SUPREME COURT OF QUEENSLAND

CITATION:	*Speziali v Nortask Pty Ltd and anor* [2023] QSC 166
PARTIES:	**STEVEN SPEZIALI** (plaintiff) **v** **NORTASK PTY LTD** (first defendant) and **DALBY BIO-REFINERY LIMITED** (second defendant)
FILE NO:	BS1557/21
DIVISION:	Trial Division
PROCEEDING:	Claim
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	1 August 2023
DELIVERED AT:	Brisbane
HEARING DATE:	6 – 8 March 2023
JUDGE:	Hindman J
ORDER:	**1. Judgment for the plaintiff against the first defendant in the sum of the sum of $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55].** **2. Judgment for the plaintiff against the second defendant in the sum of $1,341,573.00 (comprising $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55] plus $442,319.00 on account of past and future care).** **3. The aforementioned damages of $899,254.00 are apportioned between the defendants as 25% to Nortask, 75% to DBRL.** **4. The parties provide either an agreed proposed costs order or written submissions on costs within 14 days.**
CATCHWORDS:	NEGLIGENCE – CONTRIBUTORY NEGLIGENCE – SAFE SYSTEM OF WORK – BREACH OF DUTY – BREACH OF STATUTORY DUTY – BREACH OF CONTRACT – DAMAGES – CONTRIBUTORY NEGLIGENCE – where plaintiff slipped and fell from a ladder onto concrete slab – whether risk of injury foreseeable –

whether the defendants owed duty of care to provide a safe system of work – whether the plaintiff failed to keep a proper lookout so as to avoid injury – whether damages can be reduced for contributory negligence – where defendants failed to provide a safe system of work – whether plaintiff contributed to injuries

TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – DUTY OF CARE – EMPLOYER AND EMPLOYEE – where plaintiff suffered personal injury when carrying out duties – where plaintiff brings proceedings against defendants – where risk of injury was foreseeable – where risk of injury was not insignificant – where a reasonable person would have taken precautions against the risk of injury – whether the defendants breached duty to take all reasonable steps to avoid exposing plaintiff to a foreseeable risk of injury

TORTS – NEGLIGENCE – DAMAGE AND CAUSATION – CAUSATION – whether the plaintiff's injury was the result of a breach of a duty of care by employer – whether the access system by way of a ladder was compliant with Australian Standards

TORTS – NEGLIGENCE – CONTRIBUTORY NEGLIGENCE – GENERALLY – where plaintiff suffered personal injury when carrying out a task – whether plaintiff failed to take precautions against the risk of injury – whether there ought to be a finding of contributory negligence

DAMAGES – MEASURE OF DAMAGES – ASSESSMENT OF DAMAGES IN TORT - PERSONAL INJURY – where plaintiff slipped on ladder –what measure of damages for general damages

DAMAGES – MEASURE OF DAMAGES – PAIN AND SUFFERING – QUANTUM – LOSS OF EARNING CAPACITY – whether plaintiff continues to suffer problems as a result of the accident – whether there is a loss of earning capacity

NEGLIGENCE – CONTRIBUTORY NEGLIGENCE – whether plaintiff failed to take extra precautions given the conditions

DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES – PERSONAL INJURIES – LOSS OF EARNINGS AND EARNING CAPACITY – PARTICULAR CIRCUMSTANCES – whether plaintiff has proven economic loss to the requisite standard

	Law Reform Act 1995 (Qld)
	Bankstown Foundry v Braistina [1986] 160 CLR 301; 65 ALR 1 *Bell v Mastermyne Pty Ltd* [2008] QSC 331 *Hill v Richards* [2011] NSWCA 291 *Reddock v ST&T Pty Ltd and anor* [2022] QSC 293 *Roads and Traffic Authority (NSW) v Dederer* (2007) 234 CLR 330 *Wyong Shire Council v Shirt* (1980) 146 CLR 40
COUNSEL:	PJ Woods and G Hampson for the plaintiff RM Treston KC and S McNeil for the first defendant GC O'Driscoll for the second defendant
SOLICITORS:	LHD Lawyers for the plaintiff Hede Byrne & Hall Lawyers for the first defendant McCabes Lawyers for the second defendant

Introduction

[1] Steven Speziali (**the plaintiff/Mr Speziali**) claims damages for injuries suffered by him in an accident on 15 June 2017 that occurred during the course of his employment with the first defendant (**Nortask**). Nortask carries on the business of civil construction and engineering (including steel fabrication), servicing the mining, gas and energy sectors. On the day of the accident, Nortask was carrying out repair works, including to the metal flooring of a 14.5m cyclone structure at the premises of the second defendant (**DBRL**).

[2] Mr Speziali suffered significant injuries when he slipped from a ladder used to access the site of the repair works, falling approximately 10 metres onto a concrete slab at ground level.

[3] The liability in negligence of Nortask to Mr Speziali is admitted. In issue in respect of liability are:

(a) the liability in negligence of DBRL to Mr Speziali;

(b) contributory negligence of Mr Speziali as asserted by DBRL;

(c) apportionment and contribution as between Nortask and DBRL.

[4] The parties are agreed as to the proper quantum of Mr Speziali's claim, bar the quantum of his claim for past and future care (which the parties agree is only recoverable against DBRL).

[5] I find that:

(a) DBRL was negligent;

(b) Mr Speziali was not contributorily negligent;

(c) Mr Speziali is entitled to judgment against Nortask for damages for negligence in the sum of $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55];

(d) Mr Speziali is entitled to judgment against DBRL for damages for negligence in the sum of $1,203,193.00 (comprising $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55] plus $303,939.00 on account of past and future care);

(e) The aforementioned damages of $899,254.00 are apportioned between the defendants as 25% to Nortask, 75% to DBRL.

The circumstances in which the plaintiff's injury was sustained

The Cyclone

[6] One of the pieces of plant at DBRL's premises was a dryer, constructed by Dedert Corporation in November 2015. Part of the dryer plant included a silo, referred to as the cyclone (**Cyclone**).[1] The Cyclone was a conical device used to separate material with different densities. It stood at approximately 14.5 metres tall.

[7] At the top of the Cyclone was a top platform. The top platform was accessible from the ground via a series of three ladders and two intermediary platforms, specifically the low and mid platforms.[2] The ladders were between the ground level and the low platform, the low platform and the mid platform, and the mid platform and the top platform.

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1 A picture of same is exhibit 2.

2 See photographs at figures 19 and 20 of Intersafe Report of 6 October 2020 at page 17 (exhibit 19).

Nortask quoting for repairs to the top platform of the Cyclone

[8] Nortask was familiar in carrying out various jobs at DBRL's premises having been there numerous times.[3] Mr Speziali had performed site specific inductions for DBRL, the most recent one prior to the accident being on 13 April 2017.[4]

[9] Prior to carrying out any kind of work at DBRL's premises for DBRL, Nortask was required to complete a Job Safety and Environmental Analysis (**JSEA**) setting out the description of the task to be carried out at the premises, specific job requirements, personal protective equipment worksite requirements, and identifying various health and safety hazards and risk control measures.

[10] The completed JSEA was required to be provided to DBRL who then approved the contents of the JSEA before Nortask was permitted to commence work on DBRL's premises. Nortask usually sent the JSEA to DBRL by email, and then took a hard copy of the document to DBRL's premises.

[11] As part of the approval process for works to be carried out at DBRL's premises, DBRL would issue Nortask with a work permit (**Work Permit**). The Work Permit specifically referred to the relevant JSEA. The issuing of a Work Permit authorised Nortask to undertake the work activities described in the approved JSEA. The Work Permit contained a section titled "Additional Risk Controls Required", that stated:

> "…controls are in addition to any workplace controls identified in an approved JSEA for the task. The controls must relate to the operational hazards from the task and any other ongoing activity or site conditions that may impact on the task."[5]

[12] At some point prior to 7 June 2017, DBRL asked Nortask to provide a quote to carry out repair works required at the top platform of the Cyclone following a fire.

[13] In order to prepare the quote, Mr Speziali attended DBRL's premises and accessed the top platform of the Cyclone via the access system described in [7] above.[6]

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3 T1-28, L33; the plaintiff said he had been to DBRL's premises between dozens and a hundred times.
4 Exhibit 12; T1-68, L12.
5 Exhibit 14; see for example Work Permit 10360 dated 14 and 15 June 2017.
6 T1-69, L27.

[14] A quote dated 7 June 2017[7] was prepared and provided by Nortask to DBRL. The quote stated as follows:

> "Please find attached our quotation below:
>
> - To supply 55T Crane, Man Box,[8] Rigger & Fitters to remove Damaged doors at dryer air ducting and take doors to Nortask workshop for Inspection & Report (inclusive of Report). Remove and lower to ground 2 only Grid Mesh Panels damaged by fire (for DBRL for Repairs by DBRL).
> - To Supply 55T Crane, Man Box, Rigger & Fitters to Reinstall repaired doors at DBRL Dryer ducting and Install 2 Grid Mesh Panels following repairs (by DBRL).
> - Please note: Not including any repairs that maybe needed at ducting door opening "Flanges" following doors repairs & installation.
>
> Total $6,394.00
>
> Above price are GST exclusive."

[15] The quote was accepted by DBRL.

Removal of the damaged plant

[16] On 8 June 2017, Mr Speziali completed a JSEA for the first part of the quoted job (**8 June JSEA**), being the removal of damaged doors and floor grating, that was identified in the 8 June JSEA as follows: "Remove fire damaged doors and floor grating from cyclone unit".[9] The relevant floor grating formed part of the top platform floor.

[17] The 8 June JSEA noted the potential health and safety hazards as including "fall from heights".[10] Risk control measures were identified as "fall arrestors – harnesses and lanyards";[11] hazard control measures were identified as "Wear harness and lanyard when working at heights".[12]

[18] On the fourth page of the 8 June JSEA the elements of the task were identified as:

(a) 1 - Mobilise to site

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7 Exhibit 7.
8 Also referred to as a man basket. A picture of same is exhibit 1.
9 Exhibit 8.
10 On pages 3 and 4.
11 On page 3.
12 On page 4 relating to elements 3 and 4 in the paragraph following which identified a risk of fall from heights.

(b) 2 - Set up crane

(c) 3 - Remove cyclone doors

(d) 4 - Remove floor grating

(e) 5 - Pack up crane

(f) 6 - De-mobilise from site.

[19] In the task description in the 8 June JSEA, there was no reference to the activity of ascending or descending the ladders to the Cyclone.

[20] The 8 June JSEA was provided to DBRL and it was approved by Steven Hirst on 8 June 2017, as evidenced by the issue of the Work Permit number 10329 (**8 June Work Permit**) to Nortask in respect of "removing doors and floor grating at top of main cyclone".[13]

[21] Mr Speziali, and Messrs Bruce and Finlay of Nortask attended DBRL's premises on 8 June 2017, arriving and signing in on the contractors sign in sheet at 7:10am.[14]

[22] Subsequently, they commenced the removal of the fire damaged doors and floor grating on the top platform of the Cyclone. Mr Bruce was the crane driver. Messrs, Speziali and Finlay accessed the top platform via the ladders and carried out the work removing the damaged floor grates. The grates were taken to the ground via the man box that was attached to the crane.

[23] As mentioned, Messrs Speziali and Finlay used the ladders to access the top platform. Although they did not wear harnesses while using the ladders, they did wear harnesses while on the top platform. It is worth noting that they were removing part of the top platform's flooring which created a fall risk. The harnesses were attached to the guardrail around top platform (albeit not a certified anchor point and not rated for fall arrest equipment[15]) by way of lanyard.

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13 Exhibit 9.
14 Exhibit 4.
15 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [14] (page 26).

[24] At no time before or during the plaintiff's attendance at DBRL's premises on 8 June 2017 (or 7 June 2017 for that matter) was he told by DBRL not to use the ladders, that he had to use a harness and lanyard on the ladders or that he was to use the man box lifted by crane to ascend to and descend from the top platform.[16]

[25] The task of removing the fire damaged doors and floor grating from the top platform was completed on 8 June 2017. After floor grates had been removed, a barricade was installed around the bottom of the ladders at ground level. There were witches' hats and red and white tape put up by DBRL at ground level.[17] Plainly, the implementation of those measures aimed to prevent persons using the Cyclone access system, in circumstances where part of the floor of the top platform had been removed by Nortask.

[26] On 9 June 2017, following the removal of the doors and floor grating the previous day, the Health, Safety and Environment Manager of DBRL sent an email to "all staff" of DBRL in respect of "Access to Dryer Cyclone Platform", which email stated:[18]

> "All,
>
> Maintenance team and Nortask have removed platform grids at the top of the cyclone vent doors.
>
> Access ladder cage entry point to this area has been barricaded with RED/WHITE tape and chain/lock to prevent any unauthorised entry.
>
> An information tag has been placed too.
>
> **Please be informed that this area is "Entry By Permit Only".**
>
> Thanks".

Other works being carried out about the Cyclone around the same time

[27] On 12, 13, 14 and 15 June 2017, personnel from a business called Contract Resources (denoted by the initials "CR") signed in and out of DBRL's premises (in the contractors sign in sheets) on the following days, and for the following periods of time:[19]

(a) on 12 June 2017 at 10:45am, Dean Langworthy, Adrian Peters and Todd Williams signed in, and then signed out at 5:52pm;

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16 T1-73, LL31-34.
17 T1-72, LL43, 44.
18 Exhibit 3.
19 Exhibit 4.

(b) on 13 June 2017 at 6am, Dean Langworthy, Todd Williams and Adrian Peters signed in, and signed out at 6pm;

(c) on 14 June 2017 at 6am, Dean Langworthy, Todd Williams and Adrian Peters signed in, and signed out at 5:47pm;

(d) on 15 June 2017 at 6am, Dean Langworthy, Todd Williams and Adrian Peters signed in, and signed out at 1:30pm.

[28] The works that Contact Resources was attending to perform were certain cleaning works utilising high pressure water cleaning equipment. At least some of the works appear to have been carried out in the general vicinity of the Cyclone.[20]

[29] Further, on 14 June 2017 Renier Opperman, an employee of DBRL, completed a Job Safety and Environmental Analysis (JSEA)/Safe Work Method Statement (SWMS) (**DBRL's 14 June JSEA**) in respect of the work activity of "open/close inspection covers at dryer for inspection main Fan WO#22278". The work location/area where the work was to be undertaken was identified as "Dryer".[21]

[30] Whilst the front page of the document is dated 14 June 2017, it appears to cover work activities also carried out on 15 June 2017, which is consistent with the Work Permit 10360 issued on those same dates. The document at part 2 on page 3[22] identified Renier Opperman and Wolfgang Warzecha as mechanical fitters employed by DBRL. They each signed this document on 14 and 15 June 2017.

[31] Part 3 of the document provides for "Hazard Analysis, Control and Legislation Worksheet". The steps in Part 3 appear to relate to work carried out on the Cyclone. Nowhere in DBRL's JSEA is the use of ladders to reach the top platform of the Cyclone identified, but a potential hazard is identified being "heights" and the hazard control measure is identified as "use work platform". That must logically be a reference to the top platform.

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20 Exhibit 14.
21 Exhibit 13.
22 Exhibit 13.

[32] There is also no reference in DBRL's 14 June JSEA to accessing the top platform using Nortask's (or any) crane. Nor is there any reference to acting under the direction of Nortask when working in the area on 15 June 2017.

[33] Further, also on 14 and 15 June 2017, DBRL issued (to its own employees) Work Permit 10360 (which bear the same dates).[23] This document (and the JSEA of the same dates) was required by Messrs Warzecha and Opperman to carry out the work on the top platform of the Cyclone to remove a spray bar.

[34] In the "Additional Risk Controls Required" section there is no reference to (1) using the ladders to access the Cyclone, (2) using a harness and lanyard to ascend and descend the ladders or (3) using a crane or some alternate means to access the top platform. The following is however noted:

> "…be cautious of hydro cleaning in the area.
> Floor has been reinstalled at main cyclone.
> Area around crane and drop zone to be barricaded."[24]

[35] The reference to the hydro cleaning in the area was a reference to the work being carried out by Contract Resources, who attended DBRL's premises on each of 12, 13, 14 and 15 June 2017. In that respect, the plaintiff recalled seeing high pressure water cleaning carried out "several times" at DBRL's premises in the days prior to the accident. He recalled seeing "vapour in the air".[25]

Reinstallation of repaired plant by Nortask

[36] In his evidence, Mr Warzecha referred to the presence of Contract Resources on site on 15 June 2017. He had noted that the ground conditions were fairly muddy due to the cleaning of the dryer, which was mainly from the high-pressure water cleaning being carried out by Contract Resources.[26]

[37] On 15 June 2017, Mr Speziali prepared a JSEA for the work to be carried out as quoted in reinstalling the floor grating to the top platform (**the 15 June JSEA**). The 15 June 2017 JSEA described the task description as "reinstall floor grating to cyclone access

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23 Exhibit 14.
24 Exhibit 14.
25 T1-80, L23.
26 Exhibit 39, page 2; T3-14, L27.

platform". The relevant personnel were identified as Mr Speziali (rigger/dogger), Hermes Speziali (crane operator), Trent Finlay (fitter) and Rodney Foley (fitter). Personal protective equipment required was identified as safety glasses, head protection, foot protection, high-viz clothing and safety harness.

[38] The potential health and safety hazards were identified as "fall from heights" and risk control measures were noted as "fall arresters – harnesses and lanyards".

[39] The task description, potential safety and environmental hazards and hazard control measures were identified in the methodology and were the same as were provided for in the 8 June JSEA.

[40] Like previously, Mr Speziali used the ladders to access the top platform of the Cyclone. He did not wear a harness whilst using the ladders, but did wear a harness whilst on the top platform. Again, the harness was attached to the guardrail around top platform (albeit not a certified anchor point and not rated for fall arrest equipment[27]) by way of lanyard.

[41] At about 9.30am, after reinstalling the repaired plant (which had been carried to the top platform via the man box using the crane), the plaintiff commenced his descent from the top platform via the top ladder.

[42] The accident occurred as Mr Speziali was descending the top ladder between the top platform and the mid platform.

Relevant data about the access system to the Cyclone

[43] The vertical distance of the top ladder, from the mid platform to the top platform measured 5,695mm and featured 20 rungs.[28] The rungs were spaced between 275mm and 290mm, had a width of 400mm and a rung diameter of 20mm. The dimensions of the stiles (the vertical component of the ladder) were 11mm x 65mm. The rungs and stiles were made of hot-dipped galvanised steel. There was no treatment or coating to improve the slip resistance of the rungs and stiles.[29]

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27 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [14] (page 26).

28 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [2(a)(i)-(ii)] (page 18).

29 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [2(d)] (page 18). See also figure 21 (page 18).

[44] The mid platform had a guardrail that extended around the mid platform. The height of the guardrail was 1,010mm from the mid platform[30] (with a further mid guardrail at about half that height and a lip a platform level). The distance from the mid platform to the ground below was 8.8m.[31]

[45] At the time of the accident, the top ladder was partially enclosed by a steel cage. The steel cage was welded onto the stiles on the ladder.[32] The cage was 720mm in width, and 745mm in depth.

[46] The steel cage only partially enclosed the top ladder, as it stopped at a distance of 2,090mm above the mid platform floor.[33] This resulted in a gap between the bottom of the steel cage and the guardrail of the mid platform. This, and the features mentioned in the preceding three paragraphs, can be seen in the photographs in exhibit 15.

[47] The horizontal distance between the ladder rungs and the rear[34] guardrail of the mid platform was 890mm.[35]

[48] The distance to the closest side[36] guardrail measured laterally from the outside of the closest ladder stile was 410mm.[37]

[49] There were no certified anchor points on the platforms or on the ladders for use of lanyards and harnesses when using the platforms or ladders.[38]

The access system was non-compliant

[50] Relevantly, the access system was non-compliant with the relevant Australian Standard AS1657 (**AS**) in that:

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30 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [4(b)] (page 18). See also figure 22 (page 19).

31 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [4(b)] (page 18). See also figure 22 on page 19.

32 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [8] (page 22).

33 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [2(a)(v)] (page 18).

34 As a person is facing the ladder.

35 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [4(c)] (page 19). See also figure 22 (page 19).

36 As a person is facing the ladder.

37 Exhibit 19; Intersafe report of 6 October 2020, section 7.4 at page 40 (numbered paragraph 3).

38 Exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [13-14] (pages 25-26).

(a) the horizontal distance between the top ladder and the rear guardrail of the mid platform was 890mm rather than 900mm;

(b) the distance between the top ladder and the side guardrail of the mid platform was 410mm rather than 500mm.

[51] DBRL suggests that the evidence is more consistent with Mr Speziali having fallen over the rear guardrail of the mid platform (because of where he landed and because he hit a conveyor during the fall – see DBRL's written primary submissions at [40]) and there is no evidence that the marginal shortfall in distance (10mm) to the rear guardrail would have been causative of the fall to the ground.

[52] I do not accept DBRL's analysis. It treats the AS non-compliances as being in a two-dimensional space rather than a three-dimensional space. Both non-compliances mentioned, in combination, are likely to have contributed to the circumstances of Mr Speziali hitting the top of the mid platform guardrails (likely rear and side) and tumbling over the edge of same, rather than tumbling onto the mid platform, when he slipped from the top ladder.

The accident

[53] Mr Speziali described the accident having occurred as follows:

(a) at about 8.35am on 15 June 2017, when arriving at DBRL's premises, Mr Speziali noted the ground conditions were very boggy, describing the condition as 'puggy' where the black soil was like a sponge. When the soil became wet, it turned into a clay-like substance, sticking to everything.

(b) to set up the crane securely, Nortask had to use four stabilisers made of dunnage, which are large hardwood sleeper planks. These stabilisers were essential to prevent the crane's legs from sinking into the soft ground.

(c) the entire site was muddy and filled with water, even the concrete platform had puddles. Mr Speziali assumed the water was dew since there had been no recent rainfall in the area.

(d) the access system to the Cyclone was constructed of hot-dipped galvanized steel, resulting in a very smooth surface. This made the ladders extremely slippery due

to the water. Despite the slippery conditions, Mr Speziali climbed the ladders with caution to reach the top of the Cyclone and perform the required tasks.

(e) once at the top platform, Mr Speziali retrieved harnesses and lanyards from the man box and put same on, and then completed the job by putting in bolts and arranging the floor grating sections. Mr Finlay was assisting him throughout the process.

(f) after finishing the installation, the crane disconnected from the man box to put up the sling (a further job the crane was undertaking for DBRL whilst the crane was on site). Mr Speziali removed his harness and climbed down the ladders to retrieve some tools from the utility vehicle below. He returned back up the ladders and completed the job.

(g) when descending the ladders, he followed the industry standard of maintaining three points of contact. As Mr Speziali was approximately a third of the way down the top ladder, he placed a foot on a rung (he was unable to recall which foot), suddenly his foot slipped, causing him to lose balance and tumble downward, hitting various parts of the ladder and tower before eventually landing on the concrete below. Mr Speziali recalled flashes of hitting the inside of the top ladder cage, his back hitting the mid platform guardrail, his legs then hitting the conveyor tower, before landing on the concrete. The next thing he recalled was waking up winded with people around him.

Credit findings

Mr Speziali

[54] Mr Speziali impressed me as having a clear recollection of the accident (at least prior to the fall), and of giving his evidence in an unembellished and unbiased manner, directly and without fear or favour. I find that Mr Speziali is an honest and reliable witness. I generally accept his evidence.

Ms Speziali

[55] Ms Speziali's evidence was only relevant to quantum issues. I consider that she also gave her evidence in an unembellished and unbiased manner. I find that Ms Speziali is an honest and reliable witness. I generally accept her evidence.

Key findings

[56] I accept that the accident occurred as generally described by Mr Speziali. Mr Speziali was descending the top ladder in an orthodox and careful manner having regard to the prevailing conditions (including the ladder and surrounds being wet, and possibly muddy) when he lost his footing and fell in an uncontrolled way. Rather than landing on the mid platform, he tumbled over the mid platform guardrails to the ground below.

[57] There was nothing unreasonable in the ladders being used by Mr Speziali as his method of access to the top platform. That was the obvious access provided. There was no indication that the ladders were not suitable for use in any particular weather conditions. There was no indication that the use of the ladders required some fall arrest system to be used. Insofar as the JSEA referred to the use of harnesses and lanyards whilst working at heights, that was properly a reference to working on the top platform (in the particular circumstances where the works included part of the top platform floor being removed and reinstalled). DBRL allowed its own staff access to the ladders including on the day of the accident, without the use of any fall arrest system on the ladders. That seems to have been the case in respect of the top platform as well.

[58] There was no compelling or obvious reason for the man box to be used in lieu of the ladders for access by persons to or from the top platform. The purpose of the man box was to move plant and equipment unsuitable to be moved via the access system.

[59] The key failure of the access system was the unacceptably large gap between the bottom of the steel cage around the top ladder and the top guardrails of the mid platform which permitted the circumstance that a person slipping from the top ladder may go over the top of the mid platform guardrails, thereafter falling more than 8.8m metres onto concrete below. That gap made the access system non-compliant with the relevant AS as set out above although that of itself does not necessarily determine whether negligence exists or not.

[60] Because of that failure, it is unnecessary to determine if the slipperiness of the rungs of the ladder by themselves constitute negligence of DBRL. If the rungs were not so slippery, the accident may or may not have occurred. However even a misstep on the top ladder in dry conditions may have had the same outcome of a fall to ground level.

[61] It was not unreasonable for DBRL (or Nortask for that matter) to have permitted use of the access system in wet conditions. There is no cogent evidence that use of the ladders in wet conditions ought to have been prohibited. It may have been sensible to have a sign at ground level warning that the ladders would be slippery when wet, but that here is unlikely to have made any difference. Mr Speziali was aware that the rungs of the ladders were wet and he was taking extra care accordingly. Thus to my mind, it does not matter in this case if the ladders were wet because of the cleaning works of Contract Resources or for some other reason (like dew).

[62] I do not consider that any negligence rests with DBRL for failing to supervise the use of the ladders. Nortask was a competent contractor. It could be assumed its staff could safely use the access system provided.

[63] Identification and rectification of the non-compliant gap between the top ladder steel cage and the mid platform guardrails were the responsibility of DBRL as occupier of the premises. It should not have permitted use of the top ladder (without a fall arrest system) whilst that non-compliance existed. The risks of serious injury associated with that non-compliance was readily foreseeable. The rectification works required to rectify the non-compliance were not onerous.

[64] It is no answer to that for DBRL to say that it had a reputable international contractor build the Cyclone and its access system back in about 2015. The evidence about that construction is scant. There is no evidence that DBRL took any steps since that time to identify and rectify any non-compliances in the construction (see [17(j)] of the statement of claim). It should have for the reasons identified in the preceding paragraph. It was not a matter that could simply be left by DBRL to others who might attend DBRL's premises to determine whether the access system was compliant with relevant AS and otherwise safe to use.

Based on the facts as found, is negligence by DBRL established

Breach of duty of care

[65] *Wyong Shire Council v Shirt*[39] per Mason J at 47-48 and *Roads and Traffic Authority (NSW) v Dederer*[40] set out basic and settled matters of legal principle with regards to negligence that are not necessary to repeat here.

[66] I find:

(a) The risk that a person descending the top ladder may slip from the ladder and fall within the steel cage towards the mid platform was foreseeable. That was particularly so where:

(i) the ladder did not contain any ready mechanism for the attachment of a fall arrest harness for use on the ladder,

(ii) there was no warning at ground level that the top ladder should only be accessed with the use of a fall arrest harness,

(iii) there was a steel cage around the ladder and guardrails on the platforms which suggested on a visual inspection that the access system had been designed and built with fall risks in mind;

(iv) there was no anti-slip coating on the ladder rungs;

(v) the ladder rungs would be slippery when wet,

(b) The risk that if a person did so slip from the top ladder, that they may at the end of the steel cage tumble over the mid platform guardrails to the ground below was also foreseeable;

(c) The above risk of injury was not insignificant. The distance from the mid platform to the ground was significant, and the ground surface was concrete;

(d) A reasonable person in the position of DBRL would have:

(i) identified the non-compliance of the access system with the relevant AS;

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39 (1980) 146 CLR 40.

40 (2007) 234 CLR 330 at 337-338 [18]-[19] and at 345 [43]-[44] per Gummow J, with whom Callinan J (at [270]) and Heydon J (at [283]) agreed.

(ii) identified the risk that a person falling from the top ladder may fall through the gap between the bottom of the steel cage for the top ladder and the mid platform guardrails;

(iii) thereafter closed the gap between the bottom of the steel cage for the top ladder and the mid platform guardrails so that a person could not go over the guardrails and thereafter fall to the ground,

(e) If such precautions were not taken, it was probable that injury would occur to a person who slipped from the top ladder and that the injury would be serious;

(f) It was not burdensome for the person in the position of DBRL to close the gap between the bottom of the steel cage and the mid platform guardrails so that a person could not fall through the gap.

[67] In the above circumstances and considering the facts as I have found them, I am satisfied that DBRL breached a duty to take precautions against a risk of injury to Mr Speziali in respect of the accident.

[68] I do not consider it is an answer to the allegation of breach of duty for DBRL to say that Nortask was an independent contractor specialised in the task. There is no specialisation required for the ascending and descending of a ladder. Nor is this properly a case about an independent contractor being required to ascertain its own system of work. It is a case about an occupier of premises making a method of access available to a person attending its premises in circumstances where it should have identified and fixed a non-compliance that made the method of access unsafe.

[69] I conclude that Mr Speziali has established liability on the part of DBRL.

Causation

[70] I am satisfied that causation is established here.

[71] I find that had there not been the significant gap between the bottom of the steel cage for the top ladder and the guardrails of the mid platform, Mr Speziali's slip from the top ladder would have resulted in him landing on the mid platform – a small fall, unlikely to have resulted in any serious injury.

[72] DBRL submits in its written primary submissions that (at [33]):

> "Relevant to the question of causation therefore, there is an uncontrolled fall and on the Plaintiff's own version he seems to be tumbling downwards and striking parts of the cage on the way down. We do not know how he in fact went over the rail, was it the front, the back or the side and critically, he must have hit the platform with some force and tumbled over. Compliance with the standard may not have made any difference."

[73] With respect, I consider it plain that Mr Speziali did not hit the mid platform. If he had done so, that would have arrested his fall. The only way an adult could fall from the top ladder and end up on the ground is by passing through the gap between the bottom of the steel cage for the top ladder and the top of the mid platform guardrails (even if hitting the guardrails on the way through, which is likely). Compliance with the relevant AS would not have permitted Mr Speziali to fall to the ground. The non-compliance might be considered small, but it was critical and not merely trivial. It was sufficient to constitute a lack of reasonable care by DBRL.

[74] DBRL ought to have known of the non-compliance. Its premises are a work site accessed by its own staff and contractors. Maintaining the safety of workers on the premises is paramount. Where ladders are present, the risk of falls from ladders is obvious. That is particularly so in respect of falls from near vertical ladders, of significant height, exposed to external conditions (that may make the ladders slippery when wet).

Conclusion on negligence

[75] There is no dispute that Mr Speziali suffered damage. Accordingly, the negligence of DBRL is established.

Contributory negligence

[76] DBRL alleges that Mr Speziali's injury and any loss and damage resulting therefrom were caused and contributed to by Mr Speziali's failure to take precautions against the risk of injury to himself that a reasonable person in his position would have taken. Mr Speziali is held to the standard of care expected of a reasonable person in the plaintiff's position and that is based on what the plaintiff knew or ought reasonably to have known at the time.

[77] Counsel for DBRL submitted that the contributory negligence of Mr Speziali present is sufficient to defeat the plaintiff's claim and otherwise ought be assessed at 50 percent.

Counsel for the plaintiff submitted that there should be no finding of contributory negligence.

[78] In *Bankstown Foundry v Braistina*[41] the majority, Mason, Wilson and Dawson JJ said:

> "A worker will be guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonable and prudent man, he would expose himself to risk of injury. But his conduct must be judged in the context of a finding that the employer had failed to use reasonable care to provide a safe system of work, thereby exposing him to unnecessary risks. The question will be whether, in the circumstances and under the conditions in which he was required to work, the conduct of the worker amounted to mere inadvertence, inattention or misjudgment, or to negligence rendering him responsible in part for the damage."

[79] DBRL alleges that a reasonable person in the position of Mr Speziali would have:

(a) used a fall arrest harness on the top ladder;

(b) once contaminants on the ladders were observed, re-assessed the risks associated with using the ladders (and presumedly decided not to use the ladders as they were);

(c) used the man box (via the crane) rather than the ladders to access the top platform;

(d) taken steps to remove any contaminants from the ladders;

(e) taken steps to avoid moisture on the ladders.

[80] DBRL says that had Mr Speziali taken such steps, the accident would not have occurred.

[81] I find:

(a) There was no negligence in Mr Speziali not using a fall arrest harness whilst using the top ladder. The top ladder was not constructed for ready use with a fall arrest harness. The reference to the use of same in the Work Permit 10355 and the JSEA attached to that Work Permit clearly referred to workers carrying out work on the top platform (in circumstances where the repair involved removing and replacing panels in the top platform floor). The ladders (and platforms) were commonly used by DBRL staff and its contractors without any fall arrest harness. If that had

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41 [1986] 160 CLR 301; 65 ALR 1

been reasonably required, it would be expected that the ladders would have some sign at the base indicating access was only permitted with the use of a fall arrest harness.[42]

(b) There was no negligence by Mr Speziali in not re-assessing the risks associated with the use of the ladders after observing them to be contaminated and considering them to be very slippery.[43] The contaminant was water. The Cyclone is an outdoor piece of plant which undoubtedly would need to potentially be accessed in a wide variety of weather conditions, including during and after rain and when dew had settled on the plant. It is obvious that the ladders could become slippery, even very slippery, when wet (even without any signage to that effect). However in the absence of any sign at the base of the ladders indicating that access was only permitted when the ladders were dry, I consider any person likely to access the ladders would simply appreciate that in wet conditions extra care would need to be taken ascending and descending the ladders as the risk of slipping would be higher (but not unacceptable).

(c) There was no negligence by Mr Speziali in using the ladders rather than the man box (via the crane) to access the top platform. The ladders were the logical means of persons accessing the top platform. The purpose of the use of the man box via crane was to move materials and equipment unable to be safely brought up and down the ladders.

(d) There was no negligence by Mr Speziali in not removing contaminants (water) from the ladders or by not attempting to avoid water on the ladders (if either even be practical). It was reasonable for Mr Speziali to assume that the ladders were safe for use in a wet condition.

[82] There was some suggestion during the hearing, although seemingly not pressed by DBRL in its submissions that:

(a) Mr Speziali may have descended the top ladder carrying a tool box in his hand;

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42 That in 2020 an expert was instructed to and did use a full body harness and twin lanyards at all times on the ladders and platforms does not, in my opinion, lend any significant weight to the suggestion that Mr Speziali should have known that he should had done something similar. See exhibit 19; Intersafe report of 6 October 2020, section 4 (Observations from the Inspection), at [13-16] (pages 25-26).

43 T1-45, L11.

(b) Mr Speziali may not have had sufficient hand grip on the top ladder whilst descending;

(c) Mr Speziali may have descended the top ladder in some otherwise unsafe manner.

[83] I would not accept any such submission if made. There is no evidence that persuades me that Mr Speziali descended the top ladder otherwise than in an orthodox and safe manner (with certain items in his pockets but nothing in his hands). He was taking adequate care given he was aware that the ladders were wet and slippery. That was the appropriate response, nothing more was required from him.

[84] I am satisfied that Mr Speziali's conduct in descending the top ladder resulting in a slip amounted (at most) to 'mere inadvertence, inattention or misjudgement' which would, by reference to *Braistina*,[44] absolve him from a finding of contributory negligence.

[85] I do not find any contributory negligence on the part of Mr Speziali.

Apportionment between the defendants

[86] By way of third-party statement of claim DBRL has sought indemnity or contribution from Nortask for:

(a) negligence; or

(b) breach of contract.

[87] In the alternative, DBRL seeks contribution from Nortask under section 6 of the *Law Reform Act 1995* (Qld).

Negligence

[88] I accept that Nortask owed DBRL a duty of care to undertake the repair works with due care and skill (which implicitly would include avoiding risks of harm about the repair works that were reasonably foreseeable). I do not consider that the duty of care owed was any wider than that (cf [13] of the third-party statement of claim). DBRL has not referred me to any authorities to suggest that the duty of care is any wider.

[89] DBRL submits that Nortask breached its duty of care owed to DBRL by:

(a) not requiring Mr Speziali to use the man box;

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44 *Bankstown Foundry v Braistina* [1986] 160 CLR 301; 65 ALR 1.

(b) not requiring Mr Speziali to use a safety or fall arrest harness when using the ladders;

(c) not requiring Mr Speziali to safely maintain three points of contact on the ladders;

(d) not requiring Mr Speziali when ascending the ladders to ensure that (1) he did not deposit any contaminants on the ladders; (2) the rungs were free from contaminants; (3) he cleaned contaminants from the rungs;

(e) not performing the repair works safely;

(f) not utilising all necessary equipment and tools to enable the work to be undertaken with due care and skill and to avoid exposing Mr Speziali to unnecessary or unreasonable risk of injury.

[90] In respect of each of these alleged breaches, DBRL submits that because Nortask has admitted liability to the plaintiff, where the plaintiff's pleading contains allegations of negligence against Nortask to the same effect, it flows that Nortask must be found to have breached the same duty in respect of DBRL because to find otherwise would lead to inconsistency. For example, [16(c)] of the plaintiff's further amended statement of claim alleges that Nortask was negligent for "failing to ensure that the plaintiff safely descended the structure in the basket."

[91] With respect, I do not agree that any such finding is compelled, or that if I fail to make such findings there will be inconsistency. No authority has been cited by DBRL in support of its contention.

[92] I am not satisfied that Nortask breached its duty of care owed to DBRL in any of the ways alleged. In that respect:

(a) Not requiring Mr Speziali to use the man box was not negligent. There was no reason for Nortask to suspect that the ladders, even in a wet and slippery condition, were not a suitable way for persons to access the top platform;

(b) Not requiring Mr Speziali to use a safety or fall arrest harness when using the ladders was not negligent. Again, there was no reason for Nortask to suspect that the ladders, even in a wet and slippery condition, were not a suitable way for persons to access the top platform;

(c) In respect of not requiring Mr Speziali to safely maintain three points of contact on the ladders, there is simply no evidence to support that allegation. I accept Mr Speziali's evidence that he descended the top ladder maintaining three points of contact at all times.[45] There is no evidence that Mr Speziali's gripping of the styles rather than the rungs of the top ladder made any difference to the safety of his descent (noting DBRL's primary written submissions at [70(a)(iii)]);

(d) Not requiring Mr Speziali when ascending the ladders to ensure that (1) he did not deposit any contaminants on the ladders; (2) the rungs were free from contaminants; (3) he cleaned contaminants from the rungs, was not negligent. There is no compelling evidence of the ladders being contaminated with anything other than water. There was no reason for Nortask to suspect that the ladders, even in a wet and slippery condition (or even in a dirty condition for that matter), were not a suitable way for persons to access the top platform;

(e) In respect of it being alleged that Nortask did not perform the repair works safely, I do not accept any negligence by Nortask is proven. The allegation is unparticularised. The repair works were performed safely;

(f) In respect of it being alleged that Nortask did not utilise all necessary equipment and tools to enable the work to be undertaken with due care and skill, to avoid exposing Mr Speziali to unnecessary or unreasonable risk of injury, DBRL here again relies on use of the man box and a fall arrest harness which have been dealt with in (a) and (b) above.

[93] DBRL has not established any negligence by Nortask towards it.

Breach of contract

[94] DBRL alleges breaches by Nortask of both express and implied terms.

[95] The relevant express term is alleged to be that in order to undertake the repair works, Nortask would supply a crane and man box.

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45 T1-58, L45.

[96] That allegation of breach is readily disposed of. Even if there be such an express term, Nortask did supply a crane and man box about the repair works. No breach is established.

[97] The alleged implied terms ([13] of the third-party statement of claim) in large part go no further than the negligence claim and are disposed of on the same basis.

[98] Insofar as it is further alleged that Nortask failed to comply with alleged implied terms that it comply with the requirements of the JSEA and the terms of any Work Permit issued by DBRL, even if such terms are to be implied (which is very doubtful) there is no breach of those terms. Nortask did comply with the requirements of the JSEA and the terms of Work Permit issued by DBRL.

[99] DBRL has not established any breach of contract by Nortask.

Contribution

[100] Nortask submits that the proper apportionment between itself and DBRL is 25/75.

[101] DBRL submits that the proper apportionment between itself and Nortask is 0/100 or no more than 10/90.

[102] Because the liability of Nortask to Mr Speziali was admitted, none of the parties led any significant evidence as to the basis of Nortask's liability to Mr Speziali. The plaintiff pleaded the basis of the alleged liability of Nortask at [16] of the further amended statement of claim.

[103] DBRL submits that in the circumstances of Nortask's admission of liability without indicating on what basis that admission was made, I should proceed on the basis that all of the particulars of negligence pleaded should be assumed to be made out. I would not be prepared to proceed on that basis. That is because, for reasons I have given in this judgment, there are certain particulars of negligence that I would have rejected. For example, the allegation that Nortask was negligent for failing to ensure that Mr Speziali descended from the top platform in the man box.

[104] Nor do I accept, as DBRL submits, that there is no basis upon which the relative culpabilities can be assessed as between the parties such that there should be no finding of apportionment. That is a peculiar submission. Where both defendants are negligent

and I will assess damages against each of them, without apportionment it would not be clear which defendant is responsible for which part of the damages.

[105] I start from the position that equity is equality. If the relative culpabilities and causal impacts of the defendants are indistinguishable, then I would apportion 50/50,[46] not 100 to Nortask and 0 to DBRL as appears to be submitted for by DBRL.

[106] Here I do not find that the relative culpabilities and causal impacts of the defendants are indistinguishable.

[107] The dominant cause of the plaintiff's injuries in my opinion was the fact that there was a gap between the bottom of the steel cage to the top ladder and the guardrails for the mid platform which a person, slipping in an uncontrolled way from the top ladder, could fall between to the ground. The responsibility for that state of affairs lies with DBRL, and could not have been readily identified by Nortask.[47]

[108] Accordingly when it comes to compare as between the defendants the culpability of each of them and the relative acts of the parties causing the damage, a significantly larger proportion of liability should rest with DBRL.

[109] I accept Nortask's submission that the proper apportionment between Nortask and DBRL is 25/75. If anything, that is a generous assessment in favour of DBRL and Nortask might properly have sought to sheet home an increased apportionment to DBRL.

Assessment of damages

The plaintiff's reported ongoing difficulties, care requirements

[110] The unchallenged medical evidence is that Mr Speziali has suffered a 48% loss of whole person function.[48]

[111] Mr Speziali says he continues to suffer considerable ongoing pain, and therefore requires help from his wife and daughter for domestic duties as he is physically restricted. He and his wife gave comprehensive evidence as to the personal and household related tasks

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46 *Reddock v ST&T Pty Ltd and anor* [2022] QSC 293 at [128].

47 cf where the risk of injury posed by the steps was as obvious to the contractor as it was to the occupier in the decision in *Hill v Richards* [2011] NSWCA 291.

48 Dr Morgan, orthopaedic surgeon, report dated 17 July 2017 at page 14 (exhibit 21).

he carried out prior to the accident, and what of those tasks are now required to be carried out by his wife and daughter.

[112] In *Bell v Mastermyne Pty Ltd*,[49] McMeekin J said at [19]:

> "….The assessment of damages for personal injury depends to a very large extent on a plaintiff's honest reporting - of his or her symptoms; of their impact on the plaintiff's life; of pre-existing problems; of the genuineness of effort to regain employment after injury; and of their capacity to maintain employment. These are all difficult issues for a defendant to thoroughly investigate and test. In truth no-one knows what level of pain an individual experiences and what impact that pain has on any particular plaintiff's capacity to maintain their activities."

[113] Mr Speziali is plainly a man who was well used to being physically active, independent and substantially contributing to household related tasks. I am satisfied that he continues to contribute as much as his ongoing pain allows. What he is capable of doing on any given day will change and so both his and his wife's evidence as to the differences in Mr Speziali's contributions pre- and post- accident will necessarily only be estimates. The affected tasks include personal care, meal preparation, laundry, home and garden maintenance, gardening, mowing, pool maintenance, car cleaning, driving and grocery shopping.

Past care

[114] The plaintiff's total claim in respect of past care is for $140,700. DBRL submits that the appropriate allowance is $59,040.

[115] I accept DBRL's submission that the plaintiff's claim in respect of past care is necessarily based on estimates many years after the event (in respect of some of the care). No diary of care provided has been kept.

[116] The plaintiff has presented his claim in respect of past care by reference to different periods of time as follows:

(a) Period 2: 3 August 2017 to 11 September 2017[50]

(b) Period 4: 15 September 2017 to 11 December 2017[51]

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49 [2008] QSC 331.
50 DBRL refers to this as period 1.
51 DBRL refers to this as period 2.

(c) Periods 6 to 11: 16 December 2017 to 8 March 2023.[52]

[117] The tasks are split into the following headings: personal care, domestic care, transport, home/property maintenance and vehicle care. Generally the time required each week for each work heading type appropriately decreases over time as Mr Speziali has improved or adjusted and has been able to contribute more.

[118] An exception seems to be in respect of home/property maintenance which increased in periods 6 to 8 to 6 hours per week, but which I only allow at 4 hours per week (consistent with periods claimed before and after). That is, a reduction from the claimed amount for past care of $2,320. The parties are agreed that the appropriate rate is $40 per hour.

[119] DBRL has submitted its own assessments that it says are reasonable for the tasks of cleaning, laundry, meal preparation, shopping/banking/outside appointments, travel, care needs, yard/pool maintenance and vehicle care over the relevant periods. Likewise it is generally assumed that the time required each week for each work task type decreases over time.[53] There are also some explanations for why lesser amounts of time are assessed (for example, it is suggested that it is not reasonable to assume that someone would be cleaning their car every week and banking could be conducted online rather than in person).

[120] I prefer the estimates of the plaintiff and his wife. I am satisfied those estimates reflect a true and accurate recollection of the past care the plaintiff has required.

[121] I allow past domestic care in the amount of $138,380.

Future care

[122] The plaintiff submits for future care to be allowed at 8.75 hours per week, $45 per hour x 893.94 (5% multiple for life expectancy), giving $351,988 rounded down to $350,000.

[123] 8.75 hours per week is 1.5 hours less per week than claimed for the last period of past care, and is claimed at $5 extra per hour compared to past care. Again, these at best are estimates. I think with time there is likely to be some slight improvement with

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52 DBRL appears to refer to most of this period as periods 3 to 5.

53 I assume that the 4 hours per week in [110(d)] and 5 hours per week in [110(e)] should be swapped around, thereby reducing the total.

Mr Speziali's capacity to contribute to household tasks because I expect he will find ways to contribute despite his ongoing difficulties.

[124] DBRL's position about future care is not entirely clear to me. At [116] of its written primary submissions it gives a figure of $195,975 which it discounts by 15% to $166,578. I think that is arrived at by calculating 5 hours per week at $45 per hour over a period of 23 years (multiplier of 871). 5 hours per week is what DBRL calculated in respect of its period 5 mentioned at [110(e)] of its written primary submissions, although that is more than the 4 hours per week allowed for period 4 at [110(d)]. At [111] of its written primary submissions DBRL contends that in respect of care, "no further amount should be allowed than has been historically provided".

[125] I am prepared to allow 8.5 hours per week at $40 per hour (the same rate as the past care), giving a calculation of $303,939.

[126] I do not make any further reduction for contingencies or the vicissitudes of life, or for rounding. The cases to which I have been referred in that respect are not *ad idem* as to the circumstances in which a discount of that nature is appropriate. I have sufficiently accounted for such matters in the estimates I have made. There is nothing about this case that to my mind requires a further discount to be applied.

[127] I allow future domestic care in the amount of $303,939.

Orders

[128] Accordingly the orders I make are:

(a) Judgment for the plaintiff against the first defendant in the sum of the sum of $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55];

(b) Judgment for the plaintiff against the second defendant in the sum of $1,341,573.00 (comprising $899,254.00 [inclusive of the WorkCover refund of $355,177.33 and the common law rehabilitation refund of $15,934.55] plus $442,319.00 on account of past and future care);

(c) The aforementioned damages of $899,254.00 are apportioned between the defendants as 25% to Nortask, 75% to DBRL;

(d) The parties provide either an agreed proposed costs order or written submissions on costs within 14 days.