SUPREME COURT OF QUEENSLAND

CITATION:	*Schneider v Smith & Anor* [2016] QSC 47
PARTIES:	**JEFFREY IAN SCHNEIDER** (Plaintiff) v **REBECCA ANN SMITH** (First Defendant) And **RACQ INSURANCE LIMITED ABN 50 009 704 152** (Second Defendant)
FILE NO/S:	S233/2015
DIVISION:	Trial Division
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court of Queensland
DELIVERED ON:	11 March 2016
DELIVERED AT:	Rockhampton
HEARING DATE:	15, 16, 17 February 2016.
JUDGE:	McMeekin J
ORDER:	**1. Judgment for the plaintiff in the sum of $447,969.94**
CATCHWORDS:	DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES – PERSONAL INJURIES – GENERAL PRINCIPLES – where liability admitted – where plaintiff was injured in a motorcycle accident – where plaintiff suffered multiple injuries – where plaintiff alleges ongoing pain due to his injuries – where plaintiff alleges ongoing psychiatric condition – where plaintiff admits consuming cannabis before and after accident – whether the plaintiff is a witness of credit – whether the accident caused the psychiatric condition – whether the plaintiff resigned employment due to accident – whether the plaintiff has suffered loss of earning capacity – whether the plaintiff satisfies pre-conditions for award for provision of gratuitous care

Civil Liability Act 2003 (Qld)

Civil Liability Regulation 2014 (Qld)

Evidence Act 1977 (Qld)

Allwood v Wilson & Anor [2011] QSC 180, followed
Bailey v Nominal Defendant [2004] QCA 344, cited
Beard v Richmond (1987) Aust Torts Rep 80-129, cited
Coles Supermarkets Australia Pty Ltd v Fardous [2015] NSWCA 82, cited
Grey v Simpson (Unreported – NSW Court of Appeal – 3 April 1978 – CA 327 of 1977), cited
Havenaar v Havenaar (1982) 1 NSWLR 626, cited
Hopkins v WorkCover Queensland [2004] QCA 155, cited
Hunter Area Health Service v Presland (2005) 63 NSWLR 22, cited
Lisle v Brice [2002] 2 Qd R 168, cited
Malec v JC Hutton Pty Ltd (1990) 169 CLR 638, cited
March v E & MH Stramare Pty Ltd (1991) 171 CLR 506, cited
Phillips v MCG Group Pty Ltd [2013] QCA 83, cited
Purkess v Crittenden (1965) 114 CLR 164, cited
Seltsam Pty Ltd v Ghaleb [2005] NSWCA 208, cited
Smith v Topp [2003] QCA 397, cited
State Rail Authority of New South Wales v Wiegold (1991) 25 NSWLR 500, cited
Watts v Rake (1960) 108 CLR 158, cited
Wylie v The ANI Corporation Ltd [2002] 1 Qd R 320, cited

COUNSEL: TA Arnold for the plaintiff

GF Crow QC for the defendants

SOLICITORS: Rees R & Sydney Jones for the plaintiff

Cooper Grace Ward for the defendants

[1] **McMeekin J:** The plaintiff is Jeffrey Ian Schneider. This case involve the assessment of damages for personal injuries that he suffered on 9 March 2010 in a motorcycle accident. Liability is admitted.

The Injuries & Issues

[2] Mr Schneider suffered extensive injuries. They are listed in his statement as follows:

a) Multiple Le Fort fractures of the face;
b) dental injuries;
c) facial scarring;
d) left wrist fracture;
e) right hand injury;
f) left knee injury;
g) right knee injury;
h) soft tissue injuries to the cervical, thoracic & lumbar spines;

i) general scarring; and
j) a psychological disorder.

[3] Mr Schneider was hospitalised in Rockhampton and Ipswich, underwent surgery, and rehabilitated at home with care being provided by his family. He then returned to his work as a clerk in the payroll section of Queensland Health on 17 May 2010, so a period of about 10 weeks off work post-accident.

[4] It is not in issue that he suffered significant injuries. By far the most serious of the physical injuries were the Le Fort fractures. They were repaired with a reasonably good result. Mr Schneider is not noticeably disfigured. My attention was not drawn to any scarring and I could not observe any as he sat in the witness box. While there is some debate on the issue, the various orthopaedic injures have largely settled.

[5] Mr Schneider resigned from his employment on 26 September 2011, effective two weeks later, and has not worked since.

[6] Mr Schneider attributes his resignation and his continued absence from work to an anxiety disorder, more latterly diagnosed by one psychiatrist as a dysthymic disorder. The significant issue in the case related to the existence and impact of that claimed psychiatric condition.

[7] Complicating the assessment is Mr Schneider's consumption of cannabis. He concedes that he was a user of cannabis both before and after the accident, more so after, until about two years ago when he ceased consumption entirely. The extent, duration and effect of that consumption is in issue.

[8] Further complicating the issue is Mr Schneider's expressed views that "what most people did by working 40 hours a week for most of their life was a waste of time, and was simply serving the interest of corrupt societal institutions."[1] He found greater meaning in his surfing.[2]

[9] There seems to me to be four significant questions:

(a) Is Mr Schneider a witness of credit?
(b) Was his decision to resign his secure employment, 19 months after the accident and 16 months after returning to work, brought about by disinterest, or a lack of motivation due to the consumption of *cannabis sativa*, or rather by a psychiatric condition consequent on the subject accident and the injuries sustained, or that in combination with serious facial pain and headaches?
(c) Does Mr Schneider have a psychiatric disorder presently impacting on his earning capacity?
(d) Can Mr Schneider satisfy the pre-conditions of s 59 of the *Civil Liability Act* 2003 justifying a substantial award for the provision of gratuitous care?

Applicable Legislation

[10] The assessment is governed by the provisions of the *Civil Liability Act* 2003 (Qld) ("the Act") and the *Civil Liability Regulation* 2014 (Qld) ("the Regulation").

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[1] Ex 2.2 p 31 para 6.3
[2] *Ibid* p 37 para 6.39

The Plaintiff - Pre Accident Qualifications and Employment

[11] Mr Schneider was born on the 19 September 1987. He was therefore 22 years of age when injured and is now aged 28 years old.

[12] Mr Schneider was an above average student. He achieved an OP of 4 in 2004. He had undertaken a university level subject in his Grade 12 year. He gained entry to a university in 2005 studying Information Technology, a subject that had interested him throughout his secondary schooling. He dropped out of university in 2007. He had failed subjects. The university records indicate that he had lost interest. He was informed by the university that if he continued to fail he would be excluded. He has not returned to university since.

[13] Mr Schneider's pre-accident employment history was quite limited. That is not surprising given his age. He was employed when a youth at a McDonalds store and then, when at university, at a meatworks as a packer. He started there in late 2005. He worked full time when a full time student. The work was well paid. He gave up that employment at some point, perhaps around mid-2006. Why is not clear. He then went with his father to Bundaberg. I reflect his evidence here although the university records indicate that he was still studying in 2007.[3] He appears to have been unemployed then for about 18 months or so (or – if the university records provide a more reliable guide – six months or so) until he gained employment on a part time basis with Queensland Health on 11 February 2008. He gained a full time, albeit temporary, position three months later. He was pursuing a permanent position but had not achieved one at the time of the accident.

[14] In the 16 months between his return to work and his resignation Mr Schneider was promoted from a temporary to a permanent position at Queensland Health. As well he was given temporary contracts as an Acting AO3 clerk for much of that period – one level above the permanent position that he had eventually obtained.

Criticisms of Mr Schneider

[15] The assessment depends to a very large degree on acceptance of Mr Schneider's evidence. While he was supported in various ways by his father, his de facto and his best friend, that support can only go so far. That he has become more withdrawn since the subject accident, less interested in his surfing or other activities, friends and social events, and now complains of pain and takes pain relieving medication are all confirmed by them. They were obviously honest witnesses. However the location, extent and timing of the onset of his symptoms depends on Mr Schneider alone, as does his explanation for his resignation from secure employment which is the critical issue.

[16] The defendant submitted that Mr Schneider was not a witness of credit. The defendant pointed out:

a) That his account was at times very much at odds with medical records;

b) That despite a request by Dr Chalk, and two repeat requests by the solicitors acting for the defendant, the plaintiff had not taken a drug test until 57 days

[3] Ex 1.18 p 504

after that initial request – sufficient time to allow any residual cannabis in his body to dissipate;

c) That claims that the plaintiff had difficulties at work post-accident with problem solving, thinking or the like were not supported by any witness or record or contemporaneous complaint;

d) That video evidence suggested that the plaintiff's alleged problems with social anxiety were at least exaggerated, if not fictitious;

e) That the plaintiff's lifestyle since his resignation was a life very much of the type that he had told Dr Flanagan he would prefer to lead, and not one foisted on him by any accident caused psychoses.

[17] In my view neither the delay in taking the drug test or the activities displayed on the video established that Mr Schneider was either deliberately misleading or should be thought unreliable. I will say more about those issues later. One of the difficulties in assessing a person who claims to have a psychiatric impairment is that, if the claim is true, it is unlikely that the person will behave or react "normally".

[18] However I accept that there were worrying aspects of Mr Schneider's evidence. One was the vagueness at times when asked about his past. That may be explicable because of his drug habit over the years or may be due to an anxiety disorder, but in either case impacts on his reliability.

[19] Some of his answers whilst vague were innocuous. Others were more surprising. I will give some examples. He and a friend were apprehended by the police in Townsville and marijuana seeds were located in the vehicle. He could not say whether the vehicle or the seeds were his.[4] When asked if this was his only apprehension by police he replied "as far as [he] can remember".[5] I suspect most people could recall with some certainty if they had been apprehended by police on potential drug charges only once or more than once. He was unable to explain why he gave up well paid employment at the JB Swift, a meatworks.[6] He claimed not to recall receiving four different letters from the university addressed to him to three different addresses – each of them being his address at the time.[7] As well he claims not to have received, or not to have opened, two letters from Central Queensland Mental Health Service acute care team attempting to make contact in relation to a referral to Dr Rofe, a psychiatrist, Mr Schneider being, at the time, in some distress emotionally.[8] Another example is that he believes that he went away on a break immediately before he resigned his employment at Queensland Health but could not recall with any certainty where he went[9] nor could he say with certainty whether, before the event, he had discussed with his de facto his decision to resign.[10]

[20] Another concern was the discrepancy between his present recollections of his activities and the history given to medical practitioners. Again some were of more significance

[4] T1-68/22-45
[5] T1-69/6-9
[6] T1-19/21; T1-65/16-40
[7] T1-64/4-20; T1-66/1-32
[8] T2-14/3-34; for his explanation: T2-15/8-12
[9] T1-39/31-33 - T2-15/1-7
[10] T1-40/2

than others. For example Dr Flanagan recorded him relating that he had just returned from a weeks' surfing at Fraser Island. While accepting that he had a week at Fraser Island he denied he had gone on a surfing holiday.[11] I very much doubt that Dr Flanagan misunderstood what he was told. He denied the accuracy of a record concerning the amount of bicycle riding he had undertaken.[12]

[21] Another concern was the discrepancy between his claimed symptoms and the history given to medical practitioners. The most graphic example, and one the defendant stressed as of some significance, is the record made by a Dr Maloney of his conversation with the plaintiff. It goes to an important issue. I analyse the evidence below.

[22] For present purposes my conclusion is that at the very least Mr Schneider is an unreliable reporter. Unless his evidence is inherently probable I am cautious in acting on his claims if unsupported by some other cogent evidence.

Facial Pains

[23] As mentioned, the crucial issue in the case is the cause of Mr Schneider's decision to abandon his secure employment more than a year after returning to work after the accident. The principal argument advanced on his behalf was that he suffered from a psychiatric condition. His evidence also suggested a physical cause – debilitating facial pains with associated headaches. It is to this issue that Dr Maloney's conversation is directed.

[24] Dr Maloney is an oral and maxillofacial surgeon. He saw the plaintiff on 4 December 2012 at the request of Mr Schneider's solicitors for the purpose of preparing a medico-legal report. His report was tendered by the plaintiff. His report reads under the heading "Present Status":

> "Your client remains unemployed since the accident and believes that the main obstacle to his return to employment is psychological in nature and in no way directly related to his facial injuries. He complains of occasional pain from the region of his face but not of such severity as to warrant the regular intake of analgesics medication."[13]

[25] There can be no doubt that the doctor would have been particularly interested in any complaint of pain in the facial area. That was his area of expertise and in his report he states that he concerned himself only with his area of specialty. Mr Schneider denied that he had ever said any such thing to the doctor in very emphatic terms.[14]

[26] Mr Schneider's evidence was at odds with the account recorded by Dr Maloney. He complained of pain in his face that was "extreme", and requiring substantial quantities of medication to reduce the symptoms to a "bearable" level and which persisted so long as he was at work and to a lesser extent beyond that time.[15] Mr Schneider says that these pains in his face, while not so frequent, have never gone entirely, and indeed have remained a persisting and significant problem. When asked how often the pains

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[11] T1-86/26-32
[12] T2-16/35 - T2-17/3
[13] Ex 2.7 p 87
[14] T2-22/20-30
[15] For Mr Schneider's evidence in chief see T1-31/12 – 32/5

occurred currently he replied: "Much less regularly than before. Still once a week I would say would be my best – best guess at an average."[16]

[27] The topic was returned to in cross examination:

> "Since you returned to work in May 2010, the pain in your face has reduced very significantly, hasn't it? -- The occurrence of that really debilitating soreness I talked about – the occurrence of that has reduced and it's been replaced with general headaches where it's reduced. I get general headaches now more frequently than – than those really bad ones.
>
> It's true, isn't it, that your face pain now is only occasional? -- No. I get headaches nearly every day, like I said, four, five days a week.
>
> It's true, isn't it, that your face pain has been occasional since at least December 2012, at least then? -- I couldn't tell you where it's changed to – where the weight changed from being more of that – that really bad one to more of just headaches.
>
> And it's been occasional – your face pain has been occasional since you returned to work in the May of 2010. Yes, it's there sometimes; not other times? -- *Certainly while I was at work, that face pain was most of the time, that very bad pain*."[17]

[28] There is therefore a marked discrepancy between the symptoms now claimed, which it is said go back to 2010-11 and have been present to a degree ever since, and Dr Maloney's report obtained in late 2012.

[29] Dr Maloney was not called. So I do not have the advantage of understanding his history taking technique or whether he has contemporaneous notes of his conversation with Mr Schneider. But I find it difficult to believe that he received a history of debilitating facial pains needing copious quantities of analgesics, as Mr Schneider's evidence suggests, and simply misunderstood it. I think it far more likely that if there is fault it lies with Mr Schneider. It would be consistent with his general vagueness of presentation in the witness box.

[30] I make two observations. The first is that the account that Mr Schneider gave of his symptoms to other medico-legal examiners around the time that Dr Maloney saw Mr Schneider, and the observations recorded of family members, support the presence of ongoing and debilitating symptoms, albeit no account puts the symptoms at quite as serious a level as Mr Schneider presently does. Ms Fruk, Mr Schneider's de facto, supports the account that headaches were present on a daily basis at the time of his return to work, although the basis of her recollection is unclear. Ms Fruk also supports there being a significant intake of Nurofen or Nurofen Plus.[18]

[31] The second observation is that Mr Schneider's present claim of having debilitating symptoms when at work has no support from contemporaneous medical records.

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[16] T1-50/27-38

[17] T2-22/1-7 – T2-21/37-22/7 – my emphasis

[18] T3-30/41 – 31/20

[32] I will detail the relevant evidence. First to the accounts given at much the same time as Dr Maloney's conversation with Mr Schneider.

[33] Mr Schneider was seen by a Dr Flanagan, a psychiatrist, on 1 November 2012. The doctor records the history given as:

> "4.4 He would develop frequently a pain around the right temporo-mandibular area, which if it lasted for half an hour or more, would result in a bad headache. He took Nurofen and Nurofen Plus, sometimes Codeine Forte, for this.
>
> 4.5 The headaches were very bad and would stop him functioning until he took something for them. He had them for a couple of hours every day.
>
> 4.6 He was having an unusually good day today." [19]

[34] Dr Gillett, an orthopaedic surgeon, saw Mr Schneider on the same day as Dr Maloney, or at least his report is dated that day. He records: "The dominant problem relates to his facial injuries….he has facial pain and jaw issues. He gets head pain associated with that." A little later in the report the doctor says: "He has problems with daily life pursuits when he has a lot of facial pain; he just can't do much on those days. He is bed ridden."[20]

[35] A report of symptoms similar to that obtained by Dr Flanagan appears in the report of Dr Terry Coyne, a neurosurgeon, who saw Mr Schneider in January 2013.[21]

[36] Finally I note that in a statement tendered pursuant to s 92 of the *Evidence Act* 1977 the plaintiff's now deceased grandmother, Mrs Rofe, observed: "Jeffrey does have particularly bad days, once or twice a week, where he experiences severe pain from his head and facial injuries which causes him effectively to do nothing all day."[22] Instructions for the statement were taken by the solicitor in July 2012 and the statement signed by Mrs Rofe on 30 October 2012. Objection was taken to the paragraph and I ruled part of it inadmissible. The basis for Mrs Rofe's conclusion that Mr Schneider "experiences severe pain" is not revealed in the statement. She may be reflecting on observations that she has made or she may be reporting statements that Mr Schneider has made. If construed merely as a statement by the plaintiff of his complaints of pain, the statement is admissible to establish that the complaint was made, but not the truth of the complaint.

[37] The reports to the various practitioners of course do not establish the truth of the statements but rather show the history assumed and the fact the symptoms were reported. No practitioner claimed to have observed Mr Schneider at a time when he said he was experiencing the symptoms.

[38] The frequency of occurrence, the extent of the impact on Mr Schneider, and the need for medication differ from one account to another. However the consistent theme is that to some extent the symptoms occur and, when present, are debilitating to a considerable extent.

[39] The evidence therefore shows that there were complaints of facial pain and at a serious level in place by mid-2012. While Ms Fruk supports the account that symptoms were

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[19] Ex 2.2 p 29 para 4.4, 4.5 and 4.6
[20] Ex 2.5 p 73
[21] Ex 2.9 p 97
[22] Ex 16 para 14

present, particularly upon Mr Schneider's return to work, she was unable to recall complaints of pain "being an issue" as time went on.[23] That might simply reflect the fallibility of her memory. But the evidence does not establish that the symptoms were present and debilitating while Mr Schneider was employed in 2011 and leading up to his resignation.

[40] The difficulty in accepting that there were such significant symptoms at the time of his employment is that the contemporaneous records are not only not reconcilable with the present complaint, but the records tend to contradict the claim.

[41] On 9 August 2010, and so about three months after his return to work, Mr Schneider attended at the Rockhampton Base Hospital at the Orthopaedic unit. The record reads: "Patient mobilising. No pain. No problems. Also has R wrist pain - was lifting heavy weight in the gym recently."[24] There is no entry suggesting pain in the facial area or any complaint of headaches.

[42] The next entry is for 25 August 2010 at the Oral and Maxillofacial clinic at the same hospital. The note is difficult to read – it records the attendance is five months "post op" but thereafter is illegible. However the note is very short and I am confident does not record a history of the type of pain that Mr Schneider now says that he was suffering. There was no claim made at trial that it did. There is no referral for follow up at the clinic subsequently that I can see which I would expect if there was an ongoing problem reported. None was referred to in evidence. Mr Schneider's statement refers to attendances at the Orthopaedic unit at the Base Hospital – those post-dating his return to work are on 9 August 2010, 25 January 2011, 22 March 2011 and 3 May 2011. The records of the hospital were tendered. There is no mention of any complaint of pain in the facial area in any record tendered.

[43] There is no record of any attendance on any medical practitioner then until July 2011. There are two entries for that month in the Mandalay Medical Centre records. Mr Schneider attended there (a general practitioner's surgery) on July 10 and July 16. On the first occasion the record is of a complaint of flu like symptoms of four days and a request for a certificate as he had had four days off work. The treating doctor has recorded problems with a rash and a cut on the foot which was dressed. There is no reference to the debilitating face pain and headaches.

[44] On the second occasion the complaint recorded is of "colds" and another personal matter. Again there is no reference to the debilitating face pain and headaches.

[45] Mr Schneider obtained medical certificates to be away from work on 10 August and 31 August 2011. These are of some interest as he resigned a month later. The certificates relate to wrist pain on one occasion and an abscess of the right ear on the other. The very fact of obtaining certificates for such conditions but not one that Mr Schneider now says involved pain at "very bad" levels that "stopped him functioning" calls into question the reliability, at least, of the memory.

[46] Mr Schneider initially attended at the Base Hospital in relation to the abscess and then on his general practitioner. The hospital records relating to the abscess record symptoms of dizziness feeling faint and pain of "2/10."[25] It is noted that Mr Schneider

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[23] T3-31/39-42
[24] Ex 1.3 volume 1 p 60
[25] Ex 1 Volume 1 p 117

is a "young healthy looking gentleman walked in comfortably."[26] Five days later the GP notes record a diagnosis of a probable viral infection and "He is feeling better now."[27] Again there is no reference to the pains now complained of.

[47] Indeed the first treatment record that I have been referred to that relates to "headaches" is on 17 December 2014 – more than three years after Mr Schneider resigned his employment. That the complaint was related to "headaches" depends on Mr Schneider's account: see his statement tendered in evidence.[28] The medical record for the attendance that day reads: "neck pain today – more with rotation. It happened a year after his MVA" and "severe neck pain – more with rotation."[29] There is no mention of headaches as a symptom nor of facial pain. At best for the plaintiff, if headaches were present, there may be a connection with neck pain, albeit pain that he then said came on a year after the accident but remained unreported to any medical practitioner at the time.

[48] No witness was called from his place of employment who could support any behaviour or complaint consistent with a condition that stopped Mr Schneider functioning. A Mr Bailey was called in the plaintiff's case. He was the plaintiff's superior at Queensland Health. He clearly had a deal to do with the plaintiff both before and after the accident. He counselled him on several occasions in the three months before he resigned. He did not report any complaint made to him of debilitating headaches or of facial pain. Given that the plaintiff was on notice at the time that his performance had to improve or steps might be taken to dismiss him it is at least odd that no reference was made to a condition that one would expect would excite some sympathy for the plaintiff, and explain his apparently poor performance, if the condition was indeed present.

[49] That Mr Schneider has pains in his facial area has been reported to Dr Maloney, Dr Flanagan, Dr Coyne, Dr Gillett, his partner and his grandmother. Family members confirm that medication is taken reasonably regularly. There is frequent mention of facial pains and the taking of Nurofen and the like in the medical records of more recent years. That this has been an on-going problem is clear. To the extent that the account given to Dr Maloney is inconsistent with these many reports I think it more probable that the problem lies with the account he received rather than Mr Schneider's honesty. So the attack on Mr Schneider's credit (as in honesty) on this ground fails.

[50] There remains the question of the severity of symptoms during 2010-11 and their impact on Mr Schneider's employment. The earliest report independent of the plaintiff is in mid-2012 to his grandmother and some nine months after ceasing work. The lack of evidence from any co-employee and the contemporaneous medical records suggests that if he was suffering from facial pains at work in 2011 the problem was nowhere near as great as Mr Schneider now recalls.

[51] That does not mean that Mr Schneider is deliberately attempting to mislead. On his own case he has consumed significant quantities of cannabis over the years. That could affect memory. And it is difficult for even careful people to recall the degree of seriousness of symptoms of pain long after the event and when it is a recurring part of life. Rather I conclude that Mr Schneider has had long experience of these symptoms

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[26] Ex 1 Volume 1 p 105
[27] Ex 1 Volume 1 p 218
[28] Ex 2.1 p 5 para 47
[29] Ex 1.6 Volume 1 p 232

and has come to believe that they were worse at a time than the objective evidence indicates they could have been.

[52] I conclude with four observations. The first is that if Mr Schneider's aim was to inflate his damages then it is odd that he reports a lessening of his symptoms in his face and the associated headaches in more recent times. Secondly, it is another odd feature of the attack on Mr Schneider that much of it was based on the honesty and accuracy of his self-report of his own drug taking, thinking and beliefs. Had he wished to conceal these various matters now used against him he could easily have done so – and he is too intelligent a person not to have appreciated the impact these statements might have on any potential award. Thirdly, the failure to report the symptoms to Dr Maloney means that there is no evidence from an expert as to the aetiology of the symptoms, the possible treatment modalities, or their prognosis. Fourthly, Mr Schneider's claim as formulated does not depend on any finding that his facial pains were so severe when at work that he was forced to resign. That is not his case, or at least the case his counsel presents. It does mean that his case for substantial damages stands or falls on the claimed psychiatric condition.

Cannabis Use

[53] Before considering that condition it is necessary to consider an alternative cause – drug use. There are three issues. The first is the extent of Mr Schneider's drug taking. The second is the effect of it. The third is the legal consequences of consuming illegal substances, if brought about by the tort of the defendant.

The Extent of Drug Taking

[54] The plaintiff's account of his drug taking is that he had used cannabis since he left school at age 17, used it sporadically and on a recreational basis, had not used cannabis for about three to four months immediately before the accident, had increased his consumption markedly not immediately after but some time after the accident, but had sought treatment and had eventually stopped using cannabis either shortly after attending an ATODS counsellor or about two years before the trial. He gave both accounts of his cessation.

[55] The defendant argued, or at least cross examined on the basis, that an inference should be drawn that Mr Schneider's smoking was at a level of two to ten cones per day effectively since he was 17 years old, and that he had not given up smoking cannabis as he claims. The first submission depended on a record of a conversation with Mr Schneider made by a counsellor as being an accurate reflection of Mr Schneider's drug taking over the years. The latter submission depended on the inference to be drawn from Mr Schneider's approach to drug testing.

[56] When Mr Schneider first saw Dr Flanagan (November 2012) the doctor diagnosed cannabis abuse and recommended that he seek treatment. The defendant's solicitors wrote insisting that the plaintiff follow the doctor's advice. Subsequently Mr Schneider saw a counsellor at ATODS on 22 April 2013, a Ms Annette Hill. The counsellor's records read in part:

> "Substance History PDOC: Client states he first started smoking cannabis at the age of 17 years old. Client states when he smokes cannabis he would smoke about 2 to 10 cones on a typical day. Client states when he smokes

> cannabis he uses a billy and smokes hydro or bush. Client states the last time he smoked cannabis was last Sunday and the longest time he has ever been abstinence (*sic)* from cannabis is 2 weeks. DSM-IV: Evidence of dependence was completed and a score 2 and this indicated that the client is not depended *(sic).*
>
> Mental Health Status:
>
> A DASS 21 (Depression, Anxiety and Stress Scale) was completed, the results showed normal – 6 for depression, normal – 4 for anxiety, and normal – 4 for stress. Client denies of *(sic)* having any mental health concerns.
>
> …..
>
> Client states he is taking Nurofen plus 1 to 2 tablets when needed for his pain in the jaw from the motorbike accident. Client denies of *(sic)* having any health concerns."[30]

[57] Mr Schneider denied that history as accurate. He denied that the longest that he had been abstinent from cannabis was for a period of two weeks. He explained the "2 to 10 cones on a typical day" referred to his typical consumption on the days that he smoked – not that he smoked to that extent on a typical day.

[58] Dr Chalk, a psychiatrist, saw the plaintiff at the defendant's request on 1 October 2014. He asked that the plaintiff undertake testing for drugs. He was interested in his mental state and what may have been influencing him on the day of his examination. The solicitors assert that Dr Chalk gave Mr Schneider a referral letter to an adjacent QML laboratory. Mr Schneider did not attend. Two follow up letters were sent insisting that Mr Schneider provide the necessary sample and again Mr Schneider did not respond. Eventually, 57 days after the initial request, a sample was provided. The analysis showed no tetrahydrocannabinol in Mr Schneider's body. Obviously the sample is irrelevant for the purposes of determining whether Mr Schneider's mental state on the day of his examination by Dr Chalk was affected by drugs.

[59] The defendant argues that Mr Schneider's failure to attend for testing as requested by Dr Chalk gives rise to the inference that he was deliberately avoiding the test as he knew it would disclose cannabis in his system. That the inference is potentially open is clear.

[60] Mr Schneider's explanation was that he had no recollection of being asked by the doctor to provide a sample and that his continued delay was explained by his mental state:

> "The only thing that I can say is that to me it seems to be around, matching in with the times of this, I – I really took a hell of a step back and went into a – a higher level of depression somewhere around this time and – and you'd probably be able to find it. And that's where I saw Glenys Conrade. So that's where you'll find your dates – whether that matches in or – or what exactly. During that time, I didn't really leave the house for anything. So that's possibly a reason as to why this took a bit longer. That's – that's

[30] Ex 1.8 p 301

> the only thing I could find that could explain why that took a bit longer there."[31]

[61] The medical records confirm that he did see a Dr Glenys Conrade at around this time. Mr Schneider attended at the Mandalay Medical Centre on 21 November 2014. The GP recorded: "Not coping still. Low energy. Poor concentration." The purpose of the visit was described as "Anxiety/Depression. PTSD." On 24 November the record is: "Seen Dr Glenys for counselling." I assume that is a reference to Dr Glenys Conrade. I note the past tense. The QML tests were performed on 27 November. On 30 November 2014 there is a record headed "Dr Glenys Conrade" which I think refers to an attendance on Dr Conrade at some prior time as it includes: "was to start taking Lexapro 29/11/14," that is the day before.[32]

[62] The issue is whether an inference should be drawn from the failure to take the test that the claimed withdrawal from cannabis use had not occurred as at October 2014. There is an explanation proffered. While it does not cover the October period the medical records do suggest that Mr Schneider was at least complaining of problems consistent with psychiatric difficulties at around this time, as he claimed.

[63] As well, those close to him, to a degree, support his claim that he was not consuming cannabis in more recent years. Mr Schneider's good friend Mr Iwers had not seen him consume cannabis for a long time by the time of trial.[33] Evidence was called from Mr Schneider's de facto Ms Fruk. She was an impressive witness. While she worked through the week, and so was not in a position to observe Mr Schneider during the day, she said that she had not seen any evidence of him smoking cannabis for "a few years."[34] Finally there were tests undertaken previously which were consistent with no drug taking in 2013, the tests being undertaken on 6 September and 13 November 2013.[35] None of this is conclusive.

[64] In my view the evidence is not sufficient to draw the inference the defendant seeks and the probabilities favour the view that Mr Schneider gave up consuming cannabis as he says and probably earlier than he now recollects, sometime in mid-2013. I note that Ms Hill at ATODS noted that a test she applied in April 2013 suggested that Mr Schneider was not dependent. If accurate – and I have no evidence which would permit me to determine the efficacy of the test – that might explain how Mr Schneider could give up taking cannabis relatively quickly after seeing Ms Hill, as the QML tests in 2013 suggest. It also suggests that while drug taking took place over some nine years the quantities consumed were not so significant over so long a period. Mr Schneider's claim to be only a recreational user pre-accident is not contradicted by any evidence.

[65] In the end, while hardly persuaded that Mr Schneider was a reliable reporter of his own drug abuse, that account is supported to a degree by more reliable evidence. Ms Fruk supported his claim of recreational use and that he had given up the drug in the months leading up to the accident. As well it does seem that he was accepted at his workplace as reasonably reliable pre-accident – Mr Bailey thought he was at least average and the promise of a permanent position was clearly made well before the accident. That

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[31] T1-94/25-33
[32] Ex 1.6 p 232
[33] T3-14/13 and 34-46; T3-19/25-31
[34] T3-32/14-16; 3-35/12
[35] Ex 2.12 and 2.13 – pp 107-109

suggests that his consumption was not excessive, or at least not impacting on him to a significant degree.

[66] Mr Schneider's own account is that his consumption of cannabis increased markedly after the subject accident. There is no reason to think that the account given to ATODS is not reasonably accurate and reflects his drug taking at that time.

[67] It leaves the question as to how frequently consumption at that level occurred. Mr Schneider's evidence was again hardly precise. Mr Schneider maintained that prior to the accident he smoked cannabis once or twice a month on average but sometimes not for months – and not at all for three to four months immediately before the accident - but that after the accident he smoked cannabis perhaps two or three times a week, perhaps none for some weeks and, perhaps, four or five times in other weeks.[36] His modest pre-accident consumption was supported by Ms Fruk.[37] I note that Dr Flanagan thought that consumption at that level was not "heavy."[38] There is no direct evidence to put against this account.

[68] It is important to bear in mind that Mr Schneider was seeing Ms Hill about his excessive consumption of cannabis at a particular point in time. I am inclined to think that his account to Ms Hill reflects the true situation as at April 2013 more accurately than does his evidence given three years later. I accept then that two weeks would be as long an abstinence as Mr Schneider had during the time that he was smoking heavily, ie following the accident. The account was given contemporaneously with the heavier consumption and he was then seeking help. There is less reason to think he would mislead. But it is impossible to be certain.

The impact of the drug consumption

[69] Whatever the consumption, and on the plaintiff's own case it was considerably heavier after the accident than prior to the accident, the important matter is the effect of that consumption.

[70] Dr Flanagan opined that the cause of Mr Schneider's present psychiatric status was "multi-factorial". He mentioned in his report that the consumption of cannabis can have "negative effects on motivation and mood." He thought that it was "certainly possible" that his consumption of cannabis was "contributing to his mood and motivational problems."[39]

[71] What is striking is that the symptoms that Dr Flanagan said would follow from heavy and sustained use of cannabis very much reflect Mr Schneider's problems post-accident. When asked about the long term effects Dr Flanagan said:

> "….Heavy long-term cannabis abuse … can cause problems with motivation, cognition, problem solving ability … engagement with the world. It can produce the… so-called amotivational syndrome.
>
> And the amotivational syndrome, can you explain that to us in layman's terms, please? -- Well, it simply means that – an impairment of motivation

[36] T1-44/40-46
[37] T3-25/43 – 26/8
[38] T2-76/20
[39] Ex 2.2 p 45 para 12.3

> for doing – for engaging in the, you know, the important functions of life, work and social relationships and recreation. A person seems to become withdrawn and – and mainly preoccupied with their – with their drug habit and less interested in – in engaging with – with life and less motivated to – to, let's say, go to work or engage in healthy activities."[40]

[72] That describes some aspects of Mr Schneider's presentation almost precisely. After the subject accident he lost interest in his work and confidence in his abilities, lost interest in his surfing and in his motorcycle riding, he became withdrawn and uninterested in social outings or relationships with his good friends. It is difficult to avoid the conclusion that this is the result of the heavier use of cannabis after the accident, perhaps in someone susceptible to its effects at such dosages.

[73] I am conscious that Dr Flanagan thought that the extent of the cannabis use described by Mr Schneider was not such as to cause the problems that the doctor enumerated from "heavy long-term cannabis abuse". However he conceded that individuals differ widely in their susceptibility. In the state of the evidence it is impossible to know with any certainty the extent of the use or the susceptibility of the plaintiff. But given the coincidence of the known problems of cannabis abuse with Mr Schneider's presentation, cannabis use is almost certainly a contributor to, and remains a potential significant cause of, his disillusionment with work and his decision to resign.

The legal consequences of illicit drug use

[74] I think that there follows two relevant questions. The first is whether that increased consumption was itself a result of the accident and its sequelae? The second is, if that is so, are the deleterious effects of drug taking compensable? Or conversely are those effects to be taken into account in diminution of the damages otherwise to be awarded?

[75] Mr Schneider claims that following the accident he started consuming greater quantities of cannabis to cope with pain, "especially the head pain."[41] It numbed some of the pain, he said, "just that little bit more than just Nurofen."[42] There is no way, of course, of testing this claim but it accords with claims often made by the users of cannabis. As well, if one accepts that Mr Schneider abstained from drug consumption in the three to four months before the accident, as I do, it is not improbable that such a motive was the trigger to re-commence his drug taking. Assuming that to be true what are the consequences?

[76] This is not a case of a person with an addictive personality who succumbs to drug taking because of his or her exposure to significant painful symptoms. Some cases suggest that the effects of that drug taking are within the bounds of compensable loss: *Grey v Simpson* (Unreported – Court of Appeal New South Wales – 3 April 1978 – CA 327 of 1977) (addiction to heroin following pain consequential on injuries); *Havenaar v Havenaar* (1982) 1 NSWLR 626 (over-indulgence in alcohol causing pancreatitis). Whether the decision in *Grey* remains authoritative is doubtful: see *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22 at [72] per Spiegelman CJ.

[77] A different conclusion follows where the drug taking – whether illegal or not – is taken as a result of a deliberate and voluntary act of the injured person: see *Beard v*

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[40] T2-72/19-29
[41] T1-44/27-31
[42] T1-45/4-6

Richmond (1987) Aust Torts Rep 80-129 per Ambrose J at pp 69,003-69,004. Ambrose J there thought that the crucial determining factor was whether the decision to consume the drugs was foreseeable and that in turn depended on whether the decision was a reasonable one.

[78] Here the decision of Mr Schneider to turn to the consumption of an illegal drug cannot be seen to be, in any sense, a reasonable one. He does not claim, for example, that he had reported his symptoms to medical practitioners taken their advice, found it wanting in terms of the relief offered and so tried his alternative method of treatment. I do not say that on that hypothesis the plaintiff would merit damages, in fact I think on the authorities he would not, but merely highlight that the facts here are a long way from what might be arguably "reasonable".

[79] The test to be applied where an injured person engages in criminal conduct is that a defendant should not be held responsible for the losses that a plaintiff sustains that results from a rational and voluntary decision to engage in that criminal activity: *State Rail Authority v Wiegold* (1991) 25 NSWLR 500 at pp 515-516 per Samuels JA, Handley JA agreeing, Kirby P dissenting. The majority view has been accepted in Queensland: *Bailey v Nominal Defendant* [2004] QCA 344 at [4] per Jerrard JA; at [93]-[94] per Philippides J (as her Honour then was) – Chesterman J (as his Honour then was) agreeing. And see *Hunter Area Health Service v Presland* (supra) at [64] and [86] per Spiegelman CJ.

[80] Hutley JA put the point emphatically in this way in *Havenaar*:

> "There is no case of which I know that has, as yet, decided that a foreseeable, though voluntary, subsequent act of an injured person provides the basis for a claim for damages. The concept of voluntariness in a world of universal causation has been challenged, but the legal system is built upon the retention of some measure of individual responsibility and it has not been wholly abolished in the law of torts. A foreseeable deliberate and voluntary act, not part of the treatment prescribed, recommended or reasonably undertaken, of a victim of an accident does not, in my opinion, sound in damages because it is not part of the legal consequences of the accident."[43]

[81] If the plaintiff's cessation of his employment came about because of his use of illicit drugs then the defendant is not liable for the consequences of that decision.

Cessation of Employment

[82] I come then to one crucial issue in the case - the cause of Mr Schneider's decision to resign his employment at Queensland Health.

[83] At one level the case is straight forward enough. Prior to the accident Mr Schneider was a well performed employee who had been assured of promotion to a permanent position only to find after his return to work, following a near death experience in the subject accident, that his attitudes had changed and the demands of his work were overwhelming. There is no evidence of any criticism of him before the accident. The offer of a permanent position tends to support the view that his work performance was at least reasonable. While he was obviously frustrated with his superiors' refusal to

[43] [1982] 1 NSWLR 626 at 627-628

offer him the permanent position there was no suggestion that his ongoing frustration impacted on his work performance. After the accident and despite obtaining the long hoped for permanent position his performance fell away – his employer was plainly dissatisfied with his attendance and performance and he resigned. The source of the frustration was removed yet his dissatisfaction remained. To a significant degree his reaction was illogical. Despite obtaining the much sought after permanent position he gave up. A psychiatrist, Dr Flanagan, has diagnosed an anxiety condition triggered by the subject accident and its sequelae thus providing the necessary causal link.

[84] However, there are at least four competing explanations for his otherwise odd decision to resign. Their effects, of course, can overlap. One explanation is that Mr Schneider was simply dissatisfied with his superiors at Queensland Health, because of the failure for two years to honour what he regarded as a promise of the promotion to the permanent position.[44] Another potential explanation lies in his excessive consumption of cannabis, leading to a lack of motivation to work. A third is that he had no great desire to spend his life working 40 hours a week, particularly for "corrupt" organisations - he would rather go surfing. A fourth is the existence of a psychiatric condition.

[85] From the viewpoint of principle the existence of competing potential causes is not fatal to the plaintiff's case. The burden of proof overall, of course, is on the plaintiff. After a review of authorities Thomas JA held in *Wylie v The ANI Corporation Ltd*[45] that whatever view be taken of the applicability of the "effective cause" test in contract the approach in tort to issues of causation had been "watered down" – it was easier to satisfy the requisite test of causation in tort. The test Mr Schneider must satisfy was identified in *March v E & MH Stramare Pty Ltd*.[46] In discussing the slightly different issue of causation in the context of concurrent or successive tortious acts Mason CJ said in *March*:

> "Nonetheless, the law's recognition that concurrent or successive tortious acts may each amount to a cause of the injuries sustained by a plaintiff is reflected in the proposition that *it is for the plaintiff to establish that his or her injuries are "caused or materially contributed to" by the defendant's wrongful conduct*: *Duyvelshaff v Cathcart and Ritchie Ltd* (1973) 47 ALJR 410, per Gibbs J at 417; 1 ALR 125, at 138; *Tubemakers of Australia Ltd v Fernandez* (1976) 50 ALJR 720, per Mason J at 724; 10 ALR 303, at 310; *Bonnington Castings Ltd v Wardlaw* [1956] AC 613, per Lord Reid at 620; *McGhee v National Coal Board* [1973] 1 WLR 1, at 4, 6, 8, 12; [1972] 3 All ER 1008, at 1010, 1012, 1014, 1017-1018. Generally speaking, that causal connection is established if it appears that the plaintiff would not have sustained his or her injuries had the defendant not been negligent: see *I.C.I.A.N.Z. v Murphy* (1973) 47 ALJR 122, at pp.127128. But, as the decision in that case illustrates, it is often extremely difficult to demonstrate what would have happened in the absence of the defendant's negligent conduct."[47]

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[44] See, for example, his answer at T1-81/20; the history to Dr Gillett: Ex 2.5 p 72

[45] [2002] 1 Qd R 320 at [43]-[48]; see also *Lisle v Brice* [2002] 2 Qd R 168 at [4] per Thomas JA; [24]-[27] per Williams JA

[46] (1991) 171 CLR 506

[47] *Ibid* at [16]– my emphasis

[86] Here the injury in question is the claimed onset of a psychiatric condition resulting in an impairment to Mr Schneider's earning capacity.

[87] There are several questions. The first is whether Mr Schneider in fact had a psychiatric condition at the relevant time? The second is whether, if he has such a condition it has been caused by the subject accident? The third is, assuming an affirmative answer to the first two questions, whether that condition was operative in his decision to resign? The fourth is, assuming that there is a psychiatric condition consequent upon the accident and impacting on Mr Schneider's earning capacity, whether it is the defendant who must sort out the competing causes?

[88] My responses to these questions are: I do not accept that it is shown that Mr Schneider had a psychiatric condition at the time of his resignation from Queensland Health and so it follows that it is not shown that his resignation was the result of a psychiatric condition. Nonetheless, in my view, the evidence establishes that Mr Schneider has a psychiatric condition as Dr Flanagan has diagnosed. I accept that it is shown that the subject accident was a material cause of that condition. However I do not accept that the defendant has disentangled the competing causes so as to avoid compensating the plaintiff.

[89] I will explain my reasons.

Why I do not accept that the resignation was brought about by a psychiatric condition

[90] The argument advanced on Mr Schneider's behalf is set out at para [83] above.

[91] This argument fails to come to terms with two important points. First Dr Flanagan's diagnosis so far as it relates back to a time 13 months before he saw Mr Schneider depends virtually entirely on Mr Schneider's self-report. I have expressed my reservations on accepting Mr Schneider. And there are particular considerations relevant here which I will set out in a moment. The doctor is on much stronger ground relating what he himself saw and heard. As well, to a significant extent he is supported by Dr Chalk who saw the plaintiff two years later and his treating psychologist, Mr Bruce Acutt.

[92] Secondly, the argument does not meet the point that at the time of resignation Mr Schneider was consuming substantial amounts of cannabis and could not but have been affected by what Dr Flanagan thought was cannabis abuse. That was Dr Chalk's view.[48] I have discussed its potential impacts. That consumption is quite capable of explaining that impulsive resignation. Accepting that there is an evidential onus on the defendant to disentangle non tortious competing causes, that onus does not arise until the plaintiff has discharged the burden on him.[49] In my view Mr Schneider failed to do so.

[93] At the outset I should acknowledge that I accept that Mr Schneider's self-report, if accurate, is capable of supplying a basis for the existence of a psychiatric condition. In a statement tendered he explained his position as follows:

> 55. Even before the new system was unrolled, it was obvious to me and other employees in the Payroll Department that there were major flaws in

[48] See Ex 21 p 2
[49] See below at [123]-[124]

the way the system was being implemented. In addition, there were unrealistic expectations about the time frame that would be needed to bed the new system down.

56. These issues had caused me to come into conflict with my managers in the Payroll Department even before my accident. However, I was able to manage this stress and perform my job at work. I believed that I was doing a good job at work.

57. When I returned to work after the accident, I was still employed on a contract basis. This had been an ongoing source of tension for me because I had previously been given assurance by my managers that I would become a permanent employee of Qld Health.

58. From memory, my employment with Qld Health did become permanent a few months before I resigned but by then, I simply could not cope with the requirements of my job.

59. Even though I was unhappy about not being made a permanent employee before the accident, I never let this affect my work. My general philosophy in life was to get on with the job and not let the situation get me down.

60. After I returned to work, I had increasing difficulty coping with my duties. I started to experience panic attacks in the workplace.

61. There were numerous problems with the new payroll system which were well publicised at the time. This added additional stress to the work environment but I knew that other employees were also having trouble coping too.

62. After I returned to work after the accident, I did have to take time off work for medical appointments for the treatment of my injuries. However, I also started taken "sickies" because I was having difficulty handling the stress at work.

63. After the accident, I found that I no longer had the means to cope with the stressors of my job. At times, my head felt like a "washing machine" and for most of the time I could not think properly.

64. I no longer seemed to enjoy my work as much as I did before the accident. I became less reliable than I was before the accident.

65. By the end of my employment with Qld Health, I simply could not cope and I dreaded the thought of going to work in the morning. I completely lost my confidence.

66. I recall that on some occasions I was reduced to tears in the work place.

67. In about August 2011, my then manager (Andrew Walker) placed me on a Performance Improvement Plan (PIP). The main concerns

> surrounded my attendance record, punctuality for work and my work output.
>
> 68. The PIP was to conclude on 17 November, 2011. My performance was to be reviewed on a weekly or fortnightly basis. I had an exchange of emails with Andrew Walker after I was placed on the PIP. My father helped me draft my email to Andrew Walker dated 25 August 2011.
>
> 69. I recall having regular follow up meetings with my manager, Clay Bailey.
>
> 70. I had never been counselled about my work performance prior to my accident. In fact, I had always been told by my managers that my performance was more than satisfactory."[50]

[94] In his oral evidence Mr Schneider repeated his claim that his head was turning into a "washing machine". He said:

> Well, did – what were you feeling – what were your feelings? The best I can describe the way I felt and it got to the point where it was nearly every day that I felt like it – it felt like my head just turned into a washing machine. I'd be sitting there – like, I was sitting there quite often just sort of rocking back and forward and pacing and on the spot, if I was standing, and absolutely feeling just overwhelmed and not able to think of what I was even stressed about. Just feeling absolutely over the top stressed and it just felt like I couldn't even pinpoint what exactly I was worrying about at the point to try and fix it. You know, just – just felt like everything go too much for me and my head just went into an absolute washing machine. There were ideas and thoughts running around and …"[51]

[95] If these statements be accepted as accurate then there is ample evidence to support the onset of some significant psychological problem when at work.

[96] However I am not persuaded that they can be accepted. I have noted already that I have reservations about accepting Mr Schneider's unsupported statements. I do not mean to say that I think Mr Schneider is deliberately attempting to mislead but rather that he is unreliable – particularly when attempting to accurately describe his condition, whether physical or mental, long after he experienced it. On this issue, as with the facial injuries, there are problems.

[97] There is no independent evidence that Mr Schneider did take "sickies" at all, let alone because of an incapacity to cope with stressors at work.[52] His evidence provided no support for the claim.[53] An odd feature of the evidence is that the defendant sought to tender Mr Schneider's attendance records in the course of his cross examination precisely for the purpose of comparing pre and post absences from work, that was successfully objected to on the grounds that the necessary foundation for the admission of business records had not been laid and otherwise there had been no adoption of the records by the plaintiff, and in the end they were not proved. Each side had an interest

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[50] Ex 2.1 pp 6-7
[51] T1-35/39 - 36/2; and see T1-36/19; T1-81/37
[52] See para 62 of his statement quoted above at [93]
[53] T2-37/5 – 38/25

in proving the records – either to establish or demolish the plaintiff's claims - but neither did. I do not think it appropriate to draw any inference – however there is simply no support for the plaintiff's claim of increased absences post-accident.

[98] Nor is there any reliable contemporaneous evidence of Mr Schneider's mental state. The most comprehensive examination of his mental state was undertaken by Dr Flanagan in November 2012, 13 months after his letter of resignation. Prior to that referral, which was for medico-legal purposes, Mr Schneider had not seen any medical practitioner for psychological or psychiatric problems. In a case full of odd features Mr Schneider denied to the ATODS counsellor, Ms Hill, that he had any mental health issues[54] despite having seen Dr Flanagan months before complaining of those symptoms. His explanation is that he wanted to deny the existence of those problems. That is not an unreasonable explanation but the fact remains that there is no support for the plaintiff's account.

[99] Nor did the only witness from his work place speak of any apparent difficulties of that type. There was no support for his claim that he was in tears at his workplace or that he would "quite often just sort of rocking back and forward and pacing and on the spot." The only contemporaneous record of what may have been going on at the time is Mr Schneider's letter of resignation. Mr Schneider attributed his decision to resign to "unnecessary stress in my life."[55] The stresses are not identified.

[100] Dr Chalk has pointed out that Mr Schneider's response, made late in his employment, to the performance improvement plan imposed by his employer, was articulate and well considered.[56] That, the doctor said, is inconsistent with his claims to be seriously affected psychiatrically.[57] Mr Schneider says that he received assistance from his father in the drafting of the response. That meets Dr Chalk's point. But the need for assistance does not show the existence of any mental illness - Mr Schneider may have had a need for that same assistance whether the cause be cannabis use or otherwise. That evidence does not meet the point that there is no independent evidence supportive of the claimed psychiatric condition.

[101] Subsequently Mr Schneider has given differing accounts as to why he resigned, none necessarily inconsistent with a psychiatric cause, but the emphasis plainly being on his dissatisfaction with his employers.

[102] He told Dr Gillett in late 2012 that his decision to stop work was "not related to the accident causing problems with his work but problems he had with his employer."[58]

[103] He told Dr Coyne in January 2013 that he left "due to difficulties with management" that he had been able to deal with before the accident but not after.[59] Dr Coyne thought that his psychological condition may have played a role in him leaving his employment. [60]

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[54] Ex 1.8 Volume 1 p 301
[55] Ex 1.20 Volume 2 p 538
[56] Ex 2.17 p 149
[57] Ex 21 p 3
[58] Ex 2.5 p 72
[59] Ex 2.9 p 98
[60] Ex 2.9 p 100

[104] These statements are not conclusive against the plaintiff. Dr Flanagan's view was that the plainly expressed dissatisfaction with societal institutions could be explained by the mixed anxiety disorder that he had diagnosed:

> "12.1 I would see the philosophical or existential stance as a rationalisation of the underlying phenomenology being a loss of confidence in himself, anxiety about his capacity and future, social anxiety and some generalised anxiety. This is accompanied by impaired motivation, and low mood when on his own. He has become emotionally dependent on his surfing associates, father and girlfriend."[61]

[105] Dr Flanagan's views provide an answer. But all this pre-supposes an accurate account of how Mr Schneider felt 13 months before he saw Dr Flanagan. I see no reason why I should be persuaded to the necessary standard that his account was accurate.

[106] There is another problem. While it is clear that Dr Flanagan thought that the psychiatric condition he had diagnosed was causally linked to the subject accident, that is not the same thing as saying that the resignation from employment was. In his second report prepared in June 2015 Dr Flanagan opined:

> 10.3 Question 4: If you consider that any part of that impairment is referrable to other factors, please apportion the percentages appropriately:
>
> I am unable to identify any other factors other than some developmental adversity that may have predisposed and a disillusioned resignation from his job. *The latter may have been partly due to anxiety and depressive symptoms.*

[107] The answer in paragraph 10.3 that I have quoted is not sufficient to discharge the onus on the plaintiff. That the "disillusioned resignation" from the employment with Queensland Health "*may have been partly* due to anxiety and depressive symptoms" does not satisfy the relevant test. It is necessary for the plaintiff to show that the resignation was, on the balance of probabilities, due to the diagnosed anxiety state. A possibility is not enough. That is fundamental.

[108] This is not a case where the plaintiff can argue that there is no other apparent reason for an impulsive and illogical resignation. His disillusionment and the intake of cannabis provide alternative explanations. Alternatively, Dr Chalk's view could be adopted – his view was that if Mr Schneider had accurately described his attitudes to Dr Flanagan his decision to resign and go surfing was hardly illogical, not reflective of mental illness at all, and consistent with his pre-accident attitude to university studies.[62] The plaintiff bore the onus of causally relating his decision to resign to the psychiatric condition subsequently diagnosed 13 months later. In my view he failed in that endeavour.

[109] While I accept that at some point in time Mr Schneider developed a psychiatric condition sufficient to interfere with his earning capacity I am not persuaded that there is any sufficient basis to accept that it was in place or so significant during 2011.

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[61] Ex 2.2 p 45
[62] Ex 21 p 3

Why I accept that there is a psychiatric condition

[110] That decision does not necessitate a rejection of the view that Mr Schneider has developed a psychiatric condition, and as a result of the accident. On the latter point, the issue is not whether there are possible causes for the ongoing presentation other than a tortiously caused illness but rather whether the subject accident was a material contributing cause.

[111] Both psychiatrists clearly thought that something was amiss psychiatrically. Both (in the end) thought that the presentation was the result of the subject accident and its sequelae. One treating psychologist, Glenys Conrade, suggested anti-depressant medication. The care provider who had most to do with Mr Schneider's mental health, another psychologist Mr Bruce Acutt, also thought that there was a problem. While of much lesser significance I note too that Dr Maureen Field, a neuropsychologist and Dr Terry Coyne, a neurosurgeon, spoke of psychological factors impacting on his presentation. I turn then to the evidence of the psychiatrists.

[112] Dr Flanagan set out his views in response to questions posed. At the initial examination in November 2012 Dr Flanagan considered that Mr Schneider was suffering from an anxiety disorder. In his second report, prepared in June 2015, Dr Flanagan opined that Mr Schneider's condition was worsening. He added the following comments:

> "Causation
>
> 8.1 I note Dr Chalk's reservation about this issue. However, in the absence of any pre-existing disorder, I find it hard not to see the accident and its sequelae as having been a significant cause.
>
> …
>
> 8.5 I think his injury experiences were very stressful. He had very severe multiple injuries and facial injuries in particular can be potentially traumatic, particularly to young persons. His memory of the early dental treatment is particularly traumatic. Though he has had, as one specialist says, an excellent outcome to treatment, he has significant ongoing physical symptoms reminding him of his injuries and causing some physical impairment.
>
> …
>
> 8.7 Overall, I am inclined to say that the accident was a major significant factor in the causation of his complex psychiatric disorder.
>
> …
>
> 9.1 It is now over five years since the accident. His condition is a chronic one. The chances of a significant benefit from medication are not high. His condition can be considered as permanent and I have completed a PIRS.
>
> …

> 10.4 Question 6: In your view, what impact has Jeffrey's condition had on his ability to obtain employment from October 2011 to the present date:
>
> I think his insidious worsening depressive and anxiety disorders have had a very significant impact on his employability."[63]

[113] In 2014 Dr Chalk responded to a question asked in these terms:

> 7. Whether, in your opinion, the claimant sustained a diagnosable psychiatric injury as a direct result of the accident:
>
> I think it is unclear whether this man has developed a diagnosable psychiatric injury as a direct result of the accident. I am particularly troubled by the fifteen months of full-time work that he completed in the aftermath of this accident. Indeed he seems to have continued to work over an extended period of time, and then to have somewhat impulsively quit work, and has not sought employment since. Certainly I am of the view that his symptoms are suggestive of the development of an adjustment disorder with depressed and anxious mood though a clear causal relationship between that and the accident is in my view less than clear.[64]

[114] With respect to causation the question directed the doctor's attention to a false issue. The question to be resolved is not how "direct" the cause might be but rather that posed by Mason CJ that I have mentioned – was the injury "caused or materially contributed to" by the defendant's wrongful conduct. The following extract from the doctor's cross examination clearly shows his acceptance that the test is satisfied:

> "Now, Doctor, it's not uncommon for people who develop – well, who suffer severe trauma, such as a car accident with a severe injury, to suffer mental illness afterwards, is it? Yes. That's very common.
>
> Right. And in this case the following factors are apparent: (1) my client had amnesia about the accident. Are you aware of that? Mmm.
>
> He had a severe facial fracture? Mmm.
>
> He had surgical intervention? Yes. He absolutely had a significant injury.
>
> Two months of rehabilitation? Mmm.
>
> And importantly he had no pre-accident psychiatric history or complaint; that's right, isn't it? As far as I'm aware, yes.
>
> You would have to say, in those circumstances, wouldn't you, Doctor, that the accident, given all of those factors, must be a significant contributing factor to his presentation on that day? I haven't disputed that the accident certainly contributed towards his difficulties.

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[63] Ex 2.4 pp 65 - 68
[64] Ex 19 p 13

> I see. And you would agree that it's a significant contributing factor, wouldn't you? I – I think that the accident probably was a significant contributing factor."[65]

[115] So the initial hesitation that Dr Chalk expressed about the causal link between any psychiatric illness and the accident was effectively dispelled, at least for my purposes. And while his views that Mr Schneider's "symptoms are suggestive of the development of an adjustment disorder with depressed and anxious mood" are not quite aligned with Dr Flanagan's, they both agree that anxiety and depression were playing a part, albeit differing in their views on the degree. I note particularly Dr Chalk's agreement that the symptoms that he listed as reported to him are consistent with a dysthymic disorder,[66] as Dr Flanagan said. And if persistent they would be considered chronic and potentially more difficult to treat.[67] While Dr Chalk clearly had reservations about Mr Schneider's presentation his views are not so different from Dr Flanagan's. I note that Dr Chalk recommended psychological and pharmacological treatment modalities.

[116] Dr Flanagan has the advantage of seeing Mr Schneider twice. The psychiatrists, of course, assessed him at different times and it may be that his condition fluctuates, as Mr Schneider says it does.

[117] Another point worth mentioning is that while Dr Chalk was concerned about the 15 months of employment post-accident he assumed that "there was no suggestion that his work performance was poor in the aftermath of that time."[68] That is not accurate. Mr Schneider was eventually put on a performance improvement plan because his work performance was not acceptable. There were three matters the subject of that review – leave taken, timeliness of showing up for work, and the extent that Mr Schneider was logged into the phone system.[69] Mr Bailey spoke of counselling him. It is quite clear there was a deterioration in performance. Dr Chalk's misapprehension about his performance was eventually dispelled but his initial misgivings were not based on accurate assumptions.

[118] A very experienced psychologist, Bruce Acutt, also thought that Mr Schneider had a psychiatric disorder. Mr Acutt reported that Mr Schneider presented with high levels of anxiety, social phobia and a lack of self-confidence. Mr Acutt saw Mr Schneider on some eight occasions from early in 2014 and can claim to have had by far the most contact with him. Mr Acutt thought that Mr Schneider met the DSM-IV criteria for a post-traumatic stress disorder. The psychiatrists did not support that diagnosis although Dr Flanagan thought it a possibility. The problem seems to be one of labelling rather than any concern that there is no mental health problem.

[119] The defendant submits that the condition should either not be accepted or not be seen in as serious a light as Mr Schneider would have it. In support the defendant played several videos of the plaintiff going about his daily life. The videos were taken on 29 April 2013, 7 May 2013, 24 August 2013, and 25 August 2013. On each occasion on which Mr Schneider was filmed he was outdoors. He placed his surf board on his car roof on one occasion and strapped it in place. He worked on his vehicle. He drove his

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[65] T3-92/44 to T3-93/42
[66] T3-88/30 – 3-90/5
[67] T3-90/30-40
[68] Ex 19 p 11 para 220
[69] Ex 2.16 pp 144-146

vehicle. He attended shopping centres. He wandered around shops apparently unconcerned. He was then accompanied by his partner, Ms Fruk.

[120] It is difficult to judge the impact the videos should have when the complaint is one of a fluctuating condition. Nonetheless it seems to me that there is some merit in the argument that the condition, which Dr Flanagan described as "societal anxiety", is not as serious as Mr Schneider perceives and describes it to be. However neither psychiatrist was shown the videos and so I do not have their comments on how it impacts on their views. If the activities depicted disproved the existence of the condition I would have expected to hear that said expressly.

[121] Finally, I note that Dr Flanagan's analysis placed emphasis on a different aspect of his condition. While acknowledging that societal anxiety was an aspect of his presentation it is clear that the doctor saw other features as more prominent in his inability to work. He was asked the following question and gave the following answer:

> "…what were the main factors, that is, the main factors in the information that you had, that gave cause to you to diagnose at that time a mixed anxiety disorder for this gentleman? --- Most of his symptoms, I thought, were basically of an anxiety nature. He had – in particular, he had loss confidence in himself and his problem-solving ability, lost confidence in his ability to go back to work or work anywhere or with anyone, and he felt that, for some reason, he had lost his ability to think analytically and to problem solve and to deal with things in a productive way."[70]

[122] Essentially I have come to the view that despite the defendant's criticisms of him Mr Schneider is essentially honest. I accept that there has been some overstatement. However he has consistently presented for a considerable time now to a variety of practitioners with experience in the mental health field and each has come to the view there is a problem. That view accords too with the evidence of Mr Schneider's father and de facto.

[123] Once it be accepted that Mr Schneider has a psychiatric disorder caused by the defendant's tort then it is for the defendant to untangle the competing causes. I understand the principles to be as follows. Where the defendant alleges that a pre-existing condition (here the deleterious effects of excessive cannabis consumption) would have brought the plaintiff to a particular state of health irrespective of the supervening injury an evidential burden is placed on the defendant to disentangle the causes: *Watts v Rake*;[71] *Purkess v Crittenden*;[72] *Hopkins v WorkCover Queensland*;[73] *Smith v Topp*.[74] *Purkess* is usually cited for the proposition that the defendant may not merely suggest but must show with "some reasonable measure of precision, what the pre-existing condition was and what its future effects, both as to their nature and their future development and progress, were likely to be".[75]

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[70] T2-61/41 – 62/2
[71] (1960) 108 CLR 158
[72] (1965) 114 CLR 164
[73] [2004] QCA 155
[74] [2003] QCA 397 at [38]
[75] *Seltsam Pty Ltd v Ghaleb* [2005] NSWCA 208 at [104] per Ipp JA with whom Mason P agreed. Quoted with approval by White JA in *Phillips v MCG Group Pty Ltd* [2013] QCA 83 at [57] (Fraser JA and Daubney J agreeing)

[124] However the pre-requisite to that proposition is that the "plaintiff has, by direct or circumstantial evidence, made out a prima facie case that incapacity has resulted from the defendant's negligence" and the persuasive burden remains on the plaintiff "upon the whole of the evidence to satisfy the tribunal of fact of the extent of the injury caused by the defendant's negligence."[76]

[125] I am persuaded by the coincidence in the views of the psychiatrists and psychologists, to the extent that they do coincide, that the plaintiff has discharged the burden on him of establishing both the existence of the psychiatric condition and that there is the necessary causal connection to the subject accident.

[126] No question was directed to the issue of whether Mr Schneider's presentation would have been the same had the subject accident not occurred. The prime alternative hypothesis for a cause lay in his cannabis consumption. I have found that the cannabis intake ceased around mid-2013. There is no evidence that the level of consumption demonstrated should still be operative long after Mr Schneider stopped taking the drug. Dr Flanagan clearly thought that the long term consumption would need to be of much greater duration and more substantial than the evidence suggests here for there to be long term problems. Dr Chalk too thought that with the cessation of cannabis consumption any continuing psychiatric illness was not attributable to that cause.[77]

Exhibit 8

[127] The defendant led evidence that became Exhibit 8. Its relevance depended on my accepting that the contents reflected conflict in Mr Schneider's identification of his sexual orientation. I am not so persuaded. His explanation was sufficient for me to determine that there was no proper basis on which to accept the defendant's premise. I mention the matter out of completeness.

[128] With those general observations on the principal arguments I turn to the various heads of loss.

Pain & Suffering

[129] The assessment must be made in accord with the Injury Scale Values (ISVs) set out in the *Civil Liability Regulations*.

[130] The plaintiff contends for an ISV of 54. The submission assumes the facial injury falls within Item 14 (Extreme facial injury) of Schedule 4 to the Regulations and allows for an uplift of 25% given the discrete multiple injuries suffered by the plaintiff as well as the psychiatric condition.

[131] The defendant contends for an ISV of 25. The submission assumes that Item 15 applies (Serious facial injury) and that an ISV at the top of the range (14 to 25) is appropriate. The argument is that the facial injuries alone would score towards the bottom of the range but that to allow for the multiple injuries sustained an allowance of the maximum dominant ISV is appropriate.

[132] At the outset I note that the defendant sought to argue that because Mr Schneider, or whoever acted on his behalf, failed to include certain of the injuries in a Q Super claim

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[76] *Purkess v Crittenden* (1965) 114 CLR 164 at p 168 per Barwick CJ, Kitto and Taylor JJ

[77] Ex 21 para 1

form completed on 24 March 2010 then that was evidence justifying rejection of the existence of those injuries at all. The form provides one line in which to insert the relevant "condition". Mr Schneider has inserted, or caused to be inserted, the following: "bruising and multiple fractures to facial bones and wrist and laceration to hand."[78] There are a number of problems with such an argument. It ignores that the purpose of the form – ie to justify the claim brought – was achieved by the information provided. It ignores the timing of the completion of the form – only two weeks after the accident and before Mr Schneider was fully mobilised. It assumes that all injuries would have been then evident or thought relevant at so early a time. It ignores the overwhelming effects of what must then have appeared to be quite disastrous facial injuries that Mr Schneider had suffered. And it ignores the fact that when he did mobilise Mr Schneider did complain of symptoms - most graphically by the reference to the right knee injury. I did not find the argument to be of much assistance.

Facial Injuries

[133] The parties are agreed that the facial injuries represent Mr Schneider's dominant injury. The parties also agreed that 15% was a reasonable assessment of the overall permanent impairment, relying on the views of Dr Maloney, the oral and maxillofacial surgeon previously mentioned.[79] However, they differed as to the appropriate classification.

[134] The facial injury does not fall within the description of injury to which Item 14 applies. To fall within Item 14 it is necessary that the degree of incapacity and disfigurement after reconstructive surgery is "very severe" or causes "incapacity in daily activities". As mentioned, no disfigurement was apparent from the witness box. I note that Dr Harris, a plastic and reconstructive surgeon, reported fine scarring and "some asymmetrical appearance relating to the right zygomatic arch, but otherwise no marked abnormality in relation to his facial appearance."[80] While Mr Schneider has had some incapacity in daily activities because of his facial pain at times there is no medical support for that as a continuing feature nor does it seem to be in fact a significant continuing problem from the evidence, some of which I review later.

[135] Mr Arnold who appeared for Mr Schneider argued that it is was noteworthy that Mr Schneider had suffered a Le Fort III fracture on the right side and along with a Le Fort II and Le Fort I fractures of the left orbital floor – three Le Fort fractures in all. He submitted that you need only one such fracture to be classified in Item 14. While true enough, the submission assumes that it is the number of fractures that is the major significant feature and that one should ignore their consequences, or lack of consequences. The Schedule gives no hint that that approach is the correct one.

[136] Rather the defendant is correct, in my view, to assert that the facial injuries fall within Item 15. Mr Schneider's injuries and their consequences do not fall squarely within any of the examples or descriptors given in Item 15. However one example that comes close is of an injury that is "a very serious multiple jaw fracture that will require prolonged treatment" and "despite reconstructive surgery, cause permanent effects, for example severe pain…". Mr Schneider had multiple fractures of his jaw, the treatment required was reasonably prolonged,[81] and Mr Schneider certainly complains of severe

[78] Ex 1.19 p 529
[79] Ex 2.7 p 89
[80] Ex 1.1 p 4
[81] See the description given by Dr Maloney – Ex 2.7 at p 86

pain in his face at times. For present purposes I put to one side the reasonably significant psychological reaction.

[137] It appears from the comments that the author of the schedule has assumed that cosmetic deformity and adverse psychological reactions will go together. The greater the one the greater the other. The comments are:

> **"Comment about appropriate level of ISV**
>
> An ISV at or near the bottom of the range will be appropriate if the injury causes permanent cosmetic deformity, asymmetry of 1 side of the face and limited adverse psychological reaction.
>
> An ISV at or near the top of the range will be appropriate if the injury causes serious bilateral deformity, and significant adverse psychological reaction"

[138] Mr Schneider has no great deformity, very limited asymmetry, but has some pain and while he has had an adverse psychological reaction that is not due, principally at least, to the facial injuries in the sense I think intended by the Regulation but more to his "brush with death."

[139] I assess the facial injuries as having an ISV of 14. It is necessary to turn to the other injuries to determine whether an ISV at the top of the range of Item 15 (the "maximum dominant ISV") is appropriate to reflect the plaintiff's multiple injuries, or whether an uplift is required.

Other Injuries with disputed classifications

Cervical Spine

[140] The plaintiff contends for an ISV of 10, on the basis that Item 88 applies (Moderate cervical spine injury). The defendant contends for an ISV of 0-4, on the basis that Item 89 applies (Minor cervical spine injury). The experts differed as to this injury – 0% from Dr Gillett, an orthopaedic surgeon, and 2% for pain from Dr Coyne, a neurosurgeon.

[141] The evidence is limited. The plaintiff complained of "neck strain, neck pain and back pain" from sitting at work a couple of months after the accident.[82] He has "tension type symptoms" after an hour's surfing.[83]

[142] The cervical spine injury does not fall within the description of injury to which Item 88 applies as there is no objective evidence of moderate permanent impairment. It seems to fall into the descriptor in Item 89 which I set out:

> **Example of the injury**
>
> A soft tissue or whiplash injury if symptoms are minor and the injured person recovers, or is expected to recover, from the injury to a level where the injury is merely a nuisance within 18 months after the injury is caused.

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[82] T1-34/27-29

[83] Dr Gillett - Ex 2.5 p 72

Comment about appropriate level of ISV:

An ISV at or near the bottom of the range will be appropriate if the injury will resolve without any ongoing symptoms within months after the injury is caused.

An ISV at or near the top of the range will be appropriate if the injury, despite improvement, causes headaches and some ongoing pain."

[143] It is noteworthy that the hospital records show that there were investigations into the cervical spine from the earliest time. There is some minor ongoing pain. I accept Dr Coyne's assessment. I assess an ISV of 4 for the cervical spine injury.

Thoracic and Lumbar Spine

[144] The plaintiff also complains of injuries to his thoracic and lumbar spine, contending an ISV of 4 for both, based on Item 94 (ISV 0-4) (Minor thoracic or lumbar spine injury). The defendant argues that it is not shown that there was any injury to these areas in the accident.

[145] Mr Schneider's complaints are of intermittent symptoms that when present make him "stiff and uncomfortable."[84]

[146] The defendant's point is that Mr Schneider did not complain of pain in those areas of his spine either contemporaneously with the accident or when seen at the orthopaedic clinic on several occasions in the months following the accident. He told Dr Gillett that he only noticed the pain when he became more active. As well he complained of lower back problems to his GP and was referred for an X-ray of the lumbosacral spine for "chronic back pain" on 3 April 2009, ie shortly before the subject accident.[85]

[147] Those two criticisms are met here. The explanation for non-complaint is not improbable – the plaintiff had numerous other injuries of a more serious kind and one would not expect him to be greatly concerned by them until he did get more active.

[148] There are two further matters that favour a finding in the plaintiff's favour. First, it would be surprising if a serious motor cycle accident involving very substantial injuries to the face did not cause symptoms throughout the spine.

[149] Secondly, the evidence is one way - Dr Gillett thought that the "mechanism of accident would be consistent with producing" soft tissue injuries in these areas. He was not cross-examined. Dr Gillett was not asked about the significance of the symptoms that pre-dated the accident.

[150] In the circumstances I accept the existence of the symptoms and their causal connection with the subject accident.

[151] Dr Gillett assessed an impairment of 0% in each area. Following his examination Dr Gillett said "in relation to the thoracic and lumbar spine he has a full range of motion

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[84] Dr Gillett – Ex 2.5 at p 72; Ex 2.1 p 13 - Quantum statement: "I also experience pain in my middle and lower back but this pain comes and goes."

[85] Exhibit 1.6 p 216

of those areas with some discomfort in the lumbosacral junction at the extremes of motion but no guarding, spasm or asymmetry of motion."[86]

[152] At best for Mr Schneider the symptoms are minor. However they have not resolved. They have reached maximum medical improvement. An ISV at the top of the range is indicated.

[153] I assess an ISV of 3 for both injuries.

Right and Left Knees

[154] The plaintiff contends for an ISV of 10, on the basis that Item 139 applies (Moderate knee injury). The defendant contends for an ISV of between 0 and 5, on the basis that that Item 140 applies (Minor knee injury). The descriptors for Item 139 and 140 state:

> **Examples of the injury**
>
> A dislocation or torn cartilage or meniscus causing ongoing minor instability, wasting and weakness (Item 139).
>
> A partial cartilage, meniscal or ligamentous tear (Item 140).

[155] Dr Gillett assessed a 3% impairment of the right knee due to ligamentous laxity.[87]

[156] An MRI of the right knee performed on 13th May 2010 found a tear in the body of the medial meniscus, as well as tears in the proximal third of the anterior cruciate ligament and lateral collateral ligament.[88]

[157] In his evidence the plaintiff described soreness and clicking in both his knees, with his left knee being worse. The plaintiff is still able to surf for periods up to two hours and he has reported to Dr Gillett that he gets the odd pain in his right knee and that it is "mostly good."[89]

[158] In relation to the right knee I am satisfied Item 139 applies as there is evidence of a meniscal tear with some minor instability or weakness. I assess that an ISV of 6, at the bottom of the range, is appropriate.

[159] For the left knee the parties were in agreement that Item 140 applied. As outlined above the plaintiff complains of clicking and soreness. I assess an ISV of 2. While of no great moment, it is an odd feature of the evidence that subjectively Mr Schneider says the left knee is worse than the right, but the medical opinion rates the right as more impaired than the left.

Scarring to the body

[160] The plaintiff contends for an ISV of 25 on the basis that Item 155.1 applies (Extreme scarring to a part of the body other than the face). The defendant contends for an ISV of 4-8, on the basis that Item 155.3 applies (Moderate scarring to a part of the body other than the face). Dr Harris assessed 4% impairment for this injury.

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[86] Ex 2.5 p 81
[87] Ex 2.5 p 75
[88] Ex 1.3 p 41
[89] Ex 2.6 p 79; Ex 2.5 p 72

[161] The scarring does not fall within the description of injury to which Item 155.1 applies. Even if it were to be classified as extensive scarring or significant cosmetic disfigurement the plaintiff does not have a need to keep a limb covered or wear special clothing, nor does he have ongoing limitation in the ability to participate in activities.

[162] The injury fits within Item 155.3 as there are several scars including on his anterior neck, right hand, left forearm and hand, knees and left deltoid region.[90] However these are largely described as fine or superficial scars. An ISV of 4 is appropriate.

Other Injuries with no dispute as to classification

[163] The left wrist – the plaintiff had a fracture to the left wrist, which required the insertion of K wires.[91] The parties are agreed Item 108 applies (Minor wrist injury – ISV 0-5). He complains of severe pain when writing, but can play an Xbox for periods up to two hours.[92] The difficulty with writing came on long after the accident and is probably psychologically based rather than physical.[93] I assess an ISV of 3.

[164] The right hand – the plaintiff suffered a tendon laceration to the right hand. The parties are agreed Item 120 applies (Minor hand injury – ISV 0-5). The plaintiff described pain during his period of convalescence but reports the pain has improved.[94] I assess an ISV of 2.

[165] Psychological – Dr Flanagan diagnosed the plaintiff with anxiety disorder and THC abuse. In his second report Dr Flanagan thought that the condition had worsened and he diagnosed a dysthymic disorder with 7% impairment. The cannabis abuse was in remission. Dr Chalk diagnosed the plaintiff with an "adjustment disorder with depressed and anxious mood" with 5% impairment but a maximum of 2.5% related to the accident. Dr Flanagan has had the advantage of seeing Mr Schneider on two occasions and, I think, has more accurately assessed him. The relevant Item is Item 12 with an ISV range of 2-10. A PIRS rating of less than 10% is typical for this level of injury. Treatment might well assist and perhaps halve the disability. I assess an ISV of 7.

[166] The teeth – the plaintiff has had four teeth extracted and has shear[95] fractures on two other teeth consistent with trauma from the accident. The parties are agreed Item 18.1 applies (ISV 6-10).

[167] The plaintiff's description of his problems was graphic:

> "And was it painful to clean your teeth? Very, yeah.
>
> Yes. And how long did that persist for? A long time and it still is now. It's – I still get nerve pain in – in my teeth – cleaning my teeth. At the start, it was very painful, and especially then once I cracked half my tooth at the top, that was very painful, of course, then, to try and brush. And like I said, decay seemed to start very quickly where the wires had been pulled

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[90] Ex 1.1
[91] Ex 2.1 p 4; T1-6/14-15
[92] T1-87/26-33; T2-4/37-40
[93] Ex 2.4 p 67 para 8.6
[94] Ex 2.1 p 13
[95] Ex 1.10 Volume 1 p 312

> back through and as soon as that decay started, then it started to hurt more of course. Having those wired pulled back through was honestly the most traumatic experience I have ever experienced in my life – the most painful thing I have ever experienced in my life, and so I was terrified to actually go back to a dentist afterwards, and that's why I didn't go in and have things fixed quick enough, probably, afterwards …"[96]

[168] The plaintiff's dental treatment has not yet been completed and will be protracted.

[169] I assess an ISV of 10.

[170] Facial Scarring – the parties are agreed Item 21 applies (Moderate facial scarring: ISV 6-10). Dr Harris assessed 6% for this injury. I have previously outlined that I could not detect any scarring when the plaintiff was in the witness box nor were any photographs put into evidence. I assess an ISV of 6.

Whether Maximum Dominant ISV adequate?

[171] The table below summarises my findings:

Body Part	**Item No.**	**Descriptor**	**ISV Range**	**ISV**
Wrist [left]	108	Minor wrist injury	0 – 5	3
Hand [right]	120	Minor hand injury	0 – 5	2
Knee [left]	140	Minor knee injury	0 – 5	2
Knee [right]	139	Minor knee injury	6-10	6
Cervical spine	89	Minor cervical spine injury – soft tissue	0 – 4	4
Thoracic spine	94	Minor thoracic spine – soft tissue	0 – 4	3
Lumbar spine	94	Minor lumbar spine – soft tissue	0 – 4	3

[96] T1-33/30-41

Psychological	12	Moderate mental disorder	2 – 10	7
Teeth	18.1	Loss of or serious damage to more than 3 teeth	6 – 10	10
Skull	15	Serious facial injury – incapacity and disfigurement after surgery will not be very severe	14 – 25	14
Face	21	Moderate facial scarring	6 – 10	6
Body	155.3	Moderate scarring to body	4 – 8	4

[184] In *Allwood v Wilson*[97] I summarised my views as to the correct approach to the assessment where, as here, there are multiple injuries:

> "[20] … In such a case it is necessary to determine the dominant injury as it is defined[98], have regard to the range of ISVs applicable to that injury, 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.[99] 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.[100] In arriving at an appropriate ISV the court needs to bear in mind that the effects of multiple injuries commonly overlap.[101]"
>
> [21] 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.
>
> [22] 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.

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97 [2011] QSC 180
98 See Sch 7 of the Regulations
99 Sch 3 s 3 and s 4 of the Regulations
100 Sch 3 s 4(3)(b) of the Regulations
101 See notes to Sch 3 s 3 of the Regulations

> [23] Additionally, in assessing an ISV, a court may have regard to other matters to the extent they are relevant in a particular case: Sch 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.
>
> [24] The extent of whole person impairment is an important consideration "but not the only consideration affecting the assessment of an ISV": Sch 3 s 10…."[102]

[185] The facial injuries represent the dominant injury. The maximum dominant ISV then is 25. Is that adequate to reflect the adverse impact of all the injuries?

[186] I note that 12 of the items in the schedule are engaged and that the total of the injury scale values I have assessed is 64. There clearly are overlaps. Relevant factors include the plaintiff's age – only 22 when injured; that his life expectancy is substantial – over 50 years; that while his orthopedic problems are each relatively minor he is affected in both legs, both upper limbs, and his back; that he must bear cosmetic deformities; that he is affected psychologically; and that he has complete insight.

[187] In my view the maximum dominant ISV is not sufficient to compensate for the overall adverse impact of such a range of impairments over so long a period.

[188] I increase the maximum dominant ISV by 25% and allow an ISV of 30.

[189] General damages are assessed at $45,000.[103]

Past Economic Loss

[190] The plaintiff claims $203,600. The defendant argues that no amount should be allowed after Mr Schneider returned to work – the decision to cease work was a voluntary one and he has chosen not to work since.

[191] The plaintiff's claim is in two parts. He was off work immediately following the accident for about 10 weeks. I take the date of his return to work as 17 May 2010.[104] An amount of $7,400 is claimed. I cannot see there is any ground to disallow that amount.

[192] The second period dates from the time of his resignation. The loss of earnings claimed for this period is in the order of $196,000. That underlying assumption is that he would have had employment at an AO3 level, which was not certain.

[193] As explained I do not accept that the resignation, and the income loss that followed, at least in its entirety, was a compensable consequence of the first defendant's tortious conduct.

[194] That finding creates a difficulty. The assumption underlying the claim is that the plaintiff's employment at Queensland Health would have continued but for the

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[102] [2011] QSC 180 at [20]-[24]
[103] See s 62 of the Act, schedule 7 Table 1 Item 6 of the Regulations
[104] Ex 1 para 50

accident. No attempt was made to show what alternative employment opportunities might have otherwise been available.

[195] In the circumstances, apart from the $7,400, the assessment can only be in a global amount. Given the necessary imprecision involved I will consider the issue under the next head of loss.

Global Economic Loss

[196] For the future the plaintiff seeks $417,235. The defendant argues for a global allowance of $20,000 reflecting a minimal impact on his earning capacity from his physical problems.

[197] The plaintiff assumes that but for the accident he would have maintained employment at Queensland Health until age 67. The AO3 wage rates are adopted. A 50% discount is applied to allow for residual earning capacity, including amelioration of his psychiatric condition, and for contingencies.

[198] Mr Schneider's significant impairment to his earning capacity stems from his psychiatric condition. The principal relevant complaint that Mr Schneider makes is that he is unable to cope with people – particularly groups of people. He says that he becomes scared or terrified when confronted by groups of people and that he feels people are looking at him. He gave one instance of walking out of his grandfather's funeral unable to face even family members. That occurred nearly two years ago. He feels he would be unable to face a job interview. He has good days and bad days.

[199] As mentioned, Dr Flanagan emphasises different aspects of the presentation as relevant here and thinks the condition now to be chronic and was pessimistic on the chances of successful treatment.

[200] I consider that there are grounds for some optimism about the future course of the condition. There are three considerations relevant here.

[201] The first is that I do not accept that the societal anxiety condition is as serious as Mr Schneider's perception of it may be and as he conveyed to Dr Flanagan. The video evidence supports that view.

[202] The second is that both psychiatrists thought that treatment was available that had yet to be tried. Mr Schneider has, to date, resisted taking medication at all for fear of side effects but it is difficult to see that as a reasonable response to a debilitating condition, debilitating at least in the economic sense, particularly when no side effects have ever been experienced and particularly when recommended by two psychiatrists.

[203] The third is the point that Dr Chalk made that "litigation related factors are of significance."[105] The comment is justified given Mr Schneider's statement to Dr Flanagan that he was waiting to see what money he obtained from litigation – in the context of whether he could set up in a business of some sort.[106] I think the relevance is that the pending litigation has been an obvious barrier to successful treatment. The resolution of the case will remove one significant stressor.

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[105] Ex 19 p 17 para 340

[106] Ex 2.2 p 38 para 6.46

[204] The defendant argued that his orthopaedic injuries were of no great consequence to this issue. While Dr Gillet thought that his physical injuries would not have prevented him returning to work[107] that comment is, I think, applicable to more sedentary forms of employment. The very multiplicity of his many impairments would make life as a physical labourer at least uncomfortable, and probably fairly difficult, for Mr Schneider. He has problems with symptoms to some degree in his neck, upper and lower back, both arms and knees. He continues to experience some facial pain associated with headache. At the very least it would be surprising if he did not experience discomfort as he claims.

[205] Nonetheless that debate does not loom large in the assessment as it seems likely that if uninjured Mr Schneider would have pursued clerical or shop work rather than labouring work if he could obtain it. That was his decision in 2008. But his range of options has been limited by his physical problems.

[206] In the two and half year period since mid-2013 I think it probable that if he had been diligent (and uninjured) it is likely that he would have obtained employment, at least on a part time basis. He is obviously intelligent. He had shown some enterprise in obtaining work both at the meatworks and at Queensland Health.

[207] I have no evidence that any employment was available to him. He did not seek any.

[208] However the defendant submits that given his past performances there is no reason to think that he would have been diligent, pointing to his performance prior to obtaining work at Queensland Health. I do not accept that his behaviour in 2005-2007 should impact so significantly on the probabilities.

[209] It is true Mr Schneider voluntarily left each of the two jobs he has held, and apparently impulsively. As well he gave up his studies. But he was still only a teenager when he left the employment at the meatworks and he had never claimed that he saw his future as a packer at the meatworks – very few students with an OP of 4 from Grade 12 would do so. And many students grow disillusioned with study. Neither decision means that for the rest of his life Mr Schneider was bound to look on employment as a transient thing. If either decision was influenced by cannabis use – and it is not shown that either was - the impact of that consumption, now in the past, on his motivation and capacities is not shown to be a continuing factor. He may of course go back to consuming cannabis but there seems good reason to think that unlikely. It is noteworthy that his father only learnt of his cannabis use as a result of reading reports obtained for this litigation and promptly took steps to help his son cease that consumption. His influence continues. Nor does Ms Fruk share Mr Schneider's previous enjoyment of cannabis and it is reasonable to suppose she too may have some influence.

[210] Section 55 of the Act is relevant and provides:

> **When earnings can not be precisely calculated**
> (1) This section applies if a court is considering making an award of damages for loss of earnings that are unable to be precisely calculated by reference to a defined weekly loss.
> (2) The court may only award damages if it is satisfied that the person has suffered or will suffer loss having regard to the person's age, work history,

[107] Ex 2.6 p 82

> actual loss of earnings, any permanent impairment and any other relevant matters.
> (3) If the court awards damages, the court must state the assumptions on which the award is based and the methodology it used to arrive at the award.
> (4) The limitation mentioned in section 54(2) applies to an award of damages under this section.

[211] The limitation mentioned in s 54(2) is not relevant here. I am appropriately satisfied as required by s 55(2).

[212] While I have mentioned many of the relevant matters previously I here summarise the major assumptions that I make and on which I base the award:

(a) Mr Schneider's resignation from his employment was not shown to be due to the accident and the loss of income following from that decision is not compensable;
(b) at that time of his resignation he was still in the grip of his cannabis habit;
(c) by mid-2013 he had ceased his cannabis consumption and that some time thereafter he would have been in a condition to seek employment and would have been more likely to do so but for the accident;
(d) however he developed a psychiatric disorder as a result of the accident caused injuries that impacted on his capacity to seek employment and probably to maintain it, if he had notionally gained employment;
(e) it is not certain that if uninjured he would have regained employment nor is it shown that if he had gained employment that he would have earnt as much as he did at Queensland Health;
(f) in his injured state he will struggle to obtain or retain employment unless his psychiatric condition is successfully treated;
(g) acting reasonably he should pursue the treatment options suggested by the psychiatrist;
(h) while recovery from his anxiety state is not certain there is a significant chance that he will recover;
(i) his future, in both his injured and uninjured state, probably lies in clerical or shop assistant type employment;
(j) Mr Schneider has no great interest in working 40 hours a week;
(k) Mr Schneider has capacity for higher paid employment. His ability to engage in study and obtain tertiary qualifications is non-existent unless his psychiatric condition is improved. It is far from certain that he would ever have been interested in exercising that capacity nonetheless the chances of him doing so were not so minimal as to deserve being completely disregarded: *Malec v JC Hutton Pty Ltd*.[108]

[213] I note that a clerical wage at the AO3 level is $917 net per week.[109] There is no evidence of other wage rates although I think I am entitled to take notice[110] that a shop

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[108] (1990) 169 CLR 638
[109] Ex 1.23
[110] *Coles Supermarkets Australia Pty Ltd v Fardous* [2015] NSWCA 82 at [36] per Macfarlan JA: "[d]epending on the circumstances, the want of specific evidence on aspects of a damages claim does not prevent the court doing the best it can to address the plaintiff's loss":

assistant can earn around $750 net per week. Award wage rates are accessible on government internet sites to everyone in the community.

[214] Doing the best I can with many imponderables I assess this head of loss at $325,000. To the extent that there is any arithmetic involved the amount reflects a loss of about $325 per week from mid-2014 to age 65. While that approach follows Mr Arnold's submission, albeit from a lower base, I have not assumed that is necessarily the proper approach. Mr Schneider may improve over a short time, a long time, or not at all. His earnings uninjured may have been no higher than a part time shop assistant, or some multiples of that. He may recover his full earning capacity in time, or he may not. The amount is intended to be a significant sum reflecting a complex maze of possibilities.

[215] I am informed that the parties have agreed on the appropriate rates for the loss of superannuation – 9.25% for the past and 11.33% for the future. I apportion $33,500 to the past loss for the purposes of calculating superannuation loss and interest.

Domestic Assistance

[216] Substantial claims are made for the gratuitous provision of past and future care ($54,250). Section 59 of the Act is relevant and provides:

> **Damages for gratuitous services provided to an injured person**
>
> (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.

[217] The defendant submits that no amount should be allowed because the pre-conditions laid down in s 59(1) are not met. That is, the services provided were not necessary, or the need for them did not arise solely out of the subject injuries, or were not provided, and will not be provided, for six hours per week and for at least six months.

[218] The services claimed were provided by Mr Schneider's partner, Ms Fruk, his father and to an extent his grandmother, Mrs Rofe, until she died. The services in question relate to domestic chores such as cleaning the house, washing clothes, preparing meals, performing yard work and putting out rubbish bins. In the early stages of convalescence there was more personal assistance rendered, such as showering, toileting, feeding, obtaining necessities, driving Mr Schneider to appointments and preparing food. This period of greater dependence was relatively short. The evidence was not precise but it is clear that by the time of the return to work 10 weeks after the

accident the more intense period of care had come to an end. It can be accepted that the level of services provided in that 10 week period, or at least for most of it, would have satisfied the three pre-conditions.

[219] Ms Fruk's evidence was that she spent about four to five hours per week cooking, "maybe" two hours per week cleaning, and an hour or two washing.[111] If accepted these estimates put the level of work within the home performed by Ms Fruk on an ongoing basis at seven to nine hours per week. However these estimates reflect the work that she does for them jointly. As well Mr Schneider does not usually put out the wheelie bin for collection by the Council. He does little or no yard work. His father or de facto do (or his grandmother did) those chores usually. This seems to have been the pattern for some years.

[220] I have no difficulty in accepting that family members do the bulk of domestic chores. However the principal difficulty in accepting the claim is in accepting that there is any need derived "solely out of the injury" for them to do so. The reasons for Mr Schneider not carrying out household tasks range from complaints of pain to having difficulty "mentally getting out of the house".[112] When challenged in cross examination he gave these responses:

> "Mr Schneider, there's no physical impediment to you cooking a meal, is there? Not particularly physically to cooking it, no.
>
> And cooking can be quite enjoyable and pleasurable, can't it? I wouldn't say I've taken particular pleasure in it, but I don't find it unenjoyable either. It's something – it's a part of life.
>
> Yeah. There's absolutely no reason why you can't cook a meal? Mentally there is, yeah.
>
> You are able to cook a meal, sir, are you not? Physically, yes. Mentally, sometimes, on occasions. And I do cook a meal on occasions when I'm feeling good and up for it.
>
> I suggest to you at all times since you've been injured – sorry – since you've returned to work in the May of 2010, you've at all times, physically and mentally, been able to prepare and cook and eat a meal? I've clearly answered that. No.
>
> There is no reason, sir, why you can't do your own washing, is there? Yeah. Once again, exactly the same reason, with a bit more of the physical side of things. That can cause me neck strain, hanging clothes out on the line. That's the only thing in that.
>
> You can lift a surfboard up and strap it to your car and take it on and off? Some – some days I can.
>
> Surely you can hang your clothes out, sir? Some days I can. And it's not – it's different, hanging clothes out above your head.

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[111] T3-33/20-25
[112] T2-7/43

> You can do – you can wash your own clothes, can't you? Sometimes.
>
> You can sweep the house out if you wish to, can't you? I get back pain in the days after, generally when I sweep, vacuum, mop, where I'm bending and pushing.
>
> But you've got all day to do it, haven't you? It depends what I'm doing. I'm not saying I have all day to do it. I try and spend time with dad.
>
> Let's get this clear. Are you saying to the court that you cannot sweep your house out? Sometimes I can.
>
> Are you saying to the court that you cannot mop your house out? Sometimes I can and I do.
>
> I suggest to you that you can do that at any time you wish – any time? I've answered that. No.
>
> You can do your own laundry, should you wish to do so? Should I be mentally feeling up to getting out and doing it, yes.
>
> You can take the bins in and out, should you wish to do so? Once again, exactly the same answer.
>
> And you can do your mowing and your gardening, should you wish to do so? No. Mowing seems to – to cause me too much pain."[113]

[221] There is no support in either the psychiatric evidence or the orthopaedic evidence[114] for Mr Schneider being unable to carry out these domestic chores or needing any assistance in doing so. In my view Mr Schneider cannot satisfy either of the conditions in ss 59(1)(a) and (b).

[222] Subsection 59(2) requires there to be a comparison between the situation before, and the situation after, the subject accident. That complicates the picture as Mr Schneider and Ms Fruk were living together prior to the accident and the general impression is that while they shared duties, Ms Fruk was the busier of the two.

[223] As well Mr Schneider's concession that he performs these tasks essentially when he feels up to it makes it difficult to accept that the six hour threshold can be met. Accepting for the moment that there is a "need" for the services within the meaning of the legislation, how often he feels up to it is unknown. When one brings into account that Ms Fruk was describing work that she performed on her own behalf as well as providing services to Ms Schneider the evidence falls short of meeting the pre-conditions in ss 59(1)(c) that the legislature has laid down.

[224] No amount is allowed under this head of loss.

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[113] T2-20/22 – 21/28

[114] Ex 2 p 82 – Dr Gillett's opinion was against a need.

Future Costs of Medication and Psychological treatment

[225] The plaintiff claims $25,000. The defendant allows nothing.

[226] Both psychiatrists thought there was a need for treatment. I will allow $2,000 for the counselling and pharmacotherapy that Dr Flanagan spoke of. I assume about a 12 month period of treatment.

[227] I accept there is a need for Nurofen and Panadol. The future costs can only be an estimate. The plaintiff's perception of his difficulties may improve once litigation has ended and if the treatments suggested by Dr Flanagan are effective. I will allow $3,500.

[228] Thus I allow a total of $5,500.

Future Surgical and Medical Costs

[229] The defendant concedes an amount of $17,020. The plaintiff contends for $19,520. Essentially the difference represents the plaintiff taking the higher estimate where there are any differences. No reason is shown why the defendant should bear the burden of the higher estimates.

[230] I allow $17,020 under this head of loss.

Special Damages

[231] An amount of $11,492.04 is claimed. Two items of special damages are contested.

[232] The defendant points out that claims are made for items totalling $535.40 that on their face appear unrelated to the accident caused injuries. Mr Arnold effectively conceded the point.

[233] The second matter relates to the global claim in the sum of $2,100 for the cost of pain relieving medication such as Panadol and Nurofen. Virtually no receipts were produced. While that is so there was supporting evidence from family members that pain medication was purchased and consumed by Mr Schneider. The evidence was far from precise but an amount significantly greater than the defendant's concession of $100 is merited. I will allow $500.

[234] Damages under this head are assessed at $9,356.64.

Summary

[235] In summary I assess the damages as follows:

Pain, suffering and loss of amenities of life	$45,000.00
Past economic loss	$40,900.00
Interest on past economic loss[115]	$972.44
Future loss of earning capacity	$291,500.00
Loss of superannuation	$3,885.5
Future Loss of Superannuation	$33,026.95
Future expenses	$22,520.00
Special damages	$9,356.64
Interest on special damages[116]	$808.41
Total Damages	**$447,969.94**

Orders

[236] There will be judgment for the plaintiff in the sum of $447,969.94.

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

[115] $7,500 x 1.44% x 6 yrs + ($33,500 - $25,307) x 1.44% x 2.75 yrs
[116] $9,356.64 x 1.44% x 6 yrs