

AUSTRALIA / JUDGMENT

Lederer Group Pty Ltd v Hodson [2024] NSWCA 303

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Court of Appeal

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Supreme Court

New South Wales

Medium Neutral Citation: Lederer Group Pty Ltd v Hodson [2024] NSWCA 303

Hearing dates: 17 October 2024

Date of orders: 18 December 2024

Decision date: 18 December 2024

Before: Ward P at [1]; Leeming JA at [280]; Basten AJA [286]

Decision: 1. Appeal and cross-appeal each be allowed with costs.

Catchwords: NEGLIGENCE – Duty of care – Mental harm – Where respondent exposed to traumatic incident in the course of employment – Whether respondent's exposure to incident was causative of post-traumatic stress disorder and major depressive disorder – Whether respondent actually exposed to incident – Whether respondent's employer breached duty of care in failing to direct respondent not to attend incident – Whether duty of care negated by s 32 of the Civil Liability Act 2002 (NSW) – Appeal allowed

EVIDENCE – Expert evidence – Where assumptions made by experts called by respondent not proved on the facts – Where facts as proved dissimilar from expert assumptions – Where little to no weight can be attributed to expert evidence as to causation

Legislation Cited: Civil Liability Act 2002 (NSW), ss 5B, 5C, 5D, 30, 32

Law Reform (Miscellaneous Provisions) Act 1946 (NSW), s 5(1)

Work Health and Safety Act 2011 (NSW), ss 17, 19, 20

Work Health and Safety Regulation 2011 (NSW), cl 34-39

Workers Compensation Act 1987 (NSW), s 151Z, Div 3 Pt 5

Cases Cited: Benic v State of New South Wales [2010] NSWSC 1039

Bunnings Group Ltd v Guidice [2018] NSWCA 144

Capar v SPG Investments Pty Ltd t/as Lidcombe Power Centre [2020] NSWCA 354

Chappel v Hart (1998) 195 CLR 232; [1998] HCA 55

Collins v Insurance Australia Ltd (2022) 109 NSWLR 240; [2022] NSWCA 135

Culver v Sekulich (1959) 80 Wyoming 437

Dasreef Pty Ltd v Hawchar (2011) 243 CLR 588; [2011] HCA 21

Davidson v R [2022] NSWCCA 153
Eric Preston Pty Ltd v Euroz Securities Ltd (2011) 274 ALR 705; [2011] FCAFC 11
Karzi v Toll Pty Ltd [2024] NSWCA 120
Koehler v Cerebos (Australia) Limited (2005) 222 CLR 44; [2005] HCA 15
Kozarov v State of Victoria (2022) 273 CLR; [2022] HCA 12
Kubovic v HMS Management Pty Ltd [2015] NSWCA 315
Makita (Aust) Pty Ltd v Sprowles (2001) 52 NSWLR 705; [2001] NSWCA 305
Mount Isa Mines Pty Ltd v Pusey (1970) 125 CLR 383; [1970] HCA 60
Optus Administration Pty Ltd v Glen Wright by his tutor James Stuart Wright [2017] NSWCA 21
Palmer-Bruyn and Parker Pty Ltd v Parsons (2001) 208 CLR 388; [2001] HCA 69
Paric v John Holland Constructions Pty Ltd (1985) 62 ALR 85; [1985] HCA 58
Paric v John Holland Constructions Pty Ltd [1984] 2 NSWLR 505
Prouten v Chapman [2021] NSWCA 207
R v Ryan [2002] VSCA 176
Ramsay v Watson (1961) 108 CLR 642; [1961] HCA 65
Roads and Traffic Authority of NSW v Dederer (2007) 234 CLR 330; [2007] HCA 42
Robinson Helicopter Company Inc. v McDermott [2016] HCA 22; (2016) 90 ALJR 679
Robinson v EACH Ltd [2024] VSCA 313
Stojan (No 9) v Kenway [2009] NSWCA 364
Sydney Wide Distributors Pty Ltd v Red Bull Australia Pty Ltd [2022] FCAFC 157
Tame v New South Wales; Annetts v Australian Stations Pty Limited (2002) 211 CLR 317; [2002] HCA 35
TNT Australia v Christie (2003) 65 NSWLR 1; [2003] NSWCA 47
Top Hut Banoon Pastoral Co Pty Ltd t/as Trustee for the Wakefield Family Trust v Walker [2021] NSWCA 296
Watson v Foxman (1995) 49 NSWLR 315
Wicks v State Rail Authority (NSW) (2010) 241 CLR 60; [2010] HCA 22
Zaghloul v Bayly [2021] WASCA 125
Texts Cited: D A Ipp (Chairman), Review of the Law of Negligence Report (2 October 2002)
JD Heydon, Cross on Evidence (14th ed, 2023, LexisNexis)
JJ Spigelman AC, "Truth and the law" in N Perram and R Pepper, The Byers Lectures 2000–2012 (The Federation Press, 2012)
Category: Principal judgment
Parties: Lederer Group Pty Ltd (Appellant)
Andrew Hodson (First Respondent)
Hurex Pty Ltd (Second Respondent/Cross-Appellant)
Representation: Counsel:
D A Lloyd SC with T Kane (Appellant)
D Campbell SC with J L Magee (First Respondent)
M Gerace SC with J Ryan (Second Respondent/Cross-Appellant)

Solicitors:

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RMB Lawyers (First Respondent)

Bartier Perry (Second Respondent/Cross-Appellant)

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Jurisdiction: Civil

Date of Decision: 26 April 2024

Before: Fitzsimmons SC DCJ

File Number(s): 2023/00084062

[Note: The Uniform Civil Procedure Rules 2005 provide (Rule 36.11) that unless the Court otherwise orders, a judgment or order is taken to be entered when it is recorded in the Court's computerised court record system. Setting aside and variation of judgments or orders is dealt with by Rules 36.15, 36.16, 36.17 and 36.18. Parties should in particular note the time limit of fourteen days in Rule 36.16.]

HEADNOTE

[This headnote is not to be read as part of the judgment]

In the morning on 26 October 2020, there was a fatal accident in an external loading dock at the Corrimal Shopping Centre (Centre) in New South Wales, when an elderly man was run over by a truck. The deceased suffered horrific injuries.

The Centre is owned and occupied by Lederer Group Pty Ltd (Lederer), the first appellant, who engaged Hurex Pty Ltd (Hurex), the second respondent/cross-appellant, to supply cleaning contractors at the Centre. The first respondent, Mr Hodson, was employed by Hurex and worked as a cleaner at the Centre, where he also performed some caretaker/security duties. Lederer was in the position of host employer. At the relevant time, Mr Hodson worked under the direction of Ms Necovski, a Lederer employee who was responsible for overseeing the Centre from an operational and business perspective.

Mr Hodson usually worked the afternoon shift at the Centre and the morning shift was worked by his colleague, Mr Brydon, who was also a Hurex employee. Mr Brydon arrived at the loading dock shortly after the accident and was the first Centre worker on the scene. Mr Brydon saw the uncovered body of the deceased. Ms Necovski arrived just after the first ambulance had arrived, at which time the body was still uncovered. Mr Brydon was distressed and Ms Necovski formed the view that he was unable to continue working his shift. Ms Necovski telephoned Mr Hodson and asked him to come into the Centre, telling him that there had been a fatality and that Mr Brydon was not able to continue working. Mr Hodson attended the Centre shortly after Ms Necovski's call and went to the office area, which was vacant. Mr Hodson called Ms Necovski and asked where she was. When told that Ms Necovski was at the northern dock, Mr Hodson went there. Ms Necovski told him what had happened and, when he asked where Mr Brydon was, Ms Necovski pointed to Mr Brydon. By this time, paramedics had already covered the deceased's body with a white sheet and, when Mr Hodson went over to his colleague there was no direct line of sight to the covered body. However, when Mr Hodson went to leave the area with Mr Hodson, a police officer called them over and at that stage there was a line of sight to the covered body (some metres away). From the CCTV footage it is clear that at no stage when Mr Hodson was at the scene could he have actually seen the deceased's injuries as the body was covered by the white sheet. Mr Hodson finished working both Mr Brydon's shift and his own. He claimed, but Ms Necovski denied, that she had directed him back to the scene in afternoon; and that he went back to the scene twice.

The day after the incident Mr Hodson consulted with his medical practitioner, whom he had been seeing since August 2019 for anxiety and depression and was prescribed a low dose of diazepam (valium). Mr Hodson brought a workers compensation claim, having been diagnosed with anxiety and depression. He was certified as unfit to work by his medical practitioner and in May 2021 was referred to a consultant psychiatrist.

A few days or weeks after the incident, Mr Hodson saw CCTV footage of the incident in the office of a colleague (not relied upon for the purposes of his claims against either Lederer or Hurex) and he learnt, from gossip in the Centre, that the deceased had been a regular customer at the Centre.

Over the period through to 2024, Mr Hodson had consultations with a variety of doctors, psychologists and psychiatrists (some providing medico-legal reports for workers compensation purposes). In March 2023, Mr Hodson commenced proceedings in the District Court against both Hurex and Lederer, claiming damages for breach by each of duties of care owed to him. Mr Hodson, in reliance upon various medical and medico-legal reports, claimed that he suffered a major depressive disorder and post-traumatic stress disorder as a consequence of being exposed to the scene of the accident.

The primary judge found that Hurex, as Mr Hodson's employer, breached its duty of care owed to Mr Hodson for failing to direct him not to attend a significant incident. As to Lederer, the primary judge found that its duty of care was not negated by s 32 of the Civil Liability Act 2005 (NSW) (which provides that there is no duty to avoid mental harm except if the relevant entity knew or ought to have known that a person of normal fortitude might suffer a recognised psychiatric illness if reasonable care were not taken), that the duty of care had been breached by Lederer (by Ms Necovski's failure to direct him not to attend the scene of the accident), and that Mr Hodson's exposure to the accident was causative of Mr Hodson's psychiatric conditions.

The primary judge apportioned liability as between Lederer and Hurex in the ratio of 85% to Lederer and 15% to Hurex; and was satisfied that a finding of contributory negligence should be made (assessed at 10%). His Honour assessed damages accordingly (and there is no challenge to the assessment of damages).

Lederer has appealed, and Hurex has cross-appealed, against the findings of liability made against it.

The Court held (Ward P, Leeming JA and Basten AJA agreeing), allowing both the appeal and cross-appeal with costs:

As to Lederer's appeal

(1) The primary judge erred in finding that Lederer owed Mr Hodson a duty of care.

As to s 32 of the Civil Liability Act, Ms Necovski, being the agent of Lederer, could not have foreseen that a person with normal fortitude might suffer a psychiatric injury if confronted with the scene of the accident (i.e., the presence of a body covered by a white sheet, emergency vehicles and a distressed colleague. At no stage could Mr Hodson see the body of the deceased, which was covered at all material times, nor was it clearly established that he could sense a "smell" emanating from the deceased. Nor was Ms Necovski aware of Mr Hodson having the kind of vulnerability identified by Gaudron J in *Tame v New South Wales*; *Annetts v Australian Stations Pty Ltd* (2002) 211 CLR 317; [2002] HCA 35. It was not open on the evidence to find that Mr Hodson had suffered a "sudden shock" in circumstances where he was advised in advance as to the nature of the incident and the distress of his colleague: [171]-[180] (Ward P); [280]-[281] (Leeming JA); [305]-[315] (Basten AJA).

(2) Though the risk of harm was correctly found to be not insignificant, Lederer

(through Ms Necovski) did not breach the duty of care owed to Mr Hodson in failing to direct him not to attend the scene of the accident. There was not a reasonable probability that the limited exposure of Mr Hodson to the scene would cause him to suffer psychological injury: [204]-[213] (Ward P); [283] (Leeming JA); [316]-[321] (Basten AJA).

(3) His Honour erred in finding that Mr Hodson's diagnosed PTSD and major depressive disorder were caused by his attendance at the scene of the accident. The expert evidence relied upon was based, among other things, upon the erroneous assumption that Mr Hodson had actually seen the deceased's injuries at the scene of the accident (and the unproven assumption that he had been repeatedly exposed to the scene). The weight that could be attributed to the experts' (and other medical) reports on the issue of causation was limited at best: [235]-[257] (Ward P); [284] (Leeming JA); [304] (Basten AJA).

Ramsay v Watson (1961) 108 CLR 642; Paric v John Holland Constructions Pty Ltd (1985) 62 ALR 85; [1985] HCA 58; Makita (Aust) Pty Ltd v Sprowles (2001) 52 NSWLR 705; [2001] NSWCA 305; Eric Preston Pty Ltd v Euroz Securities Ltd (2011) 274 ALR 705; [2011] FCAFC 11, considered.

Kubovic v HMS Management Pty Ltd [2015] NSWCA 315, considered and applied. As to Hurex

(4) It was not reasonably foreseeable by Hurex, which was not in control of the Centre and not responsible for giving day-to-day instructions to Mr Hodson, that a person in Mr Hodson's position might suffer psychiatric injury if not directed by Hurex not to attend a significant incident at work: [274]-[276] (Ward P); [281] (Leeming JA); [320] (Basten AJA).

(5) As to causation, the same conclusion followed in relation to the expert evidence as in the case of Lederer.

JUDGMENT

1. WARD P: On 26 October 2020, there was a fatal accident in an external loading dock at the Corrimal Shopping Centre (Centre) in New South Wales, when an elderly man walked in front of a large truck which had reversed into the loading dock area and then suddenly moved forward and ran over him. It is not disputed that the deceased suffered terrible injuries.
2. The Centre is owned and occupied by the appellant, Lederer Group Pty Ltd (Lederer), and has various retail shops and offices. The northern loading dock where the accident happened is used by Woolworths. The deceased was a regular customer at the Centre.
3. Lederer had engaged the second respondent, Hurex Pty Ltd (Hurex), to supply cleaning contractors for the Centre. The first respondent, Mr Hodson, was one of the cleaning contractors employed by Hurex, who worked at the Centre under the instruction or direction of Lederer. At the relevant time, Mr Hodson worked under the direction of Ms Sonja Necovski, a Lederer employee who was responsible for overseeing the Centre from an operational and business perspective, engaging cleaning contractors, supervising and directing their activities.

4. After the incident, Mr Hodson brought proceedings against both Hurex and Lederer, claiming damages for breach by each of a duty of care owed to him. Mr Hodson claimed that he suffered a major depressive disorder and post-traumatic stress disorder (PTSD) as a consequence of being exposed to the scene of the accident at a time when the body of the deceased was still there. I set out below in more detail the chronology of events and the discrepancies in Mr Hodson's accounts to various medical practitioners (and in his pleading) of his involvement in, or observation of, the events.
5. The primary judge found that Hurex, as Mr Hodson's employer, was liable for breach of the duty of care it owed to Mr Hodson, in essence in failing to direct him not to attend a "significant incident". Hurex challenges this finding on its cross-appeal.
6. As to Lederer, his Honour concluded that the general law duty of care owed by Lederer was not negated by s 32 of the Civil Liability Act 2002 (NSW) (Civil Liability Act) (which provides that there is no duty to avoid mental harm except if the relevant entity knew or ought to have known that a person of normal fortitude might suffer a recognised psychiatric illness if reasonable care were not taken); that the duty of care had been breached by Lederer; and that Mr Hodson's psychiatric disorders were caused or materially contributed to by that breach. Each of those findings is challenged by Lederer on this appeal.
7. Lederer has joined Hurex as the second respondent to its appeal on the basis that Hurex has an interest in resisting the orders sought by Lederer in its appeal.
8. His Honour apportioned the liability as between Lederer and Hurex in the ratio 85% and 15%, respectively. The primary judge awarded damages against Lederer in the sum of \$597,916 and against Hurex in the sum of \$472,793. There is no challenge by Lederer or Hurex to the apportionment finding nor to the quantum of the damages awarded by the primary judge.
9. For the reasons set out below, I am of the opinion that both the appeal and cross-appeal should be allowed with costs.

Background

1. Mr Hodson commenced employment with Hurex in about June 2020. His offer of employment from Hurex described his position (in the Schedule to the offer) simply as "Cleaner" and provided that he was to report to "Admin" (at the relevant time, as noted above, this was Lederer's administrative assistant, Ms Necovski).
2. Once employed by Hurex, Mr Hodson was allocated to be the afternoon shift cleaner at the Centre, but his duties extended beyond simply cleaning. The evidence was that Mr Hodson's work involved cleaning duties (including cleaning the bathrooms and outside areas of the Centre), locking and unlocking the Centre, and some security tasks (including removal of intoxicated persons from the Centre or deterring children from riding bikes and, in respect of any drug use in the toilets, contacting the police). Ms Necovski's evidence was that there

was no difference between the duties of a caretaker and a cleaner.

3. Ordinarily, Mr Hodson worked the afternoon shift at the Centre from 2pm to 9.30pm; and Mr Josh Brydon worked the morning shift from 6.30am to 2pm, although there were some occasions when Mr Hodson would work the morning shift.
4. Hurex had no control over the day-to-day operations of the Centre or Mr Hodson's activities at work. Representatives of Hurex attended the Centre for routine visits and inspections to review work performance and to review any significant issues notified to it arising from the employment. In particular, the evidence disclosed that Stephen Jung, the director of Hurex, visited the Centre periodically (once every four weeks) to check on the system of work and undertake general inspections of the levels of cleaning, staff presentation and work performance and would review any significant incidents or events which had occurred since the previous visit, and identify issues for management, or areas of improvement, to be worked through. Mr Jung would correspond with Ms Necovski and possibly other staff about the timing, frequency and issues identified for management or improvement. Mr Hodson could contact Mr Jung directly if he needed.
5. Hurex had an on-site cleaning supervisor (Ms Margaret Bullen), to whom Mr Hodson initially reported and who would give him instructions on a daily basis. Prior to the incident on 26 October 2020, Ms Bullen had left Hurex and Mr Josh Brydon took over her duties. It was not disputed that Mr Hodson was under the day-to-day control of Lederer in the performance of his duties. Ms Necovski provided instructions to Mr Hodson on tasks to be performed by him. In particular, Ms Necovski said she required Mr Hodson to undertake cleaning of the bathrooms, to oversee the carparks, to sweep the floors and to make sure the bins were emptied.
6. Hurex had in place policies for employee conduct and behaviour, and incident and grievance reporting processes. There was no evidence that Mr Hodson had raised with Hurex any incident, grievance or specific concern about the duties he had to perform at the Centre. Hurex did not have any specific policies regarding the witnessing of traumatic incidents involving third parties while on duty, and considered the events as they unfolded occurred outside the normal scope of contracted duties.
7. Lederer had provided no specific instruction to Mr Hodson on handling confronting or tragic events.

Chronology of Events

1. The precise chronology events of the events that unfolded on 26 October 2020 (much of which can be determined by reference to the CCTV footage in critical respects, which I have reviewed) is important to note.
2. Mr Brydon was performing his work at the Centre doing the morning shift, when at 10:13:17 am, the fatal accident occurred.

3. Mr Brydon arrived at the scene at 10:22:56am (after having been alerted by a member of the public). Mr Brydon was the first Centre employee on the scene. At that time, the deceased's body was uncovered.
4. Ms Necovski arrived at 10:26:54am, just after the first ambulance had arrived. By 10:27:40am, paramedics had placed a white sheet over the deceased's body. By 10.33am, a tarpaulin had been erected by the fire brigade to shield members of the public in the public car park from the scene. There is no doubt that the body of the deceased was covered by the time Mr Hodson arrived in the northern loading dock area (a fact that assumes no little significance in light of the accounts he gave to various medical practitioners or recorded by them that he had seen the uncovered body of the deceased at the scene).
5. From the time of her arrival, Ms Necovski stayed at or close to the scene of the accident. Ms Necovski made a number of telephone calls while at the scene. Initially, Ms Necovski contacted Lederer's head office. At some point shortly after Ms Necovski arrived, she made a telephone call to Mr Hodson to tell him that there had been a fatality and to ask him to come down to the Centre (earlier than his scheduled start time of 2pm) (see primary judgment at [22]). Ms Necovski told him that Mr Brydon was distraught and in no state to continue working. Ms Necovski asked Mr Hodson to come to the Centre "to take over operationally from Josh in the cleaning aspect of the Centre". Thus, as emphasised by Lederer, before Mr Hodson attended the northern dock (the scene of the accident) he knew both that there had been a fatality and that Mr Brydon was distraught and in no state to continue working. (This is relevant to whether Mr Hodson had suffered a "sudden shock", see s 32(2)(b) of the Civil Liability Act.)
6. Mr Hodson attended the Centre shortly after Ms Necovski's call. Mr Hodson first went to the office area, which was vacant, and then attended the cleaning room in the Centre and got his keys and radio (primary judgment at [22]). Mr Hodson called for Mr Brydon but there was no answer. Mr Hodson then had a radio conversation with Ms Necovski and asked where she was. Ms Necovski told Mr Hodson that she was at the northern dock and Mr Hodson walked there. There is no evidence that Mr Necovski directed Mr Hodson to attend the scene but Lederer accepts it may reasonably be inferred that when he asked her where she was he was likely to do so (see AT 24.3).
7. When Mr Hodson attended the northern dock, he was met by Ms Necovski and she told him what had happened. The primary judge found that Ms Necovski "directed" Mr Hodson to Mr Brydon and that Mr Hodson immediately walked to Mr Brydon and attempted to console him. Pausing here, the CCTV footage clearly shows that Ms Necovski pointed in the direction of Mr Brydon and that Mr Hodson then went over to him. However, the evidence from both Ms Necovski and Mr Hodson is that Ms Necovski pointed to Mr Brydon in response to a question from Mr Hodson as to where Mr Brydon was (rather than directing him, as such, to go over to Mr Brydon). While there is no challenge to the finding that Ms Necovski "directed" Mr Hodson to Mr Brydon, there is therefore some dispute as to what was meant by this.

8. Mr Hodson walked Mr Brydon away from the scene. In so doing, he was summoned by a police officer and they walked over to him (at which time the truck and covered body of the deceased was in his line of sight).
9. Mr Hodson continued at work for the day, remaining at the Centre until about 10pm that night, effectively working a double shift that day ([26]). There was a factual dispute as to whether Ms Necovski directed him to return to the scene of the accident during the day (the primary judge found that he did not ([94])) and there was no finding that Mr Hodson actually returned to the scene that afternoon. The deceased's body was removed at about 3pm.
10. A few days after the incident, Mr Hodson saw CCTV footage of the incident. This is recorded in the clinical notes of Mr Rodney Ward, a clinical psychologist to whom Mr Hodson was referred (see below). Mr Ward notes that about five days later Mr Hodson realised (from gossip in the Centre) who the deceased was.

Medical evidence

1. At this stage it is convenient to set out some of the medical evidence.

Dr Saroha

1. The day after the accident (27 October 2020), Mr Hodson had a consultation with Dr Harender Saroha, a general practitioner whom he had been seeing for anxiety and depression since August 2019 (Exhibit J). Dr Saroha recorded the following:

distressed

witnessed an accident yesterday

in the car park

a old men [sic] getting crushed by a truck ...

1. Dr Saroha recorded that Mr Hodson was "tearful", "low", had "poor sleep" and was "anxious ++ +". Dr Saroha prescribed a low dose of diazepam. Further surgery consultations in November 2020 recorded that he remained stressed, was anxious about his work and family; as at 19 November 2020 he had returned to work and he was less anxious, but subsequent entries recorded that he was working long hours, was anxious and stressed, and was having "flashbacks".
2. Dr Saroha's notes indicate that in May 2021 Mr Hodson was referred to a consultant psychiatrist, Dr Narinder Panesar; the referral notes (and letter of referral) record that "[h]e has been extremely distressed and had witness [sic] a fatal accident at work, and since then has been troubled by Flashback[s], which have been impacting his ability to work".
3. Pausing here, Dr Saroha's notes indicate that Mr Hodson gave a history that he had witnessed the fatal accident, which implies that he had actually seen the deceased being crushed by the truck. Ordinarily, one would not "witness" something happening simply by

seeing the aftermath of the event, though I accept that this assumes a level of accuracy in the clinical notes. Suffice it to note that the history does not record that Mr Hodson arrived at the scene after the accident had happened and the deceased's body was already covered, as was the case.

4. Dr Saroha also issued a medical certificate for workers compensation purposes diagnosing anxiety and depression, certifying that Mr Hodson had no capacity for any employment until further reviewed (see primary judgment at [102]-[103]).

Dr Panesar

1. Dr Panesar saw Mr Hodson on 11 June 2021. Dr Panesar's report stated that Mr Hodson presented with PTSD with secondary depression; and that Mr Hodson reported "severe PTSD symptoms including reliving his recent trauma in flashbacks and nightmares ...". Dr Panesar recorded that:

Mr Hodson's trauma is related to having involvement in an incident at work in November 2020 [sic]. While he was at work at the supermarket, he was called out to the dock area where an elderly person was crushed under a truck's front wheels. He saw the crushed deceased body parts. ... Mr Hodson told me that he used to see the deceased person regularly when he would go shopping at the supermarket

1. After referring to Mr Hodson having experienced severe anxiety and panic attacks, Dr Panesar noted that "[h]e can smell the victim's body, see his blood in his flashbacks".
2. I interpose to note that the history here recorded is one where Mr Hodson "saw" the crushed body parts (something that Mr Hodson cannot have seen at the scene of the accident and could only have seen on the CCTV footage that he watched a few days after the incident; and in any event, the detail which may be gleaned from a viewing of the CCTV is limited). Nor could the blood seen in the "flashbacks" have been attributable to any actual sight of blood at the scene. I refer in due course to Mr Hodson's account of smelling the victim's body.

Dr Saroha's further report

1. On 17 September 2021, Dr Saroha sent a report to the Centre Health Medical Centre Woonona, again noting that Mr Hodson "was witness to an [sic] fatal accident at work place on 26/10/2020" and stating that since the accident Mr Hodson has had anxiety and depression "with flash backs". Dr Saroha had difficulty commenting on a tentative date of a return to work.

Mr Ward

1. Dr Saroha referred Mr Hodson to a clinical psychologist, Mr Rodney Ward, "for an assessment and management of his psychological state under workers compensation". Mr Ward saw Mr Hodson on 11 July 2021. Mr Ward noted that Mr Hodson "reported the presenting problem" as follows (apparently quoting Mr Hodson's words):

diagnosed with PTSD and depression / anxiety (Dr Panasar Psychiatrist), working at Corrimal Shopping Centre and elderly gentleman squashed at the back of loading dock, it was a horrible image and smell, constantly getting triggered now to the event and avoiding places and things related to the incident, I feel [I've] changed since that event.

1. Mr Ward stated his belief that Mr Hodson was showing the signs and symptoms of PTSD (DSM-5). The handwritten assessment notes of Mr Ward record that:

... working Corrimal Shopping Centre, gentleman squashed back doc [sic]

got called in (Centre Mgt called me in). I arrived colleague standing there crying – looked over. gentleman hit by semi-trailer – regular customer in 60's

10am in ... (mess, skull popped) smell (horrible image)

...

Sick @ smell

... truck wheels

Truck backing beeping

1. In evidence were Mr Ward's clinical notes, which included notes of a consultation on 25 January 2022 including:

Sonia called me distressed, fatality at centre, can you come in

rushed down, got there quick, parked one end shopping centre went into shopping centre, grabbed radio, called other radio, said at Woolworths Dock, approx. 10am, taken off up there, turned past subway, could hear police sirens, Ambo just pulling in, saw Sonia, pointed to Josh, offsider

everyone emotional, frantic, got to Josh, asked what going on, he pointed, that's when I seen it

I still don't understand what I seen, arm, leg/torso, bruised in between drive wheels (contorted) ... 'Fuck' felt sick & confused – Josh had tears rolling down his eyes, I tried to protect him

got Josh into office ...

I can smell it, meat/shit

Sonia told me to block of [sic] entry way, grabbed tape, blocked entry off

...

couple of days later, I was in office, manager Tony Warren, Centre Manager had video played I saw live what happened added more distressing photos of what happened

about 5 days later, gossip in the centre, realised a few days later who it was – most distressing part, seeing the truck go up, like hit bump ...

recalling it (felt sick)

Flashback ...

1. In Mr Ward's notes of the consultation on 1 February 2022, it is recorded that:

...

Sonia pointed at Josh, walked over to Josh, sobbing & crying, pointed to truck

can't describe what I saw, mass of body twisted up between wheels, parts not where they should be

Could see police tying up tarp ...

Incident couple days later, walked in on Tony Warren, saw trick on this computer screen. Asked who was it. I'll show you, truck backed back – 10 scd's, saw truck bump up, walked back into my office burst into tears & felt like I was going to throw up. ...

1. In Mr Ward's notes of a consultation on 9 February 2022 there is again an account of "glance over – I can't explain it, lump/mess, torso (distorted) squashed".
2. In a report dated 2 November 2022 to Mr Steve Throsby of Resilia, Mr Ward repeated his belief that Mr Hodson was showing the signs and symptoms of PTSD (in the same terms as set out in his 14 October 2022 letter).
3. Again, aspects of the history recorded by Mr Ward described things that Mr Hodson could not have seen at the scene (particularly the graphic description of the deceased's body parts). Nor is it apparent from the CCTV footage that Mr Hodson could have seen or heard the "truck backing beeping" at the scene; since the truck appears stationary on the CCTV footage at all times that Mr Hodson is there.

Dr Bertucen

1. Meanwhile, in May 2022, the solicitors for Mr Hodson had referred Mr Hodson to Dr Jeff Bertucen for the purposes of an independent medico-legal examination. Dr Bertucen saw Mr Hodson on 10 May 2022 by video consultation. In his report dated 18 May 2022, Dr Bertucen included the following in his account of the history of the incident:

Mr Hodson walked to Josh and asked what was going on and Josh pointed saying "He's f**king dead". Mr Hodson then looked towards a parked semi trailer and saw a deceased elderly gentleman about 4 metres away. Mr Hodson initially approached with the intention of possibly performing CPR; however, as he approached, he was suddenly horrified by the man's fatal injuries. In his personal statement [not in evidence] Mr Hodson stated that he visualized the dead man at close quarters and that "half of his face was squashed and I could see brain matter and other horrific injuries" ...

1. Dr Bertucen goes on to record that about an hour later "Sonya" allegedly told him to "see if anything... needs to be cleaned up when they move the truck", by which Mr Hodson took to mean that he was being tasked to clean up any human remains; and that by the time Mr Hodson went back to the dock the truck had gone and the fire and rescue were hosing off the car park.
2. I note that much of the history extracted above is simply impossible to have occurred. By the time Mr Hodson arrived at the scene the body of the deceased was already covered. The CCTV footage does not show Mr Brydon pointing towards the deceased and nor does Mr Hodson approach the covered body (the suggestion that he had an intention to perform CPR is inherently implausible when the body was already covered by the white sheet). And, as already noted, Mr Hodson cannot possibly have seen (when he was at the scene) the horrific injuries there described.
3. Dr Bertucen noted in his report that the history and assumptions on which his opinions were based were in the section of the report marked "History of Incident" and that the assumptions were drawn from the oral history provided by Mr Hodson, supplementary GP notes, as well as correspondence of Mr Hodson's treating professionals including Dr Panesar, Mr Ward and Dr Saroha.
4. Dr Bertucen diagnosed Mr Hodson as suffering from a chronic PTSD and comorbid major depressive disorder. Dr Bertucen said that there appeared to be sufficient evidence to suggest that Mr Hodson was suffering from a pre-existing major depressive disorder, although in partial remission at the time of the incident. Dr Bertucen referred to a report by a medico-legal psychiatrist, Dr Judith Clarke, which was dated 27 January 2022 (only a page of which was in evidence which referred to pre-existing and underlying depressive symptomatology). Dr Bertucen partially agreed with Dr Clarke that Mr Hodson's pre-existing and fluctuating major depressive symptoms led to a vulnerability to mental illness but went on to say that:

... however, I would argue that if Mr Hodson's account of the subject incident is correct, exposure to a disfigured deceased accident victim would be likely to induce post-traumatic stress disorder in any individual of normal fortitude, even one that did not have a pre-existing psychiatric condition.

1. The problem with that contention is that Mr Hodson did not in fact have exposure to a disfigured deceased accident victim (at least not at the scene of the accident). I would add that there is no indication on the CCTV footage that Mr Hodson approached the deceased's body (as opposed to approaching Mr Brydon, with whom he stayed) and the suggestion that Mr Hodson had an intention to perform CPR is implausible.

Dr Malik

1. In August 2022, the solicitors acting in relation to Mr Hodson's workers compensation claim retained Dr Nabil Malik as an independent expert to provide a medico-legal report, noting that Mr Hodson had alleged he suffered a psychological injury after seeing a fatal accident at work. Dr Malik, a psychiatrist, was provided with a copy of Dr Bertucen's report and various other documents.
2. Dr Malik assessed Mr Hodson via a telehealth consultation. Dr Malik recorded that Mr Hodson told him that "he was exposed to [the deceased's] fatal injuries; he tells me his face was squashed and his brain matter was exposed" and that "everyone was emotional at the time and some of the details of the incident is blurred". Mr Malik records that Mr Hodson also told him that after an hour or so, once legal matters were sorted, he was asked to clean the human remains at the incident site and that when he went back to the site it was being cleaned and hosed down by the fire and rescue department.
3. Mr Malik did not believe that there were any signs of exaggeration, inconsistent responses to examination or testing or malingering.
4. Dr Malik's opinion was that, on the balance of probabilities, the history provided and Mr Hodson's mental state examination fulfilled the DSM-5 diagnostic criteria for PTSD and major depressive disorder; and that these were predominantly caused by the work-related incident, noting that he was exposed to a traumatic event.

Dr Allnut

1. In July 2023, Mr Hodson's solicitors qualified Dr Stephen Allnut as an expert psychiatrist to provide a full medico-legal report, requesting that he make a number of assumptions including (at [18]) that Mr Hodson "observed a deceased elderly man who had been run over by a truck" and (at [19]) that the deceased "suffered horrific injuries which were observed by Mr Hodson". The letter stated that photographs of the scene were available but warned that they "contain graphic images".
2. Dr Allnut was provided with various documents including the pleading and particulars, the statement of Mr Hodson (not in evidence) and various medical and clinical notes and reports.

3. Dr Allnut's report, dated 6 September 2023, following a clinical evaluation through audio visual connection on 28 August 2023, included a report of Mr Hodson's account to him of the day of the incident (which did not include a reference to seeing the deceased body) but also noted that Dr Allnut had reviewed the solicitors' letter of retention (which did include such a reference as noted above).
4. Dr Allnut recorded that when he asked Mr Hodson about what he saw, Mr Hodson said "I can see the area of the truck, I can't see the pictures", at which point he broke down crying. Dr Allnut also recorded Mr Hodson's account that Ms Necovski had asked him to go back and check if the body was still there (and he saw that the police were still there) and that, about one hour later, Mr Hodson was directed to go back to the scene to make sure there was "no mess on the ground", and when he got there firemen were there; that he could not recall what he saw but said that he saw "stuff on the ground" and he did not know what it was.
5. Dr Allnut then reviewed the various medical and clinical documents and reports with which he had been provided, including a psychiatric report dated 27 January 2022 from Dr Clarke (not in evidence) which had concluded that Mr Hodson presented with symptoms consistent with a DSM-5 diagnosis of PTSD in partial remission and an adjustment disorder with anxiety and depression at the time of the trauma exposure. Relevantly, Dr Allnut noted that Dr Clarke thought the history was notably different from the provided documents "which had resulted in some uncertainty most notably about whether he met Criterion A of the condition due to conflicting accounts of what he had witnessed". Dr Allnut noted from Dr Clarke's report that Mr Hodson "noted that he sighted the bodily fluids during this event but there was conflicting evidence about this"; and that Dr Clarke thought that his social situation and pre-existing condition were the predominant cause of the PTSD and that he had experienced a traumatic aggravation of an adjustment disorder but that he appeared to have been partially recovered from that aggravation and it would remit within 6-8 weeks.
6. Dr Allnut explained that generally symptoms of anxiety, depression and PTSD can overlap making diagnostic categorisation difficult. He concluded that Mr Hodson was suffering a major depressive episode and a trauma related condition (noting that trauma related conditions include chronic PTSD disorders and chronic adjustment disorders which can lie on a spectrum). He explained that a chronic adjustment disorder was generally diagnosed when a person does not meet the full criteria for a diagnosis of chronic PTSD and/or when a person does not meet Criterion A in the DSM-4/5 diagnosis of chronic adjustment disorder. Dr Allnut expressly noted that there was some issue as to whether Mr Hodson met Criterion A and noted that there was some issue put forward by (unidentified) others that Mr Hodson's account was unclear.
7. Dr Allnut, acknowledging that "factual determinations are a matter for the adjudicator", said that:

Based on his account – that he learnt of a traumatic event that involved a colleague, he does not particularly recall seeing the damage caused to the deceased, but he was at the site, but he knew what happened and his poor recollection can be seen in the context of trauma and stressor related condition can be attributed to an inability to remember important aspects of the traumatic event which is in and of itself a symptom of post-traumatic stress disorder (post traumatic amnesia). In my view, given that he was involved an [sic] exposed to an actual death, that he witnessed the circumstances of that death, that he learnt of the traumatic events, that he was repeatedly exposed to the event by having to go up on two occasions, there are reasonable grounds to argue that on balance, he meets criteria for Criterion A for post-traumatic stress disorder as defined in DSM5 and on this basis I would diagnose him with a chronic post-traumatic stress disorder. The differential diagnosis could include an adjustment disorder with a depressed and anxious mood however, I would add that if Criterion A is rejected, he manifests a full quotient of symptoms found in people with chronic post-traumatic stress disorder.

1. Pausing here, by this stage it appears that the account by Mr Hodson was not that he had actually seen the horrific injuries (inconsistent with the assumptions that Dr Allnut was instructed to make) but that he could not recall all the details (hence the reference by Dr Allnut to an inability to remember important aspects of the traumatic incident). Dr Allnut is clearly aware that there is a factual issue as to what in fact Mr Hodson observed at the scene. I would simply add that, in the present case, what in fact seems to have occurred was not so much an inability to recall details of the incident at a later stage but, rather, a professed recollection at an earlier stage of things that Mr Hodson simply could not have seen at the time. It is by no means clear to me that this would fall within a diagnosis of post-traumatic amnesia (and this was not an issue tested at the hearing, not least because Dr Allnut was not cross-examined). Further, insofar as Dr Allnut's conclusion as to PTSD was predicated in part on Mr Hodson repeatedly being exposed to the events, the evidence does not establish that this was the case. As already noted, the primary judge rejected the assertion that Mr Hodson had been directed back to the scene by Ms Necovski after he had escorted Mr Brydon from the scene.
2. Dr Allnut, under the heading "Causation", referred to Mr Hodson's previous history of depressive episodes and said that in the context of his history he would be diagnosed with a recurrent depressive disorder. Dr Allnut said that a differential diagnosis would be an adjustment disorder or a trauma and stressor related disorder at that time.
3. Dr Allnut also said that the index injury was in his view significant and that information "suggests" a deterioration that was proximal and triggered by the index injury. Given that the symptoms Mr Hodson experienced were specific to the index injury (such as nightmares specifically related to it, avoidance of shopping centres, unusual smells and intrusive memories of the index injury), which would suggest that it had triggered a chronic PTSD, and that there was no evidence of a pre-existing diagnosis of a trauma and stressor related disorder "although there is evidence of a mood disorder pre-existing", Dr Allnut concluded that he "would regard the index injury as making a substantial and material contribution to

[Mr Hodson's] chronic [PTSD] and a substantial material contribution to triggering a recurrence of his pre-existing recurrent depressive disorder" .

Dr Malik's updated report

1. In August 2023, Dr Malik was requested to provide an updated report, which he did. There does not appear to be anything of significance in the updated report. I note that it does not appear that Dr Malik was provided at this stage with Dr Allnut's report (I say this without any criticism of the solicitors requesting the report as it may be that they had not yet been served with Dr Allnut's report). Dr Malik was provided with a vocational assessment report dated 25 March 2022 from Resilia, which recorded a history of injury obtained from Dr Clarke's medical report (and which included the statement that Mr Hodson had "looked over and saw the body of the deceased, which had not yet been covered" and that this made him sick in the stomach). Again, that history is demonstrably incorrect.

Dr Christmas

1. After a move by Mr Hodson to Temora, Mr Hodson commenced seeing another general practitioner, Dr Rachel Christmas. By letter dated 14 September 2023, Mr Hodson's solicitors sent a letter of instruction to Dr Christmas requesting a report from her (and clearly intending to qualify her as an expert witness, since they referred to the Expert Witness Code of Conduct). The letter requested that Dr Christmas take into consideration the matters which were set out at paragraphs 1-27 of the letter and that Dr Christmas take those assumptions (and the documents referred to) into account in providing her report. The documents with which Dr Christmas was provided were the Statement of Claim, a statement dated 29 April 2022 of Mr Hodson (which was not in evidence) and Dr Allnut's report dated 6 September 2023.
2. The instructions that Dr Christmas was requested to take into consideration included those contained at [18] and [19] of the earlier letter to Dr Allnut. They also stated that Mr Hodson had been diagnosed with PTSD with secondary depression (that being in substance the very subject of the opinion that Dr Christmas was being asked to give, i.e., whether in her opinion Mr Hodson currently suffered from a psychological or psychiatric condition pursuant to DSM-5 as a result of the events on 26 October 2020).
3. Dr Christmas provided her report dated 5 October 2023, noting that her first appointment with Mr Hodson was on 5 July 2023, the intent being the completion of a workcover certificate for ongoing workcover purposes and at that time she ascertained that he was suffering from flashbacks, significant anxiety and psychological distress "which he related to a work related incident". Dr Christmas expressed her opinion that Mr Hodson suffers from PTSD "directly as a result of the incident at work in 2020".

Mr Hu

1. On 19 January 2024, Mr Hodson's solicitors requested that a psychologist who had previously treated Mr Hodson (Mr Candour Hu) provide a report. In the letter of instruction, the solicitors again included statements at [18] and [19] that appear in letters of instruction to other medical practitioners. The letter recorded that "[i]n September 2022 it was accepted that Mr Hodson suffers from 17% whole person impairment".
2. Mr Hu's report dated 15 January 2024 acknowledges that it is unclear what level of exposure Mr Hodson had to the accident site and the deceased on the day of the incident; and Mr Hu says that Mr Hodson cannot remember specific details of the scene "which can be interpreted as dissociative amnesia relative to the incident". Mr Hu records that Mr Hodson was asked by senior management to "clean up" the mess (a fact which is not established on the evidence) and says that, given that Mr Hodson was physically present "in the management of the incident", Mr Hu considered that he met the extreme exposure to aversive details for Criterion A.
3. After considering matters relevant to Mr Hodson's ability to work and level of current functioning, Mr Hu concludes that "[a]ssuming that Mr Hodson does have a PTSD diagnosis, the subsequent symptoms appear to be a direct consequence of the incident on the 26 October 2020".

Joint report

1. Finally, Drs Malik and Allnut participated in an expert conclave on 13 February 2024 and the transcript of that conclave comprised their joint report. The briefing materials provided to both of those doctors for the purposes of a conclave and the preparation of the joint report were not in evidence.
2. In the joint report, the psychiatrists agreed on a diagnosis of major depressive disorder and chronic PTSD. They also agreed that Mr Hodson had a pre-existing diagnosable psychiatric condition in that he had a recurrent depressive disorder with associated anxiety, which they noted was being treated. They considered that by the time of the index injury, while he might have had residual symptoms, Mr Hodson appeared to be functioning adequately with limited relatively insignificant symptoms and no mental impairment.
3. The doctors agreed that "the index injury was significant" and it met the DSM-5 Criterion A, triggering the onset of initially an acute PTSD, developing into a chronic PTSD and a recurrence of a major depressive episode and anxiety. They agreed that the "index injury" made a substantial contribution to Mr Hodson's current mental state.

4. Both psychiatrists thought at the time of their reviews that Mr Hodson had ongoing significant psychological symptoms causing distress and impairment and said that these psychological symptoms were a direct result of the incident at work. They said that Mr Hodson's repressive symptoms could be seen as a retriggering of his pre-existing current depressive disorder and in that sense an aggravation.

Pleaded case

1. Mr Hodson's pleaded case (see amended statement of claim) was that there was a fatal motor vehicle incident which resulted in him sustaining a psychiatric injury (at [9]). That allegation was then particularised by reference to 27 matters, including that:
 - (d) The victim's injuries were significant with his skull being detached and his brain clearly visible, and his arms and legs also degloved;
 - ...
 - (h) Sonja Necovski directed the Plaintiff to attend the Centre immediately as there had been a fatality that had occurred at the Centre;
 - (i) Within approximately 10 minutes, the Plaintiff urgently attended the Centre without having knowledge of the details of what had occurred at the Centre that morning;
 - ...
 - (k) The Plaintiff arrived at the scene of the incident at around the same time as the Police and Ambulance;
 - (l) When the Plaintiff arrived at the northern entrance, Ms Necovski directed him to his Supervisor, Joshua Brydon (who was employed by the first Defendant [Hurex]), who was standing in the back dock area, in close vicinity to the victim;
 - (m) The Plaintiff walked over to Mr Brydon and observed that he was visibly upset. Mr Brydon directed the Plaintiff's attention by pointing towards the victim's body lying on the ground;
 - (n) The Plaintiff looked towards the deceased's body and saw the victim's injuries which included his face being squashed and his brain matter visible;
 - (o) The Plaintiff instantly felt frightened, nervous and as if he was going to vomit;
 - (p) Due to how upset Joshua Brydon was, the Plaintiff took him to an office within the shopping centre, telephoned his partner and requested her to come in to get him, while he tried to settle him down;
 - ...
 - (r) Approximately an hour later, Sonja Necovski directed the Plaintiff to go back outside to update her on the status of the scene;

- (s) The Plaintiff revisited the scene and saw that the ambulance had gone;
- (t) Sonja Necovski then said to the Plaintiff words to the effect of "when they move the truck, see if there is anything that needs to be cleaned up";
- (u) The Plaintiff took that to mean he would have to clean up any human remains left as a result of the fatality;
- (v) The Plaintiff revisited the scene again and saw that the semi-trailer had left the scene and that there were firemen hosing off the car park where the accident had occurred and assumed that they were hosing off the bodily remains;
- (w) The Plaintiff returned to the office and informed Sonja Necovski that the truck had gone and that the firemen had cleaned up;
- (x) Sonja Necovski then directed the Plaintiff to return to the scene and take the Police tape down so that the dock could be used;
- (y) The Plaintiff went back to the scene again but the Police informed him he could not take the tape down;

...

(aa) The Plaintiff was then required to continue with his normal cleaning duties and so cleaned the Centre and did his other duties until approximately 10:00pm that night.

1. Pausing here, a number of those particulars were not made good: as to (d), while the horrific injuries there described had been sustained by the deceased, it is clear that Mr Hodson did not observe this at the scene; as to (i), Mr Hodson knew before he attended the Centre at least that there had been a fatality and on Ms Necovski's account (as his Honour found) that Mr Brydon was distressed; as to (k), Mr Hodson arrived at the scene after at least one ambulance was there; as to (l), as noted above, there is some doubt as to what is meant by the finding that Ms Necovski "directed" Mr Hodson to Mr Brydon (as opposed to pointing out where he was in response to a question to that effect); as to (n) this is patently incorrect by reference to the CCTV footage; as to (v)-(y), his Honour did not find that Ms Necovski directed Mr Hodson back to the scene at any point after he had taken Mr Brydon away from the scene.
2. Having alleged (at [5]) that at all material times both defendants owed him a duty of care and were obliged to provide adequate supervision of his work which he carried out at the Centre; that Hurex owed a non-delegable duty of care to ensure that he was not exposed to unnecessary risk of injury ([6]); and that both defendants were under a duty of care not to expose him to unnecessary risk of injury ([7]), the pleading made the following allegations.
3. At [16A], it was alleged that there was, following on from the "traumatic incident", a risk of psychological injury to persons including Mr Hodson in the event that such persons were exposed to the "aftermath of the traumatic incident".

4. The duty of care was then pleaded from [17].
5. At [17], it was alleged that Hurex, as the employer who directly controlled the activities and duties of Mr Hodson in the workplace, was under a duty of care to exercise proper care and skill to protect the safety of all its employees from risk of personal injury.
6. At [18], it was alleged that Lederer, as the owner and occupier of the Centre and the company directing and controlling the activities of Hurex, was under a duty of care to exercise proper care and skill to protect the safety of all workers in the Centre from "risk or personal injury". It was there noted that Lederer was the employer of Ms Necovski who gave Mr Hodson the "various directions as noted above".
7. At [19], it was alleged that, due to his exposure to the traumatic incident Mr Hodson was at a foreseeable risk of harm of developing a psychological injury and entrenching and/or worsening any psychological injury, pre-existing condition.
8. At [20] it was alleged that at all material times the defendants (i.e., both Hurex and Lederer):
 - (a) owed the Plaintiff a non-delegable duty of care to take reasonable precautions (and to ensure that reasonable precautions were taken) against risks;
 - (b) were vicariously liable for the acts and/or omissions of its employees, officers, contractors and/or agents within the scope of, and during the course of, their employment; and
 - (c) had a duty to:
 - (i) take all reasonable precautions to protect the Plaintiff from being exposed to traumatic incidents;
 - (ii) not place the Plaintiff in a position of significant risk of psychiatric injury from being exposed to traumatic incidents; and
 - (iii) not expose the Plaintiff to a risk of damage or injury of which the Defendant knew or ought to have known.
1. At [21], it was alleged that the injury was caused or significantly contributed to by the negligence and breach of duty of care by the defendants "its servants or agents"; at [22], that the risk of harm was foreseeable, not insignificant and such that a reasonable person would have taken steps to avoid or minimise the risk of harm; that the risk was within the actual knowledge of the defendants and that the risk of harm was not insignificant (referring to the gruesome nature of the victim's injuries); and that "exposing the Plaintiff to the traumatic incident was far beyond the scope of his ordinary duties and expertise in the scope of his employment".
2. At [23], it was alleged that reasonable precautions available to the defendants were "ensuring the Plaintiff was not unnecessarily exposed to the traumatic incident involving a fatality as they did".

3. Under the heading "Particulars of Negligence" it was alleged (at [24]) that:

The Defendants breached the duty of care owed to the Plaintiff by:

- (a) failing to take reasonable precautions to protect the Plaintiff from being exposed to traumatic incidents in the workplace.
- (b) requiring the Plaintiff to attend the shopping centre when they knew, or ought to have known of the horrific scene that he would observe.
- (c) having required the plaintiff to attend the shopping centre, failing to direct him to avoid the loading dock and its surrounds.
- (d) directing him towards the scene of the traumatic incident.
- (e) failure to undertake an identification of the risks associated with the scene of the traumatic incident.
- (f) failing to recognise that exposing the Plaintiff to the traumatic incident put him in significant risk of harm.
- (g) failing to implement a system of work where risks of psychiatric injury in the workplace are identified and avoided.
- (h) failing to properly warn the Plaintiff of the potential of him sustaining a psychiatric injury from the traumatic incident.
- (i) failing to identify the Plaintiff was at risk of developing a psychiatric injury by exposing him to the traumatic incident.
- (j) exacerbating the Plaintiff's psychiatric injury by not providing him with adequate support following him being subject to the traumatic incident.

1. The pleading then went on (from [25]) to allege that the "Defendant" (not identifying which defendant) was in breach of statutory duties imposed under the Work Health and Safety Act 2011 (NSW) (ss 17, 19, 20) and Work Health and Safety Regulation 2011 (NSW) (cll 34-39), by its failure to take, prevent or provide any of the matters "pleaded above" (in context it would appear that this is a reference to the content of the statutory duty pleaded at [26]) ([27]).

2. Lederer denied liability but cross-claimed against Hurex seeking an indemnity or contribution pursuant to s 5(1) of the Law Reform (Miscellaneous Provisions) Act 1946 (NSW) (Law Reform (Miscellaneous Provisions) Act) if it were found to have liability to Mr Hodson. Hurex, in its defence at [18], indicated that further, and in the alternative, as a complete or partial defence to the claim it would cross-claim against Lederer seeking contribution or indemnity pursuant to s 5 of the Law Reform (Miscellaneous Provisions) Act and indemnity or contribution pursuant to s 151Z of the Workers Compensation Act 1987 (NSW). It does not appear that Hurex did file the foreshadowed cross-claim but nothing turns on this for present purposes.

Primary judgment

1. In the introduction to his Honour's reasons, his Honour noted (at [4]) that there was no issue that Hurex, as the employer, and Lederer as the host employer owed Mr Hodson a duty of care. His Honour identified the central issues as: whether Mr Hodson suffered a recognised psychiatric illness as a result of the exposure to the scene of the accident, the alleged breach by each of the defendants, and whether any alleged breach was causative of Mr Hodson's psychiatric injury. His Honour noted that the issues were in part complicated by Mr Hodson's pre-accident psychiatric history and the "alleged incorrect history relied upon by the medicolegal experts in reaching their opinions".
2. As will be seen, there is no doubt that some of the history relied upon by at least some of the medicolegal experts was incorrect; in particular, the assertion that Mr Hodson had been exposed at the scene of the accident to the deceased's uncovered body (and thus had seen his horrific injuries). That assertion is clearly falsified by the CCTV footage. Indeed, it would appear that the only occasion when Mr Hodson saw the deceased's uncovered body was when he walked into a colleague's office at the Centre some days later at a time when the colleague had the CCTV footage open on his computer and Mr Hodson then viewed the CCTV footage. Mr Hodson was not directed, or required, to view the CCTV footage as part of his work responsibilities and this was not pleaded as a particular of breach in any event.
3. At [81], his Honour found that, on several occasions prior to the day of the accident, Mr Hodson had failed to open the Centre on time at the commencement of his morning shift (as already noted, Mr Hodson ordinarily worked the afternoon shift but there had been some occasions when he worked in the mornings). His Honour found that on at least one of those occasions Mr Hodson explained his failure as attributable to personal issues. His Honour was satisfied that prior to 26 October 2020 Mr Hodson had shared with his colleagues, including Ms Necovski, that there were issues at home and that he "demonstrated as emotionally upset when doing so". (This is of relevance in light of his Honour's finding as to Lederer's knowledge of Mr Hodson's susceptibility to psychiatric injury – see below.)
4. His Honour noted at [83] that the substantial factual contest related to the events on the day of the accident including the nature and extent of directions issued by Ms Necovski to Mr Hodson.
5. At [84], his Honour referred to the difficulties that were apparent through the course of Mr Hodson's evidence in his recollection of some of the detail relating to the day in question, and noted the concession by his counsel in closing submissions that Mr Hodson demonstrated problems with his memory and was "plainly unreliable" in some respects. His Honour noted that there were occasions when Mr Hodson hesitated when giving evidence, in part due to his emotional state but also at times where he appeared unsure.
6. As to the course of events following the accident, his Honour found that: (at [86]), Mr Brydon arrived at the scene of the accident shortly after it occurred and that emergency vehicles arrived thereafter, and Ms Necovski at around the same time; (at [87]) Ms Necovski

telephoned Mr Hodson to attend the Centre and advised him that there had been a fatality at the Centre and that Mr Brydon was distressed and was in no state to complete his shift; (at [88]), Mr Hodson initially attended the Centre office and, finding no one present, retrieved his radio and keys and then called Ms Necovski, who advised him that she was at the northern dock.

7. His Honour also found (at [88]), that Mr Hodson immediately attended the northern dock where he was met by Ms Necovski "and advised as to what occurred". His Honour found that Ms Necovski "then directed the plaintiff to Mr Brydon" and that Mr Hodson immediately walked to Mr Brydon and attempted to console him. (Pausing here, as noted above, the evidence was that Ms Necovski pointed to Mr Brydon in response to a question from Mr Hodson as to where he was. It is in that sense, that the finding that Ms Necovski "directed" Mr Hodson to Mr Brydon must be understood.)
8. At [91], his Honour found that at the time of Mr Hodson's attendance at the northern dock there were several ambulances and a police vehicle there; and that the truck involved in the accident was still in situ as was the deceased, whose body had been covered with a white sheet or tarp. His Honour expressly found that, at the time Mr Hodson first consoled the distressed Mr Brydon, the truck was visible to Mr Hodson but the deceased's body was not (contrary, as I have noted, to the accounts apparently recorded as having been given by Mr Hodson after the event). His Honour found that, as Mr Hodson was walking Mr Brydon away from the scene of the accident he was summoned by a police officer, and walked in the direction of the police still in the company of Mr Brydon. His Honour noted that a brief conversation occurred. His Honour was satisfied that Mr Hodson's position at that stage was such that the truck and covered body of the deceased was within Mr Hodson's line of sight. All of this is apparent from the CCTV footage.
9. His Honour accepted Mr Hodson's evidence that he sensed a smell emanating from the victim (though, significantly, his Honour added the qualification "whether real or imagined", which suggests that his Honour did not accept that Mr Hodson actually smelt what he had described in his evidence and thought there was a possibility that he may simply have imagined it).
10. His Honour accepted Mr Hodson's evidence that while in the loading dock area with Mr Brydon he was confused, upset and felt sick; that Mr Hodson's stomach was "turning, shaking" and he was attempting to "keep it together" to be an effective support for Mr Brydon; and that for the balance of the day he felt numb, emotional and upset, necessitating his return to the office on several occasions where he sat alone and cried ([93]). His Honour noted that this evidence was largely unchallenged and that, when giving this evidence Mr Hodson was emotional and struggling to maintain his composure.
11. His Honour considered that Mr Hodson's demeanour in the witness box was consistent with him genuinely recalling the trauma of the day and his emotional/physical response to it.

12. Also of some significance having regard to the pleaded claim, his Honour accepted Ms Necovski's evidence that Mr Hodson was not directed by her to return to the scene of the accident for any reason and said that, to the extent that he did so, it was of his own initiative and absent any direction from her ([94]). (There was no finding that Mr Hodson had actually returned to the scene of the accident on subsequent occasions that day – yet one of the assumptions on which some of the medical evidence relied was that Mr Hodson had been repeatedly exposed to the scene of the accident.)
13. From [95], his Honour considered the medical evidence, which included clinical notes from a number of doctors (including reference to a history of Mr Hodson being the victim of sexual abuse by an uncle at the age of 12), as well as the reporting by Mr Hodson to Dr Saroha in August 2019 of anxiety and depression in the context of domestic violence allegations (from his in-laws) "necessitating a move from Canberra". His Honour noted that the clinical notes for the remainder of 2019 demonstrated fluctuating psychological symptoms requiring prescription medication.
14. His Honour noted the medical records of Mr Hodson's consultation the day after the accident, including that he was then prescribed with diazepam which had not previously been prescribed by the doctor. His Honour then records the referral of Mr Hodson to a psychiatrist (Dr Panesar) and a psychologist (Mr Rodney Ward), his consultations with Dr Christmas and treatment by a psychologist Mr Candour Hu; and his review by other doctors, including Dr Stephen Allnutt (the psychiatrist who reviewed him at the request of his solicitors in August 2023) and Dr Nabil Malik (the psychiatrist who reviewed him at the request of Hurex' solicitors in August 2022). As noted above, those psychiatrists participated in an expert conclave and produced a joint report dated 13 February 2024, agreeing on a diagnosis of major depressive disorder and chronic PTSD, and agreeing that Mr Hodson had a pre-existing diagnosable psychiatric condition (a recurrent depressive disorder with associated anxiety).
15. From [131], his Honour set out his findings as to Mr Hodson's psychiatric condition, noting at [131] that the thrust of Lederer's submission was that the opinions of each of the experts were premised on an incorrect history as to the extent of Mr Hodson's exposure to the aftermath of the accident and, more particularly, to the deceased's injuries; and that Mr Hodson had not provided a complete picture of his psychiatric history.
16. His Honour rejected Lederer's submission for four reasons, each of which is challenged by Lederer (see below): first, that the experts' opinions were likely to have been reached after considering a number of factors (of which the history provided by Mr Hodson of his experiences on the day and his psychiatric history were only two); second, that in the absence of evidence by the experts as to the weight given to the multiplicity of factors, the Court was unable to assess the relative weight given to such factors; third, that Mr Hodson was not challenged as to the symptoms he reported to the various medical experts, other than to suggest he had exaggerated the extent to which he suffered from some of those symptoms; and, fourth, the need to approach with caution the reliability of recorded

accounts to health professionals (see [132]-[136]).

17. Having considered the opinions of each of the experts, and having referred to evidence which his Honour considered supported the finding of PTSD arising from Mr Hodson's "exposure to the accident site" (note, not exposure to the deceased's injuries as such), his Honour concluded at [146] that he was satisfied on the balance of probabilities that Mr Hodson suffers from a recognised psychiatric illness in the form of PTSD and major depressive disorder "arising from the plaintiff's exposure to the scene of the accident, in accordance with the findings of fact as made".
18. In other words, having regard to the factual findings summarised above, his Honour's finding as to the psychiatric illness suffered was attributed to Mr Hodson's exposure, not to the uncovered body of the deceased, but only to his exposure to the sight of the covered body of the deceased, at a scene where emergency vehicles were present and his colleague was visibly distressed and in need of consolation; and in circumstances where he had sensed a smell (real or imagined) coming from the deceased's body.
19. His Honour next turned to consider the liability, first of Hurex and then of Lederer.
20. As to Hurex, his Honour was satisfied that Hurex owed Mr Hodson a personal non-delegable duty of care requiring it to take reasonable care to avoid a foreseeable risk of injury ([159]). His Honour did not accept Hurex's submission that the circumstances leading to the suffering of the psychiatric injury fell outside the ordinary course of his duties ([160]), noting that the evidence established that he was required to perform other duties such as maintenance and security work.
21. His Honour said that Hurex continued to exercise a degree of supervision and control over Mr Hodson's work ([161]). However, while his Honour was satisfied that the PTSD was caused by the negligence of Lederer, he said that this did not absolve Hurex for the harm suffered to Mr Hodson ([162]).
22. At [164], his Honour said that it was reasonably foreseeable that a person employed to perform cleaning and other duties at a shopping centre, including quasi-security type work, could be confronted with a significant incident; and, at [165], that it was reasonably foreseeable that a person such as Mr Hodson, by being exposed to such an incident, could suffer psychiatric injury. His Honour went on to say that:

165 ... Considering the magnitude of the risk of such an injury, and the probability of its occurrence, a reasonable response to such a risk would have been to direct that a person in the plaintiff's position not attend such an incident, thereby exposing him to the risk of a psychiatric injury. I am satisfied that Hurex breached its duty of care it owed to the plaintiff.

1. Applying the common sense test for causation, his Honour was satisfied that the failure of Hurex to give the direction referred to in [165] was a cause of Mr Hodson's psychiatric injury ([167]).

2. At [169], his Honour referred to a concession by Counsel for Hurex that Mr Hodson was exposed to a highly charged scene and that he should not have been exposed to such an event. At [172], having referred to the High Court decisions in *Tame v New South Wales*; *Annetts v Australian Stations Pty Limited* (2002) 211 CLR 317; [2002] HCA 35 (*Tame*), his Honour said that he was satisfied that it was reasonably foreseeable that a person of normal fortitude might suffer a recognised psychiatric illness if exposed to the aftermath of a fatal vehicle accident such as that to which Mr Hodson was exposed. At [173], his Honour concluded that liability had been established against Hurex.
3. As to Lederer, his Honour commenced by considering the operation of s 32 of the Civil Liability Act (extracted below), which provides that a person does not owe a duty of care to another to take care not to cause the other mental harm unless the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.
4. His Honour noted (at [175]) the reliance by Lederer on the observations of Basten JA at [54] in *Optus Administration Pty Ltd v Glen Wright* by his tutor James Stuart Wright [2017] NSWCA 21 (*Optus Administration*) as to the need to specify the critical event with a degree of precision when assessing whether a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken; and (at [176]) that Lederer contended that the traumatic incident pleaded necessarily included the allegation that Mr Hodson saw the victim's injuries (including his face being squashed and the brain matter visible) (an allegation that I have already noted was not established – at least as at the scene of the accident). The primary judge noted that, while Mr Hodson did not see the injuries, he gave evidence of his feelings at the time.
5. His Honour noted (at [177]) that in oral submissions it was contended for Mr Hodson that the traumatic incident referred to in the pleadings was the event which gave rise to the death of the deceased and pointed to the articulation at [16A] of the pleading of the risk of injury in the event that persons were exposed to the "aftermath" of that event, which Senior Counsel for Mr Hodson explained as being the presence of police cars, an ambulance, a body under a white sheet and a truck, saying that "there is plainly a body[,] there is introduced a white sheet ... If you see someone underneath the sheet, it's even more traumatising because you know the sheets [sic] over them for a pretty good reason: they're dead". Pausing here, that submission fails in my opinion to acknowledge that seeing a white sheet (covering what would be assumed to be a deceased body) could not on any view of things amount to seeing the injuries themselves; rather the somewhat surprising submission was that seeing emergency vehicles and a white sheet covering what would be assumed to be a body at the scene of an accident is "even more traumatising" (presumably more than seeing the injuries themselves) because one would know there had been a death at the scene.

6. His Honour noted (at [178]) that Mr Hodson's case did not rely upon the subsequent viewing by Mr Hodson of the CCTV footage; and that senior counsel for Mr Hodson had expressly disavowed reliance on that event as contributing to Mr Hodson's psychiatric condition.
7. Accordingly, the primary judge articulated Mr Hodson's case (at [179]) as being that the critical event was his attendance at the northern dock in circumstances where he was aware that it was the scene of a fatal motor vehicle accident; that Mr Hodson witnessed the presence of emergency services vehicles including police and ambulance; that Mr Hodson was able to see the truck involved in the fatal accident and the covered body of the victim located next to the wheels of the truck. His Honour added to that the fact that Mr Hodson was confronted with a distressed colleague who he knew was unable to complete his shift because of his emotional state.
8. At [180], his Honour said that he did not accept Lederer's submission that the plaintiff's case could only succeed if he established that he saw firsthand the victim's injuries, treating that fact as "just one particular of injury" which his Honour said must be read in the context of the pleading as a whole including the articulation of the risk of harm at [16A].
9. His Honour next turned to s 32 of the Civil Liability Act, which for convenience I set out at this point:

32 Mental harm—duty of care

- (1) A person (the defendant) does not owe a duty of care to another person (the plaintiff) to take care not to cause the plaintiff mental harm unless the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.
- (2) For the purposes of the application of this section in respect of pure mental harm, the circumstances of the case include the following—
 - (a) whether or not the mental harm was suffered as the result of a sudden shock,
 - (b) whether the plaintiff witnessed, at the scene, a person being killed, injured or put in peril,
 - (c) the nature of the relationship between the plaintiff and any person killed, injured or put in peril,
 - (d) whether or not there was a pre-existing relationship between the plaintiff and the defendant.
- (3) For the purposes of the application of this section in respect of consequential mental harm, the circumstances of the case include the personal injury suffered by the plaintiff.
- (4) This section does not require the court to disregard what the defendant knew or ought to have known about the fortitude of the plaintiff.

1. His Honour noted that the enquiry under s 32 of the Civil Liability Act is not whether the relevant circumstances of the case were reasonably foreseeable but rather whether, given those circumstances, a person of normal fortitude might (his Honour emphasising "might") suffer psychiatric illness (see at [183]; [184]). His Honour did not accept Lederer's contention that expert evidence was required to determine the s 32 issue ([185]).
2. At [187], his Honour said that the evidence established that there was a pre-existing relationship between Mr Hodson and Lederer (given his employment by Lederer for approximately four months before the accident) (here it would seem that his Honour must have been referring to the host employer relationship); and that the relationship was such that Mr Hodson was acquainted with his work colleague Mr Brydon. His Honour noted that Ms Necovski had conceded that at the time of the incident she was aware of Mr Hodson being a "man with some emotional problems" in circumstances where he would talk about personal matters (such as difficulties with his stepson and marital problems) and would "present as being emotionally upset". His Honour said that Ms Necovski, an employee of Lederer, was aware of the potential of Mr Hodson being emotionally fragile.
3. At [188], his Honour said that:

Whilst the evidence is insufficient to establish that Lederer knew or ought to have known that the plaintiff had an underlying disposition to react adversely if he were to witness a traumatic incident, it did demonstrate that the plaintiff was someone who was subject to emotional fragility (s 32(4)).

1. His Honour said (at [189]) that he was satisfied that, given the scene confronting Mr Hodson while present in the northern dock area, and the relationship between Mr Hodson and Lederer, including the potential of Mr Hodson to be emotional and fragile, it was reasonably foreseeable on the part of Lederer that a person of normal fortitude might suffer a recognised psychiatric illness; and therefore held that Lederer's duty of care was not excluded by s 32 of the Civil Liability Act.
2. His Honour then turned to the provisions of ss 5B and 5C of the Civil Liability Act. His Honour said at [191] that there was no issue that Lederer, as host employer, owed Mr Hodson a duty of care to avoid a foreseeable risk of harm.
3. As to the relevant risk of harm, the primary judge noted that the allegation was that the risk of harm was a risk of a person suffering psychological injury if exposed to the "aftermath" of the fatal accident including the presence of emergency vehicles, the truck involved in the fatal accident remaining at the scene with the covered body adjacent to the truck's wheels and a distressed colleague known to the plaintiff ([192]).
4. His Honour said that "for reasons already given" the risk was foreseeable in that it was one which Lederer knew or ought to have known; and that the risk was not insignificant ([193]). At [194]-[195], his Honour recorded what Mr Hodson alleged were the precautions which should have been taken to prevent Mr Hodson being exposed to the aftermath of the

incident: namely, for Ms Necovski, when requiring him to attend the Centre, directing him not to attend the northern dock (the scene of the fatality); that he ought to have been directed to remain at the Centre office; that he ought to have been directed not to attend the scene of the fatality during his shift; and that, having attended the northern dock, he should not have been directed towards the scene of the accident.

5. His Honour was satisfied that there was a reasonable probability that a person would suffer psychological injury if exposed to the scene of the aftermath of the fatal accident; that the risk of such an injury was not insignificant; and that the precaution that Lederer should have taken was relatively simple "in that it required no more than a direction that he was not to attend the scene of the fatality" ([198]).
6. Thus, his Honour was satisfied that Lederer breached the duty of care it owed to Mr Hodson ([199]).
7. As to causation, his Honour addressed s 5D of the Civil Liability Act and concluded (at [202]) that, "self-evidently", but for his attendance at the scene of the fatality, Mr Hodson would not have suffered the psychological condition as diagnosed by the experts; and said that it was appropriate for the scope of Lederer's liability to extend to the harm caused to Mr Hodson (noting that no submission was made to the contrary).
8. His Honour was satisfied that liability had been established against Lederer.
9. His Honour next turned to the issue of apportionment as between the defendants (at [206]), concluding (as noted above) that liability should be apportioned as to 15% to Hurex and 85% to Lederer.
10. As to the cross-claim, his Honour noted the parties' agreement that in the event of a finding of liability against Hurex, Lederer was entitled to a verdict on its cross-claim and said that there would accordingly be a verdict for the cross-claimant against the cross-defendant on the cross-claim.
11. As to contributory negligence, his Honour was satisfied that a finding should be made in respect of both defendants ([213]). His Honour said that the relevant risk of harm was a risk of Mr Hodson suffering further psychological injury if he were to return to the scene of the accident having experienced a psychological reaction from his initial exposure. His Honour was satisfied that such a risk was foreseeable, not insignificant and that a person in his position would have taken the precaution of not returning to the scene of the accident. His Honour was satisfied that re-exposure to the scene of the accident would have caused a further aggravation of the mental harm suffered by reason of the initial exposure, noting that this was a matter referred to by several of the psychiatric experts ([212]).
12. His Honour assessed the contributory negligence of the plaintiff at 10%, saying that, had Mr Hodson been given a direction not to attend the scene of such an accident, it is likely that he would not have returned as he did ([215]).

13. His Honour then went on to assess damages, about which there is no complaint.

Grounds of Appeal

1. As adverted to above, Lederer challenges the primary judge's decision on the following three grounds of appeal:

1. The Primary Judge erred in finding the Appellant [Lederer] owed the Respondent a duty of care.
2. The Primary Judge erred in his application of Section 5B of the Civil Liability Act 2002 (NSW) in finding that the Appellant had breached its duty of care.
3. If the Primary Judge was correct in finding that the Appellant owed the Respondent a duty of care, and that it breached that duty, his Honour erred in finding that such breach was a necessary condition of any harm suffered by the Respondent.

1. Hurex filed a notice of cross-appeal on 25 September 2024 against Mr Hodson (the first cross respondent) and Lederer (the second cross respondent), contending that:

1 The primary judge erred in finding that the cross appellant [Hurex] breached its duty of care to the first cross respondent [Mr Hodson] in finding that:

- (a) The scope and content of the first respondent's [sic; Hurex] duty of care required it to direct the second respondent [Mr Hodson] not to attend significant incidents.
- (b) The risk of injury was reasonably foreseeable.
- (c) A reasonable response to the risk would have been to direct the first respondent [Mr Hodson] not to attend a significant incident.

2 The primary judge erred in finding that the second respondent [Mr Hodson]'s injury was caused by the first respondent [Hurex]'s breach of duty of care.

1. There appears to have been some misjuxtaposition of the parties in the above grounds of cross-appeal. I have included in square brackets the party to which I understand Hurex is intending to refer in its grounds of cross-appeal. Hurex sought an extension for the filing of the cross-appeal, which was granted during the hearing in this Court (see AT 40.12).

Ground 1 of Lederer's Appeal

1. As extracted above, Ground 1 of Lederer's grounds of appeal challenges the finding that it owed Mr Hodson a duty of care. This raises the issue as to whether the duty of care that Lederer accepted was owed to Mr Hodson at general law was negated by reason of the operation of s 32 of the Civil Liability Act.

Lederer's submissions

1. In its submissions, Lederer addresses in turn the three elements required to be satisfied for s 32 to negative a duty of care in relation to the causation of pure mental harm (as set out by Basten JA in *Optus Administration* at [36]). As extracted above, s 32 specifies what Lederer must or ought to have foreseen in order for a duty not to cause mental harm to have arisen on its part, namely that: (i) a person of normal fortitude might; (ii) in the circumstances of the case suffer; (ii) a recognised psychiatric illness, if reasonable care were not taken.
 - (i) Person of "normal fortitude"
 1. Lederer submits that the primary judge misdirected himself on this question by placing undue weight on the knowledge by Lederer of Mr Hodson's "emotional problems". Lederer says that, whatever the relevance of Mr Hodson's emotional problems, they were not such that they deserved any significant weight. Lederer further points out that the knowledge of Mr Hodson's emotional problems was derived from him talking from time to time about marital problems as an explanation for failing to open the Centre on time.
 - (ii) Circumstances of the case
 1. Lederer accepts that, for the purposes of considering the "circumstances of the case" in s 32(1), it may be necessary to specify the critical event "with a degree of precision" (citing *Optus Administration* at [54]). In this regard, Lederer submits that the primary judge's consideration of the circumstances is encapsulated by his reference to the "scene" confronting Mr Hodson (referring to [189]), which Lederer accepts would presumably incorporate the findings at [91] (see above).
 2. Lederer contends that the primary judge failed to give any proper consideration to the matters in s 32(2), which sets out a non-exhaustive list of matters included in "the circumstances of the case" for the purposes of the section. Lederer submits that, while not necessary conditions of the existence of a duty of care (see *Wicks v State Rail Authority* (NSW) (2010) 241 CLR 60; [2010] HCA 22 at [27]-[29] (*Wicks*)), these factors are relevant to a finding as to the "circumstances" for s 32(1).
 3. As to s 32(2)(a) (i.e., whether or not the mental harm was suffered as the result of a sudden shock), Lederer says that, while the circumstances were plainly confronting, the primary judge does not appear to have considered whether there was a "sudden shock". In this regard, Lederer notes that before Mr Hodson arrived at the scene he knew there had been a fatality and he knew that Mr Brydon was upset. Lederer emphasises that, contrary to the pleaded case, the deceased's body was covered (noting that the primary judge only found that the covered body was within Mr Hodson's line of sight and that there was no finding that Mr Hodson actually saw it). Further, Lederer says that, if Mr Hodson did see the covered body, it could only have been for a matter seconds. Lederer thus argues that there was not a "sudden shock".

4. As to the matters in s 32(2)(b) and (c) (i.e., whether Mr Hodson witnessed, at the scene, a person being killed, injured or put in peril; and the nature of the relationship between Mr Hodson and any person killed, injured or put in peril), Lederer says that both of those matters tell against the existence of a duty in the present case. Lederer complains that the primary judge does not appear to have afforded any weight to those matters. In that regard, it is noted that Mr Hodson did not witness the accident (since he only arrived at the scene after the body was already covered) and there was no relationship between Mr Hodson and the deceased (other than that the deceased had been a regular customer of the Centre and Mr Hodson was not aware of the identity of the deceased until some time after the incident had occurred).
5. As to the matter in s 32(2)(d) (whether or not there was a pre-existing relationship between Mr Hodson and Lederer), Lederer accepts that the primary judge gave consideration to the relationship of quasi-employment in that his Honour referred to the knowledge of Lederer (through Ms Necovski) of Mr Hodson being a man with some emotional problems ([187]; [188]).

(iii) Recognised psychiatric injury

1. As to the foreseeability of a "recognised psychiatric illness", Lederer accepts that the issue of foreseeability does not require expert knowledge. Lederer says that the question whether it was foreseeable to it, in the circumstances of the case, that Mr Hodson might suffer a recognised psychiatric illness (if reasonable care to avoid the risk of mental harm were not taken) is to be determined by reference to the state of knowledge of Lederer (and not by reference to whether a person with expertise in psychology would have foreseen a recognised psychiatric illness).
2. Lederer accepts that the case was conducted on the basis that Ms Necovski's knowledge was to be attributed to Lederer. Accordingly, Lederer says that it was necessary for Mr Hodson to adduce sufficient evidence to establish the foreseeability requirements imposed by s 32 by reference to Ms Necovski's knowledge.
3. Lederer says that there was little evidence about Ms Necovski's knowledge of the foreseeability of Mr Hodson suffering a recognised psychiatric illness if exposed to the circumstances. Lederer says that, while Ms Necovski was cross-examined about her awareness of Mr Hodson being "a man with some emotional problems", and about her awareness generally of occupational health and safety (OHS) issues and the need to protect employees from stressful environments, there was no evidence before the primary judge about what Ms Necovski considered was the foreseeability of Mr Hodson (or anyone else) suffering a recognised psychiatric illness if exposed to the particular circumstances.

Mr Hodson's submissions

1. For Mr Hodson, it is contended that his Honour did not err in finding that s 32(1) did not apply to negative a duty of care owed by Lederer to him in the present case. Mr Hodson poses the relevant question as being whether it was reasonably foreseeable that, if reasonable care was not taken by Lederer, a shopping centre cleaner who was directed by his host employer to attend at a location in circumstances that were known to be confronting and sent to an area where a deceased body lay and where a distraught work colleague, ambulance persons and vehicles and police officers and vehicles were also present, might suffer a recognisable psychiatric injury as a result of his experiences at the scene (citing Wicks at [33]). Pausing here, as a factual matter it was not established that Mr Hodson was directed to attend at the location in the first place (as opposed to it being foreseeable that he might attend once he was told where Ms Necovski was – hence the debate which arose on appeal as to whether this was an 'omission' case or one involving a positive course of conduct).
2. Stated in other words, Mr Hodson asks whether it was reasonably foreseeable that sights of the kind he might see, sounds of the kind he might hear, words of the kind that may be spoken to him, smells of the kind he might smell, and tasks he might need to undertake (including to ease the suffering of his work colleague and in seeking to remove him from the vicinity) would be such, taken in combination, as might cause a person of normal fortitude to suffer a recognised psychiatric illness (again citing Wicks at [33]).
3. The enquiry being prospective, Mr Hodson argues that whether any of the matters required to be considered prospectively actually transpired (so as factually to occasion or contribute to any harm suffered) is of secondary consideration (citing *Capar v SPG Investments Pty Ltd t/as Lidcombe Power Centre* [2020] NSWCA 354 at [93]).
4. Mr Hodson points to the recognition in Wicks (at [26]) (which Lederer here accepts) that none of the matters to which s 32(2) is directed is "to be treated as a condition necessary to finding a duty of care", nor would their existence be a sufficient condition for such a finding (citing Wicks at [27]-[28]).
5. Mr Hodson acknowledges that, when discussing s 32 of the Civil Liability Act, the primary judge did not expressly address each of the matters listed in s 32(2), but Mr Hodson submits that the matters which may require attention under s 32 had already been addressed by his Honour in the earlier consideration of the circumstances of the case and the detailed findings of fact that his Honour made. Mr Hodson notes that those findings include the finding (at [93]) that, after attending upon Mr Brydon at the scene of the fatality, Mr Hodson exhibited signs (feeling numb, emotional and upset, necessitating his return to the office where he sat alone and cried) which Mr Hodson says are consistent with his having experienced sudden shock.

6. It is also noted that Ms Necovski was experienced as to human resources, OHS issues, and as to the protection of staff from stressful environments; whereas Mr Hodson had no experience of or training as to such matters.
7. Mr Hodson argues that, while not "labelling" each of the elements specified in s 32(2) of the Civil Liability Act, the content of the reasons of the primary judge gave careful attention to the event and the impact it could (and did) have on those confronted by the scene in the aftermath of the death.
8. Mr Hodson points out that, to Ms Necovski's knowledge, Mr Brydon was highly and visibly distressed and says that he was sufficiently "at peril" so as to lead Ms Necovski to direct Mr Hodson to him to get him away from there. Mr Hodson argues that those are matters central to ss 32(2)(a) and (b); not simply the "shock" and "peril" referable to the deceased, but rather from shock and peril from the circumstances of the case, including the whole of the confronting scene. Pausing here, there was not a finding that Ms Necovski directed Mr Hodson to remove Mr Brydon from the scene. Mr Hodson's own statement to Dr Allnutt was that "he... tried to get [Mr Brydon] away from the scene", i.e., on his own volition.
9. Similarly, Mr Hodson argues that the subject matter contemplated by ss 32(2)(c) and (d) was the subject of careful consideration by his Honour (namely, relationship matters as they concerned each of Mr Brydon and Ms Necovski). Mr Hodson also refers to the fact that the deceased was known to him, the deceased being a regular at the Centre. (However, as already noted, the deceased's identity was not something Mr Hodson learnt until some time after the incident.)
10. Mr Hodson points out that s 32 of the Civil Liability Act has no application to a claim brought by an employee against an employer that concerns pure psychiatric harm and hence has no application to the claim against Hurex. Mr Hodson attaches significance in this regard to the overlap of reasoning between the two claims. He argues that the observations and findings made by the primary judge as to the liability of Hurex ought be read as incorporated into the reasoning process respecting the claim against Lederer (referring in particular to what was said at [164]-[165]).
11. Reference is made to *Mount Isa Mines Pty Ltd v Pusey* (1970) 125 CLR 383; [1970] HCA 60 (Pusey) as to the duty of an employer to take reasonable care not to cause psychiatric harm to his employee (and particular reference is made to what was said by Windeyer J at 404 and Walsh J at 412). Mr Hodson says the nature and scope of this employer/employee relationship is especially important when considering s 32(2)(d) of the Civil Liability Act, particularly as to any pre-existing relationship that subsisted between Mr Hodson and Lederer. Mr Hodson argues that the relationship was one akin to that of employer and employee (citing *TNT Australia v Christie* (2003) 65 NSWLR 1; [2003] NSWCA 47).

12. Mr Hodson notes that the primary judge expressly pointed to this relationship as being a matter of significance when addressing the matter of the duty to take care not to cause mental harm, emphasising that the primary judge (at [189]), referred "the relationship between the plaintiff and the defendant including the potential of the plaintiff to be emotionally fragile".
13. Mr Hodson says that other aspects of the established relationship are necessarily relevant; again pointing to the "direction" given (in her capacity of acting as host employer) by Ms Necovski to Mr Hodson "to enter into a confronting scene in which there was inter alia a dead body and a very distressed colleague", knowing that Mr Hodson was emotionally fragile. Mr Hodson says that Ms Necovski there embarked upon a positive course of conduct thereby materially increasing the foreseeability of harm resulting to someone who has in all relevant respects been placed in a position that was the same as an employee. (Reference is made by Mr Hodson to *Zaghloul v Bayly* [2021] WASCA 125 at [120] in the context of a summary judgment application as to the interaction between such conduct and knowledge with s 32(4).) I have already noted the evidentiary difficulty in describing what happened by Ms Necovski as a "direction".
14. Mr Hodson argues that implicit in the finding (at [165]) that it was "reasonably foreseeable that a person such as the plaintiff by being exposed to such an incident could suffer psychiatric injury", is that the reference to "such a person" was a reference to a person of normal fortitude. Mr Hodson says that, read in conjunction with the reasons at [189], it is clear that, despite Mr Hodson having some emotional fragility, a like finding was then being made.
15. Mr Hodson thus argues that the analysis of the circumstances as undertaken by the primary judge was a sufficient basis for the primary judge to express the matter as to normal fortitude as he did (at [165] and [189]). Mr Hodson further argues that the references (at [174] and [189]) dispel Lederer's suggestion that references to "emotional problems" infected the primary judge's analysis of "normal fortitude". Mr Hodson says that nowhere was it said that Lederer knew, or even ought to have known, of the presence of an existing psychiatric condition such that could distinguish him from a person of "normal fortitude".
16. Reference is made to *Tame* where it was observed the term "normal fortitude" was a way of expressing the idea there are some people with such a degree of susceptibility to psychiatric injury as to make it ordinarily unreasonable to require others to have in contemplation the possibility of harm to them because of that fact. Mr Hodson points out that in *Pusey* it was said that the term is one that is "imprecise and scientifically inexact" (per Windeyer J, at 405-406 and also refers to *Tame* per McHugh J at [94]).

17. Mr Hodson says that the test requires the application of a community standard that the law imposes (referring to what was said by McHugh J in *Tame* at [115]-[116]). Mr Hodson argues that, looked at holistically, that which the primary judge said (especially at [164]-[165] and [188]) is sufficient to justify his finding that the requirements of s 32 have been satisfied in this case.

Hurex' submissions as to Ground 1 of Lederer's appeal

1. Hurex generally adopts the submissions of Mr Hodson on this ground of appeal but makes the following further submission that s 32(1) of the Civil Liability Act is cast in negative terms (citing *Wicks*). Hurex notes that s 32(2) does not prescribe any particular consequence as following from the presence or absence of one or more of the matters there included in "the circumstances of the case" for the purposes of the section. Thus, Hurex says that neither sudden shock nor witnessing a person being killed, injured or put in peril is a necessary or sufficient condition for a finding of the relevant duty of care. (As already noted, Lederer does not contend otherwise.)
2. Hurex repeats the factual circumstances as to Mr Hodson's presence on the scene and says that, "by invitation or acquiescence", Ms Necovski permitted Mr Hodson to attend the loading dock in "an environment of heightened emotion and the fresh tragedy of the customer's death", with the customer's corpse in situ and a distressed work colleague so affected he was unable to continue work and ongoing work by emergency services. Pausing here, it is by no means established that anyone, let alone Ms Necovski, realised at the time that the deceased was a customer.
3. Hurex accepts that it is difficult to categorise Mr Hodson's distress when attending at the scene as arising from a sudden shock but says that, even absent sudden shock, the scene overall and the information given to Mr Hodson before attending the loading dock and being permitted or directed to attend the loading dock and to approach and to attend Mr Brydon, were sufficient for the primary judge to conclude that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.
4. Hurex says that, like the rescuers in *Wicks* who were leading away passengers who were not physically injured but psychiatrically affected by the event, when Mr Hodson attended on Mr Brydon he had been informed and witnessed a colleague who was deeply psychologically affected by the tragic accident, and Mr Brydon's process of suffering was not over when Mr Hodson arrived at the scene of the tragedy and rendered him aid by taking him from the scene to the office. Hurex says that the primary judge was correct to conclude that it was reasonably foreseeable on the part of Lederer that a person of normal fortitude might suffer a recognised psychiatric illness and Lederer's duty of care is not excluded by s 32 of the Civil Liability Act. I note that Hurex appears to be here emphasising the impact of Mr Brydon's distress on Mr Hodson. However, I note that Mr Hodson did not specifically plead below that Mr Brydon's distress in and of itself contributed to his psychiatric injury (other than making

reference to his exposure to "the traumatic incident").

Determination

1. For completeness I note that when the matter was before the primary judge, Lederer had handed up a Statement of Issues that included whether Mr Hodson met the threshold test for mental harm under s 30(2) of the Civil Liability Act but it was accepted by counsel then appearing in the matter that the reference to this section was in error (and the issue as there expressed – issue 3 as to liability – was withdrawn). In oral submissions on appeal, it was accepted by Lederer's Senior Counsel, who did not appear at first instance, that s 30 of the Civil Liability Act might nevertheless have some relevance insofar as it might indicate the kind of mental harm contemplated to be the subject of s 32 (see AT 30). However, it was not suggested that the kind of mental harm arising from shock to which s 30 refers provided any assistance in determining the issue as to s 32 in the present case.
2. Lederer, as noted above, accepted that the case was conducted on the basis that Ms Necovski's knowledge was to be attributed to it. Lederer argues that the real issue on the first ground of appeal is as to whether Lederer had constructive knowledge (through Ms Necovski) that a person of normal fortitude might suffer a recognised psychiatric injury from exposure to the scene of the accident (or, as Mr Hodson's case was ultimately put) to the "aftermath" of the accident.
3. Lederer conceded (AT 10) that Ms Necovski either did foresee or ought to have foreseen, when she requested Mr Hodson to attend at the Centre, that he might attend the scene of the accident. That concession is an appropriate one to make in circumstances where Mr Hodson ordinarily received his day to day instructions from Ms Necovski – and Ms Necovski was at the scene of the accident. No doubt Ms Necovski ought also to have foreseen that, if Mr Hodson attended at the northern dock then he might see the emergency vehicles and the covered body, as well as his distressed colleague.
4. What I do not accept is that Ms Necovski ought to have foreseen that a person of normal fortitude might suffer a psychiatric injury if confronted with such a scene. The submission that such a scene, with a covered body, would be even more confronting than a scene where the body was uncovered and the horrific injuries were visible does not accord with common sense. One might readily foresee that a person of normal fortitude might be traumatised (and suffer some form of psychiatric injury) if actually exposed to the kinds of injuries that Mr Hodson described in his accounts to various of the medical practitioners (contorted torso, limbs under the wheels of the truck, squashed face and brain matter visible). However, by the time Mr Hodson arrived at the scene (and indeed for some time before he arrived at the scene) none of those injuries was visible.
5. Insofar as Mr Hodson's submissions suggest that a finding of "sudden shock" would have been open, I do not accept that the evidence would have permitted such a finding. Mr Hodson already knew that there was a fatality and that his colleague was distressed (that

being why he was requested to attend the Centre). The only sudden shock to which Mr Hodson referred was as to something that he could not have observed (the deceased's actual injuries) (cf the account recorded by Dr Bertucen as noted above at [44]). As to the circumstance in s 32(2)(b), it is abundantly clear that Mr Hodson did not witness the deceased being killed, injured or put in peril (and though he witnessed Mr Brydon in distress it is difficult to see this as falling within (2)(b) and was not relied on in any event). As to the matter referred to in s 32(2)(c), there was at best an indirect relationship in that the deceased was a regular customer at the Centre but this was something that Mr Hodson did not know until some time later. Thus, those circumstances (though not necessary pre-conditions to a finding of foreseeability) do not assist in establishing the requisite foreseeability of mental harm. The pre-existing quasi-employment relationship was taken into account by the primary judge.

6. Much emphasis was placed by Mr Hodson in argument on the appeal on the reaction by him to the smell he perceived to be emanating from the victim's body. Apart from the fact that it is not clearly established that this was a real (as opposed to imagined) smell (and the Court was not taken to evidence that any other person perceived such a smell at the time), nothing seems to have been put to Ms Necovski to suggest that she was aware of any such smell or to provide a basis for her to have foreseen that a person of normal fortitude attending the northern dock might have perceived such a smell and might be affected to the requisite degree by it (whether alone or in combination with other circumstances such as the presence of emergency vehicles).
7. The suggestion that it ought to have been foreseen that a person of normal fortitude, arriving at a scene where there were emergency vehicles, a covered body (indicating an actual death) and a distressed colleague, might suffer a psychiatric injury does not accord with common experience (think, for example, of motorists not uncommonly slowing down when passing the scene of a motor vehicle accident). Whether or not that is so, in my opinion there was insufficient evidence from which to conclude that Ms Necovski (and hence Lederer) either did foresee or ought to have foreseen, when she requested Mr Hodson to attend the Centre (informing him that there had been a fatality and that Mr Brydon was distressed), that if (as it may be accepted was likely) he attended the northern dock and was hence exposed to the sight of the covered body, the emergency vehicles and the distressed Mr Brydon (or any smell that might have been sensed by him as emanating from the covered body), he might suffer a recognised psychiatric injury.
8. There was some debate in submissions on the appeal as to the interaction between s 32(1) and s 32(4), the latter providing that the court is not required to disregard what the defendant (here, Lederer) knew or ought to have known about the fortitude of the plaintiff (here, Mr Hodson). In other words, the issue was as to how one applies a test as to the foreseeability of a person of normal fortitude possibly suffering a recognised psychiatric illness in circumstances where the person suffering the injury is or ought to be known not to be a person of normal fortitude.

9. This is relevant because of the evidence that Ms Necovski knew that Mr Hodson was a man who had some emotional problems. It is not necessary here to delve into that issue (which does not appear to have been the subject of consideration in other cases and on which the extrinsic materials do not shed light). That is because even if the requisite s 32 foreseeability test is considered by reference to what Ms Necovski knew or ought to have known about Mr Hodson's level of fortitude, I would reach the same conclusion that the harm was not reasonably foreseeable. The fact that someone may be late to work because he or she was experiencing marital problems, or may have been emotional when there were family issues concerning members of his or her family, in my opinion says nothing about whether that person might suffer a psychiatric injury if exposed to the scene or aftermath of the fatal accident at the northern dock. There is no suggestion that Ms Necovski had or ought to have had any awareness that Mr Hodson suffered from a recurrent depressive illness, as was the diagnosis by various of the medical practitioners, (such that he might be more likely to have his pre-existing anxiety or depression triggered by attendance at the scene of the fatal accident). Ms Necovski was not cross-examined to suggest that she had any knowledge of Mr Hodson having the kind of vulnerability identified by Gaudron J in *Tame* (at [62]).
10. What was not explored in the evidence was whether the PTSD and associated major depressive adjustment disorder, from which both psychiatrists agree Mr Hodson now suffers, was or could have been triggered by what Mr Hodson saw in the CCTV footage after the incident on 26 October 2020 (as opposed to that which he was exposed to at the scene of the incident).
11. In submissions, when pressed as to how one could distinguish between a genuine recollection of the events of the day and what Mr Hodson had seen on the video in the Centre management office a couple of days or so later, counsel for Mr Hodson submitted that the latter was "superimposed on the background of it [i.e., the events of the day]". But that illustrates the difficulty for Mr Hodson's case. As noted earlier, Mr Hodson disavowed any reliance in his case on the viewing of the CCTV footage. Therefore, what Mr Hodson needed to establish was the foreseeability that a recognised psychiatric illness might be suffered by a person of normal fortitude (taking into account, perhaps, his "emotional fragility") by reference to attendance at the scene, or aftermath, of the accident itself (not by reference to what might have been seen or heard later). For the reasons above, Mr Hodson failed to establish this.
12. Ground 1 of the appeal is therefore made good.

Ground 2

1. Lederer does not challenge the finding by the primary judge (at [193]) that the risk of harm identified by Mr Hodson was foreseeable for the purposes of s 5B(1)(a) of the Civil Liability Act. However, Lederer does challenge the finding at [193] that the risk was not insignificant.

2. Lederer notes that at [194]-[195] the primary judge sets out aspects of the way in which Mr Hodson put his case as to the precautions which he alleged Lederer was required to take for the purposes of s 5B(1)(c). Lederer takes no issue with the reference by the primary judge at [196] to authorities for the proposition that the issue as to what a reasonable person would have done in response to the risk of harm must be considered prospectively nor as to the need to take into account the matters in s 5B(2) of the Act.
3. However, Lederer's complaint is that, after addressing those matters, the primary judge's reasoning on the question of breach is to be found in one paragraph ([198]) in which his Honour found that there was a reasonable probability that a person would suffer psychological injury if exposed to the scene of the fatal accident (and that the precaution which Lederer ought to have taken "was relatively simple in that it required no more than a direction to the plaintiff that he was not to attend the scene of the fatality").
4. Lederer complains that there is no reasoning in support of the finding that the risk of harm was not insignificant. Lederer says that the primary judge erred by attributing weight to the likely seriousness of the harm in circumstances where the cross-examination of Ms Necovski was not directed to Ms Necovski's awareness of the likely seriousness of any harm to Mr Hodson from him being asked to attend the Centre and from her knowledge that he might attend the scene. Again, Lederer points to the fact that the scene when Mr Hodson arrived was one in which the deceased's body had already been covered and where Mr Hodson was not asked to attend the scene to perform any particular duties in relation to the deceased's body.
5. Next, Lederer contends that the primary judge erred in finding that Ms Necovski ought to have taken the reasonable precaution of directing Mr Hodson not to attend the scene of the fatality. Lederer complains that the primary judge failed to give any, or any proper, consideration to all of the relevant circumstances confronting Ms Necovski. Lederer says that those circumstances included that: the fatality was a matter which was plainly out of the ordinary and would be properly regarded as an emergency; Ms Necovski was the most senior person from Lederer on the scene and was required to make a series of decisions in quick succession taking into account a range of matters; Ms Necovski was managing that situation having attended the scene before the deceased's body was covered; and the matters which Ms Necovski was required to address included not only Lederer's obligations to workers to whom it owed a duty of care but also extended to its obligations to other invitees at the Centre, including shoppers and tenants. Lederer says that those other duties could not be said to be unimportant to the proper and safe operation of the Centre.
6. Lederer accepts that the ordinary system was for Ms Necovski to direct Mr Hodson as to his duties on a day to day basis (such as what work was required) but says that on this occasion Ms Necovski was plainly engaged in managing the emergency. Lederer argues that, for that reason, unless it could be said that Ms Necovski was bound to leave that area (for the purposes of giving directions to Mr Hodson as to what was required), then the obvious course was for Mr Hodson to come to where Ms Necovski was in order to receive those

directions.

7. Lederer points out (as I have already noted) that, on the evidence, Mr Hodson was not positively directed to come to Ms Necovski at the northern loading dock; rather, after Mr Hodson arrived, he contacted Ms Necovski and she told him where she was. Lederer emphasises the findings by his Honour that Mr Hodson knew before he attended the scene that there had been a fatality and he knew that Mr Brydon was distressed.
8. Lederer thus contends that, in all of the circumstances, it was a counsel of perfection for the primary judge to conclude that a reasonable person in Ms Necovski's position was negligent in failing to direct Mr Hodson not to attend the scene of the fatality. Lederer says that it is also unclear that a proposition based on this asserted precaution was squarely put to Ms Necovski in cross examination.

Mr Hodson's submissions

1. Mr Hodson submits that Lederer's complaint as to the sufficiency of the reasoning of the primary judge, when addressing the matter of "not insignificant risk", is without merit for the following reasons.
2. First, Mr Hodson says that the criticism must be seen in context and in light of earlier factual findings and findings in the context of the risk of harm identified, and the findings as to foreseeability. Mr Hodson says that the risk of harm he advanced was not the subject of challenge by Lederer and was accepted by the primary judge (as set out at [193]).
3. Mr Hodson points out that any assessment of breach depends upon an identification of the relevant risk of injury (noting *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330; [2007] HCA 42 (Dederer), at [18] and [59] per Gummow J); and that assessment is required to be undertaken prospectively (both as to foreseeability and materiality) and not by reference to the precise circumstances in which it materialised (*Stojan (No 9) v Kenway* [2009] NSWCA 364 at [136] per McColl JA). Reference is also made to *Collins v Insurance Australia Ltd* (2022) 109 NSWLR 240; [2022] NSWCA 135, at [134] per Basten AJA (with whom Meagher JA agreed). Mr Hodson notes that the purpose of such an assessment is to facilitate the determination of whether a reasonable person in the position of the defendant would have taken precautions the defendant did not (Dederer at [59]).
4. It is noted that Lederer accepts that the primary judge's finding as to foreseeability for the purposes of s 5B(1)(a) of the Civil Liability Act was open to him and makes no challenge to it. Mr Hodson says that Lederer therefore accepts the risk of injury to Mr Hodson, or the class of persons of which Mr Hodson was a member, viewed prospectively was foreseeable; and that this necessarily triggers an obligation within the terms of s 5B of the Civil Liability Act to consider, given the foresight of the risk of and response (if any) to, any possible occurrence of harm.

5. Second, Mr Hodson says that against this background the primary judge was required to find whether the risk "was not insignificant", and then determine whether, and if so, which precautions (if any) a reasonable person in the defendant's position would have taken. It is noted that this has been described as a more demanding test than the common law test (of the risk being real and not farfetched or fanciful) "but not by very much" (*Bunnings Group Ltd v Guidice* [2018] NSWCA 144 at [53]-[54]). Reference is also made to *Prouten v Chapman* [2021] NSWCA 207 at [24] (per Meagher and Leeming JJA) where the test was said to be "a slightly more demanding standard".
6. Mr Hodson points out that this is not a matter where the primary judge omitted to consider s 5B(1)(b) at all; rather, the complaint is as to insufficiency of reasoning. Mr Hodson says that Lederer's submission ignores the earlier finding (at [165]); the reference (at [193]) to "for the reasons already given"; and the inclusion of the words "there was a reasonable probability that a person would suffer psychological injury" (at [198]).
7. Mr Hodson submits that the primary judge gave sufficient reasoning as to s 5B(1)(b) but in any event he argues that the finding that the risk of harm was not insignificant was one that was, in the circumstances of the case, properly made.
8. As to the submission by Lederer that to find a reasonable person in the position of Ms Necovski would not have directed a person such as Mr Hodson to attend upon the scene of the fatality would be to require of such a person counsel of perfection (rather than the taking of a course of action that such a person would reasonably have taken to address the risk of harm present), Mr Hodson responds as follows.
9. Mr Hodson emphasises that Ms Necovski "actively" directed him to the scene of the fatality and the distressed Mr Brydon. Mr Hodson says that this was a positive course of action (not a mere omission such as the failure to instruct him to remain in the office and/or not to attend the northern dock). Mr Hodson says that the action being taken by Ms Necovski was not something she did in the heat of the moment nor was it in the course of an emergency or while she was making quick decisions.
10. Further, Mr Hodson says that no persuasive reason was ever advanced for the conduct. He argues that objectively Ms Necovski could have attended and removed Mr Brydon if that was something required. He says that any directions Ms Necovski may have wished to give him respecting his duties could have been given whether at the entrance to the northern dock, in the office, or by phone. He says that there was no warrant for the giving of the direction she did which was one that had the consequence of putting him directly in harm's way.
11. Finally, Mr Hodson emphasises the finding by the primary judge that "the precaution the defendant ought to have taken was relatively simple in that it required no more than a direction to the plaintiff that he was not to attend the scene of the fatality" ([198]); and complains that, instead, he was positively directed there.

12. Accordingly, Mr Hodson submits that breach has properly been found to have been established.

Hurex' submissions as to Ground 2 of Lederer's appeal

1. Hurex again adopts Mr Hodson's submissions on this ground. Hurex says that Mr Hodson was invited, or permitted, to enter into a highly charged, emotional and distressing environment when he did not need to attend that environment to complete his work; and that the primary judge was correct to conclude that the risk of harm was foreseeable and not insignificant and that Lederer had breached the duty of care it owed to Mr Hodson.

Determination

1. Insofar as the challenge to the finding that the risk of harm was not insignificant involves a complaint as to the adequacy of the primary judge's reasons on this issue, I accept that his Honour's reasoning on this issue was expressed in a conclusory fashion. Nevertheless, as Mr Hodson submits, his Honour did consider throughout the reasons matters relevant to the assessment of the significance or otherwise of the risk (and in any event the substantive complaint by Lederer is as to the finding that the risk was insignificant).
2. It is of course necessary accurately to identify the relevant risk of harm. In the present case, his Honour noted that the risk of harm alleged was the risk of a person suffering psychological injury if exposed to the aftermath of the fatal accident (by reference to the presence at the scene of emergency vehicles, the truck involved in the accident, the covered body adjacent to the truck's wheels and a distressed colleague known to the person) (see at [192]). There is no challenge here to the identification of the risk of harm. What is challenged is whether it was "not insignificant".
3. It is recognised that the requirement that the risk be not insignificant imposes a (slightly) higher standard than the not "far-fetched or fanciful" test at common law. The Ipp Committee, in the Review of the law of Negligence Report (2002) (Ipp Report), referred to the intention of the phrase as being to indicate a risk that was of a higher probability than the test at common law posed but not so high as a "substantial risk" (Ipp Report [7.15]; and see the authorities to which the parties here have referred). In *Benic v State of New South Wales* [2010] NSWSC 1039, Garling J noted that the phrase was intended to refer to the probability of the occurrence of the risk (i.e., not to the seriousness of the resulting harm if the risk eventuated).
4. In the present case, the possibility of a person suffering some form of mental harm as a result of exposure to the accident scene (but not to the actual injuries of the deceased other than perhaps any smell perceived as emanating from the deceased's body) was not clearly addressed. However, it is instructive to refer to the psychiatrists' evidence in that regard. In particular, Dr Allnut (who recognised that there was uncertainty as to whether Mr Hodson actually saw the deceased's injuries) considered that exposure to the scene itself (or perhaps

more accurately repeated exposure to the scene) was the cause of the mental harm suffered by Mr Hodson. In those circumstances I consider that the finding that the risk of harm was not insignificant cannot be said to be incorrect.

5. As to the challenged finding that there was breach of a duty of care owed by Lederer, the pleaded precaution that it was alleged Ms Necovski (and hence Lederer) was negligent in failing to take was the giving of a direction not to attend the scene of the fatality. The submission by Mr Hodson on appeal that there was a positive course of action taken by Ms Necovski (and therefore this was not simply a case of negligent omission) seems to be based on the finding that Ms Necovski "directed" Mr Hodson to Mr Brydon at the scene of the accident. To my mind the suggestion that Ms Necovski directed, in the sense of instructed, Mr Hodson to go over to Mr Brydon does not accord with the evidence (as I have already explained).
6. At 27/04/24; T 48.1-4, Mr Hodson's account of the conversation with Ms Necovski was that "I think I asked where Josh was, and Sonja pointed to where Josh was" and then "[I] walked over". Mr Hodson said "I could see he was upset, and I went to console him". Mr Hodson said that "Once I got to him I realised how upset he was, and I put my arm around him, I thought to myself to get him out of there".
7. Ms Necovski certainly requested that Mr Hodson attend the Centre (and on his Honour's findings told him that Mr Brydon was distressed). As conceded, Ms Necovski ought to have assumed that Mr Hodson might attend the northern dock (as he did when he learnt where she was). I am not persuaded that there was any breach of a duty of care in the omission to direct Mr Hodson not to attend the northern dock because, even given her knowledge that Mr Hodson was a man with some emotional problems, I do not accept that there was a reasonable probability that his mere attendance at the northern dock (and the limited exposure that would have been entailed in attending on Ms Necovski to obtain the necessary instructions for his work) would cause him to suffer psychological injury.
8. As to the next step (Mr Hodson walking over to Mr Brydon and hence closer to the covered body), on Mr Hodson's own evidence, as already noted, Ms Necovski only directed him to Mr Brydon in the sense that she pointed out where Mr Brydon was in answer to his question and, again, I do not accept that there was a reasonable probability that if Ms Necovski failed to direct him not to go over to Mr Brydon he would suffer a psychological injury. From the CCTV footage it is apparent that standing next to Mr Brydon, Mr Hodson would not have had a view of the covered body.
9. As to the proposition that the giving of the direction that Mr Hodson contends should have been given would have been a relatively simple step, this fails to take into account that Ms Necovski was obliged to balance a number of considerations that morning (not least being how the functions of the Centre were to continue to operate, assuming it was not to be closed, while Mr Brydon was too distressed to continue to perform his duties, and how to comply with her duties to Mr Brydon himself). In those circumstances I cannot accept that

Ms Necovski (and hence Lederer) was negligent in failing to direct Mr Hodson not to attend at the northern dock. I do consider it to have been a counsel of perfection for it to have been concluded that such a direction should have been given in all the circumstances.

10. To that extent, therefore, I consider that Ground 2 is made good.

Ground 3

1. As to whether Mr Hodson's mental harm was caused or contributed to by the breach of duty that his Honour found (i.e., the failure to direct Mr Hodson not to attend the scene), Lederer says that the most relevant evidence going to this question was given by Drs Allnut and Malik, the two psychiatrists who had been retained by the plaintiff and Hurex respectively to examine Mr Hodson and assess him for medico-legal purposes.
2. Lederer accepts that the opinions expressed by Drs Allnut and Malik (and to a lesser extent some of the other doctors and allied health professionals referred to by the primary judge) supported Mr Hodson's case that his mental harm was caused by or materially contributed to by his attendance at the scene of the fatality. However, as contended at trial, Lederer argues that the assumptions on which the opinions were based were not proved and that, as a consequence, little or no weight should be afforded to those opinions (a contention that the primary judge rejected).
3. Lederer contends that none of the matters relied upon by the primary judge when rejecting Lederer's submission on this issue supported that direction. Lederer complains that his Honour's reasoning does not engage with the degree and nature of the departure between the assumptions as instructed to be made by the experts and the facts as found by the primary judge. As to the first and second of those matters (the multiplicity of the factors considered by the medical experts and the fact that they were not cross-examined), these appear to be the nub of Lederer's present complaint (see below).
4. As to the third matter identified by the primary judge (at [135]), namely the lack of challenge made in cross-examination as to Mr Hodson's account of his symptoms other than as to exaggeration, Lederer says that this is irrelevant as the relevant analysis was the difference between the findings by the primary judge and the assumptions relied upon by the experts. Lederer says the fourth matter relied upon by his Honour (at [136]), namely the recognised caution in relying on recorded accounts of health professionals, was also irrelevant.
5. Lederer maintains that none of the opinions of various treating doctors or allied health professionals provided cogent evidence on the critical issue, namely whether Mr Hodson's psychiatric conditions were caused or materially contributed to by Lederer's breach of duty. In particular, Lederer contends that the differences between the assumptions the experts made or were asked to make and the facts proved were of such materiality that the facts proved did not provide a "fair climate" (adopting the words in Wicks) for consideration of the opinions of the experts.

6. I have summarised earlier the relevant medical evidence.
7. With respect to Dr Allnut's report, Lederer accepts that Dr Allnut recorded that Mr Hodson told him that he could not recall what he saw when he looked to the area of the truck. However, Lederer emphasises that Dr Allnut was asked to assume what Mr Hodson had seen and says that his critical opinion on causation must have been informed by that assumption. Lederer says that Dr Allnut's diagnosis of post traumatic amnesia was clearly based upon an assumption about what Mr Hodson had in fact observed even though Mr Hodson said he could not recall that detail; and that this conclusion is consistent with Dr Allnut's assumption that Mr Hodson was "involved an[d] exposed to an actual death, that he witnessed the circumstances of that death".
8. Further, Lederer emphasises that Dr Allnut relied upon an assumption that the plaintiff "was repeatedly exposed to that event by having to go up on two occasions" and that on the second of those occasions Mr Hodson could not recall what he saw but it was "stuff on the ground". Lederer says this was another important assumed fact that was not proved (or at least not subject to a finding). It is noted that the primary judge found that Lederer was not negligent with respect to any attendance by the plaintiff other than the initial attendance. Accordingly, Lederer says that even if a subsequent attendance or attendances by Mr Hodson were proved, those assumptions made by Dr Allnut were irrelevant to his conclusion as to causation.
9. Lederer submits that the assumptions made by Dr Allnut about the graphic nature of what Mr Hodson saw on his attendance at the scene; the length of time that he was at the scene; and Mr Hodson's assertions that he was repeatedly exposed to the scene were central matters relied upon by Dr Allnut in forming his opinion as to medical causation and that those assumptions departed significantly from the primary judge's findings (critically, that there was no finding that the plaintiff actually saw the body at all; and that he was only on the scene briefly and only on one occasion (or only one occasion that was capable of being relevant to the causation case against Lederer)).
10. As to Dr Malik's opinion, Lederer says that the departure between the assumptions on which he relied and the facts proved by Mr Hodson was even greater, both as to what Dr Malik was told Mr Hodson observed on his attendance at the scene and what Dr Malik was told about his later attendance to "clean the human remains and the incident site".
11. Lederer does not cavil with the primary judge's observation that it was "inherently unlikely" that, in the conclave between Drs Allnut and Malik, their respective reports would not have been considered. Lederer says that, in circumstances where on the critical question of medical causation they express a joint opinion, that joint opinion should be taken to be one based upon the relevant assumptions given to Dr Allnut as set out above and the history recorded by Dr Malik. On this basis, Lederer submits that the joint report was of little or no weight on the question of medical causation.

12. As to the other medical evidence referred to by the primary judge, Lederer says that this was of little probative value. Lederer points out that Dr Saroha was told that the plaintiff witnessed the accident, and he does not express an opinion as to causation in any event. As to the report of Dr Christmas, Lederer notes that, while it does contain an expression of opinion, no assumptions are set out. Further, Lederer submits (and I accept) that Drs Allnut and Malik would have greater expertise than Dr Christmas (she being a general practitioner).
13. As to the report of Mr Hu, which states that assumptions were made that Mr Hodson was asked to "clean up" the mess; that Mr Hodson had been called in to manage the incident; and that Mr Hodson could not recall the details but was physically present in the management of the incident, Lederer submits (for the same reasons as those above) that those assumptions differed materially from the facts proved. Accordingly, it is submitted that the primary judge erred in giving any or any significant weight to Mr Hu's opinion.

Mr Hodson's submissions

1. As to the challenge as to the finding of factual causation pursuant to s 5D of the Civil Liability Act, Mr Hodson says that at the threshold of any analysis of this issue is the assessment of any injury from which a person may suffer; and then one asks whether a defendant's conduct (breach) had some effect in the production of that injury (citing *Chappel v Hart* (1998) 195 CLR 232; [1998] HCA 55, at [23]); and that this is determined by the application of common sense. Mr Hodson says that what is required in some cases is the drawing of robust and pragmatic inferences, especially where there are various possible causes and there is difficulty in ascertaining which of them was the cause of the damage suffered (citing *Robinson Helicopter Company Inc. v McDermott* [2016] HCA 22; (2016) 90 ALJR 679, at [86]).
2. Mr Hodson points to the findings by the primary judge as to: his emotions when he was in the loading dock with Mr Brydon ("confused, upset and felt sick") ([93]); and that at the same time "his stomach was 'turning, shaking'" and "... he was attempting to 'keep it together' to be an effective support for Mr Brydon" ([93]); that, for the balance of the day, Mr Hodson felt numb, emotional and upset, necessitating his return to the office on several occasions where he sat alone and cried ([93]) and that, while giving evidence as to the matters Mr Hodson was emotional and struggling to maintain his composure; and his demeanour was consistent with genuinely recalling the trauma of the day and his emotional/physical response to it. Mr Hodson notes that his Honour found that Ms Necovski asked him not once, but on multiple occasions how he was, he appearing to her to have been affected by what had occurred ([73]).
3. Mr Hodson also points to the findings as to his attendance on Dr Saroha the day after the incident, who prescribed diazepam; and to Dr Saroha subsequently having recorded that Mr Hodson had experienced flashbacks with a lack of motivation and self-esteem; and her having completed a medical certificate and having referred Mr Hodson to a psychiatrist,

who reported him to be suffering from severe PTSD symptoms including flashbacks and nightmare, avoidance, numbness, anxiety and panic attacks, hyperarousal, lack of concentration, poor memory, angry outbursts and exaggerated startle response.

4. Mr Hodson emphasises that (as already noted) it was not suggested to him that his evidence as to the above matters was untrue; rather, the only challenge was to their extent.
5. Thus, Mr Hodson argues that, independently of any matter as to history contained in any report, by an application of common sense and the drawing of robust and pragmatic inferences, it was plainly open to the primary judge to find that factual causation had been established (i.e., that he had sustained PTSD in consequence of his exposure at the scene of the fatality). I interpose here to note that the question is not whether it was open to his Honour to reach that conclusion – on appellate review the question here is as to whether that conclusion was correct having regard to all of the evidence before his Honour.
6. Mr Hodson also points to the findings of each of the treating and qualified experts to the effect that he had PTSD that, amongst other symptoms, featured flashbacks to the event and the smell he perceived to be present there. Mr Hodson says these were not matters referable to the "challenged history" – rather, they were simply directed to what he said that he had done and seen rather than the effect which that had occasioned.
7. Further, Mr Hodson attaches significance to the fact that none of the doctors was cross-examined as to the opinions that had been expressed. Mr Hodson submits it is inconceivable that flashbacks and nightmares referable in their terms to the exposure at the scene of the fatality could have any origin other than Mr Hodson's placement there (and hence the causative effect of the breach of duty as established). (This overlooks that the actual vision Mr Hodson had of the injuries, if any at all, was gained by watching the CCTV footage afterwards. Hence the nightmares could have resulted from viewing the CCTV footage rather than his attendance at the scene itself.)

Hurex' submissions on Ground 3 of Lederer's appeal

1. Hurex adopts the submissions made by Lederer (at [32]-[38]) on factual causation in support of Ground 2 of Hurex' cross-appeal (see below). It accepts that it did not at the hearing advance any position in relation to causation. Consistently with this, in respect of Lederer's appeal, Hurex does not advance any further specific position on causation in the appeal.

Determination

1. Expert evidence which is based upon certain assumptions which are not ultimately proved in evidence is "of little or no value" or "irrelevant" (see *Ramsay v Watson* (1961) 108 CLR 642, at 649; [1961] HCA 65 (Dixon CJ, McTiernan, Kitto, Taylor and Windeyer JJ) (*Ramsay*); see also *Eric Preston Pty Ltd v Euroz Securities Ltd* (2011) 274 ALR 705; [2011] FCAFC 11, [171] (Jacobson, Foster and Barker JJ); and *Paric v John Holland Constructions Pty Ltd* (1985) 62 ALR 85; [1985] HCA 58 (Paric) (Mason ACJ, Wilson, Brennan, Deane and Dawson JJ)), to

which Lederer has referred.

2. The authors of Cross on Evidence, at [29070], express this as follows:

The "basis rule" provides that an expert opinion is not admissible unless evidence has been, or will be, admitted, whether from the expert or from some other source, which is capable of supporting findings of primary fact which are sufficiently like the factual assumptions on which the opinion is based to render the opinion of value

1. The function of this "proof of assumption" or "basis" rule has been said to highlight the irrelevance of expert opinion evidence resting on assumptions not back by primary evidence (see *Dasreef Pty Ltd v Hawchar* (2011) 243 CLR 588; [2011] HCA 21, at [90] per Heydon J).
2. There has been some debate as to whether the High Court in *Ramsay* laid down a rule of admissibility, or whether it provided instruction as to the weight to be attached to expert evidence in the absence of the proof of the facts which underlie the evidence. However, it seems reasonably clear now that, in the absence of proof, it is a matter of admissibility, not simply weight (see *R v Ryan* [2002] VSCA 176, at [9] (Ormiston, Vincent and Eames JJA)). However, one may not know at the time an expert report is tendered whether the factual assumptions on which it is based will or may ultimately be made good. It was said by Heydon J in *Makita (Aust) Pty Ltd v Sprowles* (2001) 52 NSWLR 705; [2001] NSWCA 305 (at [64]) that in circumstances where:

... other admissible evidence establishes that the matters assumed are 'sufficiently like' the matters established 'to render the opinion of the expert of any value', even though they may not correspond 'with complete precision', the opinion will be admissible and material.

1. Here, of course, as the primary judge noted, there were a number of facts or factual assumptions on which the experts' opinions were based, some of which were established or not disputed on the evidence.
2. A similar situation to the present arose in *Kubovic v HMS Management Pty Ltd* [2015] NSWCA 315 (*Kubovic*). There, the plaintiff was injured during the course of his employment with the respondent. The plaintiff tendered a number of medical reports which attested to the extent of his injuries. However, the experts did not then have the benefit of surveillance footage, which revealed that the plaintiff was more mobile, and less injured, than the experts had initially believed. Accordingly, the primary judge gave little weight to the expert evidence tendered at trial. At [172], Adamson JA, with whom I agreed (McColl JA in dissent on this particular issue), said that:

The surveillance evidence before the primary judge depicted the appellant working out at the gym.... Although the film was not very long and although the appellant's capacity to perform the exercises depicted was not entirely inconsistent with the appellant's case, the demonstrated capacity was, in the primary judge's view (with which I agree), materially at odds with his evidence in chief and, of greatest relevance for present purposes, his presentation to his own

experts; and the history he was recorded as having given to them. It was such as to undermine at least the reliability, if not the admissibility, of the opinions expressed in their reports. [my emphasis]

1. In that case, in circumstances where "not a single one of the expert medical opinions that had been relied upon by the appellant at trial was based on a foundation that included the surveillance evidence or the substance of what it revealed" (at [181]), the majority concluded that the primary judge was "correct not to accept the plaintiff's experts' opinions in circumstances where the appellant had not called any doctors to adduce evidence of his or her opinions in light of the surveillance evidence" ([182]).
2. Relevantly, in light of the submission by Mr Hodson pointing to the fact that the experts in this case were not called for cross-examination, at [184], Adamson JA said that:

There was, in my view, no obligation on the respondent to require the appellant's doctors for cross-examination to put the surveillance evidence to them and no denial of procedural fairness occasioned by their not being required for that purpose. By its cross-examination of the appellant, the respondent had amply notified its challenge on the basis of the surveillance evidence, both to the appellant's evidence and to that of his experts.

1. Kubovic is particularly apposite here.
2. In the present case, the primary judge noted at [89] that, while caution is to be exercised in making findings of fact based on photographs or other imagery, "the footage is sufficiently clear to enable findings as to the scene with which the plaintiff was confronted whilst at the northern dock are". On that basis, the primary judge then relied heavily on the CCTV footage to draw factual conclusions about Mr Hodson's exposure to the scene of the accident. Indeed, the primary judge noted at [90] that the histories provided to the respondent's experts "must be considered in the context of the other objective evidence available, particularly the CCTV footage".
3. Of the expert reports, the primary judge noted that "Mr Hu expressly acknowledged that the level of exposure the plaintiff had to the accident site and the deceased was unclear" (at [140]) and that "Dr Allnutt similarly noted that the plaintiff was unable to identify what he saw apart from 'the area of the truck'" (at [141]). These reports were nonetheless afforded weight by the primary judge, in spite of the appellant's submission that they were "premised upon an incorrect history as to the extent of the plaintiff's exposure to the aftermath of the accident, and more particularly, the plaintiff's alleged exposure to the victim's injuries" (at [131]).
4. As adverted to above, Lederer has pointed to Paric, where the High Court approved the statement of Samuels JA in the court below (see Paric v John Holland Constructions Pty Ltd [1984] 2 NSWLR 505, 509), where his Honour cited with approval the decision in Culver v Sekulich (1959) 80 Wyoming 437 at 458, in which it was said that "[f]rom our analysis of the record it appears to us that there was some evidence to support every hypothetical question

to which objections made. Such evidence was not always complete, was sometimes hazy as to time, distance and other vital words, but in general, furnished a fair climate for the consideration of the views of the expert witness"; Lederer arguing that the evidence in the present case did not rise to that level.

5. Lederer accepts that the limitations on the use of expert evidence where the assumptions made by the expert depart materially from the findings of fact is one which ordinarily goes to weight rather than admissibility (referring, by way of example, to *Davidson v R* [2022] NSWCCA 153 at [127]; *Sydney Wide Distributors Pty Ltd v Red Bull Australia Pty Ltd* [2022] FCAFC 157 at [16]) but notes that in *Palmer-Bruyn and Parker Pty Ltd v Parsons* (2001) 208 CLR 388; [2001] HCA 69, Kirby J (with whom Callinan J agreed on this point) said that (at [138]) "[t]ender of an expert's opinion is only rendered relevant to the issues for trial if the factual premises upon which the opinion is based are made good by other evidence" (relevance being a matter that goes to the question of admissibility itself).
6. In the present case, given that there was no objection to the admission into evidence of the expert reports (and no challenge based on its admission), the matter simply turns on the weight that could be attributed to them. The fact that the doctors were not challenged in cross-examination does not to my mind preclude an argument of the kind by Lederer that the reports had no probative force (see *Kubovic* above). In the absence of the (or a) key factual assumption being made good (i.e., that Mr Hodson had actually observed the injuries that he so graphically described), the weight that could be attributed to the expert reports on the issue of causation was in my opinion limited at best.
7. There is no doubt that most of the medical practitioners understood (whether from what Mr Hodson told them or from the instructions they were told to take into account or asked to assume) that Mr Hodson had actually observed the horrific injuries that the deceased had suffered. Only Dr Allnut appears to have appreciated that there was doubt as to the extent of the exposure by Mr Hodson to the actual injuries (though as already noted Mr Hu's opinion was not based on account that he had seen them).
8. Common sense suggests that seeing first-hand the blood and gore (or the "mess" as recorded in various of the medical notes) would be more traumatic than simply seeing a sheet covering what would be assumed to be a deceased body (though, as noted above, counsel for Mr Hodson seemed to suggest otherwise).
9. The difficulty caused by this factual assumption not being made good is that his Honour was largely unassisted in his determination of factual causation by expert medical evidence. While Dr Allnut did address the question as to the extent of exposure, he took into account another fact that was not established (namely, that there was repeated exposure to the scene).
10. The four reasons put forward by the primary judge for rejecting Lederer's submission that the expert opinions should be rejected are not persuasive. As to the first (that the history given by Mr Hodson of his experiences on the day was only one of a combination of factors

considered by the experts and that the reported symptoms were found by many of the experts to be consistent with a diagnosis of PTSD), this does not address the relevant issue of causation, namely whether that disorder was caused or materially contributed to by Mr Hodson's exposure to the scene or aftermath of the accident (it may be accepted that his reported symptoms were consistent with a diagnosis of PTSD but that does not answer the relevant question).

11. As to the second (that the experts had not given evidence as to the weight attached to the multiplicity of factors considered by them and hence the Court was unable to assess the relative weight to those factors), that is a reason for not according weight to the opinions (not vice versa).
12. As to the third (that Mr Hodson was not challenged as to the symptoms he reported other than to suggest exaggeration of them), it goes nowhere as to the question whether his diagnosed PTSD was caused or contributed to by his exposure to the scene or aftermath of the accident (rather than, say, to his later viewing of the accident live on the CCTV footage).
13. As to the fourth (the caution to be exercised in considering the reliability of recorded accounts to health professionals), while his Honour did not err taking this into account, the consistency of the reported accounts as recorded by various of the medical practitioners (with descriptions as to the brain matter being visible or the face squashed, and the torso contorted with the legs under the wheels) is hardly suggestive of some misrecording of what Mr Hodson said to the various practitioners as to his exposure to the scene of the accident.
14. In the circumstances, the reliance that could be placed by the primary judge on the medical evidence when determining factual causation was therefore limited. Moreover, the failure to make good the key assumption referred to above gave rise to a real question as to the causative effect of Mr Hodson reviewing the CCTV footage after the accident (that being disavowed as an element of the claim in negligence).
15. In those circumstances, I have concluded that the finding as to causation was in error.
16. Ground 3 of the appeal is made good.

Hurex' Cross-Appeal

1. As noted above, Hurex brings a cross-appeal in relation to the finding that it breached its duty of care to Mr Hodson for failing to direct him not to attend "a significant incident".

Hurex' submissions – Ground 1 of Cross Appeal

1. Hurex refers to *Koehler v Cerebos (Australia) Limited* (2005) 222 CLR 44; [2005] HCA 15 (Koehler) at [45], where the High Court held that in determining whether the kind of harm (namely psychiatric injury) to the particular employee was reasonably foreseeable and the content of the duty which an employer owes an employee to take reasonable care to avoid that injury, attention must be given to the nature and extent of the work being done by the

particular employee. Here, as noted above, Mr Hodson's primary duties were that of cleaning and closing the centre, with some basic maintenance and security work from time to time. Hurex says that Mr Hodson was neither employed, nor directed, to respond to patrons suffering life threatening conditions or significant injuries. (That submission does not take into account the evidence that Mr Hodson did have a role in responding to issues such as intoxicated persons or drug users. While his role may only have required him to contact emergency services or the police in those circumstances it can hardly be said that his role could not have exposed him to persons suffering life threatening conditions or significant injuries).

2. Hurex says that there was no evidence that the nature of the duties per se made it reasonably foreseeable that an employee could suffer psychiatric injury from performance of the duties; and therefore there was nothing in the nature of Mr Hodson's employment that would have put Hurex on notice that his work was likely to cause psychiatric injury (unlike the situation in *Kozarov v State of Victoria* (2022) 273 CLR; [2022] HCA 12).
3. Hurex says that in the circumstances, a reasonable person in the position of Hurex would not have foreseen the risk of psychiatric injury to Mr Hodson and the primary judge erred in finding otherwise (and in further finding that a reasonable response to the risk would have been to direct Mr Hodson not to attend a significant incident). Hurex accepts that, where the risk of psychiatric injury is not reasonably foreseeable from the nature and extent of the work the employee has agreed to perform, reasonable foreseeability may nevertheless arise where there are signs or information known by an employer that an employee is at risk of psychiatric injury from events at the workplace, and that information may in turn inform the content of the duty of care owed. However, Hurex says that there was no indication to Hurex of any particular vulnerability on the part of the plaintiff in doing the work he had agreed to do and there were no signs known by Hurex that he was vulnerable to harm. Hurex emphasises that there was no suggestion that the information as to Mr Hodson's emotional problems was conveyed by Mr Hodson to Hurex and that there were no evident signs warning of the possibility of psychiatric injury known by Hurex.
4. Hurex says that it was entitled to assume, in the absence of any warning signs, that Mr Hodson considered that he was able to do the job required for him under the contract, a job that he agreed to perform and enjoyed doing (referring to Koehler at [36]). (I note here that it is not clear to me that this addresses the circumstances of the present case. Whether or not Mr Hodson considered himself capable of doing the job does not address whether Hurex had a duty, as employer, to direct him how to respond if an emergency were to arise.)
5. Hurex contends that in the circumstances a reasonable person in its position would not have foreseen the risk of psychiatric injury to Mr Hodson and the primary judge erred in finding otherwise and in further finding that a reasonable response to the risk would have been to direct Mr Hodson not to attend a "significant incident".

6. It is noted that Hurex had in place systems and mechanisms for review of the work being performed by Mr Hodson, that its representative attended the Centre every four weeks to review the work being performed and met with Mr Hodson; and that it would review any significant issue apparent during those attendances or notified to it. Hurex also says that incident, grievance and reporting policies were in place and known by Mr Hodson, who could contact it at any time, if he needed. Hurex says that the content of the duty of care owed in the circumstances is satisfied by those measures.
7. Finally, it is said that even if the risk of psychiatric injury was reasonably foreseeable, the primary judge erred in finding that a reasonable response to the risk required Hurex to instruct Mr Hodson not to attend a significant incident. Hurex says that such a requirement would have imposed a qualification on Mr Hodson's ability to perform the duties required of him under his contract of employment (pointing to Koehler at [36]). It is noted that Mr Hodson was required to, and did, act under Ms Necovski's direction, and he agreed with the proposition that he did what she told him to do in order to keep his job.
8. Hurex emphasised both in written and oral submissions the practical difficulties with the finding if such a standard were to be imposed on employers such as Hurex. Hurex says that Mr Hodson would have been required to evaluate directions given by Ms Necovski and decide whether the task involved "a significant incident", the definition of which would be necessarily broad. It is submitted that such obligation would constrain contractual arrangements such as those between Hurex and Lederer, where the former provides staff to work under the direction of the latter.
9. Hurex points to the fact that the Centre was controlled by Lederer (not Hurex) and that Lederer exercised control over the Hurex staff. Hurex says (citing *Top Hut Banoon Pastoral Co Pty Ltd t/as Trustee for the Wakefield Family Trust v Walker* [2021] NSWCA 296), that the scope of the employer's duty and what constitutes a failure to fulfill this duty must depend on all the circumstances. In circumstances where Mr Hodson's usual work involved routine cleaning at a shopping centre under the direction of its management, it is submitted that the injury found to have been sustained by Mr Hodson was not reasonably foreseeable to Hurex and the circumstances surrounding his employment did not require Hurex to give the direction found by the primary judge.

Hurex' submissions – Ground 2 of Cross Appeal - Causation

1. Ground 2 of Hurex' cross-appeal goes to the finding of causation.
2. Hurex says that Mr Hodson was not directed by Ms Necovski to attend the northern dock (Ms Necovski having told him where she was when Mr Hodson asked) and that he did not do so to undertake cleaning or the work that he was being asked to perform on that day. Hurex says that it is not readily apparent that at the time Ms Necovski told him where Mr Brydon was, Mr Hodson knew the northern dock was the scene of trauma. Hurex says that Mr Hodson's exposure to the events on the north dock arose either out of his own decision to attend that area and to provide solace to his colleague (Mr Brydon) or that of Ms Necovski

(who was aware of the trauma there) having failed to direct him not to do so.

3. Hurex says that a direction by Hurex to the effect that workers such as Mr Hodson were not to attend "a significant incident", would not have prevented a worker such as Mr Hodson seeking to enquire about the well-being of a colleague. Hurex thus submits that, in the circumstances, even if breach is found against Hurex, such breach is not causative of the injury that was found to have been sustained.
4. As to the question whether the plaintiff's mental harm was in fact caused or contributed to by his attendance at the scene in the factual circumstances as found by the primary judge, Hurex adopts the submissions of Lederer. It is submitted that if those are accepted the claim against Hurex would fail on the same basis.

Mr Hodson's submissions as to Cross Appeal

1. Mr Hodson notes that Hurex accepts that Lederer provided Mr Hodson with no instructions as to the handling of confronting or tragic events; and does not suggest that it had done so. Mr Hodson says that the reasons given by the primary judge that a person in the position of Mr Hodson could be confronted with a significant incident mean that a relevant risk of injury arose, and it is noted that nothing was suggested by Hurex to have been done to address this risk whether by way of training, instruction, supervision or direction to the host employer or its own employee.
2. Thus Mr Hodson submits that the primary judge correctly found that Hurex, as Mr Hodson's employer, was liable for the injury sustained.

Determination

1. I do not accept that it was reasonably foreseeable by Hurex (who was not in control of the Centre and not responsible for giving day to day instructions as to the work that cleaning contractors supplied by it to Lederer were to do) that a person in Mr Hodson's position might suffer psychiatric injury if not directed by Hurex not to attend a significant incident at work.
2. Further, I accept the force of the criticism by Hurex that the direction it is said should have been given was imprecise and would give rise to practical difficulties in its implementation.
3. Ground 1 of the cross-appeal is made good. Ground 2 of the cross-appeal results in the same conclusions as Ground 3 of the Lederer appeal and should be upheld.

Costs

1. Ordinarily, costs would follow the event. Both Lederer and Mr Hodson sought an opportunity, depending on the outcome of the appeal and cross-appeal, to make submissions as to costs. It is not clear that either will now wish to do so, I propose that the ordinary order for costs be made and that, if any party, having considered these reasons, wishes an opportunity to make submissions as to a different costs order that party should

notify my associate by 10 January 2023 and directions can then be made for any brief submissions on costs to be made and for the issue to be determined on the papers. Subject to any such submissions, the costs order now to be made will stand.

Conclusion

1. For the above reasons I propose the following order:
1. Appeal and cross-appeal each be allowed with costs.
1. LEEMING JA: I have had the advantage of reading the reasons for judgment of Ward P and Basten AJA in draft. I agree with the orders proposed by Ward P, and with their Honours' reasons, and make the following comments by way of emphasis.
2. Both Hurex and Lederer owed a duty of care in relation to Mr Hodson, as actual and "host" employer (the duties are different, but little turns on that for present purposes). It was confirmed in *Koehler v Cerebos (Australia) Ltd* (2005) 222 CLR 44; [2005] HCA 15, which was not governed by the civil liability legislation, that a claim for damages for psychiatric injury turned on whether the risk of psychiatric injury to the plaintiff was reasonably foreseeable. "The relevant duty of care is engaged if psychiatric injury to the particular employee is reasonably foreseeable": at [35]. Such cases are intrinsically and inevitably fact-dependent. As much may be seen in this Court's decision in *Karzi v Toll Pty Ltd* [2024] NSWCA 120 at [4]-[6] and [102]; the same point was made in *Robinson v EACH Ltd* [2024] VSCA 313 at [126]-[128].
3. The enactment of the Civil Liability Act 2002 (NSW) has not altered this. Section 32 demands a cognate factual inquiry, in relation to Mr Hodson's claim against Lederer (although it is made inapplicable by s 3B(1)(f) of the same statute to the claim against Hurex for modified common law damages under Division 3 of Part 5 of the Workers Compensation Act 1987). As Ward P and Basten AJA observe, aspects of s 32 give rise to issues which need not be resolved in this appeal, and I express no view on them.
4. As the other members of this Court explain, on the facts of this case, it was not reasonably foreseeable that the limited exposure to the carpark where the fatality took place, including the presence of Mr Hodson's distressed colleagues, would result in any harm. Nor was there any breach of duty in Ms Necovski instructing Mr Hodson to attend and to walk over to Mr Brydon to remove him from the scene, especially having regard to the fact that Mr Brydon was also owed a duty of care.
5. Finally, as Ward P and Basten AJA explain, one can confidently conclude from the CCTV footage that the instructions upon which the plaintiff's experts were briefed – to the effect that Mr Hodson had directly witnessed the uncovered body of the deceased that morning – were incorrect. In this Court, counsel candidly and appropriately conceded as much. Indeed, the manner in which Mr Hodson's counsel opened the case at trial makes it tolerably plain that he anticipated that his client would not give evidence that he actually

saw the uncovered body of the deceased. This is not to imply that there was any conscious or deliberate embellishment by Mr Hodson, who had also seen albeit after the event the CCTV footage of the accident occurring. It is a simple example of the unreliability and malleability of memory, especially when – as is often inevitable in the litigation process – a witness is repeatedly called upon to recollect traumatic events. Spigelman CJ once observed that memory is plastic and "[w]itnesses can, without any dissimulation or propensity to lie, confidently assert the truth of conversations, observations and events that did not happen": JJ Spigelman AC, "Truth and the law" in N Perram and R Pepper, *The Byers Lectures 2000–2012* (The Federation Press, 2012) at 250. This is an aspect of the "ordinary human experience" to which McClelland CJ in *Eq* referred in *Watson v Foxman* (1995) 49 NSWLR 315 at 319 and which is a fundamental aspect of the fact-finding process in litigation.

6. I agree with Ward P and Basten AJA that this Court should find that the consequence was that there was an absence of evidence that Mr Hodson's injury was caused by such exposure as he had to the fatality on 26 October 2020, and as their Honours note, any claim based upon his exposure to the CCTV footage days after was disavowed. Each of the opinions upon which Mr Hodson relied was explicitly based upon assumptions that he had seen the uncovered body of the deceased and the "horrific injuries" which had been sustained. Indeed, the letters of instruction to Drs Allnut [and others] emphasised this by stating that "[p]hotographs of the scene are available if they would be of any assistance to the formation of your opinions, however, we [warn] that they contain graphic images", and direct exposure to the deceased's injuries is prominent insofar as the reports address causation.
7. BASTEN AJA: The successful plaintiff in the court below, Andrew Hodson (the plaintiff), brought proceedings against both his employer and the manager of the shopping centre in which he worked as a cleaner, seeking damages for psychological injury. The psychological injury arose from his attendance at a scene where a truck delivering goods to the shopping centre had run over and killed a pedestrian. The circumstances are fully explained in the judgment of the President, with which I agree. I also agree with her proposed orders.
8. Three further observations may be made in relation to the circumstances of the case.

Nature of the evidence

1. Only two witnesses gave oral evidence and were cross-examined, namely, the plaintiff and Sonja Necovski, the manager of the shopping centre on duty at the time of the incident. Ms Necovski gave evidence of the steps she had taken once she became aware of the accident, including requesting that the plaintiff attend, in circumstances where his colleague on duty that morning, Mr Josh Brydon, was emotionally distressed and, in Ms Necovski's view, required assistance and to be relieved of his work duties.

2. Whether Ms Necovski's employer, the appellant Lederer Group Pty Ltd, was in breach of any duty of care it owed to the plaintiff, was to be assessed on the basis of the factual evidence as to the events of that morning, as adduced from the plaintiff and Ms Necovski respectively, and the documentary records. There was little dispute as to the evidence given by Ms Necovski of the steps she took; the timing of the events was largely confirmed by CCTV footage of the loading dock where the accident occurred.
3. The critical questions, namely whether the appellant owed the plaintiff a duty of care, and whether the conduct of Ms Necovski constituted a breach of that duty, involved questions of law and inferences drawn from the facts, rather than resolving disputes as to the primary facts. Ms Necovski's perceptions as to how her conduct might be viewed were largely immaterial. The only contentious issue concerned Ms Necovski's knowledge of the degree of emotional fragility of the plaintiff.
4. The plaintiff's evidence, on the other hand, was contested, especially as to what he witnessed. This evidence was material in two separate respects. First, his observations and perceptions of the event, and his responses, formed the basis for his claim. Secondly and indirectly, his claim turned on what he told the medical experts as to his observations, perceptions and responses. What the plaintiff told the medical experts was critical to the weight to be given to, and even the relevance of, their opinions. As explained by the President, the factual circumstances witnessed by the plaintiff, as established by the evidence at trial, differed in highly significant respects from the accounts he gave to various medical practitioners.
5. The other aspect of the evidence to be noted was the absence of any cross-examination of the medical practitioners. Their reports were tendered without objection. In fact there was a substantial degree of agreement in their opinions as to the appellant's psychological conditions. In that situation, the expert evidence relied on by the appellant was of no immediate significance. The medical evidence called by the plaintiff, however, fell into a different category.
6. The plaintiff no doubt faced a forensic dilemma. If he wished to rely upon a factual scenario in which he had only a passing glimpse of the deceased under a white sheet, with the knowledge that there had been a fatal accident, he needed to obtain medical evidence as to whether those circumstances would have led the medical witnesses to qualify or vary their opinions. To do that would mean accepting at least the possibility that his accounts recorded in the medical reports were inaccurate. Not to do so, carried the risk that the Court would find his accounts to be inaccurate and dismiss the expert opinions on that basis. He chose the latter course.
7. Such forensic difficulties are not uncommonly faced by plaintiffs in personal injury cases. Sometimes they arise because witnesses give evidence under cross-examination which had not been anticipated. However, in this case the possibility of the Court making findings inconsistent with the plaintiff's reports to his medical practitioners, might have been

apparent from the CCTV footage. In any event, the Court was left to speculate as to what the medical practitioners might have said had they been presented with the alternative scenario. It was not the appellant's job to cross-examine the plaintiff's experts in order to fill a gap in the plaintiff's case.

8. Given the limited exposure of the plaintiff to the incident on 26 October 2020, a question remains as to what gave rise to his adverse psychological reaction, both on that day and over the subsequent weeks and months.

Chronology of accounts to medical practitioners

1. Unhelpfully, neither party provided a proper chronology of the events: nevertheless, the chronology was important. First, the medical records from the general medical practice which he regularly attended at that time demonstrated that he had, for more than a year before the incident, suffered from anxiety and depression and was on an antidepressant.
2. Secondly, there was undisputed evidence that the applicant was distressed and emotional on the day of the incident. He saw his general practitioner, Dr Harender Saroha, on the day after the incident and recounted that he had "witnessed an accident yesterday in the car park [of an old man] getting crushed by a truck". That account, at least as recorded in the notes taken by the doctor, included embellishments. He was prescribed a "low dose of diazepam" (Valium). However, he was not referred to a psychiatrist whom he attended until May 2021.
3. Thirdly, he gave evidence that, approximately two to four weeks after the incident, he viewed some of the CCTV footage on a screen in the manager's office at the shopping centre when about to start a shift; [1] this could have been a time at which he saw "crushed body parts" and other details recounted to later practitioners as having been observed on the day. But no further details were recorded on subsequent visits to Dr Saroha on 9 and 30 November and 22 December 2020. On the last date, he was taken off diazepam. On none of those occasions do the doctor's notes record any relevant stressor. However, on 30 November 2020 Dr Saroha gave him a referral to a psychologist, although there was no evidence he took this up. Although viewing the CCTV footage may have provided him with a source for the visual images and perceptions he later described, that is a matter of speculation.
4. Fourthly, there followed a series of consultations with Dr Saroha. On 22 January 2021 Dr Saroha recorded that he was "working long hours – still without a break – new person at work is starting soon – manager who has been troubling him has been sacked – in stable relationship but it is affecting it". (This suggests work conditions were affecting the domestic relationship.)

5. On 1 March 2021 he saw Dr Saroha again, the doctor recording the reason for contact as "anxiety/depression – separated from his wife – living in same house – sounds low in mood". Similar symptoms were recorded on 11 March 2021 and on 24 March 2021, although on the last occasion, the doctor noted that he "works 7 days 12 hours shifts – his mum passed away when he was 11 years old and considers his landlady as his mum". Lower back pains were also recorded as a result of "lifting at work".
6. There were further consultations and 31 March 2021, 1 April 2021 and 10 May 2021. On 31 May 2021 there was a note that "has still got flashbacks", though there was no further explanation as to their content, nor were there records of earlier complaints in those terms. On 30 May 2021 the notes stated that he "went to ED by ambulance on 28 May 2021 – with CP with radiation to [left ?] shoulder and neck. With associated SOB [shortness of breath?] and sweating – came on while he was have a stressful discussion – with his employer, as has not been paid for last few weeks".
7. Finally, on 11 June 2021 the plaintiff saw Dr Nacinder Panesar, a consultation psychiatrist. Dr Panesar recorded:

"Mr Hodson reported severe PTSD symptoms including reliving his recent trauma in flashbacks and nightmares

Mr Hodson's trauma is related to having involvement in an incident at work in November [sic] 2020. While he was at work at the supermarket, he was called out to the dock area where an elderly person was crushed under a truck's front wheel. He saw the crushed deceased's body parts Mr Hobson told me that he used to see the deceased person regularly when he would go shopping at the supermarket."

That account included significant further embellishments.

1. Further details of later medical reports to psychiatrists and psychologists are discussed by Ward P.
2. The limited observations of the plaintiff on the day of the accident were manifestly inconsistent with the accounts given to psychiatrists. The fatal flaw in the underlying premises of the medical opinions prevented the plaintiff relying upon that evidence to demonstrate a causal connection between his psychological state, as recorded in medical notes and reports from May 2021, and the incident in October 2020. His claim against both defendants should have failed on that basis.

Duty of care

1. Before identifying the legal principles relevant to establishing a duty of care, the indirect nature of the claims made in this proceeding should be identified. Neither Lederer nor Hurex was responsible for the death of the pedestrian. If there were negligence, which there may well have been, in the occurrence of the accident, it was the negligence of the driver of the truck who was directly responsible for the accident with likely contributory negligence

on the part of the deceased. The plaintiff did not sue the driver although, according to standard principles, any harm caused by the accident, including psychological injury to a bystander, might have been expected to fall within the scope of the duty of care owed by the truck driver.

2. However, in that case, recovery would probably have been precluded by the operation of s 30 of the Civil Liability Act 2002 (NSW). That provision applies to a claim for "pure mental harm", that is mental harm which is not consequential upon personal injury of another kind: s 27. In such a case, liability may arise where the plaintiff is a close member of the family of the victim, or where the plaintiff "witnessed, at the scene, the victim being killed, injured or put in peril": s 30(2). That limitation on liability only applies where the mental harm arises "wholly or partly from mental or nervous shock" and where it is the act of the defendant which results in death, injury or being put in peril.
3. There is no necessary incoherence between such a constraint on recovery by a plaintiff where the defendant is directly responsible for the death of the victim (for example) and the ability of the plaintiff to recover from an employer who puts the plaintiff in circumstances of the kind which arose in the present case. That is because the nature of the duty in each case is significantly different. However, there is some element of anomaly, which might have been demonstrated had either Lederer or Hurex cross-claimed against the truck driver for contribution. For present purposes, all that can and need be said is that the provisions of the Civil Liability Act with respect to claims for mental harm must be construed with close attention to the language of the provisions, as well as any apparent underlying policy or principle arising from contextual matters. However, as will be seen, the language of s 30 is reflected in parts of s 32.
4. The provision in issue in the present case was s 32, set out by the President at [119] above. Where engaged, this provision denies the existence of a duty of care. Because it is concerned with the existence of a duty of care, for this purpose the circumstances of the present case are to be viewed prospectively and objectively. The purpose of the provision is to limit the scope of a duty not to cause mental harm to circumstances where the mental harm might be suffered by a person of normal fortitude. That is, by analogy with the language sometimes used in relation to personal injury, a duty does not arise if mental harm would only be suffered by a person with an eggshell psyche.
5. The section has two areas of operation. The general denial of a duty of care in s 32(1) applies to both consequential mental harm and pure mental harm. In that respect, the "circumstances of the case" are neither limited nor defined. The second area of operation is restricted to pure mental harm and the circumstances of the case are identified to include the matters set out in subs (2). With respect to the operation of subs (1) in relation to consequential mental harm, the circumstances of the case are said to include "the personal injury suffered by the plaintiff": s 32(3). This is not a case of consequential mental harm.

6. The indeterminacy of the verb "include" is easily understood. Generally it is non-exhaustive, in some cases it is purely illustrative, in others it may extend the ordinary meaning of a defined term or the list of relevant considerations. Where, as here, it applies to relevant considerations, it is indeterminate at a further level, in that it gives no direct assistance in how the identified considerations may operate.
7. The considerations operate for the purposes of s 32(1) in determining what a defendant "ought to have foreseen" at a level of a real possibility, being the usual meaning of "might" in relation to a future event. In understanding the intended relevance of the four matters set out in s 32(2), assistance may be obtained from the fact that two of them – (b) and (c) – are equivalent to the two matters which entitle a person to recover damages for pure mental harm where s 30 applies. When taken with par (a) in s 32(2) (referring to "sudden shock") each may be inferred as militating in favour of engagement of a duty of care. Thus, for example, in the case of a sudden shock, or witnessing a person being killed, it is likely (perhaps highly likely) that the defendant ought to have foreseen that a person of normal fortitude might suffer pure mental harm in such circumstances.
8. The relevance of s 32(2)(d) (referring to a pre-existing relationship between the plaintiff and the defendant) is less obvious when read in isolation, but may be clearer if read with subs (4) which states, using a double negative, that s 32 does not require a court to "disregard what the defendant knew or ought to have known about the fortitude of the plaintiff". However, that provision has its own difficulties. It could mean that if the defendant knows or believes that the plaintiff is a person of greater than normal fortitude, there may be no breach of duty even if a duty would have arisen with respect to a person who was merely of normal fortitude. That would not contradict the operation of s 32(1). However, it is not so easy to read those provisions together where the defendant knows or ought to know that the plaintiff is psychologically fragile. If a duty of care is to arise in that circumstance where it would not arise where the plaintiff is a person of normal fortitude, then the operation of subs (4) is to contradict the unqualified language of subs (1).
9. The President concludes that it is not necessary to resolve this conundrum in the present case because there was no basis on the facts to find that either Lederer or Hurex knew or ought to have known that the plaintiff was not a person of normal fortitude. That is so. It is, however, necessary to identify the relationship between the general principles relevant to breach of duty stated in s 5B and the denial of the existence of a duty in the circumstances identified in s 32(1).
10. Although s 5B, coming in Div 2 and headed "Duty of care" is commonly understood to deal with breach, there is no bright line between duty and breach, especially once the existence of a duty is understood to incorporate an element of its content. In deciding whether a person of normal fortitude "might" suffer a recognised psychiatric illness, it is appropriate to apply the criterion of a foreseeable risk, and one which was not insignificant, in the terms of s 5B(1)(a) and (b). Although the language of the two provisions is not the same, that approach is practical and avoids unnecessary complexity. (There is already complexity in

circumstances where the Civil Liability Act applies to the claim against Lederer but not to the claim against Hurex, Hurex being the employer, pursuant to the exclusion in s 3B(1)(f) of the Civil Liability Act.) For the purpose of s 32, it should not be said that a defendant ought to have foreseen that harm might occur unless the consequence was foreseeable and the risk was not insignificant.

11. There is then a question as to the basis on which a finding that s 32 was engaged should be made. It has been said that the concept of "a person of normal fortitude" is not meaningful in psychological terms and is difficult to understand in a forensic context. Both criticisms may be valid, but the statute requires such a judgment to be made and arguably it is preferable that it be made on the basis of expert psychological evidence, rather than by taking judicial notice of matters of uncertain scope. On the other hand, where the evidence is not being sought as to the state of mind of a particular individual, psychological expertise may be of limited assistance. For reasons explained below, the better course is not to resolve these questions in the present case, in the absence of evidence and in the absence of full argument as to the operation of the statute.

Reasonable precautions

1. In my view, apart from the lack of evidence about causation, this case may be determined on the basis that no breach of duty can arise unless a reasonable person in the position of each of the defendants would have taken precautions sufficient to prevent the exposure of the plaintiff to the risk of harm.
2. As far as Lederer was concerned, it was dealing with an emergency. Accidents, even fatal accidents, occur from time to time and can occur anywhere. An employee of the shopping centre directing traffic or acting as a gate operator may witness a fatal accident of precisely the kind which occurred in this case. That person's employer would not usually be responsible for not taking precautions against such an eventuality.
3. In the present case, the accident was not witnessed by the plaintiff, and possibly not by Mr Brydon, who at least saw an earlier stage of the aftermath than did the plaintiff. Ms Necovski as the agent of the centre operator, Lederer, was required in the course of her duties to deal, amongst other things, with Mr Brydon's distress. She gave evidence that there was no other administrative assistance present before 9am or after 3pm. [2] She said there were no security staff working at 10.30am on 26 October 2020. [3] In cross-examination, Ms Necovski agreed that the situation was "confronting" and that she believed that the plaintiff was distressed by the events of the morning, even though he said he was "okay". There was no suggestion made to Ms Necovski that she should have done things differently, nor that there were other resources available to her to deal with the totally unexpected events. The plaintiff's case was merely that she should not have allowed him to be exposed to the aftermath of the accident.

4. In the circumstances, and on her evidence which was accepted, all she asked him to do was to support Mr Brydon and remove him from the scene. To suggest that she was in breach of her duty of care in asking any other member of staff to be involved was not a reasonable proposition. Had the mutilated body still been exposed, a different view might have been formed. But that was not the case when the plaintiff attended some 40 minutes after the accident occurred, after the paramedics had placed a sheet over the deceased's body and whilst other steps were being taken to shield members of the public from the scene.
5. There was no shred of evidence to suggest that Ms Necovski, or anyone else involved in the events of that morning, behaved otherwise than entirely reasonably and with due attention to their respective responsibilities. The suggestion that Ms Necovski (and therefore Lederer), let alone Hurex, failed to act appropriately or failed to anticipate the need to take some step which was not taken, defies common sense.
6. Lederer's appeal and Hurex's so-called cross-appeal should be allowed; the orders made in the District Court set aside and the plaintiff ordered to pay the costs of both other parties of the trial and in this Court.

Endnotes

1. DC Tcpt, 27 February 2024, p 49(45)-50(22).
2. DC Tcpt, 1 March 2024, p 3(35)-(45).
3. DC Tcpt, p 11(48).

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