

SUPREME COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	Massouras v Kone Elevators Ptd Ltd Pattinson v Kone Elevators Ptd Ltd Shipton v Kone Elevators Ptd Ltd Soesman v Kone Elevators Ptd Ltd
Citation:	[2020] ACTSC 66
Hearing Dates:	23, 29-30 April 2019; 1-9 May 2019; 16-24 September 2019; 5-6 November 2019
Decision Date:	3 April 2020
Before:	Burns J
Decision:	See [227]-[232]
Catchwords:	CIVIL LAW – NEGLIGENCE – Personal injury – plaintiffs injured when lift malfunctioned – first defendant was engaged by the building manager to conduct maintenance and services to the lift – whether or not the malfunction was occasioned by any negligence on the part of first defendant – if so, whether the injuries alleged to have been suffered by the plaintiffs were caused or materially contributed to by the incident – whether one of the plaintiff's claim was statute barred – consideration of the medical evidence – assessment of damages
Legislation Cited:	<i>Civil Law (Wrongs) Act 2002</i> (ACT), ss 42, 43 <i>Court Procedures Rules 2006</i> (ACT), r 215 <i>Evidence Act 2011</i> (ACT) s 69, Dictionary <i>Limitation Act 1985</i> (ACT) ss 16A, 16B, Dictionary <i>Safety, Rehabilitation and Compensation Act 1988</i> (Cth), ss 14, 68, 69, 70, 72 <i>Workers Compensation Act 1951</i> (ACT), s 4, Dictionary
Cases Cited:	<i>Averkin v Insurance Australia Ltd</i> [2016] NSWCA 122; 92 NSWLR 68 <i>Kennedy Cleaning Services Pty Ltd v Petkoska</i> [2000] HCA 45; 200 CLR 286 <i>Leichardt Municipal Council v Montgomery</i> [2007] HCA 6; 230 CLR 22 <i>Lewis v Nortex Pty Ltd (in Liq); Lamru Pty Ltd v Kation Pty Ltd</i> [2002] NSWSC 1083 <i>Minister for Immigration and Ethnic Affairs v Wu Shan Liang</i> (1996) 185 CLR 259 at 282 <i>Modbury Triangle Shopping Centre Pty Ltd v Anzil</i> [2000] HCA 61; 205 CLR 254 <i>Roads and Traffic Authority of New South Wales v Dederer</i>

[2007] HCA 42; 234 CLR 330
Sydney Water Corporation v Turano [2009] HCA 42; 239 CLR 51
Thomas v State of New South Wales [2008] NSWCA 316; 74 NSWLR 34.
Vitali v Stachnik [2001] NSWSC 303
Zickar v MGH Plastic Industries Pty Ltd (1996) 187 CLR 310

Parties:

Kellie Maree Massouras (Plaintiff)
Jane Angela Pattinson (Plaintiff)
Alison Shipton (Plaintiff)
Jessica Soesman (Plaintiff)
Kone Elevators Pty Ltd (1st Defendant)
The Trust Company Limited (2nd Defendant)
Cromwell Corporation Limited (3rd Defendant)
Cromwell BT Pty Ltd (4th Defendant)
Cromwell Property Securities Limited (5th Defendant)
Cromwell Property Services Pty Ltd (6th Defendant)
Cromwell Funds Management Limited (7th Defendant)
Cromwell Project & Technical Solutions Pty Ltd (8th Defendant)
Cromwell Property Group (9th Defendant)
Cromwell Property Fund (10th Defendant)
Cromwell Diversified Property Trust (11th Defendant)

Representation:

Counsel

A Bartley SC with F Tuscano (Plaintiff)
P Menzies QC with B K Nolan (23, 29-30 April 2019; 1-9 May 2019); B K Nolan (16-24 September 2019; 5-6 November 2019) (1st Defendant)
N Polin SC (2nd-11th Defendants)

Solicitors

Ken Cush and Associates (Plaintiff)
Moray & Agnew (1st Defendant)
McCabe Curwood (2nd-11th Defendants)

File Numbers:

SC 399 of 2016; SC 400 of 2016; SC 401 of 2016; SC 403 of 2018

BURNS J:

Introduction

1. On the morning of 4 September 2013 each of the four plaintiffs entered lift number 2 (the lift) on the 19th floor of Lovett Tower in Woden, ACT (the premises). They intended alighting from the lift on the ground floor. The lift malfunctioned. Each of the plaintiffs had a different recollection of the movements of the lift during the malfunction, but it was accepted by the defendants that the lift stopped suddenly on two occasions at the 14th floor and the 11th floor. On the 11th floor, after speaking to an operator at the Kone Service Centre, the doors of the lift opened, and the plaintiffs exited the lift. They then completed their descent to the ground floor by the fire stairs.
2. Each of the plaintiffs were injured when the lift malfunctioned. They have claimed damages in negligence against 11 defendants, who may be grouped as followed:
 - (a) the first defendant, Kone Elevators Pty Ltd (Kone), the company engaged by the building manager (the second defendant) to conduct maintenance and services to the lifts in the premises;
 - (b) the second defendant, the Trust Company Pty Ltd (Trust Company), the building manager; and
 - (c) the third to eleventh defendants, the various corporate entities described as the Cromwell entities (Cromwell), the building owners.
3. The plaintiffs' claims on both liability and quantum were vigorously defended by, in particular, Kone. The remaining defendants were represented by different counsel, who adopted a much more moderate approach probably as a result of an estimation that Kone was the party likely to bear the burden of any judgments on behalf of the plaintiffs. The plaintiffs' case on liability developed over the period of the hearing, which regrettably occupied 18 days. It was not until Kone called one of its senior elevator technicians, John Stevens, to give evidence on day 14 of the hearing that facts were revealed which significantly changed the plaintiffs' case on liability. I will return to that evidence in a moment, but the case ultimately settled upon by the plaintiffs after the evidence of Mr Stevens was that the elevator malfunction was caused by a loose wire in the lift's supply transformer which was in turn caused by negligent maintenance by employees of Kone. As identified by counsel for Kone, the issues for determination with regard to Kone are:
 - (a) whether or not the occurrence of the loose wire was occasioned by any negligence on the part of Kone?
 - (b) if so, whether the injuries alleged to have been suffered by the plaintiffs were caused or materially contributed to by the incident?
 - (c) whether the claim of one of the plaintiffs, Jane Pattinson, is statute barred?
4. The plaintiffs effectively abandoned their claims against the other defendants, but I will nevertheless address those claims. In addition, the Cromwell defendants served a Notice Claiming Contributions or Indemnity from Kone based upon a contract between the parties which required Kone to indemnify them with respect to the claims brought by the plaintiff.

5. In final submissions, Kone admitted that it owed a duty of care to persons in the position of the plaintiffs, at least in relation to the creation of a risk of injury, citing *Leichardt Municipal Council v Montgomery* [2007] HCA 6; 230 CLR 22. Kone submitted that the ambit of that duty was to exercise reasonable care in the performance of its work under the contract with the Trust Company to maintain and repair the lift. In deciding whether it had breached that duty, Kone submitted that the standard of care required is that of a reasonable person in Kone's position who was in possession of all the information that Kone had or ought reasonably to have had at the time of the incident: s 42 *Civil Law (Wrongs) Act 2002* (ACT) (the Wrongs Act).
6. Each plaintiff commenced separate proceedings, but sensibly all proceedings were heard together. For that reason, I have produced a single judgment.
7. It is convenient to begin with determining whether Mrs Pattinson's claim is maintainable.

Is Mrs Pattinson's claim maintainable?

8. There is no doubt that the incident upon which Mrs Pattinson brings her claim occurred on 4 September 2013. She did not, however, commence proceedings against the defendants until 3 September 2018. At the time of the incident, Mrs Pattinson was employed by a company which held a contract to provide services to the Commonwealth. On 4 September 2013 she was deployed by her employer to the Department of Veterans' Affairs, which occupied offices in the premises at Woden. She was not a public servant, and it has not been suggested that she was an employee for the purposes of the *Safety, Rehabilitation and Compensation Act 1998* (Cth). Mrs Pattinson testified that after the incident she was initially off work by reason of neck pain and headaches stemming from the incident for two and a half days, and then for "a few hours and days" over the next six weeks. She said that she suffered neck pain, shoulder pain and headaches. She consulted her general practitioner and underwent physiotherapy and chiropractic treatment. After the initial treatment period, her neck continued to bother her intermittently, at which times she used over the counter pain relief. She continued working.
9. Mrs Pattinson made an application for workers' compensation, which was accepted by her employer's workers' compensation insurer, QBE. In the application, Mrs Pattinson complained of suffering from a stiff neck and shoulders, as well as stress and headaches.
10. In September 2017, Mrs Pattinson developed numbness in her left thumb. Her general practitioner referred her to a neurosurgeon, Dr Justin Pik. She was told that she had a compressed spinal cord. Surgery was recommended. The surgery was not undertaken by Dr Pik because Mrs Pattinson's health insurance did not cover it, and QBE advised her not to make a claim for the surgery to be covered by workers' compensation. Plainly this "advice" was an indication that QBE would reject the claim. The surgery was performed in February 2018 by Dr Rebecca Webb-Myers in the public system. Mrs Pattinson had been informed by both Dr Pik and Dr Webb-Myers that if she did not have the surgery, there was a possibility she could become a quadriplegic.
11. In 2016, she had been contacted by the firm of solicitors acting for the other plaintiffs in these proceedings. She had a telephone conversation with one of those solicitors. The solicitors prepared a draft statement for Mrs Pattinson to sign and return,

presumably with the intention of calling her to give evidence on behalf of the other plaintiffs at any future hearing. Mrs Pattinson did not sign or return the draft statement because, she said, it contained inaccuracies. In the email accompanying the draft statement, the solicitor told Mrs Pattinson that she could also bring a claim, but she did not act upon that advice at that time. She testified that at that time her symptoms had settled down and she decided she did not want to make a claim.

12. In July or August 2018, after Mrs Pattinson had undergone surgery on her neck, she was contacted by telephone by the solicitors representing Kone with a view to her being called as a witness by Kone. After that contact, Mrs Pattinson contacted the solicitors acting for the other plaintiffs and decided that she would make a claim.
13. In cross-examination, Mrs Pattinson agreed that she could have arranged to speak to the solicitors representing the other plaintiffs in 2016 when they contacted her. She did not do so because, at that time, she did not think there was much wrong with her. She agreed that by November 2017 she had seen Dr Pik and Dr Webb-Myers and had undergone an MRI, so she knew she was not fine as she had earlier believed. She agreed that at that time she did not take steps to commence a claim.
14. Mrs Pattinson said that about a month after the incident she attended a meeting, on level 22 of the premises, at which she and a number of other workers were addressed by a representative of Kone and an independent lift expert regarding the cause of the incident on 4 September 2013. She said that they were told a “sensor had failed” and that the emergency brake had activated. Mrs Pattinson agreed that by that time she was aware that she had experienced shock and stiffness in her neck and shoulders that she attributed to the incident and she was aware that Kone “had been responsible for the behaviour of the lift.”
15. Before turning to the relevant legislation, it is necessary to refer briefly to the medical evidence regarding Mrs Pattinson’s neck. As part of the preparation of Mrs Pattinson’s case, she was seen and assessed by a number of medical experts. In a report dated 8 October 2018, Dr Kathiravel Nadanachandran, a neurosurgeon and spine surgeon, stated:

The history given by this lady indicates that she suffered initially symptoms in the neck with headaches soon after the accident which occurred in September 2013. The kind of rapid descent that she suffered twice during this event could have caused some injury to the neck similar to a whiplash injury. This caused neck pain and headaches.

However at that time, she did not have any neurological features in her symptoms and she managed the neck pain and headaches using simple analgesics and chiropractic treatment. No x-rays or scans seem to have been done at that time.

Subsequently in September 2017, she developed symptoms spontaneously of a neurological nature and was found to have quite marked disc protrusion at the C5-6 level. There was also a mild bulge at C3-4.

The records indicated on 20 January 2015, she had in fact complained of tingling and soreness on the left ulnar distribution, which is along the inner side of the left forearm and hand and also pain along the side of the neck. The general practitioner found no neurological deficits. There was decreased range of neck movement to lateral rotation and tenderness along the upper trapezius muscles on both sides. She was prescribed Mobic and advised physiotherapy. If symptoms did not improve, consideration was to be given for an MRI scan. A scan was not done at that time.

Causation

The cause of the disc protrusion causing the spinal cord compression of major nature in September 2017 is unclear. From the history, there was probably no spinal cord compression soon after the accident. At that time she had neck pain and headaches. Unfortunately, there are no scans of either CT or MR done soon after that. The records indicate that she has seen the doctors with neck pain and headaches in 2013 twice. Prior to the incident in 2013, she claims to have had no symptoms in her neck.

Medical records indicate consultation for pain in left shoulder, right hip and down right leg on 23 July 2014 and no neurological features were found.

On 10 January 2015 recurrence of tingling in the ulnar nerve distribution is recorded and no deficits found. Physiotherapy was advised. There are no further records of a neurological condition until September 2017.

There were a number of consultations thereafter in 2015 to 2017 for unrelated conditions and no neck pain or symptoms in the arm/s is recorded, On 23/10/17 she presented with numbness in the left thumb at night leading to further investigations – nerve conduction studies and MRI scan. Following this she was referred to neurosurgeons as cervical cord compression was revealed.

It would therefore seem that the incident in September 2013 may have lead to an injury to the disc/discs causing the initial neck pain and leading to recurrent neck pain and headaches. The C5/6 disc then ruptured in September 2017 spontaneously or was aggravated by some unknown stress on the neck.

It is possible for a weakened disc to bulge or rupture when stressed by normal or heavy activities. The incident of 4 September 2013 in my view is possibly a contributing factor to the disc protrusion at C5/6 in 2017.

She had fortunately fairly prompt surgical attention, which relieved the spinal cord compression, but still has some residual symptoms. It can take anything up to a year to recover fully from an operation of this nature.

The condition in the right shoulder is possibly due to local sprain or strain to one of the tendons or muscles or it could be some referred pain from the neck. It could also be a combination of both.

16. Mrs Pattinson's lawyers wrote to Dr Nadanchandran seeking clarification of some of the opinions expressed in this report. Dr Nadanachandran confirmed that it was his opinion that the incident of 4 September 2013 probably caused a weakness in her cervical spine which either caused or contributed to the disc bulge or its rupture. He described the mechanism by which a weakened disc may bulge or rupture:

A normal disc has a soft jelly in the centre and a fibrocartilaginous covering called the annulus. An injury to the disc can result in rupture/tear of the annulus. An injury may also accelerate or cause a degenerative process to set in. This in turn weakens the annulus over a period of time. With this in the background normal activities or another injury can allow the soft jelly to extrude into the spinal or the nerve root canal. Thus, an injury can result in a delayed extrusion of the disc.

17. Dr Leon Le Leu, an occupational physician, provided a report dated 30 August 2018. His diagnosis of Mrs Pattinson's condition was:

Probable exacerbation of pre-existing cervical spondylosis made symptomatic by the subject incident; alternatively, due to the forces involved in the incident, she could have suffered neck trauma which has developed into cervical spondylosis over five years. Her left shoulder problems are more likely to be secondary to the neck rather than due to an intrinsic should injury.

In oral evidence, Dr Le Leu explained the term "spondylosis" as a "degenerative disease of any part of the spine and it's due to degeneration of any of the structures which make up the spine...".

18. Dr Peter Bentivoglio, a neurosurgeon retained by Kone to assess Mrs Pattinson, provided a report dated 26 March 2019 in which he said:

My working diagnosis in (seemingly, "is") Ms Pattinson is a lady with degenerative disease in her cervical spine with a significant C5/C6 disc prolapse, which was causing cord compression and other cord changes. I do believe that the original jarring injuries back in 2013 started the problems in her neck, which progressed over the next four years, having recurrent bouts of chiropractic treatment for neck pain and then there was a sudden deterioration in 2017 simply brought on by lying in an inappropriate situation in bed, which indicates that the discs were quite unstable. The disc bulge resulted in a cord myelopathy, which required fairly urgent surgery.

19. Counsel referred me to ss 16A and 16B of the *Limitation Act 1985* (ACT) (Limitation Act) which provide:

16A Claims for common law compensation for workers compensation

- (1) This section applies to a cause of action, other than a cause of action that is a claim for compensation under the *Workers Compensation Act 1951*, if—
 - (a) the cause of action relates to a personal injury that is a compensable injury under the *Workers Compensation Act 1951*; and
 - (b) a claim could be, or could have been, made in relation to the cause of action under the *Workers Compensation Act 1951* if notice of the injury had been given as required under that Act.
- (2) The action is not maintainable if brought 3 or more years after the day the injury happened.

16B Other claims for damages for personal injury

- (1) This section applies to a cause of action for damages for personal injury other than a cause of action to which section 16 (Compensation to relatives) or section 16A applies.
- (2) The cause of action is not maintainable if brought—
 - (a) if the injury is or includes a disease or disorder—3 years or more after the day the person injured first knows—
 - (i) that the person has suffered an injury that is or includes a disease or disorder; and
 - (ii) that the injury is related to someone else's act or omission; or
 - (b) in any other case—3 years or more after the day the injury happened.

20. The first requirement of s 16A is that there be a cause of action relating to a personal injury. That is plainly satisfied, as Mrs Pattinson brings her claim in negligence alleging that she has suffered personal injury. "Personal injury" is defined in the Dictionary to the Limitation Act as including "any disease and any impairment of the physical or mental condition of a person". The second requirement of the provision is that such a cause of action must be in relation to an injury which is a compensable injury under the *Workers Compensation Act 1951* (ACT) (Workers Compensation Act). In using the term "compensable injury" in the Limitation Act, the legislature has adopted the language of the Workers Compensation Act. In the Dictionary to the Workers Compensation Act, "compensable injury" is defined to mean "an injury in relation to which compensation is payable under this Act". The term "injury" is defined in s 4 of the Workers Compensation Act as meaning "a physical or mental injury (including stress), and includes aggravation, acceleration or recurrence of a pre-existing injury." It is important to note that the Workers Compensation Act distinguishes between claims for compensation based on incapacity by reason of

injury and incapacity by reason of disease. The term “disease” is defined in the Dictionary to the Workers Compensation Act as including “any physical or mental ailment, disorder, defect or morbid condition, whether of sudden or gradual development and also includes the aggravation, acceleration or recurrence of a pre-existing disease.”

21. The provisions of s 16A only apply to an “injury” as defined under the Workers Compensation Act, and not to a condition that would qualify as a “disease” under that Act. The medical evidence in the present case establishes, on the balance of probabilities, that Mrs Pattinson suffered an injury on 4 September 2013 by reason of the subject incident which weakened her cervical spine. This has resulted in either the development or acceleration of a degenerative disease in her cervical spine. In September 2017, Mrs Pattinson suffered a “sudden or identifiable” physiological change which may be described as a disc prolapse or rupture. That change was connected to the disease process, but that does not mean that it cannot be classified as an injury for the purposes of the Workers Compensation Act. In *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45; 200 CLR 286, Gleeson CJ and Kirby J, after referring to the decision in *Zickar v MGH Plastic Industries Pty Ltd* (1996) 187 CLR 310 (*Zickar*), said, at [36], “the mere fact that a sudden physiological change is in some way connected with an underlying “disease” process does not, of itself, prevent the classification of such a change as an ‘injury’” for the purposes of the Workers Compensation Act. Later, after referring to the necessity to give consideration to the precise evidence as to the nature of any condition, they said, at [39]:

If this evidence amounts, relevantly, to something that can be described as a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state, it may qualify for characterisation as an “injury” in the primary sense of that word. If such an injury happens within the protected period of employment, it is ordinarily compensable without proof of a specific causal connection with the worker’s employment. If the propounded “injury” is distinct from the underlying pathology that constitutes a “disease” that directly or indirectly caused the sudden event to occur, it is unnecessary to proceed to the alternative and additional basis whereby, in such cases, compensation may also be recovered for the disease process if the statutory preconditions are met.

(Citations omitted)

22. The occurrence of the cervical disc prolapse or rupture was a sudden and ascertainable physiological change connected to but physiologically distinct from the underlying degenerative disease process afflicting Mrs Pattinson’s cervical spine. The occurrence of the disc prolapse or rupture constituted an “aggravation, acceleration or recurrence” of the injury she sustained on 4 September 2013. This means that it constitutes an injury for the purposes of the Workers Compensation Act, and one which occurred in September 2017. I am satisfied of the final requirement of s 16A, being that a claim for compensation could have been made under the Workers Compensation Act if the relevant notice had been given. As the limitation period set by s 16A of the Limitation Act is one of three years from the relevant injury, Mrs Pattinson’s claim was commenced well within the limitation period.
23. I will nevertheless briefly consider the operation of s 16B of the Limitation Act. This section encompasses two differing factual situations. Section 16B(2)(a) applies where there is a cause of action for personal injury which is or includes a disease or disorder. The term “personal injury” is defined in the Dictionary to the Limitation Act as including disease: see [20] above. Neither “disease” nor “disorder” are defined in

the Limitation Act. Section 16B(2)(b) applies where there is a cause of action for personal injury which is not, or does not include, a disease. It is important in considering the operation of s 16B, therefore, to identify the “injury” to which the cause of action relates. The injuries suffered by Mrs Pattinson, as set out in her Statement of Claim includes both disease (cervical spondylosis) and injury that is not a disease (spinal cord compressions due to disc bulging). The particulars of injury set out in her Statement of Particulars dated 13 March 2019, however, refers to a disc bulge at C3-4, a disc protrusion at C5-6, spinal compression at C5-6, cervical myelopathy and depression. Without the benefit of expert medical evidence, I am unable to determine whether cervical myelopathy is a condition that would be considered a disease or disorder for the purposes of s 16B of the Limitation Act. It would appear likely that depression or chronic Adjustment Disorder, on the other hand, would fall within the description of a disease or disorder for the purposes of the provision. If Mrs Pattinson’s injury for the purposes of s 16B is properly described as the entirety of the injuries set out in her Statement of Particulars, as I think it must be, then plainly s 16B(2)(a) is satisfied. The first that Mrs Pattinson would have been aware that she had suffered an injury that included a disease or disorder was in 2017 when she was diagnosed with cervical spondylosis connected to the lift incident. It follows that the limitation period in s 16B did not commence to run until September 2017. In each case, Mrs Pattinson’s claim has been brought within the limitation period.

What happened on 4 September 2013?

24. Alison Shipton gave evidence that around 8:30 am on 4 September 2013 she and the other three plaintiffs entered the lift on the 19th floor of the premises intending to travel to the ground floor. Mrs Shipton was a public servant employed in the Department of Veterans’ Affairs, and the other plaintiffs were part of a team which she managed. They were going to attend a meeting.
25. When she was in the lift Mrs Shipton heard a loud, metallic sound. The lift then started to descend. Mrs Shipton said that the decent did not “feel normal”, and that it felt like the lift was “dropping”. The lift then suddenly stopped at or around the 14th floor, before it commenced dropping again. Mrs Shipton described this initial stop as very sudden, and not gradual. She said it was “a really hard jolt”.
26. The lift then dropped again before suddenly stopping again on or around the 11th floor. Mrs Shipton said that during this incident she felt terrified. When the lift stopped on the second occasion, Mrs Shipton pushed the alarm button and spoke to someone via an intercom. They instructed her how to open the lift and she and the other plaintiffs alighted on the 11th floor. They then took the stairs to the ground floor, where they spoke to a security guard in the foyer and to a man with “Kone” on his shirt. Mrs Shipton said to that man, “[t]he lift fell, you need to turn it off.”
27. Kellie Massouras gave evidence that she was one of the four occupants of the lift on 4 September 2013. Shortly after the incident, she completed a document titled “WHS Incident Report Form” which she and the other three plaintiffs signed. In the form the incident is described as having occurred at 7:50 am on 4 September 2013. Under a part of the form that asks for a description of how the incident occurred, Mrs Massouras wrote:

Four staff members were in elevator H2 travelling to the ground floor, from level 19. As soon as the doors closed after entry there was a loud noise and the elevator dropped. Stop

[sic] for a few moment [sic] on Level 14 then falling again to Level 11. Advise [sic] from the internal phone assisted with them exiting at level 11. Once on level 11 the four staff members made the decision to walk down the stairs to exit the building do [sic] the anxiety and shock experienced in the lift.

Alison Shipton reported the incident to the security at reception. At the same time there was a Kone Elevator Technician at the front desk and the incident was reported to them as well.

28. Mrs Pattinson was taken to the WHS Incident Report Form and agreed that she signed it. She said that the description of the incident in the form coincided with her memory of the incident. She was not cross-examined about the incident itself.
29. Jessica Soesman, formerly Jessica Powell, gave evidence of her recollection of the incident in the following terms:

Myself and my three colleagues entered the lift on level 19 of the tower to go down to the ground level. From pretty much as soon as the doors closed we heard some screeching sounds and quite an abrupt stop happened, pretty rough, and then there was a bounce. It went up, I'm not sure how far, then there was a bounce again. I believe it was Alison who pushed the emergency stop and phone button and we got out – we ended up getting out at level 11 and taking the stairs...

30. In cross-examination, Mrs Soesman agreed that she gave a slightly different version of the incident to Dr Le Leu. In the version she gave to Dr Le Leu she made no reference to the lift ascending again after the first abrupt stop. Mrs Soesman stated that there was a “sudden sort of stopping that I felt twice”, and that she believed the lift travelled upwards after the first stop. She said that this was based on “the sensation I had at the time”, but agreed that she had no visual cues.
31. In addition to the evidence of the plaintiffs, there was also relevant evidence from experts and from Mr Stevens, the Kone technician. John Tibbitts, a consulting engineer, was retained by the solicitors acting on behalf of Mrs Shipton to provide an expert opinion on the way in which the subject lift worked and the likely cause of the incident as described in the WHS Incident Report Form. Mr Tibbitts carried out a site inspection on 16 June 2016, and provided three reports. For present purposes, only his first report, dated 17 August 2016, is relevant. In his first report, Mr Tibbitts provided detailed information about the construction and operation of the subject lift. It is useful to set out this information in detail:

7. THE LIFT

The site inspection revealed the lift to be of an overhead traction type lift.

The design of such a lift is that essentially the lift car is suspended by wire hoist ropes which pass over sheaves in the lift machine room (one sheave being physically connected to the driving machine). After passing over the sheaves the ropes then continue down to be connected to a counterweight on the other side of the sheaves.

To increase the efficiency of the system and allow the relatively small hoisting machine to be capable of lifting the loaded lift car, the masses of the loaded lift car and the counterweight are somewhat balanced.

The mass of the counterweight being made equal to the mass of the lift car plus between 40% and 50% of the rated load of the lift car.

Although the mass of the loaded lift car may well be some thousands of kilograms, because of the partial balancing of the lift car to the counterweight, the maximum mass the hoisting machine needs to lift is 60% of the rated load. That is 60% of approximately 1360 kg for the subject lift. So approximately 816 kg. Hence a lesser powered hoisting machine can be used to operate the lift.

This means that with only a small mass in the lift car, in this case say four passengers, the counterweight is heavier than the lift car and it would be the element to fall if control of the lift was lost. The car being lighter than the counterweight, could not pull the counterweight up allowing the lift car to fall.

For the subject lift and a four passengers weighing say less than 135 kg each, the counterweight would be heavier than the lift car carrying those passengers. So as stated, the lift car could not pull the counterweight up to cause the lift car to fall.

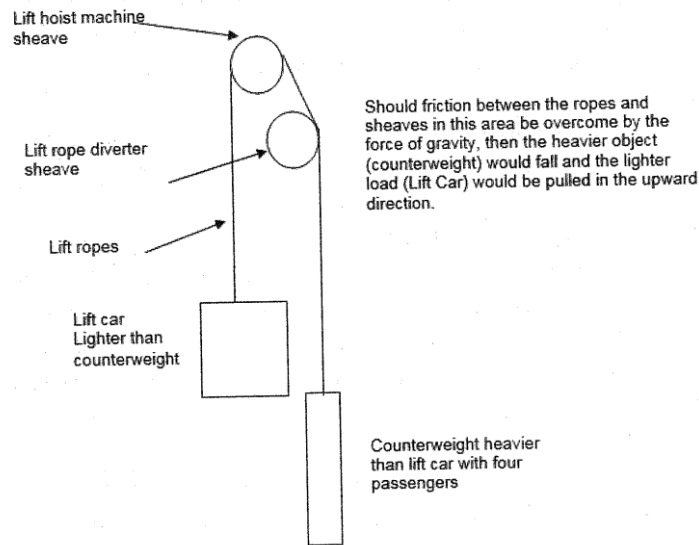


Figure 2 Simplified roping of the lift system

However having noted that in this case, the lift did not in fact fall, it also needs to be recognised that for passengers travelling in a lift it can be very easy for them to gain a perception of the lift falling. Such a perception can be gained under a number of circumstances when the passengers are totally without any visual reference to the stationary building structure.

Not being able to visually determine actual relative movements between the lift and the building structure, then experiencing a sudden stop would, in my opinion, be one such situation where it would be very easy for the passengers to perceive the lift had dropped.

Within the lift industry it is recognised that sudden stops for lifts travelling at the speeds of the lifts in the subject building, can easily cause damage to any passengers experiencing that sudden stop.

The Australian Standard for lifts AS1735 in at least two areas indicates the concern for the effect of sudden stops on passengers.

For example it requires:

- That on operation of the safety gear which stops the lift in the event that it over speeds in the down direction, it must apply progressive pressure to the guide rails thus bringing the lift to a gradual stop.

So as not to subject any passengers to a stop which can be detrimental to them, when the safety gear is operated, the retarding force must be such that the passenger is retarded by between 0.2 of the standard acceleration of free fall measured in m per sec squared and 1.0 of the standard acceleration of free fall measured in m per sec squared.

- In the bottom of the lift shaft, known as the "pit", there are buffers placed below both the lift car and the counterweight.

AS 1735.2 requires the minimum stroke of the buffers to be based on the following:

- a. The average retardation to be 9.8 m/s^2 when the car or counterweight strikes the buffer at 115% of rated speed.
- b. Where a terminal speed-checking and stopping device is installed the buffer stroke shall be based on an average retardation not exceeding 9.8 m/s^2 .

So should the lift car over run the bottom floor and strike the buffers at a speed of less than 115% of rated speed, the average retardation would be 9.8 m/s^2 , not a violent crash.

(emphasis added).

32. Part of the material provided to Mr Tibbitts by Mrs Shipton's lawyers was an email from Kone to Vince Malouf at Cromwell dated 5 September 2013. The email reads:

As requested, I would like to provide further information surrounding the breakdown of High Rise Lift 2 at 13 Keltie St, Phillip yesterday.

Whilst the lift was travelling, the control system detected that there was a fault with a control system transformer and stopped the lift. This happened twice in succession, following [sic] by the lift then moving to the next floor and opening the doors automatically to release the passengers.

This is one of the many inherent safety features built in to all the lift control systems on this site, which are checked more frequently than the manufacturer's specifications by KONE trained personnel. At time of inspection, all devices have operated correctly.

The component that caused this breakdown has been repaired at time of attendance onsite.

33. Mr Tibbitts did not believe that the lift fell, but he was of the opinion that "it would be natural for passengers having experienced such an incident to gain the perception of the lift falling and coming to a very abrupt stop." Mr Tibbitts went on to say:

Should the cause of the lift stopping have been due to the lift control system detecting a fault with the control system as indicated in Kone's email to Vince Malouf of Cromwell and dated 5 September 2013, an indication I am in agreement with, the stop would not have been a gradual one as is described above for safety gear or buffer stops.

When a fault is detected in the lift control system it is considered urgent to stop the lift and close it down before serious damage to life and/or property can occur.

In such an incident power is removed from the system and the hoisting machine brake applied. There is no requirement for a soft or gradual stop in such circumstances as a longer stopping distance may cause more damage than a sudden stop would.

In my opinion, such a stop could easily be perceived as the lift crashing into something solid.

If again, as indicated in Kone's email to Vince Malouf of Cromwell and dated 5 September 2013, the fault was intermittent and the lift was able to start again at the 14th level, the passengers would experience a second similar harsh stop at the 11th level.

34. In response to Mr Tibbitts' report, Kone sought the opinion of Ian McWaters, a director of WSP Building Pty Ltd, a building services consulting practice. Mr McWaters provided a report dated 21 September 2017. As part of his preparation for his report, Mr McWaters conducted a site visit. He observed the operation of the lift, made recordings of the speed of the lift, and simulated the incident by stopping the lift as it approached full speed by tripping the brake in a manner "similar to what would have occurred in the incident". Mr McWaters undertook this experiment "to determine an approximation of the rate at which the lift would have stopped during the incident" (emphasis added). He calculated that the average rate of deceleration was "of the

order of $1/3^{\text{rd}}$ of a “g” (gravity), whereas the code allows a deceleration rate of 1g (9.8 m/s²) for buffers and safety gear.”

35. Mr McWaters agreed with Mr Tibbitts that the lift did not fall, but that passengers inside the lift might perceive the sudden stop as the lift “falling”. He agreed that the lift would have stopped suddenly in the event of a drive fault occurring, but based on the measurements he recorded he did not agree that the lift stopped more abruptly than would be the case for safety gear and buffers. Mr McWaters further agreed that the lift “is likely to have been able to re-start from a point perceived to be near Level 14, and able to continue to a second sudden stop at Level 11”, and that it may have been perceived that the lift had hit something solid. Finally, with regard to Mr Tibbitts’ report, Mr McWaters said:
- (i) One aspect of this incident that does not appear to have been addressed is that the stopping of the lift, whilst an unwanted event in terms of lift reliability, is nonetheless not especially unusual or unsafe. The interruption of the lifts’ [sic] movement can occur for several reasons in normal service, including tripping of the safety circuit when landing door locks are ‘tripped’ due to a drift in adjustment of the door locking alignment. These events do occur infrequently from time to time and surprise passengers.
 - (ii) In respect of item (i) above, it needs to be borne in mind that the circumstances of the incident (deceleration of the lift) would have occurred in the event of a normal electrical power blackout, and in such a case neither the building owner or the lift maintenance company could have prevented the deceleration that is alleged to have occurred.
36. Mr Stevens gave oral evidence on behalf of Kone at the hearing. Mr Stevens is a senior elevator technician with Kone. He has been employed as an elevator technician, principally by Kone, for 42 years. At the request of his manager, Mr Stevens was in the habit in 2013 of visiting the premises and checking on the operation of the lifts several times a week, and sometimes daily. On 4 September 2013, he attended the premises at about 8:03 am and discovered that alarms had activated on the elevator monitoring computer (EMC). The EMC was an “old computer”, from around 1996, which was linked to the lift system. It records information on the operations of the lifts in the premises. If a problem occurs with a lift, an alarm is activated on the EMC. The EMC on 4 September 2013 recorded “two correction runs” for the lift. This told Mr Stevens that the lift was “stopping out of floor”, by which I understand him to mean between floors. When the lift stops between floors, it is designed to move to the nearest floor and reset by finding its location. Mr Stevens said that the EMC showed that the lift had stopped between floors, and then moved to the next floor down. This is what Mr Stevens referred to as a correction run. Having reset at the nearest floor, the lift then attempted to continue its descent to the ground floor. The lift then stopped again between floors, before performing a correction run to the nearest floor.
37. The most reliable evidence of what the plaintiffs perceived on 4 September 2013 during the lift malfunction is the description in the WHS Incident Report Form. This was completed and signed by the plaintiffs on the same day as the incident, when the events were still fresh in their memories. Their perception was that the lift dropped after making a loud noise, stopped briefly on the 14th floor before dropping again to the 11th floor. The evidence of Mr Tibbitts, Mr McWaters and Mr Stevens convinces me that the plaintiffs were mistaken in their perceptions. I say that without intending any criticism of the plaintiffs. I have no doubt that the incident was frightening and that

when they recorded the details of it in the WHS Incident Report Form, they were recording their perceptions of the incident to the best of their abilities. They lacked, however, any visual cues to assist their perception of movement. I am satisfied that the lift stopped suddenly around the 14th floor, reset itself by moving to the 14th floor, recommenced its descent before again abruptly stopping around the 11th floor. I accept the evidence of Mrs Shipton, who I found to be a truthful and generally impressive witness, that the first stop in particular was quite abrupt; a “really hard jolt” as she described it. The second stop was also abrupt. I accept the evidence of Mr Tibbitts that in the absence of visual cues, it was quite understandable that the plaintiffs perceived the lift to be falling.

Why did it happen?

38. On 29 June 2016, Mr Stevens provided a letter “to whom it may concern” regarding his observations on 4 September 2013. This was part of the material provided to Mr McWaters for the preparation of his report. In the letter Mr Stevens said:

Upon checking the EMC (Monitoring Computer) in the High Rise Lift Motor Room at 9:45 am I found Lift 2 had performed 2 correction runs. This told me that the lift had stopped and then reset itself to the nearest floor.

I removed the lift from service and upon investigation found a broken wire to a Terminal connection on transformer 240 intermittently going open circuit.

39. When he prepared his first report, Mr Tibbitts did not have the information that Mr Stevens had found a broken wire to a transformer terminal connection. Mr Tibbitts was required to give an opinion as to the likely cause of the behaviour of the lift during the incident without the benefit of that material. I observe, however, that while Mr Stevens’ letter provided information regarding what he observed, it provided no opinion as to the likely mechanism by which the wire was broken.
40. With the information available to him, Mr Tibbitts expressed the opinion that the cause of the lift malfunction was likely to have been vibration inside the control cabinet causing either or all of the following:
- (a) a wire connected to the drive unit in the controller to break;
 - (b) a terminal connection to the drive unit in the controller to become too loose;
 - (c) a malfunction of the contactor of the drive unit on the controller.
41. In his report, Mr McWaters accepted that vibration in the drive unit was a possible cause of the failed wiring connection, but other factors such as accidental knocking of the wire, or a poorly stripped and installed wire connection at the time of installation or during maintenance were more likely the cause of a failure of the type that occurred.
42. The Trust Company and the Cromwell parties tendered a report dated 24 January 2017 prepared by Peter Ward, a director of JCA Lifts Pty Ltd. Mr Ward has extensive experience in the operation and design of lifts. While Mr Ward agreed that it was possible that vibration could have been a contributing factor to the lift’s malfunction, he had observed nothing on his site visit in September 2013 that supported that theory. He agreed with Mr McWaters that there were other potential causes for the broken wire found by the lift technician on 4 September 2013.
43. An expert conclave was convened on 20 March 2019 involving Mr Tibbitts, Mr McWaters and Mr Ward. At that time, they did not have the benefit of the evidence

of Mr Stevens, who gave the majority of his evidence on 20 September 2019. The experts produced a document setting out their areas of agreement, which was tendered during the hearing. Relevantly for present purposes, they agreed that the likely cause of the lift malfunction on 4 September 2013 was vibration inside the control cabinet, causing either or all of a wire connected to the drive unit in the controller to break, a terminal connection to the drive unit to become too loose or a malfunction of the contactor of the drive unit on the controller.

44. As I said earlier, it was not until Mr Stevens gave evidence on behalf of Kone that any further light was shed on the likely cause of the broken wire. In his evidence, Mr Stevens explained the method by which the drive unit was inspected during servicing by Kone technicians:

When you look at the lift controller what do you mean?---That's - the lift controller would be to inspect it and have a close look at the contactors and the relays.

What is the lift controller? I'll ask it that way?---Okay, the lift controller is the two cabinets in the lift motor room. The one on the left controls all the inputs for the buttons and things like that, and the one - - -

What colour are these cabinets?---They're the red cabinets.

Please continue?---The one on the right tends to deal with the driving of the lift through the black box up the top, the drive. So you would have a general look at the whole system to make sure that there was no noises, there was no buzzing, smell even in case something might be on the way out.

When you have a general look at the whole system, how do you approach having a general look at the whole system?---My preferred way of looking at the lift is to get a screwdriver - or a couple of screwdrivers and then just go over the main contactors and relays, terminal connections. It's more to get my focus on each individual component of the lift.

So when you say 'go over' what do you mean?---Sorry. So I might start in the top left hand corner and just put my screwdriver on contactor number 1, for instance, just to make sure that the terminals are tight, but also inspecting that particular component of the lift. And then I would move across and slowly down and then onto the second control. It's a bit like - - -

What do you do specifically with your screwdriver?---I just put it on the terminals. I might tap the wires just to make sure the wires are secure, those sorts of things. I'm looking for discolouration in case that relay or contactor might be getting hot. I'm listening, as I said, for noise, buzzing, those sorts of things. It helps me focus on each component. I was about to say it's a bit like washing your car. If you grab a sponge and wash it, you suddenly see dings and scratches and things like that. So the more I focus on each individual component, the better it is.

And when you say each individual component, to what specifically are you referring, each what?---Each relay, contactor. There's plugs and wires and there's a whole control system. So I just try to go over the whole thing.

45. After observing the two correction runs on the EMC, Mr Stevens attempted to narrow down the possible causes of the problem. By tapping the wires adjacent to the connection with his screwdriver, he found a loose wire on the supply transformer which supplied voltage to the drive unit. Unusually, the wire was loose while the screw-in terminal connection was tight, indicating to Mr Stevens that the wire had broken rather than having come loose by inadequate connection. Mr Stevens described the wire as "broken" because the terminal was tight, but the wire was loose. This was causing intermittent loss of power to the drive unit. Mr Stevens repaired the fault by loosening the terminal connection, reinserting the wire back into the terminal

connection and then tightening the terminal connection. Mr Stevens was able to exclude the possibility that the wire had not been connected to the terminal properly because the screw in the terminal was tight and the problem had not occurred prior to the incident on 4 September 2013. The alternative options for how the wire may have broken were considered by Mr Stevens:

I was asked how could a wire come loose like this and I thought perhaps over tightening may have caused the problem. Or I also thought that maybe it had been bumped or damaged by us whilst doing our maintenance checks. Generally speaking, the screws for the terminals are designed so that if you get to a point where you're trying to over tighten the screw, the screw head starts to strip, so...

46. On 24 September 2019, the three experts convened a further conclave due to the evidence given by Mr Stevens. They were asked to express an opinion on the most likely cause or causes of the loose wire detected on 4 September 2013 in light of the evidence given by Mr Stevens. They responded that "the most likely cause of the loose wire was a poorly terminated wire".
47. The experts gave concurrent evidence on 24 September 2019 after the conclave. Each of the experts agreed that as a standard precaution a lift mechanic would ensure that the wires leading to and from the transformer in the controller box were sound by using a screwdriver to check them in the manner described by Mr Stevens. The witnesses were asked what they meant by the term "poorly terminated wire" in the report of their conclave earlier that day. Mr Tibbitts said, "[t]hat the wire was not held in place by the screw that should be fastening onto the terminal itself." Mr McWaters then said "[i]n a similar vein, it's likely – given that the wire was tested a number of times but came loose on this occasion – that the wire was secured partly by the screw but not sufficiently and at some point it decided to part company with the terminal." Mr Ward agreed with Mr McWaters.
48. In answer to questions put to him by counsel for the Trust Company and the Cromwell entities, Mr McWaters agreed that it was probable that the tightening of the screw had either missed the wire or it had got the wire and the wire broke, leaving a small piece secured behind the screw.
49. Mr Stevens plainly discounted the possibility that the screw had been overtightened. He discounted the possibility that the wire "hadn't been put in properly", saying "it must have been put in properly because we didn't have this problem leading up to this event." I find this to be a persuasive argument. In addition, as the person who actually observed the relevant wire and connector while it was damaged, a great deal of weight should be given to Mr Steven's opinions.
50. Counsel for the plaintiffs submitted that I should find that the malfunction of the lift on 4 September 2013 was due to a "poorly terminated wire causing in turn an open circuit to the lift drive which caused the lift to intermittently lose... power and come to two abrupt and unexpected stops and restarts in quick succession." This summation of the evidence is accurate, so far as it goes. It does not, of course, address the likely cause of the wire being poorly terminated. Bearing in mind the evidence of Mr Stevens that the possibility that the wire had not been "put in properly" was unlikely, and the unlikelihood of the possibility that the wire had broken because of overtightening of the screw, in my opinion it is probable that the wire broke or became disconnected because it was damaged by Kone staff performing maintenance checks. As Mr Stevens said, "we pulled on the wire a little bit too hard at some stage." It was apparent from the evidence of Mr Stevens that a competent technician would

be aware of the need to exercise care in the degree of force applied to wires in the process of checking whether they were soundly connected to the transformer. The clear inference is that the wire broke because of a failure by a Kone technician to exercise that care.

The plaintiffs' case on liability

51. Each of the plaintiffs pleaded their case on liability in similar terms. With the leave of the Court, the plaintiffs filed a Further Amended Statement of Claim on 24 September 2019 after Mr Stevens had given his evidence. Prior to Mr Stevens giving evidence, the case pleaded by the plaintiffs was that the malfunctioning of the lift was caused by excessive vibration inside the lift controller cabinet which caused intermittent failure of the lift due to:
 - (a) a break in wiring connected to the drive unit;
 - (b) a break in a terminal connection to the drive unit; and/or
 - (c) malfunctioning of the controller to the drive unit.
52. After Mr Stevens gave evidence, the plaintiffs amended their claim to allege, in addition to the matters referred to above, that the malfunctioning of the lift was caused by Kone's servants and/or agents:
 - (a) failing to strip or adequately strip a wire connected to the transformer;
 - (b) failing to inspect or adequately inspect a wire connected to the transformer;
 - (c) failing to install or adequately install a wire connected to the transformer;
 - (d) overtightening the screw connecting a wire to the transformer;
 - (e) failing to ensure that a wire connected to the transformer was terminated correctly; or
 - (f) bumping a wire connected to the transformer and dislodging it during maintenance.
53. The plaintiffs claimed that the second defendant, the Trust Company, was the owner and/or occupier of the premises, and that it had contracted with Kone for Kone to maintain and service the lift in the premises. The plaintiffs alleged that Kone was the servant and/or agent of the second defendant and the second defendant was vicariously liable for the acts and/or omissions of Kone. They alleged that the second defendant and Kone through their servant and/or agents owed the plaintiffs a duty of care to maintain the lift in question so that it was safe for the use by the plaintiffs. The second to eleventh defendants were sued pursuant to Rule 215 of the *Court Procedures Rules 2006* (ACT) on the basis that the owner and/or occupier of the premises is part of a complex legal trust and the plaintiffs were uncertain as to the person from whom they were entitled to relief.
54. The plaintiffs alleged that Kone and the second defendant breached their duty of care to them. Multiple particulars of negligence were pleaded, but the relevant allegations were that Kone had failed to properly inspect the lift equipment and to properly maintain it. Multiple particulars of negligence were also pleaded against the second defendant, but the substance of their case against the second defendant was identical to that alleged against Kone.

55. The plaintiffs alleged that by reason of the negligence of the defendants they suffered injury.
56. Kone admitted that it owed the plaintiffs a duty of care. It denied that it had breached its duty and denied that the alleged breach of duty could cause or caused the plaintiffs' injuries. A similar case was pleaded by the second defendant.

The Wrongs Act

57. It is accepted that the present claims are subject to the provisions of the Wrongs Act, and in particular Chapter 4 dealing with negligence. In deciding whether a person (the defendant) was negligent, the standard of care required of the defendant is that of a reasonable person in the defendant's position who was in possession of all the information that the defendant either had, or ought reasonably to have had, at the time of the incident out of which the harm arose: s 42. The following provision of the Wrongs Act is also relevant:

43 Precautions against risk—general principles

- (1) A person is not negligent in failing to take precautions against a risk of harm unless—
 - (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known); and
 - (b) the risk was not insignificant; and
 - (c) in the circumstances, a reasonable person in the person's position would have taken those precautions.
- (2) In deciding whether a reasonable person would have taken precautions against a risk of harm, the court must consider the following (among other relevant things):
 - (a) the probability that the harm would happen if precautions were not taken;
 - (b) the likely seriousness of the harm;
 - (c) the burden of taking precautions to avoid the risk of harm;
 - (d) the social utility of the activity creating the risk of harm.

A risk of harm

58. Before a determination can be made that a risk of harm is a foreseeable risk, or that a reasonable person would take precautions to avoid the risk, it is necessary to identify the relevant risk: *Roads and Traffic Authority of New South Wales v Dederer* [2007] HCA 42; 234 CLR 330 at [59]. In written submissions, counsel for the plaintiffs identified the relevant risk as "the risk of a loose wire intermittently going open and closed circuit and causing the lift to behave erratically by stopping and starting abruptly and without warning to the occupants of the lift." The relevant risk could be expressed in other terms, but the gist of the formulation of the risk remains the same: the risk was that passengers in the lift may be injured if the lift malfunctioned due to intermittent loss of power. The defendants cannot be liable in negligence unless the risk was foreseeable. In his first report Mr Tibbitts stated, "[w]ithin the lift industry it is recognised that sudden stops for lifts travelling at the speeds of the lifts in the subject building, can easily cause damage to any passengers experiencing that sudden stop." Mr Tibbitts was not cross-examined on that statement. Kone relied upon the evidence of Mr McWaters and a report from Tom Gibson, a biomechanical engineer,

dated 15 December 2017 to submit that the risk which the plaintiffs say eventuated was not a foreseeable risk, because it was not reasonably foreseeable that a passenger in the lift would sustain injury of the class sustained by the plaintiffs if the lift malfunctioned due to intermittent loss of power. This same evidence was also led on the issue of causation being that the sudden stopping of the lift would not have caused the plaintiffs' injuries.

59. Kone submitted that foresight of harm is not sufficient to show that a duty of care exists: *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2000] HCA 61; 205 CLR 254. It submitted that reasonable foreseeability of the class of injury sustained by the plaintiff is an essential condition of a legal obligation to take care for the benefit of another: *Sydney Water Corporation v Turano* [2009] HCA 42; 239 CLR 51 (*Turano*). So much may be accepted. The principle is not in doubt. What is in question is whether the evidence establishes foreseeability. Mr McWaters conducted a site visit to inspect the lift on 12 May 2017. In his report, Mr McWaters said that during that visit he "observed the operation of the lift, made recordings of the speed of the lift, and simulated the incident by stopping the lift as it approached full speed, by tripping the brake in a manner similar to what would have occurred in the incident." He stated that "the velocity profile" of the lift was recorded to obtain an "approximation of the rate at which the lift would have stopped during the incident." A graph recording the velocity of the lift during the simulation was created. The graph indicated that the rate of deceleration was "reasonably consistent and linear", and that the "average rate of deceleration is quite modest – around 3.4m/s²". Mr McWaters went on to say that the rate of deceleration shown on the graph was approximately 1/3rd of a gravity, whereas the applicable code allows a deceleration rate equal to 1 gravity or 9.8 m/s².

60. Mr Gibson was asked by Kone's lawyers to express an opinion on the likelihood of injury to a passenger riding the lift when the emergency brake was activated based upon the results of the simulation conducted by Mr McWaters. In his report, Mr Gibson said:

Mr McWaters in his Report dated 21 September 2017, measured the normal acceleration of the lift as 1 m/s² (0.1 g), the duration of the emergency braking pulse to be 1 s and the peak deceleration to be 5.4 m/s² (0.55 g). Based on human tolerance for +G_z this loading level is well below any possibility of injury.

61. The symbol +G_z in the above extract represents the vector of acceleration, being head to foot.
62. Mr Gibson was provided with copies of medical records and reports relating to each of the plaintiffs. Mr Gibson was asked by Kone's solicitors to express an opinion on whether the injuries and disabilities sustained by each of the plaintiffs were consistent with a lift decelerating at a rate of 3.4 m/s² and stopping, and he said:

The plaintiff(s) had no specific injury recorded as a result of the incident on 4 September 2013. The medical opinion is that the claimed disabilities appear to be more likely the result of pre-existing conditions being aggravated by the incident. Based on human tolerance date for +G_z loading a lift decelerating at a rate of 3.4 m/s² and stopping is well below any possibility of injury.

63. Mr Gibson expressed the same opinion with regard to the possibility that the lift had been decelerating at twice the rate suggested above, that is, 6.8 m/s².
64. Neither in his report nor in the evidence he gave as part of the conclave of experts on liability did Mr McWaters take issue with the statement of Mr Tibbitts that it is

recognised in the lift industry that sudden stops for lifts travelling at the speed of the lifts in the subject premises can easily cause damage to any passengers experiencing that sudden stop. Mr Tibbitts is an eminently qualified expert in the field of lift safety, operation and maintenance. His statement about the potential for injury in sudden stops is based upon more than 50 years' experience in the lift industry. He is also the Chair of the Standards Australia Lift Committee responsible for the production and maintenance of Australian Standards for lifts, a position he has held for 30 years. Despite being in the lift industry itself, Kone did not lead any evidence to suggest that it was not recognised in the industry that sudden stops such as occurred here can easily cause injury to passengers in the lift.

65. The statement by Mr Gibson that the forces that would have been exerted on the bodies of the plaintiffs in any sudden stop by operation of the emergency brake would have been "well below any possibility of injury" must be approached with caution. It is plain from his reference to medical opinion that the claimed injuries appear to be the result of pre-existing conditions being exacerbated by the lift incident that Mr Gibson accepts that forces of the nature of those recorded by Mr McWaters in his simulation could cause exacerbation of pre-existing injuries or conditions. Mr Gibson's statement concerning the possibility of injury being caused by forces of the nature of those recorded by Mr McWaters must be understood in that context.
66. In addition, the weight to be attributed to Mr Gibson's opinions depends on the extent to which the simulation conducted by Mr McWaters accurately reproduced the circumstances which existed on 4 September 2013, and the resultant forces to which the plaintiffs were exposed. The simulation conducted by Mr McWaters involved an empty lift. On 4 September 2013, there were four adult females in the lift. There is no evidence of what additional weight this would have added to the lift, and how this may have affected the speed of the lifts descent. Mr Tibbitts referred in his report to the lift being equipped with "safety gear" intended to stop the lift in the event that it "over speeds" in its descent, but there was no evidence of the speed at which the equipment was to commence operation. I cannot assume that the additional weight carried by the lift on 4 September 2013 would not have significantly affected its rate of descent. In addition, for the simulation conducted by Mr McWaters to accurately reflect the situation which occurred on 4 September 2013 a number of assumptions must be made. It must be assumed that the means used by Mr McWaters when "tripping the brake" on the lift on 12 May 2017 produced the same result in terms of stopping the lift that was produced by the loss of power on 4 September 2013. In his report, Mr McWaters said that he tripped the brake "in a manner similar to what would have occurred in the incident", but there is no indication in that statement that what he did was identical to what would have occurred with a loss of power. In addition, the comparability of the simulation conducted by Mr McWaters with what occurred on 4 September 2013 depends on the assumption that no relevant effect on the rate of descent of the lift, or the operation of the emergency brake, has occurred by reason of maintenance, use or deterioration of the equipment in the nearly four year period between the incident and Mr McWaters conducting his simulation.
67. In evidence to which I will refer later, Dr Stephen Buckley, a consultant physician in rehabilitation medicine, said the he did not believe it was possible to precisely calculate the axial load to which Mrs Shipton's neck was exposed by the sudden stopping of the lift without knowing the precise position of her head and neck as the lift descended and stopped. This appears to me to be a sensible statement.

68. I will also add that in cross-examination, Mr Stevens accepted that where the lift malfunctions because of loss of power, the lift “just stops”. This does not sit well with the simulation conducted by Mr McWaters which shows a reasonably consistent and linear rate of deceleration of the lift after he tripped the brake.
69. Finally, I should add that I am satisfied that the plaintiffs did suffer injuries as a result of the sudden stopping of the lift on 4 September 2013.
70. In its final submissions, Kone was critical of the evidence given by Mr Stevens, albeit that he was Kone’s witness. Kone submitted that Mr Steven’s “speculation” as to why the wire may have come loose does not provide a proper basis for the Court to draw a conclusion as to breach. I do not agree. Mr Stevens was the best qualified of all the witnesses to comment upon the cause of the incident, and the cause of the broken wire – he actually saw the wire in situ and was one of the persons who regularly serviced and maintained the equipment.
71. I am not satisfied that the simulation conducted by Mr McWaters accurately reproduced the circumstances of the incident in which the plaintiffs were injured, or the forces to which they were exposed. I accept the evidence of Mr Tibbitts that it is recognised in the lift industry that sudden stops for lifts travelling at the speeds of the lifts in the premises can easily cause damage to any passengers experiencing that sudden stop. There is no evidence that the speeds to which Mr Tibbitts refers were outside those which would be anticipated for the lift involved in this incident.
72. Returning to s 43 of the Wrongs Act, the risk of injury to a passenger in a lift by reason of the lift suddenly stopping in the course of a descent by reason of a loss of power caused by inadequate maintenance was clearly a foreseeable risk based on the evidence of Mr Tibbitts and Mr Stevens. This is particularly so with regard to Kone, which operates within the industry.
73. It was submitted on behalf of Kone that what occurred on 4 September 2013 was simply the lift operating as it was designed to do, and that the same thing would have happened if, for example, there had been a power blackout to the premises. I understand that submission to be addressed to whether, in the circumstances, a reasonable person in Kone’s position would have taken precautions to prevent that risk: s 43(1)(c). In my opinion, it is not to the point that the lift is designed to stop suddenly if there is an interruption to its power supply. The purpose of that design feature is to avoid catastrophic failure of the lift when the power supply fails. If the power supply had failed on 4 September 2013 through no fault of the defendants, then any injuries sustained by the plaintiffs would not found an action in negligence against the defendants. But that is not what occurred here. I am satisfied that the power supply to the lift failed due to a lack of reasonable care by Kone in maintaining the lift.
74. An analogy may be useful. Seat belts are designed to stop people suffering serious injuries in motor vehicle accidents, but the operation of a seat belt in such circumstances sometimes causes injury itself. It would be no answer to a claim in negligence by a passenger injured by a seat belt against a negligent driver that the same injuries could have been expected in a collision in which he or she was not at fault.
75. Based upon the evidence of Mr Tibbitts, the risk of a passenger being injured in a lift which stops suddenly due to interruption to its power supply was not insignificant.

Such events may be uncommon, but they are not unusual. Kone submitted that Mr Tibbitts' evidence that it is recognised in the lift industry that sudden stops in lifts can easily cause damage to passengers (see [31] above) should be afforded no weight. It said that this statement was "imprecise hearsay", "without stated basis" and outside Mr Tibbitts' expertise. I observe that Kone did not object to this evidence being received. At the time Mr Tibbitts' report was tendered, it was received subject to any objection which Kone might raise after examining the material. No such objection was raised by Kone in the course of the hearing. If objection had been taken at the time the report was tendered, or at the very least while the plaintiffs' case was still open, it would have been open to the plaintiffs to adduce further evidence supporting Mr Tibbitts' knowledge of the relevant facts. The fact that no objection was raised to Mr Tibbitts' evidence, but Kone now seeks to undermine his credibility by reference to matters going to the admissibility of his evidence, suggests that the decision to not object during the hearing was a tactical decision. There being no objection to the evidence, and no cross-examination of Mr Tibbitts on that statement, I see no reason why I should not give it weight.

76. All that was required in order to avoid the occurrence of the risk was appropriate care in the maintenance of the drive transformer as described by Mr Stevens: see [44] above. If the loss of power to the drive unit was, as I am satisfied, caused by damage to the wire by Kone staff in the course of routine maintenance, this was something which could easily have been avoided by the application of proper care and attention. In re-examination, Mr Stevens was asked what he would do if he "bumped something" in his inspection of the control unit, so as to ensure that no wiring had come loose, and he said:

I would have to physically check the wires. So I would have to physically pull on each individual wire in the control system.

77. Such a requirement is not unduly onerous. In his earlier evidence, Mr Stevens said that physically checking the wires could take between 10 and 30 minutes, depending upon how thorough a check was required.
78. As the risk of harm was well known, and the burden of avoiding the risk was not onerous, I am satisfied that a reasonable person in the position of Kone would have taken the appropriate actions to avoid the risk. I am satisfied that Kone breached its duty of care to the plaintiffs by performing maintenance on the connection to the drive transformer without due care and attention, resulting in the wire breaking, which in turn resulted in intermittent power loss to the lift. This resulted in the emergency brake operating, causing the lift to stop suddenly. I am satisfied that this caused injury to the plaintiffs. I am further satisfied that the risk of harm was foreseeable and that a reasonable person in Kone's position would have taken steps to avoid the risk.
79. To this point, I have concentrated on the plaintiff's claims against Kone. While the plaintiffs effectively abandoned their claims against the other defendants, it is nevertheless desirable to briefly address these claims. In his opening address, Senior Counsel for the plaintiffs identified two bases for the plaintiffs' claims against the Trust Company and the Cromwell entities. First, it was alleged that these defendants should have more closely scrutinised Kone in its maintenance task, and secondly that those defendants had failed to act upon a recommendation made some years before this incident that the motor to the lift be replaced.

80. No evidence was called by the plaintiffs to attempt to establish either of those assertions. In particular, the evidence which finally emerged from Mr Stevens plainly put an end to any case, on behalf of the plaintiffs, based upon vibration in the drive unit as the mechanism of the lift's malfunction, or that the malfunction was connected with any fault in the lift motor which Kone had earlier recommended be replaced. There was simply no evidence of any breach of any duty to the plaintiffs held by the second to eleventh defendants.
81. It follows that judgment must be entered for those defendants against the plaintiffs. The contracted arrangements between Kone and the second to eleventh defendants therefore need not be considered in the context of the claim of contribution or indemnity made by the second to eleventh defendants against Kone, but it may still be necessary to consider those arrangements when it comes to the consideration of costs.
82. Before considering damages, and for the sake of completeness, I make it clear that the evidence does not support the proposition that the lift maintenance regime adopted by Kone was deficient. The evidence satisfies me that the defect that caused the lift to malfunction was not the result of an inadequate service regime, but a single instance of carelessness. The records of the maintenance attendances by Kone staff in the month leading up to the 4 September 2013 do not support the proposition that the defect which caused the lift to malfunction was longstanding.
83. I will now consider the case for each plaintiff on damages.

The case for Mrs Shipton on damages

84. Mrs Shipton was the first of the plaintiffs to give evidence, and she was extensively cross-examined. In closing submissions, Kone suggested that Mrs Shipton had hyperbolised her symptoms, referring to her actions while giving evidence, the content of surveillance footage, and the contents of reports from vocational experts retained by Kone. I reject that proposition. Mrs Shipton was an impressive witness who endured lengthy cross-examination with a degree of poise and equanimity. The video surveillance evidence did not demonstrate any inconsistency with the evidence given by or on behalf of Mrs Shipton. In my opinion, the content of the surveillance video was entirely consistent with Mrs Shipton's case. I accept Mrs Shipton as a truthful witness.
85. Mrs Shipton gave evidence that she was educated to Year 10 level in the ACT before joining the Commonwealth public service when she was aged 16 or 17 years. She commenced work as a clerical assistant performing tasks such as photocopying, collecting mail and running errands. She worked in the public service for a number of years before leaving to work in retail. She married when she was 23 years old. She has three children, all now adults. She stayed home during the period that she was having her children. She subsequently returned to work as a District Manager for Aron International, with responsibilities for sales representatives. She then worked as an office manager in real estate, with responsibilities for sales, trust account and payroll.
86. Mrs Shipton returned to the public service in 2003 as an Executive Assistant to an Assistant Secretary in the Attorney-General's Department in Barton, ACT undertaking general administration duties. She gained experience in Information Technology. She commenced at the Australian Public Service (APS) Level 3 and was subsequently

promoted to Level 4. She was then promoted to a Level 6 position in the Department of Transport and Regional Services, working in the area of Information Technology. By the time Mrs Shipton left that Department, she was an Executive Level 1, acting as an Executive Level 2. She was a member of the relevant public sector superannuation scheme.

87. Mrs Shipton then moved to the Department of Veterans' Affairs where she continued working in Information Technology, and was in charge of application development. As of 4 September 2013, she had been in the Department of Veterans' Affairs for 5 or 6 years. At that time, she was about to leave that Department, as she had been formally offered the position of Director of IT Service Delivery at the Attorney-General's Department. That was an Executive Level 2 position. Above that level, there were positions at the Senior Executive Level 1 and 2 levels. Mrs Shipton had ambitions to be promoted to a Senior Executive level before retirement.
88. In 2013, Mrs Shipton was the "major bread-winner" in her family. Her husband had previously worked as a mechanic, but had not been able to continue in that employment due to injury. In 2013, he was working as a picture framer.
89. On 4 September 2013, Mrs Shipton was working in the premises when the incident occurred in lift 2. She had previously experienced pain in a shoulder blade while working at the Department of Veterans' Affairs. She requested and received a "sit down/stand up desk", which helped alleviate the pain. She had undergone surgery for unrelated conditions in the past, at which time it was discovered that she had an allergic reaction to opioids. In the weeks leading up to 4 September 2013, she was "quite well". At that time, her work duties required her to be available 24 hours a day in the event of an emergency. She enjoyed the work she was doing. She was frequently required to travel to interstate offices and other locations in Australia. She experienced no difficulty in driving or in the course of air travel.
90. After Mrs Shipton exited the lift on the 11th floor, she felt a sharp pain in her neck. She felt terrified by what had occurred and "really wasn't thinking about it a great deal". She continued to the ground floor using the stairs. Her neck was sore, as was her knee after walking down the stairs. This knee had been subject to surgery when Mrs Shipton was in her 20's. After the incident, Mrs Shipton made an appointment to see a general practitioner at a medical clinic. At that time, she did not have a regular general practitioner. She was not able to get an appointment until a couple of days after the incident. She continued to work until she saw the doctor. The day after the incident, it felt like every muscle in her body was hurting, and her neck was very sore. She initially saw Dr Sue Williams. After that initial consultation, she returned to see Dr Williams about one month later as her neck was not getting any better and was, in fact, getting worse. She continued to work until she was due to take up her new position in the Attorney-General's Department.
91. As time progressed, Mrs Shipton noticed not only pain in her neck but also sharp pains and a burning sensation in her right arm. She likened the pain to "an elastic band, stretching pain". She felt that her arm was getting weaker. On about 18 September 2013, she commenced employment in the Attorney-General's Department, but went on sick leave in mid-December 2013 to try to resolve her neck pain. She had many months of accumulated sick leave. She obtained a medical certificate from Dr Williams, and continued to experience neck and arm pain. She had not previously experienced similar pain. In 2014 when Mrs Shipton realised that her

condition was not improving, she commenced consulting a new general practitioner, Dr Ian Brown. At that time, she was already seeing a physiotherapist, David Berg. She did not find the physiotherapy helpful.

92. Dr Brown referred Mrs Shipton to a pain management psychologist. She did not find this particularly helpful either. Dr Brown also recommended that Mrs Shipton go to Pilates sessions, which she did. At the time of the hearing, she was continuing to participate in Pilates, which she found helped her emotionally.
93. Dr Brown also referred Mrs Shipton to Dr Pik. He recommended surgery on her neck. She found the thought of surgery frightening. Mrs Shipton eventually underwent surgery on her neck, but in the period leading up to the surgery she began to experience a lot of pain in her left wrist. This pain came on gradually. Her feelings of pain and weakness in her right arm increased. Mrs Shipton is dominantly right-handed. She attempted to do most things with her left arm rather than her right due to the pain and weakness in her right arm. Then she began to experience pain in her left arm. She received two injections in her left arm, which helped "a little bit". She found that she became clumsy in her right arm. The pain in her right arm travelled from her neck down the arm and into her hand. She described the pain as "like an electric shock, it's pins and needles."
94. Mrs Shipton agreed to surgery because she felt she had run out of options and she needed to get better. She desperately wanted to return to work. Dr Pik told her that the surgery would stabilise her neck, but he could not guarantee that it would rid her of her pain.
95. Mrs Shipton underwent surgery to the C6/7 level of her spine in February 2015. She felt sick and terrified in the period leading up to surgery. Mrs Shipton remained in hospital for four days after surgery and was then released. Very shortly thereafter, she was readmitted due to a reaction to her pain medication and she remained in hospital for a further three days. Since the surgery, Mrs Shipton has experienced a feeling of choking. This feeling is with her all the time, but it becomes worse about once a week. About once a month, Mrs Shipton can choke to the point where she becomes incontinent. The feeling was described by Mrs Shipton as a tightness in her throat, a feeling like she has "something stuck in her throat."
96. After the surgery, Mrs Shipton said there was no real improvement to the pain in her arm, but she was not as clumsy as before. She continued physiotherapy with Mr Berg. Mrs Shipton undertook exercises as prescribed by Dr Pik. She continued to perform these exercises as at the date of hearing.
97. At the suggestion of Mr Berg, Dr Brown referred Mrs Shipton to Dr Ashish Diwan at St George Hospital in Sydney for a second opinion. There was some discussion about possible treatment to her neck at the C5/6 level of her spine, but Mrs Shipton was not willing to undergo further surgery.
98. Mrs Shipton now lives on a 3 ½ acre property on the New South Wales coast. She walks around the border of the property with her husband, and also uses a Pilates machine. She does not like to walk on her own as she cannot turn her neck quickly and she is scared that someone or something will come up behind her and she will not be able to defend herself. Before the incident with the lift, she was happy to walk by herself and had no fear. From time to time, she and her husband walk their dog on a nearby beach.

99. In terms of her mental state, Mrs Shipton said that she feels like she has lost everything. She said: "I've lost my health. I've lost my career. I don't plan for anything anymore. I'm just sick of being in pain and I just want to have a day off."
100. Mrs Shipton said that her continuing disability has affected her relationship with her husband and her children. She feels that she and her husband cannot make plans anymore, and her husband is worried about leaving her alone because of her pain episodes. She feels her children are less likely to seek her assistance because they are concerned for her wellbeing.
101. Before the lift incident, Mrs Shipton and her husband shared the domestic duties. She has now reduced the amount of housework she undertakes because it causes her pain. They have modified their home to cope with her problems, and have purchased a robotic vacuum cleaner, a self-drive vacuum cleaner and a robotic window cleaner. They also have electric beds. They exchanged their front loader washing machine for a top loader. Mrs Shipton estimates that they have spent \$40,000 to \$50,000 "on stuff". Mrs Shipton sprays the shower, and her husband scrubs it. She sprays and wipes the basins. They have a steam mop to do the floors. Her husband has always been responsible for the garden work.
102. Mrs Shipton now has difficulty in self-care duties such as washing her hair. She now has a hairdresser who comes to her home to help her with her hair because she can no longer put her head back in a basin. She has put on weight because she is unable to exercise properly.
103. Dr Brown referred Mrs Shipton to a clinical psychologist, a Mr Sutton. As at the date of hearing, she continued to consult Mr Sutton. She commenced seeing him after her surgery and sees him once a month. He has assisted her in slowing her mind down and accepting her situation. She now finds pleasure in the company of her dog and her children. She tries to cook, and sometimes her husband helps her. She does not enjoy cooking as much as she did before she was injured.
104. Mrs Shipton said that she is now teary and becomes very angry quickly. She no longer socialises as much as she used to. She has accepted that she is unable to work, Mr Sutton told her that she had to accept it or she "would go crazy." She has been retired from the public service. Mrs Shipton found it difficult not being able to work. She had wanted to achieve a Senior Executive Level 1 position. She believed that before the accident her future was bright because she was "the people person between technology and the public service." She said that reliance on Information Technology was increasing. Before the accident she had no settled plans of retiring at a particular age, but she and her husband had looked at retiring at around age 65 years. She presently receives income from her superannuation and some income from Comcare.

Medical evidence

105. A number of clinical records sought to be tendered in Mrs Shipton's case were objected to by Kone. Only a handful of records were ultimately pressed by Mrs Shipton. The submission on behalf of Mrs Shipton was that the records were business records to which s 69 of the *Evidence Act 2011* (ACT) (Evidence Act) applies. Kone did not dispute that they were records of the type referred to in s 69(2), but submitted that their admission was precluded by s 69(3), which provides that s 69(2) does not apply to make business records admissible if they were prepared or

obtained for the purpose of conducting, or for or in contemplation of or in connection with an Australian or an overseas proceeding. Kone's objection was that the impugned records were created for the purpose of conducting, or in connection with, a claim for workers' compensation by Mrs Shipton with Comcare.

106. Kone submitted that the business records in question were prepared or obtained for the purpose of conducting, or for or in contemplation of, or in connection with the application to Comcare, which, Kone submitted, was an "Australian proceeding" for the purposes of the Evidence Act. An "Australian or overseas proceeding" is defined in the Dictionary to the Evidence Act as "a proceeding in an Australian court". The term "Australian court" is defined in the Dictionary to the Evidence Act as meaning, inter alia, an entity authorised by an Australian law "to hear, receive and examine evidence."
107. Comcare is an entity established by s 68 of the *Safety, Rehabilitation and Compensation Act 1988* (Cth) (the SRC Act). The functions of Comcare, as set out in s 69 include:
 - (i) to make determinations accurately and quickly in relation to claims and requests made to Comcare under the SRC Act: s 69(a); and
 - (ii) in respect of actions for non-economic loss – to take over the conduct of such actions under s 52A on behalf of the Commonwealth, Commonwealth authorities or employees against whom such actions were taken: s 69(ea).
108. By virtue of s 70 of the SRC Act, Comcare has power to do all things necessary or convenient to be done for, or in connection with, the performance of its functions. By operation of s 72 of the SRC Act, Comcare, in performing its functions:
 - (a) should be guided by equality, good conscience and the substantial merits of the case, without regard to technicalities;
 - (b) is not required to conduct a hearing; and
 - (c) is not bound by the rules of evidence.
109. Section 14(1) of the SRC Act provides that Comcare is liable to pay compensation in accordance with the SRC Act in respect of an injury suffered by an employee if the injury results in death, incapacity for work, or impairment. No evidence was led to show how Comcare goes about performing its statutory functions, but the terms of the SRC Act strongly suggest that Comcare is an administrative body carrying out administrative functions on behalf of the Commonwealth. This, of course, would not preclude Comcare from being defined as an Australian court for the purpose of the Evidence Act if that were the intention of the legislature. I am satisfied that it was not.
110. The relevant definition of the term "Australian court" refers to a body which is authorised by an Australian law to "hear, receive and examine evidence" (emphasis added). Many administrative bodies will receive and consider information in order to undertake their functions, but that is not the same as hearing, receiving and examining evidence, as that is properly understood in the Evidence Act. As the plurality of the High Court observed in *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 at 282, the use of the term "evidence" in the context of administrative decision making must be approached with caution. In *Averkin v Insurance Australia Ltd* [2016] NSWCA 122; 92 NSWLR 68, Lemming JA,

with whom McColl and Basten JJA agreed, said, at [114], with regard to the identical provision in the *Evidence Act 1995* (NSW):

In both paragraphs (a) and (b), the exception to the hearsay rule created by s 69(2) is unavailable because there is a link with litigation.

111. The rationale for the exclusion provision in s 69(3) was described by Barrett J in *Vitali v Stachnik* [2001] NSWSC 303 at [12]:

The purpose of the exclusion is, as I see it, to prevent the introduction through this exception to the hearsay rule of hearsay material which is prepared in an atmosphere or context which may cause it to be self-serving in the sense of possibly being prepared to assist the proof of something known or at least apprehended to be relevant to the outcome of identifiable legal proceeding.

(emphasis added).

112. This passage was quoted with apparent approval by Hamilton J in *Lewis v Nortex Pty Ltd (in Liq); Lamru Pty Ltd v Kation Pty Ltd* [2002] NSWSC 1083 at [4], and by Gyles AJA in *Thomas v State of New South Wales* [2008] NSWCA 316; 74 NSWLR 34.

113. The material objected to by Kone consists of:

- (a) a letter from Dr Pik to Dr Brown dated 20 July 2015;
- (b) a letter from Dr Pik to Dr Brown dated 10 April 2015;
- (c) a document titled "Operation Report National Capital Private Hospital" dated 19 February 2015 and apparently prepared by Dr Pik;
- (d) a letter from National Capital Diagnostic Imaging dated 21 January 2015 and addressed to Dr Pik;
- (e) a letter dated 11 August 2014 on behalf of Dr Pik to Ms Nicole Seale, a Comcare delegate;
- (f) a letter from Dr Pik dated 12 August 2014 to Dr Brown;
- (g) a letter dated 5 February 2015 from Dr Pik to Dr Brown;
- (h) a letter dated 7 August 2014 from Dr Brown to Dr Pik; and
- (i) a letter dated 4 February 2014 from Dr Pik to Dr Susan Williams.

114. The letter referred to in (e) above is a letter requesting Comcare approval for Dr Pik to conduct surgery on Mrs Shipton. Many of the other letters were copied to Comcare. It is apparent that Comcare accepted Mrs Shipton's claim for compensation, and approved the surgery proposed by Dr Pik. There was no legal proceeding in which it was necessary for Comcare to hear, receive or consider evidence.

115. I confirm the reception of the material into evidence.

116. On 16 November 2017, Mrs Shipton was seen by Dr Peter Giblin, an orthopaedic surgeon practising in Sydney. Mrs Shipton gave a history of being a passenger in a lift which fell from the 19th floor to the 14th floor before stopping suddenly. It then fell again to the 11th floor before again stopping suddenly. She stated that she felt like her body was being concertinaed. She complained of subsequent acute neck pain with symptoms radiating down her right arm and hand. Dr Giblin noted that Mrs Shipton had ceased work in December 2013 and had had a right sided C6/7 cervical fusion in

February 2015. She complained of constant pain in her neck associated with headaches, nausea and vomiting. She reported persisting pain in her right arm and pins and needles in the right thumb and index finger. As a result of favouring her right arm, she had developed pain around the base of the left thumb and anatomical snuff box. She also had a feeling of choking when she tried to swallow.

117. Mrs Shipton told Dr Giblin that she could still drive a motor vehicle but had difficulties accessing her blind spot and lane changing. She was having difficulty sleeping. She also had difficulty standing for more than 10 minutes, or sitting for more than 30 minutes. Prior to the accident, she did most of the housework and shopping, but after the accident she relied heavily on gratuitous support from family members. Her sex life was greatly reduced.
118. Dr Giblin examined Mrs Shipton and also reviewed available x-rays and other imaging. Based upon the history provided and his examination, he formed the provisional diagnosis of a soft tissue injury to her cervical spine with referred symptoms to the right upper extremity, reasonably causally related to the injury of 4 September 2013 and consistent with changes as noted on the MRI scans at C6/7. He acknowledged that there was a previous history of soft tissue symptomatology in the cervical spine and right shoulder area with radiological pathology noted at C6/7.
119. Dr Giblin considered Mrs Shipton's condition to be stable, and her prognosis to be guarded. He believed that her symptoms were likely to persist indefinitely and be associated with permanent physical limitations. There was also the prospect of deterioration in relation to accelerated degenerative changes at the degenerative disc at C5/6. In his opinion, she was permanently unfit to use her upper extremities in a heavy repetitious impact or forceful position that would place any strain on her neck. She was also unfit to hold her neck in a fixed awkward position or subjected to repetitive twisting or turning. These physical restrictions will apply indefinitely to her domestic, recreational and occupational activities.
120. Dr Giblin stated that as a result of Mrs Shipton's ongoing symptoms, she required a degree of permanent medical support as well as some degree of physical assistance in relation to her daily personal and household activities. It was his opinion that the surgery and treatment required, following the injury on 4 September 2013, was reasonable and necessary.
121. Dr Giblin was made available by telephone for cross-examination at the request of Kone. He agreed that from the description given to him by Mrs Shipton of the incident in the lift on 4 September 2013, it was a relatively violent event. He was asked to assume that in fact the lift had not fallen but was "pulled down by the operation of the lift mechanism" in a controlled descent, but he was not asked how such an assumption would affect his opinions.
122. At the request of her solicitors, Mrs Shipton was examined by Associate Professor Richard Stark, a neurologist practising in Melbourne. In his report dated 15 May 2017, Associate Prof Stark noted a history of pain in the neck and right arm following the lift incident on 4 September 2013, as well as a subsequent history of disability and impact upon Mrs Shipton's work and activities of daily living. In the section of the report headed "Assessment and Comment", Associate Prof Stark noted that Mrs Shipton reported severe pain in the cervical spine with radiation to the right arm. He stated that the description of the radiation and the associated sensory symptoms raised the question of radiculopathy but there was no objective evidence of such in

terms of focal muscle weakness, reflex abnormality or wasting. Images of her cervical spine showed rather non-specific bulging of the C5/6 and the C6/7 discs which had been present prior to the elevator incident, and which looked essentially unchanged on subsequent scans. Associate Prof Stark noted that there was some pre-existing discomfort in Mrs Shipton's neck, radiating to the right shoulder region which had been attributed to her posture at work. This was a relatively minor problem which changes in ergonomics at work had improved considerably. She had not required time off work because of this problem before the elevator incident.

123. Associate Prof Stark stated that it seemed clear that since 4 September 2013 there had been a substantial change in the severity of Mrs Shipton's symptoms arising from her neck. He stated that it was likely that there was a soft tissue injury of some type, with no change in the structural appearance of the neck on radiology. Although some of her symptoms raised the question of nerve root irritation, there was no objective evidence of that. Associate Prof Stark noted that there was diffuse tenderness over the cervical spine and some reluctance to move the neck and right arm for fear of pain. These features raise the question of a regional pain syndrome. Associate Prof Stark accepted that Mrs Shipton was suffering genuine pain as described, but acknowledged that there was no objective way of documenting this. In his opinion, Mrs Shipton sustained a soft tissue injury of the cervical spine in the elevator incident with ongoing symptoms which probably included elements of a chronic pain syndrome. On the basis of a substantial increase in her level of symptomatology following the incident on 4 September 2013, he accepted that the problems of which Mrs Shipton continued to complain arose from that incident. He stated that when patients develop a chronic pain syndrome of this type, the prognosis is very difficult to predict. He accepted that Mrs Shipton's social, leisure and other activities had been impaired. He accepted that based on the symptoms described by Mrs Shipton, limitations arising from those symptoms would be sufficient to interfere with her ability to work. Associate Prof Stark noted the treatment that had been given to Mrs Shipton, which included physiotherapy, Pilates and Feldenkrais. He considered the treatment reasonable and necessary, although the surgical intervention proved not to be effective. He believed, in retrospect, that Mrs Shipton's symptoms probably did not derive from the right-sided disc bulge at C6/7, but that was not clear prior to the surgical intervention. In Associate Prof Stark's opinion, future treatment was likely to be along the lines of a pain management program. He did not believe that further surgery would be helpful. Mrs Shipton's prognosis was uncertain.
124. Dr Pik provided a letter dated 4 February 2014 to Dr Williams, Mrs Shipton's then general practitioner. Dr Pik stated that Mrs Shipton had very severe neck pain with radiation down the right arm since September 2013. The pain was concentrated around the right shoulder blade as well as the right C7 distribution. Mrs Shipton also described occasional pins and needles affecting the digits of her right hand. Mrs Shipton told Dr Pik that she had had previous episodes of neck pain which resolved spontaneously over time. She had never experienced radiating arm pain before September 2013. On examination, Dr Pik noted that Mrs Shipton had a decreased range of cervical spine movements and Spurling's sign was strongly positive to the right. Neurological examination revealed minor weakness in right shoulder abduction and shoulder external rotation. All of the deep tendon reflexes were absent in the upper limbs. MRI of the cervical spine showed evidence of a right-sided C6/7 disc herniation causing right C7 nerve root compromise.

125. On 7 August 2014, Dr Brown wrote to Dr Pik advising that he had now taken over as Mrs Shipton's regular general practitioner. Dr Brown asked Dr Pik to review Mrs Shipton. Dr Brown said: "I understand that she is now eleven months down the track from a sudden lift descent accident at work, in which she has severely aggravated her neck, with daily neurological symptoms in the C7 root causing ongoing disability since, both in an occupational and domestic sense, with severe degradation of her quality of life." By letter dated 12 August 2014, Dr Pik responded to Dr Brown stating that he had reviewed Mrs Shipton on 8 August 2014. He noted that she continued to have severe right arm pain in a C7 distribution. He recommended surgery.
126. A report from Dr Ken Lau of National Capital Diagnostic Imaging to Dr Pik dated 21 January 2015 provided the results of an MRI scan of Mrs Shipton's cervical spine. The report noted there was a straightening of the cervical spine and that the cervical discs were partly desiccated with no significant disc space narrowing. At the C5/6 level, it was noted that there was a mild posterior disc bulge indenting the spinal theca without causing canal or neural foraminal narrowing. Posterior annular fissure was seen at the disc bulge. At the C6/7 level, mild posterior lobulated disc bulge was seen which was more prominent at the right paracentral location. This flattened the right anterior aspect of the cord. Annular fissure was also seen at this level. Moderate narrowing of the right neural foramen was seen secondary to posterolateral disc protrusion into the neural foramen. By letter dated 5 February 2015, Dr Pik again wrote to Dr Brown noting that he had reviewed Mrs Shipton on 3 February 2015. He advised that Mrs Shipton was scheduled to undergo surgery on 19 February 2015.
127. Mrs Shipton underwent surgery on 19 February 2015. By letter dated 10 April 2015, Dr Pik wrote to Dr Brown stating that he had reviewed Mrs Shipton on 7 April 2015. On that occasion she told him that her right arm symptoms had only been improved by about 10 per cent since the operation. Mrs Shipton also complained of pain in the back of her neck as well as intermittent swallowing difficulties. On examination, Dr Pik noted that Mrs Shipton had normal power in the upper limbs. There was also the expected range of cervical spine movements. Dr Pik stated that he explained to Mrs Shipton that he did not have a good explanation as to why she had ongoing symptoms. He suggested further tests.
128. By letter dated 20 July 2015, Dr Pik again wrote to Dr Brown after he had reviewed Mrs Shipton on 20 July 2015. Dr Pik said that Mrs Shipton stated that she had improved compared with before her surgery but not as much as she had hoped. She continued to complain of some right arm pain as well as sensory alteration affecting the digits of the right hand. Mrs Shipton complained of having a "lump in her throat", particularly when she was lying on her back or prone. She did not complain of any difficulty with swallowing, breathing or talking. Dr Pik believed that the operation had technically been a success, and was unable to explain Mrs Shipton's continuing symptoms.
129. Mrs Shipton was seen at the request of her solicitors by a psychiatrist, Professor Lorraine Dennerstein AO on 3 March 2017. Prof Dennerstein noted a history of Mrs Shipton being injured in a sudden lift stop after a lift fell on 4 September 2013. She further noted a history of ongoing pain and disability since that time, and treatment including surgery in 2015. Mrs Shipton became tearful when asked about the effects of her disability. She said at first she had expected to get better but the pain did not improve and in fact worsened. She said she became depressed when she had to give

up work, as she had enjoyed her job. She felt very guilty as she had just started a new job. She said that she felt angry with her body as she was not getting better and could not control the situation. She was frustrated with her limitations. She continues to be avoidant of lifts. She becomes anxious, and prefers to go out with her husband rather than alone. Her social life has been affected.

130. Prof Dennerstein noted that Mrs Shipton was a 50 year old married mother of three and public servant who experienced severe physical injury to the cervical spine when a lift in which she was travelling in her workplace fell precipitously on 4 September 2013. She sustained an injury to the cervical spine, exacerbating previous spinal problems, and had continual pain in her neck extending down her right arm since then. She had developed a Specific Lift Phobia, including features of anxiety about travelling in lifts and avoiding lifts. Prof Dennerstein expressed the opinion that Mrs Shipton had developed exacerbation of Adjustment Disorder with Mixed Anxiety and Depressed Mood. She believed that Mrs Shipton had work related anxiety and mood problems recorded by her general practitioner prior to the incident, but this condition was exacerbated by her physical injury, pain, frustration with her limitations, and feeling that she was no longer safe. Prof Dennerstein was of the opinion that the psychiatric injuries sustained by Mrs Shipton were related in timing and content to the effects of the incident on 4 September 2013. She noted that Mrs Shipton was limited in returning to work because of chronic pain. She also expressed the opinion that Mrs Shipton's social, leisure and other activities had been impaired by her physical injury, and that she was also limited by her motivation. She stated that Mrs Shipton had become socially withdrawn, and was anxious about leaving the house by herself. She believed that past treatment given to Mrs Shipton had been reasonable and necessary. She further believed that Mrs Shipton should continue to attend a psychologist for pain management and Cognitive Behaviour Therapy and mindfulness techniques for a period of 12 months, and visits could then be reduced to quarterly and then discontinued the following year. Mrs Shipton's symptoms had stabilised and were likely to continue for the foreseeable future.
131. Prof Dennerstein was made available via telephone for cross-examination. She agreed that an Adjustment Disorder is the development of emotional or behavioural symptoms in response to an identifiable stressor occurring within three months of that stressor taking place. She stated that it appeared that Mrs Shipton had a prior Adjustment Disorder to existing stressors at work. Her sudden injury and pain impacted on her ability to function and be at work and led to an exacerbation of that existing disorder. It was suggested to Prof Dennerstein that it may be expected that an Adjustment Disorder would dissipate within six months of the termination of the stressor. Prof Dennerstein accepted that that is what would be expected unless additional stressors occurred, as often occurred when you had physical injury which continued to be a stressor.
132. Mrs Shipton was assessed by Dr Stephen Buckley, a consultant physician in rehabilitation medicine, on 12 January 2017. He noted a history of Mrs Shipton being a passenger in a lift which fell from the 19th to the 11th floor. He further noted a history of "right neck, right shoulder and right arm pain" almost immediately after the incident. He noted a history of continuing pain and disability. The most significant disability of which Mrs Shipton complained when Dr Buckley saw her on 12 January 2017 was her neck pain. She was being treated by physiotherapy, Pilates exercises and Feldenkrais. She was taking medication to cope with the pain, and also undertook

meditation. She was capable of driving in her local area, but would not drive longer than 30 minutes.

133. Mrs Shipton told Dr Buckley that she had a feeling as if there was a lump in her throat, which worsened when she looked down. This feeling had not changed in the preceding 12 months. She also described a burning feeling over the front of her right arm. She stated that the burning goes down into the forearm along the region of the radius. At night, the ulnar side fingers go numb. Mrs Shipton said that her right hand is weak for activities such as cutting up vegetables, lifting the kettle and carrying groceries. Mrs Shipton further said that the left shoulder and arm were very similarly affected as the right, but not quite so severely. She was being treated for De Quervain's tenosynovitis in her left arm.
134. With regard to activities of daily living, Mrs Shipton told Dr Buckley that she is capable of washing her own hair and drying it, although she has a smaller hairdryer than before to reduce the weight she must hold up, and washes her hair less often than she did previously. She stated she is unable to lean back over the edge of the basin to have her hair washed at the hairdressers. She cleans her teeth with an electric toothbrush, but otherwise all personal care was independent.
135. Mrs Shipton told Dr Buckley that prior to her injury she and her husband used to share domestic chores such as vacuuming and bathroom cleaning, but now her husband completes them almost always. Mrs Shipton said that she would undertake some brief light tasks one at a time, but was very restricted in what she could do, and would do little over any one day. She was able to undertake grocery shopping, but parked close to the supermarket and used a small trolley. She had great difficulty with cooking, taking it very slowly. She could not carry heavy pots or stir food vigorously.
136. Mrs Shipton told Dr Buckley that the pain which she experienced stops her from enjoying "most things". She described trouble with sleeping, using a computer, or sitting still for any period of time. She told Dr Buckley that her husband had previously worked four days a week, but had reduced that to two and a half days in order to assist Mrs Shipton.
137. Dr Buckley examined Mrs Shipton and also reviewed images and scans including an MRI of the cervical spine from 10 October 2012, an MRI of the cervical spine from 5 November 2013, an MRI of the cervical spine from 21 January 2015 and a CT scan of the cervical spine from 29 June 2015.
138. In the section of his report headed "Diagnosis", Dr Buckley stated that Mrs Shipton had a cervical fusion, complicated by a sensation of choking, which did not appear to be related to the cervical fusion. She had bilateral shoulder traumatic capsulitis. While Mrs Shipton complained of right arm weakness, there was no other good evidence for radiculopathy following the operation. He presumed that prior to her surgery, radiculopathy in the right C7 nerve root was present. With regard to prognosis, Dr Buckley stated that the fusion is permanent and it was likely that her deficits in both shoulders would also be permanent.
139. With regard to the connection between Mrs Shipton's ongoing pain and disability and the incident of 4 September 2013, Dr Buckley noted that the MRI of Mrs Shipton's cervical spine conducted on 10 October 2012 revealed a large right C6/7 disc protrusion. Dr Buckley stated that it would seem that there was a disc injury prior to the accident on 4 September 2013, but the neck was asymptomatic. He was therefore

satisfied that the cervical fusion was required as a result of the accident. In his opinion, the bilateral shoulder capsulitis was also a result of the lift fall injury.

140. Dr Buckley stated that Mrs Shipton should see her general practitioner four times annually for ongoing pain management, twice at the level C Extended Service rate and twice at the level B Specific Service rate. She should be reviewed by a neurosurgeon once annually, but further operative intervention was unlikely to assist. Dr Buckley stated that in view of the likelihood of exacerbations of pain Mrs Shipton required 12 physiotherapy treatments annually, being six treatments over a fortnight, twice annually. She required a house with flat access, and the bathroom should have non-slip flooring and grab rails.
141. Dr Buckley stated that Mrs Shipton is unfit to carry out ordinary handyman duties, and it was an unreasonable expectation that family members should do the work she would ordinarily do. He proposed that she required three hours a week of handyman assistance for outdoor domestic maintenance, should she choose to live in an average size suburban cottage. He also believed that Mrs Shipton was unfit to carry out ordinary housekeeping duties. He also believed that it was an unreasonable expectation that family members should do the work she would ordinarily do. He believed that she required five hours a week of housekeeper assistance to carry out the ordinary indoor domestic maintenance tasks of cleaning, scrubbing, washing and vacuuming, should she choose to live in an average size suburban cottage. At the time of consultation, Dr Buckley believed that Mrs Shipton's level of pain was incompatible with employment on the open employment market. As her disability appeared to be permanent, she was, in his opinion, permanently unemployable on the open employment market as a result of her neck fusion, bilateral shoulder capsulitis and chronic pain.
142. In summary, Dr Buckley stated that Mrs Shipton suffered an exacerbation of a pre-existing intervertebral cervical disc injury in the lift fall on 4 September 2013 (wrongly identified as 4 March 2013 in the first paragraph of his summary). As a result of the extent of pain and radiculopathy, she developed traumatic capsulitis of both shoulders. She had continuing cervical and shoulder pain, and restriction in the range of movement in all three regions. Since the cervical operation she had a sense of choking with extension of the neck, and while there was a temporal association with the operation, it was difficult to conceive of any operative complication which would cause swallowing difficulty of the type that she described, although he could not rule that out. Dr Buckley suggested that she consult an Ear Nose and Throat specialist to determine the nature of her swallowing difficulty.
143. Dr Buckley gave some brief oral evidence in chief, and was cross-examined. In evidence in chief, he stated that he has been involved in rehabilitation medicine since 1981, including significant involvement with people with spinal injuries who have had surgery as a result of those injuries. He has held appointments with both the major spinal units in Sydney at various times, and continues to examine post-neurosurgical patients on a weekly basis at Royal North Shore Hospital.
144. Dr Buckley was cross-examined about the description of the incident on 4 September 2013 provided to him by Mrs Shipton. He agreed that Mrs Shipton's description suggested a fall of the lift without restraint from the 19th floor to the 11th floor, where it stopped suddenly. Dr Buckley said that he had doubted the accuracy of that description at the time it was given to him because he would have expected

greater injuries had the fall of the lift occurred in that manner. He said that he had assumed that it had not been a freefall because it would most likely have killed all of the occupants of the lift. He did not believe that it was possible to determine the precise axial loads because it was not possible to determine the precise position of Mrs Shipton's neck as the lift descended and stopped. Dr Buckley acknowledged that Mrs Shipton had prior medical conditions, but he believed that the reason she had very stiff, painful shoulders when she consulted him was a result of capsulitis in the shoulders, which was a combined result of the sudden stop in the lift and the consequent neck pain and the cervical fusion. Dr Buckley also acknowledged that people are capable of feigning pain, but he believed that he was reasonably good at judging that. He believed that his examination findings were consistent with the claims of pain made by Mrs Shipton. It was put to Dr Buckley that there was no objective evidence to support the proposition that the events of 4 September 2013 caused Mrs Shipton's ongoing pain and disability, to which Dr Buckley replied: "[a]ll we know is that this lady was substantially okay with respect to her neck until that incident and pretty much immediately after that incident she's trying to get more help because her neck is much worse. She gets a scan, she gets a referral to surgeons and ultimately gets an operation."

145. Dr Buckley accepted that spinal degeneration can occur with ageing. He referred to the report of the MRI scan undertaken in 2012 and stated that this did not reveal an aged degenerative cervical spine. It was a cervical spine with a specific injury of the C6/7 disc and possible injury of the C5/6 disc.
146. Dr Buckley was shown a surveillance video of Mrs Shipton, but nothing in that video changed his opinions.
147. Mrs Shipton was seen by Dr Ross Gurgo, a neurosurgeon, at the request of the solicitors for Kone on 3 October 2017. In his report dated 30 October 2017, Dr Gurgo noted that Mrs Shipton's main continuing complaint was neck pain. She also complained of headaches and right-sided arm pain, although this had improved somewhat since her surgery. Dr Gurgo considered that the treatment Mrs Shipton had received, including surgical intervention, Pilates, physiotherapy and Feldenkrais therapy, had been appropriate. However, he thought that the need for treatment had gone on for a longer period than he would have expected given the relatively straightforward nature of her surgery.
148. In his report, Dr Gurgo said that Mrs Shipton had described a work-related event when an elevator at her workplace malfunctioned and dropped eight floors from the 19th floor to the 11th floor. He considered that such an event could have precipitated a cervical disc protrusion. He believed, however, that Mrs Shipton's continuing symptoms were likely to be the result of a natural progression of an underlying cervical spondylosis. He believed that it was likely that Mrs Shipton had a degree of pre-existing cervical spondylosis, and the lift incident may have caused an exacerbation of that pre-existing condition as well as the right C6/7 disc protrusion. Regarding the question of economic loss, Dr Gurgo stated that most patients who had undergone a successful C6/7 anterior cervical discectomy and fusion would have returned to full work duties three or four months following the procedure. He said that he could not explain why Mrs Shipton felt that she could not return to work. He said that he could not explain the cause of Mrs Shipton's ongoing symptomology, except to say that it was probably related to degenerative cervical spondylosis unrelated to the lift incident. He saw no reason for the need for domestic assistance after

uncomplicated cervical spine fusion surgery, particularly nearly two years after that procedure.

149. Dr Gurgo did not have the pre-accident MRI images to examine but noted the reference in the report of Prof Stark that it showed disc bulges at the C5/6 and C6/7 levels. This did not change his opinion that the lift incident may have either caused the right sided C6/7 disc protrusion or significantly aggravated a pre-existing condition. Dr Gurgo could not comment on any diagnosis of a chronic pain syndrome.
150. Dr Gurgo was not required for cross-examination.
151. Mrs Shipton was also seen by Dr Reza Sabetghadam, an occupational physician, on behalf of the solicitors for Kone on 13 October 2017. He provided a report dated 23 October 2017. He stated that in his clinical examination Mrs Shipton did not present with a frozen shoulder condition or a regional pain syndrome. Inexplicably, before commenting that she did not meet the criteria of regional pain syndrome or frozen shoulder diagnosis, he said “[s]he had fully shaven underarms and was wearing jewellery”. The significance of this observation escapes me. He did not believe that Mrs Shipton had been a suitable candidate for cervical spine fusion based on “Official Disability Guidelines”. Dr Sabetghadam disagreed with the opinion of Dr Buckley that Mrs Shipton had developed traumatic capsulitis of both shoulders as a result of pain and radiculopathy. He thought that the problems described by Mrs Shipton regarding her swallowing “appeared to be more psychogenic”. Dr Sabetghadam also disagreed with aspects of the opinions expressed by Dr Pik. As an occupational physician, many of the opinions expressed by Dr Sabetghadam appear to be outside the area of his expertise, albeit that he would have some basic knowledge from his undergraduate studies and subsequent experience. I do not place significant weight on the opinions expressed by Dr Sabetghadam in his review of the documentation and reports provided to him.
152. Dr Sabetghadam conducted an examination of Mrs Shipton. He stated that on observation of the cervical spine and shoulders he did not notice any significant muscle wasting, deformity or discolouration. On palpitation of the cervical spine and right shoulder, Mrs Shipton exhibited pain and grimacing. He believed that the tenderness in Mrs Shipton’s cervical spine was global and non-specific to any anatomical landmark. He stated that Mrs Shipton declined to participate in a range of motion of the cervical spine, complaining of pain. She had minimal range of lateral rotation, flexion and extension of the cervical spine. The range of motion of both shoulders appeared to be unremarkable and symmetrical. He considered grip measurement irregularity was a sign of voluntary suboptimal effort.
153. Dr Sabetghadam expressed the opinion that Mrs Shipton presented with abnormal pain behaviour. He noted that her pain is subjective and there is no scientific measurement for her pain perception and tolerance. He believed that there were elements of exaggeration of her pain perception. He accepted that Mrs Shipton suffers from chronic pain in her cervical spine, and expressed the opinion that her prognosis is poor. He did not believe that her current medical condition could, on the balance of probabilities have been caused by the incident on 4 September 2013. He identified “intrinsic psychosocial factors” as:
 - (a) underlying psychological condition of depression and anxiety;

- (b) emotional status of fear of aggravation of underlying degenerative condition of the cervical spine or shoulder; and
- (c) emotional status of angst from the workplace incident due to a malfunctioning lift and perceived poor occupational health and safety at the workplace.

154. Dr Sabatghadam identified a number of “extrinsic reinforcers”:

- (a) poor patient education about underlying degenerative condition;
- (b) correlation of workplace incident with aggravation of underlying degenerative condition of cervical spine by general practitioners;
- (c) multiple investigations of the cervical spine;
- (d) diagnosis of radiculopathy without objective findings of such;
- (e) multiple interventions and passive therapies;
- (f) attention to pain rather than functional capacity by treating practitioners;
- (g) surgical intervention and cervical spine fusion for non-specific chronic neck pain; and
- (h) psychosocial issues at the home environment, semi-retired husband who is very supportive and over-supportive family members;
- (i) certification of disability by general practitioners;
- (j) litigation process; and
- (k) secondary gain and sick role.

155. In his clinical opinion, Dr Sabatghadam considered Mrs Shipton’s pre-accident medical conditions were a contributing factor to the level of her post-incident injury and disability. He was of the opinion that she could have had a temporary exacerbation of the symptoms of neck pain following the accident at her workplace, however this temporary exacerbation was expected to cease or subside to the residual level after a very short period of time. Due to the presence of extrinsic and intrinsic psychosocial reinforcers she continued to experience heightened pain and disability perception. Based on Mrs Shipton’s pain perception, he did not believe that she had a tolerance to work in any meaningful employment.

156. Mrs Shipton was also seen by Professor Richard Mattick, a clinical psychologist, at the request of Kone’s solicitors on 4 December 2017. Mrs Shipton reported to him that she was very depressed and feels really sad. She said that she can be anxious, tearful, feels guilty that she is not working and avoids seeing people from the workplace. Prof Mattick did not believe that she had more than a specific fear of elevators. The need for further treatment would comprise 8 to 12 sessions of Cognitive Behavioural Therapy for her lift phobia. He did not believe that she suffered from an Adjustment Disorder. He also did not agree that she suffered from a Somatic Symptom Disorder. He noted that there was no diagnosis of a pain disorder currently in the DSM-5. Prof Mattick considered Mrs Shipton to be capable of resuming pre-injury employment in administrative or other duties. He believed that the fact that she suffered pain would not disqualify her from working in suitable administrative duties.

157. At the request of Kone's solicitors, Mrs Shipton underwent an evaluation of her functional and vocational capabilities. A combined report of Gillian Stewart (physiotherapist), Annie Hartley (vocational psychologist) and Liz Atteya (rehabilitation counsellor), based upon an assessment on 17 January 2019 was tendered. With regard to the functional assessment, the report noted that Mrs Shipton's maximal safe work capacity could not be determined. She demonstrated minimal range of movement of the cervical spine and was reluctant to perform manual handling tasks. The author considered that there were inconsistencies in her presentation. It was considered that Mrs Shipton was likely to be able to perform sedentary and selected light work with a graded return over time. With regard to the vocational assessment, Ms Hartley stated that Mrs Shipton's rigid thinking and resignation that she has nothing positive in her life since the accident will impact on her recovery and ability to move forward from her preoccupation with her injury. She believed that psychological counselling to help challenge, understand and manage her current thought patterns would be recommended. It is noted that it may be difficult for Mrs Shipton to find regular, effective treatment in the area in which he is now living. Ms Hartley also noted that Mrs Shipton is fearful of further injury should she return to work, and struggles with the psychological consequences of her injuries. She believed that psychological counselling could also utilise evidence based treatment for managing phobias and anxiety. Ms Hartley stated that being involved in some form of work would also be highly beneficial in helping Mrs Shipton manage her symptoms of depression. Ms Hartley again noted that employment opportunities may be limited in the area in which Mrs Shipton is now living.

Consideration

158. I am satisfied that in the incident on 4 September 2013, Mrs Shipton suffered an exacerbation to an asymptomatic pre-existing disc herniation in her neck. This exacerbation is best described as a further disc herniation at the C6/7 level causing right C7 nerve root compromise. I prefer the evidence and opinions of Dr Pik to those of Dr Sebetghadam where they conflict, as Dr Pik was Mrs Shipton's treating surgeon and had greater opportunity to observe the injury and Mrs Shipton's behaviour. I accept that as a result of the incident she has developed bilateral capsulitis and a chronic pain syndrome which is ongoing and unlikely to ameliorate. She suffers headaches and arm weakness. She has developed a lift phobia and Adjustment Disorder with mixed anxiety and depressed mood. Where the opinions of Dr Dennerstien and Prof Mattick differ, I prefer the opinions of Dr Dennerstien as Dr Dennerstien's opinions more closely correspond to what I am satisfied was the truthful evidence of Mrs Shipton.
159. I accept Mrs Shipton's evidence that her continuous disabilities have had a severely detrimental effect upon her working, social and family life.
160. Kone submitted that Mrs Shipton would have come to the same position that she is now in due to her pre-existing neck problems. In my opinion, the expert evidence does not support such a finding.
161. Mrs Shipton's employment with the Commonwealth was terminated on 5 September 2018. She was issued with an Invalidity Retirement Certificate on 24 July 2018 by the Commonwealth Superannuation Corporation. I am satisfied that before 4 September 2013, Mrs Shipton enjoyed the work that she did, and performed it well. One only has to consider her career path to see that she was a well-regarded

employee. Bearing in mind her age at the time of the incident, her career path and the probability that she would have worked to age 65 years, there was always a possibility that she would have achieved promotion to an Senior Executive Band 1 position, but I am unable to quantify that possibility. I certainly cannot say that it was probable.

162. Kone submitted that Mrs Shipton had a continuing capacity for paid employment. I do not accept that. In my opinion, her ongoing disabilities and pain make it improbable that she could work in any form of remunerative employment. I accept the evidence of Dr Buckley that Mrs Shipton is permanently unemployable on the open market as a result of her neck fusion, bilateral shoulder capsulitis and chronic pain. As a consultant physician in rehabilitation medicine, Dr Buckley was the medical practitioner best qualified to give an opinion on that issue.
163. I will assess both past and future loss of earning capacity on the basis that Mrs Shipton would have continued in her Executive Level 2 position from 4 September 2013 until she retired at age 65 years. A forensic accountant's report dated 31 May 2017 was prepared by Ms Julia Bossert, a chartered accountant. In its written final submissions, Kone restricted itself to submitting that Mrs Shipton had a continuing capacity for employment and made no criticism of Ms Bossert's report or calculations. I accept Ms Bossert's calculations. The figures for both past and future economic loss derived by Ms Bossert need to be adjusted to allow for the period from the date of the report (31 May 2017) to the date of judgment, 3 April 2020. The weekly loss of income assessed by Ms Bossert for the period 1 July 2016 to 31 May 2017 was \$92,764.00. This is approximately 48 weeks, which equates to a nett weekly loss of \$1932.58. The period from 1 June 2017 to 3 April 2020 is approximately 148 weeks, making the adjustment required to Ms Bossert's overall figure of \$340,117.00 a sum of \$286,022.33. This equates to a sum of \$626,139.33 for past economic loss.
164. Mrs Shipton has received \$554,260.45 from Comcare for past wage loss. Deducting that sum from \$626,139.33 leaves a sum of \$71,878.88. I allow interest on that last figure at 2 per cent for four years (to average out the loss), making a sum of \$5750.31.
165. For future economic loss based on a nett weekly wage of \$1932.58 the calculation for 12 years to age 65 years on 3 per cent tables is $\$1932.58 \times 527.2$, less 15 per cent equals \$866,027.70.
166. I assess the *Fox v Wood* component as \$112,675.00.
167. Past out of pocket expenses have been paid by Comcare amounting to \$114,883.52. Kone submitted that much of that treatment was unnecessary or not connected to the incident on 4 September 2013. I do not agree. I accept the evidence of Associate Prof Stark that the treatment provided to Mrs Shipton had been reasonable and necessary. I will also allow the sum of \$114,883.52.
168. Suzanne Miller-Ravagnani considered that Mrs Shipton requires approximately seven hours of domestic assistance per week. This is supported by the evidence of Dr Buckley, although he arrived at a slightly higher figure. Ms Miller-Ravagnani estimated approximately 2071 hours of past assistance, a figure which accords with the evidence. Ms Miller-Ravagnani allowed some of those hours at \$47.74 per hour, and some at \$54.23 per hour. In my opinion, it should all be assessed at \$35.00 per hour, making a sum of \$72,485.00.

169. I accept that Mrs Shipton will require continuing support for seven hours a week. At \$35.00 per hour, with a life expectancy of 31 years and applying a multiplier of 1059.2, this would equate to \$259,504.00. In my opinion, some reduction of this sum should be made to allow for the fact that Mrs Shipton would probably have required increasing assistance as she grew older, even without the injuries she suffered on 4 September 2013. I will reduce the assessed sum by 25 per cent to \$194,628.00.
170. I assess general damages at \$140,000.00, of which I attribute half to past and half to the future. I allow interest on the past component at 2 per cent for six years, making a sum of \$8,400.00.

171. I therefore assess damages for Mrs Shipton as follows:

General damages	\$ 140,000.00
Interest	\$ 8,400.00
Past economic loss	\$ 626,139.33
Interest	\$ 5,750.31
Fox v Wood	\$ 112,675.00
Future economic loss	\$ 866,027.70
Past expenses	\$ 114,883.52
Past assistance	\$ 72,485.00
Future assistance	\$ 194,628.00
Total	\$2,140,246.48

The case for Mrs Soesman on damages

172. Jessica Soesman was born in 1988 and completed her schooling in the ACT to Year 12. She then worked in a bank for about six months before joining the public service in around 2005 or 2006. At the time of the hearing, she was employed in the Department of Defence. She worked predominantly in Information Technology around contract management and procurement. In 2013, she was working with the Department of Veterans' Affairs in the premises in Woden. At the time of the lift incident, she was travelling with her colleagues to attend a work meeting. Shortly after the lift incident she had pain in her neck and shoulders. She had previously been diagnosed with mild scoliosis in her lower back when she was about 16 years old, for which she had some physiotherapy at the time. She had no major medical problems before 2013. At the time of the hearing, she had been married for five and a half years.
173. Mrs Soesman stated that she had not previously experienced pain of that type in her neck and shoulders before the lift incident. Due to the pain, she left work at about 10:30 am or 11:00 am on the morning of the incident. By that time, her neck was quite stiff, and she could not move it very much. She said that she was in shock after the incident, and was nervous about getting back into the lift. During the incident itself, she said she was "petrified". She says that she now avoids getting into lifts wherever she can. She is no longer comfortable in lifts. The day after the lift incident she saw a general practitioner, who provided her with a certificate for time off work for the

remainder of 4 September 2013 and the whole of 5 September 2013. She was referred to a physiotherapist in relation to her neck and shoulders, and also her lower back which had been aggravated by the lift incident. She found it difficult to remain in the one position for a long time, either seated or standing, because of the back pain. That continued for at least a few weeks, but as at the date of the hearing it still re-occurs intermittently. She stated that if she is confined to either sitting or standing for a long period of time, it aggravates her back. She also suffered severe pain in her back throughout pregnancy and childbirth. As at the date of the hearing, she continued to have some pain in her neck and shoulders, for which she had been provided with a sit-stand desk at work. She had tried acupuncture but that did not assist. She remained in employment at APS Level 6. At the time of the lift incident, she had been acting at that level.

174. In her evidence, Mrs Soesman described the lift as coming to an abrupt stop, followed by a “bounce”. She said that it then went up, she was not sure how far, and then there was a “bounce” again. In cross-examination, she was taken to the WHS Incident Report Form completed on 4 September 2013, and agreed that it did not refer to the lift going back up again. She said that she remembered a “sudden sort of stopping I felt twice”. She said that she had referred to the lift going back up because “that’s the feeling, the sensation that I had at the time”. She agreed that she had no visual cues to assist her. Mrs Soesman agreed that she was involved in a motor vehicle accident in 2015 in which the vehicle she was travelling in was struck from behind by another vehicle. She said that she did not believe she took any time off work because of that. It was suggested to Mrs Soesman that her need to work from home one day a week due to her lower back was caused by her pregnancy, and not the lift incident. Mrs Soesman stated that at that time it was not a huge physical load as she was not even three months’ pregnant at that stage.

Medical evidence

175. At the request of her solicitors, Mrs Soesman was seen by an occupational physician, Dr Leon Le Leu on 8 February 2017. Dr Le Leu produced a report dated 22 February 2017 in which he noted her complaints of continuing pain to her back, neck, shoulders and also ongoing anxiety. He also noted that she was continuing to work full-time and was not having any physical treatment. She did not believe that she needed to see a psychiatrist or psychologist. She was able to undertake activities such as riding a bicycle, driving, shopping, standing or sitting for 30 minutes and walking. She was able to undertake self-care tasks. She was also able to undertake most of the housework, but her husband did any heavy lifting. On examination, there was evidence of reduction in the range of movement of the neck unusual in a 28 year old, bilateral reduction in shoulder movement with posterior shoulder pain and midline lumbar tenderness. Dr Le Leu was satisfied that Mrs Soesman had suffered a musculoligamentous injury to the neck, musculoligamentous injuries to both shoulders with possible rotator cuff injuries and temporary exacerbation of previous mechanical lumbar back pain. He did not believe that her economic capacity had been impaired by the lift incident. He stated that the treatment provided to Mrs Soesman was reasonable at the time, even if it had ultimately proved not very useful. Dr Le Leu believed that Mrs Soesman had suffered a permanent impairment, as she had some reduction in neck rotation and a significant reduction in shoulder movement. His prognosis was for complete recovery except for the continuation of her shoulder symptoms.

176. Dr Le Leu was subject to cross-examination. In cross-examination, he clarified that he believed Mrs Soesman had suffered a musculoligamentous injury to her neck in the lift incident, but it had resolved by the time he examined her. He also stated that he attributed the reduced shoulder movement to the lift incident because the records showed Mrs Soesman complained of right shoulder pain following the lift incident, but the records did not show any complaint of a shoulder pain following the motor vehicle accident.

Consideration

177. Kone submitted that Mrs Soesman provided a description of the lift incident to Dr Le Leu which was inconsistent with that found in the WHS Incident Report, and that she did so “for the purpose of self-interest”. Whilst there are possibly some differences between the two versions, these are not so great as to give me concern regarding Mrs Soesman’s credibility, particularly having regard to the period which elapsed between the lift incident and Mrs Soesman being seen by Dr Le Leu.
178. I accept that Mrs Soesman suffered pain in her neck and shoulders immediately after the lift incident. She had a pre-existing scoliosis in her lower back, but this was not troubling her to any degree before the lift incident. I accept that her pre-existing lower back condition was exacerbated by the lift incident. The duration of that exacerbation is difficult to determine, as the picture is complicated by low back pain which Mrs Soesman suffered during her subsequent pregnancy. I note that in his report, Dr Le Leu considered that Mrs Soesman had suffered a temporary exacerbation of previous mechanical lumbar back pain. It would seem likely that Dr Le Leu considered the lift incident to be partly responsible for Mrs Soesman’s ongoing low back symptoms at the time he saw her, but he expected that its contribution would cease at some point in the near future. I accept that she suffered musculoligamentous injuries to her neck and shoulders which continue to give her intermittent pain but not to the extent that it has impaired her economic capacity. Mrs Soesman has some continuing difficulties with domestic chores, but she has learned to adapt to those problems. I assess her damages as follows:

General damages	\$ 20,000.00
Interest	\$ 1800.00
Past loss of earning capacity	\$ 300.00
Past out of pocket	\$ 1,094.35
Future out of pocket	\$ 1,000.00
Total	\$ 24,194.35

Case for Mrs Pattinson on damages

179. The plaintiff Mrs Pattinson was born in 1970 and completed her schooling to Year 12 level in New South Wales. When she left school in 1988 her first employment was as a receptionist. After leaving school, she completed a Certificate in Client Services. Between 1988 and September 2013, she worked in administrative positions, before moving into project management. From time to time before the lift incident on 4 September 2013, she consulted a chiropractor for minor back pain. At the time of

the lift incident, she was working as a contractor in the Department of Veterans' Affairs as part of a team led by Mrs Shipton. She had been working in that Department for two years prior to the lift incident. Her role was that of Deployment Project Manager responsible for equipment replacement.

180. I have already set out Mrs Pattinson's evidence regarding her experience of the lift incident, and her physical condition following that incident: see [8] to [23] above. I found Mrs Pattinson to be an honest witness, who had no intention of making a claim for what she initially considered to be modest injuries arising from the lift incident. It was only when it became clear that she had suffered a significant injury connected to the lift incident that she determined to make a claim. I have no hesitation in accepting her evidence of her history and her symptoms.

Medical evidence

181. In addition to the medical practitioners to whom I have already referred, Mrs Pattinson also saw a consultant psychiatrist, Dr William Knox, who subsequently produced a report dated 5 December 2018. Dr Knox noted a history of physical and psychiatric symptoms in the weeks following the lift incident which resolved, leaving Mrs Pattinson in good health until September 2017 when she began to suffer the consequences of a seriously degenerated disc in her neck at the C5/6 level that required surgery. Dr Knox diagnosed mild, chronic Adjustment Disorder with Mixed Emotional Features. He stated that in the immediate aftermath of the lift incident, Mrs Pattinson had a period when she experienced moderate severity anxiety, and then she continued to have a mild phobia for riding in lifts. He expressed the opinion that her poor mental health was completely the outcome of the lift incident in 2013. He noted that Mrs Pattinson did not report significant restrictions to her employment, nor had there been a major interruption to her social or leisure activities. At the time that he saw Mrs Pattinson, she was about to trial a new antidepressant, but Dr Knox did not expect a major change in her symptomology.
182. Dr Knox was required for cross-examination. While Dr Knox agreed that Mrs Pattinson had initially made a good recovery from the lift incident itself, she had not made a full recovery by reason of the need for surgery and the existence of ongoing pain.
183. A report from Prof Mattick, a clinical psychologist, dated 8 March 2019 was tendered on behalf of Kone. Prof Mattick noted that Mrs Pattinson was complaining of ongoing pain and emotional symptoms which had improved with the use of a new antidepressant. Prof Mattick disagreed with Dr Knox's diagnosis of an Adjustment Disorder, believing that Dr Knox had interpreted normal human emotions as evidence of psychiatric illness. Prof Mattick believed that as a consequence of the lift incident Mrs Pattinson had suffered at most a transient reaction in terms of avoidance, with no real evidence of any phobic response. He did not believe that there was any necessity for Mrs Pattinson to take antidepressants, and did not see that any further treatment for psychological distress was warranted.

Consideration

184. Mrs Pattison either developed spondylosis of her cervical spine as a result of the lift incident on 4 September 2013, or that incident accelerated a pre-existing condition. The disc bulge or rupture that occurred in 2017 was causally related to the lift incident.

185. I accept that Mrs Pattison had four weeks off work due to her surgery in February 2018. At that time, she was earning about \$1670.00 nett per week, so I will allow \$6680.00 for this aspect of her loss of earning capacity. Mrs Pattison also claimed a loss of past earning capacity on the basis that when she saw Dr Nadanachandran in October 2018 she was unable to work more than 35 hours per week, whereas before the surgery she had been able to work more than 40 hours. Dr Nadanachandran noted some eight months after Mrs Pattinson's surgery that she was only working 35 hours a week, but added "this can be gradually increased as her symptoms improve, as expected". I allow 12 months at five hours per week at a weekly rate of \$208.00, amounting to \$10,816.00. It follows that I make no award for future economic loss.
186. Little, if any, evidence was led in Mrs Pattinson's case to support a claim for domestic assistance. It appears that there has been some reallocation of domestic duties with her household, but the evidence does not establish with any precision the number of hours per week that domestic assistance is provided because of her injuries. I would be comfortable with allowing one hour per week, both for past and future domestic assistance. There are approximately 110 weeks between Mrs Pattinson's surgery and 3 April 2020. Allowing one hour per week at \$35.00 per hour results in a sum of \$3850.00 for past domestic assistance. I would allow a further five years (as claimed by Mrs Pattinson) at one hour per week, for future domestic care, amounting to \$8491.00.
187. I allow past loss of superannuation at 11 per cent of \$17,496.00, amounting to \$1924.56.
188. I allow the claimed sum of \$320.00 for chiropractic treatment and the Medicare payback of \$2,514.35, making a total for past out of pocket expenses of \$2,834.35.
189. I accept that Mrs Pattinson suffered a serious injury which required major surgery in the form of a spinal fusion of C5/6. She continues to experience recurrent neck pain and headaches. There is a risk that she may require further surgery, but that risk does not rise so high as to be a probability. Mrs Pattinson continues to experience a mild emotional reaction to her injury. It is not important whether it be characterised as an Adjustment Disorder or as a normal emotional response. The effect on Mrs Pattinson's life from her injury is moderately severe. I allow \$90,000.00 for general damages of which I attribute two thirds to the past, and one third to the future.
190. I allow interest on \$60,000.00 at 2 per cent for 110 weeks, amounting to \$2,538.46.
191. I assess Mrs Pattinson's damages as follows:

General damages	\$ 90,000.00
Interest	\$ 2,538.46
Past economic loss	\$ 17,496.00
Interest	\$ 733.00
Past loss of superannuation	\$ 1,924.56
Domestic assistance (past)	\$ 3,850.00
Domestic assistance (future)	\$ 8,491.00
Out of pocket	\$ 2,834.35

Case for Mrs Massouras on damages

192. Kellie Massouras is currently employed as the Municipal Emergency Management Coordinator for a Council in Victoria. She was born in 1969 and completed school when she was aged 16 years. She was employed in a number of casual positions before she joined the Navy in 1987. She worked in the Navy for approximately four years, during which time she undertook a Bachelor of Management and Entrepreneurship and then a Masters in Natural Hazards and Disasters. At the time that she gave evidence, she was completing a Masters in International Development.
193. Mrs Massouras and her husband have one child, now aged 30 years. Mrs Massouras was discharged from the Navy about 18 months after her daughter was born. At the time that she gave evidence, Mrs Massouras' husband had just completed 35 years in the Navy. After leaving the Navy, she did a lot of accounting and bookkeeping work, moving around occasionally when her husband was posted by the Navy. She also undertook contract work with the Queensland Public Service. In around 2012 or 2013, she moved to Canberra to study at the Australian National University and work with the Department of Veterans' Affairs. She obtained employment with that Department as a contractor through Hays Employment. She commenced work in the governance area, predominantly around supporting committees, and then moved into the Internet and communications section. She was employed in the premises in Woden.
194. Mrs Massouras confirmed that she had completed the WHS Incident Report Form about the incident on 4 September 2013. In that report, she said that she had suffered injury to her neck and shoulders. She agreed that in the report she also stated that she had suffered shock. By that, she meant that she found difficulty forming words, and difficulty breathing. She confirmed that she heard a metallic noise shortly before the incident in the lift, and this made her feel panicked. She said that each of the stops by the lift were sudden and she felt herself lift very suddenly.
195. At that time, Mrs Massouras was working as part of a team of about 10 people, headed by Mrs Shipton. She had been working with Mrs Shipton for about 12 months at that time. After the incident, Mrs Massouras returned to work and continued working throughout that day. At the time of the lift incident, she was about to cease employment at the Department of Veterans' Affairs and take up a new position in Melbourne. Before the lift incident, she had been consulting a chiropractor for her general health. She did not have a regular general practitioner. She continued to go to work on the days after the lift incident. She consulted Dr Chris Dawes, a chiropractor in Melbourne. She consulted Dr Dawes about pain and limited movement in her hip and lower back. The problem with her lower back did not commence on the day of the lift incident, but commenced shortly thereafter. She was continuing to have trouble with her neck and shoulders. She continued to seek treatment from her chiropractor and a general practitioner.
196. In March 2014, Mrs Massouras suffered a fall in which she fractured her right wrist. She was cooking, and as she turned from the stove towards the sink her hip and left leg "gave out". She had been troubled by that side of her body since the lift incident, but there was no warning of her leg giving way. She had a plate inserted in the wrist, and she continues to have problems with arthritis. She deals with her problems mainly through holistic medication, but her right wrist continues to trouble her. She

finds driving difficult because of pain in her wrist. She is dominantly right-handed. She also continues to have pain in her neck, from the middle of her shoulders right up through to the back of her neck. Her lower back and her hip still give her problems. At a later time after the kitchen fall, she spent considerable time off work because she could not move due to pain and weakness in her hip. She continues to have trouble with strength and pain in her hip.

197. Mrs Massouras is currently in full-time employment, in which she deals predominantly with the public. She enjoys her work. The type of work that she does requires her to support people, to build their resilience, and to work from trauma that they have experienced. She now finds that she is not as tolerant as she used to be. She does not use elevators, and has a chronic fear of using them. She recounted one occasion when she had to attend a meeting on the 54th floor of a building and she had to use the elevator. She said that she was a “blubbering mess” and vomited when she got to the 54th floor.
198. Mrs Massouras stated that her psychological condition has affected her relationships with others, and particularly with her husband. She has withdrawn from a lot of her social networks, and does not have the confidence she used to. She and her husband are no longer intimate in any way. She stated that her current employer is very supportive, but she does not believe that she could cope as well as before in seeking employment in the open market. Her mental state fluctuates regularly and she describes herself as being very different from the positive, happy person that she was. She now finds herself limited in undertaking housework and gardening by reason of pain in her lower back, hips and shoulders. She regularly seeks chiropractic help and sees her general practitioner. Her daughter continues to live with her and her husband, and provides psychological support. Her husband and her daughter have taken on all domestic duties.
199. In cross-examination, it was put to Mrs Massouras that she had given a number of differing versions of the lift incident to medical practitioners who had seen her. I gained the impression that she had little recollection of what she had told those practitioners, but she readily accepted that whatever was contained in the medical report was what she would have said. It was put to her that she saw an occupational physician, Dr Slesenger, in December 2016 and told him that the lift dropped from the 19th floor to the 11th floor, and then returned to the 19th floor before dropping to the ground floor. It was put to her that she told Dr Slesenger that the lift came to a halt between floors and she and the other occupants of the lift had to be assisted out by security crew. She agreed that if that was what was recorded in Dr Slesenger’s report, that was what she said.
200. Mrs Massouras agreed that she had seen a psychiatrist, Dr Zeeva Cohen, in Melbourne in March 2017. It was put to her that she told Dr Cohen that after she entered the lift on the 19th floor it dropped almost the full 19 floors at a fast speed, before then moving upwards stopping in between levels three and four at which time she and the other occupants climbed out of the lift at mid-level and went down the stairs. She agreed that if that was what was recorded in Dr Cohen’s report, that was what she would have said.
201. Mrs Massouras agreed that she saw a neurosurgeon, Dr Brazenor, in November 2017. She gave the following evidence in cross-examination about that consultation:

Mr Menzies QC: What you told Dr Brazenor was, wasn't it, you were in the lift, the ground button was pressed and there were a few creaks and groans. That was the expression you used to describe a sound?

Mrs Massouras: I don't recall what I said but if it's there, yes.

Menzies: And you told him the lift began to descend but then entered freefall. Remember that?

Massouras: I don't remember what I actually said, but ...

Menzies: But you accept ... ?

Massouras: if it's there ...

Menzies: that's what you said don't [sic] you?

Massouras: Yes.

Menzies: 'It halted at the 13th floor with bouncing and shuddering'. That's what you told him wasn't it?

Massouras: If it [sic] it's there then yes.

Menzies: 'And then dropped precipitately to the basement, or almost to the basement'?

Massouras: If that's what's there.

Menzies: And you said that a couple of your colleagues fell to the floor. Remember that?

Massouras: I don't recall saying that, no.

Menzies: But that's what happened, wasn't it? That's your recollection?

Massouras: I don't recall.

Menzies: But you accept that if that's what appears in the doctor's notes of what you said...?

Massouras: If that's what he's written, yes.

Menzies: That's indeed what you said?

Massouras: Well, it's what he's written. I said I don't recall what's there.

Menzies: And you remained standing, or almost standing, by clutching on to the handrail?

Massouras: Yes.

Menzies: See, the fact is, isn't it, that nobody fell down during that – fell to the floor during that lift fall, did they?

Massouras: I don't recall, sorry.

Menzies: You said that the lift was arrested between the ground floor and the basement and the four of you prised the doors open?

Massouras: Sorry, arrested? That's what I'm said to have said?

Menzies: The lift was arrested. What you told him was that you found when the lift stopped it was between the ground floor and the basement. That's what you told him?

Massouras: That's what he says.

Menzies: And the four of you then prised the door open – doors open and it was in doing so that you found where the lift was positioned: between the ground floor and the basement?

Massouras: That's what his report says, yes.

Menzies: And then you climbed onto the ground floor. That's what is says. That's what ...?

Massouras: I don't recall ...

Menzies: ... you say happened, wasn't it?

Massouras: ... saying that, no.

Menzies: I beg your pardon?

Massouras: I don't recall that, sorry.

Menzies: And one of you stood at the lift to make sure people would not try to enter?

Massouras: There was a queue there waiting to get in, yes.

Menzies: And others of your group reported the lift malfunction to security?

Massouras: Yes.

202. Mrs Massouras was also cross-examined about versions that she gave it to Prof Mattick in 2018, and gave the following evidence:

Mr Menzies QC: And you told Dr Mattick that you and the other staff got into the lift on level 19, pressed the button for the ground floor and the lift shuddered and dropped to the 11th floor, went back up to the 16th floor and back down between the basement and the ground floor. That's what you told Dr Mattick, wasn't it?

Mrs Massouras: I don't recall, sorry.

Menzies: And you told him that you grabbed the rail with both arms, wrapped it – I'm sorry, grabbed the rail with both arms wrapped around the rails?

Massouras: I don't recall what I told him, sorry

Menzies: Did you grab the rails with both arms wrapped around the rails?

Massouras: I was standing in the corner and I do recall grabbing the rails, yes.

Menzies: Did the lift fall from the – in the way that he has recorded you described it?

Massouras: I recall the lift falling, but I can't recall what you just said he said, sorry.

Menzies: You said on 16 February 2018 to Dr Mattick you didn't suffer any loss of consciousness during the event and that's correct isn't it?

Massouras: Yes, but I don't recall the conversation.

Menzies: And you had full recall of all events both before, during and after the incident. That's what you told him didn't you?

Massouras: I can't recall the conversation.

Menzies: And you told him, 'I had to climb out the doors, which are prised open through a small gap'. That's what you told him wasn't it?

Massouras: I don't recall.

203. It was put to Mrs Massouras that she had told an orthopaedic surgeon, Dr Kristopher Lundine, in March 2018 that the lift fell almost 21 floors. She agreed that if the report said that, then that was what she said to the doctor.

204. Mrs Massouras denied the suggestion that she had deliberately exaggerated what had occurred in the lift to each of the medical practitioners to inflate her claim. She also denied suggestions that she had deliberately underperformed in medical examinations with the doctors who prepared reports for use in the current proceedings.

205. When Mrs Massouras first saw Dr Dawes after moving to Melbourne, she completed a patient information form which asked her to circle any of a number of written conditions that were troubling her. She circled allergies, indigestion, cold feet and hands, earache, dizziness, sinusitis and headaches. Mrs Massouras said that she was still completing the form when she was called into see Dr Dawes, and that she told him in the consultation that she had been previously receiving chiropractic services and that she was experiencing pain. She could not recall in what area of the body she told Dr Dawes she was experiencing pain. I note that the patient information form did not list amongst the written conditions that could be circled by a patient any condition relating to problems with the neck, back or shoulders.
206. Before moving to Melbourne, Mrs Massouras had consulted a chiropractor in Belconnen, ACT. In August 2012, she consulted that chiropractor complaining of pain in her neck and thoracic spine. She consulted the chiropractor on a number of occasions between August 2012 and March 2013 complaining of pain in her spine and neck. On 10 December 2012, she complained of right-sided numbness in her arms and legs. There were no further consultations until September 2013, when she gave a history of being caught in an elevator.
207. Mrs Massouras accepted that she had seen a number of general practitioners after September 2013 for various ailments but had not complained to them about continuing pain in her back and neck, until on the 8 August 2014 she complained of “back pain referred to her [right] leg” for the previous two weeks. On 27 August 2015 she again complained of back pain, which she attributed to having sat on an uncomfortable chair for a few hours. The pain at that time was in her lower back.
208. It was accepted by Mrs Massouras that almost immediately after she commenced employment in Melbourne, she began to suffer bullying at the hands of her manager. She found it unpleasant and extremely distressing. She agreed that as a result of that she felt it down, exhausted and had poor sleep and concentration. In 2016, she consulted a general practitioner who offered to provide her with a Work Cover certificate with regard to complaints of anxiety, poor sleep and lack of concentration because of bullying at work. She saw a psychologist. Her sleeping improved.

Medical evidence

209. A report dated 27 December 2016 from Dr Joseph Slesenger, a specialist occupational physician, was tendered as part of Mrs Massouras’ case. She told Dr Slesenger that she was injured while working as a contractor to the Department of Veterans’ Affairs in Canberra when a lift dropped suddenly from the 19th to the 11th floor, returned to the 19th floor and then dropped down to the ground floor. Dr Slesenger records that Mrs Massouras said that the lift came to a halt between floors, and she and the three other occupants had to be assisted out of the lift by security. Mrs Massouras told him that she had developed immediate left hip and left shoulder pain, but did not seek medical attention immediately because she was concerned as to her job security. However, the following day she attended a chiropractor who treated her left hip and left shoulder. She advised that she had been undertaking chiropractic care since that time.
210. Mrs Massouras complained of ongoing moderate to severe pain in her left shoulder, pain in her wrist with difficulty gripping and restricted range of movement, and ongoing pain in her left hip. She said that her left hip pain was the more severe pain,

and her hip was prone to “giving way”. Dr Slesenger conducted an examination, and reviewed documentation from chiropractors and a general practitioner. Dr Slesenger found the chiropractors’ notes unhelpful as they were indecipherable. Based upon the history provided, his examination and some of the documentation, Dr Slesenger thought there was evidence to support the proposition that Mrs Massouras suffered an injury on 4 September 2013, and there was evidence to support the following:

- (a) soft tissue injury to the left shoulder with possible ongoing left shoulder adhesive capsulitis;
- (b) soft tissue injury to the left hip with possible trochanteric bursitis; and
- (c) right wrist fracture.

211. With regard to a possible connection between the conditions identified and the lift incident on 4 September 2013, Dr Slesenger said:

Based on the narrative, the workplace exposures are a plausible cause of Mrs Massouras’ left hip and left shoulder impairment. Clinical examination shows evidence of an ongoing impairment in the left shoulder and left hip. It would be useful for the treating chiropractor to provide a transcript of the records in order to identify a continuum link between the workplace exposures and her current impairment.

212. With regard to the right wrist injury, Dr Slesenger noted that it would be useful to review the Northern Hospital records to address the cause of the fall and right wrist fracture.

213. On the assumption that there is a causal link between the lift incident and Mrs Massouras’ left hip and left shoulder impairment, Dr Slesenger was satisfied that there are ongoing restrictions affecting Mrs Massouras’ capacity for work. He found it difficult, due to the lack of investigation and treatment, to form an opinion as to the extent of any impairment of economic capacity and the likely duration of that impairment.

214. Dr Slesenger noted that Mrs Massouras stated that she has an ongoing disability affecting her capacity to function within the home and to perform activities of daily living. He anticipated that she may require further treatment for her left shoulder and left hip. His prognosis was guarded, primarily as the diagnosis was unclear.

215. At the request of her solicitors, Mrs Massouras was seen by Dr Zeeva Cohen, a consultant psychiatrist, on 23 March 2017. Dr Cohen provided a report dated 4 April 2017. Mrs Massouras reported that she avoided using lifts since the incident on 4 September 2013, and stated that she would experience high levels of anxiety if she had to use lifts. She would vomit due to feeling anxious about using lifts. She stated that she would feel angry with herself due to her loss of resilience and ongoing anxiety attacks as her job was to prepare people for emergencies. Mrs Massouras reported ongoing pain levels, and that she had become more reliant on her husband to help with domestic duties as well as needing an increased level of emotional support. Her sleep was disrupted due to pain and parasthesias. She reported vivid dreams and nightmares of free falling in a lift when she could not avoid using a lift during the day. She also reported intrusive re-experiencing phenomena in the form of flashbacks. She described a constant fear that she would fall and hurt herself. Mrs Massouras reported ongoing anxiety symptoms occurring once or twice a day.

216. Under the heading “Summary and Assessment”, Dr Cohen said:

Ms Massouras is a 47-year-old woman who presents in the context of an incident in a lift some three years ago where according to her self-report the lift malfunctioned falling almost 19 floors and becoming dislodged between floors 3 and 4 where she and others were able to exit the lift. She reported ongoing pain and mobility problems related to her hip and arms since then as well as phenomena suggestive of posttraumatic stress disorder including avoidance of lifts, intrusive re-experiencing phenomena of nightmares and flashbacks, hyperarousal related to anxiety symptoms particularly on exposure to triggers and some general loss of resilience. She reported a move from Canberra to Melbourne shortly after the incident and adjusting to life in a new city.

Ms Massouras presents as a woman whose capacity to be independent, self-sufficient and ability to work forming an important part of her identity and feelings of vulnerability appear to have particular psychological significance for her. There appears to be short-term treatment for symptoms of anxiety and depression in approximately 2011 in the context of work-related difficulties, but having fully recovered. There also appear to have been some symptoms in the context of bullying and harassment in the workforce which she was less able to manage. There appears to be a positive family history for major mental illness; however, Ms Massouras herself does not appear to have demonstrated such illness at any time.

217. In Dr Cohen's opinion, Mrs Massouras meets criteria for Post-Traumatic Stress Disorder due to symptoms of intrusive re-experiencing phenomena, avoidance and anxiety particularly related to using a lift. In her opinion, this condition is related to the incident on 4 September 2013 as the psychiatric phenomenology particularly relates to lifts and there were no other traumatic events to account for the symptoms. From a psychiatric perspective, Mrs Massouras' economic capacity had not been impaired. Dr Cohen believed that Mrs Massouras would be assisted by ongoing psychological treatment and antidepressant medication. Dr Cohen considered the prognosis to be uncertain given the lack of active treatment.
218. In oral evidence Dr Cohen, when questioned about the details of the account of the lift incident given to her by Mrs Massouras, said that what was important was the person's perception of the threat rather than the actual detail itself.
219. Dr Graeme Brazenor, a neurosurgeon, provided a report dated 28 November 2017 on behalf of Kone. I do not give significant weight to Dr Brazenor's report. It is clear to me that Dr Brazenor saw his role as one of picking holes in the account given to him by Mrs Massouras. A clear example of that is found on page 2 of his report when he refers to the report of Dr Slesenger. In his report, Dr Slesenger referred to Mrs Massouras' report that in March 2014 her left hip gave way, while she was cooking in the kitchen, and she fell to the right, fracturing her right wrist. Dr Brazenor commented "[i]f one's left hip gives way one inevitably falls to the *left*, not the right. Left hips or knees giving way, if they lead to a fracture of a wrist, would be expected to fracture *left* wrist." He repeats this opinion later in his report. He does, however, accept her description of the kitchen incident in the body of his report as "plausible". One must ask, if the version of events she gave to him was plausible, why did he need to cast doubt on that version of events in two separate places in his report. Another reason I do not give great weight to this report is because Dr Brazenor did not feel constrained to limit his report to the area of his expertise. He went so far as to say not only that there was no evidence of physical injury to Mrs Massouras arising from the incident of 4 September 2013, but there was also no evidence of mental harm, anxiety and shock. The willingness of Dr Brazenor to proffer such an opinion in a specialty so different to his own is a matter which gives me concern regarding whether he took an unbiased approach to his assessment of Mrs Massouras.

220. On behalf of Kone a report dated 16 February 2018 from Prof Richard Mattick, a clinical psychologist, was tendered. Prof Mattick noted that Mrs Massouras had significant prior and subsequent incidents and events relevant to her psychological well-being, as well as a family history of psychiatric disorder. He said her reported disabilities and impairments suggested pain and a lift phobia. He did not believe that her pain was necessarily related to the lift incident, but suggested further specialist opinion. The psychological condition, a lift phobia, was consistent with the incident she described. He believed that her tendency to mild anxiety and depression had little to do with the lift incident and more to do with her family history of anxiety and depression, and the separate workplace issues of bullying and other difficulties. He suspected that she has a pre-existing underlying tendency to react to stressful situations with anxiety and depression. He did not believe that the lift incident caused any aggravation or acceleration of the difficulties in the workplace. There was no evidence that she was voluntarily exaggerating her symptoms of psychological distress. Prof Mattick disagreed with Dr Cohen's diagnosis of Post-Traumatic Stress Disorder, and diagnosed a lift or elevator phobia. He believed that Mrs Massouras was fully capable of continuing with her pre-incident duties. Prof Mattick believed that she required eight sessions of Cognitive Behavioural Therapy using exposure-based treatments to deal with her fear of using a lift. With such treatment she would improve dramatically and her prognosis with appropriate care was excellent.

Consideration

221. It is difficult to assess Mrs Massouras' credibility. As Kone correctly observed, she gave varying accounts of the lift incident to various medical practitioners who examined her for the purpose of her claim. These versions were more dramatic than the account of the lift incident found in the WHS Incident Report completed on 4 September 2013. A possible inference arising from these discrepancies is that Mrs Massouras was attempting to bolster her claim. On the other hand, the injuries she claims to have suffered are very moderate, and if financial gain was the object of her exaggeration then I would have expected that she would have claimed more serious injuries. In addition, she complained to a chiropractor on 6 September 2013 of pain with a noted history of being "caught in elevator". She was experiencing pain in her hip, lower back, neck and shoulder pain. On balance, I accept that Mrs Massouras suffered soft tissue injuries to her hip and shoulder, as well as injuries to her lower back and neck as a result of the lift incident. I accept that she has some lingering minor problems with her neck, lower back and hips but she is able to cope with these through conservative treatment mainly by a chiropractor or a general practitioner.
222. Mrs Massouras suffered a psychological injury in the lift incident, described by Dr Cohen as a Post-Traumatic Stress Disorder. This diagnosis was challenged by Prof Mattick, but the label to be attached to Mrs Massouras' symptoms is unimportant. Like many people, Mrs Massouras has encountered a number of stressors in her life, all of which undoubtedly contribute to her current condition. I accept that the lift incident is a contributor to that condition, particularly as her current condition includes a lift phobia.
223. I note that Mrs Massouras abandoned any claim for damages based on her right wrist fracture. She had some time off work because of her physical injuries (not including the wrist fracture) but there is no medical basis for concluding that she will suffer any loss of earning capacity in the future.

224. I allow the claimed amount of \$2049.00 for chiropractic treatment, together with the Medicare payback of \$7894.95. I have no doubt that Mrs Massouras will require some ongoing minor treatment, but I am not persuaded that surgery will be required. I allow a buffer of \$10,000 for future medical expenses, which is roughly the equivalent of her past out of pockets.
225. Mrs Massouras gave evidence of being unable to undertake domestic duties because of the pain in her hip, back and shoulders. She claimed a buffer of \$10,000 for past gratuitous assistance, and a buffer of \$30,000.00 for future gratuitous assistance. These claims are based on a modest claim of one hour per week, with a reduction of the future component by reason of the possibility of improvement. I will allow these amounts. I assess general damages of \$35,000.00, of which I attribute \$25,000 to the past.
226. I therefore assess Mrs Massouras' damages as follows:

General damages	\$35,000.00
Interest	\$3,289.00
Past out of pocket	\$9,943.95
Future out of pocket	\$10,000.00
Past gratuitous assistance	\$10,000.00
Future gratuitous assistance	\$30,000.00
Total	\$98,232.95

Orders

227. In the proceeding brought by Mrs Shipton, SC 400 of 2016, I make the following orders:
- (a) judgment for the plaintiff against the first defendant in the sum of \$2,140,246.48; and
 - (b) judgment for the second to eleventh defendants against the plaintiff.
228. In the proceeding brought by Mrs Massouras, SC 399 of 2016, I make the following orders:
- (a) judgment for the plaintiff against the first defendant in the sum of \$98,232.95; and
 - (b) judgment for the second to eleventh defendants against the plaintiff.
229. In the proceeding brought by Mrs Soesman, SC 401 of 2016, I make the following orders:
- (a) judgment for the plaintiff against the first defendant in the sum of \$24,194.35; and
 - (b) judgment for the second to eleventh defendants against the plaintiff.
230. In the proceeding brought by Mrs Pattinson, SC 403 of 2018, I make the following orders:

- (a) judgment for the plaintiff against the first defendant in the sum of \$127,867.37;
and
- (b) judgment for the second to eleventh defendants against the plaintiff.

Costs

- 231. Each party has leave to file submissions regarding appropriate costs orders. The plaintiffs are to file and serve such submissions within 14 days of the publication of these reasons, and the defendants are to file and serve their submissions within 14 days of receiving the submissions of the plaintiffs.
- 232. I have not finally disposed of the Notice Claiming Contribution or Indemnity as that may still have some part to play regarding costs orders.

I certify that the preceding two hundred and thirty-two [232] numbered paragraphs are a true copy of the Reasons for Judgment of his Honour Justice Burns.

Associate:

Date:

.....

Amendments

14 April 2020	Replace "\$71,878.88" with "\$626,139.33"	Paragraph [171]
14 April 2020	Replace "\$1,586,728.41" with "\$2,140,246.48"	Paragraph [171]
14 April 2020	Replace "\$1,586,728.41" with "\$2,140,246.48"	Paragraph [227]