Bentley v Northern Territory of Australia & Anor [2008] NTSC 36

PARTIES:	BENTLEY, GEOFFREY v NORTHERN TERRITORY OF AUSTRALIA AND MINSON, ROBERT
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE TERRITORY EXERCISING TERRITORY JURISDICTION
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Jones v Dunkel (1959) 101 CLR 298
Payne v Parker [1976] 1 NSWLR 191

REFERENCES:

Luntz, *Assessment of Damages for Personal Injury and Death*, 4th ed, Butterworths, Sydney, 2002

REPRESENTATION:

Counsel:

Plaintiff:	I Morris
1st Defendant:	B O'Loughlin
2nd Defendant:	A Lindsay

Solicitors:

Plaintiff:	Caroline Scicluna
1st Defendant:	Legal Services Branch, Department of Health & Community Services
2nd Defendant:	Cridlands

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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Bentley v Northern Territory of Australia & Anor [2008] NTSC 36
No. 165 of 2004 (20429477)

BETWEEN:

GEOFFREY BENTLEY
Plaintiff

AND:

NORTHERN TERRITORY OF AUSTRALIA
1st Defendant

AND

ROBERT MINSON
2nd Defendant

CORAM: MILDREN J

REASONS FOR JUDGMENT

(Delivered 15 September 2008)

[1] This is an action for damages for professional negligence brought against the first defendant as the operator of the Royal Darwin Hospital (the Hospital) and against the second defendant (Dr Minson) in his capacity as a specialist cardiologist as the result of a coronary diagnostic angiogram conducted by Dr Minson on the plaintiff on 10 January 2002.

[2] The plaintiff was a self-employed retailer of clothing and manchester who operated under the style of Bentley's Warehouse Centre from leased

premises on Bagot Road, Coconut Grove. He was born on 15 March 1940 and was almost 62 years of age on 7 January 2002 when he was admitted as a patient to the Coronary Care Unit suffering from symptoms of angina and heart pain. As at that time he suffered from ischemic heart disease and other cardiac conditions and unstable angina and was taking prescribed anti-coagulant and anti-platelet medication.

[3] Following his admission a decision was made that following continuing pain and having had a number of investigations, the plaintiff needed to undergo a coronary diagnostic angiogram (the procedure). Arrangements were made for the procedure to be undertaken by Dr Minson on the morning of 10 January 2002.

[4] At that time, Dr Minson was a senior staff consultant cardiologist at Flinders Medical Centre in Adelaide who travelled to Darwin regularly to provide private and public cardiovascular services. The specialist catheterisation laboratory, which is a specialist cardiac procedure room required for the undertaking of certain cardiac procedures including angiograms, was physically located at the Darwin Private Hospital (the Private Hospital). This was because there was no room for this facility at the Hospital. There were no specialist cardiac beds at the Private Hospital. The only inpatient beds were located at the Hospital's Coronary Care Unit. The two hospitals are located adjacent to each other.

[5] There is no pleading that the Hospital is vicariously liable for the negligence of Dr Minson.

[6] The angiogram procedure involved the insertion of a specially designed needle into the left femoral artery through which a guide wire was passed. Once the wire was in place, the needle was removed and a sheath was inserted into the artery. The sheath has a three-way tap which allowed the cardiologist to inject or remove fluids into or from the artery and to seal off blood flowing from the artery. Once the sheath was inserted, a long, thin, flexible tube (the catheter) was threaded through the arterial system into one of the major coronary arteries. Through this tube a contrast dye was introduced which enabled the cardiologist to take pictures of the heart and to see, through a camera, various positions around the patient to build up a three dimensional picture of the coronary arteries. When this was done, further dye was introduced to enable the same procedure to be done in relation to the left ventricle. Once completed, the tubes were removed leaving the sheath in place. The plaintiff was subsequently removed to a recovery area by nursing staff, who removed the sheath. Once the sheath was removed it was necessary to apply digital pressure to the artery to stop blood flow. The pressure produced a blood clot at the site of the removal.

[7] The plaintiff was back in the recovery area by 11:15 am on 10 January 2002. By midday a haematoma had developed at the site of the sheath. This meant that either the clot had not held or had not formed correctly so that blood continued to leak from the artery and to spread into the surrounding tissues.

This was addressed by the nursing staff by applying a 10 pound sandbag to the leg in order to stop the bleeding. The development of a haematoma is quite common and the use of the sandbag is standard procedure. The plaintiff was discharged from the recovery room and transferred back to the Hospital at 3:30 pm, the nursing notes indicating that there was still a small haematoma present.

[8] According to the plaintiff, by 4:00 pm that afternoon his right leg was extremely swollen, the pain in the right leg and groin area was "incredible" and he was pleading with the nursing staff at the Hospital to come and have a look at him. The nursing notes (Ext P26) indicate that at 1550 hours "patient O_2 92-93% RA clammy … post SCG". Dr Mahar, a cardiologist from the Royal Adelaide Hospital called by the first defendant said that this meant that the plaintiff's oxygen saturation level was lower than it should have been; there was not enough oxygen going into his blood for some reason. However, he also noted that this may have been an inaccurate reading. In any event, the Hospital notes indicate that at 4:30 pm, Drs Tan and Whitehead had been called by the nurse to see the plaintiff.

[9] Dr Tan was a medical registrar employed by Hospital. It is not clear who Dr Whitehead was, or what role he or she played. Neither Dr Tan nor Dr Whitehead were called to give evidence. All that is available is what is recorded by either Dr Whitehead or Dr Tan in the inpatient clinical progress notes. The first note is at p 511 of Ext NT8 where it is recorded that the plaintiff stated that "he was in considerable pain from his angiogram,

especially at the site of perforation in the femoral region. This area was swollen and tender… Mr Bentley was insisting that he see the "angiogram doctor" **immediately**". The notes indicate that the plaintiff was examined and noted that the SpO_2 level was 100% at that time and that the femoral pulses and pedal pulses were present and normal and a message was left with Dr Minson to review the plaintiff.

[10] There is another note in Ext NT8 p 512 made by Dr Tan at 1820 hours in which she recorded the review of the plaintiff at 1630 hours, which suggests that the note at p 511 may have been made by Dr Whitehead. Dr Tan's note at that time records "(R) groin haematoma. Normal pulse. Pedal pulses present. Not aneurismal. P62. BP 150/90." The note continues on p 508:

> "On earlier R/V Pt angry and complained about perceived poor service at RDH and demanded to speak to the doctor who performed the angiogram. Dr Minson called and I was told he was finishing a pacemaker insertion. Message left for Dr Minson, requesting he call me back regarding Mr Geoffrey Bentley…
>
> Dr Phillippa Rabbitt (Surg. Reg. on call) came to R/V Pt. and advised further manual pressure to groin. She will R/V again. Dr Minson stated surg reg could contact him if required."

[11] Dr Minson gave evidence that he has no recollection of these calls, however, he recalled that he did a list of angiogram procedures until well into the afternoon and also a pacemaker operation after that, which could have taken between one and two hours. Whilst in the theatre his pager and mobile phone were left at the principal nurse's desk who would answer any calls until he became available.

[12] The Hospital notes are not in chronological sequence and are not easy to follow, but it appears that the next entry made was at 1800 hours by a member of the nursing staff who noted that the plaintiff was extremely agitated, yelling and complaining of severe groin pain radiating down his leg. The haematoma had extended slightly into the groin. The leg had become “mottled”, but the pulses were present. The plaintiff was given morphine, five milligrams, and panadeine forte “and settled”. Dr Tan was notified and Dr Minson was paged urgently. The notes also indicate (Ext P26) that a sandbag was applied and that there was numbness, presumably in the right leg. Blood pressure was recorded at 190/75.

[13] The evidence is that a common complication from bleeding in the femoral artery is that it can cause a false aneurysm to occur. This means that small layers of the artery bubble out but still remain in communication with the femoral artery. A rare complication of a false aneurysm is that it can, if severe enough, cause damage to the femoral nerve. The evidence is that this sequence of events occurred to the plaintiff. The question is whether either defendant was negligent in failing to take adequate measures to prevent damage to the nerve.

[14] Following the nurse’s observations at 1800 hours, Dr Tan was called. Her notes indicate that she was called “at about 5:50 pm”. She noted that the plaintiff was complaining of “excruciating pain (R) leg “mottled” appearance and cold foot”, “c/o (increased) swelling over (R) groin” and

that he "demanded again to see the cardiologist". On initial examination she noted:

> "Obs stable.
>
> (R) foot – pulses difficult to feel, cooler than (L)
> mottled, more than (L) foot."

[15] She also noted that she contacted the surgical registrar urgently, attempted to contact Dr Minson again and paged urgently. The note continues:

> "On attempting to call Dr Minson again… managed to speak (with) Dr Minson on mobile. Related above events to Dr Minson. He states he was not worried about Mr Bentley's leg from my descriptions and did not feel he needed to come and see him at present. He would see patient tomorrow."

[16] The note is recorded in the "date" column as "10/1/02 1820.

[17] Dr Minson gave evidence that he had no recollection of speaking with Dr Tan at that time. In cross-examination he agreed that if he had been told by Dr Tan about her findings as recorded in the notes Ext NT8 p 508 he would have been concerned. In cross-examination the following exchange occurred:

> "Would the concern have been that there may have been more bleeding from his artery, either into the flesh or into an aneurism? --- Well, as documented here, with pulses that are difficult to feel, there having been perhaps more palpable before – although you don't know that because there may be some inter – observer error – but that taken on face value with a cooler foot, presuming it wasn't cooler before, and a mottled appearance, that implies a reduction in arterial blood flow down the leg. In a post-angiogram patient the possibilities are dissection or embolus, but in fact you'd worry more about thrombotic narrowing of the femoral artery at the site of the puncture. So this is

a recipe for a problem for the patient and should not be left unattended.

What has been suggested is that the way to attend it is to apply manual pressure? --- Well – yes. If – you've got two separate problems here. The first problem is you're proposing that there may be some limited flow down the artery, so in that situation, if that's all there is, the last thing you want to do is squash the artery further. But if this occurs in conjunction with a growing bruise or haematoma or whichever description you want, then you need gentle pressure on the leg and careful observation and you may want to actually initiate further anti-clotting treatment which would tend to make the bruise worse but make the leg survive, but is sort of depends on the balance between these. So there's one half an argument here in Dr Tan's description, that they may be an arterial problem, but in other parts of the medical record there are other issues related to potential bleeding in the leg at that or around that same time."

[18] In his statement Ext M3 para 58, Dr Minson said:

"The aim of any treatment is to stop the bleeding with the minimal potential risk to the patient. The recommended first line treatment is for a member of the medical or experienced nursing staff to apply 10 minutes manual compression and then, if this is not successful, to apply a sandbag and clamp compression. This may be uncomfortable and analgesics are provided as well. This treatment is almost always successful. Basically you push on the leg until you think you have stopped the bleeding. It is not an exact science."

[19] As noted before, a sandbag had been applied at 1800 hours. Whether clamp compression was also applied is not recorded in the notes.

[20] The next relevant note is one made by Dr Rabbitt. The note does not record the time. There is also a note in Ext P26 made by one of the nursing staff at 1900 hours:

"10 minutes manual pressure to groin as per surgical RMO."

[21] One inference is that Dr Rabbitt attended upon the plaintiff at sometime between 6:20 pm and 7:00 pm.

[22] Dr Rabbitt, in her statement Ext NT6, said that she reviewed the plaintiff at approximately 1900 hours:

> "I examined Mr Bentley and noted the haematoma concerned in the right groin and I applied a further 10 minutes of direct digital pressure at the site of the angiogram puncture. My opinion was that the haematoma was pulsatile and I was concerned that a false aneurysm [a cavity within the haematoma communicating with the adjacent artery via the angiogram puncture site] had developed within the haematoma rather than continuing extravasation (bleeding) into the surrounding soft tissues of the groin… I noted good peripheral pulses indicating no vascular compromise to the limb, his blood pressure was stable and therefore conservative, non-operative management was appropriate awaiting investigation. His cardiac condition and the blood thinning medication created more than the usual anaesthetic and surgical risk which were further reasons for me to recommend a conservative treatment plan rather than urgent surgery. I suggested the treating medical team arrange for an ultrasound for the following day to determine if a false aneurysm had developed. My note indicates my intention to review Mr Bentley later the following day."

[23] Dr Rabbitt, in her statement Ex NT7, and in her evidence in chief, suggested that she reviewed the plaintiff, not at approximately 1900 hours as previously stated, but at a time nearer to 1820 hours. She based this on her reading of the Hospital file notes, Ext NT8, and on her understanding that the general practice of the Hospital staff is to record the time of the making of the notes which is usually done after the consultation has occurred. Clearly she had no independent memory of the time and her evidence was based on a reconstruction from the notes and her knowledge of general practice in the Hospital. There are three possibilities. The first possibility is

that Dr Rabbitt saw the plaintiff twice, once at a time between 5:50 pm and 6:20 pm and again at a time between 6:20 pm and 7:00 pm. The second possibility is that she saw the plaintiff only once, at or near 7:00 pm. The third possibility is that she saw the plaintiff shortly before Dr Tan started to make her notes at 6:20 pm. Each possibility is open from the notes. However, I think it more likely that she saw the plaintiff only once and that this occurred between 5:50 pm and 6:20 pm, probably close to 6:20 pm, because if she had seen the plaintiff twice I expect that she would have made two entries in the notes rather than one. Also Dr Tan's note of what Dr Rabbitt advised is consistent with Dr Rabbitt's note. The only contraindication is the note made in Ext P26 at 1900 hours referred to in para [20] above, which is open to several interpretations and may not be accurate as to time.

[24] Evidence was also given by a cardiologist, Dr Leo Maher, the Clinical Director of Cardiovascular Services at the Royal Adelaide Hospital. In his statement, Ext NT5, he states that "normal practice would suggest that the digital pressure recommended by Dr Rabbitt… had been applied before Tan had finished writing her notes". When cross-examined on this point, there was no specific cross-examination of Dr Maher's understanding of what the normal practice at the Hospital (or in hospitals generally) in recording times in hospital notes. Dr Maher in his evidence interpreted the note in Ext P26 to mean that manual pressure had already been applied before 7:00 pm and I agree that the note is open to that interpretation. Dr Maher also said that

"doctors are terrible at this, putting the exact time when the patient was attended, what time they did what…"

[25] Counsel for the plaintiff, Mr Morris, submitted that I should find that Dr Rabbitt did not attend upon the plaintiff until about 7:00 pm. For reasons which I will discuss later, the time at which Dr Rabbitt attended is critical to one of the issues in this case. It was submitted by Mr Morris that I would reject Dr Rabbitt's evidence that the time was before 6:20 pm as recent invention. Further, it was submitted that, because the first defendant did not call Dr Tan or any of the nursing staff involved and gave no explanation for not calling them, I should resolve any doubt in favour of the plaintiff and, further, that I should draw the inference that the evidence of these witnesses would not assist the first defendant.

[26] In my opinion these submissions should be rejected. First, I consider that from my own reading of the notes (and leaving aside Dr Rabbitt's and Dr Maher's evidence) it is more probable than not that she attended upon the plaintiff before Dr Tan began to make her notes at 6:20 pm for the reasons discussed previously in para [23]. Secondly, I do not think there is any real doubt which should be resolved in favour of the plaintiff. I note that Dr Rabbitt had no independent recollection of the time she attended. It is unlikely that Dr Tan or the nursing staff would have any independent recollections of times, now, some six years later. Thirdly, the way the case was originally pleaded did not make this time critical. The claim, as originally pleaded, was that the first defendant failed to have on call or to

engage a vascular surgeon or other qualified health professional in a timely fashion when the plaintiff's haematoma continued to expand despite the application of manual pressure, during 10 and 11 January 2002, when femoral nerve damage occurred. The nub of the plaintiff's case at that stage was that there should have been surgical intervention to prevent damage to the femoral nerve. The plaintiff called a cardiologist, Dr Aroney, whose reports and opinions were contained in Ext P16. A further report dated 24 October 2003 was tendered by Mr O'Loughlin for the first defendant as Ext NT2. I note in this report that Dr Aroney said:

> "Femoral artery bleeding is an unexpected complication in the majority of cases and I can see no part of Mr Bentley's care that was inappropriate.
>
> I do not believe that other actions taken by the medical and nursing staffs would have significantly altered the outcome."

[27] There is nothing in Dr Aroney's reports to suggest that there was an unacceptable delay between 5:50 pm and 7:00 pm to apply manual pressure to the haematoma. It was mentioned by Dr Aroney for the first time in cross-examination, when Dr Aroney said that the pressure needed to be applied within minutes of a diagnosis of a severe re-bleed in the groin being made and to provide a sufficient dose of morphine to lower the plaintiff's blood pressure. Contrary to an earlier opinion given, he said, in cross-examination for the first time, that it was likely that nerve injury occurred between 6:00 pm and 7:00 pm. I will deal with the merits of these opinions later, but clearly the case changed dramatically at this point and resulted in the

Statement of Claim being amended. Indeed in final submissions Mr Morris specifically identified the period between 1750 hours and 1900 hours as the period during which the treatment of the plaintiff by the first defendant fell below the relevant standard of care required and causative of the nerve damage which the plaintiff suffered. The old case (in which it was claimed that there needed to be surgical intervention) was abandoned. No application was made by the defendants to apply for an adjournment to enable further witnesses to be called.

[28] In the circumstances, the question arises whether it would be natural for the defendants to have called these witnesses, or that the defendants might reasonably be expected to call them. There is no evidence that these witnesses were still in the first defendant's employ and it would not be open to me to infer that any of them still were after six years. Further, none of these witnesses were high in the hierarchy of the Hospital. There is no evidence that these witnesses had any connections with the second defendant. There is no evidence which would enable me to infer that they were not also as available to the plaintiff as to the defendants[1]. Finally, even assuming the principle in *Jones v Dunkel*[2] has any application to the circumstances of this case, the principle, at best leads to the inference that the uncalled evidence would not have assisted the defendants' case and would enable the Court to more readily draw an inference fairly open to be drawn from the evidence in favour of the plaintiff's case. The rule does not

[1] See *Payne v Parker* [1976] 1 NSWLR 191 at 201-202 per Glass JA.
[2] *Jones v Dunkel* (1959) 101 CLR 298

apply where the most probable inference from the facts can readily be drawn in favour of the defendants; the rule does not permit an inference that the evidence, if given, would have been damaging to the defendants.

[29] In the circumstances, I find that Dr Rabbitt attended and either she or the nursing staff at her direction applied digital pressure for 10 minutes at some time before 6:20 pm.

[30] The next note is a nursing note made at 2000 hours on 10 January 2002. The note reads:

> "Afebrile. Haemodynamically stable. R) groin – bruising evident extending into groin, limb pale, cool; pulses present. Pt remains anxious and c/s about events surrounding procedure. Nil c/o chest pain. Given panadeine forte and Termazepam (?) to settle."

[31] At 0700 hours on 11 January 2002 there is a nursing note:

> "Afebrile… R) groin site remains tender, bruising more evident – panadeine forte given for groin discomfort with effect. R) limb cool, pulses present."

[32] At 0845 on 11 January 2002 there is a further note, probably by a doctor, that:

> "Peripheries warm good pulse pedal pedal/sacral oedema."

[33] At 0850 there is a note by Dr Whitehead that the plaintiff was seen by Dr Minson:

> "Groin wound examined. Diffusely tender, pulsatile bruit+ ? false aneurism → for U/S."

(A bruit is a murmur or other sound relating to the circulation of the blood in a part of the body.)

[34] On 11 January there is a note that the plaintiff underwent a further ultrasound procedure. A false aneurism was found and corrected successfully by the Hospital staff. It is not in dispute that the plaintiff suffered injury to his femoral nerve at some time during 10 and 11 January 2002.

Scope of Duty – First Defendant

[35] It is not in dispute that the first defendant owed a non-delegable duty of care towards the plaintiff and that the scope of the duty was to provide reasonable care and skill in the provision of care to the plaintiff given his condition and symptoms.

[36] It is also the opinion of all of the experts that a false aneurism is a not uncommon complication following the procedure and that it is a known, but rare, complication of a false aneurism that, if severe enough, a false aneurism can cause damage to the femoral nerve. Damage to the femoral nerve is, however, extremely rare. None of the cardiologists who gave evidence in this case had any personal experience of such a complication. Dr Aroney knew of only one such case in the Royal Brisbane Hospital, but it was not a case in which he was personally involved. Nevertheless, the risk of the complication occurring was plainly reasonably foreseeable.

[37] The question is whether the servants and agents of the first defendant failed in their duty towards the plaintiff to take reasonable care to avoid the risk of the complication occurring. This depends upon what steps could have reasonably been taken by way of response to the risk. This calls for a consideration of the magnitude of the risk, the degree of probability that it may occur and the difficulty of taking alleviating action particularly if there are additional risks of injury of a different kind which may inherently be the result from any alleviating action.

[38] Essentially, stripped to its fundamentals, the plaintiff's case is that by 5:50 pm the plaintiff's condition was such that immediate action needed to be taken by the hospital staff to reduce the haematoma by applying manual pressure for 10 minutes and providing a suitable dose of morphine.

The Evidence of the Plaintiff

[39] The plaintiff's evidence, as set out in Ext P2, was that when the sheath was removed, "blood spurted out everywhere". The nurse who removed the sheath called upon another nurse to help and they both pressed their fingers into the wound and were there for some time before the bleeding seemed to ease. Then a sandbag was applied and he was told to keep his hand on it and keep up the pressure. "I was in some pain immediately following the procedure and by the time I was taken back to my room at the Royal Darwin Hospital I was in tremendous pain." He said that he kept up pressure on the sandbag from the time it was put on by the nurse at the Royal Darwin Hospital until he was sent off for an ultrasound at 12:30 the following day.

[40] The plaintiff said:

> "By 4:00 pm that afternoon [i.e. the 10th of January], my right leg was extremely swollen. I could feel the blood flowing into my right leg and my right testicle had also commenced to swell. The pain in my right leg and groin area was just incredible. I was pleading with the nursing staff to have Dr Minson come and look at me.
>
> By 8:00 pm that evening, I was in horrific pain. I asked a nurse to give me something for the pain and she informed me that I could not have anything because Dr Minson did not prescribe anything. I asked her again to call Dr Minson as I was in excruciating pain. I don't know whether she called him or not but Dr Minson did not come to see me that afternoon or evening or during the night to check on my condition. Neither did Dr Minson prescribe or advise any other doctor to prescribe pain killing medication for me.
>
> My right leg then commenced to numb and I was unable to move my toes. By 11:00 pm that night I was just off the planet screaming with pain… I was left in this excruciating pain all night.
>
> By the following morning on 11 January 2002, my right leg and genital area were extremely swollen and black… Dr Minson came to see me that morning; he agreed with the Registrar's opinion that I should have an ultrasound and I was then sent off for an ultrasound, I was given morphine to help me cope with the pain…"

[41] In his oral evidence, Mr Bentley said that the haematoma was growing and painful all afternoon; that it got worse by 6 o'clock; that the bruise was right down his leg to the back of he ankle that night and the haematoma got bigger and bigger until it looked like a football. He claims also that he did not sleep all night and was screaming all night.

[42] The evidence of the plaintiff is not borne out by the Hospital file notes in many important respects. This is not surprising given the time that has lapsed since the events and the drugs which Mr Bentley received. He was

also prone to exaggerate. Wherever his evidence conflicts with the notes, I prefer the notes[3].

Was the Response to the Risk Appropriate?

[43] The evidence of Dr Aroney upon which the plaintiff relies, is that the treatment given to the plaintiff up to 1800 hours did not concern him. However, the notes indicate that the plaintiff developed very severe pain at 1800 hours and at the time his blood pressure was recorded at 190 on 75. At that point the plaintiff has suffered a re-bleed in the groin which began shortly before that time. The note recorded numbness and he assumed from that that that was when damage to the femoral nerve occurred. The sudden appearance of severe pain associated with high blood pressure needed "pretty urgent treatment" by administration of a very large dose of morphine and then the application of manual pressure to control the bleeding; as well other agents such as GTM should have been used to lower the blood pressure. He said that it was appropriate to call for the medical registrar, to administer morphine at that stage and to try to contact Dr Minson.

[44] The notes, however, indicate that the haematoma had only extended slightly into the groin and there is no note of numbness made by the nurse. Also, the note of Dr Tan when she was called to review the plaintiff at 5:50 pm does not refer to numbness, only that the pulses were difficult to feel. There is, however, reference to numbness in another nursing note, Ext P26, and that a

[3] See the observations of Hutley JA in *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 at 548-549.

sandbag was applied at 1800 hours. It may be that the nurse who made the entry in P26 is the same nurse who made the note in the inpatient clinical notes at 1800 hours, as the handwriting appears to be very similar.

[45] I find that the plaintiff had been in pain since 1630 hours when first seen by Drs Tan and Whitehead, but that the pain had, shortly before 1750 hours, become much worse. I further find that by this time the plaintiff complained of numbness in his right leg and that his leg was swollen in the area of the right groin and had been swollen at least since 1630 hours. The haematoma had extended slightly into the groin. The leg had a mottled appearance, but pulses were present and the leg was cool to touch. His blood pressure was high at 190/75. I further find that the nurse applied a sandbag, that a dose of 5 mg of morphine was administered promptly and the plaintiff was given panadeine forte. I also find that the nurse called Dr Tan who examined the plaintiff at or shortly after 1750 hours. I find that at that stage his pulses were present and otherwise the observations had not changed. I find that Dr Tan contacted Dr Rabbitt who attended shortly thereafter – certainly before 6:20 pm. At some time between 5:50 pm and 6:20 pm, Dr Tan spoke to Dr Minson on the telephone and she related to Dr Minson what she knew of the plaintiff's condition. Dr Minson told Dr Tan that he was not worried about the plaintiff from the information given to him, that it was not necessary for him to see the patient at present, but that he would see him the next day. I also find that Dr Minson told Dr Tan that the Surgical Registrar could contact him if required. So far as Dr Rabbitt is concerned, I find that

when she attended, she ordered 10 minutes of pressure to be applied manually; that there were good peripheral pulses; that she suspected a false aneurism; and that consideration should be given to an ultrasound the next day. I find that she did not contact Dr Minson that evening. I find that the pressure advised by Dr Rabbitt was applied. I find that by 8:00 pm the plaintiff's blood pressure was 136/75; that his limb was pale and cool, but the pulses were present; and he was given panadeine forte and Termazepam. I also find that the plaintiff did sleep on occasions during the night and that on the following morning his pulses were present, but that when seen by Dr Minson at 0850, there was a bruit found.

[46] On the findings I have made, I accept that the Hospital's medical staff did need to take prompt action to reduce the swelling and the high blood pressure levels. In fact, the Hospital's staff did do both. A sandbag was applied immediately and morphine was administered. So far as the dosage of morphine is concerned, Dr Aroney's evidence was that the dosage should have been higher and given more rapidly. In cross-examination he expressed his view more tentatively:

> "Would morphine lower blood pressure?--- Yes, it does have an effect on lowering blood pressure but you need to get enough of it to alleviate the pain to have that effect, and if you don't give enough, and five milligrams is by no means a large dose in someone in severe pain, sometimes I need to use 20 milligrams of morphine in patients with severe pain. So that a small dose of five milligrams may not be sufficient to have an effect on lowering blood pressure and alleviating that pain. And of course if you don't alleviate the pain rapidly that puts the blood pressure up further and has a vicious cycle effect of increasing blood pressure and increasing bleeding. And so the important management practice in these cases is to relieve pain

and blood pressure at the same time with large doses of morphine and other blood pressure treatment, whatever is required.

[47] There is a note in the Hospital records, NT8 p 634 (which is a blood pressure chart), which shows a reading at 1800 hours of 141/65, which Dr Rabbitt said was an acceptable level. This reading is not referred to in the note by the nurse at p 512, but that note does indicate that the plaintiff settled after the morphine was given. I think that it is probable that the note at p 634 is a later reading and that the morphine given did reduce the blood pressure to an acceptable level. Subsequent readings from the chart at p 634 show that the plaintiff's blood pressure readings dropped to 136/75 by 2000 hours and then to between 95/57 and 110/49 overnight. I find that on the balance of probabilities the plaintiff's blood pressure was reduced to an acceptable level.

[48] As to prompt pressure being applied to the site of the haematoma, I consider that the evidence does not persuade me that there was an unacceptable delay in applying pressure. No criticism was made by Dr Aroney of the decision of Dr Rabbitt to apply manual pressure for 10 minutes. His criticism was based upon what turned out to be a false assumption, namely that Dr Rabbitt did not attend until 7:00 pm. Whilst I am unable to find out exactly what time Dr Rabbitt attended, I have found that it was before 6:20 pm. The evidence of Dr Maher was that if digital pressure had been applied by 1825 hours or thereabouts, this would have been a good and appropriate response.
Dr Rabbitt was also of the opinion that digital pressure applied shortly after

1820 was appropriate. I am not satisfied that the plaintiff has proven that there was an unacceptable delay in applying digital pressure to the haematoma.

[49] In conclusion I am not satisfied that the plaintiff has proven that the Hospital staff were in breach of their duty of care to the plaintiff and the action against the first defendant must be dismissed.

The Claim against the Second Defendant

[50] The claim as pleaded against the second defendant in the Amended Statement of Claim was that he was negligent and in breach of duty including a non-delegable duty in that:

> "8. (a) he failed to implement or put in place in his absence, any adequate post angiogram treatment plan to deal with any poor operative complications which may have arisen including femoral artery haemorrhage and femoral nerve damage.
>
> (b) he failed to assess the risk of complications in the plaintiff's case.
>
> (c) He failed to recommend, conduct or arrange the surgical intervention necessary to prevent the damage or further damage to the Plaintiff's femoral nerve."

[51] Late in the trial the plaintiff was given leave to amend paragraph 8(c) by deleting the words "the surgical intervention" and replacing those words with the word "treatment". The particulars of the treatment were as set out in para 7(a)(ii) which were amended at trial to read:

> "The proper treatment was administration in a timely fashion of a sufficient dose of morphine to lower the plaintiff's blood pressure and alleviate the pain suffered by the plaintiff, the application of digital pressure at the puncture site to reduce bleeding and surgical intervention to control the haematoma."

[52] No submission was made by counsel for the plaintiff that surgical intervention by Dr Minson was necessary. The case against Dr Minson falls to be decided on the same facts as were alleged against the first defendant. In other words, the plaintiff's case depended upon proof that if Dr Minson had attended shortly after the time when he was spoken to by Dr Tan, he would have taken the steps which it is alleged that the first defendant should have done and, had he done so, the treatment would have prevented the damage to the femoral nerve. Even if Dr Minson should have attended in response to Dr Tan's call, it has not been shown that his failure to attend made any difference given that there is no evidence that he could have done more than the treatment provided by the Hospital staff. For this reason the claim against Dr Minson must also fail.

[53] However, in fairness to Dr Minson, there is no evidence that his failure to attend showed a want of care for the plaintiff on his part. The difficulty for the plaintiff is that the evidence is lacking as to what precisely Dr Minson was told by Dr Tan. It is for the plaintiff to prove that his attendance was necessary, i.e. that he ought not to have left the plaintiff's care at that stage in the hands of the Hospital staff. As Dr Minson has no recollection of the conversation and all that is available is Dr Tan's note of it, it is not possible to conclude that his expertise was needed at that stage. I am not able to say

whether or not, for instance, Dr Tan had told Dr Minson that Dr Rabbitt had already attended and what steps were being taken at that stage, but it is quite likely that she did, given the note that he could be contacted by the surgical registrar if needed.

[54] The plaintiff was not a private patient of Dr Minson. Dr Minson was a "stand-in" for the Hospital's cardiologist who was on leave. His services were provided by the Hospital to the plaintiff under an arrangement made between the Hospital and the Flinders Medical Centre. His salary was paid for by the Flinders Medical Centre. He was, in my opinion, a borrowed servant of the Hospital. The plaintiff was a public patient of the Hospital. As part of the arrangement, post operative care was undertaken by the Hospital under a team of doctors employed by the Hospital. This included Dr Tan, the medical registrar for the consultant physician, Dr Diane Howard, and Dr Rabbitt, the General Surgical Registrar, as well as other doctors and nursing staff. Dr Minson was available during post-operative care, if necessary.

[55] The evidence does not support a conclusion that Dr Minson spoke to Dr Tan on more than one occasion, although she did try to speak to him at a time when he was in surgery and unable to be contacted. There is no evidence that Dr Minson could have, but did not, respond to Dr Tan's calls at a time earlier than he in fact did. There is no evidence that the staff at the Hospital were incapable of managing the plaintiff's post-operative care. The staff were not employed by Dr Minson, nor were they under his control. No doubt

Dr Minson owed a duty of care to the plaintiff if his services were needed, but there is no evidence that they were required. I find that the reason why Dr Tan called Dr Minson was because the plaintiff demanded his attendance and because Dr Tan was unable to reassure the plaintiff.

Causation

[56] Even if, contrary to my findings, the defendants breached their duty of care towards the plaintiff, I am unable to find that the alleged breaches were a cause of the femoral nerve injury which the plaintiff suffered. The difficulty with causation is that the evidence does not support a finding that the nerve injury occurred at any particular time. The medical opinion was unanimous that the nerve injury could have been caused by the compression of the ultrasound performed on 11 January 2002.

[57] Only Dr Aroney offered the opinion that the nerve injury occurred shortly after 6:00 pm because the haematoma was not treated promptly. However, Dr Aroney's opinion is, in my opinion, not to be preferred, in part because, in my opinion, it was treated promptly. However, to the extent that Dr Aroney relied upon the complaint of numbness, there is evidence that the plaintiff did not have any neurological damage prior to the compression by the ultrasound. Dr Maher's opinion was that the neurological observations recorded on 11 January before the ultrasound suggested that no nerve damage occurred on 10 January. Dr Rabbitt gave a similar opinion. I prefer the opinions of Dr Maher and Dr Rabbitt to Dr Aroney. I consider it most unlikely that femoral nerve damage could have occurred on 10 January, but

on 11 January there was no evidence of neurological damage. In my opinion, the most likely cause of the femoral nerve compression was the treatment of the false aneurism by the pressure applied during the ultrasound.

[58] Accordingly there must be judgment for both defendants.

Damages

[59] In case I am wrong in my findings, I make the following findings as to the quantum of the plaintiff's loss, assuming that the defendants ought to have promptly dealt with the plaintiff's false aneurism, which had development by or before 6:00 pm, more promptly than they did, that the nerve damage occurred at about 6:00 pm and that had the defendants acted promptly, no nerve damage would have occurred. For convenience I will refer to these events as "the accident".

[60] The plaintiff was born on 15 March 1940. At the time of the accident he was 61 years of age. His evidence was that he commenced his working life at the age of 14 with a road construction company in Ballarat as a machinery driver. He remained in this employment for five years. In 1959 he married and he commenced employment as a driver in the transport industry. He remained in that employment until 1970. There are three children, now adults, from the marriage. In 1970 he went into business on his own account, trading as Bendigo Warehouses. The business was a retail, bulk manchester, clothing and toys shop. In 1990 his marriage was dissolved. He remarried in 1991.

[61] In 1995, he moved to Port Douglas, Queensland, where be bought an existing business called “Tropical Desires”. In 1996 he and his second wife were divorced. In March 1999 he moved to Darwin and established a business called “Bentley’s Warehouse Centre”. Initially he operated the business in Darwin for four months then transferred the business to Alice Springs. Apart from a short period in 1999–2000 when he operated the business again in Darwin, he continued to operate the business in Alice Springs until December 2000 when he decided to relocate the business to Darwin.

[62] In June 2001 he said he entered into a two year lease of premises at Shops 7 and 8, 268 Bagot Road, Coconut Grove. The lease contained an option to renew for a further term of two years. An unsigned copy of the lease was tendered as Ext P8 with the word “Draft” written on it. This document referred to a right to renew for two further terms of five years. No signed copy of the lease was produced. Nevertheless, I find that a tenancy of some kind had been entered into. The business, which operated under the registered business name “Bentley’s Warehouse Centre”, was similar in type to his previous businesses, i.e. a retail shop selling manchester, clothing and toys. A number of photographs of the business were tendered as Ext P14 which show that the business held a sizeable stock of manchester, clothing and toys. The business was solely owned by the plaintiff.

[63] Prior to the accident, the plaintiff claimed that he worked seven days per week. Typically he was at his business premises between 8:00 am and 8:30

to 9:00 pm. The business was open to the public each day between 8:00 am and 5:30 pm. During business hours he worked at the check-out. After the store closed he spent his time unpacking stock, stocking shelves, doing the accounts and banking. He employed three casual staff. The unsigned and unlodged tax returns prepared by his accountant (Ext P5) indicated only a modest amount was paid out of the business for wages: $25,800 for the year ended 30 June 2002; $29,800 for the year ended 30 June 2001; and $31,250 for the year ended 30 June 2000. In cross examination he said that he paid the wages out of cash from the till and kept no record of it. He said that his brother helped out for "quite a while" but he was not paid for his services.

[64] The plaintiff claimed that before the accident, he was reasonably fit and healthy and had an active social life. He said he enjoyed tennis, dancing, jogging, walking, golf, fishing, driving and playing tennis. He said he played tennis once a week. He went dancing monthly. He used to walk/jog most nights after work. His other activities were only occasional. He enjoyed a good sex life.

[65] In cross examination, the plaintiff conceded that he had suffered from angina heart attacks prior to the accident. He said he had an attack at Warrnambool, Victoria, when he was aged 42; another at aged 45; another at Cairns when aged 52. At this stage he was diagnosed as having some problems with his heart valves. He also had had three hernias which he had repaired at Epworth Hospital after the accident. In 2004 he suffered a stroke. He was on medication for high cholesterol levels. Before the accident he

also suffered slightly from asthma; and also he had sleep apnoea, but did not have it at the time of trial.

[66] In January 2002, he said that he suffered a “heart attack” and was admitted to the Royal Darwin Hospital by ambulance. He was admitted to the Coronary Care Unit on 7 January 2002. According to the Hospital notes he was referred to the Hospital by his general practitioner with a history of cardiac chest pain for the last three weeks and a history of ischemic heart disease. It was this admission which led to the angiogram performed by Dr Minson on 10 January 2002. The results of the angiogram were that the plaintiff had significant coronary artery disease but no really tight stenosis. He had mild aortic stenosis, moderate aortic regurgitation and moderate left ventricular dysfunction. The treatment for this condition was to prescribe medication.

[67] The Hospital records indicate that the plaintiff was not discharged until 18 January 2002. After the ultrasound, the plaintiff still complained of pain in his groin area as well as headaches and chest pains; and was receiving morphine. The headaches and chest pains are not proven to be related to the femoral nerve damage. However, the notes record he was pain free on 12th or 13th January, although still complaining of groin discomfort and aching pain. The Hospital notes indicate that he told the medical registrar that he had had an argument with his wife and stepdaughter concerning the way they were running his business whilst he was in hospital. His wife did not give evidence. According to the plaintiff’s statement he did not have a wife

at that time. The statement says only that he was residing with a friend, Theresa O'Brien, at her house, since 18 January 2002. It may be that Ms O'Brien is his de facto partner.

[68] Over the next few days the notes indicate that he complained of chest pain and tenderness and pain in the groin area, worse when ambulatory, although the notes indicate that he appeared to be able to walk without difficulty. The last entry, on 18 January, indicated that he still complained of pain in the groin and right scrotum.

[69] Two photographs were tendered as Ext P4 which showed extensive bruising over the lower abdomen, upper right thigh and groin area. These photos were taken six weeks after the accident.

[70] After the accident, the plaintiff convalesced at Theresa O'Brien's house. He was virtually bed-ridden; and he relied upon her to provide for his care for a period of about six weeks after his discharge. Ms O'Brien did not give evidence. No claim was made for her services.

[71] The plaintiff was readmitted to the Hospital on 24 January 2002, presenting with intermittent chest pain and a constant frontal headache. There is a note also of a complaint of constant pain in the right groin. The headache was thought to be secondary to a drug (Imdur) prescribed for his heart condition. He was discharged on 29 January 2002.

[72] The plaintiff said he resumed in his business in about early March 2002. However, before that he was referred to another cardiologist at the Hospital, Dr Smythe, for his heart problems. He apparently told Dr Smythe on 19 February 2002 that "he is working at a warehouse centre and has considerable concerns about this. He was requesting a letter from me so that he might be able to terminate the lease". Dr Smythe's letter of 19 February 2002 (Ext M4, p 400) does not refer to leg pain. Dr Smythe wrote another letter the same day (Ext M4 p 214) which was the letter the plaintiff requested. The letter does not refer to leg pain, but only to his cardiac condition. Dr Smythe wrote:

> "In terms of his exercise and work capability, I would estimate that he is able to perform sedentary activities, and any activities involving a level of exercise equivalent to walking with no difficulty. I would not advice (sic) that he perform any activity requiring heavy lifting, or that brings on chest pain."

[73] On 6 March 2002, Dr Smythe wrote again to the plaintiff's general practitioner concerning his cardiac condition. He had performed exercise stress testing which showed that he was at a low risk of having a cardiac event. He continued to have chest pains responsive to GTN. On this occasion Dr Smythe reported:

> "He had quite an amount of pain in his right leg today. He has been getting ongoing pain in the right leg since his angiogram. It starts at the medial side of his thigh and radiates down the lateral side of his calf. It is non-exertional and I suspect it relates to some nerve damage which occurred at the time of coronary angiography which was complicated by haematoma. Given his levels of worry about this, I have referred him to see Dr Jim Burrow for an opinion on whether

> nerve studies would help to evaluate this or whether we can just continue watching."

[74] The plaintiff said that when he returned to work he went in for a couple of hours for two days. On each of those days he went home feeling sick and suffering a lot of pain in his right leg. He decided that he could not keep the business going. He said he was unable to find staff competent enough to keep the business operating. He closed the business in April 2002 and put his stock into storage, hoping that his leg would improve and he could reopen the business.

[75] The plaintiff was again admitted to the Hospital on 12 April 2002 for intermittent chest pains, worse on exertion and exacerbated by stress. He remained in hospital on this occasion until 15 April 2002. He also complained of leg pain. It was noted in the discharge summary that there did not seem to be a particular nerve distribution to the leg pain.

[76] On 1 July 2002, the plaintiff saw Dr Burrow, a neurologist, who noted in his letter of 1 September 2003 that the pain had never gone away and that it prevented the plaintiff from standing for any length of time and was particularly aggravated by walking about. Dr Burrows opined that the cause of the pain was neuralgia from the femoral nerve arising from a compression from the bleeding from the angiogram. Dr Burrow noted that the plaintiff was unable to work as a result of the pain. However, in his evidence Dr Burrow said that he was unable to find a significant compressive cause for the injury and, so far as incapacity to work is concerned, he said that he

was only repeating what the plaintiff told him. He agreed that there were other factors including financial worries and depression which complicated the picture, but he felt that the plaintiff was genuine. He also said that complaints made by the plaintiff of his legs giving way were not related to neurological disease and did not mean a great deal. Nevertheless he said the femoral neuralgia would interfere with his capacity to work but was not able to say whether it prevented him from working. However, he did provide a medical certificate on 9 January 2003 to the effect that the plaintiff was unfit for work for a period of two years.

[77] In November 2002, the plaintiff became an inpatient at the Private Hospital for his angina. I am unable to find for how long he was admitted. There are also records of admission at the Hospital between 7 February and 11 February 2005 for his cardiac problems and at the Holy Spirit Northside Hospital on 25 June 2003 under the care of Dr Aroney.

[78] In June 2003 he was referred to Dr Aroney who performed an angiogram and subsequently a primary angioplasty and stint procedure. He has also consulted another specialist in Brisbane in 2007 for atrial fibrillation and Dr Aroney also saw him on 21 September 2007 for chest pain, but he required no further treatment.

[79] Between 7 February 2005 and 11 February 2005 he was again admitted at the Hospital in relation to chest pains. In September 2007 he was seen by

Dr Masterson, a consulting cardiologist at the Holy Spirit Hospital and was admitted for two days for tests which were uneventful.

[80] One of the difficulties with this aspect of the plaintiff's claim is explaining the cause of the symptoms of pain he experienced in his leg. Whilst femoral nerve damage may be a cause, the question is what caused the femoral nerve damage. Dr Kapur, a senior consultant in the Pain Management Unit of Flinders Medical Centre, who was called by the plaintiff, said that he thought this may have been the result of needle puncture at the time of the angiogram. The plaintiff had also by the time he was seen by Dr Kapur had an MRI on 21 October 2002 which showed that the femoral and obturator nerves appeared to be normal. Moreover the plaintiff was, by the time he saw Dr Kapur on 30 November 2005, suffering lumbosacral pain which may have been due to an arterially derived extensive haematoma. Dr Kapur agreed that MRI of his lower back was completely normal. He expressed the view that this may be an unconscious complication from these proceedings. He assessed his incapacity from his right lower limb at 20 per cent of the impairment of the whole body based on the American Medical Association Guides to the Assessment of Physical Impairment. The difficulty I have with this opinion is that it does not relate the problems with the right leg to the accident but rather to the insertion of the catheter and does not take into account the plaintiffs other health problems. However, I will assume for these purposes that the loss was caused by the defendant's negligence.

[81] On 20 May 2004 he was referred to Dr Kinloch, an expert consultant physician in pain medicine and rehabilitation. He was admitted to Epworth Hospital under his care from 24 May 2004 to 9 June 2004. Ketamine infusions were run intravenously which significantly reduced the burning pain in the leg below the knee. As he still had groin pain an ultrasound was arranged which showed a large indirect non-reducible hernia on the right and indirect, inguinal hernia on the left and a direct inguinal hernia on the left as well. These were repaired surgically by a general surgeon. Following this repair he mobilised quite rapidly. There was some recurrence of his right leg pain. His opinion in his report, Ext P24, was that he was totally incapacitated for work due to his femoral nerve injury.

[82] Assuming the femoral nerve damage was caused by the defendant's negligence and is the cause of the plaintiff's ongoing pain, I am satisfied that, on the evidence, the plaintiff has suffered significant pain and discomfort which has prevented him from working and which has resulted in loss of capacity to enjoy his pre-accident activities. However, the evidence also shows that he has had ongoing cardiac and other problems which, independently of his femoral nerve pain, would have significantly affected his lifestyle and capacity for work. Since January 2002 the heart condition has in itself limited his capacity to sedentary duties. Dr Aroney in his evidence accepted that his chest pains, which were due to his cardiovascular problems, precluded him from doing most heavy activities and anything more that sedentary work. Dr Aroney gave evidence that his atrial

fibrillation was chronic and produced breathlessness and exertional fatigue. Further, in 2007, Dr Aroney considered that the plaintiff also suffered from chest pain which was possibly musculo-skeletal on origin which prevented the plaintiff from lifting his arms above his shoulders.

[83] The plaintiff, I find, closed his business in April 2008 because of his heart condition. The plaintiff made a note in his records, Ext P8, “sick heart” which indicates that this was the reason he closed the business. Further, he told his accountant, Mr Fong, that this was the reason he closed the business. He theoretically could have worked in a sedentary capacity, but there is no evidence that he could have obtained employment in that capacity, or what the value of his limited capacity might have been. I am not satisfied that the plaintiff’s limited capacity as a result of his heart condition would have enabled him to have earned anything in regular permanent employment after January 2002. His business activities involved lifting, unpacking stock and stocking shelves. He might have been able to continue to operate the check-out and look after record-keeping had he employed staff in the business to attend to the other activities he could not do, but on his own evidence he was unable to find suitable staff. At best, had he not suffered from his leg pain, he might have eventually been able to reopen his business when suitable staff became available. There is no evidence as to what the cost of employing such staff might have been. Furthermore, his heart condition required him to have ongoing periods of hospitalisation from time to time and I am unable to find that the plaintiff was prepared to

employ someone to manage his business in his absence. The best I can do is make modest allowance for lost earnings for a few years for loss of opportunity. I do not think that at his present age there is any basis for an award for future loss of earning capacity.

[84] On the evidence, I consider that the plaintiff's ongoing heart problems would have, to a large extent, interfered with his ability to enjoy his other activities such as playing tennis or other energetic sporting activities including dancing, walking or jogging. I expect that he could have continued to so some light gardening and fishing. I accept that the femoral nerve pain has virtually reduced his capacity in this respect almost to nil. He is entitled to a modest sum for loss of enjoyment of life.

[85] On the evidence, I accept that the plaintiff has suffered and continues to suffer considerable pain and discomfort from the femoral nerve injury and that this is ongoing. I accept that this causes a burning sensation in his leg and also interferes to some extent with his sleep patterns. He has to use a walking stick and has a limp. There is some depression as a result. There is no evidence as to his future life expectancy. He is now aged 68. According to the life expectancy tables in Luntz[4], he now has a statistical life expectancy of 14.45 years. This must be reduced for the contingency that he may not live that long.

[4] Luntz, *Assessment of Damages for Personal Injuries and Death*, 4th ed, Butterworths, Sydney, 2002

[86] I note that the plaintiff's claim is to be assessed in accordance with common law principles. The Personal Injuries (Liabilities and Damages) Act, other than Part IV Division 6 (which does not apply to this case) does not apply to claims which arose before the commencement of that Act[5].

[87] I would assess damages as follows:

1.	For pain and suffering and loss of amenities of life	$180,000.00
2.	For lost earnings to the date of trial based on lost opportunity	$50,000.00
3.	Special damages (agreed)	$4,188.28
4.	Future medical expenses – There are no figures available, but on the basis that he is likely to need ongoing medication for pain relief I am prepared to allow a modest sum	$1,000.00
5.	Loss of the Land Rover – No evidence was led to prove there was a financial loss following its repossession	–
		$235,188.28

Orders

[88] The action is dismissed. There will be judgment for the defendants with costs to be taxed.

[5] See s 4(2)