SUPREME COURT OF QUEENSLAND

CITATION:	*Mules v Ferguson* [2014] QSC 51
PARTIES:	**NANCY LEANNE MULES** (plaintiff) **v** **KAYLENE JOY FERGUSON** (defendant)
FILE NO/S:	SC No 339 of 2011
DIVISION:	Trial
PROCEEDING:	Civil
ORIGINATING COURT:	Supreme Court at Cairns
DELIVERED ON:	25 March 2014
DELIVERED AT:	Mount Isa
HEARING DATE:	9, 10, 11, 12, 13 September 2013; 28, 29, 30, 31 October 2013; 1, 4 November 2013.
JUDGE:	Henry J
ORDERS:	(a) Claim dismissed. (b) I will hear the parties as to costs.
CATCHWORDS:	TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE (ALTERNATIVELY FOR BREACH OF CONTRACT) – DUTY OF CARE – SPECIAL RELATIONSHIPS AND DUTIES – PROFESSIONAL PERSONS – where the plaintiff claims damages for injury and loss occasioned by the alleged breach of the defendant's duty in contract and tort – where the plaintiff is blind and deaf as a result of contracting cryptococcal meningitis – where her illness was diagnosed and treated in time to save her life but too late to prevent irreversible neurological harm – whether the defendant's failure to refer the plaintiff for specialist assessment was a breach of her duty to exercise reasonable care and skill in the provision of advice and treatment to the plaintiff – whether specialist referral would have prevented irreversible neurological harm TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE (ALTERNATIVELY FOR BREACH OF CONTRACT) – STANDARD OF CARE – GENERALLY – where the plaintiff sought treatment for sore neck and headaches – where the plaintiff claims she advised her general practitioner, hospital staff and her physiotherapist

of dizziness, loss of hearing and sight – whether the defendant was negligent in not conducting a physical manipulation of the plaintiff's neck

TORTS – THE LAW OF TORTS GENERALLY – GENERAL PRINCIPLES – causation and breach – where the plaintiff is blind and deaf as a result of contracting cryptococcal meningitis – whether the defendant's failure to refer the plaintiff for timely specialist assessment was causative of her permanent injury

DAMAGES – GENERAL PRINCIPLES – GENERAL AND SPECIAL DAMAGES – assessment of damages – where the plaintiff is blind and deaf as a result of contracting cryptococcal meningitis

Civil Liability Act 2003 (Qld) s 9, s 11, s 22, s 51, s 61, s 62
Civil Liability Regulation 2003 (Qld) reg 6, sch 7

Breen v Williams (1996) 186 CLR 71, cited
Heywood v Commercial Electrical Pty Ltd [2013] QCA 270, considered
McNeilly v Imbree [2007] NSWCA 156, cited
Munzer v Johnston & Anor [2008] QSC 162, considered
Rogers v Whitaker (1992) 175 CLR 479, cited
Sharman v Evans (1977) 138 CLR 563, cited
Tobler v Halverson (2007) 70 NSWLR 151, considered
Waller v McGrath & Anor [2009] QSC 158, followed

COUNSEL: RJ Lynch with AS Katsikalis for the plaintiff
GW Diehm QC with JC Trevino for the defendant

SOLICITORS: Shine Lawyers on behalf of the plaintiff
K&L Gates on behalf of the defendant

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A. INTRODUCTION

[1] The plaintiff is blind and deaf as a result of contracting cryptococcal meningitis in 2008. Her illness was diagnosed and treated in time to save her life but too late to prevent irreversible neurological harm.

[2] She blames her general practitioner for this. She alleges her doctor, the defendant, should have referred her for specialist assessment earlier. She alleges that had that occurred, her illness would have been diagnosed and treated earlier and she would not have suffered the loss of sight and hearing which has devastated her life.

[3] The plaintiff claims damages for injury and loss occasioned by the alleged breach of her doctor's duty in contract and tort.

The parties

[4] The defendant obtained her Bachelor degree in Medicine in 1995 and thereafter undertook her training at hospitals and practices in Newcastle. She qualified as a fellow of the Royal Australian College of General Practitioners in 2000.[1] In 2001 she moved to Cairns. Thereafter she worked part-time as a general practitioner at a medical centre and an aboriginal medical service. In about 2006 she started part-time work at the Omega Medical Centre, which is where she was working when consulted by the plaintiff.[2]

[5] At the time the plaintiff fell ill she was 43 years old. She worked full-time as an operations manager for a hotel business.[3] She had a teenage son from a past relationship. The onset of her illness coincided with the breakdown of her marriage to her then husband, a man from England.[4] Her husband actually departed her home and left Australia on 25 September 2008, the day before the plaintiff was finally diagnosed with cryptococcal meningitis.[5]

What is Cryptococcal Meningitis?

[6] Cryptococcal meningitis is an extremely rare infection that most general practitioners will never see during their practising life.[6] In Australia it is more common in the tropical north but even there only about 20 cases per million people occur per year.[7]

[7] Cryptococcal meningitis is a form of fungal infection of the meninges, the tissue membranes that protect and enclose the brain and spinal cord. It is caused by infection of the lung by a yeast, cryptococcus neoformans, which then spreads though the blood stream to the brain causing meningitis.[8]

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1 T8-48 L47.
2 T8-49 L13—T8-50 L8.
3 Ex 3 tab 3 p 19; T1-36 L10.
4 Ex 3 tab 3 p 18.
5 T1-52 L7.
6 Ex 2 tab 8 p 18; Ex 2 tab 12 p 47.
7 Ex 2 tab 8 p 17.
8 Ex 2 tab 8 p 17.

[8] Its onset is more insidious and gradual than bacterial meningitis. While its onset can sometimes be rapid,[9] the symptoms of cryptococcal meningitis typically develop over a period of at least two to four weeks.[10] However in that period symptoms may not be sufficiently present to be recognised.[11] It is frequently not diagnosed in the early presentation of a patient because it is a chronic low-grade inflammatory disturbance until the later stages of the illness.[12]

[9] The classical symptoms of cryptococcal meningitis are chronic headache and meningism, which is typically indicated by neck stiffness,[13] with the patient unable to flex the neck forward so that the chin touches the chest.[14] Other cardinal features of meningitis are aversion to light, nausea and vomiting and raised temperature.[15]

[10] Diagnostic investigation of cryptococcal meningitis usually includes microbiological analysis of cerebrospinal fluid taken by a lumbar puncture[16] performed in hospital after specialist referral.[17] Treatment includes repeated lumbar punctures to relieve intracranial pressure and an initial course of up to six weeks of intravenous antifungal medication, using amphotericin B and 5-flucytosine, followed by a prolonged course of an oral anti fungal drug.[18]

[11] Persons with illnesses that reduce existing immunity, such as AIDS and organ transplant patients, contract it most commonly. However about 30 per cent of patients who contract the condition are not immunosuppressed.[19] The plaintiff was such a patient. Among patients who are not immunosuppressed the mortality rate, with treatment, is about 25 to 30 per cent and of those who are cured, 40 per cent are left with significant neurological deficits.[20]

[12] Delay in diagnosis and treatment of cryptococcal meningitis substantially increases the morbidity and mortality of the disease.[21] For this reason it is a condition that is emphasised in clinical teaching at both undergraduate and postgraduate levels in general practice.[22] If neurological features have developed before the commencement of treatment they are unlikely to be reversed.[23] Thus while delayed diagnosis and treatment might save the patient's life, the patient is likely, as here, to suffer permanent disability.

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9 Ex 2 tab 12 p 47.
10 Ibid.
11 T10-27 L47.
12 Ex 14B p 3.
13 Ex 2 tab 8 p 17.
14 Ex 2 tab 12 p 47.
15 Ibid. While the consensus of the experts at trial was that raised temperature is a cardinal symptom, Harrison's Text Book of Internal Medicine (Ex 2 tab 3) suggests fever is usually absent.
16 Ex 2 tab 8 p 17; Ex 2 tab 8 p 9.
17 Ex 2 tab 17 p 9.
18 Ibid.
19 Ibid.
20 Ex 2 tab 13 p 57; Ex 2 tab 15 p 74.
21 Ex 2 tab 33 p 329.
22 Ex 2 tab 12 p 46.
23 Ex 2 tab 13 p 58.

Progression of the plaintiff's condition in brief

[13] In early September 2008 the plaintiff was suffering headaches and a sore neck. She perceived she had a musculo-skeletal problem and attended upon a chiropractor on 5, 8 and 11 September.

[14] On 12 September she consulted the defendant who advised her to take simple analgesia and continue with chiropractic or physiotherapy treatment.[24]

[15] The plaintiff attended upon her chiropractor later that day, and on 15 and 17 September 2008, but her headaches and neck pain persisted.

[16] She consulted the defendant again on 18 September 2008. A CT scan was ordered and it detected some irregularities with the cervical spine. The defendant discussed the scan with the plaintiff the following day. The defendant perceived the scan confirmed the plaintiff's problem was musculo-skeletal and she prescribed additional medication for pain relief. The plaintiff alleges that as at the consultations of 18 and 19 September the defendant should have perceived a more sinister condition was involved and urgently referred the plaintiff for specialist assessment. This is the nub of the case.

[17] The plaintiff attended a physiotherapist on Tuesday 23 September 2008.

[18] On Wednesday 24 September her condition had declined so dramatically that she was conveyed by ambulance to Cairns Base Hospital. However after examination and the administration of some tests she was discharged. The plaintiff initially alleged there was negligence by Cairns Base Hospital during this visit, making the State of Queensland the second defendant in her claim. However that aspect of her claim was no longer pursued at the time of trial.

[19] The defendant next saw the plaintiff on Thursday 25 September 2008, by which time the plaintiff's health had dramatically declined in comparison to her state when she had last seen the defendant almost a week earlier on Friday 19 September. The defendant immediately arranged for the plaintiff's admission to Cairns Private Hospital. Diagnosis of cryptococcal meningitis occurred the following day after cerebral spinal fluid collected in a lumbar puncture tested positive for cryptococcal infection.

[20] The intensive and prolonged treatment which ensued at Cairns and Townsville Hospitals saved the plaintiff's life but her illness left her with sensorineural hearing loss, cortical blindness, impaired balance, altered sensation and discomfort in her lower limbs and fingertips and adjustment disorder with depressed mood.

The duty owed

[21] The duty owed to the plaintiff by her doctor was effectively the same in contract and tort.

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[24] There is a factual dispute as to which of those two forms of treatment the defendant told the plaintiff to continue with.

[22] In contract the primary duty owed by a medical practitioner is the duty "to exercise reasonable care and skill in the provision of professional advice and treatment."[25] The duty in tort was described by the High Court in *Rogers v Whitaker*[26]:

> "The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment'; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case." (citations omitted)

[23] One of the ways a doctor is called on to exercise skill and judgment is to determine whether a patient ought be referred for specialist assessment. Failure to refer a patient for further investigation or consultation can potentially constitute a breach of duty.[27]

[24] While there are a variety of alleged shortcomings in the care and skill exercised by the defendant, the key allegation is that the failure to refer the plaintiff for specialist assessment was a breach of her duty to exercise reasonable care and skill in the provision of advice and treatment to the plaintiff.

The alleged breaches

[25] The plaintiff pleaded the damage to the plaintiff's health was caused or materially contributed to by the negligence and or breach of contract of the defendant.[28] By way of particulars thereof it was pleaded the defendant:

(a) Failed to obtain a complete history from the plaintiff;
(b) Failed to perform any or any adequate clinical examinations;
(c) Failed to recognise the significance of the plaintiff's deteriorating clinical features;
(d) Failed to recognise that the plaintiff's clinical features were deviating from those of a persistent musculo-skeletal condition;
(e) Failed to refer the plaintiff for further assessment in circumstances where the result of the CT scan of the cervical spine did not sufficiently explain why the plaintiff was suffering from the symptoms reported;
(f) Failed to appropriately refer the plaintiff either to a private neurologist or general physician or to a hospital emergency department for urgent assessment.

[26] The alleged failure of critical causal importance was the failure to refer. For that reason a determination of the true state of the plaintiff's symptoms when she consulted the defendant – a topic about which there is significant evidentiary conflict – is of pivotal importance to the outcome of this case. Even if the defendant conducted professionally incompetent consultations that would not be to the point if competently conducted consultations would not have identified symptoms suggesting a need to refer the plaintiff.

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25 *Breen v Williams* (1996) 186 CLR 71, 103-104.

26 (1992) 175 CLR 479 [5].

27 See for example, *Tran v Lam* NSWCA No 20359/96, 20 June 1997; *Boehm v Deleuil* [2005] WADC 55; *Kalokerinos v Burnett* NSWCA No 40243/95, 1 November 1995.

28 Amended Statement of Claim [38].

[27] Whether the causally critical non-referral involved a breach necessarily turns upon whether the defendant, exercising reasonable care and skill, should have referred the plaintiff. Relevantly to that issue, the essence of the other pleaded failures is that the defendant failed to properly consult and examine the plaintiff and recognise the potential presence of a condition, other than a musculo-skeletal disorder, of sufficient seriousness to warrant referral for urgent specialist assessment.

Determining the alleged breach of duty

[28] The determination of whether the defendant breached her duty to exercise reasonable care and skill in the provision of professional advice and treatment is subject to the general principles in s 9 of the *Civil Liability Act* 2003 (Qld) ("CLA"):

> "**9 General principles**
>
> (1) A person does not breach a duty to take precautions against a risk of harm unless—
>
> (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought reasonably to have known); and
>
> (b) the risk was not insignificant; and
>
> (c) in the circumstances, a reasonable person in the position of the person would have taken the precautions.
>
> (2) In deciding whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (among other relevant things)—
>
> (a) the probability that the harm would occur if care were not taken;
>
> (b) the likely seriousness of the harm;
>
> (c) the burden of taking precautions to avoid the risk of harm;
>
> (d) the social utility of the activity that creates the risk of harm."

[29] The plaintiff does not allege the defendant should actually have foreseen that the plaintiff may have been suffering from cryptococcal meningitis. Rather, it is in effect contended, the defendant ought reasonably have known that the plaintiff's clinical features were not attributable to a musculo-skeletal condition and indicated the presence of a potentially serious condition involving the central nervous system. It is further contended in effect that there was a not insignificant risk of grave harm to the plaintiff's health if the precaution was not taken of referring the plaintiff to a neurologist, general physician or emergency department for urgent specialist assessment.

Relevance of Expert Evidence of Acceptable Medical Practice

[30] Evidence was adduced at trial of whether what was done by the defendant was consistent with acceptable medical practice. Such evidence is relevant to the assessment of whether there has been a breach of duty but it does not define the content of the duty. It is not determinative of the appropriate standard of care. That is a matter for the courts to adjudicate upon.[29]

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29 *Rogers v Whitaker* (1992) 175 CLR 479, 487.

[31] However evidence of compliance with acceptable medical practice may ground a defence where causal liability is otherwise proved.[30] That defence is contained in s 22 of the *CLA* which provides:

> "**Standard of care for professionals**
>
> (1) A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.
>
> (2) However, peer professional opinion can not be relied on for the purposes of this section if the court considers that the opinion is irrational or contrary to a written law.
>
> (3) The fact that there are differing peer professional opinions widely accepted by a significant number of respected practitioners in the field concerning a matter does not prevent any 1 or more (or all) of the opinions being relied on for the purposes of this section.
>
> (4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.
>
> (5) This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information, in relation to the risk of harm to a person, that is associated with the provision by a professional of a professional service."

[32] The plaintiff submits s 22(5) has the effect of excluding a s 22 defence where the alleged breach involves a failure to refer a patient for more expert examination or treatment. However that sub-section relates to giving or failing to give a warning, advice or information "in relation to the risk of harm to a person, that is, associated with the provision by a professional of a professional service." Section 22(5) is apt to those cases where the breach otherwise arising flows from a failure to properly provide a patient with sufficient information to allow the patient to make an informed decision about the risk of harm in undergoing a particular medical service. It is not apt to a case like the present where the gravamen of the breach lies in failing to identify and warn the patient of the need for the patient to be provided with a medical service by another.

[33] The evidence of expert opinion adduced at trial is thus relevant not only to the assessment of whether there has been a breach of duty but also to whether or not the defendant has a s 22 defence.

The Expert Evidence

[34] The parties called a number of expert witnesses relevant to the progress and diagnosis of cryptococcal meningitis and the competency of the defendant's assessment and management of the plaintiff's condition.

[35] The plaintiff called:

(a) Associate Professor Damon Eisen, a consultant infectious diseases physician who has specialised in infectious diseases since 1991;[31]

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30 See *Tobler v Halverson* (2007) 70 NSWLR 151.

(b) Dr John Vinen, an emergency physician since 1986;[32] and
(c) Dr John Turnbull, an experienced general practitioner of over 40 years standing.[33]

[36] The defendant called:
(a) Professor Michael Whitby, an infectious diseases physician for over 20 years;[34]
(b) Dr John Cameron, a consultant neurologist who has practised as a specialist neurologist since 1979;[35] and
(c) Dr Robert Kable, an experienced general practitioner of nearly 30 years standing.[36]

[37] Some of the expert reports were obviously gathered at a stage when it was still intended to take the plaintiff's case against the State of Queensland to trial. While the events at the Cairns Base Hospital on 24 September are relevant it is unnecessary to reach a concluded view on the opinions of the experts in respect of the adequacy of care provided by the hospital on that date.

[38] As will be seen, the utility of much of the expert evidence about the defendant's competency turns upon whether, as a matter of fact, the defendant's consultations with the plaintiff of 18 and 19 September occurred largely as described by the defendant or largely as described by the plaintiff and her mother, who gave evidence in support of her daughter's case.

The contest of fact

[39] By the time the plaintiff's illness was diagnosed on 26 September, and probably by the time of her attendance at the Cairns Base Hospital on 24 September, it was too late to prevent the permanent damage to health that followed. Thus, even if the Cairns Base Hospital staff were negligent in discharging the plaintiff, rather than pursuing diagnostic investigation apt to detect meningitis and trigger appropriate treatment, it is unlikely there would be a causal link between that negligence and the harm suffered.

[40] The plaintiff asserts however that her permanent disabilities would likely have been avoided had she been referred for specialist assessment back on 18 or 19 September when seen by the defendant. She contends that by then her presenting symptoms were so sufficiently advanced that her doctor, if exercising reasonable care and skill, should have immediately referred the plaintiff to a private neurologist or general

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31 Report of 22 December 2009 Ex 2 tab 8; Report of 10 February 2010 Ex 2 tab 10; Joint Report with Professor Whitby of 11 June 2013 Ex 2 tab 17 and Report of 22 October 2013 Ex 15.

32 Report of 8 February 2010 Ex 2 tab 18 (a report dealing with the treatment by Cairns Base Hospital rather than by the defendant); Report of 20 March 2012 Ex 2 tab 19 and Memorandum of Conference of 30 August 2013 Ex 2 tab 35.

33 Report of 18 January 2010 Ex 2 tab 1; Report of 17 September 2010 Ex 7; Report of telephone conference of 20 January 2012 Ex 2 tab 5; Report of 29 May 2012 Ex 8; Report of telephone conference of 2 September 2013 Ex 2 tab 6 and Report of 18 October 2013 Ex 16.

34 Report of 11 January 2011 Ex 2 tab 12; Report of 21 June 2011 Ex 2 tab 13; Report of 26 July 2011 Ex 2 tab 14; Report of 13 August 2012 Ex 2 tab 15; Joint Report with Dr Eisen of 11 June 2013 Ex 2 tab 17 and Report of 9 September 2013 Ex 17.

35 Report of 10 August 2010 Ex 14A (a report directed predominantly to the plaintiff's present and future condition); Report of 5 March 2012 Ex 14B and Report of 24 February 2013 Ex 14C.

36 Report of 24 February 2010 Ex 5; Report of 17 August 2012 Ex 26A; Report of 4 January 2013 Ex 6 and Report of 4 October 2013 Ex 22.

physician or hospital emergency department for urgent assessment and, had that occurred, it is likely that successful diagnosis and treatment would then have ensued.

[41] The defendant accepts there was a significant decline in the plaintiff's condition but asserts that decline only became apparent during the week after the consultations of 18 and 19 September. The defendant argues the plaintiff has in hindsight blurred the timing of the marked onset of her condition, which was underway when the defendant saw her on 25 September, with her earlier consultations with the defendant of 18 and 19 September. The defendant submits the plaintiff and her mother have overstated the true extent of the symptoms the plaintiff was in fact suffering on 18 and 19 September 2008. The defendant submits that at that stage the plaintiff was only complaining of a sore neck, sometimes associated with headache and dizziness. The defendant submits the plaintiff's symptoms were not then so severe as to have put the defendant on notice of the need to refer the plaintiff for specialist assessment.

[42] The defendant alternatively submits that had the plaintiff's symptoms been as extreme as the plaintiff says they were as at 18 and 19 September 2008 that would indicate the process of irreversible neurological harm was already underway, making it unlikely the permanent injury to health suffered by the plaintiff would have been avoided had treatment then been initiated.

[43] The resolution of this case turns to a large extent upon what symptoms the plaintiff told the defendant she had, and what symptoms the defendant should have detected, in her consultations with the plaintiff. These aspects of the case are important because the determination of what the defendant knew or should have known about the plaintiff's symptoms necessarily informs the determination of whether she should have referred the plaintiff for specialist assessment on 18 or 19 September.

[44] Assessments of the reliability of evidence about the plaintiff's consultations with the defendant do not fall to be made in a vacuum. The evidence of expert witnesses about cryptococcal meningitis[37] has background relevance to that assessment. Further, the plaintiff also interacted with other medical professionals during the relevant era and those consultations provide some assistance in determining what likely occurred in the consultations with the defendant.

B. CHRONOLOGICAL REVIEW AND FINDINGS

[45] It is useful to review the plaintiff's consultations with the defendant and other medical professionals chronologically.

[46] That exercise necessarily involves some consideration of the contemporaneous documentary records of the defendant and the other medical professionals. However their records are not determinative. Medical records seldom purport to be a verbatim report of all that was said or done between practitioner and patient. Dr Vinen, an emergency physician who was particularly critical of some of the note-taking by doctors in this case, indicated the guiding criterion about what to note is relevance, so that a practitioner should ordinarily document "the significant positives and significant negatives".[38] This accords with the defendant's practice of

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37 Some of which has already been summarised above.

38 T4-15 LL2-6.

making a note of anything that is "positively significant" and anything "negatively significant" to the same extent.[39]

[47] The risk a medical practitioner might fail to record information wrongly perceived to be irrelevant or of no significance is self-evident. However where error as to the significance or relevance of information is unlikely because the information is obviously significant or relevant, then the fact it is not recorded may support an inference that such information was not provided. Much will depend on the surrounding circumstances.

June 2008 consultation with defendant

[48] Before dealing with the sequence of events of September 2008 something ought be said of the earlier contact between the parties.

[49] The plaintiff first consulted the defendant on 18 July 2007 and had a follow up appointment on 25 July 2007. Those consultations were unconnected with the development of her serious illness the following year. There is a dispute as to when it was in the following year that the plaintiff next saw the defendant.

[50] The plaintiff alleges she consulted the defendant in June 2008 complaining of rushes of blood to the head and dizzy spells.[40] The defendant has no recollection of such a consultation and the defendant's medical practice has no record of the alleged consultation.[41] There is no Medicare billing record relating to the plaintiff on that date.[42] In contrast, the defendant's medical practice has electronic records of each of the consultations that the plaintiff alleges occurred with the defendant in September 2008.

[51] The plaintiff asserts of the alleged June consultation that after the defendant checked the plaintiff's age the defendant said the plaintiff's symptoms were probably the beginnings of menopause. On the plaintiff's account, the defendant allegedly observed the plaintiff was six months overdue for a mammogram and wrote a contact for Breast Screen Queensland on a sticky note that she handed to the plaintiff. The plaintiff recalled she was in a hurry in departing the practice and the receptionist had her sign a form but did not request payment.[43]

[52] The consultation is surplusage to the plaintiff's case and thus an unusual event to concoct. It is also unlikely that on this occasion the plaintiff actually visited a different doctor and is mistaken about that. In the absence of a record of the consultation it is unsurprising, if the consultation occurred, that the defendant cannot recall it. On the other, hand it is surprising no record, not even of Medicare billing, exists in respect of the consultation.

[53] Ultimately it is unnecessary to resolve this anomaly in the evidence. The plaintiff described the symptoms she was suffering on this visit as the first symptoms, inferentially of cryptococcal meningitis, noticed by her. However none of the expert evidence suggests the symptoms of the illness are likely to have had material

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39 T9-55 L7.
40 T1-35 L3.
41 T8-53 L30.
42 T8-54 L20.
43 T1-35 L15.

onset as early as that. Even if the consultation happened it has no apparent relevance to the alleged negligence of September 2008. Further, if it did occur, the fact that the defendant's practice has no record of it has no material bearing on the reliability of the defendant's account of the consultations of September 2008. It is common ground the September consultations did occur and the defendant does have records of them.

5 September 2008 (Friday) consultation with chiropractor

[54] The material chain of medical consultations began on 5 September when the plaintiff consulted chiropractor Dennis Collis at North Cairns Chiropractic complaining of neck pain and headaches. It is common ground that Mr Collis did not perform a manipulation but arranged for the taking of an x-ray of the plaintiff's cervical spine, thoracic spine, lumbar spine and pelvis.

[55] During this attendance the plaintiff endorsed a new patient form indicating that she was seeking help for her neck, shoulders and back.[44]

[56] The plaintiff recalls in addition to having an "extremely sore neck" and "getting headaches periodically on and off", she was having rushes of blood and dizziness.[45] According to the plaintiff she informed Mr Collis she was experiencing "some rushes of blood and some dizzy spells."[46] Mr Collis made no record of and gave no evidence of being informed to that effect. Further, in a form completed by the plaintiff, where she ticked a number of ailments that were affecting her, she did not tick "dizziness", notwithstanding that it was listed directly beneath an entry, "headache/migraine", which she did tick.[47] The plaintiff was on later dates to mention flushing to the face and dizziness in her visits to the defendant. It is likely she did not report rushes of blood or dizziness to Mr Collis on 5 September and may have confused the detail of when and to whom she mentioned those symptoms.

[57] Mr Collis recorded the plaintiff's major complaint as "neck pain, headaches and shoulders" with an onset from "early July."[48] Above this entry Mr Collis noted "sub occipital" and reduced "strength." The latter entry, he explained, recorded a general complaint of decreased strength.[49] As to the former, which is a reference to the base of the skull, Mr Collis initially said it meant the plaintiff had discomfort there.[50] On the other hand in cross-examination he agreed the note "sub occipital" described the location of the plaintiff's headache, which he said was where "most cervicogenic headaches" are caused.[51] Mr Collis appeared uncertain as to whether his noted reference to "sub occipital" meant his patient had discomfort there or had a headache there.

[58] The plaintiff testified that she had problems with her right leg in the ensuing weeks and there was a possibility that some pain in the leg did exist when she consulted Mr Collis on 5 September. However she was uncertain about that and was

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44 Ex 4 v 1 tab 3 p 166.
45 T1-36 L25.
46 T1-36 L34.
47 Ex 4 v 1 tab 3 p 172.
48 Ex 4 v 1 tab 3 p 170.
49 T7-44 L40.
50 T7-44 L35.
51 T7-52 L45.

uncertain about whether she told Mr Collis of it.[52] Mr Collis noted that the plaintiff's type of pain was "aching" and it referred to her right arm and right leg.[53] However he was not asked in evidence to explain what these entries meant. In interpreting another of his records from that date Mr Collis gave evidence the entry meant that there was no deficiency in leg strength although the plaintiff had a tendency to stagger to the right when walking.[54]

[59] These entries likely relate to the plaintiff's musculo-skeletal condition and not to a symptom of cryptococcal meningitis. Dr Whitby, an infectious disease specialist, opined that the detection by Mr Collis of pain in the right arm and right leg on 5 September 2008 was unlikely to be related to cryptococcal meningitis and more consistent with neurological irritation around the lumbosacral region of the spine.[55]

8 September (Monday) consultation with chiropractor

[60] On 8 September the plaintiff again consulted Mr Collis. It is common ground that he performed a manipulation on the plaintiff's cervical spine, thoracic spine, lumbar spine and pelvis.

11 September (Thursday) consultation with chiropractor

[61] On 11 September 2008 the plaintiff again consulted Mr Collis. It is common ground Mr Collis again performed a manipulation on the plaintiff's cervical spine, thoracic spine, lumbar spine and pelvis.

[62] The plaintiff testified that her further visits to Mr Collis did not improve her symptoms and her symptoms steadily became worse.[56]

12 September (Friday) consultation with defendant

[63] The plaintiff consulted the defendant unaccompanied on 12 September 2008.

[64] The defendant's notes of the consultation are as follows:

> "**Friday September 12 2008 09:08:33**
> Dr Kaylene Ferguson
> Paps to date
> Mammogram due June this yr
> Given another referral
>
> Nil FH ca bowel, nil bowel changes
> Intermittent neck pain, worse 6/52, causing headache and flushing to face
> Chiropractor did XR C spine, showed loss of normal curvature
> Is finding that massage is resolving symptom
> Nil head injury, nil neurological def, nil visual disturbance
> FH CVA both Grandmas
> BP 118/80

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52 T2-14 L30.
53 Ex 4 v 1 tab 3 p 170; T7-45 LL11-24.
54 Ex 4 v 1 p 169; T7-46 L35; T7-47 L26.
55 Ex 17 p 9.
56 T1-37 L15.

IMP
Cervical spondylosis
Plan
Simple analgesia
Cont physio
R/V if any changes or concerns."

[65] The following matters are common ground on the pleadings. The plaintiff reported to the defendant that she had been suffering from neck pain that had been worsening over the past six weeks. She indicated she consulted a chiropractor on a number of occasions, that the chiropractor had performed an x-ray of her cervical spine and that the x-ray had shown loss of the normal curvature of her lumbar spine. The defendant recorded the plaintiff's blood pressure as 118/80mmHG but did not otherwise perform a medical examination on the plaintiff. The parties are otherwise in dispute as what else occurred at the consultation.

[66] The plaintiff testified that she told the defendant:

> "I was having rushes of blood to the head, I had dizzy spells, I had a very sore neck, I was getting headaches and I was occasionally losing strength in my right leg."[57]

[67] The plaintiff testified that she told the defendant she was taking Panadol but there was no further discussion on medication other than that and she was not given any prescription.[58] The defendant recalled the plaintiff mentioned she was sensitive to medication and was not taking much or any analgesia.[59]

[68] The defendant testified she had a partial recollection of the consultation and in the process of giving evidence refreshed her memory from her clinical notes. She testified the plaintiff told her:

> "She…had neck pain. She said the neck pain was intermittent. It had been worse over a six week period and the neck pain was causing headache and a flushing to the face, that she'd been to see the chiropractor and that he had done an x-ray of her cervical spine, and that had showed some loss of normal curvature of the spine that initially going to the chiropractor helped, and simple things like massage helped."[60]

[69] The defendant acknowledged she did not actually see the x-ray that the chiropractor had done and had in effect acted upon the plaintiff's information that the x-ray showed some loss of normal curvature of the spine.[61] She explained that is a fairly common finding.[62]

[70] When pressed in cross-examination about the lack of detail in her notes about the headache and the flushing to the face the defendant explained they "were occurring with the neck pain or from the neck pain."[63] She conceded that she viewed them as

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57 T1-37 L26.
58 T1-39 LL24-31.
59 T8-56 L45.
60 T8-55 LL33-41.
61 T8-79 LL15-22.
62 T8-79 L21.
63 T8-77 L30.

secondary to the primary symptom of neck pain.[64] Such a view is not inconsistent with the plaintiff's own recollection. For instance, the plaintiff agreed that she told the defendant her neck pain was sometimes associated with headaches.[65] It was suggested to the defendant that she was not overly concerned about the symptom of flushing to the face because she had, in the alleged consultation of June 2008, concluded the plaintiff was probably menopausal.[66] The defendant rejected that suggestion.

[71] The defendant gave evidence she asked the plaintiff questions relating to neck pain and headache, establishing that the plaintiff had no relevant history of head injury, neurological deficit or visual disturbance.[67] Enlarging upon her note to that effect she explained she would have asked the plaintiff whether she had a cough or cold, any recent sinusitis, any fever or rash, any light bothering the eyes or any vomiting.[68] She explained the purpose of asking such questions:

> "It was just a general screen for neck pain and headache to make sure there aren't any red flags or anything more serious that might be causing the pain… If she'd had a head injury or trauma, that would be significant. If she'd had a cold, a sinusitis or mouth ulcers, those things can precede meningitis. Some people have migraines, and obviously things like rash and that can occur in meningitis as well – fever or systemic illness."[69]

[72] The plaintiff also testified that by this consultation she was tending to move her shoulders, turning with her upper body rather than moving her neck and causing it pain.[70] However she volunteered in cross-examination that her head and neck movement were "still relatively good."[71] The defendant did not physically test the range of movement of the plaintiff's neck.

[73] In cross-examination the defendant asserted she would have asked about weakness in the course of her neurological screening questions.[72] She acknowledged that where there is concern about a neurological problem it would be a standard question to enquire whether a patient had noticed any numbness, weakness or clumsiness in the arms or legs.[73] However the defendant did not suggest she made an enquiry of that kind, explaining she was not thinking more broadly beyond the symptoms of neck pain associated with intermittent headache as suggestive of neurological symptoms.[74]

[74] The defendant was asked if she formed any view about what the nature of the plaintiff's condition was and she replied:

> "I thought that she had a probable musculo-skeletal insult to her neck. It could be cervical spondylosis, that she was taking very little or an inadequate amount of analgesia for that, that she was continuing to

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64 T8-77 L35.
65 T3-35 L42.
66 T8-78 L1.
67 T8-56 L5.
68 T8-56 L14.
69 T8-56 LL24-33.
70 T1-39 L7.
71 T3-47 L46.
72 T9-10 L5.
73 T9-10 L16.
74 T9-10 L32.

> work and she sounded like a hard worker and she had stressors at home, that she'd been seeing a chiropractor which I thought might be aggravating her neck rather than helping."[75]

[75] The above reference to "stressors at home" derived from the plaintiff having mentioned she had difficulties at home with her husband, who she wanted to leave, and with her teenage son, although she did not enlarge on what the difficulties involving the son were.[76] The defendant explained those matters were not recorded in her notes because of the risk of such entries being used in family court proceedings.[77] When cross-examined about why she did not at least write "stress" in her notes she explained she is always reluctant to write that anything is "just caused by stress".[78] In any event the plaintiff accepted, contrary to her Amended Reply,[79] that she did speak to the defendant about the stress at home.[80]

[76] There was a divergence in witness recollection about some aspects of this consultation. Some of the differences are of minor significance but have some relevance to credibility.

[77] The defendant's notes make reference to a "mammogram" having been due in the middle of 2008 and to the fact that the plaintiff was given another referral.[81] The defendant gave evidence to the effect that she would have given the plaintiff a referral for breast screening.[82] When it was put to the plaintiff in cross-examination that she was given a referral for a mammogram at this consultation she denied that a mammogram was even discussed at the consultation, maintaining they had a discussion about a mammogram in the alleged consultation of June 2008.[83] The defendant's use of the word "another" in her note about the referral is consistent with the prospect of the defendant having previously given the plaintiff a referral for a mammogram however the defendant denied having given the plaintiff a referral on a prior occasion.[84] Regardless of whether there had been a consultation in June the content of the doctor's notes of 12 September renders it inherently implausible a referral was not discussed and provided during the consultation.

[78] The defendant recorded the plaintiff had no bowel changes whereas the plaintiff denied having been asked about that on 12 September.[85] The plaintiff's denial of a matter she would not have had any certainty of recollection about was not credible. It is unlikely the defendant concocted such an entry.

[79] The defendant's notes recorded that massage was resolving the plaintiff's symptoms, but in cross-examination the plaintiff denied telling the defendant that.[86] Again this was not a credible denial. The repetition of the plaintiff's visits to the chiropractor suggests she found his treatment beneficial. I am satisfied the

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75 T8-57 L35.
76 T8-57 L14.
77 T8-57 L22.
78 T8-75 L10.
79 [2](g).
80 T3-45 L30.
81 Ex 4 v 1 tab 1 p 14.
82 T3-55 L14; T3-55 L23.
83 T2-12 LL30-45; T3-49 L38.
84 T8-72 L6.
85 T3-47 L25.
86 T3-38 L17.

defendant's entry on this topic is not an invention, although, considered in context, the use of the word "resolving" was likely meant in the sense of giving temporary relief.

[80] There is imprecision where in recording the future treatment plan the defendant's notes record "Cont physio". There had not yet been an attendance upon a physiotherapist by the plaintiff and thus no physiotherapist's treatment to continue. There had however been repeated chiropractic manipulation and the plaintiff continued to attend the chiropractor subsequent to the consultation with the defendant on 12 September. The plaintiff rejected the suggestion that the defendant told her she should try a physiotherapist.[87] Had she understood the defendant had recommended she should see a physiotherapist I accept she likely would have seen one. The defendant gave evidence that she ordinarily would not refer patients to alternative health practitioners such as chiropractors.[88] The defendant even testified she thought that chiropractic treatment might be aggravating rather than helping.[89] That recollection seemed speculative. It is not reflected in her notes, which specifically included the words, "is finding that massage is resolving symptoms."

[81] The probability is that there has been some imprecision in the notes made by the defendant on this topic and it is likely, despite the defendant's professed disposition against recommending chiropractic services, that the defendant told the plaintiff if the massage or manipulation was helping then she should continue with it.

[82] I bear that imprecision in note-taking in mind in considering the reliability of the defendant's notes and recollection of the following more significant matters of divergence between the plaintiff and defendant.

[83] The plaintiff testified she complained to the defendant of dizziness but such a symptom was not pleaded by the plaintiff in respect of this consultation. Nor was such a symptom noted by the defendant at this consultation. The defendant recorded detail such as "flushing to the face" during this consultation. At the consultation of 18 September she did record the fact the plaintiff was getting dizziness. It is therefore unlikely the defendant would have failed to record dizziness had the plaintiff actually complained of it during the consultation of 12 September. It is more likely the plaintiff's memory is unreliable as to the timing of the onset of dizziness and she did not mention it at the consultation of 12 September.

[84] As to the general severity of the plaintiff's symptoms, in cross-examination the plaintiff asserted she had told the defendant she had an "extremely" sore neck and had "extremely" bad headaches.[90] She testified that her headaches fluctuated between quite bad and into "something dull" and they were increasing and were "bad quite a lot."[91] She also asserted that, as at 12 September, her neck was "sore all the time".[92] That assertion is at odds with the defendant's notation of "intermittent" neck pain. Further, the plaintiff went to the Cairns Amateurs racing carnival the following day. The plaintiff's symptoms did eventually become

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87 T3-49 L27.
88 T8-58 L5; T9-3 L35.
89 T8-57 L36.
90 T3-36 LL40-48.
91 T3-37 LL40-48.
92 T3-38 L4.

extreme but it is surprising, if the plaintiff's recollection of her then degree of suffering is accurate, that she went to the Amateurs the following day. Her explanation for this is that she made a commitment to go and had paid money to go but did not enjoy it.[93] It is difficult to be precise about degrees of pain, but I do not accept the plaintiff's reporting of her then degree of suffering to the defendant suggested it was as extreme as described by the plaintiff before me.

[85] The plaintiff gave evidence that by 12 September she was occasionally losing strength in her right leg.[94] She testified it was not then so bad that she could not use her motor vehicle pedals safely,[95] although she would have to pull up on occasion because of rushes of blood to her head and dizziness.[96] The plaintiff claims to have told the defendant about the loss of strength to her right leg[97] and about having to pull her vehicle over because of rushes of blood to her head and dizziness.[98] She was uncertain whether she told the defendant there was pain to her leg.[99] The plaintiff asserts the defendant asked her no questions about the loss of strength to the plaintiff's leg.[100] The defendant made no notes of such a symptom and testified nothing was said about the plaintiff having to pull her vehicle over.[101] The plaintiff undoubtedly did experience a loss of leg strength eventually. However if the plaintiff had mentioned such symptomology during the consultation of 12 September it is surprising the defendant not only failed to note it but also failed to ask questions about it. The likely explanation is the topic was not mentioned at this consultation and the plaintiff's recollection of the timing and degree of onset of the symptom is unreliable.

12 September (Friday) consultation with chiropractor

[86] Later on 12 September the plaintiff again consulted Mr Collis. It is common ground that he again performed a manipulation on the plaintiff's cervical spine, thoracic spine, lumbar spine and pelvis.

13 September (Saturday) attendance at Cairns Amateurs

[87] The plaintiff attended the Cairns Amateurs racing carnival on Saturday 13 September 2008 and saw her mother there.[102] Her mother testified that the plaintiff at times had to support herself on a table or a chair when she stood up.[103]

15 September (Monday) consultation with chiropractor

[88] On 15 September the plaintiff again consulted Mr Collis, reporting that her neck was still sore. It is common ground that Mr Collis performed a manipulation on the plaintiff's cervical spine, thoracic spine, lumbar spine and pelvis.

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93 T3-38 L10.
94 T1-38 L3.
95 T1-38 L4.
96 T1-38 L1.
97 T1-37 L26.
98 T1-38 L10.
99 T2-16 L7.
100 T2-15 L42.
101 T9-46 L5.
102 T1-40 L45.
103 T-54 L23.

[89] Mr Collis' notes of the consultation recorded that the plaintiff was still sore.

[90] In cross-examination Mr Collis agreed that the plaintiff did not complain of headache on 15 September.[104] That evidence was unconvincing. It was obviously not premised on an independent recollection of each of the complainant's visits and what she told Mr Collis. Rather it appeared to be premised merely upon the absence of a specific reference to a headache in the small space allocated in his pro forma consultation record of the plaintiff's repeat visits. Mr Collis is unlikely to have had a reliable recollection whether or not the plaintiff complained of headache on 15 September.

17 September (Wednesday) consultation with chiropractor

[91] On 17 September 2008 the plaintiff again consulted Mr Collis. It is common ground she reported her neck was still sore and that she was suffering from headaches. Mr Collis again performed a manipulation on her cervical spine, thoracic spine, lumbar spine and pelvis and certified her unfit for work from 17 September 2008 to 21 September 2008.

[92] The plaintiff was certain that she at some point told Mr Collis about a loss of strength in her right leg but was uncertain when she told him of it, explaining the loss of strength in her right leg had become extremely regular by around 18 September.[105] The plaintiff testified that by 17 September she told Mr Collis her leg was collapsing on occasion, although she was unsure whether she had told Mr Collis it was giving her a problem with walking.[106] Mr Collis made no record of and gave no evidence that he was told of a loss of strength in the plaintiff's right leg or of the leg occasionally collapsing.

[93] According to the plaintiff she was experiencing nausea by 17 September and had vomited on the evening of 16 September however she made no mention of this to Mr Collis.[107] Nor in her evidence-in-chief did she make reference to nausea as one of her symptoms when describing her symptoms as at 17 September.[108]

[94] Mr Collis' brief notes of the consultation on 17 September recorded merely that the plaintiff was still sore and had a headache.[109]

[95] In contrast to that benign entry, the plaintiff's evidence-in-chief of her symptoms as at that time was to this effect:

> "…my symptoms had increased quite a deal. I [was] still having rushes of blood and dizziness but more frequently. The pain in my neck and head had <u>increased dramatically</u> and I – for that particular appointment with Mr Collis, when I had initially tried to make the appointment, he had not had availability and I had particularly asked him if – I said – told him that things were <u>extremely bad</u> and I really

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104 T7-51 L23.
105 T2-16 LL15-47.
106 T2-17 LL10-29.
107 T2-19 LL14-27.
108 T1-41 LL20-26.
109 Ex 4 v 1 p 171.

> asked him if he could squeeze me in, which he did. But – yeah, so it had all increased substantially."[110] (emphasis added)

[96] In cross-examination the plaintiff emphasised she had stressed "how much worse things had become" to Mr Collis, saying the neck pain and headaches "had become a lot, a lot worse" and the loss of strength in her right leg had "become much more frequent."[111] She swore that the loss of strength in her right leg at this stage was occurring several times a day and actually involved unsteady movement.[112]

[97] The plaintiff did not plead or give evidence that she informed Mr Collis her symptoms had degenerated to the substantial extent she described in her evidence.

[98] It is common ground that Mr Collis did certify the plaintiff unfit for work from 17 to 21 September, which is consistent with the evidence of the plaintiff that whilst she attended work for a brief period on 17 September she was not well enough to continue working.[113]

[99] It is unlikely the plaintiff represented to Mr Collis her decline was as dramatic or as extreme at this stage as she represented in evidence. It was a recurring feature of the plaintiff's evidence that her condition was more extreme at an earlier stage than any of the medical professionals she consulted appear to have noted or recalled. While the plaintiff may have been quietly stoic about the extent of her suffering, the probability is her condition was not as extreme as early as she in hindsight recollects.

18 September (Thursday) consultation with defendant

[100] On Thursday 18 September 2008 the plaintiff consulted the defendant again.

[101] The defendant's notes of the consultation are as follows:

> "**Thursday September 18 2008 10:33:47**
> Dr Kaylene Ferguson
> Neck remains painful
> Getting dizziness
> Reduced ROM
> Plan
>
> Reasons for contact:
> Neck – Pain
> **Actions:**
> Diagnostic Imaging requested: CT cervical spine
> Prescription added: STEMZINE TABLET 5mg 1 t.i.d. p.r.n.
> Prescription added: PANADEINE FORTE TABLET 500mg/30mg 2q.6.h. p.r.n.
> Prescriptions printed:
> PANADEINE FORTE TABLET 500mg/30mg 2q.6.h. p.r.n.
> STEMZINE TABLET 5mg 1 t.i.d. p.r.n.
> r/v here immediately after imaging."

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110 T1-41 L20-26.
111 T3-51 LL34-40.
112 T3-51 L45—T3-52 L20.
113 T1-41 L43.

[102] The following matters about the consultation are common ground on the pleadings. The defendant did not perform a physical examination. The defendant referred the plaintiff for a CT scan of her cervical spine and prescribed Panadeine Forte tablets (500mg/30mg to be taken every six hours (two tablets) as required) and stemzine tablets (5mg to be taken three times a day (one tablet) as required). A CT scan was later performed of the plaintiff's cervical spine. It showed posterior disc bulges at C2/3 and C3/4, a slight posterior bulge at C5/6 and a mild broad based posterior spondylitic protrusion at C6/7. The parties are otherwise in dispute as to what occurred at the consultation with the defendant.

[103] On the plaintiff's account her estranged husband drove her to the surgery but he remained in the car.[114] She gave evidence that walking caused pain to her neck and head and she walked into the consultation room slower than normal.[115] As against this, the defendant explained it was her usual practice to walk with patients the 10 to 15 steps from the practice waiting room to her consultation room and in the course of doing so she would observe how the patient appeared.[116] She gave evidence she followed that practice on 18 September and that the plaintiff was walking normally.[117]

[104] The plaintiff testified of the consultation:

> "I told Dr Ferguson that my symptoms had <u>increased immensely</u>. I – they were the same symptoms, but <u>a lot stronger</u>: rushes of the blood to the head a lot more often, a lot more dizzy spells, losing the strength in my right leg more regularly and severe pain in my neck and particularly the base of my head. I told Dr Ferguson also that I was – I had nausea and I had vomited several times. I did say that I thought this may have been because of the excessive amount of Panadol I was taking, trying – and I was taking some Mersyndol as well, which I'd told her – trying to alleviate the pain, but I was getting no relief from the pain. Dr Ferguson suggested that I get – I have a CT scan and she also suggested that she'd write me a prescription for some stronger medication for the pain and for an anti nausea, and she gave me a referral to North Queensland X-Ray… I told Dr Ferguson at that time that my estranged husband had driven me to the surgery and that he would be able to take me over to North Queensland X-Ray, which is a little distance from the surgery, to have the – the CT scan. I told her I was not – I was not able to drive – I was not in any condition with my symptoms to drive safely… I told Dr Ferguson that I – not – that I had ceased working because I was unable to work, and I told her I was struggling at home…due to the pain."[118] (emphasis added)

[105] The plaintiff's testimony conveyed the impression there had been a significant decline in her condition since last she had seen the defendant. The defendant said the plaintiff did not report that her symptoms had deteriorated or that her neck pain

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114 T1-42 LL10-23.
115 T1-42 L35; T3-53 L27.
116 T8-58 LL27-44.
117 T8-58 L47; T8-59 L7; T9-47 L17.
118 T1-42 L42—T1-43 L27.

was severe.[119] Rather the defendant recalls the plaintiff reported her neck was still painful.[120]

[106] Some aspects of the consultation were explored by the plaintiff's counsel with a view to demonstrating the plaintiff's condition must have been demonstrably worse.

[107] The fact the defendant prescribed stronger analgesia was highlighted to suggest the plaintiff's pain must have been worse. The defendant maintained that the plaintiff's symptoms had not become worse in comparison to 12 September.[121] The implication of her evidence was that she was concerned the plaintiff's neck was "still painful", that is, it had not improved and Panadeine Forte would better manage her pain.[122] The expert general practitioners called by both parties testified it is unremarkable, where a patient complaining of pain is advised to take a normal dose of simple analgesia but returns complaining the pain has not been relieved, for a medical practitioner to prescribe a stronger medication to try and obtain relief from the pain.[123]

[108] The fact the plaintiff was taking time off work was also highlighted to suggest the plaintiff's condition must have become worse. The plaintiff gave evidence that she told the defendant she had ceased working because of her condition but the defendant had no memory of being given that information.[124] Had the defendant been told the plaintiff had become physically unable to work or drive I accept she would have noted such information and she did not. The topic of the plaintiff not working, albeit not in the context of physical incapacitation, was at the very least discussed the following day when, at the plaintiff's request, the defendant gave the plaintiff a letter certifying she was unfit for work for a week.[125] The defendant conceded the question of whether or not a person is still working can be a marker of the severity of their symptoms,[126] however the defendant explained she considered avoidance of work would assist in avoiding further aggravation of the condition.[127] The import of the defendant's evidence on this issue was, in effect, that taking time off work was a sensible reaction to the need to better manage and aid recovery from a painful condition that had not improved, as distinct from it being a reaction to a significantly worsening condition.

[109] The plaintiff's notes of the consultation of 18 September refer to a "reduced ROM", [128] that is, a reduced range of movement. In cross-examination the plaintiff testified she told the defendant that the pain in her neck had increased.[129] However the plaintiff testified that the defendant did not ask and the plaintiff did not mention the fact that her neck had restricted movement.[130] The defendant acknowledged the

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119 T9-4 LL15-27.
120 T9-47 L25.
121 T9-9 L7.
122 T9-8 L19; T9-8 L47.
123 T11-13 L46; T7-19 L2.
124 T9-15 L18.
125 T9-31 L46.
126 T9-15 L11.
127 T8-63 L44 – T8-64 L7.
128 Ex 4 v 1 tab 1 p 3.
129 T-53 L40.
130 T3-55 L8.

plaintiff's posture and movement suggested her neck and head had less freedom and some reduced range of movement.[131]

[110] The reference in the defendant's notes to reduced range of movement implicitly acknowledges there may have been some decline in the plaintiff's condition relative to her previous presentation however I do not accept the plaintiff told the defendant that her symptoms had "increased immensely" or were "a lot stronger". As will be seen the plaintiff's symptoms eventually went into extreme decline but the plaintiff's recollection of the precise timing and gradations of her decline is unreliable. If the plaintiff had, as she alleges, informed the defendant on 18 September that her symptoms had increased immensely and had become a lot stronger, it is apparent from the nature of the defendant's note-taking that she would have noted a worsening of the plaintiff's symptoms.[132] I do not accept that the plaintiff was told on 18 September that the symptoms reported on 12 September had increased immensely or were a lot stronger.

[111] On the plaintiff's account of the consultation of 18 September she told the defendant she had the same symptoms but she did not specifically refer to a headache. Rather she referred to "severe pain in [her] neck and particularly the base of [her] head".

[112] The defendant gave evidence that the plaintiff had not said anything to her on 18 September about a headache.[133] However I accept the plaintiff's evidence that in referring to her neck pain she also referred to experiencing pain at the base of her head. That evidence is consistent with her past reporting to Mr Collis and to the defendant of a headache associated with her neck pain. It was at the very least an assertion that the defendant should have clarified. Given the continuation of the neck pain reported to the defendant on 18 September, and given the defendant had noted on 12 September that the neck pain was "causing headache", the defendant, exercising reasonable care, should have clarified whether the plaintiff's headaches were also continuing. Had she done so the plaintiff would inevitably have explained she was from time to time still experiencing headaches, apparently associated with her neck pain.

[113] The defendant did not ask the plaintiff in this consultation whether the flushing to the face of which she complained on 12 September was still occurring and nor, on the defendant's evidence, did the plaintiff report flushing to the face during this consultation.[134] The defendant acknowledged that symptom was unlikely to be caused by cervical spondylosis[135] but regarded it as a common benign symptom that was not unusual in the absence of a clearly demonstrated cause.[136] Be that as it may, on 12 September the defendant had noted that the plaintiff's intermittent neck pain was causing flushing to the face. Because of that and because her patient was still complaining of neck pain the defendant should, exercising reasonable care, have enquired whether the neck pain was causing flushing to the face as had previously been reported to her.

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131 T8-59 L17; T9-13 L46; T9-49 L14.
132 Compare for example her note's reference to "worsening pain" on 25 September.
133 T8-61 L42; T9-47 L32.
134 T9-12 L43; T9-13 L10.
135 T9-12 L34; T9-57 L45.
136 T9-13 L2.

[114] It is difficult to predict what she would have been told had such enquiry been made. Unlike the references to headaches that recurred in the notes of the various medical professionals who did deal with the plaintiff, the symptom of flushing to the face only appears to have been noted by the defendant and only in her notes of 12 September. It is much less clear therefore whether she would, if asked, have reported that symptom on 18 September. The plaintiff's account in evidence of what she told the defendant in the consultation of 18 September incorporates a number of assertions which I have already explained I do not accept. The description she gave in her evidence of having told the defendant on 18 September that she was having "rushes of blood to the head a lot more often" may be a reference to a worsened form of flushing to the face. While I do not accept there had been a significant worsening of that symptom I infer that, had the plaintiff been asked if her neck pain was still causing flushes to the face, she would have indicated it was.

[115] It was put to the plaintiff in cross-examination that she had not told the defendant she had nausea and had vomited but the plaintiff maintained she did tell the defendant that.[137] The defendant testified the plaintiff did not ever report having nausea or vomiting.[138] The fact that Stemzine was prescribed and that it has a known anti-nauseant quality[139] does not materially assist fact finding on this issue because it is commonly prescribed for the management of dizziness, a symptom it is agreed the plaintiff had.[140] Nausea culminating in vomiting is such a physical manifestation of illness as to be obviously relevant information. It is the type of information the defendant would have recorded in her notes but no reference to it is made in the notes. I do not accept the plaintiff's evidence that she informed the defendant of it.

[116] The defendant recorded that the plaintiff was "getting dizziness". The plaintiff denied in cross-examination that this was the first occasion on which she told the defendant she was experiencing dizziness and asserted that in this consultation she told the plaintiff she was "still" experiencing periods of dizziness.[141] For the reasons already mentioned it is likely this was the first occasion on which the plaintiff mentioned dizziness to the defendant.

[117] The defendant had no independent recollection of asking the plaintiff any questions about the dizziness noted by her.[142] She rejected the suggestion the note of this symptom was inadequately detailed.[143] She asserted her practice when a patient complained of dizziness was to ask questions to ascertain whether the patient was suffering dizziness, that is, light-headedness and wooziness, as distinct from vertigo, where the patient feels the room or other things are moving about them.[144] If there was no rotational element to the sensation then the defendant said she would consider the symptom to be dizziness.[145] She said the fact that she recorded

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137 T3-55 LL20-28.
138 T8-64 L10; T9-48 L24.
139 T11-7 L40.
140 T7-27 L46.
141 T3-54 LL2-9.
142 T8-59 L27.
143 T9-11 L45.
144 T8-59 LL35-47.
145 T8-60 L2.

"dizziness" meant she had thought it was dizziness rather than vertigo.[146] I accept that evidence. It is unsurprising she would not record the detail of the standard queries she would make about a complaint of dizziness to ensure it is not a complaint of vertigo before recording it as a complaint of dizziness.

[118] While the plaintiff had seen the chiropractor after the consultation with the defendant of 12 September no reference was made to that fact during the consultation with the defendant of 18 September.[147] It was highlighted in cross-examination that at the previous consultation of 12 September the defendant made a note, "Cont physio", but the defendant gave evidence she did not ask on 18 September whether the plaintiff had consulted a physiotherapist in the meantime.[148]

[119] When asked what plan the defendant developed with the information and observations from the consultation she said:

> "I considered trying to find the x-ray and I thought there may not be much benefit to that so I thought the next step would be to do a CT. I also felt that maybe I'd undertreated her by asking her just to take Panadol. So I stepped up her pain relief to some Panadeine Forte and I've given her Stemzine for the dizziness to use on an as need basis."[149]

[120] The defendant explained she believed dizziness could accompany cervical spondylosis[150] and explained:

> "I wanted to look closer to see there wasn't anything else that may not have been picked up on the x-ray… I wanted to see if, in fact, she did have spondylosis. I wanted to see that there wasn't something more sinister like a tumour or something. Her mammogram was overdue. To make sure there wasn't some secondary thing or some unusual thing happening in the neck."[151]

Involvement of plaintiff's mother

[121] Late on the afternoon of 18 September the plaintiff's mother, Mrs Kippin, spoke with her by telephone and then decided to cancel her booking on a flight she had planned the following day with her husband and stepdaughter to Brisbane.[152]

[122] Mrs Kippin testified her daughter said she had serious pains in her neck and her head, could not cope and wanted Mrs Kippin to come and stay with her to help.[153] Mrs Kippin gave evidence of an understanding that while the plaintiff's estranged husband was still living at the plaintiff's house and was prepared to be of assistance, her daughter did not want him to help her.[154] The personally stressful circumstances that were prevailing in the plaintiff's life at this time did not attract prolonged attention at trial however they would hardly have been irrelevant to the decision that Mrs Kippin would stay with her daughter.

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146 T9-17 L5.
147 T9-5 L33.
148 T9-6 L23.
149 T8-60 L10
150 T8-60 L35.
151 T8-60 L43.
152 T7-54 LL33-47.
153 T7-64 L35.
154 T7-64 L44.

[123] On the morning of 19 September Mrs Kippin went to the plaintiff's house.[155] Mrs Kippin gave evidence that her daughter was lying on her bed with her eyes closed and was obviously unwell.[156]

[124] Mrs Kippin testified that at this stage her daughter had serious pains in her neck and her head and was unable to do anything except get out of bed and go to the toilet and return to bed.[157] Mrs Kippin told lawyers acting for her daughter that her daughter's sight and hearing were affected as at 19 September.[158] An initial report of the plaintiff's expert general practitioner, critical of the defendant, was premised on the accuracy of that important information.[159] In cross-examination Mrs Kippin acknowledged her daughter's sight and hearing were not yet affected as at 19 September and those problems actually began to commence on 23 September.[160] She explained she had earlier been mistaken about the topic because things had been "a bit hazy" and she was "under pressure".[161]

19 September (Friday) consultation with defendant

[125] On 19 September 2008 the plaintiff consulted the defendant at approximately 2.00pm.

[126] The defendant's notes of the consultation are as follows:

> "**Friday September 19 2008 14:00:51**
> Dr Kaylene Ferguson
> **Actions:**
> Result notified by Dr Kaylene Ferguson – COMPUTED TOMOGRAPHY – SCAN OF SPINE, CER 18/09/2008
> See report
> Nil asthma, nil reflux
> Prescription added: BRUFEN TABLET 400mg 1 q.i.d. p.r.n.
> Prescription added: VALIUM TABLET 5mg half/one t.i.d. p.r.n.
> Prescriptions printed:
> BRUFEN TABLET 400mg 1 q.i.d. p.r.n.
> VALIUM TABLET 5mg half/one t.i.d. p.r.n.
> Letter created – re. Medical Certificate."

[127] The following matters about the consultation are common ground on the pleadings. The defendant advised the plaintiff that the CT scan had shown she had five bulging discs in her cervical spine. The defendant did not perform a physical examination on the plaintiff. The defendant prescribed brufen tablets (400mg one tablet every four hours as required) and valium tablets (5mg, half a tablet three times a day as required). The defendant provided the plaintiff with a medical certificate for the period 19 September 2008 to 26 September 2008. There is again a substantial dispute of fact as to what else occurred during this consultation.

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155 T-55 L4.
156 T7-55 L17.
157 T7-65 L14.
158 T7-65 L25.
159 Ex 2 tab 1 p4.
160 T7-65 LL7-38.
161 T7-65 L25; T7-67 L3.

[128] On the plaintiff's account her mother came to her residence on 19 September and drove the plaintiff to her appointment with the defendant, the plaintiff being unable to drive. The plaintiff testified that her mother came into the waiting room with her and, at the plaintiff's request, walked into the consultation with her. The plaintiff said:

> "…I was struggling with walking. By this stage I was losing strength in the right leg on a regular occurrence but the pain in my neck and my head was also incredible so I was struggling with walking and I had my right arm linked with my mother's left. I wasn't leaning on her heavily but I was using her for some balance and some support. We followed Dr Ferguson down – a few steps down the hall to her room. She ushered us in. As we walked into the room, I was in awful pain. My manners were a bit remiss. I said, 'This is my mum. She has come to look after me.'"[162]

[129] The defendant's recollection was that nobody was present in company with the plaintiff during the consultation.[163] Her expression of her memory to that effect varied between "to the best of my memory"[164] and "a hundred per cent certain".[165] It is common ground that the defendant did encounter Mrs Kippin later, on 25 September, when she came to the practice wheeling her daughter in to the consultation. The defendant was also visited by Mrs Kippin about two months later when Mrs Kippin attended and requested a copy of the defendant's notes, potentially for medico-legal purposes.[166] When it was put to the plaintiff and Mrs Kippin in cross-examination that Mrs Kippin had not attended the consultation of 19 September both of them rejected that suggestion.[167]

[130] The plaintiff's mother Mrs Kippin gave evidence to the effect that she accompanied her daughter into and out of the consultation with arms linked because her daughter was unsteady on her feet.[168] When asked to describe the fashion in which the plaintiff walked out of the consultation the plaintiff responded:

> "The same way I walked in. I linked my right arm in my mother's left arm and I used my mother for some support. The walk was slow. I was definitely walking a lot slower by this stage, not lifting my feet well, not stepping properly."[169]

[131] In cross-examination the plaintiff asserted the difficulty with walking and the loss of strength in her right leg was worse than the day before and a loss of strength that made her wobbly on her feet had become "quite frequent."[170] She testified that every time she stood or sat the pressure through the lower back part of her head or upper back part of her neck, around the base of her skull, would increase the pain.[171]

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162 T1-45 L5-13.
163 T8-62 L23; T9-37 L46.
164 T9-38 L27.
165 T9-37 L46.
166 Ex 4 tab 1 p 4.
167 T4-16 L44; T7-66 L13.
168 T7-55 LL28-35; T7-56 L27.
169 T1-46 L43.
170 T4-17 LL10-43.
171 T4-22 LL1-15.

[132] On the plaintiff's evidence she did not reiterate to the defendant the symptoms described the previous day and rather emphasised in a general sense that her pain and the symptoms were growing worse.[172] Inconsistently with this, her mother, who had not been at the consultation the previous day, testified that the plaintiff told the defendant:

> "…she was losing the strength in her right leg – her right leg was giving way – and that she was still suffering the dizzy turns and the blood rushes to the head, headaches, neck ache."[173]

[133] According to the defendant she followed her usual practice of walking from reception to her consultation room with the plaintiff and observed the plaintiff was unchanged from the day before.[174] Her notes make no reference to any difficulty about leg strength or ability to walk. Her notes of the day before do refer to a reduced range of movement but on the whole of the evidence it is obvious that was a reference to the vicinity of the neck. Even allowing for the defendant's notes not being a precise or complete record of what she saw or was told it is incredible that she could have witnessed the plaintiff needed physical support to walk and, at least on Mrs Kippin's account, be told of a loss of leg strength to the point where the leg was giving way, yet make no note whatsoever of such a problem.

[134] The plaintiff, her mother and the defendant have for some years lived with the knowledge of the catastrophic fate which befell the plaintiff and have probably trawled their recollection of these events repeatedly and to an extent likely to have made each of them more entrenched as to the certainty of their recollection. There is no doubt that, eventually, the plaintiff did need Mrs Kippin's assistance to move. However that need inevitably arose progressively. There is a real prospect of error in recollection as to the timing of Mrs Kippin's presence, vis-à-vis her daughter, transitioning from being a nearby maternal presence to a physical support necessary for safe movement. Mrs Kippin and the plaintiff are unlikely to be mistaken about the fact Mrs Kippin was, at least generally, in company with the plaintiff at the consultation. If Mrs Kippin's role was merely a comforting rather than physically essential presence then perhaps her presence on 19 September may not have been a factual detail the defendant is likely to have noted or remembered. However I do not accept that by the consultation of 19 September the plaintiff actually needed or appeared to need her mother's support to walk. That need, and the loss of leg strength occasioning it, came days later. I reject the evidence the plaintiff exhibited difficulty in walking unsupported. I reject the evidence that Mrs Kippin and her daughter walked arm in arm into and out of the consultation of 19 September.

[135] The plaintiff agrees that on 19 September she did not tell the defendant of any new symptoms such as her hearing or vision being affected, because she had no new symptoms.[175]

[136] The defendant gave evidence that the plaintiff looked no different than she did the previous day and there appeared to be no change in her ability to communicate and

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172 T1-45 L46.
173 T7-56 L12.
174 T8-62 L7.
175 T4-18 LL1-34.

interact.[176] According to the defendant, the plaintiff said nothing to her on 19 September about headaches.[177]

[137] On the plaintiff's account she told the defendant that Panadeine Forte, prescribed the previous day, was not alleviating the pain and the pain and symptoms were getting worse.[178] The defendant denied that was said.[179] I accept that denial. If it had been said it was information of such obvious importance that it would have been noted and it was not noted. The plaintiff testified that when the defendant prescribed brufen and valium she did not actually explain what they did, other than indicating they would assist with the pain and "to relax a little."[180] The defendant explained she prescribed those additional drugs to help the plaintiff with her cervical spondylosis.[181]

[138] In the course of the consultation the defendant revealed to the plaintiff that the CT scan showed five of the discs in her neck were swollen and protruding. The plaintiff and her mother testified that the plaintiff asked what caused that, and the defendant responded "that sometimes it happens."[182] The defendant agreed she would have said to the plaintiff "that sometimes this happens".[183]

[139] The plaintiff thought from what she was told that the swollen protruding discs were the reason why she had her symptoms.[184] The defendant explained the CT scan's conclusion, that there were multilevel spondylitic bulges without overt neuro impingement, confirmed her impression that the plaintiff's pain was a result of cervical spondylitis.[185] The defendant said:

> "I was satisfied that the CT result explained her symptoms and she remained well looking. Then if I gave her the other components of the broad management of the musculo-skeletal pain or dysfunction that it would improve."[186]

[140] While the plaintiff did not expressly complain of headache on 19 September the defendant acknowledged that the headache of which she had previously complained would also be consistent with her having cervical spondylosis.[187]

[141] In the defendant's statutory declaration in answer to the plaintiff's request for information pursuant to s 27 of the *Personal Injuries Proceedings Act 2002* (Qld)[188] the defendant said the plaintiff's cervical spondylosis and the abnormalities reported on the CT scan "seemed a possible cause for her complaint of neck pain, reduced range of movement and intermittent headache".[189] The defendant did not include dizziness in that list of complaints. Consistently with her evidence about dizziness

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176 T8-62 LL7-17; T9-50 L10; T9-51 L41; T9-51 L42.
177 T8-64 L43; T9-37 L5.
178 T1-45 L36.
179 T9-51 L22.
180 T1-47 L15.
181 T9-5 L32.
182 T1-45 L30; T7-55 L48.
183 T8-65 L14.
184 T4-20 L9.
185 T8-62 L44 - T8-63 L6.
186 T8-65 L25.
187 T9-2 L42.
188 Ex 23.
189 T9-35 L45 - T9-36 L2.

and spondylosis she acknowledged she should have included dizziness in that list and explained its omission was in effect an oversight.[190]

[142] The plaintiff does not recall the defendant having told her to come back if she had any changes or concerns but acknowledges she knew she had that option.[191] The defendant indicated that it was her usual practice to tell patients to return if they had any concerns.[192]

19 - 23 September

[143] This case turns to a large extent upon what symptoms the defendant knew or, exercising reasonable care, should have known the plaintiff was suffering from as at the consultations of 18 and 19 September. However events subsequent to those consultations are of general relevance in the case, as well as relevant to my assessment of the reliability of the evidence of the plaintiff, the defendant and Mrs Kippin, particularly in respect of the events of 18 and 19 September.

[144] The plaintiff gave evidence that during the three days following the plaintiff's consultation with the defendant of 19 September:

> "Things got – got worse… I – the pain had – the – got so bad and – the strength issue on my right side with my right leg that when I needed to go to the toilet or anything – go to the toilet or get up off the bed for any reason whatsoever, my mother would have to help me. I have a clear memory that I had – that I needed to get up and have a shower, and she assisted me to the shower and stayed in the bathroom to ensure that I didn't fall over. So it didn't – the pain, particularly, and, that, like I said, the loss of strength in my legs, they were deteriorating and it was becoming extremely difficult."[193]

[145] The plaintiff testified her condition continued to worsen on a daily basis after 19 September.[194] She said that by 23 September she required assistance for the toilet, the shower, to get out of bed, to walk anywhere and that she needed a "lot" of support, not merely "gentle" support.[195] She explained that both legs did not have much strength but the right leg was worse and the pain in it was excruciating when she would stand.[196] She explained there was a risk that she would fall if she did not have assistance to stand and to walk.[197] She asserted that by 23 September she continued to feel dizzy and would feel dizzy every time she stood up.[198]

[146] When asked to describe what her headache was like by 23 September the plaintiff gave an answer which would suggest, as before, that her headache and neck pain were not manifesting themselves as two entirely separate symptoms:

> "The worst of the pain in my head was at the base of the skull and the back here, the back part of it – of your head. It certainly felt like that was where it was riveting from, where it was coming out from, but the

190 T9-36 L2.
191 T4-22 L42.
192 T8-65 L28.
193 T1-47 LL35-45.
194 T4-23 LL10-29.
195 T4-23 LL30-38.
196 T4-24 L10.
197 T4-24 L15-27.
198 T4-26 L8.

> pain in that base section of the skull particularly, just in that section which I don't know the medical terms for, that was the worst and then it riveted through your head. The neck, of course, was excruciating and it was pain all over the body, but this—this here in the back base of the skull, you know."[199]

[147] Mrs Kippin testified that her daughter's condition consistently deteriorated between 19 to 23 September, saying:

> "Her ability to walk became worse and the pains in her head and neck were so extreme that she wasn't getting much sleep. She wasn't eating much at all, if anything."[200]

[148] On the plaintiff's own account between 19 and 23 September her condition had become significantly worse. Her neck in particular was in extreme and constant pain and she needed assistance to walk; yet she chose not to arrange to see a doctor during this period.[201] Her apparent explanation for not doing so was:

> "Dr Ferguson had already told me that there was no explanation for this and that it just occurs and that rest was what I had to do. I was following her instructions. I believed in my doctor at that point. I believed that she had told me what I should be doing and that there was just no explanation for my illness, there was no reason for this, it just can happen and go home and rest. I was waiting for the improvement to start…I believed in my doctor. I followed her direction in that there was no reason for what I had, it just happens, go home and rest, take the medication. That's what I did…I'm under the assumption that this is just something I have to ride out, this is what I'm being told. There is no reason, there's no cause. I'm offered no treatment, I'm offered no advice, other than a prescription and to rest…I took the advice, I took the medication and I rested and I believe there was – if you don't have a reason or a cause, you just – you do what you're told, go home and rest and wait – and take the medication and wait for things to improve."[202]

[149] That explanation makes sense if the plaintiff's symptoms continued for some days to be as they were the last time she saw the defendant but it is a less compelling explanation for the inaction between 19 and 23 September in seeking further medical assistance if the plaintiff's symptoms worsened as dramatically as is alleged by the plaintiff and her mother.

23 September (Tuesday) consultation with physiotherapist

[150] On Tuesday 23 September 2008 the plaintiff consulted physiotherapist Timothy Elsmore at Physio Health. She provided Mr Elsmore with a copy of the CT scan report of 18 September 2008. It is common ground Mr Elsmore observed the plaintiff was protecting of movement. He applied traction, passive flexion and acupuncture to the cervical spine and recommended the plaintiff wear a cervical traction collar.

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199 T4-25 LL10-17.
200 T7-56 L40, T7-68 L3.
201 T4-26 LL7-45.
202 T4-27 LL7-32; T4-28 LL20-35.

[151] The plaintiff gave evidence that her mother drove her to the consultation, went inside with her and completed the standard patient information form that would ordinarily be completed in the waiting room area.[203] The plaintiff gave evidence that her mother assisted her into the consultation room because the plaintiff "needed a little bit of assistance" with walking.[204] Her mother testified that the plaintiff also had serious difficulty in getting up the few stairs to the physiotherapist's building because of the lack of strength in the plaintiff's legs.[205] According to Mrs Kippin she actually had to help the plaintiff get on to the physiotherapist's consultation bed to put her in the position requested by the physiotherapist.[206]

[152] On the question of whether the plaintiff was accompanied by someone that day Mr Elsmore replied:

> "I believe there was somebody else in there, but in my mind's eye I couldn't say 100 per cent sure whether they came into the consult room or if they waited in the waiting room. I'm not 100 per cent sure of that."[207]

[153] The plaintiff explained her recollection of some of the consultation was "a little bit fuzzy"[208] and that her memory by this era starts to get fuzzy.[209] She gave evidence that she told Mr Elsmore:

> "I had – rushes of blood to the head, dizziness, loss of strength in the right leg and excruciating pain in my neck and the base of my head and the pain was – I was describing it as excruciating by this stage because it definitely was…I told him that I was experiencing loss of strength in my right leg and I – I don't recall telling him that I couldn't walk but I do recall telling him I was – I had a loss of strength in my right leg and I was in severe pain."[210]

[154] Despite asserting in evidence-in-chief that she told Mr Elsmore she was experiencing loss of strength in her right leg when it was put to her in cross-examination that she had made no complaint to Mr Elsmore about her right leg the plaintiff responded that she could not remember the conversation.[211] She gave a similar response in cross-examination when it was put to her that she had not described her neck pain or headache as severe talking to Mr Elsmore.[212]

[155] Mr Elsmore had the benefit of his contemporaneous notes in giving evidence. He had no particular recollection of the consultation[213] other than of a distressed woman.[214] His notes do not suggest the plaintiff was experiencing the excruciating pain described by the plaintiff in evidence. He did not recall the plaintiff responding unusually when he physically manipulated her, applying traction force

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203 T1-48 L36 - T1-39 L41; Ex 4 v 1 tab 2 p 164.
204 T1-49 L13.
205 T7-57 L15.
206 T7-57 L20.
207 T9-61 L10.
208 T1-48 L42; T1-50 L2.
209 T4-23 L33.
210 T1-49 LL27-44.
211 T5-2 L33.
212 T5-3 LL7-15.
213 T9-59 L23.
214 T9-61 L18.

to her neck.[215] Had she given an adverse response he explained he would have noted that, but he made no such note.[216] I accept that evidence. An adverse response to his main treatment would obviously have been regarded as noteworthy by him.

[156] Mr Elsmore's notes included a sketch of the rear of the human body with lines shading from the rear of the skull just below the ears down to between the shoulder blades.[217] He explained that indicated the patient had said she had pain from the base of her skull down through into her back.[218]

[157] Mr Elsmore noted against the plaintiff's clinical history that she had experienced increasing pain in the previous two months and she had a prior history of headaches.[219] While his written notes were difficult to decipher he conceded the most likely explanation of what he wrote was that the plaintiff's headaches were increasing.[220] Mrs Kippin recalls her daughter complained of headache to Mr Elsmore.[221]

[158] Mr Elsmore also noted the plaintiff had a two to three month history of vertebral artery symptoms.[222] He did not record what those symptoms were but explained they could have involved fainting, nausea[223] or dizziness or a loss of balance.[224] Mr Elsmore could not detect anything more specific in his notes to indicate that the plaintiff had dizziness or balance problems.[225]

[159] When it was suggested one of his recorded notes may have suggested the plaintiff had trouble "walking" with pain he favoured an interpretation of that entry that it referred to trouble "waking" with pain.[226] That interpretation seems more probable because nearby to the entry Mr Elsmore recorded the plaintiff was stiff and sore in the mornings, her symptoms were aggravated by rotating her neck and lying on her side and eased when she laid flat.[227] It is also consistent with Mrs Kippin's recollection of her daughter telling Mr Elsmore that her pain was waking her from her sleep.[228]

[160] Mr Elsmore indicated that if the plaintiff indicated she was experiencing problems with balance he would probably have noted that fact.[229]

[161] Overall, Mr Elsmore's evidence confirms the impression already apparent from the evidence of Mr Collis and the defendant that the onset and severity of the plaintiff's symptoms was not as apparent as early as the plaintiff or her mother recalled in evidence.

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215 T9-64 L22 – T9-65 L9.
216 T9-65 L12.
217 Ex 4 v 1 tab 2 p 163.
218 T9-61 L40.
219 T9-64 L1; T9-67 L13.
220 T9-67 L34.
221 T7-68 L36.
222 Ex 4 v 1 tab 2 p 163.
223 T9-63 L28.
224 T9-68 L36.
225 T9-70 L46.
226 T9-70 L15.
227 Ex 4 v 1 p 163.
228 T7-68 L38.
229 T9-71 L10.

24 September (Wednesday) conveyed by ambulance to Cairns Base Hospital

[162] On Wednesday 24 September the plaintiff was suffering from severe pain in her neck. Her mother testified she had become very concerned that her daughter was "getting a lot worse" and she made contact with the defendant's medical practice. The defendant was not working that day. Mrs Kippin rang the practice later that day and the receptionist suggested that if she was concerned she should get an ambulance and take her to hospital.[230]

[163] Mrs Kippin contacted the Queensland Ambulance Service, which arrived at the plaintiff's home at 6.00pm. The plaintiff pleaded, and the defendant admitted, that the plaintiff reported she was in moderate pain and had been suffering from severe neck pain. She reported the medication prescribed to her the previous Friday by the defendant had little effect on her pain levels and that the physiotherapy treatment performed the previous day had little effect on her symptoms.

[164] The plaintiff could not recall what she told the ambulance officers of her symptoms.[231] She testified:

> "When the ambulance had collected me, my pain level was absolutely excruciating. It – it's just – it's undescribable. It was totally excruciating. After the painkiller they had given me – a small amount of relief, but still not a lot. I was still in extreme pain – neck, base of the head and it just radiates through the body. But the pain level is – it's unbelievable. It just can't be described."[232]

[165] The plaintiff testified she did not have a problem with light at the time she dealt with the ambulance.[233] Mrs Kippin could not recall if the ambulance officers were told the plaintiff was losing her sight or vision.[234] The ambulance officer, Mr Elliott, who had the benefit of the contemporaneously recorded ambulance report, gave evidence that there was no complaint made of problems with the plaintiff's hearing or her vision or of aversion to light.[235]

[166] Mr Elliott also testified that no complaint was made about nausea, explaining that morphine was administered and before administering it ambulance officers would have been careful to enquire whether the plaintiff had experienced nausea or vomiting.[236] Further, the plaintiff's temperature, taken soon after the ambulance attended on the plaintiff, was normal.[237]

[167] Mr Elliott's notes recorded that on arrival the patient's complaint was "cervical spine pain" and under the heading of past history his notes recorded the plaintiff had suffered headache for the past couple of months. The entry recorded against "case history" recorded:

> "Pt states she has had severe pain to cervical area of neck this past week. Pt saw private GP on last Friday who prescribed medication for

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230 T7-57 L44.
231 T5-8 L14 – T9 L14.
232 T1-51 L25.
233 T5-9 L3.
234 T7-70 L23.
235 T8-37 L38 – T8-38 L7.
236 T8-38 LL9-19.
237 Ex 4 v 1 tab 4 p 175.

> relief of pain. little effect. Pt saw physiotherapist yesterday with little effect. Pt's mother states Pt in severe pain and called QAS as medication did not appear to be working. …"[238]

[168] Mr Elliott acknowledged he did not have an independent recollection of the case. He initially interpreted his note's reference to the plaintiff's complaint of headache to mean that the headache had been continuous for the past couple of months up to the present day.[239] However his notes of the patient's complaint "on arrival" and in her "case description" contained no reference to the plaintiff then having a headache. The only reference in the notes to the headache was under the heading "past history" against the sub heading "pre-exist".[240] He ultimately conceded that he did not know whether the plaintiff complained of having a headache as at the time he saw her as distinct from in the past[241] or whether the past headaches had been constant or recurring.[242]

24 September examination at Cairns Base Hospital

[169] The plaintiff was conveyed by ambulance to Cairns Base Hospital.

[170] The following aspects of the plaintiff's examination at the hospital are common ground. The plaintiff reported to the assessing nurse that she had chronic neck pain for several months and that the neck pain had worsened over the past week. She provided a copy of the CT scan on 18 September. At 8.30 p.m. she was reviewed by Dr Andrew Miller. She told him that she had been suffering from increasing neck pain since July 2008 and reported she felt she could not walk due to her neck pain. Dr Miller formed the impression that the patient was drowsy, secondary to her medications, and that her increased pain was due to not mobilising and that she needed a chronic pain opinion as an outpatient. Following receipt of pathology results on blood taken from the plaintiff Dr Miller noted a raised white cell count of 15.7 and noted some very slight basal crackles in the plaintiff's right lobe and diagnosed the plaintiff with a possibly very early chest infection. He decided to discharge her home with tramadol, maxolon and amoxil. The plaintiff required the assistance of a wheel chair to go to the bathroom and complained to hospital staff that the pain in her neck was increasing but she was discharged. The parties are otherwise in dispute about what occurred at the hospital.

[171] Dr Miller, the resident medical officer who examined the plaintiff, held a bachelor of medicine, bachelor of surgery and bachelor of science (in anatomy). He trained in Wales and was in his second post graduate year as a medical practitioner. He had been working in Australia at Cairns Base Hospital for about one month.[243] He had learned about, and met a patient with, cryptococcal meningitis when studying infectious diseases at university.

[172] The only relevant member of the hospital staff called as a witness was Dr Miller. He had no independent recollection of treating the plaintiff however he made notes

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238 Ex 4 v 1 p 173.
239 T8-34 L8.
240 Ex 4 v 1 p 173.
241 T8-34.
242 T8-34 L35 – T8-36 L16.
243 T4-42.

detailing the examination and was able to explain and enlarge upon their meaning in giving evidence.

[173] He accepted the fact the plaintiff waited ramped in the ambulance for a lengthy period outside the hospital[244] would indicate it was a busy time in the emergency department.[245] However his observation notes appear to be comprehensive and do not suggest a rushed examination.[246] It is readily apparent from those notes and Dr Miller's discharge letter that the plaintiff's presenting complaint at the hospital was of increasing neck pain accompanied by drowsiness. As to the latter the plaintiff indicated to him that her main concern was that she was "over drugged".[247] The ambulance records, which the hospital would have had a copy of, made reference to headaches. However the observation notes of Dr Miller and of other hospital staff do not suggest that any of the additional constellation of symptoms potentially suggestive of meningism were reported at the hospital.

[174] Dr Miller agreed that headache and neck stiffness were two cardinal signs of meningitis.[248] He also agreed he would have been keen to exclude a diagnosis of some form of meningism had the plaintiff's history of worsening neck pain also been accompanied by severe headaches, neck stiffness, nausea and dizziness.[249] However he did not detect that additional constellation of symptoms.

[175] Notwithstanding the plaintiff's predominant complaint related to neck pain, Dr Miller's notes did not record the performance of an examination of the plaintiff's neck to ascertain what her range of movement was.[250] He conceded an examination of what the plaintiff's range of motion in her cervical spine was would have been an important part of a musculo-skeletal examination but asserted it did not necessarily dictate a diagnosis or prognosis.[251] He maintained the neurological examination, which he did conduct, was more relevant so as to ensure there was no compression of any nerves.[252] He also explained had he done a musculo-skeletal examination including of the range of movement of the cervical spine and if the plaintiff had pain on forward flexion it would not necessarily have drawn him towards a conclusion of meningitis because that would equally have confirmed a diagnosis of neck pain secondary to a musculo-skeletal disorder.[253]

[176] In cross-examination Dr Miller acknowledged the plaintiff had high blood pressure readings while at the hospital but that her blood pressure returned to normal during her stay.[254] Dr Miller explained that patients in significant amounts of pain can have elevated blood pressure.[255] The plaintiff's temperature when taken at the hospital was normal.[256]

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244 Ex 4 v 1 tab 4 p 177.
245 T8-10 L37.
246 T8-11 L10.
247 Ex 4 v 2 p 884; T8-12 L6.
248 T8-6 L10.
249 T8-7 LL5-13.
250 T8-23 L20.
251 T8-24 L8.
252 T8-23.
253 T8-24 L23.
254 T8-18 L27.
255 T8-27 L45.
256 Ex 4 v 2 p 881; T4-51 L8.

[177] Dr Miller also acknowledged testing of the plaintiff's white blood cell count showed a figure of 15.7 when the normal range was four to 11.[257] He acknowledged that could be suggestive of infection but explained it could also be suggestive of an inflammatory, traumatic or allergic response to something.[258] He ultimately suspected the raised white blood cell count was associated with an early chest infection.[259]

[178] In the course of the trial some attention was also paid to the CRP (C-Reactive Protein) and ESR (Erythrocyte Sedimentation Rate) levels detected on testing at the hospital. It transpired that while the plaintiff had a raised CRP level in the course of her second hospital admission her level of 2.4 as at 24 September was within the normal reference range.[260] The ESR level as at 24 September was 14, above the ceiling of the normal reference range of 12.[261]

[179] There was some criticism in the expert evidence adduced at trial of Dr Miller's failure to pursue further examination and testing of the plaintiff in light of the elevated white blood cell count and ESR level. For instance, Dr Cameron, a consultant neurologist called by the defendant opined:

> "A white cell count of 15 would be regarded as quite elevated in a young woman and this should have alerted the doctors at the time to exclude meningitis".[262]

[180] However it is unnecessary to judge whether the hospital's treatment of the plaintiff on 24 September was professionally negligent because the plaintiff was no longer pursuing her case as against the State of Queensland at trial. The sufficiency of Dr Miller's examination and testing nonetheless has some background relevance to an understanding of the progression and diagnosis of the plaintiff's illness.

[181] The plaintiff gave evidence her memory of this occasion is "definitely fuzzy."[263] She and her mother testified that during this consultation Mrs Kippin was speaking loudly into the plaintiff's ear so that she could hear.[264] The plaintiff testified in evidence-in-chief:

> "…we told the doctor that my sight was blurry. I couldn't keep my eyes open, though, and he asked via my mother – my mother was speaking loudly into my ear so as I could hear. We told the doctor that my hearing was – was not good as well, and – but my sight was blurry. I wasn't actually losing it at – it was blurry. And he asked me whether the lights hurt my eyes, and I said no… I just can't keep them open."[265]

[182] The accuracy of the plaintiff's evidence-in-chief of what was said to the doctor about her symptoms is doubtful. This is because in cross-examination when she was asked a wide array of questions about what she had told the doctor she

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257 T8-28 L30.
258 T8-21 L33.
259 T8-22 L2.
260 Ex 4 v 2 p 613.
261 Ex 4 v 2 p 595.
262 Ex 14B p 4.
263 T1-50 L41.
264 T5-21 L12; T7-59 L23.
265 T1-51 LL5-11.

repeatedly and consistently responded that she did not remember the conversation with the doctor.[266]

[183] The plaintiff's mother testified her daughter's hearing had reached the point where Mrs Kippin would loudly repeat the questions from doctors or medical staff to her daughter so she could hear.[267] Mrs Kippin's evidence-in-chief of what was said to the doctor at the hospital about her daughter's main complaint was:

> "She told him that she'd – what had happened, that she had the blood rushes to the head from back in June, that she'd been to the doctor, that she was getting worse. She'd been to a chiropractor. She'd been to a physio. And because she was getting so much worse, she – we'd gone to the hospital, because we felt she should be in hospital."[268]

[184] Mrs Kippin was asked in evidence-in-chief whether there was any discussion about pain and she responded:

> "Yes. That's all part of the symptoms, the pain – the serious pain in the neck, the head, the bulging discs, the loss of ability to walk, the loss of her hearing and the fact that she was also losing her sight."[269]

[185] The plaintiff elaborated in cross-examination that while light was not hurting her eyes at the hospital, the peripheral parts of her sight were deteriorating and becoming vague and shadowy.[270] Mrs Kippin claimed the plaintiff actually told the doctor that she was losing her sight.[271] She testified Dr Miller said, "Your eyes and your ears have got us tricked," and told them to go home and see the plaintiff's doctor the following day.[272]

[186] Mrs Kippin testified that in departing from the hospital she took her daughter to the car in a wheelchair.[273] The fact that the plaintiff needed the assistance of a wheelchair while at the hospital is confirmed by an entry in the hospital observation notes to the effect that she was assisted to the toilet through the use of a wheelchair.[274] None of the observation notes or the evidence of Dr Miller suggest medical staff understood the plaintiff lacked the physical capacity to walk, for instance because of a lack of power. It seems likely the hospital medical staff understood the plaintiff's difficulty with walking was that she found it too painful to do so because of her chronic neck pain. That was certainly Dr Miller's understanding, for in his written observations he noted the plaintiff "feels she cannot walk due to neck pain"[275] and that she did not have any reduced power or sensation to anywhere in her body.[276] His systems review of the cardiovascular system revealed no difficulty with ability to walk[277] and his discussion of the plaintiff's social history revealed no difficulty in performing the activities of daily

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266 T5-10 L45 - T5-20 L28.
267 T7-58 L25.
268 T7-59 LL1-6.
269 T7-59 L10.
270 T5-21 LL24-42.
271 T7-59 L13.
272 T7-59 L38.
273 T7-60 L3.
274 Ex 4 v 2 p 882.
275 T4-47 L35; Ex 4 v 2 p 884.
276 T4-47 L37.
277 T4-49 L43.

living.[278] He testified that had he been told Mrs Kippin had moved in to look after the plaintiff he would have noted that as a relevant feature of the plaintiff's social history.[279]

[187] It is surprising that the hospital saw fit to discharge a patient who was in such pain she could not walk. As Dr Cameron, a consultant neurologist called by the defendant, noted, the plaintiff was in effect leaving with the same significant neck pain problem that she arrived with.[280] However it stretches credulity that the hospital would discharge such a patient if she were apparently also losing her sight and hearing. None of the hospital observation notes or the evidence of Dr Miller suggest the plaintiff was then experiencing any material impairment of her sight or hearing.

[188] In his neurological symptoms review of the plaintiff, Dr Miller explained he would have asked the plaintiff whether light bothered her.[281] That same systems review would ordinarily involve the doctor also asking the plaintiff whether she had a headache.[282] In light of the fact the plaintiff had reported to ambulance officers she had experienced headaches for the past couple of months,[283] it is surprising if the plaintiff had been asked if she was suffering from a headache that she failed to mention her recent past history of headaches to Dr Miller. He did not mention it. That raises the possibility that Dr Miller's systems review on this occasion did not necessarily involve all of the questions he would ordinarily ask as part of his standard practice.

[189] However his records do show that he paid attention to the plaintiff's sight in his systems review. For instance, his notes record the acronym PERLA, an abbreviation for "pupils equal, and reactive to light and accommodation".[284] He explained that meant he tested the plaintiff's eyes, shining a torch in them, and recorded her pupils were equal and reactive to light.[285] He tested her range of eye movement[286] and her visual acuity, having her read with each eye,[287] and detected no abnormality. It is inherently unlikely, given the attention paid to the plaintiff's sight in this examination, that Dr Miller would not have recorded that the plaintiff's peripheral vision was impaired had he been advised of it. There is no doubt the plaintiff's vision did go into rapid decline, but the timing of the commencement of that process may not have been readily apparent. It may for instance have been that the beginnings of some blurred vision were masked by or mistaken for being part of the drowsiness the plaintiff was apparently exhibiting at the hospital. However I do not accept Dr Miller was actually told by the plaintiff or her mother that the plaintiff's sight was adversely affected.

[190] As to the alleged hearing problem, Dr Miller's testing of the plaintiff's cranial nerves included testing of the cochlear nerves to check the plaintiff could hear.[288]

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278 T4-50 L12.
279 T4-50 L23.
280 T10-15 L47.
281 T4-50 L6.
282 T4-50 L6.
283 Ex 4 v 2 p 876.
284 Ex 4 v 2 p 885; T4-52 L30.
285 T4-52 L30; Ex 4 v 2 p 885.
286 T4-53 L33.
287 T4-53 L22.
288 T4-54 LL1-6.

Dr Miller recorded a number of quotes from the plaintiff in his notes, something he explained he would only have done if the plaintiff answered in those words.[289] He explained that had the plaintiff been unable to hear him when he asked questions that would have been "extremely significant" and he would have noted it.[290]

[191] While at first blush this may appear to be at odds with Mrs Kippin's description of how she relayed the doctor's questions, repeating them loudly into her daughter's ear, it may be Mrs Kippin was not performing that task as frequently as she did the following day. As with the onset of diminution in the plaintiff's sight it may also be that the onset of diminution in the plaintiff's hearing was masked by her drowsiness. Given Mrs Kippin was present at the consultation at the hospital and her daughter was drowsy it is likely Mrs Kippin did, as an incident of maternal concern, involve herself in the consultation and may sometimes have repeated the doctor's questions to or discussed the doctor's questions with her daughter. However it appears that process did not by then involve such frequency of intervention by Mrs Kippin as to suggest to a third party observer such as Dr Miller that it was driven by necessity because of a hearing problem.

[192] The evidence of what occurred at the hospital is consistent with a seeming tendency to overstatement by the plaintiff and her mother about how early and extremely the plaintiff's symptoms manifested themselves. That is not to suggest the plaintiff was not in extreme pain by the time of her examination at hospital on 24 September. It is likely she was on the cusp of the acute phase of her tragic decline. It must have been a confusing and terrifying ordeal for her and her mother in the ensuing days as the plaintiff was admitted to Cairns Private Hospital and thereafter transferred to Cairns Base Hospital. It is not surprising in the aftermath that their recollection of the detail of consultations in the lead up to that era is not entirely reliable.

25 September (Thursday) consultation with defendant

[193] When asked if she was in any different condition the following day, Thursday 25 September 2008, the plaintiff testified:

> "I – worse. I was deteriorating. On that day, I had – I started to lose peripheral – the peripherals sight, and things were starting to come – become a bit black and – more shadowy. And I started to lose this peripheral - I still had hearing, but it was certainly deteriorating at that point, and the pain was still going up. And I couldn't walk at all, but then I – I really couldn't walk the day before either."[291]

[194] Mrs Kippin testified that her daughter was losing her hearing and her sight and could not walk at all, being unable to hold her own weight.[292]

[195] The plaintiff's mother telephoned the defendant's rooms on 25 September, advising the plaintiff had been taken to the hospital's emergency department the previous night and requesting an appointment. Mrs Kippin was advised to bring her daughter to the defendant's rooms. Mrs Kippin drove the plaintiff to the defendant's rooms and the plaintiff was seen by the defendant.

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289 T8-5 L7.
290 T8-5 L13.
291 T1-51 LL37-43.
292 T7-60 L36.

[196] The defendant's notes of her consultation and related activity are as follows:

"**Thursday September 25 2008 08:48:00**
Dr Kaylene Ferguson
Presented to CBH ER last night
With worsening pain
Given Tramadol and maxolon
Feeling very weak
Mum is helping but cannot transfer to toilet safely
Nil other sig PMH
Given amoxil for ? early LRTI at CBH
Plan
I will organise admission to Cairns Private.
Actions:
Prescription added: TRAMADOL HYDROCHLORIDE CAPSULE 50mg 1 q.i.d. p.r.n.
Prescriptions printed:
TRAMADOL HYDROCHLORIDE CAPSULE 50mg 1 q.i.d. p.r.n.
I have phoned Cairns Private, they will ring back with admission time.
Thursday September 25 2008 09:20:32
Dr Kaylene Ferguson
Cairns Private are holding a bed.
Dr Morrey 0400205512, he is not answering his mobile,
I have rung secretary, Ruth she believes he is not on call until tomorrow, that Dr Todd is on call today.
Dr Bounty will try Ian Cole.
Will have admission under Dr Cole
I have phoned pt to present after lunch
Actions:
Letter Created – re. STANDARD LETTER to CAIRNS PRIVATE HOSPITAL."

[197] The following aspects of the consultation are common ground. Mrs Kippin reported to the defendant that the plaintiff's neck was worsening, she was feeling very weak and Mrs Kippin was having difficulty transferring the plaintiff to the toilet safely. Mrs Kippin reported to the defendant that the plaintiff had loud ringing in her ears but that the hospital had suggested this was a side effect of the medications. Mrs Kippin told the defendant she wanted the plaintiff admitted to a private hospital and the defendant advised Mrs Kippin that she would organise the plaintiff's admission to the Cairns Private Hospital. The defendant referred the patient to the Cairns Private Hospital.

[198] The plaintiff has no memory of this consultation.[293] Neither her mother nor the defendant gave evidence of a full recounting of the plaintiff's symptoms having occurred at the consultation. It is likely there was no such recounting because of the obvious urgency associated with the plaintiff's state.

[199] Her mother gave evidence that she borrowed an office chair from the defendant's practice to transport the plaintiff, wheeling her seated in the chair to see the defendant.[294] The defendant recalls she assisted that process.[295]

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293 T1-52 L25; T5-25 L46.
294 T7-60 L37.

[200] The defendant observed the plaintiff had changed significantly from when she had seen her on 19 September.[296] She appeared to be in pain and a bit drowsy.[297] Her mother was talking for her and explained her daughter had ringing in her ears, apparently impairing her hearing.[298] Mrs Kippin told the defendant she had been told at the hospital that the ringing in the ears was from the medication the plaintiff was on. That made no sense to the defendant.[299] That allegation was not explored with Dr Miller.

[201] The defendant agreed that ringing in the ears was a significant complaint but that she had made no note of it in her clinical notes.[300] She explained her main focus was on trying to find the plaintiff a bed at Cairns Private Hospital and her clinical notes mainly recorded that process.[301] It is likely that from the outset of this consultation the defendant's approach to her role was to no longer diagnose and treat but rather to urgently refer the plaintiff to hospital for diagnosis and treatment. Considered in that context it is not surprising that her clinical notes on this occasion dealt only briefly with the plaintiff's presentation. The omission from her notes of this urgent consultation of a significant complaint such as ringing in the ears does not materially undermine her assertion that she would usually note anything positively or negatively significant about a patient's condition.[302]

[202] As her notes suggest, the defendant made arrangements for the admission of the plaintiff into Cairns Private Hospital. In the course of making those arrangements, the defendant made some handwritten notes on the lower half of a printout of one of the pages of her typed clinical notes. The defendant would type her clinical notes at the time of her consultations.[303] These handwritten notes erroneously recorded that the intermittent neck pain had been occurring for "6/12", an entry representing six months, when it appears obvious the note was meant to read "6/52", an entry representing six weeks. The defendant, in making her clinical notes of 12 September, had used the latter style of entry. Similarly, the defendant's hand written notes of 25 September refer to the CT scan having occurred on "12/09" when the notation should obviously have been "18/09". Her writing also recorded that the plaintiff had been seeing a chiropractor "daily" but this was not literally correct and, as the defendant explained, her understanding was that the plaintiff had been seeing a chiropractor regularly before she came to see her.[304] She also wrote the plaintiff had been worse in the previous 10 days. That was an obvious error in that the plaintiff had become worse since the consultation of 19 September, which was closer to a week rather than 10 days earlier.[305] She rejected the suggestion she had written that because as at 18 and 19 September the plaintiff had been a lot worse.[306]

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295 T8-66 L7.
296 T8-66 L6.
297 T8-66 L8.
298 T8-66 L17.
299 T8-67 L46.
300 T8-69 L2.
301 T8-69 LL5-11.
302 T9-55 L6.
303 Ex 4 v 1 tab 1 p 29.
304 T9-5 L20.
305 T9-33 L41.
306 T9-34 L24.

[203] These errors, made in obviously rushed hand written notes the defendant made while in the process of trying to have the plaintiff admitted to hospital, were obviously not intended to serve as a clinical record. The fact those notes were jotted on one of the pages of the typed clerical notes and other material faxed to the hospital[307] was seized on in the plaintiff's submission as showing an intention her handwritten note should be relied on. That is unlikely and the recipient is unlikely to have had that impression from the appearance of the notes. Considered in context, the errors in the handwritten note do not cause concern as to the reliability of the defendant's clinical record keeping.

25 September admission to Cairns Private Hospital

[204] The plaintiff was taken by her mother to Cairns Private Hospital and was admitted at 11.30am. It is common ground she there complained of tinnitus and deafness. The plaintiff had no memory of conversations about her symptoms at the hospital.[308]

26 September (Friday) examination at Cairns Private Hospital

[205] It is common ground that on review at the hospital at 5.50 a.m. on 26 September 2008 the plaintiff was suffering from profound deafness, her pupils were both sluggish and her neck was bilaterally swollen. At 9 a.m. she was suffering from left facial weakness. Her tongue was deviated to the right and she had decreased reflexes and decreased power.

[206] Dr Jennifer Yarker reviewed the plaintiff and because of the plaintiff's deficits associated with cranial nerves and her sluggish reflexes Dr Yarker suspected the plaintiff may have been suffering Guillain-Barre Syndrome.[309] She did not suspect the plaintiff had cryptococcal meningitis.[310]

[207] Dr Yarker ordered investigations including a lumbar puncture. It is common ground that the cerebral spinal fluid collected in the lumbar puncture tested positive for cryptococcal infection. An MRI of the brain showed no abnormalities. The plaintiff was transferred into the intensive care unit of the Cairns Base Hospital and management and treatment for cryptococcal meningitis ensued there and at Townsville General Hospital.

Findings as to symptoms as at 18 & 19 September

[208] The upshot of the foregoing factual review and findings is that as at the time of the defendant's consultations with the plaintiff of 18 and 19 September the plaintiff:

(a) had continuing neck pain;
(b) exhibited in her presenting demeanour a reduced range of movement of her neck;
(c) was sometimes experiencing dizziness;
(d) was sometimes experiencing headaches which appeared to be connected with her neck pain;

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307 T10-48 L36.
308 T5-27 L2.
309 T10-44 L8.
310 T10-45 L23.

(e) was sometimes experiencing flushing to the face which appeared to be connected with her neck pain.

[209] As at those consultations the defendant knew the plaintiff had the first three of those symptoms. She also either knew, or, exercising reasonable care, should have known, that that the plaintiff had the fourth and fifth of those symptoms, they being symptoms she had previously complained of in connection with her neck pain.

[210] These findings are of particular relevance to a consideration of the potential presence and significance of two of the cardinal symptoms of cryptococcal meningitis: neck stiffness and headache. Whether the plaintiff's reduced range of neck movement was the result of stiffness or pain and whether and how the defendant exercising reasonable care should have investigated that question is considered further below.

[211] As for the remaining cardinal symptoms of cryptococcal meningitis the plaintiff did not inform the defendant on 18 or 19 September that she was suffering from a raised temperature, aversion to light or nausea or vomiting. I accept the defendant exercising reasonable care made adequate enquiry of the defendant about her health to prompt the reporting of those symptoms by the plaintiff had she been suffering them. She was not suffering from them. The plaintiff did allege she told the defendant on 18 September that she had nausea and had vomited but I have rejected that evidence.

C. BREACH

[212] The importance of the above determination of the factual conflict in this case to whether there has been a breach is readily illustrated by the evolution of the opinion of Dr Turnbull, the expert general practitioner called by the plaintiff in this case.

[213] Dr Turnbull initially opined that as at 19 September the plaintiff's condition should have alerted the defendant to a more widespread neurological disorder and she should have referred the plaintiff to either a private neurologist or a general physician or at least to a hospital emergency department for urgent assessment.[311] However that opinion was premised upon the accuracy of information about the supposedly marked deterioration in the plaintiff's condition which occurred between 18 and 19 September, apparently including information from the plaintiff's mother, the effect of which included that the plaintiff was suffering from increasing pain, nausea, difficulty with walking and was both sight and hearing affected.[312] Dr Turnbull observed that the latter two symptoms were especially worrying and not explicable by the relatively minor changes on the CT scan.[313] He opined:

> "The role of the GP in this case was to recognise when the clinical features began to deviate from those of a persistent musculo-skeletal condition and started to indicate a more sinister disease involving the central nervous system, requiring referral on for hospital based investigations and treatment."[314]

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311 Ex 2 tab 1 p 5.
312 Ex 2 tab 1 p 4.
313 Ex 2 tab 1 p 4.
314 Ex 2 p 7.

[214] That is undoubtedly a reasonable summary of the role of the defendant if those were the facts, but they were not. Dr Turnbull's initial opinion was premised upon the existence of symptoms I have not found to be present. In his second report, Dr Turnbull was invited to comment upon the adequacy of the defendant's management of the plaintiff on 18 and 19 September premised on the accuracy of the defendant's account of events and opined:

> "If Dr Ferguson's version is accepted, then I feel her management of the case on that day was in fact consistent with a reasonable standard of General Practice. There were certainly no symptoms suggestive of a serious condition such as meningitis… The unfortunate outcome appears to be a result of the insidious and atypical nature of this form of meningitis, which at no time prior to her admission showed any of the classical signs and symptoms of meningitis."[315]

[215] The significance of the findings of fact is also illustrated by the joint report of Dr Eisen and Dr Whitby. They opined if the defendant's version of events is to be preferred to that of the plaintiff's that the defendant did obtain a complete history from the plaintiff and did perform an adequate clinical examination of the plaintiff in her consultations with her.[316]

[216] While the findings of fact do not involve a complete acceptance of the defendant's version of the consultations and the symptoms which were present, they are substantially consistent with it and certainly much closer to that version than the version of the plaintiff.

[217] In the light of those findings should the defendant, acting with reasonable care and skill, have referred the plaintiff for specialist assessment? Did she fail to properly consult and examine the plaintiff? Did she fail to recognise the potential presence of a condition other than an apparent musculo-skeletal disorder of sufficient seriousness to warrant referral for urgent specialist assessment?

The general practitioner's role on a consultation

[218] The role of the general practitioner in consulting a patient may involve the examination, diagnosis and treatment of the patient and will inevitably involve the provision of appropriate information and advice. The extent to which examination, diagnosis and treatment is called for will inevitably depend upon the individual circumstances of each consultation by a general practitioner.

[219] Importantly those circumstances are different from those of an infectious disease specialist seeing the patient on a referral for a suspected infectious disease. As Dr Eisen acknowledged, the amount of time a general practitioner has to see a patient, the degree of experience the practitioner has with a variety of conditions and the severity of those conditions is different from the setting in which an infectious diseases specialist would ordinarily examine a patient.[317]

[220] Thus general practitioners exercising the care and skill which is reasonable for their setting may not make a diagnosis of a rare and difficult to diagnose condition such as cryptococcal meningitis but they should query and examine their patients

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315 Ex 7 p 4; Ex 8.
316 Ex 2 tab 17 p 111.
317 T7-31 LL1-13.

sufficiently enough to know whether they ought refer a patient for specialist assessment.[318]

[221] The examination process necessarily involves observation. Dr Kable emphasised one of the essential aspects of clinical examination techniques taught to undergraduate medical students and registrars in training is observations made of the patient, not only during the consultation, but between their movement from the waiting room to the consultation and afterwards.[319] I accept the defendant's evidence that she did observe the plaintiff in those ways.

[222] However the defendant did not lay her hands on the plaintiff and physically examine her. There was a divergence of views between the experts in this case as to whether the defendant should have physically examined the plaintiff's neck. That debate is linked inextricably with the question whether an examination would have detected anything which ought to have caused the defendant to take a different course.

Examination of the neck

[223] Dr Vinen, the emergency physician called by the plaintiff, emphasised that while observation of a patient's movements is important, a physical examination, actually laying hands on the aspects of the anatomy related to the patient's complaint, should occur.[320] He was critical of the defendant for not doing a physical examination each time she saw the plaintiff.[321]

[224] Dr Vinen opined a general practitioner should assume the worst and diagnose by exclusion, because if that approach is not taken serious conditions may be missed. Thus, he explained, if a patient presents with a headache the general practitioner should assume the patient has meningitis until satisfied that is not the case.[322] That is an overstatement of what ought reasonably be expected of general practitioners when a patient presents with such a commonly occurring symptom as a headache. Carried to its logical conclusion, it means anyone who presents with a headache ought have a lumbar puncture. Dr Vinen acknowledged that would be going too far but insisted that a proper physical examination should occur for the general practitioner to be satisfied a patient does not have something serious.[323]

[225] Mandating such an approach appears to ignore that a general practitioner may be able to readily arrive at such a point of satisfaction through other means. Dr Vinen acknowledged that the question whether physical examination of a patient is necessary involves a matter of judgment but maintained a practitioner would have to "have very good reasons not to examine a patient" and "be completely satisfied that there was no need to examine the patient".[324] He accepted experienced general practitioners would be in a better position to comment on what might reasonably be

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318 Ex 2 tab 19 p 154.
319 Ex 6 p 2.
320 T2-38 L18; T2-39 L44; T2-40 L2.
321 Ex 2 tab 19 p 152.
322 T2-37 LL27-41.
323 T2-37 L37.
324 T4-11 LL9-44.

expected of general practitioners in a particular clinical presentation than he as an emergency physician.[325]

[226] The experienced general practitioner called by the plaintiff, Dr Turnbull, gave evidence that the importance of conducting a physical examination where a patient complains of neck pain is emphasised both at medical school and in the training of general practitioners. He explained such an examination should include looking at, feeling and moving the patient's head, neck and upper thorax.[326] As to whether the defendant should have performed such an examination, his initially robust view that she should have done so appeared to be premised on an understanding there had been a marked decline in the plaintiff's symptoms.[327]

[227] Dr Turnbull was to retreat from his initial position on this issue. In the course of cross-examination he acknowledged that a physical examination will not always be necessary when a patient presents with neck pain or a complaint of neck pain, saying:

> "I suppose in every case of neck pain there are certainly wide variations in the – in the – in each case and on some occasions I think perhaps a physical examination may not be fully necessary, apart from observing the patient movements, et cetera, the gait when she walks in, et cetera."[328]

[228] Further Dr Turnbull's criticism of the defendant for not conducting a physical examination upon the plaintiff's neck became difficult to reconcile with his opinion in his reports of 17 September 2010.[329] That opinion was to the effect that if the defendant's version of the consultations is accepted, her management of the case was consistent with a reasonable standard of general practice. That opinion was given on 17 September 2010[330] and he did not introduce criticism of the defendant for not conducting a physical examination until a telephone conference of 20 January 2012.[331] Despite this, in his subsequent report of 29 May 2012[332] he confirmed he still retained the views set out in his report of 17 September 2010, based on the defendant's version of events. It is implicit in those views that the defendant's consultation, even without having conducted a physical examination, was consistent with a reasonable standard of general practice.

[229] Dr Kable, the expert general practitioner called by the defendant, disagreed that it was standard practice for a full clinical examination to occur where a patient complains of neck pain.[333] He testified that examination of a patient complaining of neck pain did not necessarily require physical touching, explaining that examination by observation and taking of information may suffice.[334] He explained that whether it was necessary to have recourse to a physical examination of the patient's neck as described in medical texts[335] depended upon the practitioner's

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325 T2-28 L30.
326 Ex 16 p 2.
327 Ex 2 tab 5.
328 T7-13 L14.
329 Ex 7.
330 Ex 7.
331 Ex 2 tab 5 (duplicated Ex 20).
332 Ex 8.
333 T9-88 L2.
334 T9-86 LL25-45.
335 As explained in Ex 24.

assessment of the presenting severity of symptoms, including whether a patient appears to have a reasonable facility of movement.[336]

[230] Dr Kable emphasised that neck stiffness from meningitis had an acute onset and manifested itself in the patient being virtually unable to move the neck.[337] Dr Kable explained that meningeal inflammation causes a patient to protect their neck by holding the head in a rigid position and refusing to move it forward in a normal fluent way, such as to alert an examining doctor as to the possibility of underlying meningeal irritation. This, Dr Kable explained, may prompt an examining practitioner to examine for neck stiffness by attempting to flex the neck forward, pointing the chin towards the chest. Such a manoeuvre elicits pain and marked resistance. Dr Kable explained this was a different sign than the loss of range of movement that commonly occurs with cervical spondylosis so that movement in any plane causes discomfort but does not have the specific feature of resistance.[338]

[231] Dr Kable opined that on none of the consultations of 12, 18 or 19 September was there any indication that the specific test for neck stiffness should be carried out. What though of the reduced range of movement noticed on 18 September? Dr Kable did not think that meant the patient had a "stiff" range of motion.[339] He explained patients with meningeal irritation sit quietly and do not move their head and neck in a fluid and natural way, as if guarding against movement as likely to cause pain.[340] He suggested reference to a reduced range of movement implied there remained some movement of the neck and was not indicative of meningeal irritation because the patient would be unlikely to be moving her neck at all.[341]

[232] There was little specificity in the defendant's notes or testimony about the nature of the reduced range of movement. In the absence of some greater detail about the nature of the reduced range of movement a physical examination would have been a prudent and simple means of seeking that detail and sufficiently brief to be easily conducted in the course of a standard consultation by a general practitioner. I accept the plaintiff's complaint of neck pain did not of itself necessarily call for an physical examination of her neck, however once it was apparent the plaintiff had a visibly reduced range of movement on 18 September the defendant, exercising reasonable care and skill, should have physically examined her neck.

[233] The real difficulty for the plaintiff's case in this context is that had the defendant physically examined the plaintiff's neck on 18 or 19 September it would have made no difference to her opinion.

[234] Dr Vinen asserted that if the defendant had examined the plaintiff she may have detected signs "such as meningism".[342] Dr Whitby explained that neck stiffness caused by meningism is a result of it being painful to move the neck and therefore patients resist movement because it hurts.[343] He explained in the presence of

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336 T9-87 L45.
337 T9-89 L40.
338 Ex 5 pp 5-6.
339 T11-9 L3.
340 Ex 6 p 3.
341 T11-10 LL4-9.
342 Ex 2 tab 19 p 153.
343 T10-26 L13.

meningeal pain, resistance to movement was likely no matter how the neck movement was tested.[344]

[235] It is significant that physical manipulation of the plaintiff's neck by physiotherapist Mr Elsmore on 23 September was able to occur and apparently did not encounter an extraordinary reaction or a reaction so severe it caused that process to be abandoned. That fact makes it unlikely that physical examination of the plaintiff's neck four or five days earlier on 18 or 19 September would have provoked a response suggestive of meningism.

[236] Dr Cameron explained an examination of the neck ought show whether the patient has a stiff neck.[345] He opined that if a physiotherapist had been able to produce neck flexion the neck problem must not have been particularly troublesome.[346] While acknowledging the detail of exactly what physically occurred during the physiotherapist's treatment was important[347] he explained it would be an odd response for a patient to be able to tolerate neck flexion and neck traction with meningeal irritation and suggested the therapist would not have been able to do it without complaint if the patient did have meningeal irritation.[348]

[237] Dr Kable opined in addition that because neck stiffness is a late sign in the course of meningitis, any examination for neck stiffness carried out on 12, 18 or 19 September would be unlikely to have yielded an indication of neck stiffness.[349]

[238] The other experts were not so precise about the likely timing of the onset of neck stiffness. However they were at one in the view that it is not merely neck pain but neck stiffness, due to reflexive and involuntary limitation of movements that stretch the meninges, which is an indicator of meningism. [350]

[239] The plaintiff's evidence referred repeatedly to her neck pain. Her only reference to stiffness of any kind was informing the physiotherapist that she was stiff and sore in the mornings. No-one gave evidence of observing her holding her neck stiffly or without movement. Her neck was manipulated without reported resistance by a chiropractor on 17 September and a physiotherapist on 23 September. Had the defendant physically examined the plaintiff on 18 or 19 September she would not have detected neck stiffness suggestive of meningeal irritation. Such an examination would not have caused her to suspect the presence of a symptom with a cause any more sinister than a musculo-skeletal cause.

[240] The defendant obviously suspected her patient's problems had a musculo-skeletal cause. It was entirely appropriate that she ordered a CT scan on 18 September and arranged for a follow up appointment on the day immediately following. The results of the CT scan confirmed that the plaintiff had cervical spondylosis, a condition which explained the plaintiff's symptoms.

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344 T10-26 L36.
345 T10-19 L20.
346 T10-20 L46.
347 T10-23 L47.
348 T10-20 LL40-47.
349 Ex 6 p 4.
350 Dr Eisen referred to Taiwanese research of non-HIV infected patients with cryptococcal meningitis showing that neck stiffness was the most common sign of the condition, present in 69 per cent of patients (Ex 15 p 3).

[241] Dr Vinen[351] and Dr Turnbull[352] did not consider that the CT scan provided a reasonable explanation for the plaintiff's symptoms however those opinions were obviously premised on the plaintiff's symptoms being more severe than I have found them to have been as at 18 and 19 September. Moreover, Dr Turnbull well knew of what the CT showed when he reported that on the defendant's version of events she had managed the case appropriately – a report he confirmed in evidence.[353]

[242] Dr Turnbull acknowledged cervical spondylosis can be a cause of neck stiffness and can be the cause of neck stiffness in combination with a headache being present from time to time.[354]

[243] Once Dr Cameron moved from proffering an opinion confined by the plaintiff's version of her extreme decline[355] he opined it would be reasonable to conclude by 19 September that the plaintiff's neck discomfort was related to the degenerative changes seen on the CT cervical scan.[356] He considered it reasonable as at 19 September 2008 that the defendant contemplated a period of one weeks rest for the plaintiff "to see if her symptoms improve".[357]

[244] The plaintiff's neck pain was occasionally associated with flushing to the face. It is unlikely the flushing to the face had a direct musculo-skeletal cause, however Dr Kable opined it could be brought on indirectly by pain so caused[358] or by anxiety and hyperventilation.[359] It was therefore not a symptom reasonably likely to arouse concern as being inconsistent with the presence of a musculo-skeletal disorder causing pain.

Headache

[245] I have found the defendant was aware, or, acting with reasonable care and skill should have been aware, on 18 and 19 September that the plaintiff was still sometimes experiencing headache associated with her neck pain.

[246] Dr Kable explained it would be important for a general practitioner, told of a headache, to ascertain its location, duration, intensity and frequency.[360] He opined if a practitioner has not elicited the nature of the headache and its location it makes it more difficult to identify its causation.[361] It was not suggested however that there were likely to be any revelations discernible from the pursuit of such detail here. The evidence suggests the location of the plaintiff's intermittent headache was predominantly towards the lower back of the head, consistently with its reported

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351 T2-41 L22; T2-41 L8; Dr Vinen appeared to be immediately defensive and reluctant to directly address questions which went to an obvious variation between the facts upon which he had founded his opinion and the information contained in the defendants notes (T2-32 L7—T2-35 L5).
352 Ex 16 p 6.
353 T7-26 L37.
354 T7-20 L27.
355 Ex 14B p 2.
356 Ex 14C p 3.
357 Ex 14C p 4.
358 T9-84 L29.
359 T11-9 L26.
360 T9-85 LL17-30.
361 T9-85 L43.

association with the plaintiff's neck pain. It is not suggestive of a cause inconsistent with the suspected musculo-skeletal cause.

[247] Further, the feature that the headache remained intermittent is inconsistent with the type of headache associated with cryptococcal meningitis. As Dr Whitby explained, headache associated with cryptococcal meningitis once begun, continues, and becomes worse and the headache persists without break.[362] He opined a headache that is intermittent is more likely to derive from neck pain than from cryptococcal meningitis.[363]

Dizziness

[248] Dizziness is not said to be a cardinal symptom of cryptococcal meningitis. Dr Whitby did explain that dizziness may occur as an incident of the acute stage of cryptococcal meningitis:

> "Cryptococcal meningitis is one of a number of types of meningitis that specifically affect the area of meninges around the emergence of cranial nerves from the brain stem, and thus specific neurological features related to each of these cranial nerves become obvious. As a general example, damage to the second cranial nerve can cause vision defects, damage to the seventh cranial nerve can cause paralysis to muscles of the face, while damage to the third cranial nerve can cause paralysis to the muscles that control the eye and double vision. As infection passes down the brain stem, further cranial nerves can become infected, damage to the eighth cranial nerve may affect hearing, or the organ of balance, producing disequilibrium and dizziness.
>
> These are specific neurological features as opposed to the general neurological features associated with meningitis because of increased intracranial pressure because of infection, which may induce persisting nausea, vomiting, headache and temperature."[364]

[249] While dizziness may occur in the way explained by Dr Whitby the expert evidence does not suggest it is regarded in the medical profession as a diagnostic hallmark of cryptococcal meningitis in the same way that neck stiffness and chronic headache are.

[250] The relevance of dizziness as a symptom here, as at 18 and 19 September, is whether it was inconsistent with a musculo-skeletal condition and ought to have indicated to the defendant that a more sinister disease involving the central nervous system may have been occurring.

[251] Dr Cameron observed the word "dizziness" is a term used by patients rather than a medical term and suggested:

> "When a patient comes in and says they're dizzy, you then have to embark on questioning further to determine what the person means by dizziness. A lot of people mean they have vertigo when you delve into it, you know, where they have a sense of spinning with other

362 T10-38 L18.
363 T10-38 L21.
364 Ex 17 p 3.

> symptoms of nausea and so forth. Other people can be dizzy because their blood pressure has dropped. Other people can be dizzy because they have vasoconstriction due to hyperventilation and anxiety. Dizziness is a very vague term. You have to elucidate further what the person means".[365]

[252] Dr Turnbull was critical of the defendant's notes not indicating whether the nature and cause of the dizziness was explored.[366] Dr Kable opined that a practitioner presented with a complaint of dizziness would normally inquire as to the nature and prominence of the dizziness in relation to other symptoms, whether it was constant or intermittent, whether it was precipitated by any common factor and whether it was a generalised complaint of dizziness or dizziness deriving from positional vertigo.[367] Dr Cameron emphasised that the investigative questions he contemplated being asked to ascertain what form or source of dizziness might be involved was in the context of his questioning of a patient as a neurologist. He explained it would not be expected that a general practitioner would descend into as much detail but said some clarifying questioning about what is associated with the dizziness would be appropriate.[368]

[253] Matters of degree are obviously involved here. The defendant explained she asked questions and clarified that the plaintiff in referring to dizziness did not mean vertigo and rather that it was a feeling of light headedness. Further it was associated with mention of a broader array of symptoms, particularly of neck pain and associated intermittent headache. While more might arguably have been asked on the topic there was not a falling below the requisite standard in the context of this consultation.

[254] Dizziness can suggest a problem with the central nervous system.[369] However it may also be a consequence of cervical spondylosis. Dr Whitby explained dizziness in the sense of somebody who has vertigo is inconsistent with cervical spondylosis, whereas dizziness in the sense of a feeling of light headedness can be associated with cervical spondylosis.[370] This distinction did not appear to be drawn by Dr Eisen, who did not think dizziness could be accounted for by cervical spondylosis because the mechanism of dizziness derives from either middle ear pathology or pathology associated with cerebello dysfunction, neither of which are features of cervical spondylosis.[371] He considered only with an advanced form of spondylosis would it be likely that there would be a change in the posture of the cervical spine resulting in a minor impairment of blood flow and thus dizziness.[372] However Dr Eisen did acknowledge a neurologist would be more suitably placed to comment on these issues.

[255] The neurologist, Dr Cameron, went on to explain people can experience a light headed feeling with a cervical spasm. He explained that neck posture can be altered from a natural c curve to a more elongated straight posture due to muscle spasm or

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365 T10-11 L15.
366 Ex 16 pp 5, 6.
367 T11-8 LL4-44.
368 T10-19 L5.
369 Ex 16 p 5; Ex 2 tab 35 p 343; T10-12 L7.
370 T10-25 LL30-43.
371 T7-34 L10.
372 T7-34 LL15-33.

local pathology which can cause slight traction or slight kinking of one or more or other of the vertebral arteries and this can result in a feeling of light headedness or dizzy discomfort.[373] He agreed that a neck spasm would usually be observable on a clinical examination[374] however I have found the plaintiff was sometimes experiencing dizziness rather than actually experiencing dizziness as at the time of the consultation with the defendant.

[256] Dr Kable opined that non-specific dizziness may be caused by pain and muscle contraction contributing to intermittent vascular insufficiency, which can be aggravated if a significant cervical spondylosis impinges on blood flow through the vertebral arteries.[375] He opined a person suffering cervical spondylosis sufficient to cause dizziness would likely also have neck pain and muscle contraction type headaches.[376] That is not inconsistent with the present case. Dr Kable also opined that dizziness could be occasioned through hyperventilation and through pain.[377]

[257] Dr Turnbull, the plaintiff's expert general practitioner, conceded that cervical spondylosis may occasion transient dizziness, although not significant dizziness.[378] He explained much would depend on investigating what the patient meant by dizziness and that if the patient described "sort of brief episodes of transient dizziness then that in itself may not be particularly significant."[379] Further, he acknowledged, in opining the defendant's management of the case was consistent with a reasonable standard of general practice if her version was accepted, that he knew her version included reference to the plaintiff having had intermittent episodes of dizziness.[380]

[258] The symptom of dizziness was consistent with the plaintiff's apparent musculo-skeletal problem and should not have caused the defendant to suspect that a more sinister disease involving the central nervous system may have been occurring.

Missing cardinal symptoms

[259] It is apparent in hindsight that the plaintiff did have cryptococcal meningitis when she saw the defendant on 18 and 19 September. However as earlier mentioned cryptococcal meningitis is frequently not diagnosed in the early presentation of a patient because it is a chronic low-grade inflammatory disturbance until the later stages of the illness.[381]

[260] Dr Whitby explained that the effect of meningeal inflammation around the brain stem is usually sudden as the inflammation caused by the infection reaches the point where it disrupts blood supply to the cranial nerves.[382] Dr Whitby considered it unlikely the plaintiff would have commenced experiencing symptoms of cranial

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373 T10-11 L25.
374 T10-12 L15.
375 Ex 5 p3.
376 T11-7 L18.
377 T11-9 L31.
378 T7-20 L38.
379 T7-21 LL 1-18.
380 T7-21 LL15-25; Ex 7.
381 Ex 14B p 3.
382 Ex 2 tab 14 p 66.

nerve abnormality as early as 19 September given they did not become profound until 26 September.[383]

[261] Some criticism of the defendant by the plaintiff's experts was historically based on erroneous understandings of the nature and extent of symptoms present as at 18 and 19 September.

[262] Dr Vinen was critical of the defendant for not investigating the possibility that a process other than musculo-skeletal abnormality was under way, particularly by reason of his understanding of the facts that at least three of the five cardinal features of meningitis were present. His understanding as to those three features was that the plaintiff had "neck stiffness", "had a headache", and "did vomit".[384] However for reasons already explained, I do not accept the defendant was informed the plaintiff was nauseous and had vomited. Further the plaintiff had neck pain, as distinct from neck stiffness, and she was suffering headache sometimes, not all the time.

[263] This falls considerably short of the chronic headache, neck stiffness, nausea and vomiting, aversion to light and raised temperature which are the classical symptoms of cryptococcal meningitis.

[264] As to the latter two symptoms, Dr Vinen appeared to be of the view they were likely present and missed by the time of the plaintiff's attendance at Cairns Base Hospital.[385] The implied relevance of such an observation is that such features might even have been present earlier. However there is no evidence the plaintiff had photophobia or raised temperature when seen by the defendant on 18 or 19 September or indeed when seen at Cairns Base Hospital on 24 September.

[265] Dr Vinen opined that because the defendant did not take the plaintiff's temperature it is unknown whether the plaintiff had a fever and emphasised in any event that a patient who has taken an antipyretic such as paracetamol or aspirin might not have a fever because of the effect of that medication.[386] Dr Whitby did not think the absence of a raised temperature was likely to be explained by the plaintiff having medication such as Panadol or Panadeine Forte. He explained even with easily treated viral infections such medications did not tend to persistently prevent raised temperature.[387] Further to this, the plaintiff did not complain of having had a fever and her temperature was normal when taken by ambulance officers and hospital staff on 24 September. There is no evidence to suggest the defendant should have treated the defendant on the basis she would have had a raised temperature had she not taken medication.

[266] As to photophobia or hypersensitivity to light, Dr Vinen acknowledged it is typically represented by patients having to close their eyes, cover their eyes or squint.[388] Dr Whitby explained that photophobia is a presenting system that a patient will complain of rather than being a symptom that is specifically tested for

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383 Ibid.
384 Ex 2 tab 19 p 154.
385 Ex 2 tab 19 p154.
386 Ex 2 tab 35 p 343.
387 Ex 2 tab 15 p 69.
388 T2-49 L39.

without information prompting the need for a test.[389] Even Dr Vinen conceded that ordinarily photophobia would be obvious from seeing a patient in a room with lights on and it would be expected a patient would report the problem.[390]

[267] There is no evidence the plaintiff presented to the defendant with any indication or complaint of such a symptom. In any event it is a condition Dr Miller expressly checked the plaintiff for on 24 September and, despite some demanding criticisms of that process by Dr Vinen,[391] it is clear from Dr Miller's evidence and his notes that she did not have it. The plaintiff did not have an aversion to light when she consulted the defendant on 18 or 19 September.

No relevant breach

[268] Hindsight bias, driven by knowledge the plaintiff was the subject of a much more catastrophic condition than suspected, may naturally cause commentators to make more than is reasonable out of symptoms which had more than one potential cause. However the plaintiff's symptoms suggested a musculo-skeletal cause was likely. The CT scan supported that conclusion. The plaintiff did not as at 18 or 19 September have a discernible collection of symptoms which should have caused the defendant, acting with reasonable care and skill, to conclude she should refer the plaintiff for urgent or specialist assessment.

[269] The only shortcoming in the defendant's conduct was that in circumstances where the plaintiff complained of neck pain with accompanying headaches and flushing of the face on 12 September and presented with neck pain and a limited range of movement on 18 September, the defendant should, acting with reasonable care and skill, have physically examined the plaintiff's neck and enquired about the progress of the plaintiff's past reported symptoms of headache and facial flushing. However, such examination and enquiry would not have detected anything that would have prompted a different course than that taken. The omission did not have a causal connection with the plaintiff's injury and loss.

[270] The defendant did not breach her duty to exercise reasonable care and skill in not recognising a potentially serious central nervous system may have been developing. Nor did she breach that duty by not referring the plaintiff to a neurologist, general physician or emergency department for urgent specialist assessment.

[271] The tragic outcome which befell the plaintiff as a result of this insidious disease was not the result of any breach on the part of the defendant.

[272] The plaintiff has failed to prove any causative breach of duty by the defendant in contract or tort and her claim must fail.

Section 22 defence

[273] Dr Kable opined the defendant's actions were reasonable and the defendant provided competent and comprehensive care of a standard expected of a general practitioner.[392] He opined that there would be a significant number of general

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389 Ex 2 tab 15 p 71.
390 T2-50 L7.
391 T2-51 LL25-47; T2-61 LL7-40.
392 Ex 5 p 6.

practitioners who would have managed the plaintiff in exactly the same manner as she was managed by the defendant on 12, 18 and 19 September 2008.[393]

[274] Dr Turnbull also considered on an acceptance of the defendant's version of events her management of the case was consistent with a reasonable standard of General Practice.

[275] These opinions of both expert general practitioners are persuasive in circumstances where the facts as found are largely consistent with the defendant's version of events.

[276] In the event it be necessary to consider the application of the defence provision in s 22 of the *CLA*, my conclusion on the whole of the evidence is that at the time of the consultations of 18 and 19 September the defendant acted in a way that was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice. For that reason also, the defendant did not breach her duty.

D. CAUSATION

[277] Because I have found there was no breach of duty it follows the defendant's conduct was not causally responsible for the harm tragically suffered by the plaintiff and her case must fail. However lest I am wrong in my finding as to breach (and the s 22 defence) it is appropriate to also deal with the issue of causation.

[278] Consideration of whether the alleged breach caused the harm suffered requires an application of the general principles in s 11 of the *CLA*, which relevantly provides:

> **"11 General principles**
> (1) A decision that a breach of duty caused particular harm comprises the following elements—
>
> (a) the breach of duty was a necessary condition of the occurrence of the harm (***factual causation***);
>
> (b) it is appropriate for the scope of the liability of the person in breach to extend to the harm so caused (***scope of liability***).
>
> …
> (4) For the purpose of deciding the scope of liability, the court is to consider (among other relevant things) whether or not and why responsibility for the harm should be imposed on the party who was in breach of the duty."

[279] In this case the critical causation issues translate to two critical questions of fact:

(a) would referral on about 19 September have likely resulted in timely diagnosis and treatment for cryptococcal meningitis?

(b) if treatment for cryptococcal meningitis had commenced on or soon after 19 September would the permanent damage to health suffered by the plaintiff have been avoided?

[280] If those questions are answered in the affirmative then the failure to refer was a necessary condition of the occurrence of the harm. It would be appropriate for the

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393 Ex 26A pp 2-3.

scope of the defendant's liability for the breach to extend to that harm because, based on the defendant holding herself out as a medical practitioner providing professional advice and treatment, the plaintiff entrusted herself to the care of the defendant in the reasonable expectation the defendant would advise and treat her properly and refer her for specialist medical assessment if appropriate.

Would there likely have been a timely diagnosis of and treatment for cryptococcal meningitis?

[281] Dr Vinen opined that had the plaintiff been referred for speciality assessment on 12, 18 or 19 of September a diagnosis of cryptococcal meningitis would have been made.[394] However the plaintiff's symptoms were not as marked as Dr Vinen had been given to believe when he arrived at that opinion.

[282] Accepting the plaintiff's symptoms were as I found them to be it is certainly not obvious that a referral on about 19 September would have resulted in a timely diagnosis and treatment for cryptococcal meningitis.

[283] The joint report of Dr Eisen and Dr Whitby highlighted that a diagnosis of cryptococcal meningitis was far from inevitable in the event of such referral, observing:

> "[I]t must be understood that assessment by the admitting Specialist Physician, and Endocrinologist, on 25 September 2008 … and previously a Resident Medical Officer at Cairns Base Hospital Emergency Department, did not immediately lead to such a diagnosis."[395]

[284] Dr Whitby noted that even after 25 September, while an infectious diseases physician may have hypothesised the correct diagnosis, a consultant physician, Dr Yarker, while making a neurological diagnosis, did not make a diagnosis of infection.[396] Dr Whitby explained the diagnosis only became obvious well after 19 September, as the inflammatory process selectively infected the cranial nerves as they emerged from the brain stem.[397]

[285] The plaintiff's symptoms as I have found them to be did not cry out for urgent attention in the same way symptoms becoming acute from cranial nerve infection later may have. The plaintiff's symptoms as at 19 September, even if sufficiently concerning to warrant a referral, were inherently unlikely to have given rise to a referral to the emergency section of a hospital, as distinct from to a neurologist or specialist physician. It is also unlikely a referral would have commanded urgent attention in the emergency department of a hospital. Further, as Dr Cameron explained, even if there had been a referral to a specialist physician or neurologist as at 19 September 2008 there does not appear to be any specific medical reason for the defendant to have made that an urgent referral. He considered a referral would likely have involved a delay of several days or longer before examination by a

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394 Ex 2 tab 19 p 157.
395 Ex 2 tab 17 p 109.
396 Ex 2 tab 12 p 48; Ex 2 tab 12 p 50.
397 Ibid.

specialist physician or neurologist.[398] He noted there were not even any consultant neurologists practicing in Cairns as at September 2008.[399]

[286] The temporal window of opportunity for the plaintiff to be diagnosed and treated for cryptococcal meningitis after 18 or 19 September and avoid permanent damage to her health was limited. It is impossible to identify it precisely but it is common ground that it was likely too late by 24 September 2008. It may reasonably be inferred that once armed with a referral the plaintiff would not have wasted time in arranging and attending upon an appointment. Whether that would have resulted in assessment on Friday 19 September or the ensuing weekend is doubtful but I infer it would have occurred by or on Monday 22 September.

[287] On the whole of the evidence I infer the looming damage to cranial nerves and the resultant permanent harm was then yet to occur and could still be prevented if treatment ensued promptly. Whether the assessing doctor would have perceived a need for urgent action is difficult to predict. A referral would of its nature have prompted the relevant doctor to appreciate a cause other than the seemingly obvious musculo-skeletal cause was suspected. Against that background at the very least blood tests would likely have been taken. Dr Cameron, the neurologist, explained that cryptococcal meningitis would probably have been present in the plaintiff for some weeks prior to the onset of her acute symptoms and that it was more likely than not if blood tests had been performed on the plaintiff on 18 or 19 September they would have shown a heightened white blood cell count.[400]

[288] The increased white blood cell count detected by Dr Miller on 24 September at Cairns Base Hospital did not prompt a diagnosis of cryptococcal meningitis. Dr Miller regarded it as suggesting a chest infection. While Dr Miller was not proceeding with the benefit of the content of a referral from a treating doctor it is, as I have already observed, surprising the plaintiff was discharged given her problem in walking. I do not infer the events at Cairns Base Hospital on that night suggest a pattern that ought inform my assessment of what would ordinarily be likely in the event of a referral to the Cairns Base Hospital and what that institution might ordinarily do to exclude an infective process.

[289] Dr Cameron explained, had a heightened white blood cell count been obtained, it would then have been necessary to exclude an infective process.[401] The speed with which that process would then have diagnosed cryptococcal meningitis is also difficult to predict. The day's grace needed at Cairns Private Hospital before there was finally a correct diagnosis provides some assistance. Assuming the application of reasonable care and skill I infer cryptococcal meningitis would likely have been diagnosed and treatment commenced by or on Tuesday 23 September.

If treatment for cryptococcal meningitis had commenced on or soon after 19 September would the permanent damage to health suffered by the plaintiff have been avoided?

[290] In the joint report of infectious diseases experts Dr Eisen and Dr Whitby they agreed that had a diagnosis of cryptococcal meningitis been made on or soon after

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398 Ex 14C p 5.
399 Ex 14C p 5.
400 T10-17 LL20-39.
401 T10-17 L42.

19 September the standard treatment would have commenced soon thereafter and it is more likely than not that the plaintiff would not have suffered her permanent disability.[402] They explained that the standard treatment for cryptococcal meningitis would have avoided the plaintiff's cranial nerve palsy, hearing loss and blindness.[403]

[291] Dr Eisen explained that once treatment of cryptococcal meningitis with amphotericin commences it rapidly kills cryptococcus neoformans in the cerebral spinal fluid.[404] He made reference to a Papua New Guinea study to opine that patients who have normal vision at the commencement of treatment are more likely than not to retain their normal vision by the end of treatment.[405] He considered the Papua New Guinea study's findings in relation to blindness would suggest similar statistical outcomes would occur in relation to hearing loss because the pathology of intracranial pressure or nerve infarction leading to vision abnormality is the same pathology which would lead to hearing loss.[406]

[292] Dr Whitby was somewhat less robust in his predictions and emphasised it cannot be said that there is any date by which, if a person infected with cryptococcal meningitis commences treatment, it can be guaranteed there will be an outcome free of neurological disability.[407]

[293] For the reasons explained above it is likely treatment would have commenced before or on 23 September. While the plaintiff's sudden serious decline was nearly upon her it appears more likely than not from the evidence of physiotherapist Mr Elsmore that even at that date the plaintiff's condition had not reached the acute stage. Accordingly it is more likely than not that had treatment commenced by then the plaintiff would not have suffered the permanent injuries to her health.

[294] It is unnecessary, given my findings of fact, to address the defendant's alternative argument that if the plaintiff's account of the timing and extent of her symptoms is correct her condition was too advanced by 18 and 19 September for treatment soon thereafter to have avoided the permanent damage to her health.

E. QUANTUM

[295] While my finding that there was no breach has the consequence that the plaintiff's case must fail, I should identify the awards I would have arrived at had she been successful.

[296] It is not in dispute the following injuries were suffered by Ms Mules as a result of her condition:

(a) sensori-neural hearing loss;
(b) cortical blindness;
(c) impaired balance;
(d) altered sensation and discomfort in her lower limbs and fingertips; and
(e) an adjustment order with depressed mood.

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402 Ex 2 tab 17 p 110.
403 Ex 2 tab 17 p 113.
404 Ex 15 p 4.
405 Ex 15 p 4.
406 T7-39 L38.
407 Ex 17 p 5.

General Damages

[297] General damages are assessed according to the scheme set out in the *CLA*.

[298] General damages are damages for:
(a) pain and suffering; or
(b) loss of amenities of life; or
(c) loss of expectation of life; or
(d) disfigurement.[408]

[299] When assessing general damages a court must:
- make an assessment of the injury scale value ("ISV") of the relevant injuries;[409] and
- calculate the damages pursuant to that ISV in accordance with the formulae set out in the *CLA*, as applied when the relevant injuries arose.[410]

[300] The ranges of ISVs for particular injuries are set out in reg 6 of the *Civil Liability Regulation* 2003 (Qld) ("*CL Regulation*"). Where there are multiple injuries, as is the case here, the court must identify the dominant injury, that is, the injury having the highest ISV range: see sch 7 of the *CL Regulation*.

[301] The dominant injury in this case is Ms Mules' hearing loss and blindness. Dr Cameron, a neurologist, considered Ms Mules to be totally blind, only being able to occasionally determine slight light and dark shadowing, and to have profound deafness in both ears.[411] The parties agree Ms Mules therefore has a total sight and hearing impairment, falling into Item 23 of the *CL Regulation*, reg 6. That item has an ISV range of 90 to 100 (100 being the highest possible ISV).[412]

[302] Having identified the dominant injury, it must be considered if the maximum ISV adequately reflects the adverse impact of all injuries.[413] The parties agree that given the catastrophic injuries of Ms Mules' injuries, an ISV of 100 is appropriate and accordingly Ms Mules would be entitled to the statutory maximum of **$250,000.00**.

Economic Loss

[303] The parties agree Ms Mules is totally unemployable as a result of her injuries.

[304] At the time of contracting meningitis Ms Mules was employed as an operations manager in a full time capacity at The Queenslander Hotel in Cairns. She earned $65,000 per annum, inclusive of superannuation. The parties agree this equates to $43,795.62 per annum or $842.22 per week after superannuation, taxes and the Medicare levy.

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408 *CLA* s 51.
409 *CLA* s 61.
410 *CLA* s 62.
411 Ex 14A; Report of Dr Cameron dated 10 August 2010.
412 The other injuries would have the following ISV ranges: altered sensation and discomfort in lower limbs and fingertips – six to 20 (minor brain injury, Item 8); psychological injury – two to 10 (moderate mental disorder, Item 12).
413 *Munzer v Johnston & Anor* [2008] QSC 162, [5]-[14]. If the maximum ISV does not adequately reflect the adverse impact of all the injuries the ISV can be increased (usually by no more than 25 per cent) however not beyond 100.

Past Economic Loss

[305] The parties' submissions about past economic loss differ only marginally. The plaintiff argues her net income would have increased slightly each year. On this basis the plaintiff submits past economic loss should be calculated as $900.00 per week.[414]

[306] On the other hand, the defendant submits Ms Mules' income would not have increased and notes the evidence actually suggests it would have decreased.[415] The defendant therefore argues the income amount of $842.22 should remain the same.

[307] I agree with the defendant. The plaintiff's past employer made clear that had Ms Mules continued in her employment she may well have earned less.

[308] I would award the plaintiff 287 weeks of lost income, which equates to $241,717.14 plus lost superannuation at nine per cent, which equates to $21,754.54.

[309] In total, past economic loss would be **$263,471.68**.

Interest on Past Economic Loss

[310] The defendant submits no allowance for interest should be made given the plaintiff has been in receipt of a pension,[416] but in the circumstances of this case I would not deprive the plaintiff of interest for that reason.

[311] The plaintiff's submission that there should be interest on past economic loss calculated at the rate of 1.7 per cent per annum (being one half of the 10 year bond rate of 3.4 per cent)[417] accords with s 60 *CLA* and I would award interest on that basis.

[312] Interest on past economic loss over 5.52 years would be **$24,724.18**.

Future Economic Loss

[313] The plaintiff is unemployable. The plaintiff submits the plaintiff would have worked until she was 67 years old in about 18 years time (the plaintiff will turn 49 on 28 April) and continued to earn $900 per week. The plaintiff submits that amount should be reduced by 10 per cent for contingencies,[418] and the future superannuation loss should be calculated at 11 per cent.[419]

[314] The defendant, on the other hand, argues the plaintiff would have continued to earn the same amount ($842.22 per week) plus superannuation at 10 per cent.[420] The defendant submits for a 15 per cent reduction for contingencies.[421]

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414 Plaintiff's Outline of Submissions, [197] – [203].
415 Defendant's Submissions – Quantum, [17] & [18]; Ex 3 tab 16.
416 Defendant's Submissions – Quantum, [20].
417 Plaintiff's Outline of Submissions, [204].
418 See the plaintiff's Outline of Submissions, [207].
419 Plaintiff's Outline of Submissions, [208]; citing the decision of *Heywood v Commercial Electrical Pty Ltd* [2013] QCA 270.
420 Defendant's Submissions – Quantum, [22] & [23].
421 Ibid, [22], citing *Craddock v Anglo Coal (Moranbah North Management) Pty Ltd* [2010] QSC 133, [72] – [76].

[315] I would adopt the continued net weekly earnings of $842.22 for a further 18 years to about age 67 using the five per cent tables (multiplier 625), providing a total of $526,387.50 and would adopt a discount of 12 per cent for the vicissitudes of life[422] to assess future economic loss at $463,221.

[316] I would calculate future superannuation at 11 per cent, to assess that loss as $50,954.31.

[317] Total future economic loss would therefore be **$514,175.31**.

Past Gratuitous Care and Services

[318] Section 59 of the *CLA* governs the assessment of damages for past gratuitous care and services.

[319] The plaintiff does not submit there should be damages for past gratuitous care for the periods she was in hospital, rehabilitation and in Brisbane residing with her brother.

[320] The parties agree the plaintiff would be entitled to damages under this head for the 200 week period from 31 January 2009 to 30 November 2012 during which she lived at the home of her mother and stepfather and her mother cared for her.[423] Both parties also agree the level of care should be assessed at 24 hours per day,[424] although they digress as to what allowance ought be made for the fact the care was provided at Mrs Kippin's home where Mrs Kippin would still sleep and tend to her other daily obligations, albeit to a diminished extent. I would allow for that by fixing a rate payable for 12 hours a day.

[321] There is also disagreement about what rate should be used. The plaintiff says the rate would be $35 per hour.[425] The defendant says the rate should be $24.50 per hour.[426]

[322] The defendant contends a rate of $24.50 per hour is appropriate given the contents of a report by Mr John Hart, director of Quality Lifestyle Support Pty Ltd, an accredited provider of care and support services. Mr Hart's report, dated 6 June 2011, costs a 24-hour care model at $4,129.11 per week, which equates to $24.50 per hour.[427]

[323] The plaintiff criticised Mr Hart's rates on the basis they were well below award rates.[428] The low rate may reflect the reality that some of the 24 hour period involves inactive presence only. Here, where I will only allow for 12 hours of each 24 hour period, I favour a higher hourly rate as reflecting more active work obligations.

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422 As Martin J did in *Waller v McGrath & Anor* [2009] QSC 158.

423 Plaintiff's Outline of Submissions, [211]; Defendant's Submissions – Quantum, [40].

424 Plaintiff's Outline of Submissions, [211]; Defendant's Submissions – Quantum, [36].

425 Plaintiff's Outline of Submissions, [212] & [213]. The plaintiff submits the award rates paid to level 2 disability care workers in 2010 was $42.85 per hour, minus agency fees and penalty rates gives $35 per hour.

426 Defendant's Submissions – Quantum, [40].

427 Ex 10 p 4.

428 Plaintiff's Outline of Submissions, [223].

[324] The other evidence of rates was in reports prepared by Lighthouse Health Group Pty Ltd. The relevant report[429] states that the 2012 rates were $49.80 per hour for AM and PM rates and $150.00 for sleepovers. I would adopt a lower rate than that to reflect the non-inclusion of a component which would be attributable to agency and other administrative fees and to allow for the rate having been lower earlier in some of the era concerned. A rate of $35 per hour for 12 hours a day is appropriate.

[325] The total for this head of damages is therefore **$588,000** ($35 x 12 hours x 7 days x 200 weeks).

Interest

[326] The relevant breach occurred before 1 July 2010 so the s 60 prohibition on interest on this head does not apply. Using the above adopted rate of 1.7 per cent per annum for the period of the commencement of the past gratuitous care to the present (about 268 weeks or 5.15 years) gives rise to interest on past gratuitous care of **$51,479.40**.

Future Care

[327] The plaintiff submits that she will require substantially more care in the future than she is currently receiving. Her case advanced an estimate by disability nurse Ms Jane Burns nee van Groningen that the plaintiff will require 21 hours per day of care, nine hours of which would be inactive sleep-over care.[430]

[328] The defendant does not dispute the need for active day-time care. Ms Libby Gallagher nee Murphy, the defendant's expert Occupational Therapist, considered 13 hours of active care per day was sufficient into the future. Ms Burns favoured 12 hours, although, unlike Ms Murphy, she favoured an additional 9 hours inactive sleep-over care.

[329] The defendant submitted the plaintiff would be unlikely to utilise 13 hours of care per day into the future, given her desire to live independently. While I favour a period of active care of slightly less than 13 hours, the prospect of the plaintiff being less likely to want to utilise the full period into the future needs to be balanced against the reality that the plaintiff's capacity to care for herself will not continue to improve into the future and may decline to a markedly different extent than among the able bodied ageing population. In any event, these variables can be allowed for as contingencies. The 12 hour period of active care at the rates contemplated in the 2013 schedule by the Lighthouse Health Group annexed to Ms Burns' revised report[431] is appropriate.

[330] The defendant disputes the plaintiff's need for overnight care.

[331] Overnight inactive care is sought principally to address security and safety issues and other needs arising unexpectedly during the night. However it also is relevant in addressing the plaintiff's inevitable need for the psychological comfort of knowing she has support to deal with the unexpected during the night.

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429 Ex 3 tab 6 p 102.

430 Plaintiff's Outline of Submissions, [218]; Ex 3 tab 11 p 201.

431 Ex 3 tab 11 p 207.

[332] Assessment of the need for overnight care involves consideration of the "relationship between the additional proposed cost and the anticipated benefit."[432] The criterion is one of reasonableness, not of what would be ideal.[433] As was observed by Gibbs and Stephen JJ in *Sharman v Evans*:[434]

> "The touchstone of reasonableness in the case of the cost of providing nursing and medical care for the plaintiff in the future is, no doubt, cost matched against health benefits to the plaintiff. If cost is very great and benefits to health slight and speculative the cost involving treatment will clearly be unreasonable, the more so if there is available an alternative and relatively inexpensive mode of treatment, affording equal or only slightly lesser benefits. When the factors are more evenly balanced no intuitive answer presents itself and the real difficulty of attempting to weigh against each other two incomparables, financial cost against relative health benefits to the plaintiff, becomes manifest."

[333] The defendant contends in effect that funding a prolonged period of inactive sleepover care is unreasonable when weighed against the limited benefit it will deliver, particularly when weighed against less expensive options likely to deliver only slightly less security, slightly less ready assistance and slightly less psychological reassurance during nights. The defendant also emphasised that the plaintiff has been staying overnight in her own residence without a carer present since November 2012, which has been a voluntary circumstance flowing from the plaintiff's desire to live independently.[435]

[334] In her report of February 2011, Ms Murphy opined that the plaintiff would be able to sleep in her own home without a carer present provided the plaintiff has sufficient security and urgent electronic communication aids and equipment in place to maximise her own safety, good security at her residence and a good care and support network.[436]

[335] I do not accept that the plaintiff should have no component of overnight care. Applying the cost benefit balancing process discussed in *Sharman v Evans* I accept the cost of having a carer immediately present for 24 hours a day is not warranted. However the mere provision of electronic security and communication devices falls considerably short of the care required overnight. Such aids may ease the need for the continuous immediate presence of a carer, but the absence of an "on premises" carer for a span as long as 11 or 12 hours does not place enough weight on the needs of the plaintiff or on the benefit of care. A more appropriate balance might be struck if the span of complete absence during the 24 hour cycle were reduced to a shorter, less concerning period in the order of four hours. A period of 12 hours active care and eight hours inactive or sleep-over care is an appropriate balance.

[336] I am fortified in arriving at that view by the existence in the care industry of a rate for inactive care which is much less than the active care rate. The funding model contained in the 2013 rate schedule to Ms Burns' revised report[437] contemplates a

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432 *McNeilly v Imbree* [2007] NSWCA 156, 155.
433 *Arthur Robinson (Grafton) Pty Ltd v Carter* (1968) 122 CLR 648, 661.
434 (1977) 138 CLR 563, 573.
435 T3-3; T3-4.
436 Ex 9 pp 26-29.
437 Ex 3 tab 11 p 207.

single shift rate of $121.20 for the entire eight hour period from 11 p.m. to 7 a.m. This contrasts with hourly rates for active care from 7 a.m. to 4 p.m. and 7 p.m. to 10 p.m., a total active care period of 12 hours. That structure well reflects the balancing moderation of cost weighed against benefit required by the present exercise.

[337] I will adopt the 2013 Lighthouse rate schedule. It calculates an annual figure of $281,415, which converts to $5,411.82 weekly.

[338] The defendant urged the benefit of a shared accommodation arrangement wherein a carer would be permanently on site supporting the needs of two or three clients as their needs arise. This model advanced by Mr John Hart, director of Quality Lifestyle Support,[438] incorporates a case manager and supervision of any care regime by a registered nurse. Mr Hart's evidence was that co-tenancy models utilising duplex or triplex accommodation enable very independent lives to be led by clients of his service, but still enables them to utilise and maximise support options. The defendant submits that this type of arrangement would be beneficial to the plaintiff and that the prospect of the plaintiff entering into such an arrangement for some periods in the future should be a consideration.

[339] The prospect of such an arrangement being available proximate to where the plaintiff will want to live and apt to her individual needs and preferences is difficult to predict. The evidence did not proffer an immediately appealing existing option of this kind, and the plaintiff's desire for independence makes it unlikely to be an alternative favoured by her in the short term. The possibility that the plaintiff might in the future adopt such a shared care/accommodation mode and thus reduce her care costs can be adequately taken into account by a discount for contingencies.

[340] Based on a weekly figure of $5,411.82 and the plaintiff's current life expectancy on the prospective tables of 39 years (she turns 49 next month), the cost of her future care funded commercially for 39 years (multiplier 910) is $4,924,756.20. After discounting by 12 per cent for contingencies, the amount awarded for future care would be **$4,333,785.46**.

Case Management

[341] The plaintiff claims for case management costs in accordance with the report of the Lighthouse Group, comprising an initial burst of 80 hours of case management, followed by two hours per month at an hourly rate of $165 by an Occupational Therapist.[439]

[342] The defendant agrees that the plaintiff will require an independent case manager, however the defendant submits that it would be appropriate for such a service to be provided by a registered nurse, as recommended by Ms Murphy.[440] Ms Murphy, an Occupational Therapist, gave evidence that a registered nurse would be a suitable case manager as they would offer a "good multi disciplinary option for managing care."[441] Ms Murphy considered that after an initial start up burst of 15 hours, two

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438 Ex 10, 12.
439 Ex 3 tab 9.
440 Defendant's Outline of Submissions [70].
441 T9-77.

hours of case management per fortnight (one hour a week) was appropriate at an hourly rate of $67.72.

[343] Ms Murphy's approach involves more hours per year, but a shorter proposed burst of set up work than the Lighthouse Group. The shorter set up period but more regular ongoing hours contemplated by Ms Murphy is apt to the plaintiff's circumstances, given that communication with her is slow and the management of her circumstances is likely to be difficult to predict with confidence at the outset. I accept a registered nurse would be a suitable case manager.

[344] I would allow a fixed set up cost of (15 x $67.72 =) $1,015.80. In addition, $67.72 per week over 29 years, applying the five per cent tables (multiplier 910), amounts to $61,625.20. The total allowance for case management would therefore be $62,641, discounted by 12 per cent for contingencies to **$55,124.08**.

Future domestic and home maintenance needs

[345] The plaintiff claims for domestic maintenance as follows: Eight hours per year of spring cleaning at $35 per hour, two hours per month of handyman assistance at $40 per hour, five hours per week of heavy domestic assistance at $35 per hour and two hours per week of lawn mowing and gardening at $40 per hour.[442]

[346] The defendant submits these are excessive estimates. As the evidence of Ms Murphy indicated, the plaintiff is capable of carrying out some household cleaning tasks herself. Further, it is likely her funded carers will assist with or perform light domestic and maintenance tasks. Realistically, the plaintiff would be unlikely to require added assistance, for heavy domestic and maintenance tasks, for more than an average of two hours per week. I would allow two hours per week at $30 an hour.

[347] This equates to an award at $60 a week over 39 years on the five per cent tables (multiplier 910) of $54,600, then discounted by 12 per cent for contingencies to **$48,048**.

Future aids and equipment

[348] The plaintiff's counsel provided as annexure A to his written submissions a comprehensive list of the plaintiff's future costs of therapeutic aids, appliances and equipment, including replacement costs, giving a total of $59,972.66. The information therein was drawn from the detailed report of Ms Lindy Williams, Occupational Therapist.[443] It was the most comprehensive report before the court on this aspect and is an apparently reasonable forecast of the plaintiff's needs.

[349] I would, after discounting 12 per cent for contingencies, award **$52,775.94**.

Future medical expenses

[350] The defendant does not dispute the plaintiff's claim for the cost of general practitioner reviews every three months, blood tests every three months and twelve psychology treatment sessions in the amount of $10,430.99.

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442 Amended Statement of Claim, Schedule 'P'.

443 Ex 3 tab 5.

[351] After discounting 12 per cent for contingencies I would award **$9,179.27**.

Future paramedical expenses

[352] The plaintiff submits that she will require psychological counselling, occupational therapy, podiatry services and Neurolink or alternative therapies, which will amount to $73,927.78 before contingencies.

[353] The defendant contests the inclusion of a component for alternative therapy consultations twice a month due to no evidence being presented as to the therapeutic benefits of such therapies. [444] However Ms Burns and Williams in their joint care and equipment table[445] reasonably explain this component is intended for relief of the plaintiff's neuropathic pain as an additional form of relief to pharmacological management.

[354] After discounting 12 per cent for contingencies I would award **$65,056.45**.

Future pharmaceutical expenses

[355] The plaintiff claims a weekly cost of $4.47 to cover flu and pneumococcal vaccines and wound care products. A weekly cost of $4.47 for 39 years on the five per cent tables (multiplier 910) is $4,067.70. The defendant does not materially dispute this head of damage.

[356] After discounting 12 per cent for contingencies, I would award **$3,579.58**.

Future accommodation costs

[357] The defendant concedes a cost under this head of $35,436, being the cost of special features and modification to a standard project home to meet the plaintiff's special needs, as identified in the joint report of construction consultants Gordon Leck & Associates.[446]

[358] Further to that cost, the plaintiff will have annual recurrent costs, depreciation costs and house maintenance costs[447] which Mr Leck assesses at $210, $288 and $2,784 respectively. That gives a total of $3,282 or $63.12 a week which over 39 years, on the five per cent tables (multiplier 910), equates to $57,439.20, and after discounting 12 per cent for contingencies, to $50,546.50.

[359] Taken with the cost of special features and modifications, the total award for this head would be **$85,982.50**.

Additional vehicle costs

[360] The plaintiff pleads a total amount for vehicle expenses of $9,198.84, calculated on the cost difference between a manual and an automatic car and the cost difference of additional insurance for multiple drivers and roadside assistance.

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444 Citing *Redden v Forde* [1998] ACTSC 42, [38]-[39].

445 Annexure B to Ex 3 tab 5 p 82.

446 Ex 3 tab 12 p 213.

447 These are additional to the costs I contemplated above in respect of domestic and house maintenance needs.

[361] The defendant only concedes the additional insurance cost. It was not shown why an automatic car would be necessary or that the plaintiff would have purchased a car of this type absent her disability. Further, roadside assistance is a cost the plaintiff would have likely incurred in any event.

[362] The additional insurance cost of 96 cents a week for 39 years, applying the five per cent tables (multiplier 910), is $873.60. Discounting 12 per cent for contingencies, I would award **$768.77**.

Future technology needs

[363] The defendant does not contest the plaintiff's calculated claim of $188,309.58 for future technology needs. It is reasonable given the nature of the plaintiff's disability.

[364] Discounting 12 per cent for contingencies, I would award **$165,712.43**.

Holiday/leisure costs

[365] It is the plaintiff's submission, founded principally upon Ms Williams' report,[448] that she would incur additional holiday and leisure costs associated with carer's airfares to travel with her, carer's meal allowance and additional hotel room accommodation. Ms Williams proposes annual amounts for those purposes of $1,969.90, $1,400 and $4,200 respectively. That is a total of $7,569.90 or $145.57 a week. That amount for 39 years, applying the five per cent tables (multiplier 910), gives rise to $132,468.70.

[366] The defendant submits that no award should be made for these costs given that the plaintiff has provided no evidence of a desire to take regular holidays.[449] I readily infer such a desire. Ms Mules aspires to lead her life to the fullest allowed by her disability. She may experience holidays differently than people without disability, but her desire to holiday away from the shackles of her day to day existence is likely to be as forcefully present in her as in an able bodied person, if not more so.

[367] Applying a 12 per cent discount for contingencies, I would award **$116,572.46**.

Special damages and out of pocket expenses

[368] The plaintiff submits for special damages of $7,497.38 for pharmaceutical, $33,657.43 for travel, $3,016.90 for medical, $3,789.20 paramedical, $38,237.24 for therapeutic aids and $4,620 for expenses; a total amount of $90,818.15.

[369] The defendant does not appear to dispute these components.

[370] I would award **$90,818.15**.

Interest on special damages and out of pocket expenses

[371] Interest at 1.7 per cent per annum on special damages and out of pocket expenses over 5.52 years would be **$8,522.38**.

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448 Ex 3 tab 5 p 73.

449 Defendant's Outline of Submissions [82].

Quantum Summary

General Damages	$	250,000.00
Past economic loss	$	263,471.68
Interest thereon	$	24,724.18
Future economic loss	$	514,175.31
Past gratuitous care and services	$	588,000.00
Interest thereon	$	51,479.40
Future care	$	4,333,785.46
Case management	$	55,124.08
Future domestic and home maintenance needs	$	48,048.00
Future aids and equipment	$	52,775.94
Future medical expenses	$	9,179.27
Future paramedical expenses	$	65,056.45
Future pharmaceutical expenses	$	3,579.58
Future accommodation costs	$	85,982.50
Additional vehicle costs	$	768.77
Future technology needs	$	165,712.43
Holiday/leisure costs	$	116,572.46
Special damages and out of pocket expenses	$	90,818.15
Interest thereon	$	8,522.38
Total	$	6,727,776.04

[372] Had the plaintiff's claim on liability succeeded, I would have awarded $6,727,776.04.

Orders

[373] My orders are:

(a) Claim dismissed.

(b) I will hear the parties as to costs.