SUPREME COURT OF QUEENSLAND

CITATION:	*Stewart v Fehlberg & Anor* [2008] QSC 292
PARTIES:	**GENE SCOTT AIDEN BRETT STEWART** (Plaintiff) **v** **GARY ALLAN FEHLBERG** (First Defendant) And **PERSAL & CO CONSTRUCTIONS PTY LTD** (Second Defendant)
FILE NO/S:	Rockhampton 373 of 2007
DIVISION:	Trial Division
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court at Rockhampton
DELIVERED ON:	21 November 2008
DELIVERED AT:	Rockhampton
HEARING DATE:	22, 23, 24, 25 September and 9 October 2008
JUDGE:	McMeekin J
ORDER:	**1. Judgment for the plaintiff against the first defendant in the sum of $369,867.49.** **2. Judgment for the plaintiff against the second defendant in the sum of $358,600.36.**
CATCHWORDS:	DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES - PERSONAL INJURIES – SUPERVENING NATURAL CAUSE – assessment of damages for personal injuries - where the plaintiff received an electrical shock – where no organic basis for symptoms - whether the patient's tremors involves Parkinson's disease *Bendix Mintex Pty Ltd v Barnes* (1997) 42 NSWLR 307 at 311, followed *Lee v Quality Bakers Australia Limited* [2000] QCA 285, followed
COUNSEL:	M Grant-Taylor SC and R Morton for the Plaintiff G O'Driscoll for the Defendants
SOLICITORS:	Suthers Lawyers for the Plaintiff Gadens Lawyers for the Defendant

[1] **McMEEKIN J:** In this action Mr Stewart seeks damages for personal injuries suffered when he sustained an electric shock on 2 February 2000, when aged 34 years,[1] at the premises of the first defendant and while in the course of employment with the second defendant. Liability is admitted.

Circumstances of the accident

[2] The only account of the accident itself comes from the plaintiff and he has given slightly differing versions according to the reports tendered. The differences relate to the period of exposure to electric current and the immediate effect as to whether he fell or not. Those differences do not seem to me to be particularly relevant. The early reports seem to indicate that he did not fall or lose consciousness. Mr Stewart said in his evidence that he could not say for how long he was exposed[2] but in his statement that was tendered said that the length of exposure was 12 seconds.[3] Counsel seemed content to argue the case on that basis. The current was normal domestic current of 240 volts.

[3] The probabilities suggest that the current travelled from Mr Stewart's right hand, where he suffered an entry wound, probably through his chest, and out through the left hand.[4] There is no evidence that the current reached the brain or spinal chord.[5]

The Aftermath

[4] Following the incident Mr Stewart was seen at a local hospital, an ECG test was normal,[6] he was not admitted, developed more significant symptoms later that day and admitted to hospital overnight at the request of his general practitioner after complaining of pain "all over [his] chest and limbs".[7] Complaints on admission were of muscle pains and weakness and chest pain. Mr Stewart gave a history of having earlier had a "tremor feeling" and "muscle tightness". He is recorded in the hospital record as feeling much better the following day.[8]

[5] Mr Stewart was seen by a psychiatrist, Dr Alroe, within weeks of the incident. Dr Alroe diagnosed an acute distress disorder, albeit with a very optimistic prognosis.

[6] The plaintiff was originally under the care of a general practitioner, Dr Rayner. On 14 February 2000 she recorded "a lot of pain (R) arm with a sensation of a constant pulse" and "severe headaches". By 31 July 2000 Dr Rayner thought that Mr Stewart had improved and counselled that "his continuing work is of prime importance." [9] She reported in September 2000 that Mr Stewart had "improved quite dramatically" noting difficulties continuing with some memory loss, complaints of pain in the right arm and some change in mood and anger control.[10]

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1 Mr Stewart was born 23 October 1965

2 T 1-19/40

3 Ex 40 para 2

4 Dr Reid: 4-15/10

5 T 4-17/14; There is no evidence of brain damage: Dr Field: Ex 45 at p17; Mr Salzman: Ex 31 at p 11. All tests have proved normal – Ex 8 at p1; Ex 68 at p 8. I note the views of Dr Andrews (T5-13/10-15/20) but have no reason to think they are based on evidence as opposed to theoretical assumptions. Dr Todman mentioned only the possibility of current having passed through the brain: T 1-51/35-50 but altered that to a "reasonable proposition" but with no proof: T1-53/10.

6 Ex 3

7 Ex 4 – Dr Monsour. Dr Rayner records severe loss of memory, headache and three days after the event developing difficulty moving his right arm with weakness – Ex 8 at p 1

8 Ex 5 - St Stephen's Private Hospital progress notes

9 Ex 8

10 Ex 9

[7] On 8 November 2000 Dr Rayner recorded that Mr Stewart was "doing very well" overall, managing full time employment and family life.

[8] This improvement was still evident at the visits thereafter in January 2001[11] and February 2002[12]. Nonetheless there were still continuing complaints of arm pain, memory problems, and sleep disturbance. There appear then to be no entries relevant to complaints or treatment concerning these symptoms in the general practitioners' notes between 25 February 2002 and 21 June 2003 by which time Dr Darlow had taken over the plaintiff's care.[13] Following that time there seems to have been a dramatic increase in prescription of medication associated with complaints of pain particularly in the right arm.

[9] Mr Stewart had about five weeks off work following the incident, returned to work with some modification of his duties – mainly that he not test electrical equipment for some months – but eventually returned to full duties in his pre accident employment and then worked until 6 April 2006, without significant time off, when his employment was terminated.

The Issues

[10] Considerable controversy surrounds the assessment of damages. The two most significant questions of relevance to the assessment of damages are:

(a) whether the subject incident and its consequences were a material cause of the termination of Mr Stewart's employment in April 2006; and

(b) whether the markedly increased symptoms, notably a tremor of the arm and leg but including an apparent increase in pain, that have come on in more recent times are the result of the subject incident.

[11] As will be seen the assessment is substantially complicated by three things – the discrepancy between the plaintiff's complaints and his actual performance, the disagreement between the medical practitioners called, and the late onset of very significant symptoms.

[12] On the plaintiff's own case his complaints cannot be related solely to an organic cause. On his case the various symptoms are explained by a combination of organic damage and a psychiatric reaction to the shock and subsequent injury, that reaction affecting his perception of his pain and disability. The defendant called expert neurological evidence that the plaintiff had no demonstrable neurological impairment from the electric shock and was suffering from an unrelated disease process, probably Parkinson's disease, which explained his symptoms of recent times.

[13] In order to determine these issues it will be necessary to reach conclusions as to the credibility of the plaintiff, his work capacities in the years following the electric shock injury, and the timing of onset of significant and debilitating symptoms.

Credibility and Reliability

[14] Mr and Mrs Stewart were patently honest and sincere. I have no doubt that they attempted to relate what they thought to be the truth. It would appear from the cross

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11 Ex 10

12 Ex 43 – entry 14 Feb 2002. I note the entry for 25 February 2002 which seems to coincide with the events at the workplace described by the manager Mr McGuire (see para [33]).

13 See Exs 42 and 43

examination of some witnesses that they held the perception that allegations had been made by the employer that this was a fraudulent claim.[14] They clearly believed in the justice of the case. I am reinforced in my view of Mr Stewart by the comments of his managers at his workplace, which I will detail later, who plainly considered him to be of good character.

[15] However I have considerable reservations about the reliability of the testimony given by Mr and Mrs Stewart. Firstly, they have lived with symptoms of varying degrees for well over eight years. I am not satisfied that their current memories, particularly concerning the onset and past severity of symptoms, are accurate.

[16] Secondly, their evidence about the time of onset of the tremor in the right arm seems at odds with a deal of other evidence. I detail my reservations later.

[17] Thirdly, it is clear that Mr Stewart's descriptions of his problems to practitioners are completely at odds with his recorded activities. The defendant had the plaintiff watched and a video was taken of his activities in November 2002. The video was disclosed to the plaintiff's side well prior to the hearing, probably in mid 2003. The significance of the video is not so much as to the level of his activity but rather as to the reliability of the descriptions that he gave to the examining practitioners of his problems.

[18] The video shows Mr Stewart using his right hand and arm extensively. He uses a hammer to hammer in nails, and to remove nails. He uses a drill. He holds up timber boards with his right hand. At one point he comes off the ladder and hangs suspended from a beam holding on with both arms. He paints palings on a fence with the brush held in his right hand. I can detect no abnormality in the use of the right hand and arm.[15] That was the view too of the neurologists called, Drs Todman and Reid. I note that the video is consistent with Dr Rayner's views expressed the year before to the effect that Mr Stewart was doing "very well" and that she hoped for continued improvement.[16] It is consistent too with the lack of attendance on medical practitioners and the work performance reported.

[19] The criticisms that the plaintiff's counsel make of the significance of the video, such as the limited length of time spent working, the possibility of rest periods, and the effects of medication[17], overlook that the video graphically displays a level of activity inconsistent with the Mr Stewart's reporting of his condition both before and after the film. The most contemporaneous reports to the film were one by a Dr Andrews a year before and one by a Dr Todman three months after.

[20] It needs to be borne in mind that Mr Stewart was throughout this period undertaking full time work. The video was not relevant to the plaintiff's capacity to carry out commercial employment. He demonstrated that every working day.[18]

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14 I was referred to Ex 62 in submissions but that relates to a later claim presumably in respect to the left shoulder.

15 Dr Likely made the obvious point that one expects some limitation if there is a significant degree of pain – T 3-65/10

16 Ex 9

17 Panadol and possibly Tramal – T1-22/20. As to the Tramal it was supplied by the plaintiff's mother on or about his birthday (23/10) and lasted a "couple of weeks": T2-21/50-22/5. The video was taken on 17 November and following.

18 I note that Mr Stewart not only worked full time but consistently averaged about 45 hours work per week throughout this time – see the schedule supplied by the defendants with the agreement of the plaintiff under cover of a letter of 12 November which I have marked Ex 73.

[21] Dr Andrews, a general practitioner, was advanced as a witness with a special interest and expertise in electrical injuries. In a report dated 15 November 2001, after detailing the limitations reported to him in the use of the right arm and hand Dr Andrews concluded: "Thus this man is severely disabled with an arm of limited usefulness, and quick fatiguability, with sensory deficit such that he cannot manipulate objects, and is not in command of the position of the limb due to lack of proprioceptive ability".[19]

[22] Dr Todman saw the plaintiff on 10 February 2003 for the first time. He recorded symptoms of persistent pain in the right arm aggravated by use, diminished use of the right arm, loss of strength and dexterity, inability to type or hold a pen, and numbness in the right forearm and hand. He recorded complaints of problems with memory, change in mood, and muscle spasm throughout the body.[20]

[23] After viewing the video Dr Todman concluded that if truthful in his reports Mr Stewart would best assessed by a psychiatrist, and: "The video footage evidence of Mr Stewart is at variance with his stated ability to function with the right upper limb. As such, I conclude that there is no organic neurologic deficit in the right upper limb or alternatively that it is not of the extent as alleged by Mr Stewart in his history."[21]

[24] I note that Dr Andrews too reached the view, following his viewing of the video, that the use of the right hand and arm was "more than one might expect".[22] Dr Andrews' conclusion that I earlier described in [21] above was inaccurate and entirely misleading. Whilst it no doubt reflected the picture painted by Mr Stewart I do not accept that it was accurate when made or at any time. It is not until the onset of the significant tremor evident subsequent to the dismissal from employment in April 2006 that it seems to me Mr Stewart's right arm became significantly disabled.

[25] Fourthly, the uncertainty about the reporting extends beyond the neurologists. The neuro-psychologist, Dr Maureen Field, reported that when initially asked about aspects of his history Mr Stewart could not recall what schools he went to, whether he repeated grades, and whether he had learning difficulties.[23] Dr Field advised that this was "really unusual" because even those with brain damage causing memory loss typically can recall such matters. She pointed this out to Mr Stewart who then was able to recall some of these matters. As Dr Field said this called into account the accuracy and reliability of the information provided by Mr Stewart. She said that he was "suggestible".[24] Later testing demonstrated no deficit in long term memory.[25]

[26] Similarly Dr Cantor recorded that his presentation was "highly unusual" and that he gave a number of responses that were not consistent with his clinical history. He too noted what he described as "the curious discrepancy between the relatively intact short term memories but a marked deficiency in memories for his early life". [26]

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19 Ex 19 p3
20 Ex 32 p2
21 Ex 33 p2
22 Ex 22 pp 2-3
23 Ex 45 at p 6
24 T 3- 29/20-55
25 T 3- 33/30-50
26 Ex 37 at p 23

[27] Fifthly, Mr Stewart's description of his condition to doctors is at variance with the reports of his work mates, which I detail later. Claims of serious and debilitating pain are at odds with the hours worked and the nature of the work performed.

[28] Finally, there is the odd feature of the case that for some years Mr Stewart appeared to be following the usual path of recovery and improvement normally expected but then worsened several years post accident.

Work Capacities

[29] Co-employees were called. They impressed me that they too were doing their best to recollect matters sometimes going back six and eight years. They were plainly sympathetic to the plaintiff and held him in high regard. In my view their account of his capacities and abilities is reliable.

[30] Mr McGuire is and was the general manager of the Handy Hire business conducted by the second defendant. He was familiar with the plaintiff's performance over the years since the accident. When asked how he regarded the plaintiff as an employee he said that he was "great, very good employee" and that his performance only fell off in the latter part of 2005.[27] He described him variously as "a top bloke", a "good worker" and "straight forward".[28]

[31] Mr Bates was a co-worker. He described the tasks that the plaintiff performed. They included deliveries of machinery and equipment to customers throughout the Maryborough area, sometimes up to 15 trips a day. Those deliveries required that he tie down loads – usually four to a load.[29] Mr Bates described the force involved as "a fair bit of force".[30] He observed Mr Stewart to have no difficulty with this activity over many years.[31] He observed no physical difficulty in carrying out any manual task and no difficulty in the use of the right arm. There were occasional complaints of pain apparently prompted if someone observed to Mr Stewart that his arm must be feeling better.[32]

[32] Mr Stewart's duties included performance of maintenance work.[33] To do so he must have had a significant level of dexterity. Mr Bates observed no difficulties in that regard.[34] His long term memory must have been intact or substantially so.[35]

[33] Mr Einam is the manager of the Maryborough branch of Handy Hire. He had known the plaintiff through his employment going back to 1995. He too held the plaintiff in high regard. He said that the plaintiff was his "right hand man"[36] and his "best employee. He was like 2IC for me. He could fix anything. There was never a job that was too hard for him."[37] He too received occasional reports of pain in the right

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27 T 3-39/42 -60

28 T 3-40/20

29 T 2-78/15

30 T 3-26/30

31 T 3-18/25-55

32 T 3-16/10-30

33 T 3-17/10

34 T 3-27/40

35 Dr Field: T 3-35/20. Mr Bates commented on forgetfulness only with paperwork: T 3-17/55. Mr Einam mentioned the plaintiff reporting losing his way on one occasion in Maryborough: T3-88/1.

36 T 3- 86/30

37 T 3- 84/15. Mr Grant-Taylor submitted that this answer was intended to reflect Mr Stewart's performance pre injury. I disagree. The context of the questioning was plainly in relation to post accident performance. For example see T3-82/40-60. There was nothing in the questions to suggest that Mr Einam was being asked to describe Mr Stewart's abilities nearly 9 years before, nor in my

arm and associated, on one occasion, with a spanner falling from his right hand.[38] It is evident that problems of any significance were observed in 2000 and in the latter part of 2005. [39]

[34] I am conscious of the effect of the documents tendered from the employer's personnel file. It is evident both from those documents and the oral evidence that there was some alteration in performance subsequent to the subject incident. However the evidence independent of the plaintiff suggests that the diminishment in performance was not great. Mr McGuire spoke of an attitudinal change which took place over the 6 months prior to his statement of 21 May 2002.[40] This affected not only customer relations but his readiness to perform some of the testing of equipment. There resulted a reduction in hours and a written reprimand.[41] According to Mr McGuire's statement the change was relatively short lived such that by 21 May 2002 the plaintiff was "as good today in his physical and mental health as he was before the accident".[42] No reason was advanced as to why Mr McGuire would fabricate such a statement.

[35] On 15 March 2006 Mr Stewart received a "Warning Record Form". It recorded that his manner on the phone to a customer had been "rude and inappropriate".[43]

[36] The only other documentary record of any dissatisfaction with Mr Stewart's performance is in a letter written to Workcover just prior to the termination of his employment by a Mr Terry Hemming, the safety officer for the company, where he wrote: "I must stress that Gene Stewart has never been able to fulfil his Duty Statement Program since his first compensation claim in the year 2000".[44] In what respect he failed to do so is not specified. It is not clear whose views Mr Hemming is reflecting in that statement. The extent of the contact between Mr Hemming and the plaintiff was not explored in the evidence. It is plain that that view did not reflect the opinions of the co-employees called who would seem to be the men best positioned in the company to form a view.

[37] The evident discrepancy between the views of the personnel in the second defendant's head office and the views of those in daily contact with the plaintiff may have its explanation in those in the head office having an eye on the company's cost of premiums and like considerations.

Termination of Employment

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view in any answer he gave. Indeed Mr Einam was called by the defendant to demonstrate that Mr Stewart's performance post accident was virtually unchanged from that pre injury.

38 T 3- 84/5. The plaintiffs' counsel sought to make a great deal from the relatively few occasions that Mr Einam either observed anything out of the ordinary or received a complaint from Mr Stewart. It is not insignificant that the complaints of pain were related by Mr Einam, at times, to Mr Stewart having recently seen "his legal counsel' or solicitor– T 3-84/30; 3-88/5. I mean no criticism of those advising Mr Stewart. Rather this reflects Mr Stewart's susceptible personality.

39 T3-96/50

40 Ex 48

41 See Exs 46 and 47.

42 Ex 4 at p3

43 Ex 57

44 Ex 54. Mr Grant-Taylor made a submission based on Ex 60 as reflecting the views of Mr Einam as it is signed by him but that document purports to accurately record what Mr Stewart said at the time of his termination – not the observations of Mr Einam. As to the evidence at T3-95/20 the context and later answers seemed to me to indicate that Mr Einam was speaking of the position at the end of his employment.

[38] It is common ground that in late 2005 Mr Stewart developed a painful condition of the left shoulder resulting in him taking some few weeks off work on workers' compensation. After he returned to work there were reports from employees of observing him taking medication and concerns were raised as to how much medication Mr Stewart was taking. Enquiries of his general practitioner resulted in that practitioner advising that Mr Stewart should not be driving machinery.[45] His employment was terminated as a result.

[39] The picture that I have is that until towards the end of 2005 the plaintiff competently performed his various duties. There was little if any time off.[46] There were occasional complaints of pain that the employees plainly thought were on at least some occasions prompted rather than reflecting any evident difficulty. The case was argued on the basis that the left shoulder problem was unrelated to the subject incident and adversely affected the plaintiff's performance only temporarily.

The Neurological Evidence

[40] Dr Todman was the neurologist relied on by the plaintiff. I have earlier set out his conclusion following his viewing of the video.[47] In that same report he also noted that he could not find "evidence of organic neurological deficit nor any organic impairment of the brain, spinal cord or peripheral nerves".[48] He could not find any organic cause for the variable "give-way type weakness" in the right hand. He suggested that a psychiatrist should assess that claimed disability. There was no muscle wasting and reflexes were normal and symmetrical. Thus there was no objective sign of any neurological disability. There was a subjective complaint of sensory impairment in the right hand and forearm. Whether the impairment is related to a known anatomical distribution is not stated.

[41] Dr Todman thought that the headaches complained of were of the "chronic tension type". He concluded that if one accepted that Mr Stewart was giving a truthful account of his symptoms then "there is a disability related to a pain syndrome and recurring headaches".[49] No explanation was advanced as to the cause of any pain syndrome presumably because any explanation lay outside the field of neurology.

[42] Examination by Dr Todman in September 2008[50] showed no change in the presentation. All examinations were essentially normal save for the tremor in the right arm and occasionally right leg that had developed. The subjective sensory impairment in the right hand and arm is described as "mild" and again its location is not precisely described.

[43] Despite the normal examination Dr Todman concluded that the plaintiff had a chronic pain syndrome in the right upper limb which had features of "a neuropathic pain syndrome". What features these might be are not stated. Dr Todman thought that the syndrome was "consistent with an electrical injury" but I am not told why.[51]

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45 Ex 10

46 See Ex 73 – no attempt was made to demonstrate that any time off was due to symptoms consequent on the subject accident save for the initial period.

47 See para [24] above

48 Ex 33 p 2 para 2

49 Ex 33 p 2 para 3

50 Ex 35

51 I refer to the written reports. There was some evidence. The closest Dr Todman came to an explanation is at T1-50/50 where he asserts that chronic pain is a feature of electrical injuries. See also his description of the pain reported to him at T1-41/40

[44] As best I can tell it is the historical linking of the symptoms to the electric shock accident that is mentioned at one point in his report[52] that results in the conclusions expressed by Dr Todman. That linking of course depends entirely on the reliability of the plaintiff's reporting of symptoms. I have expressed my reservations about that. As well there is no examination of the six years of successful employment history post accident, or the performance on the video, or how these features of the evidence might impact on the suggested diagnoses.

[45] Against that background it is difficult to understand the sustained attack made by the plaintiff's counsel on the neurologist called by the defendants, Dr Alison Reid. Because of that attack I will record my impressions of Dr Reid. It was clear from her evidence that she was an intelligent and careful witness who had put a deal of thought into the case. She was familiar with literature relevant to the issues. She said that she worked with electricity every working day and as a result had taken a particular interest in that area of medicine and had done extra training to understand the effects of electricity on the human body. She had treated patients over the years with electrical injuries from exposure to domestic current.[53] Her evidence in my view confirmed her claim to having some reasonable knowledge of the area.

[46] Dr Reid was criticised by Dr Andrews for the paucity of her notes and for the conclusions she reached. I will deal with the detail of that criticism later. Dr Reid explained that her reports are prepared on the same day as the examination. The inference plainly is that the examination is fresh in her mind and hence the notes are more of an aid than intended as a transcript of the examination. Hence it is the report which records her findings. In my experience she is not alone in that approach. Unsurprisingly, given the attack on her that was made by Dr Andrews, Dr Reid took the view that her notes had been obtained to "denigrate and deride" her.[54] Unsurprisingly some of her answers were plainly coloured by her perception of that perceived attack.

[47] Dr Reid's insistence that there be some objective evidence for her to make a finding that there is an organic problem falling within her discipline of neurology is precisely what the court expects of her. Medicine is not the only discipline that seeks to be evidence based.

[48] Dr Reid like Dr Todman could find no objective evidence of any neurological deficit or disability. Dr Reid found some weakness of grip which she felt was not caused by any organic muscular weakness but may have been consistent with pain.[55] She noted the complaint of mild sensory impairment in the right hand which she recorded as being in a "glove" distribution and hence one that was not consistent with any known anatomical nerve distribution. She did not accept the findings of the physiotherapist concerning sensitivity in the right hand and arm[56] as soundly based.[57]

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52 Ex 35 at p 3
53 T 4-4/1-10
54 T 4-53/25
55 T 4-43/50
56 See Ex 28
57 T 4-48/55 - 49/30

[49] In this Dr Reid seems to be at one with Dr Todman who reported that "[t]he weakness and sensory symptoms in the right upper limb appear to have conversion or dissociative features to them".[58]

[50] Dr Reid, like Dr Todman, noted the absence of any muscle wasting – if the plaintiff had a significant pain problem in his right hand and arm such that he favoured the left over the right (as he asserted) then one would expect over time some evidence of wasting due to disuse. I observe that one would not expect any such wasting given the evidence of workmates and the video.

[51] Essentially Dr Reid's view was that in the absence of any abnormality in her examination of the plaintiff she was not prepared to find a neurological impairment – which strikes me as a perfectly logical position to take and indeed one that Dr Todman did take after examining the video and, so far as I can see, one that he had no good reason to depart from subsequently, if indeed he did so.

[52] Where Dr Reid departed from Dr Todman was in her views concerning the pain that Mr Stewart complained of and the alleged link between any such pain and the electric shock, based on an organic cause.

[53] Dr Todman described the pain as "neuropathic" presumably meaning pain which is due to disease or injury of the central, or peripheral, nervous system, or a malfunction thereof. As Dr Reid observed, where there are no neurological features why refer to a pain as neuropathic? It is simply a complaint of pain.[59] Dr Reid believed the pain to be psychogenic.[60] It is evident that Dr Todman's diagnosis relied heavily on Mr Stewart's description of his symptoms about which I have considerable reservations.[61]

[54] I observe that any assessment of such a complaint would need to bring into account the inconsistency between reporting and performance demonstrated by the video and the reports of workmates over 6 years.

Dr Andrews

[55] The plaintiff relied substantially on the views expressed by Dr Andrews. He has published extensively on the effects of lightning and electric shock injuries. However I am cautious in giving any significant weight to his opinions for three reasons. First, it is evident that he set out to champion the plaintiff's cause. Secondly, despite expressly disavowing such an approach, he seems to hold the view that virtually any complaint made by a victim of an electric shock at a time after the shock should be accepted uncritically as caused by that shock.[62] Thirdly, there seems to me to be no evidence to support his views and much against them.

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58 Ex 32 at p 4. The views of the physiotherapist were not put to Dr Todman to see if he thought that the testing methodology was sound or the conclusions otherwise soundly based. His conclusions suggest that he agrees with Dr Reid

59 T4-44/53

60 T 4-32/20; 4-42. Mr Grant-Taylor SC submitted that because Dr Reid accepted that Mr Stewart was in pain then that concluded the case in the plaintiff's favour – I remark that in relation to such a subjective matter it is not for the experts to assess the credibility of the plaintiff. Rather their function is to point out those features consistent or inconsistent with a diagnosis within their discipline. Dr Reid's remark is no more persuasive than it would have been if she had denied Mr Stewart was in pain.

61 Dr Todman remarked that the pain "has features of a neuropathic quality. That is a severe pain with some sharp jabs of pain superimposed": T1-41/40

62 Dr Andrews notes: "… the over attribution one sees in electrical injury…Certainly victims see themselves as suffering from a malady they do not understand, and feel lost in the notion that no-one

[56] I will note only a few aspects of Dr Andrews' testimony to demonstrate my concerns. In relation to the video Dr Andrews, after criticising the deceitful nature of it, reported: "…my understanding is that Mr Stewart was aware that he was being filmed as the clandestine filmers were quite obvious in their deceit. …It is quite obvious that both Mr Stewart and the lady involved looked at the camera a number of times, and I fancy I saw a wink at the camera at one stage." All this is fanciful. Mr Stewart swore, and I have no reason to disbelieve him, that he was unaware of the fact that he was being filmed at the time.

[57] Dr Andrews was vehement in his attack on Dr Reid. For example in a report dated 17 November 2001 Dr Andrews said of Dr Reid that she "raises the art of pejorative reporting to an art form". After referring to her conclusion that from a neurologist's perspective she could find nothing wrong with Mr Stewart and that he had no organic deficit, Dr Andrews described this view as "ill conceived arrogant nonsense".[63] The plaintiff's solicitors obtained Dr Reid's notes and supplied them to Dr Andrews. After reading the notes he concluded that Dr Reid "found nothing because she examined nothing of consequence". He questioned that "much was even examined". He found "Dr Reid's opinions and options insulting to this man". He determined that her opinions were "based on minimal and inappropriate examination" and "highly typical of the prejudice and vilification that victims of electric shock are subject to". Dr Andrews suggested that Dr Reid's opinions were determined by who was paying her fee and that Workcover should look into the matter.[64] I should record that plaintiff's counsel, quite rightly, did not attempt an attack along these lines.

[58] The vehemence and immoderation of the attack on Dr Reid, especially given the concurrent findings by her and Dr Todman,[65] says more about Dr Andrews than it does about Dr Reid.

[59] The dispassionate identification of the relevant signs and symptoms and the relating of those to an identifiable injury to the person of the plaintiff have not been attempted. Critically in this case there needed to be some explanation of how the plaintiff could perform at the level he did at his workplace over 6 years and on the video whilst suffering from an organically based debilitating injury supposedly causing significant pain, which pain was largely if not wholly unnoticed by his workmates.[66]

[60] Effectively Dr Andrews' views, as I understood them, were that Mr Stewart had suffered an injury of uncertain type at a molecular level to either muscles or neuropathic pathways or both, which injury was incapable of being picked up by any known test.[67] If Mr Stewart had reliably shown consistent symptoms since the subject accident, or if his reporting of his symptoms was reliable, or if studies of substantial numbers of patients over the decades had established a history similar to that displayed by Mr Stewart then, despite the limits of medical science, it may have been possible to accept the proffered diagnosis as established on the balance of probabilities. In my view none of those conditions are established here. Of

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else understands it either. Attribution of all subsequent sympatology (sic) to the electric shock is therefore easy, and provides justification for adoption of the sick role": Ex 19 Appendix at p 4

63 Ex 20 p 5

64 Ex 24 p3

65 And it would seem the Workcover Neurology Assessment Tribunal – see Ex 68 at p 4 para 4

66 I draw a distinction between an assertion that one is in pain and that being evident to those around you.

67 T5-10/1-20; 5-12/50-13/10

particular concern is the "diphasic" response as Dr Reid termed it – the evident improvement in symptoms and then a worsening of them.[68] No explanation was offered as to how there could be a significant organic disturbance of the body with obvious improvement and then dramatic decline years later.

[61] Whilst I give very little weight to Dr Andrews' assessment of this plaintiff I do accept that he has obviously read widely in the field and can give some guidance as to the probabilities based on the reports of other patients over the years. What I do take from Dr Andrews' evidence are two things – the prognosis usually expected and the consistency in reporting of psychological disturbance following an electrical injury.[69]

[62] As to the prognosis - amelioration of symptoms but not necessarily complete recovery is expected over two to five years. I note that Mr Salzman's experience was similar – cognitive functions improve and psychological problems often diminish after four to five years following an electrical injury.[70] In this context I should say something of the evidence of the 40th birthday party. Mr Stewart set up a device which could give his guests an electric shock to some minor degree. I am satisfied that he probably did not give himself any such shock. Nonetheless it seems to me to show fairly plainly that he had overcome much of his earlier phobia concerning electricity. The fact he saw the humour in he putting on such a device as a party trick says a great deal about his recovery to that point in time.

[63] As to the psychological disturbance – depression and anxiety along with cognitive and emotional disturbances are commonly reported. Memory and concentration disturbance, relationship breakdowns, sleep disturbance and a "short fuse" are also commonly reported.[71] Mr and Mrs Stewart report similar symptoms. There has been a consistent reporting of such complaints to general practitioners over the years. I accept that they have been present, are due to the electric shock injury, and are of concern.

The Psychiatric Evidence

[64] I am not persuaded that there is any organic basis for Mr Stewart's presentation. In my view the only possible explanation, consistent with honesty, for Mr Stewart's complaints lies in the psychiatric evidence.

[65] There are some differences in the psychiatric opinions. Dr Likely had the advantage of seeing the plaintiff on three occasions – 13 September 2001, 22 May 2006 and 26 August 2008. In the earlier consultations he detected no psychiatric disorder. On the last examination he diagnosed an adjustment disorder with depressed mood of delayed onset and under Axis III of the DSM-IV–TR multiaxial diagnostic formulation (medical) he diagnosed chronic pain. He expressed the belief that Mr Stewart was not suffering from a somatoform disorder.[72] In his evidence in chief[73] Dr Likely explained that he held that belief because it was first necessary to rule out that there was any underlying physical disorder or contribution from use of substances. He explained that a somatoform disorder was one where 'subjectively experienced physical symptoms which can't be explained by demonstrable organic pathology' and those symptoms can include 'pain symptoms, pain in different

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68 E.g. T4-18/15-55

69 See Appendix to Ex 19 "General Appraisal of Injuries"

70 Ex 31 at p11

71 Ex 19 Appendix p 2-3; T5-15/5-25

72 Exhibit 53 at p 3.

73 I note that the transcript wrongly records that he is being cross-examined at T3-67.

locations of the body, symptoms of gastro and intestinal disturbance, sexual dysfunction or ill-defined neurological symptoms.'[74]

[66] Dr Cantor interviewed Mr Stewart on two occasions in August 2007. His psychiatric diagnoses included conversion disorder, disassociative amnesia, chronic adjustment disorder with anxiety and depression and chronic pain disorder associated with both psychological features and a general medical condition. Whilst he accepted the suggestion that there was 'likely to be a type of underlying nerve damage and possible neuropathy' in reliance on the views of Dr Andrews and his American colleagues that was not, I think, fundamental to his view. He pointed out that the diagnosis of a conversion disorder was not precluded by the presence of a neurological condition and in this regard evidently held a different view to that of Dr Likely. His report explains that a:

> 'conversion disorder involves the presence of symptoms of deficits affecting the voluntary motor or sensory function that suggest a neurological or other general medical condition. However, psychological factors are judged to be associated to (sic) deficits, which in effect are reactions to stress. Importantly these symptoms are not intentionally produced.'[75]

[67] I accept the views of Dr Cantor. I note that they seem to be generally in accord with the opinions expressed by Mr Salzman.[76] The only basis advanced by Dr Likely for not diagnosing such a condition is his assumption that there was an organic basis for the complaints, which assumption I reject. The validity of Dr Cantor's approach is supported by the extracts from the DSM-IV-TR that he appends to his report. Further his assessment of Mr Steward as a 'psychologically unsophisticated gentleman' seems to me to be precisely right. The end result is that Mr Stewart's perception and reporting of his condition is distorted by psychological factors over which he has no control.

[68] As well I think the probabilities favour the view that the consumption of prescription medication that Mr Stewart has pursued has influenced his presentation. Dr Likely pointed out that the Benzodiazepine medication that Mr Stewart had been taking for many years was known to have detrimental effects on cognitive functioning.[77] Dr Ringrose, a physician called expressly to comment on the medication regime, expressed the view that the combination of drugs that he assumed Mr Stewart was taking would have caused him to be 'very slowed up', depressed, and that the mixture of Tramadol and Paroxetine in particular could cause a lot of symptoms including confusion and agitation.[78] There is no suggestion that this is a causally independent condition for which the defendants are not responsible.[79]

[69] Both Mr Salzman and Dr Cantor indicated that Mr Stewart's perception and reporting of his symptoms would be influenced by his reaction to whatever stress that he might be under. In my view this is consistent too with Dr Likely's opinion

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74 T 3-67/30-40.
75 Exhibit 37 at p 25.
76 See exhibit 31 at p 11&13.
77 Exhibit 53 at p 5.
78 T3-54/50-60. Dr Darlow reports that the mixture had been altered in September 2007 (Ex 17) but the combination was in place long before and the point is good.
79 Cf *Mahony v J Kruschich (Demolitions) Pty Ltd* (1985) 156 CLR 522 at 529

that the main contributing factor to the development of the adjustment disorder that he diagnosed was the loss of employment and consequent feelings of guilt and loss of self esteem that he was unable to provide for his family.[80]

Conclusion re Causation of Termination of Employment

[70] In summary Mr Stewart sustained an electric shock which he considered a severe one and as a result of which he feared he had sustained a serious injury. I accept Dr Cantor's opinion that 'Mr Stewart's psychologically unsophisticated orientation is likely to have contributed to his highly subjective processing of his underlying physiological injury.'[81] Dr Field's comment that Mr Stewart was "suggestible" also seems to me to be accurate. These aspects of his make-up has the unfortunate consequence here that Mr Stewart, exposed as he has been to endless examinations over eight years through the legal process, has had his view that he has a debilitating condition constantly reaffirmed. Unfortunately the critical importance of retaining employment, the undesirability of dwelling on incapacity and the need to continue to extend himself without medical care, as advised by Dr Rayner in November 2000[82], was either forgotten or not appreciated by the treating practitioners in later years. As a result whilst there is no sufficient basis to find any continuing organic injury the psychological consequences have been ongoing and their effects debilitating.

[71] It is no coincidence in my view that the increased attendances on the general practitioners from mid 2003 occurred at about the time that the video of Mr Stewart's activities obtained by the defendants was released to the plaintiff's side. The consequent stress resulted in an increase in Mr Stewart's perception of his difficulties even though objectively they were minimal. The onset of the left shoulder problems and the uncertainty that produced in Mr Stewart's mind as to the continuation of employment undoubtedly increased the stress experienced by Mr Stewart. That combined with the cocktail of medications in place by early 2006 resulted in the loss of his employment. That cocktail was in place significantly because of the symptoms experienced by Mr Stewart through the prism of his psychiatric reaction to the electrical injury.

[72] There is nothing to indicate in Mr Stewart's past that he was likely to develop traumatic stress or depressive symptoms had the electrical injury not occurred.[83]

[73] In my view the psychiatric evidence that I accept is sufficient to satisfy the onus on the plaintiff to establish a causal link between his cessation of employment and the electric shock injury. That injury has made a material contribution to the condition leading to the termination of employment: see *Bendix Mintex Pty Ltd v Barnes* (1997) 42 NSWLR 307 at 311 applying *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 at 514.

[74] There remains the question of whether in addition to the consequences of the electrical injury Mr Stewart is suffering from a separate disease process or disorder which has caused the tremor of his right arm and leg and perhaps pain over the last several years and to assess the significance of that condition.

The Tremor of the Right Hand, Arm and Leg

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80 T3-66/1-10; and see Dr Darlow to the same effect: T2-51/40.

81 Exhibit 37 at p 26.

82 See Ex 9 at p 2

83 Dr Cantor - Ex 37 at p26;

[75] The tremor is variously described by the medical witnesses. My own observation of it when Mr Stewart was in the witness box was that it was quite marked and present noticeably even when Mr Stewart was at rest.

[76] There is a dispute as to the time of its onset. Mr and Mrs Stewart each gave evidence to the effect that the tremor in the right arm or hand had been present, albeit at a lesser level, ever since an early time after the subject incident.[84] Mr Stewart has been examined by numerous medical practitioners each of whom had a responsibility to observe and note symptoms of significance. None reported such symptoms prior to a neuro-psychologist, Dr Maureen Field, in April 2006.[85] Nor did the co-employees called, who had seen the plaintiff, in some cases almost daily, over several years, ever observe such a symptom.[86]

[77] Mr Grant-Taylor of senior counsel who appeared for Mr Stewart pointed to evidence that he said was consistent with complaints at an early time of such a tremor – namely a note in Dr Rayner's reports of Mrs Stewart reporting that Mr Stewart complained of "shimmers" in his arm and face[87] and an observation by Dr Andrews of a "tremor of effort" noted in June 2003.[88] It is significant that Dr Rayner did not observe any "shimmer" and nor apparently did Mrs Stewart report it as her own observation. Dr Rayner did not record observing any tremor. Nor did Dr Darlow.[89] They are the two general practitioners who had most to do with Mr Stewart over the years. Not only did they not record observation of such a symptom they did not record a complaint of any tremor by Mr Stewart. Nor did the two other general practitioners, mentioned as providing treatment, report any such complaint or symptom.

[78] With respect to Dr Andrews' observation I note that he made no mention of a tremor being present in his description of Mr Stewart's presentation in October 2001.[90] The tremor now is plainly present without exertion or effort. And shaking of the hand when under load or effort is hardly uncommon.[91] In my view the "tremor of effort" reported by Dr Stewart on one of three visits to him is not established, on the balance of probabilities, as in any way connected to the constant, obvious tremor that emerged years later and generally described as of a "resting" tremor type..

[79] To my mind the probabilities strongly favour the finding that the tremor had its onset long after the subject incident, and probably, after the termination of employment.

[80] The neurological evidence was consistent – it was unlikely that there was a causal link between the tremor and the electric shock assuming a late onset.[92]

[81] Dr Reid was adamant that the tremor she had observed was consistent with and indicative of Parkinson's disease. She described the tremor as "a florid pill-rolling classically resting tremor" and concluded that "a diagnosis of Parkinson's disease is

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84 At least that is how I interpret Mr Stewart's evidence: See paragraph 18-19 of Ex40. But see T2-57/1-58/10; Mrs Stewart: T 2-100/12

85 Ex 45 p 6 – "mild resting tremor of the right hand" and T 3-30/45-31

86 Mr Bates: T 3-16/15; Mr McGuire: 3-40/50; Mr Einam: T 3-83/40

87 Ex 9 at p 1 para 2

88 Ex 32 at p 4

89 It would seem Dr Darlow first made any particular note of a tremor on 20 September 2007: T2-39/20

90 Ex 19 at p 3

91 Note too the distinction drawn by Dr Reid between resting tremor and action tremor: T4-24/15

92 Dr Todman: T1-50/40; Dr Reid: T4-20/10

perfectly valid".[93] She pointed out that there was some evidence of "rigidity" on clinical testing, a confirmatory finding.[94] It is not irrelevant that Dr Reid has treated "hundreds and hundreds and hundreds" of patients suffering from Parkinson's disease over 30 years. Her experience certainly far outstripped that of either Dr Darlow or Dr Andrews, both general practitioners, whose patient numbers in this category were in the double figures.[95]

[82] Dr Darlow was Mr Stewart's treating general practitioner for many years. He thought that a lot of Mr Stewart's symptoms would fit the diagnosis of Parkinson's disease.[96] He seemed to consider that the tremor he observed was of a type that he related to Parkinson's disease.[97] Despite that he was not confident that he could diagnose the disease as present, although it seems it is Mr Stewart's reluctance that has to date prevented a referral to a specialist for a detailed examination.[98]

[83] The features that the defendants point to as indicating the presence of Parkinson's disease were the nature of the tremor, described by one practitioner as "the typical Parkinsonian pill-rolling manner"[99] and by others as "a coarse tremor" and a "resting tremor', increasing pain in the right arm despite the cessation of employment with associated impact from manual tasks, the increasing ineffectiveness of pain controlling medications[100], the increasing need for assistance with agitation and restlessness, the intrusion of psychiatric symptoms such as increasing depression, the slurring of speech and difficulties with sleeping, all of which Dr Darlow accepted as present and consistent with the diagnosis of Parkinson's disease.[101]

[84] Dr Todman conceded the possibility of a diagnosis of Parkinson's disease but thought that there were insufficient signs and symptoms to arrive at a diagnosis.[102] Dr Todman pointed out that "tremor as a symptom occurs in a wide variety of other settings and disease conditions".[103] Despite that he did not suggest any alternative diagnosis.[104] He was concerned at the absence of other symptoms associated with Parkinson's disease such as abnormalities in movement, gait, facial expression, balance, stability and autonomic disturbances such as blood pressure problems. He however only observed a tremor that was "almost inconsequential" and no other symptoms.[105] I observe that at trial the tremor was far from "inconsequential" and that seems to have been the observation of most other witnesses who have seen Mr Stewart in the recent past, both lay and medical. Contrary to his assumptions there are other features commented on by Dr Darlow that need to be brought into account.

[85] Dr Stewart too disagreed with the attribution of the tremor to Parkinson's disease. His views in summary are that the presence of tremor alone is an insufficient basis to diagnose the disease, that in any case the tremor he observed was of a different

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93 T4-24/10; see also 4-23/53, 4-29/20

94 T4-23/55

95 Dr Reid: T4-20/23; Dr Andrews: T5-8/30; Dr Darlow: T2-41/19

96 T2-38/55; 2-42/55

97 T2-43/40

98 T2-50/50

99 Dr Cantor - Ex 37 at p 22

100 As to which see Dr Reid's evidence at T4-29/40 that pain relieving medications are ineffective in treating symptoms of the disease

101 See the cross examination principally at T2-43/1-40

102 T1-38/30.

103 T1-39/5

104 Unless it be that the tremor was the result of the electric shock injury, which theory I reject.

105 T1-38/50 - 39/20

type to that classically seen, that there was an absence of rigidity and bradykinesia[106] which he thought essential to establish the diagnosis, and an absence of other confirmatory symptoms such as impaired postural reflexes and gait.[107]

[86] A significant problem in reaching any view on the issue is that the disease can apparently present with a wide variety of symptoms. I am far from satisfied that there needs to be any particular constellation of symptoms for the diagnosis to be made.[108] The essential feature apparently is the presence of a tremor of a particular type that a medical practitioner knows when they see it.

[87] Dr Andrews thought that there had been sufficient time from the supposed onset of the disease for classic symptoms to develop and they had not. One difficulty with that view is that it presuppose a time of onset which is unknown. He also brought into account the lack of response to Madopar, a drug used to treat the symptoms of Parkinson's disease, usually very successfully. Not much can be made of that point – Dr Reid advised that the dose was not at a therapeutic level ("infinitesimal"), was prescribed for a condition of "restless legs", a well recognised and different condition to Parkinson's disease,[109] was prescribed before any coarse tremor was observed, and in any case the general practitioner recorded, contrary to Dr Andrews' assumption that the Madopar had some effect.[110]

[88] Whilst it can hardly be said that the diagnosis is certain there seems to me to be a preponderance of evidence that the late onset of the tremor is more likely than not a symptom of developing Parkinson's disease. The great experience of Dr Reid, the support that Dr Reid receives from others as to their description of the tremor observed, the symptoms that Dr Darlow conceded he had noted that could fit the diagnosis, and the lack of any evidence supporting an alternative cause for the tremor all seem to me to favour the finding. Whilst there may possibly be alternative causes none have been specifically identified.

[89] There remains the issue of whether the Parkinson's disease was itself the product of the electric shock. Dr Andrews claimed that there were "a number of papers from neurologists in the neurology literature, suggesting Parkinson's disease as a result directly of electric shock".[111] His report cited only one such paper – that by Cherington published in 1995, presumably because that author reviewed all literature to that time.[112] Dr Reid in my view effectively disposed of the contention that there was any scientific basis for the attribution of the development of Parkinson's' disease to an electric shock injury many years before.[113] She examined the sources that Cherington relied on. None, on analysis, supported the thesis advanced. Dr Reid's analysis was not challenged despite the plaintiff's side having the opportunity to further cross examine after an adjournment of over two weeks. Nor did Dr Andrews advance any further evidence despite having that two week period of notice of Dr Reid's views before giving his evidence.

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106 Slowness of movement

107 See Ex 26 p4; T5-9/30-55

108 Dr Reid – T4-24/10

109 T4-22/1-5

110 Ex 42 – entry May 20 2003 by Dr Gunn. Mr Stewart's recollection was to the contrary: T2-84/5

111 T5-9/55

112 Ex 26 fn 9 at p 4

113 See T4-30/50 - T4-31 (incorrectly numbered)

Summary

[90] The assessment of the plaintiff is extremely complicated. He has symptoms of a developing disease unrelated to the electric shock. His damages are to be reduced to the extent those symptoms will impact, and have impacted, on him. That affects damages for past and future treatment costs, and economic loss and necessarily impacts on the assessment of general damages.[114] The plaintiff submitted that the onus lies on the defendant to establish not only the presence of the disease but also its probable consequences.[115] In my view that is not quite accurate – the plaintiff first needs to establish the causal connection between any symptom and the electric shock. I have rejected the establishment of any such connection between the tremor and the shock.

[91] As well the plaintiff has psychiatric, but no significant physical, consequences of the electric shock. Those psychiatric consequences ought to ameliorate over time but are unlikely to resolve completely. There is the prospect of treatment improving his condition. Dr Cantor considered that 'a modest degree of progress might be achieved whilst also reducing his long-term impairment by approximately 30-40 per cent'.[116] Some allowance needs to be made for the fact that Mr Stewart will probably be somewhat resistant to the notion that he requires psychiatric treatment.

[92] In my view there is no reason why, with appropriate treatment, Mr Stewart should not get back to the stage that he was at for the six years following the subject incident – namely capable of full time employment involving a degree of manual work. I do not accept that medication had any significant bearing on his performance – rather the stress he experienced was the determining factor.

[93] The onset of Parkinson's disease complicates the picture considerably. Dr Reid was of the opinion that patients who presented in their 40's with Parkinson's disease could, with appropriate treatment, be gainfully employed for a further 10 years or so from the time of commencement of treatment.[117] I am conscious of Dr Ringrose's more conservative views but he has not seen the plaintiff and Dr Reid I think can claim more expertise. I prefer her views.

[94] In my view, without that successful treatment, Mr Stewart is presently, and would be, unemployable by reason of the symptoms of the Parkinson's disease.

[95] The matter is further complicated by Mr Stewart's evident reluctance to accept the diagnosis of Parkinson's disease. I will proceed however on the assumption that despite his reluctance he is very likely to give such treatment a trial, there being no rational reason not to. I will assume that in a relatively short space of time the symptoms attributable to the Parkinson's disease can be brought under control.

[96] I do not discount the fact that the psychiatric conditions from which Mr Stewart suffers would, in all probability, impact on his perception of the consequences of the Parkinson's disease as much as anything else in his life. I was struck by the fact that Dr Todman observed only an "inconsequential tremor" whereas most other

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114 Mr O'Driscoll referred me to *Lee v Quality Bakers Australia Limited* [2000] QCA 285 where the court applied *Jobling v Associated Dairies Limited* [1982] AC 794. See generally the discussion in A*ssessment of Damages for Personal Injury & Death* (4th edn) Luntz at pp 110-113

115 Relying on *Watts v Rake* (1960) 108 CLR 158; *Purkess v Crittenden* (1965) 114 CLR 164; *Lee* (supra)

116 Exhibit 37 p 27.

117 T 4-27/45.

reporters in recent times have observed a much more significant one – consistent perhaps with stress impacting on Mr Stewart's presentation at times.

[97] As to the assessment of past economic loss I hold the view that on the balance of probabilities the symptoms of Parkinson's disease have had an increasing effect, such that at some point in time those symptoms overwhelmed the impact of the psychiatric condition induced by the electric shock. The onus, in my view, rests on the defendants to establish when it was that this condition would have interfered with the plaintiff's employment that he would have enjoyed otherwise. In April 2006 Dr Field observed a 'mild resting tremor'. By September 2007 Dr Darlow considered that he was 'more conscious' of the tremor than previously. Dr Darlow reported that he received complaints of increasing severity of pain from Mr Stewart as the tremor worsened.[118] That accords with Dr Reid's views that pain can be associated with Parkinson's disease and that in Mr Stewart's case one aspect of his condition consistent with the attribution of pain to the disease is that the pain had spread to his right lower limb and was becoming bilateral.[119]

[98] Doing the best I can I will assume that but for the onset of the Parkinson's disease, Mr Stewart would have been able to maintain employment until about the end of 2007. Thereafter his absence from employment would have been caused by the overwhelming effects of the Parkinson's disease.

[99] For the future I will assume that within about six months of judgment Mr Stewart will have been treated successfully for the symptoms of the Parkinson's disease such that he should be able to return to employment but for his ongoing psychiatric condition attributable to the electric shock. I will assume that appropriate treatment from a psychiatrist will take at least one further year to be effective.[120] Thereafter he should be able to maintain employment for about 8 ½ years before the Parkinson's disease again impacts on his earning capacity. The assessment of damages for loss of earning capacity in that period needs to bring into account the probable difficulties that Mr Stewart will have in convincing an employer to take him on after such a long period out of the work force, his age and his vulnerability.

[100] For the purposes of lending some accuracy to the assessment I will adopt the rate of pay appropriate for his work at the second defendant's work place although on my findings that is not necessarily the wage he might have enjoyed in the future given the intervention of Parkinson's disease and the presumed cessation of employment by the end of 2007. Whilst that figure might overstate Mr Stewart's probable earning capacity there is a strong argument that he will have significant difficulties re-establishing himself in the work force. Assuming the starting point stated I assess that the difficulties I have mentioned will cause a 50% reduction in the earning capacity that he would otherwise have had. Some of these assumptions could be more favourable to Mr Stewart – the Parkinson's treatment might be implemented more quickly or be more effective, the psychiatric treatment may not be as successful as supposed and so on. For that reason I will not discount the future loss.

[101] For the purpose of assessment of damages I am prepared to accept that Mr Stewart has suffered a degree of pain in his right arm which has been variable. His performance on the video and at work persuades me that when he experienced pain

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118 See T 2-39/25.

119 T 4-69/1-25. Whilst pain can precede the onset of a tremor it is not necessarily so – Dr Reid: T4-26/30-40

120 That period reflects Dr Cantor's opinions that there needed to be 8 treatments by a psychiatrist over the course of a year.

it was generally at a mild level. I accept that he suffers from headaches from time to time and alterations in mood and irritability. There are occasional memory problems but they are not at a significant level. I am not prepared to accept that Mr Stewart has the condition of allodynia. How he could have attended work for 6 years performing manual tasks with such a condition and not have it observed by his workmates is inexplicable to me.

[102] Nonetheless, to Mr Stewart his condition can be debilitating at least at times. It has impacted considerably on his personal life, both socially and in his relations with his wife and family. There will be a need for medication from time to time, depending on stress, but plainly what has been prescribed in the past is inappropriate. The assessment must of necessity be on global basis. I will allow the costs of attendance at a pain clinic, the assumption being that will ease any future need for medication considerably.

[103] With those findings in mind I turn then to the assessment of damages as follows:

Description	**Amount**
Pain, suffering and the loss of amenities	$50,000.00
Interest at 2% on $25,000 over 8.8 years	$4,400.00
Past economic loss[121]	$70,500.00
Interest on $68903.20[122] at 5% over 2.3 years	$7,923.87
Past loss of employer's contribution to superannuation at 9 per cent of the past economic loss award	$6,344.00
Future impairment of earning capacity[123]	$170,000.00
Future loss of employer's contribution to superannuation calculated at 9% of the award of future impairment of earning capacity	$15,342.00
Cost of pain management program	$6,000.00
Costs of future counselling[124]	$2,600.00
Future pharmaceutical and medical expenses[125]	$10,000.00
Special damages (paid by WorkCover)	$9,547.02
Special damages (paid by the plaintiff)[126]	$12,900.00
Interest on $8,685[127] at 5% cent over 8.8 years	$3,821.40
Fox v Wood	$489.20
Total	**$369,867.49**

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121 Five weeks off work initially at $3,710 together with the loss from 6 April 2006 to 31 December 2007 – approximately 90 weeks at $742 net per week.

122 Allowing for $1,586.80 in workers' compensation payments.

123 Allowing $773 over 12 months but delayed six months and $390 (50 per cent of the notional net wage of $780) over 8.5 years delayed 1.5 years. The wage levels adopted are those proposed by plaintiff's counsel – see Ex 72

124 A global sum based on Dr Cantor's views

125 Again a global sum

126 I have largely followed the schedule in exhibit 72 which in turn reflects the material contained in exhibit 40 save that there must be some allowance both for the fact that the plaintiff is doing no more than estimating and I am concerned at the reliability of his recollections and, more significantly, that my findings are to the effect that the Parkinson's disease has contributed to the symptoms and the need for medication reflects that unrelated problem.

127 After allowance for the Medicare charge

[104] The judgment against the second defendant must bring into account the refund due to WorkCover Queensland of $11,267.13.[128]

Orders

[105] There will be judgment for the plaintiff against the first defendant in the sum of $369,867.49. There will be judgment for the plaintiff against the second defendant in the sum of $358,600.36.

[106] I will hear from counsel as to costs.

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128 Section 270(1) W*orkers' Compensation & Rehabilitation Act 2003*