SUPREME COURT OF QUEENSLAND

CITATION:	***Reck v Queensland Rail*** **[2004] QSC 340**
PARTIES:	**NIGEL RONALD RECK** (Plaintiff) v **QUEENSLAND RAIL** (Defendant)
FILE NO:	60/2002 (Mackay)
DIVISION:	Trial Division
DELIVERED ON:	20 September 2004
DELIVERED AT:	Mackay
HEARING DATES:	14, 15, 16 and 22 July 2004
JUDGE:	Dutney J
ORDERS:	**1. Judgement for the plaintiff against the defendant in the sum of Six Hundred and Forty-Four Thousand, Seven Hundred and Fifty-Six Dollars and Eight Cents ($644,756.08).**
CATCHWORDS:	NEGLIGENCE – MASTER AND SERVANT - BREACH OF DUTY – FAILURE TO WARN – where plaintiff fell face first from the door way of a stationary locomotive – where the access system for the locomotive is acknowledged to be dangerous – where plaintiff given no safety instructions or information - where remedial measures available would not have prevented accident – whether the defendant had an obligation to train drivers in the safe ingress to and egress from the locomotive NEGLIGENCE – CONTRIBUTORY NEGLIGENCE – where plaintiff had entered and exited a 3100 series locomotive many times – where plaintiff familiar with hazard – whether plaintiff failed to take reasonable care for his own safety *Alphacell Ltd v Woodward* [1972] AC 824, referred to *Birkholz v Gilberton Pty Ltd* (1985) 38 SASR 121, referred to *McLean v Tedman* (1984) 155 CLR 306, considered

Tame v New South Wales (2002) 211 CLR 317, followed
Wyong Shire Council v Shirt (1980) 146 CLR 40, followed

COUNSEL: Mr JR Baulch SC for the plaintiff
Mr MT O'Sullivan for the defendant

SOLICITORS: Taylors Solicitors for the plaintiff
McInnes Wilson for the defendant

[1] Between March 1994 and August 1997, Nigel Ronald Reck must have entered and exited a 3100 series locomotive hundreds, if not thousands, of times. During that period he worked for Queensland Rail as a locomotive driver on the coal line from the Bowen Basin to the terminals near Mackay.

[2] On 26 August 1997, Mr Reck fell face first from the doorway of the locomotive onto the ballast which supported the track. At the time of the fall the train was stationary at Hatfield siding. Mr Reck intended exiting the locomotive by climbing the 2.2 metres from the doorway to the ground to use the toilet in the remote-controlled 3200 series locomotive behind.

[3] 3100 locomotives carry two drivers and the additional equipment needed to control the three remote controlled locomotives which collectively haul the coal train. As a result of the additional equipment required to be carried in the manned locomotive there is no room for a toilet. The other three locomotives all have toilets.

[4] As Mr Reck commenced manoeuvring himself out of the locomotive, his foot caught on the raised lip at the doorway and he pitched forward onto the ground beside the track.

Liability

[5] The access to a 3100 series locomotive is cramped. There is a short ladder allowing access to the ground. Because of restrictions on protrusions beyond edge of locomotives or rolling stock the rungs of the ladder are narrow and the ladder itself slopes back towards the locomotive. I am, however, not directly concerned with the ladder in this case. In addition to the ladder there are handrails external to the locomotive on either side of the door opening. These handrails consist of a 38 mm by 10 mm flat bar. The handrails are located 55 mm from the edge of the door cavity on either side.

[6] Because of space restrictions the procedure required to exit the locomotive is as follows. The driver must first open the door. He does this by pulling the door towards himself as he stands to the left of the door as he faces out. The door is hinged on the left. When there is no platform, the locomotive can only be safely exited by descending the ladder backwards. When the driver is facing the opening he must, either turn around, position himself with his heels

protruding over the door sill and reach back for the handrails, or, more likely, turn and reach for the left hand handrail with his right hand in one motion

[7] A report from Mr Brendan McDougall[1], an engineer specialising in safety issues, records that in normal walking the shoe height from the floor is commonly less than 28 mm and can be less than 10 mm. The significance of 28 mm is that that was the height of the raised lip at the doorway. Mr McDougall opined that when a person was moving slowly and taking short steps, as in the motion of turning to grasp the handrail and descend the ladder in this case, the shoe clearance is likely to be even less than when walking normally.

[8] The other feature of the doorway to which attention was drawn in evidence was its height. The opening is only 1680 mm. Mr Reck is taller than that. As a result he must necessarily bend as he exits the locomotive to clear the top of the door.

[9] It is relevant to note that Mr Reck was given no safety instructions or information concerning entering or exiting the locomotive at any time. This is despite numerous accidents over a period of years being suffered by persons entering or leaving locomotives. None of those accidents were similar to the accident suffered by Mr Reck. Since this accident a video has been prepared giving such instruction and warning of risks.

[10] It is not disputed that Mr Reck fell forwards out of the locomotive. It was suggested in cross examination that he may have been standing in the doorway urinating onto the track, lost balance and fell. Mr Reck rejected the suggestion. There is, in the result, no evidence that Mr Reck was doing anything other than exiting the locomotive in the conventional manner. In any event, there is no evidence that the defendant had ever instructed its employees not to urinate from the opening, despite the fact that they were often in remote and uninhabited parts of the countryside. Even though Mr Reck recognised in the witness box that such a practice would be dangerous it is common experience that employees often do dangerous things unless instructed not to. It is foreseeable that such a practice might develop if not expressly prohibited.

[11] Mr Reck's recollection is that he opened the door, moved forward to grasp the handrail, tripped on the lip in the doorway and fell. At the time of the fall Mr Reck was reaching towards the handrail. Mr Reck could not recall which foot connected with the lip but logic suggests it must have been his right foot since he would have to have been standing to the right of the door as he faced it and reaching for the left handrail with his right hand. I found Mr Reck to be a credible witness and I accept his account of what happened.

[12] Much of the expert evidence from the defendant's side of the record concerned how the plaintiff could have come to have fallen forwards out of the

[1] Exhibit 9.

locomotive given the expectation that he would have come to a stop after opening the door and before reaching for the hand rail.

[13] The relevant principle to apply in determining liability is that enunciated by Mason J in *Wyong Shire Council v Shirt*[2]. This required, in the first instance, an examination of whether the risk of someone, like Mr Reck, tripping on the lip and falling forward from the Locomotive was foreseeable in the sense of not being far fetched.

[14] This part is easy. The presence of the lip was an obvious danger to persons using the entry. Mr McDougal pointed out in his first report[3] that the potential for raised lips in pedestrian access ways to cause persons to trip is well documented. In public access ways, design standards exclude such lips. Such lips frequently occur in private houses where there are sliding doors. The danger of a serious fall there is much less likely, however, because the normal response to having the progress of one foot stopped by such an obstruction is to move the other foot forward to regain stability.[4] Such a movement will, of course, probably result in injury if the lip is more than 2 metres above the ground.

[15] The lip in this case fulfils a practical function. It forms part of the seal for the door. This prevents dust, particularly coal dust entering the locomotive and damaging the sensitive equipment inside. It also assists with the air conditioning of the locomotive which operates in extremely trying tropical conditions for much of the year.

[16] The second part of the test in *Shirt* requires a consideration of what steps could have been taken to alleviate the foreseeable risk.

[17] A number of possible remedial measures were suggested by the plaintiff's expert. These included a ramp to eliminate the lip from the inside, better highlighting of the lip, placing the handrails closer to the door to reduce the reach required to use them or installing an internal handle.

[18] As explained by McHugh J in *Tame v New South Wales*[5] the test in *Shirt* requires as a third step that the Court to determine whether it is negligent on the part of a defendant to ignore a risk that is not far fetched or fanciful and where there are measures that can be undertaken to prevent it. In other words, it is not sufficient merely to answer the first 2 questions, those relating to foreseeability and preventability, in favour of the plaintiff.

[19] To determine whether the defendant's failure to take the identified steps or any other step was negligent requires a consideration of the practicality of the preventative measure, the likelihood of a person aware of the existence of the lip tripping on it and the likely consequences of any such trip. In that context the question of whether it was negligent to ignore the risk can be answered.

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[2] (1980) 146 CLR 40 at 48.
[3] Exhibit 8.
[4] see discussion in exhibit 9 at pp 5-6.
[5] (2002) 211 CLR 317 at 351-356, [96] – [108].

[20] The last question is the easiest. The consequence of a fall of the type suffered by Mr Reck was almost inevitably a serious injury.

[21] The existence of the lip was well known to the locomotive drivers. Highlighting it was, in my view, unlikely to materially affect the risk of someone tripping. It is not a case where the entrance was likely to be used by persons unfamiliar with the problems associated with its design. Mr Reck was aware of the lip. He would not have fallen in the way he did from a stationary position if he was watching the door sill. Highlighting would be of assistance only in drawing the attention of the lip to someone who was otherwise not aware of it.

[22] The construction of a ramp up to the inside edge of the lip is described by Mr McDougall in exhibit 8. It seems to me that construction of such a ramp would lessen the likelihood of someone tripping on the lip as they commenced to rotate to grasp the left hand rail with their right hand. At the same time, it is noted by Dr Grigg in exhibit 23, correctly in my view, that the presence of the lip is a tactile cue to the edge of the doorway. Dr Grigg deals with this issue as follows:

> "**3.2 Likelihood of the lip being avoided**
>
> Obviously, if there is a lip, there is a potential for work boots to contact the lip. However, if there were no lip, there would be potential for the boot to pass through the door further than necessary to maintain a secure footing. Furthermore, I believe that a person familiar with the use of this entry to the locomotive would rely substantially on tactile cues rather than visual cues. In that regard, the door itself, and in particular the door handle, the hand rails mounted on the outside of the doorway and the lip, all provide tactile cues that would enable a person to enter or exit the locomotive with their eyes closed, once they were aware of these features."

[23] I accept Dr Grigg's assessment. Removal of the lip, while perhaps reducing the likelihood of a fall like that suffered by Mr Reck, would create a danger of at least similar magnitude by removing the tactile cue which establishes the edge of the door sill. Mr Reck himself appeared to use the lip as a tactile cue in the video, exhibit 36, when he is shown placing his foot sideways on it when exiting. On the evidence this is the only incident of a driver falling forwards out of the locomotive after tripping on the door sill despite some 700 use years for this class of locomotive[6].

[24] Next, it was suggested that the handrails should have been closer to the door opening to reduce the distance the driver had to reach to grasp them. They could not have been moved much further because at present they are located only 55 mm from the edge of the opening on each side. The scope for

[6] See exhibit 26 page 6. There were other instances of drivers stumbling recounted by various witnesses but none of them actually fell.

movement of the rails would appear to be at most an inch. I am not persuaded that such a difference would have materially reduced the risk of the plaintiff suffering this injury for the reasons given by Dr Grigg[7].

[25] The next proposal was to place an additional handle on the door or inside the locomotive near the door. The difficulty would be in siting such an additional handle. If it was placed on the door there would be a risk that if outward pressure was placed on the handle, the door would begin to swing shut and shift the drivers centre of gravity outside the locomotive, thereby creating an enhanced risk of falling. While raising the placement of an extra handle as an issue in his reports, Mr McDougall did not specify in those reports where such a rail might be positioned which might have prevented this particular accident. Mr McDougall referred to the placing of such handles on truck doors. Of course, truck doors open outwards rather than inwards which makes the likelihood of the door moving in such a way as to cause a fall, when downwards and outwards force is applied, much less. In this case I cannot see how such a handle would help. This fall did not take place after Mr Reck had turned around and started to descend. The video, exhibit 36, shows the demonstrator making use of the door handle as an initial point of support but releasing it before taking hold of the handrail. I am satisfied that what is shown in the video is how an experienced driver who had become somewhat blasé about the risks would ordinarily exit the locomotive.

[26] The problem I have faced in considering this matter is that identified by the defendant's experts. How did the fall come about? When the driver commences to exit the locomotive he is necessarily stationary having just opened the door inwards. When he commences to exit he must rotate and reach for the hand rail. He has minimal forward momentum at that point. The risk of falling out forwards if that is done in a proper manner is thus very low or non existent. As I understood the evidence of Mr Smith[8] it was to the effect that if a person standing wholly within the cabin of the locomotive rotates, the person's momentum is such that even if the rotation is arrested by his foot striking an obstruction he will not fall outside his plane of rotation. He would not be likely to fall out of the cabin. Dr Grigg also draws attention[9] to the fact that the handrails should be grasped while the centre of gravity is still within the cabin. It is thus necessary to explain the fall in some other way. The only probable explanation is that Mr Reck was exiting the locomotive in a manner similar to that shown in photographs 3 – 9 of exhibit 8. The low height of the doorway is likely to contribute. Although the left handrail can be readily seen by a person standing wholly within the locomotive, it is easy to imagine a person, not thinking of the risk, bending forward out of the doorway so that the person's head clears the top of the opening thus putting the centre of gravity over the sill or outside the locomotive. This is consistent with Mr Reck's description of "moving forward" to grasp the handrail. If the driver was leaning outside the locomotive when the rotation occurred the driver would have to reach for the handrail and turn at the same time. The right foot would pass over the sill of the door and outside the locomotive during the

[7] See Exhibit 22, page 5, paragraph 13.
[8] See T225 – T227
[9] Exhibit 22 page 5 paragraph 13.

course of this manoeuvre. To achieve this, the right foot would commence by thrusting forward in the manner illustrated in photograph 6. If the movement of the foot was arrested by the lip in the course of doing this and the head was outside the opening it is easy to imagine that a person who had not yet grasped the handrail could fall forward in the manner Mr Reck described. Mr Smith claimed never to have seen a driver exiting the locomotive by rotating with his foot over the sill as demonstrated in the video, exhibit 36. The demonstrator in exhibit 36 is exiting in a natural manner. I accept that it is a common means of exiting. I suspect Mr Smith has simply had no cause to pay much attention to drivers getting in and out of the 3100 series locomotive.

[27] If a person exited the train in the manner illustrated by photographs A – E of exhibit 8, I agree with the defendant's experts that a fall forwards would be nearly impossible. The difference is that in this instance the driver rotates wholly within the cabin except for the arm reaching out towards the handrail. There is no forward momentum which could take the driver outside the cabin. If the driver stumbled as his foot rotated, it would probably be a stumble inside the cabin.

[28] The access system for the 3100 is acknowledged to be dangerous. Apart from the possibility of increasing the height of the opening to the door to remove the temptation to bend out of the locomotive before commencing to rotate, the remedial measures suggested by the plaintiff are either unlikely to have impacted on this accident or create alternative risks which, having regard to the low likelihood of this accident happening were such as it would not be negligent on the part of the defendant to ignore.

[29] Having regard to the recognised problems with the access there was, in my view, an obligation on the defendant to train drivers in the safe ingress to and egress from the locomotive. The importance of remaining wholly within the cabin until the driver has a hold on the handrail is not necessarily so obvious as to pass unremarked. In 2001 the defendant prepared a safety video[10] entitled "Accessing and Egressing Locomotives". The video deals with a number of safety issues including the importance of three point contact when using access systems. Mr Richards, a driver since 1993, only became aware of the importance of the three point contact after seeing the video. Dr Grigg expressed the view that 3 point contact was possible when exiting this class of locomotive by using the external door handle as a third point until the handrail is successfully grasped[11]. This would make it very difficult to move the centre of gravity over the will prematurely. If this was done it would be difficult to move the centre of gravity over or outside the sill prematurely. Although the video does not deal expressly with the footplate it alerts the drivers to the danger generally of the access systems of locomotives and the need for care in using them. In *McLean v Tedman*[12] in the joint judgement of Mason, Wilson, Brennan and Dawson JJ their honours said of an employer's obligation to its workers:

[10] Exhibit 41.
[11] Exhibit 22, page 3, paragraph 6.
[12] (1984) 155 CLR 306 at 313.

> "The employer's obligation is not merely to provide a safe system of work; it is an obligation to establish, maintain and enforce such a system. Accident prevention is unquestionably one of the modern responsibilities of an employer … And in deciding whether an employer has discharged his common law obligation to his employees the Court must take account of the power of the employer to prescribe, warn, command and enforce obedience to his commands."

[30] An illustration of the defendant's failure to take proper steps to ensure safety on the part of the workers is the failure to prohibit drivers urinating from the doorway of the locomotive. It was put to Mr Reck that this was a practice at the time he was injured. It was put to him that it was dangerous and it has not been suggested that any step was taken to warn drivers of the risk involved or to proscribe the practice.

[31] It is not without significance that Mr Smith thought that the demonstrator in the video, exhibit 36, was incorrectly exiting the locomotive. The fact that the access system as a whole was potentially dangerous and that there were few, if any, practical remedial measures open made it more important that the defendant took steps to ensure that drivers were aware of the risks and of the correct way to exit the locomotive so as to minimise those risks.

[32] In this case I am satisfied that the defendant, knew generally of the risks associated with the use of the access system on these locomotives. Having knowledge or constructive knowledge that a lip in an access way was a potential hazard, even if a necessary one, the defendant had a duty to properly instruct drivers in the safe use of the access system. The failure to do so, in my view, materially increased the risk of this accident occurring. In *Birkholz v Gilbertson Pty Ltd*[13] King CJ adopted a statement by Lord Salmon in *Alphacell Ltd v Woodward*[14] where his Lordship said that, "In the circumstances of the present case it seems to me unrealistic and contrary to ordinary common sense to hold that the negligence which materially increased the risk of the injury did not materially contribute to causing the injury."

[33] It follows that in my view the defendant was negligent in not warning the plaintiff of a risk about which it knew or ought to have known and that such failure materially contributed to the injury. The defendant was also negligent and in breach of its duty to provide a safe system of work in failing to instruct the plaintiff in the proper way to use the access system so as to avoid the risk of having his centre of gravity outside the cabin before he had a secure grip on the handrail. I am satisfied that had the plaintiff been properly informed of the danger of leaning out of the locomotive before taking hold of the handrail and shown how to exit safely on the balance of probabilities the accident would not have occurred. In any event had the defendant given such information and instruction the defendant could not have complained if he failed to follow those instructions.

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[13] (1985) 38 SASR 121 at 132.
[14] [1972] AC 824 at 847.

Contributory Negligence

[34] Being aware of the existence of the lip and the problems associated with exiting the locomotive, Mr Reck would be unlikely to have fallen forwards out of the locomotive if he had been taking reasonable care for his own safety. Having successfully negotiated this access system on hundreds if not thousands of previous occasions without mishap it follows, in my view that the plaintiff was not taking proper or reasonable care for his own safety in the manner of his attempted exit from the locomotive. In my view, the plaintiff must bear a significant portion of the blame for his own accident. I accept the submission of counsel for the defendant that contributory negligence should be assessed at 25%.

Quantum

[35] Prior to his accident the plaintiff was healthy man of 33 years. He was born on 28 April 1964.

[36] The plaintiff and his wife were questioned at length about the plaintiff's visits to a chiropractor prior to the accident. I accept the evidence of Mrs Reck that as a family they visited a chiropractor as part of their normal health routine. I am satisfied that the fact of such visits was not indicative of any serious underlying health problems.

[37] In all probability, but for the accident the plaintiff would have continued to work either for Queensland Rail or some equivalent employer to normal retirement age.

[38] As a result of the fall from the locomotive Mr Reck suffered a brief period of amnesia. He recovered and climbed back into the locomotive but did suffer a fractured skull with associated closed head injury, facial fractures, fractures of T8, T9 and T10 as well as a right knee injury.

[39] Mr Reck was operated on at the Rockhampton Base Hospital by Dr Djamshidi to repair facial damage. He had pain in his face for many weeks.

[40] Mr Reck was released from Rockhampton Base Hospital on 2 September 1997. At that time he was suffering thoracic pain and pain from his facial injuries. Mr Reck had trouble eating because of his wired jaw and also developed mouth ulcers. He had trouble sleeping. Some root canal treatment was carried out. Mr Reck had an arthroscopy on his right knee on 14 April 1998 which relieved some of his knee pain. In June 1998 Dr Djamshidi performed an osteotomy on the plaintiff's jaw.

[41] After the accident the plaintiff suffered depression and loss of concentration. He noticed difficulty reading correspondence. He became less tolerant of his wife and children. His marital relationship was strained to the point where he separated from his wife and children in March 2001. He still lives apart from them but the relationship itself appears to be continuing.

[42] The plaintiff was diagnosed with sleep apnoea after the accident. He takes CPAP to relieve the symptoms. He has seen a psychologist on a number of occasions and has also consulted a psychiatrist, Dr Futter, for treatment. Mr Reck takes Efexor to relieve his depression. He has previously taken Zoloft. He was also prescribed Lithium to relieve suicidal thoughts.

[43] Mr Reck still suffers back and knee pain. He suffers from headaches. His cognitive skills appear to be affected. There is disagreement between the psychiatrists as to whether he suffered frontal lobe damage in the accident. Despite this disagreement the preponderance of the psychiatric evidence supports the finding that Mr Reck has suffered some personality and cognitive change as a result of the accident. This change is permanent. If I were required to identify the cause of the psychiatric changes I would accept Dr Futter's evidence that there is an element of physical injury involved. Dr Futter has an advantage over the other psychiatrists in being the treating doctor. Dr Varghese accepts that neurological testing has not disclosed frontal lobe damage but comments that frontal lobe damage can be subtle and difficult to detect even with neuropsychological testing.

[44] Mr Reck returned to work with Queensland Rail on 20 March 1998 under a rehabilitation programme. From 14 April 1998 until 24 April 1998 Mr Reck was off work recovering from the arthroscopy on his right knee. From 4 June 1998 until 17 June 1998 Mr Reck was off work because of the operation on his jaw. Mr Reck did not return to train driving but was employed in an administrative capacity. He was ultimately terminated on medical grounds on 6 October 2000 and has not worked since. Before the accident Mr Reck also worked part time driving taxis. While I accept that this may have continued until trial I am not persuaded that the plaintiff would have continued to work a second job indefinitely particularly once his family was well established in school.

[45] In my view, while from a physical point of view Mr Reck is capable of performing all but heavy work, it is unlikely he will actually get a job. His general practitioner refused to give him a medical clearance to get a taxi licence. Dr Futter when asked if the plaintiff could work as a taxi driver said:

> "I wouldn't want to be in a taxi driven by a person who I knew had a head injury and I wasn't sure that they'd been adequately tested or retrained."

[46] This followed general comments on Mr Reck's employability:

> "I think the stress would be on intensive retraining and I think the proof of the pudding would be how he coped with the retraining. People with organic brain injuries do not tolerate frustration very easily and give up very easily, so one would – it would depend on how he did during that retraining and if one could ascertain that he was in fact learning new skills and being able to apply them appropriately, so I would have to say a lot would depend on how he would perform

> during any retraining, and one would have to accept that one might come to the conclusion that he wasn't able to be retrained."

[47] Dr Pickering, a psychiatrist was even more pessimistic. He said in examination in chief:

> "Again, if we address the issue of employability it's – he's become unreliable. His ability to organise himself and discipline himself has become compromised. Now he may be able to work as a cab driver but whether he could consistently sustain employment and remain somebody that an employer would want to keep on is something else again. I would have doubts that he would have the kind of reliability that I would look for if I were employing a cab driver."

[48] Later Dr Pickering said that the fact which made Mr Reck unemployable in a practical sense was his impaired judgement and this was irrespective of whether he was suffering depression at any particular time.

[49] Mrs Reck described the plaintiff's response to stress as a "shut down". She said:

> "On many occasions Nigel gets very confused. He likens it to having a thousand thoughts going around in his mind at any one time, and if anyone's actually – just even the slightest thing, if the children are coming up and asking him a question, or if there's a lot of things happening around him all at once, he actually goes through what I call a physical shutdown. You can see it just building up in his face. His muscles get very tense. He just goes into – he shuts his eyes so you know that that's the first sign of it coming on. His head will go down. His hand will go across his head and it's like he shuts the whole world out. It just goes through this physical shutdown. Or at times, even leading up to that, he will actually give a response like, "I don't know. How do you expect me to know the answer to that question?" You know it's just that he can't process the thoughts that are going through his mind at one time, so it's easier just to shut down and blank it all out."

[50] Mr Reck exhibited precisely this behaviour at one point in his examination in chief.

[51] In the result, while I am satisfied that Mr Reck is physically capable of employment he is not employable because of his psychiatric condition. He retains a residual earning capacity, but being unlikely to sustain employment, it is probable that it will be reflected in occasional piecework or short term jobs.

[52] Apart from general damages and economic loss the other heads of damage are agreed. In the result I assess damages as follows:

Pain & Suffering	70,000.00
Interest	-
Past Economic loss[15]	274,377.08
Interest[16]	43,152.24
Future economic loss[17]	466,200.00
Loss of superannuation benefits[18]	61,164.40
Future expenses[19]	30,000.00
Special damages as agreed	41,997.09
Interest on special damages[20]	6,417.60
TOTAL	993,308.41
Less contribution of 25%	744,981.30
Less WC Refund	100,225.22
BALANCE	**644,756.08**

[53] I give judgement for the plaintiff against the defendant in the sum of $644,756.08.

[15] If wages for comparable workers 2 and 3 (Schedule E to exhibit 13) are used, the average income from 26.08.97 to 20.09.04 is $330,384.08. Income received was $81,851.00 leaving a nett loss from QR of $248,533.08. Allowing a nett of $71 as a taxi driver over 7 years adds $25,844 giving a total of $274,377.08.

[16] Interest should be allowed from the beginning of 2001 (3.7 years) @ 5% on $235,758.08.

[17] I accept the defendant's first methodology set out in note 6 of its submissions. The higher discount rate of 30% adopted, the non inclusion of taxi earnings for the future and the use of a retirement age of 60 rather than 65 reflects the plaintiff's residual earning capacity and my finding regarding his not continuing a second job indefinitely. There is no material difference between this figure and the figure submitted by the plaintiff.

[18] Agreed at 7% for the past and 9% for the future.

[19] While not agreed expressly, each side submitted the same figure.

[20] $18,336.00 @ 5% for 7 years.