which demonstrated a significant directional preponderance to the left. This supported some vestibular involvement but did not localise the site of the lesion.

[29] These reports were reviewed by Dr Benedict Panizza who is an expert in otolaryngology – head and neck surgery. Dr Panizza reported that the ENG and calorics on Mr Mott suggested that there was a significant directional preponderance to the left side. He recommended that should Mr Mott develop unilateral tinnitus or a unilateral decrease in hearing, further investigations would need to be undertaken.

[30] Mr Mott was also examined by Dr William Coman who is also an otolaryngologist. He said that although Mr Mott complained of the dizziness which was occasionally associated with loss of consciousness, no significant vestibular disorder was detected on carrying out the audiological and vestibular investigations. The loss of consciousness associated with dizziness suggested vaso vagal postural hypotensive reaction and was not indicative of any intrinsic labyrinthine disorder.

[31] Ms Harding-Clark again assessed Mr Mott on 10 June 2003. Ms Harding-Clark said that although his intellectual functioning appeared intact, he continued to demonstrate residual cognitive deficits following the accident. Areas of cognitive deficit included poor attention and concentration, distractibility, reduced attention to fine detail, severe impairment in verbal learning and memory functioning, impaired memory for complex visual information and difficulty switching cognitive sets. These deficits occurred against a background of reported significant levels of stress, anxiety and depression, along with motivational fluctuation and persistent headache. It was highly likely that psychological factors continued to interfere with Mr Mott's level of cognitive efficiency. Ms Harding-Clark thought that psychiatric management might assist and that she would expect his cognitive deficits to improve with effective remediation of his psychological problems. In a later report she said:

> "the nature of Mr Mott's work accident in December 1999 and the related history suggests he suffered significant psychological problems as a result of the accident."

[32] After viewing the reports of Dr Coman, Dr Bodel, Ms Harding-Clark and Dr Chittenden, Dr Saines said that he did not feel that Mr Mott had any significant structural damage to the vestibular end organ, had minor, if any, residual impairment as a result of organic brain damage and had an ongoing mood disorder which might require further attention.

[33] On 17 February 2004, Dr Miller was asked if a medical and psychological report relating to Mr Mott's worker's compensation claim for stress arising from a work incident in New South Wales in August 1996 was relevant to his present position. Dr Miller said that he could not see any relevance to the neurological symptoms he presented with, that is, headache and dizziness, nor to the cognitive symptoms, as

no mention of headache or dizziness were made in the reports of Dr O'Halloran or the psychologist, Mr Wenzell, in September-October 1996.

[34] Mr Mott's neurological symptoms are consistent with frontal lobe damage. This damage is relatively minor in itself but has left him with headaches and episodic dizziness and has exacerbated pre-existing personality traits to a point where he is no longer capable of withstanding the day-to-day buffetings of the interpersonal relationships in the normal workplace. Adding to his disabilities are the psychiatric and orthopaedic injuries suffered.

Psychiatric injury

[35] The borderline between neurological damage and psychiatric injury is not well marked in this instance. There is a clear overlap between the two. Mr Mott's psychological problems as a result of the accident were obvious from soon after his accident. When he returned to the Gold Coast Hospital on 10 January 2000, he was noted as having suicidal ideation.

[36] Mr Mott saw Dr John Chalk, a psychiatrist engaged by the defendant, on 23 April 2003 for assessment and report. He complained of disabling pain which commenced in his right temple and extended to the crown of his head and also to the forehead. The pain was associated with dizziness and with memory disturbance. He had been taking anti-depressants but they had not helped him and he still felt like killing himself. Dr Chalk said that Mr Mott had apparently been chronically disabled by his post-concussional symptoms since his accident. That had been associated with some depression which, unusually, had not responded to pharmaceutical treatment. Dr Chalk thought that his depression was of mild severity and did not explain his current level of disability. Dr Chalk concluded:

> "…whilst this man has undoubtedly had a mild head injury and a significant fracture to his wrist, he does not appear to have exhausted all treatment options and certainly I do not think that his depression is of such severity as to prevent him from returning to work through a formal rehabilitation programme. I am of the view that litigation in these circumstances is likely to be playing a significant part in focusing his mind upon his disabilities rather than on the future".

[37] Mr Mott was assessed by Dr Judith Chittenden, a psychiatrist retained by the plaintiff, on 12 June 2003. As well as speaking to the plaintiff, she obtained an independent report from Mrs Janita Neale, from whom he has rented a room since November 2002.

[38] Dr Chittenden reported that in the period after the accident Mr Mott had short term memory deficits, impulsivity, lack of logical thought and control of his life with continuing emotional lability, with anger, sadness and frustration often directed at others although dependent on others at that time and he had no one to give him real support which increased his erratic activity and behaviour. Due to his difficulties with memory, he appeared to have a degree of perseveration. Dr Chittenden also reported that he had a marked sleep disturbance with poor restless sleep at night, occasional nightmares (about general things rather than his accident of which he has no memory), and he would wake up in the early hours of the morning and not be able to get back to sleep again, feeling frustrated and irritable and worried about the

future. He had severe headaches accompanied by what he described as "head spins" being vertigo.

[39] Dr Chittenden reported that his marked irritability and aggression accompanying his frustration was with little or no provocation and fairly extreme towards those around him. He became increasingly anxious about his situation, having insight about his condition but not enough insight to be able to control his symptoms. This resulted in considerable depressive feelings which resulted in minor suicidal attempts on various occasions and a great amount of suicidal thinking.

[40] Dr Chittenden also reported that Mr Mott had difficulty in mixing due to his social "lack of graces" and, to a certain extent, his social inappropriateness, together with his initial memory impairment, minor impairment in language (difficulty in finding the right word and comprehending information), his marked difficulty in attention and disturbance in functioning (planning, organising, sequencing and abstraction) caused major difficulties, which appear to have been the main reasons for his inability to return to work and also to continue pursuing his martial arts, as he had difficulty in remembering sequences of actions etcetera. When he did try to return to work, she reported, his headaches and vertigo caused considerable problems.

[41] Dr Chittenden said that due to Mr Mott's obvious disturbance of mood with severe depressive features, he took medication of the SSRI type, but when seen by a specialist neurologist, this was changed to Deptran because it was thought that this would relieve his headaches and reduce his difficulties in sleep, which were major problems at that time. She reported that he was now undergoing appropriate rehabilitation with the North Coast Head Injury Service.

[42] In assessing him, Dr Chittenden said there was no evidence of any kind of over-accentuation or over-reaction when he recounted his history. Dr Chittenden diagnosed mild neuro-cognitive disorder as well as post-concussional disorder. With regard to his past and present psychiatric history and symptomology, she thought there were two alternative diagnoses: either mood disorder due to his general medical condition; or adjustment disorder with depressed mood. The mood disorder would encompass both his history of a traumatic skull and underlying brain injury accompanied by a subsequent severe depressive mood disorder as a result of his ongoing neurological symptoms which had severely affected his occupational, domestic, social and leisure time activities with decrease in self-esteem and self-confidence and an increase in frustration and resentment about his neurological condition, over which he had little or no control. Alternatively, the adjustment disorder would be due to Mr Mott's neurological condition which had caused disruption and disarray to his occupational, domestic, social and leisure time activities with an inability to recoup these due to his underlying neurological condition of which he had reasonable insight and a great deal of anger, resentment and frustration, which was ongoing.

[43] Dr Chittenden said that, in her opinion, whether Mr Mott suffered from a mood disorder or an adjustment disorder with depressed mood, his history suggested that he had a severe depressive mood disorder in the past and still continued to exhibit a depressive mode of thinking with recurrent severe depressive episodes where he could become quite suicidal in ideation, although denying recent suicide attempts. She made treatment recommendations including treatment by a specialist psychiatrist with an interest in head injury as well as by a clinical psychologist and a

social worker with an interest in head injury such as has already been offered by the North Coast Head Injury Service. He might also require help with regard to his domestic issues. He required some type of formal rehabilitation plan which might include some kind of return to work. However, Dr Chittenden thought this might be fraught with difficulties given Mr Mott's rather irritable, distractible and limited concentration profile.

[44] On cross-examination, Dr Chittenden reiterated her view, which I accept, that Mr Mott has suffered from ongoing depression as a result of his injuries and the difficulties that has caused to his ability to work and his personal relationships. He has, as she said, "psychological sequelae to his very real head injury".

[45] Dr Chittenden's prognosis was as follows:

> "In my opinion, Mr Mott is unlikely to perform at the level that he did previously, he is unlikely to earn financially the remuneration that he did previously as a result of his work, and due to his continuing neurological symptoms, is unlikely to work for the hours that he did previously, nor is he likely to be able to perform the same type of work intellectually or physically that he did previously.
>
> Mr Mott is able to cope with independent living, but requires input from a psychologist/social worker and possibly assistance to help him with less demanding work than he has performed in the past. It is quite possible that Mr Mott will find it extremely hard to obtain work on the open job market and may require some type of semi sheltered occupation where continuing input is given to him with regard to support and encouragement both for him and possibly his future employer.
>
> It is likely that any future relationships that Mr Mott has will be marked by difficulties due to his increased irritability and frustration and lack of personal control as a result of his neurological injury, together with his inability to financially earn as well as he did previously. In my opinion, it is possible that Mr Mott will not work in a formal sense again in the future.
>
> Mr Mott has a continuing mild to moderate level of depression which can become acute at times, particularly with regard to lifestyle setbacks, and which can send him into fairly suicidal mode at short notice. Mr Mott is likely to become recurrently depressed in the future with regard to his mood and there is a much higher possibility that he may self injure in the future as a result of his neurological state.
>
> In my opinion, Mr Mott's present psychiatric state is entirely secondary to his neurological deficits which, although not extreme, are diverse and comprehensive and are likely to cause extreme difficulty in any kind of occupational, domestic, social and lifestyle activities."

[46] In cross-examination, Dr Chittenden said his ongoing symptoms were consistent with mild frontal lobe disorder. That disorder accounted for much of his unpredictable mood and behaviour.

[47] Dr Chalk was asked to review his opinion once he had read the report of Dr White dated 17 June 2003, Therapy Solutions dated 12 June 2003, Ms Harding-Clark dated 8 July 2003 and Dr Chittenden's report of 14 July 2003. Dr Chalk concluded:

> "My view remains essentially the same. This man has had significant problems since the head injury that he suffered in December of 1999. The balance of evidence suggests that his ongoing difficulties are related to his emotional state and not to a 'dementing' type picture.
>
> That he has had psychiatric and psychological problems since would appear to be common ground but he has not had an adequate trial of supervised treatment so as to adequately judge his response and in these circumstances suggesting that his deficits are permanent, is in my view somewhat premature."

[48] In his oral evidence, Dr Chalk said that Mr Mott's organic brain damage was part of the explanation for his depression and emotionality. The frontal lobe damage had exacerbated his pre-existing personality traits. As well as that, he had reactive depression which led to major endogenous depression. The brain injury was not treatable but the depression, to the extent it was not organically caused, was treatable. There is, however, an overlap between the organic injury and the psychological effects of it.

[49] On 19 February 2004, Dr Chittenden also considered whether or not there was any connection between Mr Mott's workers' compensation claim in 1996 and the claim relating to the accident of 28 December 1999. She said that it was likely that Mr Mott's emotional condition had quickly resolved after leaving his place of work where there was a history of harassment and workplace bullying. Mr Mott had a quick temper and was a person who reacted badly to inappropriate or forceful criticism. There was no suggestion that he was generally an anxious person or had a paranoid personality disorder. In contrast, Mr Mott's condition at the time of her assessment of him on 12 June 2003 was that of a person who had a traumatic head injury, who was sufficiently injured to be transported from the Gold Coast Hospital to the neurosurgical unit of the Princess Alexandra Hospital in Brisbane. He continued to have evidence of brain trauma particularly of the frontal lobes in January 2001 on CT scan and an area of liquidity and later scarring in the right frontal lobe. He complained of dizziness and other symptoms and a third CT scan showed defined scarring of the right frontal lobe. She said there was thus no doubt about the brain trauma sustained which was significant, but resolved with conservative treatment. She said that Mr Mott has continued to have a considerable disturbance of temperament and volatility of mood, particularly depression. When last seen, he was living in a room being looked after by an older person and in receipt of a disability pension.

[50] She said that Mr Mott had a mild neuro-cognitive disorder and post-concussional disorder and a marked depressive mood disorder with a marked labile temperament. Although he had a quick temper previously and obviously responded badly to bullying, his temperament now was a reflection of the traumatic brain injury of his

frontal lobes (governing behaviour, temperament, frustration and control). Dr Chittenden said that she had real concerns as to whether Mr Mott was able to manage sensibly any moneys he might receive as a result of this litigation. She was inclined to feel that he required substantial help with his affairs although this might result in a stormy relationship with any financial adviser due to Mr Mott's impulsivity and temperamental difficulties.

[51] Dr Chittenden concluded that Mr Mott's injury in 1999 was very real and has had unfortunate consequences for him and is a permanent condition. There was no evidence of malingering or similar behaviour. Mr Mott had behavioural and temperamental consequences from his severe head injury of 23 December 1999, quite unrelated to his previous workers' compensation claim three and a half years previously.

[52] In summary, Mr Mott has suffered and continues to suffer from depression partly related to his neurological injury and partly as a result of the consequences for his personal and working life of the injuries he suffered on 23 December 1999.

Orthopaedic injuries

[53] In addition to the neurological and psychiatric injuries, Mr Mott suffered a fractured wrist. He returned to the Gold Coast Hospital on 10 January 2000 after saying that his plaster cast had fallen off. In fact, it appears that he took the cast off so that he could return to work. He said he was keen to return to work as his "wife has just left him and he feels he will go mad if stays at home". He was advised not to use his wrist for driving and lifting, and to return if pain persisted. He was given a certificate to return to work only in a supervisory role.

[54] Mr Mott saw his general practitioner Dr Linnett at the Parkwood Family Practice on 2 February 2000 with an intra articular fracture of the distal radius which had been plastered for two weeks and then bandaged for a further four weeks. X-rays revealed some callus formation at the distal radius and that he had a healing Colles fracture. He was advised at the time that the fracture was not at full strength but insisted on a return to work. Dr Linnett advised him that the injury was serious and that a return to work might damage the wrist. He was also advised that as the fracture was into the joint at that time, he might develop arthritis in the future.

[55] Mr Mott was examined by Dr David White, an orthopaedic surgeon, on 26 July 2001. Mr Mott complained to Dr White of problems consequent to his head injury being 'head spins … headaches and loss of memory' and that as a result he had tried to commit suicide. Dr White's area of expertise was however with regard to Mr Mott's wrist injury. Mr Mott told him that although his wrist was improved it continued to 'click a lot'. He had not noticed any swelling and had no complaints of pain. He was able to undertake his usual occupation without discomfort in the wrist. On examination there was no swelling or deformity in the right wrist and it did not appear to be tender. However, it lacked approximately ten degrees of dorsiflexion. All other movements appeared to be normal, however, marked audible crepitations were noted on movement of the wrist. Clinically, that is evidence of the development of arthritis.

[56] Dr White noted that plain x-rays of Mr Mott's wrist taken at the Gold Coast hospital on 23 December 1999, the date of the accident, demonstrated a fracture of the distal

radius involving the articular surface where there was an approximately two millimetre gap. Further x-rays taken on 26 July 2001, showed his fracture to have healed. There was no obvious irregularity of the articular surface of the distal radius. A spur had developed at the dorso-lateral corner of the lunate bone, however, which roughly corresponded to the previously noted gap in the articular surface.

[57] Dr White said that the injury to the right wrist had involved the articular surface and there were already signs of the development of degenerative change which was likely to be progressive throughout life. The actual extent, or the degree, to which that developed could not be stated with any certainty as it depended on the use to which the arm was put. Dr White said that in view of the fact that this was his dominant hand and that he was employed in a relatively vigorous occupation, significant degenerative change was likely to be present within the next five to ten years. This might necessitate consideration of a limited arthrodesis, although the exact extent of any surgery undertaken could not be predicted with any accuracy at that stage.

[58] Dr White said that he would regard the condition of Mr Mott's wrist as stable and stationary and that he had suffered a fifteen per cent whole upper body limb impairment as a consequence of the accident. With the development of sufficient degenerative change to warrant consideration of an arthrodesis this would have risen to the order of twenty to twenty-five per cent. Dr White said that he would regard Mr Mott as unfit for work involving heavy physical labour or repetitive use of the upper right limb for moderate physical tasks. On cross-examination, Dr White said that Mr Mott's condition was progressive and if he had engaged in heavy manual labour after the accident, as apparently he had done, then this was likely to have accelerated the degenerative process and pain.

[59] Mr Mott was examined by Dr Bodel, an orthopaedic surgeon in Sydney, on 2 August 2002, who said that Mr Mott had minor mechanical symptoms in the neck, the right wrist and the right hip but that from a purely physical point of view he should be able to cope with work except that he was having significant difficulty with dizziness and headache. Dr Bodel was of the opinion that his condition was now static and that he should be capable of moderate manual tasks including carpentry work although his head injury would probably make it difficult for him to return to work.

[60] When Mr Mott was assessed by the psychiatrist, Dr Chalk, on 23 April 2003, he complained of continuing problems with his right wrist. He had trouble holding things, got cramps when it was cold and it went 'clunk'. He could not use hand tools as a result.

[61] Mr Mott was reviewed again by Dr White on 10 June 2003. Mr Mott told Dr White that his right wrist was worse and that it clicked a lot and got very sore. Mr Mott said that his discomfort was particularly aggravated by cold weather although the pain was there most of the time. Dr White examined the wrist and saw no obvious swelling or deformity. Tenderness was general but particularly marked over the dorsal carpus. The wrist lacked approximately fifteen degrees of extension and twenty degrees of flexion. No crepitations were detected.

[62] Plain x-rays of his wrist taken on 10 June 2003 demonstrated significant hypertrophic spurring on the dorsal aspect of the small wrist bones and developing degenerative change at the scapho-lunate articulation. Dr White confirmed his earlier opinion and said that the current radiological evidence confirmed the prediction that significant degenerative change was likely to be progressive throughout life and warrant the suggested arthrodesis in time. Dr White said that the extent of the pathology apparent would indicate that definitive surgery was likely to be required within the next two or three years. The current day costs of this type of procedure were in the order of $2,000 for all medical attendants. A hospital stay of two to three days would be required followed by a convalescence of three to four months prior to the resumption of gainful employment requiring physical use of the upper limb. Mr Mott was, however, likely to remain permanently unfit for work involving heavy physical labour or repetitive use of the right wrist for moderate physical tasks.

[63] In oral evidence, Dr White said Mr Mott would be physically capable of supervisory work but doubted his capacity to do clerical work except on a limited basis. The movement of the joint associated with physical effort would accelerate wear and tear and subsequent development of post-traumatic osteoarthritis. While the pain and wear and tear would be reduced by immobilisation, this would also decrease flexibility and fine movements and therefore the utility of his right hand.

[64] If the pain was such as to require arthrodesis, the movement of his right wrist would cease altogether because the joint would be fused. A brace or arthrodesis would adversely affect his capacity to carry out the finer movements of cabinet-making and his ability to get into awkward places putting him at a commercial disadvantage in the workplace. Pain from post-surgical neuroma is not uncommon after arthrodesis. In Dr White's view, post-traumatic arthritis of the right wrist was inevitable.

[65] Dr Bodel reviewed his opinion about Mr Mott on 1 August 2003 at the request of the defendant's solicitors. Dr Bodel said the reports of the x-rays and the history of his wrist injury were consistent with Dr White's diagnosis that post-traumatic osteoarthritis was a distinct possibility. Dr Bodel said that the intra-articular nature of the fracture was the reason that the post-traumatic osteoarthritis could occur.

[66] In summary, Mr Mott suffered from a fractured right wrist which has left him with a fifteen per cent disability in his right dominant arm which will increase with osteoarthritic changes to a twenty to twenty-five per cent disability within a few years. This is in addition to his neurological damage and ongoing psychiatric injury.

Personal and work history before the accident

[67] Mr Mott was born on 3 May 1968, the fifth of six children, and educated to Grade 10 level in Sydney. He then completed a four year apprenticeship as a cabinetmaker. He thereafter worked primarily as a cabinetmaker also obtaining qualifications to drive a forklift, a bobcat, a front end loader, and he is also a scaffolder. Throughout his working life he worked as a cabinetmaker apart from a brief period where he worked for a company which removed asbestos. He was in constant employment working for a number of employers.

[68] Mr Mott worked for Crest Cabinets from April 1999 until the time of his injury as a sub-contractor. He was on the top grade (level 3) as a cabinetmaker and was paid above award wages. His employer, Peter Watkins, thought he was a good tradesman who "got the work done on the day, everyday".

[69] As a leisure time activity, he engaged in martial arts, teaching Zen Chi Ryu and obtaining a fourth dan black belt. He was unable to return to this after the accident. He had been a very active person, enjoying the beach, touch football and running. He was also active in house and garden maintenance and housework.

[70] Prior to the accident, Mr Mott was a meticulous, conscientious, orderly person who paid attention to detail, was reliable, stuck to routine, was a precise, careful, cautious, conservative person who disliked erratic change, was dependable, worked well without supervision, set high standards for himself and others, and was regarded as a good worker, particularly within the industry in which he was involved which required precision. He was a moderately ambitious person who hoped to eventually be able to run his own business in cabinetmaking or an associated area. He was also quite quick-tempered.

[71] Mr Mott was told that he suffered sexual abuse when he was three years old. He had no memory of it. It does not appear to have had a great psychological impact upon him. He had been involved in a number of relationships with women including four serious relationships but had never been married. He had a child born in 1987 and one born soon after his accident in January 2000.

[72] Mr Mott had had a previous workers' compensation claim in Sydney in August 1996, when he had been verbally abused by a foreman at Beny's Joinery where he had been working for about two months. He was dismissed from that employment in September 1996 and referred for counselling. Dr Michael O'Halloran, a GP who examined him, was of the opinion that inappropriate actions against Mr Mott in the workplace were the reason he was unable to maintain his employment there. He was of the opinion that Mr Mott had a pre-existing personality condition but that he had maintained his workload until he was persecuted in the workplace. Dr O'Halloran concluded that the employment at Benny's was a substantial cause of his leaving his employment and his requirement for counselling and rehabilitation.

[73] A psychologist, Gerry Wenzel, said in September 1996 that Mr Mott had developed a moderate to severe reactive depression and moderately severe levels of anxiety and needed anger management as well as general stress management strategies. Neither Dr O'Halloran nor Mr Wenzel were called by the defence, who relied upon their reports, to provide any further elucidation. It appears that his condition had satisfactorily resolved by the time of his accident in December 1999 and therefore has little relevance to this claim. Mr Mott did not refer to this incident in the history he gave to Dr Chalk or Dr Chittenden but only because he did not remember it as being significant or relevant to his claim. This does not make him an unreliable historian.

[74] Mr Mott's relationship with his de facto partner, Sue Mott, was very unstable at the time of the accident. He had changed his surname by deed poll in August 1999 from Luxford to Mott to be the same as hers but the relationship deteriorated. There was a short separation in about October 1999. By the time of his accident, they had separated temporarily and reunited. They separated permanently immediately after

the accident. She was close to giving birth to their daughter at the time of the accident. Their daughter was born in January 2000.

[75] Much was made of conflict which arose at Crest Cabinets involving Mr Mott prior to his accident. It is true that he had arguments with a tiler about such matters as not adequately protecting bench tops from scratch marks installed by Mr Mott and arguments with another sub-contractor when he tried to stop Mr Mott working during a break. On another occasion, he was very annoyed when it appeared an apprentice had lost Mr Mott's cordless screwdriver. These were never more than verbal stoushes. Mr Mott was somewhat of a perfectionist and intensely proud of his work. These kinds of disputes are not at all unusual in the building trade and were, to use the words of one of the defendant's witnesses, genuine disputes and not arguments just for the sake of argument.

Work and personal history since the accident

[76] Mr Mott returned to work at Crest Cabinets on 10 January 2000. He was from that time employed as a permanent wage employee rather than as a sub-contractor. Mr Watkins did this to try to assist Mr Mott. He wanted to help him out because he was a good employee. He continued working there until October 2000. He had a number of dizzy spells which necessitated the hospital visits to which I have earlier referred. Although Mr Mott's memory of it is different, I accept Mr Wakins' evidence that he was on light duties for the first two weeks and then returned to installing kitchens. Mr Mott was not being dishonest about this. He suffers from genuine memory deficits as a result of his injuries which were obvious in court.

[77] After he returned to work, Mr Mott suffered from headaches, giddiness and pain and grip difficulties with his right hand because of the injury to his right wrist. He left after an argument with a new foreman. What made this episode different to anything that happened pre-accident at work was Mr Mott's reaction. Before the accident, he had had verbal arguments but never reacted with physical violence to person or property even on an occasion where he was physically assaulted by being pushed.

[78] It appears that with the headaches and pain from which the plaintiff was suffering, he was unable to tolerate the interpersonal exigencies of the working environment. Added to that was the frontal lobe syndrome from which he suffered. His extreme over-reaction to provocation was consistent with someone who has frontal lobe syndrome. Although he had a rather quick-tempered perfectionist personality before the accident, after it, he suffered from much more impulsivity and volatility. His employer and fellow employees appeared unaware of the changes in his personality until his extreme rage and violent reaction on his last day of work which led to the police being called. His extreme self-centredness and inappropriate rages were, as Dr Chittenden said, consistent with frontal lobe injury. Such a person is likely to inflict great damage to his relationships as Mr Mott has done. Consistently with this, he has lost most of his friendships and now leads a quite isolated and lonely life.

[79] Mr Watkins gave evidence that Mr Mott had many days off. He was unaware however of his visits to the hospital. Although, Mr Watkins said Mr Mott was capable of being appointed estimator and foreman, when he had to make the

decision, he did not appoint Mr Mott. His personality after his injuries made him quite unsuitable for that position.

[80] Mr Mott worked for Superior Cabinets (Qld) P/L from 25 October 2000 to 7 March 2001. His net earnings were $7,736.69 or $430 net per week.[2] His maximum earnings in one week were $539.00 net. He was a casual employee but expected to work a 40 hour week. He was reluctant to complain because he feared losing work but he often had time off and finally left that work because of his headaches, giddiness and pain. During the time he was there he had another fall with some time off work. He thereafter worked at various employers for short periods of time, leaving because he could not cope with the pain. This work showed that he was capable of working as a cabinetmaker for a short period of time. The uncontradicted orthopaedic evidence was, however, that each time he did so, the work exacerbated the pathology in his wrist and hastened the onset of arthritic changes and was inadvisable from a medical point of view.

[81] Dr Chittenden said that after having stayed in hospital a minimal time, Mr Mott's follow-up appeared to be somewhat erratic (although he was given appointments, he often forgot the dates) and his rehabilitation appeared to be non-existent. She reported that he was given to understand that he could start work, however, when he tried to do so he found it extremely difficult and it was obvious that he was not coping. She said that it sounded as if he had made every effort to go back to work due to the fact that he could not stand being inactive and that his whole life previously had largely been composed by either his work, his martial arts, interspersed with normal domestic duties. She reported that he was frustrated and irritable with extreme lability of mood, he was in some considerable pain, particularly with headaches, it is likely that his ability to control his emotions was greatly diminished by the effects of his head injury.

[82] Mr Mott told Ms Harding-Clark that he left a job on the Thursday before his appointment with her on 15 October 2001 as he had difficulty carrying out his work duties because of pain. At that time, he was living with his de facto partner, Ronette, and her nine year old son. That relationship commenced in late 2000 but was turbulent due to the effects of the accident. Subsequently he entered into a relationship with a woman named Debbie which lasted seven months.

[83] During the nine months he was residing with Ronette, she performed a number of domestic services for him which she would not have performed had it not been for his injuries. Those services took six to eight hours a day.

[84] Mr Mott was employed as a casual by Red Jaffa Designer Kitchens at Port Macquarie from 27 August to 12 September 2002 assembling cabinets. He received $1,050.00 net. He left this job because of the pain he was suffering and has not been in the paid work force since. He is now on the disability support pension.

[85] Mr Robson, from the North Coast Head Injury Service, said on 3 January 2003 that the employment possibilities for Mr Mott were in cabinet-making or teaching self defence. Cabinet-making appeared an unlikely future job unless he were able to change into undertaking quotations for a cabinet-making company. To undertake that change he would require further training in literacy skills as well as computer

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[2] This amount derives from dividing his net earnings by 18 weeks, the number of weeks he worked at Superior Cabinets.

programming. However, Mr Robson doubted Mr Mott's capacity to undertake that job given his memory problems and Ms Harding-Clark's report of his moderate to severe impairment in complex verbal learning. So far as teaching self defence was concerned, that would appear to be too risky given his injuries.

[86] Mr Mott was seen by Stephen Hoey, an occupational therapist, from the firm Therapy Solutions, on 12 June 2003. Mr Mott told Mr Hoey that he attempted to return to work in January 2000. He worked full hours but completed light duties only. He had difficulties with dizziness, headaches, heavy lifting and repetitive or forceful use of his right hand and upper limb. Because of his ongoing difficulties he ceased work at the end of March 2001. Mr Hoey said that since that time Mr Mott had attempted work as a cabinetmaker with five to eight employers. In each of those jobs he had ongoing difficulties of the same type. He remains unemployed and is receiving a disability pension.

[87] Mr Mott reported to Mr Hoey that he had the following ongoing difficulties: constant headache; intermittent neck pain; vertigo and dizziness when rising quickly or when lying on his back; audible crepitus in the right wrist; intermittent right wrist pain made worse by cold weather or forceful or repetitive use of the hand; occasional tenderness in the right hip and buttock region; a loss of general flexibility; severely disturbed sleeping pattern; a feeling of general fatigue; short term memory problems; decreased concentration; a feeling of being stressed and frustrated frequently; ongoing mood swings; and increased irritability.

[88] Clinical and functional testing was undertaken of his functional capacities. That testing revealed that he had decreased range of motion of the right wrist in extension and ulnar deviation; pain in resisted extension; reduced grip strength in his dominant right hand; audible crepitus with movements of the wrist; decreased range of motion of the cervical spine in extension; sub-occipital tightness; bilateral tightness in the upper fibres of trapezius; and limited manual activities because of the decreased strength of the right wrist. There was a full range of motion of the right hip and strength was normal. There was a full range of motion of the shoulders and his strengths were normal. He could squat and kneel and his gait was unaffected. In Mr Hoey's opinion, Mr Mott had the following occupational restrictions: he was unfit for lifting loads greater than 10 kilograms; he had a reduced capacity for handling loads on a repetitive basis; restrictions with holding the neck in fixed postures; and restrictions with forceful or repetitive use of the right upper hand. As a result, he is now capable of occupations in the sedentary to light range only. He could not work as a cabinetmaker.

[89] Occupations for which he is reasonably qualified but now precluded because of his injury include cleaner, factory process worker and labourer, mining and construction labourer, agricultural and horticultural labourer, general labourer and road and rail transport driver. Hypothetically, he has a residual capacity for sedentary and light occupations such as car park attendant, service station attendant, courier driver and meter reader. However, as Mr Hoey said, a hypothetical physical capacity for work does not necessarily translate into commercial employment.

[90] Mitigating against his future capacity to gain commercial employment was the fact that he would be changing vocations at 35 years of age and therefore would be competing against younger, able bodied applicants for jobs in which he had no experience and training. He has no experience or qualifications in clerical, sales or

service occupations, and has no experience or qualifications with cash registers, computers or photocopiers. He has been out of the commercial workforce for greater than six months and now has a history of a compensation claim. Although physically capable of sedentary and light occupations, these factors will seriously impede Mr Mott's future searches for commercial employment. Mr Hoey's opinion was that Mr Mott's prognosis for future employment is poor. He is unlikely to secure commercial employment in the foreseeable future.

[91] Mr Hoey is an experienced occupational therapist who appeared to take a conservative approach. I was able to rely on his opinion as to Mr Mott's employability. Mr Hoey was cross-examined about Mr Mott's capacity to work as a foreman or an estimator. Mr Hoey gave convincing reasons as to why that would not be realistic. He has no previous experience supervising men; most estimating in the building industry is done by the person controlling the business; and most employers are unwilling to take on an employee who has an injury or who can not do all components of the job. Mr Mott did give evidence that he had some experience of being an on-site foreman with Crest Cabinets but it would appear that he did not have well-developed skills in that area and would not be able to do the physical work assisting other employees usually required of a foreman working in small business. He has no experience of doing the required graphic work on the computer or of pricing. Even if he could acquire these skills, he would now be incapable of the public relations skills that an estimator needs with members of the public who are the customers of the business.

[92] The orthopaedic surgeon, Dr Bodel, agreed with Mr Hoey's opinion that although Mr Mott is clinically capable of lighter duty work, he may have difficulty gaining work in the open labour market because of his difficulties with concentration and his ongoing memory problems and dizziness. Dr Bodel said Mr Mott's long term prognosis for return to work overall is somewhat guarded but he should be capable of light to moderate manual tasks purely from the physical point of view in association with the wrist injury. On cross-examination, Dr Bodel conceded that Mr Mott's wrist injury was such that an orthopaedic surgeon would advise against his working as a cabinetmaker.

[93] In Port Macquarie, Mr Mott lives with an older woman, Janita Neale, an aged pensioner, with whom he is not in a de facto relationship. He has rented a spare room with her since November 2002. She has observed that he suffers from short term memory loss and short concentration span which seems to frustrate him. She has also noted various mood swings. The physical symptoms she has noticed are that he is easily fatigued and that he has many problems with his right wrist which clicks a lot and gives him a lot of pain. She has noticed that he has had ongoing trouble with his neck and that he frequently suffers from severe headaches and from dizzy spells. She undertakes a number of household tasks for him, including washing, cooking and driving. The extra tasks she undertakes because of his disabilities take about three to four hours a day, three to five days a week. She also assists him with budgeting. She has tried to help him overcome his depression.

[94] Mr Mott continues to suffer from constant headaches of variable intensity, being unable to function at all when they are at their most severe. Even less severe headaches impede his capacity to work. He is prescribed morphine for these headaches. He continues to suffer from dizzy spells but his balance has improved. He wears a pressure bandage on his right wrist for pain relief in particular because it

has developed a bony spur. He is unable to use any of the heavier tools required of a cabinet-maker and lacks strength in his right arm. The movement in his right wrist is noticeably restricted and has an audible, indeed quite loud, cracking noise in his wrist when he attempts to extend its movement. It is increasingly painful.

[95] All of these physical symptoms have restricted not only his ability to work but also his capacity to engage in physical activities recreationally, such as martial arts, swimming and cycling. He continues to suffer from depression and a labile temperament although his suicidal ideation has decreased. He lacks energy and has problems with short term memory loss. He uses a diary to record everyday events to cope with his memory problems.

[96] He is now quite unable to work in his trade as a cabinet-maker. He has remained very motivated to obtain work but is now unable to do so. While none of his orthopaedic, neurological or psychiatric injuries alone might prevent him from obtaining and retaining paid work, when combined, they mean that he has become commercially unemployable.

Damages

Pain and Suffering

[97] Mr Mott has significant pain, suffering a loss of amenities for which he should be awarded $50,000.00. In addition, interest at 2 per cent[3] per annum on $20,000.00 should be allowed since the date of the accident. This is an amount of $1,700.00.

Special damages

[98] I propose to allow the agreed amounts of $706.00 to be refunded to Queensland Ambulance Service, $1,833.00 to be refunded to Princess Alexandra Hospital, $100.00 to be refunded to Mayne Health Diagnostic Imaging, $213.55 to be refunded to the Health Insurance Commission, $800.00 travelling expenses, $2,500.00 for future pharmaceutical expenses as reported by Dr Miller, $8,510.00 for future medical and rehabilitation services as recommended by the North Coast Head Injury Service as well as $4,000.00 for an arthrodesis. This is a total of $18,662.55 for special damages.

Economic Loss

[99] The accident and its consequent injuries have had, as the plaintiff submitted, a dramatic effect not only on his personal life but also on his employability. Prior to the accident, he maintained employment with a number of employers, not apparently having any difficulty in moving from one job to the next. As a result of his injuries, neurological, psychiatric and orthopaedic, he is now effectively unemployable.

[100] With the exception of the year ending 30 June 1997 when his earnings were reduced because of a Workcover claim in New South Wales, his average net weekly earnings for the period 1 July 1996 to 30 June 2000 were $411. In the financial year ending 30 June 2000, his average net weekly earnings were $497. In the period

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3 *Jackson v Bagwell* [1992] 2 QdR 390; *Camm v Salter* [1992] 2 QdR 342 at 345.

7 July to 13 October 2000, his net average weekly earnings were $525.55 and his average earnings at Red Jaffa were much the same. He earned less on average at Superior Cabinets but there his earning capacity was affected by his injuries. It is reasonable therefore to use approximately $500 net a week as the amount he would have been likely to have been able to earn and continue to earn if he had not been injured. From this should be taken the Medicare levy of 1.5 per cent for the past loss.[4] I have not deducted the levy from the $500 a week used to calculate the future loss as I have taken that to have incorporated the Medicare Levy.

[101] His past economic loss is the amount of $492.50 per week less his actual earnings. The earnings revealed were $20,811 from the defendant from the date of the accident to October 2000, $7,736.69 from Superior Cabinets from October 2000 until March 2001 and $1,050 from Red Jaffa in August and September 2002. However he had a number of other jobs for a short period of time for which he was paid in cash. I intend to deduct $10,000 to take account of those and other contingencies. His past economic loss is therefore $64,812.31. Interest should be allowed at 5 per cent per annum from the date of the accident until the date of judgment. This amount is $13,934.65.

[102] So far as future earnings are concerned, I am prepared to accept that there is no reason that he would not have continued working until the age of 65. However 15 per cent should be deducted for the normal contingencies both negative, for example that he may have suffered some other unrelated injury, and positive, for example that he may have obtained a position which paid better. It is appropriate to base this head of damage on $500 per week until the age of 65, discounted on the 5 per cent tables less 15 per cent which is $349,350.

Superannuation benefits

[103] It is appropriate to allow 9 per cent on the plaintiff's past and future economic loss as the amount he would otherwise have received for superannuation entitlements. It is however appropriate to discount that by a further 30 per cent to take account of the possibility that he would have worked as a sub-contractor rather than an employee. This gives a figure of $5,833.11 on his past economic loss and $22,009.05 on his income earning capacity for the future. Interest should be allowed on his past loss at least 3 per cent[5] giving $752.47.

Gratuitous care

[104] The claim for past gratuitous care was limited to assistance provided to him by his de facto partner Ronette. The claim for future care was based on the care currently provided by Mrs Neale. He has nevertheless, as was submitted, established a need for such assistance although it can not be valued with any mathematical precision. I would be prepared to allow a global amount of $5,000 for past gratuitous care together with interest of 2 per cent thereon being $430.00 and, as submitted by the defendant, $30,000 for future gratuitous care.

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4 Luntz, H *Assessment of Damages for Personal Injury and Death* 4th ed Australia: Butterworths, 2002 at para 5.2.3; *White v Combridge* (1984) 59 ACTR 18.

5 *Knight v Breakwater Island Resort Pty Ltd* (unreported, Supreme Court of Queensland, Williams J, 24 April 1995); *O'Brien v McMullen* [1999] QSC 208 at [58].

Protection order

[105] I have accepted the submissions of both parties that the plaintiff is not in need of an administrator of his award of damages as defined in s 12 of the *Guardianship and Administration Act* 2000. It is therefore unnecessary to allow by way of future damages fees that would be charged by the Public Trustee were it appointed to administer his damages award.

Conclusion

[106] In summary, there will be judgment for the plaintiff against the defendants. I award damages in the sum of $560,508.40 being: $50,000 for pain, suffering and loss of amenities; interest thereon of $1,700; special damages of $18,662.55; $349,350 for loss of earning capacity; $64,812.31 for lost earnings; $13,934.65 interest thereon; $4,083.11 for loss of past superannuation entitlements; $526.73 interest thereon; and $22,009.05 for the loss of future superannuation entitlements; $5,000 for past gratuitous services; $430 interest thereon; and $30,000 for future gratuitous services. I will hear argument as to costs.