SUPREME COURT OF QUEENSLAND

CITATION:	*Scott v Brannigan & Anor* [2012] QSC 64
PARTIES:	**JOHN DANIEL SCOTT** (applicant) **v** **JOSHUA JAMES BRANNIGAN** (first respondent) and **SHANNON DAVID GREEN** (second respondent)
FILE NO/S:	BS769/10
DIVISION:	Trial Division
PROCEEDING:	Application
DELIVERED ON:	19 March 2012
DELIVERED AT:	Brisbane
HEARING DATE:	16 March 2012
JUDGE:	Ann Lyons J
ORDER:	**That the respondents are jointly and severally liable to pay the applicant the sum of $75,000 by way of compensation.**
CATCHWORDS:	CRIMINAL LAW AND PROCEDURE – JURISDICTION, PRACTICE AND PROCEDURE – JUDGEMENT AND PUNISHMENT – ORDERS FOR RESTITUTION AND COMPENSATION – QUEENSLAND – where the respondents pleaded not guilty to offences of attempted murder and, in the alternative, malicious act with intent – Where the respondents were convicted prior to the commencement of the *Victims of Crime Assistance Act* 2009 (Qld) on 1 December 2009 – where the applicant suffered multiple injuries to his arm, chest and abdomen – where the applicant has suffered injuries to his mental health – where the applicant seeks criminal compensation for injuries sustained pursuant to the *Criminal Offence Victims Act* 1995 (Qld). *Criminal Offence Victims Act* 1995 (Qld), s 22, s 24, s 25, s 25(2), s 25(7), s 40. *Uniform Civil Procedure Rules* 1999 (Qld), r 105(1), r 110, r 389. *Victims of Crime Assistance Act* 2009 (Qld), s 154, s 155(1), s 155(2), s155(3).

McDonald v Appoo [2006] QSC 111.
Birch v Tevita and Janz [2008] QSC 96.

COUNSEL: F Muirhead for the applicant
No appearance for the respondents

SOLICITORS: Legal Aid Queensland for the applicant
No appearance for the respondents

A LYONS J:

Background

[1] On 3 November 2008 the first and second respondents Joshua James Brannigan and Shannon David Green pleaded not guilty in the Supreme Court at Brisbane to:

> Count 1 attempted murder; and, in the alternative,
> Count 2 malicious act with intent.

[2] On 14 November 2008 the first and second respondents were found not guilty of the first count of attempted murder and guilty of the second count of malicious act with intent. On 25 November 2008 I sentenced the first and second respondents to a period of imprisonment of eight years. A declaration of 36 days in pre-sentence custody was made and the convictions were declared as serious violent offences. On 11 November 2009 appeals to the Court of Appeal by the first and second respondents were dismissed and leave to appeal against sentence was refused.

This application

[3] The applicant applies for compensation under s 24 of the *Criminal Offence Victims Act* 1995 (Qld).

[4] This act was repealed by the *Victims of Crime Assistance Act* 2009 (Qld), which commenced on 1 December 2009. Division 6 of the *Victims of Crime Assistance Act* 2009 deals with Repealed and Transitional Provisions.

[5] Section 155(1) of Chapter 6, of the *Victims of Crime Assistance Act* 2009, provides that where a conviction occurs before commencement, a person may apply to the court for orders for criminal injuries compensation if section 154(1)(a)(i) applies to the person.

[6] The first and second respondents were convicted in the Supreme Court of Queensland at Brisbane on 14 November 2008. The conviction occurred prior to the commencement of the *Victims of Crime Assistance Act* 2009 and, therefore, section 155(1) is satisfied.

[7] Section 154 provides:

> "(1) This division applies if:
> (a) a person could have, if this chapter had not commenced, applied to a court for an order requiring the payment of

compensation for injury suffered because of a personal offence committed before the commencement, under-

(i) section 24 of the repealed Act; or

(ii) section 663B of the repealed Criminal Code chapter; and

(b) at the commencement, the person has not made an application under a provision mentioned in paragraph (a)(i) or (ii) for the injury."

[8] Section 24 of the *Criminal Offence Victims Act* 1995 provides that if someone ("the convicted person"):

(a) is convicted on indictment of a personal offence, or

(b) is convicted on indictment and a personal offences is taken into account on sentence

the person against whom the personal offence is committed may apply to the court for an order that the convicted person pay compensation for injury suffered because of the offence.

[9] The applicant is a person who could have applied under s24 *of Criminal Offence Victims Act* 1995 by reason of the fact that the applicant is the victim of a personal offence committed against him by the respondents who were convicted on 14 November 2008 upon indictment in the Supreme Court of Queensland. Section 154(1)(a)(i) of the *Victims of Crime Assistance Act* 2009 is satisfied.

[10] Section 155(2) of the *Victims of Crime Assistance Act* 2009 provides that an application must be made before the earlier of the following:

(a) the expiry of the period within which the person could have, if this chapter had not commenced, applied for the order mentioned in section 154(1)(a);

(b) the end of two months after the commencement.

[11] In relation to section 155(2)(b) of *Victims of Crime Assistance Act* 2009, this Act commenced on 1 December 2009. Accordingly under s 155(2)(b) an applicant had until 31 January 2010 to apply for orders from a court under section 24 of the *Criminal Offence Victims Act* 1995. This application was filed on 25 January 2010. Section 155(2)(b) of *Victims of Crime Assistance Act* 2009 has therefore been complied with and the application is within time.

[12] Section 155(3) of the *Victims of Crime Assistance Act* 2009 provides that the court to which the application is made must hear and decide the application under the relevant provision. Section 155(4) provides that for subsection (3), the repealed provision and any other provisions of the repealed legislation that are necessary or convenient to be used in relation to the application continue to apply as if chapter 6 of the of the *Victims of Crime Assistance Act* 2009 had not commenced.

[13] The offences were committed against the applicant on 30 September 2006, accordingly the application for criminal injuries compensation is commenced under the *Criminal Offence Victims Act* 1995.

[14] Section 40(1) of the *Criminal Offence Victims Act* 1995 provides that an application to a court for a compensation order against a convicted person must be made:

(a) within 3 years after the end of the convicted person's trial; or
(b) if the applicant is a child at the time of the trial - before the end of 3 years after the child becomes an adult; or
(c) with the court's order under section 41 - at any other time.

[15] The Dictionary contained in Schedule 3 to the *Criminal Offence Victims Act 1995* defines "trial" as follows:

> "…includes a proceeding in which a person is sentenced."

[16] The respondents were convicted in the Supreme Court of Queensland at Brisbane on 14 November 2008 and sentenced on 25 November 2008.

[17] The applicant therefore had three years from the date of sentence within which to file his application for criminal injuries compensation, that is until 25 November 2011.

[18] The application was filed on 25 January 2010 and has been filed within time under the *Criminal Offence Victims Act* 1995.

[19] Both respondents are currently serving a term of imprisonment in excess of three years at the Southern Queensland Correctional Centre. *Uniform Civil Procedure Rules* 1999 ("UCPR") r 105(1) provides that a person serving an originating process must serve it personally on the person intended to be served. In relation to prisoners, UCPR section 110 provides that a document required to be served personally must be served either on the Public Trustee, if they are the manager of the prisoner's estate under the *Public Trustee Act* 1978 (Qld), or the prisoner's litigation guardian, or the person in charge of the prison in which the prisoner is held. I am satisfied on the basis of the affidavit material before me that service has been affected on the manager of the Southern Queensland Correctional Centre. I am satisfied both respondents have been served.

[20] Rule 389 of the UCPR provides that if a step has not been taken for one year from the time of the last step a party who wants to take a step must give a month's notice to every other party. The application expired on 25 January 2010. Service was affected on the first and second respondents on 23 January 2012. The applicant sought to proceed with this application on 16 March 2012. I am satisfied that the respondents have been provided with one month's notice in accordance with the rule.

Circumstances of the offence

[21] The sentencing remarks of March 2007 outline the relevant circumstances as follows:

> "In the early hours of the morning of the 1st October 2006, on Marine Parade at the Gold Coast near the Grand Hotel, Mr Scott and Mr Williams were fishing from a pontoon in front of an apartment building where you were having some drinks and where you had had some cocaine. You had both had a large quantity of alcohol throughout the afternoon.

> Mr Scott and Mr Williams were drinking and noisy and a verbal altercation ensued whereby insults were traded between the two groups. However, nothing that Mr Williams or Mr Scott said or did could reasonably have provided the response from the two of you. It simply defies belief that in response to noise and insults from these two men, you armed yourselves with a baseball bat and a knife, got dressed, went down in the lift, across a road and into the park.
>
> I consider that the factual findings on the basis of the jury's verdict are these, that the both of you left the unit with the full knowledge that Mr Brannigan was armed with a baseball bat and prior to reaching the top of the pontoon, Mr Brannigan became aware that Mr Green was also armed with a knife.
>
> You both left the unit with the full knowledge that each was intending to threaten violence and then this evolved, with the knowledge of each of you, into intent to do grievous bodily harm to Mr Scott and Mr Williams.
>
> The insults offered by Mr Scott and Mr Williams were not sufficiently provocative to excuse or justify the reaction of the both of you. I do accept that there were some words used to the effect of "bring it on." Neither Mr Williams nor Mr Scott were initially armed with a knife and at no time was Mr Williams armed with a knife.
>
> Mr Brannigan initially assaulted Mr Scott with the baseball bat, rendering his left arm useless, and then assaulted Mr Williams with the baseball bat intending to seriously injure him. Mr Scott retrieved a filleting knife to defend himself and approached Green, who then stabbed him twice, intentionally causing grievous bodily harm to him.
>
> Mr Scott was bleeding profusely and was left seriously injured by both of you and you ran off when informed that the police had been summoned. You both tried to avoid detection by forcing the ambulance to stop in transit to the Gold Coast Hospital.
>
> But for the arrival of the paramedic Goeldner, Mr Scott would have lost his life. But for Mr Williams raising his left hand to protect his head, Mr Williams would have suffered serious head injuries at the hands of Mr Brannigan. Clearly the jury accepted that neither Mr Green or Mr Brannigan, you had an intention to kill either Mr Williams or Mr Scott. Mr Brannigan did assist Mr Williams in climbing out of the water."

Injuries

[22] In the sentencing remarks Mr Scott's injuries were described in the following terms,

> "Mr Scott suffered three main injuries, a stab wound to his left chest which caused a leakage of air into the chest cavity or pneumothorax, the second was a stab wound to the right upper chest that entered the chest cavity, perforating his lung, and then went into the liver, which

caused a significant laceration and life threatening amounts of blood loss. He also suffered a collapsed lung.

Mr Scott's arm was also broken in three places and he is now left with a permanent deficiency in the use of that arm. Mr Scott spent three months in hospital and has endured a number of procedures, including various surgical procedures on his injuries. He was also in an induced coma for some period of time."

[23] Dr Christopher Podagiel in his report dated 15 February 2007 states:

"Mr John Scott was transferred from the Gold Coast Hospital to the Princess Alexandra Hospital on 2 October 2006. At that time he was noted to have suffered the following alleged assaults:

1. Stab wound to the anterior chest,
2. stab wound to the right upper abdomen.
3. fractured left arm.

The best description I can provide of these wounds is that the left chest wound was through skin. The right abdominal stab wound was sucking and a deep wound into the muscle with muscle protruding out through the wound. X-rays demonstrated a fracture left olecranon, a fractured left ulna with a butterfly segment at the mid shaft and a free segment and a fractured left radial mid shaft. As a result of these injuries Mr Scott had additionally suffered bilateral haemopneumothoracies. A contained laceration to his liver and was haemodynamically unstable.

Mr Scott was originally taken to theatre at the Gold Coast Hospital urgently as he had been haemodynamically unstable. At this time he was found to have a damaged diaphragm which was repaired. There was a 5cm liver laceration which was actively bleeding so that >2.5 litres of blood was lost. Despite attempts at packing with Gelfoam and oversewing, this liver laceration continued to bleed. Therefore, further packing was applied and the abdomen enclosed. At this point the patient was too unstable for further exploration of his stab wound to the left anterior chest. Despite this intraoperative assessment and management of his orthopaedic injuries were undertaken. The findings included a Grade 1 compound fracture of the left olecranon which was comminuted, a segmental fracture of the left ulna and a transverse fracture of the left radius. At this time the median ulna and radial nerves were deemed to be intact and the radial pulse was found to be good. The wounds were extended and the skin edges and tract excised. Bone fragments were removed, the wound irrigated with saline and gauze pack applied. This wound was therefore packed and left open and a back slab of paris applied.

At this point the patient was transferred to the Princess Alexandra Hospital.

On 03.10.2006 Dr Andrew Hughes, a general surgeon and trauma fellow, took Mr Scott back to theatre for a second laparotomy with

removal of pack and pericardial window. At this point the peritoneal cavity was washed and no active bleeding was found. Also a pericardial window was performed with the evacuation of approximately 40-50ml of clear serous fluid.

On 08.10.2006, Dr Ben Hope, an orthopaedic registrar at Princess Alexandra Hospital, took the patient to theatre for a compound scrub of his open elbow fracture. The fractures were not fixed at this time.

On 16.10.2006, Dr Geoffrey Smith, an orthopaedic registrar at Princess Alexandra Hospital, took the patient to theatre for fixation of his elbow fracture. It was found that the olecranon fracture was highly comminuted with bone and cartilage loss. It was there fore not felt possible to originally fix this fracture. The matter was discussed intra operatively with Dr Mark Ross, one of our consultant surgeons. Provisional fixation was undertaken with K wires and one left in situ. A 4mm lad screw was applied to the ulna fragment and an Acumed olecranon palate applied to the proximal ulna and used as a template to reconstruct with proximal ulna. Bone graft was harvested from the iliac crest and missed with a gram of vancomycin and used to fill the cavity that had been formed. The wound was closed at this time. After this Mr Scott continued to improve and was discharged from Princess Alexandra Hospital on 18.10.2006.

Mr Scott was gain admitted to Princess Alexandra Hospital on 03.11.2006 and discharged on 21.12.2006. The reason for this was an infected plate in the left elbow. For this episode of care, Mr Scott required surgery on the following occasions:

1. On 07.11.2006 by Dr Geoffrey Smith for a washout and debridement of left elbow wound. The wound was debrided at this time and irrigated and dressings applied. The wound was left open for further assessment and debridement.
2. On 17.11.2006, Dr David Wheatley, for washout of left arm and affected metal plate, at which time the wound was felt to be clean and ready for flap coverage.
3. On 28.11.2006 by Dr Anthony Kane, for debridement of left olecranon wound and left radial artery forearm flap. At this time the soft tissue defect that had resulted from previous operations was going to be covered by a soft tissue flap harvested form the left forearm. However as the underlying issues and plate were infected, this was abandoned at the time as the chance of the newly laid flap becoming infected was too high.
4. On 08.12.2006 by Dr Pritpal Bansi who took Mr Scott to theatre for a change of dressing left elbow.
5. On 12.12 2006 Dr Anthony Kane performed a reverse lateral arm flap to the left olecranon wound.

> The wound was therefore closed at this time with flap coverage.
>
> As I have already stated Mr Scott was discharged then on 21 December 2006 for follow up with our infectious Diseases, Plastic Surgery and Orthopaedic Units.
>
> Mr Scott continues to undergo further medical and allied health treatment for his injuries."

[24] Mr Scott was examined by Dr Trevor Harris, Plastic and Reconstructive Surgeon, on 8 November 2011. Dr Harris, in summary, states that there are two scars due to the stabbing injury, one three centimetres in length in the left pectoral region and one four centimeters in length in the right lower costal region. Dr Harris states that all other scars of the chest, left iliac crest region and the left upper limb result from surgery that has been necessary to, firstly, maintain his life and secondly, repair the damage done to the liver and to the tissues of the left upper limb.

[25] Dr Harris states that there has been some affect on the nerve sensation in the left upper limb. Dr Harris states that the scarring will be permanent and he does not consider that any surgical treatment would have any significant effect on the scarring of the trunk.

[26] Dr Harris states that, in relation to the left upper limb, most of the scarring could not be improved by further surgery. Some of the deformity of the limb has occurred due to soft tissue loss and dysfunction following fixation of his left elbow.

[27] Dr Harris states that the long scar along the dorsal aspect of the forearm lies in a deep groove and some improvement could be possible, to excise this scar and re-suture, but it is unlikely that worthwhile improvement could be effected. Dr Harris estimates the cost of such procedures to be approximately $8,000.

[28] Mr Scott was examined by orthopaedic surgeon Dr Lloyd Toft on 25 October 2011 who stated that there was an obvious deformity of the left upper extremity, as well as considerable scarring around the left elbow. He also noted that the elbow movement was restricted to a flexion of 140 degrees and extension to 70 degrees and he indicated that there is a significantly reduced sensation of almost the whole of the forearm as well as an area of numbness on the lateral side of the elbow. He also notes the atrophy of the left arm and multiple body scars.

[29] Dr Toft indicated that x-rays show that there have been fractures in mid shafts of the radius and ulna which have been fixed with plates and screws. He considers that Mr Scott has eight percent upper extremity impairment and considers the sensory loss is not in a typical distribution and it would appear to be due to injury to the cutaneous nerves which include the medial, lateral and posterior antebrachial cutaneous nerves. He considers Mr Scott has a Grade III sensory deficit with a combined upper extremity impairment of eight percent and therefore gives an upper extremity impairment of 15 percent, which would equate to nine percent whole person impairment.

[30] He considers that it is probable that Mr Scott will develop degenerative arthritis in his left elbow joint and could require an arthrodesis of the elbow in ten to twelve

years time, the cost of which would be in the vicinity of $5,000. He considers that after a successful arthrodesis he would be left with a 30 percent upper limb extremity impairment which would equate to 18 percent of the whole person. He considers that Mr Scott's impairment is permanent.

[31] Mr Scott also saw Dr Ian Brown, a thoracic and sleep physician on 2 November 2011. Dr Brown considers that the injuries to the lung and liver had healed satisfactorily but that there is ongoing limitation in his activities of daily living because of pain and scarring in relation to the wounds. He considers that there are ongoing symptoms of cough, sputum production and intermittent wheeze related to asthma and bronchitis. He considers that half of the impairment of lung capacity is related to the injury and the surgical intervention and the other half relates to asthma and bronchitis. He considers this would represent a whole person impairment in respect of lung function of about 15 percent. He also stated that the injuries described of the pneumothorax and the bleeding involved in both the lung cavities as well as the injury to the liver were each life threatening injuries. Dr Brown considers there is a 20 percent impairment of the whole person in respect of lung function. He considers that 50 percent of this is permanent and 50 percent may respond to intervention.

[32] Dr Barbara McGuire, psychiatrist, provided a report dated 9 November 2011. She indicates that Mr Scott is suffering from post tramatic stress disorder and has symptoms of nightmares, flashbacks, avoidance behaviour, anxiety, irritability, hypervigilance and exaggerated startle reflex. Dr McGuire considers that Mr Scott is suffering from the disorder to a severe degree. In particular, Dr McGuire outlined the feelings that Mr Scott had when he knew that he had been stabbed and abandoned on the road where people were driving around him. He experienced panic and was taken to hospital via ambulance where he was in an induced coma for six days. Dr McGuire indicates that Mr Scott found the hospitalisation difficult and had hallucinations whilst on the morphine drip. He was in hospital for over three months. Dr McGuire also indicates that Mr Scott has anxiety and he also hates the look of his left arm and is embarrassed by it. He has been suffering depression and has had suicidal thoughts. He also has panic attacks and has lost 20 kilograms in weight.

Applicable law

[33] There is no doubt that Mr Scott has indeed suffered serious injuries as a result of a personal offence and that he is entitled to compensation for the affects of that injury pursuant to s 24 of the *Criminal Offence Victims Act* 1995. It is clear, however, that pursuant to s 25 the court is limited to not ordering more than the scheme maximum, which is $75,000. It is clear that compensation is assessed by comparing the injuries suffered to the injuries listed in the compensation table.

[34] Section 22 provides that the compensation ordered by the Court is not meant to reflect the amount of compensation that he would have been entitled to receive under the common law. It is also clear that the maximum amount is reserved for the most serious cases. Section 26(7) provides that if each of more than one convicted persons directly and materially contributes to an injury, the Court may make a compensation order against each of the convicted persons. Under s 26(8), where an order for compensation is made against more than one convicted person the total amount payable must not be more than the scheme maximum and must provide a

separate liability of each of the convicted persons scaled according to the convicted persons contribution to the injury. This section also provides for joint liability.

[35] I will allow the following assessments:

ITEM 16 Fracture/Loss of use of arm/wrist (displaced immobilised) Submitted Range 8 percent to 30 percent	X-rays demonstrated a Grade I compound fracture of the left olecranon which was comminuted, a segmental fracture of the left ulna and a transverse fracture of the left radius. The wounds were extended and the skin edges and tract excised. Bone fragments were removed. Loss of function and sensation in the left forearm due to injury to the medial, lateral and posterior antebrachial cutaneous nerves. Probable future degenerative arthritis in his elbow joint and could require an arthrodesis of the elbow in approximately ten to twelve years time, leaving him with a 30percent upper limb extremity impairment which would equate to 18 percent of the whole person. **I will allow 25 percent.**	$18,750
ITEM 26 Gun Shot/Stab wound (severe) Submitted Range 15 percent to 40 percent	1. Stab wound to the anterior chest; 2. Stab wound to the right upper abdomen. The left chest wound was through skin. The right abdominal stab wound was sucking and a deep wound into the muscle with muscle protruding out through the wound. The applicant also suffered a damaged diaphragm which was repaired. There was a five centimeter liver laceration which was actively bleeding so that more than two and a half litres of blood was lost. Ongoing limitation in the activities of daily living because of pain and scarring in relation to these wounds. Ongoing symptoms of cough, sputum production and intermittent wheeze relate to asthma and bronchitis. Both of these have been affected by a significant stress, anxiety and continued smoking. Half of the impairment in lung function is likely to be related to the injury and surgical intervention and the other half relates to asthma and bronchitis. Dr Brown states that this would represent an impairment of whole person in respect of the lung function changes of about 15 percent.	$22,500

	This impairment is consistent with the reduced exercise capacity outlined in the history. The improvement in lung function with optimal management of the airways disease including smoking cessation and satisfactory compliance with preventive treatment may bring a partial improvement. The potential improvement is about 50 percent of the total current impairment whereas 50 percent is permanent. **I will allow 30 percent.**	
ITEM 28 Facial Disfigurement or bodily scarring (severe) Submitted Range 10 percent to 30 percent	Two scars due to the stabbing injury: 1. one 3cm in length in the left pectoral region: and 2. one 4cm in length in the right lower costal region. The other scars of the chest, left iliac crest region, and the left upper limb result from surgery that has been necessary to, firstly, maintain his life and, secondly, repair the damage done to the liver and to the tissues of the left upper limb. Dr Harris states that he scarring will be permanent. Dr Harris states that in relation to the left upper limb, most of the scarring could not be improved by further surgery. Dr Harris states that the scarring of the arm above the elbow is reasonable. The flap of tissue covering in the elbow is somewhat flabby and redundant and could be reduced in thickness somewhat, but may require two operative procedures to do this. The degree of improvement may make this extra operative procedure not worthwhile. Dr Harris states that the scarring on the anterior aspect of the forearm is of good quality and could not be improved. Dr Harris states that the long scar along the dorsal aspect of the forearm lies in a deep groove, and some improvement could be possible, to excise this scar and re-suture, but it is unlikely that worthwhile improvement could be effected. **I will allow 20 percent.**	$15,000
ITEM 32 Mental or nervous shock (moderate)	Dr McGuire states that the applicant is suffering from posttraumatic stress disorder as demonstrating by his exhibiting the following symptoms; nightmares, flashbacks, avoidant behaviour, anxiety, irritability,	$24,000

	hypervigilance, exaggerated startle reflex. Dr McGuire is of the opinion that the applicant suffers from the condition to a severe degree. **I will allow 32 percent.**	
TOTAL	**107 percent.**	$80,250

[36] It is clear therefore that on the above assessments Mr Scott would be entitled to an award of 107 percent which is $80,250.

[37] Section 25(2) of the Act provides that the compensational order may only be for the maximum amount. Accordingly, the maximum amount is sought.

[38] Section 25(7) of the Act requires the court to have regard to any behaviour of the applicant that directly or indirectly contributed to the injury.

[39] Having considered the circumstances of the offences and the factors I am required to take into account, I am satisfied that the applicant did not contribute to the injury. I also accept the evidence of Dr McGuire that the "injuries inflicted upon him are solely responsible for the post traumatic stress disorder".

[40] I am satisfied, therefore, that the applicant should not have his award of compensation reduced.

[41] I am satisfied that Mr Scott is entitled to an award of the maximum amount payable, being $75,000, as I consider that the injuries inflicted on Mr Scott were severe and widespread. He nearly died and was indeed lucky to have survived. He was beaten and seriously stabbed in a senseless and unprovoked attack. That attack has had an enormous impact on his life. He required three months hospitalisation and has had to endure further surgery and hospitalisations on a number of occasions. He has impaired lung function and serious injuries were inflicted to his chest, abdomen and liver. He has widespread scarring. He is still in pain some five and a half years after the attack. He has deep psychological scars as well as obvious physical deformities. He is obviously physically affected and has a withered arm as well as the scarring.

[42] I take into account in particular the decisions of Atkinson J in *McDonald v Appoo*[1] and *Birch v Tevita and Janz*[2] in coming to a determination that the maximum amount payable is appropriate in the circumstances of this case.

[43] I consider that the respondents are jointly and severally liable for the award of compensation.

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1 [2006] QSC 111.
2 [2008] QSC 96.