
AUSTRALIA / JUDGMENT

Gergis v Ware [2010] NSWDC 274

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New South Wales

District Court

CITATION: Gergis v Ware [2010] NSWDC 274

HEARING DATE(S): 15/11/2010-19/11/2010, 22/11/2010-24/11/2010,26/11/2010,29/11/2010

JUDGMENT DATE: 8 December 2010

JURISDICTION: Civil

JUDGMENT OF: Murrell SC DCJ

DECISION: Verdict and judgment for the plaintiff in the sum of \$1,052,829.00

LEGISLATION CITED: Motor Accidents Compensation Act 1999

PARTIES: Steven Gergis (Mr Gergis Senior as Tutor)

Susannah Ware

FILE NUMBER(S): 2008/00319130001

COUNSEL: Mr Cranitch SC with Mr Grey

Mr McIlwaine SC with Mr Davidson

SOLICITORS: Carroll & O'Dea Lawyers

McLachlan Chilton

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Introduction

1 The plaintiff claims damages for injuries sustained in a motor vehicle accident on 31 May 2006. The plaintiff suffered a severe traumatic brain injury, and injuries to his left knee (damage to the left anterior cruciate and medial collateral ligaments) and left forearm (left distal ulna fracture). At the time of the accident, the plaintiff was a 21-year-old student with four units to complete before obtaining a Business (Accounting) Degree from the University of Western Sydney. Following the accident, the plaintiff completed the Degree. He was unemployed until June 2010, when he obtained employment as a teller with the St George Bank. At the end of the probationary period, his employment was terminated because of "ongoing poor performance and behavioural issues" (Exhibit A, p 566). The plaintiff comes from a close and religious family that has high academic expectations and a strong work ethic.

2 It is agreed that the degree of permanent impairment caused to the plaintiff by the accident exceeds 10%, the threshold under s 131 of the Motor Accidents Compensation Act 1999.

3 The parties have agreed on the attribution of liability. The Court is asked to determine damages.

The Witnesses

4 The defendant submitted that the Court should be cautious about accepting the plaintiff's evidence because the plaintiff failed to reveal his complete pre-accident medical history to doctors and was not forthright with the Court about the extent to which he played poker.

5 No doctor suggested that the plaintiff was malingering. When the plaintiff's employment at the St George Bank was terminated, the plaintiff and his father sought reinstatement (Exhibit A, p 566). Such conduct is inconsistent with malingering. Just as the plaintiff failed to flesh out the details of his pre-accident medical history, he failed to provide the Court with details of his current problems. The latter failure is inconsistent with malingering. Dr Akkerman opined that the plaintiff downplayed his problems because he was embarrassed about and/ or lacked the insight to appreciate the low level at which he was functioning (T486.35).

6 In my view, the plaintiff's failure to provide a complete pre-accident medical history to doctors and his failure to elaborate on his current problems is due to a lack of insight and judgement about what is sought, and may reflect difficulty in mental application to the task at hand. The plaintiff was an honest witness whose evidence about medical issues was unreliable only to the extent that it was superficial and incomplete.

7 As to the playing of poker, the plaintiff concealed that conduct from his family, despite their concern about the plaintiff's whereabouts late at night. At some level, the plaintiff appreciates that it is undesirable to play poker frequently. For this reason, he has been less than forthright about the extent to which he plays poker.

8 The defendant criticised the opinions of the plaintiff's expert witnesses on the basis that they had not fully considered the implications of the plaintiff's pre-accident medical history when forming a view about the aetiology of his current condition.

9 With the exception of Dr Langeluddecke, the plaintiff's experts had some knowledge of the plaintiff's pre-accident medical history. With the exception of Dr Langeluddecke, when provided with additional historical details, none changed his/her opinion. Each of the plaintiff's expert witnesses was highly qualified. I find that the opinions expressed by each witness were adequately informed and genuinely held.

10 The defendant relied upon the expert evidence of only one witness, Professor Mattick, a neuropsychologist. The defendant obtained but did not serve expert reports from Dr O'Neil (a neurologist), Dr Kossof (a psychiatrist), Dr Bye (an orthopaedic specialist), Ms Burnes (an occupational therapist) and Professor Jones (a rehabilitation physician). The Court infers that the expert evidence of those witnesses would not have assisted the defendant's case.

11 Issues

- (1) The nature and extent of the plaintiff's pre – accident psychological/psychiatric problems.
- (2) The extent of disability caused by the brain injury.
- (3) The plaintiff's past and future economic loss.
- (4) The plaintiff's need for care.
- (5) The plaintiff's need for fund management.

Pre-Accident Mental Condition

12 As a child and adolescent, the plaintiff had significant cognitive and behavioural problems. In 1988, when the plaintiff was 3 1/2 years old, his parents (who conducted day care centres for young children) realised that his development was delayed. They consulted the Children's Hospital. The plaintiff was diagnosed with "global developmental delay" (Exhibit 4). He had "minor behaviour problems", and was functioning at the level of a 2 1/2-year-old. In March 1989, the plaintiff presented with "very significant global delay with more specific disorders in

language and motor planning". Dr Hutchins (an expert in attention deficit disorder) concluded that the plaintiff needed treatment for a "language disorder " (Exhibit 4). His mother understood the diagnosis to be attention deficit hyperactivity disorder (ADHD), a diagnosis with which she disagreed. In January 1991, the plaintiff was still suffering from "mild global delay functioning" (Exhibit 4).

13 In 1995, the plaintiff (who was then 10 years old) had significant learning difficulties. He was functioning in the low average range. He had difficulty sustaining attention and concentration, and he manifested organisational and planning problems consistent with ADHD. Dr Hutchins suggested a trial of stimulant medication, but the plaintiff's parents were opposed to that course (Exhibit 4).

14 From an early age, the plaintiff played competition chess. He became a proficient player. In 1995, the plaintiff played chess as part of the Under 10 Lakers Team that won a trophy for "most consistent team" (T282.21).

15 In 1997, when the plaintiff was in Year 7, the Christian Brothers School at Burwood expressed concern about his "progress and behaviour". He was "performing significantly below expectations" (Exhibit 6).

16 In August 1998, Dr Hutchins observed that the plaintiff was "a very pleasant and socially appropriate adolescent boy" who still suffered from organisational problems. Dr Hutchins continued to advise a trial of stimulant medication to address ADHD (Exhibit 4).

17 In April 2000, when he was a Year 10 student at Trinity Grammar School, the plaintiff experienced his first acute episode of anxiety and depression. He consulted Dr Dosseter (a psychiatrist). The plaintiff was treated with Sertraline (an antidepressant medication) and Risperidone (an antipsychotic medication that acts as a mood stabiliser) for a short time. By late April, the episode had largely resolved. Due to a "pleasing rapid response to medication," Dr Hutchins predicted that "with appropriate support," the plaintiff would "do well." The plaintiff, though much calmer and less anxious, continued to feel some anxiety and to experience high-level language problems (Exhibit 4).

18 At Trinity Grammar School, the plaintiff was teased and bullied. A school report of November 2000, refers to an assault on the plaintiff which was inferentially associated with the plaintiff's difficulty in relating to students and masters (Exhibit 6).

19 In 2001, the plaintiff was captain of the school's Senior Chess Team and was Senior High Scorer in a regional secondary schools chess competition. That year, the plaintiff's school Interim Report referred to "high levels of anxiety", "antisocial behaviour problems ", lack of punctuality, immaturity, attention-seeking behaviour and rudeness when rebuked. It noted that the plaintiff wasted time in class but "worked at home for hours and can be quite obsessive about the requirements of set tasks". It also referred to an improvement in written work (Exhibit 6).

20 In mid-September 2001 (when the plaintiff was in Year 11), there was a meeting at the school regarding the plaintiff's behaviour and progress. Ms Pearce, a psychologist, referred to the plaintiff's "significant language processing difficulties" which made it difficult for him to grasp more complex schoolwork. School staff expressed concerns about the plaintiff's rudeness, egocentricity, obsessiveness and compulsiveness. The plaintiff promised to work harder in Year 12. In November 2001, the plaintiff was placed on probation and was required to address his classroom behaviour, lateness to class and failure to heed advice (Exhibit 6). Nevertheless, in December 2001, the plaintiff was aggressive and verbally abusive to a younger boy (Exhibit 6).

21 On 8 November 2001, Dr Dosseter observed that, having regard to the plaintiff's rapid response to medication, it was "not likely" that his two episodes of acute depression and anxiety had reflected "a major psychiatric illness". He described "a long-term disability of social development" (presumably a reference to ADHD) providing a context within which the two episodes of "acute depression with anxiety and agitation" had occurred (Exhibit 5).

22 On 9 May 2002, when he was in Year 12, the plaintiff consulted Dr Dosseter and a second psychiatrist, Dr Benjamin because he was experiencing difficulty with sleep, concentration and memory. In addition, he was experiencing pains and paranoid thoughts (Exhibit 7, 9 May 2002). He had just completed his mid-year Year 12 examinations. Dr Dosseter referred to a recurrence of acute anxiety and depression "provoked by excessive expectations" (Exhibit 5). Dr Benjamin reported that the plaintiff "most likely suffers from insidious schizophrenia" (Exhibit 7, 9 May 2002). Professor Sachdev (Professor of Neuropsychiatry, UNSW, Director of the Neuropsychiatric Institute at the Prince of Wales Hospital) gave evidence that "insidious schizophrenia" is a prepsychotic state that may be diagnosed where an episode of depression is accompanied by erratic behaviour (T154.13). The plaintiff was medicated with Risperidal and Prothiaden. He recovered quickly.

23 The plaintiff's Year 12 school reference described him as "a pleasant, good-humoured young man with the potential for success". His final school report (Semester Two 2002) was much more positive than the Semester One report. As well as referring to a "poor" attitude and the need for "a more disciplined approach" to physics, and absences from class, the final report contained comments such as "conscientious", "gives it his best", "industrious and self disciplined". There was a significant range of achievement; the plaintiff was placed 22/103 in mathematics (and was enrolled in extended mathematics) but was placed 50/53 in physics (Exhibit B).

24 In relation to the Higher School Certificate, the plaintiff applied for "special consideration" based on a history of learning difficulties, ADHD and anxiety/depression (Exhibit 6, 13 May 2002). He completed the HSC, obtaining a UAI of 82.3 (better than 82.3% of students who sat the HSC) (T278.34).

25 In 2003, the plaintiff commenced a Bachelor of Business Administration (Accounting and Information Systems) Degree at the University of Western Sydney. The plaintiff said that he found the course to be difficult. In October 2003, the plaintiff consulted Dr Benjamin, complaining of insomnia, anxiety and poor concentration (Exhibit 7, 29 October 2007, paragraph (d)). He had

stopped attending university. Dr Benjamin noted a relapse of depression. He considered that the plaintiff was unfit for study until the end of October 2003 (Exhibit 7, 14 October 2003). He prescribed an antidepressant and a mood stabiliser. In the 2003 autumn session, the plaintiff gained two passes and a credit, and failed one subject. In the 2003 spring session, he passed three subjects and failed two subjects (Exhibit A, page 621).

26 In 2004, the plaintiff transferred to a Bachelor of Business (Accounting) Degree. In the 2004 Autumn Session, he passed two subjects, failed one subject and withdrew from another subject without penalty. In the 2004 Spring Session, he passed two subjects and failed one subject. In 2005, he gained two credits, passed another four subjects and failed two subjects. In the 2006 Autumn Session, he passed all four subjects (Exhibit A, pages 619, 620).

27 After leaving school, the plaintiff continued to play chess at a chess club. The plaintiff's older brother recalled an occasion when he accompanied the plaintiff to a speed chess competition that lasted all day. The plaintiff appeared to maintain intense concentration throughout the day (T339.15-25).

28 Before the accident, the plaintiff had no difficulty attracting girlfriends. He socialised extensively through the Coptic Christian Church. He had a significant circle of friends. Friends often visited the family home.

29 The plaintiff's friends Mr Robert Michael (who met the plaintiff in 2002) and Mr George Gerges (who had known that the plaintiff since the boys were 10 years old) gave evidence that, prior to the accident, the plaintiff was sociable, good-humoured, polite and considerate (T306.20, T306.47, T309.16). The plaintiff's brother described the plaintiff as an outgoing boy (T335.25, 338.11-19) who enjoyed school, was respectful towards women (T340.26) and appeared to concentrate on study for long periods of time (T336.40. 337.3-10).

Discussion Of The Plaintiff's Mental Condition Prior To The Accident

Global Developmental Delay

30 It is a matter of common observation that children develop at different rates and that the cognitive, psychological and behavioural problems of childhood and adolescence may resolve by early adulthood. I accept the advice of Professor Sachdev that, in order to assess the plaintiff's psychological and cognitive status at the time of the accident, the Court should focus on the period of time most proximate to the accident (T195.47).

31 By the time that he reached Year 12, the plaintiff no longer suffered from global development delay. Dr Langeludekke (a neuropsychologist) articulated the self-evident proposition that, had the plaintiff been suffering from a global learning disability, he would have been unable to achieve a UAI of 82.3. (T278.42)

32 Given the plaintiff's entirely average IQ of 99 (assessed post – accident, see paragraph 51 below), the only explanation that Dr Langeludekke (a neuropsychologist) could give for the plaintiff's strong HSC result was that he had a very varied cognitive profile and sat HSC subjects

that tapped his cognitive strengths (for example, mathematics) (T255.45). I accept this explanation. It is consistent with the plaintiff's prowess at chess, a game requiring a high level of skill. On the other hand, the plaintiff's indifferent pre-accident university results are consistent with his average IQ (Exhibit 1, page 40).

Attention Deficit Hyperactivity Disorder (ADHD)

33 In childhood and adolescence, the plaintiff almost certainly suffered from ADHD (the reports of Dr Hutchins, a specialist in ADHD, in Exhibit 4, the basis on which Professor Sachdev held ADHD to be a "reasonable diagnosis" at T158.43). At least in part, the plaintiff's behavioural difficulties at school probably reflected ADHD. Professor Sachdev opined that the repeated references in early medical reports to obsessional behaviour could reflect compensatory behaviour arising from attention deficit (T187.45) and a reaction to parental pressure to succeed (T188.16-35), each of which could independently cause anxiety (T188.11). He said that attention difficulties associated with ADHD usually improve gradually through the teenage years and into young adulthood. Consequently, in the late teens and 20s, one expects to see academic improvement (T152.48-153.8).

34 In the plaintiff's case, there was a dramatic academic and behavioural improvement in Year 12. Having regard to the plaintiff's underlying IQ, his pre-accident university performance was reasonable, and was consistent with substantial resolution of childhood ADHD. Further, the evidence of family and friends was that, in his pre-accident university days, the plaintiff behaved like a normal young man. I conclude that, by the date of the accident, ADHD had no significant impact on the plaintiff's academic performance or behaviour.

Prepsychotic or Psychotic Condition, Depression and Anxiety

35 The plaintiff was a person of average intelligence who had always felt great familial pressure to succeed academically. In 2000 (Year 10), 2001 (Year 11), 2002 (Year 12) and 2003 (first-year university), usually in the context of academic pressure, he experienced acute episodes of anxiety and depression that resolved quickly with short courses of low-dose medication. In contrast to the preceding four years, between October 2003 and May 2006 the plaintiff did not experience an acute episode of anxiety/depression. He did not consult a psychiatrist.

36 In October 2007, Dr Benjamin referred to the plaintiff having a history of "psychological difficulties" from his mid-teens and maintained the view that, prior to the accident, the plaintiff had suffered from a "mild chronic psychotic disorder" (Exhibit 7, 29 October 2007, paragraph (b) and (c)). Considerable weight must be attached to the view of a treating psychiatrist. However, Dr Benjamin's 2002 diagnosis of probable insidious schizophrenia differs from Dr Dosseter, another treating psychiatrist, who diagnosed recurrent acute depression and anxiety in the context of "a disability of social development" (presumably, a reference to ADHD, see paragraph 21). Professor Sanchez, Dr Akkerman (a psychiatrist) and Dr Buckley (a rehabilitation specialist) agreed with the 2002 diagnosis of Dr Dosseter, rather than that of Dr Benjamin. Both Dr Akkerman and Dr Buckley said that, had the plaintiff been exhibiting the early signs of schizophrenia in 2002, he

would very likely have experienced an episode of full-blown schizophrenia by his early 20s (T462.40, T470.13; Exhibit A, tab 28, page 436). As the weight of expert opinion favours the diagnosis of Dr Dosseter over that of Dr Benjamin, on the balance of probabilities I find that, prior to the accident, the plaintiff suffered from recurrent acute episodes of depression and anxiety and did not suffer from a prepsychotic or psychotic condition.

37 I am satisfied that, by 2006, the plaintiff had largely overcome earlier significant cognitive problems (global developmental delay and ADHD). His brain function was essentially normal for his age and IQ, but he had an unusually broad range of cognitive ability, enabling him to achieve well above average in relation to mathematics and chess. Although there had been no such episode since October 2003, he remained somewhat vulnerable to episodes of acute anxiety/depression, particularly in the context of pressure. Any such episode was easily treated with medication.

The Injuries Caused by the Accident

38 A vehicle travelling at considerable speed hit the plaintiff, who was a pedestrian. He suffered injuries to the head, left arm and left knee (Exhibit A, tab 7, pages 171-181).

39 When ambulance officers arrived at the scene of the accident, the plaintiff's Glasgow Coma Score was 6/15 (3/15 after sedation). The plaintiff was hypertensive. He was conveyed to Westmead Hospital. He underwent emergency surgery to repair a severe left parietal scalp laceration and insert a right frontal external ventricular drain via a burr hole. Lip lacerations were repaired. He was admitted to the Intensive Care Unit. On 1 June 2006, he was extubated. On 3 June, he was transferred to the wards. The plaintiff experienced post-traumatic amnesia until 9 June, 9 days after the accident (Exhibit A, tab 13). He has no recollection of the accident or the immediate aftermath. He was discharged on 14 June 2006 (Exhibit A, tab 7).

40 Initially, a fractured left ulna was treated with a plaster back slab. On 8 June 2006, Dr Wong (an orthopaedic surgeon) undertook an open reduction and internal fixation of the fracture (Exhibit A, tab 7). According to Dr Ryan (an orthopaedic surgeon, report of December 2008, Exhibit A, tab 27), the plaintiff has no measurable impairment of the left forearm, although the metal plate may require removal.

41 On 16 October 2006 Dr Brighton (an orthopaedic surgeon) performed a left anterior cruciate ligament reconstruction for injury to the left anterior cruciate and medial collateral ligaments. The plaintiff complains of ongoing pain in the knee, particularly when driving. He has been unable to return to pre-accident recreational activities that include significant running (such as soccer). When Dr Ryan saw the plaintiff in December 2008, there was a 2 cm wasting of the left quadriceps and the left knee was unstable. Dr Ryan noted that there was an associated risk of re-injury.

Brain Injury

42 Radiological results, the post-accident Glasgow Coma Scale and the period of post-traumatic amnesia provide powerful evidence that the plaintiff suffered severe traumatic brain damage.

43 An MRI scan taken by Dr Masters on 24 June 2010 showed diffuse haemorrhage in white matter bilaterally, in a classic pattern for diffuse axonal injury (Exhibit A, tab 32). In evidence, Dr Masters indicated significant lesions in the left frontal lobe. In the view of Dr Masters, the radiological results unarguably illustrate a significant traumatic brain injury to the frontal lobes (T371.16, Exhibit C). Dr Darveniza (a neurologist) agreed that the MRI provided "irrefutable" evidence of severe traumatic brain injury (T375.16). Based on the radiological results, Dr Masters considered that there was "a reasonable likelihood" that the plaintiff's brain function would have been affected (T371.45). According to Professor Sachdev, "such injury is almost invariably followed by varying degrees of cognitive deficits which usually become persistent" (Exhibit A, tab 33).

44 Professor Sachdev, Dr Langeluddeke and Dr Buckley said that the GCS of 6/15 (less than 8/15) and the period of post-traumatic amnesia (greater than seven days) supported a diagnosis of severe brain injury (T256.46; T414.40). In cross-examination, Professor Mattick agreed that the plaintiff's injury should be characterised as a "severe brain injury" (T504.49).

Symptoms and Impact of Brain Injury

45 The frontal lobes deal with executive function. In adolescence, the frontal lobes develop and become "myelinated", causing adolescent behaviour to mature into adult behaviour (Dr Buckley, T435.47).

46 Frontal lobe damage can affect capacity in three areas: problem - solving, judgment and insight; energy and motivation; and impulse control and social judgment. Loss of judgment and problem-solving ability is often reflected in an inability to plan and organise, inability to multitask, difficulty with maintaining attention/concentration (particularly for long periods or when the task is unexciting), an inability to remember a series of tasks and inattention to the environment. Loss of energy may appear as "neurological fatigue" (a physiological need for more sleep) (T416.10-28). Impulsivity may cause socially inappropriate behaviour such as loss of temper or social misjudgement, including the making of inappropriate remarks. Frontal lobe damage does not necessarily affect the ability to function physically, but it does affect the way in which physical functions are carried out. For example, a person may be quite capable of driving a car but incapable of exercising the foresight and judgement to avoid unnecessary risk (T442.16-31). For much of the time, brain injured people may appear to behave normally. The symptoms of brain injury may appear unexpectedly (Dr Buckley). Drs Akkerman and Buckley said that frontal lobe damage may cause an adult to behave like a 14 or 15 year old (T459.2; T436.12-15). Dr Langeluddeke said that frontal lobe damage usually affects memory, although the impact is not readily detected on testing (T275.50-276.10).

47 The effects of traumatic brain injury improve over a period of two years after the trauma. Thereafter, the condition is stable and disabilities are permanent (Dr Buckley, T440.26; Prof Sachdev, Exhibit A, tab 33, page 499).

The Neuropsychological Evidence

48 Prior to the accident, the plaintiff had been tested for verbal and non-verbal IQ. Unfortunately, he had not been tested for memory function. Since the accident, the plaintiff has been tested for both IQ and memory function on several occasions, most recently in February 2009 (by Dr Langeluddecke on behalf of the plaintiff) and in September 2009 (by Professor Mattick on behalf of the defendant).

49 In all areas of testing, the results obtained by Professor Mattick were significantly higher than those obtained by other testers, including Dr Langeluddecke (Exhibit 1, page 40 and page 44). Dr Langeluddecke said that, as a result of the "practice effect", when a person is retested within six months of sitting a test, an increase of 7 - 8 points can be anticipated (T269.1-8). In cross-examination, Professor Mattick agreed that a "practice effect" operated in relation to retesting within six months (or perhaps up to 12 months) (T505.20).

50 It is very probable that the superior results obtained by Professor Mattick were influenced by the "practice effect" and by the fact that Professor Mattick "prompted" or "assisted" the plaintiff, when the plaintiff was responding to the test questions in an impulsive manner, was disinclined to persevere and wanted to finish the test quickly (T493; T506.49). Consequently, the results obtained by Dr Langeluddecke in February 2009 provide the most reliable indicator of the plaintiff's current IQ and memory functioning.

51 Consistent results were obtained from premorbid and post-accident testing of verbal and non-verbal IQ. In 1995, the verbal IQ result was in the range 80 -- 89, but it was subsequently assessed as 100 (1998), 103 (August 2006) and 103 (February 2009). These results are in the middle of the average range for verbal IQ. Similarly, the test results for non-verbal IQ have been reasonably consistent. Non-verbal IQ was assessed at 80-89 (1995), 74 (1998), 87 (August 2006), and 90 (February 2009). The 1998 result was affected by the plaintiff's excessive attempt to achieve perfection in two tests, which resulted in a very poor outcome in each. Allowing for this factor, the plaintiff's non-verbal IQ has always been about 90, the bottom of the average range. Dr Langeluddecke assessed the plaintiff's full scale IQ at 99 (Exhibit A, tab 29, pages 442-467).

52 Post-accident testing of memory has yielded average results for auditory /verbal memory, and poor results for immediate and delayed visual memory. In relation to immediate visual memory, the results have been 71 (February 2007), 71 (February 2009) and 78 (Professor Mattick, September 2009). The results for delayed visual memory have been 62 (February 2007), 78 (February 2009) and 88 (Professor Mattick, September 2009) (Exhibit 1).

53 IQ is commonly well preserved after brain injury (T434.5). Neuropsychological testing targets "measurable" cognitive function such as memory and logic, and as such is a poor instrument for testing frontal lobe dysfunction (ie executive dysfunction) (T415.40). Psychometric testing may

not identify deficits in executive function as the test situation is brief, structured and distraction free. It does not test a person's capacity to prioritise without prompting (Dr Langeluddecke, T261 – 262). Professor Mattick agreed that, as it can be difficult to assess frontal lobe damage in the context of psychological testing, it was important to obtain a history from those close to the subject.

54 Consequently, the IQ test results say nothing about whether the plaintiff suffers frontal lobe dysfunction. The plaintiff's impulsive behaviour and short attention span during testing by Professor Mattick are consistent with frontal lobe dysfunction. The poor test results for visual memory function are consistent with frontal lobe damage. However, there was no premorbid testing with which to compare the results. Fortunately, the lay evidence is a rich source of information about the impact of the injury on the plaintiff's cognitive functioning and associated behaviour.

Lay Evidence Of Cognitive And Behavioural Changes

55 The lay evidence establishes that, since the accident, the plaintiff has suffered impairment in functions commonly associated with frontal lobe damage. There is ample evidence of functional impairment in three of the principal areas associated with frontal lobe damage: high - level skill and judgment, interpersonal functioning and memory. Unprompted, the plaintiff's father has described the plaintiff's behaviour as that of a 14-year-old child (T376.24-27).

56 In relation to high level skill and judgment, the plaintiff's older brother gave evidence that the plaintiff's chess prowess has suffered (T321.34-47). Since the accident, the plaintiff has been knocked out of chess competitions at an early stage and has been far less successful in games played against a chess "machine" (T339). Dr Akkerman said that, as chess "is a frontal lobe activity", it is obvious that frontal lobe damage would affect the ability to play chess (T463.47). The plaintiff's father gave evidence that, prior to the accident, the plaintiff had undertaken bookkeeping for the family business in a competent manner. Since the accident, Mr Gergis Senior has had to thoroughly review the plaintiff's work because the plaintiff makes many mistakes (T240.16-241.19). When the plaintiff was at university, Mr Gergis Senior assisted him to reach the appropriate lecture rooms at the appropriate times and sometimes took notes to assist the plaintiff to extract the content of lectures (T230.25-31). On several occasions, the plaintiff has caused damage or incurred parking fines when using his mother's car, but has failed to advise her of the damage or fines (T404.47). He did not behave in that way before the accident (T405.16-19). Mr Michael described the plaintiff as "slower" to "register" (T327.9-13).

57 Since the accident, the plaintiff's interpersonal relationships have been troubled. The plaintiff has lost the capacity to maturely regulate his social behaviour and has become short-tempered and irritable. His behaviour towards women has been inappropriate; the plaintiff makes embarrassing remarks to passing women and experiences difficulty in maintaining a normal conversation with a woman. The plaintiff's brother said that the plaintiff's propensity to make inappropriate remarks to women and engage in name-calling is such that, on occasions, the brother has felt compelled to intervene and diffuse a situation (for example T308.16; T309.5-16;

T327.33-50; T340.6-31, 40-50). The plaintiff has insulted his grandmother and, rather than behaving like a mature older brother, he often disrupts and annoys his 15-year-old sister (T406.6-9; T341.40-342.1). Since the accident, his circle of friends has diminished dramatically. He no longer brings friends to the family home. Indeed, he has few friends (T407.29-41; T308.25). Generally, he keeps company with his brother and his brother's group of friends, which has the advantage that his brother is able to supervise the plaintiff's social interaction (T348.42).

58 The plaintiff has significant difficulty with memory. Mr George Gerges said that the plaintiff repeats himself. For example, he forgets that he has told a story and repeats it an hour or two later, becoming irritable when reminded that the story has already been told (T308.12-50). Mr Michael described apparent memory lapses. For example, the plaintiff had forgotten that Mr Michael had relapsed into smoking (T328). Around the home, the plaintiff is very forgetful. He forgets to lock the front door when he leaves the house. He leaves the refrigerator door open; the stove and lights on; the taps running (T404.36-42). He has to be reminded of appointments, so much so that the plaintiff's father prefers to drive the plaintiff to appointments (T245.8-17).

59 The evidence regarding the plaintiff's recent unsuccessful employment provides strong support for the claim that the plaintiff's functioning is impaired in the areas of planning and organisation, social interaction and memory. On 28 June 2010, the plaintiff commenced employment as a teller with a city branch of the St George Bank, subject to a three-month probation period. The plaintiff's brother worked at a location close to the plaintiff's place of work. From time to time, he "checked up" on the plaintiff. He observed that, during the period that the plaintiff was employed by the Bank, he appeared to enjoy going to work but he also appeared to be stressed. The plaintiff had to be reminded to wear clean clothes and tuck in his shirt (T346.13-39). His mother helped with ironing, made a packed lunch and ensured that the plaintiff was awake in time to get to work (T406.25-30). At the end of the probation period, his employment was terminated because of "ongoing poor performance and behavioural issues, including numerous customer and staff complaints" (Exhibit A, tabs 41 and 42). The plaintiff and his father asked that the plaintiff be reinstated, without success.

60 Professor Mattick agreed with Dr Buckley's view that the behaviour described by the plaintiff's brother was consistent with that of a person who suffered from frontal lobe dysfunction.

61 The defendant tendered surveillance evidence, which confirmed that the plaintiff is capable of ordinary daily activities such as shopping, travelling by public transport, using a mobile telephone and accessing an automatic teller machine. The film illustrated the plaintiff attending a shopping centre, where he entered a florist shop twice and a sunglasses shop thrice (on one occasion, he left flowers in the shop) (Exhibit 2, 3). The shopping centre sequence is consistent with the plaintiff suffering impairment in relation to organisation and sequential planning.

62 The defendant placed considerable reliance on surveillance evidence establishing that the plaintiff is a frequent competition poker player, participating in a succession of games for periods of up to six or seven hours in one night. The defendant submitted that such conduct was inconsistent with impaired concentration.

63 The expert evidence was that a person suffering from frontal lobe damage was capable of engaging in an exciting task such as playing computer games, but would have difficulty sustaining attention on a task that was boring or required mental flexibility (Dr Langeluddecke, Dr Darveniza, T262.24-46; T377.19-27). A person suffering from frontal lobe damage would be capable of short spurts of attention but could not maintain the concentration necessary to be a successful poker player (Professor Sachdev, Dr Buckley T395).

64 Mr George Gerges gave evidence that, although competent, the plaintiff's poker playing was affected by "irrational decisions" (T309.47-310.4). The plaintiff considers poker to be a "social hobby" (T32.26) and the Australian Poker League records show that the plaintiff is a frequent and enthusiastic player, but his rankings vary greatly and he is often well down in the rankings (Exhibit 2).

65 The plaintiff's varying results are consistent with performance affected by lapses of concentration, the making of "irrational decisions", and the significant element of chance associated with the game of poker. The frequent playing of poker is not inconsistent with the plaintiff suffering from impaired concentration.

Bipolar Disorder

66 On 18 July 2006, Dr McCarthy (a consultant in rehabilitation medicine with the Brain Injury Rehabilitation Service at Westmead Hospital) reviewed the plaintiff and noted that he had developed significant distress and anxiety, with insomnia and perseverative thinking (Exhibit A, tab 13). Neuropsychological assessment in August 2006, showed difficulty with concentration, memory and speed of processing. High levels of anxiety and stress were detracting from the plaintiff's performance. Dr McCarthy and Ms Walker, the assessing neuropsychologist, were concerned that the plaintiff may be manifesting the early stages of a psychotic process (Exhibit A, tab 15).

67 In May 2007, Mr Michael was with the plaintiff when the plaintiff became confused, disoriented, highly emotional and affected by manic delusions. The plaintiff's parents became concerned about his "bizarre behaviour". Dr Benjamin was consulted. In May 2007, Dr Benjamin advised the University of Western Sydney that the accident had "caused some impairment of (the plaintiff's) cognitive functions and also resulted in a mood disorder ... characterised by mood instability, impulsivity, poor judgement, irritability and inappropriate behaviour" (emphasis added). Dr Benjamin stated that there was an impact on the plaintiff's "ability to study and interact with other students and university staff". He asked that the plaintiff be given special consideration (Exhibit A, tab 17). The plaintiff's father took the plaintiff to a monastery.

68 The plaintiff did not improve. On 13 June, he was admitted to the Westmead Hospital Psychiatric Ward. He remained there as an inpatient until 26 July 2007. The diagnosis on discharge was "frontal lobe syndrome due to traumatic brain injury in May 2006, secondary bipolar affective disorder" (emphasis added, Exhibit A, tab 19, page 245).

69 In a note of 26 July (Exhibit A, tab 22, page 344), Dr Cubas, a psychiatric registrar, wrote:

"(The plaintiff) suffers from traumatic brain injury with secondary cognitive deficits affecting his ability to concentrate and keep to task. He has also been suffering from an emotional disturbance which required six weeks of hospitalisation."

70 On discharge, the plaintiff was referred to Dr Jungfer, a psychiatrist specialising in traumatic brain injury. In addition, the plaintiff was to be followed up by Dr Benjamin. The referral report of Drs Valachova and Cubas (psychiatric registrars), noted episodic illnesses "most likely precipitated by stress from the university exams". It stated, "the nature of these presentations is unclear" (Exhibit A, tab 23).

71 Dr Jungfer noted the plaintiff's long-standing frustration with his parents regarding the need to study and obtain qualifications (Exhibit 9). She noted that the plaintiff had developed manic features since the accident. On 3 October 2007, Dr Jungfer wrote to the plaintiff in stern terms concerning the amount of time that he spent socialising and his failure to comply with medication. On 22 October 2007, after noting that the plaintiff's neuroimaging was normal, she wrote:

"The ongoing functional impairments ... is likely to be longstanding personality characteristics and a longstanding mental health disorder, which with time have become more substantial."

72 Dr Jungfer saw the plaintiff only once. It is apparent that Dr Jungfer was very unhappy with the plaintiff's noncompliant behaviour. In my view, Dr Jungfer's opinion should be accorded less weight than that of the experts who were aware of the 2010 MRI scan results and/or who had more extensive dealings with the plaintiff.

73 As noted in paragraph 36, in his most recent report of 29 October 2007, Dr Benjamin advised that the plaintiff's 2007 problems "occurred against a background of mild chronic psychotic disorder (possibly schizophrenia), which he suffered since his midteens". Dr Benjamin noted the diagnoses of bipolar affective disorder (moderate severity), traumatic brain injury -- mild cognitive impairment, and chronic mild psychotic disorder. In this report, Dr Benjamin appears to be referring to three distinct diagnoses, only one of which (chronic mild psychotic disorder) in his opinion preceded the accident (Exhibit 7).

74 Professor Sachdev and Drs Akkerman and Buckley gave evidence that bipolar affective disorder can follow traumatic brain injury. The aetiology of this phenomenon is unknown. Dr Akkerman acknowledged the possibility that the plaintiff's bipolar disorder may have developed regardless of the accident (bipolar disorder typically appears in the late teens or early 20s). However, in the absence of a manic episode prior to the accident, he considered that it was likely that the accident had caused the bipolar disorder (T460). Professor Sachdev gave evidence that, in relation to bipolar disorder generally, a significant proportion of sufferers (perhaps 40 to 50%) had a family history of psychosis (T155.10-19). The first manic episode was often preceded by a sustained depressive episode that was not stress-induced.

75 Dr Akkerman stated that, while frontal lobe damage is largely permanent, bipolar disorder can be treated with reasonable success (T459.40). Bipolar disorder is principally characterised by periods of depression, which are easily treated. In a lifetime, a person may suffer only one or two episodes of mania. Each may last only 2 - 4 weeks, particularly if treated. Sufferers have lengthy periods when they are well, or even "extra well" in that they are more creative due to the influence of underlying mania (T461-462).

76 With the exception of Dr McCarthy (a rehabilitation specialist, rather than a psychiatrist) and Dr Jungfer (a psychiatrist who saw the plaintiff only once), the other experts (Professor Sachdev, Dr Akkerman and Dr Benjamin) are inclined to the view that the plaintiff's bipolar affective disorder is secondary to the traumatic brain injury. Factors relevant to this determination include the absence of a family history of psychosis; previous episodic depression/anxiety that was reactive to stressors; and the fact that the first manic episode occurred after the traumatic brain injury. I accept the opinion of these experts that, on the balance of probability, the plaintiff's bipolar disorder is secondary to traumatic brain injury.

Past and Future Economic Loss

77 When he returned to university in 2007, the plaintiff had four outstanding units to complete before obtaining his degree. He applied for "special consideration". An "academic integration plan" was developed. The plaintiff was allowed a note taker for lectures, extra time to complete examinations and other concessions (Exhibit A, tab 38). In 2007, the plaintiff completed his degree, obtaining two passes and a credit in the Autumn Session, and a credit in the Spring Session. In 2008, he enrolled in a law degree at the University of Western Sydney, but he discontinued because he found the course too difficult. In 2009, he enrolled in a Master of Business in Finance at the University of Technology Sydney. He has failed three subjects and passed only one subject in 2009, with a mark of 50. (Exhibit A, tab 47, page 1126).

78 From 11 March to 31 May 2006, the plaintiff held casual employment as a telemarketer with the Australian Mortgage Advisory Service, working about 12 hours a week and earning \$234 net per week (Exhibit A, tab 37). In addition, he earned \$100 per week completing GST and BAS returns for his parents' company, M and F Gergis Pty Ltd, (Exhibit A, tab 36).

79 I consider that the plaintiff's "most likely future circumstances but for the injury" (s 126 (1) of the Act) were as follows. He would have continued his desultory progress towards a business degree. Consistent with his results in the first semester of 2006, he would have completed the remaining four subjects of his degree at the end of 2006. During that period, he would have continued to work for his parents' company earning \$100 per week, as well as working casually as a telemarketer, earning about \$234 net per week. He would have earned at least \$300 net per week until the end of 2006. Thereafter, he would have searched diligently for employment. In that search, he would have been somewhat hampered by his indifferent university results. It is most unlikely that he would have obtained employment at the high end of the market. However, after some time he would have obtained employment as an accountant. Having secured employment, he would have maintained it. Had there been a delay in obtaining employment as an accountant,

the plaintiff would have obtained alternative short-term employment, possibly as a telemarketer. Once he obtained employment as an accountant, the plaintiff would have ceased working for his parents' company and devoted himself to working full-time as an accountant. To allow for these considerations, I have assumed that there would have been a 12 month delay in the plaintiff obtaining work as an accountant, during which time he would have earned at least \$300 per week.

80 The plaintiff has made diligent and genuine efforts to obtain employment as an accountant (Exhibit D), but has failed in that endeavour. Although he has not disclosed the injuries arising from the accident to prospective employers, the plaintiff has not gained an interview. Contributing factors may include the 2008 "global financial crisis", the length of time that the plaintiff took to complete his degree and his poor academic results. Since the accident, the only employment that the plaintiff has undertaken has been with the St George Bank (see paragraphs 1 and 84 below) and with his parents' company (where his work completing GST and BAS returns is closely monitored by his father).

81 The defendant accepts that the plaintiff's entry into the workforce was delayed by six months because he was unable to return to his studies until 2007. Otherwise, the defendant submits that the plaintiff has sustained no past or future economic loss.

82 Initially, Professor Mattick expressed the view that the plaintiff could work as an accountant because he had the necessary qualifications and his IQ was average. However, Professor Mattick conceded that the difficulties that the plaintiff experienced at the St George Bank were consistent with a person who had frontal lobe disorder (T516.37) and stated that it was likely that the plaintiff would obtain a relatively isolated job, such as driving a courier van (T516.46).

83 With the possible exception of Professor Mattick, expert opinion was to the effect that the plaintiff was incapable of working as a full-time accountant and that it was quite likely that the plaintiff was incapable of obtaining and maintaining any form of employment on the open employment market. In his October 2007 report, Dr Benjamin doubted that the plaintiff would be capable of full-time work as an accountant. He opined that the plaintiff might work "in a less demanding type of work" or as an accountant working in "a reduced job role or limited capacity". Dr Darveniza (Exhibit A, tab 31, page 483) described the plaintiff as "basically unemployable on the open labour market in his chosen field" although he "could be employed in a benevolent environment with a simple accounting tasks". He considered that the plaintiff's performance with the Bank was entirely predictable and showed that the plaintiff would struggle to maintain any job in the "real adult world", where immature conduct was unacceptable. Dr Buckley expressed the opinion that, as a result of the traumatic brain injury, the plaintiff was "unemployable on the open employment market" (Exhibit A, tab 28, pages 435 and 436). Dr Akkerman described the plaintiff as "totally unfit for work" (Exhibit A, tab 30, page 477). Professor Sachdev considered it unlikely that the plaintiff would obtain a job as an accountant in the open market and that it was "likely that he will not be able to hold even a less demanding job" (Exhibit A, tab 33, page 498).

84 The extent of the plaintiff's incapacity to work was clearly established when he attempted to work at the St George Bank. The plaintiff was highly motivated to succeed at the Bank. His attempt to work was strongly supported by his family. In the morning, his mother assisted him to prepare for work. During the day, his brother checked on the plaintiff. When the plaintiff's employment was terminated after the probationary period, he and his father sought reinstatement, without success. Although the employment tasks at the Bank were simple compared to those of an accountant, the plaintiff struggled to concentrate and maintain the work pace. He experienced memory problems. His behaviour was socially inappropriate. Each of these areas of dysfunction was symptomatic of the plaintiff's severe traumatic brain injury. Further, the work challenges caused him stress and exposed him to possible depression and anxiety. The plaintiff's experience at the Bank demonstrates that he is totally unfit for employment on the open employment market.

85 Contrary to the suggestion of Professor Mattick, the plaintiff could not work as a courier driver. Such work would require a reasonable memory, the ability to prioritise a sequence of tasks and the capacity to interact in a socially appropriate manner. There is no employment on the open employment market for which the plaintiff is suited.

86 In order to quantify his loss, the plaintiff relies upon figures showing the earnings of an average accountant, by reference to age (Exhibit E). For the period to date, the plaintiff relies upon the earnings of accountants in the 20 -- 24 age group. For the future, he relies upon earnings for accountants in the 35 -- 39 age group as that age would be an approximate midpoint in a working career. In relation to past economic loss, I have deducted \$100 from the relevant sums to allow for the fact that the plaintiff has earned that sum by working for his parents' company. The plaintiff claims a loss of superannuation at the rate of 11% rather than 9% because the calculation is based on net loss rather than gross loss. The defendant did not object to that approach and I consider that it is appropriate.

Care

87 Pursuant to section 128 (2) and (3) of the Act, no compensation is to be awarded for attendant care services if the services would have been provided to the person even if the person had not been injured by the motor accident and no compensation is to be awarded unless the services are provided (or to be provided) for at least 6 hours per week, and for a continuous period of at least 6 months.

88 For a few months after the plaintiff was discharged from hospital, the plaintiff was both physically and cognitively disabled and his mother did "everything" for him. She helped with showering, cleaning his room, and cutting up his food (T403.35-38).

89 When the plaintiff returned to university in 2007, his father observed that he was having difficulties. His father accompanied him to lectures to ensure that the plaintiff attended the correct location at the correct time. On a few occasions, the plaintiff's father took notes so that he could "spoon feed" the plaintiff, ensuring that the plaintiff extracted "the message" from the lectures. (T232.5-10).

90 With the exception of the first few months after the plaintiff was discharged from hospital, the main tasks undertaken by the plaintiff's family have been supervision and motivation. For example, the plaintiff's mother sits next to him while the plaintiff writes job applications to ensure that he does not forget to complete the task. The plaintiff's brother supervises the plaintiff in social situations to ensure that he does not provoke a fight through inappropriate remarks or behaviour.

91 Dr Buckley (the rehabilitation specialist) said that, within the routine that is currently provided by the family, the plaintiff was capable of driving a car, using public transport, using a ATM, using a mobile telephone, dressing and showing himself, dining out etc (T440). Most severely brain injured people can undertake such activities, although they may need to be reminded. Dr Buckley noted that, while teenagers can undertake such activities, they are not allowed to hold drivers licences because they have poor impulse control and limited ability to predict and judge risk. The same problems of immaturity exist in the brain injured (T442.16-30). If the plaintiff lived away from his family, he would need two hours per day assistance from a housekeeper/supervisor. He would need four hours per day for five days a week from an activities coordinator, who would plan and maintain activities (a function currently undertaken by the plaintiff's family) (Exhibit A, tab 28, page 433). People with brain injury are inclined to gradually reduce their activities until their principal activity is watching television. The decrease in activities is frequently associated with an increase in depression because of the very poor quality of life ("living a life of quiet desperation") (T421.17-26). Brain injured people need activities that are physically and mentally stimulating, such as watching sports and visiting the shops. In addition, Dr Buckley recommended the assistance of an independent case manager, who would be responsible for helping the plaintiff to manage "the more advanced requirements of domestic care". He proposed that the case manager be actively involved with the plaintiff for two hours a week (plus travelling time) (Exhibit A, tab 28, pages 433 – 434).

92 Dr Darveniza agreed that, in the absence of his family, the plaintiff would require alternative domestic support in the way of supervision once or twice a week to ensure that he did not "run off the rails" (T378.13-19).

93 Ms Flanagan (an occupational therapist) assessed the plaintiff's current needs on the basis that he does not require "hands on assistance" but does require prompting, assistance with planning and organising schedules and supervision of daily activities. Ms Flanagan relied upon the history given by the plaintiff and his family to calculate the level of assistance that has been provided in the past. She referred to a history of care at the following levels.

1. 13 June to 13 August 2006 (first two months after discharge), assistance with personal activities, including transfers, showering, eating, attending appointments, 28 hours per week.
2. 13 August to 13 September 2006, 24.5 hours per week.
3. 13 September to 15 October 2006, 12.5 hours per week.
4. 18 October to 31 December 2006, 12.5 hours per week.
5. 1 January to 12 June 2007, assistance with daily and university activities, 15.5 hours per week.
6. 22 July to 31 December 2007, 15.5 hours per week.
7. 1 January 2008 to 11 June 2008 (date of assessment), 10.5 hours per week.

94 Ms Flanagan concluded that, while the plaintiff was living with his parents in the family home, he needed assistance 1 1/2 hours a day or 10.5 hours per week. If he lived away from home in a three-bedroom house on an average block of land, he would require assistance for two hours a day or 14 hours per week (Exhibit A, 26, page 392).

95 For the three-month period following discharge, I consider it reasonable to allow three hours a day or 21 hours a week for assistance with physical and cognitive tasks. Thereafter, I consider it reasonable to allow at least one hour a day, and will allow 8 hours a week. I consider it likely that the plaintiff will remain living at home until his parents become elderly. I proceed on the basis that he would live at home for the next 15 years. Thereafter, he is entitled to the professional costs of providing domestic services for eight hours a week. As his family takes a close interest in the plaintiff's affairs and he will have a fund manager, there is no need for a case manager.

Out of Pocket Expenses

96 Past out-of-pocket expenses were agreed at \$21,330.75 (Exhibit F).

97 In relation to future medical care, Dr Buckley recommended that the plaintiff consult a general practitioner four times a year (for general health maintenance and review of cognitive and behavioural impairments), a consultant physician in rehabilitation medicine (traumatic brain injury specialists) once a year, a psychiatrist with skills in managing traumatic brain injury once a year, and a lower limb orthopaedic surgeon and a wrist surgeon once every three years (Exhibit A, tab 28, pages 434 – 435). He considered it unlikely that the plaintiff would require further operative intervention. The cost of the services proposed by Dr Buckley was close to \$1,000 pa. Dr Akkerman proposed an allowance of \$2,000 per year for future psychiatric and medication expenses (Exhibit A, tab 28, page 477). In final submissions, the plaintiff claimed \$14 per week, a modest amount.

Fund management

98 Dr Buckley was of the opinion that the plaintiff's poor insight and vulnerability left him open to financial exploitation and he needed assistance in relation to the management of funds (Exhibit A, tab 28, page 435). Professor Sachdev said that the plaintiff may need some supervision in relation to financial organisation and budgeting because of his impulsivity and poor judgement (T149.1-17). Dr Darveniza agreed that, while the plaintiff was capable of handling day-to-day financial affairs, he should receive professional help in relation to more complex financial matters. He considered that moneys received by way of compensation should be held in trust (Exhibit A, tab 31, page 484).

99 As the plaintiff has the insight and judgement of an adolescent boy it is appropriate that the sum awarded for damages be held in trust.

100 The cost of funds management should be calculated in accordance with the tables developed by Furzer Crestani, based on a 5% discount rate with no allowance for fund management of the fund management costs themselves.

Summary

101 Well prior to the date of the accident, the plaintiff overcame his early developmental delay. By the date of the accident, symptoms associated with childhood attention deficit hyperactivity disorder had largely resolved and ADHD was having no significant impact on the plaintiff's behaviour or academic performance. The plaintiff was vulnerable to recurrent episodes of acute anxiety/depression, particularly when under academic pressure. However, there was no such episode between October 2003 and the accident in May 2006. Such episodes were readily treated by antidepressant and mood stabilising medication.

102 As a result of the accident, the plaintiff sustained a fractured left ulna and damage to left knee ligaments (anterior cruciate and medial collateral ligaments), requiring a reconstruction. He is left with no measurable loss of function in the left arm. The plaintiff's left knee remains unstable, and he cannot run for extended periods of time. More importantly, the plaintiff suffered a severe traumatic injury to the frontal lobes, which has affected his memory, his capacity for appropriate social interaction, and his judgement, concentration, ability to multitask and other high level executive functions. He also suffers from bipolar mood disorder secondary to the trauma.

103 The plaintiff is unemployable on the open employment market. He requires attendant care services to motivate him, assist with planning and the organisation of activities, and provide some supervision of social interaction. The award of damages should be subject to fund management.

104 Damages 1 Non-economic loss \$250,000

2 Past economic loss

a. 31.5.06 – 31.12.07 (83 weeks at \$300 net pw) \$24,900

b. 1.1.08 – 27.6.10 (130 weeks at \$736.15 net pw less \$100 pw) \$82,700

c. 29.9.10 – 6.12.10 (10 weeks at \$736.15 net pw less \$100 pw)

\$6,360

\$113,960

3 Future economic loss – to 67 years of age (\$1,202 pw x 41 years, 5% multiplier is 924.8, less 15% for vicissitudes) \$944,546

4 Lost superannuation

a. Past loss (\$113,960 x 11%) \$12,536

b. Future loss (\$944,546 x 11%) \$103,900

5 Past domestic services

a. 13.6.06 – 13.9.06 (21 hours x 13 weeks x \$22.10) \$6,033

b. 14.9.06 – 6.12.10 (excluding 7 weeks in hospital, 8 hours pw x 213 weeks x \$22.31 - \$24.67, say \$23.50) \$40,044

6 Future domestic services

a. 6.12.10 – 6.12.25 (8 hours pw x \$24.67, 5% multiplier is 555) \$109,535

b. Thereafter, for remaining life expectancy of 44 years, deferred 15 years, 8 hours pw x \$35 ph x 944.5 x .481) \$127,205

7 Past out of pocket expenses \$21,331

8 Future out of pocket expenses (\$14 pw x 59 years, 5% multiplier is 1009.3) \$14,130

9 Funds management \$181,219

Decision

105 On 8 December 2010, the agreement between the parties that the plaintiff was 50% responsible was approved.

106 On 10 December 2010, the funds management expenses were agreed at \$181,219.

107 There is a verdict and judgment for the plaintiff in the sum of \$1,052,829.

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