1 of 1 DOCUMENT: Unreported Judgments NSW

351 Paragraphs

WALLER v JAMES - BC201302162

Supreme Court of New South Wales
Hislop J

2001/67486

31 January, 1, 3-15, 17, 21-24 February 2012, 6 May 2013

Waller v James [2013] NSWSC 497

COMMON LAW -- Medical negligence -- Child born with antithrombin deficiency -- Father known to suffer from that condition -- Failure of gynaecologist to inform parents or cause parents to be informed prior to conception of the hereditary aspects of the condition -- Condition alleged to have caused or materially contributed to a stroke suffered by the child some days after birth -- Claim by parents for the cost of having, raising and caring for the disabled child and for damages for resultant physical and psychological harm to themselves.

(NSW) Health Care Liability Act 2001

(NSW) Civil Liability Act 2002

(NSW) Law Reform (Miscellaneous Provisions) Act 1965

(CTH) Social Security Act 1991

(CTH) Family Law Act 1975

(CTH) Child Support (Assessment) Act 1989

Waller v James [2006] HCA 16 ; (2006) 226 CLR 136; *Jones v Dunkel* [1959] HCA 8 ; (1959) 101 CLR 298; *Rogers v Whittaker* [1992] HCA 58 ; (1992) 175 CLR 479; *Breen v Williams* [1996] HCA 57 ; (1996) 186 CLR 71; *Roads and Traffic Authority (NSW) v Dederer* [2007] HCA 42 ; (2007) 234 CLR 330; *Rosenberg v Percival* [2001] HCA 18 ; (2001) 205 CLR 434; *F v R* (1983) 33 SASR 189; *Tai v Ivy Hatzistavrou* [1999] NSWCA 306; *Caltex Refineries (Qld) Pty Ltd v Stavar* [2009] NSWCA 258; *PD v Dr Nicholas Harvey* [2003] NSWSC 487; *Fox v Percy* [2003] HCA 22 ; 214 CLR 118; *Malco Engineering Pty Ltd v Ferreira* (1994) 10 NSWCCR 117; *Wyong Shire Council v Shirt* (1980) 146 CLR 40; *Gover v South Australia & Perram* (1985) 39 SASR 543; *Varipatis v Almario* [2013] NSWCA 76; *Chappel v Hart* [1998] HCA 55 ; (1998) 195 CLR 232; *Luton v Lessels* (2002) 210 CLR 333; *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; *Duyvelshaff v Cathcart & Ritchie Ltd* (1973) 47 ALJR 410; *Tabet v Gett* [2010] HCA 12 ; (2010) 240 CLR 537; *Roads and Traffic Authority v Royal* (2008) 245 ALR 653; *Cattanach v Melchior* [2003] HCA 38 ; (2003) 215 CLR 1; *Adelaide Stevedoring Co Ltd v Forst* (1940) 64 CLR 538; *Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd* [1997] AC 191; *McDonald v Sydney South West Area Health Service* [2005] NSWSC 924; *G & M v Armellin* [2008] ACTSC 68; *Rand v East*

Dorset Health Authority [2000] Lloyds Rep Med 181; *Hardman v Amin* [2001] PNLR 11; *Gaynor N v Warrington Health Authority* [2003] Lloyds Rep Med 365; *Todorovic v Waller* [1981] HCA 72 ; (1981) 150 CLR 402; *Manser v Spry* (1994) 181 CLR 428; *Harris v Commercial Minerals Ltd* (1996) 186 CLR 1; *Ervan Warnink BV v J Townsend & Sons (Hull) Ltd (Advocaat case)* [1979] AC 731; *Esso Australia Resources Ltd v Cmr of Taxation (Cth)* (1999) 201 CLR 49; *Moorgate Tobacco Co Ltd v Phillip Morris Ltd (No 2)* (1984) 156 CLR 414; *Peters (WA) Ltd v Petersville Ltd* (2001) 205 CLR 126; *Griffiths v Kerkemeyer* (1977) 139 CLR 161; *Sullivan v Gordon* [1999] NSWCA 338 ; (1999) 47 NSWLR 319; *CSR Ltd v Eddy* [2005] HCA 64 ; (2005) 226 CLR 1; *Van Gervan v Fenton* (1992) 175 CLR 327; *Grincelis v House* [2000] HCA 42 ; (2000) 201 CLR 321; *Livingstone v Rawyards Coal Co* (1880) 5 App Cas 25; *Harriton v Stevens* [2006] HCA 15 ; (2006) 226 CLR 52; *Blundell v Musgrave* (1956) 96 CLR 73; *Tame v New South Wales* [2002] HCA 35 ; (2002) 201 CLR 317

Hislop J.

Introduction

[1] Keeden Waller was born on 10 August 2000. The plaintiffs are his parents. Keeden was conceived by invitro fertilisation (IVF) using the second plaintiff's sperm and the first plaintiff's ovum. The method used was intra-cytoplasmic sperm injection (ICSI). This involved injecting a single sperm directly into an ovum in the laboratory. In all, 11 embryos were developed in this way, seven of which were cryo-preserved. Two of the embryos were implanted into the uterus of the first plaintiff. A successful pregnancy developed in respect of one embryo. This was the first plaintiff's first pregnancy.

[2] On 14/15 August 2000 Keeden suffered an extensive cerebral sinovenous thrombosis (CSVT), or stroke, as a result of which he is, and will remain, profoundly disabled.

[3] The plaintiffs allege a factor contributing to the CSVT was that Keeden had an anti thrombin deficiency (ATD) (also known as Factor III Deficiency or AT3) which he had inherited, genetically, from the second plaintiff.

[4] The defendant practised as a general gynaecologist with a subspecialty in infertility and IVF. The first plaintiff was referred to the defendant by the second plaintiff's general practitioner, Dr Noonan, pursuant to which referral the plaintiffs consulted the defendant.

[5] The plaintiffs allege that, in essence, the defendant was in breach of contract and his common law duty of care to the plaintiffs in failing to inform, or cause the plaintiffs to be informed, of the hereditary aspects of ATD. The plaintiffs allege that had they been properly informed, they would not have proceeded to conceive a child using the second plaintiff's sperm and thus would have avoided the harm which has befallen them.

[6] The plaintiffs claim damages for their involvement in the IVF procedure and the pregnancy. Each plaintiff pleads a claim for damages for psychiatric and physical injury caused by or resulting from Keeden's injuries and disabilities. The plaintiffs also seek to recover the cost of having, raising and caring for Keeden.

[7] A claim by Keeden to recover damages for his disabilities and their consequences failed (*Waller v James* [2006] HCA 16 ; (2006) 226 CLR 136). The High Court held that Keeden's life with disabilities was not actionable damage. No aspect of the claims of the plaintiffs was in issue in the High Court appeal: per Crennan J at [85].

[8] The defendant has defended the plaintiffs' claim. He has raised issues as to scope of duty, breach, remoteness and causation. In the alternative, he has alleged the plaintiffs were guilty of contributory negligence. Significant issues have been raised as to damages if the plaintiffs succeed on liability.

[9] The proceedings pre-date the Health Care Liability Act 2001 (NSW) and the Civil Liability Act 2002 (NSW) which, accordingly, have no direct application. The common law applies.

Background

ATD

[10] ATD (whether type 1 -- from which Keeden suffers -- or type 2) is an inherited condition that can affect a person's normal clotting pattern and can give rise to an increased risk that the person with the condition will suffer a thrombosis. It is autosomal dominant. In this context that means it is a non-gender related condition capable of inheritance with only one copy of the defective gene, hence from one parent. This means there is a 50% chance the person who carries the ATD gene will pass that gene on to his or her child. Approximately 50-60% of people who carry the ATD gene will develop symptoms over their lifetime. Thus there is, statistically, a 25-30% chance that each child of a person who carries the gene will develop symptoms over his or her lifetime, and a corresponding 70-75% chance the child will never be affected by the condition.

[11] ATD is a disease of adulthood, not childhood. The history of ATD is that, usually, if a person is in the group that will become symptomatic, the symptoms (in the form of a thrombosis) will not develop before their twenties or thirties. After the first thrombotic event the diagnosis of ATD is made by means of repeat coagulation studies (not by genetic testing), and the condition is managed by Warfarin and the monitoring of international normalised ratio (INR) levels. ATD is not a rare condition and thousands of children are born in Australia with it each year and many more worldwide. However it is very rare for ATD to have any effect on children. Neonatal CSVT is also rare. It is extremely rare for neonates with ATD to develop thromboses. There is an issue between the parties as to the association, if any, between neonatal CSVT and ATD. This issue is dealt with later in this judgment.

[12] In 1999 the genetic testing of embryos for ATD (Pre Implantation Genetic Diagnosis (PGD)) was not available nor was antenatal testing. Professor Amor, a clinical geneticist qualified by the plaintiffs, gave evidence that if he was asked in 1999 he would have said there was a reasonable chance these tests may become available within the following 3-5 years but this was not certain and they may not be available until quite a lot longer.

Background

The first plaintiff

[13] The first plaintiff was born in June 1974 at Port Kembla. She attended school until part way through Year 11 when she left to commence work as a medical receptionist. She was, by her own account, a good school student.

[14] In July 1990 the first plaintiff, after successfully completing the public service entrance examination, commenced employment with the Department of Social Security (later Centrelink). She remained so employed until she took maternity leave six weeks before Keeden's birth. She undertook TAFE studies during this employment, obtaining certificates in office skills (clerical) in 1991, travel industry in 1992 and small business in 1993.

[15] Following the birth of Keeden the first plaintiff resumed work with Centrelink on a part time basis of 15 hours per week 18 months after commencing maternity leave. She continued to work on a part time basis for various employers up to the date of hearing, save for the period February 2007 to September 2008 when she was unemployed. The first plaintiff received a carer's payment from 22 August 2001 at a reduced rate due to her working part time and at the full rate in respect of the period of unemployment.

[16] The plaintiffs had met in 1990. A relationship began about six months later. In 1994 they commenced to live together and in November 1997 they married. In September 1999 they purchased a home at Falls Creek.

[17] After the birth of Keeden, the first plaintiff made many inquiries and sought and obtained advice from Australian university and overseas sources as well as Australian medical practitioners in respect of having a second child. This process was expensive and time consuming. In March 2001 she consulted Dr Meredith Wilson, a clinical geneticist, in relation to the ATD inheritance. The focus of the consultation was upon the availability of ATD testing. The question of donor sperm was not discussed. In 2005 she considered using donor sperm to conceive but did not proceed as she could not get a sufficient medical history in relation to the potential donors. She was aware that the use of donor sperm reduced, but did not eliminate, the risk of a child inheriting ATD. In 2008 she requested testing of the cryo-preserved embryos. Certain embryos were identified as unaffected by ATD. They were transferred but pregnancy did not eventuate. Two further attempts were made to conceive using donor sperm in late 2008/2009 but pregnancy was not achieved. A further attempt resulted in the first plaintiff falling pregnant. The first plaintiff, at the time of the hearing, was pregnant with a child conceived using donor sperm. She intended to return to work on a part-time basis three to six months after giving birth.

Background

The second plaintiff

[18] The second plaintiff was born in November 1965. He grew up in the Dapto area. He did not like school and would truant from it. From about 12 years of age he would stay out at night with friends smoking, drinking and using cannabis. He gave evidence that it was not until he met the first plaintiff that he settled down. He obtained the school certificate in year 10. He then left school and worked as an apprentice at Harrigan Ford, completing his trade qualification as a motor vehicle spray painter in 1989. He then was employed in a few jobs for short periods of time before working for six months at BHP steelworks as a battery attendant in the coke ovens. Thereafter he generally worked as an employed car detailer and spray painter until 1994. In 1994 he took employment as a bricklayer's labourer in his brother's business but injured his back on 2 May 1994 and was off work as a result for about 3 years. The injury was an aggravation of an injury sustained in 1987. He settled a claim in respect of the 1994 injury. In 1997 he resumed car detailing work and in

1999 became a self-employed car detailer for a time. He completed a small business certificate course through TAFE. He also was employed as a cleaner for part of the time. At the time of Keeden's birth he was working as a car detailer and as a cleaner. Following Keeden's birth he was employed at Nowra Naval Base as a cleaner on a casual basis. He ceased employment in August 2001 and thereafter has been Keeden's primary carer.

[19] He made an unsuccessful attempt to resume work (five hours per week) as a cleaner in May 2005. He has received a Centrelink carer's pension since 14 November 2001.

[20] When the second plaintiff was a teenager his older brother, Darryl, was diagnosed with ATD. At the time the whole family underwent coagulation testing. His mother had a history of clotting when giving birth to her first child. The second plaintiff gave evidence he had understood his test was negative for ATD. He guessed from this incident that ATD could "run in families".

[21] In June 1988 the second plaintiff experienced a sore and swollen left calf followed a few days later by a shortness of breath. He coughed up a small amount of blood. He was admitted to Wollongong hospital on 16 June 1988 where he was diagnosed as suffering from a deep vein thrombosis (DVT) and pulmonary embolism (PE). He was in hospital for about one month. He was informed by the treating haematologist that he suffered from ATD to which the DVT and PE were attributable. He said he was told there was no cure for ATD and that he needed to take care of his health, that he would require ongoing daily treatment with Warfarin and should not play contact sports. He was also told to give up smoking, which he eventually did in 1990. He said he was not told at that time that any children he may have could inherit ATD from him.

[22] The second plaintiff gave evidence that as a result of the ATD he took Warfarin daily and had INR blood tests monthly. He ceased to play contact sports though he continued to surf. He gave evidence he had declined eye surgery for short sightedness because of concern as to ATD.

[23] The records of the second plaintiff's general practitioner contain an entry in relation to the second plaintiff which reads:

> 5 Dec 1997 Factor III syndrome rpt Warfarin 5 mgm ... left message with Kerry Duggan re info
>
> 8/12 Inherited disorder, need to be homozygous to have it will chase up details re tests avail

[The condition is homozygous where the foetus receives from each parent the identical alleles at the corresponding genetic loci. This is to be contrasted with heterozygous where the alleles are not identical.]

[24] The circumstances of the entry are unclear. It was apparently made by Dr Noonan's locum, Dr Miller. Neither Dr Miller nor Dr Noonan gave evidence. The Medicare records refer to a consultation with Dr Miller on 5 December 1997. There is no Medicare record of a consultation on 8 December 1997. The notes appear to record the leaving of a message on 5 December 1997 with Ms Duggan seeking information and a return call by Ms Duggan on 8 December 1997 when she provided some information and when either she or Dr Miller agreed to chase up details re tests available. Alternatively the entry dated 8 December 1997 may indicate the result of Dr Miller's own researches. The second plaintiff gave evidence he had no recollection of the consultation or of discussing the matter with Dr Miller. The first plaintiff said she did not recall anything about it. There is no record of any further consultation of the second plaintiff with Dr Miller or that the inquiry as to the availability of tests was followed up or that the matters noted on 8 December 1997 were passed on to the first or second plaintiff. There is no note Dr Noonan had advised or passed on this information to the first or second plaintiff. There are no details of available tests.

[25] Ms Duggan, in a statement tendered in evidence, said it was possible she received a call from Dr Miller in

December 1997 as to ATD but she had no recollection of doing so and no record of ever having spoken to the plaintiffs or to any doctor about them.

[26] The subject entry was followed by a note of a consultation later in December 1997 between the second plaintiff and Dr Noonan for dizziness.

[27] The next note in Dr Noonan's records relating to the second plaintiff is dated 20 March 1998 and appears to state:

> Insomnia -- off cigarettes for 10 days. Trying euhypinos 20m ÷ [?]
>
> Factor 3 deficiency
>
> To Raj Ramakrishna.

[28] Dr Ramakrishna is a haematologist. The second plaintiff recalls a consultation with him and some details of the consultation. That the consultation occurred is confirmed by Medicare records and is conceded by the defendant. The consultation was on 27 March 1998. Dr Ramakrishna did not give oral evidence but, by consent, a statement by him was tendered in evidence. In the statement Dr Ramakrishna said he had practised as a haematologist since 1996. He had no records pertaining to the second plaintiff and did not recall his attendance. His clinical practice would usually include about six patients with inherited ATD at any one time. His usual practice in 1998 in the event of an inquiry in respect of inheritance directed to him by a patient affected by inherited ATD was to say that the condition was known to be autosomal dominant and hence there would be a 50:50 chance of transmission of the condition to a child of that patient. He would also have said that inheritance of the disease does not necessarily lead to development of symptoms. He would also have said to such a patient that if he or she was in a relationship in which the partner of the patient had the same inherited ATD, then there was a risk that a child would acquire a homozygous form of the condition, which is incompatible with life.

[29] The consultation between Dr Ramakrishna and the second plaintiff was the result of a request by the first plaintiff to the second plaintiff that the latter see a doctor "So that I could find out if there was anything in the broad sense of terms that we needed to know [about ATD] before we had children. I had no concept of the idea that it could be passed on. That's why I was asking for information".

[30] The second plaintiff gave evidence as follows:

> Q -- The reason you wanted to go and see him [Dr Ramakrishna] was to understand how your factor III syndrome--
>
> A -- Yes.
>
> Q -- might effect you having kids?
>
> A -- Yes.
>
> Q -- And specifically, the chance the kids getting the condition?
>
> A -- Yes.
>
> Q -- And perhaps also, concerns about the pregnancy and so forth, is that true as well?
>
> A -- Just mainly if the children were going to get it, yeah.

[31] The second plaintiff gave evidence that at the consultation with Dr Ramakrishna he said to the doctor "Me and my wife want to have children. Can they get this condition [ATD]?" to which Dr Ramakrishna replied "Ask your wife if her family have this blood clotting condition because it takes both sides to come through to your children."

[32] The second plaintiff's evidence was that the understanding that he had after seeing Dr Ramakrishna was that, if his wife did not have the condition, it was impossible for him to pass on the condition to his children.

[33] The first plaintiff knew, well before marriage, that the second plaintiff had ATD. She gave evidence she was told by the second plaintiff immediately after he saw Dr Ramakrishna that, if her family did not have any history of blood clotting, "we are right to have kids". There was no history of a blood clotting condition in the first plaintiff's family. The first plaintiff, in her evidentiary statement, said "My memory now is that the doctor [who gave the advice to the second plaintiff] was Dr Ramakrishna".

[34] After the second plaintiff had consulted Dr Ramakrishna the first plaintiff understood "There would be no impact on my children if [ATD] didn't run in my family". She said she did not know ATD could be inherited.

[35] The first plaintiff's mother, speaking of a time prior to the first plaintiff's pregnancy, said:

> [8] I recall that Debbie later spoke to me and said something like "Lawrence went to the doctor; his Factor III won't be a problem for children unless we have the same condition on our side of the family". I said to her something like "Well, there is no one in our family with that sort of problem". (Statement of Evidence)

This conversation occurred following a conversation in which the first plaintiff told her mother:

> [2] Lawrence is going to visit a doctor to have a check done regarding his Factor 3 condition and its possible impact on children we might have. (Supplementary Statement of Evidence)

[36] The defendant submitted that the first plaintiff's statement "we are right to have kids" was not inconsistent with the defendant's version of what Dr Ramakrishna told the second plaintiff. "It doesn't mean you are assured they are not going to have ATD but you are right to have kids. No dramatic dangers here." Accordingly, so it was submitted, the plaintiffs at all times knew there was the risk of ATD but they were prepared to run that risk. I am unable to accept the defendant's submission. It conflicts with the balance of the evidence, particularly that of the second plaintiff and the actions of the plaintiffs following the consultation with Dr Ramakrishna. It involves a degree of subtlety which I would not attribute to the plaintiffs.

[37] The advice which the second plaintiff attributed to Dr Ramakrishna was wrong. The source of the second plaintiff's understanding is uncertain. There are a number of possibilities including the provision of erroneous information by Dr Ramakrishna or the second plaintiff misunderstanding him or the second plaintiff originally correctly understanding what he was told but later recalling it erroneously. No submission was made that the plaintiffs gave false evidence about their understanding. I would have rejected such a submission. The plaintiffs had demonstrated a concern as to the effect of the ATD on their children sufficient to cause them to arrange consultations with doctors but following the consultation with Dr Ramakrishna, insofar as the defendant observed, the plaintiffs exhibited no concern that the condition could be passed to their children.

[38] It was submitted by senior counsel for the plaintiffs, notwithstanding the evidence of the plaintiffs, that it was Dr Miller who advised the second plaintiff not Dr Ramakrishna. It is difficult to determine this issue on the available material. However, in my opinion, on that material, it is more likely than not that the second plaintiff did consult Dr Miller but that Dr Miller did not chase up details re tests available and did not inform the second plaintiff of the result of his inquiries thus giving rise to the need for the later referral to Dr Ramakrishna. This is the more likely as Dr Miller was a locum and presumably only at Dr Noonan's practice for a short time. Presumably the plaintiffs could have clarified this issue by calling Dr Miller or Dr Noonan to give evidence, had they wished. I infer that the evidence of Dr Miller and Dr Noonan would not have assisted the plaintiffs' case -- *Jones v Dunkel* [1959] HCA 8 ; (1959) 101 CLR 298.

Background

The defendant

[39] The defendant graduated MBBS from Sydney University in 1974. He obtained his qualifications as an obstetrician and gynaecologist in 1980 He ceased to practice obstetrics in 1988.

[40] By late 1993 the defendant was practising as a general gynaecologist with a sub-speciality in infertility and IVF. In 1995 he obtained a Certificate in Reproductive Endocrinology and Infertility from the Royal Australian College of Obstetricians and Gynaecologists. He continued to practice in Wollongong as a general gynaecologist with a sub-specialty in infertility and IVF. He had been accredited to use the facilities of Sydney IVF and was doing so in 1999. He gave evidence he was not, and never had been, an employee, agent or subcontractor of that organisation.

[41] The defendant is not a geneticist. In 1999 he was aware of the existence of the condition of ATD. He understood that condition was not usually life threatening and could be managed by medication in the way the second plaintiff's condition was managed by Warfarin. He had no knowledge as to how the condition may manifest in babies or children. He understood that it was possible that there was a genetic element to the condition. He was not aware of the specific mode of inheritance. In particular, he was not aware if it was autosomal dominant or autosomal recessive. He did not know whether there was any pre-implantation genetic testing available for the condition. He had not treated an ATD patient previously though his wife had been suspected (wrongly) of having such a condition at one stage.

[42] The defendant's practice in relation to genetic testing was set out in his answer to Interrogatory 14 as follows:

14 In 1999:
- (a) Was it part of your usual practice to order genetic testing directly for some patients, if either proposed parent had a history of disease that was known by you to be potentially hereditary in origin?
- (b) If so:
  - (i) did that include antithrombin III deficiency or disorder, and
  - (ii) if so, what testing or investigations was it your usual practice to recommend.

14A
- (a) Yes
- (b)
  - (i) No
  - (ii) Pre-implantation of fertilised eggs or earlier chromosomal testing of the parents if either parent have a history of major disease, such as Down Syndrome or translocations or Fragile X Syndrome or Cystic fibrosis, for which I knew there was testing available. I also arranged direct chromosomal testing for male patients with low sperm counts to check for AZF mutations on the Y chromosome which can be responsible for low sperm counts and can be transmitted to male children. If there was a family history of some other potentially hereditary problem I would either refer the couple either to a geneticist or a genetic counsellor through

> Wollongong Hospital. I would initiate a referral for genetic counselling if I was not sure if a disease was potentially hereditary and/or the parents were significantly worried about it and required further information.

[43] The defendant confirmed in evidence that if he understood that one or both prospective parents had a condition, or a family history of a condition, that he thought may have a genetic element, his practice in 1999 was to recommend that the couple contact a genetic counsellor, Ms Kerry Duggan, who was associated with the Outpatient Clinic at Wollongong Hospital.

[44] As Ms Duggan said in her statement, genetic counselling is an educational process that seeks to assist individuals to understand the nature of a genetic disorder, its transmission and the options open to them in management and family planning. In her statement she said had she been consulted by the plaintiffs in 1999--

> ... I would have explained that AT3 is usually an autosomal dominant condition, which means that there is a 50% chance of passing on the gene fault responsible for the condition to an offspring and that only one parent needs to have AT3 to pass on the condition.
>
> ... I would not have known enough about the condition, the variability of its effects and whether or not pre-natal testing was available, I would have recommended to Mr and Mrs Waller that they consult with Dr Mowat, clinical geneticist, in one of his Wollongong Genetic Clinics.

Background

The consultations

[45] The plaintiffs gave evidence they had tried to conceive naturally from the time of the second plaintiff's consultation with Dr Ramakrishna but without success. In January 1999 they consulted Dr Noonan who arranged for the second plaintiff to have a sperm test. That test showed a low sperm count and poor motility. Dr Noonan referred the first plaintiff to the defendant.

[46] A letter of referral from Dr Noonan to the defendant dated 18 January 1999 was provided. It stated:

> Subject -- Ms Deborah Waller
>
> DOB 11/6/74
>
> Problem -- Fertility assistance.
>
> 24 yr
>
> 
>
> on o/c [oral contraceptive] for 3 yrs continuously
>
> No H/o [history of] pregnancy

> Married for 1 yr -- trying to conceive
>
> Husband (Laurie) has Factor III deficiency and takes Warfarin daily.
>
> Please assess.

[47] The plaintiffs consulted the defendant pursuant to the referral. The defendant made brief notes of the consultations and related matters. The notes recorded inter alia that the plaintiffs first consulted the defendant on 3 March 1999 and that further consultations, at least with the first plaintiff, occurred on 15 March 1999, 5 May 1999, 28 July 1999 and 7 December 1999. The notes also recorded that on 28 July 1999 the plaintiffs informed the defendant they wished to proceed with IVF. On 11 November 1999 oocytes were removed and subsequently embryo transfer occurred. On 22 December 1999 the defendant referred the first plaintiff to Dr Hoolahan for management of the pregnancy.

[48] The first page of the notes of the consultation on 3 March 1999 is in a printed form which was completed by the defendant. The notes record a history and examination of the first plaintiff by the defendant. Relevantly, the notes record a 28-35 day menstrual cycle lasting 3-5 days and 13/12 primary infertility, ie the plaintiffs had been trying, unsuccessfully, to conceive for 13 months. There was the following entry under the heading "Partner":

> Lawrence 33 Car detailing Factor III def (warfarin) DVT + pulmonary embolus

[49] The notes of the first consultation do not contain any other detail in regard to ATD though the defendant had a recollection, and the plaintiffs confirmed, he was told a member of the second plaintiff's family also had the condition.

[50] The notes of the first consultation refer to "azoospermia". The second plaintiff gave evidence he was "a bit shell shocked" at finding he, and not the first plaintiff had the fertility issue as the results of the sperm test had been incorrectly reported to him as normal by a member of Dr Noonan's staff.

[51] The first plaintiff gave evidence in her evidentiary statement that:

> 33. At some point during that first consultation, Dr James gave one of us a post it note which is reproduced below. It says
>
> GENETIC COUNSELLOR
>
> Kerry Duggan
>
> 4222 5000
>
> 34. I did not have a clear understanding of why the post it note was given to us by Dr James.
>
> 35. He said words to the effect of "Ring that lady about that" after we discussed Lawrence's low sperm count and after he told Dr James about his history of DVT and pulmonary embolism and his diagnosis with the AT3 condition.

The plaintiffs' evidence was that nothing more was said in this regard.

[52] The second plaintiff gave evidence in his evidentiary statement. He said:

53. At some point during that first consultation, Dr James gave Debbie a post it note which is reproduced below. It says

GENETIC COUNSELLOR

Kerry Duggan

4222 5000

54. I did not have a clear understanding of why the post it note was given to Debbie and me by Dr James. He said words to the effect of "Ring that lady about that" after we discussed my low sperm count and after I told him about my history of DVT and pulmonary embolism and my diagnosis with the AT3 condition.

[53] The perception of the parties as to their recollection of events was reported to be as follows:

(a) The defendant gave evidence he could not clearly recall the discussions that took place at each consultation or at which consultation certain discussions took place. He had some recollection and some limited notes but, generally, he gave evidence on the basis of his usual practice.

(b) The first plaintiff gave evidence she had a clear memory (99%) of what happened in the first consultation with the defendant.

(c) The second plaintiff gave evidence that he remembered "vaguely" the first time he went to see the defendant. He remembered being in the waiting room and getting called in. Later he gave the following evidence:

Q -- Is your evidence to the Court that you have a very clear memory of events back in 1999?

A -- Certain things.

Q -- Referring to your interaction with Dr James?

A -- Yes.

[54] I do not accept the recollections of the plaintiffs were as claimed. They had no contemporaneous notes. Such a degree of recollection would be unusual. It was not borne out by the evidence. Senior counsel for the plaintiffs conceded in respect of the first consultation "It's clear that no one has a clear memory of what went on."

[55] The defendant on previous occasions, had referred patients to Ms Duggan. He normally received a report of the resultant consultation from her. The defendant conceded it was his writing which appeared on the post it note. He did not now recall writing Ms Duggan's name on the post it note and providing it to either plaintiff, but he had no reason to doubt that this is what he did. It was accepted the defendant at the first consultation also handed to the plaintiffs an application for blood tests for the first plaintiff and an application for a repeat semen and hormone test for the second plaintiff as well as, probably, the Sydney IVF pamphlets. Reference to the application forms appears at the end of the defendant's notes of the first consultation but there is no reference in those notes to a referral to Ms Duggan or the Sydney IVF pamphlets.

[56] The second plaintiff gave evidence that a day or so after the first consultation with the defendant he rang the telephone number written on the post it note. The phone rang out. He made no further attempt to contact Ms Duggan. The first plaintiff made no attempt to contact Ms Duggan. Ms Duggan, in her statement, gave evidence that the

telephone number 4222 5000 was the general number for Wollongong Hospital and a call to that number would go to the general hospital switchboard. The second plaintiff denied the suggestion that he had not telephoned at all.

[57] The plaintiffs did not tell the defendant they had not contacted Ms Duggan nor did they tell the defendant of the second plaintiff's earlier consultation with Dr Ramakrishna. The defendant made no inquiry of the plaintiffs as to whether they had contacted Ms Duggan.

The existence and scope of the duty of care

[58] The general duty owed by a medical practitioner was stated by the High Court in *Rogers v Whittaker* [1992] HCA 58 ; (1992) 175 CLR 479 at 483 in the following terms:

> ... The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case.
>
> The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill.

[59] Brennan CJ in *Breen v Williams* [1996] HCA 57 ; (1996) 186 CLR 71 at 78 observed:

> In the absence of special contract between a doctor and a patient, the doctor undertakes by the contract between them to advise and treat the patient with reasonable skill and care ... A duty, similar to the duty binding on the doctor by contract, is imposed on the doctor by the law of torts ...

[60] The plaintiffs have sued upon an implied term of the agreement between the parties and in tort. The defendant has accepted that he owed the general duty of care to the plaintiffs both pursuant to the implied term and in tort. There is a dispute between the parties as to the scope of the duty.

[61] As Gummow J observed in *Roads and Traffic Authority (NSW) v Dederer* [2007] HCA 42 ; (2007) 234 CLR 330 at [43]:

> Although the existence of a duty of care owed by the RTA to Mr Dederer was not in dispute, two points must be made about the nature and extent of that obligation. First, duties of care are not owed in the abstract. Rather, they are obligations of a particular scope, and that scope may be more or less expansive depending on the relationship in question. Secondly, whatever their scope, all duties of care are to be discharged by the exercise of reasonable care. They do not impose a more stringent or onerous burden.

[62] The plaintiffs contended that the scope of the duty extended to the protection of the plaintiffs from harm of the type which they claim to have suffered, namely physical, including psychological, damage and economic loss associated with having, raising and caring for Keeden consequent upon Keeden suffering severe permanent physical disabilities.

[63] The defendant denied that such matters were within the scope of the overall duty as damage of the nature claimed was not a reasonably foreseeable consequence of the acts and omissions the plaintiffs alleged against him. This aspect will require consideration of issues which are also relevant to remoteness and causation and will be considered later in

this judgment.

[64] The particulars of duty ultimately pressed by the plaintiffs may be summarised as follows:

(a) to raise with the plaintiffs the issue of potential inheritability of ATD;
(b) to explain to the plaintiffs the purpose of the referral. It was not explained and, as a consequence, the plaintiffs did not know the purpose of the referral;
(c) to properly refer the plaintiffs to an appropriate person such as a genetic counsellor to find out further information on the topic (or alternatively to inform himself and then provide that information personally to the plaintiffs). The mode of reference, by use of the post it note, was not proper and indicated to the plaintiffs the matter was of little significance;
(d) to follow up the plaintiffs to ascertain what had occurred with Ms Duggan;
(e) to raise the possibility of using donor sperm as a means of potentially avoiding transmission of ATD.

[65] The defendant denied that the scope of his duty extended to the matters in the preceding paragraph.

[66] In the absence of express contractual terms (which are not here alleged) the scope of the duty, whether in contract or in tort, is to be determined as a matter of law informed by the circumstances of the case and accepted professional standards.

[67] In *Rogers v Whitaker* at [487] it was held:

> ... Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, ... it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life."

[68] As Gleeson CJ observed in *Rosenberg v Percival* [2001] HCA 18 ; (2001) 205 CLR 434 at 439 [7]:

> ... the relevance of professional practice and opinion was not denied; what was denied was its conclusiveness. In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act. But, in an action brought by a patient, the responsibility for deciding the content of the doctor's duty of care rests with the court, not with his or her professional colleagues.

[69] The plaintiffs and the defendant each called an expert, (Dr O'Loughlin and Professor Saunders respectively), to give evidence on the question of breach/scope of duty. There was a large measure of agreement between the experts. The joint expert report dated 29 November 2011 recorded the following:

> 1 Was it a departure from reasonable professional standards for an obstetrician and gynaecologist practising in the area of infertility in 1999, for Dr James:
>
> (a) not to enquire of Mr & Mrs Waller to their understanding of the inheritance of the AT3 mutation by an embryo formed from Mr Waller's sperm;
>
> Difference of opinion -- see individual answers.
>
> Professor Saunders: No There was in 1999 no inheritance test or information. Infertility specialist would have relied on the previous haemalogical diagnosis and treatment and the patient information,

particularly as it was perceived to be a multi-factorial adult disease.

Dr O'Loughlin: Yes I believe it was appropriate for Dr James to ensure that they understood clearly the inheritance nature of the AT deficiency disease.

(b) not to warn Mr & Mrs Waller that all embryos from Mr Waller's sperm carried, statistically, a 50% chance of inheriting the AT3 mutation;

Difference of opinion -- see individual answers

Professor Saunders: No This is a difficult question that I cannot answer for what may have occurred in 1999.

Dr O'Loughlin: Yes particularly in view of the high risk of transmission.

(c) not to inform Mr & Mrs Waller that an accurate prediction could not be made as to how severely the quality of life and disabilities of an AT3 affected embryo would be if such an embryo were transferred to the Mrs Waller's womb to create a pregnancy and was subsequently carried to term and born alive thereafter;

Joint Answer

No. We do not believe that the detailed knowledge regarding the variable and unpredictable nature of the condition was within Dr James' expertise as an infertility specialist and that such detailed information should have been sourced at this time from Mr Waller's treating doctors.

(d) not to obtain an opinion and report from a qualified genetic counsellor on the risks of transmitting AT3 to any child of Mr & Mrs Waller using artificially assisted human reproduction procedures;

Difference of opinion -- see individual answers

Professor Saunders: No but difficult. He sought an opinion but did not get the opinion.

Dr O'Loughlin: Yes No opinion was obtained.

(e) not to ascertain the range of clinical outcomes for persons affected by the AT3 deficiency.

Joint Answer

No. Whereas we would expect Dr James to inform himself of the nature and clinical aspects of AT deficiency, this detailed information should have been accessed at this time from Mr Waller's expert treating doctors to enable them to make an informed decision. The ultimate decision whether to proceed with IVF was in the hands of the Waller's and not Dr James.

2. In 1999 would a reasonable obstetrician and gynaecologist practising in the area of infertility in 1999, knowing that Mr Waller suffered from the AT3 condition, have regarded it as necessary to refer Mr and Mrs Waller to a genetic counselling if they had not requested it?

Joint Answer

Yes, and in fact he did refer them for counselling.

3. Was it a departure from reasonable professional standards for an obstetrician and gynaecologist practising in the area of infertility in 1999, for Dr James:

(a) to recommend that Mr & Mrs Waller consult a qualified genetic counsellor (Ms Duggan) for the investigation of and or provision of advice as to the possibility that the AT3 deficiency could be transmitted during IVF in whole or in part by providing them with the details of the counsellor in the form of the document at Annexure A without a written letter of referral; and/or

Joint Answer

Yes, Some form of referral should have been made, preferably in writing or verbally by phone and recorded in the clinical notes.

(b) not to ask Mr & Mrs Waller at subsequent consultations about the advice or information or services they had received from Ms Duggan.

Joint Answer

Yes, However if Dr James had recorded the reference in his clinical note it is likely that this would have triggered such an enquiry.

4. Would a reasonable obstetrician and gynaecologist practising in the area of infertility in 1999, in the position of Dr James, who had been told that Mr Waller suffered from the AT3 deficiency, and had recommended that the plaintiffs consult a genetic counsellor, also have informed himself as to any or all of the following matters before providing IVF treatment to Mr & Mrs Waller:
   (a) the possibility that a child conceived from Mr Waller's sperm would inherit the AT3 mutation;
   (b) the possibility that any such child would develop symptoms of the AT3 deficiency over his or her lifetime; and/ or
   (c) the risk of thrombosis associated with inherited AT3 deficiency to a neonate or child.
   (d) the range of clinical outcomes for persons affected by AT3 deficiency.

   Please indicate whether your answers would alter, on the assumption (in the alternative to assumption D) that Dr James recommended that the plaintiffs consult a genetic counsellor regarding Mr Waller's low sperm count.

   Joint Answer

   Whereas we agree that it would be appropriate for Dr James to have informed himself about the nature and potential of the disease the detailed information as outlined in (a),(b),(c) and (d) could not reasonably be expected to be within his expertise. A referral back to Mr Waller's treating doctors would have been appropriate for this advice.

   We believe that if a genetic cause for oligo spermia was determined it would have been within Dr James' expertise to provide the appropriate counselling.

5. Please assume that, at or shortly after the consultation on 3 March 1999, Dr James had informed himself of relevant information (available as at March 1999) as to:
   (a) the possibility that a child conceived from Mr Waller's sperm would inherit the AT3 mutation;
   (b) the possibility that any such child would develop symptoms of the AT3 deficiency over his or her lifetime; and
   (c) the risk of thrombosis associated with inherited AT3 deficiency to a neonate or child.
   (d) the range of clinical outcomes for persons affected by AT3 deficiency.

   What advice or information should a reasonable obstetrician and gynaecologist practising in the area of infertility in 1999, in the position of Dr James and possessed of such knowledge, provide to Mr & Mrs Waller?

   Please include in your answer, any advice that should have been provided as to the significance of the risk of thrombosis associated with inherited AT3 deficiency to a neonate or child.

   Joint Answer

   Given that Mrs Waller did not have AT deficiency, the generally mild nature of the disease in adults, it's multi-factorial associations, the fact that the condition is manageable with appropriate treatment, the fact that there is no significant increased mortality over that of the general population, and the fact that a neonate and a child would most unlikely be affected by thrombotic episodes, we agree that it would have been appropriate for Dr James to proceed with IVF provided the Waller's were agreeable.

   We believe that if Dr James had obtained the detailed information re AT deficiency from the Waller's treating doctors or from his own investigation then he would have been in a position to offer advice on this matter.

6. Was it a departure from reasonable professional standards for an obstetrician and gynaecologist practising in the area of infertility in 1999, for Dr James:
   (a) not to have formed the opinion and advised Mr & Mrs Waller that any IVF procedures which would use Mr Waller's sperm (and embryos made from that sperm) were unreliable and contra indicated and should not be carried out;

   Joint Answer

   No. The procedures were not unreliable and were not contraindicated.
   (b) not to inform Mr & Mrs Waller that the risk of transferring an embryo to Mrs Waller that carried the AT3 mutation could be avoided by using sperm obtained from an anonymous sperm donor who did not have a family history of AT3;

   Joint Answer

There is no evidence that Dr James had a conversation with the Waller's prior to IVF offering an alternative in the form of donor insemination with a screened anonymous donor given the AT deficiency and oligospermic problems. This may or may not have been acceptable given economic and other considerations and the geographic dislocation necessary. However we believe that this alternative should have been offered.

(c) not to ensure that only embryos which were not affected by AT3 deficiency were transferred to Mrs Waller on 14 November 1999; and/or

Joint Answer

No. Pre Implantation Genetic Diagnosis was not available in 1999.

(d) to use Mr Waller's sperm in the IVF procedures with Mrs Waller's eggs to facilitate the formation of embryos for implantation into Mrs Waller.

Joint Answer

No. Provided the Waller's had been adequately informed and understood the risks associated including those of genetic inheritance.

[70] There was a difference of opinion between Dr O'Loughlin and Professor Saunders in respect of para 1(a), (b) and (d) of the joint report. Upon reflection Professor Saunders agreed with Dr O'Loughlin in respect of para 1(a) and (b). Professor Saunders also agreed with Dr O'Loughlin that there was a departure in respect of para 1(d). I note that in respect of answer 1(b) the defendant did not at that time have the knowledge to be specific as to the 50% chance of inheriting ATD.

[71] Professor Saunders sought to withdraw his answer to question 2. Under cross-examination he gave the following evidence:

Q -- Now we've been over a whole lot of things, the assumptions that you say you would make and whether or not they're reasonable, the understandable lack of knowledge about this condition in 1999, among other things. Can I suggest to you that, upon reflection, as reluctant as you are, understandably, to criticise a fellow practitioner that nonetheless, upon reflection, reluctant though it might be, which is understandable, you stand by, don't you, without modification, your answer to question 2 as recorded in the joint report?

A -- Yes. As long as you accept my reluctance and the fact that I would not have done it myself. The Court accepts that.

In re-examination he said:

Q -- Based on that bundle of material in November you agreed to the answer, yes. Okay. Now forgetting Mr Higgs' assumptions, what is your position on question 2? ... taking into account what you had in the bundle?

A -- Of course, it comes down to the word reasonable. It comes down to the word reasonable. In 1999 would a reasonable obstetrician and gynaecologist, me, hopefully, knowing that someone had required it as necessary to refer to a genetic counsellor if they had not requested it. And you can understand that this is difficult. As you might perceive, there's been a vacillation here. And it comes down to how I define the word reasonable.

Now I would have presumed that I, in 1999, would have been a reasonable obstetrician. So, I'm putting myself in this. So, that's when I came back to the, I would not have done it. That's why I said, being a reasonable person, that I would not have said yes. I'd have said it's not reasonable because I would not have done it. This is as far as I can go.

Q -- Is that still your position?

A -- Yes.

[72] In the circumstances I regard Professor Saunders' evidence in relation to question 2 as equivocal.

[73] In the course of the evidence five factors were identified by Dr O'Loughlin and agreed to by Professor Saunders as relevant to determining whether there was a duty to refer for genetic counselling. They were:

(a) the chance of inheritance;
(b) the significance of the condition if inherited;
(c) the commonality of the condition;
(d) the patient's own perception of the condition;
(e) the extent to which the condition can be managed in the prospective child.

[74] Dr O'Loughlin considered that the application of those factors in this case led to the conclusion that a duty was owed to inform the plaintiffs of the hereditary aspects of ATD but it did not mean the plaintiffs should not have children. He did not accept that ATD was in "the grey area where reasonable people might disagree" as to whether it was sufficiently significant as to require it to be brought to the patient's attention. Professor Saunders was of the opinion that the issue involved subjective judgment and was within the "grey area".

[75] The defendant gave evidence impacting on the question of the scope of his duty. His evidence was that:

(a) there was a need for the plaintiffs to have access to a genetic counsellor so as to reach an informed view as to the concerns about passing on the condition of ATD;
(b) it was his obligation to give the couple an opportunity to understand and alter their course toward pregnancy -- if they wished;
(c) he would expect someone in his position to provide a referral and a referral to Ms Duggan was important;
(d) he meant to convey at the first consultation that genetic counselling was something that the plaintiffs should do (albeit it was up to them);
(e) it was desirable to have up to date information in what was a time of rapid advancement in knowledge in this area particularly where, as here, a fertility question had arisen and there was a significant possibility of IVF;
(f) it was unreasonable not to keep contemporaneous notes to prompt a recollection of a referral.
(g) the referral to Ms Duggan was part of his work-up responsibilities described in the IVF pamphlets given to the plaintiffs at the first consultation;
(h) the IVF pamphlets which were signed by the plaintiffs as having been received and read contained the following references:

> As well as fertility treatment, Sydney IVF also specialises in all aspects of genetic analysis to do with fertility and pregnancy, including prenatal testing, preimplantation, genetic diagnosis, and specialised diagnostic tests for genetic diseases such as cystic fibrosis and fragile x.

There was also reference to the availability of donor sperm.

(i) it was important to convey to the plaintiffs the desirability of getting genetic counselling and that they understood the reason why it was desirable;
(j) it was part of his usual practice to go over all options with patients particularly if he had a letter from a geneticist. He agreed it was important that patients be given as much information as possible and part of his role was to assist them to understand the advice they had been given by the geneticist. He would see the patient after receipt of advice from a genetic counsellor if they wished to return.

[76] Insofar as the plaintiffs allege a duty on the defendant to inform himself and advise them, I accept the evidence of Dr O'Loughlin that:

> ... I wouldn't expect an infertility doctor to be aware of the myriad range or the range of these conditions, the full range, but I would expect an infertility doctor to be aware of some of those conditions which have a strong inheritance association and, if inherited, have the potential to cause significant morbidity to an offspring.
>
> Q -- ... Given the limits that an IVF doctor or a fertility doctor is going to have in his or her knowledge about these type of genetic conditions, frequently it will be better for them to refer a patient who needs to find out this information off to a genetic counsellor a genetic clinician or perhaps a specialist in a particular area to find out that information, you'd agree?
>
> A -- Yes, I'd agree with that.
>
> ...
>
> Q -- ... The key issue then for you, Dr O'Loughlin, in dealing with this duty that we've been discussing is to put the patient or patients in the position to be able to access that information, you'd agree?
>
> A -- Yes.
>
> Q -- And that doesn't necessarily mean, and commonly won't mean, the fertility doctor himself or herself providing that information?
>
> A -- Yes.
>
> Q -- Commonly, not always, but commonly it will be better coming from one of those other types of specialists we've spoken about?
>
> A -- Yes.
>
> Q -- When I use the word "specialist", I include the genetic counsellors, even though they are not doctors. You understood that?
>
> A -- Yes.
>
> ...
>
> Q -- Just to be clear, whether the duty is filled through a referral of or through the doctor informing himself it is the one duty we are speaking about?
>
> A -- Yes, the duty to make sure the patients properly informed.
>
> Q -- That's right. So where I have been using the shorthand, "duty to refer", you understood that to be effectively what you have now just called the duty to inform through whatever appropriate means are available.
>
> A -- Yes. To inform by the best means available and, in general terms, in my view, that would be to refer.

[77] Thus the duty owed by the defendant to supply the relevant information is a single duty which he could fulfil either by obtaining the necessary information himself from source or other material or by referring the plaintiffs to an appropriate genetic consultant and, if necessary, by following up that referral.

[78] The duty of a medical practitioner "extends to the ... provision of information in an appropriate case" -- *Rogers v Whitaker* at 483.

[79] In *F v R* (1983) 33 SASR 189, King CJ said:

> What a careful and responsible doctor would disclose depends upon the circumstances.

> ...
>
> The purpose of disclosure is to provide the patient with the information necessary to enable him to make informed decisions concerning his future.
>
> ...
>
> The extent of the duty to disclose must depend greatly upon the patient's expressed or apparent desire for information:...

[80] The scope of the duty of care "may be more or less expansive depending on the relationship in question" -- *RTA v Dederer* at [43] and will depend "upon the precise facts of the relationship between the doctor and the patient" -- *Tai v Ivy Hatzistavrou* [1999] NSWCA 306. The standard is that of the ordinary skilled person exercising and professing to have the special skill, in this case, the skill of a gynaecologist with a sub speciality in infertility and IVF -- *Rogers v Whitaker* at 483.

[81] In *Caltex Refineries (Qld) Pty Ltd v Stavar* [2009] NSWCA 258 Allsop P (with whom the other members of the court agreed) held:

> [102] ... If the circumstances fall within an accepted category of duty, little or no difficulty arises. If, however, the posited duty is a novel one, the proper approach is to undertake a close analysis of the facts bearing on the relationship between the plaintiff and the putative tortfeasor by references to the "salient features" or factors affecting the appropriateness of imputing a legal duty to take reasonable care to avoid harm or injury.
>
> [103] ... His Honour here set out 17 "salient features". He then continued:
>
> [104] There is no suggestion in the cases that it is compulsory in any given case to make findings about all of these features. Nor should the list be seen as exhaustive. Rather, it provides a non-exhaustive universe of considerations of the kind relevant to the evaluative task of imputation of the duty and the identification of its scope and content.

[82] Usually issues as to disclosure of information arise in the context of a risk in a procedure where the procedure is to be carried out by the treating doctor within his area of expertise. In those situations the accepted principle is that stated in the following terms in *Rogers v Whitaker* at 490.9:

> ... The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it ....

However the duty to disclose is not confined to proposed treatment see eg -- *PD v Dr Nicholas Harvey* [2003] NSWSC 487.

[83] The duty is a continuing one. As Priestley JA said in *Tai*:

> [75] It would seem that all of the cases referred to in the text are, to a greater or lesser degree, distinguishable on their facts from those in the present appeal. They appear however generally to support the view that, depending upon

> the precise facts of the relationship between the doctor and the patient, when a doctor is treating a patient for what may be a serious health problem, and the doctor thinks it necessary, even if only for prudential reasons, that the patient should submit to a particular surgical procedure, then the doctor has a continuing duty to advise the patient to submit to the surgical procedure, so long as the doctor/patient relationship is on foot. This does not mean that the doctor should seek to impose the doctor's view upon the patient against the patient's will, but it does mean that the doctor has a duty to keep the doctor's opinion and advice before the attention of the patient so that the patient can decide upon the patient's course in light of up to date knowledge of the doctor's opinion.

[84] The primary duty to give information to the second plaintiff as to the hereditary aspects of ATD rested with the haematologist who treated the second plaintiff for DVT and PE whilst the relationship of doctor and patient subsisted and with Dr Ramakrishna when specifically consulted in this regard. Such a duty by a treating haematologist was accepted by Dr Monagle as being clearly owed. It was apparent from the evidence given by Professor Saunders that he expected the treating doctor would have given such information to the patient.

[85] As Dr Amor stated:

> Genetic advice regarding the inheritance of AT3 deficiency would usually be offered at the time of initial diagnosis of AT3 deficiency. If Mr and Mrs Waller had requested additional genetic advice at the time of contemplating pregnancy, then it would have been appropriate for further genetic counselling be offered.

[86] The defendant submitted the relationship between the plaintiffs and the defendant did not give rise to the duty contended for as:

(a) the defendant was not a geneticist or haematologist. He was a gynaecologist with a sub speciality in infertility and IVF;
(b) as such he could not be expected to be aware of the "myriad range" of genetic conditions, or to have detailed information of any given genetic condition or the risks inherent therein;
(c) the duty to provide genetic advice lay elsewhere;
(d) the defendant had been retained to assess a fertility assistance problem. The plaintiffs had not sought advice from him about ATD and did not rely on him for any advice in that regard;
(e) the defendant did not believe the plaintiffs wanted any advice from him about the hereditary aspects of ATD. At no consultation did either of the plaintiffs raise the topic of genetic counselling, inheritance or any concerns in relation to ATD. After the first consultation the defendant did not have the impression the plaintiffs had any particular interest in knowing whether the second plaintiff's condition had a genetic element. The defendant's recommendation was not in response to any concerns that the plaintiffs had expressed about the condition. It was done in accordance with his usual practice. See para [42];
(f) the five factor test upon which Dr O'Loughlin and Professor Saunders had agreed would be impractical in its application by reason of the different views that may be held as to the seriousness of a given condition and the limited knowledge of the gynaecologist as to the condition;
(g) the defendant by his concessions in evidence could not create a duty of care resting upon him where such a duty would not otherwise exist;
(h) the defendant was entitled to assume that if the plaintiffs wanted to know about the potential for inheritance of the condition they would take the opportunity to follow his recommendation and see Ms Duggan. It was their right not to do so, if they wished;
(i) a number of "salient features" supported the submission that there was no duty owed;
(j) this was not a failure to warn case. It was an opportunity to obtain information case. *Tai's* case, which was a failure to warn case, was quite different. The factors that were relevant in imposing a duty in that case and which were not present here were:

(i) reasonable to expect the doctor to be in a position to advise;
(ii) there may be a serious health problem;
(iii) the information sought could affect treatment; and
(iv) the doctor thought it was necessary, if only for prudential reasons, for the patient to submit to the recommended procedures.

[87] The plaintiffs submitted the relationship did give rise to the alleged duty as:

(a) the defendant was aware, as a result of the terms of the letter of referral to him, that the second plaintiff had ATD. This was confirmed at the first consultation;
(b) he was aware ATD may have the potential to be genetically inherited by the offspring of a person suffering that condition;
(c) one would expect a infertility doctor to be aware of some of those conditions which have a strong inheritance association and, if inherited, have the potential to cause significant morbidity to an offspring. The defendant was aware of conditions such as Down Syndrome, Fragile X Syndrome and Cystic fibrosis which were in that category. However there were situations where the condition was less significant than those but nevertheless sufficiently significant as to require the provision of information by the doctor or referral;
(d) the defendant's own practice, as set out in his answer to interrogatory 14 [42] illustrates that it was practicable to identify matters arguably in the grey area and to refer the parties to a genetic consultant in relation thereto;
(e) there was no evidence that the referral was intended to be without legal effect;
(f) the first plaintiff, prior to Keeden's birth, had not received any information directly from any qualified person as to ATD. She relied upon what the second plaintiff told her;
(g) the defendant did not know whether the plaintiffs had received any information as to the hereditary aspects of ATD;
(h) even if the plaintiffs had received such information it may not have been absorbed at the time, or have been misunderstood or since forgotten;
(i) the need for the plaintiffs to receive accurate and adequate information was of significance to the plaintiffs. The plaintiffs should have been given all information reasonably relevant to the exercise of their choice;
(j) compliance with the duty could take place at any of the consultations prior to the transfer of the embryo and would involve no expense difficulty or inconvenience;
(k) the information was also of relevance to the defendant as he was aware there was a significant possibility he would embark on a course of action that could lead to the birth of a child with a permanent medical condition of some significance;
(l) the defendant assumed a degree of responsibility by providing the referral at his own initiative. One of the "salient features" specifically referred to in *Caltex* at [103f] was "any assumption of responsibility" by the defendant. This was in addition to other salient features which supported the existence of a duty;
(m) the defendant, being on notice of the second plaintiff's ATD and that it may be transmittable, should not have proceeded to implant an embryo without ensuring the plaintiffs were adequately informed and understood the hereditary aspects of ATD or had decided (as they were entitled to do) that they did not require that information. This involved a duty to follow up the referral.

[88] That the defendant was subject to such a duty was supported by Dr O'Loughlin and Professor Saunders in their evidence generally and in paras 1, 2 and 3 of their joint report (subject to a rider in respect of Professor Saunders' evidence re question 2) and by the evidence of the defendant himself. I have given considerable weight to the evidence of the medical practitioners in determining whether a duty was owed.

[89] I accept the primary duty to inform the plaintiffs of the hereditary aspects of ATD did not rest with the defendant. I

accept that the defendant was a fertility doctor and not a geneticist and not equipped to provide an expert opinion on hereditary aspects of ATD. However the defendant knew the second plaintiff had ATD, he knew there was a possibility any child of the plaintiffs may inherit the condition and he knew that the first plaintiff was very likely, as part of the IVF treatment, to undertake a procedure which would involve transferring the plaintiffs' embryo to the first plaintiff.

[90] The plaintiffs' knowledge as to the hereditary aspects of ATD was unknown to the defendant and may have been non-existent. The inheritance of ATD by the plaintiffs' child was a matter of significance. In these circumstances to impose a duty on the defendant to inquire of the plaintiffs' as to their knowledge of the hereditary aspects of ATD, to explain the desirability and purpose of a referral of a genetic counsellor or geneticist and, if appropriate, to arrange such referral and to follow up the referral would not involve expense, difficulty or inconvenience for the defendant and does not appear unreasonable.

[91] In my opinion the defendant, in the circumstances of this case and subject to the considerations raised in [63] owed a duty of care to the plaintiffs to ascertain if the plaintiffs were aware that ATD was potentially inheritable; to explain to the plaintiffs the purpose of the proposed referral; to properly refer the plaintiffs to an appropriate person for the obtaining of that information subject to the plaintiffs' agreement. It was also the duty of the defendant, whilst the doctor/patient relationship continued, to ascertain if such consultation had taken place and if it had not to make further inquiry as to the reason why the consultation had not occurred and to reinforce the reasons why it would be desirable to consult with the genetic consultant or a geneticist.

[92] In my opinion (subject to the overriding considerations raised in [63], remoteness and causation) the defendant owed a duty to the plaintiffs generally as alleged in [64(a)-(d)].

[93] The plaintiffs also alleged there was a duty to inform them as to the availability of donor sperm. There was little support for this among the experts.

[94] Professor Saunders was not aware from his experience or study of any cases where anonymous donor sperm had been offered to a couple where one patient had ATD. He confirmed that ATD did not require the raising of the issue of donor sperm.

[95] The joint report of the causation experts (Professor Monagle, Professor Amor and Associate Professor Evans) recorded:

> We all agree donor sperm was available in 1999; however it would have been very unusual for a couple to utilise donor sperm for AT deficiency, given that AT deficiency is typically a mild condition that in the vast majority of cases can be effectively managed.

[96] Professor Monagle confirmed that he would not have raised the issue of sperm donation. He considered there was no logical rationale to raise that issue in advising people as to the issue of inheritance when having children. Dr Amor was of a similar opinion.

[97] Dr O'Loughlin alone thought the question of donor sperm should have been raised with the plaintiffs though he accepted it was quite likely they would not have accepted the option.

[98] The defendant did not advise the plaintiff as to the availability of donor sperm. He expressed no opinion on this issue in his evidence.

[99] In any event the second plaintiff gave evidence he knew of this option when he first consulted the defendant. The first plaintiff gave evidence to like effect. She would have been aware of it in any event upon reading the IVF pamphlets handed to her at the first consultation with the defendant.

[100] In my opinion, no duty in relation to advice as to the availability of donor sperm has been established.

Credit

[101] Senior counsel for the defendant submitted the plaintiffs' evidence was unreliable and false in a number of respects. He asserted the second plaintiff put Keeden and his interests above all else and would say whatever he needed to say in order to advance Keeden's interests and that the first plaintiff tailored her evidence to further the plaintiffs' case.

[102] No allegation of false evidence was made against the defendant, senior counsel for the plaintiffs stating "I want to make it plain, I am not suggesting that [the defendant] is a liar." He did however, submit that, from time to time, the defendant was inaccurate or "defensive".

[103] Senior counsel for the defendant provided a number of examples of matters which he relied upon as demonstrating the problems with the credit of the plaintiffs and the reliability of their evidence. The examples reflect the approach suggested by Kirby J in *Fox v Percy* [2003] HCA 22 ; 214 CLR 118 at 129 [31] where his Honour said:

> ... in recent years, Judges have become more aware of scientific research that has cast doubt on the ability of judges ... to tell truth from falsehood accurately on the basis of ... appearances. Considerations such as these have encouraged judges ... to limit their reliance on the appearances of witnesses and to reason their conclusions, so far as possible, on the basis of contemporary materials, objectively established facts and the apparent logic of events. This does not eliminate the established principles about witness credibility; but it tends to reduce the occasions where those incidents are seen as critical.

[104] The approach of the court in considering the evidence of a witness who gives false evidence in an attempt to gain compensation to which he or she is not entitled was outlined by Handley JA in *Malco Engineering Pty Ltd v Ferreira* (1994) 10 NSWCCR 117 at 118D-E:

> ... The respondents ... established to the point of demonstration that the worker had told deliberate lies in an attempt to obtain compensation to which he was clearly not entitled.
>
> This did not necessarily require the trial Judge to reject the whole of his evidence. Nor on the other hand was the trial Judge entitled to simply accept the whole of his evidence except those parts that the respondents had established was false.
>
> In my opinion the perjury by the worker required the trial Judge to carefully assess the rest of his evidence in order to determine its honesty and reliability. Some of his evidence may have been acceptable because it was confirmed by other independent or objective evidence. However where the worker's evidence was not independently supported it clearly had to be assessed with great care to determine whether it could properly be accepted as proof of any matter that was in issue in the proceedings.

[105] The defendant's submissions as to some of the examples provided by him are discussed hereunder.

[106] The evidentiary statements were not independently compiled by the plaintiffs in that:

(a) the second plaintiff gave evidence he prepared his evidentiary statement himself. He did not show the plaintiff a draft of his statement before finalising it, though he discussed some points with the first plaintiff. He prepared and reviewed his statement and read it carefully before signing it. The first plaintiff did not show him a draft of her statement before finalising it.
(b) The first plaintiff gave evidence that she prepared her statement in conjunction with her legal team, not in conjunction with the second plaintiff. She saw copies of his statement before she finalised her own.
(c) The original evidential statements of the plaintiffs were almost identical in relation to critical issues (see

eg [51] and [52] hereof) indicating the statements were a collaborative effort which resulted in the merging of individual recollection and evidence thereby limiting the court's opportunity to independently assess each witness on his or her evidence.

[107] The second plaintiff exaggerated the effect of ATD upon him in that:

(a) he gave evidence the ATD was of real significance and concern to him. In support of this assertion he said in his evidentiary statement "I must attend for blood testing once a month". In his supplementary statement, he said "I regularly attend the doctors each month to have my blood tested as directed by Dr O'Neil." The second plaintiff gave evidence the blood tests were done generally by pathologists. He did not recollect paying for any such tests. He was cross examined on Medicare records which recorded that he had had six blood tests within the 2½ years ending 7 September 2000. He agreed in cross examination that the evidence in the supplementary statement was "incorrect";

(b) he gave evidence he left Harrigan Ford because of his concern about fumes from spray painting affecting his lungs. However, he subsequently took employment with BHP where he was exposed to similar fumes as he was to a degree in later employment involving car detailing and spray painting.

[108] (a) The second plaintiff sought to alter the history he had given to Dr Phillips. Dr Phillips, in his report of 14 April 2003 took account of "what was probably a relatively unsatisfactory relationship [of the second plaintiff] with his parents." The plaintiffs' then solicitor wrote to Dr Phillips, recording the second plaintiff's belief that he had a normal relationship with his parents prior to the events involving Keeden. Dr Phillips responded to the solicitors letter as follows:

> whilst I recognise that Mr Waller has told you that he enjoyed a normal relationship with his parents and siblings prior to events involving Keeden, I had obtained a somewhat different history at the time of my first consultation.

(b) In cross examination the second plaintiff conceded he did not have a normal relationship with his parents prior to the birth of Keeden though he denied knowledge of the solicitor's letter.

[109] The plaintiffs' actions did not support their alleged concern about having a child affected by ATD in that:

(a) the plaintiffs gave evidence that following marriage they only had unprotected sexual relations after the second plaintiff had consulted Dr Ramakrishna on 27 March 1998;

(b) however the first plaintiff had said in her evidential statement that after marriage in November 1997 she had wanted to fall pregnant and the plaintiffs had regular unprotected sexual relations during 1998. The first plaintiff observed that what was written could mean anytime in 1998 and meant from the time of the consultation with Dr Ramakrishna. The defendant recorded in his notes of the first consultation, "13/12 primary infertility" which meant that unprotected sexual relations had commenced over seven weeks before the consultation with Dr Ramakrishna. Similarly the referral letter from Dr Noonan dated 18 January 1999 recorded "married for one year -- trying to conceive" though it does not expressly say that the trying to conceive took place for the whole of that year. This evidence is inconsistent with the plaintiffs having a significant concern about any children they had being affected by ATD as prior to consulting Dr Ramkrishna they did not know what effect the condition may have on their children;

(c) the second plaintiff initially agreed it was possible they had been trying to conceive since early February 1998, though he later changed his evidence to confirm that it was only after he had seen Dr Ramakrishna that the plaintiffs stopped using contraception. Further he accepted that, prior to marriage the plaintiffs had been using unreliable forms of contraception in particular rhythm and withdrawal. The first plaintiff claimed the methods of contraception which she used were one hundred percent safe. The second

defendant did not make the same claim.

[110] The second plaintiff gave evidence in his statement that when Dr de Souza saw Keeden before the stroke, the second plaintiff told him that he had ATD. Dr de Souza told him, after consulting a journal or a book, that Keeden had a 50% chance of inheriting "AT3 protein c&s acquired". The second plaintiff's oral evidence however was that Dr de Souza asked him if there was any medical condition in the family and he told him he had "a blood clotting disorder factor III". In his first statement the second plaintiff said "I was very shocked to be told of that information, given what I had been told previously [by Dr Ramakrishna]." In cross examination the second plaintiff initially agreed that what Dr Ramakrishna had told him was "the complete opposite" of what Dr de Souza had told him. However he then said that he had understood that Dr de Souza was talking about some condition other than ATD. The second plaintiff's oral evidence was that the first time he realised the possibility that Keeden had inherited his condition was when speaking to Dr Badawi, after Keeden's stroke.

[111] The plaintiffs alleged they did not know in 1999 what "genetics" or "inheritance" meant though these words are to be found in their evidentiary statements and were used in the Sydney IVF pamphlets. The first plaintiff told Dr Brown (report 15/3/10) that in 1999 she did not have an understanding of genetics in any type of detail. I accept that statement as accurate but I do not accept that the first plaintiff, at least, would not have enquired of the defendant as to the meaning of those words if her understanding was not adequate at the time.

[112] The second plaintiff said he was careful about reading things in relation to Keeden's health. If a doctor gave him material to read about his health he would read it carefully. The second plaintiff said he initialled the Sydney IVF documents to indicate he had read and understood them. In his evidence, when taxed with the knowledge he would have gained if he had read the material, he resiled from that position and ultimately said he had not read any of the documents but had relied upon the first plaintiff to read them and tell him anything he needed to know. Ultimately he stated he did not recall discussing any of those documents with the first plaintiff.

[113] The defendant relies particularly upon the matters dealt with at [137]-[141]. The consultation between Dr Brown and the first plaintiff took place on 9 March 2010 and is the subject of Dr Brown's report dated 15 March 2010. The consultation between Dr Brown and the second plaintiff took place on 14 July 2010 and is the subject of Dr Brown's report dated 15 July 2010. Dr Brown was called to give evidence but not cross-examined on the reports in this regard.

[114] I accept the plaintiffs have a deep bond with Keeden. I accept, as the plaintiffs concede, they are angry at what has befallen them. I accept the plaintiffs would do all in their power that they legitimately could to assist Keeden. These are normal human reactions. Whether those matters have led to the giving of unreliable and false evidence, as the defendant contends, is difficult to determine.

[115] Senior counsel for the plaintiffs submitted there should be no findings of dishonesty against them. Their demeanour, he submitted, was that of truthful witnesses who were honest but confused. They made admissions and concessions that were unhelpful to their case which confirmed their honesty.

[116] Some of the examples of false evidence relied upon by the defendant, such as those related to employment choices, may be put aside as equivocal as they may have been dictated by the nature of available work and the second plaintiff's limited qualifications. Similarly, the allegations of unprotected sexual relations after marriage but before the consultation with Dr Ramakrishna may be the result of imprecise calculations, though "13" months infertility in itself has a certain precision. Inconsistent evidence in respect of Dr de Souza/Dr Badawi may be due to confusion resulting from the stress when it was thought that Keeden would not survive. Some matters, particularly in relation to the frequency of blood testing, the history obtained by Dr Phillips and the reversal of evidence in respect of the reading of the Sydney IVF pamphlets are not so readily explained. There is difficulty with the evidence relating to the histories obtained by Dr Jones though the first plaintiff ultimately acknowledged the accuracy of the report in that regard. Due allowance must be made for the effect of the passage of time on recollections, the traumatic circumstances in which events sought to be recalled occurred and the pressures resulting from caring for Keeden and giving evidence in a case

as stressful as the present. In my opinion some parts of the plaintiffs' evidence is unreliable whatever be the reason. I am not prepared to find the plaintiffs have committed perjury. However the plaintiffs' evidence should be considered with particular care where it is not otherwise objectively corroborated.

Breach of duty

[117] In *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47 Mason J stated the relevant principles in the following terms:

> In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk. The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position.

[118] In *Gover v South Australia & Perram* (1985) 39 SASR 543 it was held:

> It would be a revolutionary notion to hold that a doctor is obliged to put everything into writing, say, or to cross-examine his patient exhaustively, to ensure that she both understands and will remember his advice. He is obliged to act reasonably in the circumstances, and the circumstances will include a fair appraisal of his patient's intelligence and temperament and apparent understanding, made in the light of the simplicity or complexity of the recommendation he is making... His explanation was adequate, and he was entitled to assume that the patient understood?;

[119] The plaintiffs' factual case was that they were uncertain as to the purpose of and utility of the referral to Ms Duggan. This was because the defendant did not explain it to them. All he said were words to the effect "Ring that lady about that". Further the plaintiffs were actively misled as to the importance of the referral by the use of a post it note as the means of referral. Had they been made aware that consultation with Ms Duggan was important, or the purpose of it was to do with questions of genetic inheritance, they would have persisted in attempting to make an appointment with Ms Duggan and would have attended the resultant consultation, obtained the appropriate information and, as a result, avoided harm.

[120] It is appropriate to consider each of the particulars of duty.

To raise with the plaintiffs the potential inheritability of ATD

To explain to the plaintiffs the purpose of the referral

[121] The question of the potential inheritability of ATD was of significance to the plaintiffs. It was a matter of which the plaintiffs should have been informed. The initial obligation to inform the plaintiffs rested with the doctors who treated the second plaintiff for his DVT and PE and Dr Ramakrishna of whom specific inquiry was made;

[122] There was no evidence the defendant was aware that any information as to the inheritability of ATD had been given to the plaintiffs by the treating doctors. There was no evidence the defendant was informed of the involvement of

Dr Ramakrishna.

[123] The defendant, though he understood it was possible that there was a genetic element to the condition of ATD, was not aware of the specific mode of inheritance. He lacked the knowledge to personally advise the plaintiffs as to the hereditary aspects of ATD. This lack of knowledge was not the result of negligence on his part.

[124] The defendant should have inquired of the plaintiffs, as to whether they had knowledge as to the inheritability of ATD and, if so, the nature of the knowledge, its source and date. He should have informed them clearly and firmly of the purpose of referral and its desirability. He should have enquired whether they wished to be referred to a genetic consultant or geneticist for appropriate information. These matters would have involved a simple inquiry and explanation during the first consultation. They would have involved no expense, difficulty or inconvenience.

[125] It was common ground that ATD was referred to at the first consultation. There were issues as to whether at that consultation the potential inheritance of ATD was raised or the purpose of the referral was explained.

[126] The post it note was taken to be a referral to Ms Duggan in her capacity as a genetic consultant. The post it note was introduced by the defendant in accordance with what he said was his usual practice. The usual practice was to provide a patient with any referral or other written information at the end of the consultation and to tell the patient why he was providing the referral or written information and what needed to be done with it. The post it note was introduced at the defendant's initiative, it was not sought by the plaintiffs,

[127] It was clear from the words on the post it note that the referral was concerned with genetics, but beyond that it was dependent upon its purpose being explained.

[128] The defendant had no independent recollection of what he said at the first consultation relating to ATD though he recollected the discussion about the second plaintiff's condition was brief. He gave evidence that, based on his notes, the discussion about ATD occurred toward the beginning of the first consultation.

[129] The defendant cannot now recall the words he used when he handed one of the plaintiffs the post it note. He had not previously referred anyone to a genetic consultant for ATD. He gave three versions as to what he may have said when handing over the post it note:

(a) based on his usual practice when referring patients to Ms Duggan (which he had no reason to believe he had departed from) he would have said words to the effect of, "Ring Kerry Duggan to discuss Lawrence's Factor III condition and its genetic aspects and if necessary, she will make arrangements for you to see a geneticist at Wollongong Hospital";

(b) he gave the following interrogatory answer:

> 7A(d) I suggested to Mr and Mrs Waller that they contact Ms Kerry Duggan, genetic counsellor at the Wollongong Hospital outpatient clinic:
>
> (i) so that she could discuss with them the AT3 condition and if necessary then make arrangements for them to see geneticist at Wollongong Hospital
>
> (ii) for them to learn more about the AT3 condition, to ascertain the implications for a forthcoming pregnancy and so that they could obtain more information about the disease and its inheritance.;

(c) in cross-examination he gave the following evidence:

Q -- The words to the effect of: Well, given your condition, you really need to see a genetic counsellor, Ms Duggan, so that you can be properly informed about the things that you should consider in order to make an informed choice; is that what you meant to convey?

A -- Yes.

Q -- It was your view that she should be seen by them, so that they can be armed with information as to the effect that the condition could have on their children?

A -- I don't know if that was verbatim, but that was the gist of it.

Q -- That is something that you would expect to be said by you in order to make it plain to them why it was they were going off to see her, correct?

A -- Correct.

Q -- It wouldn't be sufficient to simply say something along the lines of, "Ring Kerry Duggan to discuss Lawrence's factor III condition", would it?

A -- I wouldn't expect so.

...

Q -- You would need to say that to them; that it's important for you to know what the ramifications are, in order for you to make an informed choice as to whether you want to proceed; that's right, isn't it?

A -- I've already said I can't remember the exact words I used.

[130] Thus the defendant did not recollect the words he used. Two of the three versions put forward by him did not include express reference to inheritance and one of the versions, he agreed, was insufficient in its terms.

[131] Each plaintiff gave evidence the defendant never said words to the effect "Ring Kerry Duggan to discuss your Factor 3 condition and the genetic aspects and if necessary she will make arrangements for you to see a geneticist at Wollongong Hospital". The plaintiffs deny there was any reference to inheritance at the first consultation. The plaintiffs asserted there was no discussion of the hereditary aspects of ATD at this or any other consultation with the defendant.

[132] The plaintiffs' evidence was that the defendant in respect of the post it note said only words to the effect "Ring that lady about that". The reference to "that lady" was presumably to Ms Duggan the other "that" presumably was a reference to the topic under discussion when the note was handed over or, if discussion had ceased, the last matter discussed;

[133] The plaintiffs gave evidence that at the first consultation the second plaintiff had asked the defendant if the ATD may have caused his infertility. The defendant replied it was unlikely. The plaintiffs asserted the question of fertility was being discussed when the post it note was handed to them.

[134] The defendant gave evidence he was certain that he did not say at the first consultation that there may be a genetic aspect to the second plaintiff's infertility, as he would not have raised this as a possibility without seeing the repeat sperm tests. However this is not inconsistent with the plaintiffs' assertion that the second plaintiff raised the issue, not the defendant. It is, of course, possible that the plaintiffs confused it with the consultation on 5 May 1999 when the

defendant admittedly discussed with the plaintiffs the need for the second plaintiff to undergo genetic testing in relation to his low sperm count. This raises the possibility of additional confusion as to the purpose of the proposed consultation with Ms Duggan. It seems to me probable the plaintiffs would have asked if the ATD could have caused the second plaintiff's infertility and I accept that this occurred at the first consultation.

[135] The defendant considered that it was important to the plaintiffs to be given the opportunity to obtain advice from a genetic counsellor in relation to their plans to have a child in the circumstances of the second plaintiff having ATD. The plaintiffs, in the defendant's opinion, needed to see Ms Duggan to discuss the second plaintiff's condition and what effect it had upon the children. The defendant agreed it was important for him to make clear to the plaintiffs the purpose of the referral and to convey his opinion that it was desirable for the plaintiffs to see Ms Duggan. The defendant knew at the time there was a significant possibility of IVF down the track.

[136] If the defendant had specified the purpose of the post it note referral he would have asked or would have been told by the plaintiffs that they had advice from Dr Ramakrishna in respect of this issue. The absence of any reference to Dr Ramakrishna in relation to the consultations confirms the conclusion that inheritance issues were not raised or discussed at the first consultation or any consultation thereafter. Even on the defendants own case the explanation which he suggests he gave fell short of what he agreed in his evidence was appropriate.

[137] The second plaintiff denied in cross-examination that the reason he did not make greater efforts to contact Ms Duggan was because of the advice he had received from Dr Ramakrishna though he said that if he had seen Ms Duggan he would have said to her that he had seen Dr Ramakrishna about his condition.

[138] However the report of Dr Brown dated 15 July 2010 recorded the following history from the second plaintiff:

> ... Mr Waller recalled Dr James having written a name and telephone number on a sticky post-it note and which he understood was the contact details for a genetic counsellor to discuss the clotting issue. Mr Waller explained that he telephoned the number on a single occasion but with the call eventually having rung out. He indicated that because he had started his new business and was very busy, and also because he had already seen a haematologist, he did not make any further efforts to contact the genetics counsellor. In addition, Mr Waller explained that because he had not been provided with a proper referral, he had not paid the matter more "significant attention"

The second plaintiff asserted Dr Brown "Got it quite wrong".

[139] The first plaintiff denied discussing with the second plaintiff after the first consultation what the post it note was all about.

[140] Dr Brown in a report dated 15 March 2010 recorded the following history from the first plaintiff:

> Mrs Waller recalled Dr James writing the name and telephone number of a genetics counsellor on a post-it note and giving it to her and her husband at the end of their consultation. However Mrs Waller said that when her husband telephoned the number there was no answer and given that he had already seen a haematologist he did not follow through with trying again to make an appointment...

[141] The first plaintiff said when reminded of her conversation with Dr Brown

> If that's what I said, I don't recall that specific set of circumstances but if that's what I said, it's obviously true.

[142] The plaintiffs' evidence was that they were uncertain as to the purpose and utility of the referral. The second plaintiff in his evidential statement said he did not have a clear understanding at all of why the post it note was given to the second plaintiff and that if Ms Duggan had answered his telephone call he would not have been able to tell her the reason for the call. Subsequently he gave evidence that the post it note was "something to do with fertility" and in his mind, it had nothing to do with factor 3. The first plaintiff gave evidence she assumed the purpose of the post it note was to explore if the factor III condition was connected to the second plaintiff's infertility. She didn't ask for any clarification as "it wasn't directed at me".

[143] The first plaintiff was cross-examined as to the significance of the post it note as follows:

> Q -- Dr James didn't strike you, in that first consultation, as someone who was going to waste your time, did he?
>
> A -- One would think not.
>
> Q -- And you understood he was not going to make a suggestion about seeing someone if it was going to be insignificant?
>
> A -- Well, he certainly didn't make it very clear as to what this course of action was that he wanted us to do...
>
> ...
>
> Q -- Well, it was your understanding, I suggest to you, that this was on something significant?
>
> A -- No, I didn't have a clear understanding that it was significant. It was never portrayed as significant. It was a post it note given to us, or onto the counter, "Ring that lady about that". That's not significant...

[144] In my opinion the defendant did not raise with the plaintiffs the potential inheritance of ATD nor did he adequately explain to the plaintiffs the purpose of the referral with the consequence the plaintiffs did not seek to contact Ms Duggan after the failure of the first attempt.

[145] A subsidiary question is whether in the circumstances the plaintiffs owed a duty to seek clarification from the defendant as to the purpose of the referral. A plaintiff is required to take reasonable care for his or her own safety -- *RTA v Dederer* at [45].

[146] It appeared from the demeanour of the plaintiffs in court that the first plaintiff was the driving force in the family. Dr Phillips describes her as a very capable woman of above average intelligence. Senior counsel for the defendant described the first plaintiff as "no shrinking violet". The first plaintiff gave evidence the defendant was approachable and friendly and she was not afraid of asking him questions. The second plaintiff was described by psychiatrists who gave evidence as being of average intelligence.

[147] An appropriate course for the plaintiffs, taking reasonable care in their own interests and before discarding the referral would have been to inquire of the defendant as to the purpose of the referral. This aspect may be relevant to contributory negligence but would not defeat the plaintiffs' primary claim.

To properly refer to an appropriate person such as a genetic counsellor

[148] The plaintiffs do not contend that a referral to Ms Duggan was not a referral to an appropriate person. The plaintiffs, however alleged the mode of referral, by use of a post it note, was not "proper" and indicated to the plaintiffs the matter was of little significance. The second plaintiff submitted that a proper referral would involve him being given a letter to the doctor or other medical professional who he was to consult.

[149] Prior to 1999 Ms Duggan had given the defendant a supply of her business cards for the purpose of enabling patients to contact her directly. Thereafter the defendant's usual practice was to provide couples whom he was referring to Ms Duggan with one of her business cards to enable them to contact her for the purpose of arranging a consultation. The only reason he used a post it note, that he could think of, was that he must have run out of Ms Duggan's business cards.

[150] The only purpose of handing the post it note to the plaintiffs was to provide them with the means of contacting Ms Duggan in order to make an appointment to see her. This could have been achieved by a business card, post it note or any piece of paper. It was not necessary to write a referral to Ms Duggan as she was not a specialist medical practitioner and there was thus no need to qualify the plaintiffs for a Medicare rebate. The note achieved its purpose as Ms Duggan was telephoned by the second plaintiff at the telephone number on the post it note. In my opinion, the defendant did not breach his duty of care to the plaintiffs by the form which the referral took.

[151] The contact details given to the plaintiffs by the defendant in order to contact Sydney IVF were by way of a business card. The plaintiffs made no complaint about this as they said there was no lack of an explanation for the card. The problem in the present case was in the failure to properly explain the reasons for the referral, not in the use of the post it note. In the absence of an adequate explanation the use of the post it note suggested the referral was of less importance than the application for further blood and semen tests which unlike the referral to the genetic consultant were noted at the end of the defendant's consultation notes and were accompanied by printed application forms.

[152] The defendant's practice, except in cases of emergency, was to forward the referral letter directly to the doctor to whom the referral was being made and, if required, to provide contact details to the patient. In my opinion this was an adequate system provided the purpose of the referral was adequately explained to the patient. I do not consider the failure to conform to the preferred position referred to in para 3(a) of the joint expert's report of Professor Saunders and Dr O'Loughlin constitutes negligence.

The follow up

[153] The plaintiffs did not inform the defendant they had not contacted Ms Duggan. The defendant received no correspondence from Ms Duggan to indicate she had seen the plaintiffs. He made no inquiry of the plaintiffs as to what occurred with Ms Duggan.

[154] The defendant's explanation for not following up the referral was that at no consultation did the plaintiffs raise the topic of genetic counselling or any concerns in relation to ATD. The defendant did not believe that the plaintiffs wanted to exclude the possibility of transmission of the condition before deciding to proceed with IVF. Nothing that they said to him at any later consultation altered the understanding he had when he gave them Ms Duggan's details and so he did not, at any later consultation, ask them about the information they had received from Ms Duggan or whether it affected their decision to proceed with IVF.

[155] The defendant gave evidence that he expected the plaintiffs to consult with Ms Duggan and that if he had found out the plaintiffs had not seen the genetic counsellor he "would have been surprised and would want to know why". He agreed he was concerned in terms of discharging his duty to explain why it was important for the plaintiffs to seek out genetic counselling. He would have explained to the plaintiffs why it was important to have the consultation with the genetic counsellor as to the effect the condition could have on their children. He considered it was important the advice should be up to date.

Causation

[156] Two hypothetical questions arise, namely whether, in fact:

(a) the plaintiffs, when followed up, would have sought and obtained proper advice as to the hereditary aspects of ATD;

(b) as a result of advice thus received they would have refrained from having a child using the second plaintiff's sperm.

Would the plaintiffs have sought and obtained proper advice?

[157] If the plaintiffs had consulted Ms Duggan it is probable that they would have been referred by her for further information to the genetic specialist, Dr Mowat, with whom Ms Duggan worked and to whom she referred a number of her patients. There was no issue that if Ms Duggan and/or Dr Mowat or persons of similar qualifications were consulted by the plaintiffs that the plaintiffs would receive appropriate advice. The issue is whether the plaintiffs would have sought advice.

[158] The defendant, throughout 1999, was unaware the plaintiffs had obtained advice from Dr Ramakrishna.

[159] The second plaintiff gave evidence that if asked by the defendant if he went and saw Ms Duggan he would have told the defendant he had seen Dr Ramakrishna about his condition and his understanding of the advice Dr Ramakrishna had given him.

[160] The defendant gave the following evidence:

> Q -- Well, certainly, the starting point is that you would be interested to know, at the very least, why they hadn't seen Ms Duggan?
>
> A -- Correct.
>
> Q -- You would have advised them that, in effect, in your view, they needed to see Ms Duggan to discuss Lawrence's condition and what effect it could have on their children?
>
> A -- At some stage I would say that, but I would expect, first, an answer to my, "why not".
>
> Q -- Yes, but, irrespective of the answer, its still remains that, in your view, they needed to see Ms Duggan to discuss Lawrence's condition and what effect it had upon their children; that's right, isn't it?
>
> A -- Yes.

[161] The defendant in his supplemental statement said:

> 6. I have further been asked to assume that, in the course of this discussion, I was told that they had already obtained advice from Mr Waller's haematologist, Dr Ramakrishna.
> 7. In 1999, I knew that Dr Ramakrishna was an experienced haematologist and would have considered that he was entirely qualified to advise the Wallers on the genetic aspects of Mr Waller's condition and, in particular, whether it could be passed on to any children they may conceive.
> 8. If I had been told that the Wallers had obtained advice from Dr Ramakrishna, I would have asked them what that advice was.
> 9. I have further been asked to assume that the Wallers told me that Dr Ramakrishna advised them that Mr Waller would not pass the condition on to his children unless Mrs Waller also had a family history of the condition.
> 10. In 1999, I would have accepted that advice. I would not have recommended to the Wallers that they go and seek further advice on the issue. Nor would I have taken steps to check for myself whether this information was correct, as I would have believed that Dr Ramakrishna was suitably qualified to advise the Wallers in this matter. I would not have raised any concerns about the Wallers continuing with IVF.

[162] The supplemental statement did not indicate that the advice was obtained from Dr Ramakrishna approximately one year before the plaintiffs' first consultation with the defendant.

[163] In cross-examination the following evidence was given by the defendant:

> Q -- Despite the fact that he [Dr Ramakrishna] is a specialist haematologist, there is approximately one year that elapses when it is said he gave his advice and when you saw them on 3 March. It is desirable, is it not, because of the matters that we have been over, that they have up-to-date advice about the various things that they needed to consider when determining whether or not they would go ahead and have children?
>
> A -- Yes, they needed updates.

[164] The defendant conceded he did not know at the time the nature of the condition except in general terms, he did not know if PGD was available in relation to ATD or whether the condition was autosomal dominant or recessive.

[165] He gave the following evidence:

> Q -- ... it was important for you in those circumstances in that hypothetical situation to make it plain to the Wallers that it was important that they receive up-to-date genetic information, irrespective of the fact that Doctor Ramakrishna had given advice a year ago?
>
> A -- Correct.
>
> Q -- By March 1999, I want you to assume that when Mr Waller saw Doctor Ramakrishna in March 1998, there was no suspicion of infertility problems. It was hoped that they could conceive a child naturally and in the interim, that hope had not eventuated which led, as you know, to them being referred to you with a significant likelihood of IVF. Again, in addition to the reasons we have already been over, that is another reason, is it not, for it being desirable that they get up-to-date genetic information?
>
> A -- Correct, and that is what I did.
>
> ...
>
> Q -- The other thing is that in respect of accepting a report from a patient about advice that had been received in the past concerning whether or not the condition could be passed on, part of the consideration as to whether or not you would accept that advice without referring back to the doctor who had provided the advice, part of that would be your assessment of the patient's capacity to understand advice of that type, that is correct, isn't it?
>
> A -- It would be a factor, yes.

[166] The defendant gave evidence that it would be easy to telephone Dr Ramakrishna as he knew him. Initially he said he might do that but later he gave the following evidence:

> Q -- All right, I am asking you to inject into that a year ago. You would ring him up, wouldn't you, and ask him, just double check with him what his advice was?
>
> A -- Yes, I have already said that I probably would do that.

[167] In re-examination the defendant gave the following evidence:

Q -- The question then is, would you have advised them, that you have said out loud to them in this hypothetical situation that it was important to seek up-to-date advice?

A -- 1999, no, I would have accepted that advice.

[168] There is a degree of tension between the answer given in re-examination and the other evidence extracted above. However, in my opinion, it is probable that the defendant would have inquired as to when the advice was given by Dr Ramakrishna and then telephoned Dr Ramakrishna. This, more likely than not, would have revealed the plaintiffs' misunderstanding and the defendant would have informed the plaintiffs of this.

[169] The first plaintiff was asked to assume that the second plaintiff informed the defendant of Dr Ramakrishna's involvement. She then gave the following evidence:

Q -- Assume Dr James then said, "Okay then". That would have been the end of the conversation, do you agree with me?

A -- If Dr James said "okay then" would that be the end of the conversation?

Q -- Yes.

A -- I guess it would depend if he was happy with that or whether he asked us to provide something to -- I mean, I do not know what his formal practice is.

Q -- Did you ask, did you show them something from that doctor?

A -- I have no idea.

Q -- He basically indicated he was happy with that then you just move on?

A -- Well, if he's the professional/the specialist, if he's happy, then it must be the standard to believe what a patient said.

Q -- You move on with it?

A -- Well, I have no reason not to if he's the specialist.

[170] The second plaintiff gave evidence that, if asked why he didn't see Ms Duggan, he would have told the defendant that he had seen a haematologist called Raj Ramakrishna about his condition. The following evidence was then given:

Q -- And if Dr James had said, when you told him that, "okay then," that would have been the end of the conversation?

A -- Righto.

Q -- Do you agree?

A -- I'm not sure sir.

Q -- In other words, if he hadn't asked you anything more about it, just said "okay then" and went back to talking about the other things you had to talk about, that would have been the end of the conversation about Kerry Duggan?

A -- I guess so.

Q -- Sorry?

A -- I guess so.

[171] It is necessary to keep in mind the paramount consideration that a person is entitled to make his or her own decisions about his or her own life and a doctor should not lightly make the judgment that the patient does not wish to be fully informed -- *F v R* (1983) 33 SASR 189 at 192-193.

[172] In my opinion the defendant, mindful of his obligations, would have given a broader explanation to the plaintiffs on follow up. He would have pointed out to them the fact that there was the possibility of change in the last 12 months, there was the added factor of known infertility which was absent when Dr Ramakrishna advised, the significant likelihood of IVF and the possibility of PGD becoming available for ATD.

[173] There was evidence from Professors Monagle and Amor that the advice which would have been given would have been substantially the same in 1998 or 1999. However the defendant would not have known this without enquiry.

[174] The onus is upon the plaintiffs to establish that more likely than not they would have sought and obtained proper information and acted on it. The plaintiffs gave evidence that if informed by the defendant that the consultation was to clarify transmission of ATD to their child they would have consulted with Ms Duggan. In my opinion the plaintiffs, with the benefit of the further explanation by the defendant, would have attended the proposed consultation with Ms Duggan and with Dr Mowatt, if Ms Duggan had advised a consultation with a geneticist was required. In reaching that conclusion I have given particular emphasis to the fact the plaintiffs considered the issue one of particular significance as illustrated by the seeking of the opinion of Dr Ramakrishna and of Dr Miller in this regard, which occurred well before any litigation between the parties and can be accepted; the need to have up to date advice; the fact that with less than a full explanation the plaintiffs had made a telephone call to Ms Duggan when they knew they had information from Dr Ramakrishna and that infertility was not likely to be the result of ATD which suggests that a fuller explanation by the defendant would have led to the consultation taking place. I have also taken into account that the second plaintiff attended at the consultation with Dr Skyring and the plaintiffs attendances for medical tests as requested. In my opinion a further referral would not have been "an exercise in futility" -- *Varipatis v Almario* [2013] NSWCA 76 at [38]. Alternatively the plaintiffs may have requested the defendant to make an enquiry of Dr Ramakrishna on their behalf.

Would the plaintiffs, if properly advised, have had Keeden?

[175] The determination of causation issues of this nature is often productive of difficulty. As Cox J said in *Gover v South Australia* at 566 (quoted with approval by Gummow J in *Rosenberg* at 462):

> ... The court has to reach a decision about a topic to which the patient, in most cases, will not have addressed his mind at the time that matters most. His evidence as to what he would have done is therefore hypothetical and is very likely to be affected, no matter how honest he is, by his own particular experience ... It will often be very difficult to prove affirmatively that a plaintiff would not have taken a risk, say, that the evidence shows that many other people freely take...

[176] Gummow J in *Rosenberg*, after commenting upon the difficulties, said:

> [89] These matters have also been discussed in recent English authority. In *Smith v Barking, Havering and Brentwood Health Authority*, Hutchison J said:
>
> > [T]here is a peculiar difficulty involved in this sort of case -- not least for the plaintiff herself -- in giving, after the adverse outcome of the operation is known, reliable answers as to what she would have decided before the operation had she been given proper advice as to the risks inherent in it.

> Accordingly, it would, in my judgment, be right in the ordinary case to give particular weight to the objective assessment. If everything points to the fact that a reasonable plaintiff, properly informed, would have assented to the operation, the assertion from the witness box, made after the adverse outcome is known, in a wholly artificial situation and in the knowledge that the outcome of the case depends upon that assertion being maintained, does not carry great weight unless there are extraneous or additional factors to substantiate it. By extraneous or additional factors I mean, and I am not doing more than giving examples, religious or some other firmly-held convictions; particular social or domestic considerations justifying a decision not in accordance with what, objectively, seems the right one; assertions in the immediate aftermath of the operation made in a context other than that of a possible claim for damages; in other words, some particular factor which suggests that the plaintiff had grounds for not doing what a reasonable person in her situation might be expected to have done.

[177] The test to be applied in respect of such matters is subjective -- *Rosenberg* at [24] per McHugh J:

> Under the Australian common law, in determining whether a patient would have undertaken surgery, if warned of a risk of harm involved in that surgery, a court asks whether this patient would have undertaken the surgery. The test is a subjective test. It is not decisive that a reasonable person would or would not have undertaken the surgery. What a reasonable person would or would not have done in the patient's circumstances will almost always be the most important factor in determining whether the court will accept or reject the patient's evidence as to the course that the patient would have taken. But what a reasonable person would have done is not conclusive. If the tribunal of fact, be it judge or jury, accepts the evidence of the patient as to what he or she would have done, then, subject to appellate review as to the correctness of that finding, that is the end of the matter. Unlike other common law jurisdictions, in this field Australia has rejected the objective test of causation in favour of a subjective test.

[178] In *Chappel v Hart* [1998] HCA 55 ; (1998) 195 CLR 232 McHugh J at [32](fn64) said:

> In practice, there is likely to be little difference in the application of the subjective and objective tests in medical issue cases. Human nature being what it is, most plaintiffs will genuinely believe that, if he or she had been given an option that would or might have avoided the injury, the option would have been taken. In determining the reliability of the plaintiff's evidence...demeanour can play little part in accepting the plaintiff's evidence. It may be a ground for rejecting the plaintiff's evidence. But given that most plaintiffs will genuinely believe that they would have taken another option, if presented to them, the reliability of their evidence can only be determined by reference to objective factors, particularly the attitude and conduct of the plaintiff at or about the time when the breach of duty occurred...

[179] The onus is on the patient to prove what he or she would have decided to do -- *Rosenberg* at 462.2 [45].

[180] At present ATD has no cure. Its effects can be minimised by preventative strategies and treatment. The condition is normally symptomless and if there are symptoms they are usually mild. There is a risk that a person could suffer a DVT or PE as did the second plaintiff or blood clots in other parts of the body. Particular care is required should surgical procedures be necessary. There is no significant increase in mortality over that of the general population, though the condition could prove fatal if a PE was not treated. Generally the condition is managed by drug therapy. This involves the taking of Warfarin tablets daily and monthly blood tests. These matters would become routine and be a minor inconvenience though the anti coagulation therapy does carry its own risk of haemorrhage. It would be advisable to avoid contact sports.

[181] Had the plaintiffs been properly informed as to the hereditary aspects of ATD they would have been faced with the choice of continuing with IVF using the second plaintiff's sperm, using donor sperm, fostering or adopting a child, ceasing all steps to have a child pending the development of appropriate tests or foregoing having children altogether.

[182] The question is, which choice would the plaintiffs, properly informed, have made.

[183] The plaintiffs gave evidence they would have decided not to have Keeden had they been properly informed for the reasons that follow.

[184] The first plaintiff was young. Some delay in starting a family was of no real consequence at that stage. The success rate of IVF is directly proportional to a woman's age so by deferring treatment the plaintiffs would be decreasing the likelihood of success of IVF though by a pretty small amount at that stage.

[185] The second plaintiff asserted he had been highly concerned about ATD and its impact upon him (see [21] and [22]) at all times since his diagnosis. This had made him scared and angry. The force of this evidence was undermined, to a degree, when in cross-examination he admitted the Medicare records showed infrequent visits for INR tests and that he took a job after completing his apprenticeship which involved working in an atmosphere which exposed him to fumes.

[186] The second plaintiff consulted Dr Miller within a month of the marriage and consulted Dr Ramakrishna less than three months later to enquire as to the effect of ATD on any child of the plaintiffs. This evidence confirms the concern the plaintiffs had in relation to ATD and that such concern was genuine.

[187] The plaintiffs provision of the second plaintiff's ATD history to medical and allied health professionals provided further corroboration of the seriousness with which they viewed the condition. The defendant submitted that what it showed was the plaintiffs knew ATD could affect the plaintiffs' children, a submission which the plaintiffs deny and with which I do not agree.

[188] The long delay in having a second child indicated particular concern with the risks of ATD though by then influenced by the supposed link of ATD with CSVT.

[189] The plaintiffs gave evidence they would not have sought medical opinion as to what course they should take and would have made their own assessment.

[190] Professor Amor gave evidence that it would not be irrational for the plaintiffs to be concerned about passing on the condition to a child and that it would be rational and reasonable for the plaintiffs to defer a decision on the issue for some time.

The Defendant's response

[191] The defendant submitted that if the plaintiffs had been properly informed they would have proceeded in the manner in which they did, that is they would have had Keeden. The defendant relies upon the following factors:

[192] The plaintiffs, after discussion, had mutually decided it was time to have children. They were both keen to have children at that time;

[193] To that end they married, having previously lived together, purchased a house with a room for a baby near a family day care centre and actively sought to conceive their first child.

[194] IVF assistance was sought promptly once a difficulty in conceiving a child became apparent. The plaintiffs were prepared to undergo the potentially costly and difficult process of conceiving a child by IVF.

[195] The first plaintiff's deep desire for a child was underscored by endeavours subsequent to Keeden's birth to have a second child in respect of which inquiries were commenced shortly after Keeden's birth.

[196] As PGD or antenatal testing was not available in 1999, and it was anticipated would not be available for some years, considerable delay and uncertainty was inevitable if it was desired that the risk of the plaintiffs conceiving a child

with ATD was to be excluded by screening.

[197] The plaintiffs did not ask the defendant for information in respect of hereditary matters. This may be some evidence they were not concerned or maybe that they simply accepted that the defendant was not qualified to give that information.

[198] There was a 50% chance the offspring of the plaintiffs would not inherit ATD.

[199] There was a 70-75% chance the offspring of the plaintiffs would never be affected by ATD. There was no evidence that the children of the second plaintiff's brother, Darryl, were other than healthy.

[200] The second plaintiff's preference was to conceive a child using his own sperm. He regarded the use of donor sperm as "a last resort".

[201] Dr Phillips in July 2007 reported the first plaintiff told him she had problems coming to grips with donor sperm. The first plaintiff in evidence denied she had told Dr Phillips this. However she conceded she spent a considerable sum of money because she "wanted to explore every option before she used donor sperm". The first plaintiff ultimately became pregnant using donor sperm.

[202] The use of donor sperm in 1999 involved a risk of ATD from the donated sperm as well as other hereditary problems, though regard would be had to the family history of the donor in so far as it was disclosed. As Dr Amor said, the use of donor sperm would have raised substantial issues in respect of psychological, legal and medical consequences and a greater risk of hereditary problems than would occur if the child was fathered by the second plaintiff.

[203] The issue of donor sperm was not raised with Meredith Wilson, a geneticist who the first plaintiff consulted in March 2001 in relation to having another child.

[204] Neither of the plaintiffs raised the option of fostering or adopting a child until the hearing. There was no evidence of any steps taken by the plaintiffs to do either in the years since Keeden's birth. The court should not accept this was an option which the plaintiffs would seriously have contemplated.

[205] The defendant gave evidence the plaintiffs did not appear concerned about the risk of ATD. The plaintiffs did not raise the question of hereditary aspects of ATD with the defendant. However the plaintiffs believed at the time that their children were not at risk of ATD as a result of what they understood to be the opinion of Dr Ramakrishna.

[206] There was only one attempt to contact Ms Duggan.

[207] There was evidence that the plaintiffs prior to the consultation with Dr Ramakrishna had engaged in unprotected sexual relations prior to their marriage, relying upon rhythm and timing methods to avoid conception. The second plaintiff acknowledged that there was a risk of pregnancy associated with such behaviour though this was denied by the first plaintiff.

[208] The knowledge that Keeden has ATD would, if necessary, result in earlier management thus lessening any risk of significant repercussions from the condition though, as Dr O'Loughlin observed, it was highly improbable the ATD would require management during childhood.

[209] In the first plaintiff's further supplementary statement of evidence she said:

> In about 2003 I had conferred with Dr Knight of IVF Australia. I said to him "My son Keeden is severely disabled from a stroke due to having inherited his father's AT deficiency. I do not want to risk having another child inheriting this condition."

This view is one which, on the available medical evidence, is incorrect. However both plaintiffs accept it. It would influence the plaintiffs' evidence as to what they would have done if properly informed.

[210] Dr Monagle stated there are thousands of children born with ATD. In his opinion, the risk of ATD was not such as to justify delaying having children. Professor Monagle advised parents in the plaintiffs' situation to "go out and have your children". Professor Saunders did not know of any couple not going ahead with pregnancy due to ATD. The joint report of Dr O'Loughlin and Professor Saunders stated:

> Given that Mrs Waller did not have AT deficiency, the generally mild nature of the disease in adults, it's multi-factorial associations, the fact that the condition is manageable with appropriate treatment, the fact that there is no significant increased mortality over that of the general population, and the fact that a neonate and a child would most unlikely be affected by thrombotic episodes, we agree that it would have been appropriate for Dr James to proceed with IVF provided the Waller's were agreeable.

[211] Neither plaintiff in his or her evidential statements, in terms, excluded the possibility that they may have proceeded with IVF using the second plaintiff's sperm. In their evidentiary statements, the plaintiffs said that had they been properly informed they would have sought out alternatives such as pre-implantation testing if available, antenatal testing if available and the use of donor sperm. However, the second plaintiff in his oral evidence emphatically stated that he would have refused point blank to have an ATD baby. The first plaintiff also gave evidence she did not wish to have an ATD baby.

Conclusion

[212] Although each of the plaintiffs gave evidence they would not have conceived Keeden if properly informed it seems to me that evidence may have been influenced by the plaintiffs' anger and their view that the CSVT was due to ATD. These matters post-dated Keeden's birth and would have had no role in the election required of the plaintiffs if properly informed. It is appropriate to consider what a reasonable person, uninfluenced by these considerations, would have done in the circumstances.

[213] In my opinion it is probable that most reasonable people, when faced with the prospect of at least some years delay before appropriate tests may have become available, the understandable desire to father ones own children, the higher risk of hereditary problems associated with donor sperm in 1999, the relatively small risk of any significant symptoms arising from ATD particularly when there is the opportunity for early detection and appropriate management of the condition, would have elected to proceed with the pregnancy as planned.

[214] However a decision not to proceed to conceive Keeden could not, in my opinion, be categorised as unreasonable. The downside of suffering ATD is potentially significant. The fact that the second plaintiff had suffered a DVT and PE which had hospitalised him for about a month and the prompt steps taken to obtain medical advice as to the effect of ATD on their children once the decision to have children was made suggests the plaintiffs had reason to have, and did have, greater concerns than the ordinary reasonable person in relation to ATD.

[215] The onus rests with the plaintiffs to prove that properly informed, they would not have had Keeden. The test is subjective. The court is required to take into account "objective factors, particularly the attitude and conduct of the plaintiffs at or about the time when the breach of duty occurred". In the ultimate analysis the concern which the plaintiffs demonstrated in seeking the opinion of Dr Ramakrishna and Dr Miller as to the inheritance aspects of ATD is, in my opinion, sufficient to tip the scales in favour of the plaintiffs. Accordingly I find that properly informed, the plaintiffs would have elected not to have Keeden.

Factual Causation

[216] The issue that then arises is whether the harm of which the plaintiffs complain was caused or materially contributed to by the acts or omissions of the defendant. This issue is to be determined by applying the well known principles of causation to the facts of this case.

[217] The relevant question is whether the defendant's breach was so connected with the plaintiffs' loss that "as a matter of ordinary commonsense and experience it should be regarded as a cause of it" -- *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 at 522.

[218] It is for the plaintiffs to establish that their injuries were "caused or materially contributed to by the defendant's unlawful acts" -- *Duyvelshaff v Cathcart & Ritchie Ltd* (1973) 47 ALJR 410.

[219] In *Chappel v Hart* McHugh J held:

> [23] Proof of a cause of action in negligence or contract requires the plaintiff to prove that the breach of duty by the defendant caused the particular damage that the plaintiff suffered. In civil cases, causation theory operates on the hypothesis that the defendant has breached a duty owed to the plaintiff and that the plaintiff has suffered injury; but causation theory insists that the plaintiff prove that the injury is relevantly connected to the breach of duty. The existence of the relevant causal connection is determined according to common sense ideas and not according to philosophical or scientific theories of causation...
>
> [26] Underlying the rejection of the "but for" test as the determinant of legal causation is the instinctive belief that a person should not be liable for every wrongful act or omission which is a necessary condition of the occurrence of the injury that befell the plaintiff. As Mason CJ emphasised in *March*, causation for legal purposes is concerned with allocating responsibility for harm or damage that has occurred. So the mere fact that injury would not have occurred but for the defendant's act or omission is often not enough to establish a causal connection for legal purposes...
>
> [28] In principle, therefore, if the act or omission of the defendant has done no more than expose the plaintiff to a class of risk to which the plaintiff would have been exposed irrespective of the defendant's act or omission, the law of torts should not require the defendant to pay damages....

[220] Kiefel J in *Tabet v Gett* [2010] HCA 12 ; (2010) 240 CLR 537 at [111] [112] held:

> The "but for" test is regarded as having an important role in the resolution of the issue of causation, although more as a negative criterion than as a comprehensive test. The resolution of the question of causation has been said to involve the common sense idea of one matter being the cause of another. But it is also necessary to understand the purpose for making an inquiry about causation and that may require value judgments and policy choices.

[221] In *Roads and Traffic Authority v Royal* (2008) 245 ALR 653 Kiefel J held:

> [144] The present state of authority does not accept the possibility of risk of injury as sufficient to prove causation. It requires that the risk eventuate. Kitto J in *Jones v Dunkel* said that one "does not pass from the realm of conjecture into the realm of inference" unless the facts enable a positive finding as to the existence of a specific state of affairs. Spigelman CJ pointed out in *Seltsam Pty Ltd v McGuiness*, with respect to an increased risk of injury, that the question is whether it did cause or materially contribute to the injury actually suffered. This enquiry is consistent with the commonsense approach required by *March*.

[222] In short, the test for causation involves two considerations:

(a) would the plaintiffs' harm have occurred "but for" the acts or omissions of the defendant;
(b) should the defendant have to answer for the consequences of those acts or omissions. This aspect may require consideration of value judgments and policy choices, such matters being "regarded as central to the common law concept of causation" -- *Chappel v Hart*, McHugh J at [24].

The Claim

[223] The plaintiffs in their Fourth Further Amended Statement of Claim particularised the breaches which "caused or materially resulted in the first plaintiff and the second plaintiff suffering injury, loss and harm to date and continuing". The injury, loss and harm complained of was essentially that if properly informed, the plaintiffs would have deferred undergoing the IVF procedure of October-November 1999 until there were available methods to ensure that only embryos not affected by AT3 mutation would be transferred to the first plaintiff or alternatively would have chosen to use donor sperm. The IVF procedures between March and December 1999 were an expensive waste of time and money and subjected the first and second plaintiff to indignities undergoing those procedures and subjected the first plaintiff to a pregnancy carrying an AT3 affected child. Keeden's needs will subject the plaintiffs to "great expense" in excess of those expenses that would be incurred in raising and looking after a "normal" person without such a genetic illness and disease [AT3] causing and materially contributing to Keeden's injuries and disabilities and has caused each of the plaintiffs to experience substantial psychological pain and suffering caused by or resulting from Keeden's problems.

[224] The defendant submitted that the breaches alleged against him concerned the information that the plaintiffs had in relation to the risk that Keeden may inherit ATD. In order to satisfy the considerations that apply in the common sense test of causation, the plaintiffs must establish, on the balance of probability, that Keeden's ATD played a causative role in bringing about his disabilities. If the stroke would have occurred even if Keeden had not inherited ATD, the plaintiffs cannot succeed.

[225] The plaintiffs submitted that the evidence established that Keeden's ATD played a causative role in bringing about his disabilities. Alternatively they submitted that the fact that they may not be able to prove to the requisite degree that Keeden's CSVT was caused by his ATD is irrelevant.

Was the CSVT caused or materially contributed to by the ATD?

[226] There were a number of hospital and medical reports in evidence. These reports expressed varying opinions as to the cause of the CSVT. They were not the product of any in depth study as to the cause of the CSVT and accordingly I attach little weight to them.

[227] Three experts however were qualified by the parties for the purpose of giving evidence as to causation. They were Professor Amor, a clinical geneticist, Associate Professor Evans, a neonatologist, (both of whom were qualified by the plaintiffs) and Professor Monagle, a paediatric haematologist qualified by the defendant. It was their evidence that was relied upon primarily on this issue. No haematologist was called to give evidence by the plaintiffs.

[228] Professor Amor was of the opinion that the contribution of ATD to the CSVT might range from a possible contributing factor to being an incidental finding of no relevance. He considered it was impossible to state where in between those ends of the spectrum it sat. Professor Amor did not claim in depth knowledge of haematology or clotting processes. He would defer to a haematologist on the issue as to whether it was more likely than not that Keeden's CSVT would have occurred even if Keeden was born without ATD.

[229] Associate Professor Evans in 14 years had seen 6-10 infants with CSVT. He observed that the group of conditions where there is an increased tendency for the blood to clot are called thrombophilias. These conditions have been consistently demonstrated in the literature to be over represented in case series of neonatal stroke and biological

plausibility which would suggest that they play a role in defining the vulnerability of an individual to a cerebral thrombotic event. However he acknowledged that ADT was not one of the thrombophilias that had commonly been found in neonatal stroke series. Cnossen reviewed all case series in the literature where there was testing for thrombophilias. He reported that "In five papers which included 244 cases of cerebral arterial stroke, none had antithrombin deficiency diagnosed and in four papers in which 32 cases were tested none had AT3 deficiency diagnosed." However the incidence of AT3 in these series may have been underestimated due to possible unavailability of testing. A search of the whole of the medical literature back to 1988 by Associate Professor Evans produced four cases which described thrombosis in a cerebral vessel in a neonate diagnosed with ATD. One of these was Keeden's case. Each of Professor Amor, Associate Professor Evans and Professor Monagle agreed that no cause and effect linkage had been made in those cases. Associate Professor Evans said:

> ... one would have to conclude from the available literature that the risk of neonatal thrombotic events in the context of AT3 deficiency is extremely low. But because of the diagnostic difficulties there remains considerable uncertainty about this risk. However in the context of an individual like Keeden, with a defined family history and a spontaneous thrombotic event in the new born period, it is more likely than not that his AT3 deficiency was one factor in determining his risk for this outcome. It is unlikely however that it was the only factor.
>
> ...
>
> ... There is considerable uncertainty about the risk of neonatal thrombosis in the context of AT3 deficiency but the available literature suggests that the risk is extremely low. The association has been described in a number of individual case reports in the literature. For Keeden, it's more likely than not that his AT3 deficiency was one factor in determining his risk of this outcome. It's unlikely that it was the only factor.

[230] In the course of his evidence Associate Professor Evans was shown some more recent studies produced by Professor Monagle. He agreed that in none of the studies did the babies have ATD. He concluded:

> ... In a lot of ways I would agree with Professor Monagle that actually there's nothing in here that supports the association between ATIII and venous thrombosis.
>
> ...
>
> On the other hand, we still don't have the numbers to say the association is excluded so to my mind I would say the jury is still out on it...

[231] Associate Professor Evans in answer to the question "is there anything particular about Keeden Waller's case which aids you in your conclusion that CSVT was probably caused in part by AT3 deficiency". "No I don't think there are specific links, no".

[232] Associate Professor Evans deferred to Professor Monagle as to the way in which AT antigens work in a neonate. He conceded he lacked the expertise to comment on the mechanistic issues that Professor Monagle had talked about and deferred to Professor Monagle on such matters. He said he didn't have particular expertise in thrombophilia.

[233] Professor Monagle has advised people with AT3 deficiency, including advising them about inheritance issues. It was part of his practice to deal with neonates who had suffered venous or arterial strokes, thrombophilias and ATD. These were very much within the realm of a paediatric haematologist. It was his particular area of expertise. Thrombosis in children was the subject of textbooks written by him, international committees chaired by him and clinical guidelines which he has written. He is involved in the care of more than 10 children per year with CSVT.

[234] Professor Monagle stated:

> ... On the epidemiological data at the minute, I think that there is more data suggesting that there is not a relationship than there is.
>
> ...
>
> ... If one then goes and looks at the adult epidemiological studies of a family or large kindred studies that actually determined the antithrombin deficiency was associated with thrombosis in adults, in almost none of studies was there an association with thrombin events due to the newborn period. If you look at the study in that way, I think that evidence is actually strong, that there is not such a relationship.

[235] Professor Monagle continued:

> ... I absolutely accept the fact that there is clear data that antithrombin deficiency is associated with venous thrombosis in adults and pulmonary embolism in adults. That doesn't translate to the neonatal arena because we're dealing with an entirely different population and an entirely different physiology at that point in time.
>
> ...
>
> ...Even at the time that we wrote this report I was very clear in what I said, that I believed antithrombin at most was a minor contributing factor and was possibly irrelevant to the outcome and the reason for raising it is just to say in my mind I am more slewed toward that.
>
> ...
>
> ... If you look at it epidemiologically, for example the rate of thrombosis in neonates is far lower than the rate of adults.
>
> About 2 to 5 per cent of adults will experience thrombosis at some point during their lives.
>
> In children, you're talking about a risk that is something in the hundred thousands of children.
>
> ...
>
> ... I think what I am saying there, in 2007, if you asked me, I would have said it's possible that the AT played a role. I think what I am saying now is with the benefit of the increased knowledge that we have from 2007 through to now, I feel more strongly that it's less possible.
>
> ...
>
> ... I think it is less likely that the AT is a major player.
>
> Can I say that it is absolutely not involved? No, I can't. But as I said in the joint statement, I think it is, um, I can't say that it was not a minor contributing factor, but it is equally possible that it was irrelevant to the outcome.
>
> ...
>
> "based on my understanding of the physiological research which supports ATIII" as a minor contributor to the regulation of thrombin in new born infants' and the epidemiological data that I believe that it was more likely than not that this event would have occurred anyhow.
>
> ...
>
> We have almost between 250 and 300,000 children a year born in Australia, so if you are just talking about low anti-thrombin levels, then there would be tens of thousands of children born in Australia, thinking about those who have clinical syndrome, as I have described earlier, then there would be thousands of children born in Australia each year.

[236] The plaintiffs sought to rely on the judgments of Starke J and Rich J in *Adelaide Stevedoring Co Ltd v Forst*

(1940) 64 CLR 538. There Rich J concluded:

> ... But, while science presents us with no more than a blank negation, we can only await its positive results and in the meantime act on our own intuitive inferences...

[237] This is not a case of blank negation. Professor Monagle's conclusion has been based upon biological and epidemiological evidence sufficient to justify his conclusions. Professor Amor effectively deferred to Professor Monagle. Associate Professor Evans deferred to Professor Monagle on mechanistic matters and agreed that there was no epidemiological evidence which established the association of ATD and venous thrombosis. I accept the evidence of Professor Monagle on these matters.

[238] In my opinion the plaintiffs have failed to establish that the CSVT was caused or materially contributed to by the ATD.

[239] The defendant submitted that "the harm here was the economic loss caused by what happened to Keeden. Specifically it was the economic loss caused by the CSVT". The alleged physical and psychological harm sustained by the plaintiffs was similarly caused by the CSVT. The plaintiffs' case is that, but for the alleged negligence, they would have undergone IVF with donor sperm or waited for screening for AT3. IVF costs on pregnancy and related costs would have been incurred in any event. The plaintiffs suffered no harm consequent upon Keeden inheriting ATD. The plaintiffs have not established liability on the part of the defendant. I accept the defendant's submission.

Other risk factors

[240] The plaintiffs submitted that the CSVT was a consequence of other risk factors related to the pregnancy and birth of Keeden and thus the harm was caused or contributed to by the defendant's negligence.

[241] A neonatal birth summary relating to Keeden dated 10 August 2000 indicated the duration of the first stage of labour was 11 hours 45 minutes and the second stage 2 hours 45 minutes. The records of Royal Alexandra Hospital for Children dated 18 August 2000 recorded CSVT "cause unknown".

[242] Associate Professor Evans reported:

> Neonatal history: Keeden was born in moderate condition. His Apgar scores were 41, 85 and 910. He was suctioned, had oxygen via bag and mask, was given cardiac compressions for 15 seconds and was given Narcan 40mg IMI. He responded well to this as shown by his improving Apgar scores.
>
> At 1430 hours, his physical examination was normal and he was put to the breast and is reported as sucking well. His birth weight was 4.045g, length 59cms, and head circumference 35cms. Through the 10th and 11th August. He seems to have breast fed well. Between 1600 hours and 3.45 hours on 13th August, there are comments that he either didn't attach well or was not interested. At 4:00 hrs, he was given 10mls of expressed breast milk. The subsequent feeds on the 13th August suggest good sucking feeds. He was weighed on 13th August and was 3650 grms, a loss of 395 g or 9.8% of birth weight.

[243] The joint experts report stated:

> Nick Evans would say that AT deficiency was probably a risk factor in this outcome, but is not able to quantify the extent to which it contributed to the risk and it is very likely that it was not the only risk factor even if the other risk factors were not identified.

> David Amor is saying that the contribution of AT to the CSVT might range from a possible contributing factor to it being an incidental finding of no relevance; it is impossible to state where in between those ends of the spectrum it sits.
>
> Paul Monagle is clear that AT deficiency was not the major contributing factor, based on epidemiological and physiological data about the role of AT in neonates. He agrees that it is possible that AT was a minor contributing factor and equally possible that it was irrelevant to the outcome.
>
> We all agree that the only other identified risk factor is the dehydration noted in Keeden however the degree of dehydration was not extreme and is often seen in many babies who do not have any adverse outcome.
>
> We all agree that in most cases of CSVT there are no risk factors identified and we never establish why the CSVT occurred, and there are clearly many factors involved in neonatal CSVT that are currently not understood.

[244] The following possible risk factors for Keeden's CSVT were considered in concurrent evidence and may be summarised as follows:

> Dehydration -- This was one of the most common precipitants of thrombosis. Keeden had borderline hydration. Keeden's degree of weight loss was very common. It was within acceptable limits.
>
> Preeclampsia -- It is unclear from the hospital notes how firmly this diagnosis was made. The first plaintiff was really on the edge of the criteria of the diagnosis of preeclampsia. If it was preeclampsia it was extremely mild. It is debatable in any event if preeclampsia is a possible risk factor.
>
> Prolonged second stage of labour -- the second stage of labour was two hours 45 minutes. This is within the normal range of 2-3 hours. It is not known if a longer second stage is a risk factor for CSVT. It is plausible though there is not a lot of evidence to support it.
>
> Complication at birth -- CSVT has a common association with complicated deliveries. This delivery was not completely normal but it was at the lower end of the complication spectrum.
>
> Foetal distress -- the suction etc may be evidence of foetal distress but the five minute Apgar score of 8 probably would be interpreted as evidence that there had not been foetal distress.
>
> Head position -- Associate Professor Evans was unsure of any reason head position should be more or less a risk factor.

[245] Dr Hoolahan, in a letter to the defendant dated 16 August 2000, recorded:

> Deborah Waller's recent pregnancy was uncomplicated apart from a low grade rise in blood pressure towards the end which did not require treatment. She went into spontaneous labour at 6 days overdue and had a normal vaginal delivery with a small second degree tear, of a 4045gm male and they had no post natal problems whilst in hospital.

[246] The Discharge Summary dated 21 August 2000 reported:

> ... He was seen by Mark de Souza in the newborn period and checked by him at discharge on the third postnatal day. The baby was making good progress and there was no neurologic abnormality.

[247] The cause of Keeden's CSVT was not determined. At the highest some possible risk factors were identified. The plaintiffs' senior counsel, in his written opening, conceded:

> 179. None of these other risk factors [in addition to AT deficiency] for CSVT [alone or cumulatively] were of a degree as would explain this CSVT.

[248] These risk factors are not sufficient to establish the cause of the CSVT. Even if they were shown to be causative of the CSVT it would not create a liability in the defendant, the CSVT being unrelated to the ATD.

Cattanach

[249] The causation argument upon which senior counsel for the plaintiffs primarily relied purported to be based upon the decision of the High Court in *Cattanach v Melchior* [2003] HCA 38 ; (2003) 215 CLR 1.

[250] In *Cattanach* a married women underwent a sterilisation procedure. There was a failure to warn her concerning a risk she may fall pregnant notwithstanding the procedure. As a consequence of this failure unprotected sexual relations occurred with her husband and she became pregnant. She gave birth to a healthy child. It was reasonably foreseeable that the breach of the duty could lead to the parents incurring the financial burden of raising and maintaining a child. The parents claimed and were awarded the costs of having, raising and maintaining the child to age 18.

[251] The plaintiffs submitted *Cattanach* was directly applicable. There was, they said, no material difference between *Cattanach* and the present case. The intention in a sterilisation case is to prevent the birth of a child for whatever reason. Similarly in this case, the intention was to prevent the birth of a child who may later develop the symptoms of ATD.

[252] It was submitted that, but for the negligence of the defendant, Keeden would not have been born. As a result of the fact that he had been born the plaintiffs have incurred the losses which they now claim. The losses were occasioned by the CSVT contracted by Keeden. It was irrelevant the CSVT was not caused or materially contributed to by the ATD.

[253] The defendant submitted *Cattanach* was distinguishable. He also made the formal submission that *Cattanach* was wrongly decided.

[254] The difference between *Cattanach* and the present case is that in *Cattanach* the parents did not want a child and the injury to the parents flowed directly from the negligence of the medical practitioner. In the present case the plaintiffs wanted a child but one who would not develop the symptoms of ATD.

[255] Kirby J in *Cattanach* at [148] said:

> ... it is not the birth of the child that constitutes the harm, injury or damage for which the parents sue. Instead, it is for the economic harm inflicted upon them by the injury they have suffered as a consequence of the negligence that they have proved...

See also *Cattanach* at [68] and [90].

[256] *Cattanach* does not establish any general principle that when a child is born due to the negligence of a third party the parents of the child are entitled to recover the costs of having, raising and caring for the child from the third party. It remains necessary to establish causation by the application of ordinary legal principles -- *Cattanach* [57], [152].

[257] In the present case the defendant's liability was the result of the failure to ensure the plaintiffs were properly

informed of the hereditary aspects of ATD so that they could determine if the risk that their children may contract ATD was such as should be avoided.

[258] Keeden inherited ATD but this has caused the plaintiffs no loss. Keeden has not been on any anti-coagulants such as Warfarin, at any time. ATD is a disease of adulthood not childhood. As Dr O'Loughlin said "it is highly improbable the ATD would require management during childhood". The probabilities are that if Keeden suffers any symptoms of ATD they will be suffered after he has attained his majority and there is a near 50% chance he will never suffer any such symptoms.

[259] The defendant submitted that causation was not established as:

(a) the harm alleged by the plaintiffs was a consequence of the CSVT. The CSVT was unrelated to the ATD. It was one of the risks of life. It was no more relevant to the defendant's acts or omissions than if Keeden had suffered profound injuries in a car accident;
(b) the CSVT was totally unrelated to the acts and omissions of the defendant. It would have occurred in any event. It would be unreasonable and contrary to principle to impose liability on the defendant for harm which resulted from an unrelated condition;
(c) no harm was occasioned to the plaintiffs by reason of Keeden's ATD;
(d) the liability was sought to be imposed solely in consequence of Keeden's existence;
(e) the existence of Keeden was not causative of the plaintiffs' loss in a legal sense, it being merely the factor which secured the presence of Keeden when he sustained CSVT see:
    (i) *March v E & MH Stramare* [at 516]:

> The commentators acknowledge that the "but for" test must be applied subject to certain qualifications. Thus, a factor which secures the presence of the plaintiff at the place where and at the time when he or she is injured is not causally connected with the injury, unless the risk of the accident occurring at the time was greater: see Hart and Honore, at p 122. As Windeyer J observed in *Faulker v Keffalinos*:
>
> > But for the first accident, the [plaintiff] might still have been employed by the [defendants], and therefore not where he was when the second accident happened: but lawyers must eschew this kind of "but for" or sine qua non reasoning about cause and consequence.

    (ii) *Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd* [1997] AC 191 at 213:

> ... A mountaineer about to undertake a difficult climb is concerned about the fitness of his knee. He goes to a doctor who negligently makes a superficial examination and pronounces the knee fit. The climber goes on the expedition, which he would not have undertaken if the doctor had told him the true state of his knee. He suffers an injury which is an entirely foreseeable consequence of mountaineering but has nothing to do with his knee.

    (iii) *Chappel v Hart* (1998) 195 CLR 232 at [66]:

> It is true that in some cases of a failure to warn by a medical practitioner an application of the "but for" test without qualification could lead to absurd or unjust results. Such would have been the situation if, for example, instead of suffering damage to her laryngeal nerve, Mrs Hart had been injured through the misapplication of anaesthetic. Whilst it would still be open to conclude that, but for Dr Chappel's failure to warn her of the possibility of damage to her voice, she would not have opted for the operation at that time and would not have been injured by the anaesthetic, the law would not conclude that the failure to warn of the risk of injury to the laryngeal nerve caused the injury resulting from the anaesthetic.

(f) the loss claimed was totally disproportionate to the degree of fault for any foreseeable consequences of ATD;

(g) the plaintiffs wanted a child. They had a child albeit with ATD. The ATD has been and remains asymptomatic. The measure of the loss to the plaintiffs by reason of Keeden having ATD is nil. To render the defendant liable for the financial burden of having, raising and caring for a child disabled by CSVT, perhaps for the whole of his life, is totally disproportionate to the degree of fault and far exceeds any damage which was likely to flow from any act or omission of the defendant in relation to referring the plaintiffs for information about ATD.

[260] I accept the defendant's submissions. In my opinion, the plaintiffs have not established their loss was so connected with the defendant's fault that "as a matter of ordinary common sense and experience it should be regarded as a cause of it". The onus of proof rested with the plaintiffs. It was not discharged.

Additional bases

[261] The defendant submitted the plaintiffs' claim must fail for the following additional reasons:

Scope of duty

[262] The defendant submitted harm of the type which the plaintiffs claim to have suffered, namely physical, including psychological, damage and economic loss associated with having, raising and caring for Keeden was consequent upon Keeden suffering permanent physical disability as the result of the CSVT.

[263] Such matters were not within the scope of the duty as damage of the nature claimed was not a reasonably foreseeable consequence of the acts and omissions alleged against the defendant. The defendant's liability concerned a failure to cause information to be obtained in relation to ATD. The harm suffered was caused by an event which was not reasonably foreseeable. As Professor Monagle observed:

> If you are asking me whether in 1999, there was any way to predict that the paternal AT ... deficiency may have led to the clinical outcome for Keeden Waller, I am very clear that the answer is no, based on all the information provided in this and my primary report.

This evidence was not challenged and I accept it. See also para [267] hereof. In my opinion the plaintiff's harm was not within the scope of the overall duty alleged.

Remoteness of damage

[264] The damages recoverable for breach of contract

> ... should be such as may fairly and reasonably be considered either arising naturally, ie, according to the usual course of things, from such breach of contract itself, or such as may reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract, as the probable result of a breach of it ... -- *Hadley v Baxendale* (1854) 2 CLR 517.

[265] The damage that the plaintiffs claim to have suffered as a result of the alleged breach of contract by the defendant is too remote, in that on the information available to the defendant when the contract was made a reasonable person in his position would not have realised (and the defendant did not realise) that such damage was sufficiently likely to result from the breach of contract to make it proper to hold that the loss flowed naturally from the breach or that loss of that kind should have been within his contemplation.

[266] A duty of care is owed in tort only if the defendant ought reasonably to foresee that his or her conduct may be likely to cause the loss or damage to the plaintiff complained of.

[267] It was foreseeable Keeden might inherit ATD and it may become symptomatic at some stage during his lifetime. However, the harm for which recovery is sought, namely the consequences of CSVT was not reasonably foreseeable. There were ten cases in the English and German literature where a heterozygous neonate developed a thrombosis of any kind, not limited to cerebral thrombosis. There were four cases in the literature back to at least 1966, English or German, where a thrombosis occurred in a cerebral vessel. So ten in total, subset of four, which is cerebral, not necessarily venous and one of which was Keeden's case, in a situation where, as Professor Monagle indicated, thousands of children were born with ATD in Australia and countless worldwide every year. See also para [263].

[268] In my opinion the loss sought to be recovered is too remote.

Conclusion

[269] In my opinion the plaintiffs have failed to establish liability on the part of the defendant. Accordingly there will be judgment for the defendant. The plaintiffs are to pay the defendant's costs.

Contributory negligence

[270] The contractual duty of care is concurrent and coextensive with the duty of care in tort. Any damages awarded for breach of contract are liable to be reduced for contributory negligence; Law Reform (Miscellaneous Provisions) Act 1965, ss 8 and 9, Sch 1, Pt 2.

[271] The defendant alleged the plaintiffs were guilty of contributory negligence which senior counsel for the defendant particularised in his written closing submissions as follows:

(a) failure to heed the defendant's suggestion that they obtain genetic counselling;
(b) failure to inform the defendant that they had not obtained genetic counselling;
(c) failure to inform the defendant that they did not intend to proceed with IVF treatment if there was a risk that embryos produced as a result of the treatment could inherit the ATD condition.
(d) expressly representing to the defendant by signing the Request for Treatment Form that they wished to proceed with IVF treatment in the absence of genetic counselling; and
(e) undertaking IVF treatment knowing they had not had genetic counselling.

[272] As the plaintiffs' primary case has not succeeded, it is inappropriate to consider this aspect of the matter further.

Damages

[273] It is unnecessary, by reason of the above findings, to determine the quantum of damages. However against the possibility that the matter may go further and the damages are determined on the basis that damage flowing from the CSVT is recoverable I make the following comments.

[274] It was common ground that Keeden's disability, in consequence of suffering the CSVT, was such as to require full time care for his lifetime. His life expectancy, as agreed, is to the age of 52 years. The defendant accepted that there was every likelihood the plaintiffs would continue to involve themselves in the provision of that care.

[275] The plaintiffs' major claim is to recover damages for the provision of past care, future care and related out of pocket expenses resulting from Keeden's disability.

[276] The assessment of damages gives rise to a number of issues which are referred to hereunder.

Age limit

[277] It was accepted by the defendant that Keeden will need care for the remainder of his life.

[278] The defendant, however, contended that the scope of the defendant's liability is to be identified by reference to the nature of the harm for which compensation is being awarded. The relevant harm is the burden of raising a child, in this case a child with disabilities. It is a harm that the plaintiffs will incur because, as parents, they have a legal responsibility to care for and maintain Keeden -- Family Law Act 1975 (Cth) ss 60B, 61(C)(1), 66C, Child Support (Assessment) Act 1989 (Cth) s 3 -- *Luton v Lessels* (2002) 210 CLR 333 at [6]. Accordingly, the claim should be limited to the period of time in which the plaintiffs have a legal responsibility to care for Keeden. The legal obligation on the plaintiffs will cease when Keeden attains his majority upon his eighteenth birthday.

[279] In *Cattanach* McHugh and Gummow JJ at [68] said "..it is the burden of the legal and moral responsibilities which arise by reason of the birth of the child that is in contention." Kirby J in his judgment also made reference to legal and moral responsibilities. The plaintiffs contended that the reference to "moral" responsibilities in those judgments extended to a responsibility beyond the statutory legal obligation. The plaintiffs submitted they have a moral obligation to care for Keeden for the rest of his life. This may be. However, in context, it is probable that the above comments were referring only to the parents' responsibility to a child up to the age of 18 years as this is what was in contention in *Cattanach*.

[280] Reference was also made to the decision of Kirby J in *Cattanach* where his Honour said the "full damages against the tortfeasor for the cost of rearing the child" must be taken to be the "reasonable costs of rearing an unplanned child to the age when that child might be expected to be economically self-reliant, whether the child is 'healthy' or 'disabled'". The plaintiffs submitted that Keeden would never be in that position but would, in the eyes of the community, become economically self-reliant when he commenced to receive a full pension.

[281] The defendant contended that the conclusion that liability should cease upon Keeden obtaining his majority would impose intelligible limits on the recoverable damages and would keep the law of negligence within the bounds of common sense and practicality -- *Cattanach* at [32] per Gleeson CJ (dissenting).

[282] There is no binding authority on this issue. It was not decided in *Cattanach* because the claim there was limited to a claim for care to age 18. The authorities which were referred to were inconsistent. In *McDonald v Sydney South West Area Health Service* [2005] NSWSC 924 at [88] Harrison AsJ held the responsibility of parents for their children does not always cease at age 18 but may continue during tertiary studies. In *G & M v Armellin* [2008] ACTSC 68 a claim for the cost of continuing to support the additional child during tertiary education was refused, the court noting that it was "not part of the legal responsibility of a parent to support a child through university and many parents do not do so."

[283] In the United Kingdom there are a number of first instance decisions. In *Rand v East Dorset Health Authority* [2000] Lloyds Rep Med 181 the parent of a disabled child was awarded damages reflecting the costs of raising the child

until the age of 25. In *Hardman v Amin* [2001] PNLR 11 the damages extended to the lifespan of the claimant's parent. See also *Gaynor N v Warrington Health Authority* [2003] Lloyds Rep Med 365 at [16].

[284] The authorities to which reference has been made provide little guidance beyond age 18. The issue appears to be an open one. Any entitlement beyond 18 years will depend upon policy considerations. At this stage of the development of the law, if I was awarding damages I would limit them to the period up to Keeden's 18th birthday.

Deduction for costs of rearing a non-disabled child

[285] There was evidence from Dr Henman in his first report calculating the cost of raising a non-disabled child. The defendant did not challenge his calculations.

[286] The defendant submitted that the plaintiffs were intending to have a child. The first plaintiff does not say that if she had known about the possible inheritance of ATD she would have ceased all attempts to conceive a child. The damages should be limited to the additional losses caused by reason of Keeden's disability.

[287] The plaintiffs submitted that the established legal position in Australia was that the ordinary costs of raising an unwanted but healthy child were recoverable -- *Cattanach* at [180]. It would be both artificial and contrary to the principles in *Cattanach* to distinguish between the costs incurred in raising that part of Keeden that was disabled and the cost incurred in raising that part of Keeden that is healthy.

[288] The plaintiff in *Cattanach* did not want a child. As a result of the defendant's negligence she had a healthy child. She was liable for the cost of the child's upbringing when but for the defendant's negligence she would have had no child and no liability.

[289] The plaintiffs wanted a child. Keeden's ATD condition occasioned them no loss. Such loss as was sustained was due wholly to the CSVT. Accordingly the damages should be limited to the losses occasioned by the CSVT.

Set offs

[290] Once Keeden attains the age of 16 years he will be entitled to a disability support pension and other social security allowances and benefits. The defendant submits those entitlements are to be used solely for Keeden's benefit and should be offset against the plaintiffs' claims for future out of pocket expenses (including paid care) for Keeden.

[291] The plaintiffs submit no set off should be made as the benefit will be paid to and for Keeden in circumstances where Keeden himself will not be compensated by the defendant. In *Rand v East Dorset* such an argument was upheld.

[292] The defendant further submitted that as Keeden becomes entitled to pensions and benefits that governments had put in place for people with his level of disability, for the maintenance and care of the disabled, that there is a corresponding reduction in the plaintiffs' burden to provide and maintain Keeden and incur expenditure. True it is, as the defendant has repeatedly stated, that the claim here is the plaintiffs' and not Keeden's. But their liability -- and the defendant's -- does not go beyond bearing the burden of their legal and moral responsibilities. To the extent Keeden is supported by the community, then the plaintiffs' burdens are reduced and the economic consequences are ameliorated. On any rational view, to compensate the plaintiffs on the assumption that Keeden would not receive any such benefits, would result in over-compensation and would not be reasonable.

[293] Additionally to any social security benefits payable to Keeden, the plaintiffs have been in receipt of a carer's payment, supplement and allowance, a pensioner supplement and other social security benefits. These will continue to be received in the future. The defendant submits these payments, unless made refundable by legislation or agreement, should be deductible from any verdict recovered by the plaintiffs. The defendant refers to no authority in this regard.

[294] The plaintiffs concede there would be a set off but for the fact that the benefits would be repayable to the

government in the event the plaintiffs succeeded in these proceedings -- see Pt 3.14, s 1160 of the Social Security Act.

[295] The defendant submits:

(a) the carer's payments are not repayable under the social security legislation as they are not "compensation affected payments" within the meaning of the Social Security Act 1991 (Cth), s 17;
(b) alternatively, any repayment is discretionary (s 1178K) and there is no evidence before the court as to whether the discretion would be exercised. Accordingly, the payment should be set off.

[296] These issues, were referred to in argument in *Cattanach* in the High Court, but as they were not argued in the court below the High Court did not determine them. Their determination will require analysis of each of the statutory entitlements of Keeden and the plaintiffs against the statutory provisions requiring refunding of payments. In the event the issue is not determined by the statutory provisions resort to the general law as stated in *Manser v Spry* (1994) 181 CLR 428 to 434-437 and *Harris v Commercial Minerals Ltd* (1996) 186 CLR 1 will be required.

Discount rates

[297] The defendant contends two distinct types of claim are made by the plaintiffs, namely:

(a) individual personal injury claims by each of them, and
(b) a joint, stand alone, claim for economic loss in relation to the cost of raising and caring for Keeden.

[298] The damages sought in respect of both types of claim include compensation for future losses. Such losses conventionally are to be discounted to present value.

[299] In respect of the individual personal injury claims the defendant impliedly accepted that the appropriate discount rate was three percent. This accords with the decision of the High Court in *Todorovic v Waller* [1981] HCA 72 ; (1981) 150 CLR 402 at 409 where the court published a statement as to the effect of the decision in the following terms:

> In an action for damages for personal injuries, evidence as to the likely course of inflation, or of possible future changes in rates of wages or of prices, is inadmissible. Where there has been a loss of earning capacity which is likely to lead to financial loss in the future, or where the plaintiff's injuries will make it necessary to expend in the future money to provide medical or other services, or goods necessary for the plaintiff's health or comfort, the present value of the future loss ought to be quantified by adopting a discount rate of 3 per cent in all cases, subject, of course, to any relevant statutory provisions. This rate is intended to make the appropriate allowance for inflation, for future changes in rates of wages generally or of prices, and for tax (either actual or notional) upon income from investment of the sum awarded. No further allowance should be made for these matters.

[300] The defendant contends that the claim for economic loss in relation to the cost of raising and caring for Keeden is not a claim for personal injury. Thus *Todorovic* has no application and it is necessary for this court to determine the appropriate discount rate.

[301] Subsequent to the decision in *Todorovic* legislation was enacted in most Australian jurisdictions fixing the discount rate for future losses in personal injury claims at five percent. This included New South Wales -- Civil Liability Act 2002, s 14.

[302] The defendant referred to the range of discount rates adopted in commercial cases but concluded that the approaches taken by the courts in determining appropriate discount rates in such cases reflected the circumstances of businesses and investors and was unlikely to be of much assistance in the present case. I agree with this submission.

[303] The defendant conceded that the heads of damage claimed in personal injury cases were more closely aligned with the heads of damage sought, and the circumstances of, the plaintiffs in this matter. The vast majority of legislatures

had adopted a five percent discount rate for future economic loss in cases of personal injury. By analogy a five percent discount rate should be applied to the plaintiffs' claim.

[304] The defendant referred to the observations of Lord Diplock in *Ervan Warnink BV v J Towend & Sons (Hull) Ltd (Advocaat case)* [1979] AC 731 at 743 that:

> over a period of years there can be discerned a steady trend in legislation which reflects the view of successive parliaments as to what the public interest demands in a particular field of law, development of the common law in that part of the same field which has been left to it ought to proceed on a parallel rather than a diverging course.

It was submitted there was a "steady trend" reflecting the "view of successive parliaments" across jurisdictions that the appropriate rate was five percent. It was submitted that development of the common law in this area should reflect that view. *Warnink* was cited with approval in *Esso Australia Resources Ltd v Cmr of Taxation (Cth)* (1999) 201 CLR 49; *Moorgate Tobacco Co Ltd v Phillip Morris Ltd (No 2)* (1984) 156 CLR 414; *Peters (WA) Ltd v Petersville Ltd* (2001) 205 CLR 126.

[305] Additionally it has been recognised that the common law's method for assessing damages for personal injury is "far from satisfactory" -- *Todorovic* at 423-424 per Gibbs CJ and Wilson J. This observation lends further weight to the defendant's submission that a discount rate of five percent should be adopted in preference to the common law rate set out in *Todorovic*.

[306] Further, there was evidence before the court that any damages could be invested in a conservative long term growth fund at a rate which, after allowance for inflation of three percent, would provide a real rate of return in the order of five percent.

[307] The plaintiffs contended that if the economic loss claim was not a personal injury claim (which they disputed), then s 14 of the Civil Liability Act 2002, if otherwise applicable, would not have applied as it applied only to an award of damages for personal injury.

[308] The plaintiffs submitted that if the three percent rate provided by *Todorovic* cannot apply, the court should follow the approach which existed before that decision which still exists now for commercial and similar matters not governed by it, of determining a suitable discount rate by reference to available projected interest rates and inflation rates.

[309] In my opinion, the economic loss claim in respect of raising and caring for Keeden is not a stand alone claim but is properly categorised as part of a total claim for damages for personal injury. Economic loss is a separate head of damage in a personal injury claim. This is consistent with the need for uniformity of approach in respect of the various heads of damage claimed. Accordingly, the three percent discount in *Todorovic* is applicable. The legislature, in fixing the statutory discount rate of five percent, chose not to render the Civil Liability Act 2002 retrospective, Sch 1, cl 2 of the Civil Liability Act 2002 expressly provides:

> (1) Part 2 of this Act extends to an award of personal injury damages that relates to an injury received, or to a death resulting from an injury received, whether before or after the commencement of this Act.
>
> (2) However, Part 2 of this Act does not apply to or in respect of:
>
> (a) an award of damages in proceedings commenced in a court before the commencement of this Act...

These proceedings were commenced in the court before the commencement of the Civil Liability Act 2002.

[310] Alternatively, if the economic claim is to be regarded as a separate stand alone claim, I would apply *Todorovic* by analogy. That the analogy is appropriate is apparent from the defendant's submissions in respect of the application of the five percent discount.

[311] Additionally the determination of an appropriate discount rate is necessarily arbitrary. This is illustrated in that the parties are able, by reference to the evidence before the court, to demonstrate a real rate of return of five percent (defendant) or .09% (plaintiffs). The mid point of those figures coincidentally is three percent.

The basis of calculation for the provision of care

Griffiths v Kerkemeyer

[312] The plaintiffs claim damages for gratuitous care that they have and will continue to provide to Keeden.

[313] The defendant assumed that the basis for such claim was to apply, by analogy, the principles in *Griffiths v Kerkemeyer* (1977) 139 CLR 161.

[314] In *Griffiths v Kerkemeyer* the High Court held that in a claim for personal injury the injured party was entitled to recover an amount equivalent to the commercial cost of nursing and domestic services that had been and would be provided voluntarily by family or friends to him. The need for such services entitled the injured party to recover the reasonable cost of meeting those needs at commercial rates. The injured parties' claim was as a receiver of the services. This decision is anomalous because it involves provision of compensation in circumstances where there is no obligation on the plaintiff to recompense the carer for the services provided and on the basis of a legal fiction as to the rate to be applied, namely commercial care rates.

[315] The present claim differs from a *Griffiths v Kerkemeyer* claim in that the claim is by the plaintiffs as the providers of the gratuitous services.

[316] In *Sullivan v Gordon* [1999] NSWCA 338 ; (1999) 47 NSWLR 319 the New South Wales Court of Appeal accepted *Griffiths v Kerkemeyer* damages could extend to persons who were not the recipients but were the providers of gratuitous care.

[317] In *CSR Ltd v Eddy* [2005] HCA 64 ; (2005) 226 CLR 1 a husband had provided domestic assistance to his wife, who suffered from osteoarthritis. He claimed damages at commercial care rates for the services that he would have rendered to his wife, had it not been for the injuries he suffered as a result of the negligence of the defendant. The High Court, overruling *Sullivan v Gordon*, held that the loss of the capacity to provide gratuitous personal or domestic services was not compensable as a separate item of damage. *Griffiths v Kerkemeyer* damages were not there to compensate persons for the cost of services which because of their incapacity they cannot render to others. In each instance there may be a need for services but it is a different kind of need and the recipient of the services is different.

[318] The plaintiffs' claim is not a pure *Griffiths v Kerkemeyer* claim as the plaintiffs are not the recipients of the care. Nor is the claim a *CSR v Eddy* claim as the claim is for the provision of care and not for the loss of the ability to provide the care.

[319] The defendant contends the distinction drawn between a person with a need for services and a person with the need to provide the services is not just one of form, it was central to the reasons why the majority in *CSR v Eddy* decided against drawing an analogy between *Sullivan v Gordon* and *Griffiths v KerkemeyerCSR v Eddy* referred to a difficulty in determining the nature and extent of the care that a person "needs" to provide to another, compared to the relatively easy task of determining the nature and extent of the services that an injured person "needs":

> [32] *Different fields of operation*. Thirdly, there is an important difference between the field in which *Griffiths v Kerkemeyer* applies and the field in which *Sullivan v Gordon* applies. In applying *Griffiths v Kerkemeyer* it is relatively easy to estimate the extent of the plaintiff's needs for personal care or services, and to calculate, by reference to the costs of professionals providing that care or those services, what the damages should be (even if it is possible or likely that the care will not be provided, either at all or by paid professionals). But the "need" of the plaintiff to care for others is much harder to evaluate. To examine it by reference to what care the plaintiff ought to have provided in the past would trigger invidious inquiries. To examine it by reference to what care the plaintiff in fact provided in the past would require investigation as to whether the intensity of the plaintiff's interests in providing the services might have been likely to change after the tort because of possible future events like divorce or the birth of new children, or for other reasons. The *Sullivan v Gordon* problem is not the practical one of calculating costs. It is the legal problem of deciding what test should be employed in deciding what costs need to be calculated. To that *Sullivan v Gordon* problem there is no *Griffiths v Kerkemeyer* parallel.

[320] This problem does not appear to arise in the present case where the claim is for the actual provision of the services and that is essentially determined by having regard to the full format of Keeden's needs.

[321] In *Cattanach* the trial judge awarded damages for what was described as past *Griffiths v Kerkemeyer* damages and future *Griffiths v Kerkemeyer* damages but this was not in issue in the High Court.

[322] The defendant submitted:

(a) *CSR v Eddy* was decided after Cattanach and comments by McHugh and Gummow JJ in *Cattanach* at [67] indicated that those judges pre-supposed *Griffiths v Kerkemeyer* was not available:

> [67] ... Similarly, for the purpose of this appeal, the relevant damage suffered by the Melchiors is the expenditure that they have incurred or will incur in the future, not the creation or existence of the parent-child relationship. If, for example, their child had been voluntarily cared for up to the date of trial, they could have recovered no damages for that part of the child's upbringing. And, if it appeared that that situation would continue in the future, then the damages they would be able to recover in the future would be reduced accordingly.

(b) In *CSR v Eddy* the court held that *Griffiths v Kerkemeyer* was an anomaly. It was contrary to fundamental and basic principle and was not to be extended to any class of case where its use was not covered by authority. The defendant submitted, in summary, there was no legal basis for the plaintiffs' claim for payment for gratuitous care and the reasoning in *CSR v Eddy* was a direct and insurmountable obstacle to any extension of principle in other fields by analogy, as a basis for the claim.

(c) The only right consistent with legal principles to recover for gratuitous care was pursuant to the principles in *Griffiths v Kerkemeyer*. Those principles are not applicable in the circumstances here.

[323] The defendant did not dispute that if otherwise entitled to a verdict the plaintiffs were entitled to be compensated for any loss of earnings in caring for Keeden.

[324] The plaintiffs submitted that:

(a) In *Cattanach* McHugh and Gummow JJ described the different types of damage compensable by an

award of damages in negligence and it follows "damage is either physical injury to person or property or the suffering of a loss measurable in money terms or the incurring of expenditure as the result of the invasion of an interest recognised by the law." The compensation here was as a result of "the invasion of an interest recognised by the law".

(b) In *Cattanach* the losses claimed by the parents fell into the third category. At [90] McHugh and Gummow JJ described the relevant damage as "the financial damage that the parents will suffer as the result of their legal responsibilities to raise the child."

(c) The defendant chose to ignore the value of the work which the plaintiffs do to care for Keeden. There was no need to go to a nursing agency as the plaintiffs are now skilled carers. They are entitled to the value of their work and it would be wrong not to so compensate them. They are entitled to compensation for both past and future gratuitous care.

(d) If it is found that gratuitous care is not available to the plaintiffs, then the plaintiffs have at least a moral obligation to care for Keeden for the rest of his life. As a matter of fact, this will happen. The plaintiffs will therefore incur significant loss of earnings due to their inability to go to work. As Keeden grows older and heavier he will require greater care and both parents will be required to care for him over 24 hour periods. Consequently a claim is made for both plaintiffs' loss of wages in the alternative to the claim for gratuitous care.

[325] The defendant accepted that the plaintiffs were entitled to past loss of earnings subject to the usual requirement of proving what their income would have been and proving they would have worked anyway. Senior counsel for the defendant stated:

> ... we agree wage loss is payable. That's their economic loss. We don't dispute they have reduced their working hours in the past and will do so in the future, and that has caused their economic loss. We are not saying they don't get anything. They get their economic loss, their wage loss.

[326] My preference would be to compensate on a *Griffith v Kerkemeyer* type basis for the supply of gratuitous care. However the issue involves policy considerations in the light of which the preferable course, at first instance would be to adopt the alternative of awarding loss of wages.

Application of caps under Civil Liability Act

[327] The compensation recoverable in *Griffiths v Kerkemeyer* claims has been capped in the Civil Liability Act 2002. That Act has no direct application here as the statement of claim was filed before its commencement. The defendant submits nevertheless that the capping in the Act should apply. Reliance was again placed upon *Warnink*.

[328] The plaintiffs contend that it was open to parliament to extend the Civil Liability Act 2002 to claims that were filed before the commencement date of the Act. It chose not to do so. It expressly enacted a provision excluding the application of the Act to such claims. In these circumstances there is no basis to apply the provisions of the Civil Liability Act 2002.

Overall

[329] *Griffiths v Kerkemeyer* damages are awarded on the basis of the value of the need for the services. Generally the market cost of the services is evidence of the reasonable and objective value of the need for those services -- *Van Gervan v Fenton* (1992) 175 CLR 327.

[330] The defendant submits that if the *Griffiths v Kerkemeyer* past claim is allowed, the damages should be limited in a sensible way. The amount awarded should be limited to the income foregone by the plaintiffs for the amount that would

be payable to a carer under the relevant award; alternatively, average weekly earnings rather than some commercial rate. It is noted that the plaintiffs have acquired a high degree of skill in caring for Keeden.

Interest on gratuitous care

[331] A claim for interest on past gratuitous care is made. Such a claim is permissible under the common law -- see *Grincelis v House* [2000] HCA 42 ; (2000) 201 CLR 321 but not where the Civil Liability Act 2002 applies -- Civil Liability Act s 18.

[332] The defendant submits:

(a) an award of interest is normally made on the basis that a party has been kept out of moneys due to it. That is not the case here and any award of interest is based on a fiction.
(b) No interest should be allowed on any damages for gratuitous care awarded by analogy with *Griffiths v Kerkemeyer*.

[333] If damages for gratuitous care are awarded by analogy with *Griffiths v Kerkemeyer* then prima facie interest pursuant to *Grincelis v House* should be awarded.

Future paid care

[334] In the alternative to the claims for gratuitous care the plaintiffs claim for future paid care on the basis of 24 hour, seven days a week live-in care provided at commercial rates.

[335] There is no evidence the plaintiffs would be able to fund such care in the absence of a substantial verdict. They have not employed paid carers to date and have themselves provided adequate and appropriate care for Keeden.

[336] The defendant, in his submissions, referred to what were described as the compensatory principles which were identified by reference to the following authorities:

(a) *Livingstone v Rawyards Coal Co* (1880) 5 App Cas 25 at 39:

> ... where any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages you should as nearly as possible get at that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation...;

(b) *Harriton v Stephens* [2006] HCA 15 ; (2006) 226 CLR 52 Heydon J said at [168]:

> To say of a plaintiff that he or she has suffered "damage" or "harm" likewise invites comparison between what would have been and what is. That inquiry cannot be made in the abstract. First, it directs attention to the position of the particular plaintiff, not some hypothetical class of persons of which the plaintiff might be said to be a member. But secondly, and critically, it requires identification of the condition of, or state of affairs concerning, that plaintiff which would have existed had the tort not been committed...;

(c) *Blundell v Musgrave* (1956) 96 CLR 73 at 79:

> ... the basis on which a plaintiff recovers expenses as special damages is that he will have to pay them whether he obtains the amount from the defendant as damages or not. The question here must therefore be whether the plaintiff really stands in a situation in which he must pay the expenses which apparently now stand debited to his pay account whether he recovers from the defendant or not. For it cannot be enough to entitle a plaintiff to recover from a defendant in respect of money still to be paid that the plaintiff is liable to pay it if and only if he recovers a corresponding amount from the defendant. His liability or the necessity of his meeting the expenditure must be independent of his recovery from the defendant...

[337] The defendant submitted the application of the "compensatory principles" had the consequence that the plaintiffs could not recover damages as compensation for expenditure that they will not incur absent an award of damages.

[338] The defendant's senior counsel posed the following:

> ... How, it will be asked, how is that different from a plaintiff, an impoverished plaintiff who was injured in a car accident and needs an expensive wheelchair say, and will need it replaced every five years, and there is no way he would have been able to afford that from his own funds. And yet one would not doubt that the law would award damages for the wheelchairs even though he would not otherwise have been able to pay for them.
>
> How is that different? And that's the hardest question against me on this argument. It is different because in that case the plaintiff who needs the wheelchair has a need created by the accident. If that need is not met because he can't afford it, the compensatory principles of Lord Blackstone is not fulfilled. The plaintiff is not and would not be in the same position as if the tort had not occurred. He would be left without a wheelchair that he needed to reclaim any kind of quality of life. That's why he would be entitled to damages for the wheelchairs.
>
> Here, as I have said over and over again, the plaintiffs are the parents, not Keeden. Their loss, leaving aside the nervous shock claims, is economic loss. To be clear, it is no part of my argument that we need to characterise this as a pure economic loss claim. There is debate about that in *Cattanach v Melchior*. It doesn't matter here which box you put it in. There is no doubt that their loss is economic loss. However you characterise the overall negligence claim, the loss is economic loss.
>
> ...
>
> ... The plaintiffs will not, absent an award, use paid care. That still wouldn't be a sufficient answer for me if that left their legal and moral responsibilities unfulfilled, because that would mean their need, if we get this far, we have created is unfulfilled, just as for the chap that needed the wheelchair, but it doesn't, because their legal and moral responsibilities in this case are perfectly well fulfilled without the provision of paid care.

[339] The defendant submitted that there was no Australian case that had grappled with this issue. In the United Kingdom there are conflicting judgments.

[340] The defendant's submission relies upon the distinction between general and special damages. It accepts the traditional view that "an item of special damages could only be recovered as compensation in respect of a liability paid or incurred." -- *CSR v Eddy* at [101], see also [31]. That distinction was seen as central by McHugh J in *CSR v Eddy* at [89]. His Honour observed at [90] that:

> ...since the decision in *Griffiths v Kerkemeyer*, the distinction between special and general damages in some cases has been blurred, if not rendered entirely redundant.

His Honour also observed:

> [95] Courts are far more pragmatic than they once were. If the courts perceive a rule as requiring an unfair or unjust result in a particular case, they are likely to distinguish the rule, make an exception to it, or even in some cases abolish it. Court are much more ready to do this than they once were. Pragmatism has become a powerful force in the law.

The defendant's submission is unattractive. Whilst a court at first instance may be bound to accede to it, a more pragmatic approach may well prevail.

Capital gains tax and GST

[341] Claims for capital gains tax and GST have been made. It was agreed by the parties that those claims should be stood over until after judgment was delivered.

Future care

[342] There is no agreement as to how future care will be provided. The parties have presented a number of scenarios and costings as to how the care may be provided, ranging from care being provided full time by the plaintiffs to care being provided full time by professional carers employed at commercial rates.

[343] The second plaintiff gave evidence he was motivated to care for Keeden and got pleasure in fulfilling that role. He regarded the full time care of Keeden as his job and a lifelong commitment. He was convinced few persons were capable or prepared to provide the quality of care which he and the first plaintiff provided to Keeden and would prefer to continue to provide care because of his concerns about the safety and wellbeing of Keeden. However, he would like to have some respite from the caring role. He would like a break each day "just head space".

[344] Dr Brown concluded the second plaintiff would wish to keep caring for Keeden, even if carers were made available. This was the second plaintiffs' focus and the doctor considered he would continue in that role. Dr Phillips expressed a similar view.

[345] The evidence does not point to a likely abdication of the carer's role by the plaintiffs save to the extent that some respite may be provided and taken. In my opinion, the most likely future scenario provided funds were available would be that the plaintiffs would continue to care for Keeden subject to the provision of paid respite care to be provided for four hours seven days per week.

Psychiatric injury

[346] Claims are also made on behalf of each plaintiff for damages for physical and psychological damage as a consequence of Keeden suffering CSVT.

[347] In order to succeed in their claims for psychiatric injury, it is necessary for the plaintiffs to prove they have suffered a recognisable psychiatric injury -- *Tame v New South Wales* [2002] HCA 35 ; (2002) 211 CLR 317 at [7], [44], [193].

[348] There is a conflict in the medical evidence in this regard. Dr Phillips, a psychiatrist qualified for the plaintiffs, who has had three consultations with each of the plaintiffs, concluded that each was suffering from a recognisable psychiatric injury.

[349] Dr Brown, a psychiatrist qualified for the defendant, who had one consultation only with each of the plaintiffs, was of the contrary view.

[350] I would accept Dr Phillips' opinion in preference to that of Dr Brown as Dr Phillips had the advantage of assessing the plaintiffs on three occasions as opposed to Dr Brown's one. However, the psychiatric repercussions are relatively mild and accordingly I would have awarded general damages of $50,000 to each of the plaintiffs. It is unlikely the plaintiffs' symptoms will warrant antidepressant medication or counselling.

Orders

[351] The orders of the court are:

1. Judgment for the defendant
2. The plaintiffs to pay the defendant's costs.

Order

1. Judgment for the defendant.
2. The plaintiffs to pay the defendant's costs.

Counsel for the plaintiffs: *D Higgs SC*, *R Royle* and *J Donnelly*

Counsel for the defendant: *J Kirk SC* and *V Thomas*

Solicitors for the plaintiffs: *Slater & Gordon*

Solicitors for the defendant: *Blake Dawson*