

DISTRICT COURT OF QUEENSLAND

CITATION: *Roane-Spray v State of Queensland* [2016] QDC 348

PARTIES: **MOYRA BRIDGETTE ROANE-SPRAY**
(**plaintiff**)

v

STATE OF QUEENSLAND
(**defendant**)

FILE NO/S: BD4097/2014

DIVISION:

PROCEEDING: Civil Trial

ORIGINATING COURT: District Court at Brisbane

DELIVERED ON: 21 December 2016

DELIVERED AT: Brisbane

HEARING DATE: 6-8 June, 8 August 2016

JUDGE: McGill SC DCJ

ORDER: **Judgement that the defendant pay the plaintiff \$557,669.79, including \$272 by way of interest.**

CATCHWORDS: NEGLIGENCE – Personal injury – fall of one end of ambulance stretcher – whether paramedic negligent – whether statutory defence – assessment of damages.

Civil Liability Act 2003 s 27

Shaw v Menzies [2011] QCA 197 – applied.
Westfield Shopping Town Liverpool v Jevtich [2008] NSWCA 139 – cited.

COUNSEL: P B Rashleigh for the plaintiff
C J Fitzpatrick for the defendant

SOLICITORS: McInnes Wilson Lawyers for the plaintiff
Crown Solicitor for the defendant

- [1] On 25 January 2012 the plaintiff was living on Lamb Island in Moreton Bay. An ambulance was called for her and it attended her residence, and after she was examined by the paramedic it was decided that she would be taken to hospital. She travelled in the ambulance to the landing stage for Lamb Island where a boat maintained by the ambulance service was waiting. She claims that while she was being moved from the back of the ambulance on a stretcher before being wheeled down the landing stage to the boat, the head of the stretcher on which she was lying

fell to the ground causing her to slide down and hit her head on the bitumen of the carpark. She alleges that as a result of this she suffered personal injury. The defendant disputes that such an incident occurred, or that the plaintiff suffered any injury in the way she described; quantum is also in issue.

Background

- [2] Lamb Island has a small population and no resident paramedic, though an ambulance vehicle is kept on the island in a shed near the landing stage. When an ambulance is required on the island, it is necessary for a paramedic to be collected by the ambulance boat from Russell Island and conveyed to Lamb Island, so that the shed can be opened and the ambulance vehicle driven to wherever it is required.¹ If a patient has to be taken to a public hospital, the vehicle then conveys the patient back to the landing stage where the ambulance boat transfers the patient to the mainland where another ambulance should be waiting to take the patient to the Redlands Hospital.²

Plaintiff's version

- [3] On the morning of 25 January 2012 the plaintiff developed a stabbing pain in the left side of her head when she bent over to dry her dog: p 14. The pain continued, and after a while the plaintiff's husband called an ambulance. According to the ambulance service records the call was received by it at 8.04 am, and the ambulance arrived at the plaintiff's residence at 8.39 am.³ The paramedic came into the house and examined the plaintiff who was lying on a couch: p 15. He said it looked like she was having a stroke, and she should go to hospital.
- [4] The plaintiff said that she walked to the ambulance, including going down the front stairs (27 steps) with the assistance of her husband and her son, who held an umbrella over her: p 15, p 47, p 49. She climbed into the ambulance through an open sliding door on the passenger side, lay on a stretcher and put her head on a pillow. She said that the stretcher was flat, she did not notice any safety belts, and none were put on her.⁴ Her husband put her hospital bag and handbag on her stomach and left: p 15, p 52. She said that as she was getting in the paramedic was putting what she described as his bags (presumably some equipment) at the end of the stretcher through the door at the back of the ambulance, which he then closed; he then walked around, closed the door on the passenger side, got into the driver's seat and said something indicating he was in a hurry to get back to the ambulance boat: p 16, p 46, p 49. He then drove the ambulance to the ferry terminal.
- [5] The weather that day was very bad, with rain and a strong wind coming from the south-east: p 17. The plaintiff's home faces north, and there was some protection from the wind there, but at the landing stage it was quite exposed, and she said that the paramedic put a silver blanket over her which he said would help her keep the rain off. He then went around and opened the back door of the ambulance, and began to pull the stretcher out, but the wind blew the silver blanket into his face, and he was trying to push it down: p 18, p 45.

¹ Smyth p 3-22.

² Berkett p 4-12.

³ Exhibit 1, Part 1 p 36; Berkett p 4-11.

⁴ See also p 40.

- [6] The plaintiff said that she seemed to be pulled out very fast and the next minute the head end of the stretcher crashed to the ground, but he kept pulling her along: p 18.⁵ She screamed out for him to stop. She was slipping off backwards, having lost the pillow and her bag: p 19. Then the paramedic rushed up and lifted the head of the stretcher. She had to manoeuvre herself back onto the stretcher, he picked up the bag and the pillow, and began to wheel her down to the boat.

The stretcher

- [7] I should at this point explain that the stretcher that was in use was one with legs with wheels which were designed to fold up when the stretcher was inside an ambulance, but which were supposed to unfold automatically, and lock in a down position, as the stretcher was pulled out of the ambulance. In effect the support structure for the stretcher was folded up when the stretcher was stowed in the ambulance, but it automatically unfolded so as to support the stretcher on four wheels as the stretcher was removed from the ambulance. There is a third set of wheels on the stretcher which does not drop down, and which will support the very end of the stretcher within the ambulance. In this way one paramedic could safely remove a stretcher with a patient from the ambulance, and immediately have a wheeled trolley on which the patient could be moved: p 3-22.
- [8] The precise model of stretcher in use on this occasion was not conclusively identified by the evidence, but I was provided with an operations manual for stretchers from Ferno, the relevant manufacturer, which shows how the mechanism operates for a number of different models of stretcher from that operator, which are generally similar except for matters of detail.⁶ An example of such a stretcher was produced in court during the trial, and I took some measurements from it: p 3-71.
- [9] When the stretcher was in the ambulance with the wheels folded up the wheels would run on runners so that the stretcher could be easily removed from the ambulance.⁷ As one end of the stretcher was pulled free from the ambulance, the wheels and the frame supporting them at that end were designed automatically to drop down, and upon deploying in the extended position, to lock into place. As the wheels to support the other end of the stretcher came clear of the ambulance, they would ordinarily also drop down and lock into place. It was common ground in this matter that the leading set of wheels did correctly deploy, but the trailing set of wheels, initially, did not lock into place.⁸

Paramedic's version

- [10] The paramedic who attended the plaintiff was called. He is and was an advanced care paramedic of Queensland Ambulance Service, and has a good deal of experience in providing ambulance services in New Zealand and Australia: p 4-4, 5; Exhibit 9. He said that he was familiar with the Ferno model 26 stretcher which he said was the stretcher used at that time at Lamb Island: p 4-6, 7. He has never had a situation where such a stretcher had collapsed or failed while transporting a patient. He said if such a thing did occur, he would inform his supervisor and record the event on the

⁵ She thought he pulled her nearly the length of the rear door of the ambulance: p 43.

⁶ Exhibit 1, Part 1 pp 1-27.

⁷ Smyth p 3-26; and see Exhibit 1, Part 2, p 49, p 57.

⁸ When the stretcher was examined later, no defect to explain the collapse was identified: Exhibit 1 part 1 p 46.

electronic patient report form which he completed for each patient. The stretcher in question had two lap belts and these were always used when there was a patient on the stretcher: p 4-8. At the time he was based on Russell Island, but would attend Lamb Island using an ambulance boat.

- [11] He recalled attending the plaintiff and identified the electronic patient report form which he completed.⁹ Some details of this, particularly the initial times, were inserted on the form automatically by the computer system: p 4-9. For example, the time at scene was ended as a result of his advising the communication centre that he had arrived at the scene: p 4-10. The effect of the form was that the call was received through triple-0 at 8.04 am, and he was contacted and dispatched at 8.05 am, he was in his vehicle on Russell Island at 8.06 am, and at the scene on Lamb Island at 8.39 am, with the patient at 8.40 am, and he advised communications that he was leaving the scene with the patient at 9.11 am.¹⁰ He said however that the time shown from leaving the scene to the destination time was too short, because the boat trip alone would take about 15 minutes: p 4-12. The time shown as the triage time actually related to when he hands the patient over to another paramedic after the boat arrived at the mainland, so from his point of view the patient is at the destination when the boat ties up. The electronic form was completed at 10.30am.¹¹
- [12] He said he had some recollection of this particular case, because his attention had been drawn to it a number of times over the years: p 4-13. When he arrived he took his equipment and walked up the front stairs and into the lounge room where the plaintiff was lying on a couch.¹² He did an ECG and obtained a normal rhythm: p 4-14. The heart rate was regular, he took her blood pressure and was aware of the various symptoms noticed on the form. He formed the impression that she was possibly having a transient ischaemic attack, a mini stroke, and therefore required transportation to hospital: p 4-15. He said the plaintiff was anxious but willing to go to hospital. It was too difficult to get a stretcher into the house, but she was willing to walk to the ambulance.
- [13] He said he gathered his equipment, went downstairs, entered through the left hand sliding door, put his equipment back in the ambulance, prepared the stretcher for her, then went back upstairs and assisted her to the ambulance: p 4-15. She was able to walk beside him unaided.¹³ She entered the ambulance through the left hand sliding door, and he had her get on to the stretcher where he had the back raised so she was in the semi-recumbent position,¹⁴ and put a pillow behind her head: p 4-16; p 4-30.¹⁵ He said he then took a further set of vital signs and blood pressure, listened to her chest with a stethoscope, put the side rail of the stretcher up and applied two seat belts – one across her legs and one about her midriff: p 4-17. He said the cardiac monitor automatically records times that things happen, and at the end he was able to print out a code summary with all the times and observations on it: p 4-19.

⁹ Exhibit 1, Part 1 p 35.

¹⁰ Berkett p 4-11; Exhibit 1, p 36.

¹¹ That was when it was saved and closed: Berkett p 4-27. He took about 30 minutes to complete it.

¹² In a semi-recumbent position, not flat: Berkett p 4-28.

¹³ Under cross-examination he said it was possible her husband and son assisted her down the stairs, but he did not recall that: p 4-28.

¹⁴ The plaintiff denied this, and said she was lying flat, to ease her head pain: p 52. She said she was also lying flat in the ambulance on the mainland: p 3-13.

¹⁵ He denied that the plaintiff's husband assisted in this, but admitted the husband brought her her handbag: p 4-28, 41.

- [14] The paramedic said that when he had made the plaintiff secure he explained that he was going to proceed to the jetty to move her onto the boat, then left the ambulance by the left hand door which he slid closed, climbed into the driver's seat, advised communications that he was departing the scene, reversed out of the driveway and drove down to the jetty, which took a minute or two: p 4-19. He parked the ambulance on an angle in the parking bay opposite the jetty, then opened the left hand sliding door to enter the ambulance again to explain to the plaintiff that as she would be moved out into the rain he was putting a silver blanket on her which would provide some rain protection for her: p 4-21. He said he then undid the seatbelts and resecured them outside the silver blanket to prevent it from blowing away, and told the plaintiff that they would be moving out quite quickly to minimise the rain: p 4-21.
- [15] He then left the ambulance through the left side door, opened the rear doors and locked them open, checked the ambulance boat was in position to receive the patient, and unlocked the latch which secures the stretcher in place: p 4-21. He held the stretcher and moved backwards, sliding it out of the ambulance, and the back legs dropped down and clicked into place: p 4-22. He moved it out quickly, listening for the second set of legs to drop and click, but did not hear the click, and realised that something was not right. He put pressure on the rear of the stretcher to create lift on the front, and realised that the front wheels were past the ambulance¹⁶ so he attempted to push it forwards to try to get it back into the ambulance: but it dropped down and landed on the step of the ambulance.¹⁷ When he tried to push it back in it came down with a sudden jolt onto the step, which the plaintiff would have felt: p 4-23. He then moved beside the stretcher, lifted it at the left front and pushed it backwards and he heard the rear wheels click into place, which stabilised the stretcher. He said he apologised to the plaintiff and asked if she was okay and she said she was fine, and then he moved the stretcher round and down to the jetty. While he was doing this someone came and held an umbrella over the plaintiff: p 4-24.
- [16] When they got to the boat the boat skipper assisted in moving the stretcher onto the boat, but this was just a matter of rolling it on because the boat was the same level as the jetty: p 4-24. The stretcher was then pushed into a plinth and locked into place, like having it in the back of an ambulance. He asked the plaintiff if she was okay and she said she was, then he got the rest of his kit out of the ambulance which he locked up, untied and boarded the boat, hooked up the cardiac monitor, took a set of vital signs, and the boat proceeded to the mainland. There was an uneventful crossing which took 15-20 minutes, after which the boat was met by another ambulance crew, the plaintiff was transferred onto their stretcher and taken to hospital in their ambulance. He provided a hand-written form to that crew to give them the information they needed, keeping a carbon copy which he used later to fill in the electronic patient report form: p 4-25.¹⁸

The plaintiff's complaints

- [17] There was no one else present at the time this incident occurred, whatever its content. There was however evidence that the plaintiff had complained about what had happened to her fairly soon after this incident. Ms Taylor was at the time a resident

¹⁶ By a few inches: p 4-34.

¹⁷ He said it looked like the step in the photograph on p 53 of Exhibit 1 Part 2. See also p 4-32.

¹⁸ He had left the computer with the form on the boat: p 4-38. He did not have it with him at the plaintiff's house. What happened was first recorded on the handwritten form while crossing to the mainland.

of Lamb Island, and a neighbour of the plaintiff: p 2-9. When the ambulance containing the plaintiff arrived at the ferry landing she was there in a shed waiting for a ferry. She said the ambulance arrived and the ambulance officer seemed to be taking a long time to get the patient out of the back of the ambulance, and because she had an umbrella she walked out of the shed and held her umbrella over the patient, and then realised that it was the plaintiff. She said the plaintiff kept repeating that she had just fallen and hit her head,¹⁹ and she responded by telling her that she would be alright because she was going to hospital.

- [18] She continued to hold the umbrella over the plaintiff as the stretcher was taken down to the boat. She also said that the plaintiff became frightened when the stretcher was to be transferred from the jetty to the boat, and the paramedic had said, “It’s okay, it’s fixed, it won’t happen again” as she was moved onto the boat: p 2-10. Under cross-examination she said she did not notice whether there were any belts to hold the plaintiff on the stretcher, the paramedic was at the foot end of the stretcher, which stood on four wheels when she went up there: p 2-11. She said she recalled seeing a silver blanket over the plaintiff, although she agreed she could not be certain about that: p 2-12.
- [19] After the plaintiff was taken to the mainland, she was handed over to another ambulance with two paramedics, one of whom was Mr Backwell, and a student paramedic: p 3-9. He completed the report form which is in Exhibit 1 Part 1 p 40. There was no reference in that report to this incident, just to the plaintiff’s complaining about the headache which led to the ambulance being called in the first place. The plaintiff said that at the time of the hand-over there was some light-hearted reference to the incident by the paramedic, in which she joined, and that during the journey she told the paramedic with her, who must have been Mr Backwell, what had happened: p 41. Mr Backwell said that he had no recollection of anything like that, and that if he had been told about an incident with the stretcher he would have recorded it in his form: p 3-11. He would also have passed on that information to the triage nurse at the hospital. The other paramedic for this ambulance also gave evidence that he had, if possible, even less recollection of the job than Mr Backwell: p 3-18. He said he was driving that day so he would not be aware of any conversation that went on in the back of the ambulance: p 3-19.
- [20] Mr Backwell was unable to recall whether, at the time he collected the patient on the ferry, she was on the stretcher: p 3-13. His report form notes that at the time he received the patient, her position was supine, that is lying flat.²⁰ Mr Backwell said that most patients prefer the semi-reclined position, but that if the plaintiff had been in that position he would have recorded it as semi-reclined: p 3-14. Although the report form refers to the patient as ambulatory throughout treatment and transport, that meant that she was able to walk, rather than that she was actually walking: p 3-14. He said he took his first set of observations after the patient was in his ambulance: p 3-15. The reference to reassurance being provided to the patient was something done routinely: p 3-16.
- [21] After the plaintiff arrived at the Redlands Hospital, she was seen by a doctor who recorded her complaint about the headache, but also noted:

¹⁹ The plaintiff’s recollection of what she said was different: p 20. I expect Ms Taylor’s evidence is more reliable.

²⁰ Exhibit 1 Part 1 p 42; Backwell pp 3-13.

“She had a head/neck trauma while being transported by QAS from the Island. While the patient was coming out of the QAS ambulance she was on the stretcher. The front two stretcher legs did not engage, and she went head down. No discomfort initially, but is complaining of cervical spine tenderness.”²¹

The notes recorded the plaintiff being tender over the C3-C4 level of the cervical spine, and tender over the T8-T11 area, the lumbar spine and the sacral spine: p 63.

- [22] On 26 January, the following day, a different doctor noted that the plaintiff:
 “Had back trauma after fell from ambulance trolley – no pain at the time, but pain started afterward – Xray NAD.” [That is, no abnormality detected].

Also noted was:

“Very severe pain last night on high lumbar back and right lower back and right buttock. Straight leg raising was restricted on the right, but there were normal reflexes and sensation on the lower limbs.”²²

- [23] That day Ms Brodie, who was then the duty officer in charge at Redland Bay Ambulance Station, saw the plaintiff at the Redcliffe Hospital and took a complaint from her, the details of which she could not now recall: p 3-6. She said she spoke to the officer concerned, and subsequently spoke again to the plaintiff, but could not recall the detail of what was said then: p 3-7. She made some notes at the time, but was not able to recognise document 6 on p 45 of Part 1 of Exhibit 1, which was not her document: p 3-8. That document however also records the plaintiff’s complaint.
- [24] The following day a physiotherapist saw the plaintiff and noted complaints of low back pain and neck pain for the last two days “which is now worse since collapse of ambulance stretcher.”²³ The plaintiff remained in hospital until 10 February 2012; the discharge summary identified her main problem as an acute exacerbation of chronic back pain: Exhibit 2 Part 2 p 82.

Other evidence

- [25] There were aspects of the paramedic’s evidence which were inconsistent with evidence given by other witnesses. The plaintiff’s husband confirmed that on the day in question she was complaining about pain and he called an ambulance (p 86, 87), the paramedic came and examined the plaintiff and said she should go to hospital. He said that he and his son helped her down the stairs and to the ambulance: p 87. He said the door was open and he helped her in, and she sat on the stretcher and then lay down; the stretcher was flat but she had a pillow to put her head on: p 88, 92. He could not remember straps or seatbelts on the stretcher. He put a handbag and a small bag of toiletries and a nightdress on her lap: p 88. He said that the paramedic put something into the ambulance through the back door, then closed the side door, got in the driver’s side and drove away. He next saw his wife in hospital: p 89.
- [26] Mr Roane-Spray acknowledged that his short-term memory had been affected by two strokes which he had suffered: p 82, 90. He denied however that the reliability of his

²¹ Exhibit 2 Part 2 p 61, 62; also see plaintiff p 42.

²² Exhibit 2 Part 2 p 64.

²³ Exhibit 2 Part 2 p 65.

recall had been affected: p 91. He said that the paramedic took observations while the plaintiff was in the house, but not inside the ambulance itself: p 91. He denied that the paramedic helped the plaintiff into the ambulance through the left-hand door and that the paramedic placed her on the stretcher and fitted two safety belts.

- [27] At the time the plaintiff and her husband had a friend staying with them, a Mr Smithers, who shared an interest in sailing: p 2-3. Mr Smithers said that the plaintiff's husband and their son helped her down the stairs to the ambulance, which he observed from the front veranda. He said that Mr Roane-Spray helped the plaintiff into the ambulance and gave her bag to her, while the paramedic put his bag into the back of the ambulance, and then got into the driver's seat and drove off: p 2-4.
- [28] Mr Smithers acknowledged that the plaintiff and her husband were good friends and that he did stay with them from time to time: p 2-4. He was first asked to recall this incident nearly three years after it occurred: p 2-5. He denied that the paramedic got into the ambulance with the plaintiff: p 2-5. He could recall that it was raining that day, but did not remember whether there was an umbrella used while the plaintiff was going downstairs to the ambulance.
- [29] The skipper of the ambulance boat was called, but he had no recollection of anything involving this particular incident: p 3-49. He also confirmed the procedure, the fact that the landing at Lamb Island can only accommodate one boat at a time, that there was a ferry due at the island at about 9.23 am, that if necessary he would move from the dock to let it in, and that the transit time from Lamb Island to the mainland is about 20 minutes: p 3-59.
- [30] The Director of Operations for the Metro South Local Ambulance Service Network in January 2012, Mr Smyth, (p 3-21) was called and gave evidence about the system. He conceded that if the stretcher was pulled out of the back of the ambulance and the paramedic did not hear the legs click down, it would be unsafe: p 3-24. He said that it would be possible to balance the stretcher on the first set of wheels that had locked into place in an attempt to gain control of what was going on at the head end: p 3-32. He said as an interim measure it would be possible to rest the stretcher on the bumper while the paramedic went to the front, but thought it would be a difficult exercise especially if the paramedic were alone: p 3-33.
- [31] Mr Smyth accepted that, if the legs had not deployed properly, it would not be appropriate to pull the stretcher right out of the ambulance: p 3-24. At first he denied that if the second set of wheels did not properly deploy, when the stretcher was pulled clear of the ambulance it would crash to the ground, saying that rather there would be a controlled lowering to the ground from the back of the ambulance: p 3-25. Later however, he admitted that if the second wheels did not deploy properly, and one kept pulling the stretcher out, then the head end would crash to the ground: p 3-26. Later still he said that the head end of the stretcher was going to bump onto the bumper bar first rather than the ground (p 3-28) but if you did not, at that point, stop pulling it out, the stretcher would drop to the ground: p 3-31.

Analysis

- [32] The question of liability turns first on the factual issue of whether things occurred in the way that the plaintiff described, or in the way the paramedic described. I find, on the balance of probabilities, that things occurred as the plaintiff described, that is, when the stretcher was pulled out of the ambulance and the second set of legs did not

properly deploy, the head of the stretcher fell onto the ground, with the plaintiff sliding up the mattress so that her head also hit the ground. Although I have some concern about the reliability of the plaintiff's evidence, this arose in the context of evidence about the consequences of pre-existing problems with the back, and it is understandable, in light of the plaintiff's condition overall, that she would now be disposed to attribute all of her spinal problems to this incident. I acknowledge some concern about the plaintiff's reliability, but I think it is quite significant that there were complaints consistent with her account to Ms Taylor very soon after the incident must have happened, and to the hospital when she was seen there.

- [33] It is difficult to believe that these complaints were triggered by the relatively minor jar that she would have received on the paramedic's version, and quite inconsistent with her evidence that when he spoke to her she said she was alright. There is also the consideration that the paramedic's evidence was inconsistent with the evidence of both the plaintiff's husband and Mr Smithers, and also to some extent Ms Taylor, about the plaintiff's concern about being wheeled onto the boat, and what was said to her at that stage, though I agree that the last point was not inconsistent with the paramedic's version. On the plaintiff's account, there had been a serious failure to follow proper procedure on the part of the paramedic, which gives him a motive not to be frank about what happened.²⁴
- [34] The evidence of the husband and Mr Smithers is inconsistent with the paramedic having applied the safety straps to the plaintiff when she was put on the stretcher, and having had the stretcher in the semi-recumbent position. Also, Ms Taylor thought that when she came to the ambulance the paramedic was putting a silver blanket over the plaintiff, and said that she held it in place as the plaintiff was wheeled down to the landing stage because of the way the wind was blowing: p 2-12. That suggests that the blanket was not held in place by having the safety straps secured over it, as the paramedic claimed.
- [35] Ms Taylor does not seem to have said anything about whether the stretcher was flat or in a semi-recumbent position when she saw it. The fact that the plaintiff was lying supine on the stretcher in the second ambulance would be, I think, more consistent with her having been supine on the first stretcher, as her husband said she was, and as she said, given that the practice was to have the stretcher in whatever position the patient was most comfortable, in the absence of a specific medical issue.
- [36] I cannot see how having the head of the stretcher drop a few inches from the floor of the stretcher to the step would have been likely to produce any problems for her spine, given that she was lying on a reasonably well-padded mattress on the stretcher. Indeed, Dr Cameron thought that even if the head of the stretcher had fallen to the ground, the padding of the mattress would have prevented her from suffering any aggravation of her back problems (p 3-38), although I suspect that this evidence was really directed to the proposition that in these circumstances she would not have suffered any real bony injury to the spine, something which obviously did not occur given that no bony injury was detected in the x-rays taken at the hospital.

²⁴ Even the version he gave in evidence was not noted on his report form for the plaintiff, filled in after the event (p 4-38), but emerged only when he was questioned about the plaintiff's complaint later: p 4-25. He said he thought it too trivial to report: p 4-26. Any stretcher collapse is supposed to be reported: Smyth p 3-23.

- [37] There is also the consideration that the paramedic's account seemed to be, at least initially, that when the head of the stretcher became unsupported he was able to balance the stretcher on the wheels that had deployed, and the head went onto the step only when he attempted to push the stretcher back into the ambulance: p 4-46. That would have been possible if he had been expecting to take the weight as soon as the end wheels came clear of the ambulance;²⁵ on my calculations the downward force required on the handles to keep the stretcher horizontal and balanced on the rear wheels was 23.2 kgs,²⁶ which could have been feasible. It would however have been extremely hard to push the stretcher forward while keeping it balanced horizontally in this way, given that the pivot point is on the axel of the wheels, well below the line of the frame of the stretcher where the handles are. On the other hand, if the paramedic had not been pressing down on the handles as the end wheels came clear of the ambulance, it would have been difficult to prevent the head of the stretcher falling at least as far as the step before he was able to get control of it.
- [38] I think it would be very difficult to apply the downward pressure at just the right moment, particularly in circumstances where he agreed with the plaintiff that he moved the stretcher out of the ambulance quickly: p 4-22 line 20. There is also the consideration that, although the force required to keep the stretcher horizontal is not that great, as soon as the head of the stretcher begins to drop, the force increases, because as the stretcher pivots about the axel of the rear wheels, the distance between the pivot point and a vertical line down from the centre of mass of the stretcher and patient rapidly increases. When the stretcher has rotated just ten degrees, the perpendicular distance to that vertical line has increased from 210 mm to 366 mm, and there would be a decrease in the perpendicular distance between the vertical line down from the centre of the handles and the pivot point from 950 mm to 776 mm, with the result that the force required to balance the stretcher and patient, that is, to regain control of the situation, has increased to 50 kgs,²⁷ a much more challenging task. Another factor is that the step at the rear of the ambulance is only 17 cm wide.²⁸ If the stretcher is being pulled out of the ambulance quickly, the paramedic would have to react very quickly to the drop in the head of the stretcher in order to prevent the head of the stretcher from coming clear of that 17 cm step.
- [39] The paramedic said that the head end wheels do not lock down until the little front wheels are almost right at the end of the floor of the ambulance: p 4-45. That seems inconsistent with the diagram in Exhibit 1 Part 1 p 16.
- [40] A consideration of the combined effect of all of these factors leads me to a conclusion that what actually happened is that, when the paramedic pulled the stretcher out and the second set of wheels did not properly deploy, the head of the stretcher fell to the ground before the paramedic was able to get control of the situation. That is, things happened essentially in the way described by the plaintiff. I therefore reject the paramedic's evidence as unreliable. The only qualification to that is that I doubt if the stretcher was pulled along to any significant extent after the head end went down, since it would have been immediately apparent to the paramedic what had happened.

²⁵ Smyth p 3-32, 33; Berkett p 4-32, p 4-37.

²⁶ Based on a weight of 80kg for the plaintiff (p 56) and 25 kg for the stretcher: Exhibit 1, Part 2, p 9. I am assuming that the plaintiff's centre of mass was above the stretcher's centre of mass; if it were closer to the head end, the force required would be greater.

²⁷ 49.52 kgs as calculated. This assumes the centre of mass of the loaded stretcher was at the top of the mattress.

²⁸ Exhibit 1 Part 2 p 47.

I suspect the position was that the momentum of the stretcher, which was pulled quickly out of the back of the ambulance, carried it forward some distance; I noted that when the stretcher in court was resting on its head end and one set of wheels, the wheels at the head end on which it would roll when in the back of the ambulance were on the ground, so that the stretcher could still roll freely along the ground: p 57.

- [41] The paramedic conceded that he should not have pulled the stretcher clear of the ambulance without confirming that the wheels near the head of the stretcher had locked into place: p 4-32. That is also what is required by the manufacturer's instructions,²⁹ and consistent with Mr Smyth's evidence: p 3-24. There was no real dispute on behalf of the defendant that, if events occurred in the way described by the plaintiff, that is if the stretcher was pulled out and the head of the stretcher fell to the ground, this involved negligence on the part of the paramedic, for which the defendant is vicariously liable. I so find.

Civil Liability Act 2003 s 27

- [42] The next issue in relation to liability is that the defendant relies on the *Civil Liability Act 2003*, s 27 to provide it with an exemption from liability: defence para 6. That s 27 applies in the circumstances of this case was denied by the plaintiff: reply para 6. I was not told of any decisions on s 27, and I am not aware of any.

- [43] Section 27 provides relevantly in subsection (1):

“Civil liability does not attach to an entity, prescribed under a regulation, that provides services to enhance public safety in relation to an act done or omitted in the course of rendering first aid or other aid or assistance to a person in distress if –

- (a) The first aid or other aid or assistance is given by the entity while performing duties to enhance public safety; and
- (b) The first aid or other aid or assistance is given in circumstances of emergency; and
- (c) The act is done or omitted in good faith and without reckless disregard for the safety of the person in distress or someone else.”

- [44] The *Civil Liability Regulation 2014*, s 5 prescribes the entities mentioned in Schedule 2 as the entities prescribed for the purpose of s 27 of the Act. Schedule 2 lists a number of entities including “Queensland Ambulance Service established under the *Ambulance Service Act 1991*.” That Act provides for the establishment of the Queensland Ambulance Service, but does not expressly provide that that Service is a body corporate, or is capable of suing and being sued in its own name.³⁰

- [45] The 1991 Act provides that ambulance officers are employed under that Act, but not that they are employed by the “Service”, which is defined as simply the commissioner and all staff, including ambulance officers: s 3B. There are provisions concerning

²⁹ Exhibit 1 Part 2, p 16, para 5.8-3, and note box marked “important”.

³⁰ There is however, in s 60 a transitional provision in relation to a legal proceeding that could have been started by or against the corporation established under the *Ambulance Services Act 1967*, which was repealed by the 1991 Act, being able to be started or continued by or against “the service” that is the “Queensland Ambulance Service”.

disciplinary proceedings involving ambulance officers, but the identity of the employer is not clearly defined, so far as I can see. However, for the present proceeding, it is common ground on the pleadings that the relevant paramedic was employed by the defendant: Statement of Claim para 3(e), Defence para 1. The defendant is therefore vicariously liable for the negligence of its employee. The defendant is an entity properly sued under the *Crown Proceedings Act* 1980: see s 8. The defendant is not an entity listed in Schedule 2 to the Regulation. The short answer to the defence reliance on s 27 is that it does not apply to the liability of State of Queensland in the form of vicarious liability for its employee, the relevant paramedic, and therefore cannot provide a defence.

- [46] It may, however, be worth recording something of the history of the section, in case it may be thought to throw some light on the interpretation of it. In 1973, the Queensland Parliament passed the *Voluntary Aid in Emergency Act* 1973, which contained one operative provision, s 3, as follows:

“Liability at law shall not attach to a medical practitioner or nurse in respect of an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency-

- (a) at or near the scene of the incident or other occurrence constituting the emergency;
- (b) while the injured person is being transported from the scene of the incident or other occurrence constituting the emergency to a hospital or other place at which adequate medical care is available, if-
- (c) the act is done or omitted in good faith and without gross negligence; and
- (d) the services are performed without fee or reward or expectation of fee or reward.”

- [47] Section 2 defined “injured person” as including a person suffering or apparently suffering from an illness. When the bill for this Act was initiated in Committee,³¹ the Minister for Justice said that it was based on Good Samaritan Acts in north America, and that, because of the risk of liability if coming to the aid of injured persons in an emergency, many medical practitioners and nurses may be hesitant to render aid for fear of becoming involved in litigation. The bill was said to have been suggested by Dr Crawford, a government MLA and surgeon, and was supported by Dr Edwards. Opposition speakers claimed that it was too “sectional”, and asked about others offering help in an emergency, including “ambulance bearers”. The Minister said in respect of them, that they had been covered for years by their own Act.³² Much the same was said when the bill was read a second time.³³

- [48] That Act was subsequently incorporated in the *Law Reform Act* 1995, where it essentially became Part 5 of that Act. In 2002, the *Personal Injuries Proceedings Act* included s 71, which was in terms essentially reproduced as s 26 of the *Civil Liability*

³¹ Queensland Parliamentary Debates Vol 262, p 523, 13 September 1973.

³² Ibid, page 533, presumably a reference to the *Ambulance Services Act* 1967, which contained in s 53 a provision excluding liability for anything done in good faith for the purpose of carrying out or giving effect to that Act. Whether that would have protected an off-duty bearer acting in an emergency is unclear.

³³ Ibid, p 717, 27 September 1973.

Act 2003. Significantly, that section, like s 27, expressly preserves the *Law Reform Act 1995* Part 5. The Explanatory Notes for s 71³⁴ stated that:

“[It] provides protection from liability at law to persons performing duties to enhance public safety in the course of rendering first aid or other aid or assistance in circumstances of emergency to an injured person. For the protection to apply, the act done or omitted must be in good faith and without reckless disregard for the injured person’s safety. This clause does not limit or affect the *Law Reform Act 1995* Part 5 (Voluntary Aid in Emergency).”

- [49] There was nothing in s 71 which expressly confined it to a person acting as a volunteer. The following year, when the Civil Liability Bill was introduced, clause 26 of that Bill was said in the Explanatory Notes to relocate s 71 of the *Personal Injuries Proceedings Act 2002* so that all relevant statutory provisions may be brought within the one piece of legislation.³⁵ The Notes went on, in relation to clause 27:

“Clause 27 expands the indemnity provided under clause 26 to those organisations for which a volunteer is performing duties. This indemnity only extends to those situations where the organisation is involved, through its volunteer, in the provision of first aid or similar assistance and is acting in good faith.”

- [50] Clause 27 of the Bill was essentially in the same terms as s 27 of the Act.³⁶ Again there was no express provision confining its operation to volunteers, despite the Explanatory Notes. Nothing was said about either of these provisions in the second reading speech of the Minister.³⁷ In the circumstances, there must be some doubt about the scope of the section, arising from the presence of subsection (2).
- [51] The remaining issue for me about liability is whether the plaintiff suffered any loss or damage, since the defendant disputed the allegation that the plaintiff suffered injury, loss and damage as a result of the incident. It is convenient to consider that question in conjunction with the assessment of damages, since, if damages did result from this incident, this element of the cause of action in negligence will be satisfied.

Quantum

- [52] The plaintiff was 70 years old at the time of trial, and was 66 at the time of the accident: p 13. She claimed that she had been left in considerable pain in her back and neck, which was much worse than anything that she had had before the accident: p 23. Prior to the accident, she had usually been able to engage in various activities around the house, taking care of the housework and cooking (p 28), doing the gardening (p 29), taking the dog for walks, and working with her husband on their 40 ft ketch, which involved painting and cleaning, general maintenance, and sailing: p 23.³⁸ She also enjoyed craft and painting pictures: p 26. She is now very depressed by the effects of the pain and resulting immobility, and the extra burden this places on her husband: p 30.

³⁴ 2002 Explanatory Notes, Vol 1, p 492.

³⁵ 2003 Explanatory Notes, Vol 1, p 458.

³⁶ The only difference is that it was introduced by the words “liability at law” rather than the words “civil liability.”

³⁷ Queensland Parliamentary Debates, Vol 368, p 364, 11 March 2003.

³⁸ She has not been on the boat since the accident: p 83.

- [53] Her husband confirmed that prior to the accident the plaintiff was able to engage in ordinary activities (p 82) and did the various domestic work around the house: p 83. Since the accident she requires help with showering³⁹ and dressing, cooking, washing up, house cleaning and laundry: p 83-84. He said that he now has to do the gardening and wash the dog, which his wife used to do, and that her sleep is now disturbed at night, which disturbs him: p 85. His wife can't sit normally anymore, but must lean back in the chair: p 84. The plaintiff is depressed and upset, and cries a lot, and takes medication for this: p 86. Mr Smithers also said that when he has visited since the accident the plaintiff does virtually nothing, her husband does most of the housework and cooking, and the garden is overgrown: p 2-6, 7.
- [54] On 6 February 2012 the plaintiff underwent a CT of the lumbar spine, which revealed a disc bulge at the L3/4 level, without central canal narrowing or exit narrowing, and at the L4/5 level mild to moderate central canal narrowing, and at the L5/S1 level a minor disc bulge without significant narrowing. All levels showed degenerative change in the facet joints. This was thought to be contributing to the plaintiff's lower back pain.⁴⁰ On 10 February 2012 the plaintiff was discharged for review for back pain by her GP.⁴¹ On 10 February the plaintiff saw a general practitioner, Dr Day, to whom she repeated her complaint about having fallen to the ground when she was pulled out of the ambulance, and of having suffered neck and back pain, and the next day sciatica in the right leg.⁴² She saw a physiotherapist on 17 February 2012 for an additional assessment, complained of back pain which was aggravated by sitting, standing or walking, and eased by heat and rest.⁴³ She had limited mobility and a global decrease in function.
- [55] In June 2012 the plaintiff saw an orthopaedic surgeon on referral from a general practitioner, who advised the GP on 18 June 2012 that he did not consider that her symptoms had an obvious surgical solution given the extensive areas of pain in the head, neck, back and right lower limb.⁴⁴ He suggested getting an MRI scan to see if anything could be done to help, particularly with view to locating a cause for recent incontinence. Otherwise he suggested that she be assessed through a back rehabilitation program. The MRI was conducted on 10 July 2012, and found all sorts of problems with the spine. The diagnosis was cervical spondylosis, with extensive arthritic degeneration. There was also a cystic lesion detected, thought to be benign. On 25 July 2015 she was referred to the back rehabilitation program at the Wesley Hospital by the orthopaedic surgeon, who advised that she had advanced facet arthropathy in the lumbo sacral spine but that otherwise the MRI appears relatively benign compared to the symptoms of which she complains.⁴⁵ He also ordered some injections into the facet joints which occurred in October.⁴⁶ The plaintiff was not able to attend the back rehabilitation program, because she could not afford the cost of it.⁴⁷ In January 2013 the plaintiff's medication for back pain was changed.

³⁹ See also plaintiff p 37.

⁴⁰ Exhibit 2, Part 2, p 76.

⁴¹ Ibid, p 82-83.

⁴² Ibid, p 85.

⁴³ Ibid, p 87.

⁴⁴ Ibid, p 109. Dr Todman agreed that the plaintiff was not a candidate for surgery: p 2-27.

⁴⁵ Ibid, p 113.

⁴⁶ Ibid, p 117. The plaintiff said later that they did not help: see [56]; p 35.

⁴⁷ Ibid, p 121, per report of orthopaedic surgeon. See also plaintiff p 36.

Medical evidence

- [56] The plaintiff was seen on 29 January 2013 by Dr Todman, a neurologist, in January 2013 for the purposes of a report.⁴⁸ She reported to Dr Todman neck and low back pain on a daily basis, with pain increased with movement, activities, and with various postures. There were also occasional headaches, and disturbed sleep; she was then walking with two sticks. She was no longer getting physiotherapy, but had used TENS machine. She did not benefit from the cervical facet joint blocks. On examination there was an unusual gait, with tenderness in the lumbar spine, muscle spasm and reduced forward flexion. There was reduced movement in each range of the cervical spine, again with tenderness and muscle spasm. Strength reflexes and sensation were normal in the limbs, as was cranial nerve testing. The MRI was said to demonstrate moderately severe age related degenerative changes in the cervical and lumbar spine.
- [57] Dr Todman thought the plaintiff's continuing symptoms could be directly attributed to the accident: p 4. He thought the symptoms had stabilised, and the plaintiff had chronic musculo-ligamentous strain to the cervical spine, in DRE category 2 of the AMA 5 Guidelines. This represented a 7 per cent whole person impairment. The lumbar spine also had a DRA category 2 injury, again, chronic musculo-ligamentous strain, and again representing a 7 per cent whole person impairment. Dr Todman thought the plaintiff required assistance for heavier domestic tasks and home maintenance of up to five hours per week. On 3 June 2015, Dr Todman advised that after seeing some additional information, particularly medical records from 2015, he did not change his conclusions from the 2013 report.⁴⁹
- [58] Dr Todman under cross-examination did not think that whether there was neck pain immediately or that came on a couple of hours later was a major point: p 2-19. He did note that it might be difficult to distinguish the neck pain for somebody who was already suffering from head pain. The doctor agreed that if the head and wheels of the stretcher did not lock and that end was unsupported, it would fall to the ground with some force, and that force would be applied to both the head and the neck in those circumstances: p 2-20. As to whether the incident as described by the paramedic could have caused the injury to the plaintiff that Dr Todman saw, his position was that she had an injury and it was caused by whatever it was had actually happened to her: p 2-23. Dr Todman acknowledged that his assessment of needs was necessarily an approximation, and an assessment in the home would be much more reliable: p 2-24. He thought she would probably need assistance with showering and dressing: p 2-25.
- [59] Dr Todman explained that one could get problems with the neck either from movement or from maintaining a fixed posture in one particular position: p 2-26. The loss of forward flexion was a very significant restriction: p 2-26. In his assessment of the injury under the AMA Guidelines, he did not make allowance for any pre-existing impairment: p 2-26. Dr Todman said that as many as 15 per cent of the population have a history of episodic back pain that takes them to the doctor, but only a relatively small percentage, 1 or 2 per cent, have back pain as severe as that suffered by the plaintiff: p 2-27. At most, the history of episodic low back pain suggests a vulnerability to an injury causing more severe problem: p 2-28. He did not think that

⁴⁸ Exhibit 2, Part 5, p 1.

⁴⁹ Exhibit 2, Part 5, p 11.

this was an example of a chronic pain disorder, because that applied to people who complained of pain at a high level for which there was no explanation, which did not apply to the plaintiff: p 2-28.

- [60] The plaintiff was seen on 22 January 2013 by Dr Estensen, a psychiatrist, for the purposes of a report.⁵⁰ He said the plaintiff reported that she was angry about being left with chronic pain and an impairment when she had been taken to hospital for something that proved not to be sinister, and that she was frustrated and upset that she was not able to do what she used to be able to do. By mid-2012, she was agitated, irritable and often cried and had been prescribed an anti-depressant by her general practitioner. She had seen a psychologist on seven occasions to assist with adjustment to the injury in terms of her current symptoms. Her mood, confidence and self-esteem were diminished, outlook was pessimistic, with a sense of guilt about imposing on her husband and son. She was unable to enjoy her usual activities, her sleep was disturbed, her attention and concentration were reduced and she was worried about the extent to which she could assist her husband as he aged.
- [61] Dr Estensen diagnosed a major depressive episode of mild to moderate severity causally related to the accident, as a result of the pain and physical impairment secondary to the injury: p 124. A PIRS assessment produced an impairment rating of 6 per cent; by way of contrast, applying the AMA 5 Guides, the plaintiff's condition produced an 11 per cent whole person impairment, although the doctor acknowledged that the authors of the Guide advised against the use of percentages in this context. The doctor noted there was no suggestion of the plaintiff's suffering cognitive impairment. He thought that the plaintiff would benefit from ongoing psychological treatment at a cost of approximately \$4,300, and anti-depressant medication, which over a period of two years would cost \$750 and require regular review by a general practitioner, at a cost of \$1,000.
- [62] On 6 November 2015, Dr Estensen reported further in the light of some material he had seen since his original report, particularly the report of Dr Kevat.⁵¹ He thought Dr Kevat's opinion was consistent with his assessment of the plaintiff, although he described the plaintiff's condition as a "pain disorder associated with both psychological factors and a general medical condition", in accordance with DSM IV.
- [63] In oral evidence Dr Estensen said that going into a pain clinic could be of benefit to the plaintiff, particularly in assisting with the process of living with and managing the pain: p 2-40. In his experience, however, although often people have a significant improvement by discharge from a pain clinic, the beneficial effect often wanes across time: p 2-40. Dr Estensen was not confident that the plaintiff's mental approach to dealing with the pain was at a stage where a pain clinic would be helpful for her: p 2-43. He also thought that her condition had been severe for so long that that would make it more difficult for a pain clinic to produce some real benefit: p 2-43, 44. One of the consequences of her depression is that it diminishes her capacity to manage the pain: p 2-44. A longer-term engagement with a psychologist, and medication, would probably be required anyway. Overall, however, he did not think that the suggested treatments would make any significant difference, and he was very confident that her mental state would be worse at some time in the future than it is now: p 2-41.

⁵⁰ Exhibit 2, Part 5, p 113.

⁵¹ Exhibit 2, Part 5, p 138.

- [64] On 20 November 2013 the plaintiff was examined by Dr Cameron, a neurologist, for the purposes of a report.⁵² The plaintiff complained to Dr Cameron of continuing severe neck and lower back pain, which prevented her from lifting or driving, or standing for more than 20 minutes at a time. She used a TENS machine and cannot wash clothes, shower herself or engage in former recreational activities. At the time he saw her she was wearing a back brace, and using walking sticks. There was no complaint of continuing incontinence. On examination she had moderately restricted neck movement in all directions, though Dr Cameron thought that the range of movement was variable throughout the examination. There was no spasm or specific focal tenderness along the spine. There was no lumbar movement on standing but straight leg raising was unrestricted. There were some complaints which did not match nerve distributions, but upper and lower limb reflexes were symmetrical and normal and she had normal pulses.
- [65] The MRI report in July 2012 indicated widespread spondylitic degeneration in the cervical and lumbar spine. There was no indication of acute structural injury: p 14. She may have suffered underlying aggravation of the pre-existing degeneration but he would have expected any soft tissue injury to have settled within a period of a few months, and attributed the continuing symptoms to the underlying degeneration. He also thought there were some non-organic features present. Because of what he described as non-organic features, he was not able to make an assessment of impairment using AMA 5. He thought that any impairment was totally related to the pre-existing condition. He did not consider there was any physical impairment preventing her from looking after her household and her son and husband, and undertaking pre-accident recreational activities: p 16.
- [66] In oral evidence, Dr Cameron said that the absence of any contusions or lacerations to the head, and the absence of any confusion or concussion symptoms, suggested that there was no significant force involved to the head in the particular incident, and that was supported by the absence of complaints of pain until some time after she was in hospital: p 3-36. As well, there were no radiological changes to suggest acute trauma or joint injury, and that, although she suffered a soft tissue injury, such injuries tend to recover in a few months: p 3-36. Dr Cameron expressed the view that in light of the padding provided by the mattress on the stretcher, the plaintiff would not have suffered any injury even if the head of the stretcher had dropped to the ground: p 3-38. At most in that context she would have suffered a jarring injury: p 3-39. Dr Cameron accepted that the plaintiff may have been suffering from a chronic disorder: p 3-39. One point Dr Cameron seemed to be saying that the musculo-ligamentous strain would have got better though it may have aggravated some underlying pathology, but then seemed to say that any aggravation of the degeneration in the spine would itself have been temporary: p 3-39, 40.
- [67] Dr Cameron postulated that the plaintiff may have been suffering from severe headaches while in hospital because of the consequences of a lumbar puncture which was undertaken, in the course of investigating whether she had initially been suffering an aneurysm in the brain: p 3-41. Dr Cameron's position was essentially that the plaintiff should have got better from the injury that she suffered: p 3-41. He did however acknowledge that one can get continuing pain from degeneration in the spine which has been aggravated by some trauma (p 3-42), and that there was a recognised mechanism to have pre-existing degeneration which was generally asymptomatic and

⁵² Exhibit 2, Part 4, p 8.

which has been turned into degeneration which is generally or always symptomatic: p 3-43. He did think that it was a fair comment that the plaintiff was someone who, in a sense, just handled physical problems badly: p 3-44.

- [68] On 24 March 2015, the plaintiff was seen by Dr Kevat, a rheumatologist, for the purposes of a report.⁵³ He noted complaints of continuing pain in the neck extending down the back to the lumbar region and radiating down the back of both legs, which limited her ability to sit and perform household activities. She was now able to sleep without being disturbed by pain, because of sleeping tablets. On examination, she was said to be exhibiting moderate pain behaviour as well as hyper-reactivity to any discomfort during a range of movement examination, which was restricted in the cervical spine, the shoulder, lumbar spine and, to a lesser extent, hip movements. Dr Kevat considered that the physical examination was compatible with degenerative joint disease in the cervical and lumbar spine and some peripheral joints though he also thought there was some non-organic pain behaviour and that she had developed a chronic pain syndrome, in that the reported level of disability was in excess of that expected from the effects of the specific physical trauma.
- [69] Dr Kevat said that chronic pain syndrome was something frequently encountered amongst his patients: p 3-61. It was not well understood but was thought to involve psychological factors and social factors: p 3-62. He said that osteoarthritis can be made worse by trauma, and by other things, but it cannot be slowed by intervention: p 3-62. Dr Kevat, under cross-examination, conceded that the effect of the accident was that it made previous episodic pain and discomfort continuous and amplified: p 3-63. He thought that there would be some interaction between her depression and her expression of pain: p 3-64. At one point Dr Kevat said that he thought that the plaintiff had 25 per cent less disability than claimed: p 7. Under cross-examination, he agreed that this was essentially an estimate based on the comparison between the plaintiff's complaints and what he found on examination and saw in x-rays, and his general experience of managing patients with painful conditions, and seeing patients with chronic pain complaints: p 3-64.
- [70] Dr Kevat said that the need for services now arose from a combination of pre-existing problems and the new problem: p 3-65.⁵⁴ For that reason, he apportioned one third of the need for the services to the accident and two thirds to the pre-existing state: p 3-66, 67. He explained that on examination there was a positive Romberg sign, which is an indication, though not a conclusive one, of a neurological condition which means that vision is needed in order to maintain balance: p 3-69. Dr Kevat said that he saw a lot of people with chronic pain syndrome, and it is generally something that, from their point of view, is happening unconsciously: p 3-69. He also thought that, in the case of the plaintiff, the chronic pain syndrome was mostly unconscious: p 3-70.

Analysis of medical evidence

- [71] Overall I did not find Dr Cameron's evidence particularly helpful, because of his approach: the plaintiff did not suffer any new bony injury, and therefore all that could have happened to her was a stirring up of the pre-existing arthritic degeneration of the spine, or perhaps a soft-tissue injury; in either case, it was a condition which ordinarily abates over a few months; the plaintiff was displaying inconsistent symptoms and pain behaviour, which indicated that her complaints were not reliable;

⁵³ Exhibit 2, Part 4, p 1.

⁵⁴ This is of course speaking of causation in scientific terms, rather than in legal terms.

accordingly she should be treated as someone who just has the consequences of the long-standing arthritic degeneration. In assessing the significance of that, I suspect Dr Cameron was not uninfluenced by the circumstance that his own longstanding arthritic degeneration has not significantly impaired his capacity for further activity: p 3-40, 41. The difficulty with this analysis is that it assumes that, because aggravation and soft tissue injury are ordinarily of relatively short duration, that necessarily happened in the case of this plaintiff. That may be normally the case, but as even Dr Cameron conceded it is not invariably the case, and I suspect it is those individuals who fall into the exceptional category who end up in court, because, if they do get better in a few months, they tend not to sue.⁵⁵

- [72] There is also the consideration that Dr Kevat, who evidently has a good deal of experience of patients with chronic pain syndrome, regards the condition as ordinarily unconscious, that is not malingering or deliberately exaggerating, and considered that in the plaintiff's case that was mostly the situation.⁵⁶ That was consistent with my impression of the plaintiff, that there was a slight tendency to theatrical hyperbole in her evidence, but generally I thought she was being honest in her answers.⁵⁷ It is also consistent with the fact that there had been previous examples of pain behaviour in earlier medical reports, not linked to litigation.⁵⁸ She is certainly someone who has had a lot of problems with arthritis in the past, and has from time to time had various investigations, and treatment.
- [73] A right knee replacement for arthritis was recommended by an orthopaedic surgeon in May 2010.⁵⁹ There had been various complaints in the past of back pain,⁶⁰ and many years before she suffered a whiplash injury to the neck following a motor vehicle accident.⁶¹ There is also the consideration that the plaintiff is suffering from depression, brought on largely by the fact that she cannot now do the things that she used to be able to do, and concern about the burden this places on her husband who is significantly older than she is, and not in good health.⁶² It was suggested, for example by Dr Kevat, that sometimes chronic pain syndrome is prompted by some element of secondary gain, but it is difficult to see that this is present in this plaintiff, at least in the ordinary sense of a desire to adopt an invalid role.
- [74] There is also, I think, a factor that the plaintiff is simply somebody who handles pain badly, in the sense that the subjective effects on her of pain are more severe than with most other people. This probably also contributes to the consideration that, so long as the plaintiff is still seeking a treatment or a cure for her current spine problems, she will not be able properly to embark on the process of adjusting to living with them. This may perhaps be characterised as a vulnerable personality, but I do not think that it means that the plaintiff is deliberately exaggerating her condition, or inventing symptoms that do not exist. I accept that the pain that she is suffering is real for her, and in those circumstances it may not matter very much to what extent

⁵⁵ I have certainly seen lots of such people as plaintiffs in the course of my career.

⁵⁶ I regard Dr Kevat's evidence as essentially inconsistent with Dr Cameron's opinion.

⁵⁷ My trial notes record my impression that the plaintiff was genuine in her evidence.

⁵⁸ For example, the report of Dr Devereaux at 22 February 2008, Exhibit 2, part 2, p 39: "chronic somatoform pain disorder." See also Exhibit 2 Part 2 p 54.

⁵⁹ Dr JN Scott, Exhibit 2, part 2, p 55.

⁶⁰ Exhibit 2 Part 2 pp 18, 19, 23, 32, 59.

⁶¹ Exhibit 2 Part 2 p 1: It was in 1981.

⁶² He has a history of heart attacks and strokes, and is now 85.

this is attributable to physical causes and what extent it is attributable to her personality and the psychological reaction she has suffered.⁶³

Liability finalised

- [75] On the question of whether the plaintiff suffered an injury as a result of the incident, I accept that the plaintiff suffered either a jarring of the spine which aggravated the arthritic degeneration in the spine, or a soft tissue injury to the spine which had the same effect. It is true that this did not produce any physical injuries such as bony fractures which would show up on an X-ray or scan, or superficial injuries such as laceration to the scalp, but that does not mean that there would not have been a significant jarring force applied to the plaintiff's spine.⁶⁴ No doubt it was the presence of the mattress that prevented more serious injury to the plaintiff. Her head would have been to some extent protected by the bun of hair at the back of her head. I find that the plaintiff did suffer injury as a result of the negligence of the paramedic, and as a result the cause of action against the defendant is complete.
- [76] It was submitted that the absence of any immediate complaint of pain in the spine until some time after the plaintiff arrived at hospital was inconsistent with her having suffered any real injury in the way she described. I do not accept that analysis; at the time the plaintiff was suffering from a severe pain in the head, which she had been told might have been a stroke, potentially a very serious matter. In those circumstances, she was necessarily going to be preoccupied with that symptom, and it was only after she is at the hospital, at a time when she might well be more relaxed about what was going on in her head, because of the prospect of immediate care if it was anything serious, that she became more aware of what was happening in the rest of her body. Far from being implausible, that strikes me as a natural and obvious situation.
- [77] There was a plea of contributory negligence in the defence of the defendant (para 5) but it was not pressed in submissions on behalf of the defendant at the hearing, there was no evidence to support it, and in the circumstances frankly I regard it as silly.

Quantum (again)

- [78] Broadly speaking, I prefer the evidence of Dr Todman to the evidence of Dr Cameron. I do not accept that some difference between what was told to Dr Todman by the plaintiff and the plaintiff's evidence before me is of significance; this related mainly to the question of causation, and it is clear on all the evidence that the plaintiff's relevant injuries were caused by the accident. I consider that Dr Todman's assessment of the plaintiff's condition was more realistic than that of Dr Cameron, whose evidence I do not accept, for the reasons stated earlier.
- [79] In terms of assessment of the plaintiff's damages, what matters is not what in the scientific sense is the cause of the plaintiff's present condition, but to what extent the plaintiff's condition is worse than it would have been had the accident not occurred.⁶⁵ On the evidence of the plaintiff, her husband and Mr Smithers, the plaintiff's condition after the accident was dramatically worse than her condition before the

⁶³ At common law it would have made no difference, but it may be relevant in the operation of the *Civil Liability Regulation*.

⁶⁴ Admittedly, nothing like the sort of force that would have been applied if she had been hit by a train (see p 3-38), but no doubt had something like that occurred I would not have been trying this action.

⁶⁵ Applying the "but for" test in the *Civil Liability Act 2003*, s 11(1)(a).

accident, though she had vulnerabilities prior to the accident in view of the pre-existing history of arthritic degeneration and a personality disposed to problems with handling pain. These are factors which are relevant to the assessment of damages, but the starting point is compensating the plaintiff for the fact that after the accident her condition was made worse, apparently on a permanent basis. For that reason, the apportionment made by Dr Kevat is not relevant to the assessment of damages.

General damages

- [80] It was submitted for the plaintiff that she had suffered three injuries, a moderate cervical spine injury within item 88, a moderate thoracic or lumbar spine injury within item 93 and a moderate mental disorder within item 12. The difficulty with this submission is that it seems to me clear, on the basis of Dr Estensen's evidence, that s 5 of Schedule 3 of the *Civil Liability Regulation 2014* applies, and what the plaintiff is suffering is an adverse psychological reaction to her physical injury, rather than a psychological injury caused directly by the accident itself. In these circumstances it is simply a feature of the injury, rather than a separate injury to be assessed under the regulation. I agree that the plaintiff has suffered the injuries in items 93 and 88; because of the range of ISV for each of those items, either would amount to the dominant injury for the purposes of ss 2 and 3 of Schedule 3 to the regulation.
- [81] I adopt item 93 as the dominant injury, but in the circumstances where item 88 has the same ISV range, and where the plaintiff has suffered an adverse psychological reaction of some significance, which had it been a separate psychiatric injury would have fallen within item 12, and bearing in mind the significant impact on the plaintiff's amenity of life as a result of this injury, it seems to me that the level of adverse impact on the plaintiff is so severe that the maximum dominant ISV is inadequate to reflect the level of impact. In the light of the adverse psychological reaction, if the plaintiff had suffered either the item 88 injury or the item 93 injury, an ISV of 10 would have been appropriate. In those circumstances I consider that this is a case where it is appropriate to award an ISV which is more than 25 per cent higher than the maximum dominant ISV, something which would necessarily apply to any ISV above 12.
- [82] I am also conscious of the terms of s 9 of Schedule 3, which requires that I have regard to the plaintiff's age, degree of insight, life expectancy, pain and suffering and loss of amenities of life and the effects of her pre-existing conditions, and difficulties in life likely to have emerged whether or not the injury happened, apart from the specific provision which is relevant to the assessment of an ISV for multiple injuries. I accept that the plaintiff had significant pre-existing arthritic degeneration of the spine, this had caused her intermittent problems from time to time, but that for most of the time she was able to lead a fairly normal and active life. She also had other problems, in particular arthritis in the knees, which was causing her some problems, but evidently problems she could live with, and she had other pre-existing problems in much the same category: p 23, p 25.
- [83] I also accept that, given that she had a vulnerable spine, there was a risk of something else happening to her at some stage in the future which would have produced similar problems, or at least some other aggravation of the symptoms suffered by her as a result of the arthritis. The fact that she has a bad spine does not necessarily condemn her to that state sooner or later anyway, in the light of Dr Todman's evidence that only 1 or 2 per cent of people end up as badly disabled by the arthritis in the spine as

the plaintiff is now, but obviously it is a risk. I think it likely that the plaintiff would not have suffered the adverse psychological reaction she has suffered if the degeneration had been progressively worsening slowly over time, rather than coming on suddenly as it did. The plaintiff's age is also relevant.

- [84] On the other hand, s 9 requires me to take into account pain, suffering and loss of amenities of life, and as I have indicated, these are particularly significant for this plaintiff. These are factors which tend to increase the ISV, whereas the other factors I have mentioned tend to decrease it. In all the circumstances therefore I assess an ISV of 15, which produces a sum of \$21,850.
- [85] Special damages were agreed at \$15,346.79: Exhibit 5. Of this, the amount of \$3,083.94 represents out of pocket expenses, on which I will allow interest at the rate of 1.8 per cent per annum from mid-January 2012, 4.9 years: \$272.

Past gratuitous care

- [86] Damages for gratuitous services are subject to the *Civil Liability Act* s 59. I accept the services were necessary because of the plaintiff's conditions, and that the need for the services arises solely out of the injury in relation to which the damages are awarded, for the purposes of the Act. I do not consider that the effect of this section is that, if the plaintiff's injuries are an aggravation of underlying arthritic degeneration, the need does not arise solely out of the injury; rather the effect of the section is to exclude services which the plaintiff would have needed other than as a result of that injury, so that if the plaintiff had some need for services anyway it is only extra services which are covered by the section.⁶⁶ It is also necessary to show that services are provided for at least six hours per week and for at least six months in order to cross the threshold in s 59(1)(c).⁶⁷
- [87] I accept that since the accident the plaintiff has required assistance with personal care in terms of showering and to some extent dressing, which would occupy an hour a day. She has needed assistance in cooking, housekeeping, laundry and gardening which would also require a good deal of time. An assessment of the need for services was undertaken by an occupational therapist, Mr Hoey, who prepared two reports. The first report was dated 25 March 2013 after an interview on 19 March 2013.⁶⁸ At that stage his assessment of the gratuitous assistance needed by the plaintiff was 11.55 hours each week (p 9). This was excluding self-care assistance, which was assessed separately at 7 hours per week, because it would be provided commercially at a higher rate. That produced a total assessment of 18.55 hours per week. Mr Hoey said that when the husband was doing tasks which involved a shared benefit, such as cooking a meal or cleaning the house, he had halved the time taken: p 2-33. I will assume that that is the correct approach to adopt; this was not the subject of specific argument for me. There was no contrary evidence, and his assessments were not challenged in cross-examination. I accept his evidence.
- [88] Mr Hoey reported further on 18 April 2016,⁶⁹ which was largely an exercise in updating the assessment and updating the market cost; the assessment at this stage was 18.64 hours per week including seven hours per week of personal care, covering

⁶⁶ *Westfield Shopping Town Liverpool v Jevtich* [2008] NSWCA 139 at [25], [26].

⁶⁷ *Shaw v Menzies* [2011] QCA 197.

⁶⁸ Exhibit 2, Pt 5, p 13.

⁶⁹ Exhibit 2, Pt 5, p 26.

showering and dressing. Mr Hoey also put in evidence some photographs taken by one of his staff at the plaintiff's residence: p 2-30; Exhibit 8.

- [89] The defendant submitted that the cost of past care should be discounted by two thirds because of Dr Kavat's attribution of two thirds of the plaintiff's current problems to her pre-existing condition. As I have already explained, that is not the test of causation for legal purposes, which is an exercise in assessing the care made necessary by this injury, subject to a deduction for the chance of the plaintiff's needing some or all of that care anyway for some other reason. On Mr Hoey's assessment, using the figures in his two reports, care to 17 April 2016 comes to \$124,592.56, and care at the rate of 18.64 hours per week thereafter is \$29,227.52, a total of \$153,820.08. I consider that the chance of the plaintiff's requiring gratuitous care anyway had the accident not occurred is sufficient to make some discount from this figure, and I will discount it to \$140,000, to allow for that. In other respects I accept the approach in the schedule attached to the submissions of the plaintiff's counsel.

Future care and assistance

- [90] As I have indicated, there was no substantive challenge to Mr Hoey's assessment and I therefore accept that now there is a need for care at the rate of 18.64 hours per week, continuing indefinitely. The plaintiff has an expectation of life of about 19 years (Exhibit 4), but there are two particular factors which must be taken into account in moderating the award for future care. The first of these is the prospect of some improvement in the plaintiff's condition in the future, and the second is the prospect of the plaintiff's requiring care, to this or a lesser extent, for some other reason anyway at some time in the future.
- [91] Mr Hoey spoke about the Wesley Pain Clinic, which he described as a cognitive behaviourally based clinic, teaching people to feel safe and confident in doing basic chores and managing their pain while doing so: p 2-31. He recommended that the plaintiff undertake this, and also recommended some modifications to her bathroom which would assist in her independence: p 2-32. Mr Hoey was optimistic that as a result of this some of the significant care areas could be reduced somewhat, although he recognised that the plaintiff was quite chronic and it would be an uphill battle: p 2-32. He noted that the track record of the Wesley Pain Clinic was that there was a success rate, that is an increase in basic functional day to day activities, in up to 60 per cent of patients: p 2-34.
- [92] It was submitted for the defendant that this indicated the prospect of significant reduction in the need for care in the future, and I accept that the plaintiff had expressed willingness to attend the Wesley Pain Clinic, subject to being able to afford to do so, and accommodation arrangements for her husband.⁷⁰ I accept that the plaintiff will probably undertake the Wesley Pain Clinic, and should do so, but a success rate of up to 60 per cent does not I think justify a particularly large degree of optimism in terms of producing a significant reduction in care requirements for this plaintiff, particularly bearing in mind her personality, the other matters Mr Hoey mentioned as justifying caution, and Dr Estensen's concern about the prospects of any improvement being maintained in the longer term.

⁷⁰ Mr Hoey said that patients attending the clinic are commonly accommodated at nearby apartments, at a cost of \$150 per night, which is not cheap: p 2-31.

- [93] To the extent that there is some conflict between Mr Hoey and Dr Estensen about the plaintiff's prospects of improvement as a result of attending a pain clinic, I prefer the evidence of Dr Estensen. Mr Hoey's evidence was based on generalisations, in terms of the way most pain clinic patients respond to the treatment provided there, whereas Dr Estensen was basing his more pessimistic view on the personality and characteristics of this particular individual, the plaintiff. For that reason I think it is a better guide to the prospects for the plaintiff. I think it would be helpful for the plaintiff to undertake the pain clinic, and it is likely that she will achieve some benefit from it, and this will reduce the need for care in the future, at least in the relatively short term, although it will not remove it and it will still be appropriate to make some allowance for the possibility that the pain clinic will prove to be unhelpful.
- [94] The other factor is the risk of the plaintiff's needing care anyway, at least to some extent, for other reasons. Given her many other problems, and the fact that the spine was obviously vulnerable anyway, I think there was a substantial prospect that, had it not been for this accident, at some time in the future the plaintiff would have had a need for at least some care anyway. Indeed, she would probably have developed a need for at least a few hours of care anyway, simply as she became more frail with age. The prospect of something else arising is one which will obviously increase as time passes. On the other hand, the allowance for the improvement from the pain clinic should be reduced as time passes, in the light of Dr Estensen's evidence.
- [95] There is no ideal mathematical model which conveniently allows for the various possibilities. The discount rate for the prospect of something else happening to the plaintiff should be increasing as time passes. The discount because of the effects of the pain clinic should cut in after there has been time for the plaintiff to undertake that, but I think the improvement associated with that would probably then diminish slowly over time. What I propose to do by way of rough approximation is allow 90 per cent of the calculated future care costs for 12 months,⁷¹ then 70 per cent of the future care costs for 15 years, but no future care costs thereafter.
- [96] The discount which should apply because of the prospect of the plaintiff requiring care for some other reason should be increasing progressively as time passes, but to some extent I am offsetting that against the reduction in the pain clinic discount as time passes, and the rest I am taking into account in shortening the period over which the future care costs are allowed at all. This is intended to be a rough and fairly conservative approach to the assessment of future care costs, to some extent adopted for ease of calculation, bearing in mind that these amounts have to be discounted to a present value anyway. The first year's costs therefore are 18.64 hours per week at \$44.80 per hour for 52 weeks which comes to \$43,424, discounted to \$39,000 to cover the risk of a need for some care anyway, and to give a present value. 18.64 hours per week at \$44.80 per hour comes to \$835 per week which, with a multiplier of 529,⁷² comes to \$441,715. If that is then discounted by 30 per cent, it produces a sum of \$309,200. After adding the amount for the first 12 months, \$39,000, this produces a total for future care costs of \$348,200.

⁷¹ To accommodate the probability that there might have been a need for some care already anyway.

⁷² Multiplier for 16 years, 580, minus multiplier for one year, 51 = 529. Multipliers from Luntz, *Assessment of Damages*, 4th Ed, Table 2, p 683.

Future treatment

- [97] Amounts claimed for the pain management program, \$5,101, accommodation during the program, \$1,500, ongoing psychological treatments, \$7,200, anti-depressant medication, \$2,100, and general practitioner attendances, \$1,600 were not controversial. Apart from that the plaintiff claimed pharmaceutical costs for Norspan patches, Valium, Panadol and Sertraline. The pharmaceutical claim however includes an anti-depressant (Sertraline), which seems to be claimed already in the Schedule; without this the plaintiff's claim comes to \$8,484.61. If the plaintiff is going to become more active it is likely that her need for medication is not going to diminish, so prima facie the plaintiff's calculations are otherwise correct although a discount should be allowed because of the prospect that the plaintiff may have needed some medication of this kind anyway for other reasons. I think it unlikely that the need for an anti-depressant would have arisen on some other basis, but it is obviously possible. In the circumstances I allow \$5,500 for future pharmaceutical costs, discounting for the reason I have indicated.
- [98] The plaintiff also made a global claim of \$5,000 to cover other treatment such as physiotherapy, a supervised gym program, hydrotherapy and ongoing mental health care beyond five years. On the whole I think it unlikely that the plaintiff would undertake anything in the nature of a supervised gym program or even hydrotherapy; she seemed just too disabled for something like that, even if the pain clinic achieves some improvement. There is some prospect that she may benefit from physiotherapy at times in the future, but more importantly the mental health allowance has been calculated only for 5 years, and I think it is likely that there will be some ongoing need beyond that. Overall I will allow \$3,000 for the cost of these other treatments. That produces a total for future treatment of \$26,001.
- [99] The plaintiff also claimed future travel costs of over \$10,000, based largely on the assumption that she will remain for the rest of her life on Lamb Island. I can understand that there would be attractions for the plaintiff and her husband in living on Lamb Island, but it does seem to me that, in the light of the plaintiff's current state, many of the advantages of living on the island must have disappeared, and there is also the consideration that a large block of land, and a house which is high-set at the front, are undoubtedly less convenient for the plaintiff now than they used to be. Although this was not a matter which was particularly explored during the trial, I think it likely that the plaintiff will at some time have to move off Lamb Island to more practical accommodation, probably sooner rather than later, and this would reduce the cost of future travel. In the circumstances, I allow a lump sum of \$3,000 for future travel.
- [100] The plaintiff also claimed for a list of future aids and equipment. Some of these were recommended by Mr Hoey, such as non-slip flooring for the bathroom, a shower chair, a special kit to make the shower more usable for someone who is disabled, and a frame over the toilet, and I would allow these amounts subject to the discount that I have otherwise allowed. There is also a claim for an electric lift and modulation chair, referred to in Mr Hoey's second report.⁷³ I think this is a cost which would be avoided by moving away from Lamb Island, and in the circumstances I will not allow this item; there is I think no reason to disallow the claim for the walking sticks, subject

⁷³

Exhibit 2 Part 5 p 47.

to the usual discount. That leaves a total of \$4,198.60 based on the plaintiff's Schedule, which I would discount to \$3,000.

Summary

[101] I therefore assess the plaintiff's damages as follows:

A.	General damages	\$21,850
B.	Special damages	\$15,346.79
C.	Interest on out-of-pocket special damages	\$272.00
D.	Past gratuitous care	\$140,000
E.	Future care	\$348,200
F.	Future treatment	\$26,001
G.	Future travel	\$3,000
H.	Future aids and equipment	\$3,000
	TOTAL COST	\$557,669.79

[102] There will therefore be judgment that the defendant pay the plaintiff \$557,669.79, including \$272 by way of interest. I will hear submissions in relation to costs when these reasons are delivered, but expect costs to follow the event.