SUPREME COURT OF VICTORIA

COURT OF APPEAL

S EAPCI 2021 0048

CDC CLINICS PTY LTD (ACN 109 209 921) Applicant

v

ZEINAB DAEMOLZEKR Respondent

JUDGES:	NIALL, KENNEDY and MACAULAY JJA
WHERE HELD:	MELBOURNE
DATE OF HEARING:	9 March 2022
DATE OF JUDGMENT:	7 April 2022
MEDIUM NEUTRAL CITATION:	[2022] VSCA 54
JUDGMENT APPEALED FROM:	[2021] VCC 292 (Wischusen J)

TORT – Medical negligence – Damages – Breach of duty of care – Laser treatment – Cause of scarring injuries – Where burns finding dependent on judge's assessment of oral evidence – Whether burns finding 'glaringly improbable' and/or open on the evidence – Whether adverse inference should be drawn from failure to call witnesses – Whether failure to consider evidence admitted on voir dire – *Lee v Lee* (2019) 266 CLR 129, applied – *Robinson Helicopter Co Inc v McDermott* (2016) 90 ALJR 679, applied – *Jones v Dunkel* (1959) 101 CLR 298, considered – *Cargill Australia Ltd v Viterra Malt Pty Ltd (No 28)* [2022] VSC 13, considered – Leave to appeal refused.

APPEARANCES:	Counsel	Solicitors
For the Applicant	Mr M O'Connor	Moray & Agnew Lawyers
For the Respondent	Mr N Murdoch with Ms F Ellis	Henry Carus & Associates

NIALL JA
KENNEDY JA
MACAULAY JA:

1 On 28 June 2017, the respondent attended the applicant's clinic (the 'CDC Clinic') in order to undergo laser treatment to remove tattoos from each of her forearms. The respondent claims that the scarring which now appears on her forearms was caused by the applicant's negligence in administering that treatment.

2 It was agreed by the parties that the resolution of the case turned on what caused the scarring, and, in particular, whether the respondent was burnt by the treatment.[1]

3 A County Court judge found that the scarring of the respondent's forearms in the area treated by the applicant resulted from burns sustained in the course of her treatment on 28 June 2017, during which too high a fluence[2] was applied to her tattoos. His Honour thereby ordered the applicant to pay the respondent damages fixed at $90,000, plus interest and indemnity costs.

4 The applicant now seeks leave to appeal from this decision, and advances the following three relevant proposed grounds:[3]

> 1. The trial judge erred in finding that the applicant caused burns to the respondent's skin when such a finding was not open on the evidence.
>
> 2. The trial judge erred in failing to draw any inference from the plaintiff's failure to call any medical practitioner from the Wantirna Mall Clinic or from the Monash Medical Centre.
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> 3. The trial judge erred in rejecting the contemporaneous note of the treating nurse Ms Clow, without any evidential basis; and after admitting it into evidence on a voir dire.

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1 Since it was never suggested that the respondent had consented to the risk of being burnt.

2 According to Dr Rish (whose evidence was accepted by his Honour), the 'fluence' is the measurement of power applied to the skin by the laser machine, measured per centimetre square.

3 Ground 4 concerned a complaint that there were insufficient reasons. However, given that ground 1 fails, the applicant's counsel accepted that ground 4 cannot succeed.

Ground 5 concerned a complaint that his Honour erred in awarding costs in favour of the respondent. It was not pressed as an independent ground, and does not arise given that the application has been unsuccessful.

5 For reasons stated below, we have determined that leave to appeal will be refused.

Evidence[4]

6 There were six witnesses called in the case.[5] However, the key evidence was the evidence of the respondent, the clinical records of the respondent's attendances on doctors and other medical staff, the evidence of two experts, Dr Rish (called by the respondent) and Mr Holten (called by the applicant), as well as certain photographs taken by the respondent. There was also a particular clinical note of Ms Nicola Clow, a nurse at the CDC Clinic, which warrants individual attention.

7 It is helpful to commence with the respondent's evidence surrounding the chronological history of attendances on doctors and other medical staff. As observed by his Honour, the respondent confirmed her attendances for treatment in accordance with the clinical records that were tendered.[6]

Laser treatment on 28 June 2017

8 The respondent gave evidence about her attendance at the CDC Clinic on 28 June 2017. She said that following her initial consultation with Dr Shvetsova, the laser treatment was administered in a separate room. She stated:

> First, they put numbing cream on me for about 45 minutes. I went inside the room where there was only one nurse. There was [sic] no other doctors or anyone else except for me and the nurse. She removed the gel that was on my arm, the numbing gel and then she started doing the injections.

9 The respondent stated that the nurse then administered 'a lot of injections', and that she remembered 'skin flickering off', 'visible holes in my arm on the … tattooed area', and that it was 'very painful'.

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4 Given the nature of the (primary) ground 1, a detailed summary is necessary.

5 The plaintiff called Zeinab Daemolzekr (the respondent) and Dr Adam Rish. The respondent called Dr Galina Shvetsova, Jacqueline Thorn, Mr Ian Holten, and Cynthia Weinstein.

6 *Zeinab Daemolzekr v CDC Clinics Pty Ltd (ACN 109 209 921) & Anor* [2021] VCC 292 ('Reasons'), [30].

10 The respondent contrasted a previous time she had undergone laser treatment at a different clinic (Global Beauty), at which time 'it wasn't hurting at all', with her experience at the CDC Clinic, stating:

> The whole process [at the CDC Clinic] was painful. It looked – the laser machine looked different and felt different. My skin was flickering off at CDC Clinic and I could see visible like circles of holes…where with Global Beauty, I don't remember any of that happening, it was just very soft laser with Global Beauty.

11 The respondent stated that she told the nurse during the treatment that she was in pain, to which the nurse replied 'we'll numb you up a bit more', and gave the respondent a Lignocaine anaesthetic injection. At one stage the nurse told the respondent 'we will turn it up' so that there would be less sessions and they would remove the tattoo quickly.

12 Following the treatment, the respondent stated that the nurse bandaged the respondent's arm and told her to go home. She stated that once the anaesthetic started to wear off, she felt like her 'arm was on fire' and she was in a lot of pain.

13 Under cross-examination, the respondent maintained that she had seen skin flickering off, and had smelt burnt skin during the procedure. She said that the goggles (placed on her eyes during the treatment) did not stop her seeing what was happening because they were only colour tinted. She accepted that she had not mentioned the skin flickering off and observing holes in an earlier statement she had made to the Health Complaints Commissioner ('HCC'),[7] but said she was more worried about the wound at that time.

14 The consultation record of Dr Shvetsova, dated 28 June 2017, recorded a consultation with the respondent at 1:05 pm in relation to 'tattoo removal'. It stated that the respondent was told that tattoo removal 'may require more than 6 treatment sessions', and that healing after the tattoo removal 'takes at least 5 days'.

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7 The respondent made a complaint to the HCC regarding her treatment at the CDC Clinic in August 2018, which was referred to the Australian Health Practitioners Regulation Authority. An interview was conducted as part of the complaint, during which the respondent described her treatment at the CDC Clinic.

15 Dr Shvetsova gave oral evidence about her consultation on 28 June 2017. She stated that she had a general conversation with the respondent wherein she discussed the risks involved in the laser procedure, including the possibility of blistering, scarring, and incomplete removal of the ink. It was put to Dr Shvetsova during cross-examination that she did not mention 'blistering' as a possible risk in her clinical note. She accepted that there was a 'missing part' of the note.

16 Dr Shvetsova also confirmed that she was not involved in actually performing the laser treatment, and did not see the respondent either during or after the laser treatment on 28 June 2017. Rather, the respondent was treated by Ms Clow, who was not called as a witness (although the applicant tendered Ms Clow's clinical note of 28 June 2017, which is discussed, below).

Attendance subsequent to tattoo removal, including at Monash Medical Centre ('MMC')

17 On 1 July 2017, the respondent attended the Wantirna Mall Clinic and was seen by Dr Joseph Sous, a General Practitioner ('GP'). The clinical note recorded that the respondent had a 'wound on her left forearm after laser removal of tatto [sic]' which 'looks infected', and that Keflex (cephalexin) capsules were prescribed.

18 On 3 July 2017, the respondent again attended the CDC Clinic, and was seen by Dr Shvetsova. When asked about this attendance, the respondent said that she complained of pain and of a burn, but that they told her it 'looks fine and it's going to be fine.'

19 The clinical note of 3 July 2017 recorded 'concerns re may have an infection'. It further noted some erythema[8] on treated areas, with no pus, and minor swelling. The oral evidence of Dr Shvetsova was that she saw a 'slight swelling … some redness which is expected, but not excessive, and it looked pretty much what we normally see after treatment'. There was also a consultation record completed by a nurse employed at the CDC Clinic, Jacqueline Thorn, which recorded that she

[8] Abnormal redness of the skin due to local congestion, as in inflammation. *Macquarie Dictionary* (online at 23 March 2022) 'erythema'.

applied a new dressing to the wound. She had no actual recall of the consultation, though she did give evidence that user manuals and 'cheat sheets' were used by the nurses in administering the laser treatment. However, no training documents were actually produced.

20 On 4 July 2017, the respondent again attended the Wantirna Mall Clinic and was seen by Dr Lawrence Baria, GP. His clinical note recorded: 'had tattoo laser removal 6/7 ago; got swollen the next day', and that antibiotics should be 'cont'(inued). On the same day, the respondent was also seen by a nurse at the Wantirna Mall Clinic to have her wound dressed. The nurse wrote: 'Wound dressing: had leaser [sic] Tatoo [sic] removal and burned the skin'. The nurse also recorded that the wound appeared 'red', 'inflamed' and 'infected'. It was put to the respondent during cross-examination that what was stated in the nurse's note regarding burning of the skin was what she told the nurse. The respondent denied this suggestion.

21 On 8 July 2017, the respondent attended the Wantirna Mall Clinic and was seen by Dr Sidra Akhtar, GP, who recorded that the respondent had 'second degree burns post tattoo removal with laser', and 'should see a plastic surgeon'. She also wrote that the respondent was 'in a lot of pain', and prescribed Amoxil capsules (amoxicillin). She referred the respondent to Maroondah Hospital.[9] Under cross-examination, the respondent maintained that Dr Akhtar had observed second degree burns, and the respondent had not told her to write that.

22 On 9 July 2017, the respondent was taken by ambulance to MMC. The ambulance record stated that 'Pt has developed burns to the areas which now appear infected'. The hospital admission note stated '32yo F presenting with increasing pain over ?burns secondary to laser for removal of tattoos'. It further stated that the respondent was 'in a lot of pain', and that 'she has had laser done before again for tattoos but did not have these issues last time'. The admission notes also reported that the respondent's white blood cell count was normal. The respondent was given

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9 The respondent attended Maroondah Hospital but did not remain, as it was too busy.

antibiotics and analgesia, and remained in hospital overnight. The discharge note dated 10 July 2017 recorded a diagnosis of 'cellulitis', and 'localised infection to the wound site'.

23 On 10 July 2017, the respondent then attended on Dr Baria at the Wantirna Mall Clinic. Dr Baria wrote a referral letter to Dr Dhillon, a plastic surgeon, which noted that the respondent 'had laser tatto [sic] removal 2 weeks ago; presented with infected wound and possibly full thickness burn on the area'. Under cross-examination, the respondent explained that she did not see a plastic surgeon (despite Dr Baria referring her to one) because her wounds were really fresh, and she did not feel good about anything at that time because of her arms.

24 The respondent subsequently saw Dr Baria at the Wantirna Mall Clinic again on 19 July, 25 July, 9 August, and 29 August 2017 regarding the wounds on her forearms. On 25 July 2017, it was noted that there was an area of blister and that the respondent had 'reportedly accidentally banged her left arm on a door knob'. On 9 August 2017, Dr Baria recorded 'left arm wound healing, scabs on 2 areas'. On 29 August 2017, he wrote: 'scabs are gone, ; area scarred with skin discoloration' [sic].

Subsequent events: August 2017 to February 2019

25 The respondent gave evidence that she did not have any treatment after August 2017 (including no Intense Pulsed Light ('IPL') treatment), save for Bio Oil vitamin E oil and make up to cover the scars. She said that it was very embarrassing having the scars, and she experienced a lot of anxiety about them. She said that she had not pursued treatment because she could not afford to do so.

26 It was put to the respondent during cross-examination that the blistering shown in the photographs dated around two months after the treatment was a result of her receiving or treating her arm with something just prior to the photograph being taken. The respondent denied that the photograph showed a blister. She was also adamant that '… I didn't do anything to jeopardise my healing process, no, I didn't. I

wouldn't do that'. When asked why she would not have received further treatment to her arm given the residual tattoo, the respondent stated: 'When you have fresh wounds why would you want to play around with them and make them worse? I don't understand. That just doesn't sound right to me'.

27 The respondent attended the Wantirna Mall Clinic again several times on 1 November 2017, 14 January 2018, and 26 August 2018 and was seen by Dr Daoud, another GP. Dr Daoud noted that the respondent had a 'massive scar' from the tattoo removal, and was 'depressed, worried about the scar'. He provided the respondent with a plastic surgeon referral on both 1 November 2017 and 26 August 2018, neither of which were followed up. However, the respondent's evidence was that she did not think 'they' would be able to fix it. She denied that she was only interested in compensation, and said that she wanted her arms to be 100 per cent better (not just 70 per cent better).

Mr Stapleton – February 2019

28 The respondent was assessed by Mr Stapleton, a plastic surgeon, in February 2019. In a report of 13 February 2019 he opined that she had severe scarring as a result of the laser tattoo removal, and that the degree of impairment was more than five per cent. He also annexed photographs of the respondent's arms taken in February 2019, which show extensive scarring and substantial removal of ink (the 'after photographs').

29 The after photographs may be compared with certain photographs taken prior to the laser treatment which show a clear clean cat tattoo (on the right arm) and 'wing' tattoo on the left arm (the 'before photographs').

30 The respondent was taken to the after photographs in cross-examination and asked where the ink had gone by the time she saw Mr Stapleton. She replied that the area scabbed over as it was burnt, and the scabs later started to fall off, such that the tattoos 'ended up like this'.

Note of Ms Clow

31 As indicated already, the nurse who administered the laser treatment, Ms Clow, was not called as a witness. Although the applicant opened its case on the basis that Ms Clow would be called, she did not attend court as anticipated. There was some evidence that she was dissuaded by her husband from doing so. Nevertheless, the applicant did not subpoena Ms Clow, nor request an adjournment in order to call her. Instead, a note Ms Clow allegedly wrote was adduced into evidence after the completion of the other evidence on day six of the trial.

32 In order to adduce the note, Cynthia Weinstein, the former proprietor of the applicant company, gave oral evidence as to the circumstances in which it was found. She said that she went back to the CDC Clinic on 2 February 2021 (after mediation, and two weeks prior to the trial) and discovered that there were two files, one under 'Daemolzekr, Zainab,' and the other under 'Daemolzekr, Zainab known as Alyssa'. Ms Weinstein then 'merged' the files so no trace of the recently found file remained in the system.

33 His Honour admitted the note as a business record, in circumstances where the respondent did not (and could not) suggest that the document was altered or newly created.

34 The note read as follows:

> **CONSULTATION RECORD: Ms Zeinab DAEMOLZEKR**
>
> **Date:** Wednesday, 28/06/2017 2:35PM
>
> **Presenting Problem: Tattoo removal**
>
> **Provider:** Ms Nicola Clow
>
> **History**: Patient tattoos removal
>
> Asked by Dr Galina to remove
>
> Risks discussed by Dr Galina and cosnetn [sic]
>
> photos
>
> **Treatment/Plan: Tattoo Removal**

Area: left arm and right arms cat

Local: numbing cream and injections fraxel local supervised/authorised by doc

Local Volume: 20 ml dilute local under doc supervision

Wavelength: 1064nm

Energy: 4.2j/cm2 after test spot on left arm

Spot size: 4mm

Hz: 5-10 hz

Dressing: mefix

Review: by doc

Comments: end point whitening. No bleeding. patient toleated [sic] well. No ocmplaints [sic] of pain

Treated by: Nicola under Dr Galina supervision.

35 The note therefore suggested that the machine was set at 4.2 joules per centimetres squared, which was a critical matter. As highlighted by his Honour, if treatment was given in accordance with this setting, the experts were in agreement that burns would not have resulted.

36 However, there were discrepancies with the note. First, the other evidence suggested that the treatment was completed before the 2:35 pm time recorded in the note.[10] This would mean that the note was not made contemporaneously with the giving of the treatment (even if it was made later that day). Secondly, there was the evidence of Dr Shvetsova that she was not actually present in the room with Ms Clow at the time the treatment was being conducted. This meant that the concluding remarks, 'treated … under Dr Galina supervision' were liable to be misleading. His Honour also made findings about the paucity of evidence as to Ms Clow's training, which will be referred to below.

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[10] The consultation clinical note of Dr Shvetsova gave a time of consultation of 1:05 pm, followed by some 45 minutes of treatment (in accordance with the respondent's evidence).

Expert evidence of Dr Rish

37 Dr Rish is a medical practitioner practising in cosmetic and laser medicine. He has a particular interest in tattoo removal. He has been performing tattoo removal with a Q switch laser for over twenty years and has done the majority of 9,000 cases himself.

38 In his first report of 21 May 2020, Dr Rish opined:

> In summary on review of the file sent to me and photographs, Ms Daemolzekr has sustained full thickness burns to her forearms, worse on the left side than the right, as a result of inappropriately high fluence from a Medlite Q switch Nd:YAG laser… In this case as is common with all burns, they become easily infected.

39 A conference note of 27 May 2020 included the following further statements of Dr Rish:

> The ink in a tattoo is located in the dermis layer of the skin. This layer is under the outer layer of the skin, the epidermis. The particles of ink in a tattoo are too large for the body's macrophages (white blood cells that remove debris) to remove naturally. This is what makes a tattoo permanent. The aim of laser treatment is to remove the ink from the dermis without damaging the epidermis. The laser causes the ink particles to become smaller so that the body's macrophages can remove them. The macrophages then take the particles of ink to the lymph nodes where they are disposed of ….
>
> Laser treatment applied at too high a fluence causes particles of skin to flicker off, leaving a visible hole or holes in the treated area. In this case, if the practitioner had stopped to assess the site of treatment he or she would have observed this. The patient would have been in pain ….
>
> The very fact of a burn speaks of excessive fluence. The Hertz will make the laser faster but will not necessarily damage the dermis. The excessive fluence is really the reason for damage.

40 After subsequently receiving the clinical note of Ms Clow, Dr Rish said (on 11 February 2020):

> The application of the laser with those measurements would be highly unlikely to have caused burns and/or scarring to the plaintiff ….
>
> With regard to the history provided by the plaintiff and the appearance of her scars, I believe that the levels of fluence/joules recorded in the notes were less than actually applied to her tattoos for the treatment.
>
> Having seen photographs of the plaintiff's scarring and having regard to its

> nature it is my opinion that, more likely than not, the plaintiff's scarring was caused by burns from the laser at the time of treatment.
>
> The appearance of the plaintiff's scars are consistent with the laser treatment being applied at an inappropriately high fluence. I believe that this inappropriately high fluence, for an initial treatment, has damaged/burnt the plaintiff's skin causing tissue necrosis and later supra-infection which has led to eventual scarring ….
>
> I am confident that the scarring the plaintiff sustained was as a result of inappropriate laser treatment; that is there was an inappropriately high level of energy/joules applied to the tattoos during treatment causing tissue necrosis.

41 On 16 February 2021, Dr Rish considered a photograph taken of the respondent's arms on 9 July 2017, and stated:

> The photograph on page 182 of PACB is consistent with laser burns to the forearms. I am told that the photograph was taken on approximately 9 July 2017. From the appearance of the burns depicted it appears as if they occurred in approximately the previous fortnight. All of the area treated is affected by burning. This is a completely abnormal outcome following appropriate Q switch laser treatment and is entirely consistent with the fluence being too high. Further, the appearance of the treated area is wholly consistent with burning of the skin with full thickness burns.

42 In his final report of 17 February 2021, Dr Rish agreed with Mr Holten that the respondent did not have significant infection when she attended MMC on 9 July 2017, given she had promptly seen a GP and was on antibiotics. However, he reaffirmed his conclusion that:

> The scarring is mostly due to excessive fluence applied at the time of her laser treatment and witnessed by the deeply damaged skin all over both tattoos in the good quality photographs taken at Monash Medical Centre.

43 During his evidence-in-chief, Dr Rish gave evidence of what would happen with appropriate laser treatment. He stated that there should be no skin breaking, and the skin should settle down within two or three days and be flat. He further stated that by one week post-treatment, the tattoo should look like it had not been treated at all. He said that what was seen in the photographs was 'overtreatment'. He explained the almost complete disappearance of the ink between the photographs taken in July 2017 and those taken in February 2019 as follows:

> … what's happened is the whole of the upper epidermis and dermis

(indistinct) off and taken all the – or most of the ink with it and left a scar.

44 Under cross-examination, Dr Rish explained that if there is excess fluence in the laser treatment then you puncture the blood vessels and generate heat such that you can 'easily cause a full thickness burn'. He said that if the machine was set at 10, you would 'almost certainly' get this type of injury. He later explained that you would normally do multiple treatments because if you use too much power, 'then the ink does come out faster but it leaves a scar'.

45 As to whether any full thickness burn should have been manifest by 1 July 2017 when the respondent first attended the GP, Dr Rish explained that it took time for these things to manifest because the dead tissue 'kind of sloughs off.' Taken to the consultation at the CDC Clinic five days after treatment and asked how a burn was not apparent, he said:

> Because – well, it's evolving. It's evolving. It's underneath the skin. There is still an intact layer of dead tissue on top of the wound, so it hasn't sloughed off yet, and we see when from the photos from the medical centre, it's starting to all slough off, all the dead tissue.

46 Later, he did suggest that burns should have been apparent by day five when the respondent was examined by Dr Shvetsova, but observed that people do not always record matters if they have caused a problem.

47 Dr Rish was taken to the MMC notes of 9 July 2017, and the following exchange took place:

> Counsel: Now, that's the clinical examination on 9 July at Monash. You would agree that's not consistent with observation of burns either second or third degree burns?
>
> Dr Rish: No, that is very much the burns, the burns are just not infected. And also, this signifies that it's not through any absence of care of the wound by not taking antibiotics, not looking at getting medical help to manage the burn. It's the – the burn is the cause of the problem, not the infection.
>
> Counsel: There's no identification of a burn though per se is what I'm putting to you, doctor?
>
> Dr Rish: Well, there is a burn because otherwise she wouldn't have that – why has she got all that slough and things coming off her tattoo? The pictures tell the story. There's been a significant

> dermal injury and the photo (indistinct) injury to that tattoo from the laser to the area.

Expert evidence of Mr Holten

48 Mr Holten is a plastic and reconstructive surgeon, who operates four clinics at which nurses conduct laser tattoo removals.

49 In his report of 9 February 2021, Mr Holten considered that the respondent's presentation on day five (with mild erythema and some swelling) was 'normal' and 'expected', and that if the respondent had suffered second or third degree burns it would have been apparent by this time. Mr Holten considered that *infection had 'clearly caused' the scarring*, not the laser treatment. He considered that the infection came about in the second week following the laser treatment.

50 Mr Holten recorded that his main objection to Dr Rish's report was his statement that the laser was used in an inappropriate high fluence, given he would use about 4 joules. Mr Holten stated that '*based on the recorded levels in the CDC notes*, this was in fact the level of energy used on the Plaintiff's forearms'.

51 Mr Holten made various other criticisms of the respondent, including that she failed to attend at the CDC Clinic later that week, and that there was a possibility that she had paranoid delusions and interfered with dressings (given her 'unstable schizophrenia') leading to subsequent infections. He also raised the possibility of self-harm. He stated:

> It is unreasonable and unfair to hold a practitioner or clinic accountable for a patient's outcome if that patient fails to comply with the post treatment protocols. In legal terms, the patient "voids the contract".

52 After viewing some photographs, he provided an addendum to his report on 14 February 2021. He considered that, in the early recovery period, the arms were healing normally with the presence of a lot of dark pigment. He confirmed this in a further email of 15 February 2021, where he again cited the notes (which documented the appropriate levels of the laser treatment) and that there were photographs two to three weeks after treatment showing that the lasered areas were

'practically healed.'

53 In a further email of 17 February 2021, he considered that the photograph of the cat tattoo taken three to four weeks post treatment showed 'NORMAL HEALING' and no signs of burns, with residual ink present. He compared this to the after photographs which showed scarring and less ink, and suggested that this could only be explained by 'a SUBSEQUENT EVENT.' He referred to the MMC notes which recorded that the respondent was on the correct antibiotics with a normal white blood cell count. He said that this further confirmed that 'there was no infection in early July 2019'. His conclusions that the scarring was explained by a subsequent event, rather than an infection, marked a sharp contrast with his earlier view that the scarring was 'clearly caused' by infection.

54 In a further report, prepared after Dr Rish's evidence had concluded (on 23 February 2021), Mr Holten took issue with Dr Rish's comments that the early photographs showed deep dermal or full thickness burns, and stated that they showed 'relatively normal post laser recovery'. He reaffirmed that there must have been a '"SECONDARY" event'.

55 Under cross-examination, he confirmed his view that the photographs taken around 9 July 2017 were consistent with normal treatment. Therefore, the only explanation for the scars could be either 'some form of secondary event like infection, or a patient doing something to the wounds, or a subsequent treatment'. He disagreed that the loss of ink could be removed in the sloughing off process, as sloughing off was usually confined to the epidermis, whereas the whole skin comes off with a full thickness burn (likening it to a terminator movie where you would see the person's fat and muscle). He maintained that the burns would have been apparent five days after treatment, and said that a thermal burn peaks at 24 hours.

56 Under further questioning from his Honour, Mr Holten explained that a by-product of the process of breaking up the ink (via the laser) was heat which is generated where the ink was (which is one to three millimetres under the skin).

Therefore, one of the reasons for multiple treatments was that you cannot get to the very bottom layer of the ink in one go. However, he accepted that 'part of the reason' was also that too much energy would be required. He also accepted that it was heat which caused the pain.

Photographs

57 The respondent took around 40 photographs of her forearms in the period both prior to, and following, her treatment at the CDC Clinic, which were produced as evidence during the trial. His Honour provided a description of these photographs in Annexure 1 to his Reasons.

58 The great majority of the photographs were taken at the time of the MMC admission. For example, photograph A1 was a photograph of the left arm wing tattoo taken at MMC on 9 July 2017. Dr Rish was asked whether the respondent's arm would have appeared as it does in this photograph if it was treated in accordance with the parameters recorded in Ms Clow's consultation note, to which he responded 'no'. He further stated that, based on what he saw in photograph A1 (along with photograph A2), he 'would be worried that this is most likely to cause a scar', and was 'not surprised' it had turned out like that. He accepted that there could be significant differences in appearance from the photography, depending on the angle. In relation to photograph A1, however, he stated 'nobody would say that doesn't look terrible'. Mr Holten stated that based on the poor quality of the photograph, he was unable to answer whether photograph A1 was consistent with normal healing.

59 Photograph A2 was taken on 9 July 2017 'or earlier', possibly prior to the attendance at MMC. Dr Rish described this photograph as 'horrendous', and as showing evidence of a 'full thickness burn'. He further observed 'exudate', and said that 'the whole thing looks like it's badly burnt'. He stated that, based on his experience conducting more than 9,000 treatments, what he saw in photographs A1 and A2 was 'not normal'. Mr Holten was also asked whether he thought photograph

A2 was consistent with normal healing, to which he responded that he 'would have some levels of concern', but again could not make an accurate statement based on the poor quality of the photograph.

60 Photograph A12 was a photograph of the left arm wing tattoo in the first two weeks after treatment (same as B1, B20, and B21). Dr Rish stated that this photograph showed evidence of a 'full thickness burn' that had 'gone right through the dermis.' He said that, in order to get the damage seen in photographs A1, A2 and A12, he expected that the laser machine had been set at 10 joules. When asked if this photograph showed evidence of normal healing, Mr Holten stated that he 'wouldn't be overly concerned', and that he 'would have to keep a close eye on it', but that his opinion was that there was 'no evidence of full thickness burns'. He considered that it was consistent with normal healing post first tattoo removal treatment, and to be expected with a fluency of 4.1 centimetres squared.

61 Having inspected these photographs for ourselves (A1, A2, and A12), they cannot be described as 'normal.' Rather, even allowing for the imperfection of the photographs, they are fairly described as 'horrendous,' consistent with the evidence of Dr Rish.

62 Photographs B25 and B26 (replicated at A24a and A24b; and called the 'colourful T-shirt photographs') were taken in late August or early September 2017. When asked to account for the damage and apparent blister seen in these photographs, Dr Rish stated that the wound might have still not healed underneath that area from the original treatment, but conceded that it was possible that what was seen in these photographs could be consistent with an intervening event. Mr Holten stated that photographs B25 and B26 were evidence of a 'secondary event' because the wound appeared to have been 're-wounded'.

63 Photograph B15 was the last photograph taken in 2017 on 4 December. It shows scarring, but also a large amount of ink removal and, as his Honour observed, an even appearance over the treated area. Dr Rish stated that this photograph showed

what he would expect to see after a deep burn, and that it was evidence of 'excess blood vessels flooding the area' (known as 'hyperaemia'). Mr Holten disagreed, as the hyperaemia described was usually 'well and truly over in normal healing by day ten, day 12', and only if someone has a subsequent infection or subsequent injury would there be a repeat of that hyperaemia.

Reasons

64 Early in his Reasons, his Honour noted that there was a good deal of consensus between the experts about how Q switch lasers perform the task of tattoo removal. It was common ground that a by-product of the breaking up of the ink by the laser is heat and some cellular damage as the particles break up under the influence of the nanosecond bursts of laser energy.[11] In cases of dense black ink tattoos such as were being treated in this case, somewhere between five and seven treatments would be required to remove all the ink.[12]

65 His Honour recorded that the experts were in agreement that for the tattoos the respondent presented with, the first treatment with the Q switch machine set at four joules per centimetres squared, with a spot size of four millimetres, would be an appropriate first treatment,[13] and that if treatment in accordance with those parameters had been applied, burns would not have resulted.[14]

66 After outlining the respondent's evidence, his Honour found that the respondent's account and her credibility were not damaged by cross-examination, and, although her recall of some aspects of what had gone on in the past was demonstrated to be unreliable, it was very clear that she was emotionally disturbed at the time by the state of her arms and, given her background of other influences upon her mental state. He considered that it was unsurprising that there were

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11 Reasons, [24].

12 Ibid [25].

13 Ibid [28].

14 Ibid [29].

variations in her account. However, he noted that much of her account was corroborated by the clear clinical records and the photographs in any event.[15]

67 Significantly, his Honour also stated:

> I accept her evidence that she took no steps to obtain further treatment or to perform any treatment herself upon the scarring on her forearms between the date of treatment and the photographs taken on 4 December 2017, or after that time[16] (the 'no further treatment finding').

68 He also accepted that the respondent was very embarrassed by the appearance she was left with as the scars were very noticeable and uneven in texture and colour.

69 After subsequently summarising the other evidence, his Honour found:

> After reviewing all of the evidence, I am satisfied, on the balance of probabilities, that the condition of the plaintiff's arms resulted from the application of too high a fluence to the black ink tattoos, causing burning of the plaintiff's skin and, ultimately, the scarring so clearly evident on inspection now.[17]

70 In reaching this conclusion, his Honour preferred the expert evidence of Dr Rish to that of Mr Holten where they were at odds.[18] His Honour noted that Dr Rish's evidence had been consistent from the outset, was based upon having himself performed around 9,000 such treatments, and fit well with the observations made and photographs taken following the treatment.[19] More particularly, his Honour stated:

> [Dr Rish's] explanation – in short, that the burn occurs at the level of the ink below the epidermis, and so does not emerge for days when the skin sloughs off – fits with the mechanism of the laser treatment, the plaintiff's report of pain, the recorded observations of redness and swelling in the days before showing itself in the photographs taken at Monash Medical Centre on day 11 after treatment as horrendous burns, and the all-but-complete removal of ink from the treated areas demonstrated in the last of the 2017 photographs – Photograph B-15.[20]

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15 Ibid [50].

16 Ibid.

17 Ibid [132].

18 Ibid [133].

19 Ibid.

20 Ibid.

71 By contrast, his Honour did not accept Mr Holten's analysis, stating that he was 'not an impartial expert and appeared to assume it was his function to attribute legal responsibility'.[21] His Honour stated the following:

> [Dr Holten] began his analysis with the clear statement that this scarring was due to infection. After viewing the photographs, he all but abandoned this hypothesis, as he then stated what was to be seen in the Monash Medical Centre photographs was "normal" for the treatment he believed had been administered, and as it became clear that the plaintiff had been on antibiotic cover since day three after the procedure, he pronounced the photographs taken, perhaps three or four weeks after treatment, as showing normal healing. Further, he rejected Dr Rish's analysis that what was shown in the Monash Medical Centre photographs was sloughing off of the dermis and epidermis, and the ink with it, and staunchly held to the view that some other ink removal procedure must have later occurred. He did not suggest that all the ink in these tattoos could have been removed following a single treatment at the levels described, yet when examining the photographs showing it had all but gone within six months, maintained that it must have been further treated in that time. As to this, when pressed, counsel for the defendant, in the course of submissions, put that the further ink removal must have taken place between December 2017 and the Stapleton photographs, February 2019. Further, Dr Holten's contention that the colourful t-shirt photographs showed further blistering, evidencing further treatment, is difficult to reconcile with the apparently even appearance of the treated area so clearly shown in photograph B-15. If those two small areas of the treated area were further damaged, the damage is not there to be seen at any other time – rather, that appearance seems to fit more closely with differences in the rate at which the scabs fell off, and this is recorded by the general practitioner (9 August 2017 – "left arm … scabs on 2 areas") and is consistent with the explanation Dr Rish offered.[22]

72 His Honour stated that further support for Dr Rish's explanation of the outcome was found in the respondent's account of the way the treatment was administered, noting that her evidence as to this was in the main consistent with a statement made earlier to the HCC to which she was taken in cross-examination and which remained in many other respects unchallenged.[23]

73 In relation to the note made by Ms Clow, his Honour found that, in her absence, and having regard to the very unusual circumstances in which the note was discovered, he was not satisfied that the note was made contemporaneously, or that

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21 Ibid [135].

22 Ibid.

23 Ibid [136].

it accurately recorded the treatment that was administered.[24] He also considered that the evidence as to her level of training was somewhat unconvincing, noting that Ms Thorn was not able to identify any process of testing, and the documents the nurses actually used were nowhere in evidence. If Ms Clow had obtained laser certification and had laser safety officer training accreditation, there was no evidence of this.[25]

74 His Honour noted Mr Holten's view that the only means by which the ink could have been removed was by subsequent treatment (and recognised, again, Mr Holten's departure from his earlier hypothesis about infection).[26] His Honour was, instead, persuaded by Dr Rish's opinion, that one or both of two mechanisms produced the final result:

> The first is that the burn was at such a level in the skin that the skin (and the ink it contained) above it became necrotic and sloughed off. Second, the fluence applied was sufficient, in a single treatment, to break up the full thickness of the black ink in the tattoos into small enough particles so that over the six months or so that separated the treatment from the 4 December 2017 photograph, the macrophages removed the broken up ink.[27]

75 His Honour was also not persuaded to draw any inference from the failure to call the practitioners from the Wantirna Mall Clinic or from MMC, noting that the 'clinical notes are quite clear, and consistent with the many photographs taken at around that time'.[28] In saying this, his Honour observed:

> Whatever might be said about when it was that burns should have been apparent, Dr Rish explained that the burn caused by the laser when it contacts the ink occurs below the surface of the skin and so may not be immediately apparent, but that by day eleven the burn was plain to see, and in any event earlier clinical entries made reference to burns as early as 4 July 2017.[29]

76 His Honour reiterated his finding that the scarring resulted from burns sustained

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24 Ibid [134].

25 Ibid [136].

26 Ibid [137].

27 Ibid.

28 Ibid [138].

29 Ibid.

in the course of the laser treatment, and noted that it was not in contest that this finding established that the applicant's negligence was a cause of the respondent's suffering.[30]

Proposed grounds of appeal

Proposed ground 1

Applicant's submissions

77 The applicant's primary submission was that his Honour's finding that the applicant caused burns to the respondent's skin was not open on the evidence. In oral submissions, counsel for the applicant submitted that none of the treating doctors confirmed a diagnosis of a burn. Counsel also contended that Dr Shvetsova confirmed the absence of a burn five days after the treatment. Ms Thorn also did not observe a burn in her notes. This was despite the evidence of the experts that a burn should have been apparent by this time. The applicant also suggested that, although there may have been references to burns in the doctors' notes, this was consistent with what was being told to the doctors, and did not constitute a diagnosis of burns.

78 The applicant invited this Court to reject the evidence of Dr Rish in favour of Mr Holten. The applicant suggested that Dr Rish's opinion (that there was a full thickness burn) should be rejected for a number of reasons, including that it was based upon poor quality undated photographs almost three years after the treatment, that he did not actually see the respondent, that he was not a burns expert (as compared with Mr Holten), that he worked backwards from the respondent having scars to a conclusion that the treatment was not appropriate, and that he was not impartial. The applicant also contended that his Honour was wrong to characterise Mr Holten as abandoning the infection hypothesis, given that the applicant was still diagnosed with cellulitis on discharge from MMC.

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30 Ibid [139].

79 The applicant also suggested (in oral submissions) that the capacity of the machine to burn was a hypothesis of Dr Rish, and was speculation. The applicant's counsel again attacked the evidence of Dr Rish (who clearly accepted that the machine had capacity to burn), emphasising that he was not a burns expert and had never burnt someone. The applicant's counsel also suggested that Mr Holten contradicted this position.

80 Counsel maintained that there must have been a supervening event, and that it was not for the applicant to prove what the event was. He did however highlight the colourful t-shirt photographs as constituting evidence of further treatment.

81 The applicant made various challenges to the respondent's credibility, including that she had a history of mental illness, that she did not mention her skin 'flickering off' during treatment to the HCC, that she gave inconsistent evidence to that given by Ms Thorn about whether the goggles obscured the respondent's vision during the treatment, and that she denied that the colourful t-shirt photographs showed a blister. The applicant's ultimate submission was that his Honour should not have accepted the respondent's evidence that there was no subsequent self-treatment.

82 By way of conclusion, the applicant submitted that it was 'glaringly improbable' for his Honour to conclude that there was a burn. The applicant submitted that his Honour did not meaningfully engage with a number of matters: the unreliability of the respondent's evidence, the absence of contemporaneous medical evidence of horrendous third-degree burns, the unexplained failure to call treating doctors, the critical question of whether the respondent suffered a burn, the loss of tattoo ink (without numerous treatments), the unreliability of the photographs, and the unreliability of the non-burns expert who was contradicted by the expert burns witness evidence of Mr Holten.

83 The applicant submitted that a finding of too high a fluence causing severe burning was 'glaringly improbable'.

Respondent's submissions

84 The respondent submitted that there was ample evidence to support his Honour's decision.

85 The respondent highlighted the unchallenged photographic evidence which established that, by 13 February 2019, the respondent had significant scarring on both forearms where previously she had tattoos (citing the before and after photographs).

86 Counsel highlighted the respondent's evidence:

(i) about the treatment on 28 June 2017, including that it was very painful, that the laser caused skin to flicker off, and that it caused visible holes to appear in her arms;

(ii) about her medical treatment and development of the wounds in the first few weeks afterwards; and

(iii) that she had no further medical treatment, laser treatment, or cosmetic treatment in relation to those areas, nor was any specific act or occurrence said to constitute such an intervention put to the respondent.

87 The respondent also highlighted that there was no other evidence of any intervening or secondary event of the type suggested by the applicant. Such an event was therefore mere conjecture.

88 In oral submissions, the respondent's counsel highlighted that there were four bodies of evidence his Honour relied on in making his decision: the respondent's own evidence, the clinical records, the photographs, and the expert reports.

89 The respondent contended that his Honour accepted the respondent's account on the basis that the respondent's credibility was not damaged by cross-examination, any variations in her account were unsurprising in the circumstances, and much of her account was corroborated by the clinical records and photographs. Furthermore,

his Honour accepted the respondent's evidence that she took no steps to obtain further treatment or to perform any treatment herself. The respondent submitted that, absent any 'glaring improbability' or 'contrary compelling inference', these findings must stand. Further, once the respondent's evidence was accepted as to the absence of subsequent treatment, that was enough to dispose of the application.

90 The respondent submitted that a review of the evidence strongly supports the findings made in any event. This included the evidence of Dr Rish based on the photographs, as well as the clinical notes.

91 There was a disagreement between the experts regarding the cause of the respondent's scarring. However, his Honour was correct to prefer Dr Rish to Mr Holten on the bases he gave. In doing so, his Honour relied in part on his impression of the witnesses giving evidence, and on inferences from other primary facts such as photographs. The respondent submitted that, in the absence of anything glaringly improbable or compelling to the contrary, these findings should not be disturbed.

92 The respondent highlighted that Dr Rish's view was based on extensive experience in performing 9,000 laser treatments, was consistent with observations and photographs following the treatment, and was consistent with other evidence. This was contrasted with the change in the approach of Mr Holten. While initially suggesting that the respondent's scarring was 'quite clearly' caused by infection, Mr Holten's hypothesis later became one of an unspecified 'secondary event.' There was no support in the evidence for an intervening or secondary event.

93 The respondent submitted that the failure on the part of other witnesses called by the applicant to record or notice the presence of burns on 3 July 2017 (Dr Shvetsova and Ms Thorn) was immaterial. His Honour correctly accepted Dr Rish's explanation of the evolving nature of the burns. In any event, some six days after the laser treatment, the respondent was taken by ambulance to MMC for treatment of injuries to her arms consistent with serious burns.

Analysis

94 Although this Court is bound to conduct a real review of the evidence, restraint is appropriate where a trial judge has made factual findings which are likely to have been affected by impressions about the credibility or reliability of witnesses as a result of seeing and hearing them give their evidence. In such a case, there should not be interference unless those findings are 'glaringly improbable,' 'contrary to compelling inferences,'[31] or demonstrably wrong by reason of 'incontrovertible facts.'[32]

95 The applicant did not seek to challenge the application of these principles, which have significance in this case. Thus, the critical finding that the scarring resulted from the laser treatment turned on an assessment of an array of oral evidence, including that of the respondent. More particularly, unless the applicant can impugn the 'no further treatment' finding, it cannot maintain its hypothesis (based on Mr Holten's evidence) that there was some supervening event.

96 We are not satisfied that any of his Honour's findings were made in error. They were certainly not 'glaringly improbable.'

97 Dealing first with the respondent's evidence, his Honour's reasons evidence a clear engagement with that evidence. Thus, he acknowledged that some aspects of the respondent's account were unreliable, as well as her mental state. Despite this, he considered that her account and credibility was not damaged by cross-examination. He also expressly accepted that she undertook no further treatment. His Honour had the advantage of seeing and hearing the respondent give her evidence over some three days, and there is no 'glaring improbability' about his acceptance of her account. To the contrary, his findings were consistent with the other evidence in the case, including the clinical records and photographs (as his Honour correctly noted).

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31 *Lee v Lee* (2019) 266 CLR 129, 148–9 [55] (Bell, Gageler, Nettle and Edelman JJ); [2019] HCA 28.

32 *Robinson Helicopter Co Inc v McDermott* (2016) 90 ALJR 679, 686–7 [43] (French CJ, Bell, Keane, Nettle and Gordon JJ); [2016] HCA 22.

98 In terms of the clinical records, they clearly evidence a pattern of attendance and connection with the events of 28 June 2017, consistent with the respondent's account. As his Honour highlighted, they fit in with the respondent's reports of pain, and record the appearance of redness and swelling shortly after the treatment. Critical, too, is the absence of any record of any subsequent attendance or treatment which would suggest a 'supervening event.' For the reasons given below, there was also no need to call the array of doctors who treated the respondent (as his Honour found), given that the records largely speak for themselves.

99 The main complaint made about the clinical records concerned the absence of a formal diagnosis that there was a burn. In particular, it was suggested that Dr Shvetsova 'confirmed' the absence of a burn. However, first, Dr Shvetsova did not 'confirm' the absence of a burn, she merely made no reference to a burn. Secondly, the records were consistent with the evolving nature of a burn (which occurs below the epidermis) as explained by Dr Rish, and accepted by his Honour. Finally, and most importantly, even if a burn should be readily apparent shortly after it is experienced, the notes contained numerous references to 'burns' from as early as 4 July 2017 (as well as on 8 July, 9 July, and 10 July 2017). The suggestion that these references reflected statements made by the respondent herself is without merit. It can hardly be supposed that Dr Baria (for example) would write a referral letter referring to 'possibly full thickness burns' solely on the word of his patient, rather than based on his own professional judgment.

100 It terms of the photographs, they do vary in quality, consistent with the circumstances in which they were taken. However, his Honour's description that they show 'horrendous burns' (at the time of the admission to MMC) is entirely justifiable.

101 The applicant's complaint about the experts was tantamount to a suggestion that we should prefer the evidence of Mr Holten over that of Dr Rish. This is not a proper basis for complaint where his Honour's preference was again liable to be affected by his assessment of both experts in the witness box. His Honour also gave

many cogent reasons for preferring Dr Rish. These included that his views were consistent, he had performed 9,000 such treatments, and his views fitted with the clinical observations and photographs. This was compared with Mr Holten, who was not impartial, and altered his view about the cause of the scarring.

102 There is no error in this approach. Thus, although Dr Rish may have made one gratuitous statement,[33] he was otherwise measured, consistent, and ready to make appropriate concessions. His expertise was not the subject of challenge, consistent with the fact that the central question in this case concerned the operation of a laser machine. This may be compared with Mr Holten, who had a substantial interest in laser clinics (he owned four clinics), and made some strongly adverse statements about the respondent. It was also fair to describe Mr Holten as abandoning his earlier infection hypothesis (as his Honour did).[34] Mr Holten's oral evidence may have allowed for the possibility of an (unidentified) subsequent infection. However, he plainly altered his initial, unqualified, view that the infection 'clearly caused' the scarring, to a position that there was no infection in early July 2019,[35] but that there 'must have been' a (capitalised, unidentified) 'secondary event.'

103 As well as the matters identified by his Honour, Mr Holten's hypothesis (that there was another event) cannot be accepted given the critical no further treatment finding. Mr Holten's evidence was also problematic given that he relied so heavily on the note of Ms Clow. This included the setting applied during the treatment (4.2 joules), and the fact that the respondent's account of pain was not recorded. Neither of these matters can be relied upon given that his Honour found that the note was neither accurate nor contemporaneous.

104 His Honour therefore amply engaged with the expert evidence, and made no error in preferring the evidence of Dr Rish. That evidence importantly included the

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33 In his first report he said that he believed the patient 'deserves compensation for her injuries and self-esteem' via the insurance cover held by the treating doctor and nurse.

34 See Reasons, [137].

35 This was consistent with the MMC records which showed a normal white blood cell count, and therefore no ongoing systemic infection (notwithstanding the cellulitis).

formal burns diagnosis (which the applicant said is missing). It also included the evidence that properly administered laser treatment would not break the skin, and that the skin would not appear to be affected one week after treatment. This can then be compared with the photographs which show terrible damage, as Dr Rish stated. As his Honour identified, the evidence of Dr Rish also explained the fact that nearly all of the ink was ultimately removed (even though there was no subsequent treatment).[36]

105 It remains to deal with the applicant's oral submission that the laser machine lacked the capacity to cause a burn (which did not appear to have been raised before his Honour). However, the expert accepted by his Honour, Dr Rish, clearly accepted that the machine was capable of, and did, cause the burn. The applicant's counsel at various stages suggested that Mr Holten disagreed with this position. Even if this was so, this does not assist the applicant given Dr Rish's account was accepted. In any event, counsel was unable to identify any clear statement from Mr Holten that there was no such capacity. He did say that you 'hardly ever' see burns with laser machines. However, (as was ultimately conceded by counsel) this did not mean that the machine could never cause a burn.

106 Overall, then, his Honour actively and carefully engaged with each of the matters the applicant complained about, including the respondent's evidence, the contemporaneous medical evidence, the photographs, and the expert evidence. More particularly, the applicant has not demonstrated that his Honour made any error by finding that the scarring was caused by burns sustained during the laser treatment. Nor was the critical 'no further treatment finding' affected by error.

107 To the contrary, his Honour's findings were clearly open to his Honour, and certainly not glaringly improbable.

108 Proposed ground 1 cannot succeed.

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[36] Reasons, [137].

Proposed ground 2

109 The applicant submitted that his Honour erred in failing to draw an adverse inference from the respondent's failure to call any of the contemporaneous treating doctors from the Wantirna Mall Clinic or from MMC to provide evidence on the existence of a burn, given that it was a critical issue in this case. The applicant submitted that the failure to produce medical reports from any of the many available doctors should have resulted in an adverse inference that the doctors' evidence would not have supported the respondent's case that she sustained a burn.

110 In oral submissions, the applicant confirmed that the adverse inference sought was that the treating doctors would not have assisted the respondent in establishing a burn. Counsel specifically identified Dr Sous and Dr Baria as two such doctors.

111 The inference the court was invited to draw is commonly referred to as the *Jones v Dunkel* inference.[37] Thus, the unexplained failure to call a witness *may* in appropriate circumstances give rise to a number of possible inferences,[38] including that sought by the applicant, ie that the uncalled evidence would not have assisted the party that failed to call the witness. The inference is that the evidence would not assist, not that it, in itself, would be adverse or unfavourable to the party's case.[39]

112 His Honour considered whether to draw the inference sought, and determined not to do so, given that the clinical notes were quite clear and consistent with the photographic evidence.

113 There was no error in this approach. Thus, the drawing of the inference was a matter for his Honour to decide, and his approach was perfectly explicable in circumstances where the objective contemporaneous evidence was liable to be more reliable than the memories of busy doctors about events which occurred some years

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37 *Jones v Dunkel* (1959) 101 CLR 298 (Kitto, Menzies and Windeyer JJ (Dixon CJ and Taylor J dissenting)); [1959] HCA 8 ('*Jones v Dunkel*').

38 See *Cargill Australia Ltd v Viterra Malt Pty Ltd (No 28)* [2022] VSC 13, [1989] (Elliott J), as to the other possible inferences.

39 Ibid [1989] footnote [1147].

before.

114 In any event, the applicant was unable to demonstrate any relevant consequence which would follow from the drawing of the inference sought such as would advance its case. As noted above, the rule does not permit an inference that the untendered evidence would in fact have been damaging – for example, that Dr Akhtar would withdraw her opinion that the respondent had 'second degree burns', or that Dr Baria would alter his finding of a possible 'full thickness burn.'

115 His Honour therefore made no error in failing to draw the inference sought, and proposed ground 2 is without merit.

Proposed ground 3

116 The applicant submitted that his Honour erred in rejecting the contemporaneous note of Ms Clow, without any evidential basis, and after admitting it into evidence on a voir dire. The applicant submitted that his Honour provided no explanation for his rejection of this critical evidence.

117 The applicant made extensive reference to the circumstances in which the note was admitted as a business record following the voir dire. The applicant also highlighted that the absence of Ms Clow as a witness was quite properly not the subject of any adverse finding or comment against the applicant.

118 The applicant submitted that his Honour's finding that the note was not made contemporaneously and was not accurate was not only without any evidential basis, it was contrary to his Honour's finding to admit the note as a business record on the voir dire.

119 In oral submissions, counsel emphasised that the applicant always intended to call Ms Clow, and that no criticism was made of the failure to call her. He suggested that her late withdrawal meant that it was too late to obtain a subpoena, but accepted that he did not apply for an adjournment. He again emphasised that the voir dire

determined the authenticity of the document as a business record (during which time the respondent was given opportunity to take the matter further) and that, once it was admitted, it needed to be given weight given how significant it was.

120 We accept the respondent's submission that the applicant's complaints under this ground are misconceived, and presume that any evidence which is admitted must ultimately be accepted (even where there is conflicting evidence).

121 We also accept the respondent's submission that there was a 'massive hole' in the evidence given that the maker of the note was not called to give evidence. Thus, Ms Clow was the only person, other than the respondent, who could give direct evidence about what happened during the laser treatment. His Honour was clearly entitled to take into account the 'absence of Ms Clow' in considering whether to reject the accuracy of the note, and prefer the direct evidence of the respondent (as he did).

122 There was also other evidence which cast doubt over the accuracy and contemporaneity of the note, including whether the setting was entered contemporaneously with the time the setting was fixed, whether the level of supervision was accurately recorded, and even the level of training received by Ms Clow. These matters provided additional grounds on which his Honour was entitled to reject the note.

123 In all the circumstances, his Honour made no error in rejecting Ms Clow's note, and proposed ground 3 is also without merit.

Conclusion

124 Leave to appeal will be refused.
