SUPREME COURT OF QUEENSLAND

CITATION:	*Allen v O'Donnell & Anor* [2021] QSC 63
PARTIES:	**BLAISE ANTHONY ALLEN** (plaintiff) **v** **MATTHEW THOMAS O'DONNELL** (first defendant) **RACQ INSURANCE LIMITED** ACN 009 704 152 (second defendant)
FILE NO/S:	SC No 915 of 2019
DIVISION:	Trial Division
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court at Rockhampton
DELIVERED ON:	25 March 2021
DELIVERED AT:	Rockhampton
HEARING DATE:	22, 23, 24, 25, 26 February 2021
JUDGE:	Crow J
ORDER:	**1. Judgment for the plaintiff against the second defendant for $2, 499, 399.69.**
CATCHWORDS:	DAMAGES – ASSESSMENT OF DAMAGES IN TORT – PERSONAL INJURY – METHOD OF ASSESSMENT GENERALLY – where the plaintiff suffered physical and psychological injuries in a motor vehicle accident – where liability is admitted – where the plaintiff claims damages for personal injuries arising from the motor vehicle accident – where damages are assessed under the *Civil Liability Act* 2003 (Qld) DAMAGES – ASSESSMENT OF DAMAGES IN TORT – PERSONAL INJURY – METHOD OF ASSESSMENT GENERALLY – LOSS OF OPPORTUNITY - where a recruitment agent approached the plaintiff post-accident regarding employment in the mining industry - where the employment in question had a much larger salary range than plaintiff's previous employment – where recruitment agency received hundreds of applications – whether the plaintiff was likely to have obtained such employment – whether it effects the calculation of future economic loss DAMAGES – ASSESSMENT OF DAMAGES IN TORT –

PERSONAL INJURY – OTHER HEADS OF DAMAGES – GRATUITOUS CARE OR ASSISTANCE RENDERED TO CLAIMANT – GENERALLY - where plaintiff received past care and assistance – where the plaintiff will receive future care and assistance – assessment of damages for gratuitous care

Civil Liability Act 2003 (Qld), s 59, s 61
Civil Liability Regulation 2014 (Qld)

Alridge v Allianz Insurance [2009] QSC 257, cited
CSR Limited v Eddy (2005) 226 CLR 1; [2005] HCA 64
Malec v JC Hutton Pty Ltd (1990) 169 CLR 638; [1990] HCA 20, followed
Munzer v Johnston & Anor [2008] QSC 162, applied
McAndrew v AAI Limited [2013] QSC 290 , applied
Seltsam Pty Limited v Ghaleb [2005] NSWCA 208, cited
Wilson v McLeay (1961) 106 CLR 523; [1961] HCA 56, cited

COUNSEL: S J Deaves, with M M Willey, for the plaintiff
K S Howe, with M Forbes, for the second defendant

SOLICITORS: Grant and Simpson for the plaintiff
Cooper Grace Ward for the second defendant

Background

[1] On 5 January 2015 the plaintiff, Mr Allen, and his three children embarked on a journey from Townsville to Brisbane with the intention of staying at Mr Allen's mother's house for a holiday. Mr Allen's then-partner and now wife, Dr Gail Kingston, was unable to join the family on the journey as she had work commitments in Townsville.

[2] The journey from Townsville to Rockhampton was uneventful. Mr Allen drove the family's Kia Carnival and insisted his three children inhabit the rear passenger seats. Mr Allen's daughters were then aged 12 years, 9 years and his son was then 3 years. According to Mr Allen,[1] his eldest daughter had begged him to be allowed to sit in the front on the entire trip, however, "I wouldn't allow it… and so she had to sit in the back. All three of them had to sit in the back…"

[3] After overnighting in Rockhampton, Mr Allen and his children began to drive from Rockhampton to Brisbane. Mr Allen succumbed to his eldest daughter's request to allow her to sit in the front seat, a decision which he deeply regrets.

[4] The Kia did reach Brisbane. Mr Allen was driving in a southerly direction along the Gateway Motorway when a Nissan Patrol driven by the first defendant veered onto the incorrect side of the road and caused a high-speed head-on collision to occur. Liability is admitted in respect of the collision.

[5] Exhibit 3 consists of photographs of the Kia after the accident showing the front of the motor vehicle being crushed in to almost the driver's seat. Exhibit 4 is a series

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1 T1-19.

of four photographs of Mr Allen in the intensive care unit showing his extensive facial and head injuries. That Mr Allen was badly injured and is deserving of substantial compensation is not in issue. In a broad sense, the issue to be determined between the parties is the nature and extent of the injuries suffered by Mr Allen and the probable effects in terms of his ability to obtain and engage in employment and the need for treatment and care.

The Injuries

[6] Mr Allen alleges he suffered the following injuries:[2]

(a) Chronic Post-Traumatic Stress Disorder, co-morbid adjustment disorder, anxiety and depressed mood;

(b) Fracture/dislocation of the left hip and fracture of the left hip acetabulum requiring reconstructive surgery;

(c) Laceration of the right knee;

(d) Fractured ribs 5 to 8 on the left side;

(e) Facial laceration with mental nerve evulsion and repair;

(f) Post-operative pulmonary effusion and embolus;

(g) Laceration to left ring and little fingers requiring extensor tendon repairs;

(h) Left knee complete tear of PCL (posterior cruciate ligament);

(i) Right knee complete tear of ACL (anterior cruciate ligament);

(j) Facial injuries that include scarring;

(k) Injuries to the plaintiff's teeth and gums;

(l) Sight impairment (incongruous inferior left homonymous quadrantanopia);

(m) Hearing impairment;

(n) Spinal injuries that include a C8-T1 radiculopathy;

(o) Soft tissue injuries to the plaintiff's left shoulder, elbow, wrist and hand; and

(p) Traumatic brain injury.

[7] The defendants admit entirely paragraphs (b), (c), (d), (e), (f), (g), (j) and (o).

[8] The defendants admit Mr Allen has suffered from a post-traumatic stress disorder and "an aggravation of pre-existing recurrent major depressive disorder" but deny the balance of the psychiatric injury.

[9] With respect to paragraphs (h) and (i), the defendants' case is that the left knee is properly diagnosed as a partial but not a complete tear of the PCL and the injury in respect of the right knee is a partial but not complete tear of the ACL. The defendants do not admit the injury to Mr Allen's teeth and gums, admit that Mr Allen has a sight impairment in respect of the accident, however allege it is a

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2 Paragraph 9 of the Statement of Claim.

minor impairment, in that Mr Allen is fit from an ocular point of view to drive a normal motor vehicle and does so. The defendants admit that Mr Allen suffers from a hearing impairment but say that it is mild hearing loss at 1KHz bilaterally.

[10] In respect of paragraph 9(n) the defendants admit that Mr Allen has suffered from a musculoligamentous injury to the cervical spine resulting in a 7% whole person impairment, a lumbar spinal soft tissue injury resulting in a 0% impairment, but deny there is a C8-T1 radiculopathy. At paragraph 5(l) the defendants admit that Mr Allen has suffered from a traumatic brain injury but say that any impairment of cognition or memory is minor.

Evidence of Non-Expert Witnesses

[11] Mr Allen is a difficult witness to assess. Mr Allen broke down on several occasions, and in particular, lost complete control of his emotions when discussing how his children have suffered. Dr Isailovic, psychiatrist, described in her reports and in her evidence Mr Allen's "highly tangential style", that is, that Mr Allen would not always respond to questions but rather say what he thought was relevant. Dr Isailovic noted that Mr Allen was unresponsive to most questions asked of him but rather tended to respond as he wished to respond, which Dr Isailovic said was consistent with her diagnosis of post-traumatic stress disorder and major depressive disorder. Mr Allen himself said that he always "goes off on tangents" and that he had grave difficulty in himself determining what part of his problems were physical and what part were psychiatric. I accept that Mr Allen was an honest witness, but I have concerns about his accuracy and reliability which stems from his severely emotional state and his "highly tangential" state.

[12] Dr Kingston, Mr Allen's wife, was a very impressive witness, and I accept her evidence. In particular, I accept Dr Kingston's evidence as to Mr Allen's personality prior to the motor vehicle accident. She described Mr Allen as: [3]

> "An exceptionally charismatic gentleman. Full of wit. We laughed a lot… There was a lot of fun, very quick – very quick with his quips. An exceptionally patient man. … Exceptionally patient with his children. … To the point where I would say particularly about the girls that he needed to be a bit stronger with them because they would get – run over him all the time. So never lost his temper. I never, ever saw him lose his temper with the children ever. And you know, we had a lot of laughs and we had a lot of fun. And very bright and we really had a good – we had a very good marriage, our relationship."

[13] Dr Kingston described her observations of her husband post-accident as follows: [4]

> "…I'm here as his wife and not as an occupational therapist but I will preface this with saying I am – I've been an OT for longer than I've been his wife so I talk a lot in that language. And for the past six years, he's not the man I met. … So physically, he has a loss of stamina, fatigue and pain, a loss of strength and a range of motion. He can't lift things or anything from up high. If he bends down, it

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3 T3-52.

4 T3-79 to T3-80.

> causes him pain in the back. I think the biggest impact, though, has been the cognitive and the psychological. So cognitively, he's – he's unable to – so he will either – and you may have seen it with him, with the way that he has been is that he either perseverates on one task. … Or he goes off on the biggest tangents that you've ever seen. … So the planning, prioritising, sequencing, problem solving, all those things, he needs loads of prompting and – and encouraging. Psychologically, … if he gets too stressed, he just loses it. He just loses it."

[14] Mr Paul Holden has been a friend of the plaintiff for approximately 10 years. Mr Holden is the executive director with the office of the coordinator general within the Queensland Government. He was an impressive witness and I accept his evidence. Of his pre-accident function, Mr Holden said[5]:

> "He's a very intelligent guy, very capable. Physically, very, very capable. A family man. He was very, very committed to his – his kids and his – his now-wife and took his job very, very seriously. He was a – a workplace health and safety practitioner with the James Cook University when I first met him; knew his work responsibilities inside out; was very capable, in my view. And a very social human being. Very, very friendly. He was outgoing, so if we had social gatherings and they would come, he – he tended to know everybody by the end of the night and made people feel very comfortable. He was a very outgoing and extroverted personality and – and a very good person to talk to."

[15] Of his pre-accident functioning, Mr Holden said that he would have "absolutely given him a person [reference]". Likewise, Ms Fiona Austin, a former work colleague of Mr Allen and corporate solicitor, gave extremely positive evidence as to Mr Allen's pre-accident capabilities as a workplace health and safety officer. Ms Austin would also gladly be a personal referee based on her observations of Mr Allen in their work together at Ergon prior to the injury. Notably, Mr Holden said that he would be obliged to decline to provide Mr Allen a personal work reference based on his observations of Mr Allen since the accident.

[16] Mr Cameron Cook is the managing director of TP Human Capital Townsville. TP Human Capital is a recruitment, labour hire human resource and training business which has operated in Townsville for more than 20 years. Mr Cook has known Mr Allen for approximately 20 years. Mr Cook explained that he first knew Mr Allen when Mr Allen was working for Suncorp. Suncorp was a client of TP Human Capital and Mr Cook assisted with recruitment for Suncorp in Townsville. Mr Cook also knew Mr Allen when Mr Allen worked for Adecco, a competitor in his own business market.

[17] Later when Mr Allen was an owner of a Baker's Delight shop 150 metres from TP Capital, Mr Cook would often "run into him". Mr Cook observed that pre-accident Mr Allen was a "big guy, looked strong and healthy"[6] and thought that he, was in a business sense:[7]

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5 T2-78.

6 T3-60

> "…switched on – you know, switched on, intelligent guy. He seemed very confident – confident, charismatic, he was easy to – easy to get along with which is why I think he – he was marketable to a company like Adecco because in a recruitment industry, there's a sales business development component of it and you've also got to be quite adaptable to a range of different industries and positions, because you're dealing with different clients. … So yeah, he struck me as – yeah, a – definitely a quality – and he had drive, you know. He had – he always had drive and that's why when I'd run into him and we discuss business when he was at Baker's Delight. He was always trying to, you know, get to that next level. He was trying to improve the business. And what he did – some people get quite lazy, he wasn't one of those."

[18] Of his observations post-accident, Mr Cook said he observed Mr Allen "walking with a limp. He's always got his cane. He put on weight and just didn't look – I mean, it looked like a different person to me compared to how I'd known him for years beforehand…"[8]

[19] Of his psychological status post-accident, Mr Cook said:[9]

> "he still can converse and he still seems – seems to be quite switched on but he used to be more positive and I suppose that was part of that charisma – more – just easier to, you know, to get on with and what I found over catching up with him, there was a bit of a – like a, just a little bit defeated, a little bit pessimistic and yeah. Just different is probably the way – in more in a – it's hard to put my finger on what I would describe, but just a different outlook on things, I think."

[20] The other important part of Mr Cook's evidence is that on 3 and 4 March 2016, before he knew Mr Allen had been injured, Mr Cook text messaged and telephoned Mr Allen and eventually got a response. Mr Cook was chasing Mr Allen to permit Mr Cook to allow Mr Allen's name to be put forward for a workplace health and safety role. Given Mr Cook's work experience he was also able to give evidence of salary levels. Team manager level workplace health and safety officers earn between $130,000 per annum and $180,000 per annum in Townsville. General managers earn in range of $220,000 to $260,000 per annum. Mr Cook also gave evidence of mining incomes earned by workplace health and safety employees starting with safety advisors earning around $130,000 and safety superintendents earning $150,000 to $180,000 plus incentives at between 10% and 20% of salary.[10]

Assessment of Injuries

[21] In respect to the issue of organic brain injury, the neuropsychological testing shows that Mr Allen has retained his high level of intelligence. There is little difference between the experts as to the impairment resulting from the brain injury. The

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7 T3-61.
8 T3-61.
9 T3-61.
10 T3-62 to T3-63.

experienced neurologist Dr Saines and the experienced neurosurgeon Dr Campbell concur that Table 13.6 of AMA5 was the appropriate table (which provides for a range of between 1 and 14% impairment), Dr Saines assessing a 5% impairment and Dr Campbell an 8% impairment.

[22] The evidence of Dr Saines and Dr Campbell places Mr Allen's brain injury at an item 8, minor brain injury, with an Injury Scale Value (ISV) range of 6 to 20. For item 8, the degree of permanent impairment is not stated to be an example of a factor affecting the ISV assessment. Both Dr Saines and Dr Campbell's assessments at 5% and 8% whole person impairment respectively place the ISV for the brain injury in the vicinity of an ISV of 8. Accepting, as I do, the evidence of the neuropsychologist, Ms Bradshaw, and the evidence of Dr Saines and Dr Campbell, it is likely that the extent of any personality change and depression and cognitive limitation experienced by Mr Allen is a result of his serious psychological injuries, rather than his minor brain injury.

Facial Injuries, Teeth, and Gums

[23] Mr Allen's facial injuries are graphically shown by the photographs in Exhibit 4. There is a deep laceration to the left part of Mr Allen's chin which was repaired by a plastic surgeon at the Royal Brisbane and Women's Hospital. Dr Saines has described the injury as a deep laceration to the chin with avulsion of the mental nerve. On Page 3 of his report of 1 June 2019[11] Dr Saines records "[h]e has residual mild left facial weakness and sensory alteration with a patch of anaesthesia over the left ch[in]. He has pain in the left lower jaw and gum which recurs in bouts every month or so lasting five to seven days. He has been reviewed by a Maxillofacial Surgeon. no [sic] course has been established."[12]

[24] Dr Saines has described that injury as "a lesion of the mental branch of the mandibular nerve and minor left lower facial nerve injury." Dr Saines quantifies a 3% whole person impairment as a result of that injury.[13]

[25] Dr Campbell says that he has ongoing left facial numbness which warrants a 4% whole person impairment. [14]

[26] In my view, the facial injury ought to be classified as an item 16, moderate facial injury, as it fits within the example of this injury as a severed sensory nerve of the face with minor permanent paraesthesia. The loss of sensation in the left chin causes difficulties for Mr Allen because he is prone to dribble or leave food in the area of the paraesthesia. Item 16 has an ISV range of 6 to 13 and in my view as a standalone injury, the facial injury would be allocated an ISV of 13.

Neck Injury

[27] Mr Allen's evidence is that he suffers from ongoing hip pain, back pain, neck pain and headaches, shoulder pain, stiffness in his hip and instability in knees, and wrist pain. [15] This has not been challenged. The neck injury although pled as a C8-T1

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11 Exhibit 1, page 284.
12 Exhibit 1, page 277.
13 Exhibit 1, page 280.
14 Exhibit 1, page 114.
15 Exhibit 1, page 12.

radiculopathy has been diagnosed by Dr Campbell as a C6-7 disc protrusion and with a 15% whole person impairment. Dr John Maguire, orthopaedic surgeon, diagnosed both a C6-7 disc protrusion and a C8-T1 disc protrusion. Dr Allan Cook and Dr Peter Dodd, orthopaedic surgeons, diagnosed the neck injury as a musculoligamentous injury of the cervical spine with Dr Cook assessing a 6% whole person impairment and Dr Dodd a 7% whole person impairment. Dr Saines' opinion based on his assessment of 6 June 2019 is of no permanent impairment.

[28] I accept the opinion of Drs Dodd and Cook in respect of the neck injury. Dr Dodd is an experienced orthopaedic surgeon and his opinion and assessment of permanent impairment align closely with that of another very experienced orthopaedic surgeon, Dr Allan Cook.

[29] The neck injury is therefore categorised as an Item 88, moderate cervical spine injury soft tissue injury, with an ISV of 5 to 10. Of itself the cervical injury would quantify as an ISV of 9 due to the level of permanent impairment and the ongoing symptomatology for a period of more than 5 years.

[30] In respect of the neck injury, Dr Campbell is of the view that Mr Allen "may benefit from cortisone trigger point injections into the cervical spine region as recommended by his treating orthopaedic surgeon at a cost of $1 000 to $2 000. He may benefit from the occasional course of physiotherapy 6 to 8 sessions at $90 to $120 per session for any acute exacerbations of neck complaint that may occur in the future." [16]

[31] Dr Allan Cook and Dr Peter Dodd do not recommend any treatment with respect to the cervical spine injury.

[32] Dr John Maguire opines that Mr Allen's neck may "require injection of the disc to relieve some discomfort over the next year and may require surgery with the partial excision of the disc and fusion in the future costing in the order of $20,000 with such surgery occurring within three to five years." [17]

[33] As I accept the accuracy of the diagnoses of Dr Dodd and Dr Cook in respect of the cervical spine injury, I also accept that there is no need for further surgical treatment in respect of the cervical spine. I do not consider it is reasonable to subject Mr Allen to injections in his cervical spine as I accept the evidence of Drs Dodd and Cook.

Left Shoulder Injury

[34] Mr Allen demonstrated in the witness box the area of pain to both the front and back of his left shoulder from his left breast across to his left scapular. As a result of the examinations on 23 February 2017 and 6 March 2018 and radiology, Dr Cook diagnosed a soft tissue injury to Mr Allen's left shoulder. Dr Cook quantified a 7% whole person impairment in respect of the left shoulder injury on the basis of a reduction in the range of motion. Dr Cook did not recommend any surgery in respect of the left shoulder injury.

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16 Exhibit 1, page 113-114.
17 Exhibit 1, page 268.

[35] Dr Dodd, orthopaedic surgeon, following examinations on 5 June 2019 and 7 October 2020 also diagnosed a soft tissue injury to the left shoulder. On examination, Dr Dodd did notice a minor deltoid wasting of the left shoulder and a slight prominence of the acromioclavicular joint. On examination Mr Allen reported tenderness over the anterior joint line of the left shoulder. In respect of range of motion, although Dr Dodd detected Mr Allen to have normal range of external and internal rotation, there was a decrease in range of movement in the left shoulder in respect of flexion, extension, abduction and adduction. This reduction in range of motion led Dr Dodd to opine a 4% whole person impairment in respect to the left shoulder injury.

[36] In respect of the left shoulder, the range of movement had improved between Dr Cook's assessment on 6 March 2018 and Dr Dodd's assessment on 5 June 2019 and then slightly altered again upon Dr Dodd's assessment on 7 October 2020. The reports of Dr Cook and Dr Dodd show shoulder range of motion as follows:

	Dr Cook (6 March 2018)	Dr Dodd (5 June 2019)	Dr Dodd (7 October 2020)
Flexion	130º	140º	150º
Extension	40º	40º	50º
Abduction	100º	150º	130º
External Rotation	60º	80º	80º
Internal Rotation	60º	70º	70º

[37] In respect of the left shoulder injury, I accept the opinions of Drs Dodd and Cook as to the nature of the injury to Mr Allen's left shoulder. As Dr Dodd's assessments of permanent injury post-date Dr Cook's and are relatively consistent in showing some improvement from when Dr Cook assessed Mr Allen, then I accept Dr Dodd's assessment of a 4% whole person impairment due to the left shoulder injury. The left shoulder injury is an Item 97, moderate shoulder injury with an ISV range of 6 to 15. Of itself the shoulder injury, in my view, warrants an ISV of 6 as the percentage impairment is at the bottom of the range.

[38] Dr Cook does not suggest there is a need for any left shoulder surgery. The treating orthopaedic surgeon, Dr Maguire, proposes left shoulder surgery. In Dr Maguire's examination of Mr Allen on 13 November 2020 (approximately one month after Dr Dodd's examination) he records less of a range of motion in each plane other than forward flexion. As Dr Dodd explained,[18] medical experts may record different examination results for examinations at differing times due to experience of pain or other psychological factors rather than any alteration in the underlying pathology. Dr Dodd does not agree with Dr Maguire's opinion that it is likely Mr Allen will require shoulder surgery costing $10,000 within the next year.[19] Dr Dodd consider

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18 T4-13.

19 Exhibit 1, page 267, 322. 335-336.

that the x-ray taken shortly after the accident on 6 January 2015 showing a prominent left acromioclavicular joint indicated osteoarthritis of that joint, which pre-existed the accident but was asymptomatic.[20]

[39] Dr Dodd says in those circumstances the diagnosis would be of an aggravation of osteoarthritis in the acromioclavicular joint, together with a subacromial bursitis with impingement. As the impingement is recorded as being minor, and because operations attempt to cure osteoarthritis in the acromioclavicular joint "are somewhat disappointing and can make the situation worse"[21] and because of Mr Allen's severe psychological issues, Dr Dodd recommends against surgery, "particularly in the next 12 months". Dr Dodd has then added "in due course, he may require a procedure for his acromioclavicular joint but at this point in time, the degeneration in that joint does not warrant that nor does his clinical examination indicate to me that surgery is imminently necessary."

[40] I accept Dr Dodd's evidence that the x-ray taken shortly after the accident on 6 January 2015 indicated osteoarthritis of that joint and I therefore accept that Mr Allen did suffer from an asymptomatic pre-existing condition in his left shoulder, being osteoarthritis of the acromioclavicular joint. I do accept Mr Allen's evidence that he did not have prior symptoms in his left shoulder. I accept Dr Dodd's evidence that what has occurred is an aggravation of the osteoarthritis in the acromioclavicular joint, together with subacromial bursitis with impingement. Absent the motor vehicle accident, there is no suggestion that Mr Allen would have ever been symptomatic in his left shoulder or require an operation in respect of same.

[41] In my view, the defendant has not discharged its onus in showing that the pre-existing condition would have caused Mr Allen to suffer from symptoms in any event. I therefore consider it appropriate to make some allowance in respect of future treatment of Mr Allen's left shoulder. I do, however, consider that the reasoning of Dr Dodd is sound in his recommendation against shoulder surgery, at least in the near future. That is, the operation may prove somewhat disappointing, may make the situation worse, and in respect of Mr Allen's case, he has the co-morbidities of a most serious psychological condition as well as prior medical history of pulmonary embolism and deep vein thrombosis.[22]

[42] I consider it reasonable to allow a sum of $5,000 for all future left shoulder treatment being in the nature of injections suggested which may be recommended or at some distant and unknowable time, left shoulder surgery.

Lumbar Spine Injury

[43] Dr Dodd, Dr Saines and Dr Cook diagnosed musculoligamentous injury of the lumbosacral spine. Dr Maguire diagnosed an L4-5 disc protrusion. Dr Campbell makes no mention of low back pain in his report. Dr Saines and Dr Dodd quantify a 0% impairment of the lumbar spine and Dr Cook quantifies a 5% impairment of the lumbar spine. Although there is a consistency in the opinions of Drs Saines and Dodd, I prefer the assessment of Dr Cook as to the level of permanent impairment.

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20 Exhibit 1, page 335-336.
21 Exhibit 1, page 336.
22 Exhibit 1, page 322.

Dr Cook's diagnosis is the same as Dr Saines' and Dr Dodd's. Accepting, as I do, the evidence of Mr Allen, Dr Kingston, Mr Holden and Mr Cook that Mr Allen was fit, well and strong prior to the accident and accepting Mr Allen's and Dr Kingston's evidence that since the accident Mr Allen has suffered from back pain which affects him particularly when bending, I consider it reasonable to accept that Mr Allen has some minor impairment of his lumbar spine.

[44] Dr Cook's opinion of the nature and level of the impairment as a result of the lumbar spine injury accords with my own view based upon the evidence of Mr Allen and Dr Kingston. This quantifies the lumbar spinal injury as an item 93, moderate lumbar injury, with an ISV of 5 to 10. As a standalone injury, I would assess this at an ISV of 8.

Scarring

[45] In respect of the multiple scars (other than facial scars) upon Mr Allen's body, Dr Cook has assessed a 4% whole person impairment and Dr Dodd a 5% whole person impairment. In my view the doctors' assessment and notes upon the nature of the scarring does not meet the category of 155.2 of serious scarring, but rather fits within the category of 155.3 moderate scarring with an ISV range of 4 to 8. I allow an ISV of 8 in respect of the scarring as it is extensive and forms a moderate level of permanent impairment between 4% and 5%.

Chest Injury

[46] Mr Allen suffered "approximately"[23] five fractured left ribs with haemothorax,[24] and a post-operative pulmonary effusion and embolus.[25] This constitutes a moderate chest injury and is properly classified as an item 38, with an ISV range of 11 to 20. As four or five ribs were fracture I would find alone an ISV of 14.

Left Hip Injury

[47] The severity and nature of the injuries sustained by Mr Allen's left hip are well-explained by the photographs in Exhibit 3. The photographs show that the Kia Carnival suffered from such a heavy front-on blow that it collapsed almost to the front line of seats. As has been noted by witnesses, Mr Allen is a large man. The effect of the collision upon Mr Allen's left hip was such that the force of the collision caused the dashboard to impact upon Mr Allen's left knee and push his left femur through the ball of Mr Allen's left hip and right through his body taking "a bit of bone with it on the way out". [26]

[48] The first treatment to Mr Allen's left hip occurred at the scene.[27] Mr Allen explained how there were off duty paramedics in the car behind his Kia which attended first at the scene. Mr Allen said that one of the paramedics:

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23 Although the Statement of Claim alleges four fractured ribs (a fact admitted by the defendant), Dr Dodd considers there were "approximately five" ribs fractured.

24 Exhibit 1, page 289, 296.

25 Exhibit 1, page 226; Exhibit 1, page 289.

26 T4-17, lines 30-36.

27 T1-21, 22.

> "…says to me something along the lines of, "Mate, I have to put your hip back in right now, otherwise you're going to fucking lose it." And so he reached down the side where my – my leg and everything was trapped, and I could [indistinct] and he started to lift my leg up to put my hip back in, and then I was just screaming, and this has been a split second, and then passed out."

[49] It is common ground that Mr Allen's left hip was shattered as a result of the motor vehicle accident. The surgical repair was insertion of a long ten-hole plate and seven screws on the posterior part of the acetabulum[28]. The injury to the left hip is correctly diagnosed by Drs Cook and Dodd as a fracture/dislocation of the left hip. Dr Cook opines a 4% whole person impairment and Dr Dodd a 6% whole person impairment. I accept Dr Dodd's latter in time assessment of permanent impairment as 6% whole person impairment. I accept the submissions of the defendant that the injury is properly characterised as an Item 127, moderate pelvis or hip injury, with an ISV range of 11 to 25. Of itself, I would find an appropriate ISV for such a severe injury would be 20.

[50] Although a severe and traumatic injury, the evidence does not support the placing of the left hip injury within an Item 126 serious pelvis or hip injury as the nature of the injury and its level of permanent impairment does not fall within an Item 126.

[51] There is agreement among medical experts that Mr Allen will require further hip surgery at some point. The issue is when that surgery is likely to be necessary. Based on his assessment of 6 March 2018, Dr Allan Cook considered that Mr Allen would require a primary hip joint replacement costing in the region of $50,000 "eight to twelve years post-injury" and that every endeavour should be made to prolong the life of the natural hip joint with the use of anti-inflammatory type medications[29]. Dr Cook thought it was likely that Mr Allen would "undergo a Left Total Hip Joint Replacement" although hopefully this may not be "needed until he is in his early to mid-50s or even longer if possible."[30]

[52] Although advocating for a delay in surgery as long as possible, Dr Cook thought that Mr Allen would require the total hip replacement between 2023 and 2025 at a cost of $50,000. Dr Cook considered that a further revision of hip surgery (after the total hip replacement) would be unlikely.[31]

[53] Dr Dodd in his report of 29 June 2019 considered that it is likely that Mr Allen would require a total hip replacement "within the next 5 years at the outside". Dr Dodd's opinion was of a total hip replacement costing $35,000 and that it is likely to occur before 2024. [32]

[54] In his report of 8 March 2019, Dr John Maguire, orthopaedic surgeon, recommended that Mr Allen undergo a total hip replacement costing in the order of $35,000[33]. In his file note of 8 October 2020[34], Dr Maguire commented "revision

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28 Exhibit 1, page 130.
29 Exhibit 1, page 153.
30 Exhibit 1, page 153.
31 Exhibit 1, page 154.
32 Exhibit 1, page 307.
33 Exhibit 1, page 242.
34 Exhibit 21.

surgery for the knees is likely in the mid to late 60s and revision surgery for the hip is likely in the late 60s." Dr Dodd is rightly critical of the use of the word "revision" surgery as he said during cross-examination "[r]evision surgery. He hasn't had a primary operation yet."[35]

[55] There is however some consistency between Dr Dodd's and Dr Maguire's opinions, with Dr Dodd's further examination of 8 October 2020 showing a worsening of symptoms in terms of a positive Trendelenburg response and some atrophy of the left thigh. Dr Dodd thought it important to obtain up-to-date radiology prior to providing an opinion. The plain x-ray was taken, however the CT scan recommended by Dr Dodd was not. In respect of the x-ray, Dr Dodd says[36] "The plain x-ray indicates there is absolutely no osteoarthritis in his hip and this is demonstrated quite well with the maintenance of good joint space, no sclerosis and no osteophytes (Note: it is more than 5 years since the accident)."

[56] My conclusion on the issue of left hip surgery is to accept the opinion of Dr John Maguire and Dr Dodd that it is likely there will be left hip surgery in the form of a total hip replacement costing approximately $40,000 and occurring when Mr Allen is in his late 60s. I consider it appropriate to allow the cost of surgery at $40,000, delayed for some 15 years (5% multiple 0.481) a sum of $19,240.

Knee Injuries

[57] The fact that Mr Allen has suffered from serious knee injuries cannot be in doubt. Exhibit 3 shows how the dashboard was crushed so far as it was impossible not to have had significant impact upon Mr Allen's knees. Dr Cook's diagnosis was of soft tissue injuries to both knees.[37] Dr Cook considered there was mild laxity of the ligaments of Mr Allen's right knee and quantified a 3% whole person impairment of the right knee and a 2% impairment of the left knee.[38]

[58] Dr Dodd thought there was no permanent impairment,[39] however I accept Dr Cook's opinion on the permanent impairment as it reflects Mr Allen's ongoing knee problems.

[59] Both knee injuries fall within Item 139, moderate knee injuries, with an ISV range between 6 to 10 and with the combined permanent impairment of themselves, would score an ISV in the vicinity of 8.

[60] Dr Cook did not suggest any treatment with respect to the knees. Dr Maguire proposed surgery of both knees. By Exhibit 1 page 267, Dr Maguire said "……..it is of note that with both knees that they will progress to osteoarthritic change in the future and he will require a total knee replacement for both knees. This will cost in the order of thirty thousand dollars per knee."

[61] Dr Dodd did not agree, stating:[40]

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35 T4-18.
36 Exhibit 1, page 333.
37 Exhibit 1, page 150.
38 Exhibit 1, page 155.
39 Exhibit 1, page 299.
40 Exhibit 1, page 337.

> "On the basis of normal range of motion and relatively normal MRI scan, one would not contemplate total knee replacements in this man now or in the immediate future.
>
> Of course progress scans will need to be done over the years and I appreciate he has had dashboard injuries bilaterally but from that particular point of view, he seems to have made an incredibly good recovery and his only presenting features now are of mild chondromalacia patellae."

[62] Dr Maguire thought the knee surgery would be likely to occur when Mr Allen is in his mid to late 60s. I accept Dr Dodd's opinion that currently knee operations are contraindicated, however Dr Dodd does suggest there ought to be progress scans over the years because Mr Allen has suffered from such a severe dashboard injury. Dr Maguire thought the knee surgery would be likely to occur when Mr Allen is in his mid to late 60s. I have also borne in mind that Dr Maguire has suggested other surgeries to the knees[41] including a left posterior cruciate ligament reconstruction and a right knee arthroscopy and chondroplasty.

[63] In respect of Mr Allen's bilateral knee injuries although, as noted by Dr Dodd, Mr Allen has done remarkably well, I find due to the nature of the injuries it is likely Mr Allen will, in his mid to late 60s, require knee surgery. That is, I do not accept Dr Maguire's evidence for the necessity for two operations on each knee, but rather one operation on each knee, delayed as long as possible until Mr Allen's mid to late 60s and in respect of which I consider it is appropriate to allow the higher cost of $30,000 for a total knee replacement. The allowance for future knee surgery therefore is $60,000 deferred for 15 years (5% multiplier 0.481) a sum of $28,860.

Other Physical Injuries

[64] The admitted soft tissue injuries to Mr Allen's left elbow and left hand are not the subject of expert evidence. Given that there is no specific evidence as to the nature or extent of the elbow (other than scarring), I asses the injury as an item 124, minor upper limb injury with an ISV of 0-5. The laceration on the left little finger and little finger are an item 119, moderate hand injury, with an ISV range of 6 to 15.

[65] The hearing impairment is not the subject of medical evidence, but the fact that there is a slight hearing impairment is admitted by the defendants. The hearing impairment is an item 33.3, minor ear injury with an ISV of 0 to 3 for each ear. The eye injury is an item 29, minor eye injury with an ISV of 0 to 5.

Psychiatric Injuries

[66] Mr Allen's evidence as to the immediate aftermath of the collision is:[42]

> "We had the collision and I was sitting in the front driver seat of the car, and all I recall is fighting to stay conscious and hearing my three little ones screaming for my help, to help them, but I couldn't help them. I was pinned, the car had crushed in over the front of my knees.

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41 Exhibit 1, page 266 to 267.
42 T1-21.

> … – this was all in a split second and blood gushing everywhere … the car was on fire, and I was just trying to stay conscious … and as I am losing consciousness, I can just see them screaming, "Daddy, daddy, daddy." …"

[67] Mr Allen's evidence is that he relives this experience with nightmares and "[t]here's not too many nights that I don't have them." [43] As discussed above, I accept Mr Allen has had a complete change in personality since the accident. That Mr Allen has suffered from a severe post-traumatic stress disorder is admitted and plain upon the medical reports and Mr Allen's presentation. There is, however, significant dispute as to the appropriate PIRS assessment with Dr Isailovic quantifying the PIRS at some 7% and Drs Likely and Caniato assessing the impairment at 27% and 26% respectively.

[68] Counsel for Mr Allen submits that Dr Isailovic has failed to pay regard to the range of percentage of impairment as set out in the PIRS for each area as a guide to the level of impairment as suggested in section 4(3)(b) of Schedule 5 of the *Civil Liability Regulations* 2014 (Qld) which provides:

> "**4 How to assess a PIRS rating**
>
> …
>
> (3) In deciding which level to choose for an area of functional impairment, the medical expert—
>
> (b) *may* have regard to the range of percentages of impairment set out in the PIRS for the area as a guide to the level of impairment."
>
> (Emphasis added.)

[69] I accept that submission insofar as there is no indication in any of Dr Isailovic's extensive reports that she did have regard to the range of percentages set out in Schedule 6. However, as set out above, whilst s 4(3)(a) requires examples of indicators to be taken into account and all other factors to be taken into account including pre-existing functional capacity for the area, the range of percentage assessments do not *have* to be taken into account but "may" be taken into account. Mr Deaves for Mr Allen points out that prior to the accident the evidence is plain that Mr Allen was a very high functioning and capable man. I accept that submission, however the PIRS system does have a peculiar scheme and, under s 4, it is required to be followed on a step-by-step basis.

[70] As to self-care and hygiene I accept Dr Isailovic's opinion of a Class 2 impairment over Dr Caniato's Dr Likely's assessment of Class 3. I consider the evidence does support a Class 2 level of mild impairment in respect of self-care and personal hygiene. In particular, the examples of indicators of level of impairment for Class 3 moderate impairment such as "cannot live independently without regular support" are not made out on the evidence. Certainly, Mr Allen does, it appears, miss an occasional meal and relies on takeaway food, but it is plain that Mr Allen is not so psychiatrically disabled that he could not live independently.

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[43] T1-39, line 14.

[71] In respect of social and recreational activities, the psychiatrists agree that Mr Allen would be classified as a Class 3, that is with a moderate impairment. I consider this is correct. The descriptors in that category of are that the person is quiet, withdrawn, will not go out without a support person, does not become involved in social events, and rarely goes to social events., That is an appropriate descriptor of Mr Allen's current distressed functioning as compared to his prior functioning.

[72] With respect to travel, the only impediments to travel in the evidence of Mr Allen are those imposed by the pain he suffers from his multiple physical injuries. I therefore consider that Mr Allen is best classified as a Class 1, little or no impairment in respect of travel.

[73] In respect of social functioning I prefer Dr Caniato's classification of Class 3 over Dr Isailovic's classification of Class 2, as I consider Mr Allen does have a moderate impairment of his social functioning. I consider it is appropriate, particularly on the basis of Dr Kingston's evidence, to describe established relationships as being "severely strained" and that other family members (such as Dr Kingston) are providing most of the care for the children.

[74] As to concentration, persistence and pace, Mr Deaves' argument in respect of s 4(3)(b) of Schedule 5 is relevant. Mr Allen was a very capable man prior to the accident and although he had retained his intelligence, he has lost his drive, his personality, his ability to concentrate and importantly, his mental pace. There is no difficulty, however, with persistence, rather the problem is perseverance, which is a major problem for his mental functioning. In my view it would be unfair to quantify this impairment as a loss of less than 10% of function, rather the loss of function is in the vicinity of 30%, that is at the top of a Class 3 impairment.

[75] As to adaptation, Dr Isailovic considers Mr Allen has a Class 3 moderate impairment, whereas Dr Caniato considers Mr Allen has a Class 5 total impairment. Schedule 6 defines adaptation as the functional impairment which "deals with employability". As discussed below in respect of employability, I do not consider that Mr Allen is totally and permanently unemployable, nor within Class 5 as he does not need "constant supervision and assistance within an institutional environment". Nor, however, do I consider it appropriate to categorise Mr Allen's employability as suffering from a Class 3 moderate impairment with 11% to 30% in capacity. In my view, as discussed below, the effect of the accident from a psychiatric perspective is to cause Mr Allen to suffer from a Class 4 severe impairment, that is, with a reduction in mental capacity for employment between 31% and 60% loss of function.

[76] Applying s 4(4) of Schedule 5 of the Regulations, the class scores are read in ascending order as follows: 1, 2, 3, 3, 3, 4. As may be observed, the middle two scores are 3, and so that the median class is 3. Section 4(6) sets out that step 4 is the calculation of the total class score by adding each of the class amounts together. The total class score is 16 (1 + 2 + 3 + 3 + 3 + 4). Section 4(7) then requires in step 5 the utilisation of the conversion table in s 7. It may be observed with a median class score of 3 and with a total class score of 16 that the PIRS assessment is properly formulated as a PIRS of 17%.

[77] A PIRS score of 17% results in the classification of Mr Allen's psychiatric injury as an Item 11, serious mental disorder, with an ISV range of 11 to 40. If the psychiatric

injury were the only injury sustained by Mr Allen, then I would find the appropriate ISV to be an ISV of 20, that is, finding slightly below the median of that item.

General Damages

[78] The method of quantification of general damages was set out by McMeekin J in *Munzer v Johnston & Anor* [2008] QSC 162. Schedule 3 to the *Civil Liability Regulations* provides in respect of multiple injuries that the dominant injury needs to be identified. The dominant injury is the psychiatric injury with an ISV range of 11 to 40. It is plain in this case that there are multiple serious personal injuries. This engages s 4 of Schedule 3. I find that the maximum dominant ISV of 40 is inadequate to reflect the impact of the accident upon Mr Allen and this is due to the adverse impact of the multiple injuries upon Mr Allen, as the combined effect of the physical, psychiatric and brain injuries is extremely severe.

[79] The appropriate level of uplift is guided by the considerations referred to by McMeekin J in *Munzer* where his Honour said:

> "[8] Whilst the regulations indicate that the purpose of the elaborate scheme set out there is to promote consistency in awards , sight must not be lost of the overriding purpose of the ISVs prescribed – to reflect the level of adverse impact of the injury on the injured person.
>
> [9] The court is required to have regard to the guidance provided by the provisions in Schedule 4 concerning its use in so far as they are relevant to the particular case but is not necessarily limited to those factors: Sch 3 s. 8.
>
> [10] This case concerns multiple injuries. In such a case it is necessary to determine the dominant injury as it is defined, have regard to the range of ISVs applicable to that injury and determine where in the range of ISVs provided for that injury it should fall, and determine whether the maximum ISV in that range ('the maximum dominant ISV') adequately reflects the adverse impact of all the injuries. If the maximum dominant ISV is not sufficient then the ISV may be higher but not more than 100 and only rarely more than 25% above the maximum dominant ISV selected.6
>
> [11] Additionally, in assessing an ISV, a court may have regard to other matters to the extent they are relevant in a particular case; Schedule 3 s 9. The examples provided of other matters are the injured person's age, degree of insight, life expectancy, pain, suffering and loss of amenities of life. In assessing an ISV for multiple injuries, the range for, and other provisions of schedule 4 in relation to, an injury other than the dominant injury of the multiple injuries can be considered."

[80] With respect to consistency in awards, s 61(1) of the *Civil Liability Act* 2003 (Qld) provides:

> **"61 Assessment by court of injury scale**

> (1) If general damages are to be awarded by a court in relation to an injury arising after 1 December 2002, the court must assess an injury scale value as follows—
>
> (a) the injured person's total general damages must be assigned a numerical value (***injury scale value***) on a scale running from 0 to 100;
>
> (b) the scale reflects 100 equal gradations of general damages, from a case in which an injury is not severe enough to justify any award of general damages to a case in which an injury is of the gravest conceivable kind;
>
> (c) in assessing the injury scale value, the court must—
>
> (i) assess the injury scale value under any rules provided under a regulation; and
>
> (ii) have regard to the injury scale values given to similar injuries in previous proceedings."

[81] In *Munzer*, Ms Munzer sustained grave multiple injuries such that Ms Munzer used "a wheelchair essentially after lunch each day."[44] Ms Munzer's physical injuries had a much greater adverse impact upon her than Mr Allen's have had upon him, however, Mr Allen's psychiatric illness is severe, whereas Ms Munzer's was minor. Although Ms Munzer's multiple injuries differ from Mr Allen's multiple injuries, I consider the overall level of adverse impact to be similar.

[82] I consider there ought to be a 10% uplift from the dominant ISV of 40 to an ISV of 44, observing s 4(3)(b) provides that rarely should the uplift be more than 25% higher than the maximum dominant ISV.

[83] I consider that the appropriate ISV is an ISV of 44 which quantifies general damages at $109, 640.

Past Economic Loss

[84] The parties agree at the time of the accident, Mr Allen was earning $1,660 nett per week as an associate director of workplace health and safety at James Cook University Townsville (JCU). As would be apparent from the medical evidence, Mr Allen has not returned to work since the accident and the defendants do not contend that Mr Allen has failed to mitigate his loss by failing to return to the workforce. It is apparent that during 2015 and 2016 there was a reorganisation of some of the business units within JCU such that Mr Allen's pre-accident position was not available from 25 March 2016. Mr Allen accepts that his redundancy from JCU on 25 March 2016 is not related to the accident. In the period between 6 January 2015 and 25 March 2016, Mr Allen has lost $1,660 nett per week for the 63.57 weeks, a sum of $105, 526.20.

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44 *Munzer v Johnston & Anor* [2008] QSC 162 at [23].

[85] As discussed above, on 4 March 2016 Mr Cameron Cook had approached Mr Allen in respect of alternative employment, however, that was simply to put Mr Allen's name forward in a panel with a number of other persons. There is no evidence to gauge the likelihood of Mr Allen obtaining that alternative position. The defendants submit that it is appropriate that for some three months from 25 March 2016 to 25 June 2016 ought to be considered an appropriate period that Mr Allen would likely have been out of employment as a result of the forced redundancy. I accept that submission as it fairly accords weight to Mr Allen's excellent pre-acident work history and prospects.

[86] Mr Allen's counsel submits that the economic loss ought to be allowed at a loss of $2,050 nett per week being the midpoint of salaries available for work at Ergon allowed on a likely salary of $155,000 per annum, taking into account real prospects of career advancement, particularly in the mining industry. The evidence of Mr Cameron Cook is that the salary levels to bands of employment at the upper echelons of workplace health and safety have not altered significantly between 2016 and present. For reasons as discussed below, I think it unlikely Mr Allen would have pursued employment in the mining sector and, had he done so, it is further unlikely that he would have obtained such employment in the foreseeable future. I consider that Mr Allen's pre-accident nett per week ("npw") earnings of $1,660 reflect a proper finding of Mr Allen's economic capacity, at least for the several years from the date of the accident.

[87] From 25 June 2016 until date of judgment (25 March 2021) is a period of 247.85 weeks which quantifies a total loss of $411, 431.00.

[88] Although the defendants accept that a loss of $1,660 npw ought to be allowed from 25 June 2016, the defendants argue there ought to be a discount of 25% to the proper calculation of past economic loss. The defendants submit the 25% discount ought to be applied because, as shown by Exhibit 18, Mr Allen's earnings at JCU were significantly higher than what he had earned in the past. The defendants also point to the adverse performance letters written to Mr Allen by his superiors at JCU (Exhibits 5-9) submitting that it would be unlikely that Mr Allen would have received a positive reference from his most recent employer.

[89] This, however, must be balanced with Mr Allen's evidence of the nature of the relationship with his former supervisor, Ms Wasson, her dismissal from JCU and Mr Allen's evidence that he did enjoy a favourable working relationship with his supervising officer, the vice chancellor, immediately prior to the accident. Whilst no evidence was led by Mr Allen to suggest that JCU would have given him a positive job reference, likewise the material obtained by the defendant criticising Mr Allen's performance does not lead me to conclude that Mr Allen would not have received a positive reference from JCU. I consider the evidence of Mr Paul Holden, Mr Cameron Cook and Ms Austin, as referred to in paragraphs [14] to [20] above lead me to conclude that following his redundancy from JCU and after a period of three months out of employment, Mr Allen would have secured employment at the same remuneration of $1,660 npw and would have remained so employed absent the accident. I therefore conclude there ought to be no discount for past economic loss.

[90] I therefore quantify past economic loss at $516, 957.20 ($105, 526.20 + $411, 431.00).

Interest on Past Economic Loss

[91] Although Mr Allen has been in receipt of income protection payments, the parties accept that such payments ought to be ignored in relation to both the assessment of past economic loss and interest on past economic loss.[45] The calculation of interest on past economic loss therefore is $516, 957.20 at 0.556% multiplied by 6 years, a sum of $17, 245.69.

Past Loss of Superannuation

[92] As Mr Allen was being paid superannuation at 17.5% at JCU, the parties agree that for the initial period from the accident to 25 March 2016, superannuation ought to be allowed at the rate of 17% of the nett loss of $105, 526.20, a sum of $17, 939.45. The parties also agree that the lesser and normal statutory rate of 9.5% ought to be applied on losses from 25 June 2016, that is a further $39, 085.94 ($411, 431.00 x 0.095). The allowance for past loss of superannuation is therefore $57, 025.39

Future Economic Loss

[93] On behalf of Mr Allen it is submitted that future economic loss ought to be assessed at $1,790,000 being a total loss of economic capacity for 20 years (666)[46] calculated by a loss of earning capacity measured at $2,105 npw less 10%, a sum of $1,261,737 together with an extra $530,000 allowance for prospect of advancement, with the $530,000 being calculated as a loss of an additional $1,058 npw for 20 years (666) less 25% for contingencies.

[94] The defendants' submission of future economic loss at $673,395 is based on a loss of $1,660 npw for 20 years (666) less a discount of 40% for all contingencies.

[95] The difference of over a million dollars between the plaintiff and defendants' submissions based upon the same evidence highlights the difficulty of the proper quantification of damages for loss of economic capacity. The principles concerning quantification of future loss are set out by Deane, Gaudron, McHugh JJ in *Malec v JC Hutton Pty Ltd* (1990) 169 CLR 638 at 643:

> "Hence, in respect of events which have or have not occurred, damages are assessed on an all or nothing approach. But in the case of an event which it is alleged would or would not have occurred, or might or might not yet occur, the approach of the court is different. The future may be predicted and the hypothetical may be conjectured. But questions as to the future or hypothetical effect of physical injury or degeneration are not commonly susceptible of scientific demonstration or proof. If the law is to take account of future or hypothetical events in assessing damages, it can only do so in terms of the degree of probability of those events occurring. The

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45 *Walgast v Connolly's News & Anor* [2008] QSC 97; *McAndrew v AAI Ltd* [2013] QSC 290.

46 666 being the 5% discount, 20 year factor.

> probability may be very high - 99.9 per cent - or very low - 0.1 per cent. But unless the chance is so low as to be regarded as speculative - say less than 1 per cent - or so high as to be practically certain - say over 99 per cent - the court will take that chance into account in assessing the damages."

[96] In *Seltsam Pty Limited v Ghaleb*,[47] Ipp JA (with whom Mason P agreed) held that *Malec v JC Hutton Pty Ltd* (1990) 169 CLR 638 required the application of the following principles:

> …
>
> "(a) In the assessment of damages, the law takes account of hypothetical situations of the past, future effects of physical injury or degeneration, and the chance of future or hypothetical events occurring.
>
> (b) The court must form an estimate of the likelihood that the alleged hypothetical past situation would have occurred.
>
> (c) The court must form an estimate of the likelihood of the possibility of alleged future events occurring.
>
> (d) These matters require an evaluation of possibilities and are to be distinguished from events that are alleged to have actually occurred in the past, which must be proved on a balance of probabilities."

[97] The first matter to be assessed or "conjured up" is Mr Allen's likely employment history but for the injury. The evidence shows that Mr Allen had advanced rapidly in his career from insurance through to workplace health and safety. Although in his role with JCU Mr Allen performed some travel, he had never previously worked in the mining industry which required extensive periods of time away from one's home and family. Whilst the financial rewards in the mining career are well known, there is great personal cost in terms of time away from one's family. The evidence in the current case is plain; that Mr Allen is a very strong family man, heavily involved with his children. In my view it is unlikely Mr Allen would have given up this role which is of high personal importance to him to pursue higher earnings in the mining industry, particularly when those higher earnings would have been taxed at likely the top marginal rate and in circumstances where his wife, Dr Kingston, was also likely to forge a busy and successful career as an academic.

[98] Furthermore, even if Mr Allen would have wished to obtain mining work, the evidence from Mr Cameron Cook is that such roles were difficult to obtain, i.e. the role in March 2016 suggested by Mr Cook to Mr Allen had 160 applicants including one applicant with significant mining experience who did not get the role[48]. Mr Allen was, however, an intelligent and motivated man and I do not conclude that he would not have advanced in his career. I consider the prospects of advancement including potential advancement to the mining industry to be a positive vicissitude in the assessment of damages.

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47 [2005] NSWCA 208 at [103].

48 T3-68, T3-69.

[99] As to the negative vicissitudes, there is the matter of Mr Allen's prior recurrent depressive episodes, such that Dr Isailovic had diagnosed Mr Allen as having a pre-existing recurrent depressive disorder. I note in respect of three of the past events of depression that Mr Allen had lost some work and had been on medication for a period exceeding 2 years. Mr Allen, however, had returned to work, and accordingly whilst it is correct to consider the pre-existing recurrent depressive disorder as a negative vicissitude, it is a most minor matter, and a matter upon which the evidence suggests I should place little weight.

[100] In my view, Mr Allen's earnings at the time of the accident ($1,660 npw) showing significant improvement in earnings from the previous years,[49] do suggest that Mr Allen's economic capacity ought to be assessed at $1,800 per week, approximately 10% above his earnings at the time of the accident.

[101] The defendants accept that Mr Allen is incapable of returning to his former employment. In respect of his physical injuries, the evidence is plain that Mr Allen can return to sedentary employment, but requires an extremely empathetic employer and an ability to move around and work as his pain dictates. It is the psychiatric injuries which are predominant driver in Mr Allen's practical inability, at the current point, to return to any form of employment.

[102] I accept Dr Kingston's evidence of her assessment of her husband, Mr Allen, as a very intelligent man[50]. It is plain on the medical evidence, however, that Mr Allen, is significantly disabled by his post-traumatic stress disorder. In his current state, I find that Mr Allen is unemployable. However, Mr Allen is only 49 years of age and will benefit in the future from significant psychiatric care and treatment, which may be expected to improve Mr Allen's psychiatric status. I accept Dr Isailovic's evidence that many patients with PTSD are able to work. As he is an intelligent man and, in the past, has been a motivated man, I consider there is a reasonable likelihood that at some point in the future Mr Allen will return to part-time paid employment.

[103] As that period of time is unknowable at the present time, it is inappropriate to make a deduction of a specific amount at a specific time to reflect Mr Allen's residual income earning ability. Consistent with the above authorities, I conclude it is appropriate to adopt a *Hopkins*[51] type approach. It is necessary to take into account both positive vicissitudes and negative vicissitudes and Mr Allen's high intelligence, the cessation of litigation and its adverse effect upon Mr Allen's mental health when affixing the level of discount. Importantly, as stated above, I do not conclude that Mr Allen is permanently unemployable, and I have made an allowance for a return to part time work at some time in the future. I consider these factors lead to a discount of 20%.

[104] Accordingly, I assess loss of economic capacity as a loss of $1,800 npw for 20 years to age 69 (666) less 20%, a sum of $959,040.

Future Loss of Superannuation

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49 Exhibit 18.
50 T3-78.
51 *Hopkins v WorkCover Qld* [2004] QCA 155.

[105] The parties agree that the loss of future superannuation ought to be set at 11.33% of the assessed loss of economic capacity. The loss is therefore $108, 659.23 ($959,040 x 9.5%).

Alternative Accommodation

[106] At the time of the collision, Mr Allen lived with his family at 88 Todd Street, Railway Estate. As a high set house with a downstairs laundry and a raised showering facility with a claw foot bath and with three different levels in the house, it is plain that the residence was unsuitable for a man suffering from Mr Allen's injuries.

[107] The experienced occupational therapists Mr Scalia and Ms Zeman considered the house unsuitable for someone with Mr Allen's disabilities, as did Dr Dodd. Although Mr Allen and his family did not move from the premises at Todd Street until after the Townsville floods, and even accepting the reasons for the move were multifactorial, I consider that the move from Todd Street to an appropriate unit is a loss causally connected to his injuries for which Mr Allen ought to be compensated.

[108] The loss from 20 November 2019 to date of judgment is a loss for 70.28 weeks at $650 per week, a sum of $45, 682.00. Interest should be allowed at 0.556% for 1.3 years, a sum of $330.18.

Future Rental Expenses

[109] The residence at Todd Street was owned by Dr Kingston and not Mr Allen. The residence has now been sold. The selling of the residence disposes of the unsuitable premises at Todd Street. The plaintiff seeks further damages for rental expenses at the rate of $650 per week for the next two years. I do not accept that such a claim ought to be allowed. The defendants submit that as the current lease expires on 30 September 2021, a period of 31 weeks[52] a further 18 weeks ought to be allowed at $650 per week, a sum of $11,700.

[110] As the unit at North Ward was leased predominantly to provide a reasonable place of residence for Mr Allen, I consider that the payment for the balance of the lease is an accident-related expense. If Mr Allen chooses to extend that lease or obtain another suitable unit or house, that is something that would have been necessary when Todd Street was sold. There is no evidence to suggest that there is any difference in rental price between a disability-appropriate unit and any "ordinary" unit. The sale price for Todd Street was less than $200,000 and photographs shown in the Ms Zeman's reports show its state.

[111] Mr Allen's evidence was that the divorce from his first wife had left him financially bereft and he was "starting from scratch". I consider the likelihood in the longer term is that Dr Kingston and Mr Allen (had Mr Allen not been injured) would have both succeeded in their careers, such that it was likely they would have purchased a

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52 T2-15.

more accommodating family home. I therefore allow the balance of the lease, 28 weeks at $650 per week, a sum of $18,200 for future rental expenses.

Home Modifications

[112] Mr Allen and Dr Kingston have purchased a property at 30 Paxton Street, North Ward. The photographs at Exhibit 14 show it to be an older-style, low-set home with seven steps at the front and on a gently sloping block. Mr Allen and Dr Kingston gave evidence of their intention to build a ground-level extension on the back of the building. The building is single level and Mr Allen and Dr Kingston have spent approximately $40,000 over the last few years renovating the house at 30 Paxton Street.

[113] I accept Dr Dodd's evidence that it is highly unlikely that Mr Allen will need to return in the future to the use of a wheelchair. I do not accept therefore that Mr Allen "now requires a universally accessible home" as suggested by Mr Scalia. I do accept Ms Zeman's evidence that a single level low set dwelling is appropriate for Mr Allen.[53] I do consider that it is appropriate for the dwelling to meet the current design standards for adaptable housing AS 4299-1995 as well as AS 1428.1-2009 Design for access and mobility, General requirements for access - New building work in respect of the extension. There is no evidence, however, as to what this would cost, and the plaintiff bears the onus of proof in this regard.

[114] I accept there ought to be some allowance for grab rails in the shower and the toilet and for a fully-accessibly bathroom. Given the plan shown in Exhibit 14 shows a bathroom beside the kitchen simply with a bath and given the age of the home, it is unlikely that the current bathroom facilities at 30 Paxton Street meet Mr Allen's needs. Mr Allen will, however, renovate the home by providing extension to the rear, and, as Ms Zeman said, hob-less type showers are ordinarily installed in new or renovated building works in Queensland.

[115] The principles have been discussed in *Alridge v Allianz Insurance* [2009] QSC 257. As is shown in *Munzer v Johnston & Anor* [2008] QSC 162[54] where there was an absence of specific evidence, all that ought to be allowed is a conservative estimate. Mr Lok's reports costs modification to a standard house of $5, 955 for ensuite modifications and $3, 350 for accessible paths, a total of $9, 305.[55]

[116] I consider that $10,000 ought to be allowed for future home modifications, being a sum in my view sufficient to cover providing proper access paths, and grab rails in the toilet and shower.

Future Medical Expenses

[117] Mr Allen's evidence is that he sees his general practitioner fortnightly, his psychologist weekly, and his psychiatrist every three weeks. Despite extensive assistance, it is apparent he has not improved. In her report of 17 June 2019, Dr Isailovic made the point that despite a good deal of psychiatric input and psychotherapy, Mr Allen had not improved and that consideration ought to be given

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53 Exhibit 1, page 426.
54 At [110].
55 Exhibit 1, page 964.

to different psychotherapy such as adjustment commitment therapy, given that Mr Allen did not respond well to Eye Movement Desensitisation and Reprocessing ("EMDR") and has already undertaken the classic cognitive behavioural therapy. Dr Isailovic commented that Mr Allen ought to be trialled on different psychotropic medications, given that his current medication (current in the sense that he has been on it since 2007) of Zoloft was not proving to be effective.

[118] As Dr Isailovic said:[56]

> "Psychiatric treatment could however make differences. There are a number of psychotropic medications, (as specified in RANZCP or the International APA guidelines) that Mr Allen did not even try. His low energy could be addressed by the use of SNRI or even dexamphetamine augmentation. His nightmares could be addressed by prazosin. A night time mirtazapine which is a potent anxiolytic antidepressant, in addition to venlafaxine is another effective combination for post-traumatic stress disorder. It is puzzling to understand why Mr Allen did not have a change of medication despite reported inefficacy. Given that he had pre-existing recurrent depression and his prognosis is guarded with respect to PTSD, he may require a form of antidepressant for long term, at least several years. The need for medication is usually assessed periodically but I anticipate for at least the next two years Mr Allen will require psychotropic medications as well as psychotherapy."

[119] In her later report of 20 October 2020, Dr Isailovic then commented on the great deal of psychotherapy Mr Allen had undertaken and said: [57]

> "It is difficult to justify the need for continuation of treatment that is proving to be ineffective. The role of a psychiatrist is also questionable, given Mr Allen has been taking the same medications that he was prescribed by his General Practitioner seven years previously and that his psychotherapy has been provided by his psychologist. He is instead taking testosterone, which may even be a cause of the reported mood swings and irritability. In my opinion, the monthly visits to psychologists should be sufficient to maintain the status quo."

[120] I accept Dr Isailovic's evidence of the need for a review of Mr Allen's treatment. In my view it is appropriate to allow $58 per week for psychologist appointments[58] and to allow that for 35 years (discount factor 876), that is the balance of Mr Allen's life. That is a sum of $50, 808.

[121] In my view the medical evidence does not support the need to see a psychiatrist every three weeks, however as Dr Isailovic has said, there is necessity for psychiatric review to alter medication and reconsider the psychotherapy being provided by the psychologist. This may occur occasionally, perhaps monthly, for the next two years and less frequently over the next several years. Therefore, I

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56 Exhibit 1, page 466.
57 Exhibit 1, page 488.
58 One appointment per month at $250 per appointment.

consider it appropriate to allow a global sum of $10,000 for future psychiatric treatment.

[122] In terms of general practitioner visits, given the anticipated need for future surgery and monitoring Mr Allen's condition, I consider it reasonable to allow a visit upon the general practitioner every few months. The planned surgeries ought not to occur for perhaps 15 years or more. Allowing an attendance at a general practitioner once every two months at a cost of $160 is an allowance of approximately $18.50 per week (160 x 6 ÷ 52). I consider this ought to be allowed for Mr Allen's life expectancy of 35 years (876), a sum of $16,206.

[123] The allowance for future medical expenses is therefore $77, 014. I do not consider it appropriate to discount this sum as it is a necessarily imprecise estimate of future medical expenses.

Future Medication

[124] Mr Allen's evidence that he spends $70 per week on medications ought to be allowed for the plaintiff's life expectancy of 35 years (876) however I consider there ought to be a discount of approximately 30% applied to that as there is a great deal of uncertainty as to the likely effect or efficacy of Mr Allen's medication regime. Further, as Dr Isailovic pointed out there needs to be some alteration in Mr Allen's medication regime as his present regime is not effective. I allow $43,000 for future medication.

Future Aids

[125] Mr Allen requires hearing aids and has obtained them and obtains benefit from them. Hearing aids cost $10,400 with a three-year warranty and after care service. The cost is $10,400 ÷ 3 is $66.66 per week.[59] If allowed for the plaintiff's lifetime, would quantify future hearing aid costs at $58,500. Whilst the aids themselves have a three-year warranty, and $10,400 represents the future cost, there is no guarantee that that cost will be maintained into the future. I consider it appropriate to allow $50,000 for future hearing aids.

[126] I further consider it appropriate to allow for orthotics which cost the plaintiff $600 every two years, which over his lifetime of 35 years discounted by 10% equates to a sum of $4,500.

[127] In respect of assistive technology equipment, both Mr Scalia and Ms Zeman recommend a number of items.[60] I will allow $5,500 in respect of assistive technology equipment.

[128] I therefore quantify future aids at $60,000.

Special Damages

[129] The parties have agreed special damages at $55,000 and interest at $900.

Past Gratuitous Assistance

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59 Exhibit 1, page 1016.

60 Exhibit 1, page 189-190; Exhibit 1, page 439-441.

[130] Section 59 of the *Civil Liability Act* 2003 (Qld) provides:

> **"59 Damages for gratuitous services provided to an injured person**
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> (1) Damages for gratuitous services provided to an injured person are not to be awarded unless—
>
> (a) the services are necessary; and
>
> (b) the need for the services arises solely out of the injury in relation to which damages are awarded; and
>
> (c) the services are provided, or are to be provided—
>
> (i) for at least 6 hours per week; and
>
> (ii) for at least 6 months.
>
> (2) Damages are not to be awarded for gratuitous services if gratuitous services of the same kind were being provided for the injured person before the breach of duty happened.
>
> (3) In assessing damages for gratuitous services, a court must take into account—
>
> (a) any offsetting benefit the service provider obtains through providing the services; and
>
> (b) periods for which the injured person has not required or is not likely to require the services because the injured person has been or is likely to be cared for in a hospital or other institution."

[131] In this case, the defendants accept that the threshold requirements required under s 59(1) are met. The parties agree that the appropriate rate for past care is $42 per hour. Two experienced occupational therapists have vastly differing opinions concerning Mr Allen's need for past and future care, however, both Mr Scalia and Ms Zeman accept that services were necessary for time frames which exceed the threshold in s 59(1)(c) of the *Civil Liability Act*.

[132] In order to obtain damages for past gratuitous services, it must be demonstrated not only that their services are necessary, and this has been demonstrated by the medical evidence and the opinions of both occupational therapists, but also that they have in fact been provided for at least 6 hours per week for 6 months. Both Mr Scalia and Ms Zeman have framed their assessments as a "needs" assessment rather than an assessment of what care was actually provided.

[133] I am conscious that Mr Scalia does, in his needs assessment, frame the hours as "assistance provided" within any particular period. Insofar as Mr Scalia's reports purport to be an assessment of actual care provided, that must necessarily be based upon information provided by Mr Allen. The unusual aspect in the present case is that the principle care provider to Mr Allen is Dr Kingston, herself an extremely experienced occupational therapist. I accept the evidence of both reporting

occupational therapists that Mr Allen's reasonable needs for assistance exceed the statutory threshold in s 59(1)(c). I generally prefer, where those assessments differ from the evidence of Dr Kingston, to accept Dr Kingston's evidence of estimates of care provided.

[134] However, as noted below Dr Kingston's evidence is imprecise and does include elements of childcare which is not compensable. Furthermore, on principle, what ought to be allowed is not the amount of care actually provided, but the amount of care which is shown to meet the "need of the plaintiff for services".[61] While evidence of caregivers is superior evidence of the care provided,[62] it is not necessarily superior evidence of the "need of the plaintiff" for services.

[135] The occupational therapists have assessed care in the following six periods.

Care Period 1: 6 January 2015 to 12 March 2015

[136] Full time care as an inpatient from 6 January 2015 to 12 March 2015. It is not appropriate to allow for damages for gratuitous services in this period pursuant to s 59(3)(b) of the Act, because Mr Allen was cared for in hospital.

Care Period 2: 13 March 2015 to 8 May 2015

[137] Following discharge, Mr Scalia assessed a need for care for 25 hours per week and Ms Zeman assessed a need for care of 24.63 hours per week.[63] In this period, Dr Kingston assessed the amount of care that she provided at 4 to 5 hours per day,[64] however, Dr Kingston could not give an itemised breakdown of the periods of time she spent[65] and in respect of one of the tasks that Dr Kingston included in her estimates of time was 15-30 minutes per day caring for her children.[66] As Dr Kingston's evidence was imprecise and her care estimate of 5 hours a day included caring for her children, in this period I prefer the evidence of Mr Scalia and Ms Zeman as more accurately reflecting Mr Allen's need for services.

[138] In respect of care period two, I note that Mr Scalia and Ms Zeman's estimates are very similar, and I consider it appropriate to allow 25 hours per week in care period two. That sum is 25 hours x $42/h for 8 weeks, a sum of $8,400.

Care Period 3: 9 May 2015 to 6 June 2016

[139] The third care period is from 9 May 2015 to 6 June 2016, a period of 56 weeks. In this period Mr Allen progressed from using a wheelchair and two crutches around his home, resumed full weight bearing and was able to rely on a single crutch or walking stick. Mr Allen was not able to drive. A concise definition of this period's assistance is contained in Exhibit 1.[67]

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61 *CSR Limited v Eddy* (2005) 226 CLR 1 at 14-16.
62 *McAndrew v AAI Limited* [2013] QSC 290 at [119].
63 Exhibit 1, page 437; Estimate is reduced as time is allotted for childcare.
64 T3-84.
65 T3-93.
66 T3-92.
67 Exhibit 1, page 370.

[140] Mr Scalia's assessment was of care at 22[68] hours per week during this period and Ms Zeman's estimate of care as 15.88[69] hours per week. In this period, Dr Kingston estimated the care that she provided at 4 to 5 hours per day,[70] however I do not accept that as a proper assessment as it has the same difficulties identified above[71] and if provided it exceeded what is "needed" as assessed by Mr Scalia and Ms Zeman.

[141] I prefer Mr Scalia's assessment with the exception of the prompting for self-care at 3 hours per week (which I do not considered to be a necessary care need), and accordingly in this period I consider it reasonable to allow 19 hours per week. The allowance in this period therefore is 19 hours per week at $42/h, a sum of $798 per week for 56 weeks is a sum of $44,688.

Care Period 4: 7 June 2016 to 7 October 2018

[142] Care period 4 spans the 122 weeks from 7 June 2016 to 7 October 2018. In this period, Mr Scalia assessed the assistance at 14 hours per week,[72] achieved by reducing his estimate from care period 3 of 22 hours per week by 5 hours per week for transportation, two hours per week for meal preparation and one hour per week for domestic cleaning. In this period, Ms Zeman estimated the care at 9.375 hours per week.[73] In this period, Dr Kingston estimated her care at 1.5 to 2 hours per day[74]. Although Dr Kingston's assessment accords with Mr Scalia's assessment, Dr Kingston's assessment includes an amount of care for their children, which is not recoverable pursuant to the principles in *CSR Limited v Eddy* (2005) 226 CLR 1. An example is provided in Dr Kingston's evidence in respect of the children's lunches, taking 15 to 30 minutes per day.[75]

[143] In this period I consider that the conservative or lower end of Dr Kingston's estimate of 10.5 hours per week is a reasonable estimate and accordingly I allow 10.5 hours per week at $42 per hour, a sum of $440 per week for 122 weeks, a sum of $53,802.

Care Period 5: 8 October 2018 to 5 November 2018

[144] Mr Allen was an inpatient at Buderim Private Hospital for a period of 4 weeks to achieve the difficult goal of opiate withdrawal. Accordingly, pursuant to s 59(3) of the Act I will not allow domestic gratuitous assistance for that period.

Care Period 6: 6 November 2018 to present

[145] In my view, care ought to be allowed at one hour per day, seven hours per week for the reason the care is essentially the same as provided in period 4, but reflecting that Mr Allen had improved[76] in this period and, from 20 November 2019, benefited from living in an appropriate unit. An allowance of seven hours per week at $42 per

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68 Exhibit 1, page 188.
69 Exhibit 1, page 437; Estimate is reduced as time is allotted for childcare.
70 T3-84.
71 At [137].
72 Exhibit 1, page 188.
73 Exhibit 1, page 438.
74 T3-84.
75 T3-92.
76 T2-68.

hour in the period of 123 weeks between 6 November 2018 to present quantifies an allowance of $36, 162 in this period.

[146] The total amount of past care is therefore $143, 052.

Future Care

[147] The parties agree that future care ought to be allowed in respect of any paid or gratuitous care at $46 per hour. Mr Scalia has estimated Mr Allen's needs for care at 17 hours per week[77] and Ms Zeman has assessed an ongoing need of 1.25 hours per week in a unit[78] or 3.25 hours per week if Mr Allen relocates to a single level home.[79] As discussed above, I prefer Dr Kingston's evidence at the conservative end of about one hour per day, seven hours per week at $46/h a sum of $322 per week.

[148] The defendants argue for a discount of 20% off the calculated sum for all contingencies. The plaintiff argues there ought to be no discount because the assessed periods do not allow for the additional care provided after the future proposed surgeries. As discussed above, the future proposed surgeries are quite some time in the distance and would be likely to involve only a little amount of additional care for a confined period of time. Furthermore, the significant psychiatric assistance, psychological assistance, psychotropic medications (properly managed) and the cessation of this litigation ought to in the longer term provide Mr Allen with significant improvement in his predominant psychological symptoms.

[149] Mr Allen admits that his investment in this litigation has been a "great focus" for him.[80] Mr Allen terminated the services of his CTP appointed case manager Ms Jones and sought to manage his own rehabilitation by making over 400 claims for rehabilitation expenses,[81] Exhibit 13 is a sample of 20 such claims. Mr Allen made "lots of" complaints to the Motor Accident Insurance Commission (MAIC) about RACQ and had a MAIC complaint active at the time of the trial. Mr Allen has made more than 70 complaints to RACQ[82] and would write "daily emails, letters, and complaints".[83] Mr Allen has called the head of RACQ and "gave it to him in spades" to "soften the insurer" up.[84] Mr Allen has rejected an offer from RACQ of an advance payment of $100, 000 to help with rehabilitation and has also rejected an RACQ's offer to pay for all his pharmaceuticals.[85] I accept Dr Bradshaw's opinion that Mr Allen dealings with the insurer "add to [his] level of psychological distress."[86]

[150] Accordingly, with the conclusion of this litigation I would expect that Mr Allen's mental health will improve considerably in the future. Currently it is plain that

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77 Exhibit 1, page 216.
78 Exhibit 1, page 439.
79 Exhibit 1, page 439.
80 T3–4; T3-44 to T3-45.
81 T2-65.
82 T2-70.
83 T2-71.
84 T3-19.
85 Exhibit 16; Exhibit 17; T3-20; T3-24.
86 Exhibit 1, page 1000.

Mr Allen suffers from very poor mental health and has developed a fixation upon this litigation.

[151] As I expect some time in the future for there to be improvement in Mr Allen's mental health, I consider it appropriate to discount the future care award by 20%.

[152] In respect of future care, I allow seven hours per week at $46/h, a sum of $322 per week for 35 years (discount factor 875.6) less 20%, a sum of $225, 554.

Wilson v McLeay Damages

[153] Mr Allen claims a global sum of $5, 000 for *Wilson v McLeay*[87] damages on the basis that Dr Kingston "spent a considerable period of time with him during his time in hospital."[88] However, there is no evidence to support the conclusion that those visits by Dr Kingston were necessary to alleviate Mr Allen's condition. Rather, I conclude that those visits were prompted by extreme worry, stress, and "love and affection" and accordingly non-compensable.[89]

Damages Summary

[154] I summarise the awards of Mr Allen's damages as follows:

General damages	$109, 640.00
Past economic loss	$515, 957.20
Interest on past economic loss	$17, 245.69
Past loss of superannuation	$57, 025.39
Future economic loss	$959,040.00
Future loss of superannuation	$108, 659.23
Alternative accommodation	$45, 682.00
Interest on alternative accommodation	$330.18
Future rental expenses	$18,200.00
Future home modifications	$10,000.00
Future medical expenses	$77,014.00
Future surgery	$53, 100.00
Future medications	$43,000.00
Future aids	$60,000.00
Special Damages	$55,000.00
Interest	$900.00
Past care	$143,052.00
Future Care	$225, 554.00
TOTAL	**$2, 499, 399.69**

87 (1961) 106 CLR 523.
88 Exhibit 25, paragraph 159-160.
89 *McAndrew v AAI Limited* [2013] QSC 290 at [130]-[135].