# SUPREME COURT OF QUEENSLAND

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| CITATION: | *Austin v Parmalat Australia Ltd* [2013] QSC 227 |
| PARTIES: | **KEAN AUSTIN**<br>(plaintiff)<br>**v**<br>**PARMALAT AUSTRALIA LTD ACN 072 928 879**<br>(defendant) |
| FILE NO/S: | BS 5810 of 2011 |
| DIVISION: | Trial |
| PROCEEDING: | Trial |
| ORIGINATING COURT: | Supreme Court at Brisbane |
| DELIVERED ON: | 26 September 2013 |
| DELIVERED AT: | Brisbane |
| HEARING DATE: | 11, 12, 13 and 14 June 2013 |
| JUDGE: | Dalton J |
| ORDER: | **Judgment for the plaintiff against the defendant in the sum of $974,856.80** |
| CATCHWORDS: | TORTS – NEGLIGENCE – CONTRIBUTORY NEGLIGENCE – where the plaintiff worked for the defendant – where the plaintiff suffered injuries during a work accident – whether there was contributory negligence on behalf of the plaintiff<br><br>TORTS – NEGLIGENCE – CAUSATION – whether the plaintiff suffers from epilepsy or other psychiatric injury caused by the accident<br><br>DAMAGES – GENERAL PRINCIPLES – GENERAL AND SPECIAL DAMAGES<br><br>*Workers' Compensation and Rehabilitation Act* 2003 (Qld)<br><br>*Brown v New South Wales Trustee and Guardian* [2012] NSWCA 431<br>*Gold Coast Bakeries (Qld) Pty Ltd v Heat & Control Pty Ltd* [1992] 1 Qd R 162<br>*Ingot Capital Investments Pty Ltd v Macquarie Equity Capital Market Ltd* [2008] NSWCA 206<br>*Kirchner v ITT Water & Wastewater Ltd* [2010] QSC 413<br>*Malec v Hutton* (1990) 169 CLR 638<br>*Rodger v Johnston* [2013] QSC 117 |

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| COUNSEL: | J Kimmins for the plaintiff<br>M O'Sullivan for the defendant |
| SOLICITORS: | McCowans for the plaintiff<br>HWL Ebsworth for the defendant |

[1] The plaintiff sues for injuries he alleges were sustained during a work accident. The defendant conceded that primary liability ought to be found against it. It ran a case on contributory negligence and as to whether the injuries claimed resulted from the accident.

**The Accident**

[2] The plaintiff was born on 1 September 1971. He began working for the defendant on 3 March 2008 as a truck driver. He had long experience working as a truck driver for previous employers. On 29 November 2008 the plaintiff drove a truck and trailer from the defendant's South Brisbane depot to its Richlands depot. The trailer was loaded with crates of milk product in two litre plastic bottles. The two litre bottles were packed into plastic crates. Each crate held nine bottles and so weighed around 18 kilograms. The bottom of each plastic crate had a short lip running around, and slightly inside, its perimeter which provided some, but not much, stability when crates were stacked one on top of the other.

[3] On the day of the accident the plaintiff had not stacked the crates of milk product in the trailer he was to transport. That was not his job.[1] Someone else had stacked crates inside the trailer and they were stacked six high, and six wide across the trailer. The defendant's policy was that crates ought only to be stacked five high, but there was evidence which I accept[2] that loads were stacked six high on a regular basis.

[4] There were two sprung metal rods used to secure the load. These hooked into slots on the walls of the trailer to provide some restraint to the load moving in transit. The slots on the walls of the trailer were at a fixed height so that the restraint bars were at heights around the level of the second and fourth crates in the stack of six. The restraint bars could be only of indirect and limited effect on crates stacked above the level of the fourth in the stack. As well, the restraint bars were known sometimes to fall to the floor during transport.[3] There were various reasons for this – the restraint bars were of different sizes and care had to be taken to select bars of the correct size for the trailer involved;[4] some restraint bars were ageing and had become too elastic to stay in place.[5] As well, the walls of some of the trailers were flexible rather than stiff, so that during transit the walls moved and the restraint bars dropped to the floor. The trailer in question had flexible walls. The defendant knew or ought to have known of all these matters.

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1 tt 1-14, 1-70.
2 tt 1-14, 3-49.
3 tt 3-39, 3-45.
4 tt 1-84, 3-42.
5 tt 3-43, 3-48.

[5] The plaintiff's evidence was that he arrived at the Richlands depot and parked the truck and trailer on pavement adjacent to the loading dock area. He then went to the back of the trailer. Both doors needed to be opened and latched back before the trailer could be docked – t1-53. The trailer was to be docked, then unloaded. The plaintiff's evidence was:

> "Now, can you describe what occurred once you got out of the vehicle?--- Just normally procedure really. I walked around to the back there and I proceeded to open the right hand side door. There's two handles on the door. They're held together with what's called cam locks and the way to open is to undo your swing locks and then you can lift the handles out and as you just start to undo 'em, you'll be able to feel for a bit of weight on the door. And like, a good way to explain it is if you've got a door at home and somebody's leaning on the outside of the door and you go to open it, you're going to feel that there's something up against it. So technically you wouldn't actually open it. But it felt fine. It felt like there was no weight under it or anything like that. And as I went to proceed go open the door up, the weight of something just grabbed the door – that's when pretty well much it was a blur after that but the door obviously got---" – t1-17.

[6] The plaintiff was knocked to the ground when he opened the trailer at the Richlands depot on the day in question. He thought that he lost consciousness for a short time.[6] The plaintiff said he woke up on the ground, realised he had injuries to his head and was, with some difficulty, able to make his way into the depot where he was given assistance. The surface onto which the plaintiff fell was concrete – t 1-19. An ambulance was called and the plaintiff was taken to hospital. The plaintiff remained conscious and was able to walk from the depot to the ambulance. On every occasion when he was assessed after the accident, he was assessed to have a Glasgow Coma Score of 15. At hospital the plaintiff was noted to have two lacerations on his scalp. These were cleaned and closed. He was given pain relief. He was given a CT scan of his head. It showed no abnormality. He denied any loss of function, numbness, nausea or vomiting. He showed no abnormal neurological signs and was released home, after a few hours at the hospital.

**Contributory Negligence**

[7] Section 305F of the *Workers' Compensation and Rehabilitation Act* 2003 (Qld) provides:

> "(1) The principles that are applicable in deciding whether a person has breached a duty also apply in deciding whether the worker who sustained an injury has been guilty of contributory negligence in failing to take precautions against the risk of that injury.
>
> (2) For that purpose—
>
> (a) the standard of care required of the person who sustained an injury is that of a reasonable person in the position of that person; and

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6 I accept the medical evidence that it is difficult for someone to know accurately whether they have lost consciousness.

(b) the matter is to be decided on the basis of what that person knew or ought reasonably to have known at the time."

[8] The defendant pleaded three bases for a finding of contributory negligence against the plaintiff. First, the defendant contended that the plaintiff drove the trailer too fast so as to cause the load to shift during transit. There was no evidence of this[7] and it was not pressed in submissions. Secondly, it was pleaded that the plaintiff stacked the crates of milk product six high when there was a requirement, to which he ought to have adhered, that crates be stacked no more than five high. Once again, this matter was not pressed in submissions. The evidence (above) was that it was not the plaintiff's job to stack the crates in the trailer; someone else did that. The evidence (above) also was that crates were regularly stacked six high in the defendant's trailers. I reject the plea of contributory negligence on those two bases.

[9] The third basis pleaded for contributory negligence was that the plaintiff failed to remain behind the door (singular) of the trailer as he opened it. It was uncontentious on the evidence before me that it was proper practice, of which the plaintiff was aware, to open only one of the two rear doors to a trailer initially; to test whether there was weight on a door before opening that door fully, and to stand behind the door when opening it fully in case the load had shifted during transit and fell out the open door.[8]

[10] It was the defendant's case that the plaintiff opened both the rear doors of the trailer at the same time. In this way the case run at trial was different from that pleaded. There was no objection during evidence or during submissions. I am therefore satisfied that there was an acquiescence in the running of the case so that it is fair to determine the matter on the evidence in this respect rather than on the pleadings.[9]

[11] The plaintiff conceded that it would be possible to open both doors of the trailer at the same time – t 3-32. He had earlier said it would be impossible to do so – t 3-31. My view is that the inconsistency between these answers does not reflect poorly on the plaintiff's credit, but that in his early answers he simply did not understand the questions being asked of him.[10] Other witnesses also gave evidence that it would be possible to open both doors at once – eg. t 2-14. If one were to open a set of doors this way it would be dangerous as, if the load had shifted, the driver would be positioned right between the two doors as they opened, maximising the potential that he would be hit by any falling load – t 2-16. The plaintiff said that to open both doors at once would be like "committing suicide" – t 3-32. He said it was "a silly way to open a pair of doors" and "reckless" – t 3-32. The only evidence was that it was an incorrect and dangerous procedure to open both doors at once, and the truck drivers were aware of that. I find that opening both doors at once would involve such a failure to take reasonable care for one's own safety that it would amount to contributory negligence.

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7 cf t 1-16.

8 tt 1-17, 1-86, 1-87, 3-32.

9 *Ingot Capital Investments Pty Ltd v Macquarie Equity Capital Market Ltd* [2008] NSWCA 206 [424].

10 Compare another witness who at first said it was possible only to open one door at a time but then corrected himself to say it was not possible to open the second door until the first one was unlocked – t 1-86.

[12] The plaintiff denied that he opened both doors at once and, as per the extract at [5] above, said that he opened the doors in the proper way. He did not resile from that position in cross-examination – t 3-32.

[13] The strongest evidence in the defendant's favour on this issue is the fact that two workers, Mr Ekueti, and Mr Moncrieff, gave evidence that after the accident they saw both doors of the trailer standing open.

[14] When the plaintiff found his way inside the depot building after the accident, he was observed and taken to the office. He was given first aid and an ambulance was called. Mr Ekueti was sent out from the office with a torch to show the ambulance into the depot from the road. It was not until after the plaintiff had been taken away in the ambulance that he had "a good look at what was – where the trailer was and what was on the ground" – t 3-56. His memory was that the trailer was not docked and that there were two crates on the pavement, together with some spilt cream and what he believed to be blood. He thought there were bottles on the ground outside the crates but could not recall how many. He looked at the doors to the trailer and saw they were both open – t 3-56 – and when he looked inside the trailer he saw that the crates were stacked up six high but there were some crates on the floor of the truck that looked like they had fallen from the top of the stack – t 3-56. Mr Ekueti did not remember seeing Mr Moncrieff either at the office or at the trailer – t 3-59. Mr Ekueti remembered that he put the two crates into the trailer and hosed down the pavement – t 3-59. He did not move the trailer as he was not a driver – t 3-59.

[15] Mr Ekueti thought that he waited about 10 minutes for the ambulance – t 3-62 – and that it took another 10 to 15 minutes after the ambulance arrived before the plaintiff was taken away – t 3-63. He agreed with the proposition that it was about half an hour between the time he first became aware that the plaintiff had had an accident and the time he went out to start cleaning up the mess at the trailer – t 3-64. This time estimate is important in assessing how his evidence fits with that of Mr Moncrieff.

[16] Mr Moncrieff was a truck driver and was also delivering a load to the Richlands depot that morning. He pulled in behind the trailer which the plaintiff had been driving. He said:

> "I drove around the building and as I pulled up …. there was a truck in front of me or a semi-trailer in front of me with the doors open and maybe about 30 to 40 crates of milk – cream – milk crates on the floor with cream spilt everywhere but nobody around."

[17] He walked into the office and could see the plaintiff sitting in a chair and others helping him. He was told to, "stack all the crates up and put the truck on the loading dock or one of the docks" – t 2-4. He said he did that. He said:

> "And what method did you use to stack the crates?--- I restacked all the bottles into the crates because a lot of the bottles were on the ground and not necessarily in crates. I restacked – put all the bottles into the crates and then restacked them across the back of the truck and then when – I think I backed it onto the dock and then I restacked them all up, however high they would have been, so it was in a reasonably uniform row."

[18] Mr Moncrieff could not recall what he did after restacking the crates in the back of the trailer. He thinks he then drove the trailer onto a dock and went to report to the office that he had done so, but he had no actual recollection of this – t 2-5.

[19] Mr Moncrieff had not been asked to think about the matters in issue until very shortly before the trial – t 2-6, but he impressed me as both intelligent and reliable. I accept his evidence that there were numerous crates of milk product – many more than two – on the pavement. I think his memory is likely to be reliable as to whether or not he picked up about two crates of milk product or considerably more than that (30 to 40 he estimates). It was an unusual event and one likely to remain in his memory. He was careful in his evidence to distinguish between what he could remember, and what he said he believed he would have done. He made these distinctions unprompted and gave answers consistent with them when questioned more closely on the distinction – see for example t 2-5 l 5 and, for example, t 2-7 l 3 and l 43.

[20] When cross-examined about the number of crates he said:

> "I believe that there is no way that there was only two. The amount of cream spilt on the floor was more than was in the trailer, and it took me at least 10 minutes to restack the crates and put the product back into the crates and back in.
>
> So 10 minutes to restack 30 or 40 crates. Is that what you said?--- Yep.
>
> And then put them all back into the trailer?--- Lift them into the trailer and push them in. Yes.
>
> And then you had to, obviously, get into the back of the trailer to stack them one on top of the other. Is that correct?--- Yeah. I did that after I put the trailer on the dock. So I've restacked them back up---
>
> Well, no. Let's just go back. When you got there, you say there were about 30 or 40 crates on the ground?--- Yep.
>
> Outside the trailer. Is that what you're saying?--- Yes."

[21] Furthermore Mr Moncrieff was quite definite that he restacked the trailer rather than Mr Ekueti:

> "What do you say to the proposition that Mia was in fact instructed to go out and to re-stack the back of the trailer?--- Well, I know that didn't happen, so.
>
> What, because you say you did it?--- Yeah, definitely.
>
> And on your account, there'd be no opportunity for him to come out and to only find two crates on the ground; is that correct? That's on your account?--- What's that?
>
> Well, on your account it's impossible for him to have come out and found only two crates on the ground at the rear of the trailer?--- He may have. I may have left two crates with only the damaged product on the floor.
>
> Of?--- Of broken bottles – any bottles that were broken, I may have separated them from that but I don't recall any of that.

> Floor of what? Are we talking about the cement?--- Yeah, on the cement. Sometimes if I have ever had a spill, I might clean it up and I put the damaged product in one or two crates, stack up anything that's undamaged back into the load and leave the two crates separate of damaged product to be disposed of however the depot staff disposes that or so on.
>
> So there may have been two crates at the rear of the truck as – of the trailer---?--- Not at the rear of the truck but where the---
>
> The rear of the trailer?--- Where the spill had occurred.
>
> What, out in – on the cement?--- Yeah.
>
> Well, away from the dock?--- Yeah.
>
> And just left there; is that what you're saying?--- Not left there because I believed someone else was going to clean the product up. I believed that that they would have disposed of the damaged product.
>
> But no arrangement, according to you, was made for that to happen?--- Not that I'm aware of or not that I remember.
>
> You see, I put it to you that that just did not occur, that you were involved in re-stacking the back of the trailer?--- That I didn't re-stack the back of the trailer?
>
> That's right?--- I don't believe that to be the case at all. I do remember re-stacking that truck."

[22] I find that at the time of the accident 30 or 40 crates fell out of the back of the trailer, rather than two. I find that Mr Moncrieff put the 30 or 40 crates into the back of the trailer. I find that Mr Moncrieff attended the scene of the accident and restacked the crates into the trailer before Mr Ekueti came to observe the scene of the accident. At the time Mr Moncrieff went to the office the plaintiff was still in the office, being attended to. It seems likely that at that stage Mr Ekueti was out awaiting the arrival of the ambulance. It was also the plaintiff's recollection that Mr Moncrieff went to clean up while the plaintiff was still inside the office – t 1-21 – and the plaintiff's recollection that Mr Moncrieff returned to report that he had cleaned up while the plaintiff was still in the office – t 1-21. It may be that Mr Moncrieff left one or two crates of damaged product on the pavement and this is what Mr Ekueti saw when he attended later. It may also be that Mr Moncrieff did not immediately drive the truck onto the dock – on his evidence he could not recall whether he did that immediately or not. It may therefore be that the trailer was still on the pavement, undocked, when Mr Ekueti attended it. The alternative in my view is that Mr Ekueti's memory is at fault.

[23] My findings that Mr Moncrieff attended the trailer and restacked its contents before Mr Ekueti saw the trailer mean that Mr Ekueti's recollection that both doors to the trailer were open when he attended is irrelevant to my determination as to how the plaintiff opened the door or doors to the trailer. Mr Ekueti agreed with the proposition that you would not attempt to restack the crates in the back of the trailer with one door shut – t 3-66. By the time Mr Ekueti saw the trailer Mr Moncrieff had restacked it, so the fact that both doors were open when Mr Ekueti saw it does not bear upon how the plaintiff opened the doors.

[24] This makes Mr Moncrieff's evidence about the state of the doors when he first saw the trailer very important. When asked in examination-in-chief and in cross-examination about the back doors of the trailer, both times he gave an answer that he believed both doors were open, rather than stating definitely that they were open – t 2-3 and t 2-7. In cross-examination he said by way of clarification that he gave a statement of belief because he was 99.9 per cent sure, but not a hundred per cent sure, about this – t 2-7. As I say, I accept Mr Moncrieff as a reliable witness, but on his own evidence there must be some doubt as to his recollection on this point.

[25] Mr Moncrieff was cross-examined as to whether or not the number of crates he saw on the pavement could have fallen out with only one door open. He said that he thought the entire width of the top four levels of crates had fallen out – t 2-13. He was then asked:

> "Okay. And that can only occur, obviously, if both doors are open; is that correct?--- <u>If you had one door open, it would – could still fall like that but that's not what happened in this case.</u>
>
> Well, it couldn't have happened because the right door has to be opened first, is that correct?--- Well, you can open the left or the right door. Some of them open – the left door will open first.
>
> Well, the doors overlap, don't they?--- Yeah.
>
> So that you can't open the left until you open the right?--- Yeah. Some trucks it's the other way.
>
> All right?---- But yes, one – one truck, one door before the other, yes.
>
> Assume this one's the right door opening first. If you open the right door – I'll rephrase the question. For you to find the product that you saw on the ground, it would only be consistent with both doors being open for that product to fall the way it did?--- Yeah. Both doors together, yes." (my underlining).

[26] I read that passage as Mr Moncrieff acknowledging that the crates which did actually fall out could have fallen out with one door open, but stating his belief that that had not happened in this case, because he believed both doors were open and the product had fallen out both doors. He was not saying it was impossible for the number of crates which fell out to have fallen out if only one door was open, but he believed both doors were open in this case – see the underlined part. In any event, Mr Moncrieff was not an expert as to this matter. He was giving his opinion (which was not objected to) as a layperson with limited experience[11] in seeing loads like the one here fall. I do not regard the fact that 30 to 40 crates fell out of the truck as necessitating a finding that the plaintiff opened both doors of the trailer together.

[27] Furthermore, Mr Moncrieff's recollection that both doors of the trailer were open when he came across the scene of the accident does not necessarily mean the plaintiff's evidence that he did not open both doors of the trailer together was incorrect. The plaintiff relied upon evidence that there were 17 people working at the depot on the morning in question.[12] It was submitted that any one of them may

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11 t 2-14.

12 t 3-64.

have opened the second door of the trailer after the accident, and before Mr Moncrieff arrived and restacked the crates. There is no evidence that any other person went out to the trailer, but neither is there evidence that no one attended the scene until Mr Moncrieff did. There is evidence that at least one other employee in the docking area was aware of the accident – a forklift operator who was unloading in the depot at the time – t 3-77. Further, there were people in the office when the plaintiff was brought in for assistance and they were thus aware of the accident – t 3-78. It is possible that one of them attended the scene of the accident and opened the second door out of curiosity.

[28] Further, there is evidence that the trailer in question was not in good condition. It was inspected on or about 10 December 2008 and the condition was reported as follows:

> "Condition – Stainless floor is cracked badly, floor uneven, side walls are ply only and showing signs of wall rot at the bottom edges, Main floor bearers have rusted badly in critical areas, Doors are unserviceable.
>
> Summary – Floor and walls are the main structure of this trailer. Advise not to put maximum weight in this trailer as the floor will not handle forklifts. This floor has cracks in areas that indicate internal insulation and floor timbers are rotten. Due to the age of this trailer moisture entering the floor corrodes main bearers. These main bearers are showing signs of severe corrosion and are now 50% thinner than original. Suspected corroded areas indicate this trailer will require all new bearers and internal timber and insulation replaced. Side walls will be a issue in 12 to 18 mths.
>
> Cost to repair this trailer – Floor only $32,000.00. Rear doors $5,000.00 No Frig motor in trailer
>
> Value of trailer now - $4,000.00." – exhibit 1, p 99. (my underlining)

[29] No witness was able to shed light upon what the description, "Doors are unserviceable" meant,[13] although from the cost to repair – $5,000 – it appears there was some significant problem. As well, it is not known whether problems such as rotting floors and rusted bearers might influence the behaviour of the doors. The cam lock system depended on a metal bolt or tongue latching into the base of the trailer – t 1-55. The plaintiff submits that having regard to the poor condition of the trailer he may indeed have opened only one door and the second door may have come open as crates fell against it. If there were 30 crates weighing 18 kg each, a weight of 540 kg fell.

[30] Generally my impression was that the plaintiff was an honest witness. I discuss his demeanour and make more detailed comments about his credit below – see [45]. I reject the idea that he deliberately or consciously lied about opening both doors at once. I recognise there is a possibility that he does not remember at all and has convinced himself of a position to which he now honestly adheres, viz., he took proper care for his own safety.

[31] The contemporary documents probably favour the plaintiff more than not. The ambulance report mentions opening "doors" – exhibit 1, p 3. The hospital report is

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13 t 3-86.

more detailed and speaks of opening a "door" and checking for weight – exhibit 1, p 13. The site documentation uses the word "door" – exhibit 1, p 86. They are all hearsay, and all depend on the plaintiff's version of events. I do not put much weight on them.

[32] Looking at the plaintiff's likely actions objectively, I cannot see that there was any advantage to him in opening both doors at once, and he was not cross-examined along the lines that to do so would save time or be in any way more advantageous to him than opening one door at a time. They both had to be latched back individually – t 1-53. I think it is significant that, because of the cam locking system, a deliberate decision would have to be made to open both doors at the same time – both cam locks would have to be released individually and then two hands would be necessary, one to open each door. That is, it is not the sort of failure to take care that could occur through oversight or failing to put in place a protective mechanism. So, objectively, the plaintiff would have to have made a deliberate decision to do something he knew to be dangerous and there is no suggested motivation or advantage to him in doing so.

[33] It was accepted that the defendant bore the onus of proof on the issue of contributory negligence. In considering onus of proof issues, I must reach a position where I feel an actual persuasion on a preponderance of probability.[14] I am not persuaded that the plaintiff opened both doors at once. He says he did not. He knew it would be dangerous to do so. He would have had to act deliberately to do so, and I can see no reason for him to decide to do so. Mr Moncrieff may have been mistaken in his recollection as to both doors being open, although he was fairly certain on the point. Even if Mr Moncrieff is correct and both doors were open, there remains a possibility that the falling load opened the second door or that another employee opened the second door in investigating what had happened. On the evidence before me I cannot account for why the doors were open when Mr Moncrieff arrived, but I am not persuaded, even on the balance of probabilities, that it was because the plaintiff opened both at once.[15]

[34] The alternative position open to the defendant on the evidence, and the only position actually pleaded with respect to the doors, was that the plaintiff opened one door, but did not feel for weight on the door, and did not stand behind the door as he opened it so as to shield himself from any falling load. The plaintiff's evidence was that he did feel for weight, and did try to stand behind the door when he opened it – see the extract at [5] above. The plaintiff said, "I was standing behind the door" – t 1-18 – but the force of the falling load "just blew the door open on me" – t 1-55. There is no evidence to contradict this.

[35] The evidence from Dr Olsen was that if there was friction in the hinges of the door, or if the doors were out of alignment, so there was some pressure towards either the floor or the top of the truck, it may be difficult to open the door, and so, even if an employee did feel for weight, load against the door might not be apparent.[16]

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14 Fleming, *The Law of Torts*, 7th ed, p 286, the origin of which seems to be Dixon J in *Briginshaw's* case, (1938) 60 CLR 336, 361; see the cases cited at *Brown v New South Wales Trustee and Guardian* [2012] NSWCA 431 [52].

15 cf *Gold Coast Bakeries (Qld) Pty Ltd v Heat & Control Pty Ltd* [1992] 1 Qd R 162, 166-168.

16 Report 12 November 2012, p 5.

[36] Mr Bell, another driver, said:

> "I've seen it before where there has been a few crates that have fallen off into the back and no matter what, if there's weight on the back of that door, it doesn't matter how careful you are and that weight's on there, it's going to fall back regardless and push you out of the way or hit you or whatever." – t 3-48.

[37] If there were a large weight on the door – here perhaps several hundred kilos – there might be very limited opportunity and time to feel for weight or react appropriately if weight was felt. Further, standing behind the door might well be ineffective as a shield if over 500 kilograms of product fell against the door when it was opened. Once again, I am not persuaded on the balance of probabilities that the plaintiff did not open the doors correctly – checking for weight and standing behind the door. That the load fell and knocked him to the ground, as he said in his evidence, does not mean that he did not take these precautions.

[38] I therefore find that there was no contributory negligence on behalf of the plaintiff.

**Causation of Injury**

[39] The plaintiff says he suffered immediate pain and so forth at the time of the accident which took him a matter of days to get over. He says that there were permanent sequelae from the accident. First he says he suffered organic brain damage and was left with cognitive deficits: memory loss, loss of concentration, loss of balance, loss of motor co-ordination and recurrent headaches. Secondly he says he suffers from epilepsy caused by the accident. Third he says he suffers from post-traumatic stress disorder, adjustment disorder, anxiety and depressed mood from the accident. Apart from the immediate effects of the accident, the defendant contests that the plaintiff suffers any of the conditions he alleges as sequelae from the accident. I shall deal with each in turn.

**Epilepsy**

[40] The plaintiff's case was that he has a particular sub-type of epilepsy: he suffers partial epilepsy or absences in which he is in an altered state of consciousness, apparently blank or absent. The defence case was that the plaintiff was consciously feigning epilepsy; had a psychiatric disorder in which he subconsciously mimicked epilepsy, or did have epilepsy, but of genetic origin, not caused by the accident.

[41] After the immediate effects of the accident the plaintiff felt quite normal and returned to work. He says this situation deteriorated. The hospital made a follow-up phone call to him a few weeks after the accident. He reported problems and was assessed at the hospital by an occupational therapist who diagnosed a post-concussion syndrome. The plaintiff was then off work on WorkCover for nine weeks and at the end of this time was re-assessed as fit to work. He did begin working again, but on 9 April 2009 made an elementary error in failing to secure a load at work. An accident resulted. The plaintiff found this behaviour unaccountable. With hindsight the plaintiff attributes this accident to the first of the epileptic absences of which he was aware – t 1-28.

[42] The plaintiff consulted his General Practitioner who referred him to a neurologist, Dr Melinda Pascoe. Dr Pascoe gave evidence before me. There are often

difficulties when a treating doctor attempts to give evidence in litigation and in my view these were particularly acute in the case of Dr Pascoe. She raised the dilemma herself in cross-examination.[17] As well, it seemed to me that Dr Pascoe's thinking about the issues relevant to me was rather undisciplined, disorganised and imprecise.

[43] The evidence as to epilepsy was unusually complicated and I summarise it, and my view of it before giving detailed analysis and reasons. Dr Pascoe thought that the plaintiff suffered from epilepsy and that the epilepsy was caused by the accident. When she ceased treating the plaintiff, Professor Eadie took over that treatment. He gave two reports to the plaintiff's General Practitioner and was called to give evidence by the defendant. In contrast to Dr Pascoe, Professor Eadie presented a coherent and thoughtful opinion on the plaintiff's condition. Professor Eadie had long experience both as a clinician and as an academic and approached the matter of the plaintiff's condition in an objective and scientific way. He did not rush to a diagnosis of epilepsy, but came to that view slowly over two consultations. His opinion was that the plaintiff had a genetic type of epilepsy, not caused by the accident. This was based largely on his view that the plaintiff suffered from myoclonic jerks. His view was that if the plaintiff did not, in fact, suffer from those jerks, he did suffer from epilepsy, but of a non-specific type. The defendant called Dr Ohlrich who had examined the plaintiff for the purpose of earlier WorkCover proceedings and for this litigation. His view was that the plaintiff was *probably* either feigning epilepsy or in some unspecified way was otherwise presenting with symptoms of epilepsy, though he did not in fact suffer from it. The defendant also called Dr Kar, a psychiatrist, who took the view that the plaintiff did not suffer from epilepsy but subconsciously mimicked it. I record that the plaintiff called Dr Campbell, a neurosurgeon. Some neurosurgeons treat epilepsy surgically; he does not – t 2-27. He does not diagnose epilepsy – t 2-28. Sometimes neurosurgeons see epilepsy if it is associated acutely with head injury – t 2-27. In that last respect, he had expertise relevant to the issues I must decide.

[44] I prefer the evidence of Professor Eadie and find that the plaintiff does indeed suffer from epilepsy. However, I reject his view that the plaintiff suffers from juvenile myoclonic epilepsy as I see this as based on incorrect information given by the plaintiff. I find that the plaintiff's epilepsy was caused by the subject accident. I now descend to the detail of the expert evidence to explain the reasons for these findings. Before I do so I will address the plaintiff's credit, and that of his mother, as it figures significantly in the discussion which follows.

**Credit Findings**

[45] Both the plaintiff and his mother were unsophisticated people. They both struck me as being a little out of the ordinary in their responsiveness to questioning and my impression is that they would appear a little out of the ordinary in everyday life.

[46] The plaintiff's evidence was that he left school halfway through Grade 10. He said:

> "And what were – how did you find school? Did you do well at school or not so well?--- Oh, school was all right but it was a – had a lot of fallouts with teachers and all that as well. It – school was something that I didn't really enjoy and it's always been a good

[17] t 3-15.

> example set from the families that, while most people were playing sports and so forth, I'd be the sort of bloke that sit inside a house and pull apart an engine or pull apart a clock or something and put it all back together so that was my interest, anything mechanical. But anything theory wise or literature wasn't really much of an interest for me so I didn't really like school for that reason." – t 1-12.

[47] In cross-examination, material was put to the plaintiff which demonstrated that at a fairly early stage in his schooling he had been the subject of some attention from the Stafford Guidance and Special Education Centre. His gross and fine motor skills were apparently poor and so was his participation in class activities and his communication. When his school records are examined it is apparent that in Years 8, 9 and 10 he rarely achieved over 50 per cent in any subject, including physical education and manual arts. Most of his ratings are between 20 and 40 per cent, but some are well below that – exhibit 11. Neither he nor his mother really accepted the burden of the school assessments, although the plaintiff's mother did recall that the school had contacted her due to behavioural problems which she attributed to sibling rivalry.

[48] I have no reason to doubt the assessments which were made and recorded in the contemporaneous records of the Education Department. They are consistent with the plaintiff's presentation in the witness box. I found him fully co-operative with the Court process but his manner was just slightly odd. He assumed some unusual and awkward physical postures or attitudes in the witness box. His manner of answering questions, word choice, and the content of his answers were also consistently slightly unusual. I notice that Professor Eadie makes some reference to unusual behaviour in his initial report to the General Practitioner, see the extract at [57]. Dr Ohlrich does too.[18]

[49] My assessment was that the plaintiff did not necessarily comprehend and communicate as well as the ordinary person; sometimes he seemed old-fashioned or somewhat stilted in his mannerisms and responses, and there were times when I was not satisfied that genuine communication was occurring, notwithstanding that was the apparent content of the language used. I tried to satisfy myself that he understood what was being discussed when the topic of myoclonic jerks was raised with him. I had the impression that he made a sincere effort to communicate with me, but I am not certain that in fact happened – see t 3-34. The plaintiff's mother was similar in her demeanour. I thought she was a genuine lady who was sincerely doing her best, but having difficulty with the need to be responsive and precise – for example, tt 1-80-81.

**Medical Evidence as to Epilepsy**

[50] Dr Pascoe first saw the plaintiff on 22 April 2009. Her thoughts about his condition and management are recorded in a series of letters to his General Practitioner. In April 2009, she did not clearly diagnose anything, but suggested further investigations including brain MRI; a prolonged ambulatory EEG to see if there was evidence of epileptic activity, and an assessment by a psychologist because she was worried that he might have anxiety or post-traumatic stress disorder as a result of the accident. The EEG tracings from the ambulatory report were assessed by

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[18] Report 24 May 2012, p 6, and 3 April 2013 file note, second last sentence.

Dr Pascoe. They were not available for use in the litigation. Dr Pascoe's contemporary assessment was that they were abnormal. Her report was that there were electrical changes suggesting a "lowered seizure threshold" but no overt epileptic activity. At the top of this report of 12 May 2009 against the words "provisional diagnosis", Dr Pascoe wrote "? epilepsy". The MRI was unremarkable. Dr Pascoe started the plaintiff on medication, Topamax, an anti-epileptic drug "to see if we can prevent further turns". She recommended that he see a psychologist in relation to "the issue of cognitive impairment and particularly stress related issues".

[51] On 22 June 2009 Dr Pascoe saw the plaintiff again and reported, "He still has mild vague episodes, perhaps related to alcohol. He saw a neuropsychologist who confirmed that he has a very mild organic brain disturbance, with a significant post traumatic stress disorder." She then gave the opinion that the plaintiff had "mild epilepsy as a consequence of his work related injury and a post traumatic stress disorder". Dr Pascoe conceded that she had no expertise to diagnose a post-traumatic stress disorder and that nor had the psychologist to whom she sent the plaintiff.[19] Another ambulatory EEG was undertaken. Again, the tracings have been lost and all that is available is Dr Pascoe's interpretation of them. This time on the form against the words "provisional diagnosis" she records, "epilepsy ? control". Again she notes electro-physiological evidence of a disturbance in brainwave function, suggesting a lowered seizure threshold. Her conclusion was, "The Ambulatory EEG is minimally abnormal".

[52] On 8 July 2009 Dr Pascoe reviewed the plaintiff again. She took him off Topamax recording that he had not "done well" with it and "feels woozy in the head". She wrote: "I've suggested that Kean stop Topamax, even though I believe he has mild epilepsy". She referred the plaintiff to a psychiatrist because she wanted to "optimise his anti-depressive medication". It is not recorded what this medication was, who had prescribed it, or who, if anyone, had diagnosed depression.

[53] On 16 September 2009 Dr Pascoe performed another EEG which again she described as "mildly abnormal", with "no overt epileptogenic activity". The plaintiff reported an increasing number of absences since ceasing Topamax so she re-commenced him on it. On 28 October 2009 she changed the medication to Keppra. She records the plaintiff reporting "3-5 vague episodes a day". On 13 November 2009 another EEG was performed by Dr Pascoe and reported by her as being minimally abnormal with no overt epileptogenic activity.

[54] On 30 November 2009 Dr Pascoe reported that on his new medication the plaintiff was very well with "no auras" for a couple of weeks and what she described as a quiescent EEG. Similarly on 11 February 2010 Dr Pascoe reported "no turns" since October 2009. At that point she gave him clearance to drive. On 1 March 2010, however, the plaintiff reported "a recent turn while driving" and Dr Pascoe recommended increasing the medication Keppra and recommended that he cease driving. The letter to the GP reported, "Unfortunately Kean had a funny turn while driving recently. He said it was not as bad as previously and he certainly felt it coming on. This is a little different to his previous episodes … Kean's had a further mild turn … He is now surrendering his driver's licence." In May 2010 Dr Pascoe reported that, "Kean continues to be relatively well but has had a couple of turns,

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19 t 3-9.

particularly at the computer and with roadworks". She again recommended increasing the Keppra and ended her report by saying she was leaving her practice in Brisbane.

[55] Dr Pascoe gave a report for the litigation dated 3 June 2013. In her report to the Court (see below) she says that she hopes the psychiatrist could "help with medication for his stress disorder" and records that it is a side effect of Topamax that it "can cause exacerbation of depression" and that it was for this reason she decided to discontinue his medication. She also says that she referred the plaintiff to a psychiatrist for treatment for "his depression".

[56] In this report she gives her opinion that the plaintiff:

> "Presented with symptoms consistent with partial epilepsy and absences. These symptoms were temporally related to an injury sustained while at his workplace in 2008 and associated with a significant head injury and scalp laceration. His head injury appeared significant with memory loss of unknown duration and subsequent 'collapse'. … Mr Austin had superimposed Post-Traumatic stress which was contributing to his symptoms. His Neuropsychological profile confirmed a mild organic brain injury and a significant post-traumatic stress disorder. When I last saw Mr Austin he continued to have mild and frequent absences and his stress disorder appeared appropriately treated."

[57] After Dr Pascoe left Brisbane the plaintiff was sent to Professor Eadie to treat his epilepsy. In his initial report to the plaintiff's General Practitioner he recited the history of the accident in November 2008; the diagnosis of post-concussion syndrome, which he rejected as a clinical entity;[20] the return to work, and the April 2009 incident where the load was not secured. He said of the time after this:

> "… because of concern about this EEG studies were done and he was told that he had petit mal epilepsy and treated with topiramate and, when this did not suit him, levetiracetam, of which he is now taking 1000mg twice daily. Despite this he continues to have episodes in which his wife [says] he looks blank and his head may slump forward. I found it difficult to get a clear history of the episodes or of how frequent they were but the more I talked the more the wife told me of more and more episodes. One had occurred when he was driving. He has been forbidden to drive. However, he still rides a motor bike. He ceased taking his levetiracetam for a week and he had more episodes. His wife says he has become very difficult to live with and irritable.
>
> There seems nothing else relevant in the past history or family history except that he says that flashy lights distress him. He does not seem to get jerks with the lights but says he occasionally gets jerks at other times.
>
> Examination:
>
> I really found no neurological or general abnormality though his blood pressure was low at 115/75. However, during examination he was greatly disturbed by my looking in his eyes with an

[20] See report to GP, 27 July 2010.

> ophthalmoscope and he would not tolerate me flashing a light in his eyes. He made a lot of groaning sounds, hardly exerted any voluntary power and in general behaved in a rather strange way which may simply reflect anxiety but I thought there was no neurological disease."

[58] Professor Eadie concluded:

> "Though features in his history are suggestive of epilepsy I am not entirely sure how reliable the whole story in its details is. Clearly levetiracetam does not suit him and I have suggested weaning him off this over the next month and substituting Epilim beginning with 200mg twice daily and working up to 400mg in the morning and 500mg at night. If he can tolerate that dose it would be simpler to switch him to the 500mg dosage units, one twice daily. At that stage, in about six weeks, I would like to see him and do his EEG but I am concerned as to how reliable a diagnosis of epilepsy is and yet it would be hazardous to cease treatment and see what happened. In any event I think at the moment he is not suitable to be driving trucks or a motor bike." – report to GP, 27 July 2010.

[59] Professor Eadie followed up on 7 September 2010. He wrote to the General Practitioner that the plaintiff was much happier on Epilim, "though he could have had one possible episode at night". He said that his EEG was "not particularly stable" and therefore thought he ought to continue the Epilim treatment for the present but, if he went six months without any known lapse of consciousness, Professor Eadie would be prepared to look at the question of him driving on a limited basis. Mr Austin failed to follow up his treatment with Professor Eadie. He thought that Professor Eadie only wanted to see him if he could go six months without any suspicious episode.[21] The EEG which Professor Eadie performed in September 2010 he reported as showing "non-specific abnormality of a rather paroxysmal nature and one possible local disturbance in the right temple region".

[60] The defendant called Professor Eadie. His view was that the plaintiff did have epilepsy and that it was juvenile myoclonic epilepsy. This is a genetic form of epilepsy not caused by head injury. Professor Eadie found the history of absences, sometimes associated with flashing lights, suggestive of juvenile myoclonic epilepsy. However, central to his diagnosis of juvenile myoclonic epilepsy was the report which the plaintiff made to him that he gets myoclonic jerks of his body at times, independently of absences.[22]

[61] I have no doubt that the plaintiff did report to Professor Eadie that he suffered from jerks. Professor Eadie has a contemporaneous note of his consultation. The relevant part is:

> "She [the plaintiff's de facto] hasn't seen jerks. Speech muddled after one [absence]. He is a bit cranky. Bright flashing lights cause them [absences]. Flashing lights upset him. Occasional jerks when sitting." (my underlining)

[62] Clearly enough from his note, Professor Eadie was interested to elicit information about his patient's suffering from jerks and took this up with both the patient and

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21 t 1-32.

22 t 2-45 and t 2-50.

his de facto. He was recording information in his treatment notes for his own use, not for the purpose of litigation. It was a very relevant matter to his mind. From his evidence it is clear that his clinical experience over many years has led him to approach the topic in a particular way. He said this in his evidence:

> "Okay. And can that juvenile myoclonic epilepsy not be picked up during the juvenile years?--- Yes. Well, it may not even start in juvenile years. It's an epilepsy that typically begins about the age of 15 or 16 but it can begin as early as five or six and it may not come until the twenties and thirties. And the diagnosis is nearly always missed, if one doesn't ask leading questions. It was only first recognised in 1958, despite epilepsy being written about for 3000 years, and it's that people didn't get the histories of these jerks and patients never volunteer that. One has to use the leading questions to get that story. One gets the story of going blank and having convulsions when they occur but often the people have had jerks for several years before the series of jerks goes into a convulsion and then they come to attention.
>
> All right.
>
> HER HONOUR: What – can I just ask, I don't understand. What do you mean? I'm – I don't understand what you're talking about 'jerks'?--- They're sudden twitches that occur, nearly always in the upper part of the body. They're very brief. Unless they're of large amplitude, patients largely seem to think they're normal. If they're large amplitudes, they're apt to drop things.
>
> Is this in association with an absence or is this separate?--- The absences are really just going blank but there's probably a brief interruption of consciousness in some of the jerks and absences are present in the minority of juvenile myoclonics – a fairly substantial minority – and it merges to a couple of other forms of epilepsy where are purely absence ones.
>
> What did Mr Austin tell you about jerking? I'm not sure that's recorded anywhere, is it?--- Well, I've only my notes and I've written jerks down there but I haven't recorded verbatim what I was told. They're basically my summary for my own purposes and I would have asked that as a leading question because in my handwritten notes, it's coming quite late in the account, and I think it's when I basically didn't know the sort of epilepsy he had, and started to – Dr Pascoe had used the term petit mal, which is a superseded term, and had different meanings in Europe and in America and Britain. But the absence in Britain and America was actually the petit mal, but in Europe, it was any little turn. So she may have really thought that was a diagnosis, but I can't read her mind. So I basically saw, or heard, the story of what would pass as absences, and then by asking the question about jerks, satisfied myself that he was getting jerks from his statements. But I can't amplify that, I'm afraid.
>
> All right. And that's – it's that, is it, that alerted you to the idea that it was juvenile myoclonic epilepsy?--- I think it would have. Yes.

> All right. And is that essential to your diagnosis; that is, if he didn't have jerks, could you diagnose what you have – juvenile myoclonic epilepsy?--- On the evidence I had then and since, no. Nothing else was specific.
>
> If it weren't – if everything else remained the same, but there were no history related by him of these jerks, what would your diagnosis be?--- I would, I think, have had to leave it as epilepsy of undetermined type, which I'm afraid is the situation that seems to have play about half of the time." – t 2-44-45. (my underlining and my corrections to transcript in shading).

[63] The plaintiff was recalled so that the conversation recorded in Professor Eadie's notes could be put to him. He denied telling Professor Eadie that he had occasional jerks. He also denied that he had jerks. The plaintiff's mother was also recalled so she could give evidence about this matter. She told me that she had never seen her son have jerks – t 3-35. Her son had lived with her for most of his life. They still see each other regularly. The effect of Professor Eadie's evidence was that if a person was suffering from the type of myoclonic jerks relevant to his diagnosis it would be noticed by those observing the patient and by the patient themselves (notwithstanding the patient may very rarely report it, without specific questioning).[23] I accept the evidence which the plaintiff gave to me on this topic was honest. Likewise I accept the evidence which his mother gave to me was honest.

[64] I accept that the plaintiff told Professor Eadie that he did occasionally suffer from jerks when that was not the case. Professor Eadie was frank both in examination-in-chief and in cross-examination that the history of jerking came out of leading questions – t 2-48 ll 25-35. As noted above at [45]-[49], my assessment is that the plaintiff sometimes appears to understand and communicate when there is no true communication taking place. He goes along with a conversation. I think he likely agreed with Professor Eadie's leading questions in this vein, not being consciously dishonest, but participating superficially, and inaccurately, in what was going on. Because the answer was given in this way, it is not at all surprising to me that the plaintiff denies giving the answer to Professor Eadie. It was not true, and meant nothing, or almost nothing, to him at the time. In those circumstances he would not be likely to remember giving it. Now his attention has been focussed on it as significant to the litigation, it seems obvious to him that he would not have given false information to Professor Eadie, and he denies having done so.

[65] In my view, the plaintiff does not suffer myoclonic jerks, and never has. In those circumstances, I prefer the opinion of Professor Eadie, extracted at [43] above,[24] that the plaintiff does suffer from some sort of epilepsy but it is not juvenile myoclonic epilepsy. In reaching this conclusion I reject the opinion of Dr Ohlrich given as an independent expert for the defendant in the matter. Dr Ohlrich's opinion in his report was as follows:

> "Mr Austin has suffered from episodes of varying frequency since approximately March/April 2009 following a mild head injury on 29 November 2008, during the course of his employment. During these episodes he seems to go blank for up to 30 seconds. I note that

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23 tt 2-51-52; t 2-52.

24 And at t 2-51 and t 2-53 l 45; t 2-54.

> he has fallen on two occasions, apparently with these episodes, once sustaining a black eye when he struck a kitchen bench and on another occasion he suffered a soft tissue injury to his left wrist. He says that with one episode he wet himself but not badly.
>
> There are no specific epileptic features to the episodes and no associated temporal lobe phenomena.
>
> His EEGs have shown non specific temporal lobe abnormalities with no frank epileptic activity.
>
> I do not consider that his blank spells are epileptic in origin and the EEG abnormalities are likely to be coincidental. The diagnosis of epilepsy can be difficult to completely exclude. If the episodes are epileptic I do not consider that they relate to the mild head injury that he sustained during the course of his employment on 29 November 2008."

[66] Dr Ohlrich called the plaintiff's condition pseudo-epilepsy, something he did not explain terribly much either in his reports or his evidence. He said:

> "HER HONOUR: Well, what does that mean?--- It means that the episodes that – pseudo-epilepsy indicates that a person is having episodes which may resemble epilepsy but in fact are not due to epilepsy. Now, that may have various causes. The person may consciously feign epilepsy or the person may subconsciously – in other words, not conscious feigning an epilepsy – in other words just the patient may not be aware or consciously producing the episodes. But the main point is that the episodes are, although they resemble epilepsy, are not due to epilepsy." – t 2-62 (my transcript correction shaded).

[67] Dr Ohlrich did not know that Professor Eadie considered the plaintiff to suffer from epilepsy – his understanding was to the contrary. He readily acknowledged that he would give weight to Professor Eadie's opinions.[25] In his evidence, as in his written report, Dr Ohlrich made it quite clear that he could not exclude the diagnosis of epilepsy.

[68] It weighed heavily in Dr Ohlrich's opinion that Mr Austin never described any temporal lobe phenomena such as strange tastes, strange smells, a feeling of déjà vu, a feeling of disembodiment, etc, during the periods of absences – t 2-66. Nor did he elicit any history of phenomena such as jaw clenching, eyelid flickering, etc, during the periods of absence. He would expect such descriptions from, and about, a patient who truly experienced epileptic absences. His view was the lack of report of these phenomena was not "an absolute indicator that the turns are not epileptic".[26] He came to the conclusion he said, "on the balance of probability", that what was going on was not epilepsy. He said this in evidence:

> "… Now, the diagnosis can be very – the differentiation between pseudo-epilepsy and epilepsy can be very difficult to differentiate and it may only occur, as I've indicated in my report, over a period of time. With careful monitoring, which I would have preferred his treating neurologist to have carried out, over a period of time it may

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25 t 2-64.

26 t 2-66, transcript correction in shading.

> become apparent that episodes were or were not epileptic and this would be the way that one would normally proceed in the management of a patient with this type of problem and you'll remember that I said that I could not completely exclude the diagnosis but it was – of epilepsy but it was my opinion that he did not suffer from epilepsy on the balance of probability. Am I making myself clear?" – tt 2-66-67.

[69] I am not entirely sure what Dr Ohlrich meant by saying he formed his view on the balance of probability. I doubt he uses the phrase in the way lawyers do, i.e., I doubt he has mistaken his role for mine. Nonetheless it does not assist in assessing his opinion. I think he used the phrase to mean that his opinion is not beyond doubt, and indeed that was clear – he could not rule out that the plaintiff suffered from epilepsy. He thought the risk that the plaintiff does have epilepsy was sufficient to warrant a recommendation that he continue not to drive or operate heavy machinery until the matter was put beyond doubt.[27]

[70] Dr Kar is a psychiatrist called as an independent expert for the defendant. Dr Kar thought that the plaintiff had "abnormal illness behaviour" which was "unconscious and not deliberate". He thought that Dr Pascoe's reports and diagnoses, together with her EEG studies, had increased the plaintiff's stress and convinced the plaintiff he had epilepsy when in fact he did not.

[71] Dr Kar is more qualified than a layperson to give an opinion as to medical matters generally, including outside the area of psychiatry. It must be the case that psychiatrists need to deal with diagnoses of medical conditions outside the field of psychiatry in order to come to a conclusion that a patient does not have a physical illness but a psychiatric one which resembles or even mimics a physical condition.[28] Dr Kar was quite clear in his report, and in his evidence, that he used the on-line resource Mediline Plus to research the signs and symptoms of epilepsy in order to give his opinion that the plaintiff did not have epilepsy. No doubt Dr Kar is better qualified than a layperson to comprehend and analyse such information and assess the significance of it in relation to a patient. Nonetheless, I prefer the neurological opinions to Dr Kar's on the question of whether the plaintiff has epilepsy, and I do not think that he would quarrel with that approach – see his reference to the debate between the neurologists at p 7 and following of his report, and see eg., tt 3-27-28.

[72] I do not think that the plaintiff is consciously feigning epilepsy. I do not think he is sophisticated enough to continue to feign illness for the time, and to the extent, he has since 2008. I do not think he is sophisticated enough to have given dishonest evidence for the better part of a day. In any case, the objective indicators are against it. It seems to me most unlikely that if the plaintiff were minded to feign an injury resulting from the accident he would choose to feign epilepsy, and in particular, a rather lesser known type of epilepsy – partial epilepsy or absence epilepsy – which, when it really does result from a head injury, manifests some months after the injury in a way (for a layperson) apparently unconnected with it. I cannot see that this relatively uneducated, unsophisticated man would choose this rather obscure illness with its obscure connection to the accident, rather than some more likely sequelae, such as injury to the neck or back if he determined to feign

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27 Report 26 November 2009; report 24 May 2012.

28 This was Dr Kar's evidence – t 3-26.

some injury as a result of the accident. To feign absence epilepsy would require a great deal of information about the symptoms and the likely time of occurrence. It was not suggested to the plaintiff that he had undertaken any research or otherwise come by such information. Further, it is to my mind exceedingly odd that a plaintiff would consciously decide to feign epilepsy in circumstances where coincidentally, his EEG tracings have proved to be abnormal, and abnormal in a way consistent with the rather obscure disease he has chosen to feign. It was not suggested to the plaintiff that he had previously had any EEG readings, or knew that his EEG tracings were abnormal and consistent with epilepsy. Further, if he wished to choose an illness or injury to feign for secondary (monetary) gain, an illness which prevented him driving, which he did not only for a living, but also as recreation (motorbikes and speedway), seems a very poor choice.

[73] The question whether the plaintiff is a suggestible person who, when he received investigation, and then treatment, from Dr Pascoe, came to believe (wrongly) that he had epilepsy is a more difficult question. This was Dr Kar's opinion, and while I treat that with respect, I must note that his reasoning is premised on his conclusion that the plaintiff does not have epilepsy, and he works from that premise to explain the symptoms the plaintiff reports as proceeding from an abnormal state of mind.

[74] As I have explained, I do not put great store on the professional opinions of Dr Pascoe. My assessment of Professor Eadie is however to the contrary. He struck me as an experienced and thorough clinician. He was of course a treating doctor. However, as his letters to the plaintiff's General Practitioner, and his evidence demonstrate, he took a dispassionate and objective view of the plaintiff. It is clear from the reports he made to the plaintiff's General Practitioner – [57] and [58], that he did not regard him as a run-of-the-mill case from the beginning, but sought to form a conclusion on a slightly odd presentation. He has come to a considered view on a difficult presentation. I prefer Professor Eadie's view to Dr Ohlrich's view. In part this is because Dr Ohlrich himself expresses doubt about his opinion and because he does not articulate any reasoning (other than feigning which I reject) to support his conclusion that the plaintiff has what he calls pseudo-epilepsy. Whether there is such reasoning, I do not know, but if he will not articulate it, I cannot judge its strength. Once feigning is discounted, his evidence came down to little more than a circular assertion that the plaintiff does not have epilepsy because he has pseudo-epilepsy, which is a condition where one reports the symptoms of epilepsy but does not have epilepsy – see [66] above. Insofar as he does articulate reasoning for his view, it is based on a failure to report temporal lobe phenomena. Having seen the plaintiff for the better part of a day, and seen his mother, I think I am somewhat more prepared than Dr Ohlrich to make allowances for the plaintiff having difficulty in communicating sensations which, in anyone's estimation are odd. In any event, Dr Ohlrich acknowledged that this failure to report temporal lobe phenomena did not exclude a diagnosis of epilepsy.

[75] All the neurologists agreed that all the EEG reports on the plaintiff were consistent with, but not themselves diagnostic of, epilepsy.[29] The plaintiff, the plaintiff's mother (t 1-79), the plaintiff's de facto wife (t 1-90) and a friend of the plaintiff's de facto wife (t 1-99) all gave evidence that the plaintiff suffers from absences. I accept this evidence. The plaintiff says he had never experienced absences before the accident – t 1-29 and t 1-63. I accept that evidence. The plaintiff's mother said

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29 Eadie, t 2-49; t 2-54 l 35; Ohlrich, t 2-63; Pascoe, t 3-6.

she has never seen her son have an absence before the accident – t 1-80. I accept her evidence about that.

[76] The plaintiff and his de facto wife both give a history that the plaintiff began to suffer absences about four to five months after the accident.[30] The onset of absences after a period of months following a head injury is what one would expect clinically.[31]

[77] If the plaintiff were to be hospitalised; have his anti-epileptic medication withdrawn, and have continuous EEG monitoring whilst being videoed at the same time it would be possible, in Dr Ohlrich's view, to come to a definitive diagnosis one way or the other for, if an EEG is undertaken at the time when a patient is suffering an epileptic episode, it will be possible either to ascribe the episode to what is happening on the neurological trace or not.[32] As appears from the extract at [68] above, Dr Ohlrich is critical of the plaintiff's treating doctor for not doing this. On the other hand, Professor Eadie regarded it as impractical because it would involve EEG monitoring for days – t 2-55. I have had some difficulty determining what use I should make of the fact that, despite having had Dr Ohlrich's report since 24 May 2012, the plaintiff has not taken this step which would put the matter beyond doubt. On the other hand, nor has the defendant required the plaintiff to do so. The defendant did not submit I should make anything in particular of the plaintiff's failure to undergo this testing. That is, both sides were content for me to determine the matter on the evidence before me. I am not undertaking a scientific enquiry, and I do not have to be satisfied to the point of scientific certainty. On the evidence before me I am comfortably satisfied on the balance of probabilities that the plaintiff does have epilepsy. I turn to the question of whether or not that was caused by the subject accident.

[78] Dr Pascoe thought that the accident had caused the injury. She expressed that view on the basis that the head injury suffered in the accident was "significant". I do not know what the factual basis for that assessment was. In cross-examination she said she assessed the injury as "mild" – t 3-11. The issue raised before me is whether or not the head injury was sufficient to have caused epilepsy.

[79] Of the head injury Professor Eadie said, "Well, I didn't think that it was an adequate sort of head injury to explain any brain damage, and so I really didn't seriously consider it at the time. I wasn't seeing him for legal purposes. …. I was basically seeing him to try and sort out his treatment." – t 2-45. It is evident from Professor Eadie's evidence that he discounted the head injury as a cause of the epilepsy partly because it was minor, but also partly because he had decided that the plaintiff had juvenile myoclonic epilepsy which was genetic, not acquired – see t 2-47:

> "Right. In any event, if we *just* look at the epilepsy, did you see anything in respect of this injury caused by the – being struck by the crate – the crates which would cause epilepsy?--- I really didn't think it was a sufficient cause.
>
> HER HONOUR: Because it was so minor?---- Because it was minor and because it was the wrong sort of epilepsy to go with it."

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30 The plaintiff thought that the first absence coincided with the accident at work in April 2009 – t 1-28, and as to the de facto wife, t 1-90.

31 t 2-56, t 2-30.

32 t 2-63.

[80] Dr Ohlrich was concerned that the head injury which the plaintiff suffered was only mild, but conceded that it was possible for a mild head injury to cause epilepsy – tt 2-62-69. Dr Kar expresses opinions on whether or not the reports of the head injury suffered by the plaintiff were significant enough to cause epilepsy. I think that opinion is well within the neurological field and prefer the evidence of the neurologists as to this.

[81] Epilepsy which follows a head injury is the result of damage to the brain itself.[33] One factual difficulty in this case is that there was no witness to the accident so it is not known exactly how the plaintiff's head was injured.[34] The lacerations to his scalp were, in my view, most likely caused by the edges of plastic crates falling onto his head. The plaintiff cannot remember how he fell. It is known that he fell onto a concrete pavement. It is not known whether he hit his head on the concrete. The plaintiff says he lost consciousness in the fall, but he thought that loss of consciousness was brief. The difficulty is that in the absence of other witnesses, a person is not really able to say that they have themselves lost consciousness, or for how long, for what they experience may be a period of amnesia, rather than a period of loss of consciousness. No abnormal Glasgow Coma Score ratings were observed, and no neurological signs were evident at the hospital, on the day of the accident. CT imaging on the day showed no abnormality of the brain and later MRI by Dr Pascoe showed no abnormality, but this in itself does not mean that the injury received in the accident was not sufficient to cause epilepsy – Professor Eadie, t 2-54; Dr Campbell, t 2-30.

[82] I think that in the scheme of things the plaintiff suffered a fairly mild head injury but all doctors conceded that a mild head injury could cause epilepsy.[35] In this case there is evidence which I accept that the plaintiff never suffered epileptic absences before the accident, but suffered them after the accident. Not only that, the plaintiff and his de facto report that he began to suffer them some months after the accident, which is consistent with Professor Eadie's opinion that a brain injury resulting from an injury to the head could cause epilepsy "often after some months and it can be up to 20 years or so".[36] The plaintiff's head injury may have been mild and thus unlikely to cause epilepsy – t 2-69. However, in my view, having regard to the evidence of epileptic activity after the accident but not before it, and having regard to the time of onset of the epileptic activity after the accident, this accident did cause this plaintiff to suffer epilepsy.

**Other Cognitive Damage**

[83] As recounted in the initial part of this judgment, the plaintiff returned to work after the accident and appeared to function normally. However, after a follow up telephone call from the hospital which had initially treated him for his head injuries, he spent nine weeks on workers' compensation. During this time he attended the Brain Rehabilitation Unit at the Princess Alexandra Hospital. He had complained of memory loss, headaches, blurred vision and generally not being himself – exhibit 1 p 19. An occupational therapist assessed poor cognitive function and poor memory – exhibit 1 p 20 and an RMO made a note, "Likely post-concussion syndrome" – exhibit 1 p 20. From p 73 of exhibit 1 it appears that this RMO was a

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33 t 2-47.

34 t 2-34.

35 Campbell, t 2-29 and t 2-32; Eadie, t 2-48; Ohlrich, t 2-69; Pascoe, t 3-8.

36 t 2-56; see also Dr Campbell, t 2-30.

junior house doctor, Dr Speed, who did no more than an initial examination and review an occupational therapist's testing. He was not called at the trial.

[84] It appears from the hospital files that during his time at the Brain Rehabilitation Unit the plaintiff saw occupational therapists on some days for a period of some weeks. His discharge report shows that he reported no problems with his vision, scored increasingly well on memory function testing and demonstrated "good functional cognition". He was cleared to drive and returned to work as a delivery driver on a gradual basis. No one who saw him at the Unit was called at the trial.

[85] As noted, Professor Eadie rejected post-concussion syndrome as a clinical entity.[37] A Dr De Leacy was called by the plaintiff. He is a psychiatrist. The plaintiff submitted that his reports and evidence gave some credence to the diagnosis of post-concussion syndrome. I thought it was tolerably clear from Dr De Leacy's first report (23 September 2009) that he was recording what the plaintiff told him in respect of headaches, blurred vision and problems with concentration and memory, and likewise recording that he had seen others diagnose the plaintiff with what he called "post-concussional syndrome", just as he records that he has seen others diagnose seizures and orthopaedic injuries (although the plaintiff's case did not involve any assertion of orthopaedic injuries).[38] Dr De Leacy quite clearly says that the plaintiff ought to be seen by a neurologist in respect of organic brain injury. Nonetheless in his evidence-in-chief he said that the plaintiff reported headaches and memory disturbance to him, "And at that stage, I was not sure about the seizure activity, that's why I actually made the diagnosis of this condition, post-concussional syndrome, because I was going to leave it up to my neurological colleagues to further investigate the seizure activity".[39]

[86] In cross-examination this position was not sustained. Dr De Leacy first asserted that the plaintiff suffered a head injury in the accident which he classed as "at least moderately severe" – t 2-37. He was then asked how that was compatible with a Glasgow Coma Score of 15, and asserted that it would depend upon when the Glasgow Coma Score was assessed. He then asserted that the assessments of Glasgow Coma Scores could "fluctuate wildly". The plaintiff's did not. It was then put to Dr De Leacy that the fact that the plaintiff almost immediately resumed his normal work after the accident told against his having a moderately severe head injury. It is evident from Dr De Leacy's reports that he never appreciated this aspect of the plaintiff's history (see below). At this point in the cross-examination Dr De Leacy entirely retreated saying that "I'm not really an expert in traumatic head injuries, so I'm not sure that I can answer that question in an illuminating way". He said he would defer to neurologists – t 2-38. Later he said that he would defer to a neurologist on whether the plaintiff had "post-concussional syndrome" which he said was a neurological, rather than psychiatric, diagnosis – t 2-39.

[87] Dr De Leacy's reports and evidence were unimpressive, and I discuss this at some length below in relation to the psychiatric opinions he expresses. As I say, I thought his first report made it clear that he did not diagnose post-concussion syndrome but left that to neurologists and, for that reason I found his assertion of a diagnosis in his evidence-in-chief disconcerting, and telling against his impartiality. This was confirmed by his very quick retreat in cross-examination. In my view he does not

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37 Exhibit 2, Tab 23.

38 See pp 3, 5, 6, 7 and especially 9 and 10 of that report.

39 t 2-36.

have the expertise to diagnose post-concussion syndrome (assuming it exists as a clinical entity) and in any event it is clear from his reports that he did not do the testing which he thought ought to be done in order that a diagnosis of organic brain damage be made.

[88] None of the neurologists called in the case diagnose the plaintiff with post-concussion syndrome or any neurological conditions other than epilepsy.

[89] Dr Ohlrich was asked to consider the matter, and gave the opinion in both his reports that there was no organic brain damage. It did not occur to Professor Eadie in his treatment of the plaintiff, despite what I think was a particularly thorough examination consequent on his not necessarily being convinced at first that the plaintiff did suffer from epilepsy. Dr Pascoe in April 2009 suspected the plaintiff had epilepsy with some kind of psychiatric overlay. She sent him to a neuropsychologist in May 2009 "to address the issue of cognitive impairment and particularly stress related issues". After she received the report from the psychologist, Troy, she made no comment on cognition to the General Practitioner, but did recommend that the plaintiff go to see a psychiatrist. In her report to the Court she records that a neuropsychological assessment was requested by her, "in view of the possibility of associated post-traumatic stress as it contributed to his symptoms" – paragraph 2.5. That is, she does not there record that she sought the neuropsychological assessment in relation to cognitive issues. This is also what she said in her evidence-in-chief – that the referral was in relation to psychiatric disorder rather than organic brain damage – t 3-9. Nonetheless she does record at paragraph 3.3 of her report to the Court that the assessment from the psychologist "was consistent with a very mild organic brain dysfunction and a more significant post-traumatic stress disorder". In examination-in-chief and cross-examination Dr Pascoe gave no evidence at all as to post-concussion syndrome or any organic cognitive loss. The plaintiff's counsel raised the matter in re-examination, directing her attention to the relevant notes in the PA Hospital charts. Having read the notes she attributed the symptoms to stress rather than any organic brain damage –t 3-22. This is consistent with Dr Kar's opinion.

[90] That leaves Dr Campbell. In his report of 24 October 2009 he purports to diagnose cognitive deficits resulting from a closed head injury; chronic soft tissue injury to the cervical spine, and traumatic onset of partial epilepsy. I am not certain that Dr Campbell had the expertise to diagnose any of these conditions. He conceded readily in cross-examination that it was not part of his job to diagnose epilepsy and he would defer to the neurologists as to this.[40] In any case Dr Campbell's report does not reveal how he came to this diagnosis except that it is apparent from the table at pp 5-6 of his report that he administered three very brief tests, and otherwise seems to have accepted what the plaintiff told him as to his memory etc. The report reads generally as though Dr Campbell were not aware of the standard required from an expert who makes an independent assessment of someone for use in court proceedings. The report of 6 June 2012 reads similarly, except that in this report Dr Campbell also purported to diagnose "psychological distress". Dr Campbell had no information as to the plaintiff's past memory or cognitive abilities – t 2-33 – and of course to properly assess whether or not any cognitive impairment which was found on proper testing was caused by the accident, one would have to thoroughly

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40 tt 2-27; 2-28; 2-29; 2-31; 2-32.

investigate the plaintiff's past history in that regard including the matters raised in the school reports which I deal with above.

[91] Ms Troy was a clinical psychologist who administered a series of tests over four hours to assess "persisting symptoms associated with concussion post closed head injury". This was at the instance of Dr Pascoe, as part of her treatment of the plaintiff. The results were to the effect that the plaintiff had low average intelligence, low average reading ability, and average to low average memory, as would be predicted by his IQ scoring. The testing showed that his memory – one of the plaintiff's main complaints – was not deficient. He did show some deficits (mental arithmetic; sustained directed attention; adjusting to changing task demands; visuomotor speeding co-ordination and incidental learning of information). The psychologist then concluded:

> "Mr Austin showed evidence of mild organic brain damage consistent with the mild head injury sustained in the accident on 11 November 2008. The deficits were primarily in fine motor co-ordination and executive processes, and fluctuated, suggesting that his epilepsy may be contributing to the deficits detected. He meets the diagnostic criterion for mild neurocognitive disorder (DSM – IV – TR)." (my underlining)

[92] The psychologist also expresses the view that as the assessment was conducted only 6.5 months after the injury she expected he would show spontaneous recovery in terms of "his organic brain damage". The only doctor who directed their attention to this report was Dr Pascoe, who commissioned it. She never diagnosed organic brain injury. The height of her dealing with this topic was to note that the results were consistent with mild organic brain damage. It was clear from her evidence in re-examination on this topic that she thought from the symptoms Mr Austin reported, that he experienced stress or, consistently with her reports to the general practitioner, some other psychiatric disorder. Dr Kar also says that the plaintiff's assessment by the neuropsychologist could be accounted for by stress – report 3 March 2010 p 8.

[93] The psychologist did not have any reliable background information as to the plaintiff's abilities before the injury. From her report it seems he told her that he had "struggled with maths at primary school" and "did not pass any subjects" although it is unclear as to whether she meant in Grade 10 or more generally. I do not think that the psychologist could have had any understanding of his actual performance at school, see for example her comment at paragraph 4.3 "Reported premorbid difficulties with mathematics": that is not consistent with the school results which were in evidence before me. They show a much more generalised and consistent pattern of failure across all subjects. As well, the early special education information shows difficulties with fine motor skills etc. which the psychologist did not have when she performed her assessment. Ms Troy was argumentative in cross-examination when confronted with the detail from the Education Department records. For example, after rejecting that any useful information could be gained from reports that as a seven year old the plaintiff could not tie shoelaces, balance, run, hop or grip his pencil properly – t 2-22, she completely reversed her stance when it suited her, to argue that reports of his block design skills at age seven were in the superior category so that he may have had a higher than average executive functioning premorbidly – t 2-24.

[94] I do not think that anything more could be derived from the testing which Ms Troy undertook than that the testing was consistent with the plaintiff suffering mild organic brain damage. Her report is certainly not enough to convince me that there was any organic brain damage. I cannot see that she has any expertise to express the medical opinions she purports to give. Moreover she does not say that the accident caused the poor results on testing. I prefer the opinions of the neurologists on this issue. Their reports and evidence show a thorough and considered approach to the plaintiff's condition, and display conventional reasoning processes and conclusions. In addition, without any background as to the plaintiff's pre-accident cognitive abilities, I cannot see any safe basis for concluding that any cognitive deficit exists or was caused by the accident. I do not find that the accident caused the plaintiff brain injury other than that which caused his epilepsy.

**Psychiatric Injury**

[95] Dr Pascoe mentioned several psychiatric conditions in her reports to the General Practitioner. She seems to use terms such as anxiety disorder, post-traumatic stress disorder and depression as interchangeable and used a psychologist, at least initially, inappropriately to diagnose psychiatric conditions. Generally I would prefer the evidence of a psychiatrist to a neurologist as to psychiatric conditions. Dr Pascoe said she would defer to psychiatrists in this regard – t 3-18. I disregard her evidence as to the plaintiff's suffering from any psychiatric disorder.

[96] Dr De Leacy gave a report dated 23 September 2009 in which he said that the plaintiff had post-traumatic stress disorder. He gave a subsequent report – 26 March 2012, saying that he thought he had a chronic adjustment disorder. Dr De Leacy's reports were unimpressive: they are repetitive, vague, and unclear as to whether he is recording something he has been told, or is giving his opinion as to the existence of something. The carelessness with which the reports were prepared is perhaps indicated by the fact that the second contains a paragraph explaining that Dr De Leacy is a consultant pathologist with areas of interest spanning endocrinology, therapeutic drug monitoring and toxicology.

[97] Dr De Leacy's reports contain many inaccuracies. He mentions (several times) that the plaintiff was a poor historian. However, none of the other medical reports contain this number of errors, and the errors are not limited to information from the plaintiff, so I do not attribute the great number of inaccuracies to the plaintiff, but to Dr De Leacy.

[98] In his first report he mentions three times (at p 2 and twice on p 6) that the plaintiff was crushed in the accident in November 2008. He makes several comments clearly overstating the severity of the initial accident.[41] In cross-examination he began along the same lines as to the head injury suffered being at least moderately severe – t 2-37. He retreated as soon as he was confronted with objective facts from the hospital record (see above). He describes the plaintiff at the time he opened the doors to the trailer as being "extremely shocked by the incident for a second or two as he saw the weights falling on him. He feared for his life and then was rendered unconscious" – first report p 2. The plaintiff gave no such description in evidence. The description he gave is incompatible with his standing for a second or two

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41 "The whole load fell on him" – p 2; "three severe scalp lacerations sutured" – p 3; "crushed by a load of full milk crates"; "crushed by a heavy load and thought he would probably die".

watching weights fall towards him and fearing for his life – see the extract at [5] above. Dr De Leacy's reports say the plaintiff did not work after the November 2008 accident[42] and he was unaware in cross-examination that the plaintiff had worked for some considerable time – through to January 2009. Incompatibly with the fact that the plaintiff returned to work as a truck driver after the accident, he states several times that the plaintiff was scared of trucks and tried to avoid them after the accident.[43] He says that the plaintiff left school halfway through Grade 9. He says that the plaintiff was thoroughly assessed by Dr Hazelton. I find this rather remarkable as the list of information Dr De Leacy received shows that he has what he describes as two reports from Dr Hazelton. In fact they were both single page letters – one, very short – three sentences – to an occupational therapist and one slightly longer, but still well within a page, to a General Practitioner. Neither of them states that Dr Hazelton has examined the plaintiff.

[99] Dr De Leacy recites that the plaintiff re-lives the accident; can remember the cartons [crates of milk] falling onto him, and records that he was also traumatised during his hospital stay because he saw other cases coming into emergency. The plaintiff gave no evidence of any of this. Dr De Leacy records that the plaintiff was phobic of stacked items and worried about things falling on him, as well as being frightened of trucks. Again there was no evidence of this given by the plaintiff. Dr De Leacy seems simply to accept what the plaintiff has told him, for example, "he has major problems with concentration and short term memory and ability to organise himself" – p 8 first report, without any testing of these matters.

[100] In Dr De Leacy's second report he says, of his first report, "I found [the plaintiff] to be significantly impaired from a psychiatric condition which came under a general umbrella of post-traumatic stress disorder, …" – p 4. The conclusion in the first report was that "[the plaintiff] has post-traumatic stress disorder which needs further treatment" – see p 7 of the report. Although, in the discussion of that diagnosis he never progresses beyond the first of several criteria which need to be satisfied before a diagnosis of post-traumatic stress disorder can be made in accordance with DSM IV. The other criteria seemed to be lost in discussion of more general matters. The description "general umbrella of post-traumatic stress disorder" seems to be a preliminary to Dr De Leacy's conclusion in his second report that although he feels he was justified in having diagnosed post-traumatic stress disorder, he thinks it is now significantly less severe, and could be better described as chronic adjustment disorder of significant severity. Later in his report he goes on to discuss "his mood disturbance" for which he says he needs to continue the anti-depressant medication Zoloft. He does not diagnose any mood disorder. He refers to "significant depressive symptoms", but does not make a diagnosis of depression.

[101] The reports are not of the standard this Court is used to seeing from medical experts. They do not display clear reasoning. His evidence in Court was no different. He presented as having only a vague and unfocussed grasp of the facts pertinent to the plaintiff's case, and also of his own opinions: compounding his prevarication as to what diagnosis he made of the plaintiff there was this passage in cross-examination:

> "Ultimately, can I put this to you that Mr Austin did not have any psychiatric condition or disorder arising from this particular incident? I put that as a proposition to you?--- I wouldn't agree with

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42 First report p 6; second report p 7.

43 P 4 first report; p 7 first report.

> that. Even if there is some doubt about the actual diagnosis, he would have some diagnosis. It would be hard to imagine that a person could suffer an injury of this type without any sequelae.
>
> But it might be normal sequelae. That is anger, frustration, stress, normal sequelae?--- Depression. Anxiety.
>
> Well, they're all, aren't they, in a band. They can be normal reactions, but you need to get to a disorder before you have the psychiatric disorders. Isn't that correct?--- That's correct. Yes. And that's where conditions judgment comes into it."

[102] Dr Kar gave evidence as to psychiatric conditions on behalf of the defendant. The conclusion in his written report of 3 March 2010 was as follows:

> "In my opinion, Mr Austin does not have any current psychiatric diagnosis. He does feel angry and reported some stress, particularly after the findings of the MAT, which did not believe he had suffered a significant head injury. I believe he is stressed by the WorkCover process. I believe unresolved compensation issues are causing him stress. Being unable to work and also not being able to function at home at his previous levels is playing a role. He has felt clumsy around the home and been unable to complete tasks. This could be the result of the antiepileptic drug that he is on. Antiepileptic drugs act on the brain and can cause subtle cognitive deficits of the type found by the neuropsychologist.
>
> Specifically, Mr Austin does not have a current Adjustment Disorder or a Post-Traumatic Stress Disorder, or any other psychiatric condition."

[103] Apart from this, Dr Kar allows that the plaintiff may have had some brief anxiety initially after the accident, but he doubts that he would have met the criteria for Adjustment Disorder. He thought he was otherwise stressed because of the cancellation of his driver's licence, the diagnosis of epilepsy and because WorkCover Assessment Tribunal had found that he did not have epilepsy but still would not give him clearance to drive. Conformably with Dr Kar's conclusions, the plaintiff's de facto gave evidence that it was not until he was stood down from work that she noticed him becoming angry, erratic and moody – t 1-93 and tt 1-94-95. Dr Kar said that the plaintiff's frustration as to the Tribunal's contradictory approach to his case was something that could make anyone upset or angry, "but I did not feel there was a disproportionate emotional response that would qualify for a separate psychiatric diagnosis" – t 3-30.

[104] I prefer the opinion of Dr Kar to Dr De Leacy. I note my view, which is consistent with Dr Pascoe's evidence,[44] that the psychologist had no expertise to diagnose a medical condition as she purported to do.[45]

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44 tt 3-9.

45 Her report says that the plaintiff did not meet the diagnostic criteria for post-traumatic stress disorder but did meet the criteria for adjustment disorder with mixed anxiety and depressed mood. Contrast Dr Pascoe's interpretation of it.

**Summary as to Injuries and Effects of Epilepsy**

[105] In summary I find that the plaintiff suffered pain and discomfort after the accident but was able to return to his normal work duties four days later. He suffered stress and anxiety as a result of the accident which I find accounts for the symptoms which led to his treatment in the Brain Rehabilitation Unit. He suffers from epilepsy as a result of the accident. It can be assisted with medication, but to date medication has not controlled it sufficiently to allow the plaintiff to resume driving an ordinary car. I now turn to quantum.

**General Damages**

[106] I award an amount of $40,000 as general damages. The plaintiff referred me to the case of *Kirchner v ITT Water & Wastewater Ltd.*[46] The plaintiff's injuries here are less than those suffered in that case. He spent a few hours at hospital, and a few days in pain and discomfort initially. On a continuing basis he will experience absences and require medical supervision and medication for the remainder of his life. He has suffered, and will continue no doubt to suffer, some anxiety and embarrassment because of the absences and because of the very fact of his having epilepsy. He will also suffer the lack of mobility caused by his inability to drive in the future. As noted above he drove for pleasure, motorbikes and speedway, as well as for work. I allow interest at 2% on one third of the amount ($13,300) for the time since the accident, a period of 248 weeks: $1,269.

**Past economic loss**

[107] The plaintiff had a stable work history. He had taken a year off work which reduced his earnings in the financial years ended 30 June 2007 and 30 June 2008. He gave evidence that he took this year off work to stay home with his family because his first child had just been born – t 1-12. At the time of the accident the plaintiff was working full-time for the defendant, but also worked a Saturday job driving for Toll. In total his net figures per week were an average of $1,196. Allowing past economic loss from 13 January 2009 to 13 September 2013, and allowing for an annual increase in earnings of 3% per annum across this period gives an amount of $304,366. I reduce this by a global figure of 10% to account for the matters dealt with at [113], [114], [115] and [116] below. Although these matters relate more to future earning potential than past loss, logically they still impact negatively on this head of loss. I assess past loss at $273,929.

[108] The plaintiff has received $51,544.20 WorkCover payments in this time, and Centrelink payments of $68,950. Once these are deducted an amount of $153,434 is yielded. Interest on this amount at 5% for a period of 248 weeks is $36,824.

[109] At 9% of earnings, lost past superannuation entitlements amount to $24,653.

[110] The *Fox v Wood* component was said to be $13,519.76. The defendant did not submit to the contrary.

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46 [2010] QSC 413.

**Loss of Future Earnings**

[111] There are several matters which must be assessed in this case as bearing on loss of income in the future. They should be assessed according to the approach in *Malec v Hutton*:[47] an assessment on the possibilities of all the relevant hypothetical future events as bearing on the prospect of earning capacity in the future. Logically, perhaps the first to consider is the possibility of the plaintiff's driving in the future. Professor Eadie thought that it was a very difficult question as to when an epileptic patient would be allowed to drive. He said he prefers to have people clear for five years before "thinking of letting them get an ordinary, say, C-class licence. Heavy vehicles, I think, should probably be longer." – t 3-57. Dr Pascoe said that the matter of whether a patient can drive is a matter for the treating doctor based on all the signs and symptoms experienced by the patient from time to time – t 3-10. Dr Campbell was to the same effect – if absences continue the patient should not drive – tt 2-30-31. Exhibit 13 was the National Transport Commission's standards for licensing when medical conditions affect fitness to drive. At p 79 it shows that a person with epilepsy will never hold either a private or commercial licence unconditionally, but a conditional private licence may be issued if there have been no seizures for 12 months, whereas a conditional commercial licence will not issue unless there have been no seizures for 10 years.

[112] The plaintiff says he still has absences even though he is now appropriately medicated – t 1-29. He is 42 years old. It seems unlikely that he will ever again work truck driving or operating machinery.[48] He may eventually drive an ordinary car again, and that may increase his potential for employment.

[113] The plaintiff had been diagnosed with pre-existing degenerative conditions affecting his neck and back as far back as July 2004 by Dr William Sutherland. The plaintiff had pursued a WorkCover claim in the past – t 1-40. The plaintiff had stress and back problems which had interfered with his work in the past – t 1-41-42 – and suffered headaches and neck problems which interfered with his work – t 1-43. Allowance must be made for the fact that these degenerative conditions would have increasingly affected the plaintiff's employment in the future. He had suffered injuries at work in the past, and injuries outside work, for example speedway injuries.

[114] As well, there is the fact that the plaintiff had in the past chosen to spend a year at home with his first child, not working – t 1-12. There is a possibility that he would have made a similar lifestyle choice at another time or times in the future.

[115] The plaintiff asserted that he had always worked two jobs – t 1-49. I am not sure that there is any real evidence of this – see t 1-12 and exhibit 3 which does not say that he held more than one job simultaneously, even though more than one employer is often listed for one time period. Nor can I safely make anything of the description "(casual work)" where it appears there as showing that the plaintiff was working more than one job simultaneously. At t 1-49 the plaintiff said that the reason he was working two jobs at the time of the accident was because he wanted his wife to be able to stay home with their children. Accepting this, he also gave evidence that in the past he had limited himself to working locally so that he could spend more time with his family – t 1-12 – and that he decided to take a year off

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47 (1990) 169 CLR 638, 643-645; *Rodger v Johnston* [2013] QSC 117, [14].

48 tt 2-30-31; tt 3-10-13.

work for family reasons – t 1-12. So I think it is fair to conclude that his intentions as to work fluctuated, and it would not be safe to assume that he was going to work two jobs from the time of the accident until he ceased work.

[116] To date the plaintiff has made almost no attempt to gain employment – he has made only two casual enquiries since the beginning of 2009 – t 1-31, t 1-69 and t 1-95. I do not think the plaintiff is unemployable. It is recorded in the report of the psychologist that he has qualifications as a gardener/groundsman. He had limited schooling, but he has always worked, and at a variety of jobs – see exhibit 3. His lack of ability to drive will hinder him in obtaining employment, as will the fact of his propensity to suffer absences. Further, his degenerative back and spine conditions will also, increasingly into the future, rule out heavy manual labour. I think he could probably obtain a job, say as a groundsman or gardener, on a part-time basis, and continue in that type of employment until he is 65. I accept that this type of part-time employment will be more difficult to find, and less likely to be as continuous and long-lasting, as full-time work as a truck-driver. I accept the plaintiff's submission that this residual earning capacity should be valued at $300 per week.

[117] The figure of $1,307 per week is the net amount the plaintiff would have been earning in September this year had he worked for the defendant, and on weekends (increased by annual amounts of 3% as above). I subtract $300 from that to account for residual earning capacity. I allow for the plaintiff suffering loss of $1,000 per week over a period of 23 years, ie., until the age of 65, I do not think the assumption of any longer working life is justified on the evidence. On the 5% tables this gives $721,200. Having regard to the matters discussed above, I am of the view that the 15% discount rate commonly used is inadequately low to reflect the potential vicissitudes and other matters which might have interrupted the plaintiff's future working life, and earnings at that rate, but for the accident. In addition to the usual potential for vicissitudes, it is known that the plaintiff had medical conditions which would likely have affected his work; it is unlikely that he would have continued in 2 jobs for the whole of his working life, and he may have taken time off work for family reasons. I use a rate of 20% discount. This gives a figure of $576,960.

[118] Future loss of superannuation at 9% is $51,926.40.

**Special Damages**

[119] A schedule, which was exhibit 5, shows past special damages. I allow the amount of $250 for past pharmaceutical products. It is a little difficult to tell from the schedule what cost is attributable to epilepsy drugs and what to other drugs. I do the best I can to allow compensation for epilepsy drugs and make a small allowance for Panadol and Panadeine relating to the weeks immediately following the accident. I allow an amount of $1,653.60 as Medicare gap payments for attendances on medical providers listed at exhibit 5 except Dr Campbell. I cannot see that there was any purpose, except a litigation purpose, in attending Dr Campbell.

[120] I allow an amount of $595.78 for travel expenses. I allow $66, half the amount claimed, in relation to Dr Ting, given that there is no better basis before me to discriminate between attendances related to what I have found to be compensable injuries and other attendances. I allow $26.84 in relation to Dr Daunt; $24.97 in

relation to a radiologist on 9 April 2009; $272.25 in relation to Dr Pascoe; $24.97 in relation to a radiologist on 8 May 2009; $4.40 in relation to a radiologist on 25 May 2009; $25.74 in relation to Ms Troy; $9 in relation to General Practitioners Kahawita etc., on the basis that I cannot better discriminate as to the purpose of the visits; $74.14 to Dr Majumdar; $26.95 for Professor Eadie; $25.52 to Dr Salanitri and $15 for attendance at pharmacies on the basis that there is no way of discriminating as to the purpose of the visits. Other amounts claimed seem to me to be litigation costs.

[121] I do not make an allowance for medical aids, on the basis of my findings as to injury, there is no need demonstrated.

[122] Otherwise I allow the amounts in the schedule, a total of $20,403.19. Interest on this at 5% for 248 weeks is $4,866.15. I allow the cost of Epilim at $30 per month for 43 years, discounted on the 5% tables: $6,620 and an attendance at a general practitioner at $15 per visit four times a year for 43 years: $1,200.

**Total Quantum**

[123] In summary I make the following allowances:

| | | |
|---|---|---|
| (a) | General damages | $ 40,000.00 |
| (b) | Interest on general damages | $ 1,269.00 |
| (c) | Past economic loss | $ 273,929.00 |
| (d) | Interest on past economic loss | $ 36,824.00 |
| (e) | Past superannuation loss | $ 24,653.00 |
| (f) | *Fox v Wood* component | $ 13,519.76 |
| (g) | Future economic loss | $ 576,960.00 |
| (h) | Future loss of superannuation | $ 51,926.40 |
| (i) | Past special damages | $ 20,403.19 |
| (j) | Interest on past special damages | $ 4,866.15 |
| (k) | Future special damages | $ 7,820.00 |
| **TOTAL** | | $1,052,170.50 |

[124] I give judgment for the plaintiff against the defendant in the sum of $1,052,170.50. I will hear the parties as to costs.

[125] I add a note that after delivery of this judgment on 18 September 2013, the parties brought to my attention my failure to deduct the WorkCover refund in the amount of $77,313.75 pursuant to s 270 of the *Worker's Compensation Act.* I did this and delivered this revised judgment on 26 September 2013.