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

№ 552 of 1987
(8719220)

BETWEEN:

EIAM-UM THONGBAI
Plaintiff

AND:

NORTHERN TERRITORY OF AUSTRALIA
Defendant

CORAM: Mildren J

REASONS FOR JUDGMENT
(Delivered 3 November 1992)

The plaintiff's claim is for damages arising out of an accident at work. Liability is admitted, and there remains only the question of the quantum of damages.

The plaintiff's injury occurred on 25 November 1986. She was employed at the Royal Darwin Hospital as a kitchen hand. At the time of her accident she was working in the main kitchen serving food onto plates in trays passing along a conveyor belt. Her right hand came into contact with a metal part of the belt imparting an electric shock. She was taken to the outpatient section of the hospital and admitted overnight for observation under the care of a resident medical officer. The hospital notes reveal that there were no obvious signs of burns. The right little finger was sensitive to touch, but nothing else abnormal was detected. She complained of a slight headache. The history, as recorded in the inpatient notes, is that the little finger of the right hand came into contact with a "bell" [? bare] wire. She had yelled out, but could not remember what she said. Everything "went black" and she next remembers being on her feet slumped forward over a

box. She was told to sit down and given a drink. There is also a note in the outpatient's section of the file that she complained initially of pain in the left side of the chest, shortness of breath, and that the shock "threw her to the ground." At the hearing, the plaintiff gave no evidence to this effect, and no witnesses to the accident itself were called. There is therefore no direct evidence that she fell to the ground, or, if she did, how she may have fallen. Her evidence before me was that she remembers telling the medical staff that she burnt her hand, she recalls that she blacked out, and she also recalled her supervisor telling her to sit down immediately after the accident. The plaintiff was not cross-examined on this part of her evidence.

The next day, she was discharged from hospital and according to the hospital file, provided with a medical certificate for 25 and 26 November.

On 27 November, she consulted a doctor at the Malak Square Clinic. I find that she initially saw Dr Hauge. The history as recorded at that time is that she "... touched a metal table top and received an electric shock which threw her to the ground and clouded her consciousness. She 'came to' in the Intensive Care Unit ... She was first seen at Malak on 27 November 1986 when she was noted to be sore through the left chest and shoulder, presumably as a result of her fall."

The plaintiff did not mention a fall to any other doctor who examined her. According to Prof. Jones, who appears to have taken a careful history from her in March 1991, she told him that she was not thrown to the floor.

It appears that she was paid worker's compensation up to and including 12 December 1986, and I infer from this that she returned to work on about 13 December. In the meantime,

she had attended again at the hospital as an outpatient on 2 December complaining of a painful left shoulder. The notes state:

> "Presents with a form of left sided torticollis, with main muscle pain centred on supraspinatus, but also extending into post wall of chest and into arm ... range of shoulder movements mainly above right angle limited by pain and spasm. Neck is fairly mobile."

She next saw Dr Wake on 6 December 1986. Dr Wake stated that when he first saw her on that date she presented by then with "classical pectoral girdle syndrome" with poor movements about the neck, shoulder and arm. He described this condition in evidence as a soft tissue injury, quiet common in his experience, involving intractable pain mainly focused over the back and between the thoracic spine and shoulder blade, involving the pectoralis major muscle anterior, posterior of the muscles trapezius, and the rhomboideus and subscapularis or large muscles of the shoulder blade. The pain is often exacerbated by movement and disturbs sleep. Dr Wake said he often saw persons with this type of injury as a result of motor vehicle accidents and rugby scrum accidents. He said recovery was often protracted, particularly in women, especially when it affects the dominant side. In this case, the plaintiff is left-handed. He prescribed pain-killers and transcutaneous nerve stimulation. He described her appearance as having her left arm dangling, sometimes held by the right, with the head inclined to one side; tearful and looking forlorn.

After returning to work, the plaintiff claims that she had an incident at work when a large container of milk slipped from her left hand and fell to the floor. She claims that this incident occurred on the first day she returned to work and that she saw a doctor at the hospital about it who gave her a week or two off work. However, there is no entry in the hospital notes, and I note that she did not receive any compensation again until 10 January 1987 when she had two days' off work. The plaintiff says this incident

occurred before she saw Dr Wake, and it may be that she is right and the doctor she refers to is the person she saw on 2 December. Nothing much turns on this. In any event, she claims that when she returned to work in December, she had difficulty with her left arm, stiffness in the shoulder area, and difficulty sleeping, but with the help of her workmates, she persevered until January 1987 when she was referred to Dr Chongwah by Dr Wake for a course of acupuncture. According to Dr Chongwah's report, she received treatment on 12, 13 and 16 January 1987, which gave some relief, but she did not complete the course.

The plaintiff says that when she returned to work after this, she was sent to work in the cafeteria serving food, but had difficulty lifting large food containers from a dumb waiter onto a trolley and then into a bain marie. It appears nevertheless that the plaintiff continued working throughout the rest of January, February, March and April, until at least the end of April, with a few days off each month for which she received compensation. In April 1987, Dr Wake says he wrote to the hospital seeking light work for her, and as her condition did not improve he referred her to Mr Baddeley, an orthopaedic surgeon. By 20 May, Dr Wake observed that she had marked torticollis or wry-neck, her head was pulled to one side, the left shoulder was up, and she had visible muscle spasm, and was suffering from anxiety.

Mr Baddeley gave evidence that he first saw the plaintiff on 12 May 1987. At that time he felt she was fit for light work. However, on 20 May, he saw her again. He said that she presented as being in severe pain. She had a decrease in rotation of her cervical spine indicating injury to the ligamentous and muscular structures around the neck. On 22 May, he performed a manipulation under general anaesthetic. She was seen again on 15 June, by which time she seemed to be much improved with a full range of movement of her

cervical spine, and arrangements were made for her to continue with a "gentle regime of physiotherapy."

On 24 June 1987, the "worker's compensation insurer" stopped payments to her, and the plaintiff believes that the insurer did this in the mistaken belief that she had begun working at the Lao Thai Restaurant, a food outlet at Casuarina Shopping Square. I say 'mistaken' because there was no evidence that she was in fact working there at that time. On 29 June 1987, the plaintiff consulted Dr Wake, who found her to be anxious or depressed, and prescribed anti-depressants. No immediate diagnosis of depression was made, but over a period of over a year until 17 August 1988, he continued to see her on a number of occasions and eventually formed the opinion that she was suffering from a depressive illness caused by her inability to get back to work. He did not refer her to a psychiatrist because psychiatric services were "thin on the ground" and it took several months to get an appointment.

Returning to 1987, between 4 August 1987 and 30 August 1987, the plaintiff returned to Thailand to visit her mother, and on 25 August 1987 the Writ in the present action, with the Statement of Claim endorsed thereon, was issued. On 30 October 1987, her solicitors referred her to Mr Yaksich, a neurosurgeon, for a medico-legal report. At that time her complaints were of pain in the region of the left shoulder radiating to the left limb as far as the forearm, reduced neck movement, and difficulty sleeping. Mr Yaksich considered that she appeared to have sustained a significant soft tissue neck injury with continuing pain and limitation of movement, as well as some nerve damage to the left side and a secondary supraspinatus tendonitis as a result of her injury and inactivity. I will return to his findings later. Thereafter, she continued to consult with Dr Wake and did not resume any employment.

On 5 May 1988, she commenced a course of physiotherapy at the Bradshaw Terrace Physiotherapy Clinic, but it is not clear who arranged this. She had not seen Dr Wake since 15 March, and it may be that he arranged this. Coincidentally, in about May 1988 the plaintiff was referred to a Ms Edmonds who was then assistant personnel manager for the Department of Health and Community Services. It is not entirely clear how this came about, but apparently Ms Edmonds was under the impression that the plaintiff had been off work on sick leave and was about to resume duties. In fact I find that the plaintiff was not in actual receipt of sick leave payments at this time. In any event, Ms Edmonds contacted the plaintiff and arranged to see her at her office at Monterey House. Initially the plaintiff attended, and was given simple clerical tasks in the office. However she had difficulties with that work due to her lack of English. Shortly thereafter she was sent to Block 4 at the Royal Darwin Hospital to work as a tea lady where she commenced on 9 May. She attended until 16 May, with some periods of time off. It is to be noted that during this period she consulted Dr Wake on four occasions and her physiotherapist on one occasion, as well as a neurosurgeon, Dr Reilly on behalf of the defendant, for a medico-legal report. Ms Edmonds was not personally familiar with the job of tea lady at Block 4 and had only limited personal contact with the plaintiff, but conceded in cross-examination that whilst the plaintiff was working at Monterey House, the plaintiff tried very hard but needed some training and assistance.

The plaintiff said that she found this work too heavy for her, that it caused her to have a sore arm and stiff shoulder and that she had to see Dr Wake who gave her a certificate of unfitness. She claimed that the work involved lifting "heavy things." She described the work as "pushing the tea trolley, and make the tea for the people in the office, and clean up the tea room."

However, Dr Reilly, who examined the plaintiff on 13 May, noted her to be relaxed and in no discomfort, and he could find no organic disability of any significant degree and considered her quite capable of working. I will return to Dr Reilly's evidence in due course.

I note from Dr Chongwah's report that the plaintiff had "flare-up symptoms" and had further treatment on 30 April 1988 and 6 May 1988, but nothing after that until 1989.

Thereafter the plaintiff consulted Dr Wake on two occasions in late May 1988 and twice on the same day in mid July 1988. She also continued having physiotherapy until 10 June. Dr Wake noted that the plaintiff was depressed in July 1988.

A Ms Day, previously Superintendent of Malak House, gave evidence of a short period of employment of the plaintiff. On 2 August, the plaintiff attended at Malak House where the Department of Correctional Services had placed her in a position where she might do light work. Initially she answered the telephone and worked with the receptionist, but her English skills were not good enough for this, and she then did kitchen work, cutting vegetables and doing light food preparation. As a result of discussions between the staff there, she was also asked if she could do sewing but the plaintiff said that she could not sew. The plaintiff also attended on 3 August for about one hour, and then left to attend an English beginner's class at the Adult Migrant Education Centre. That was the last time she attended at Malak House.

The plaintiff's evidence was that she attended the English course arranged for her by the defendant on two occasions. The evidence was that course was intended to be run for two hours, five days a week, from 3 August 1988 to 29 September 1988. She claimed that she got a sore hand and did not

learn anything and also claimed that she did not know that the course was intended to run daily until the end of September. I do not believe her evidence. She also stated that she did not return to Malak House because after working in the kitchen for between four to six days, her neck was sore, and she saw Dr Wake for further treatment. However, she did not consult Dr Wake until 17 August and I find that she did not work in the kitchen at Malak House for more than 2 August and 1½ hours on 3 August, and made no complaint to Ms Day that she was unable to continue. I do not accept the plaintiff's evidence.

According to Dr Wake, the last time he treated the plaintiff was on 17 August 1988. He noted her then to be depressed and upset, and he prescribed anti-depressants. The plaintiff gave no satisfactory explanation for her failure to seek medical treatment after this. She did not seek treatment from any other doctor, apart from two further attendances in mid 1989 for acupuncture from Dr Chongwah, who states "she did not complete the course of treatments." In cross-examination she claimed the reason for this was that she had no money and felt guilty that she could not pay. I do not believe this evidence.

In December 1988 she saw Dr Wake again, but the purpose of this, I find, was to obtain a letter from him to Dr Bullen, a Commonwealth medical officer, who saw her in connection with a decision to have her retired from government service on the grounds of invalidity. It appears that she was retired officially on 23 January 1989. In this connection Dr Wake wrote to Dr Bullen by letter dated 3 January 1989 wherein he said:

> "This woman continues to be significantly disabled by a left pectoral girdle syndrome secondary to an electrocution injury. I believe she will be disabled effectively for manual work for another year.
>
> As expected she begins to show significant improvement with the neck and shoulder stiffness having effectively resolved. The major problem now is

'heaviness', hyperaesthesia and a lack of personal confidence in her ability to be well again.

She is well disposed to work and most certainly not a malingerer. She is taking English tuition.

This whole problem has been compounded by the T.I.O.'s untimely withdrawal of support with the attendant inability to find suitable physiotherapy etc.

I remain of the view that she will make a full recovery."

Some of the matters in this report are palpably false e.g. the statement that she is taking English tuition, and the statement that there is an "attendant inability to find suitable physiotherapy"; and I place no reliance upon those observations. It is particularly noteworthy, however, that Dr Wake stated that she began to show significant improvement "with the neck and shoulder stiffness being effectively resolved." This is to be contrasted with the plaintiff's own evidence, and her complaints made to Mr Yaksich and Prof. Jones subsequent to January 1989.

After being retired by the government, the plaintiff made no effort to find any work, although she clearly understood that her medical advisers considered her fit for light work.

In 1989, she saw Dr Chongwah twice in the middle of that year, as I have already observed, and has apparently sought no other medical treatment since then apart from (possibly) one consultation with Dr Hauge on 24 October 1989. The only other medical practitioners to see her in this period were (1) Mr Yaksich on 14 September 1989 and on 29 November 1989, a few days before the beginning of this hearing, for medico-legal purposes and (2) Prof. Jones on 26 March for a medico-legal report on behalf of the defendant. Apart from that, I was told little else about the plaintiff's recent history, except that she visited Thailand for eight weeks in 1989 and for four weeks in 1991. The defendant's counsel

attempted to make out a case that after her retirement in 1989 the plaintiff had been working, but I am unable to find that this was so. The attempt was based on an examination of the plaintiff's accounts with the NT Credit Society, but I am not satisfied that the monies deposited into those accounts were as a result of earnings made by her.

The main issues between the parties were whether any of the plaintiff's complaints were caused by the accident, and if so, have any of these resolved, and if so, when. There were other issues depending on my findings in relation to the main issues, as to whether the plaintiff has any future loss of earning capacity, and if so, the extent of that loss, and as to whether the plaintiff has failed to mitigate her loss.

Were the plaintiff's complaints caused by the accident?

The difficulty from the plaintiff's point of view is that the medical experts were not in agreement as to whether her complaints were genuine, and if they were, could be attributed to the accident.

Dr Wake, the plaintiff's general practitioner, described her condition as "left pectoral girdle syndrome." His view that it is related to the "electrocution" rests on the presumption that she must have fallen when she was electrocuted: see Ext P2. Apart from the evidence contained in his medical report, he was neither examined nor cross-examined on this issue. The difficulty with this is that there is no evidence that the plaintiff did fall over. The plaintiff herself gave no such evidence, has never told any of the other doctors she saw of a fall, no witnesses were called to say she fell over, and the only evidence of a fall are the histories contained in the hospital notes, which are hearsay at best and supposition at worst, and in my opinion not reliable.

Mr Baddeley gave no evidence that her condition was consistent with being caused by the electric shock.

Mr Yaksich, in his report of 10 November 1987 (Ext P4), states that: "As a result of the electrocution at work this woman appears to have sustained a significant soft tissue neck injury ..." In his evidence in chief he was not asked to explain what connection there was between the "electrocution" and the injury. In cross-examination he conceded that the plaintiff had not told him that she was thrown to the floor, and he appears to have relied upon Dr Wakes's report in making the possible causal connection as he said that "there was some reference to it in one of the other reports I've seen."

Dr Reilly, in his report Ext D2, states:

> "Her account suggests that she received an electric shock. It would be of value to know whether this was subsequently verified by testing the equipment in question. Accepting that she did suffer an electric shock, it would seem to have been brief and not associated with any contact burn. The initial symptoms are consistent with an electric shock. The symptoms which developed some days later, namely of neck and left arm pain, might be explained by twisting or wrenching of the neck at the time of the shock although it is curious that these symptoms did not occur sooner."

Despite extensive cross-examination, Dr Reilly was not shaken. In short, he explained that the initial symptoms she described to him, of lights before the eyes and lifting both hands in the air, were consistent with an electric shock. He found it difficult to accept that the complaints of neck stiffness and shoulder pain were related to that for a number of reasons. Firstly, he said that if the shock was severe enough to cause a major, as opposed to a quite minor injury, the painful condition should have been noticeable immediately and not a day or so later, although he conceded that this might not occur if she had been given

analgesics or had been drowsy whilst at the hospital. Reference, however, to the hospital's nursing notes indicate that she complained on admission on 25 November 1986 of left shoulder and muscular pain on the chest wall below the left arm and was given "2 panadol with good effect," and a second note indicates a similar complaint later that evening recorded by the nursing staff. Secondly, Dr Reilly said that a number of her present complaints could not be accounted for on an anatomical basis, particularly complaints relating to sensory nerve loss. Thirdly, the findings he did make on examination were nebulous. He said, for example:

> "This injury, hypothetical or real, has resulted in severe pain, sufficient to prevent her working then, 18 months after the event. The findings were all rather nebulous and such as were there were not easily explicable on the basis of the injury that she described and I don't have an explanation as to why an electric shock wrenching the neck should end up with a sensory loss in the left fourth and fifth fingers. There's not an easy explanation for that, in my view."

Fourthly, he disagreed with Mr Yaksich's opinion that she had a supraspinatus tendonitis, and even if she did, this was even more difficult to explain as a consequence of the "electrocution". Fifthly, even if she did suffer some sort of wrenching injury to the neck, he found it "difficult to explain why she should continue to suffer pain 15 months after the accident, much less why there should be a specific nerve injury to the left arm" (bearing in mind that there was nothing to suggest that the electric current came to earth through her left arm).

Prof. Jones did not comment upon whether or not the plaintiff may have had, prior to his seeing her, some sequelae as a result of the "electrocution".

The conclusion I have reached is that, on the balance of probabilities, that the plaintiff did suffer, as a result of the accident, a soft tissue injury involving her neck,

shoulder and left arm, and that this required her to continue to seek medical treatment from Dr Wake, Mr Baddeley and others throughout 1987. I consider the fact that there was a complaint recorded in the nursing notes on the day of the accident puts this question beyond doubt. It is not necessary, in those circumstances, for there to be proof of a fall. It may be that the plaintiff fell over, or it may be that the shock caused her to injure herself in some other way. Whilst the precise mechanism of her injury can only be speculated upon, I conclude that somehow the plaintiff must have, as Dr Reilly postulated, twisted or wrenched her neck at the time she was "electrocuted."

The nature of the injury and its consequences

Here again there is considerable divergence in the opinions of the medical experts. Generally speaking, I have little difficulty in accepting the evidence of Dr Wake. I am satisfied, however, that Dr Wake did get somewhat personally involved in this matter. He was clearly upset that the worker's compensation insurer stopped payments to the plaintiff for what he considered to be an unjustifiable cause, and I think therefore he tended to be unconsciously partisan and not as objective as he might have been and that this became obvious from his demeanour in the witness box. But nevertheless I formed the opinion that his evidence was generally reliable as to what he observed; although I do not accept all that he said, particularly in relation to the subject of depression.

As to Mr Yaksich, a lot of his evidence was difficult to hear because of an irritating tendency to mumble excessively, and much of the transcription of his evidence by the court reporting staff contains passages which could not be transcribed. However, I was able to make up for some of these deficiencies by reference to my notes, copies of which I made available to counsel to assist them with their submissions. In general terms, I accept that when seen by

Mr Yaksich in October 1987 the plaintiff still had some symptoms from her neck and shoulder area, and her symptoms were such as to suggest supraspinatus tendonitis as a possible explanation. However, I prefer the evidence of the defendant's doctors on this issue. In my opinion the plaintiff did not suffer from that condition, and also I prefer the defendant's doctors' opinions that the plaintiff does not suffer from any nerve damage or loss of power on the left side. In reaching this conclusion I have taken into account the demeanour of the various specialists in the witness box, their qualifications and experience, the extent to which they attempted to test the plaintiff's allegations by looking for objective signs, and the probability of such a condition as a likely consequence of the accident itself. I was particularly impressed with Dr Reilly who I considered to be careful, objective and very fair to the plaintiff, and whose qualifications, which are set out in Ext D4, impressed me as someone upon whose opinion I could act with confidence. Professor Jones, who similarly had impressive qualifications, whilst not a neurosurgeon, I find had sufficient training to express a view on these matters, and I note that his opinion supported that of Dr Reilly's. (Incidentally, although Dr Reilly is a specialist, he also held the degree of MD, and was entitled to the title of "doctor").

I conclude that the plaintiff no longer suffered any significant physical injury by May 1988. I accept Dr Reilly's opinion that by that time, the plaintiff had no serious organic disability which prevented her from resuming her former employment. However, I find that from time to time thereafter the plaintiff suffered from mild symptoms of an organic nature which had resolved themselves completely by the time she saw Dr Wake on 17 August 1988. Some allowance will have to be made for this under the heading of pain and suffering and loss of enjoyment of life, but I do not consider that the plaintiff's earning

capacity was affected by those symptoms after May 1988.

As to her earning capacity prior to then, I find that the plaintiff was totally incapacitated for work until last seen by Mr Baddeley in June 1987 and for some months thereafter. I note that Mr Baddeley saw the plaintiff again in February and April 1988. The plaintiff's counsel sought to lead evidence from Mr Baddeley in relation to those consultations but this was objected to by counsel for the defendant as no report had been provided from Mr Baddeley in accordance with O33 of the *Supreme Court Rules*. Except by leave, r33.08(5) precludes a party from adducing evidence from a medical expert unless the evidence is disclosed in a medical report served pursuant to O33. The following exchange took place between counsel and myself:

> "Ms Gearin: I object to this your Honour. I've been served with a report dated 18 August 1987; that's the only report that I've received from this doctor and I object to any evidence in relation to matters that aren't contained in that report.
>
> His Honour: Well?
>
> Mr Tippett: Well, your Honour, as I understand it, that's so, and, of course, Mr Baddeley was the patient's treating surgeon beyond August 1987. I'm not sure how my learned friend, bearing in mind that I understand she intends to call 2 specialist surgeons herself, could possibly be prejudiced by Mr Baddeley now giving evidence, but if she was so prejudiced it may be necessary for her to have the opportunity, at some later time, to further cross-examine Mr Baddeley if she considered it necessary . But I - - -
>
> His Honour: Can you outline the nature of the evidence that you are seeking to call from the doctor that's not the subject of his report?
>
> Mr Tippett: To the extent that he continued to treat the neck and arm to 1988 and medication procedures that were carried out after, in fact - I'm sorry; I withdraw that. Yes, after the report of 18 August was compiled.
>
> His Honour: Report of 18 August of what year?
>
> Mr Tippett: I'm sorry, your Honour, 1987. There

were a number of occasions that Mr Baddeley saw the plaintiff after that time and I do not have a report in relation to those occasions. They were occasions in relation to - well, treating occasions and - but I'll confine myself, for the moment, to the report, your Honour, if I may. As I say, I don't see how my learned friend could be prejudiced bearing in mind the - - -

His Honour: Well, make up your mind, Mr Tippett. Are you asking me to allow you to call the evidence or not?

Mr Tippett: Well, I am, your Honour, yes. I'm sorry.

His Honour: Well, that's your application.
Mr Tippett: That's my application.

His Honour: I've asked you to give me an outline of the nature of the evidence and you've told me it relates to further treatment after 1988.

Mr Tippett: Yes.

His Honour: Can you tell me what it is, please?

Mr Tippett: Well, there was treatment of the; there was consideration by Mr Baddeley of various treatments, one involving a nerve conduction treatment that was not carried out and there were assessments by him of her disability on those occasions, her complaints and I - in the short time available to me with Mr Baddeley I must confess that I am unable to be more descriptive than that.

His Honour: In other words, you don't have a proof yourself?

Mr Tippett: No.

His Honour: Well. And that is all you can tell me?

Mr Tippett: That's all, I'm sorry, your Honour. That's all I can tell you.

His Honour: It's opening up a can of worms, Mr Tippett. We don't know where you're going.

Mr Tippett: May it please your Honour. Then I will confine myself - - -

His Honour: No, you don't have to. I mean, you've got another alternative. You can apply for an adjournment of the trial.

Mr Tippett: Yes, your Honour, but there are other witnesses I intend to call that can deal with the period.

His Honour: Or you can seek to recall the doctor at a later time.

Mr Tippett: I may, your Honour.

His Honour: But, one way or the other, you've got to, I think, get more information than you are able to present to me.

Mr Tippett: I appreciate that, your Honour.

His Honour: Because I don't think I can rule on whether, by allowing the doctor to roam at large with material about which neither the court nor you, nor anyone else knows, except the doctor, there may not be significant prejudice to the defence in the way in which they conduct the defence of the case, which can't be cured.

Mr Tippett: May it please your Honour.

His Honour: I just can't know.

Mr Tippett: What I undertake to do, your Honour, is that if I wish to call such evidence I'll provide my learned friend with a proof of it and then she may object and we can argue about it at another time, if that's convenient to your Honour."

No attempt was made by counsel for the plaintiff to recall Mr Baddeley, and the plaintiff's counsel closed his case on the following day of the hearing. No explanation was offered as to why he was not recalled. I can only assume that the opportunity to obtain further instructions from Mr Baddeley and to recall him to give further evidence having been offered to the plaintiff, that whatever Mr Baddeley might have said in relation to the plaintiff's case concerning his investigations in 1988 would not have advanced her case: see *Jones v Dunkel* (1959) 101 CLR 298. I note also that Mr Yaksich, in October 1987, expected some improvement in her condition over the next six months, and Mr Baddeley in his report dated 18 August 1987 felt that she would not be fit to return to full duties for at least three months after 1987, and that he then expressed the

opinion that "the plaintiff will be able to return to her normal activity and is unlikely to experience long term disability ..." Doing the best I can, I consider that the plaintiff did not recover sufficiently from her injuries until about May 1988 when seen by Dr Reilly. It may be that she was fit for light work prior to then, but I consider that it was probably not unreasonable for her to continue off work until she was fully recovered, and that this occurred by about 13 May 1988. I do not accept the plaintiff's evidence that the work at Block 4 of the Royal Darwin Hospital was too heavy for her.

The remaining question is whether, notwithstanding that the plaintiff had recovered from her physical disabilities by then, she may have suffered from an anxiety state which lead her to believe, unconsciously, that she was disabled, and prevented from continuing to work. Again there are conflicting views in the medical evidence concerning this possibility.

Dr Wake, as I have already observed, considered that she had reached a stage by late 1988 where he was sure that she was suffering from a depressive illness. It is interesting to note that he gave no evidence of this in examination in chief, other than what appears inferentially in his letter to Dr Bullen (Ext P3), and that he prescribed anti-depressants in August 1988. However, in cross-examination he went further, and said that she appeared anxious as early as May 1987 and that he felt, after seeing her over the next twelve months or so, that this had developed into a depressive illness:

> "I'm trying to understand in relation to your treatment that would it be fair to say that on the occasions that you've written 'depressed', in your view, there was a complaint of depression and you prescribed medication for it?---Well, no that wouldn't be fair.
>
> Wouldn't it?---No. Typically what would happen in that situation: the patient's usually in - and with

extreme anxiety and upset, as in this case. It's not usually one goes straight to some type of anti-depressant medication or straight into a diagnosis of depression. One waits and watches and tries to improve the circumstance which is inducing the anxiety. Quite commonly that anxiety, and the pressures upon the patient over a period of time, will reduce their resources to stay well and so one will see a depressive illness creeping in or, perhaps, some months after the various anxiety episode. So that's really what these notes show. They show a progression from about May 1987 through till I ceased treating her in August 1988, of anxiety through to depression.

I'm going to suggest to you doctor that the only time that you felt that she was truly depressed, is when you wrote 'depressed' in your notes?

Is that a fair comment?---You can suggest that, but I don't accept it.

Right. Well why do you write it sometimes and not other times, doctor?---Because by that time - as I've just explained to you, when one works in clinical practice, you see a spectrum of psychiatric problems and typically these matters fit in as anxiety overlay. Now what one tries to do in this situation is to undo the cause of the anxiety overlay, in this case the injury to the shoulder and the work conditions. If one is successful at that then usually there is no need to do more. Typically in these situations, over the months, if there is non-resolution of baseline problems, then you will see the development of depressive illness. My purpose in writing 'depression' is usually to remind myself that by that stage I am absolutely convinced that we're dealing with a depressive illness.

So you were unconvinced prior to 18 July 1988 that she was depressed; is that so?---There was a spectrum of development and - no it wouldn't be fair to say that I was unconvinced. I was using a different tactic, not depressant medications in her treatment.

And you made no notes of depression in the more than 20 times that you saw her over a 2 year period other than on the last 2 occasions, is that right?---Nothing specific about that - - -

Is that right, doctor?---Yes. Nothing specific."

I find it extraordinary that if Dr Wake considered that the plaintiff had a depressive illness that he did not refer the plaintiff to a psychiatrist. Even allowing for the length of time needed to make an appointment, he saw the plaintiff on numerous occasions between May 1987 and August 1988. On each occasion he claimed that the plaintiff presented herself to him as extremely anxious and upset. There was no visible sign of any anxiety by the plaintiff when she gave evidence before me, apart from the usual nerves that witnesses often have when they first enter the witness box. The plaintiff gave no evidence that she was upset, anxious, or the like in the relevant period. Mr Baddeley noted in his report that some of her symptoms appeared to be anxiety related. I am prepared to accept that the plaintiff suffered some anxiety in 1987 and 1988 on the basis of this evidence, but I am not prepared to accept that she continued to suffer any anxiety sufficient to prevent her from working after May 1988. In answer to questions put to Mr Yaksich by me, he gave evidence that the plaintiff did not appear to be anxious on any of the occasions he examined her, although he qualified this by saying that it is difficult for him to tell, especially as she is Asiatic. Dr Reilly considered that it was easier to explain her symptomatology on a functional basis:

> "And the organic symptoms, that is those that you found to be organic, you say that you had difficulty to explain those; is that right?---I didn't say that any of them were absolutely organic. What I've been through before is to say that none of then are necessarily organic. The one which fits most easily into an organic explanation is the sensory loss that was present in the left hand, but the - whether or not these other symptoms are organic is a matter of interpretation which is based on all the other factors that we've talked about before.
>
> You don't conclude one way or the other, you - - -?--- I think that what I'm saying is that for various reasons I find it difficult to explain them on an organic basis. I find it easier to explain them on a non-organic basis, in other words.

His Honour: In other words, what?---In other words that they are - I find it easier to explain this persistence on a functional basis than on a physical basis.

Do you mean functional overlay, do you?---Well, whether it be conscious or unconscious, I couldn't say. I wouldn't - can't say that the pain is not there but all that I can say is that weighing up the physical factors in the story that it seems to be inconsistent.

Mr Tippett: All right. But, in any event, such persisting symptoms, whether they be on the basis that you have - you have found easier to explain or they be upon the basis that you find more difficult to explain; upon either basis, they are still debilitating symptoms?---They may exist. I can't say whether they exist or not."

Professor Jones' evidence on this point may be summed up in the following passage of evidence:

"His Honour: I understood the - and I may have got this wrong - but I understood that Dr Wake was referring to a condition involving discomfort involving muscles to the shoulder and the upper arm and the large - particularly the large muscles of the shoulder blade involving severe and intractable pain exacerbated by movement, often involving, as in this patient, -apparently it occurred - disturbed sleep - - -?---Yes, well, you know - - -

- - - that type of thing?---It's very difficult to interpret some other doctor's views on medical conditions but he does say there: 'It's aggravated by anxiety', I notice, and he expected her to make a complete recovery by the end of the year. I mean, there are many aspects there, your Honour, that I think really should be directed to Dr Wake because I read that report - and of course, it first a ofa all was clavicle pectoral and - I mean, it was a nonsense.

You're not ruling out in this case that the plaintiff has some non-organic disability?---Non-organic?

Non-organic?---I missed that, your Honour?

Non-organic?---Non-organic? Well, I suppose that's what I'm saying; that in the first instance there are aspects of my examination which would indicate that there is not a major physical component. Now, one looks at the alternative; is

> there a psychological component? One is tempted to say that there is a psychological component but whether there's a compensable psychological component or not, I think, is very arguable. I wouldn't have accepted that myself."

No psychiatric evidence was called, and none of the medical witnesses who proffered a view had any particular expertise in psychiatry, although Prof. Jones is, through his qualifications as a member of the College of Rehabilitive Medicine, and long experience in that field both as a practitioner and academic, better qualified, I find, than anyone else to express an opinion. Mr Tippett, counsel for the plaintiff, in his submissions, was somewhat critical of some of Prof. Jones' evidence and findings which he submitted "stood alone" and were wrong, and in cross-examination Prof. Jones' demeanour at times was unnecessarily hostile, particularly when he was challenged on some matters which he thought reflected on his credibility. However, making due allowance for those matters, I consider that Prof. Jones tried his best to be careful in arriving at his conclusions, and was not biased in favour of the defendant, and that his conclusion that any psychological component was not compensable is safe to be relied upon. Be that at is may, the plaintiff suffers from the difficulty that she gave no evidence consistent with an anxiety state and there is no medical evidence that I am prepared to accept, that the plaintiff suffered from any anxiety state which prevented her from working and which explains any significant on-going symptomatology after May 1988, and the only expert evidence which I am prepared to accept is either neutral or points in the opposite direction. Added to this, is the difficulty that any anxiety problem she may have had, did not, according to Dr Wake's report to Dr Bullen, produce symptoms of the kind complained of at times thereafter. Further to this, my own assessment of the evidence, including the plaintiff's evidence and that of Ms Day, is that the plaintiff was consciously exaggerating her case in order to obtain a high

award of damages. The indications of this are evident in the plaintiff's explanations, which I do not accept, for not continuing the English classes, and for not continuing with the light work at Malak House. Further indications are to be found in her reasons for not seeking any medical treatment after she last saw Dr Wake in August 1988 which I also do not accept. Indeed, it is apparent that after she was retired in January 1989 and subsequently received her superannuation funds that she made no effort to seek medical treatment even though the monies could have been used for that purpose. Yet her husband was in employment and she was able to travel to Thailand in 1989 and again in 1991. Her explanation that she was unable to afford any treatment after August 1988 is patently unbelievable. The other indication of conscious falsity is that the details of the descriptions of her nerve loss varied from one doctor to another. As Prof. Jones put it:

> "And you found absolutely no sensory loss whatsoever?---Well, I found this inconsistent loss. Sometimes it was there; sometimes it wasn't. But it certainly was not in the distribution that Dr Reilly describes in that report of 19 May 1988."

Finally, I base my conclusions on the demeanour of the plaintiff in the witness box. As I have already mentioned, she showed no signs of any anxiety and did not look forlorn or depressed. On the contrary, she appeared to have no signs of discomfort although she held her left arm virtually motionless throughout her evidence, but gesticulated freely with her right arm, yet I could not see any signs of neck stiffness. My impression of her was that she was extremely cunning and skilful at telling brazen untruths when she thought she would not be able to be caught out. In arriving at this conclusion I have attempted to make full allowance for her lack of English skills, and her general background and level of education.

Assessment of damages

Based on the above findings, I consider that the plaintiff is entitled to be compensated for her pain and suffering and loss of enjoyment of life from the date of the accident up to May 1988 and for some minor intermittent discomfort requiring her to seek treatment from time to time in July and August 1988 and in mid 1989.

The plaintiff was born in Thailand on 15 March 1954. She is presently married to a Thai national and has one child born on 17 January 1974. She gave no evidence of any particular interests outside of her employment or domestic household duties.

In all the circumstances, and taking into account that on my findings she was unable to resume her employment until May 1988, and that this employment appears to have been her major source of enjoyment of life outside of her marriage (and noting that there is no evidence that her marital relations were interfered with at all) I consider that, doing the best I can, the plaintiff is entitled to an award of $20,000 under this head.

As to past lost earnings, the evidence was that she would have received between $304.71 and $318.83 per week net during the period between the date of the accident and mid May 1988 (see Annexure 'A' to the affidavit of Robert Whitehead - Ext D10). Accordingly I calculate her lost earnings for this period as follows:

Period	Weeks	Rate	Total
25/11/86 to 18/03/87	16.2	$304.71	4,936.30
19/03/87 to 24/10/87	13.8	$311.27	4,295.53
25/06/97 to 02/09/87	9.8	$313.87	3,075.93
03/09/87 to 17/02/88	29	$314.60	9,123.40
18/02/88 to 13/05/88	12	$318.83	3,825.96
			$25,257.12

Special damages have been agreed at $848.50. It appears that the plaintiff has not in fact paid any of these amounts by way of special damages and is therefore not entitled to interest on the sum of $848.50: see *Volmer v Northern Territory Electricity Commission* (1985) 34 NTR 12 at 28. Similarly, as the plaintiff has received weekly worker's compensation payments up to and including 24 June 1987, no interest should be awarded on her claim for loss of wages up to that date. Thereafter, the plaintiff is entitled to interest at commercial rates. These have fluctuated considerably since 1987. No evidence was called to establish a rate. I can and do rely upon what is common knowledge. Bearing in mind that rates have declined significantly over the past year or so, I consider that an average rate of 10 per cent since 1987 will do justice to the parties. I therefore allow the sum of $8,413.08 approximately for interest on the past lost wages from 25/6/87 to date ($16,025.29).

As to interest on the amount awarded for pain and suffering, following *MBP (SA) Pty Ltd v Gogic* (1990-91) 171 CLR 657, I consider that the plaintiff is entitled to interest on the sum of $20,000 at the rate of 4 per cent per annum. This amounts to $4,733 approximately.

In summary

Pain and suffering and loss of amenities	$20,000.00
Interest thereon	$ 4,733.00
Lost earnings to date of trial	$25,257.12
Interest thereon	$ 8,413.00
Special damages	$ 848.50
	$59,251.62

In my opinion, the plaintiff has not suffered any future loss of earning capacity and I therefore make no allowance under this head.

Finally, there is the question of whether or not I should

deduct from this award the amount of worker's compensation paid by the "worker's compensation insurer."

The evidence is that the total amount of compensation paid was $4,573.79.

It appears that at the relevant time the plaintiff was entitled to receive compensation from the Commonwealth pursuant to the provisions of the *Compensation (Commonwealth Government Employees) Amendment Act 1978*. The plaintiff is under a duty pursuant to s99(3) of the *Compensation (Commonwealth Government Employees) Amendment Act 1978* to repay that compensation to the Commonwealth. If there are arrangements between the Commonwealth and the defendant for the defendant to ultimately recover this money, I have not been made aware of them. As the defendant is not the body to whom the plaintiff has a legal liability to repay the compensation I consider that no deduction should be made for the compensation paid.

Accordingly there will be judgment for the plaintiff for the sum of $59,251.62. I will hear the parties as to costs.